

*VAN DIE REDAKSIE*

*EDITORIAL*

## Darrell Combrink

Daar is nie baie sulkes nie. Ons gaan daardie groot man wat gebukkend by 'n gewone deur moes instap, nog lank mis. Iedereen wat saam met hom in vergaderings gesit het, het gereeld met plesier kon deel in sy ongeëwenaarde vermoë om die denkrigting van die lede van 'n komitee te voorspel en op te som. Hy was selde verkeerd. Sy kennis en ervaring, maar veral sy insig, is nie maklik verplaasbaar nie.

Kop onderstebo, skynbaar aan die slaap, meestal met 'n koerant voor hom oopgesprei—so het ons hom geken. Net die gloei-gloei van sy sigaret het getoon dat hy helderwakker na die besprekings luister, en gereed was om te keer as een of ander lid, of selfs die voorsitter, op 'n dwaalspoor raak wat bots met vorige besluite. Want daarin het sy sterkte gelê: 'n byna ensiklopediese geheue insake die Mediese Vereniging, en trouens alle sake rakende die beroep. Met sagte stem—soms selfs byna onhoorbaar—het hy dan die agtergrond geskets, om daarna terug te sink in sy skynbaar vol-

kome ongeërgdheid met wat daar in die vergadering aangaan.

Gedurende middagetes onthou ons hom. Bier in die hand en een voet op 'n stoel, want sy lengte het verseker dat so 'n voetrus met gemak gebruik kon word. Menige komiteelid het gedurende hierdie middagetes aan die hand van Darrel se kennis besef dat hy sy denkrigting sal moet verander om nie tromp-op met Vereniging beleid te bots nie.

Soos met alle mense wat groot van gees en van gestalte is, het Darrell Combrink se saggeardheid telkens na vore gekom. Sentimentalis was hy nooit nie, maar wanneer hy met meegevoel 'n pragmatiese vleuel oor 'n vriend en kollega uitgestrek het, was dit nie 'n leë gebaar nie. Bloot sy grootte het 'n gevoel van beskerming verseker.

Ons kan hom nooit verplaas nie—ons kan net hoop dat daar meer sulkes in die toekoms ons beroep sal verryk. So stil soos hy gekom het, het hy gegaan, maar ons sal hom lank onthou.

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## Fibre-optic Endoscopy

Fibre-optic endoscopy is possibly one of the major advances in the field of digestive diseases, as amply shown in the article by Novis *et al.*<sup>1</sup> in this issue. It remains, however, a method of investigation which is complimentary to, and not exclusive of, radiology. Radiology is a well-established speciality in this country and barium studies of the bowel are quick

and safe procedures which will detect about 80% of all lesions. On the other hand, the value of fibre-optic endoscopy in the diagnosis and efficient management of gastro-intestinal complaints has been reported on numerous occasions.<sup>2-4</sup> Oesophagoscopy enables a positive diagnosis of reflux oesophagitis to be made, carcinomas can readily be

seen and a biopsy specimen taken for histological confirmation. A patient with a barium negative dyspepsia may at endoscopy be found to have a gastric or duodenal ulcer or an early carcinoma. If a gastric ulcer is to be treated medically it should be inspected endoscopically and a biopsy done to exclude unexpected malignancy. Doubtful radiological appearances should be assessed endoscopically, particularly before surgery is contemplated. Urgent endoscopy in cases of upper gastro-intestinal haemorrhage, once the patient has been resuscitated, may help in the selection of patients for early operation. Endoscopy is particularly useful in patients with recurrent symptoms after gastric surgery. Colonoscopy may also be extremely useful in cases where a barium enema shows a doubtful lesion or in patients with rectal bleeding and a normal barium enema.<sup>5</sup> Finally, endoscopic retrograde cholangiopancreatography is a useful procedure in the diagnosis of difficult cases of obstructive jaundice and pancreatic disease.

In South Africa all the teaching hospital centres and many of the large non-teaching hospitals should be equipped to carry out gastro-intestinal endoscopy, as should specially-trained physicians in private practice. A basic set of endoscopy instruments should include a forward-viewing instrument for inspecting the oesophagus, stomach and duodenal cap and a side-viewing instrument for use in the stomach and/or duodenum. A colonoscope will be required for large bowel endoscopy.

With regard to the question of who should perform gastro-intestinal endoscopy, it seems logical that this technique should only be carried out by specialist physicians and surgeons with a special training in gastro-enterology. As endoscopy is only one aspect of a gastro-intestinal examination and investigation, there is no place for the occasional endoscopist who does not have a special knowledge of digestive diseases, just as there would be no place for a surgeon without special training in urology performing cystoscopies, or a physician without a cardiological training inserting pace-makers. Supporting staff are essential to the performance of safe and rapid endoscopy and a trained nurse or junior hospital doctor are the ideal people to fill this need. With the introduction of flexible fibrescopes the hazards of gastro-intestinal endoscopy have diminished. Yet it is worth while to note the incidence of complications reported in the literature: perforation 1:800; haemorrhage

1:3 000; aspiration pneumonia 1:1 000; cardiovascular and respiratory collapse 1:4 000. Other complications 1:2 000. The over-all incidence of complications is thus 1 in 300 with 1 in 4 000 deaths.

This recent development of fully flexible fibre-optic instruments for examining the gastro-intestinal tract has understandably led to a rapidly expanding interest in this mode of investigation. The British Society for Digestive Endoscopy has recently published a memorandum on the 'Future National Needs for Fibre-Optic Endoscopy of the Gastro-intestinal Tract',<sup>6</sup> in which many of the problems in this field are discussed, particularly the training necessary before this procedure should be undertaken.

The training and teaching of endoscopy in this country, as in most other countries, has been rather haphazard, many endoscopists learning by trial and error, to the disadvantage of their patients. All units practising endoscopy at teaching hospitals should be expected to carry out training or teaching. Registrars in medicine and surgery who have an interest in gastro-intestinal diseases should be encouraged to learn endoscopy during their 4-year specialist training period, so that they should be sufficiently well trained in the technique to be able to perform endoscopies in the peripheral areas once they leave their teaching hospitals. Those wishing to learn gastro-intestinal endoscopy should be prepared (if not impelled) to spend at least 3 months in an active endoscopy unit so that they should have performed at least 200 - 300 examinations under supervision before venturing out on their own. The practice of spending one or two mornings watching and perhaps performing half a dozen examinations is totally inadequate, and certainly no urologist or thoracic surgeon with that amount of training would do cystoscopies or bronchoscopies. An extremely valuable and diagnostically rewarding procedure should not be brought into disrepute by being undertaken by untrained personnel. As with all other procedures in medicine, gastro-intestinal endoscopy is a technique that requires special training, experience and extreme care.

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2. Morrsey, J. F. (1972): *Gastroenterology*, **62**, 1241.
3. Cotton, P. B. (1973): *Brit. Med. J.*, **1**, 161.
4. Brom, B., Bank, S., Marks, I. N. and Rubinstein, Z. (1969): *S. Afr. Med. J.*, **43**, 1549.
5. Williams, C. and Muto, T. (1972): *Brit. Med. J.*, **3**, 278.
6. Memorandum on Future National Needs for Fiberoptic Endoscopy of the Gastrointestinal Tract (1973): Published by British Society for Digestive Endoscopy.