

Bronchoscopy: Past and present

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Dr Shigeto Ikeda introduced the flexible bronchoscope in 1968. Dr Ko Pen Wang introduced biopsy forceps and transbronchial needle aspiration through the flexible scope a decade later which significantly decreased the numbers of thoracotomies for diagnosis. EBUS technology was introduced in 1990s but has really taken off in the last decade. It has replaced mediastinoscopy for lymph node assessment and staging. It is a same day procedure and leaves no scarring. Patients can leave the hospital same day and the results are available in 3-4 days. EMN has made possible tissue sampling of more peripheral nodules/masses. With the approval of CT screening in smokers, we are encountering patients with lung nodules and masses quite commonly in our offices and having these tools at our disposal is a plus.

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More and more centers are also adopting bronchoscopic techniques for obstructive airway disease. Bronchial thermoplasty is increasingly used for refractory severe persistent asthma and has been shown to reduce exacerbations and hospitalizations. Similarly, bronchoscopic lung volume reduction through bronchial valves has a role for severe COPD especially in upper lobe predominant disease.

Pleural procedures like thoracentesis, medical pleuroscopy and indwelling pleural catheters for recurrent effusions are also increasingly being done. The indications for the indwelling pleural catheters are expanding and include malignancy and even refractory CHF.

The future of this sub specialty is exciting. In the next decade, we should see some other investigational techniques getting approval and widespread use including confocal bronchoscopy, virtual bronchoscopic navigation, 3-D printable bronchial stents and tracheal transplantation.

Education through seminars, workshops and outreach should be provided to spread the awareness about the field.