

## It is time for Otolaryngologists to perform EGD

The American Society for Gastrointestinal Endoscopy considers dysphagia and reflux disease that fails to respond to medical therapy indications for esophagogastroduodenoscopy (EGD). So do the Centers for Medicare & Medicaid Services, the American Academy of Family Physicians, the American College of Physicians, the Society of American Gastrointestinal Endoscopic Surgeons, and the American College of Gastroenterology. It is time for the official organs of Otolaryngology to recommend EGD as our procedure of choice, as well, and to incorporate appropriate instruction into our educational programs.

As every physician knows, the field of medicine and each of the various specialties are endlessly evolving, generally expanding their scope as technology and knowledge increase. Over the past decade, Otolaryngology has become very involved in evaluating and treating acid reflux disease and dysphagia. Our specialty's involvement in acid reflux disease has become so prominent that a new subset of this condition has emerged, known as *laryngopharyngeal reflux* (LPR). Its symptoms include frequent throat clearing, globus, hoarseness, chronic cough, dysphagia, and others. Every major society or academy involved in GI Endoscopy considers extraesophageal symptoms of acid reflux and dysphagia indications for EGD. In my own practice, I frequently see patients for acid-reflux-related symptoms and dysphagia and recommend laryngoscopy and esophagoscopy if medical management fails. This, however, is an incomplete evaluation, for they should undergo laryngoscopy *and* EGD (not just esophagoscopy). To examine only the esophagus and larynx, for example, means I may miss a gastric tumor or duodenal ulcer. The other option is to put patients through two procedures, meaning I examine the larynx only or the esophagus and send them elsewhere for examination of the stomach and duodenum. This, of course, is inefficient and costly. It is for this reason that I decided that I could best serve my patients by performing EGD myself.

Performing EGD is not terribly difficult but does require instruction and practice. For physicians already comfortable in performing flexible or rigid esophagoscopy, EGD

is a natural extension of what we already do. As Head and Neck Surgeons perform a variety of complex, high-risk procedures, the addition of EGD is not a wide stretch. Certainly, those Otolaryngology centers and individuals performing percutaneous placement of feeding gastrostomy tubes are fully equipped to complete the process by teaching and performing EGD. If placement of feeding tubes by Otolaryngologists (a far more invasive procedure than EGD) is becoming mainstream, there is no reason EGD should not be, as well. Furthermore, the Otolaryngology literature abounds with reports on transnasal esophagoscopy (TNE). Why stop at the esophagus, an artificial boundary, especially when TNE protocols often include entry into the stomach? The proper procedure according to other specialists would be EGD. This is not to say that there is something wrong with performing TNE, but it is not a complete upper GI exam. Although TNE may be preferred at times, it seems reasonable that performing EGD should also become part of the armamentarium of the Otolaryngologist when a comprehensive exam is needed, especially since "ultraslim," flexible upper GI scopes that allow for office-based, nonsedated transnasal EGD are available.

The problem is not so much learning about upper GI pathology, proper indications, or gaining expertise in performing EGD. There are many courses, CD-ROMs, and Internet resources that provide introductory information on EGD. Adequate in-depth training, including time spent with an experienced Endoscopist, is critical and should be arranged.

The real issue is confronting ingrained stereotypes about the limits of our specialty (both within Otolaryngology and without). When I began the process of obtaining privileges for EGD, a number of local physicians objected. I naturally sought backing from the Academy. I was surprised to find that *virtually* no one in Otolaryngology was doing this procedure. I was advised to speak with Dr. Robert Sataloff, who chairs the Academy's Speech, Voice, and Swallowing Committee. He, too, was unable to offer an official endorsement but subsequently invited me to write this editorial.

Without formal backing from my Academy, I submitted my case in favor of Otolaryngologists performing EGD to my non-Otolaryngology peers on credentials.

The arguments are perhaps worth reviewing. I produced examples in the literature of our specialty's involvement in the management and treatment of reflux disease and dysphagia. I included articles regarding placement of feeding tubes by Otolaryngologists, a far more invasive procedure than EGD. I emphasized that reflux and dysphagia were indications for EGD based on the recommendations of all major academies and societies involved in GI Endoscopy. I reminded them that I was already credentialed for esophagoscopy. Furthermore, as a surgeon, I would likely have the technical capacity to master this procedure, particularly in light of the many nonsurgeons who were already performing it. I provided evidence of additional training taken for this procedure and my willingness to be proctored before full privileges were granted. Mainly, however, I sought to contest the old stereotypes of ENT being a specialty limited to the head and neck. In the end, despite some objections, I was granted probationary privileges, with full privileges pending successful completion of 50 proctored EGDs and 25 hours of CME on Upper GI Pathology.

For those Otolaryngologists concerned about "ruffling feathers," particularly those of our GI colleagues, it is worth remembering that some friction has accompanied many advances in our field, including Head and Neck Cancer Surgery, Facial Plastic Surgery, Cleft Palate Surgery, Allergy Management, and others. If a turf battle were to ensue over EGD, we should prevail there, too, in the interest of efficient patient care. Difficult cases can be referred (as for any unexpected finding), but the average Otolaryngologist should be able to master EGD. The key will be for Otolaryngology to recognize the need to perform this procedure, to teach it in our residency programs and offer courses in it, and for the Academy to back those of us who, with proper training, may want to offer EGD to our patients.

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