Editorial

Falk Symposium 177, 'Intestinal Disease Meeting', was recently held in Berlin. These congresses have been running quite successfully for the last 10 years. As part of the symposium, there was one day of live demonstrations from world-renowned experts, who demonstrated the entire spectrum of GI-endoscopy. In addition to this highlight, there were also lectures providing updates on upper GI-endoscopy, biliary endoscopy and pancreatic diseases.

Over the last few years, biliary endoscopy has seen the development of several new diagnostic and therapeutic techniques, including direct diagnostic imaging, tissue sampling, early diagnosis and palliation of biliary tumors, and management of 'indeterminate biliary strictures', as well as of difficult biliary stones, which G. Costamagna and colleagues describe in this issue. Additionally, a special topic is presented by D. Gotthardt and colleagues which deals with the difficult diagnostic and therapeutic problems in the management of primary sclerosing cholangitis.

J. Mössner gives a brief overview on the physiology of the exocrine pancreas in order to gain a better understanding of the pathophysiology of both acute and chronic pancreatitis followed by a brief overview of the German S3-guidelines regarding diagnosis and treatment of chronic pancreatitis, which have not previously been published.

The second day of the congress was devoted to the latest advancements in small-bowel and colorectal endoscopy, including inflammatory bowel disease and colorectal cancer. The past decade has seen several advances in small bowel endoscopic technologies: capsule endoscopy

allows direct endoscopic mucosal examination of the small intestine without operation, and balloon enteroscopy and spiral endoscopy offer therapeutic capabilities. However, radiological small bowel imaging is considered as the primary imaging approach to diagnose pathological changes of the small bowel in many situations (A.G. Schreyer and C. Stroszczyński). Video capsule endoscopy is superior to all other modalities for the diagnosis of small bowel lesions in nonstricturing Crohn's disease. D. Hartmann provides a paper on how the chance to get earlier diagnoses of Crohn's disease by capsule endoscopy and documenting the mucosal healing with it will influence its management in the future, but concludes that this is still an open question.

I. Jovanovic and colleagues give us a critical overview about therapeutic double-balloon enteroscopy from a binational, three-center experience.

Patients with long-standing ulcerative pancolitis and extensive Crohn's disease colitis have an increased risk for the development of intraepithelial neoplasia and colorectal cancer. However, ulcerative colitis-associated neoplasia is difficult to visualize as it mainly develops in inconspicuous mucosa resembling inflamed tissue. Surveillance colonoscopy with multiple biopsies of apparently normal tissue in addition to targeted biopsies of suspect lesions is therefore recommended. D.C. Baumgart answers the question: 'Who needs what and when?'

M. Goetz discusses whether new technologies like chromoendoscopy, virtual chromoendoscopy, confocal laser endomicroscopy or endocytoscopy can help us to reduce the number of biopsies.

New colonoscopes, colon capsule and techniques like endoscopic microscopy are used in daily practice, scientific research for cancer screening, routine investigations and therapeutic procedures in the colon. The future indications for confocal laser endomicroscopy could be differentiating neoplastic from inflammatory changes in screening for dysplasia in ulcerative colitis or in vivo molecular imaging (R. Bisschops).

J.F. Riemann provides insightful information about the significant progress that has been made in introducing population-based screening programs for colorectal cancer in Europe. He stresses that endoscopy-based programs do afford quality insurance programs which are outlined in recommendations of European commissions.

C. Pox compares genetic stool tests, guaiac-based (gFOBT) and immunochemical (iFOBT) stool tests for colorectal cancer screening.

Finally, colorectal cancers missed during colonoscopy is a problem of particular concern. S. Faiss analyzes the reasons and recommends performing colonoscopy after an optimal bowel preparation in an 'optimal setting' by an experienced endoscopist followed by an adequate histological work-up.

We believe that the selected topics published in this issue of *Digestive Diseases* will help us to improve the management of intestinal diseases.

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