Richard Whyte: who should be doing advanced bronchoscopy?

Received: 10 June 2018; Accepted: 03 July 2018; Published: 24 July 2018.
doi: 10.21037/aoe.2018.07.01
View this article at: http://dx.doi.org/10.21037/aoe.2018.07.01

Expert introduction

Richard Whyte, MD, MBA, is the vice chair of surgery at Beth Israel Deaconess Medical Center and a professor of surgery at Harvard Medical School. Richard received his BS in chemistry, his MD from the University of Pittsburgh, and MBA from the Wharton School at the University of Pennsylvania. His main clinical interests focus on thoracic malignancies such as lung cancer, esophageal cancer, and mediastinal tumors such as thymoma).

Figure 1 Photo with Prof. Richard Whyte.

Editor's notes

The 26th Meeting of the European Society of Thoracic Surgeons was held during May 27–30, 2018 in Ljubljana, Slovenia. Gathering experts all over the world, the conference devoted much attention to thoracic diseases and covered dozens of international academic researches.

During the conference, Prof. Richard Whyte, from Beth Israel Deaconess Medical Center, deeply impressed attendees with his presentation titled "Who should be doing advanced bronchoscopy?" Taking this opportunity, the Editorial Office of *Annals of Esophagus* was honored to do an interview with Prof. Whyte and invited him to share his opinions regarding the field of advanced bronchoscopy (*Figure 1*).

Interview

AOE: You will give a presentation on the topic "Who should be doing interventional bronchoscopy?" Would you like to tell us who should be doing it? And why?

Prof. Whyte: I did phrase the question that who should do interventional pulmonology or bronchoscopy but I think advanced bronchoscopy is a better term because it doesn't make any distinction between who does it, a pulmonologist or a thoracic surgeon. But I think either type of specialist can do those procedures and it depends on the individual institution where one is practicing. At my institution, the Beth Israel Deaconess Medical Center in Boston, we have a well-established program in interventional pulmonology. Our interventional pulmonologists have done training in pulmonary medicine and then advanced bronchoscopy. Other institutions don't have people with that type of training, and thoracic surgeons would be perfect for doing this type of procedure. For example, it fits very nicely with a practice related to lung cancer as it allows surgeons to provide the whole spectrum of care to their patients. So, it's an individual thing. In some places surgeons should be doing it, but in some places, pulmonologists can do it. In fact, I think both pulmonologists and surgeons can do it effectively.

AOE: Would you like to talk something about recent development of interventional bronchoscopy in thoracic oncology?

Prof. Whyte: It's a field that is constantly evolving. When you look at where bronchoscopy began, over a hundred years ago, there was only rigid bronchoscopy and, consequently, only a narrow range of things people could do. Fiberoptic bronchoscopy was developed approximately 50 years ago and the field has developed rapidly since then. In this day and age, with better technology, a better understanding of the biology of lung cancer, and the combining things such as bronchoscopy, navigation

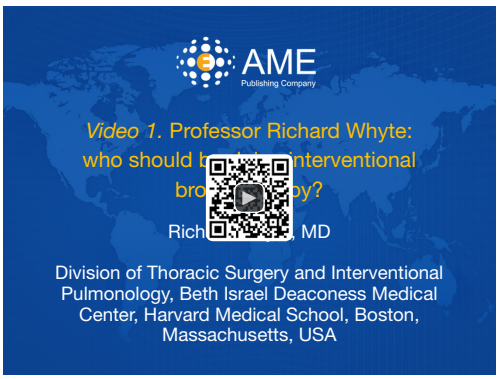

Figure 2 Professor Richard Whyte: who should be doing interventional bronchoscopy? (1).
Available online: http://www.asvide.com/article/view/26035

techniques and CAT scans, there are many different things that are evolving in the field of advanced bronchoscopy. Tumor ablation is one thing; the diagnosis of early stage lung cancers is another. In addition, one thing a procedure we used to do routinely for staging lung cancer, mediastinoscopy, where one makes a small incision in front of the throat to biopsy the lymph nodes, has the number of those operations has dropped dramatically because of the growth of endobronchial ultrasound (EBUS). Therefore, all of these procedures are constantly progressing and the field of advanced bronchoscopy is going to allow surgeons—or whoever does the procedure—to make a diagnosis of lung cancer at earlier stages. Finally, I can see the time these bronchoscopic techniques evolve to a point who can actually treat the tumor rather than just diagnose or provide staging information.

AOE: In your view, what are the challenges for interventional bronchoscopy?

Prof. Whyte: I think there's a number of challenges and one of the challenges is that it's a rapid evolving field so one has to stay up to date in the evolving techniques. Another factor need to be considered is that from a therapeutic side, such as treating the bronchial tumors, some of the equipment gets very expensive so whenever an institution supports an advanced bronchoscopy program, it needs to be prepared to keep up with the evolving technology. Furthermore, because the field is changing so rapidly, it can be difficult for referring physicians to know what's available and what's not. Finally, there are still relatively few people that have all the skills and experience needed to be both an effective practitioner and effective teacher—this makes it difficult to learn some of these techniques.

AOE: Is there a particularly professional achievement you are most proud of in your career so far?

Prof. Whyte: I have been very fortunate in my career to work at outstanding institutions. I trained at the Massachusetts General Hospital, trained and practiced at the University of Michigan, practiced at Stanford University and now I work in Beth Israel Deaconess Medical Center, which is one of the primary Harvard teaching hospitals. I feel I've always been privileged to practice at such excellent institutions so it is difficult to pick out one thing that I am most proud of in that whole 25-year professional career.

AOE: What you would like to do in the upcoming years both in life and in work?

Prof. Whyte: I struggle with that question every day. At the age of 59, I feel that I can still have a lot to contribute to the field of thoracic surgery. There are things that I want to do in my career and I do enjoy my job. While different professional opportunities come up periodically, as I indicated before I've always been able to work in prestigious institutions and it would be difficult to leave an institution like the one where I currently work. There are always advancements which I want to make professionally.

Let's enjoy the video (*Figure 2*)!

Acknowledgments

On behalf of the editorial office of *Annals of Esophagus* (*AOE*), I would like to extend my gratitude to Prof. Whyte for sharing his pearls of wisdom with us.
Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned by the editorial office, *Annals of Esophagus*. The article did not undergo external peer review.

Conflicts of Interest: Both authors have completed the ICMJE uniform disclosure form (available at http://dx.doi.org/10.21037/aoe.2018.07.01). LG and JW report that they are full-time employees of AME Publishing Company (publisher of the journal). The authors have no other conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

doi: 10.21037/aoe.2018.07.01
Cite this article as: Gao L, Wang J. Richard Whyte: who should be doing advanced bronchoscopy? Ann Esophagus 2018;1:4.

References

1. Gao L, Wang J. Professor Richard Whyte: who should be doing interventional bronchoscopy? Asvide 2018;5:634. Available online: http://www.asvide.com/article/view/26035

(Science Editors: Linda Gao, Julia Wang, AOE, aoe@amegroups.com)