Introductory preface for special series: minimally invasive procedures for gastroesophageal reflux disease

Fifteen years ago, as a newly qualified general surgeon with interest in esophagology, I sought to pursue further training in Minimally Invasive Foregut surgery. In what turned out to be a wonderful stroke of good fortune my application to join Dr. Tim Farrell at the University of North Carolina Chapel Hill (UNC) was accepted. Under his tutelage, and that of others, my familiarity with foregut operations developed and my journey into the world of management of gastroesophageal reflux commenced. It was therefore a great honour when I was asked by Dr. Farrell to collaborate as a guest editor for this series on Minimally Invasive Surgery (MIS) for gastroesophageal reflux disease (GERD).

The majority of my training to that point was in open surgery and there was excitement in learning minimally invasive approaches to common gastrointestinal disorders. At UNC, much of my time was applying those MIS techniques to the management of GERD, a common condition affecting up to 20% of the Western World. Surgical outcomes were excellent, with minimal postoperative pain, fewer pulmonary complications and surgical site infections, earlier return to full activity and increased general patient satisfaction. Bariatric surgery also made up a significant proportion of my clinical activity, and the relationship between obesity and GERD was increasingly evident.

The environment in Chapel Hill and the surrounding Research Triangle area was wonderful, with high volume clinical activity and an interesting case mix. Colleagues in the region were at the forefront of exploring novel techniques of Barrett's treatment, the prophylactic use of antireflux surgery to prevent interstitial lung disease, and the use of some of the new meshes for repair of the hiatus.

The more time I spent immersed in the field of GERD management, the more I became aware of areas of uncertainty. Which preoperative investigations are required for antireflux surgery and which commonly performed preoperative studies add only little to the management plan? What degree of fundoplication is superior and does this vary by presenting symptoms, esophageal motility or age? How best to manage GERD in patients with obesity, with the knowledge of higher recurrence rates after fundoplication surgery in the morbidly obese? How best to manage complications and side effect of hiatal surgery, including determinations about the preferred approach to revisional surgery? Where do the new devices and endoscopic treatment fit in the whole scheme of reflux management?

When the opportunity arose to collaborate with Dr. Farrell in putting together this series of *Annals of Esophagus*, I saw this as an opportunity to have these questions, and more, addressed by authorities in the field. I sincerely thank these experts for their contribution to this special series. The combined wealth of experience of these esophagologists is extraordinary. I hope you will find their reviews of the literature, descriptions of their techniques and their sage advice as informative as do I.

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