Foreword

Thierry Ponchon

Bibliography
DOI http://dx.doi.org/10.1055/s-0033-1353687
Endoscopy International Open 2013; 1: 1–1

E-ISSN 2196-9736

Corresponding author:
Prof. Thierry Ponchon
Hospices Civils de Lyon
Hépato-Gastro-Entérologie
place d'Arsonval
Pavillon H
69003 Lyon
France
thierry.ponchon@chu-lyon.fr

Dear colleagues and friends,

It is my great pleasure to be part of this new open access journal and to be joined in this endeavor by my co-editors Vitor Arantes (Brazil), Todd Baron (USA), Mihai Ciocîrlan (Romania), James East (UK), Amit Maydeo (India), Jong H. Moon (Korea), Ichiro Oda (Japan) and Rajvinder Singh (Australia).

The quality of a scientific journal is usually measured by the number and quality of publications and more precisely by the average number of citations to recent articles published in the journal (the so-called impact factor)…

Quality of the publications themselves is judged by the pertinence of the rationale, the quality of the trial design, the power, the quality of follow-up, the quality of the statistical analysis amongst other criteria. The journals *Gastrointestinal Endoscopy, Endoscopy* and *Digestive Endoscopy* are exclusively dedicated to gastrointestinal endoscopy and have a meritorious impact factor, despite the fact that a number of excellent papers in the field of endoscopy are also published in the higher ranked journals of gastroenterology or medicine.

Alongside these journals, there is room for alternative types of publication, more accessible to authors and to readers, at the price the rules of evidence-based medicine. are not totally followed. There are least for 3 reasons for this:

1) digestive endoscopy is a very active field: the number of papers is increasing and the rejection rate of papers in a journal such as *Endoscopy* is very high. When you serve in the editorial team of *Endoscopy,* a natural trend is to rapidly develop a rigorous critical appraisal of the papers. A frequent observation is that the rationale of many papers could interest the readers but that the methodology does not reach the required level. It is frustrating that there is no room for publication of these papers.

2) Unlike other areas of our specialty, such as oncology , inflammatory diseases, and hepatology, digestive endoscopy remains a discipline that cannot easily follow the rules of evidence – based medicine. a) endoscopy is a technical subspecialty, in which young colleagues can express their artistic personalities or their expertise. These same individuals may have not be highly skilled in writing articles or to in promoting or conducting protocols. b) Endoscopy requires time and, above all, energy. However, operators do not necessarily have time or energy at the end of the day to experimental and/or clinical research. c) Innovation is part of day-to-day endoscopy: we certainly do not need the same quality of evaluation if a device is slightly modified as when a new technique has been developed. d) financial support for research in endoscopy, from institutions or from industrial parners, is limited and does not reach the same level as financial support dedicated to develop and evaluate new drugs. e) an endoscopy unit is a complex unit of care involving different types of personnel and the compliance with financial and regulation issues. Management skills are necessary and not always compatible with research skills.

3) Even if prospective studies such as RCTs are regarded as providing the highest level of evidence and then should be promoted, they present a certain number of well-known limitations: a) they are expensive and do not especially aim at cost-cutting. b) the results usually require a long follow-up and are obtained late in the evaluation process of a technique or a device. c) RCTs are helpful when the difference between two procedures being compared is small but are less necessary when the difference is obvious. d) they cannot be applied to all populations (patients with associated diseases, elderly patients). e) the study conditions do not always reflect the real life. f) respective expertise of the operators can easily influence the results and RCT frequently do not take into account clinical expertise and operator expertise. g) RCTs also by principle ignore patients preferences and patient compliance.

I thus was interested in exploring the potential of the open access formula: world-wide spreading and fast publication and to give a chance to certain types of papers or to papers with suboptimal methodology or design, whilst retaining the peer-review process. For example, derivation of guidelines in the real world, measurement of patient acceptability and compliance, how procedures are disseminated, expert opinions, regional or national evaluations on a subject that interest any endoscopist in the world for his routine practice.

I am delighted that everyone pulled together to make this first issue possible in 2013. My thanks go to the authors, to the reviewers and, last but not least to the entire team behind the scenes.

We are planning with four EIO online issues per year and I look forward to presenting the next issue in spring 2014. Please also check our website as the next articles will be published soon.

Sincerely,

Thierry Ponchon, MD
Editor-in-Chief, *Endoscopy International Open*