

## Foreword



Ronald F. Martin, MD  
*Consulting Editor*

To paraphrase my former senior partner in surgery and mentor, Walter B. Goldfarb, MD, in regard to the thought process of surgeons, “Ronnie, if we were cognitive we wouldn’t know what to think.” Despite Dr. Goldfarb’s quick-witted and self-deprecating humor, he is probably one of the most cognitive persons I know. But he does bring up an interesting point on whether surgeons think and how.

I am sure that surgeons think—they think a lot and they think fast—primarily out of necessity. To consider how we think is another matter altogether. In my opinion, the best example of early modern surgical thinking is the evolution of gastric surgery. The leap from structural thinking about anatomic relationships alone to the consideration of structure and function relationships is what allowed for the development of modern gastric surgery—and its near disappearance. The understanding of humoral and neural stimulation of acid production and gastric motor function has set the stage for some of the great careers in surgical history. The further understanding of physiology and pathophysiology has allowed for mechanical alteration of a physiologic process and subsequent pharmacologic modification of acid secretion and treatment of infectious contributors to ulcer disease states. If one were to draw a parallel from physics, this would be roughly equivalent to the change from Newtonian mechanics to Einstein’s theory of relativity.

The development of thought on inflammatory bowel disease may be similar but sufficiently different in some ways. Inflammatory bowel disease treatment primarily relied upon ablative surgical therapy and has long since been of keen interest to surgeons. With the advent of flexible fiber-optic

endoscopy and better pharmacologic agents, the emphasis on primary management of patients who have inflammatory bowel disease has shifted to nonoperative management. As one reads the collection of articles in this issue, one will readily conclude that the level of discourse at this time for these problems is on a molecular level, and that our knives, strings, and staplers are reserved for prevention of neoplastic disease and management of pharmacologic failure in many cases. For a surgeon to think of inflammatory bowel disease with our current level of understanding as a collection of diseases that require only our operative abilities would be to woefully miss the point. One could draw again a rough parallel from physics that the molecular and subcellular approach to inflammatory bowel disease is analogous to quantum mechanics in that we deal with small particles and probabilities to guide our thinking.

As in physics, we in surgery continue to seek a “Grand Unified Theory”—coincidence that it is “GUT” by acronym? you decide—that bridges the gaps between immunologic and molecular management, prophylactic operative management, and ablative management of neoplastic or structural failure.

Dr. Cullen and colleagues have provided us with an outstanding collection of articles that expertly and coherently view the fundamental issue with inflammatory bowel disease from multiple vantage points. This is one collection of clinical problems that truly needs to be understood from the DNA level to the gross anatomic to the human personal level. I thank Dr. Cullen and his cocontributors for an excellent issue.

Ronald F. Martin, MD  
*Department of Surgery*  
*Marshfield Clinic*  
*1000 North Oak Avenue*  
*Marshfield, WI 54449, USA*

*E-mail address:* [martin.ronald@marshfieldclinic.org](mailto:martin.ronald@marshfieldclinic.org)