Foreword

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As we complete production of this issue we are entering a new academic year. New residents enter our program and we all reassess our tasks. Our new residents integrate themselves into the academic conferences and one asks innocently, as one always does, during a colloquy about an illustrative patient, "has she had any previous *surgeries*?" The face of each resident of PG2 or greater rank simultaneously contorts into a bemused grimace as they know that I shall reply as I always do. I explain that "surgery" is a discipline, a state of mind, a way of life—occasionally a passion. "Operations" are procedures performed by surgeons in operating rooms. And that generally sets the tone for another year. That said, if one turns to most complete dictionaries one will find that the dictionaries actually side with the resident on this matter and I am factually incorrect. Also, the use of "surgery" to describe operating rooms, clinics, and other environments is also acceptable to professional wordsmiths. Still, I think there is good reason to maintain the distinction for surgeons between "surgery" and "operation." The discipline of surgery is far more encompassing than its technical operative subcomponent. And perhaps nowhere is that better illustrated than in endocrine surgery.

Some of the great clinics of this country were built on their adeptness at endocrine surgery; at least in part. The Mayo brothers were famed for their ability to safely perform thryroidectomy among other things. My alma mater, Lahey Clinic, was also largely founded on expertise in thyroid surgery. Success of a surgeon in the early days of endocrine surgery, particularly for operations performed in the neck, was judged by one's ability to avoid catastrophic postoperative technical complication. And the discussion and literature of the field largely focused on the technical aspects of surgical care.

In the decades since the Lahey and Mayo brothers made their large-volume referral centers based largely on technical expertise, the amount of discussion over the technical aspects has largely subsided in favor of concentration on the biochemical, molecular, and genetic aspects of endocrine care. A partial resurgence of technical interest has blossomed following Dr Gagner's (another Lahey Clinic alumnus) introduction of minimally invasive approaches to endocrine operation of the neck and retroperitoneum. These discussions have been fruitful and fascinating—especially to surgeons.

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The larger endocrine community, however, is more likely to be enthralled with the nonoperative features of the expanding literature.

As one reads this issue one will find a significant amount of material addressing operative techniques. One will also find an expanse of material relating to the molecular, biochemical, imaging, genetic, genomic, and proteomic aspects of what is known about endocrinology. I can think of few other areas of study where we have advanced as much in our ability to more fully understand the physiologic and structural aspects of pathologic target organs preoperatively as we now can in endocrine surgery. These advances have in some cases allowed us to significantly and reliably reduce our need to dissect and explore at the time of operation. Conversely, we may decide to reliably expand our initial operative plans based on gene analysis.

It has been quoted (multiple times in just this issue) that the most important localizing study in endocrine surgery is to localize a competent endocrine surgeon. The corollary for that could be that the surgeon who desires becoming facile and well-employed as an endocrine surgeon must localize an endocrinologist (or preferably group) with whom he or she can work well. Part of this relationship will likely depend on having an excellent working knowledge of the nonoperative aspects of endocrinology.

Despite the desires of the American Board of Surgery to claim that all general surgeons who are board certified have demonstrated expertise in endocrine surgery, the reality of the practice place is that these operations are almost always performed by persons with additional training and defined focus in one or more subsets of endocrine surgery. To be sure, there is overlap with otorhinolaryngologists, surgical oncologists, and hepatopancreatobiliary surgeons in the management of these patients but the reality that "specialty-" and "subspecialty"-trained surgeons perform the lion's share of these procedures is inescapable.

General surgeons will still maintain a need for knowledge in these areas. If for no other reason, endocrinopathies—both recognized and unrecognized—may be encountered in other patients and must be understood to safely manage their care. Also, we remain in a highly dynamic state regarding the delivery of health care. As events unfold, there may be a need to shift workforce supply and care distribution. Given the relative distribution of general surgeons compared with subspecialists, it is not inconceivable that some aspect of care previously relegated by degrees by some general surgeons may need to be reconsidered. A more important reason to be familiar with the larger breadth of material is because that is what is required for mastery of the topic. In an age where more people are looking for "just-in-time" information about small topics, mastery is becoming rarer. For those whom surgery is a passion, mastery is imperative.

Dr Zeiger and her colleagues have assembled an excellent group of reviews that should be informative and enlightening to any interested student of endocrine surgery. We appreciate her excellent work and professionalism on this project.

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