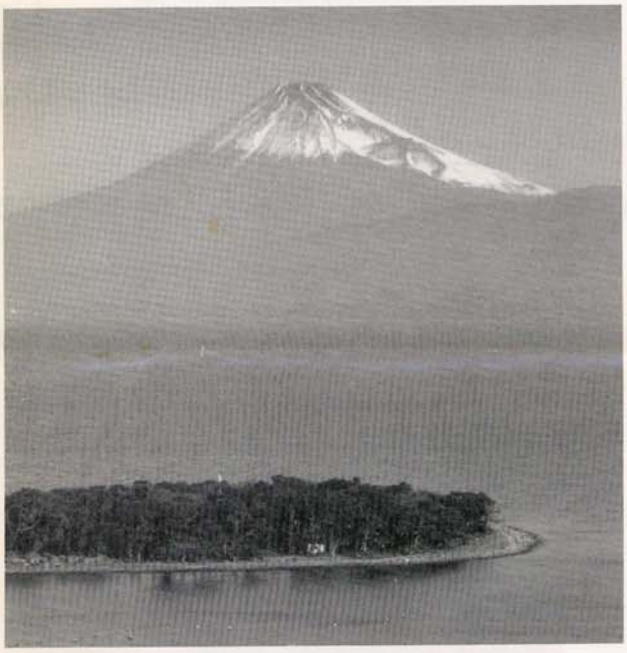
ISDE NEWS

The International Society for Diseases of the Esophagus No. 10, July. 1st, 1991

Secretariat : ISDE Office Tokyo Women's Medical College 8-1 Kawadacho Shinjuku-ku Tokyo 162, Japan Tokyo 03 (3353) 8111

FIFTH WORLD CONGRESS OF THE INTERNATIONAL SOCIETY FOR DISEASES OF THE ESOPHAGUS August 5～8, 1992 Kyoto, Japan



Mount Fuji

Kin-ichi Nabeya,M.D.

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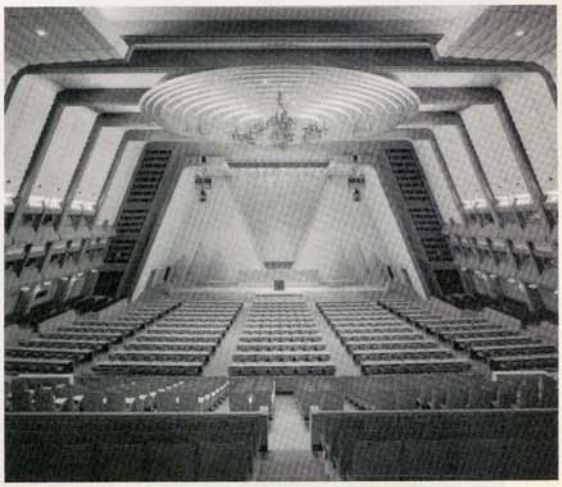


Congress Hall (Main Hall)

Scientific Program

The program will offer scientific papers, poster papers, movies and video presentations and technical exhibits on every aspect related to esophageal diseases. Topic areas to be covered will includ:

I Malignant Diseases
1. Epidemiology
2. Biology, Pathology
3. Diagnosis
4. Cancer staging
5. Surgical treatment
6. Multimodality treatment
7. Palliative treatment

II Benign Diseases
1. Congenital diseases
2. Gastroesophageal reflux
3. Barrett's esophagus
4. Benign stricture
5. Esophageal perforation
6. Esophageal varices
7. Motility disorders (achalasia)

V Congress secretary General

Prof. Tateo Hanaoka

Date of Birth : March 12, 1933

Education and Employment :
1958 Graduated from Chiba Univ. School of Medicine
1966 Teaching Assistant of 2nd Surgical Dept. of Chiba Univ.
1973 Associate Professor of 2nd Surgical Dept. of Kyorin Univ.
1987 Clinical Professor of 2nd Surgical Dept. of Kyorin Univ.

Schedule:

	August
Committee Meeting	5(Wed.)
Opening Ceremony	
Scientific sessions	6(Thu.)
Scientific sessions	7(Fri.)
Scientific sessions	8(Sat.)
General Assembly	

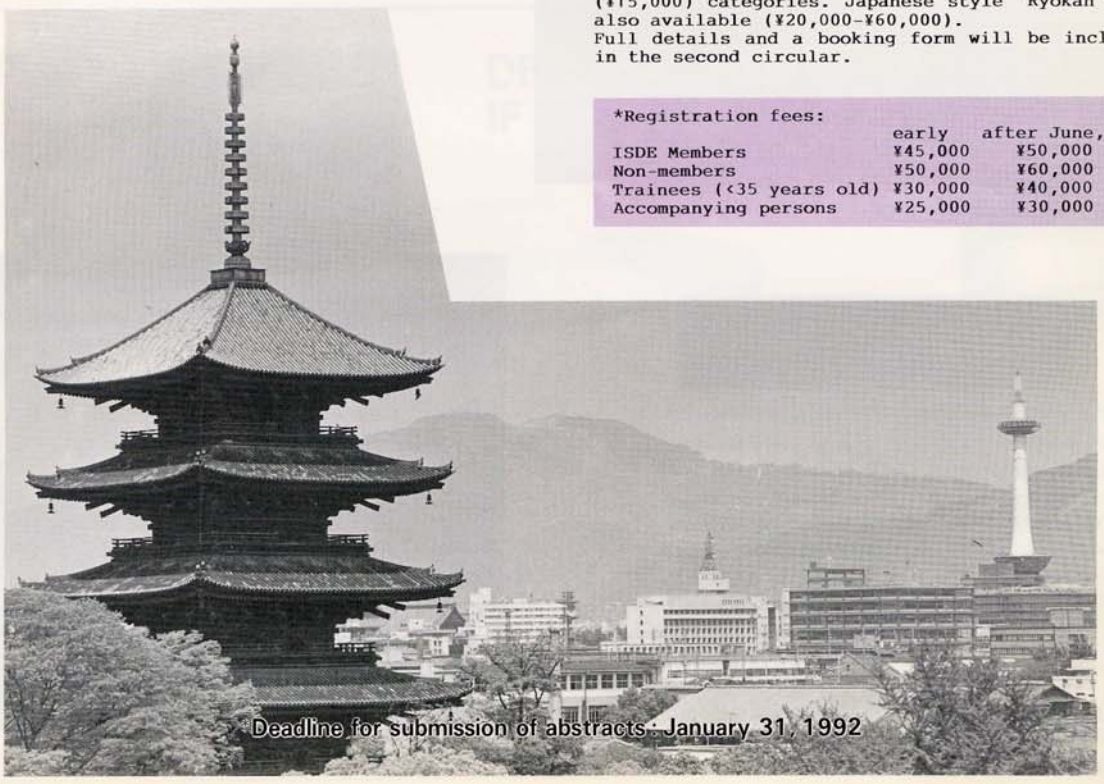
Social programs:

Opening Ceremony,
Reception
Japan Night,
Chairman's Reception
*Banquet
Farewell Events
(¥12,000 will be charged for the banquet, other events are free)

Hotel accommodations have been reserved at a number of hotels in Kyoto City.
Hotel range from deluxe (¥40,000) to standard (¥15,000) categories. Japanese style "Ryokan" are also available (¥20,000-¥60,000).
Full details and a booking form will be included in the second circular.

*Registration fees:

	early	after June,'92
ISDE Members	¥45,000	¥50,000
Non-members	¥50,000	¥60,000
Trainees (<35 years old)	¥30,000	¥40,000
Accompanying persons	¥25,000	¥30,000



Deadline for submission of abstracts: January 31, 1992

REGIONAL ACTIVITY

FRANCE

Francois Fekete, M.D.
Assistance Publique
Hopital Beaujon
FRANCE

During past year 1990, several meetings dealing with oesophageal surgery were held in France.

In February 1990 at Nice, on the occasion of a Congress on Improvememt in digestive surgery (Pr. Mouiel) a clarification about caustic burns of the oesophagus was made.

In April, during the annual post-graduate teaching in Beaujon Hospital (Pr. Fekete) one day was on carcinoma and motor disorders of the oesophagus. An interesting work studied relation between dysplasia and carcinoma, in squamous cell mucosa and in glandular mucosa. The association of "high-grade" dysplasia and squamous cell carcinoma is the rule; the transformation of a highgrade dysplasia on a glandular muccosa is possible and frequent, leading to suggest a preventive oesophagectomy.

The classification of motor disorders has been explored by manometry. The choice of treatment for achalasia (dilatation or Heller's operation) was discussed. The Zenker's diverticula are responsible for frequent respiratory complication and should be treated by resection. This attitude is still debated for thoracic diverticula, because few cases of neoplasic transformations having been reported.

In June in Paris, the third International Meeting of the OESO focused on oesophageal motor function and motor disorders.

In October 1990, during the Congress of the French Surgical Association, in association with the First European Surgical Congress, the G.E.E.M.O.(European Group for Study of Esophageal Diseases) was asked to organize a meeting on oesophagoplasty after oesophageal resection whatever the cause.

The members of GEEMO have reported more than 800 cases, in five years, of oesophagoplasty for carcinoma and more than 240 for other pathologies.

The technical problems and functional results of gastric or colonic replacement have been discussed. The next meeting of the GEEMO will be held in Montreal (Pr. Duranceau) in June 1991 from the 7th to the 14th. (F. Fekete)

U.S.A.

F. Henry Ellis,Jr.,M.D.
Clinical Prof. of Surgery
Harvard Medical School
U.S.A.

Three major surgical meetings since the first of January in the United States included several interesting papers on esophageal problems. At the San Francisco meeting of the Society of Thoracic Surgeons in February, Dr. Landreneau and associates presented a paper entitled "Combined Parietal Cell Vagotomy and Collis Nissen Fundoplication". This is a combined procedure which others have favored in the United States but has not been widely accepted. The authors report 27 patients with gastroesophageal reflux disease treated by this combined operation. Their clinical results were good, but as is usually the case, Barrett's epithelium which was present in 17 of the patients showed little evidence of regression. The question regarding this particular operation is why is it necessary to reduce gastric acid production if the anti reflux procedure has been successful in preventing acid reflux, a view which I support. An interesting paper from the Sloane Kettering Cancer Institute analyzed various treatment options for the management of malignant esophagorespiratory fistula. The report involved 207 patients seen in the 60 year period since 1926. In the majority of cases, cancer of the esophagus was present. Interstingly enough peroral intubation and exclusion procedures proved no more successful in palliating patients than just supportive therapy. Their best results were obtained with radiotherapy and with esophageal bypass procedures, the later being restricted only to those patients who could tolerate this major surgical attack.

At the Annual Meeting of the American Surgical Association in April, Dr. DeMeester's group presented a paper entitled "Three Dimensional Computerized Imaging of the Lower Esophageal Sphincter". Using modern computerized technology, sphincter imaging can be achieved based on a step wise pull back of radially oriented transducers. The computerized three dimensional imaging of the lower esophageal sphincter obtained thereby proves superior to standard technique in quantitating the effectiveness of sphincter resistance to reflux. They furture concluded that the success of an anti reflux procedure is dependent upon restoration of the sphincter image to normal.

The Annual Meeting of the American Assocoation for Thoracic Surgeons was held in Washington, D.C. in early May. Dr. Ellis's group presented a paper entitled "Barrett's Ulcer: A Surgical Disease?" The senior author, Dr. Warren Williamson, reported on 285 cases of Barrett's esophagus treated between 1974 and 1990, 73 of whom presented with adenocarcinoma in Barrett's or developed it while under surveillance. Thirty of the 212 patients of benign Barrett's esophagus were found to have a Barrett's ulcer on endoscopy for a prevalence of 14%. Aggressive medical therapy achieved complete healing in 23 of the 27 patients (85%) who were available for follow-up. A Nissen fundoplication or a Collis Nissen operation performed in 4 of the 6 patients with non healing Barrett's ulcers resulted in healing. The other two patients refused surgery. The authors concluded that the majority of Barrett's ulcers will heal on medical therapy, even large ulcers 2-3cm in diameter and recurrent ulcers. They advised surgical intervation only if there is no evidence of ulcer healing after a minimum of four months of medical therapy.

The experience of the Massachusetts General Hospital in using long colon segments as an esophageal substitute was reviewed by Dr. Mathisen. Betweemn 1955 to 1989, 136 patients underwent the operation. The authors prefer the use of the left colon and employ arteriography preoperatively in all cases. They usually resect the clavicular head of the manubrium to facilitate substernal advancement of the colon into the neck.

Their overall mortality was 10%, being higher in the group with malignant disease(16%). A 9% incidence of graft necrosis occurred being more common when the right colon was employed. Other complications included 8 cervical leaks, 8 esophageal strictures, and 4 cases of graft redundancy requiring resection in 3.

An interesting Forum paper on Oncogene Activation in Esophageal Cancer reported a mutated oncogene implicating small p53 in tumorigenesis. This finding may well have clinical prognostic significance for patients with Barrett's epithelium and high grade dysplasia as an early marker of tumor development.

Another interesting paper entitled "Laser Sealing of Hand Sewn Esophageal Anastomosis" was presented at the Forum. The authors found that laser assisted tissue sealing proved to be a simple technique which increased the strength of single layer hand sewn anastomoses and in their opinion may decrease the incidence of anastomotic leakage in clinical practice. (F. H. Ellis, Jr.)

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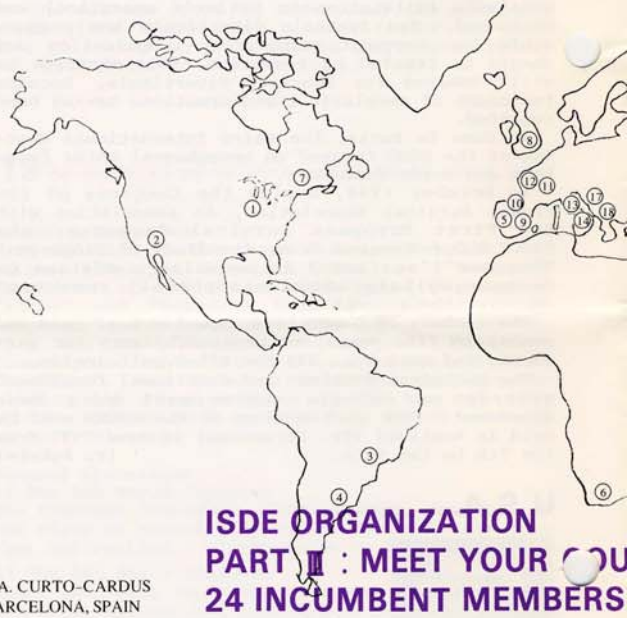
DE LA PLATA, AGRENTINE



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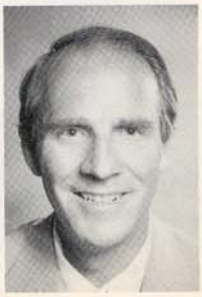

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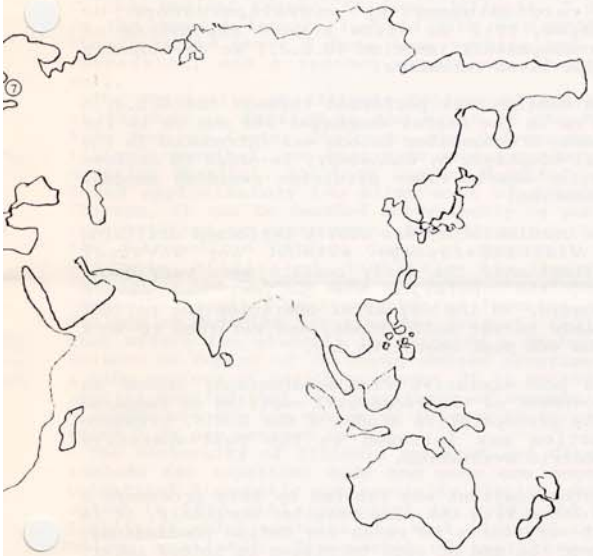

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REGIONAL ACTIVITY

Prof. Robert Giuli
Service de Chirurgie
Hopital Beaujon
Paris, FRANCE

This Congress was held from June 19 to 23 in Paris, following the original procedure conceived by Robert Giuli, and, as yet, unattempted.

In order to delve thoroughly into the subject, 370 extremely precise questions were drawn up that applied to esophageal surgeons, gastroenterologists, endoscopists, pathologists and pediatricians.
The specialists contacted to answer one or several of these questions came from the world over, and accept to attempt the difficult synthesis asked of them.

The organization of the Congress was exemplary. The most recognized specialists were brought together during this fruitful week, and the long discussions, scattered through out the 18 sessions of the meeting, supplied and additional element to the interest those present found in this event.

The 5 days of the Congress, inspite of a particularly heavy scientific program, never seemed drawn out, but, on the contrary, contiually stimulating. They were completed each evening by an outstanding social program, the highlight being the gala dinner, an equestrian and vocal event, that took place in a 12th Century Abbey near Paris.

All those who missed the Congress will have every reason to regret then absence.
However, as a follow up to the meeting, a gastroenterological treatise of 1500 pages is currently under print. It will comprise, in addition to the questions treated during the sessions, 150 additional ones, all as interesting, on motor disorders of the esophagus.

During the 90th Congress of the Association Francaise de Chirurgie, the French section of the I.S.D.E. met under the chairmanship of Professor R. Giuli.

A discussion session was organized on the following topic: - extended lymph node dissection in cancer of the esophagus

During this session, different approaches were discussed, ranging from those inspired by the more radical techniques described by the Japanese teams to those, opposed in principle, involving esophagectomy without thoracotomy.

The results published by the Tokyo Cancer Center were discussed, as well as those of different Japanese teams practising extensive dissections.

For both the French and Japanese teams, the incidence of respiratory complications was higher with this technique than with more limited dissections , and the influence on long-term survival requires further studies, currently in progress.

On this occasion, there were made available the first results of the randomized O.E.S.O. trial on cancer of the esophagus, which seem to confirm that the immediate severe postoperative state brouth about by this type of operation is not accompanied by the expected improvement in long-term survival. (R. Giuli)

CURRENT TOPIC

Prof. H. W. Pinotti
Head of Digestive
Surgery Department
University of Sao Paulo
Sao Paulo, BRAZIL

FIRST DEVELOPMENT OF CARDIOMIOTOMY BY VIDEOLAPAROSCOPY: A NEW PERSPECTIVE IN THE ACHALASIA TREATMENT

The development of the videolaparoscopy surgical technique, allowed us to perform for the first time a cardiomiotomy for the treatment of esophageal achalasia using such technique. The aim of this approach was to minimize the laparotomy inconveniences, decreasing the surgical stress, pernuting an early hospital discharge with lower costs and faster social reintegration.

A fifty-six years old male patient, with esophageal achalasia by Chagas disease, underwent the cardiomiotomy by videolaparoscopy on April,30,1991. To allow a good exposition of gastroesophageal junction (G.E.J.) we developed a special liver retractor.

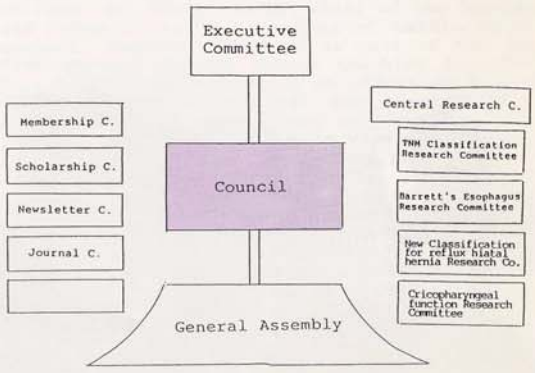
The miotomy was performed through the G.E.J.,5 to 6 cm in the distal esophagus and one cm in the stomach. A Sangstaben baloon was introduced in the distal esophagus by endoscopy, in order to achieve a better muscle fiber divulsion avoiding mucosal perforation.

The cardiomiotomy was easily performed utilizing the videolaparoscopy without any surgical complications. The early results were very good. Before the operation the patient had severe disphagia, in the day after operation the patient was able to eat solid foods, and returned to work on the 4th post operative day.

The post-operative cinedeglutography showed an improvement of the esophageal emptying as compared to the pre-operative study. A 60% L.E.S. pressure reduction was followed in the post-operative manometric avaliation.

Another patient was treated by this procedure a week later with the same results. Obviously, it is still very early to reach any define conclusions, however the use of such technique is indeed interesting for it deserves research and development of This new therapeutic procedure. (H. W. Pinotti)

Structure of the ISDE



SPECIAL CONTRIBUTIONS

A RESEARCH EXPERIENCE IN CHICAGO AND INTRODUCTION OF MY STUDYING INSTITUTE

Atsushi Sugitani, M.D.
Dept. of Surgery
University of Illinois
at Chicago, U.S.A.

Since March, 1988, I have been studying in the Department of Surgery at University of Illinois at Chicago Medical Center, Chicago, Illinois, U.S.A. In the present letter, I would like to introduce the Institute where I have been working and its impression, and a reseach experience there as well.

The University of Illinois College of Medicine at Chicago is located in the heart of the West Side Medical Center District: the University of Illinois Hospital, the West Side Veterans Administaration Hospital, and Cook Country Hospital. Located approximately two miles west of downtown Chicago, it can be reached conveniently by public trasportation or expressway. The others, part of the Metropolitan Chicago Group of University of Illinois Affiliated Hospitals are located throughout the Chicago area and offer a variety of community hospital environments for learning. The College of Medicine has also the Graduate College that offers the students for earning a Master of Science or Doctor of Philosopy degree programs in a wide variety of health sciences. It is worthy of special mention that the Department of Surgery has a unique program for Master of Science in Surgery, which I am now engaged in.

The University of Illinois Hospital and Clinics include 440 inpatient beds and over one hundred outpatient diagnostic and specialty clinics. Dedicated in 1980, this hospital is a $60,000,000 facilities which contains the most advanced technology available. The number of yearly clinic visits averages 290,000, which is one of the highest in the city of Chicago. The Department of Surgery headed by Dr. Lloyd M. Nyhus, who is a very well known surgeon-scientist as well as my supervisor, for twenty two years until June 30, 1989 and succeeded by Dr. Herand Abcarian, noted colon and rectal surgeon, has been offering the opportunity and the support to the surgical scholars of all types in their surgical studies. The Department expands the contribution to its eleven divisions under the Department : General, Plastic, Pediatric, Cardio-Thoracic, Peripheral Vascular Surgeries, Transplantation, Surgical Oncology, Surgical Immunology, Urology, Surgery Bioengineering, and Emergency Medicine. Dr. Nyhus remains active as the Warren H. Cole Professor and Director of Living Institute of Surgical Studies. He was honored by the University of Illinois Board of Trustees by being appointed Emeritus Head of the Department and Emeritus Surgeon-in-Chief of the University of Illinois Hospital.

The West Side Veterans Administration Hospital, a 538-bed, acute care hospital, is located one block west of the college. Members of the professional staff are on the faculty of the University, and a majority of the University's residency programs include rotations through this hospital. One of our laboratories and animal facilities are placed in the research building attached to the hospital.

The other hospital contained in this Medical Center is the Cook Country Hospital, a 1300-bed facilities which provides care to more patients than any other Chicago hospital. Each year,its emergency room handles 320,000 visits; its hospital outpatient department, 325,000 visits; and its neighborhood clinic, 90,000 visits. My instructor, Dr. Philip E. Donahue who is a Professor and Chairman, Division of General Surgery, Cook Country Hospital has been guiding me to this research work. Thus foreign research fellows visiting the department of Surgery can make use of these three hospitals and related facilities to achieve the basic and clinical research investigations.

Under the direction of Dr. Donahue, I have been investigating the role of afferent vagus nerves on stress gastric lesions, which is my thesis work as well. We proposed that the selective blockade of afferent vagus nerves to the stomach decreases the number of lesions supplied by that branches. At the same time, we are now working on the hydothesis: "Endoscopic ultrasound can show the pressure of fibrosis in the submucosal and muscular layers of the stomach after endoscopic sclerosis." We previously developed an endoscopic technique for the prevention of experimental reflux disease on dogs. Endoscopic sclerosis with morrhate creates a zone of fibrosis 1-2 cm distal to the gastroesophageal junction, exerting its anti reflux action by some effect on the gastric component of the reflux barrier. Since neither the time of appearance nor the precise extent of fibrosis following sclerotherapy of the cardia is unknown, we propose a comparison of the ultrasonographic appearance of the proximal stomach at time 0, 4, 8, and 12 weeks after treatment. Two dogs are sacrificed at each interval, allowing histrogic verification of the extent of fibrosis; eight dogs are used for the study. If the endoscopic ultrasound is useful for showing the extent of post-sclerosis fibrosis, then clinicians treating patients with reflux will have an extremely useful tool for evaluating the efficacy of endoscopic treatment for reflux disease.

Finally, I am indebted to Drs. Philip E. Donahue and Lloyd M. Nyhus, for having trained me in both basic and clinical studies. The Scholarship of I.S.D.E. was really helpful for me to continue the study in the U.S.A., and giving me the wonderful oportunity described above. "Windy City" Chicago is an attractive city, which is noted for its abundance of architectural styles with the magnificent skyline. I enjoy the Chicago life and valuable days in the U.S.A. (A. Sugitani)

SURGERY IN MUNICH AS SEEN THROUGH A JAPANESE SURGEON'S EYE

Hiromasa Fujita, M.D.
1st Dept. of Surgery
Kurume University
Fukuoka, Japan

The Department of Surgery of the Technical University of Munich is a major center for oncological surgery in Europe. Professor Siewert, its director, is at the forefront of this field. He has a well coordinanted unit comprising ; ICU, operation theaters, lecture halls, gastro-laboratory, photographic center, as well as departments of oncology, pathology, epidemiology, endoscopy, and radiology. They are well regarded internationally.

Professor Siewert is a great organizer of those working under him. Moreover, he undertakes several major operations himself everyday. He performs the full range of G1 surgery from the cervical esophagus to the rectum, from appendectomies to liver transplanation. He is very aggressive in his treatment. Here may be seen many cases of radical cancer surgeries and re-operation for recurrent tumors. His philosophy is that :"En-bloc resection with lymphadenectomy improves survival of patients with carcinoma. "In this he is in accord with the views of Japanese surgeons. He has a wonderful technique, in particular his use of the left hand. It dives elegantly into the abdominal cavity and undertakes the necessary maneuvers rather like a precise "U-boat". I never get tired of watching Professor's operations because of his nice tempo and harmony.

In TU Munich, more than 70 esophagectomies are performed every year. More than half are done for adenocarcinoma in a Barrett's esophagus or carcinoma of the cardia with invation to the esophagus (E>C). This situation is completely different from that seen in Japan. The common situation encountered is a patient with carcinoma in the lower esophagus or the cardia which is situated in the middle or lower mediastinum, because most patients seen in Munich tend to have a large together with the thoracic nodes.

En-bloc esophagectomy is considered to be a radical and satisfactory operation for adenocarcinoma in the lower mediastinum. Adenocarcinoma has the characteristic of local invasion and metastasis to the regional lymph nodes, rather than distant spread. Actually, it is very difficult to obtain a safe surgical margin in cases of adenocarcinoma with diffuse invasion. Mediastinectomy in en-bloc esophagectomy must be the best method to avoid a palliative operation. From a Japanese surgeon's eye, en-bloc esophagectomy is more radical operation than the procedures performed in our country in respect of lymphadenectomy of the lower mediastinum. En-bloc esophagectomy togethered with cervical and upper mediastinal lymph node dissection may be ideal operation. This is a my hope.

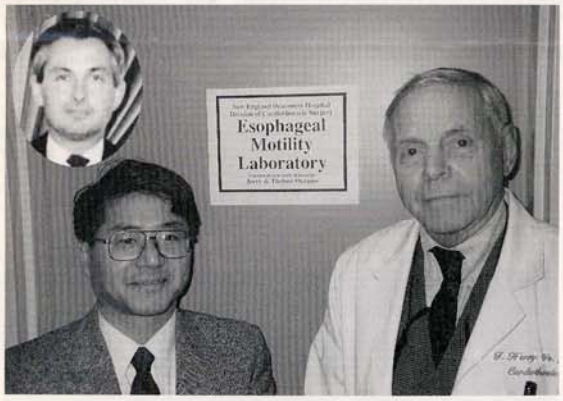
In Munich there are not so many cases of squamous cell carcinoma in the upper or middle thoracic esophagus compared to in Japan. A large number of them are unresectable because of invasion into the trachea or wide-spread metastasis to the regional lymph nodes or to the distant organs. Preoperative treatment such as radiation and/or chemotherapy are performed for these cases in an attempt to down-stage. Curative esophagectomy is, however, not usually possible. Even if a curative operation can be performed, it is often very difficult to perform the cervical and upper mediastonal lymph node dissection because of the high risk of complications.

German patients with esophageal carcinoma are very fat without an exception, in spite of esophageal narrowing. 95% of patients are heavier than me, otherwise a healthy Japanese man. This is a mystery for me. One possible reason may be that patients are able to swallow enough calories in the form of beer, a liquid which is viewed rather like a "fruit juice" or "Tonic" here in Germany.

(H. Fujita)

STAYING AT THE NEW ENGLAND DEACONESS HOSPITAL

TOSHIRO KONISHI, M.D.
2nd Dept. of Surgery
University of Tokyo
Tokyo, Japan



Since the first of September 1990, I have been visiting the department of Surgery at the New England Deaconess Hopital in Boston. My eight-month visit in Boston is supported by the Japanese Ministry of Education. The hospital is located in the Longwood medical area where many important United States medical institutions are located, including Harvard Medical School, the Brigham and Women's Hospital, the Beth Israel Hospital, the Dana-Farber Cancer Institute, the Childrens Hospital, and the Joslin Diabetic Center.

The New England Deaconess Hospital was established in 1896 by a Deaconess, Mary E. Lune who wrote as follows "science and kindliness should unite in combating human disease", thus emphasizing the importance of kindly compassion in the care of patients in addition to scientific knowledge. A formal relationship between the hospital and Harvard Medical School was established in 1977 as a result of which the institution is now one of the major teaching hospitals of Harvard Medical School.

The current chairman of the department of general surgery is Professor Glenn D. Steele Jr.,46 years old, who succeeded Dr. William McDermott as chairman in 1985 and now holds the William V. McDermott Professorship. There are 50 full-time surgeons in Dr. Steele's department including such well known figures as Blake Cady (surgical oncology). Anthony P. Monaco (transplantation) Sidney Levitsky, Chief of Cardiothoracic Surgery (cardiac surgeon) and F. Henry Ellis, Jr. (general thoracic surgery). Dr. Steele supervises an active surgical program that last year included active funding in the amount of close to six million dollars. He, together with Dr. J. Milburn Jussup are currently investigating new methods of the early detection of cancer using biological markers particularily in the early detection of colorectal and breast malignancies. Dr. Roger Jenkins, Chief of Hepatobiliary Surgery was thefirst Boston Surgeon to successfully develop a liver transplant service and now performs over fifty liver transplant operations a year. It was my pleasure to encounter Dr. Takashi Maki who, as a member of the research staff of the surgical department, is involved in work on pancreatic transplantation.

The Lahey Clinic, whose division of cardiothoracic surgery had since 1970 performed all of its clinical work at the New England Deaconess Hospital, moved its service to the new Lahey Clinic Medical Center in Burlington in the spring of 1990. Dr. Ellis, former chief of the Deaconess and Lahey Clinic's divisions of cardiothoracic surgery, however, remained as part of the full-time Harvard Medical School teaching faculty in Dr. Steele's department in an effort to fill the general thoracic surgical gap created by the departure of the Lahey Clinic surgeons.

It was of interest to me, in view of my interest in esophageal disease, to witness procedures performed by Professor Ellis who is, of course, an internationally known esophageal surgeon. Chief among the diseases that he treats surgically are malignant lesions of the esophagus and cardia, gastroesophageal reflux disease, diaphragmatic hiatus hernia, and esophageal motility disorders including phrenoesophageal diverticula.

Between 1970 and 1990 he and his residents have operated on 366 cases of cancer of the esophagus and cardia representing an overall operability rate of 83%. Three hundred twenty six of these patients (89.1%) underwent resection with a 30-day mortality of 2.5%. Complications developed in 25% of patients though in only 13% were the complications serious enough to prolong the patient's

hospital stay. The average hospital stay was 14 days and successful palliation of dyshagia was achieved in over 80% of patients. The adjusted actuarial five year survival rate for curative resections was 23.3% and for Stage I lesions was 40.4%.

During this period, neoadjuvant therapy was not employed in the management of these patients. Dr. Ellis prefers to return the patients rapidly to a reasonably normal life style without subjecting them to the prolonged therapeutic program which characterizes most current neoadjuvant protocols with their associated morbidity. His surgical approach depends on the location of the lesion. Those located in the lower thoracic esophagus or cardia are resected through a left thoracotomy, opening the diaphragm in a semiluminar fashion near the costal arch and avoiding a thoracoabdominal incision. For lesions at a higher level of the esophagus where anastomosis must be done at the level of the aortic arch, a combined laparotomy and right thoracotomy (Ivor Lewis procedure) is preferred providing a transhiatal resection can not be performed because of fixation of the tumour within the mediastinum. The use of the colon as an esophageal substitute is employed only when there is insufficient stomach available for this purpose.

Since becoming a full-time member of the Harvard Medical School faculty at the New England Deaconess Hospital, Dr. Ellis now participates in association with the Dana-Farber Cancer Institute in a neoadjuvant therapeutic protocol consisting of preoperative chemotherapy employing cisplatin and 5-Flurouracil coupled with a radiosensitizer (ETANIDAZOLE) and irradiation. The hope, of course, is that this form of therapy will not only increase survival, but will limit local recurrences and succeed in increasing the five year survival rate.

Another major aspect of his clinical activities concerns the surgical treatment of gastroesophageal reflux disease often associated with sliding esophageal hiatus hernia. He finds that medical treatment is usually effective and surgery is required in only 10-15% of patients. He prefers the transabdominal Nissen fundoplication, employing a very lose wrap of the distal 1-2cm of the esophagus. With proper patient selection, more than 90% are permanently relieved of the symptoms of gastroesophageal reflux. In his opinion, the symptoms in patients with a paraesophageal hiatus hernias are not due to reflux, but are mechanically related. Therefore, he does not elect to do an antireflux operation, except in the mixed variety of hernia, electing to reduce the hernia, excise the sac, and close the hiatus anterior to the intrabdominal esophagus.

He is currently developing an up-to-date esophageal motility laboratory in the division of cardiothoracic surgery which will provide the hospital and the surrounuding area with the availability of mordern technology in the evaluation of esophageal motor disorders. The use of 24 hour pH monitoring is part of this endeavor and its use will be particularly helpful in documenting the presence and degree of gastroesophageal reflux in doubtful cases such as those with atypical symptoms, and in patients with classic symptoms in whom other tests fail to provide objective evidence of the existence of gastroesophageal reflux. He plans also to conduct 24 hour pH studies in patients with esophageal achalasia after esophagomyotomy in an effort to determine why his technique results in such a low incidence of post-operative esophageal reflux. Many surgeons in the United States report a much higher incidence than he, and for that reason have advocated combining esophagomyotomy with an antireflux operation. (T. Konishi)

ISDE SCHOLARSHIP

Scholarship Committee Meeting

Nine applicants from all over the world appied for the 1991 Scholarship. The Scholarsip Committee Meeting was held on April 13th, 1991 in New York presided over by Prof. Siewert (Chairman). After strict evaluation, it was decided that six Research Scholarships and two Visiting Scholarships would be awarded and support per award ranged from $2,000 to $10,000.

Scholarship winners are Dr. Choong Bai Kim (Korea), Dr. Carol Stanciu (Rumania), Dr. Hideaki Tahara (Japan), Dr. Predrag Pesko (Yugoslavia), Dr. Tsutomu Nakamura (Japan), Dr. Oscar Ruben Varela Rodriguez (Mexico), Dr. Sanjay Sharma (India), Dr. Arberto Roger Garcia (Argentina).

C. B. Kim, M.D.

C. Stanciu, M.D.

H. Tahara, M.D.

P. Pesko, M.D.

T. Nakamura, M.D.

O. Ruben, M.D.

S. Sharma, M.D.

A. R. Garcia, M.D.

Their hosts and study sites are as follows:
Dr. C. B. Kim - Prof. H. Akiyama
Toranomon Hospital, Tokyo, JAPAN
Dr. C. Stanciu - Prof. K. Nabeya
Kyorin University, Tokyo, JAPAN
Dr. H. Tahara - Prof. M. T. Loetz
Univ. of Pittsburgh, USA
Dr. P. Pesko - Prof. K. Nabeya
Kyorin University, Tokyo, JAPAN
Dr. T. Nakamura - Prof. J. R. Siewert
Universitat Munchen, Munchen, GERMANY
Dr. O. Ruben - Prof. H. Akiyama
Toranomon Hospital, Tokyo, JAPAN
Dr. S. Sharma - Prof. T. Kakegawa
Kurume University, Fukuoka, JAPAN
Dr. A. R. Garcia - Prof. S. Mori
Tohoku University, Sendai, JAPAN

(N. Ando)

SCHOLARSHIP REPORT

Paolo Trentino, M.D.
2nd Surgical Clinic
University "Lasapienza"
Rome, Italy

Since my arraival at the Second Surgical Department, Kyorin University, I have been impressing by the skill, efficiency and kindness of the whole staff directed by Professor K. Nabeya (from April 2, 1989 to July 2, 1989). This is most evident in patients with esophageal and gastric cancers, which are, as everybody knows, frequent diseases in Japan. Accordingly, particular care is paid in diagnosis, staging, pre and postoperative treatment of these patients. Every effort is made to achieve an early diagnosis. Minor symptoms represent a strong indication for accurate and extensive check-up. Double-contrast upper GI x-ray, in high-speed series and by a computerized system, is the first step by which a high percentage of very small lesions may be detected. Endoscopy is then performed by an exceptionally skilled team, longtime trained to recognize early cancers. For this reason, Lugol stain is widely employed and this represents a precise guide to obtain cancer-positive cytology and histology. Preoperative staging is completed by endoultrasonography, which allows detection of metastatic lymphnodes, even smaller than 0.5 cm, and by CT and MNR.

At this point, a severe selection of patients candidates for surgery is performed, as "safety" is the first goal in Japanese colleagues'mind. So far, a considerable percentage of patients is treated by radio and/or chemotherapy and, at the end of the treatment, a new staging is carried out in order to reevaluate cases for surgery. If operative treatment is established, all patients receive nutritional support, both via parenteral and enteral routes, to minimize the incidence and consequences of post-operative morbidity.

Extended surgery is adopted as a principle, as well as extensive, precise and uncommon lymphadenectomy. It is carried out according to the "Japanese Guidelines for clinical and pathological studies" on carcinomas of different organs. Together with accuracy of preoperative diagnosis, this step is the most impressive one for a young Western surgeon. It seems unbelievable that lymphadenectomy can be performed in such a way, however it is. Moreover, its completeness is immediately checked as soon as the surgical specimen is removed. Young surgeons are very well trained in searching and classifying nodes from the specimens, as well as pathologists always carry on exhaustive studies to contribute significantly to the accurate staging of the disease.

After discharge from the hospital, patients are continuously followed-up, as long as they live. Professor Nabeya himself's dedicated to this work, with a very high number of cases checked every week. The results of this serious and extended follow-up are well-known around the world, the last obtained goals being a new classification of early esophageal cancer, because of different prognosis according to the various types; curative endoscopic resection of some early gastric cancers; up-date guidelines for breast cancer recording.

Of course, such a work requires a clever guide, a good organization and efficient structures: all of them are gathered in this Department. Nearly every day, I could attend meetings on different subjects, such as presentation of cases to be operated on, discussion on performed operations and endoscopies, as well as on various papers from the International literature. I was also offered the opportunity in attending some national Congresses, of outstanding quality. Moreover, senior surgeons continuously stimulate the young ones, both during meetings and in the surgical wards and operative theaters.

Such a type of teaching and studying creates new and efficient doctors, who are always available and ready to discuss their experience with you. This open-mind behaviour, coupled with high inborn courtesy, has always overwhelmed the expected problems related to language.

As a conclusion of my experience, I would like to recommend every young surgeon to spend some time at the Second Surgical Department, Kyorin University. Here you can enjoy learning aspects of surgical field so difficult to observe in other countries and participating in various activities at an outstanding level.

Finally, let me remember my chief, Professor Guido Castrini, who suddenly died last June, at a time I was still in Japan. I shall never forget his exceptional surgical skill, deep humanity, sincere behaviour and huge knowledge of medical and non-medical notions. Really, the loss of such a teacher and man will never be replaced.

At the same time, I shall never forget what Professor Nabeya, with his unique humanity and friendship, and all his staff, made for me on this occasion and during my whole staying in the marveillous world of Japan. (P. Trentino)

Tadashi Nishimaki, M.D.
1st Dept. of Surgery,
School of Medicine
Niigata University
Niigata, Japan

It was a great pleasure for me to be able to visit Munich, FRG, and study Barrett's esophagus from 13,6,1989 till 15,5,1990, thanks to be ISDE Scholarship. Munich, once the capital of Bavaria, is not only a city of history and art but also a city of modern technology. The Klinikum rechts der Isar of Technical University of Munich is located at the center of Minich and is playing a very active role particularly in the field of clinical medicine. Professor J.R.Siewert, director of the Department of Surgery, Technical University of Munich, is one of the most energetic surgeon and performs approx. A hundred esophagectomies for esophageal cancer a year with his diligent staffs.

I studied Barrett's esophagus bibliographically during the first two months. After the presentation of state of the art and the subsequent brainstorming at the intramural meeting of gastroenterology, the theme of my research was determined: Histopathologic Characteristics of Early Adenocarcinoma in Barrett's esophagus. Afterwards, I moved to the Institute of Pathology at the Technical University of Munich to examine the resection specimens with early Barrett's cancer (T1) macroscopically and histologically.

As well known, Barrett's esophagus develops as a result of longstanding gastroesophageal reflux and is considered as a precursor of primary adenocarcinoma of the esophagus. Therefore, great efforts have been made in search of biological marker indicating a high risk for cancer development in Barrett's esophagus. Furthermore, regular endoscopic surveillance for the patients with Barrett's esophagus is being performed to detect early Barrett's cancer (BC). However, histopathologic characteristics of early BC are poorly understood beacuse of the rarity of such cases. The theme given for my research seemed to be quite timely in the light of recent currents of the studies on Bareett's esophagus.

Fortunately, there were 13 cases of early BC at the Department of Surgery, Techhnical University of Munich. The specimens had been step-sectioned at an interval of 1 cm starting at the proximal margin, so that I could easily make a histologic map of the lesion on the xerocopy of the resection specimen. Using the histologic map, I performed morphometry of early BC as well as macroscopic and histologic evaluation of the lesion. By this study, the following characteristics of early BC were revealed:

Macroscopic characteristics

The most common gross appearance of early BC was an elevated lesion (61.5%) corresponding to I- or IIa- type in terms of the Japanese endoscopic classification for early gastric cancer.

Histlogic characteristics

The most common histologic type was well differentiated adenocarcinoma (69.2%) although there was a histologic spectrum from well to poorly differentiated adenocarcinoma. High grade dysplasia forming a part of the tumor was found in 61.5% of early BC. These data indicate most BC develop through dysplasia-carcinoma sequence as generally accepted. Vessel-invasion and regional lymph node

metastasis were found in 30.8% and in 15.4%, respectively. Interestingly, early BC had close topographical relation with squamous epithelium including residual squamous islands because 84.6% of early BC were surrounded by both squamous epithelium and specialized type columnar epithelium. Furthermore, the tumour center of the probable original site of BC was located at the metaplastic columnar-lined area within 2 cm from the squamocolumnar epithelial border in Barrett's esophagus in all cases but one. The smaller, in other words the earlier, the tumour was, the closer the tumour center was located to the squamocolumnar epithelial border. In smaller cancers, measuring 2 cm or less in size, the tumour center was located at the columnar-lined area 0.5 cm or less from the squamocolumnar epithelial border. Therfore, I concluded that the most favorite site of cancer development in Barrett's esophagus is the metaplastic columnar-lined area, particularly of specialized type, very close (within 2 cm) to the squamocolumnar epithelial border. I think this is the most important conclusion of my research in Munich because this implies the preferable biopsy site in the regular endoscopic surveillance of the patients with Barrett's esophagus.

Fortunately, I could present these results at the 107th Congress of the German Society of Surgery in Berlin. I owed my success in research to Professor J.R.Siewert and Associate Professor A.H.Holscher who was a superior supervisor of my study in Munich.

Again, I would greatly appreciate the ISDE Scholarship which gave me an opportunity to study Barrett's esophagus. (T. Nishimaki)

Rajendra A. Badwe, M.D.
Tata Memorial Hospital
Bombay, India

June 11,1989 - August 25,1989, Toranomon Hospital

For an oncologist esophageal carcinoma is one of those few tumours which carries lot of pessimism as regards rewards of treatment. This pessimism can be attributed to the delay in diagnosis due to easy ditensiiblity of the organ and inaccessibility to clinical examination. It is these challenging obstacles which inspired me to pursue surgical oncology in general and thoracic oncology in particular for last 6 years.

Japan and China being ahead of all the nations tackling this cancer in early detection and treatment, I intented to spend some time in the East. A review of literature, Prof. Ronald Belsey's comment about Prof. Akiyama's artistry and gentle ways in surgery and advice from my guide and mentor Prof. P.B.Desai from India made me approach Prof. Akiyama and he kindly consented with a project on:"PATTERNS OF LYMPHNODE METASTASIS FROM SQUAMOUS CELL CARCINOMA(SCC) OF THE THORACIC ESOPHAGUS".

MATERIAL AND METHOD:

One hundred cases of the SCC of the thoracic oesophagus were analysed retrospectively. All patients were treated by subtotal oesophagectomy and radical lymphadenectomy of the mediastinum and upper abdomen. The cervical lymphnodes were dissected when the primary tumour extended from upper thoracic oesophagus to the cervical oesophagus. The post-operative deaths were excluded from the study all patients were eligible for at least 5 years of follow up. The incidence of lymph node metastasis and survival were analized.

Assessing the first echelon N1 (the Japanese Society for Esophageal Diseases), the incidence of metastasis was only 9/52(17%). In 46/52(88%) the first two echelons (N1,N2) represented the first station of lymph node metastasis in majority and if the first two stations were negative, metastasis to the rest of the lymph nodes would be negative in about 88% of patients. The incidence of N1-2 negative and metastasis to N3 and/or N4 was 6/52(12%). The incidence of N1-2-3 negative and metastasis to N4 was 2/52(4%). The incidence of N4 irrespective of the status of N1-2-3 was 10/52(19%).

TABLE I

DISTRIBUTION OF TUMOUR ACCORDING TO SITE OF AFFECTION IN THORACIC OESOPHAGEAL CARCINOMA

SITE	LYMPHNODE POSITIVE	LYMPHNODE NEGATIVE	TOTAL %
MID THORACIC Im	25	34	59
LOWER THORACIC Ei	15	4	19
MID+LOWER THORACIC	2	2	4
UPPER THORACIC Iu	3	4	7
MID+UPPER THORACIC	2	3	5
LOWER+ABDOMINAL	5	1	6
	52	48	100

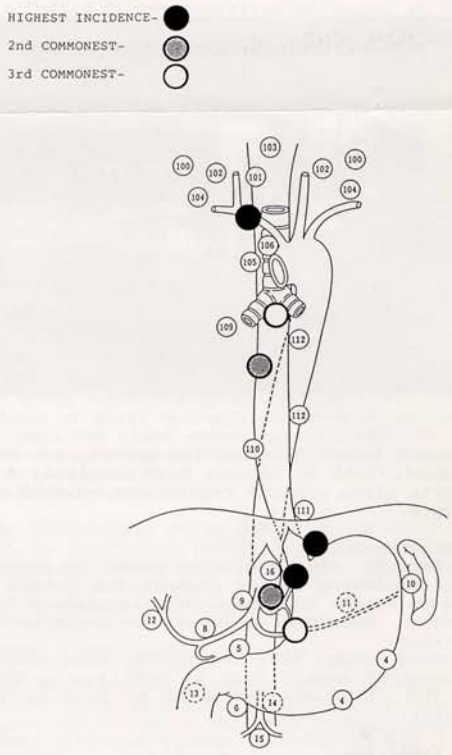
TABLE II

DISTRIBUTION OF CASES ACCORDING TO LYMPHNODE METASTASIS IN THORACIC OESOPHAGEAL CARCINOMA

SITE OF LYMPHNODE WITH METASTASIS	NUMBER OF CASES	%
THORAX	12	23.08
ABDOMEN	19	36.54
THORAX + ABDOMEN	21	40.38
TOTAL	52	100.00

FIG. I

LYMPHNODE STATIONS IN DESCENDING ORDER OF INCIDENCE OF METASTASIS



The radical lymphadenectomy offers following benefits:

1) Proper staging to ascertain the high risk group of patients for adjuvant therapy.

2) Prolongation of disease free interval.

3) Avoids symtons related to pressure or invasion of rec. Laryngeal nerve/pericardium/recontructed organ in the post.mediastinum.

FIG. II
SCC OF THE THORACIC OESOPHAGUS
IMPACT OF LYMPHNODE METASTASIS ON OVERALL SURVIVAL

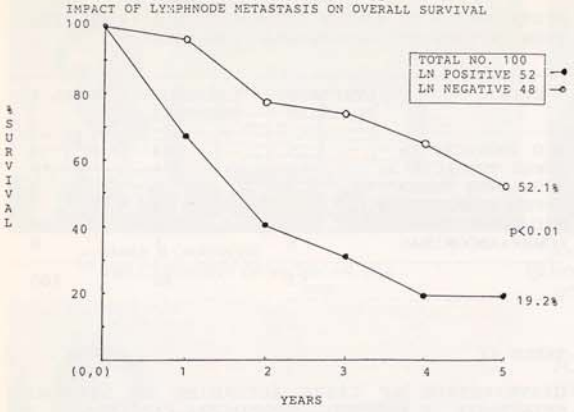
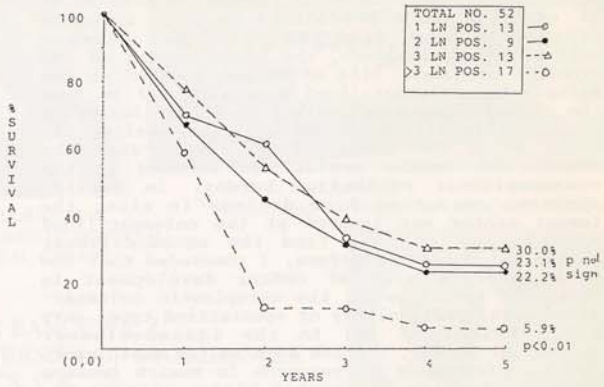


FIG. III
SCC OF THE THORACIC OESOPHAGUS
IMPACT OF NO.OF METASTATIC LYMPHNODES ON SURVIVAL



The only disadvantage of radical lymphadenectomy is slight increase in the postoperative pulmonary complications.

It remains to be proved by a randomized trial that radical lymphadenectomy adds to the overall survival. The fact that lymphnode metastasis reduces survival from 52% to 19% in spite of radical dissection, implies that the lymphnode metastasis is not the source but the sign of distant spread. It is now necessary to turn to newer adjuvant systemic therapies to aim at cure. Adjuvant chemotherapy has shown some early promises but as the long term data accurues the figures seem to drop to a dismal level. Since lymphnode metastasis is an important prognostic factor, a careful study at the celluar level to understand the mechanism which tilts the balance between tumour and host will go a long way in fathoming the tumour biology and application of immunotherapy. (R. A. Badwe)

RECENT ORGANIZATIONAL DEVELOPMENTS

The second Executive Committee meeting was held on April 14, 1991 at the New York Hospital, N.Y. The reports given and the resolutions reached are as followes.

Membership Committee

As of Dec. 31, 1990, the total number of members was 671, including 46 new members who joined in 1990. As we expect to obtain many new members from East Europe, the ISDE is likely to increase its size further.

Two credit cards, VISA and MASTER, were adopted for payment of annual dues in addition to bank draft. The 3% commission will be paid by the Secretariat.

Journal Committee

Topics of further editions will be as follows:

Vol.no.	Date	Topics	Guest Editor
V 1	Apr. 1992	Reflux diseases	A.L.Blum
V 2	Aug. 1992	(1) Caustic lesions	Celerier
		(2) Criticism on radical lymphadenectomy in esophageal cancer surgery	Nabeya
V 3	Dec. 1992	Barrett's esophagus	M.Savary

Papers on subjects other than the topics above are also adopted. Unique original papers on all subjects concerning the esophagus are always welcome.

Research Committee

In addition to the three existing Research Committees ("Central Research Committee","Research Committee of TNM Classification of Esophageal Cancer" and "Research Committee of Barrett's Esophagus") two new Committees have been added. They are the "Pharyngo-esophageal Function Committee" and "Gastro-esophageal Reflux Committee". Next Research Committee meetings including the first meeting of the two new Committees will be held in August in Munich arranged by Prof. Siewert.

General Discussion

1) The 5th World Congress

The Congress President, Prof. Nabeya, reported on the state of preparation of the Congress. For further information, please refer to the front page.

2) The 6th World Congress

There are seven candidates for the Presidency and the site of the 6th ISDE World Congress. After gathering detailed plans for the Congress from all the candidates, this matter will be discussed again at the next Executive Committee Meeting in Munich, and the final decision will be made by the General Assembly in Kyoto during the 5th World Congress (1992).

3) International Surgical Week at the SIC 34th World Congress of Surgery.

At the joint World Congress of the ISS/SIC and CICD, International Surgical Week will be held by the SIC. During this International Surgical Week, ISDE is going to organize a Luncheon Panel on Esophgeal Surgery on the topic of "More or less radical surgery in esophageal cancer". ISDE's organizing a part of International Surgical Week for the SIC World Congress was welcomed by the Executive Committee Members, and is going to be continued in the future. Consequently, we will have two international congresses organized by ISDE in 1995, i.e. the 6th ISDE World Congress and a part of SIC International Surgical Week in Hong Kong.

4) Miscellaneous

The outline of a new category of membership, senior menber (proposed name), was discussed. this form of membership will be restricted to retired members and no annual dues will be necessary.

(H. Udagawa)

RECENT PUBLICATIONS

"Atlas of Esophageal Surgery"
Editor: D. B. Skinner, M.D.

Churchill Livingstone

This book is part of the Surgical Practice Illustrated series. The author, David B. Skinner, a world-renowned surgeon and educator, is also the SPI series editor.

The book has 186 pages and eight chapters devoted to antireflux repair, curative and palliative resection for esophageal cancer, esophageal motor disorders and esophageal reconstruction. The illustrations have been done by Kathy Hirsh, a long time collaborator and friend of Professor Skinner. Her hours spent in the operating room observing the procedures that she has illustrated have paid off well.

The techniques presented in this Atlas are based on more than 25 years of investigation, extensive operative experience, and follow-up of patients with esophageal diseases by the author. Skinner emphasizes in the preface that the reader is strongly urged to learn and apply the methods for precise preoperative analysis of patients with esophageal disorders and indications for the various operations.

The indications, investigations, rationale, and the experience resulting from the operations illustrated in this Atlas are described in the recent book, "Management of Esophageal Disease", which was introduced in the No. 6 ISDE News.

(K. Yoshino)

"Endoscopic Staining in Early Diagnosis of Esophageal Cancer"
Edited by Mitsuo Endo, M.D. and Hiroko Ide, M.D.

Japan Scientific Societies Press Tokyo

Remarkable improvement has been made in the long-term results of esophageal carcinoma through advances in early detection and treatment. The 5-year survival of mucosal lesions is close to 100%, but that of submucosal lesions is only 48%. Therefore the role of endoscopy is particularly important in the diagnosis of mucosal cancer. However, by conventional endoscopy it can be difficult to correctly evaluate extremely slight changes. The supplementary role played by the spray dye technique is therefore extremely important.

The various contributors are all at the forefront of the development of this technique, and the contents should thus be of interest not only to those beginning to employ these techniques but also to those with a certain degree of experience.

The book has four chapters, featuring the background to endoscopic staining techniques, methodology of the endoscopic staining methods, cases reports and application of the staining technique in resected specimens. There are many beautiful endoscopic, macroscopic and pathologic color pictures.

(K. Yoshino)

CONGRESS NEWS

Regional Meetings of the ISDE

THE ANNUAL MEETING OF THE JAPAN SECTION
Site :International Lecture Hall
(National Cancer Center, Tokyo)
Date & Time : September 20, 1991, 9:00-17:00
President :Dr. Toshifumi Iizuka
Topic: Roles of chemotherapy for cancer of the esophagus
Special guest: Laurence P. Leichman, M.D.
Associate Professor of
Internal Medicine
University of Southern
California, U.S.A.
Lecture Meeting:Introduction & Discussion on four Research Committees of Japan Section

THE FIRST MEETING OF THE EASTERN EUROPEAN FEDERATION
CONGRESS VENUE: Hotel "Palisad"
Belgrade, Yugoslavia
CONGRESS DATE: September 25-27, 1991
LOCAL ISDE ORGANIZATION: Meeting President: Z. Gerzic
Scientific Secretary: S. Rakic
SECRETARIAT: Institute of Digestive Diseases
Department of Surgery
Belgrade University
School of Medicine
Koste Todorovica 6,
Belgrade 11000, Yugoslavia
TELEPHONE: +38(0)11-643 070
TELEFAX: +38(0)11-646 988
TOPIC: Reconstruction of the esophagus as the experience with this problem in these areas
DEADLINE: March 31, 1991

THE FIRST CONGRESS OF THE ITALIAN SECTION
Site : Venice, Italy
Date : March 12-14, 1992
President : Prof. A. Peracchia
Topic: Esophageal cancer, Esophageal motility disorders
Main guests: Prof. J. R. Siewert, Prof. K. Nabeya, Prof. E. Moreno-Gonzales

THE 1st WORLD CONGRESS OF THE INTERNATIONAL SOCIETY OF CARDIO-THORACIC SURGEONS
DATE: September 30 - October 4, 1991
PLACE:CHIANG MAI, THAILAND
Chairman: C. Ongcharit
President: J. Wada
Secretariat: Dr. Yothin Kurowat
Cardiothoracic Surgery
Chulalongkorn Hospital
Dead line: June 30, 1991

9th JOINT CONGRESS OF THE ASIAN-PACIFIC FEDERATIONS of ICS
Congress Date: November 24-28, 1991
Congerss Venue: The Westin Philippine Plaza
MANILA, PHILIPPINES
Theme: Surgical Excellence: A Global Concern
Chairman; Dr. CARMENCITA O. GOTAUCO
DEAD LINE: 15 July 1991

★Call for news items

We will be pleased to accept news items, Congress or Meeting information from members for publication. Suggestions for projects and programs will also be welcome. Please send any such information to the Secretariat.

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The Institute of Gastroenterology,
Tokyo Women's Medical College, 8-1 Kawadacho Shinjuku-ku Tokyo 162, Japan

Tel. (03)3358-1435, (03)3353-8111 ext. 25229
Fax. (03)3358-1424

ISDE News Editor-in-Chief; Hiroshi Watanabe, M.D.
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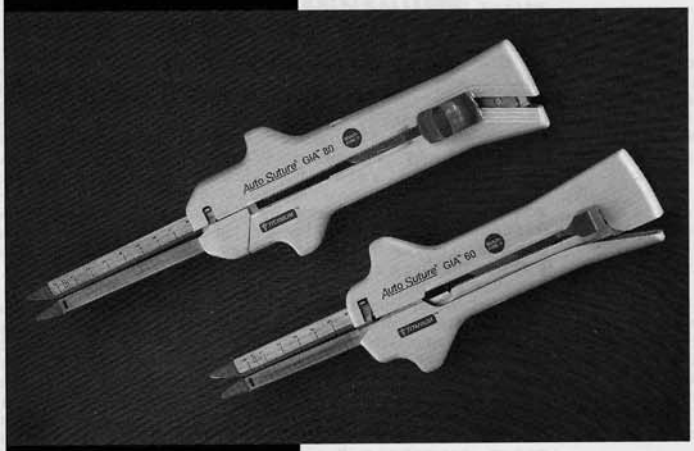

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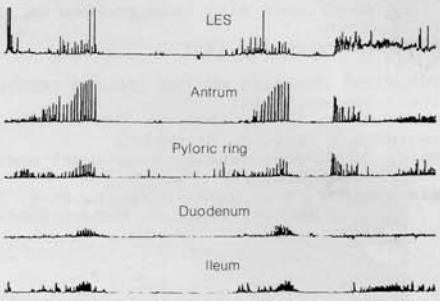

ORGAN MOVEMENT ANALYZING SYSTEM

ECS-800

This dataprocessing system efficiently and accurately arranges the large volume of readings obtained over a long period with the force transducers, providing both the overall picture and analysis of detail.

STAR MEDICAL

For details contact
STAR MEDICAL CO., LTD.
Buraun-Building 101, 6-62-3, Nishinippori, Arakawa-ku, Tokyo 116, JAPAN
TEL: 03-3800-2354 FAX: 03-3800-2359 Telex: 3265-7066 STARME J