

isde



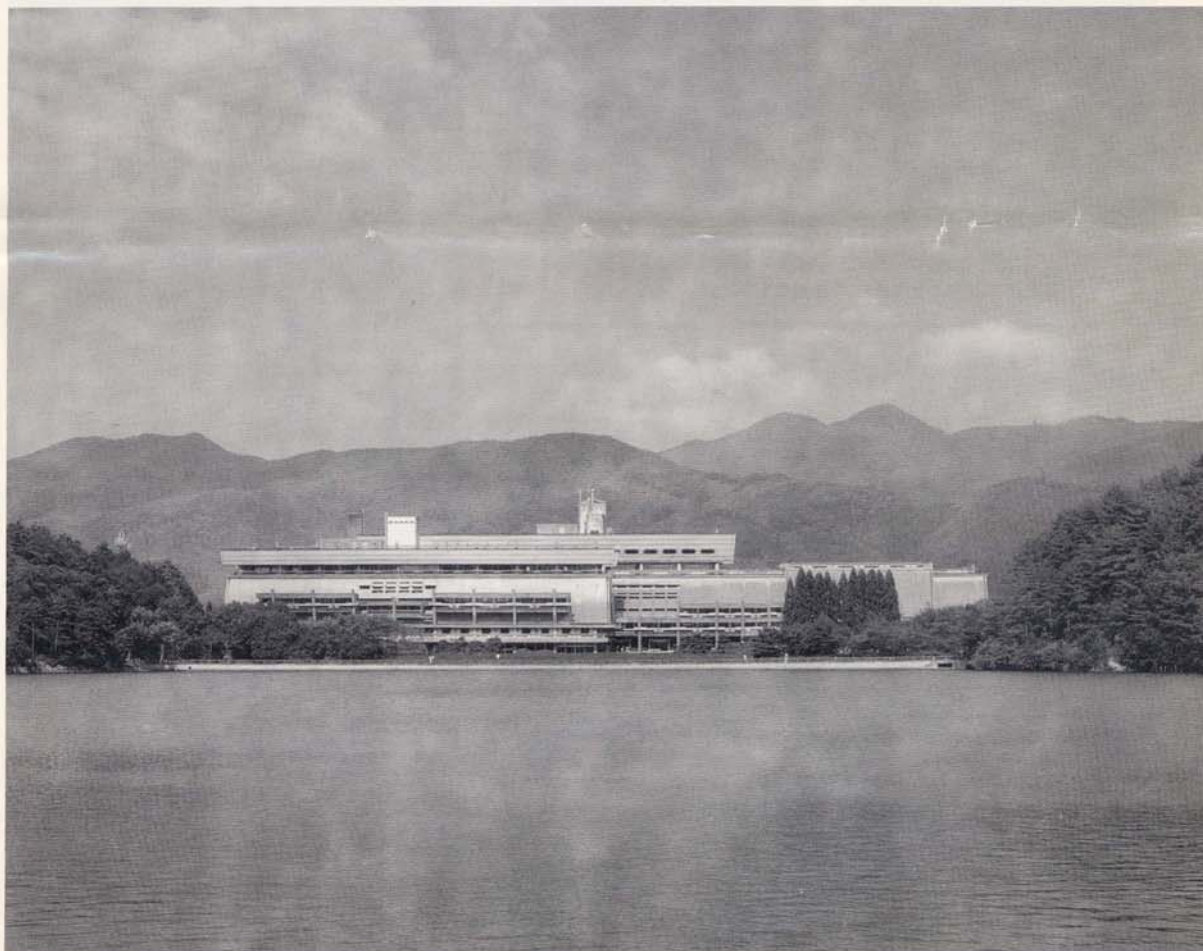
NEWS

The International Society for Diseases of the Esophagus No. 12, July 1st, 1992

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

Meet you in Kyoto

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

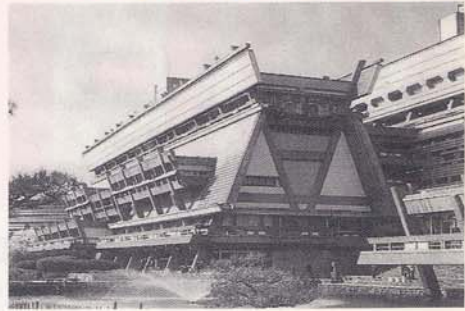


KYOTO INTERNATIONAL CONFERENCE HALL

SOCIAL PROGRAMS



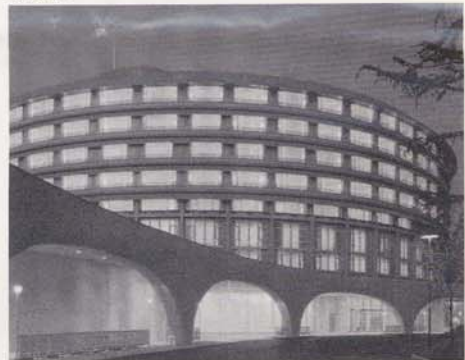
Professor Kin-ichi Nabeya
5th Congress President



Opening Ceremony and Reception
Aug. 5 (Wed) 18:00~21:00
Kyoto International Conference Hall



Congress President's Reception,
Japan Night
Aug. 6 (Thu) 19:00~22:00
Shozan



Official Banquet
Aug. 7 (Fri) 19:00~22:00
Takaragaike Prince Hotel

Farewell Events
Aug. 8 (Sat) 18:00~21:00
The Garden of Kyoto International
Conference Hall



SCHEDULE OF BUSINESS & COMMITTEE MEETINGS ❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖

SCHEDULE OF BUSINESS AND COMMITTEE MEETINGS

-
- Aug. 4 (Tue) 8:30- 9:30 Journal Committee (1st session)
 9:30-12:00 Research Committee on TNM Classification
 13:00-14:30 " on Barrett's Esophagus
 14:30-16:00 " on Paryngoesophageal Dysfunction
 16:30-18:00 Preliminary Executive Committee Meeting
- Aug. 5 (Wed) 8:30- 9:30 Journal Committee (2nd session)
 9:30-12:00 Executive Committee
-
- 9:00-12:00 Meetings for preparation of Central
 Research Committee Meeting
 - TNM
 - Barret's
 - Reflux
 - Paryngoesophageal Dysfunction
 13:00-14:00 Central Research Committee
 14:30-16:30 Council Meeting
- Aug. 8 (Sat) 17:30-18:00 General Assembly

PROGRAM COMMITTEE

* Submitted Applications		* Accepted Papers	
508 Abstracts		Oral	: 154
32 countries		Panel	: 36
		Video &	
		Film	: 56
		Poster	: 211

		Total	457



Taken by Dr. Masahiro Tada (Kyoto 1st Red Cross Hospital)

SCHEDULE OF SCIENTIFIC PROGRAM

Time	Thursday, August 6, 1992				Friday, August 7, 1992				Saturday, August 8, 1992							
	Oral Main Hall	Oral Room B-1	Film & Video Room D	Poster Exhibition Room C1/C2	Meeting & Social Program	Oral Main Hall	Oral Room B-1	Film & Video Room D	Poster Exhibition Room C1/C2	Meeting & Social Program	Oral Main Hall	Oral Room B-1	Film & Video Room D	Poster Exhibition Room C1/C2	Meeting & Social Program	
09:00	Esophageal Cancer: Epidemiology and Biology	Congenital Diseases	Videos	Exhibits		Gastroesophageal Reflux: Diagnosis [Panel]	Esophageal Cancer: Surgical Treatment (I)	Videos	Exhibits		Resection for Esophageal Cancer (I) [Panel]	Esophageal Varices	Videos	Exhibits		
10:00																
11:00	Esophageal Cancer: Pathology	Gastroesophageal Reflux (I)	Videos			Gastroesophageal Reflux: Surgical Treatment [Panel]	Esophageal Cancer: Surgical Treatment (II)	Videos			Resection for Esophageal Cancer (II) [Panel]	Benign: Other Diseases and Strictures	Videos			
12:00	Special Lecture (I)					Special Lecture (II)					Special Lecture (III)					
12:30	L U N C H										L U N C H					
13:00				Free Discussion					Free Discussion					Free Discussion	Informal Get-together of Young Researchers	
14:00	Motility Disorders (Achalasia)	Esophageal Cancer: Diagnosis and Cancer Staging	Videos	Exhibits		Multimodality Treatment for Esophageal Cancer	Gastroesophageal Reflux (II)	Videos	Exhibits		Barrett's Esophagus	Palliative Treatment for Esophageal Cancer and Others	Films	Exhibits		
15:00																
16:00	Coffee Break					Coffee Break										
16:30	Motility Disorders (Achalasia) [Panel]	Esophageal Cancer: Surgical Treatment	Videos			Multimodality Treatment for Esophageal Cancer [Panel]	Esophageal Perforation	Videos			Report of Research Committee					
17:00																
18:00																
19:00	Congress Reception, Japan Night at "Shozan"					Congress Reception, Japan Night at "Shozan"										
22:00	Official Banquet at Prince Hotel					Official Banquet at Prince Hotel										Forewell Events



1. CENTRAL RESEARCH COMMITTEE

Chairman:
David B. Skinner
The New York Hospital
Cornell Medical Center
New York, USA

Members:
DeMeester, Tom R. (USA)
Donner, Martin W. (USA)
Ellis, Jr., F. Henry (USA)
Giuli, Robert (France)
Huang, Guo Jun (PRC)
Iizuka, Toshifumi (Japan)
Inokuchi, Kiyoshi (Japan)
Kakegawa, Teruo (Japan)
Lerut, Toni (Belgium)
Matthews, Hugo R. (UK)
Nabeya, Kin-ichi (Japan)
Peracchia, Alberto (Italy)
Siewert, J. R. (Germany)
Wong, John (Hong Kong)



2. TNM CLASSIFICATION RESEARCH COMMITTEE

Chairman:
Toshifumi Iizuka
National Ooji Hospital
Tokyo, Japan

Members:
Akiyama, Hiroshi (Japan)
Altorki, Nasser K. (USA)
Bardini, Romeo (Italy)
Correnti, F. Stephano (Italy)
Desai, Braffulla B. (India)
Giuli, Robert (France)
Holscher, Arnulf H. (Germany)
Huang, Guo Jun (PRC)
Isono, Kaichi (Japan)
Lerut, Toni (Belgium)
Moreno-Gonzalez, E. (Spain)
Nabeya, Kin-ichi (Japan)
Wong, John (Hong Kong)



3. BARRETT'S ESOPHAGUS RESEARCH COMMITTEE

Chairman:
F. Henry Ellis, Jr.
New England Deaconess Hospital
Harvard Medical School
Massachusetts, USA

Members:
Aoki, Teruaki (Japan)
Cecconello, Ivan (Brazil)
Duranceau, Andre (Canada)
Gayet, Brice F. (France)
Giuli, Robert (France)
Keeling, Parnel (Ireland)
Lerut, Toni (Belgium)
Orringer, Mark B. (USA)
Stipa, Sergio (Italy)



4. REFLUX DISEASE RESEARCH COMMITTEE

Chairman:
Hugoe R. Matthews
East Birmingham Hospital
Birmingham, UK

Members:
Bancewicz, John (UK)
Feussner, Hubertusk (Germany)
Lerut, Toni (Belgium)
Siewert, J. R. (Germany)



5. PHARYNGOESOPHAGEAL DYSFUNCTION RESEARCH COMMITTEE

Chairman:
Toni Lerut
Universitaire Ziekenhuis
Leuven, Belgium

Members:
Altorki, Nasser K. (USA)
Csendes, Attila (Chile)
Cook, Ian (Australia)
Donner, Martin W. (USA)
Dupin, Beatrice (France)
Duranceau, Andre (Canada)
Feussner, Hubertus (Germany)
Hendrix, Thomas R. (USA)
Jones, Bronwyn (USA)
Monnier, Philippe (Swiss)
Savary, M. (Swiss)
Skinner, D. B. (USA)
Stell, P. M. (UK)
Winans, C. Schiller (USA)

RECENT ORGANIZATIONAL DEVELOPMENTS

NEWS FROM THE EXECUTIVE MEETING

The Fourth ISDE Executive Committee Meeting was held on March 29(Sun),1992, at the Keio Plaza Hoatel Tokyo, JAPAN. The following reports were given.

Report 1. Membership Committee:

The number of ISDE members was 638 as of December 31, 1991, which is slightly more than in 1990.

Report 2. Scholarship Committee:

Five grantees for 1992 Scholarship were determined (see the colum of Scholarship), and the total amount of support was to be US \$42,500. The description of the synopsis must be amended such that the grantee must submit a report of about 800 words within 3 months after completion of the scholarship. The report will be published in the ISDE Newsletter.

Report 3. Newsletter Committee:

Issue No.11 was published without problem.

Report 4. Journal Committee:

The status of the publication was reported.

Report 5. The 5th World Congress:

The results of the program Committee Meeting was reported.

THE FOLLOWING NATIONAL REPRESENTATIVES WERE ELECTED (1992. 8 - 1995)

A-nations ; 21, A-members ; 25
 Mammoni, O. H. (Argentina), Jamieson, G. G. (Australia), Lerut, T. (Belgium), Pinotti, H. W. (Brazil), Duranceau, A. (Canada), Giuli, R. (France), Holscher A. H. (Germany), Yannopoulos, P. (Greece), Desai, P. B.(India) Del-Genio, A. (Italy), Bazan, P.(Italy), Kakegawa, T. (Japan), Endo, M.(Japan), Mori, S. (Japan), Tilanus, H. W. (Netherlands), Huang, G. J. (PRC), De Almeida, J. M. (Portugal), Kim, J. H. (ROK), Bremner, C. G. (South-Africa), E. Moreno-Gonzalez (Spain), Wang, P. Y. (Taiwan), Bancewicz, J. (UK), Orringer, M. B. (USA), DeMeester, T. R.(USA), Gerzic, Z. (Yugoslavia)

B-members ; 7

Roka, R. (Austria), Csendes, A. (Chile), Isolauri, J. O. (Finland), Kiss, J. (Hungary) Hennesy, T. P.(Ireland), Guarner, V. (Mexico) Stanciu, C. (Rumania)

At large ; 6

Fekete, F. (France), Ellis, F. H. (USA), Launois, B. (France), Matthews, H. R. (UK), Stipa, S. (Italy), Kijima, M. (Japan)



ISDE SCHOLARSHIP ★ SCHOLARSHIP COMITTEE MEETING ★

Five applicants from all over the world appied for the 1992 Scholarship. The Scholarsip Committee Meeting was held on March 29th, 1992 in Tokyo presided over by Prof. Siewert (Chairman). After strict evaluation, it was decided that four Research Scholarships and one Visiting Scholarships would be awarded and support per award ranged from \$2,500 to \$10,000.

Scholarship winners are Dr. HARIKANT S.BHANUSHALI (India), Dr. YOSHIHIRO NABEYA (Japan), Dr. LAJOS KOTSIS (Hungary), Dr. HIDEYUKI KASHIWAGI (Japan), Dr. KUNIHIDE YOSHINO (Japan)

Their hosts and study sites are as follows:

Dr. H. S. BHANUSHALI - Prof. H. Akiyama
 Toranomon Hospital, Tokyo, JAPAN
 Dr. Y. NABEYA - Prof. D. B. Skinner
 Cornell University, New York, U.S.A.
 Dr. L. KOTSIS - Prof. K. Nabeya
 Kyorin University, Tokyo, JAPAN
 Dr. H. KASHIWAGI - Prof. J. Bancewicz
 Univ. of Manchester, Manchester, UK
 Dr. K. YOSHINO - Prof. S. K. Das
 University of Mississippi, Mississippi, U.S.A.
 (N. Ando)



H. S. BHANUSHALI



Y. NABEYA



L. KOTSIS



H. KASHIWAGI



K. YOSHINO

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 Japan

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Member : Nobutoshi Ando, M.D.
 Hiroko Ide, M.D.
 Harushi Udagawa, M.D.
 Kunihide Yoshino, M.D.
 Misao Yoshida, M.D.

Adviser : J. P. Barron
 Secretariat : Yukako Kawana
 Keiko Tashiro

REGIONAL ACTIVITY

GERMANY

POSTGRADUATE COURSE AND GERMAN CHAPTER OF THE INTERNATIONAL SOCIETY FOR DISEASES OF THE ESOPHAGUS IN THE TECHNICAL UNIVERSITY OF MUNICH

Hiromasa Fujita, M.D., Kurume Univ.
Kurume, Japan
A. H. Hölischer, M.D., Technical Univ. of
Munich, Munich, Germany

The postgraduate course was held in the lecture hall of the Technical University of Munich during the period from the 9th to the 12th of March in 1992. This course is conducted twice a year with various themes for the purpose of postgraduate training for young surgeons, not only from the Technical University of Munich but also from other universities, in cooperation with the International Gastro-Surgical Club. The particular theme of the 13th course was "The latest in esophageal surgery, 1992", therefore this meeting united the German Chapter of the International Society for Diseases of the Esophagus. Approximately, one hundred peoples attended. However, the lectures in the course were so advanced and intensive, that it seemed to me that it was a mini-congress of the ISDE rather than a postgraduate course.

During these four days, there were 48 lectures, three presentations on esophageal surgery and three courses of practical training performed by 22 German and 14 foreign lecturers who were K. Nabeya/Tokyo, J. Wong/Hong Kong, A. Peracchia & A. Ruol/Padua, J. Mendes d'Almeida/Lisbon, B. Gayet/Paris, L. Olbe, L. Lundell/Göthenburg, A. L. Blum/Lausanne, J.A. Salo/Helsinki, P. Schlag/Heidelberg, H. U. Steinau/Bochum, T.N. Walsh/Dublin and H. Fujita. These lecturers stayed in the same hotel, ate every meal at the same tables, talked from morning to night, and became friends.

On the 9th and the 10th of March, lectures concerning esophageal cancer were given. The themes of these sessions were preoperative staging, preoperative risk analysis, preoperative radio-chemotherapy, more or less radical surgery, surgical techniques of esophagectomy and reconstruction, and lastly surgery for cervical esophageal cancer. On the morning of the 10th, three operations were performed, the transthoracic en-bloc esophagectomy, the endoscopic transmediastinal esophagectomy, and colon interposition following transmediastinal esophagectomy, in the operating theaters and, were shown on by video monitors in the lecture hall.

On the morning of the 11th, lectures concerning Barrett's esophagus and adenocarcinoma were given and in the afternoon, lectures concerning gastroesophageal reflux disease were also given. On the 12th, practical sessions were held for the attendants. The sessions consisted of three training courses including esophageal functional examinations, surgical intensive therapy after esophagectomy, and endoscopic examination and endoscopic palliative treatment for esophageal cancer.

The most interesting lectures for me were as follows. Firstly, "Preoperative chemotherapy for resectable cancer" by Dr. Schlag. He reported the results of a randomized control trial in Germany comparing preoperative chemotherapy using CDDP+5Fu and surgery alone. He concluded that there was no difference in resectability, curability and survival rates between the two groups. However, the hospital mortality rate of the

preoperative chemotherapy group was higher than that of the surgery alone group (20% vs. 10%).

Secondly, in the session of "More or less radical surgery?", Professor Siewert recommended extended lymphadenectomy because of exact staging (UICC), a higher rate of resectability, a higher rate of complete tumor extirpation (R0), a lower rate of local recurrence and a better 5-year survival rate. His philosophy is the same as that of almost all Japanese surgeons.

Thirdly, in the video session on surgical technique, "Transthoracic endoscopic esophagectomy" was presented by Eypasch. All three cases which underwent this operation died in hospital. However, I think that in the near future, this type of operation might become more common. Moreover, excellent operative techniques of thoracoscopic resection of esophageal leiomyoma or thoracoscopic long myotomy of the esophagus for diffuse esophageal spasm were presented by Dr. Gayet. His procedures are very useful and can be carried out.

Finally, all lectures concerning the Barrett's esophagus or gastro-esophageal reflux diseases were very interesting for me, because these diseases are very rare in Japan. In particular, the lecture of Professor Blum was impressive. He compared the efficacy of anti-reflux surgery with that of long-term antacid therapy using omeprazole, and concluded that the indications of reflux surgery had become increasingly less, and should be limited to young patients resistant to omeprazole therapy.

In conclusion, it was impressive that for me that 18 doctors from the Technical University of Munich gave such interesting lectures in throughout this course. I felt that it demonstrates the power of the excellent staff at the Technical University of Munich directed by Professor Siewert. Moreover, all the sessions of this course were chaired by either Professor Siewert or Dr. Holscher. I was deeply impressed by their extraordinary intelligence, knowledge and physical strength. (H.Fujita, A.H.Hölischer)



CONT.

REGIONAL ACTIVITY

U.S.A.

F. Henry Ellis, Jr., M.D.
Clinical Professor of Surgery
HARVARD MEDICAL SCHOOL

TWO MAJOR CARDIOTHORACIC SURGICAL MEETINGS HAVE BEEN HELD SINCE THE FIRST OF THE YEAR WITH ESOPHAGEAL PAPERS OF INTEREST TO OUR SOCIETY

At a recent meeting of the Society of Thoracic Surgeons in Florida, the Mayo Clinic group reported on 19 Barrett's esophagus patients with an endoscopic biopsy diagnosis of highgrade dysplasia, eleven of whom were in a surveillance program. Seventeen of these patients underwent esophagectomy. Nine patients were found to have invasive carcinoma at the time of operation, but all were in Stages I and II. The median survival rate was 34 months and the actuarial five year survival rate was 67%. They concluded that high grade dysplasia is an indication for esophageal resection because of the high rate of associated early carcinoma and the excellence of the long term survival.

Dr. Duranceau from Montreal reported on the long term effect of total fundoplication (Nissen procedure) on the myotomized esophagus. Whereas in earlier publications he had recommended combining esophagomyotomy for achalasia with a Nissen fundoplication, this report concerned the late results of such patients which identified an increase in esophageal retention with poor esophageal emptying and recurrence of dysphagia. In spite of good reflux control by total fundoplication he no longer believes it to be an appropriate ancillary procedure at the time of esophagomyotomy for achalasia.

Dr. DeMeester's group reported on 78 operation in 63 patients who had a previous failed antireflux operation. The cause of late failure involved improper placement of the initial Nissen wrap around the stomach, breakdown of the fundoplication, a post-operative hiatus hernia and the presence of an underlying esophageal motor disorder. Best results were obtained in those patients with good esophageal contractility. Only 44% of patients with poor contractility were benefitted. He and his associates recommend esophageal resection for patients with either poor esophageal contractility or multiple previous esophageal procedures.

At the annual meeting of the American Association of Thoracic Surgery was held in Los Angeles at the end of April. Dr. Orringer updated his experience with transhiatal esophagectomy for benign and malignant disease of the thoracic esophagus since 1977 involving a total of 559 patients, approximately a third having benign disease and two thirds carcinoma. The overall hospital mortality rate was two percent for those with benign disease and five percent in patients operated on with malignant lesions. Excellent functional results were achieved in more than 85% of patients with benign disease although approximately 50% have required one or more anastomotic dilations within the first three post-operative months. Clinically significant gastroesophageal reflux occurred in less than 1% of patients.

The Lahey Clinic group presented their experience with 19 patients with known Barrett's esophagus under endoscopic surveillance, 1 to 14 months intervals with a

ITALY



A. Peracchia
CLINICA CHIRURGICA 1
UNIVERSITA DEGLI STUDI DI PADOVA

THE FIRST MEETING OF THE ITALIAN SECTION OF THE I.S.D.E.

The first congress of the Italian section of the ISDE was held in Venice on March 12-14 1992, under the chairmanship of Professor Alberto Peracchia. The congress was attended by most Italian members of the ISDE and by more than a hundred physicians from all over Italy. Professor J. R. Siewert, president of the ISDE, gave a lecture on "Update and future directions in esophageal surgery". Prof. K. Nabeya, president of the 5th world congress of the ISDE in Kyoto, gave a lecture on "Precancerous lesions and early cancer of the esophagus". The topics of the congress were as follows: motility disorders of the esophagus, gastro-esophageal reflux disease, mini-invasive surgery, benign and malignant tumors of the esophagus, traumatic injuries, and esophageal varices in portal hypertension. One-hundred thirty abstracts were selected by the scientific committee for oral, video or poster presentation. (A. Peracchia)

median interval of 6 months. All but one of these 19 patients underwent esophagogastrectomy after endoscopic biopsies revealed either high grade dysplasia or invasive carcinoma. Seventy-nine percent of patients under surveillance had lesions in Stages 0, I and II whereas only 36% of the patients with adenocarcinoma who were not under surveillance were similarly staged. The adjusted actuarial survival rate of those patients under surveillance was 67% as compared to 22% for those not under surveillance. These data strongly suggest that surveillance endoscopy allows early detection of developing malignancy and improves long term post-operative survival.

The need for surgical resection in patients with epiphrenic diverticula was discussed by Dr. Skinner's group from New York. Their study involved a total of 20 patients seen over a 20 year period, in 17 of whom diverticulectomy was performed. No mention was made of concomitant esophagomyotomy, but all save one of the operative survivors are currently asymptomatic, whereas of the three patients who refused surgery, one died from aspiration pneumonia and another continues to live with severe dysphagia. They conclude that surgery should be undertaken in all such patients regardless of the presence or absence of symptoms because of the risk of preliminary complications secondary to aspiration. (F. Henry Ellis, Jr.)

SCHOLARSHIP REPORT

Satoshi Ookura, M.D.
2nd Dept. of Surgery
Kyorin University
School of Medicine
Tokyo Japan

MY EXPERIENCE AT THE FIRST DEPARTMENT OF SURGERY, UNIVERSITY OF PADOVA, ITALY

In the beginning, I must report on the fact that this institution makes diagnosis and treatment on numerous cases yearly in esophageal cancer (squamous cell cancer); cardiac cancer (adenocarcinoma); and gastro-esophageal reflux disease cases. The treated number of esophageal cancer cases amount to over 150 yearly and is still rising. To be sure, the incidence rate of esophageal cancer and gastro-esophageal reflux diseases in this Veneto region is very high and this institute is actually the center of diagnosis, treatment, research in this area, but this is not the only reason that so many patients come here to be treated. I believe that the main reason for this phenomenon is that their diagnosis is correct, and that treatment results of this institute have been recognized by the public.

I would particularly like to emphasize this institute's excellence in esophageal cancer diagnosis, treatment and research.

[1] Diagnosis

Needless to say, the basic diagnostic methods such as x-ray and endoscopy, including dye-staining endoscopy are being carried out here but in addition to these methods, mediastinal CT (including abdominal CT); MRI; endoscopic ultrasonography examinations, and if necessary, mediastinoscopy and laparoscopy are utilized to perform a three-dimensional diagnosis of the stage of cancer.

Endoscopic ultrasonography is especially effective in the diagnosis of mediastinal lymph node metastasis and also in depth of invasion. At present, linear type ultrasonography is used for diagnosis.

[2] Treatment

1) Operation:

The standard operative technique for esophageal cancer, excluding cervical esophageal cancer is: a right thoracotomy; total resection of the thoracic esophagus; and an esophago-gastro tube anastomosis within the thoracic cavity. In some cases, the anastomosis is performed at the cervical site. Again, according to the stage of cancer development and general physical condition, total esophagectomy without thoracotomy (with the digital dissection technique) is selected.

One particular point that I was impressed with is their use of staplers. Further, the important point is that they do not compromise with the anastomotic apparatus and they do not hesitate to perform hand-suturing procedures whenever deemed necessary.

Lastly, I would like to emphasize on their operative procedures. It is only reasonable that sufficient lymph node dissection be made for curative resection but for severely advanced cases (non-curatively resected cases), this institute chooses an operative procedure that endows the "quality of life" of the patient.

2) Endoscopic treatment:

In inoperable cases (including contraindicated cases), Nd:YAG laser therapy and esophageal prosthesis are used for esophageal and cardiac stenotic cases, either alone or in combination. What merits attention is the fact that these procedures are carried out even in the out-patient clinic.

Endoscopic esophageal prosthesis is performed positively after a decision on suitability is made. This is a measure highly effective in advanced cases, e.g. those with a esophagobronchial fistula.

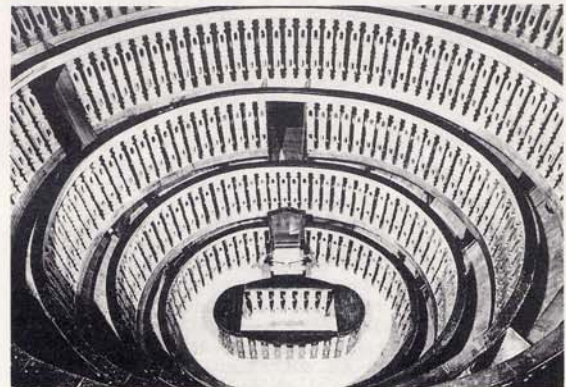
3) Chemotherapy:

Operative treatment combined with chemotherapy has produced superior treatment results. Chemotherapy (cisplatin and 5-FU Combination chemotherapy) has not only connected inoperable cases into operable cases, but has also raised the possibility of curative resection and has increased radical curability (preoperative chemotherapy). Among chemotherapy cases 50% showed, effective results and the significance of this treatment holds hope. There were actively cases of complete response (CR).

In benign diseases, many gastro-esophageal reflux disease cases are examined, diagnosed and treated. They have 24-hour esophageal pH monitoring and an esophageal manometer for diagnosis and the analysis of these data are excellent. These examinations are most important in determining indications of operation. Safety, stabilization and non-recurrence are carefully considered for operative methods and various steps are being taken.

Data on diagnosis, treatment, prognosis are registered in the computer for analysis and reported. These will surely serve as a foundation for treatment method determination in the future.

Lastly, but not leastly, I am most grateful to Professor Peracchia who was kind enough to accept me to study at Padova. I would also like to thank Professor Bardini and Professor Merigliano and many others who have helped me in every respect, in spite of their daily busy schedules in treatment and research. I extend to all the people at the Padova University, my thanks and appreciation for all their kindness. (S. Ookura)



University Palace. The Anatomy Theatre

CONT.

SCHOLARSHIP REPORT



Dirk Van Raemdonck, M.D.
University Hospitals Leuven
Leuven, Belgium

EVALUATION OF TREATMENT FOR REFLUX STRICTURE OF THE ESOPHAGUS

Reflux strictures causing dysphagia are usually treated by dilatation of the stricture, antireflux repair, or occasionally esophageal resection. The results following these procedures are usually reported in quantitative rather than qualitative terms and there has been no real attempt to measure the degree of benefit obtained from these three different treatment modalities. As a result there is considerable confusion in selection of the best method of treatment and in evaluation of the results.

In the first part of our project, we reviewed our patients with dysphagia related to a reflux stricture that presented to one consultant (HRM) in the Regional Department of Thoracic Surgery at East Birmingham Hospital between the 1st January and the 31st December 1990. All 78 patients underwent one or more esophageal dilatations in 1990. There were 46 females and 32 males (male/female ratio = 0.70). The mean age at the time of their first presentation was 66.8 years, ranging from 17 to 90.

Seventy seven percent of the patients were older than 60 and half of them were older than 70. A total of 106 dilatations were performed for reflux strictures in 1990. The total number of dilatations in these 78 patients since the time of their first presentation (1975-1990) was 309 (mean of 4.0 dilatations per patient). Out of 74 patients 49(66.2%) had active esophagitis, and 10 out of 74(13.5%) had a columnar-lined esophagus on endoscopy. Seventy patients(90%) presented with a sliding type hiatal hernia on barium meal.

The mean interval between two dilatations was 1 year, ranging from 1 month to 73 months with a median of 12 months. Seventy two patients (92.3%) were treated by dilatation only. Five patients (6.4%) subsequently had an antireflux repair in 1990.

Only one patient (1.3%) underwent esophageal resection. In the second part of the project, we tried to develop a new method for grading dysphagia. To evaluate the patients' ability in swallowing different types of food, we used an "eating chart" (table 1), in which the patient's progress in terms of his eating was plotted on a weekly basis, both before and after therapeutic intervention. In the first phase, we wanted to evaluate the applicability and reliability of this chart.

Therefore, from April to November 1990, a miscellaneous group of 30 patients presenting to our service with dysphagia related to varying esophageal problems (10 patients with a reflux stricture, 10 with an esophageal motor disorder, 7 with an obstructive carcinoma, 2 with an anastomotic stricture and one with a pharyngeal diverticulum), we asked to complete this form on a weekly basis. To fill in the empty boxes, we used an "eating scale" based on 4 simple symbols, referring to the patients' perception in swallowing that type of food: "0" =unable to eat, "-"=can eat with difficulty, "+"= no problem in eating, and "x"= don't like. These eating data were analyzed, using the following scoring system":-0- for

"unable to eat", -1-for"can eat with difficulty", -2- for "no problems in eating", and no value for "don't like" or for a blank box. Thus, no distinction in value was made between the ability to swallow solids or liquids as dysphagia, in terms of swallowing different types of food, because these can be quite different in patients with an organic lesion compared to those with a functional disorder. In this way, we were able to calculate an "eating ability percentage" (EAP) from the obtained "total eating ability score" and the "maximum eating ability score". The mean EAP in all patients cooperating in the study was 70% prior to their treatment and increased to 78% and 81% respectively one and 12 weeks following treatment.

The use of this EAT allowed us not only to quantify the immediate and long-term effect of any treatment but also to compare the results of different treatment modalities. It also gave us the opportunity to propose a new dysphagia score.(Table 2) The value of this "eating chart" and the "eating ability scoring system" in quantifying the results following treatment for reflux stricture in particular needs further evaluation in a second phase of the study.

Finally, I would like to thank Prof. T. Lerut for organizing esophageal surgical training abroad for me as well as Prof. HR Matthews for giving me the opportunity to work in his department for the period of one year. (V. Raemdonck)

EATING CHART												
EATING SCALE: 0 = UNABLE TO EAT - = CAN EAT WITH DIFFICULTY + = NO PROBLEMS IN EATING X = DON'T LIKE												
	WEEKS -1	0	1	2	3	4	5	6	7	8	9	10 11 12
STEAK												
ROAST MEAT												
CHIPS												
ROAST POTATOES												
APPLE												
ORANGE												
TOAST												
SANDWICH												
FISH												
COOKED VEGETABLES												
RICE												
PASTA												
PASTRIES												
CAKE												
BISCUITS												
CHEESE												
MINCED MEAT												
MASHED POTATO												
OMELETTE												
FRIED-EGG												
JELLY												
PORRIDGE												
BREAKFAST CEREAL												
BANANA												
ICE CREAM												
SOUP												
LIQUIDS-HOT												
LIQUIDS-COLD												
EATING OVERALL												
	WEEKS -1	0	1	2	3	4	5	6	7	8	9	10 11 12
DATE: DAY												
MONTH												
YEAR												
WEIGHT												
DRUGS: 1:												
2:												
3:												
TREATMENT-DILATATION												
SURGERY												

Table 1: The "Eating Chart"

EAP		Grade
100 %	no dysphagia	Grade 0
80 - 99%	minor dysphagia	Grade 1
50 - 79%	considerable dysphagia	Grade 2
10 - 49%	severe dysphagia	Grade 3
< 10%	total dysphagia	Grade 4

Table 2. A new dysphagia score based on the "Eating Ability Percentage"

CONGRESS NEWS

Regional Meetings of the ISDE

*** THE 8TH ANNUAL MEETING OF THE JAPAN SECTION OF I S D E ***

Site : Sendai Hotel, Sendai
Date & Time : November 28(Sat), 1992
President : Prof. Shozo Mori

2nd Dept. of Surgery
Faculty of Medicine,
Tohoku University

Topic: Malignant factors and prognosis
Special guest: Prof. Kanji Ishizaki
Title of the lecture "Loss of 17_p, mutation of the p₅₃ gene and overexpression of P53 protein in esophageal carcinoma"

*** 13th WORLD CONGRESS OF CICD ***
(Collegium Internationale Chirurgiae Digestivae)
Site : ATHENS, GREECE
Date : September 21-24, 1992
Congress president : M. SEHAS

*** NATIONAL SYMPOSIUM OF GASTROENTEROLOGY AND DIGESTIVE ENDOSCOPY ***

Site : IASI, ROMANIA
Date : October 22-23, 1992
President : Prof. C. Stanciu
Topics : - Esophageal diseases (excluding esophageal cancer)
- Obstructive Jaundice
Deadline : September 15, 1992

*** 35th WORLD CONGRESS OF SURGERY * INTERNATIONAL SOCIETY OF SURGERY # INTERNATIONAL SURGICAL WEEK #**

Site : HONG KONG
Date : August 22-28, 1993
Chairman : J. Wong, M.D.
Department of Surgery
University of Hong Kong
Queen Mary Hospital

*** THE 11th ASIA PACIFIC CANCER CONFERENCE ***
Site : Bangkok, Thailand
Date : November 16-19, 1993
Chairman : Phisit Phanthumachinda, M.D.

ENDOSCOPIC STAINING IN EARLY DIAGNOSIS OF ESOPHAGEAL CANCER

Edited by

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Concentrating on the actual methodology and techniques in addition to treating in detail the evaluation of findings, particularly in cases of intraepithelial carcinoma, this volume is strictly devoted to the practical aspects of the spray dye technique.

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1. THE BACKGROUND TO ENDOSCOPIC STAINING TECHNIQUES IN CANCER OF THE ESOPHAGUS

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- 3) Double Staining Method ... Misao Yoshida

3. CASE REPORTS

Hiroyasu Makuuchi and Mamoru Nishizawa

4. APPLICATION OF THE STAINING TECHNIQUE IN RESECTED SPECIMENS :

Its Contribution to the Diagnosis of Mucosal Cancer and Slight Pathological Changes of the Mucosa

Hiroko Ide and Masayuki Itabashi

- 1) Iodine Method
- 2) Blue Staining Method (Alcian Blue Method or Toluidine Blue Method)

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(preparation of injection)

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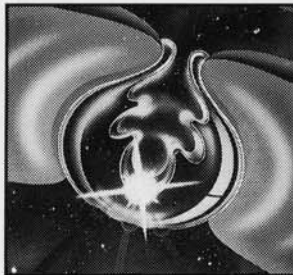
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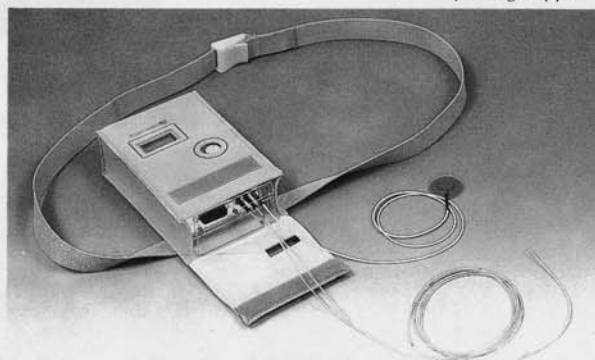
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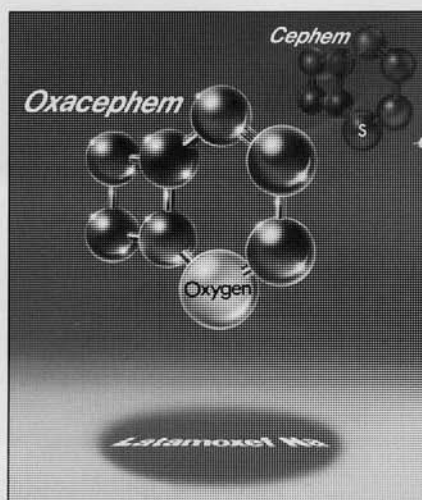
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