The Council

President
Dr. Szeto Ming Leung

Vice-President
Dr. Francis K L Chan

Hon. Secretary
Dr. Judy W C Ho

Hon. Treasurer
Dr. Yeung Yat Wah

Endoscopy Chapter Chairman
Dr. Francis P T Mok

Members
Dr. Hui Wai Mo
Dr. Philip C H Kwok
Dr. Lai Jak Yiu
Dr. Vincent K S Leung
Prof. Joseph J Y Sung
Dr. Benjamin C Y Wong
Dr. Yuen Hon

Co-opted Members
Dr. Lao Wai Cheung
Dr. Yuen Man Fung

Message from Dr. Szeto Ming Leung, President

2004 has been a good and successful year for The Hong Kong Society of Gastroenterology. To continue our objective to promote the advancement of gastroenterology in Hong Kong, this Society organized two annual scientific meetings: the Annual General Meeting and Scientific Meeting in March and the 6th Joint Annual Scientific Meeting in October, 2004. Both meetings were well attended with the number of participants at 290 and 430 respectively. General responses to the interactive case discussions and interdisciplinary scientific programme were very favourable. Our Society also organized in conjunction with the Hong Kong Society of Digestive Endoscopy a meeting in July entitled “The Evolution of PPI Therapy – an Ongoing Story” which attracted some 170 participants with active discussions.

On research and education, this Society continued to monitor the progress of the two research projects of 2003 namely, clopidogrel and GI bleeding and, NASH. The educational CME-CD on Challenges in Gastroenterology and Hepatology was completed in August by combined efforts of The Council, a Working Group headed by Prof. Joseph Sung and fellow contributors. The CD was distributed to members and fellows at the Joint Annual Scientific Meeting in October. This was also on sale to non-member practitioners who would like to pursue continuing education in this field. Two issues of the Society Newsletter containing scientific updates on specialized topics, major events and news were published this year. In appreciation of the all-time support of our members and given Society’s present good finance, the annual membership subscriptions were reduced to $300 for fellows and $100 for members.

I wish to take this opportunity to thank the following friends and contributors of this Society: all fellows and members for their continuous support and contributions; Prof. Joseph Sung and his CME-CD Working Group for their great work and valuable contributions; Dr. W M Hui for editing the Newsletter; Doctors F H Ng, C M Chang and Annie Chan for sharing with us their scientific updates, speakers and session chairmen of our scientific meetings. Last but not the least, may I extend on behalf of the Society, our heartfelt thanks to friends from the pharmaceutical industry for their ready participation and generous sponsorship throughout the year. I look forward to the continued support and encouragement of all in future.

Best wishes for a Merry Christmas and Happy New Year!
Clopidogrel and Peptic Ulcer Disease

Dr. FH Ng, Dr. CM Chang
Department of Medicine
Ruttonjee Hospital

Recently, clopidogrel (Plavix, Bristol-Myers Squibb Co.), a new antiplatelet agent, was approved by the Food and Drug Administration for use in secondary prevention of heart attacks and stroke. Clopidogrel, a thienopyridine derivative similar to ticlopidine, differs from aspirin in the mechanism by which it inhibits platelet aggregation. Aspirin inhibits platelet aggregation by irreversibly blocking the enzyme cyclooxygenase. This is essential for the synthesis of thromboxane A2, a substance that causes vasoconstriction and amplifies the platelet activation process leading to platelet aggregation. By contrast, the thienopyridines inhibit platelet aggregation by irreversibly inhibiting the binding of adenosine diphosphate, a substance released from platelets during activation that amplifies the aggregation process. This agent does not impair prostaglandin-dependent mucosal protective and ulcer-healing mechanism, which is a side effect of aspirin. The clinical efficacy of clopidogrel in secondary prevention of coronary heart disease, peripheral vascular disease and ischemic stroke is demonstrated to be marginally more effective than aspirin in a randomised controlled clinical trial, [Clopidogrel versus Aspirin in Patients at Risk of Ischemic Events (CAPRIE)]. The incidence of gastrointestinal complications was significantly lower for clopidogrel than aspirin (dyspepsia 0.97% vs 1.22%; p<0.05; gastrointestinal haemorrhage 0.52% vs 0.72%; p<0.05). Therefore, clopidogrel is safer than aspirin in average-risk patients.

What is the risk of clopidogrel in high-risk patients? Clopidogrel is contraindicated in patients with active bleeding peptic ulcer. However, there is no previous report on the safety data in patients with peptic ulcers but without active bleeding. Recently, our group has conducted two pilot studies to address the use of clopidogrel in patients with peptic ulcer disease.

The first study is a retrospective audit on the incidence of ulcer complication in patients receiving clopidogrel (75 mg daily) because they have a history of symptomatic peptic ulcer disease. Seventy consecutive patients with a mean age of 74 years were analyzed. Before commencement of clopidogrel, 59% of them had gastrointestinal bleeding. After a median follow-up of one year, 9 (12%) patients developed gastrointestinal bleeding, with one perforated duodenal ulcer after clopidogrel therapy. Previous history of gastrointestinal bleeding appears to predict an adverse gastrointestinal event while the co-prescription of proton pump inhibitor tends to protect a recurrence of ulcer complication. However, the study has several limitations. Firstly, it is a retrospective design in a small selected group of patients without a control group. Secondly, ulcer healing and evaluation of eradication success of H. pylori had not been confirmed in most patients before clopidogrel therapy. Therefore, the anti-platelet effect of clopidogrel might precipitate bleeding from an unhealed or re-bleed ulcer. Finally, there was no standardization of the acid suppression therapy.

In patients with low-dose aspirin induced symptomatic peptic ulceration, what is the best initial treatment? By analogy with trials using full-dose conventional non-steroidal anti-inflammatory drugs, our current practice is to prescribe a proton pump inhibitor while continuing aspirin in patients without a massive gastrointestinal bleeding. Although discontinuation of aspirin during the period of ulcer healing may offer a theoretical advantage, there is always a potential of precipitating an ischemic vascular event, particularly in high-risk patients like unstable angina. Our second study addresses the safety issue when clopidogrel or aspirin is co-prescribed with a proton pump inhibitor to patients with aspirin induced active peptic ulcer disease. Both groups received omeprazole 20 mg daily. This randomized controlled study enrolled 129 (69 received clopidogrel and 60 continued aspirin) patients with small ulcer without an adherent clot or visible vessels or patients with moderately severe gastro-duodenitis. Before randomization, around 40% of patients in each group had a minor gastrointestinal bleeding. Clopidogrel and aspirin was re-started after 0.86 and 0.44 days after upper endoscopy respectively. The result of this study demonstrated the incidence of unhealed ulcer or erosions at 8th week was similar in those converted to clopidogrel plus omeprazole and those continuing their original low-dose aspirin plus omeprazole (6% vs. 5%). Furthermore, no patient in both groups had a re-bleed or perforated peptic ulcer during the study period. However, the major weakness is the small sample size and using surrogate endoscopic end-point only.

In summary, in patients with no history of peptic ulcer disease or gastrointestinal bleeding, clopidogrel appears to be safer than aspirin. However, the cost-effectiveness should be analyzed since 500 patients need to be treated with clopidogrel to prevent only one aspirin induced gastrointestinal bleeding. In patients with moderately severe active peptic ulcer disease while receiving treatment with proton pump inhibitors, both approaches of early conversion to clopidogrel or continuation of aspirin are safe. Future study is required to address different anti-platelets strategies in very high risk bleeding peptic ulcers. A clinical outcome study with adequate sample size is also needed. On the other hand, the long-term administration of clopidogrel alone, without proton pump inhibitor should be cautioned in patients with history of peptic ulcer disease. A better designed long term prospective study is needed to compare the safety of clopidogrel and aspirin in patients with peptic ulcer disease and to address the choice of acid suppressive agents.

Reference
1. Food and Drug Administration. Online. Available at: http://www.fda.gov
Constipation: A review on the prevalence, investigation and management

Dr. Chan On On
Department of Medicine
The University of Hong Kong
Queen Mary Hospital

Introduction
Constipation is a symptom of many diseases and is a collective term, used by the public to imply that stools are too hard, too infrequent or too difficult to pass. Idiopathic or functional constipation is a common medical problem. In the Western population, the prevalence was reported as high as 24% in elderly subjects and more commonly among women (1). A recent survey conducted in Hong Kong showed a prevalence of 14% according to the Rome criteria (2).

Constipation can lead to more severe complications such as anal fissures, rectal bleeding, rectal prolapse, fecal impaction or hemorrhoids. In addition, the symptoms of constipation adversely affect the patient's psychological health and their quality of life. Despite that we are gaining more insights into pathogenesis of functional constipation, the mechanism of colonic motility and defecation, and the associated psychological disorders are still not fully understood. In addition, the treatment available for functional constipation is still not satisfying fully. The current paper presents a full review of the current understanding of epidemiology, pathogenesis, associated psychological problems and treatment available for functional constipation.

Epidemiology
Based on an epidemiological study in the United States (3), there were 2.5 million annual physician visits for this problem. The prevalence of self-regarded constipation in the general population varies from country to country. The prevalence of patients reporting constipation symptoms in five European countries is summarised in Table 1 (4), with the prevalence rate ranging from 6% to 23%. Whereas the prevalence of constipation in the US was reported to range from 2% to 28% (6-7), depending on the definition of constipation. The American Family Physician reported in 1998 that constipation affects as many as 26% of elderly men and 34% of elderly women (8). Reports of constipation increase with advancing age, with an exponential increase in prevalence after age 65. The age distribution is similar in both sexes, but constipation is three times more common in women than men. Exact epidemiological data however are lacking, mainly because of the difference between self-reported constipation and scientifically defined constipation. Moreover, most of the studies investigated the prevalence of constipation only, and not the incidence of constipation.

We have conducted a population-based telephone survey in the Hong Kong Chinese population on constipation too, using the diagnostic criteria of Rome II (2). We observed that there were 14.3% among the 3,282 interviewees diagnosed to have constipation. Among these interviewees, there were 33% of them complained of incomplete evacuation, and 12% complained of bowel opening less than 3 times per week. We did not observe a difference in the prevalence of constipation between the younger and the older age group, but a steady increase in constipation in the male subjects was observed. In addition, we also found that females had a higher prevalence of constipation, which is similar to other previous reports.

Diagnostic Criteria for Constipation in Adults
Definitions of constipation vary widely, and therefore true prevalence estimates are difficult to compare across studies (9). The diagnosis of functional constipation was based on the Rome II criteria. The diagnostic criteria was two or more of the following for at least 12 weeks in the preceding 12 months:

1. Straining in more than 25% of defecations
2. Lumpy or hard stools in more than 25% of defecations
3. Sensation of incomplete evacuation in more than 25% of defecations
4. Sensation of anal obstruction or blockade in more than 25% of defecations
5. Manual maneuvers (e.g., digital evacuation) to facilitate more than 25% of defecations
6. Fewer than three defecations per week
7. Loose stools are not present, and there are insufficient criteria for the diagnosis of irritable bowel syndrome.

However, these criteria may not apply when the patient is taking laxatives. In addition, the Rome II criteria do not assess the severity of constipation. Supplemental to the Rome II criteria, there were several clinician rating scales exist for assessing the severity of constipation, such as the Constipation Scoring System (10), the Constipation Assessment Scale (11).

Causes of Constipation
The causes of constipation can be categorized into symptoms due to secondary causes, or functional. Secondary causes include structural abnormalities such as anorectal disorders (anal or perianal fissures, thrombosed hemorrhoids), colonic strictures (diverticulosis, ischemia, radiation therapy), colonic mass lesions with obstruction (adenocarcinoma), or idiopathic megacolon, systemic causes include 1) chemotherapy and radiotherapy, and medical conditions such as diabetes mellitus (hyperglycemia, hyperparathyroidism, hypokalemia, hypothyroidism, pregnancy, urinia); 2) neurogenic conditions such as cerebrovascular events, multiple sclerosis, Parkinson’s disease, Hirschsprung’s disease, spinal cord tumors; 3) smooth muscle and connective tissue disorders such as enteric dysmotility (with drugs such as nitrates, antacids and metoclopramide contained in some H2 blockers, nitrates, and antihypertensives), and 4) systemic conditions such as anorexia, obesity, and Crohn’s disease.

The associations for functional constipation include dietary factors, motility disturbance, outlet delay, irritable bowel syndrome, sedentary lifestyle, and psychogenic conditions such as anxiety, depression and somatization.

Pathogenesis
Functional constipation can be further subcategorized into slow transit, normal transit, outlet blockage and mixed type. Some patients with normal transit have features of irritable bowel syndrome. To understand the pathogenesis of functional constipation, the understanding of normal colonic motility and the defecation process is of importance.

Normal colonic motility
The human colon exhibits complex motility patterns, which include short- and long-duration phasic contractions, tonus and giant migrating contractions (GMCs, also known as high amplitude propagating contractions) with variations in frequency and amplitude (12). Colonic motility is stimulated after a fatty meal, a phenomenon which is referred to as gastrocolonic response (13). GMCs occur once or twice a day and cause mass movements. In the descending colon, they propel fecal mass into the rectum and distend the rectum, leading to the passage of gas, or both, will manifest itself. The precise role of the tone of the circular muscle in the colon is not known but it could facilitate mixing and propulsion by phasic contractions and GMCs.

The normal defecation process
Defecation is a complex action requiring coordination activation of anal sphincter and the degree of the anorectal angle. It is controlled by the autonomic nervous system and voluntary control. Anal sphincter coordination depends on intact sensory and motor components of sacral nerves S2, 3, and 4 and the pudendal nerve. Together these innervate the internal and external anal sphincters (IAS and EAS) and puborectalis (PR) muscle. The puborectalis muscle surrounding the anorectal junction (the puborectal sling) usually produces an angle of about 90° between the rectal ampulla and the anal canal, so that it is closed off. At the beginning of defecation, the subject voluntarily raises intra-abdominal pressure. The puborectalis sling relaxes so as to allow the straightening of the anorectal angle. During evacuation, the anorectal junction moves down and backwards and the pelvic floor usually descends slightly. The IAS, which usually closes off the upper and middle portion of the canal, relaxes to allow passage. The circular muscles of the rectum then stimulate a wave of contraction to push feces towards the anus. As feces emerges from the anus, the longitudinal muscles of the rectum and levator ani bring the anal canal back to its normal position. The anus and rectum then open and forward to return to their normal position. The anal canal is closed tightly once again.

The altered colonic motility and defecation process in constipated patients
In severe idiopathic constipation the most important motility abnormality seems to be a decrease in the frequency, duration and amplitude of GMCs (14). The gastrocolonic response is also impaired in patients with severe idiopathic constipation (15, 16). Reduced defecation in transit times and motility patterns patients suffering from severe idiopathic constipation display other abnormalities, such as reduced relaxation of the internal anal sphincter, increased defecatory sensation thresholds and higher maximum tolerable volumes.
Associated psychological problems
There are growing interests in exploring the role of psychological factors on the pathogenesis of functional constipation. These patients report high levels of emotional distress (17-19). Patients with functional constipation who seek medical attention in tertiary centers generally have a higher prevalence of anxiety, depression, and social dysfunction than do normal controls (20, 21). In addition, a recent study (22) demonstrated that general psychosocial function, somatization, anxiety, depression, and feelings about the female role are impaired in women with constipation and are associated with altered rectal mucosal blood flow which is an indirect measurement of the autonomic function. Furthermore constipated subjects with slow bowel transit is associated with lower scores on psychological tests than normal controls (23). These findings suggest a link between psychological symptoms and gut dysfunction. Moreover, there were reports showing that these patients might have suffered a traumatic experience in their lives, such as sexual abuse (24).

The observations of the association between psychological symptoms and functional constipation was further confirmed in our study on Chinese patients with functional constipation (2). We observed that, by the Hospital Anxiety Depression Scales, the anxiety and depression scores were 11.5 ± 3.9 and 7.5 ± 5.5 vs 8.6 ± 3.09, (p < 0.0001, and 6.2 ± 4.93 vs 3.72 ± 2.45, p < 0.001, respectively), and female than male patients (7.6 ± 5.2 vs 5.3 ± 5.2, p = 0.02, and 7.5 ± 5.4 vs 4.4 ± 3.4, p < 0.0001). Patients who were aware of their symptoms perceived greater impact on their lives (p < 0.001). Females were more frequently aware of the symptoms (p = 0.004), and less frequently used coping strategies (p = 0.009). However, only 53% of the patients have sought medical advice for constipation. The patients who have sought medical advice were more likely to be female, with higher anxiety scores and those perceived that their symptoms were not controllable (2).

In addition, score evaluation for quality of life is lower in patients with chronic constipation than in normal controls (24, 25, 26). The scores appear to be inversely related to the severity of bowel dysfunction, such as the feeling of incomplete evacuation and tenesmus. The association between constipation and poor quality of life was also confirmed in one of our recent studies (unpublished results). We assessed the quality of life in patients with chronic functional constipation using the Short Form-36 (SF-36) health survey questionnaire. We observed that constipated patients differed significantly from the normal subjects in five categories. They had decreased physical functioning scores (76 vs 93, P < 0.0001), role-physical scores (66 vs 85, P = 0.05), general health scores (46 vs 60, P = 0.001), vitality scores (64 vs 84, P = 0.002), and social functioning scores (73 vs 87, P = 0.005).

Management of functional constipation
The management of patients with constipation should include a detailed medical history and physical examination to exclude secondary causes for constipation such as anatomical or systemic lesions. Laboratory evaluation does not play a large role in the initial assessment of the patient. Baseline investigations should include thyroid-stimulating hormone (TSH) levels to rule out hypothyroidism in patients refractory to dietary management, serum electrolyte profile, including sodium, calcium, glucose, and creatinine, in patients with recent-onset constipation to assess an acute electrolyte imbalance and in chronically constipated patients for whom initial medical management has failed. Fecal occult blood should be tested in the chronically constipated middle aged or elderly adult to exclude an obstructing neoplasm of the colon (Figure 1). In those patients who have been taking laxatives, detailed assessment of their use and the possible side-effects should be made.

Extensive testing usually is reserved for people with severe symptoms, for those with sudden changes in number and constancy of bowel movements or blood in the stool, and for older adults. Because of an increased risk of colorectal cancer in older adults, barium enema, sigmoidoscopy or colonoscopy is indicated in the elderly patients.

Colonic transit time
Transit studies may help differentiate colonic from pelvic floor dysfunction causing constipation (Figure 2). The colonic transit test quantifies the movement of small markers through the colon. Subjects ingest one capsule (in which 20-24 markers have been placed) each morning for 3 days, abdominal X-rays are taken on days 4 and 7. Transit through the right, left and rectosigmoidal segments of the colon can be calculated. Laxatives should be stopped prior to this test. The normal limit of normal colonic transit times ranged from 87-93 hours (27-30).

Anorectal manometry/Balloon expulsion test
The tests diagnose constipation caused by abnormal anorectal function. Failure to expel the balloon is commonly associated with pelvic floor dysfunction, anatomic defects of the rectum, or anismus. The overall defecatory process and relaxation of the puborectalis muscle is assessed by placing a urinary catheter in the rectum, inflating the balloon to 50-60 ml, and determining if it can be expelled.

Anorectal manometry evaluates anal sphincter muscle function. A capsule filled with air-filled balloon inserted into the anus is slowly pushed back through the sphincter muscle to measure muscle tone and contractions. The test identifies the presence of occult incontinence or rare syndromes, by the absence of the rectoanl inhibitory reflex. An excessively high resting and squeeze anal sphincter tone suggests anal fissures or internal anal sphincter hypertrophy. An American Gastroenterology Association for constipation and of potential value in the diagnosis and management of outlet obstruction (31, 32).

Defecography
This is an x-ray of the anorectal area that evaluates completeness of stool elimination, identifies anorectal abnormalities, and evaluates rectal muscle contractions and relaxation. During the examination, the doctor fills the rectum with a soft paste that is the same consistency as stool. The patient sits on a toilet positioned inside an x-ray machine and then relaxes and squeezes the anus and expels the solution. The detection of rectal intussusception (ocult rectal prolapse) is the most important use of defecating proctography. In addition, defecating proctograms are used to calculate resting and straining anorectal angles and outlet obstruction.

Treatment
A diet with enough fiber (20 to 35 grams each day) helps form soft, bulky stool. Sufficient dietary fiber is needed to promote normality in bowel movement frequency over the long term (8, 33).

Other changes that can help treat and prevent constipation include drinking enough water and other liquids, engaging in daily exercise, and reserving enough time to have a bowel movement. Inactivity is a frequent cause of constipation in institutionalized or bedridden patients (34). In addition, the urge to have a bowel movement should not be ignored.

Laxatives
1. Bulk-forming laxatives - also known as fiber supplements, are taken with water. These laxatives are the safest but can interfere with absorption of some medicines.
2. Stimulants - increase motor activity of the bowels by direct action on the intestines.
3. Stool softeners - promote water retention in the fecal mass, thus softening the stool.
4. Lubricants - lubricate intestinal mucosa and soften stool.
5. Saline laxatives - act like a sponge to draw water into the colon for easier passage of stool.
6. Osmotic laxatives
7. 5HT4 agonists - Activation of 5-HT4 receptors triggers the release of neurotransmitters from the enteric nerves resulting in increased contractility and stimulation of the peristaltic reflex (35-39). Tegaserod and prucalopride are representatives of the 5-HT4 agonists. Prucalopride has been shown to significantly accelerate bowel transit in healthy volunteers and in patients with functional constipation (40-42). However, the future of the prucalopride is uncertain because of safety reasons. Tegaserod is a newer drug of the 5-HT4 agonist. It has been shown to be useful in constipation - predominant irritable bowel syndrome (C-IBS) (43, 44). Its use in chronic constipation is under further investigation.

Biofeedback
There were reports of outpatient biofeedback therapy with success rates ranging from 50 to 90% (45). The therapy involves a number of outpatient sessions with a dedicated therapist during which the patient learns to appropriately relax rather than contract the pelvic floor during evacuation. Progress is monitored by either electromyographic or manometric methods. Feedback stimuli includes retraining with an intrarectal balloon, a portable home-training unit or both.

Surgery
For those refractory to any conservative or even aggressive approach, surgical treatment with colotomy and ileorectum anastomosis, should be taken into consideration. These patients are often young female with depressive symptoms and colonic inertia. It is necessary to ascertain that these patients have normal anorectal function, to assess whether the motor abnormality also affects other the stomach and small bowel by scintigraphy or manometric studies, and whether there is underlying psychopathology (46). In addition, the benefits of this surgery must be weighed against possible complications, which include abdominal pain and diarrhea.
Conclusion

Functional constipation is one of the commonest functional gastrointestinal diseases, associated with psychological alterations and affecting patients' quality of life. However, the current treatment for constipation is far from satisfactory. Further investigations directed towards the understanding pathogenesis and better treatment, both physiologically and psychologically oriented, are deemed necessary.

Table 1 - European Survey of Bowel Symptoms (%) in Five Countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Characteristic</th>
<th>Italy</th>
<th>France</th>
<th>Spain</th>
<th>Germany</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Self-perceived constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>23</td>
<td>19</td>
<td>17</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>*B. Difficult defecation</td>
<td>16</td>
<td>14</td>
<td>11</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>C. Laxative use</td>
<td>19</td>
<td>20</td>
<td>19</td>
<td>20</td>
<td>19</td>
</tr>
</tbody>
</table>

*Straining and/or hard stools and/or incomplete evacuation at least once a month.

Figure 1. Flowchart for the management of patients with constipation

- Interview and physical examination
- Metabolic and structural evaluation, IBS criteria, basal lines
- Therapeutic trial (fiber) ± simple laxatives
- Colonic transit test (CTT) ± anorectal manometry (ARM)
- Balloon expulsion test (BET) ± Barium defecography (BD)

Figure 2A. Normal colonic transit time

Figure 2B. Colonar inertia
The Sixth Joint Annual Scientific Meeting

Dr. Chan Ka Leung Francis, Reader
Department of Medicine & Therapeutics, Prince of Wales Hospital

Date : October 9, 2004
Time : 2:00 - 9:00 p.m.
Venue : 3/F, Ballroom, Sheraton Hong Kong Hotel & Towers
Co-organizers : The Hong Kong Society of Gastroenterology
Hong Kong Society of Digestive Endoscopy
Hong Kong Society for Coloproctology
The Hong Kong Association for the Study of Liver Diseases
The Hong Kong Society of Gastrointestinal Motility
Sponsors : AstraZeneca, GlaxoSmithKline

October 9, 2004 marked another successful Joint Annual Scientific Meeting, the sixth in the series of co-organized meetings. 430 doctors attended this conference and took part actively in the panel discussions. A new introduction this year was the Research Forum during which the research findings on colon cancer and GERD were presented by Drs. S Y Leung and Justin Wu respectively. Participants found this session very interesting and useful.

We were glad to have two renowned overseas speakers, Prof. Seigo Kitano from Japan and Prof. Guang Bi Yao from China to share with us at the meeting their experience and expertise. Their talks were on Management of Gastric Cancer: Endoscopy, Laparoscopy and Surgery and Traditional Chinese Medicine: China’s perspective respectively. We were equally happy to have with us prominent speakers from Hong Kong including Doctors W L Law, W K Leung, Raymond Wong, K M Chu, Benjamin Wong, Henry Chan and M F Yuen who gave enlightening talks on various aspects of colorectal cancer, gastric cancer and Hepatitis B. The presence of both overseas and local speakers and their stimulating presentations enabled a very substantial and attractive programme to be launched this year. Active participation and discussions were seen throughout the meeting. It was indeed a highly successful interdisciplinary scientific meeting.

In closing, Presidents or representatives of the five co-organizers gave the presidential address. Dr. Francis Chan, Organizing Chairman invited the presidents at the meeting: Dr. Szeto Ming Leung, Dr. Samuel Kwok, and Dr. Lai Jak Yiu to present to each guest speaker, co-chairman, and sponsor a souvenir in appreciation of their remarkable efforts and contributions.

Taking this opportunity, Dr. Francis Chan thanked all co-organizers, their members and the co-sponsors for their excellent work and participation and look forward to their continued cooperation in the coming year.

The Evolution of PPI Therapy - An Ongoing Story was held on July 15, 2004 at 6:30 p.m. in the Ballroom of InterContinental Hotel in Hong Kong. The meeting was co-organized by The Hong Kong Society of Gastroenterology and the Hong Kong Society of Digestive Endoscopy.

This meeting was a good one. Keynote lectures by two prominent speakers Dr. David Armstrong and Dr. James Lau were given. The topics were Nexium I. V. - The new benchmark of acid suppression and PPI therapy - shaping the future in treatment of bleeding peptic ulcers? respectively. Prof. S K Lam, Chairman of this meeting gave the welcoming remarks and led the Q & A Session. About 170 participants attended and took part actively in the discussions.

The meeting was sponsored by AstraZeneca (Hong Kong). A vote of thanks was given to all.
CME-CD: Challenges in Gastroenterology and Hepatology

The Hong Kong Society of Gastroenterology was incorporated in 1981. Its primary aim is to promote the advancement of gastroenterology through the coordinated efforts of organizations and individuals interested in the causes, diagnosis, prevention and treatment of gastroenterological diseases. During the past years, our Society has played an active role in advancing the science and practice of gastroenterology.

To achieve the objective of promoting continued medical education of practitioners in this field, the Council of 2002-2004 has resolved to produce an educational program on a CD ROM, named "Challenges in Gastroenterology and Hepatology." This is a combined effort of Prof. Joseph Sung, Dr. Vincent Leung, Dr. Judy Ho, Dr. Philip Kwok and Dr. MF Yuen with contributions from fellows and members of the Society.

The program covers 4 main areas namely Upper GI Disorders, Lower GI Disorders, Hepatobiliary Disorders and Liver Diseases. Each section is composed of 25 questions with illustrations and references. The program is designed for the use of both trainees in Gastroenterology and GI Surgery as well as practising Gastroenterologists & Hepatologists, GI Surgeons, Pathologists and Radiologists who want to keep themselves abreast with the latest development in the field.

Major Meetings

December 11-15, 2004
Asian Pacific Association for the Study of the Liver Biennial Congress
Organizer: Asian Pacific Association for the Study of the Liver
Location: Vigyan Bhavan, New Delhi, India
Website: www.apasindia2004.com

December 14-16, 2004
4th International Meeting of Hepatocellular Carcinoma: Eastern and Western Experiences
Organizer: The Centre for the Study of Liver Disease, The University of Hong Kong, Queen Mary Hospital
Location: Hong Kong Convention and Exhibition Centre
Website: www.hcc.eve.org

February 3-5, 2005
International Colorectal Disease Symposium
Organizer: Hong Kong Society for Coloproctology
Location: Rm 301-312, 3/F New Wing, Hong Kong Convention and Exhibition Centre
Website: www.ids-hk.org

February 10-13, 2005
8th Congress of the Asian Society of Hepatobiliary Pancreatic Surgery (ASHBPS)
Organizer: Asian Society of Hepatobiliary Pancreatic Surgery
Location: Edsa Shangrilla Hotel, Manila, Philippine
Website: www.proctology.com/ushbhp/

April 13-17, 2005
40th Annual Meeting of the European Association for the Study of the Liver
Organizer: The European Association for the Study of the Liver
Location: Paris, France
Website: www.easl.ch/

May 4-6, 2005
Annual Congress of Czech Society of Hepatology with International Participation
Organizer: Czech Society of Hepatology
Location: Karlovy Vary, Czech Republic

May 4-7, 2005
6th International Gastric Cancer Congress
Organizer: International Gastric Cancer Association
Location: Kanagawa, Japan
Website: www2.convention.co.jp/6gccc/

June 23-25, 2005
2nd International Congress on Gastrointestinal Oncology
Organizer: Hellenic Society of Gastrointestinal Oncology
Location: Santorini, Greece
Website: www.gi-oncology.com

Welcome!!!

New Member
Dr. Shan Hok Shing Edwin
Department of Medicine
Caritas Medical Centre

Annual General Meeting & Scientific Meeting

Date
March 21, 2005 (Monday)

Venue
Ballroom, 3/F Sheraton Hotel & Towers
20 Nathan Road, Kowloon

President
Dr. Szeto Ming-leung
Organizing Chairman
Dr. Vincent K S Leung

Preliminary Programme

6:15 - 7:00 p.m.
Registration & Refreshments
Viewing of Industry Exhibits

7:00 - 7:10 p.m.
Presentation of Honorary Fellowship
Dr. Szeto Ming-leung

7:10 - 7:40 p.m.
Gastroenterology - now you see it, now you don't
Professor Roy Pounder
Professor of Medicine
Centre for Gastroenterology
Royal Free Hospital
London, UK

7:40 - 8:10 p.m.
NERD - known and unknown
Professor Hu Pin-Jin
Professor and Consultant Gastroenterologist
The First Affiliated Hospital
Sun Yat Sen University
Guangzhou, China

8:10 - 8:20 p.m.
Plenary discussion

8:20 - 8:45 p.m.
EGM & AGM
Tea & Viewing of Exhibits

8:45 - 10:00 p.m.
Dinner

All members and non-members of this Society are welcome
Free registration for all