President Message

Message from Dr. Yat-Wah Yeung, President

The year of 2009 has been another successful year for The Hong Kong Society of Gastroenterology in the objective of promoting the advancement of gastroenterology in Hong Kong.

There have been the Annual General Meeting & Scientific Meeting of the Society held on 12 March 2009; the 11th Joint Annual Scientific Meeting on 5 September 2009; a scientific symposium on 10 August 2009 and the joint scientific symposium on 8 October 2009. With the enlightening presentations of honorable guest speakers, all these meetings were well received and attended.

Two issues of the Society’s newsletter containing scientific updates, highlights of events and major meetings were published during the year.

On behalf of the Society, I wish to express my gratitude to all who have contributed to the Society: Prof. Justin C.Y. Wu for organizing the 2009 Annual General Meeting & Scientific Meeting; Dr. Annie O.O. Chan for organizing the Joint Annual Scientific Meeting; Dr. Wai-Mo Hui for editing this Newsletter; Prof. Angel Lanas, Dr. Pietro Lampertico, Dr. James Y.Y. Fung, Prof. James Lau and Prof. W.L. Law for contributing to the scientific updates in this Newsletter; all fellows and members for attending the scientific meetings and last but not least, the friends from the pharmaceutical industry for their generous sponsorship and efforts.

Best wishes for a Merry Christmas and a Happy New Year.

Scientific Updates

Screening of colorectal cancer (CRC) in first degree relatives

Professor Angel Lanas
Service of Gastroenterology
University Hospital
Zaragoza, Spain

There is a high incidence of CRC in Spain, with the annual mortality due to CRC being second only to lung cancer.1

Hereditary syndromes such as familial adenomatous polyposis and hereditary non-polyposis CRC (Lynch syndrome) account for 3–5% of CRCs. Individuals with a family history of CRC are at a higher risk of developing the cancer (Figure 1).2,3 The risk is greater for an individual when associated with early age of onset of the hereditary syndromes and multiple affected relatives.

![Figure 1](image)

**Family history**

<table>
<thead>
<tr>
<th>Family history</th>
<th>RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 FDR with CRC</td>
<td>2.26</td>
<td>2.00-2.53</td>
</tr>
<tr>
<td>&lt; 45y</td>
<td>3.87</td>
<td>2.60-6.22</td>
</tr>
<tr>
<td>45-59y</td>
<td>2.23</td>
<td>1.85-2.72</td>
</tr>
<tr>
<td>&gt; 59y</td>
<td>1.82</td>
<td>1.47-2.25</td>
</tr>
<tr>
<td>Several FDR with CRC</td>
<td>4.25</td>
<td>3.01-6.02</td>
</tr>
<tr>
<td>Only 2 FDR</td>
<td>3.76</td>
<td>2.56-5.51</td>
</tr>
<tr>
<td>1 second (S) or third (T) degree R</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Two SDR</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>FDR with adenoma</td>
<td>1.99</td>
<td>1.55-2.55</td>
</tr>
</tbody>
</table>

FDR—First degree relative; SDR—second degree relative; RR—relative risk; CI—confidence intervals; y—years; CRC—colorectal cancer; R—relative

Options for prevention and screening

It has been observed that the 5-year survival rate of CRC in Europe is less than 50%, perhaps because of delayed diagnosis.4 However, with appropriate screening methods, such as colonoscopy, and early diagnosis of the disease, progress of the cancer can be arrested and mortality decreased.
Populations that should be enrolled on prevention programmes include:

- People aged ≥ 50 years
- People at increased risk, e.g., those with hereditary CRC and history of inflammatory bowel disease

Colonoscopy is the first screening option for high-risk patients. The recommended protocol for performing screening colonoscopies is shown in Figure 2.

Figure 2. Recommended protocol for performing screening colonoscopies

<table>
<thead>
<tr>
<th>Asymptomatic people</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50 y.o.</td>
</tr>
<tr>
<td>No family History</td>
</tr>
<tr>
<td>No screening</td>
</tr>
<tr>
<td>≥ 2 FDR or 1 FDR &lt; 60 y.o.</td>
</tr>
<tr>
<td>Colonoscopy at the age of 40 or 10 years earlier of the diagnosis of CRC</td>
</tr>
</tbody>
</table>

FDR—first-degree relative; y.o.—years old; CRC—colorectal cancer

Based on these guidelines, a prevention programme was initiated in Spain. (Available at: www.digestivo.net. Accessed on: 30 October 2008.) It included the following screening strategies:

1. Tests
   a. Colonoscopy
      Colonoscopy has been shown to offer the best ratio in compliance/mortality reduction.
   b. Genetic testing for patients with suspicion of hereditary CRC

2. High-risk outpatient clinics

Over the past four years, more than 60% of patients with CRC were interviewed once a year. As a result, more people with first-degree relatives suffering from CRC who were not contacted but had heard of the programme also asked to be screened.

More patients were recruited for screening colonoscopies when they received personal invitations to small centres that did not have waiting lists and had an attending physician along with a nurse compared with impersonal invitation letters for colonoscopies at university centres, with long waiting lists and no attending physicians.

Dr Lanas and his team identified the chief barriers to colonoscopy for CRC screening and sought solutions, as shown in the table.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel preparation</td>
<td>Small volume bowel preparation</td>
</tr>
<tr>
<td>Discomfort of colonoscopy</td>
<td>Sedation</td>
</tr>
<tr>
<td>Embarrassment</td>
<td>Ability to choose gender of colonoscopist</td>
</tr>
<tr>
<td>No recommendation by primary care physician</td>
<td>Paid procedure</td>
</tr>
</tbody>
</table>

As a result, the number of patients undergoing colonoscopy increased by 9% from 2000 to 2005. This has resulted in increased diagnoses of advanced adenomas and polyps in the first-degree relatives of CRC patients, reduced the number of deaths occurring due to CRC and decreased the net medical expenses per person (from €1118 to €656).

Conclusions
CRC has a high prevalence, but it can be prevented by screening colonoscopies. In a CRC prevention programme in Spain, more patients underwent the procedure when they were contacted directly and efforts were made to understand and relieve the barriers to colonoscopy. In the long term, screening colonoscopies can prevent CRC, decrease mortality due to CRC and also save public medical expenses.

References

Antiviral treatment of hepatitis B e antigen (HBcAg)-negative chronic hepatitis B

Dr. Pietro Lampertico
1st Gastroenterology Unit
Fondazione Policlinico, Mangiagalli e Regina Elena
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HBcAg-negative chronic hepatitis B (CHB) is a progressive disease with an increasing worldwide incidence. It requires long-term antiviral treatment and interferon treatment may not be effective in most cases. The endpoint of antiviral therapy is profound, long-term (maintained and/or sustained) inhibition of viral replication and a reduced likelihood of subsequent disease progression and emergence of viral resistance.
**Therapeutic strategies for HBeAg-negative CHB**

Two different treatment options (with different drugs, durations of treatment and endpoints) can be used for treating HBeAg-negative CHB.

1. **Short-term "curative" treatment**
   This includes interferon therapy. A recently published study showed that 1 year of pegylated interferon therapy was successful in producing a sustained virological response for almost 4 years after stopping treatment in about 15–25% of the patients (Figure 1). 1

![Figure 1. Sustained response after 4 years with 1-year interferon therapy](image)

2. **Long-term "suppressiv"e treatment**
   This includes treatment with nucleos(t)ide (NUC) analogues. Studies have shown that 1 year of NUC monotherapy can produce a good virological response in HBeAg-negative patients. 2,6 The end point of this therapy is considered to be hepatitis B surface antigen (HBsAg) seroconversion, reached by only 1% of the patients after prolonged periods of treatment.

- **Lamivudine monotherapy**
  Lamivudine is a very commonly used NUC analogue. It has been observed that there is a progressive decline in virological response with 4-year lamivudine therapy in HBeAg-negative patients, due to resistance development. 7 However, about 25% of patients have a sustained virological response with lamivudine monotherapy.

- **NUC resistance can be identified with regular hepatitis B virus (HBV) DNA monitoring. In such cases, a rescue-drug needs to be added.** A study by Lampertico et al showed that adding another NUC (adefovir) was 100% successful in maintaining 5-year rates of undetectable levels of HBV DNA (Figure 2). 2,8 This strategy was also successful in decreasing rates of clinical decompensation. However, it could not prevent development of hepatocellular carcinoma (HCC). Another study showed that portal hypertension was also prevented in most cirrhotic patients who were followed for 6 years. 9

![Figure 2. Good results with lamivudine and adefovir combination therapy](image)

LAM—lamivudine; ADV—adefovir; LAM-R—lamivudine resistant mono—monotherapy; HBV—hepatitis B virus

- **Adefovir monotherapy**
  A study has shown that 5 years of adefovir monotherapy in HBeAg-negative patients successfully kept HBV DNA levels under control (< 3 log copies/mL) and maintained low levels of alanine aminotransferase (ALT) levels in most of the patients. 10 Subsequent liver biopsies in these patients revealed significant improvement in necroinflammation and fibrosis, thus showing that controlling viral replication and preventing ALT activation can improve and even reverse liver fibrosis. 10

- **Telbivudine monotherapy**
  A randomized, controlled, 104-week study, with an endpoint of HBV DNA negativity on polymerase chain reaction (PCR) that compared the treatment response of telbivudine with lamivudine, showed that virological control (HBV DNA < 300 copies/mL) was better with telbivudine (82%) than with lamivudine (57%) but 9% of patients developed telbivudine resistance and 20% of patients on lamivudine were PCR-positive. 11

To improve the virological response rates it is advisable to preselect patients before starting therapy based on the baseline viraemia (< 7 log copies/mL) and continue telbivudine in patients who are PCR-negative at 24 weeks of telbivudine treatment. It has been shown that pre-treatment or on-treatment selection helps to maintain PCR negativity for longer periods of time for most patients. 12

- **Entecavir monotherapy**
  A 52-week study showed superior response rates with entecavir, as compared with lamivudine, in terms of ALT normalization, virological response and development of resistance. 5 However, very little long-term data are available for this drug.

- **Tenofovir monotherapy**
  Recently, tenofovir was approved for use in Europe and the USA. A 72-week randomized study that compared the efficacy of tenofovir with adefovir showed better virological response with tenofovir suggesting that this is a promising drug for treating HBeAg-negative CHB patients in future. 1
Conclusions

Two options exist for treating HBeAg-negative CHB patients. Short-term curative treatment with interferon therapy results in sustained virological response in 25% of patients. Long-term (life-long) suppressive NUC therapy helps to prevent viral replication, ALT activation, HCC and clinical decompensation. However, development of NUC resistance should be monitored with regular follow-up HBV DNA monitoring. Combination therapy is the recommended strategy for the management of lamivudine-resistant patients. Commonly used NUC analogues are lamivudine, adefovir and telbivudine, which have good long-term efficacy data. Newer NUC analogues like entecavir and tenofovir have good short-term efficacy data.

References


Non-invasive assessment of liver fibrosis

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The University of Hong Kong
Hong Kong

Fibrotest is a biomarker assay of liver fibrosis that measures 5 biomarkers (γ-glutamyl transferase (GGT), haptoglobin, total bilirubin, α2-macroglobulin, and apolipoprotein A1). A recent meta-analysis of 30 studies revealed that it was an effective alternative to liver biopsy in patients with chronic hepatitis B and C, alcoholic liver diseases and non-alcoholic fatty liver disease (Figure 1). However, false-positive or false-negative results may be seen in some clinical conditions and results should be deferred in cases of acute haemolysis, acute hepatitis, acute inflammation or extra-hepatic cholestasis.

Figure 1. Meta-analysis of published studies using Fibrotest
Measuring stiffness and strain with transient elastography (Fibroscan)
In this method, a shear wave is generated, propagated through the liver and its speed determined for assessing liver stiffness and strain. Generally, the shear wave propagation is faster when the liver tissue is harder. This is a quick procedure, lasting 3–5 minutes, and results are available immediately. Theoretically, this procedure surveys a larger portion of the liver versus a liver biopsy, which assesses only a small portion. A study of 800 transient elastography examinations has shown that overall inter- and intra-observer agreement was 0.98. When interpreting results, it is important to remember:

1. The cut-off values in liver stiffness are dependent on the underlying liver pathology. This is because pathogenesis of liver fibrosis depends on underlying aetiology and the distribution of fibrous material depends on the origin of liver injury.

2. The degree of stiffness is affected by the underlying inflammatory activity, and is demonstrated in those with severe flares of hepatitis (Figure 2). Therefore, the test should be performed after resolution of an acute flare.

Combination of non-invasive tests
Studies using a combination of non-invasive tests show conflicting results. While some show improved diagnostic performance, others do not. It has been suggested that a combination of two unrelated tests be used and if the results are discordant, a liver biopsy should be performed. If the results are concordant a biopsy may be avoided. But if the results are inconclusive, a biopsy may still be considered.

Conclusions
The use of Fibroscan and biomarker testing have the potential to further increase the diagnostic accuracy of liver fibrosis. For best results, strict adherence to quality criteria of each test should be followed. Results should be interpreted by an expert clinician and tests may be repeated if the results are discordant, especially after antiviral therapy is started and initial results appear very high. In future, these tests have a good potential for becoming screening tools, and for longitudinal monitoring of disease progression and response to treatment.

References
Beyond the use of intravenous proton pump inhibitors (PPI) in the management of acute peptic ulcer bleeding (PUB)

Professor James Lau
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Prince of Wales Hospital
The Chinese University of Hong Kong
Hong Kong

Using high-dose intravenous (IV) PPI is the commonest strategy for treating acute PUB patients who have undergone endoscopic haemostosis. In 2000, Professor Lau published a randomized study to test high dose IV PPI in acute PUB patients who had been treated with endoscopy. Patients were randomized to receive IV treatment with omeprazole (omeprazole 80 mg bolus followed by 8 mg/hour for 72 hours), or placebo and were followed for 30 days. On day 30, patients who received PPI had a 6.7% rate of recurrent bleeding compared with 22% in patients who received placebo (Figure 1). The hazard ratio was 3.9. Other benefits such as reduced blood transfusions, fewer further interventions and decreased mortality were also observed.

Figure 1. High-dose IV PPI reduces recurrent bleeding after endoscopic haemostosis

In February 2004, Professor Lau and his team started another trial to study the benefits of high-dose IV PPI (omeprazole 80 mg, then 8 mg/hour before endoscopy) in patients who had overt signs of upper gastrointestinal bleeding. Notably, endoscopy on the following day showed more ulcers with a clean base and a significant reduction in the number of actively bleeding ulcers in patients who had received IV PPI prior to endoscopy. Ulcers with non-bleeding visible vessels and clots were also fewer (Figure 2).

Figure 2. Benefits of high-dose IV PPI before endoscopy

Another randomized, double-blind, placebo-controlled study at 91 centres in 16 countries sponsored by AstraZeneca in Sweden also showed that the use of IV esomeprazole for prevention of PUB in patients treated with endoscopic haemostasis was beneficial in terms of decreased rates of rebleeding, reduced further intervention and need for surgery. (Unpublished data; available at: http://clinicaltrials.gov/ct2/show/NCT00251979. Accessed on: 30 October 2008)

Alternatives to high-dose IV PPI
Besides IV PPI, there are alternative strategies for reducing rebleeding after endoscopic haemostasis (Table). The strategy of planned interventions is beneficial to high-risk patients who have high rebleeding rates after endoscopy and high mortality rates. High-risk patients are defined as patients with:

- Hypotension
- Haemoglobin < 10 g/dL
- Fresh blood in stomach
- Ulcer active bleeding
- Ulcer size > 2 cm

Table. Alternatives to high-dose IV PPI

<table>
<thead>
<tr>
<th>Alternative strategy</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral PPI</td>
<td>Did not reduce the need for surgery in pooled analysis</td>
</tr>
<tr>
<td>Routine second-look endoscopy</td>
<td>Offers only a modest benefit in reducing recurrent bleeding*</td>
</tr>
<tr>
<td>Planned interventions for high-risk patients: Endoscopy, Surgery, Angiographic embolization</td>
<td>Not proven by clinical trials</td>
</tr>
</tbody>
</table>

Conclusions
The use of high-dose IV PPI is the commonest and, currently, the optimal strategy for treating acute PUB patients who have undergone endoscopic haemostasis. Pooled analyses of studies have shown that this is an effective treatment for reducing the rates of rebleeding, need for surgery and mortality from all causes. Planned intervention strategies, such as endoscopy, surgery or angiographic embolization may be useful in high-risk patients to reduce the rebleeding and mortality rates in this group.

References
Colonic stenting

Professor Wai Lun Law
Professor of Surgery
Chief Division of Colorectal Surgery
Queen Mary Hospital
Department of Surgery
The University of Hong Kong
Hong Kong

Colonic cancer is the second-most common cancer in Hong Kong. About 15–20% of the patients with primary CRC present with intestinal obstruction and most of them require urgent surgical interventions to relieve the obstruction.

Management of colonic obstruction

Emergency surgery for relieving the obstruction, which is left-sided in 70% of patients and more commonly seen in the elderly, is associated with high mortality (hospital mortality – 23%) and morbidity (leakage rate after immediate anastomosis for left colonic obstruction – 18%). The reasons for this are:

- Dilated unhealthy bowel
- Poor general condition of patients
- Surgery at odd hours
- Surgery by inexperienced surgeons
- Inadequate preoperative staging

Colonic stenting

Colonic stenting is a rapid procedure that allows a single-stage surgery with bowel preparation after decompression. It can also act as a palliative measure in advanced disease.

Colonic stents, made of mostly uncovered metal alloys with self-expanding mechanisms, are available in different diameters and lengths and have different delivery and deploy mechanisms (Figure). Newer stents can now be introduced through endoscopes, which flare at both ends (this prevents their migration), have a smooth wire loop at the end and are easier to reposition during deployment.

Figure. Different types of stents

Indications for colonic stenting are:

1. Colonic obstruction due to CRC
   - For palliation
   - As a bridge to surgery
2. Colonic obstruction due to extrinsic compression by other malignancies
   - Stomach cancer
   - Gynaecological malignancies

Nowadays, colonic stenting is also done for treating benign conditions such as:

- Diverticular strictures
- Post radiation
- Crohn's disease
- Anastomotic strictures
- Endometriosis
- Colonic fistulas

Insertion of the stent may be performed under fluoroscopic or endoscopic guidance or both, using a guide wire. The stent is manipulated so that it is deployed in the most favourable position, preferably at the centre of the constriction.

A systematic review of 598 patients from 29 series of studies has shown that the technical and clinical success of colonic stenting was high (92% and 88% respectively); it was effective as a palliative procedure (90% of cases) and bridge to surgery (85% of cases); and was associated with low mortality (0.5%). The commonest complications were as follows:

- Perforation – 4%
- Migration – 10%
- 40% with laser pre-treatment or chemotherapy
- Re-obstruction – 10%

Pooled analysis of 1,198 patients from 54 trials has also shown similar results. However, a higher number (11 adverse events, including 6 perforations) of serious adverse complications were seen in another randomized trial of stent versus surgery for stage IV left-sided CRC, which led to the early closure of the trial.

Colonic stenting for palliation

Studies by Dr Law and colleagues have shown a success rate of 96% with the use of colonic stenting for achieving palliation. The commonest complications were migration (25% of cases) and the need for subsequent operation (17.3% of patients). They did not find any significant difference in survival compared with palliation by surgery. It was also observed that although the median hospital stay, mortality, and complications were lower and the median survival was better in patients for whom stenting was done versus those who were operated on, the difference was not statistically significant.

Colonic stenting as a bridge to surgery

With the help of colonic stenting, an emergency surgical procedure can be converted to an elective operation. This allows time for preoperative staging of the disease, adequate colonic investigations and bowel preparation. This offers the surgeon an opportunity for laparoscopic resection of the colon and synchronous liver resection. When Dr Law and colleagues compared patients who underwent surgical resection after colonic stenting (group 1) with those who underwent colonic resection without stenting (group 2), they found that group 1 patients had fewer primary anastomoses, and less and shorter need for intensive care. However, the median hospital stay, hospital mortality, need of re-operation and overall complication rates were similar in the 2 groups.
Conclusions
Self-expanding metallic stents are effective in relieving colonic obstruction. Stenting has been shown to compare favourably with emergency surgery, both as definitive palliation or as a bridge to surgery. Stenting enables laparoscopic resection and synchronous dissection. It is also an effective procedure for relieving obstructions due to benign conditions.

References

Highlights

Joint Scientific Symposium:
“Update Management of Psychosomatic Symptoms”

8 October 2009 (6:15 p.m. – 10:30 p.m.)
3/F, The Mira Hotel

Co-organizers: The Hong Kong Society of Gastroenterology
Hong Kong Society of Biological Psychiatry

Sponsor: Lundbeck Hong Kong

Topic I
“Psychotropic Agent for Functional Gastrointestinal Disorders”

Speaker: Prof. Justin C.Y. Wu
Professor, Institute of Digestive Disease
Department of Medicine & Therapeutics,
CUHK

Chairman: Dr. Hon Yuen
Specialist in Gastroenterology & Hepatology

Topic II
Psychosomatic symptoms: Conscious or unconscious? Implication on management”

Speaker: Prof. Siu-Wa Tang
Emeritus Professor of Psychiatry
University of California, USA
President, Hong Kong Society of Biological Psychiatry

Chairman: Prof. Yun-Kwok Wing
Professor, Department of Psychiatry, CUHK

The joint symposium attracted about 103 gastroenterologists and psychiatrists to attend. After the two eminent speakers delivered their captivating lectures, interactive discussions followed. 90 delegates stayed for the dinner and continued exchanging their views.
**Scientific Symposium**

10 August 2009 (7:00 p.m. – 10:00 p.m.)
Aberdeen (Level 3), JW Marriott Hotel

Organizer: The Hong Kong Society of Gastroenterology

Chairman: Prof. Benjamin C.Y. Wong

Topic: “Chronic Complications of Proton Pump Inhibitors”

Speaker: Professor Ronnie Fass MD, FACP, FACG
Head of Neuroenteric Clinical Research Group and
Director of GI Motility Laboratories
University of Arizona Health Sciences Center and
Southern Arizona VA Health Care System, Arizona, USA

Sponsor: Eisai (HK) Co., Ltd.

This was a small but successful symposium attended by 23 local gastroenterologists and cardiologists. Prof. Ronnie Fass delivered his talk on “Chronic Complications of Proton Pump Inhibitors” which was informative and aroused a lot of interest. Questions were raised and discussed. After the symposium, most delegates stayed and enjoyed the dinner.

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**11th Joint Annual Scientific Meeting**

5 September 2009 (1:00 p.m. – 6:15 p.m.)
Ballroom, Level 7, Langham Place Hotel, Mongkok, Kowloon, Hong Kong

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

Organizing Chairperson: Dr. Annie O.O. Chan

Sponsors: AstraZeneca Hong Kong Limited & GlaxoSmithKline Limited

The eleventh Joint Annual Scientific Meeting held on 5 September 2009 was very successful. It was attended by approximately 400 medical professionals including 25 from Mainland China and 12 from the Philippines. The lectures delivered by distinguished speakers encompassed gastroenterology, hepatology, endoscopy and radiology. These were “Update on confocal endomicroscopy - from in vivo histology to molecular imaging” by Prof. Dr. Ralf Kiesslich from Germany; “Update on CT Colonography” by Dr. John K.F. Chan of Hong Kong Sanatorium & Hospital; “Surgical Treatment of HCC” by Prof. Ronnie T.P. Poon of The University of Hong Kong; “Diagnosis and interventional radiology treatment of HCC: the essentials” by Dr. Philip C.H. Kwok of Queen Elizabeth Hospital; “New Perspectives in CHB Therapy” by Dr. James Y.Y. Fung of The University of Hong Kong; “A Symptom-Based and Endoscopic Survey of Reflux Disease In China – The SLC Study” by Prof. John Dent from Australia; “Management of Refractory GERD” by Prof. Benjamin C.Y. Wong of The University of Hong Kong and “Recent advances in the therapy of peptic ulcer bleeding” by Prof. Joseph J.Y. Sung of The Chinese University of Hong Kong. The delegates participated actively in the discussions after each session co-chaired by Drs. Annie Chan and Wai-Keung Leung, Dr. Wai-Cheung Lao and Prof. Man-Fung Yuen as well as Dr. Kam-Chuen Lai and Prof. Justin C.Y. Wu. Crystal trophies were presented to the speakers and sponsors in appreciation of their contributions.
29th Annual General Meeting & Scientific Meeting
The Hong Kong Society of Gastroenterology

Date: 11 March 2010 (Thursday)
Time: 6:15 p.m. – 10:00 p.m.
Venue: Level 7, Langham Place Hotel, 555 Shanghai Street, Mongkok, Kowloon, Hong Kong

President: Dr. Yat-Wah Yeung
Organising Chairman: Prof. Justin C.Y. Wu

“Asia at The Crossroads - Changing Epidemiology of GI Diseases” ........ Professor Khean-Lee Goh (Malaysia)

“Inflammation and Cancer: Molecular Targets and Opportunities” ........ Professor Raymond N. Dubois (USA)

www.hksgo.org for detailed programme