



Message from Professor Joseph Sung, President

Despite the SARS epidemic in the first six months, 2003 has been a remarkable year for The Hong Kong Society of Gastroenterology. Two annual scientific meetings were held: Annual General Meeting and Scientific Meeting in March and the Annual Joint Scientific Meeting in September, 2003 with the number of participants at 180 and 400 respectively. Responses for the two scientific programs were very encouraging. In addition to these, an ultrasound training workshop was conducted between September 24 - 26 in 3 HA hospitals. The purpose of this workshop was to provide our members and fellows training on ultrasound and Doppler study of abdomen. All three sessions were oversubscribed. Two scientific symposia originally scheduled in April and May have been postponed to autumn due to SARS. These two meetings entitled "Chronic Hepatitis B Treatment: The Current Success and A New Future" and "Strategic Management of Peptic Ulcer Bleeding" were held on November 12 and 19 respectively. Both meetings were very successful and well-attended.

Our Society continues to promote research in Gastroenterology. Applications were invited for research projects on any topic of concern and interest related to Gastroenterology and Hepatology. The response was excellent. 9 applications were received. The research proposals were assessed by a research panel consisting of local and external reviewers. On the basis of the evaluation, research grants were awarded to two projects: clopidogrel and GI bleeding and, NASH. On the educational front, an educational CD on Gastroenterology and Hepatology is now in preparation. This will hopefully be ready for distribution in early 2004.

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; Dr. W M Hui for editing this Newsletter; Doctors Siu Kam Wang, Philip Kwok, Lai Kam Chuen and Leung Suet Yi for sharing with us their scientific updates. Last but not the least, our friends from pharmaceutical industry for their kind support and generous sponsorship of Society's meetings, workshop, Newsletter and other functions aimed at promoting the advancement of Gastroenterology in Hong Kong.

Merry Christmas and Happy New Year.

SCIENTIFIC UPDATES

Radiological Evaluation of Gastrointestinal Tract Tumours: Current Status

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Tumour of the gastro-intestinal tract is a common disease with significant mortality and morbidity. Successful treatment relies significantly on accurate detection and staging of primary disease, as well as early identification of the presence and extent of recurrence. With the recent advances in multi-detector CT technology and PET imaging, the algorithm of imaging is undergoing continuous evolution.

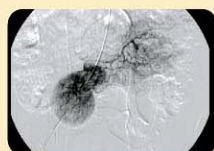


Figure 1

Injection into the superior mesenteric artery showed a tumour staining in the right lower quadrant, supplied by enlarged feeding vessels. A gastrointestinal stromal tumour is found in operation.



Figure 2

Marked irregular wall thickening of a segment of sigmoid colon, almost completely obliterated the lumen. Colonoscopy found a circumferential growth at the sigmoid.

Barium studies are the primary means of examining patients with suspected small bowel disease. Although these techniques show exquisite mucosal detail, they cannot

reliably detect and characterize extraluminal component of neoplastic disorders in the small bowel. The reported sensitivity for the detection of small bowel tumors by the small bowel follow-through examination, the most commonly used method in most institutions, varies widely. Small bowel enema is more reliable in the demonstration of small bowel tumors, as well as in the evaluation of occult gastrointestinal bleeding and of intestinal obstruction. However, the examination is much more uncomfortable for the patient. Barium examination of the colon is designed primarily for the detection of mucosal lesions. In this regard, it competes directly with colonoscopy. Although colonoscopy has an advantage in the ability to detect change in colour and the ability to obtain biopsy specimens, a properly performed barium contrast study should be fully competitive in the detection of gross as well as subtle colonic lesions. It is especially helpful for colon with redundant loops.

Ultrasonography is often the first imaging study performed in patients with abdominal pain or vague symptoms related to the gastrointestinal tract. It is useful in diagnoses of certain infective or inflammatory conditions. However, its role in detection of GI tumours is very limited. Ultrasonography can be helpful in detection of liver metastases, but its role in detection of distant metastases is largely replaced by CT.

Angiographic technique is of limited value in GI tumour evaluation. Usually it is performed in evaluation of occult gastrointestinal bleeding, when GI tumours are just incidental findings. A common example is gastrointestinal stromal tumor (GIST), which may present as a well defined vascular lesion (figure 1).



Magnetic Resonance Imaging (MRI) is not a primary test in the diagnosis of gastrointestinal tumours. It is restricted by motion artifact caused by respiration, inferior spatial resolution and lack of suitable luminal contrast agents. Modern MRI techniques, with endorectal and phase-arrayed coils, have led to better spatial resolution and staging accuracy. Current applications of MR in GI tumours include pre-operative staging and detection of recurrence of rectal tumours. This is related to the relative fixed position of rectum, which benefits from high-resolution T2-weighted spin-echo imaging. This technique, when combined with gadolinium-enhanced spoiled gradient-echo sequence, is particularly useful for evaluation of rectal carcinoma; in assessing the extent of bowel wall involvement by tumour; determining the relationship of tumour to adjacent organs, and distinguish tumour recurrence from fibrosis. MR imaging using an endorectal coil can distinguish the rectal mucosa, submucosa, and muscularis propria. This technique is found useful in prediction the depth of invasion with an accuracy of 81%. MR may be considered in preoperative evaluation of patients who are sensitive to iodinated contrast material, particularly in the evaluation of liver.

Computed Tomography (CT) is increasingly used for the evaluation of patients with abdominal symptoms and may provide the initial opportunity to detect and characterize tumors of the bowel. The recognition of certain patterns of CT findings now allows a reasonable distinction to be made between benign and malignant bowel tumors and, in cases of certain benign tumors such as lipoma and leiomyoma, may make it possible to suggest the specific diagnosis. It more accurately defines the true extent of barium-demonstrated bowel lesions by revealing their extension, mesenteric involvement, and distant disease. The imaging methods, however, cannot replace the demonstration of fine mucosal detail that is possible only by adequate barium technique or colonoscopy.

Adenocarcinoma of the colon generally appears on CT as a lobulated, soft tissue mass or as a well-demarcated, focal area of colonic wall thickening (figure 2). Lesions of the rectum and recto-sigmoid may be seen as asymmetrical or circumferential thickening of the bowel wall. Colonic obstruction is often present. Large tumours may show a central low-density area representing necrosis. Occasionally the primary lesion may perforate and cause a peri-colic abscess that may be difficult to distinguish from diverticulitis. Other possible findings include extension of tumour into peri-colic fat, invasion of adjacent structures, lymphadenopathy, ascites, adrenal and liver metastases. Spread into neighboring viscera may sometimes be difficult to predict because the tumour mass may be visually inseparable from a structure and yet not actually invade it. However, tumour

extension into adjacent bone and muscle is visualized well due to superior tissue contrast. The detection of spread of colorectal carcinoma to lymph nodes is also problematic. Though regional lymph nodes larger than 5 to 10mm usually can be seen on CT, there is a poor correlation between the size of lymph nodes and the presence of metastatic tumour within them.

Early enthusiastic results of 85% to 90% accuracy in tumor staging have been reported. Recent result from a multi-institutional study reported 74% accuracy for CT assessment of wall invasion; the sensitivity in evaluating lymph node metastases was 48%. CT demonstrated an 85% accuracy and 97% specificity in detection of liver metastases. The accuracy of local staging by CT improves as disease stage increases; this discrepancy is due to limitation of CT resolution to determine depth of bowel wall penetration. It also improves when a prepared colon is evaluated and insufflated with either air or water. Despite the poor accuracy determined from clinical trials, CT is still recommended in the initial evaluation of all patients scheduled for surgery because of its ability to obtain a rapid global evaluation and demonstrates complications (perforation, obstruction, etc.) that may not be clinically apparent. Furthermore, abdominal/pelvic CT has a high negative predictive value, which gives significant credibility to a negative report.

CT is the preferred method of detecting local recurrence of rectal carcinoma in patients who have undergone resection. Unfortunately, a major problem is the differentiation of recurrent tumour from benign, postoperative fibrosis. Baseline postoperative CT taken 3 to 4 months after operation is of great help for this differentiation. CT guided needle biopsy can be useful in problematic case.

CT colonography, or 'virtual colonoscopy', has evolved quickly as a rapid, non-invasive accurate and well-tolerated colorectal screening test. During a single breath hold, thin section helical CT images were obtained from the top of colon to the rectum. The patient was then placed in the prone position and repeat scanning with the same protocol. The images were processed in a computer workstation, and presented in a multi-image display format. The endoluminal images viewed continuously in the interactive mode provided an endoscopic-like examination. Use of multi-detector row CT scanners will allow the use of thinner collimation in an even shorter period of time, which will likely result in improved image quality with reduced motion artefact. The intravenous use of contrast agent for CT colonography may allow increased specificity with this technique. It has excellent sensitivity for the detection of clinically important colorectal polyps and cancers. Recent evidence suggests a 93% sensitivity for detection of polyp larger than 10mm diameter, with an estimated specificity of 97.7%. Advantages of CT colonography

compared with conventional colonoscopy include a shorter procedural time, less risk to the patient, and no need for intravenous sedation. Furthermore, CT colonography may be more accurate for precise localization of lesions. Disadvantages of CT colonography at this time include the need for bowel cleansing similar to that of colonoscopy. Poor colonic distension or preparation limits the accuracy of CT colonography. Small lesions are more difficult to detect with CT colonography.

Positron Emission Tomography (PET) is an emerging modality of choice in evaluation of GI tract tumours. It has a high sensitivity and specificity for detection of colorectal carcinoma and appears to be superior to CT in the staging of primary colorectal carcinoma. PET is the most sensitive non-invasive imaging modality for the diagnosis of hepatic metastases from colorectal, gastric and oesophageal cancers. It is also confirmed that PET is more sensitive than CT in detection and staging of recurrent colorectal cancer. There is good evidence suggesting PET will ultimately become routinely incorporated into colorectal cancer patient management algorithms. Currently it is still limited by its availability and cost. The most recent development in this area is the combination of a PET scanner with a multi-detector row CT scanner in one machine, **CT-PET**. The images from two systems are co-registered and this technology is likely to dramatically improve the specificity of findings. Thus, PET-CT may represent a very relevant addition to the spectrum of abdominal imaging systems currently available. For investigation of suspected GI tumours, PET should not be the first line of radiological evaluation.

PET's role in screening of normal population for colorectal cancer is not well defined. CT colonography may be useful as a tool of screening in the future.

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POLYPS OF THE STOMACH? WHAT TO DO?

CLINICAL AND PATHOLOGICAL PERSPECTIVES

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Introduction

A gastric polyp is defined as a mass that protrudes into the lumen of the stomach. The clinical significance is usually defined by its histology. Gastric polyps are relatively rare lesions in the stomach and most of these polyps are found incidentally when patients undergo upper gastrointestinal evaluation by endoscopy or barium study. Unlike colon polyps, the management of gastric polyps has been confusing because of the diversity of the types of gastric polyps, confusion over their potential for malignancy and uncertainty about the adequacy of forceps biopsy in making a definitive diagnosis. Because only few well-performed studies on gastric polyps are available, clear cut evidence-based recommendation in management of these polyps is limited. A few years ago, the American Society for Gastrointestinal Endoscopy developed one such guideline and readers can refer to the original publication for further detail (1). In the following review, only gastric epithelial polyps are included while submucosal tumour, which can usually be recognised by its distinct endoscopic appearance, is not included. A simple classification of gastric mucosal polyps is shown in Table 1.

Incidence

The reported incidence of gastric polyps varied from 1.5% to 4%, depending on whether it was a radiological series (2) or an endoscopy series (3). The most common gastric polyp is the benign hyperplastic polyp, which can account for up to 80% of the gastric polyps found. Adenomatous polyp and fundic gland polyp account for most of the remaining gastric polyps. They can be found with equal frequency in both genders and they are most commonly found in the elderly, although they may occur at all ages.

Clinical Manifestation

Because of the increasing use of endoscopy of the upper gastrointestinal tract, a large number of these lesions are discovered incidentally. Some patients with these lesions may experience mild epigastric discomfort, bloating, anorexia, nausea, vomiting, anaemia, haematemesis, or

melaena. Rarely, they present with gastric outlet obstruction.

Pathology, Endoscopic Appearance and Malignant Potential

Hyperplastic (HP) polyp (Figure 1)

They may be single or multiple, pedunculated or sessile and can occur in any part of the stomach. They are covered with normal looking mucosa and frequently have a superficial ulceration. Histologically, they consist of markedly hyperplastic foveolar glands which show elongation, twisting, branching and cystic dilatation. The lining cells consist of a single layer of columnar hypertrophied foveolar epithelium containing abundant neutral mucin. The surface is often eroded, and the epithelium may show regenerative changes mimicking adenomatous or dysplastic changes. The lamina propria is oedematous, contains bundles of smooth muscles extending from the muscularis mucosae, and infiltrated by plasma cell and lymphocytes. At the site of erosion, there is often presence of polymorph infiltration, proliferation of young capillaries and some bizarre-appearing pleomorphic cells of regenerative nature.

Hyperplastic polyp itself is considered non-neoplastic, but in occasional cases dysplastic changes or even adenocarcinoma may develop within the lesion. The reported risk of developing a neoplastic component within a hyperplastic polyp varied from 3 to 6% (4-6). Although a polyp size > 2cm has been suggested as an important factor determining the malignant potential of adenomatous polyps, no such size association has been found for HP gastric polyp and adenocarcinoma can also occur

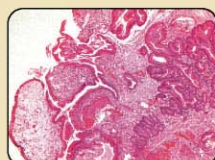


Figure 1

A hyperplastic polyp featuring hyperplastic foveolar glands, oedematous lamina propria with inflammatory cellular infiltrate.

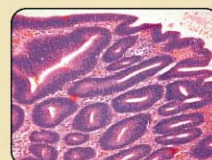


Figure 2

A small flat tubular adenoma with moderate dysplasia arising from the antral wall. The morphology is closely similar to those arising from the colon.

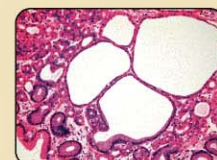


Figure 3

A fundic gland polyp composed of several dilated glands admixed with normal body type gastric glands in the gastric mucosa. The dilated glands are lined by mixture of mucin secreting cells, parietal cells and chief cells.

in smaller polyps with diameter less than 2cm (7).

Adenomatous (AD) polyp (Figure 2)

They resemble closely adenomatous polyps of the colon. Most of them are located in the antrum. They are often sessile, but can be pedunculated. Adenomas can occur both alone in the stomach or can be found in 6-12% of patients with familial adenomatous polyposis (FAP). They are covered with abnormal reddened velvety mucosa, which may be lobulated. Small flat lesions usually have a tubular pattern, whereas larger adenomas have villous or tubulovillous architecture. The epithelial linings are tall columnar cells with crowded pseudostratified nuclei. The nuclei show prominent pleomorphism and frequent mitotic activity. Based on the degree of cytological atypia and architectural disturbances, they are categorised as showing mild, moderate and severe dysplasia. In cases with severe dysplasia, examination of multiple sections is necessary to exclude presence of invasion. Similar to those arising from the colon, the risk of developing adenocarcinoma in a gastric adenoma correlates with its size and presence of villous component. One study reported a 5.9% risk of developing adenocarcinoma in tubular adenoma and 33.3% in villous and tubulovillous adenoma (8).

Fundic gland (FG) polyp (Figure 3)

They present as 2-3 mm sessile lesions that can be plucked like grapes with the biopsy forceps. Multiple polyps are more common than single polyps. They are commonly found in the body and fundus. Although FG polyps are found incidentally in older

subjects, it may be detected in younger patients with FAP. Histologically, they are composed of cysts of variable size admixed with normal glands in the gastric mucosa. The cysts are in fact dilated gastric glands lined by flattened mucin secreting cells, parietal cells and chief cells.

They are non-neoplastic in nature, and may be considered as harmless hamartomas. Follow-up is therefore unnecessary once the diagnosis is confirmed by histology. However, additional development of adenomatous changes and dysplasia in FG polyps has been found in 25-44% of patients with FAP (9,10).

Hamartomatous gastric polyps

They are rare and are made up of various benign epithelial cells normally present in the gastric mucosa. They can occur sporadically and in polyposis syndrome such as Peutz-Jeghers syndrome and juvenile polyposis syndrome. About one quarter of the Peutz-Jeghers cases involve the stomach and the duodenum and 2-3 percent develop gastric or duodenal carcinoma. Malignant change in gastric juvenile polyposis is either very rare or absent.

Associated Lesions

Gastric polyps and polyposis syndrome

FG polyps and AD polyps can be found in 10-50% and 5-10% of patients with FAP respectively. Hamartomatous polyps are frequently a manifestation of the polyposis syndromes. Association with the presence of colorectal epithelial tumours in patients with FG and AD polyps has also been reported. In one small study, colorectal epithelial tumours, mostly adenomas, were found in 35.6% of cases with FG polyps and 60.7% of those younger than 40 years (11). Radiological and colonoscopic examination to rule out the presence of colorectal tumours or the polyposis syndromes may be considered in patients who are found to have these polyps.

Associated gastric lesion

HP polyps and AD polyps are often found in a background of chronic active gastritis or chronic atrophic gastritis. Other premalignant lesions such as intestinal metaplasia are also commonly found in the surrounding mucosa. The incidence of synchronous or metachronous carcinoma elsewhere in the same stomach in patients with HP and AD polyps is more common than the general population (12-14). These observations suggest that these polyps arise from an abnormal gastric mucosal background. Biopsy of the non-polypoid gastric mucosa in patients with HP and AD polyps should therefore be performed during endoscopic examination to rule out the presence of pre-malignant lesions.

In contrast to AD polyps, patients with HP polyps are commonly (30% to 100%) infected with *Helicobacter pylori* (15). It has been proposed that *H. pylori* promotes inflammation in the gastric mucosa and contributes to the formation of HP polyps. Regression of HP polyps after eradication of *H. pylori* has been reported (16).

On the other hand, fundic glands polyps almost always appear in healthy gastric mucosa or in *H. pylori*-negative chronic inactive gastritis.

Recurrence of gastric polyps

Like colorectal polyps, gastric polyps are prone to recurrence after removal. This is true for both HP polyps and AD polyps. In one study, primary benign epithelial polyps, both HP polyps and AD polyps, recurred in the same location or different location in 38.6% of 1177 patients after an observation period of up to 7 years. Most of these recurrences occurred within the first year after polypectomy (17). The high rate of recurrence may just signify a persistently abnormal mucosal background, which cannot be reversed by simple resection of the gastric polyps.

Management of gastric polyps

Management guided by forceps biopsy versus initial endoscopic polypectomy

There is no doubt that if the gastric polyps are large or if they are associated with complications such as bleeding, they should be removed completely. On the other hand, for small and asymptomatic gastric polyps, opinion differs in the ability of forceps biopsy to provide adequate tissue for correct histologic diagnosis and to detect malignancy within the polyps. It has been controversial whether polypectomy should be performed on all polyps found or this should be reserved to AD polyps only. In a study involving 222 gastric polyps, Muehldorfer et al found a complete agreement between the histological diagnosis of forceps biopsy and the final diagnosis of the polypectomy specimen in only 55.8% of the cases. Moreover, relevant differences could be found in 2.7% of cases, with failure of forceps biopsy to detect carcinoma foci in HP polyps as the most common reason (18). These results therefore favour complete polypectomy rather than performing forceps biopsy to guide in the management of patients with small gastric polyps less than 2 cm. Although bleeding complication may be as high as 7.2% in gastric polypectomy (18), post-polypectomy bleeding may be reduced by injection with adrenaline to the base of the polyp prior to standard diathermy removal and by prescribing anti-ulcer treatment afterwards.

Surgical intervention

Surgical intervention is necessary only if the polyp is too large, or has impacted in the pyloric channel.

Surgery with adequate gastric resection is also indicated if malignancy is found in the polyp, especially in the presence of a signet ring cell carcinoma or a poorly differentiated adenocarcinoma or when there is an infiltration into the submucosa. For patients who have poor surgical risk, if the carcinoma is limited to the mucosa, is well or moderately differentiated and can be removed with an adequate margin, simple endoscopic polypectomy may be considered.

*Eradication of *H. pylori**

With the discovery of the etiological role of *H. pylori* in most peptic ulcer diseases, the effect of eradication of *H. pylori* in the natural course of gastric HP and AD polyps has been investigated in a number of studies. Ohkusa et al found in a randomised controlled trial that eradication of *H. pylori* caused regression of HP polyps in 80% of the patients after a follow-up of 12-15 months as compared with none of the patients with persistent *H. pylori* infection (19). Similarly, Ljubicic et al found complete regression of polyps in 44% of patients with HP polyps and none of the patients with AD polyps. After a median follow-up of 14 months, no patient developed recurrence of HP polyps or AD polyps after eradication of *H. pylori* and polypectomy (20).

Although regression of AD polyps is not possible with eradication of *H. pylori*, progression of gastric adenoma to carcinoma may be halted. In a non-randomised study involving 64 patients with both gastric adenomas and *H. pylori* infection, Saito et al found that over a follow-up of 2 years, 12.5% of patients with persistent *H. pylori* infection developed an early stage, intestinal type gastric cancer, while none of the patients with *H. pylori* eradicated developed gastric cancer (21).

Despite these promising results of *H. pylori* eradication for HP polyps, it is still not advisable to replace polypectomy with *H. pylori* eradication as the initial treatment, because of the inaccuracy of forceps biopsy and the small but consistent risk of malignancy in HP polyps. On the other hand, it is worthwhile to test and eradicate any *H. pylori* both in patients with HP polyps and patients with AD polyps because of the potential reduction of polyps recurrence and the potential reduction of future gastric malignancy (22).

Surveillance

After resection of the gastric polyps, regular long-term endoscopic surveillance has been suggested to detect the recurrence of polyps or, more controversially, the development of a gastric carcinoma from pre-malignant gastric mucosal lesions commonly associated with HP and AD gastric polyps.

Although it is well established that new (metachronous) gastric polyps develop later in a proportion of patients after polyp clearance, unlike colorectal adenomas, the surveillance interval for gastric polyps is not well defined. Whether the surveillance intervals for gastric polyps with different histological types and characteristics should be different from each other is also unclear. It is even more controversial whether surveillance should be performed for the gastric mucosal pre-malignant lesions associated with gastric polyps. Recently, Whiting et al found, in a non-randomized study (23), in patients who underwent annual surveillance endoscopy over a period of 10 years because of the presence of high-risk pre-malignant gastric lesions

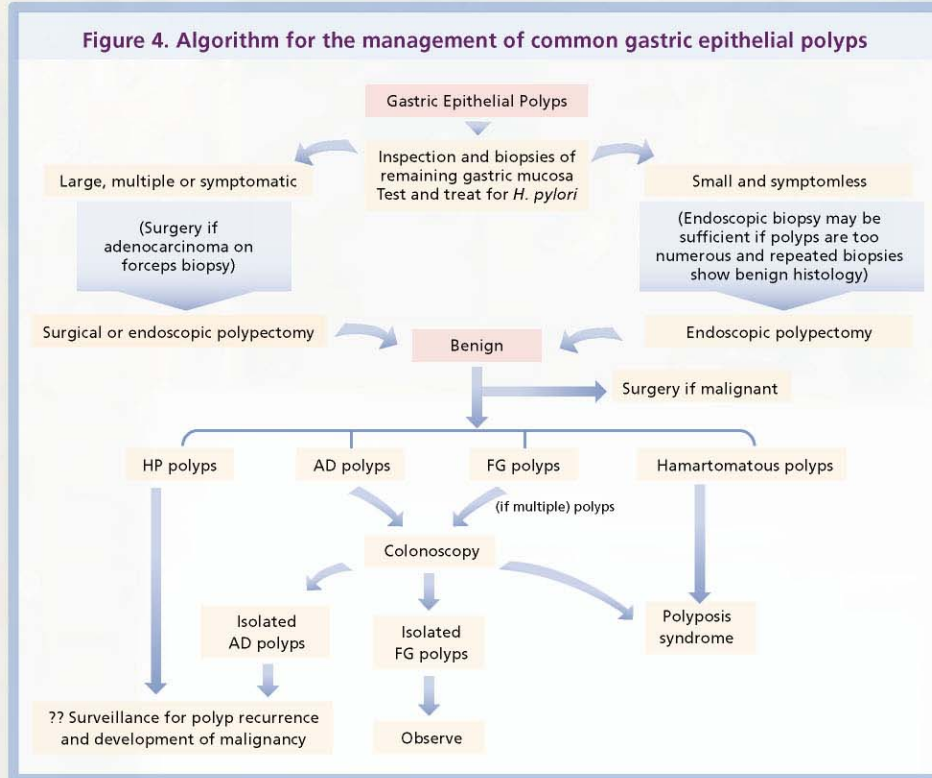
such as intestinal metaplasia, atrophic gastritis and dysplasia, gastric cancers detected were of an earlier stage, increased operability and increased long-term survival than those cancers detected during open access endoscopy. Although it seems that regular surveillance is beneficial, it cannot be routinely recommended to all patients with pre-malignant gastric mucosal lesions because of several reasons. First, the precise risk of these conditions for developing malignancies and the optimum time interval between screening endoscopies are largely unknown. Second, the long-term effect of *H. pylori* eradication on the regression of these lesions has not been adequately examined. One recent study suggested that eradication of *H. pylori* could halt the progression of intestinal metaplasia and atrophy (24). Finally, even if these questions were adequately answered, it may not be cost-effective to start surveillance endoscopy now, knowing that the incidence of gastric carcinoma and the prevalence of *H. pylori*, which is linked to a large proportion of gastric carcinoma, are continuing to decrease in most developed countries.

Conclusion

Although the vast majority of gastric polyps are benign, a consistent percentage will have malignant characteristics. Since evidence suggests that forceps biopsy alone has the risk of sampling error and discrepancy in histological diagnosis occurs between forceps biopsy and polypectomy, all gastric polyps, including HP polyps of whatever size, should be resected either endoscopically or surgically, rather than simply being observed.

Because of the high incidence of associated chronic gastritis, pre-malignant lesion and synchronous malignancy, a thorough examination of the entire stomach and biopsies of any endoscopically abnormal gastric mucosa is necessary.

Patients with HP and AD polyps should have *H. pylori* infection checked and treated. This may further reduce the recurrence of gastric polyps or halt the progression of the associated chronic



gastritis.

It is advisable to consider periodic endoscopic examination to detect both the recurrences of gastric polyp and the development of gastric malignancy in those who are found to have pre-malignant lesions in the stomach. However, the most cost-effective way of performing surveillance endoscopy is still unclear. An algorithm in the management of common gastric epithelial lesions is shown in Figure 4.

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Table 1. Classification of gastric mucosal polyps

I. Neoplastic polyps

1. adenocarcinoma
2. adenoma
3. lymphoma
4. carcinoma

II. Non-neoplastic polyps

1. Hyperplastic polyp
2. Fundic gland polyp
3. Inflammatory fibroid polyp
4. Hamartomatous polyp
 - a. Peutz-Jeghers polyp
 - b. Juvenile polyp
 - c. Cronkhite-Canada polyp

EVENTS HIGHLIGHTS

Fifth Annual Joint Scientific Meeting 2003

Dr. Chan Ka Leung Francis, Reader

Department of Medicine & Therapeutics, Prince of Wales Hospital

Date : September 27, 2003
Time : 1:00 - 9:00 p.m.
Venue : Penthouse (PH), Ballroom, Miramar Hotel
Sponsors : AstraZeneca, GlaxoSmithKline
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

This Fifth Annual Joint Scientific Meeting was another successful event of the year. Around 400 doctors attended this conference and took part actively in the panel discussions. The Meeting began with the Free Paper session. Four abstracts on different aspects of Gastroenterology and Hepatology were presented. The abstracts were of good quality and very well presented. In the end, the Young Investigator's Award went to Dr. Chan Sze Wah, Agnes. This award was presented to Dr. Agnes Chan by Dr. Perrillo and Dr. Cryer on behalf of the meeting co-organizers at dinner following the scientific sessions.

The Scientific Programme was a very substantial one this time. Two overseas speakers, Dr. Bryon Cryer and Dr. Robert Perrillo from The States, delivered their lectures entitled "Preventing GI Toxicity of NSAIDs" and "New Treatments for Hepatitis B Infection" respectively. Their talks were very captivating and thought provoking. These aside, distinguished local speakers included Dr. Philip Kwok, speaking on "Pancreatitis: Imaging & Intervention", Dr. C P Kwan, on "Irritable Bowel Syndrome in Hong Kong", Dr. James Lau, "IV PPI in the Management of Bleeding Ulcers" and Dr. Ronnie Poon, "New Treatments for Obstructive Jaundice". All four sessions were very stimulating and well-received. There was a high level of discussion and exchange throughout. It was a successful joint scientific meeting.



On behalf of the five co-organizers, Dr. Szeto Ming Leung, Vice President of The Hong Kong Society of Gastroenterology gave a presidential address stressing on the success of another multidisciplinary joint meeting. He thanked all contributors and participants and the two meeting sponsors for their gracious presence and valuable contributions and congratulated the oral presenters, in particular Dr. Chan, for their excellent performance. He then invited the presidents of the other societies: Dr. Samuel Kwok, Dr. Yuen Hon and Dr. Lai Jak Yiu to present to each speaker, guest co-chairman, and sponsor a souvenir in the form of a plaque in appreciation of their remarkable efforts and contributions.

The Hong Kong Society of Gastroenterology takes this opportunity to thank all co-organizers and their members for their excellent work and organization and look forward to similar co-operations in future.



Chronic Hepatitis B Treatment: The Current Success and a New Future

November 12, 2003 at 7:00 - 9:15 p.m. in Ballroom, Intercontinental Hotel

Dr. Hui Wai Mo, Specialist (Gastroenterology)

Co-Organizer:
 The Hong Kong Society of Gastroenterology
 The Hong Kong Association for the Study of the Liver Diseases

Co-Chairman:
 Dr. Hui Wai Mo
 Dr. Lai Jak Yiu

Sponsor:
 GlaxoSmithKline

This meeting was very successful. Lectures by the three prominent speakers Prof. Lai Ching Lung, Prof. Joseph Sung and Dr. William Sievert entitled "Current Antiviral Therapy for hepatitis B: The Perspective from Asia", "Long term efficacy and safety of lamivudine in delaying clinical progression of HBV related cirrhosis" and "Adefovir for chronic hepatitis B infection: the new therapeutic landscape" respectively were highly stimulating. Participants, about 340 of them, displayed great interest and took part actively in the discussions. Majority of the participants stayed for dinner after the meeting.

Strategic Management of Peptic Ulcer Bleeding

November 19, 2003 at 7:00 - 8:30p.m. at The Peninsula

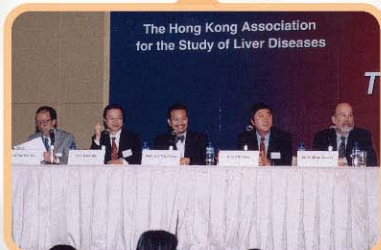
Dr. Szeto Ming Leung, Consultant Physician
 Department of Medicine & Geriatrics, Tuen Mun Hospital

Co-Organizer:
 The Hong Kong Society of Gastroenterology
 Hong Kong Society of Digestive Endoscopy

Co-Chairman:
 Dr. Szeto Ming Leung
 Dr. James Lau

Sponsor:
 AstraZeneca

The symposium was another successful event of this Society. Some 140 members of the two co-organizing societies and invited guests attended. The two distinguished guest speakers were Prof. Joseph J Y Sung and Prof. Kenneth Lee who spoke on "Pharmacological therapy of peptic ulcer bleeding" and "Pharmacoeconomic analysis of PPI therapy in managing bleeding peptic ulcers in Hong Kong" respectively. Participants found the presentations highly useful and enlightening. Response from the floor was generally good. A number of interesting questions were raised and discussed. Most of the participants attended the dinner which followed.



Research Projects 2003

Research grants were awarded this year to two projects. These included projects on "Acid suppression versus clopidogrel in the secondary prevention of ulcer complications in low-dose aspirin users" and "A study on nonalcoholic steatohepatitis (NASH) in Hong Kong".



The Ultrasound Training Workshop

September 24-26, 2003 at 9:00 a.m. - 12:30 p.m.

Dr. Kwok Chong Hei Philip

Consultant Radiologist, Department of Radiology and Imaging

Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon



Day	Venue	Co-ordinator
24th	Pamela Youde Nethersole Eastern Hospital	Dr. Lao Wai Cheung
25th	Caritas Medical Centre	Dr. Yeung Yat Wah
26th	Prince of Wales Hospital	Dr. Chan Ka Leung Francis
Organizing Chairman	Dr. Kwok Chong Hei Philip	
Tutor	Dr. Wang Yi	

The Ultrasound Training Workshop was the first successful workshop conducted by The Hong Kong Society of Gastroenterology. It aimed to provide participants training on ultrasound and Doppler study of abdomen, mainly hepatobiliary system and the gastrointestinal system. This workshop was honoured by the kind presence and remarkable lecture of Dr. Wang Yi, the workshop tutor. Dr. Wang is Director of the Department of Ultrasound of Hua Shan Hospital of Fudan University in Shanghai. Response from our members and fellows to the training was very good. The 3 sessions intended for 10 trainees per session were fully subscribed.

The workshop began with an introduction of Dr. Wang. This was followed by a short briefing and on site instruction on basic principles of ultrasound and Doppler relevant to hepatobiliary and gastrointestinal ultrasound which aroused the interest of the participants and led them into active discussions. The hands-on demonstrations by Dr. Wang were informative and stimulating. Upon having a good grasp of the basic knowledge and operational skills, trainees embarked enthusiastically on their hands-on with the hospital patients.

The 3 1/2 hour workshop was a valuable experience to the trainees. Learning spirit among the participants was high and exchange of views was seen throughout the training and at break time.

This Society thanks The Industrial Promoting Company Ltd. for sponsoring the workshop and all trainees for their active participation.

Welcome!!!

New Fellow

Dr. Chan On On
Department of Medicine
Queen Mary Hospital

Dr. Kwan Tim Lok
Department of Surgery
Caritas Medical Centre

Dr. Chang Kwong Kuifa
Department of Medicine
Tuen Mun Hospital

New Member

Dr. Hui Aric Josun
Department of Medicine & Therapeutics
Prince of Wales Hospital

Dr. Poon Tung Ping Ronnie
Department of Surgery
Queen Mary Hospital

Dr. Lau Siu Fai
Department of Medicine
Tuen Mun Hospital

Dr. Law Siu Tong
Department of Medicine & Geriatrics
United Christian Hospital

Dr. Lok Ka Ho
Department of Medicine
Tuen Mun Hospital



MAJOR MEETINGS

March 8-11, 2004
**Philippine Society of Gastroenterology and
Philippine Society of Digestive Endoscopy Annual
Meeting**
Organizers: Philippine Society of
Gastroenterology and Philippine Society of
Digestive Endoscopy
Location: Philippines

March 16-20, 2004
**Biennial Scientific Meeting of International
Association for the Study of the Liver Meeting**
Organizer: International Association for the
Study of the Liver
Location: Bahia Othon Palace Hotel, Salvador,
Bahia, Brazil
Website: www.eventussystem.com.br/liver

June, 2004
**5th Shanghai International Conference of
Gastroenterology**
Organizer: The Chinese Society of
Gastroenterology
Location: Shanghai, China



**Hong Kong - Shanghai
International Liver
Congress 2004 in Hong
Kong**
February 14-17, 2004

www.hepa2004.org



**12th United European
Gastroenterology
Week in Prague, Czech
Republic**
September 25-30, 2004

www.uegf.org

June 2-6, 2004
**6th World Congress of the International Hepato-
Pancreato-Biliary Association**
Organizer: American Hepato-Pancreato-Biliary
Association
Location: Washington, DC, USA, Hilton
Washington, 1919 Connecticut Ave., NW
Website: www.ahpba.org/ihpba/index.html

October 4-8, 2004
Australian Gastroenterological Week
Organizer: Gastroenterological Society of
Australia
Location: Brisbane, Australia
Website: www.gesa.org.au

October 21-24, 2004
Digestive Disease Week
Organizer: The Japanese Society of
Gastroenterology
Location: Fukuoka, Japan
Website: www.ddw.jp



www.hksge.org

**The Hong Kong Society of
Gastroenterology Annual
General Meeting &
Scientific Meeting**
March 23, 2004
Venue: Sheraton Hong
Kong Hotel & Towers



**Asian Pacific Digestive
Week 2004 in Beijing,
China**
October 4-7, 2004

www.chinamed.com.cn/apdw2004

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 Bhawan, 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-ewe.org



www.ddw.org

**Digestive Disease Week
in New Orleans, USA**
May 15-20, 2004

**The Hong Kong Society of Gastroenterology
The Secretariat**
Room 1203, Bank of America Tower, 12 Harcourt
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