



The Hong Kong Society of Gastroenterology

香 港 腸 胃 學 會

December 2007

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President Message

Message from Professor Francis KL Chan, President

To achieve our objective to promote the advancement of gastroenterology in Hong Kong, this Society continued to organize the Annual General Meeting & Scientific Meeting in March, the Joint Annual Scientific Meeting in September and 3 Scientific Symposia during the years of 2006 and 2007 entitled "New Advances in Therapy & Diagnosis of Inflammatory Bowel Disease" on 16 July 2006, "The controversy of NSAIDs and COX-2 inhibitors in pain management" on 16 October 2006 and "When is aspirin worth the risk?" on 26 April 2007. All these meetings were very successful and well attended.

The two research projects started in 2005 namely "Colonoscopic screening in first-degree relatives of Hong Kong Chinese Patients with sporadic colorectal cancer" and "Non-erosive gastroesophageal reflux disease (NERD): a disease of excessive acid or visceral hypersensitivity?" have just been finished and the report findings will be released soon.

I wish to thank the following friends and contributors to this Society: all fellows and members for their continuous support and contributions; Dr. Hui Wai Mo for editing this Newsletter; Prof. Joseph Sung and Prof. Benjamin Wong for sharing with us their scientific updates, local and overseas speakers of our scientific meetings and session chairpersons. On behalf of the Society, I wish to express our heartfelt thanks to friends from the pharmaceutical industry for their generous sponsorship and contributions throughout the years. I look forward to the continued support and active participation of all in the future.

Merry Christmas and Happy New Year!

Scientific Updates



Prof. Benjamin CY Wong

Advances in Clinical Management of Upper GI Disorders

Defining the Standards of Management

Professor Benjamin CY Wong

Department of Medicine

The University of Hong Kong

Patients with gastroesophageal reflux disease (GERD) typically present with symptoms of heartburn and acid regurgitation. Atypical symptoms include chest pain, asthma, hoarseness and chronic cough. In some patients, the disease co-exists with complications such as stricture, cancer or dysphagia. Rates of GERD vary from 2% in some parts of Asia to 20% in America based on weekly symptoms of heartburn or acid regurgitation.¹ In Hong Kong, the incidence of heartburn has increased steadily since 1997. The weekly prevalence of GERD in Hong Kong is about 2.5%.^{2,3} The cause for the lower but increasing prevalence of GERD in Asia is not known, but genetics and to some extent environmental factors, may have initially protected Asians against GERD. Well-established risk factors for GERD in Asian populations included hiatus hernia and obesity.^{4,5} Age and male sex also may be risk factors. Chest pain is an important extraesophageal manifestation of GERD in China.⁴

The study of GERD and its epidemiology has been restricted by the lack of consensus over the definition of the disease. A recent initiative to develop a global consensus for GERD (Montreal definition) defined GERD as a "condition which develops when the reflux of stomach contents causes troublesome symptoms and/or complications".⁶ In this consensus, it also recognizes gastro-esophageal reflux not only causes esophageal syndromes but can also result in extra-esophageal manifestations e.g. reflux cough, reflux laryngitis syndrome, and asthma etc.

A patient with GERD may have either non-erosive reflux disease (NERD), GERD with erosive esophagitis or GERD with Barrett's esophagus. While the presence of erosive disease is typically determined by endoscopy, less than 50% of patients with heartburn have evidence of erosive disease. Endoscopy is uncomfortable, invasive, expensive and unnecessary in the majority of cases. Early endoscopy is indicated for those with alarm features (e.g. dysphagia, weight loss, bleeding, abdominal mass, and anemia) and those with atypical symptoms or those refractory for treatment.⁷

In Hong Kong, two non-invasive diagnostic options are available for patients who present with possible GERD. The first of these is the validated Chinese GERD questionnaire. This has been used with accurate results.⁸ Another option is empirical use of a proton-pump inhibitor (the PPI test). A patient's response to a PPI can serve as a diagnostic indicator.⁹ A number of studies have shown that the PPI test is both sensitive and specific in diagnosing GERD in patients with non-cardiac chest pain (Table 1).⁹ It is also cost-effective. Both the Chinese GERD questionnaire and the PPI test are less invasive and cheaper diagnostic tools than endoscopy.

Table 1: Meta-analysis of PPI test in diagnosing GERD in non-cardiac chest pain patients

Reference	n	Drug (mg)	Weeks	Sensitivity	Specificity	DOR
Fass	37	O (40 + 20)	1	78	86	19
Xia	36	L (30)	4	92	67	18
Pandak	38	O (80)	2	90	67	16
Fass	20	R (40)	1	83	75	13
Fass	40	L (60 + 30)	1	78	91	35
Squillace	17	O (80)	-	69	75	7

O=omeprazole, L=lansoprazole, R=rabeprazole, DOR=diagnostic odds ratio
(Adapted from reference 7)

Treatment approaches

Following diagnostic confirmation of reflux disease, treatment is firstly aimed at symptom relief. Therapy can be initiated at a low level and then stepped up, or alternatively at a high level and then stepped down. The step-up approach, typically involving initiation on an antacid, then a H₂ blocker followed by a PPI, can result in unnecessary delay of symptom relief, slow healing of the esophagus and diagnostic uncertainty. High-level initiation with a PPI is the preferred option because it results in rapid symptom control, quick healing, diagnostic confirmation and a lower overall cost.

Recommendations from the Genval workshop suggest that in the initial

treatment of patients with esophagitis, the best medical strategy is to start with a PPI, and then to trial stepping down the intensity of therapy. For patients with endoscopy-negative reflux disease, a PPI is considered to be the most efficacious treatment. The workshop recommendation suggests that, "The most effective initial therapy for reflux disease is also the most cost-effective".

In determining which PPI to use, a number of studies have shown esomeprazole (Nexium®) to be a good choice. Labenz and colleagues showed esomeprazole 40 mg once daily to be superior to pantoprazole 40 mg once daily in healing esophagitis ($p < 0.001$).¹⁰ Esomeprazole was significantly better than pantoprazole at weeks 4 and 8 of treatment. Looking at sub-groups, the difference in favor of esomeprazole was significant in patients with Grades B, C and D esophagitis. In addition, more patients experienced complete resolution of heartburn symptoms with esomeprazole ($p < 0.001$). Another study by Castell and coworkers, showed esomeprazole 40 mg once daily to be superior to lansoprazole 30 mg once daily at healing Grade C and D esophagitis at week 8 ($p < 0.01$).¹¹

Once healing has occurred, maintenance therapy is required. Vakil and colleagues showed that in the 6 months following endoscopic remission, symptoms recurred in 71% of patients taking placebo therapy.¹² In contrast, the recurrence rate was only 21% in patients who received esomeprazole 20 mg once daily. A different study showed that symptoms recurred to the highest extent in patients with baseline Grade C or D esophagitis, but that remission was maintained in patients taking esomeprazole 20 mg once daily, regardless of the initial grade of esophagitis.¹³ A PPI is the most effective maintenance treatment for patients with GERD.

In patients with severe esophagitis, a twice-daily dose of a PPI may be necessary to maintain control of symptoms. The dose may be stepped down to once daily and continued at that level; however, depending on symptom control, re-instatement of a twice-daily dose may be required. In either case, therapy with a PPI needs to continue indefinitely. In patients with mild esophagitis, a step-down approach is appropriate in the maintenance phase of treatment.

If symptoms continue to occur, compliance may be an issue. To improve symptom control, physicians need to stress that patients must take their PPI 30 minutes before breakfast for once-daily dosing, and 30 minutes before breakfast and the evening meal for twice-daily dosing. A H₂ blocker can be added to improve control of nocturnal symptoms provided its use is only intermittent. In this setting, tolerance develops to the action of a H₂ blocker if it is used regularly. If control of symptoms is still inadequate despite these interventions, a second PPI dose in the evening can be considered. In the future, adding a visceral analgesic, transient lower esophageal sphincter relaxation (TLESR) reducer or a promotility agent to PPI therapy may assist in the treatment of patients who fail to respond adequately to treatment with a PPI alone.

References

1. Ho KY, Cheung TK, Wong BC. Gastroesophageal reflux disease in Asian countries: Disorder of nature or nurture? *J Gastroenterol Hepatol* 2006;21:1362-5.
2. Wong WM, Lai KC, Lam KF, Hui WM, Hu WH, Lam CL, Xia HH, Huang JQ, Chan CK, Lam SK, Wong BC. Prevalence, clinical spectrum and health care utilization of gastro-oesophageal reflux disease in a Chinese population: a population-based study. *Aliment Pharmacol Ther* 2003;18:595-604.
3. Wong WM, Lai KC, Lam KF, Hui WM, Huang JQ, Xia HH, Hu WH, Lam CL, Chan CK, Lam SK, Wong BC. Onset and disappearance of reflux symptoms in a Chinese population: a 1-year follow-up study. *Aliment Pharmacol Ther* 2004;20:803-12.
4. Wong BC, Kinoshita Y. Systematic review on epidemiology of gastroesophageal reflux disease in Asia. *Clin Gastroenterol Hepatol* 2006;4:398-407.
5. Rosaida MS, Goh KL. Gastro-oesophageal reflux disease, reflux oesophagitis and non-erosive reflux disease in a multiracial Asian population: a prospective, endoscopy based study. *Eur J Gastroenterol Hepatol* 2004;16:495-501.
6. Vakil N, van Zanten SV, Kahrilas P, Dent J, Jones R. The Montreal definition and classification of gastroesophageal reflux disease: a global evidence-based consensus. *Am J Gastroenterol* 2006;101:1900-20.
7. Bak YT. Management strategies for gastroesophageal reflux disease. *J Gastroenterol Hepatol* 2004;19 Suppl 3:S49-53.
8. Wong WM, Lam KF, Lai KC, Hui WM, Hu WH, Lam CL, Wong NY, Xia HH, Huang JQ, Chan AO, Lam SK, Wong BC. A validated symptoms questionnaire (Chinese GERDQ) for the diagnosis of gastro-oesophageal reflux disease in the Chinese population. *Aliment Pharmacol Ther* 2003;17:1407-13.
9. Wang WH, Huang JQ, Zheng GF, Wong WM, Lam SK, Karlberg J, Xia HH, Fass R, Wong BC. Is proton pump inhibitor testing an effective approach to diagnose gastroesophageal reflux disease in patients with noncardiac chest pain?: a meta-analysis. *Arch Intern Med* 2005;165:1222-8.
10. Labenz J, Armstrong D, Lauritsen K, Katelaris P, Schmidt S, Schutze K, Wallner G, Juergens H, Preiksaitis H, Keeling N, Naucle E, Eklund S. A randomized comparative study of esomeprazole 40 mg versus pantoprazole 40 mg for healing erosive oesophagitis: the EXPO study. *Aliment Pharmacol Ther* 2005;21:739-46.
11. Castell DO, Kahrilas PJ, Richter JE, Vakil NB, Johnson DA, Zuckerman S, Skammer W, Levine JG. Esomeprazole (40 mg) compared with lansoprazole (30 mg) in the treatment of erosive esophagitis. *Am J Gastroenterol* 2002;97:575-83.
12. Vakil NB, Shaker R, Johnson DA, Kovacs T, Baerg RD, Hwang C, D'Amico D, Hamelin B. The new proton pump inhibitor esomeprazole is effective as a maintenance therapy in GERD patients with healed erosive oesophagitis: a 6-month, randomized, double-blind, placebo-controlled study of efficacy and safety. *Aliment Pharmacol Ther* 2001;15:927-35.
13. Johnson DA, Benjamin SB, Vakil NB, Goldstein JL, Lamet M, Whipple J, Damico D, Hamelin B. Esomeprazole once daily for 6 months is effective therapy for maintaining healed erosive esophagitis and for controlling gastroesophageal reflux disease symptoms: a randomized, double-blind, placebo-controlled study of efficacy and safety. *Am J Gastroenterol* 2001;96:27-34.



Bleeding Peptic Ulcer: Strategic Questions in Management

Professor Joseph JY Sung MD, PhD
Institute of Digestive Diseases
Prince of Wales Hospital
The Chinese University of Hong Kong

Recurrent bleeding is a predictor of death in patients with peptic ulcer. The condition has a high mortality rate of between 6% and 12%

Managing ulcer bleeding

Epinephrine injection is beneficial in reducing recurrent bleeding. Almost two decades ago, Chung and colleagues showed that epinephrine injection was better than placebo in reducing the incidence of surgery, treatment and length of hospital stay in patients with a bleeding ulcer. Further studies into combination therapy showed that adding a sclerosant to epinephrine injection was not useful. However, combining epinephrine injection with heater probe treatment to induce coaptive coagulation produced better results than epinephrine injection alone. There was a lower rate of re-bleeding, surgery and transfusions in patients with spurting ulcers who received a combination of the two therapies. Hemoclips, while showing initial promise, have not proven to be better than heater probe treatment in reducing the incidence of re-bleeding in clinical practice. This is predominantly because of their high primary failure rate.

Adding a second therapy to epinephrine injection is now considered the gold standard for treatment in most of the world. Reporting on the results of a meta-analysis, Calvet and coworkers showed that combining epinephrine injection with another intervention reduces the incidence of recurrent bleeding, surgery and mortality. Another meta-analysis showed that second-look endoscopy reduces the incidence of recurrent bleeding (OR 0.64; $p < 0.03$). A repeat endoscopy on day 2 is recommended in some centers, particularly if there is a high risk of a re-bleed.

In recent years, investigators have shown that adjuvant intravenous administration of a PPI significantly reduces the incidence of recurrent bleeding. The benefit of PPI therapy is additional to that obtained with existing treatment options. For example, administration of omeprazole 80 mg plus 8 mg/h for 72 hours with epinephrine injection and heater probe treatment reduced the probability of recurrent bleeding compared with epinephrine injection and heater probe treatment alone. In another study, a lower rate of re-bleeding on day 7 was noted

in patients receiving second-look endoscopy and intermittent intravenous PPI, compared with patients receiving PPI alone. A pH level of 4 is a critical threshold for gastric pepsin activity. Administration of a high PPI dose serves to restore gastric pH levels to a more neutral level. This in turn reduces gastric pepsin activity and allows platelet aggregation to occur. In this environment, fibrin clots stabilize and bleeding is reduced. Due to its differing but complementary mechanism of action, the PPI should be given in addition to endoscopic treatment. Administration of esomeprazole in patients with recurrent bleeding can be via bolus intravenous injection or by infusion. Oral administration results in similar control of gastric pH compared with intravenous infusion, although gastric acidity remains higher for the first few hours after oral dosing.

It may be appropriate to commence high-dose intravenous PPI therapy prior to endoscopy in some cases. Interim results from an ongoing study have shown that early initiation of intravenous PPI therapy reduces the need for endoscopic treatment after admission.

In choosing between endoscopic re-treatment and surgery in patients with recurrent bleeding, Lau et al have shown that surgery is associated with a lower rate of re-bleeding but a higher rate of complications.

Conclusion

Summarizing current views on how to manage patients with bleeding peptic ulcers, combination therapy is the preferred option. Approaches to treatment have changed over the years from medical therapy to

single endoscopic treatment and then to combination endoscopic treatment. Today, endoscopic treatment, together with medical therapy in the form of a PPI, is generally recommended. Administration of the PPI intravenously is preferred; however, oral PPI therapy is sufficient for Forrest IIc or III patients. In cases of recurrent bleeding, endoscopic re-treatment should be performed, followed by surgery as the last option. Second-look endoscopy is useful, but it is not recommended for routine use. Adjunctive use of acid suppression is also useful, as is endoscopic re-treatment when signs of recurrent bleeding are present. The benefit of early elective surgery is yet to be determined. In the future, the Eagle Claw device may prove valuable.

References

1. Sung JY, Tsoi KK, Lai LH, Wu JCY, Lau JYW. Endoscopic clipping versus injection and thermo-coagulation in the treatment of bleeding non-variceal gastrointestinal bleeding: a meta-analysis. *Gut* 2007;56(10):1364-73
2. Lau JYW, Leung WK, Wu JCY, Chan FKL, Wong VW, Chiu PW, Lee VW, Lee KK, Cheung FK, Siu P, Ng EKW, Sung JY. Omeprazole before endoscopy in patients with gastrointestinal bleeding. *N Engl J Med* 2007;356:1631-40.
3. Lau JYW, Sung JY, Lee KKC, Yung MY, Wong SKH, Wu JCY, Chan FKL, Ng EKW, You JHS, Lee CW, Chan ACW, Chung SCS. A comparison of high-dose omeprazole infusion to placebo after endoscopic hemostasis to bleeding peptic ulcer. *N Engl J Med* 2000;343:310-316.
4. Sung JY. Current management of peptic ulcer bleeding. *Nature Clinical Practice Gastro & Hepatol* 2006;3:24-32.

Events Highlights

Annual General Meeting & Scientific Meeting 2007

Date: 16 March 2007

Venue: Ballroom, 3/F Sheraton Hotel & Towers, Hong Kong.

Organizing Chairman: Dr. YUEN Man Fung

This was another highly successful Scientific Meeting focusing on 3 Interactive Digestive Disease Case Discussions entitled "A female patient with persistent lower GI bleeding (PMH)" presented by Dr. Reggie Siu Ting Li & Dr. Yuen Cheong Cheung, "A pregnant lady with jaundice (QMH)[®]" by Dr. Axel Hsu and "A woman with deranged liver function (PYNEH)" by Dr. Tat Wing Li. This meeting was attended by 251 doctors who took part actively in the discussions led by Prof. Francis KL Chan & Dr. Vincent WS Wong (PWH), Dr. Yeung Yat Wah & Dr. Edwin HS Shan (CMC), Dr. Vincent KS Leung & Dr. Fu Hang Lo (UCH).

The Annual General Meeting was attended by 48 fellows and members. The Chairman and Hon. Treasurer reported on the Society's activities and financial statement for the year of 2006 and these were adopted.

Nine pharmaceutical companies participated in the exhibition and they were Altana Pharma, AstraZeneca, Bristol-Myers Squibb, Eisai, GlaxoSmithKline, Jacobson, Novartis, Roche and Takeda.

The majority of the participants stayed for dinner during which informal discussions and exchange of views continued. It was a remarkable evening for all attendants.



Scientific Meeting 26 April 2007

Venue: Level 7, Langham Place Hotel, Mongkok, Hong Kong

Organizer: The Hong Kong Society of Gastroenterology

Co-Chairmen: Dr. YEUNG Yat Wah / Dr. HUI Wai Mo

Sponsor: Takeda Chemical Industries (Taiwan) Ltd., Hong Kong Branch

2 lectures were presented: "When is aspirin worth the risk?" by Prof. Francis KL Chan, Professor of Medicine, Department of Medicine & Therapeutics, Chinese University of Hong Kong and "Gastroesophageal reflux disease (GERD) in children" by Dr. Rosanna M S Wong, Honorary Clinical Assistant Professor, Department of Paediatrics & Adolescent Medicine University of Hong Kong.

The meeting was successful. 110 doctors attended with active participation in the Questions session. Most of them stayed for the after-meeting dinner.

9th Joint Annual Scientific Meeting

Date: 8 September 2007

Venue: Level 7, Langham Place Hotel, Mongkok, Kowloon

Co-organizers: The Hong Kong Society of Gastroenterology

The Hong Kong Society of Digestive Endoscopy

Hong Kong Society for Coloproctology

Hong Kong Association for the Study of Liver Diseases

The Hong Kong Society of Gastrointestinal Motility

Organizing Chairman: Dr. YUEN Man Fung

Sponsors: AstraZeneca, GlaxoSmithKline

With 320 doctors attended this conference and took part actively in the panel discussions, it was another successful Joint Annual Scientific Meeting, the ninth in the series of co-organized meetings.

We were glad to have two renowned overseas speakers, Prof. Eamonn Quigley from Ireland and Prof. Willis Maddrey from U.S.A. to share with us their valuable experience and expertise. Each of them had two presentations, "IBS: an inflammatory disorder?", "Does functional dyspepsia exist?" and "Alcohol-induced Liver Disease", "Drug-induced Liver Toxicity" respectively. We were equally happy to have prominent local speakers including Doctors Chan On On, Lai Ching Lung, Enders Ng and Mui Lik Man.

Taking this opportunity, Dr. Yuen Man Fung thanked all co-organizers, their members and the sponsors for their participation and contributions and look forward to their continued support in the coming year.



Welcome!

New Fellows

Dr. CHAN Kam Hon

Department of Medicine, North District Hospital

Dr. LEUNG Wai Keung

Department of Medicine, Prince of Wales Hospital

New Members

Dr. WALTER Wai Kay SETO

Department of Medicine, Queen Mary Hospital

Dr. CHENG Ka Shing

Department of Medicine & Geriatrics, Caritas Medical Centre

Dr. David Yiu Kuen BUT

Department of Medicine, Queen Mary Hospital

Dr. Axel Shing Jih HSU

Department of Medicine, Queen Mary Hospital

Dr. SZE Yuen Chun

Department of Medicine, North District Hospital

Dr. Rupert Yau Han LUI

Gayton Road Health & Surgical Centre, Norfolk, U.K.

Dr. Calvin Ka Yan NG

Department of Medicine, Tuen Mun Hospital

Dr. YIP Wai Man

Department of Medicine & Geriatrics, Tuen Mun Hospital

Annual General Meeting & Scientific Meeting 2008

Date: 13 March 2008 (Thursday)

Venue: Level 7, Langham Place Hotel

555 Shanghai Street, Mongkok, Kowloon

Further details will be available soon from website

www.hksge.org/event

10th Joint Annual Scientific Meeting

Date: 6 September 2008 (Saturday)

Venue: Level 7, Langham Place Hotel

555 Shanghai Street, Mongkok, Kowloon

Further details will be available soon from website

www.hksge.org/event

11-12 January 2008

Hong Kong Surgical Forum Winter 2008

Organizers: Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons
Location: Queen Mary Hospital, Hong Kong
Website: www.hku.hk/surgery

21-23 February 2008

XXth Belgian Week of Gastroenterology

Organizer: Belgian Week of Gastroenterology
Location: Antwerpen, Belgium
Website: www.belgianweek.be

24-26 February 2008

European Multidisciplinary Colorectal Cancer Congress

Organized in co-operation with:
Colorectal Cancer Trial Group of the AIO
(Association of Medical Oncology within the German Cancer Society)
Danish Colorectal Cancer Group
Dutch Colorectal Cancer Group
Nordic Gastrointestinal Cancer Therapy Group
Swedish Society for Colon and Rectal Surgery
Location: Berlin, Germany
Website: www.colorectal2008.org



13 March 2008

Annual General Meeting & Scientific Meeting 2008

Organizer: The Hong Kong Society of Gastroenterology
Location: Langham Place Hotel, Mongkok, Kowloon, Hong Kong
Website: www.hksge.org/event

23-26 March 2008

18th Conference of Asian Pacific Association for the Study of the Liver: New Horizons in Hepatology

Organizer: The Asian Pacific Association for the Study of the Liver (APASL)
Location: Seoul, Korea
Website: www.apaslseoul2008.org

23-27 April, 2008

43rd Annual Meeting of the European Association for the Study of the Liver

Organizer: The European Association for the Study of the Liver
Location: Milan, Italy
Website: www.easl.ch

3-4 May 2008

13th Hong Kong Medical Forum

Organizer: Department of Medicine, The University of Hong Kong, Queen Mary Hospital, Hong Kong
Location: Hong Kong Convention & Exhibition Centre
Website: www.hku.hk/medicine



17-22 May 2008

Digestive Disease Week 2008

Organizer: DDW Organizers
Location: San Diego, California, USA
Website: www.ddw.org

12-15 June 2008

Hong Kong Shanghai International Liver Congress 2008

Organizers: Shanghai Organizing Committee; Cheng Si Yuan (China-International) Hepatitis Research Foundation
Location: Hong Kong Convention & Exhibition Centre, Hong Kong
Website: www.livercongress.org

11-12 July 2008

Hong Kong Surgical Forum, Summer 2008

Organizer: Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons
Location: Queen Mary Hospital, Hong Kong
Website: www.hku.hk/surgery



6 September 2008

10th Joint Annual Scientific Meeting

Co-organizers:
The Hong Kong Society of Gastroenterology
Hong Kong Society of Digestive Endoscopy
Hong Kong Society for Coloproctology
Hong Kong Association for the Study of Liver Diseases
The Hong Kong Society of Gastrointestinal Motility
Location: Langham Place Hotel, Mongkok, Kowloon, Hong Kong
Website: www.hksge.org/event

10-13 September 2008

11th World Congress of the International Society for Diseases of the Esophagus

Organizer: The International Society for Diseases of the Esophagus
Location: Budapest, Hungary
Website: www.isdecongress2008.com

17-20 September 2008

Prague Hepatology Meeting 2008

Organizer: Foundation of the Czech Society of Hepatology
Location: Prague, Czech Republic
Website:
www.congressprague.cz/en/kongresy/phm2008.html

13-16 September 2008

The Asian Pacific Digestive Week 2008 (APDW 2008)

Organizer: Indian Society of Gastroenterology
Location: New Delhi, India
Website: www.apdw2008.net

8-11 October 2008

18th World Congress of the International Association of Surgeons, Gastroenterologists and Oncologists

Organizer: International Association of Surgeons, Gastroenterologists and Oncologists
Location: Istanbul, Turkey
Website: www.iasg2008.org



18-22 October 2008

16th United European Gastroenterology Week (UEGW)

Organizer: The United European Gastroenterology Federation
Location: Vienna, Austria
Website: www.uegf.org