O.M.E.D

ORGANISATION MONDIALE D'ENDOSCOPIE DIGESTIVE

WORLD ORGANIZATION FOR DIGESTIVE ENDOSCOPY

ORGANIZACION MUNDIAL DE ENDOSCOPIA DIGESTIVA

世界消化器内視鏡学会

Bulletin No.7

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MEMBERS OF OMED 2002－2005

Hirohumi Niwa（President）（Chair Archives and History Committee）
Anthony Axon（President Elect）
William SC Chao（Vice President）（Chair Statute Committee）APzone
Jose Ramon Armengol-Miro（Vice-President） EU zone
E G Segal（Vice President） Inter-American zone
Rikiya Fujita（Secretary General）
Alberto Montori（Treasurer）（Chair Minimal Invasive Surgery）
Glaciomar Machado（Past President）（Chair Nominating Committee）
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Antonio Grassi（Webmaster）
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Melvin Shapiro（Chair Education Committee）
Jean Escourrou（Chair Research Committee）
Paul Rosen（Chair Colorectal Cancer Screening Committee）
D. Rex（Member Guideline C.）
A Nowak（President ESGE）
Jerome Waye（Adviser）
D Bjorkman（Chair Guideline Committee）
D Delvaux（Chair Terminology and Standardization Committee）
D Taullard（President SIED）
J DiSario（Chair Education Committee）
L Aabakken（Chair Terminology and Date Processing Committee）
GHK Young（Chair CRC Screening Committee）
J Sung（Chair UGI Cancer Screening Committee）

President's Address and Report (March 2002 – September 2005)

Hirohumi Niwa

It is my pleasure to finally publish this Bulletin No. 7 in which correspondence, clerical matters such as business meetings and details of OMED congresses during my term of office are recorded.

In fact, it was supposed to be published immediately after the end of my term, and Prof. Fujita, the Secretary General, and we were preparing for its publication steadily. However, Prof. Machardo, the previous President of me, had not published his Bulletin No. 7 to report the details in his term yet, so I was reluctant to publish my version ahead of his, and was waiting for it for a long time. That is why the publication of Bulletin No. 7 was delayed. Now, the Bulletin No. 7 of Prof. Machardo still has no likelihood of publication. Prof. Axon who took the place of me as the President already ended his term, and the term of new President Prof. Waye has already started. Further postponement may deprive Prof. Axon's chance to publish his Bulletin No. 8 timely, so I decided to publish the Bulletin No. 7 to record OMED activities during my term of office without waiting for the one of Prof. Machardo. Taking this opportunity, I apologize that the unavoidable postponement of this Bulletin No. 7 caused so much trouble to everyone concerned.

Bulletin No. 6 will be prepared in favor of Prof. Machardo.

Secretary General Report
Rikiya Fujita MD

On an occasion of termination of the president, Prof. Hirohumi Niwa, 2002-2005, three years and half, I would like to summarize activities during the term.

OMED was established as an International Endoscopy Society independent from Gastroenterology in 1962 and changed a name as OMED in 1976.

Aims of OMED were as follows：

1. Promotion of gastrointestinal endoscopy worldwidely
2. Establishment of standarads of practice and the training
3. To support and stimulate progress of endoscopy research
4. Promotion for education for trainers and trainees
5. Standardization of terminology and database
6. Consultation with industries and new instrumental development
7. Responsibilities for other organization, OMGE and other international societies

The organization is composed of Endoscopy Societies of the three zones：
European（ESGE), Inter-American（SIED） and Asian-Pacific（APSDE）.
OMED is currently composed of 80 countries or more.

The Genaral Assembly for every four years; Governing Council for the President, Vice Presidents, Secretary General, Chairmen and the committee members;Executive Council for the meeting of the President, Vice Presidents, Secretary General and Treasurer rotate every four years between the three zones.

We succeeded the council meeting since 2002, in San Francisco, after the meeting in 2001 at Amsterdam meeting. Unfortunately I could not attend the meeting in San Francisco of private reason, Dr. Chao was acting as Secretary General. Activities of the committees; Education committee, Terminology and Standardization committee, Colorectal Cancer committee and other businesses were reported, and also started the planning committee

for the World Congress in Montreal. The activities of them were conducted under the poor financial condition. Transfers were nothing from the former Secreatary Genaral, Prof. Abrao Netto.

The meeting in Geneva, 2002, included the executive committee and the meeting with members of OMGE. The future plan “Fundamental Operations Strategic Schedule”

from OMED were discussed, congratulated by the participants, however could not reach the agreement with members of OMGE. Proposal of OMED Fourth Zone was discussed again, but could not reach the agreement, because of infrastructures among the countries and of cooperation from European Zone being available. At the financial subcommittee, travel and accommodation reimbursement was fixed as reported in detail.

At the meeting in Orlando, January, 2003, " OMED short-term operations strategic decision meeting" was discussed again and congratulated. Financial matters were improved a little by report of the President Niwa, a contribution by Olympus.

The first meeting of IDCA（ International Digestive Cancer Alliance） was held at the theological school of the Vatican, February, 2003. According to request of IDCA, the First Spring Meeting , President of Prof. Montori, was held in Rome together with International Gastric Cancer Congress 2003.

The Governing Council meeting in Orlando, 2003, decided Dr. Bjorkman as a new chair of Guideline Committee. Proposals from Prof. Tytgat for the training course of colonoscopy, from Dr.Chao for the screening committee of Upper GI malignancies were accepted. Secretary General, Prof. Fujita reported International（Paris） New Classification of Superficial Cancer of the esophagus, the stomach and the colon which was organized by Prof Lambert in Paris, December,2002.

Dr. Bailey, President of Endoscopy at OMED at the World Congress in Montreal reported the preparing situations.

The meeting in Madrid,2003, Executive Committee, was held by members,

Publication of the New（Paris） Classification of Superficial Neoplastic Lesions of the esophagus, the stomach and the colon was announced at that occasion.

The meeting in New Orleans, 2004, Dr. Bailey reported the status of World Congress of Gastroenterological Endoscopy as follows;

Three OMED Honorary Lectures; Moutier lecture by Dr. Axon, Schindler lecture by Dr. Chopita, Tasaka lecture by Prof. Fujita. The proposal was accepted to upgrade the Terminology Committee as the standard committee.

The reports by the President of the Zones were activated and congratulated;

Asian-Pacific zone by Dr. Chao, European zone by Dr.Nowak, Inter-American zone by Dr. Taullard. Archives and History Committee and Endoscopy Museum became under chairmanship of Prof. Niwa because of inactive condition by Dr. Nagy thereafter passed away.

At the meeting in Prague, 2004, the Executive Committee could not be good cooperated accidentally therefore the minutes was not published.

At the meeting in Chicago, 2005, the Governing Council meeting was held the president Prof. Niwa expressed many thanks to the members of OMED for the termination of the presidency.

Securetary General Prof. Fujita reported many activities during the term, in addition, the abstract of 2nd Spring Meeting in Yokohama, 2005, cooperated with Prof. Kitajima, the president of International Gastric Cancer Congress attached on the appendix.

I would like to express sincere appreciations for assisting secretary works, Prof. Crespi as a Technical Secretariat and Dr. Grassi as a Webmaster who contributed to complete OMED home page.

Dr. Schpiro and Dr. Waye always encouraged our activities as adviser and exaggerator. Thank you very much for all members.

Lists of the meeting（OMED）2002-2005

（2001, Oct. Amsterdam GC）

2002, May, San Francisco GC, GA
Annex report
CRC report

Oct. Geneva EC
Balance sheet

2003, Jan. Orlando EC

May, Rome OMED 1st Spring Meeting（ 5th IGCC）

May, Orlando GC

Nov. Madrid EC（-）

2004, May, New Orleans GC

Sep. Prague, EC（-）

2005, May, Yokohama 2nd Spring Meeting（6th IGCC） (-)

May, Chicago GC（-）

Sep. Montreal GC （GA）

GC：Governing Council
GA：General Assembly
EC：Executive Committee

OMED GOVERNING COUNCIL
San Francisco. May 19, 2002

MINUTES

They were present:
Niwa, Axon, Chao, Armengol-Miro, Segal, Montori, Machado, Bailey, Rey, Schapiro, Escourrou; Quigley and Coen (representing OMGE), Tajiri as temporary Secretary.
In addition: Waye (advisor), Crespi (advisor and Technical Secretariat), Delvaux (chair
Terminology Committee), Rozen (chair CRC Screening Committee)

Absent: R. Fujita

1. Introduction by the President

The President, Professor H. Niwa, welcomed the participants and introduced the main topics for discussion:

- New Statutes: following the discussion held in Bangkok and the perplexities expressed by Axon on behalf of ESGE, it seems advisable to postpone the implementation of the new Statues. The ESGE is invited to detail in writing the points of disagreement;
- the new Governing Council (GC) will be legally constitutes only after the General Assembly (GA) on Monday, except for the President who is already fully in power. The candidates to be voted by the GA will be those decided by the GC in Bangkok on proposals from the Nominating Committee;
- a meeting between the OMED Executive Committee and Executives and new President of OMGE, G. Tytgat, was held on Saturday, May 18 and had a positive outcome. The cooperation between the Education and Research Committees was reconfirmed, as well the joint initiative in "Gastroenterology News". Proper funding on an annual basis for OMED was also discussed and OMGE pledged 300,000 USD as contribution to the OMED activities for the period 2002-2005, even if there was no surplus left from Bangkok.

2. Report by the General Secretary and Technical Secretariat

On behalf of the Technical Secretariat Crespi informed the GC that a further update of the Member Societies was achieved: to the 31 Societies which did not reply to the call for the GA by the deadline (April 30, 2002), the call was sent also by registered mail. A lawyer expert in international law was requested for a written statement about the legal constitution of the Assembly on the basis of what is provided by the Italian Civil Code for international organizations registered in Italy, as in the case of OMED. His statement dictates that the San Francisco GA has to be considered as "a second call" of the one held in Bangkok and will be legally constituted by any number of attending Members (Societies and GC Members). The OMED website, under the responsibility of the Technical Secretariat and the webmaster A. Grassi, has been once more fully updated after Bangkok with the reports of the GA, GC and Committees chairs, the list of members Societies, and the call for the San Francisco GA. Several requests of the series of OMED Videotapes were received and processed.

3. Report of the Treasurer

After a short introduction by Waye on the many achievements during his tenure as Treasurer, Montori as Financial Officer, gave a detailed report, also distributed in writing, on the incomes and expenses updated to May 2002 (see **annex** 1). After in-depth discussion and several suggestions by Axon, Bailey, Chao, Rey, Schapiro and Waye, the financial report was approved. In order to prepare guidelines for the reimbursements to the GC members and

Committees, a Financial Sub-Committee was established under the chairmanship of the new Treasurer, Montori, and composed by Axon, Bailey and Rey. In addition, the GC decided for a financial report once a year (by December 31), to be sent one month in advance to the meeting of the GC to all its members.

4. Update on the activities of the committees

4.1 Education Committee: the main goal is to achieve an enhancement of the OMED profile through the educational activities. Among the discussed actions:

- continue the participation in "Train the Trainees"
- be involved into the OMGE Training Centers (only Soweto activated)
- participate in the Gastro Pro website
- organize one week outreach programs in needy countries also in coordination with possible donations of instruments (as proposed by Di Sario)
- possibly organize an endoscopic SIED-PG in Uruguay
- be fully involved in the PG at the WCGE in Montreal
- solve the problem of the video of the PGs: those from Bangkok were not made available to OMED for distribution, as for the previous World Congresses.

4.2 Terminology and Standardization Committee: see attachment with full report

4.3 Colorectal Cancer Screening Committee: see attachment with full report (sent also previously)

5 Any other business

5.1 Bid for OMED Administrative Secretariat (AS): Machado reported the discussions on the AS establishment in the committee meeting that was held in the morning of the same day.
MedConnect would be the best choice if only they would lower the price to meet our budget.
The American company was inferior in preparation and presentation, plus they offered higher price and inconvenient contract conditions such as minimum contract term of 3 years and advance payment. Therefore the members agreed to discard this candidate.
Studio EGA remains as a possibility because of their low price, but the committee members criticized that a company representative should have come in person to explain their own services, not letting Crespi explain it on behalf of them.
From the above considerations, the committee agreed to wait for MedConnect to submit the next offer in June and keep on negotiation after that. If they would not meet our budget after several negotiation meetings, then Studio EGA will be selected.
In the discussion which followed it was anticipated that reaching consensus with MedConnect might require repeated negotiation and considerable time. Even after selecting the company, most careful discussion among the GC members is necessary to establish the system of AS, but it is well possible that there will not be an agreement with MedConnect by the next meeting in Geneva. Besides, there might not be enough members attending the meeting in Geneva. However, it is not possible to ask the current Technical Secretariat to repeatedly extend his term without knowing when the new AS contract will be finalized.
Consequently, the GC concluded that the final decision should be made at the GC meeting during the next DDW meeting. If it is not possible to come to terms with MedConnect by that time, then the contract will be made with Studio EGA.

Machado argued against this idea, but Niwa, in his authority as President, turned it down because a decision was already reached. Waye tried to offer his opinion and Niwa stopped him for the same reason, then Waye got up and left the room in anger.
Niwa greatly appreciates Waye's opinion with repeated letter exchanges prior to the meeting but stopped him at that time in order to prevent discussion from getting back to the beginning. Instead, Niwa had intended to give him time to offer his comment from the point of view as the President's advisor. It was not meant to disregard his opinion but to give consideration in an appropriate timing for his comment.
Niwa appreciates the great dedication Waye has given to the organization, as also Schapiro emphasized, but places top priority on a smooth and efficient transfer of the secretarial job from current Technical Secretariat to AS. For that, a sufficiently feasible schedule is desirable. It is not meant that Niwa is against the idea of introducing that AS system or adopting MedConnect for the role.

5.2 Planning Committees for the World Congress in Montreal: Neuhaus and Tajiri will be the OMED representatives in the Program Committee. Chao and Niwa are the OMED representatives in the Steering Committee. A first meeting was held in San Francisco and the requests by OMED of an enhanced visibility and a definite input in the endoscopic part of the Congress were accepted.

H. Niwa
President

OMED GENERAL ASSEMBLY (GA) San Francisco, May 20, 2002

MINUTES They were present:

- the members of the OMED Governing Council. *In addition:* Crespi, Delvaux, Rozen, Waye.
- the following member Societies
  - European Zone (ESGE): Austria, Belgium, Croatia, Czech Republic, Denmark, Egypt, Finland, France, Germany, Hungary, Iceland, Italy, Jordan, Latvia, Lebanon, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden.
  - InterAmerican Zone (SIED): Argentina, Colombia, Cuba, Ecuador, Uruguay.
  - Asian-Pacific Zone (APSDE): Chinese Taiwan, Hong Kong-China, India, Indonesia, Japan, Korea, New Zealand, People's Republic of China.

1. Report by the President

President Niwa welcomed the participants and detailed the rules of the legal constitution of the GA:
a) both ordinary and extraordinary sessions of the General Assembly (GA) were called during the World Congresses in Bangkok, but were not held because the requested "quorum" was not reached. This session of the GA was therefore convened as a "second call";
b) according to Italian law (OMED is incorporated in Italy as in international non profit organization) the GA convened by a "second call" is valid even if the "quorum" is not reached;
c) the current attendance is around 50% of the whole GA members. Several of the absent members sent in preliminary apologies for their absence, which means the authority of the absent members is delegates to the President. Therefore, the attendance is in fact over the half of the members and the present session reaches the "quorum", with no need to apply the rules provided by the Italian law.
The President outlined the actual situation of the OMED and reported the consensus reached at the Long Range Planning Meeting, held on Sunday, on the future lines of action (the full report of the Planning Meeting will be sent also to the member Societies)

2. Confirmation of the new Governing Council (GO and Committees

The President called for a vote for the establishment of the new GC and standing Committees. Each candidate stood up and got the members' approval by acclamation. The GA therefore unanimously approved the following:

Governing Council (2002-2005)
PRESIDENT: Hirohumi Niwa, Japan
PRESIDENT-ELECT: Anthony Axon, UK - *(President of the European Zone)*
VICE PRESIDENTS: William SC Chao, Hong Kong, China - *(President of the Asian-Pacific Zone),* Jose Ramon Armengol Miro, Spain, Eduardo G Segal, Argentina
SECRETARY GENERAL: Rikiya Fujita, Japan
TREASURER: Alberto Montori, Italy
PAST-PRESIDENT: Glaciomar Machado, Brazil
COUNCILORS: Robert Bailey, Canada *(President of the Interamerican Zone),* K Lee Goh, Malaysia, Jean Fra^ois Rey, France
WEBMASTER: Antonio Grassi, Italy
TECHNICAL SECRETARIAT: Massimo Crespi, Italy
EDUCATION COMMITTEE: Melvin Schapiro, USA, Chair
RESEARCH COMMITTEE: Jean Escourrou, France, Chair

The GA approved also the proposal to upgrade the "ad hoc" Colorectal Cancer Screening Committee as a Standing Committee and confirmed Paul Rozen from Israel as chairman, requesting him to submit to the GC an updated list of members.

3. Vote for the new Statutes

President Niwa announced his intention to postpone the vote for the new Statutes because of several remarks advanced by the ESGE on the proposal finalized by the "ad hoc" Sub-Committee, which were discussed at the GC in Bangkok. The text of the new Statutes was sent to all the member Societies, with the request to forward comments and suggestions, but no inputs were received. It was found that the presidents of some member societies did not receive the statutes draft despite the fact that it had been sent to all the member societies by the Technical Secretariat twice, also by registered mail, probably because of miscommunication between the current and former presidents of the Societies. Therefore, all the member societies were requested to inform in real time the Technical Secretariat of the changes in their governing councils, because otherwise there is no way to address properly the mails and make sure they were delivered to the current presidents. A. Axon, President ESGE and President elect of OMED, detailed some of the concerns about the new Statutes, mainly the fact that there would be less control by the Zones, which are the backbone of the OMED. He also affirmed that a two-year term for the GC members would be too short for them to fulfill the task of providing practical support for the organization, that the number of times in office allowed for one person has to be limited and the way to select candidates for the GC has to be improved.
Chao, Machado and others agreed with the President on the opportunity to postpone the vote in order to find a compromise and suggested a series of steps, namely a) the Societies send their views and suggestions to the respective Zones (APSDE, ESGE, SIED); b) the Zones report their views to the "ad hoc" Committee chaired by M. Schapiro; c) the Committee advances proposals to the GC; d) the GC submits a final proposal to the member Societies, to be voted at an Extraordinary General Assembly. **The Societies and the Zones are requested to complete the points a) and b) by mid October 2002 (at the UEGW in Geneva).**
Finally, article 13 of the current Statutes specifies that the GA should be held once every four years during the World Congress, which is not sufficient and needs to be complemented by extraordinary sessions called as appropriate.

4. Reports by the Secretary General and Treasurer

Due to the absence, for personal reasons, of R. Fujita, Secretary General, the report focused on the financial aspects. Waye (past Treasurer) and Montori (new Treasurer) highlighted the history of the OMED finances and stressed the difficulties in obtaining financial support from the World Congresses due to the structure of the contract linking the organizers of the World Congresses to OMGE. After a friendly meeting of Chao, Montori and Niwa with Tytgat and the OMGE Executives, OMGE pledged 300,000 USD as possible contribution to the OMED activities for the period 2002-2005, even if no surplus was left from the Bangkok World Congress. At this point Montori reported the current balance of the funds of the organization, that was approved by the GA members. It was decided to have an annual budget and to implement a Financial Sub-Committee (art. 16 of the Statutes). The members of that Committee are: Montori (chair), Axon, Bailey, Rey. They are expected to produce guidelines for reimbursements and allocation of funds to the Committees. **The yearly contribution from the Zones was raised to 2000 USD, to be paid in January each year.**

5. Any other business

5.1 President Niwa requested all the members Societies to be more active in their relationships with OMED, in particular:

- to updated on any changes in their Governing Councils
- to send all the possible material on their activities to the Technical Secretariat in order to allow the webmaster to widely advertise them in the OMED website.

5.2 Drs. Chao and Niwa attended the Steering Committee for the next World Congress in Montreal. Dr. Bailey will be the President of the World Congress of Digestive Endoscopy. There will be live demonstration sessions of endoscopic procedures every day and a Post-Graduate Course is scheduled on the day before the Congress.

5.3 Reports on the activities of the Education, Colorectal Cancer Screening and Terminology and Standardization Committees were delivered at the GA and are available on the OMED website (www.omed.org).

5.4 The President informed the Assembly that, pending the decision related to the establishment of an Administrative Secretariat, the Technical Secretariat in Rome (e-mail: tecsecretariat@omed.org) is confirmed for 1 year.

6. Closing

All the agenda was discussed. The President requested from the members a close cooperation and closed the meeting.

H. Niwa President

A N N E X 1

Professor Hirohumi Niwa, MD OMED
President Taimei Bldg:, 22,3-chome, Kanda
Ogawa-machi Chiyoda-ku, Tokyo 101, Japan
Fax +81 3 32915568

Financial Report at the OMED Governing Council in San Francisco

Following Doctor Waye's advice I would like to make the following financial report (according to the contributions received and the expenses) and the balance of the OMED account from 1999 to February 2002.
At the end of the Presidency of Professor Cheli and Professor Crespi I (1998), as Treasurer, published the final balance which was USD 18,537.66.
After the Vienna World Congress we obtained to have from OMGE a total of 400.000 dollars for 4 years. Of these we have received from OMGE during the year 1999 USD 50,000 sent directly to Doctor Machado who transferred USD 15,000 to the OMED Bank account; in the same year the OMGE has transferred to OMGE USD 100,000; in the year 2000 we have received another USD 100,000 and in the year 2001 in two different dates USD 63,000 and USD 50,000.
In total we have received from OMGE USD 363,000 in addition of that the OMGE retained USD 37,000 for the expenses (1/3) of the Crete Meeting (2001 Train the Trainers organized with the OMGE).
The OMED has also received the following contribution by the Industries:

1999: Wilson Cook USD 10,000
Beckman Coulter Inc. USD 10,000 Fujinon
USD 10,000

2000: Wilson Cook USD 10,000
Boston Scientific USD 10,000 Fujinon USD
10,000

2001 Olympus USD 10,000
Fujinon USD 10,000
Wilson Cook USD 10,000

2002 Wilson Cook USD 10,000
Olympus USD 10,000 Beckman Coulter
USD 2,000 Boston Scientific USD 10,000

From the 3 Zones: USD 3,000 year 2000 (USD 1,000 each) USD 3,000
year 2001 (USD 1,000 each)

There is also a positive balance as far as the OMED Educational videos are concerned: USD 621.26

During the Machado's term the Governing Council has decided to allocate the following major contributions:

USD 37,000 for Crete (2001 Train the Trainers).
USD 20,000 for Screening Committee (Doctor Rozen)
USD 20,000 for Revision of the Statutes Committee (Doctor Schapiro)
USD 20,000 for MST Committee (Doctor Delvaux)
USD 15,000 for Cancer Campaign-Rome March 23rd, 2002
USD 10,000 for Ethics Symposium, Kos June 2002

Total USD 122,000

The expenses incurred on a yearly basis are reported in detail in the periodic financial balances presented at the Governing Council.

Enclosed you will also find:

* **The yearly** prospective budget for each year, from 2002 to 2005.
* The detail of incomes and expenses from Bangkok to now.

Alberto Montori, MD, FACS
OMED Treasurer

OMED - FINANCIAL STATUS
CLOSING STATMENT ON FEBRUARY 18, 2002 (USD 216,944.72) **APPROVED AND SIGNED BY THE PRESIDENT IN BANGKOK FEBRUARY 2002**

BALANCE AT FEBRUARY 18, 2002 USD 216,944.72

FROM FEBRUARY 18 TO MAY 16,2002

	DEBITED	CREDITED
OLYMPUS		USD
THE OMED'S PLATES AND THE CRYSTAL BOWL	USD	
PROF. MACHADO PRESIDENTIAL FUND ACCOUNT : USD 8,443.63 REIMBURSEMENT AIR TICKET BANGKOK USD 5,097.93	USD 13,541.56	
REIMBURSEMENT PROF. ABRAO NETO AIR TICKET BANGKOK	USD	
REIMBURSEMENT PROF. CRESPI BANGKOK	USD 2,110.50	
REIMBURSEMENT EXPENSES IN BANGKOK PAYED WITH CREDIT CARDS: WAYE USD 751.12 MACHADO USD 1,327.36 ABRAO NETO USD 1,827.37	USD 3,905.85	
PARTIAL REIMBURSEMENT CONGRESS CENTER BANGKOK (CATERING)	USD	
REIMBURSEMENT PROF. ROZEN AIR TICKET ROME MARCH 23rd, 2002	USD	
TECHNICAL SECRETARIAT (OFFICE EQUIPMENT MAINTENANCE, PHONE, FAX, MAIL, PHOTOCOPIES, STATIONERY, MISCELLANEOUS) (SECRETARY PART-TIME FEBRUARY, MARCH, APRIL)	USD 429.74 USD	
FINANCIAL OFFICE FROM JANUARY 1 TO FEBRUARY 18 (OFFICE EQUIPMENT MAINTENANCE, PHONE, FAX, MAIL, PHOTOCOPIES, STATIONERY, MISCELLANEOUS) TREASURER OFFICE FROM FEBRUARY 25 TO MAY 16 (OFFICE EQUIPMENT MAINTENANCE, PHONE, FAX, MAIL, PHOTOCOPIES,	USD 650.00	

STATIONERY, MISCELLANEOUS)	USD	850.00	
BANK EXPENSES	USD	62.50	
OMED WEBSITE	USD	2,710.00	
BOSTON SCIENTIFIC			USD
ADVANCE WESTIN HOTEL SAN FRANCISCO FOR OMED SCREENING COMMITTEE MEETING	USD	1.000.00	

USD 35,865.15
USD 236,839.72

BALANCE AT MAY 16 USD 200,974.57

TO RECEIVE:

» DUES 2002: ESGE, SIED, APSDE = USD 2,000 EACH (USD 6,000) »
PROFESSOR MACHADO REIMBURSEMENT FOR WORLD CONGRESS IN BANGKOK (COACH AIRFARE) = USD 1,500

PENDING:

* FINAL INVOICE FROM CONGRESS CENTER BANGKOK
* FINAL INVOICE FROM WESTIN AND MARRIOTT HOTELS IN SAN FRANCISCO

REPORT

OMED Colorectal Cancer Screening Committee

In 1998 at the suggestion of Prof. M. Crespi, then Acting-President of OMED, an Ad Hoc Committee was established for Colorectal Cancer Screening. The list of members, appointed by the Governing Council, is given below

OMED CRC SCREENING MEMBER

COMMITTEE

Atkin W, UK	**Rainoldi J, Argentina**
Bertario L, Italy	**Rex DK, USA**
Crespi M, Italy	**Rozen P, Israel**
Gnauck R, Germany	**Saito H, Japan**
Hagenmuller F, Germany	**Schoengold R, USA**
Hoff G, Norway	**St John J, Australia**
Lambert R., France	**Waye J, USA**
Machado G., Brazil	**Winawer SJ, USA**

ACTIVITIES

1. **A sub-committee was established to evaluate and recommend which commercially available Fecal Occult Blood Test should be recommended for average-risk population screening. The committee members are as follows:**

OMED/WHO REPORT
RECOMMENDING AN FOBT FOR POPULATION SCREENING

- **Young GP, Australia**
- **St. John DJB, Australia**
- **Winawer SJ, USA**
- **Rozen P, Israel**

Consultants

- **Allison J, USA**
- **Bertario L, Italy**
- **Bond JH, USA**
- **Crespi M, Italy**
- **Fric P, Czech**
- **Frumorgen P, Germany**
- **Gnauck R, Germany**
- **Kronborg O, Denmark**
- **Kulakowski A, Poland**
- **Levin B, USA**
- Levin TR, USA
- Liberman D, USA
- Rakel RE, USA
- Waye JD, USA
- **ZauberA,USA**

Submitted for publication

The draft reports were circulated, extensively edited, rewritten and submitted for publication. A revised version was requested by the journal and it is now being prepared. We anticipate that the manuscript will be published later this year.

2. To compliment the FOBT Report, a sub-committee was set up to prepare video tapes on how the FOBT should be prepared by the screenee and how the FOBT should be developed in a standardized manner by the laboratory. These tapes are available in various languages.

FOBT VIDEOTAPES
Schoengold, R. USA, Rozen, P. Israel

Two videotapes were prepared:
- For the screenee:

How to prepare a guaiac FOBT
- For the laboratory:
  How to develop & read a guaiac FOBT

In: English, Spanish & Hebrew.

3. To compliment the screening techniques for the average-risk population, a subcommittee was established to define the characteristics recommended for a screening flexible sigmoidoscope. The Committee is described below and their report has been published.

OMED REPORT
CHARACTERISTICS NEEDED FOR A SCREENING FLEXIBLE SIGMOIDOSCOPE

Rex D. USA (Chairman)

Atkin W. UK
HoffG, Norway
Waye J, USA

Consultants
Crespi M, Italy
Gnauck R, Germany
St. John DJB, Australia
Winawer SJ, USA
Farraye F, USA
Rozen P, Israel
Tada M, Japan

Published: *Am J Gastrointest Endosc 2000*

4. Based on the establishment of this standardized screening methodology, the Screening Committee initiated an "Outreach" Program to help promote the performance of CRC screening internationally. Details are given below

OUTREACH PROGRAM FOR THE INTERNATIONAL PROMOTION OF CRC SCREENING

Bond J, Crespi M, Levin B, Rozen P, Winawer S, Zauber A

- In collaboration with the:

American Society for Gastrointestinal Endoscopy
International Union against Cancer, Geneva WHO
Collaborative Center at MSKCC, NY Aims:

- Evaluate the size of the problem
- Perform an international survey of CRC screening
- To promote CRC screening in countries requesting advice:
- e.g. Hong Kong, Iceland, Australia, Argentina.
- Registry of International Consultants.

This Program is strengthened by collaboration with US and International Organizations interested in the promotion of screening and prevention of cancer. In order to further develop this program, the following basic steps have been performed.

a. A Survey was performed internationally, to evaluate the actual performance and National needs to promote CRC screening in countries at risk. The initial results of the survey were presented as a poster at DDW 2001 and are now being prepared for publication.
b. A Directory of International Consultants has been developed for providing expertise in epidemiology, public health, CRC screening and its various techniques. They are available to give advice and, if necessary, visit countries requesting their assistance.
c. Consultants from the Committee have already visited and given advice on screening to countries such as Iceland, Hong Kong, Australia, Argentina and Italy. These include Drs. Atkin, Bond, Hoff, Rozen and Winawer.

MEETINGS 5. a. The Committee has met routinely at DDW and World Congresses. This has followed the meetings to take place at minimal expenses to OMED and to the committee members. At these meetings, there was obviously an interchange of ideas and an opportunity to deliver and discuss the above reports, b. At these Meetings, we were invited to participate in the OMED discussions with Industry. Specifically, we contributed to those dealing with Fecal Occult Blood Testing (Beckman Coulter and the Exact Companies); the endoscopy companies, especially as related to the pricing and design of the flexible sigmoidoscope.

PUBLICATIONS

The Committee has published descriptions of its activities on several occasions and participated in editorials, etc. There are further publications that have been submitted.

1. **P Rozen. The OMED Colorectal Cancer Screening Committee: A report of its aims and activities. Gastrointestinal Endoscopy 50:449-454,1999.**
2. **P Rozen. An update from the OMED Colorectal Screening Committee. World Gastroenterology News, 38-39,2000.**
3. **P Rozen. OMED Screening Committee. Report from the San Diego Meeting, 2000 and future plans. World Gastroenterology News, 41,2000.**
4. **P Rozen. Colorectal cancer: does early detection matter? Postgraduate Medical Journal 77:289-291,2001.**
5. **SJ Winawer, M Crespi, AG Zauber, MD Carlson, P Rozen. OMED/WHO/ASGE worldwide project for the prevention of colorectal cancer: international survey results. Gastrointestinal Endoscopy, 53: AB188,2001.**
6. **P Rozen, SJ Winawer, JD Waye. Prospects for the worldwide control of colorectal cancer through screening. Gastrointestinal Endosocopy, 55:755-759,2002.**
7. **BCY Wong, WM Wong, KL Cheung, P Rozen, GPYoung, KW Chu, J Ho, WL Law, HM Tung, KC Lai, WHC Hu, CKChan, SK Lam. Comparison of two fecal occult blood tests for the detection of colorectal neoplasia in a Chinese population (submitted).**
8. **G Young, DJB St. John, SJ Winawer, P Rozen, and the combined WHO/OMED FOBT Screening Committee. Choice of fecal occult blood tests for screening: Recommendations based on performance characteristics in population studies (submitted).**

Prof. Paul Rozen, Chairman OMED Screening Committee

OMED Executive Committee (EC) Meeting
Geneva, October 21, 2002

MINUTES

They were present: Niwa, Axon, Bailey, Chao, Fujita, Montori In addition: Rey and Crespi and, for part of the meeting, Schapiro

1. President Niwa and Secretary General Fujita welcomed the participants and
distributed an additional agenda for the meeting and an important document ***"Fundamental Operations Strategic Schedule"*** which outlines the future plans for the OMED management during their tenure (see point 9).

2. Committee on Minimal Invasive Surgery (MIS). Montori reported on the actions planned to implement the Committee. He stressed the importance to involve the representatives of the major international Societies of MIS in order to create close contacts and possible joint actions of OMED with these entities. Bailey suggested a document with criteria and aims to be prepared and diffused to the Zones and to have one representative from each Zone in the Committee; he also explained that mixed Sessions with endoscopists and surgeons are already planned in Montreal 2005. The EC gave mandate to Montori to prepare the document and further proposals for the GC in Orlando.

3. Guidelines Committee. Axon proposed that the OMED Guidelines Committee has to focus in gathering the existing guidelines issued by national or international Societies, avoiding the difficult and perhaps impossible task of issuing new guidelines due to the different endeavors in which endoscopy is performed in different areas and countries. The collected existing guidelines may be complemented with comments and diffused. Axon also proposed to rename the Committee as *"Clinical Standards Committee"*. Rey agreed on the task of the Committee and commented on the possibility to gather the different guidelines by a web search. He also proposed to name the Committee as *"Standards of Practice in Digestive Endoscopy"*. Secretary General Fujita announced that two names were proposed as chair of the Committee, both from US: Kimmey and Bjorkman (next president of ASGE): a decision will be reached at the GC in Orlando.

4. OMED Spring Meeting in Rome. The possibility to have an "OMED Spring Meeting" in Rome, in conjunction with the 5th International Gastric Cancer Congress (May 4-7, 2003) was agreed in principle. The advantage of joining with the Gastric Cancer Congress is to have a large audience and to avoid most of the organizational costs. A list of possible topics of strict endoscopic interest was distributed and agreed. Crespi and Montori were given the task to prepare suggestions for speakers and a budget to be circulated and finalized at the EC in Orlando in January 2003.

5. OMED at the WCGE in Montreal. Bailey outlined the significant part of the Congress which will be devoted to endoscopic topics: there will be 3 and a half days within the main Congress devoted to endoscopy in a large room labeled as OMED, in

addition to the Postgraduate and to "live" exhibitions every morning organized by Marcon and his team. The topics and format for the endoscopic part will be finalized in Orlando in January, with input from the OMED members of the Program Committee (Neuhaus and Tajiri) but also from the members of the OMED GC. President Niwa suggested the opportunity to have a larger OMED Committee dealing with this matter. The question whether the educational material produced during the Congress will be available to OMED to pursue its educational initiatives, outlined in detail in the "Strategic document" distributed to the participants, is still open and needs a definition at the level of Steering Committee. The President and the EC congratulated Bailey for his deep involvement and the achievements which will greatly enhance the profile of OMED at the next World Congress. Further talks will be held at the meetings scheduled in Orlando in January.

6. SIED PanAmerican Congress in Uruguay. No specific input of OMED in that congress is foreseen, being a "regional" initiative: this kind of approach may be revised in the future and talks must be held with local organizers of these meetings in an early phase. In any case, for Uruguay, Sydney Phillips was already named for a joint OMGE-OMED lecture. It is expected that Melvin Schapiro will deal with the organizers to tape and edit an educational DVD but an open question is the possible budget available to the Education Committee for such a task: a business plan is needed. Schapiro, attending the EC meeting for a short time, expressed his worries about the possibility to implement significant OMED Educational initiatives through his Committee, also for the lack of any information on the budget available. He was able to invite J. Toouli, chair of the OMGE Committee, to LA and to discuss with him several topics. He stressed the importance of an active OMED participation, in the forthcoming regional meetings (Uruguay, Singapore), the "Train the Trainees", etc. In addition he underlined the importance to get access and to edit in DVDs the educational material at these meetings and to feed with appropriate content both the Gastro-pro and the OMED websites, also implementing a "Web Sub-Committee". He also wishes a closer contact with Di Sario for the many possible initiatives linked to his Committee, which may greatly enhance the visibility of OMED among the Members Societies and the practicing endoscopists.

7. OMED Budget. Treasurer Montori distributed a detailed budget at October 10, 2002, which shows a balance of 202,354 USD. No annual contribution was received from SIED: Bailey declared that it is impossible for him to collect this money, due to the situation in Latin America. The EC decided to cancel, for 2002, the SIED
contribution, in consideration of the circumstances outlined by Bailey and to submit this decision to the GC for final approval. The Treasurer distributed the proposal for OMED Guidelines for travel and accommodation reimbursement, a task which was assigned to the Financial Sub-Committee. The rules were accepted by the EC and will be submitted for final approval to the GC (see annex 1).

8. Training Centers. Montori forwarded a proposal for a joint OMGE-OMED Training Center in Abu Dabi, where he visited, with E. Quigley, at the end of August. The proposal was accepted and Montori congratulated for the initiative. Bailey suggested a joint OMGE-OMED meeting at the Orlando DDW to discuss detailed plans for such initiatives in other areas.
9. Document "Strategic Operations Schedule " (SPSS):

9.1 President Niwa introduced the above document, elaborated with Fujita and Chao as a comprehensive management plan for OMED up to 2005. The document, distributed to the participants, has to be considered still a draft and kept confidential. The SOSS is elaborating in more detail what finalized at the "Long Range Planning Meeting" in San Francisco, but includes also new ideas and proposals and a tentative budgeting for the various initiatives. Among the highlights is the emphasis on independent OMED Educational actions, also through a new "Training Committee". Support for these important actions will be seek from the major instruments and accessories manufacturers. The presence of OMED with highly specialized educational initiatives will be pursued at major regional, international and national meetings, in agreement with the OMED Zones, and also within the activities of possible future training Centers. President-elect Axon and the other participants congratulated President Niwa and his co-workers for the great effort undertaken and fully endorsed the proposal. The different actions outlined will be further discussed in detail at the Orlando January meeting, after talks with OMGE which will be held in Geneva in the forthcoming days.

9.2 Statutes Committee. The President proposed the implementation of a new "Statutes Committee" and mentioned, as possible candidates, Chao (chair), Axon, Fujita,
Armengol, Segal and Bailey. The need to complete the by-laws with rules for calling Extraordinary General Assemblies and for other urgent matters was expressed by the President and agreed by the EC: a proposal will be prepared.

9.3 Museum project: It is the wish of the President to establish in Tokyo an "Endoscopy Museum". Members of the GC are invited to submit information, historical pictures, details of ancient endoscopes, etc. Support will be requested to the Industry and a display of the Museum materials will be also made available to the OMED website.

9.4 OMED Fourth Zone (Africa and the Middle East). This proposal was again discussed and the decision is to defer the initiative at a later date, when more details on the existing Endoscopic Sections or Groups in that area will be available.

9.5 CRC Committee. The EC gave mandate to Rozen to enlarge the Committee along his circulated proposals and to care for a fair balance between the Zones.

Being no other business, the meeting was adjourned.

H. Niwa	R. Fujita
President	Secretary General

Appendix 2

BALANCE AT OCTOBER 10,2002 USD 202,354.62
APPROVED AND SIGNED BY THE PRESIDENT
IN GENEVA OCTOBER 20, 2002

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OCTOBER 10 - DECEMBER 31,2002

	DEBITED	CREDITED
OMGE		USD 99,987.81
FUJINON		USD
DOCTOR SCHAPIRO FOR OMED EDUCATIONAL COMMITTEE ACTIVITIES	USD 515.07	
DOCTOR DI SARIO FOR MEETING OMED EDUCATIONAL COMMITTEE	USD 281.31	
OMED WEBSITE	USD 129.00	
INCOME FROM VIDEO		USD
TECHNICAL SECRETARIAT EXPENSES FOR 3 MONTHS (EQUIPMENT MAINTENANCE, INSURANCE, PHONE, FAX, MAIL, PHOTOCOPIES, STATIONERY, MISCELLANEOUS) FROM OCTOBER 1ST TO DECEMBER 31ST 2002 SECRETARY PART-TIME: FROM OCTOBER 1ST TO DECEMBER 31ST 2002	USD 409.00 USD	
FINANCIAL OFFICE EXPENSES FOR 7 V* MONTHS (EQUIPMENT MAINTENANCE. PHONE, FAX, MAIL. PHOTOCOPIES STATIONERY ETC.) FROM MAY 15TM TO DECEMBER 3 1ST 2002 SECRETARY PART-TIME : FROM MAY 15TM TO DECEMBER 31ST 2002	USD 625.00 USD	
INTEREST AT SEPTEMBER 2002		USD
BANK EXPENSES	USD 41.12	
INTEREST AT DECEMBER 2002		USD
	USD 6,275.50	USD 313,437.28

BALANCE AT DECEMBER 31, 2002 USD 307,161.78

****

PAYED IN JANUARY 2003

- OMED SCREENING COMMITTEE SECRETARIAL EXPENSES FROM JULY TO DECEMBER 2002 USD 1.546

OMED TECHNICAL SECRETARIAT: SECRETARY PART-TIME FOR SOCIAL SECURITY (2002) USD 800

OMED FINANCIAL SUB-COMMITTEE

PROPOSAL FOR OMED GUIDELINES FOR TRAVEL AND ACCOMMODATION REIMBURSEMENT

A) OMED Councils or Executive Committee Meetings usually take place twice yearly at UEGW and DDW, as well as at the World Congresses.

1. The Council Members are included within the faculty of the above mentioned
   Congresses.
2. The Council Members receive appropriate support from the Industries (National or
   International Companies).

In these cases there will be no support from OMED

B) OMED Councils or Executive Committee Meetings not organized in conjunction with the major events or taking place at major congresses, but there is no Industry or congress support:

1. Airfare: will be reimbursed at an economy rate (for air travel exceeding 3 hours in
   duration the Council Members pays the difference in business class if he/she wishes).
2. Hotel accommodation and meals: reimbursement upon submission of receipt. The
   OMED cannot reimburse any costs to spouse or guests.

These guidelines apply also for the Chairmen of the OMED Committees.

EXECUTIVE COMMITTEE (EC) MEETING

Orlando, January 19, 2003

MINUTES

Present: Niwa, Fujita, Chao, Axon, Montori, Rey, Crespi

1. QMED Short-term Operations Strategic Decision Meeting: President Niwa and Secretary General Fujita introduced the document "OMED Short-term Operations Strategic Decision Meeting" and explained in details the main goals and the financial implications (see appendix 1). The EC congratulated the President and Secretary General for the heavy but productive work done in preparing such a comprehensive approach to the future actions of the organization.

2. Financial matters: Montori produced an updated balance of the OMED budget at December 31, 2002, with a final positive balance of 307,161.78 USD (see appendix 2). He announced that the contribution to the "Train the Trainees" annual meeting, which is 37,000 USD for 2002, will be reduced to 20,000 from 2004 on. The EC authorize the payment to Rozen of 3,000 USD for the work he did for Gastro-pro on his 2002 budget and to let him know that the allocation to the CRC Committee for 2003 will total 10,000 USD.
   A contribution from Olympus of 40,000 USD for 2003 was announced by the President.

3. 1st OMED Spring Meeting. Rome 4-7 May, 2003: Montori illustrated the different possibilities of OMED contribution to the scientific program of the 5ht International Gastric Cancer Congress in Rome. The proposal of a clearly defined "1st OMED Spring Meeting" was accepted.
   The sensitization of all National Societies in order to ensure participation will be pursued. Due to the short time frame, the decision for the 1st Spring Meeting was taken by the EC and the President; for the future ones, the Governing Council will be involved in the planning.

4. QMED Committees: the Chairs of the OMED Committees are invited to decide autonomously when and where their meetings will take place. The recommendation by the EC is to exploit all the possibilities to hold frequent Committee meetings and to report regularly (at least twice a year) to the President on their activities. These reports will be included in the OMED website.

R. Fujita
Secretary General

H. Niwa
President

Appendix 2

BALANCE AT OCTOBER 10,2002 USD 202,354.62
APPROVED AND SIGNED BY THE PRESIDENT
IN GENEVA OCTOBER 20, 2002

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OCTOBER 10 - DECEMBER 31,2002

	DEBITED	CREDITED
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BALANCE AT DECEMBER 31, 2002 USD 307,161.78

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PAYED IN JANUARY 2003

- OMED SCREENING COMMITTEE SECRETARIAL EXPENSES FROM JULY TO DECEMBER 2002 USD 1,546

OMED TECHNICAL SECRETARIAT: SECRETARY PART-TIME FOR SOCIAL SECURITY (2002) USD 800

OMED GOVERNING COUNCIL MEETING
Monday, May 19, 2003 in Orlando, USA

MINUTES

Present: H. Niwa (President), R. Fujita (Secretary General), A. Montori (Treasurer), A. Axon (President Elect), J.R. Armengol-Miro (Vice-President European Zone) WSC Chao (Vice-President and President Asian Pacific Zone) EG Segal (Vice-President InterAmerican Zone), A. Nowak (President ESGE), R. Bailey (Councillor, President SIED and Chairman WGCE 2005), JF Rey (Councillor), G. Tytgat (President OMGE), M. Schapiro (Chair Education Committee), J. Escourrou (Chair Research Committee), P. Rozen (Chair Colorectal Cancer Screening Committee), M. Crespi (Technical Secretariat).

Absent: K Lee Goh (Councillor), G. Machado (Past President)

In addition were also invited and present: J. Waye, D. Bjorkman, A. Grassi, D. Delvaux

1. Introduction by the President and report by the Secretary General

The **President** greeted all those present, introduced the agenda. The **Secretary General** extensively reported on the Executive Committee Meetings held in Geneva and Rome (minutes already circulated).

The **President** reported on several important meetings and Congresses where OMED will be or was officially present: 1) Japan-Korea joint symposium of Gastrointestinal Endoscopy held on 29th March 2003 in Seoul; 2) Workshop at the 65th Congress of JGES (29-31 May 2003) in Fukuoka, Japan; 3) Train the Trainees Course, joint with OMGE, will be held on 7-10 March 2004; 4) the 67th Congress of JGES will be on 26-28 May in Kyoto. On that occasion, the 3rd Japanese-Korean joint-symposium will be held; 5) Japan-China joint Workshop, which was postponed this year, will be held in 2004, at a date to be finalized. Additional OMED sponsored events will be held in Bangkok and Singapore (under the responsibility of W. Chao, President Asian Pacific Zone): further details will be circulated soon.

Montori reported, at this point, on the success of the 1st OMED Spring Meeting held in early May in Rome, in conjunction with the International Gastric Cancer Congress (IGCC). The meeting was a success and, due to the local support by the organizers, drew only a limited amount of funds (10,000- 12,000 USD) from OMED. He expressed his wish that the President may contact early the organizers of the next IGCC in Yokohama to ensure a significant OMED role for the 2nd OMED Spring Meeting.

The **President** proposed Dr. D. Bjorkman as new Chair of the OMED Guidelines Committee: the Council approved. Dr. Bjorkman will submit to the President a list of names as members of his Committee. The President expressed gratitude for his acceptance and announced that a preliminary budget of 5000 USD for 2003 is allocated to the Guidelines Committee.

In the following discussion, several suggestions and comments were advanced by members of the GC:

- **Tytgat** proposed that OMED should take care of Training Courses for doctors and nurses with colonoscopy as a priority;
- **Chao** proposed a new OMED Committee on "Screening of upper g.i. malignancies" which was approved by the GC;
- **Fujita** mentioned the December 2002 Paris meeting on the new classification of superficial gastric cancer organized by R. Lambert and suggested, together with Rey, that OMED has to be further involved in that matter.

Screening Committee Meeting in Orlando (May 18, 2003) and will receive from Beckman Coulter USD 10,000 for the scientific activities of the OMED Screening Committee. In addition OMED will support with 5.000 USD the journal World Gastroenterology News. The GC approved the Financial report. **Axon** stressed the importance of an OMED support to the joint OMGE-OMED Training Centers

3. Updates on the Committee activities

3.1 Education Committee (see detailed report enclosed)

Schapiro detailed the actions, joint with OMGE, undertaken by the Committee. They are:

- web based video educational teaching is ongoing in the Gastro-pro website with no costs for OMED;
- the outreach program is starting by care of DiSario with support from Olympus;
- the Train the Trainees event is postponed and OMED is fully collaborating.
- **Tytgat** stressed the importance to develop teleconferencing events of sensitive education impact. In addition pointed out that rules and guidelines for joint OMGE-OMED Training Centers were established in a document which will be circulated.

3.2 Research Committee

Escourrou reported on the actions undertaken. A priority program is to gather data by a questionnaire on the existing guidelines for reprocessing endoscopes and accessories. **Rey** commented that this is an action more pertinent for the Guidelines Committee and suggested to aim to more specific topics related to research. **Bailey** supported this view.

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3.3 Colorectal Cancer Screening Committee.

Rozen summarized the actions untaken and the large consensus by the Industry and experts throughout the world to the initiative, well expresses by the success of the Committee meeting held in Orlando on Sunday in combination with the IDC A.

Rey commented on the overlap of that meeting with the DDW scientific sessions and on the format, with too many overlaps in the presentations with the IDCA meeting. **Axon** expressed the importance to continue a strict collaboration with IDCA but to concentrate these events in a shorter time frame.

3.4 Terminology and Standardization Committee.

Delvaux extensively on the actions undertaken. These are:

- the book with CD-Rom of images published by Normed Verlag, which includes the definitions of the terms in use;
- a coding system for the whole MST is ready and will be shortly implemented;
- the terms related to "capsule endoscopy" will be defined by an "ad hoc" meeting of experts;
- a more detailed classification of "flat lesions" will be also implemented by a group of experts, possibly at the Madrid UEGW;
- the translation in the different national languages is now a priority and the OMED Zones have to push the national Societies to undertake this task and to aim national editions of the MST book.

The GC approved these actions and confirmed the allocation of a budget of 12,000 USD for 2003 to the Committee.

3.5 Minimally Invasive Surgery Committee (MIS)

- a more detailed classification of "flat lesions" will be also implemented by a group of experts, possibly at the Madrid UEGW;
- the translation in the different national languages is now a priority and the OMED Zones have to push the national Societies to undertake this task and to aim to national editions of the MST book.

The GC approved these actions and confirmed the allocation of a budget of 12,000 USD for 2003 to the Committee.

3.5 Minimally Invasive Surgery Committee (MIS)

Montori reported on his mandate for the implementation of the Minimally Invasive Surgery Committee (MIS) and advanced proposals for names which were accepted by the GC. These are, at the moment: Kitano, S. Chung and Ponski.

Montori already convened a meeting with Kitano and Ponski in order to establish a plan of actions, also including pediatric MIS. Bailey ensured that the MIS will be widely represented in the program of the WCGE in Montreal.

3.6 Statutes Committee

In order to review the new Statues and draft a final proposal for approval by the GC and the Assembly, a restricted Committee was implemented with Chao (Chair), Axon and Bailey. The organizational support for this activity will be provided by Medconnect.

3.7 OMED Website

Grass! reported on the status of the website, and proposed a restyling and a more dynamic approach to the Societies and the Industry. This was accepted by the GC.

4. Update on the program of the WCGE in Montreal.

Bailey extensively reported on the situation and highlighted that endoscopy will be strongly represented within the scientific program by live and video sessions during all the days of the Congress. A detailed report will be circulated shortly.

5. Any other business.

A length discussion took place on the implementation of the Administrative Secretariat. In conclusion, the existing Technical Secretariat in Roma will continue its activities up to the General Assembly in Montreal, where the new OMED Statutes, which include the implementation of the Administrative Secretariat, will be finalized. There being no further matters to discuss, the meeting was adjourned

R. Fujita	H. Niwa
Secretary General	President

OMED GOVERNING COUNCIL MEETING
Monday, May 17,2004, New Orleans, USA

DRAFT MINUTES

Present: H. Niwa (President), R. Fujita (Secretary General), A. Montori (Treasurer), A. Axon (President Elect), G. Machado (Past President), J.R. Armengol-Miro (Vice-President European Zone) WSC Chao (Vice-President and President Asian Pacific Zone) EG Segal (Vice-President InterAmerican Zone), A. Nowak (President ESGE), D. Taullard (President InterAmerican Zone), R. Bailey (Councillor, and Chairman WGCE 2005), JF Rey (Councillor), G. Tytgat (President OMGE), M. Schapiro (Chair Education Committee), J. Escourrou (Chair Research Committee), P. Rozen (Chair Colorectal Cancer Screening Committee), M. Crespi (Technical Secretariat).

Absent: K Lee Goh (Councillor), D. Delvaux (Chair Terminology Committee)

In addition were also invited and present: J. Waye, D. Bjorkman, A. Grassi, J San Martin (Secretary SIED)

1. Introduction by the President
President H. Niwa greeted al those present, introduced the agenda and congratulated the GC Members and Chairs of the Committees for the activities developed in 2003-2004.

2. Report on the Status of the WCGE in Montreal.
R. Bailey presented an overview of the scientific and social program (available on the website www.wcog2005.org). The 3 OMED Honorary Lectures will be scheduled on Monday (Moutier by A. Axon), Tuesday (Schindler by N. Chopita) and Wednesday (Tasaka by R. Fujita). The General Assemblies of OMED and OMGE will be scheduled in conjunction in order to facilitate the access of delegates in consideration of the several overlaps. **Bailey** will send proposals to the Technical Secretariat (TC). Being the OMGE Governing Council on Saturday, he suggests to have the OMED-GC dinner on Sunday evening.
For the OMED meeting rooms **Bailey** will send to TC the relevant contact addresses of persons in charge. **P. Rozen** expressed his wish to have a meeting of the OMED-CRC Committee and the possibility to held it on Sunday morning (but, in case, there is overlap with GC) was discussed. In any case **Rozen** will contact also the chairs of the IDC A to discuss the best date, timing and format.

3. Report by the Secretary General
R. Fujita announced that several meetings in the Asian Pacific Zone will be sponsored by OMED, including one in Tokyo next November. He reported also in the requests of application to OMED by the Ecuador and Morocco Endoscopy Societies and it was reconfirmed that, on the basis of the Statutes, they will be automatically affiliated when accepted by the respective Zones. The TC will write in that sense to these Societies. In the following discussion **A. Grassi** pointed out once more the importance to get any information on meetings, events, activities of any kind, to be posted in the OMED website. The same request was made to Rozen in order to get updated material for the CRC Committee and any comment or modifications on what is already included in the web. At this point **A. Axon** raised the issue of having a "restricted area" in the OMED website, with access by password for authorized persons, in which include minutes and other information not useful for the general user; the proposal was accepted. **G. Machado,** supported also by **M. Schapiro,** advanced the proposal to upgrade the Terminology Committee as a Standard Committee; the proposal was accepted and will be implemented by the rules of the Statutes.

4. Report by the Treasurer
A. Montori distributed the certified financial report at 31/12/03 *(annex 1)* and detailed that the 2003 OMGE contribution was curtailed of 43,000 USD for the OMED share for Train the Trainees Courses. The Olympus contribution of 40,000 USD was received, as well as 15,000 USD by Beckman Coulter and Exact Sci. specially designated for the activities of the CRC Committee. For 2004 the contribution from OMGE will be reduced for the TTT activity and Olympus is scheduled to contribute the annual 40.000

USD.
The rules for reimbursement of expenses for GC and Committee chairs were confirmed. **The budget was approved unanimously.**

5. Reports by the Presidents of the Zones.

Asian Pacific. W. Chao reported on the many initiatives where OMED is one of the supporting organizations: this policy is creating a great visibility of OMED within the Zone. A Training Course of Endoscopy was held in March 7-9,2004 in Bangkok, where 15 trainees from Thailand were taught "hand on", for 2 days by faculty coming from Malaysia, Japan and Hong Kong. The course was highly appreciated and a request for another Course was advanced. Among the future meetings listed (more details will follow and will be also posted in the OMED website) are Bejing (4-7 October 2004), Seoul (2005), Manila (2006) and Japan (2007). **Chao** will also reach the OMED Councilor K. Lee Goh who never participated in the GC meetings nor replied to the mails send by the TS.

European Zone. A. Nowak extensively reported on the many activities of the Zone *(annex 2)* and was warmly congratulated.

InterAmerican Zone. D. Taullard announced that the SIED website (www. siedweb.org) was fully restructured and includes the complete list of member Societies. Several activities of the Zone are joint with the Gastroenterological Association. There is great interest in promoting the Minimal Standard Terminology also by a SIED edition. There is now again a periodic Bulletin. The SIED is working in developing endoscopic guidelines and will keep close contacts with the OMED Guidelines Committee. He announced an important meeting on GERD to be held in Cancun, September 3-4, 2004. There will be also a SIED PG Course in Peru in 2004. He was warmly congratulated for the activities. **Montori** asked for the annual contribution to OMED by SIED which he was unable to collect: further deals will be explored by direct contacts.

6. Updates on the Committees activities

6.1 Research Committee. J. Escourrou reported on the advancements of the enquiry on "Reprocession of endoscopes" with new entries from South America and North Africa; he is collecting this material in view of a report on what is ongoing on this topic "in real world", being guidelines already established and widely diffused in the various Zones. A second project, with relevance in conjunction to the awareness actions of the CRC Screening Committee, is the survey on "Colonoscopy practice", aimed at creating a large worldwide database on the rate of achievement of caecal intubation in the day to day practice. The questionnaire, in advanced phase of development, with advise from **J. Waye, M. Schapiro and M. Crespi** and further input by **H. Niwa and A. Axon,** will be anonymous in order to avoid bias and will deal with the real data on the next 25 Colonoscopies performed; it will be diffused and data elaborated by the OMED TC.

6.2 Education Committee. M. Schapiro acknowledged the excellent relationship with the OMGE which smoothed the work of this joint Committee. The performed activities are detailed in *annex 3.* One relevant contribution is the one to the Gastro-Pro website which has an important educational section on endoscopy. The Outreach program, led by J. DiSario in conjunction also with the Training Centers, is in full development thanks to the support from Olympus. **Montori** stressed the importance of a joint OMED-OMGE partnership clearly stated for each Training Center. **Rozen** complained about contribution on CRC screening requested to him by Gastro-Pro and never put on line. He also stresses the importance of the worldwide enquiry on colonoscopy by the Research Committee for the activities in the field of CRC screening.
6.3 Colorectal Cancer Screening Committee. P. Rozen reported on the successful meeting held in the previous day and was warmly congratulated for the good level of the program and attendance from representatives of 18 countries.
A detailed report is in *annex 3.* He underlined that external support was obtained but remarked that his requests for funds frequently overlaps with those by IDCA. In any case the collaboration with IDCA is good and further initiatives are foreseen.

6.4 <u>Nominating Committee.</u> **G. Machado** reported on preliminary discussion held with OMED officials for the proposals to be forwarded to the GC and General Assembly in Montreal. By the Statutes, requests for nomination by the Zones have to be circulating in September 2004. A proposal for **J.Waye** (American Zone) as future President-elect was unanimously endorsed. In any case **Machado** will forward to OMED Executives a confidential written report on his actions. **Chao and Axon,** with input from Schapiro,
discussed possible solutions for the current machinery of the Nominating Committee in view of the new Statutes, which will be almost finalized by the UEGW in Prague and diffused to Member Societies on the OMED website.

6.5 <u>Guidelines Committee.</u> **D. Bjorkman** updated on the actions joint with OMGE in using guidelines for endoscopy in the frame of the guidelines project of OMGE. A meeting of the OMED committee was held at the UEGW in Madrid and another is foreseen in Prague. He will interact with the programs on Reprocessing the endoscopes and Colonoscopy practice with **Escourrou.**
The composition of the committee was discussed. Current members are:
Chairman: Bjorkman, David (USA)
Rey, Jean Francois (France) Axon, Anthony (UK), **Mine, Tetsua (Japan), Ogoshi, Kazuei (Japan), Faigel, Douglas** (USA)

6.6 <u>Minimally Invasive Surgery Committee (MIS).</u> **A. Montori** reported on a successful meeting with
the MIS Societies in Cancun, February 2004. With the members of the committee (Kitano, Ponski and Chung) further emphasis is now focused on EMR and the "combined approach". The future meetings are foreseen in Miami, February 2005, in Fort Lauderdale, April 2005 and in Yokohama in May 2005.

6.7 <u>Archives and History Committee and Endoscopy Museum.</u> **H. Niwa,** which took the chair of this Committee after the resignation by G. Nagy, highlighted the Museum project which will be in joint venture with the Japanese Society of Digestive Endoscopy. He asked those present to contributed with their historical endoscopes and any possible archive material for this initiative. He will propose new members for the committee in the near future *(Montori and who are the others?)*

7. A meeting of the Executive Committee will be called at the UEGW in Prague.

Being no other business, the meeting was adjourned

R. Fujita	H. Niwa
Secretary General	President

OMED GOVERNING COUNCIL MEETING
Sunday, September 11,2005, Montreal, Canada

MINUTES

Present: H. Niwa (President), R. Fujita (Secretary General), A. Montori (Treasurer and Chair MSI Committee), A. Axon (President Elect), G. Machado (Past President and Chair Nominations Committee), J.R. Armengol-Miro (Vice-President European Zone) EG Segal (Vice-President InterAmerican Zone), D. Taullard (President InterAmerican Zone), R. Bailey (Councillor and Chairman WGCE 2005), K Lee Goh (Councillor), JF Rey (Councillor and President European Zone), M. Schapiro (Chair Education Committee), P. Rozen (Chair Colorectal Cancer Screening Committee), D. Bjorkman (Chair Guidelines Committee), M. Crespi (Technical Secretariat).

Absent: G. Tytgat (OMGE President), WSC Chao (Vice-President and President Asian Pacific Zone), M. Delvaux (Chair Terminology Committee), J. Escourrou (Chair Research Committee).

In addition were also invited and present: J. Waye, J. DiSario.

1. Presidential address

President H. Niwa greeted all those present and gave a presidential address: "First of all, I would like to thank you very much for attending this Governing Council meeting. Three and half years have passed since I took over the presidency of OMED from Prof. Machado. My term will finish at the end of this World Congress in Montreal and Prof. Axon will succeed me. Before starting the Governing Council let me briefly look back to the achievements of OMED that I have been involved during my presidential term. It is amazing how fast time flies and three and half years seemed very short for me to fulfil what I had planned to do at the start of my term. Budgetary restrictions made it hard for us to carry out some of the projects. Nevertheless, I think I have been able to manage my planned activities pretty smoothly owing to the great cooperation from the Asian Pacific Society for Digestive Endoscopy under the presidency of Prof. Chao, from Dr. Crespi as Technical Secretariat, Dr. Montori as Treasurer, Dr. Waye as President's Consultant and everyone else who participated in the management of OMED. I wish to thank them again very much.

I have requested several of you to write contributions for the Bulletin and for the History and Archives Committee, which I will publish after my term. I would be very helpful if they could submit the drafts by the end of December 2005. Thank you for your understanding and cooperation. I wish also to announce that the papers related to the 2nd OMED Spring Meeting in Yokohama (May 2005) will be published as a Supplement of the Japanese "Digestive Endoscopy".

2. Discussion on the introduction of temporary Statutes and discussion on the draft of the new Statutes

A. Axon explained the need to introduce some amendments to the existing Statutes in order to ensure the possibility to introduce the new Statutes before the next World Congress. In addition stresses the importance to facilitate the work of the Committees, the backbone of OMED activity, and give the Chairs sufficient flexibility to achieve their goals. Due to the absence of Chao any further discussion on the new Statutes is postponed. In the following discussion on the draft of the new Statutes **M. Schapiro** strongly advocates to include independent, reputed personalities in the Nominating Committee in order to ensure transparency and fresh proposals, not only from the previous Governing Council. **G. Machado** requested that, in the membership of the Committees, a balance between the Zones is taken into consideration. **Schapiro** stressed the importance of an interaction between the Committees and the Executive and Governing Council in order to keep control. The final text to be submitted to the Assembly reads: "1. The Statutes of OMED may be changed by postal/electronic voting provided that the changes have been approved by the Governing Council, have been circulated three months before the vote takes place and that the changes are approved by a two thirds majority;

2. The Guidelines Committee, Terminology Committee and Upper GI Screening Committee be upgraded to Standing Committees;

3. The structure and membership of the Working Committees will be the responsibility of the chairmen of the committee taking into account the recommendations of the Governing Council;

4. A report of each working committee will be circulated to the membership annually following the meeting of the Governing Council, together with a report from the President, the Treasurer and the Secretary General."

3. Report by the Secretary General; R. Fujita reported activities of OMED after the Executive Committee in Prague 2004 and the Governing Council in Chicago 2005. Vice Presidents from each 3 Zones, Dr. Taullard succeeded last year in Inter-American, Chairmen of Standing Committee and of ad hoc Committee stated their tasks during this term. In order to activate educational actions, the following events were held: Joint Seminar with Industry at APDW Oct. 4-7, 2004, in Beijing; Taormina Seminar Nov.4-6, 2004; Paris OMED Workshop on Barrett Esophagus chaired by R. Lambert, Sharma and Watanabe Dec. 11-12, 2004; Korean-Japan Symposium, March 26, 2005; the Second OMED Spring Meeting May 4, 2005 in Yokohama. The manuscript of the Paris workshop and the one of the Second OMED Spring Meeting will be published soon. At the Governing Council in Montreal there were hot and adhesive

discussions related to the new Statutes and Financial matters, and the OMED financial budget was approved. Discussion on the new Statutes will continuing, then produce a new nomination for the staffs. **Fujita** appreciated very much for the cooperation and a strong support by Technical Secretariat and Prof. Crespi is requested to complete the minutes of the meetings in Montreal during his term.

4. Report by the Treasurer

A. Montori detailed the financial status of OMED at August 31, 2005 (see Annex 1) and the provisional budget 2005 (see Annex 2). **The President** decided to proceed, during his term in office, to the payments related to the provisional budget, already discussed and approved at the Governing Councils in Chicago and Montreal, with the funds available in the OMED Bank account. The expenses related to the reimbursements to the OMED officials for the participation in the Montreal Governing Council and for the meeting rooms and other incidental expenses will be paid by the new Treasurer unless otherwise agreed.

The financial status at August 31, 2005 and the provisional budget were approved unanimously and signed by the President.

5. Report by the Technical Secretariat

M. Crespi reported on these activities as follows:

Routine activities

- Kept relationships with:
  - o OMED Members Societies and Zones o
  - OMED Governing Council Members o
  - OMED Committees
- Contacts with Normed Verlag (Mr. Reuter) about the OMED Booth in the various Congresses
- Contacts with other Scientific International Associations (ACG, ASGE, ESGE, OMGE, SIED) for mailing lists, etc.
- Diffusion of the call for the GC and Executive Committee meetings, General Assembly and other business meetings
- Organization for arrangements of hotel rooms for OMED officials at the various Congresses
- Organization for arrangements of OMED meeting rooms, equipment and catering at the various Congresses including Executive meetings at UEGWs
- Preparation, diffusion and filing of the minutes
- Diffusion among the Societies of the various surveys and initiatives promoted by the Committees, by mail, e-mail, fax
- Organization of the Industry/OMED Meetings during the major events (2002-2003)
- Updating of OMED stationery
- Organization of the " 1st OMED Spring Meeting in Rome (2003)

OMED Website

- Management of the OMED Website (2002-2005) with continuous interchange with Dr. A. Grassi and METROPA Co. to keep the website updated and to design the new layout of the website (last update August 2005)

Relationships with the 80 OMED Member Societies:

- Requests for exchange of information and national initiatives (3 times/year)
- Requests for updating in their GC Boards (3 times/year)

The participation of Member Societies to the forthcoming General Assembly was requested in June and reminded to non responders 3 times with increasingly compelling mails. *Special initiatives*

- Participation in the Sub-Committee for the new Statutes
- Definition, organization and diffusion of the questionnaire on "Colonoscopy performance" and related reminders
- Participation as OMED representative at several international scientific meetings worldwide

6. Report by the Nominations Committee;

G. Machado confirmed the list which was already submitted at the GC in Chicago with the modification of Segal as Vice President of the InterAmerican Zone instead of Taullard. In addition the Ethics Committee was cancelled as well as the Electronics Communications and the position of Webmaster. The final list to be submitted is as follows:

President	**A. Axon**
President-Elect	**J. Waye**
Secretary	**J-F. Rey**
Treasurer	**R. Bailey**
Vice-Presidents	
Asian-Zone	**R. Fujita**
European Zone	**J. Armengol-Miro**
InterAmerican Zone	**E. Segal**

Councillors	
Asian Zone	**WSC Chao**
European Zone	**L. Aabakken**
InterAmerican Zone	**G. Machado**
Standing Committees	
Education	**J. Disario**
Research	**J. Morris**
Colorectal Cancer Screening	**GHK Young**
Upper GI Cancer Screening	**J. Sung**
Nominations	**H. Niwa**
Finance	**R. Bailey**
"Ad hoc" Committees	
Terminology & Data Processing	**L. Aabakken**
Standards of Practice	**D. Bjorkmann**
Minimally Invasive Surgery	A. lMontori
Archives & History	**H. Niwa**
OMED Newsletter Editor	**J.D. Waye**

7. Nominations to be submitted to the General Assembly and Honorary positions

The proposals by the Nominations Committee were unanimously approved by the Governing Council. **Niwa, Machado and Crespi** will be awarded the status of **Honorary Presidents; Montori, Rozen and Schapiro** will be awarded the status **of Honorary Members** in recognition of their outstanding contributions to the activities of OMED.

8. Reports by the Committee's Chairs

The following written reports by the Chairs of the Committees were obtained by the Technical Secretariat and distributed. They are available in full text in the OMED website:

- Archives and History Committee (see Annex 3)
- Endoscopy Museum (see Annex 4)
- Colorectal Cancer Screening
- Terminology and Data processing
- Guidelines and Standards of Practice
- Research
- Education
- Minimally Invasive Surgery
- Webmaster

9. Appreciations by the incoming President

A. Axon recognized the great dedication by Niwa, Fujita, Montori and the other officials of OMED in managing the organization since the last World Congress and expressed his wishes to further exploit their contribution and experience. A special gratitude was expressed to Crespi for his actions, in different positions, to keep OMED active and for the intense work in the last few years as responsible for the Technical Secretariat.

Being no other business, the meeting was adjourned

R. Fujita	H. Niwa
Secretary General	President

Archives and History Committee
Hirohumi Niwa, Chairman

Among the committee members, I have requested to Profs. Gangl, Waye, Classen, Crespi, Montori, Vilardell, Machado, Axon, Chao and Fujita to write drafts on the topics detailed below. I have also requested Prof. Hirschowitz to write a draft on the development of fiberscopes, although he is not a member of the committee I have also asked Prof. Yoshino of Japan to write about the history of EUS.

The topic I requested to above members is as follows: The history of the European Society of Gastrointestinal Endoscopy should be handled mainly by Prof. Montori and supplemented by Prof. Axon. The German and Austrian history of endoscopy should be handled by Profs. Classen and Gangl respectively. Prof. Crespi will write about the Italian history of endoscopy, and Prof. Vilardell will write about the Spanish and Portuguese history of endoscopy. Prof. Nagy, the former president of the committee, received already a summary draft on the European and Spanish/Portuguese history of endoscopy from Prof. Vilardel; however, because endoscopy in entire Europe has developed greatly since that time, I have asked Prof. Montori to prepare a broad overview. Therefore, Prof. Vilardell will concentrate on the history of Spain and Portugal in detail.

If there is a need to ask Prof. Vilardell to report on the activities of European Digestive Society in the early days after reading Prof. Montori's draft, I may decide to use Prof. VilardelPs draft sent to Dr. Nagy. I have not told this idea to Prof. Vilardell yet, so if he is absent from the meeting, I will write a letter of request to him.

Prof. Machado will write about the Digestive Endoscopy in the InterAmerican Zone, Prof. Rubio sent previously to Dr. Nagy a summary draft on this theme, but it is rather too short and we need more details. I may decide to add this draft to Prof. Machado's draft afterwards. Dr. Waye will write about the history of Digestive Endoscopy in the United Stated of America excluding the InterAmerican Zone.

Prof. Chao will write about the history of the Asian Pacific Society for Digestive Endoscopy and the history of Digestive Endoscopy in Hong Kong and China. Prof. Fujita will write about the development of endoscopy for pancreatic and biliary ducts. Prof. Niwa will write about the history of OMED and Digestive Endoscopy in Japan and on early history of therapeutic endoscopy on global basis.

The texts gathered from the Committee Members will be published as a Supplement of "Digestive Endoscopy", the official journal of the Japan and Asian Pacific Digestive Endoscopy Societies. I have already obtained an agreement by the societies about this plan and the current plan is to distribute thousands of copies worldwide.

I would like to allow about 4-5 pages to each topic on a printed page basis. It is possible to allot more pages, so please try to write as much in details as possible. The number of figures and pictures should be around 10.

I have asked some of the members to hand in the drafts by the end of October his year. Because there may not be enough time before the deadline from now, I would like to ask you to hand in the drafts by the end of December 2005.

Endoscopy Museum
Hirohumi Niwa

It was decided to establish an Endoscopy Museum as a project of OMED. Due to various considerations, Japan was chosen as the venue for the Museum. I am going to report on the progress of the project at this point in time.

We have already concluded the lease agreement of the two floors in the building where the office of the Japan Gastroenterological Endoscopy Society is located. Current plan is to use the basement as the warehouse and display exhibits on the ground floor. The floors are rather small and I suppose they can accommodate quite a few instruments. If we need additional space, we can use an additional room for exhibition.

The Museum will be open for researches only, as it will be difficult to open for the public due to legal reasons and labor shortage. Those who would like to visit the Museum will be requested to apply in advance. The Endoscopy Museum of the Institute of Medical History of the University of Vienna adopt a similar policy about admission, so I am planning to search more about its management.

We have received offers of instruments for exhibits from Profs. Montori and Crespi as well as Japanese doctors. However, the endoscopes presented from overseas have not cleared the customs yet because they do not understand that the instruments not for medical practice but for exhibition. I am going to ask the current situation to Olympus that is helping us for transportation.

Present at the Museum so far are several sample of Japanese rigid gastroscopes, flexible gastroscopes, proctosigmoidoscopes, picture-taking proctosigmoidoscopes, various types of gastrocameras with fiberscope, gastrofiberscopes, duodenal and colonic fiberscopes, many kinds of videoendoscopes, ultrasound endoscopes, bronchoscopes, blind biopsy instruments and others. I am going to classify and organize them in the near future.

OMED GENERAL ASSEMBLY (GA) **Monday, September 12,2005, Montreal, Canada**

MINUTES

They were present *(their credentials were checked by care of Medconnect):*

- the members of the OMED Governing Council and Standing Committees.
- the representatives of the following member Societies - **European Zone** (ESGE): Belgium, Czech Republic, Egypt, France, Hungary, Poland,
  Portugal, Romania, Russian Federation, Spain
  - **InterAmerican Zone (SEED):** Argentina, Brazil, Canada, Chile, Peru, USA
  - **Asian-Pacific Zone (APSDE):** Japan, Malaysia, Philippine
  - **Other National Societies** : Sudan, Saudi Arabia

Absent: WSC Chao (President Asian Pacific Zone)

1. Presidential address

President H. Niwa welcomed the participants and gave a presidential address: "First of all, I would like to thank you very much for attending this Assembly. Three and half years have passed since I took over the presidency of OMED from Prof. Machado. My term will finish at the end of this World Congress in Montreal and Prof. Axon will succeed me. Before starting the Assembly let me briefly look back to the achievements of OMED that I have been involved during my presidential term. It is amazing how fast time flies and three and half years seemed very short for me to fulfil what I had planned to do at the start of my term. Budgetary restrictions made it hard for us to carry our some of the projects. Nevertheless, I think I have been able to manage my planned activities pretty smoothly owing to the great cooperation from the Asian Pacific Society for Digestive Endoscopy under the presidency of Prof. Chao, from Dr. Crespi as Technical Secretariat, Dr. Montori as Treasurer, Dr. Waye as President Consultant and everyone else who participated in the management of OMED. I wish to thank them again very much".

2. Report by the Secretary General; R. Fujita reported the activities of OMED after the Executive Committee in Prague 2004 and the Governing Council in Chicago 2005. Vice Presidents from each 3 Zones, Dr. Taullard succeeded last year in Inter-American, Chairmen of Standing Committee and of ad hoc Committee stated their tasks during this term. The following educational events were held: Joint Seminar with Industry at APDW Oct. 4-7, 2004, in Beijing; Taormina Seminar Nov.4-6, 2004; Paris OMED Workshop on Barrett Esophagus chaired by R. Lambert, Sharma and Watanabe Dec. 11-12, 2004; Korean-Japan Symposium, March 26, 2005; the Second OMED Spring Meeting May 4, 2005 in Yokohama. The manuscript of the Paris workshop and the one of the Second OMED Spring Meeting will be published soon. At the Governing Council in Montreal there were hot and intensive discussions related to the new Statutes and Financial matters, and the OMED financial budget was approved. Discussion on the new Statutes will continue. **Fujita** appreciated very much the cooperation and strong support provided by the Technical Secretariat and Prof. Crespi is requested to complete the minutes of the meetings in Montreal during his term.

3. Report by the Treasurer

A. Montori detailed the financial status of OMED at August 31, 2005 and the provisional budget 2005.The 2005 **budget was approved unanimously.**

4. Temporary new Statutes

The need to introduce some amendments to the existing Statutes was clearly explained by the **President elect A. Axon.** The final text of these amendments, unanimously approved by the Assembly, is as follows: "1. The Statutes of OMED may be changed by postal/electronic voting provided that the changes have been approved by the Governing Council, have been circulated three months before the vote takes place and that the changes are approved by a two thirds majority;
2. The Guidelines Committee, Terminology Committee and Upper GI Screening Committee be upgraded to Standing Committees;
3. The structure and membership of the Working Committees will be the responsibility of the chairman of the Committee taking into account the recommendations of the Governing Council;
4. A report of each Working Committee will be circulated to the membership annually following the meeting of the Governing Council, together with a report from the President, the Treasurer and the Secretary General."

5. Discussion on the new Statutes

In the absence of W. Chao, Chairman of the "ad hoc" sub-committees , the discussion on the new Statutes was deferred to a subsequent mailing of a draft, which will be followed by postal vote.

6. Nominations by the new Governing Council and Honorary positions

G. Machado, as Chairman of the Nomination Committee, reported on the proposals which were already cleared by the Governing Council. The proposal was unanimously approved by the Assembly and is as follows:

President	**A. Axon**
President-Elect	**J. Waye**
Secretary	**J-F. Rey**
Treasurer	**R. Bailey**
Vice-Presidents	
Asian-Zone	**R. Fujita**
European Zone	**J. Armengol-Mir6**
InterAmerican Zone	**E. Segal**
Councillors	
Asian Zone	**WSC Chao**
European Zone	**L. Aabakken**
InterAmerican Zone	**G. Machado**
Standing Committees	
Education	**J. Disario**
Research	**J. Morris**
Colorectal Cancer Screening	**GHK Young**
Upper GI Cancer Screening	**J. Sung**
Nominations	H. Niwa
Finance	**R. Bailey**
"Ad hoc" Committees	
Terminology & Data Processing	**L. Aabakken**
Standards of Practice	**D. Bjorkmann**
Minimally Invasive Surgery	A. **Montori**
Archives & History	**H. Niwa**
World Gastroenterology News	**J.D. Waye**

Axon proposed some honorary positions in recognition of the intense work in support of OMED: These are: **Niwa, Machado and Crespi** as **Honorary Presidents; Montori, Rozen and Schapiro as Honorary Members.**
The Assembly approved. A certificate was presented to the awardees.

7. Address by the incoming President

The President A. Axon presented a series of slides detailing the future plans for the management of OMED 2005-2009:

- **Principle aims of the organisation:**

Promote endoscopy world-wide - improve the quality of endoscopy practice - encourage technical development and endoscopic research - support training

- **Prerequisites for success:**

Support of our National Societies - financial security, efficient secretariat - good liaison with industry - clear objectives - effective working committees -professional publicity mechanisms

- **OMED immediate steps:**

Financial situation - Secretariat - relationship with WGO (OMGE) - liaison with industry - identify future projects

- **Relationship with WGO:**

Establish a formal partnership - retain independence - common secretariat - strategic decisions to be made together -joint and independent goal-orientated projects agreed together - collaborative fund raising

- **Liaison with Industry:**

Set up a BMI consortium - promote new techniques and equipment - organise workshops - publicise research -stimulate teaching - seek funding for specific projects - agree a budget

- **Identify future projects:**

Promotion of endoscopy world-wide - outreach programme - endoscopy directors workshops - OMED teaching fellows - "How I do it" - cost effectiveness (developing world -developed countries)

- **Improvement in quality:**

Atlas of endoscopic appearances - usable MST to apply to software - define quality parameters - agree quality standards - ethics input

- **Encourage technical development and research:**

Equipment update (Publication/DVD, Workshops/demos, Congress sessions, equipment compendium) -meeting reports - research reviews

- **Support training:**

Train the trainers - training centres - world congress course - compendium of teaching aids - training curriculum - Teacher's handbook - workshops on endoscopy training - "Hands on" at major meetings

- **Professional publicity mechanisms:**

New Logo - visible presence at international meetings - identifiable conduits for publication.

The President established also some specific priorities for the Committees as follows:

- **Research Committee - John Morris:**

Equipment updates - meeting reports - six monthly research reviews - working party on cost effectiveness of endoscopy - Present state of the endoscopic treatment of GERD.

- **Training & Education Committee - Jim Di Sario:**

Short-term teaching fellows - input to Train the Trainers - endoscopic training in training centres - hands-on sessions at major meetings - practical teaching of endoscopy (workshops on teaching, list of teaching aids and tapes, handbook for teachers, training curricula in endoscopy, train the Trainers in endoscopy).

- **Standards of Practice & Guidelines Committee - David Bjorkman:**

General guidelines - quality indicators - quality standards endoscopy director's workshop - How I do it?

- **Nomenclature & Minimal Standards Terminology Committee - Lars Aabakken:**

Atlas of endoscopic appearances, Modification of MST for software application, Universal photography standardisation.

- **Upper Gastrointestinal Screening Committee- Joseph Sung:**

Screening protocols for Barrett's oesophagus (workshop) - role of endoscopy in screening for gastric cancer (workshop) - screening for the early diagnosis of squamous cancer of the oesophagus (workshop) - serological screening for upper GI cancer (workshop)

- **Colorectal Cancer Screening Committee - Graeme Young:**

Role of virtual colonoscopy - cancer screening in inflammatory bowel disease - molecular markers in the stool • genetic predilections for colon cancer

- **Minimally Invasive Surgery Committee - Alberto MOD tori:**

Review of recent advances in minimally invasive surgery for the GI tract - workshops on specific endoscopy/surgical joint interventions

- **History Committee - Hirohumi Niwa:**

Biographies - history of Endoscopy

The Assembly congratulated the President for his broad views and clear guidelines for future actions.
Being no other business, the meeting was adjourned

H. Niwa
Past President

A. Axon
President

History of OMED
Foundation of the World Society of Digestive Endoscopy

Birth of International Society of Endoscopy (ISE)

Hirohumi Niwa MD. President

During the second congress of the World Gastroenterology Organization (OMGE) held in Munich in 1962, the idea of founding International Society of Endoscopy was first proposed for discussion by Profs. Hayashida, Yamagata, Masuda and Sakita. As a result, it was agreed that the first meeting of International Society of Endoscopy should meet in Tokyo in 1966 with Dr. Tasaka as the president, and that Japan should prepare the draft for the articles and regulations of the society. Masuda proposed the draft in the meeting of European Congress of Gastroenterology held in Brussels in 1964, which was unanimously approved in the meeting as the official article of the new association.

International Society of Endoscopy (ISE) was established in 1966 in line with the article of the association, and the first international congress was held in Tokyo in the same year. Attendance of the first congress was only about 700.

In accordance with the article of the society, a meeting was held attended by representatives from each nation in order to discuss how to organize and manage the new society. The steering committee of the society was initially consisted of the representatives of the committees elected from three zones of Asia, Inter America and Europe.

In this meeting, the members of the steering committee from Asia, Europe and America were elected and approved. Asia and Europe already had established local organizations by that time, while there was not a solid organization founded in America zone yet. Therefore, it was decided to nominate 7 members including Dr. Nelson as mere representatives of the zone, not the official committee members, and Dr. Berk was designated as the tentative general secretary.

It was also agreed in the meeting that the international congress should meet once in every 4 years as the supreme meeting of the society, and that the second international meeting should take place in Rome and Copenhagen in 1970 with Dr. Marcozzi and Dr. Wiebenga as chairmen respectively. The reason why the second congress met in two distance venues was that International Society of Endoscopy had decided to have the next meeting in Rome before the World Gastroenterology Organization chose Copenhagen as the venue for their next congress. It stirred up a controversy whether the endoscopy society should follow their initial decision or change the plan to meet in Copenhagen where the congress of the World Gastroenterology Organization would take place.

Eventually, it was decided to split the meeting into two and hold meetings both in Rome and Copenhagen. The Schindler lecture that was scheduled in this meeting as a tribute to Schindler was also held in the both venues. Part of the articles of the association was altered at the same time.

The third international meeting of International Society of Endoscopy was held in Mexico in 1974 under chairmanship of Dr. Fournier. Taking the opportunity of having the congress in the America zone, Inter American organization was officially established and International Society of Endoscopy was reorganized to consolidate three zones of Asia, Europe and America.

The board of the society was composed of the president, one vice-president from each zone totaling three in all, two councilors from each zone totaling six in all. Dr. Tasaka was elected president of the society, and vice-presidents were Dr.Colcher from Inter America, Dr. Heinkel from Europe and Prof. Yoshitoshi from Asia. As for secretarial job to take care of practical management of the society business and projects, it was decided not to have general secretary but to elect one secretary from each zone totaling three in all. Elected as secretaries were Dr. Job from Inter America, Dr. Miller from Europe and Dr. Niwa from Asia.

This reorganization and reinforcement of the society led to its great advancement in the future.

Renaming of the Society to Organisation Mondiale d'Endoscopie Digestive (OMED), and the following congresses and presidents of those congresses

At the same time as the organizational change, the name of the society was also changed from International Society of Endoscopy to "Organisation Mondiale d'Endoscopie Digestive" (OMED) as of June 3 of the same year. The English official name is World Organization for Digestive Endoscopy. The change was driven by Dr. Colcher, the vice-president representing the Inter America zone, who claimed that the word "International" merely meant "between two or more different nations" and did not have a meaning that many countries in the world participate, and that the word "world" that had a more comprehensive nuance would be more suitable to reflect the philosophy of the society.

Alteration of the articles was proposed at the same time, the draft of which was presented in the third meeting of European Gastroenterological Endoscopy Society held in 1976 and approved in the fourth world congress held in Madrid. In the Fourth World Congress held in Madrid under the chairmanship of Dr. Mazpule, Montier lecture was offered for the first time in addition to Shindler lecture. Presidency was taken over from Prof. Tasaka to Prof. Colcher in this congress. The post of general secretary was newly founded and Niwa was elected to assume the role.

The European party criticized the part of the articles in regards to the status of the membership societies composing the world society. The draft of the articles originally specified that the world society would have no linkage with local societies, but they claimed that OMED should be the roof organization that integrates the

societies in the three zones in order to eliminate any unnecessary overlap, and that affiliate societies of the three zones should automatically acquire membership of OMED. During the years that followed, there was a substantial discussion about the role of OMED and several alterations of the articles were added.

Prior to these organizational changes, a conference of vice presidents was founded with a view to further promote mutual understanding and cooperation of the three zones. The first meeting of the conference was held in Venezuela in 1975 and the second meeting in Budapest in 1976, but after that this conference has not been held regularly.

The fifth world congress was held in Stockholm in 1982 under the chairmanship of Dr. Reichard. In this congress, the Schindler lecture was managed by Dr. Sakita under the title of "Endoscopic diagnosis and therapy of early gastric cancers." The alteration of the articles was approved during the congress, the details of which are described in the 2nd Bulletin.

Dr. Heinkel succeeded the post of president after Dr. Reichard, but he suddenly passed away in a month. Dr. Masuda, then president-elect, took over the post after Dr. Heinkel, but he also passed away in two months, leaving the president post open. Dr. Sircus was elected from the Europe zone to take over the post, and this decision stirred up a stormy controversy about the appropriate turns of presidency.

The Inter America party claimed that the new president should have been elected from the Inter America zone because last two presidents were from Europe and Asia even though their service lasted for only a few months, while the European party claimed that electing the new president from Europe would be natural as it was during the European president's term that the unexpected successive misfortune happened. The Japanese society found the claim of the European zone reasonable and decided to support presidency of Dr. Sircus.

The sixth congress was held in Sao Paulo in 1986 under the chairmanship of Dr. Meirelles Filho. Although the president of the society should have been elected from Asia according to the aforesaid discussion of appropriate turns, it was decided to elect Dr. Rubio of Argentina due to various reasons. Dr. Sakita was elected the president elect.

The seventh congress was held in Sydney under the chairmanship of Dr. St. John. Due to the end of the term of Dr. Rubio, Dr. Sakita took over the presidency. The attendance of the congress went beyond 5,000 people combined with those of gastroenterology society.

The Eighth Congress was held in Los Angeles in 1994 under chairmanship of Dr. Boyce. Dr. Cheli of Italy succeeded the presidency of the society from Sakita. Next Congress is scheduled to take place in Vienna. The board members in the history of the society are listed in the Table 1.

Table 1

Past Presidents

1974~1978	Tasaka, T. (Japan)
1978~1982	Colcher, H. (U.S.A.)
1982	Heinkel, K. (Germany)
	Masuda, M. (Japan)
~1986	Sircus, W. (Great Britain)
1986~1990	Rubio, H. (Argentina)
1990~1994	Sakita, T. (Japan)
1994	Cheli, R. (Italy)
~1998	Crespi, M. (Italy)
1998~2002	Machado, G. (Brazil)
2002~2005	Niwa, H. (Japan)

Bibliography

1) OMED First Bulletin, 1977

2) OMED Second Bulletin, 1981

3) OMED Fifth Bulletin, 1994

4) The Asian Pacific Society for Digestive Endoscopy, First Bulletin, 1988

5) The Asian Pacific Society for Digestive Endoscopy, Third Bulletin, 1996

Transition of World Congress of Gastrointestinal Endoscopy

1962 Ideas of World Congress of GI Endoscopy(Muenchen)

1966 International Society of Endoscopy(Tokyo)

President Tasaka(J)

1970 Two Congress of ISE,(Rome) (Copenhagen)

1974 OMED (Mexico) (Organization Mondiale d' Endoscopie Digestive)

President Tasaka(J)

1978 OMED(Madrid)

President Colcher(USA)

1982 OMED(Stockholm)

President Heinkel(WG)-Masuda(J)-Sircus(UK)

1986 OMED(Sao Paulo)

President Rubio(Arg)

1990 OMED(Sidney)

President Sakita(J)

1994 OMED(Los Angeles)

President Chelie(It)-Crespi(It)

!998 OMED(Wien)

President Machado(Br)

2002 OMED(Bangkok)

President Niwa(J)

2005 OMED(Montreal)

President Axon(UK)

History of duodenoscopy and bilio-pancreatic disease

Rikiya Fujita MD,MDSc,FACG
Prof.Emeritus of ShowaUniversity, Consultant of Cancer Institute Hospital Ariake

1. ERCP

Digestive endoscopy for bilio-pancreatic disease started with the development of cholangiopancreatography with a fiberscope. According to the report by McCune (1), pancreatography was successful via cannulation into the ampulla of Vater. This success was a cornerstone to connect bilio-pancreatic disease and endoscopy. He was a surgeon of George Washington University and succeeded under markedly difficult conditions with an Eder fiberscope under general anesthesia. He succeeded in observations of the ampulla of Vater in 50% and cannulation in 50% of such cases. Therefore, pancreatography was successful in about 25%, while there was no description about cholangiography.

At that time, there existed no endoscope that allowed smooth insertion to the descending limb of the duodenum via the pyloric ring of the stomach and observations of the ampulla of Vater squarely without general anesthesia. The struggle of McCune was described. It was necessary to keep a distance in the duodenum for cannulation into the ampulla of Vater and he used a balloon for assistance to keep a distance in the duodenum.

a. Development of a duodenoscope

At that time, it was almost impossible to insert a gastrofiberscope into the descending limb of the duodenum without general anesthesia. Therefore, development of a duodenoscope was imperative and a duodenoscope was constructed in Japan (2) (3).

At first, a duodenoscope FDS was constructed by Machida Factory, and then a duodenoscope JF-B by Olympus Co. A panning system with two-direction angulation was adopted in FDS, while four-direction angulation in JF-B. Competitions of development were repeated at academic meetings in Japan (2) (3). A catheter for injecting

a contrast medium was directed from the right forceps channel to the center of the image, and the basic design has been unchanged to date. Since insertion of a gastroscope into the duodenal bulb via the pyloric ring of the stomach was troublesome, a flexible structure and three grades of rigidity were adopted for the tip of the duodenoscope. To reach this stage, tremendous efforts of endoscopists and technicians were required (2) (3).

A duodenoscope JFB2 (Olympus) was constructed and its clinical application was extended worldwide. Development of a duodenoscope was the main theme at the World Congress of Gastroenterology in Rome and Copenhagen and World Congress of Gastroenterology and Endoscopy in 1970.

Fujinon and Pentax constructed duodenoscpes afterwards. Specifications of the scopes are shown in Figure 1.

b. Introduction of pioneers

Oi et al (4) (5) reported that they succeeded in pancreatography in more than 80% and they were applauded at the world meeting in 1970. His first pancreatography was carried out on April 18, 1969. It was confirmed that pancreatography was easier than cholangiography. Takagi et al (6) carried out the first case in June 6, 1969 in which cholangiography was obtained simultaneously as well as pancreatography . A number of clinical ERCP cases were reported at International Congress of Gastroenterology and Endoscopy (Paris) in 1972. Main themes included diagnosis of pancreatic cancer, selective cannulation into the bile duct, and diagnosis of chronic pancreatitis etc.

Japanese endoscopists who were at the frontier at that time are as follows : Takagi and Ikeda from Cancer Institute Hospital, Hara and Ogoshi from Niigata Cancer Center, Kasugai from Aichi Cancer Center, Kawai and Nakajima from Kyoto Prefectural Medical College, Ashizawa and Shindo from Tokyo Medical College, Fujino and Niwa from University of Tokyo, Sohma and Fujita from University of Tokyo Branch Hospital, among others. Demling, Classen (West Germany) , Cotton (UK) , Salmon (UK) , Liguory (France) , Silvis (USA) , Venes (USA) ,Geenen (USA) , Siegel (USA) and others were the Western counterparts. Some of them were introduced in the book entitled Digestive Endoscopy in the Second Millennium edited by Francisco Vilardell (7).

c. History of insertion techniques

History of insertion techniques started with pushing and angulation and later the pulling back method became the mainstream. The reason why the right angle of the duodenoscope is larger than the left angle is that insertion started with the pushing and angulation method and the modification was aimed at facilitating cannulation.

With regard to the patient posture during the examination, the left lateral position or supine position, as for gastroscopy, was employed at first, but the prone position has mostly been selected recently.

d. EPCG or ERCP

As for the term of the technique, endoscopic pancreatocholangiography （EPCG） was mostly used in Japan (2) (3) (4) (5) (&), but terms for the technique were unified as endoscopic retrograde cholangiopancreatography （ERCP） at the consensus meeting of the World Congress of Gastroenterology in Mexico in 1974 and it has been used to date. At that time, few papers were submitted to English journals and priceless papers were mostly published in not only Gastroenterological Endoscopy, an official journal of the society（JGES）, but also Stomach and Intestine etc, a commercial journal in Japanese,
with or without English abstract. The reason why the technique was not widely known as EPCG in Western countries may be attributable to such facts. It was heard that there was a discussion as follows： “The word retrograde should be included in the term. Pancreatocholangiography is not appropriate alphabetically. Cholangiopancreatography is accurate.”

e. Indicated diseases

As ERCP developed, it became possible to diagnose chronic pancreatitis, pancreatic cancer, intraductal papillary mucinous neoplasm （IPMN）, biliary duct cancer, gallbladder cancer, bile duct calculi, cholecystolithiasis, sclerosing cholangitis, and anomaly of fusion of the bilio-pancreatic duct, autoimmune pancreatitis and their diagnostic criteria were established. The diagnostic criteria for chronic pancreatitis, established

by Kasugai et al (8) and Banks et al (9) have been used to date.

Although diagnostic criteria for pancreatic cancer were reported, few of them are being used currently. Pancreatography is successful in more than 95%, while cholangiography in only more than 85% and the cause of the gap has been studied. However, as ERCP techniques have changed from the pushing and angulation method to the pulling method, successful rates of selective cholangiography have improved.

f. ERCP or MRCP

According to MRCP developed, diagnosis by ERCP with a high risk shifted to that by MRCP. As to adverse events by ERCP, the cause of severe acute pancreatitis has not been clarified and pancreas stenting has been tried, but there is no reliable preventive method. In terms of diagnosis, techniques have shifted to MRCP, CT, US and EUS. At least in obstructive jaundice cases, MRCP has become the first choice. In addition, dilatation of the proximal pancreatic duct, observed in cases with pancreatic head cancer, is often difficult to diagnose by ERCP but it is easily visualized by MRCP (10).

2. EST

Classen et al on June 6, 1973, Kawai et al on August 10, 1973, and Sohma et al on June 11, 1974 succeeded in the incision of the ampulla of Vater. The papillotome that Kawai et al used for the first time was in a shape of an arrowhead (12). The push model papillotome, which was generally used later (13), was originally devised by Sohma et al (11).Classen et al (14) constructed a knife by themselves and it was a pull model papillotome. A description of a Sohma type papillotome is found in the literature (7). A symposium on endoscopic papillotomy was held at the World Congress of Gastroenterology in Mexico in 1974, and the preliminary results were reported.

Duodenoscopes by Olympus Co. have been mostly used. A metal part was exposed at the forceps channel at the tip of the duodenoscope, therefore the wire of the papillotome was broken due to the contact with the metal part when electricity was applied. In addition, there was a leak at the eye piece because duodenoscopes were fiberscopes at that time, and skin burn was caused. Gradually, mechanical setting and

devices were improved and the position of the forceps channel was lowered. The tip of the duodenoscope was replaced with an isolation material.

a. EPT or ES （EST）

Sphictero-plasty of the ampulla of Vater, conventionally done surgically, was a technique to completely incise the sphincter and suture the incised surface carefully, whereas hemostasis and knotting were impossible by endoscopy. Surgeon Sohma explored this surgical technique.

As to the term of the technique, endoscopic duodenal papillotomy, endoscopic sphincteropapillotomy of Vater, endoscopic papillotomy （EPT）, and endoscopic sphincterotomy （ES/EST） were reported. They were gradually unified into ES （EST）. In Europe, there is a group that has adhered to the term EPT. The aim was removal of common bile duct stones. It was clinically applied earlier and became prevalent in Europe and later in Japan and U.S.

b. Lithotripsy

Only an incision was made at the first session. Delivery of a stone was expected and excretion in the stool was confirmed. Later, basket extraction was employed. It was possible to incise by ES （EST） but neither hemostasis nor knotting was available and avoidance of postoperative hemorrhage was sought. The technique failed to satisfy the three principles of surgery, i.e., “incision, hemostasis, and knotting” and it was criticized by surgeons. With this topic set aside, filtration of the stool used to be carried out to confirm the elimination of stones.

In 1974 and later, techniques to extract stones with a basket catheter immediately after an incision became prevalent. As complications at that time, cholangitis, obstructive jaundice due to stone impaction, acute pancreatitis, and hemorrhage accounted for 5 – 10%. On the other hand, Starlitz, et al. devised and reported in 1983 a technique to dilate the ampulla of Vater with a balloon catheter and extract stones. Recently balloon catheters were improved and this method was revived, but the technique was indicated only for small stones.

c. Endoscopic drainage

Nagai, et al. first reported that they endoscopically inserted a catheter into the bile duct for drainage. The aim was to obtain samples for cytology, but this is the origin of naso-biliary drainage. Soehendra, et al. succeeded in biliary drainage with a pig tail stent and dramatically advanced treatment for cholangitis and obstructive jaundice, but incidence rates reached 30 – 50%. Huibregtse, et al. reported a technique to use a large-bore straight stent and it has been updated until today.

In 1980s, a metallic stent replaced a plastic stent that had been employed so far. However, compared with a plastic stent, a metallic stent was too expensive and the stent patency period was superior, but it was found that survival rates were comparable.

Drainage for a Klatsukin tumor or hilar biliary cancer has become possible. However, replacement of a stent is unavoidable because of clogging and the duration of a plastic stent is thought to be about three months. It is generally considered that a metallic stent is for malignant biliary stenosis and a plastic stent for pancreatic stenosis.

The method to carry out only drainage and leave biliary stones untouched in the elderly patients with a high risk has been reported. Stenting is an indispensable treatment technique for obstructive jaundice due to a malignant lesion.

d. Application of interventional EUS

Endoscopic ultrasonography, developed in 1975 or later, was employed at first to examine pancreatic cancer and biliary cancer. Since the introduction of EUS-fine needle aspiration cytology （EUS-FNA）, EUS has been used for treatment of bilio-pancreatic disease. EUS-biliary drainage （EUS-BD） and EUS-choledocho-duodenostomy （EUS-CDS） have been reported. This field is expected to advance further. Details of EUS are left to other sections.

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Figure 1

Specifications of the duodenoscopes

Company	Machida	Olympus	Fujinon	Pentax
Scope	FDSL	JFB	FDQB	FD32A
Length（mm）	1465	1250	1500	1600
View system	lateral panning60	lateral	lateral	lateral retrofx10
Width of view	52	70	64	83
Length of the tip	28.5	20	17	21.4
Angulation	u：120 d：90	rl：90 ud：120	rl：120 ud：90	rl：100 ud：135
Date of sale	1970	1970	1975	1981
Scope at present	none	TJF260 fc：4.2 JF260 fc：3.7	ED-530XT8 fc：4.2	ED3490TK fc：4.2

u：up, d：down, rl：right and left, fc： forceps channel

retrofx： retroflex

1ST OMED SPRING MEETING

ROME, ITALY, MAY 4 AND 5, 2003

Scientific Program

Sunday, May 4
1st Session: 10 a.m. 12 noon

President: H. **Niwa** (Japan)
Chairmen: M. **Kitajima** (Japan) – S.J. **Winawer** (USA)

- Early or Superficial esophago-gastric cancer: a question of semantics or different clinical entities?
  R. **Lambert** (France)
- Early gastric carcinoma; Its mucin phenotypes and their biological behavior
  H. **Watanabe** (Japan)
- Chromoscopy, NBI and new technologies in the endoscopic diagnosis of early gastric cancer
  R. **Fujita** (Japan)
- The burden of gastric cancer worldwide and the available screening options
  S.J. **Winawer** (USA)

Sunday, May 4
2nd Session: 2 p.m. 4.30 p.m.

President : H. **Niwa** (Japan)
Chairmen: J.R. **Armengol-Mirò** (Spain) – M. **Classen** (Germany)

- The role of echoendoscopy in the management of superficial (early) esophago-gastric cancer
  T. **Ponchon** (France)
- Endoscopic mucosal resection by cap-fitter method
  K. **Takeshita** (Japan)
- New technology of endoscopic mucosal resection
  N. **Yahagi** (Japan)
- Endoscopic techniques to improve the diagnosis of MALT lymphomas
  L. **Buri**, M **Sozzi** (Italy)
- Problems in diagnosis and endoscopic treatment for Barrett's esophagus and dysplasia
  M. **Classen** (Germany)

Monday, May 5
8.30 a.m. 10 a.m.

President : H. **Niwa** (Japan)
Chairmen: A. **Nowak** (Poland) – R. **Fujita** (Japan)

- Endoscopic (endovisceral) treatment of gastro-esophageal reflux
  G. **Costamagna** (Italy)

- Ethical problems of PEG
  M. **Del Piano** (Italy)

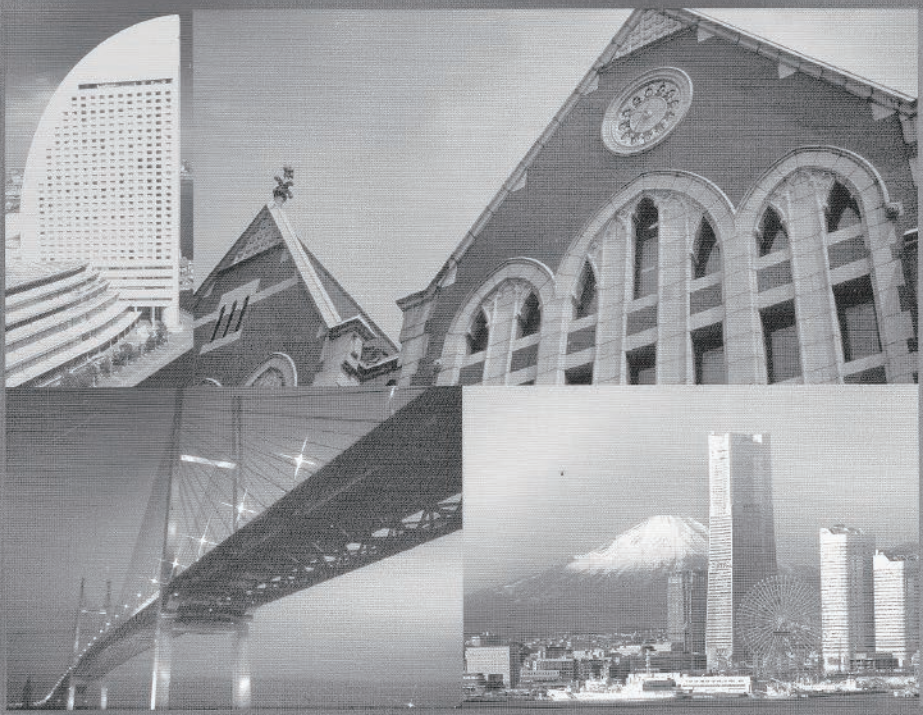
- Laparoscopy-assisted gastric surgery
  S. **Kitano** (Japan)

CLOSING REMARKS:
M. **Crespi**, A. **Montori** (Italy)

OMED

IGCA

2nd OMED SPRING MEETING ABSTRACTS



ORGANISATION MONDIALE
D'ENDOSCOPIE DIGESTIVE

CONTENTS

Organisation
Mondiale
d'Endoscopie
Digestive

OMED

INTERNATIONAL GASTRIC CANCER ASSOCIATION IGCA

2nd OMED Spring Meeting

DATE

Wednesday, May 4 , 2005

VENUE

Pacifico Yokohama

1-1-1, Minato Mirai, Nishi-ku, Yokohama-shi,

Kanagawa 220-0012, Japan

Organisation Mondiale d'Endoscopie Digestive

Greetings

I would like to offer my compliments for the second OMED Spring Meeting being held here in Yokohama. The 6th International Gastric Cancer Congress had been planned under the chairmanship of Professor Masaki Kitajima, and thanks to his great help, we have been able to hold this OMED meeting jointly with the 6th International Gastric Cancer Congress today. I would like to offer my deepest gratitude to the great trouble and effort of Professor Kitajima.

The first OMED Spring Meeting had been held in Rome 2 years ago, taking the opportunity of the 5th International Gastric Cancer Congress. It was realized by dedicated effort of Professor Massimo Crespi, the former president and now the adviser of OMED that I myself preside at the moment, and Professor Alberto Montori who has always extended the kindest courtesies to our activities. With splendid lectures by renowned doctors and a great many numbers of attendees, the first OMED Spring Meeting turned out as an exceptional success.

Because the first meeting went very successfully, Professor Crespi requested Professor Kitajima to jointly hold the OMED Spring Meeting every time the International Gastric Cancer Congress is assembled. Gaining Professor Kitajima s willing agreement, we were able to realize the second OMED Spring Meeting with this substantial program today.

I am so honored and obliged as the president of OMED to be able to have this meeting with many scheduled presentations. Although the OMED Spring Meeting is only for one day same as the last time, the 6th International Gastric Cancer Congress and the Congress of Japanese Gastric Cancer Association will last longer. I believe the attendees will find this opportunity very informative.

There will be presentations of the findings of the many years of studies by the lecturers from Japan nationwide and from overseas. I sincerely hope this meeting will make a great success again. Thank you very much.

H. Niwa

Hirohumi Niwa, M.D.
President
OMED

Dear Colleagues,

We are delighted and honored to host the 6th International Gastric Cancer Congress in Yokohama, Japan. Focused on the theme of "Strategies for Gastric Cancer Treatment in the 21st Century: Minimally Invasive and Tailored Approaches-Integration of Basic Science and Clinical Medicine," the congress promises to be a highly rewarding gathering. With over 800 interesting and varied abstracts submitted for this congress, we believe it proves to be a valuable and enjoyable gathering that contributes significantly to further advances in the field. We look forward to fresh and exciting input from young researchers who join us as well as important contributions from the many more senior experts who attend to this congress.

Since the first congress in Kyoto in 1995, we have seen remarkable progress in the diagnosis and treatment of gastric cancer. Our gathering of the world's experts at this congress to present their findings, which aid humankind by advancing the knowledge of gastric cancer treatment, is the greatest feat we can ever hope to achieve.

Recently, with the spread of such new techniques as endoscopic mucosal resection (EMR) and laparoscopic surgery, minimally invasive approaches have become more commonly used for early treatment. Also, progress has been made in treatment of advanced cases, as high response rates are being achieved in chemotherapy development and the benefits of radiotherapy are being re-explored.

Given such progress, my fellow organizers and I are very excited about hearing the many enlightening presentations that all of you have to offer. We are also eager to have young, motivated researchers attend, and thus we have set the registration fee at a reasonable rate.

Turning to our venue, Yokohama is an attractive, cosmopolitan port city. For nearly one hundred and forty years, it has been a key gateway to the rest of the world. As such, it offers a fascinating blend of traditional Japan and international flavor, giving it a robust, rich atmosphere found in few other places. Visitors find its many exotic charms, enduring traditions, and inspiring modern architecture to be irresistible.

The Second Spring Meeting of OMED (Organisation Mondiale D endoscopie Digestive) is held in conjunction with the 6th International Gastric Cancer Congress.

We congratulate the 2nd Spring Meeting, and honored to share the time in Yokohama together.

We thus enthusiastically invite you to join us in Yokohama in 2005. We are confident that each and every participant has an enjoyable and memorable stay, and return home with a richer, more knowledgeable understanding of not only the growing field of gastric cancer, but also Japan and the Japanese.

M Kitajima

Masaki Kitajima, M.D., F.A.C.S.
President
6th International Gastric Cancer Congress

OMED Spring Meeting 2005 Yokohama (6th IGCC)
Program

Date: May 4, 2005
Venue: Pacifico Yokohama

Chairman: Prof. R. Fujita

8:25-8:30 **Opening Address Prof. H. Niwa (President of OMED)**

8:30-8:35 **Welcome Adress Prof. M. Kitajima (President of 6th IGCC)**

Moderators: Prof. Crespi, Prof. Fujita

8:35-8:50	(1) Consensus meeting report for Barrett epithelium (Paris Workshop) –Pathology– H.Watanabe (J)
8:50-9:05	(2A) Consensus meeting report for Barrett epithelium (Paris Workshop) –Endoscopy– H. Inoue (J)
9:05-9:20	(2B) Terminology committee report –Colorectum– M. Crespi (It)
9:20-9:35	(3) Terminology committee report –Upper G-I and Bilio-Pancreatic d.– M.A. Fujino (J)
9:35-9:50	(4) Screening test for gastric cancer by serum pepsinogen M. Ichinose (J)

9:50-10:00 **Discussion**

10:00-10:30 **Coffee Break**

Moderators: Prof. Saigenji, Prof. Montori

10:30-10:45	(5) Endoscopic screening for hypopharinx and esophageal cancer by NBI M. Muto (J)
10:45-11:00	(6) Endoscopic screening for gastric cancer by NBI J. Fujisaki (J)
11:00-11:15	(7) Colorectal cancer screening program M. Crespi (It)
11:15-11:30	(8) Endoscopic submucosal dissection for early gastric cancer T. Oyama (J)
11:30-11:45	(9) Endoscopic and surgical integrated approach in the treatment of GI diseases A. Montori (It)
11:45-12:00	**Discussion**
12:00-13:30	**Lunch**

Moderators: Prof. Fujino, Prof. Armengol-Miro

13:30-13:45	(10) Laparoscopy assisted partial resection for early gastric cancer H. Yamaguchi (J)
13:45-14:00	(11) Magnifying endoscopy for colorectal cancer S. Tanaka (J)
14:00-14:15	(12) Endoscopic approaches for Bilio-pancreatic malignancy JR Armengol-Miro (Sp)
14:15-14:30	(13) Endoscopic management of surgical failure and Surgical management of endoscopic failure A. Montori (It)
14:30-14:45	**Discussion**
14:45-14:50	**Closing Remarks Prof. Alberto Montori**

ABSTRACTS

Organisation
Mondiale
d'Endoscopie
Digestive

Consensus meeting report of Barrett's epithelium (Paris Workshop) —Pathology—

H. Watanabe

PCL Japan and Niigata University, Japan

Since Barrett's demonstration (1950) of the chronic ulcers developed in the esophagus lined by a columnar epithelium, much development and interests have been taken and as well many problems have occurred. The key problems are the confusion of accurate and precise definition of the esophagogastric junction at the clinical images and pathological definition of Barrett's esophagus, and not enough understanding of cardiac mucosa.

In Paris workshop on the endoscopic morphology of the esophagogastric junction and Barrett's esophagus (December 11-12, 2005, in Paris), we all agreed to speak the same language and use the same definitions on the esophagogastric junction and Barrett's esophagus in practical image diagnosis and in pathology for understanding each other, resolving the problems, and comparing data from basic science and clinical medicine.

Today I will make the brief pathology reports in the consensus meeting one by one lined below;

1) Definition of esophagogastric junction in a daily practice:
   * Clinical definition;
      (1) the proximal margin of gastric folds,
      (2) the distal margin of longitudinal palisading vessels
   * Pathological definition;
      (1) Normal condition; squamo-columnar junction (SCJ)
      (2) Abnormal conditions; Distal margin of ;
         # esophageal gland or duct distal to the SCJ
         # residual squamous island distal to the SCJ
         (exclude squamous metaplasia)
         # double-layered muscularis mucosae

2) Endoscopic grading of Barrett's esophagus
   New criteria: The Prague C/M criteria
      C: Circumferential extent of Barrett s esophagus
      M: Maximal extent of Barrett s esophagus
3) Pathological definition of Barrett's esophagus: Columnar cell replacement of squamous epithelium proximal to the EGJ
4) Is intestinal metaplasia necessary for the definition of Barrett's esophagus or not?
5) Classification of cardiac mucosa

Report of "Consensus meeting for Barrett esophagus, Paris workshop"

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Lambert R and Sharma P mainly organized this consensus meeting, endorsed by OMED and WHO. From Japan, doctors of Niwa H, Fujita R, Watanabe E, Kozu T, Hoshihara , Endo T and Inoue H attended this meeting. Topics regarding to Barrett esophagus were generally discussed for consensus..

1. Position of Gastro-esophaeal junction
Western colleagues consider that proxismal end of Gastric fold indicates the position of original (anatomical) gastro-esophageal junction. On the other hand Japanese colleagues advocate the distal end of palisading vessels corresponds to original gastro-esophageal junction. It demands further study to conclude it, but at this moment when we can recognize palisading vessels it is considered to demonstrate accurately the position of original gastro-esophageal junction.

2. Magnifying endoscopy
Endo T et al advocated a classification of Barrett epithelium according to the surface pattern using magnifying endoscopy. Its outcomes are generally accepted, but still in some cases magnifying endoscopic findings are not corresponding to histological reports. Therefore it was confirmed that we continue to evaluate it in the future.

3. Recognition of high-grade dysplasia
In the typical case of high-grade dysplasia, the localization and margin of the high-grade dysplasia can be easily demonstrated. Irregular pit pattern with abnormal fine vessel in the affected area is characteristic to high-grade dysplasia. But in some cases these endoscopic findings are not corresponding to histological results, therefore we need a further evaluation to this matter..

4. Description of Barrett esophagus
CM classification advocated Sharma P et al was presented by himself. C factor is the length of circumferentially developed Barrett's epithelium and M factor demonstrates maximum length of Barrett' s epithelium. Almost all the colleague agreed it usefulness of the clinical use.

Anyway, we need to continue to discuss topics regarding to the Barrett's esophagus in the future. At that time, histologically proven discussion was strongly recommended.

The OMED Minimal Standard Terminology (MST) for Colon and Rectum

M. Crespi, A. Grassi

National Cancer Institute "Regina Elena", Roma, Italy. OMED Committee for Standardization and Terminology

Standardization of data format for creation of endoscopic reports has become one of the major issues for the development of digestive endoscopy over the last decade.

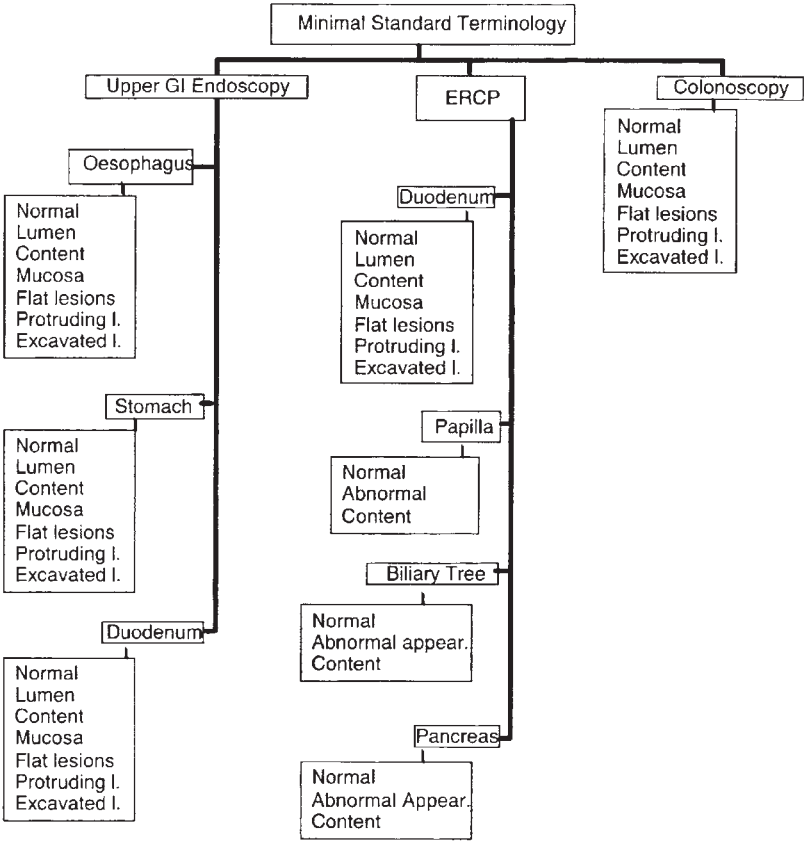
The Minimal Standard Terminology developed initially by ESGE and now endorsed by OMED, addresses the following parts of the endoscopic report: the **reasons for performing an endoscopy**; the **endoscopic findings**; and the **endoscopic diagnosis**. An additional section provides a list of terms describing the **diagnostic and therapeutic procedures** that can be performed during an endoscopy. It is organized by type of endoscopy -upper GI Endoscopy, Colonoscopy, ERCP and, within each type, by organ examined (Figure 1). The original aim of the Committee, which designed the MST was to provide a comprehensive list of terms, addressing at least the 95 % of routine endoscopic examinations and containing only terms that are used in at least 0.1 % of the examinations.

The *"Reasons for"* contains a list of terms that is larger than "indications", which are frequently restricted by regulatory authorities and/or health insurance systems. This list is divided into various categories, like symptoms, diseases, sampling and screening purposes and, for ERCP, a list of the therapeutic procedures. *"Findings"* have been classified within each organ according to the OMED Terminology proposed several years ago by Professor Maratka, which organizes the terms in various categories. Each term describing an endoscopic finding is linked to several attributes or modifiers which can be used for specifying the appearance, the number, the size and other characteristics of the lesion that are necessary arguments for the clinical decision. A list of anatomic references, or sites, is also provided for each organ in order to precisely locate the endoscopic findings. Finally, the list of *"endoscopic diagnoses"* contains diseases that may constitute the diagnoses made at the end of the procedure based on the findings observed, but not taking into account further results, like, for example, histopathological examination of biopsy specimens. This list is organized in two sections, according to the frequency of the diseases. The first section contains the *"Main diagnoses"*, listed by frequency and the second, the *"Other diagnoses"* listed by alphabetic order. For each of these diseases, an attribute can be used to state the degree of certainty of the diagnosis.

The MST should form the basis of softwares aimed to produce endoscopic reports from a structured language approach and is promoted actively with the OMED member Societies

The presentation will deal with the Section of MST devoted to Colonoscopy, with examples related to the most frequent endoscopic pathological findings.

Figure 1.


Minimal Standard Terminology
Upper GI Endoscopy
ERCP
Colonoscopy
Normal
Lumen
Content
Mucosa
Flat lesions
Protruding l.
Excavated l.
Oesophagus
Normal
Lumen
Content
Mucosa
Flat lesions
Protruding l.
Excavated l.
Stomach
Normal
Lumen
Content
Mucosa
Flat lesions
Protruding l.
Excavated l.
Duodenum
Normal
Lumen
Content
Mucosa
Flat lesions
Protruding l.
Excavated l.
Duodenum
Normal
Lumen
Content
Mucosa
Flat lesions
Protruding l.
Excavated l.
Papilla
Normal
Abnormal
Content
Biliary Tree
Normal
Abnormal appear.
Content
Pancreas
Normal
Abnormal Appear.
Content

Terminology Committee Report -Upper GI and Bilio-Pancreatic Disease-

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Since the publication of a textbook on Minimal Standard Terminology (MST) from Normed Verlag in 2002, the committee has been discussing on incorporation of the terms for superficial neoplastic lesions and for capsule endoscopy and on revision of the for the terms for additional procedures. Meanwhile, the development of double-balloon endoscopy has impacted the world of digestive endoscopy.
It was quite timely that the Paris classification of superficial neoplastic lesions was published in December 2003 in the journal Gastrointestinal Endoscopy. Considering the current situation, it will be a natural consequence to incorporate this Paris classification into the MST as the necessary terms for superficial neoplastic lesions.
The terms required for double-balloon endoscopy will be introduced in the section on additional procedures for the time being. MST for capsule endoscopy will be newly added.
The section on ERCP has already been highly completed; the terms related to newly evolving concepts on cystic neoplastic lesions would be added.
Diffusion of MST in wider circle of endoscopists must be the step realized for the terminology committee.

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High Risk Population for Gastric Cancer and Strategy for the Screening

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Despite a consistent decline in incidence throughout the world, gastric cancer is still one of the leading causes of cancer-related death in Japan; more than 50,000 people die from the cancer every year. Therefore, gastric cancer screening program was introduced in the 1960s as a public health service that has gradually extended to include the whole nation. Currently, screening is performed throughout the country and more than five million people annually undergo screening provided by either a community service or the workplace. As a result, thousands of gastric cancer cases are detected each year, and the cancer screening has greatly contributed to the reduction in the gastric cancer mortality rates. Screening most frequently includes the use of double contrast barium X-rays or panendoscopy. Several retrospective studies reveal a substantial reduction in mortality rates from gastric cancers due to screening. Nationwide gastric cancer screening has been an unparalleled success, however the number of people screened has not increased and the cancer screening covers only 7.25% of the cancer-prone aged population throughout Japan. Furthermore, the sensitivity of the barium x-ray is not very high (sensitivity for early stage cancer is 39% and that for advanced cancer is 92%). Also due to its low resolution, the barium X-ray is usually only indicative of abnormalities in the stomach mucosa, therefore more than half of the early cancer cases are not diagnosed. Recent addition of pepsinogen in the screening strategy has significantly increased the detection rate of gastric cancer.

Serum pepsinogen level has been identified as a sensitive marker for chronic atrophic gastritis together with intestinal metaplasia, a well-known precancerous lesion. Serum pepsinogen tests were introduced for mass screening to identify individuals at high risk for gastric cancer. Individuals testing positive for extensive atrophic gastritis based on their serum pepsinogen levels undergo endoscopic examination or high quality barium X-ray to test for the presence of gastric cancer. The objective of the presentation is to describe the current status of the serum screening for gastric cancer in Japan. In addition, we would also like to demonstrate a new cancer screening strategy based on the result of a longitudinal cohort study which has investigated the relationship between the progression of H. *pylori*-related gastritis and the development of gastric cancer.

Endoscopic screening for cancer in the hypopharynx and esophagus by NBI.

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Detection of the neoplasms at an earlier stage in head and neck (H&N) mucosal sites would obviously be of great merit to the patients, because most of the H&N cancer, especially cancer in the hypopharynx, is usually diagnosed in an advanced stage at presentation and the extensive surgical resection subsequently causes a loss of function for swallowing and/or speaking. While numerous endoscopists have passed the endoscope, it is extremely difficult to detect a carcinoma at an early stage such as high-grade intraepithelial neoplasia in this region during routine endoscopic examination.
In addition, the development of synchronous and metachronous squamous cell carcinoma in the H&N region and the esophagus have been well known as the "field cancerization" phenomenon. While this phenomenon is usually associated with repeated exposure to carcinogens such as alcohol and cigarette smoke, no effective and ideal screening and follow-up strategies have been developed.

Narrow Band Imaging
Narrow band imaging (NBI) is a new endoscopic system based on narrowing the bandwidth of spectral transmittance of the red-green-blue (RGB) optical filters (1,2). The NBI system has been developed as a part of the joint research between Japanese National Cancer Center Hospital East and Olympus Corp. (Tokyo, Japan) by supporting of Grant for Scientific Research Expenses for Health and Welfare Program since 1999 (3). The conventional RGB (red/green/blue) medical video-endoscope system (EVIS 240, Olympus Corp.) has a xenon lamp and rotation disk with three RGB broadband optical filters covering all spectra of the visible wavelength, which ranges approximately from 400 to 800 nm. The NBI filter sets (415±30nm, 445±30 nm, 500±30 nm) were selected to obtain fine images of the microvascular structure. Since the 415 nm is the hemoglobin absorption band, the thin blood vessel such as capillaries on the mucosal surface can be seen most clearly on this wavelength. Therefore, NBI combined with magnifying endoscopy makes it possible to clearly observe the microvascular architecture in the superficial lesion of the gastrointestinal mucosa.
We recently reported that magnified NBI easily visualized the scattered foci of microvascular proliferation in the squamous cell carcinoma in situ in the hypophaynx (4-6). Such changes are hardly identified by conventional endosocpy.

High Risk Group of Cancer in the Hypopharynx and the Esophagus
We recently identified the critical determinants of the phenomenon of "field cancerization" (7-10). Combination of inactive ALDH2 and slow-metabolizing ADH3 leads to an increase risk of this phenomenon.

Multicenter Randomized Control Study on NBI
To introduce NBI as screening method in the clinical practice, rigorous evaluation is required. To compare the detection rates of early cancer in the H&N region and the esophagus between conventional image and NBI, we have started a multicenter randomized control study on NBI using subjects at high-risk.

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Endoscopic screening for gastric cancer by Narrow Band Imaging(NBI)- Investigation for superficial microvascular pattern of early gastric cancers-

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[Aim] Most of early gastric cancers can now be treated endoscopically. However, lateral spread and depths of the cancer are often difficult to define. The narrow-band imaging (NBI) is a newly developed device, which brings about an information of the microvascular structure of GI mucosa. An aim of this study is to investigate the usefulness of the magnified NBI for more accurate endoscopic diagnosis of the early gastric cancer. [Patients and methods] We observed endoscopically 100 early gastric cancers with the magnified NBI from January to October 2004. An Olympus electronic zoom endoscope Q240Z with a lucent hood on its tip was used in this study. The superficial microvascular (SMV) pattern with magnified NBI of the cancers was collated with the histology of the resected cancers. [Results] The appearances of SMV pattern with the magnified NBI were classified as follows; fine-network, oval, spiral, and irregular patterns. Well-differentiated adenocarcinomas typically showed fine-network pattern (sensitivity: 55 %, specificity: 98 %, n=51). Moderately differentiated adenocarcinomas typically showed oval or spiral pattern (sensitivity: 58 %, specificity: 90 %, n=6). Poorly differentiated adenocarcinomas typically showed irregular pattern (sensitivity: 90 %, specificity: 96 %, n=20). An immunohistochemical study with CD34 was performed on the histology corresponding to the SMV pattern for each histological type and compared to the image of SMV pattern. The margin of the cancer was more clearly defined in cases of depressed type ("IIc") early gastric cancer. However, in cases of elevated type ("IIa") early gastric cancer, the margin was not so clearly demarcated. [Conclusion]The SMV pattern using magnified NBI observation was useful for the pretreatment histological evaluation of the early gastric cancer and for the accurate demarcation of the margin of the depressed type (IIc) of early gastric cancers.

COLORECTAL CANCER SCREENING PROGRAMS

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Introduction

Globally Colorectal Cancer (CRC) is one of the most frequent causes of cancer deaths in more developed countries, whereas is only the fourth if we consider worldwide mortality. Men and women are equally affected.

The CRC is preventable and highly curable. Unfortunately, most men and women are unaware of this disease and the benefits of screening and early diagnosis are not achieved, even when symptoms became apparent.

In the European Union, in 1997, there were 213,111 incident cases (ASR-W 29.67) and 110,669 deaths for CRC (ASR-W 13.93). The trend in incidence from 1970 to 2006 shows a steady increase in all the European countries, whereas in the USA there is downward trend starting in 1985. In addition, a downward trend in CRC mortality was observed in the USA from 1974, while in Europe mortality is stable from 1985.

These differences may be partially explained by the diffusion of endoscopic procedures (colonoscopy) with the consequent removal of precursor lesions, namely adenomatous polyps. In fact, in a recent report by Lieberman et al., out of 17,732 average risk subjects invited for a screening colonoscopy, 36.6% had already performed a colonic examination in the previous 10 years.

The 1997 Behavioral Risk Factor Surveillance System indicated that in US 20% of age-eligible surveyed participants reported a fecal occult blood test within the previous year, 30% reported a flexible sigmoidoscopy within the previous 5 years, overall 41% reported having had one or the other of these tests, and 10% reported having had both tests. In Japan CRC is on steady increase both as incidence and mortality.

A reduction in mortality of CRC may be achieved as the result of:

1) diagnosis at an earlier stage;
2) removal of adenomatous polyps.

In fact it has been demonstrated that the removal of adenomas reduces significantly the incidence, and therefore mortality, of CRC.

In populations at low incidence it is important to aim the screening initiatives to subjects at high risk. High risk may be defined as individuals with:

- age over 60 years
- one or more first degree relatives (parents, siblings) with CRC or adenomatous polyps
- familiar aggregation of CRC beyond the first degree relatives
- genetic syndromes, like Familiar Adenomatous Polyposis (FAP) and Hereditary Non Polyposis Colorectal Cancer (HNPCC).

Of interest for the consequent surveillance examinations is also the concept of "advanced adenoma", defined as adenomatous polyps with:

- a diameter larger than 1 cm
- more than 25% of villous component at histology
- high grade dysplasia (including what is sometimes defined as "in situ" or intramucosal carcinoma)

In addition:

- the number of adenomas (more than 3) is also a risk factor
- invasive cancer within an adenoma (when cancer cells spread beyond the muscularis mucosa) has to be considered already a cancer stage Dukes A, but has a highly satisfactory clinical outcome and it is a good target for secondary prevention.

Objectives

The reduction in mortality of CRC may be achieved as the result of:

1) diagnosis at an earlier stage;

2) improvement in overall treatment care;

3) removal of adenomatous polyps, which is also reducing the incidence of CRC.

Possible actions

Primary prevention of CRC may be achieved observing a low-fat diet, high in fruit and vegetables. In general a low calories intake and regular physical exercise seem to be responsible for the protective effect.

Secondary prevention of CRC may be achieved using some screening tests; those tests, well known to gastroenterologists worldwide, may save lives by detecting colorectal cancer in its earliest, most curable stage, and by detecting and removing polyps. The tests available are 1) fecal occult blood test (FOBT), widely employed and easily acceptable by healthy subjects; 2) Colonoscopy, allowing also the removal of adenomas and the procedure of choice in high-risk subjects.

The future

Being colorectal carcinogenesis the result of a series of acquired genetic alterations that occur in colonic epithelial cells, is now possible to recover analyzable DNA from the stools and test for the presence of these genetic alterations. Another screening test is virtual colonoscopy (VC) based on computed-tomographic colonography.

Conclusions

These screening test, while promising, need to be validated in large population trials.

Endoscopic submucosal dissection for early gastric cancer

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Introduction

Conventional EMR is an easy and safe method for small lesions. The specimens resected by EMR are often too small, so piece-meal resection was performed for the large lesions. A precise pathological examination of resected specimen is very important to decide whether the patient needs additional treatment or not. A precise histological examination may be difficult with piecemeal-resected specimens removed by EMR. Moreover specimens resected with EMR method are sometimes damaged by forceps or aspiration retrieval. Therefore, we developed a novel endoluminal surgery method, endoscopic submucosal dissection (ESD) with the hook knife to enhance en-bloc infections.

Indication

Endoscopic treatment should be indicated to the gastric cancer without lymph node metastasis. The database of the Japanese Gastric Cancer Association suggests that if the cancer was differentiated type and limited in the mucosal layer, the incidence of lymph node metastasis has been 0.4%. And two cm is the upper limit of en-bloc resection with conventional EMR. Therefore, JGCA decided the indication of EMR as follows; a mucosal differentiated adenocarcinoma those size was 2cm or less.

But, a large and precise en-bloc resection could be performed with ESD. Therefore, the indication of ESD has been extending.

Procedure of ESD with the hook knife

Marks are put around the lesion using the hook knife with 40W forced coagulation mode (VIO 300D, ERBE). Next, glycerol is injected into the submucosal layer to separate the mucosa from the proper muscular layer. Then, an initial mucosal cut is made using the backside of hook knife with dry cut mode (60W, effect 5). After that, the mucosa is hooked with the hook knife from the submucosal side to the esophageal lumen and cutting is repeated. Surrounding mucosal incision can also be done. Finally, the submucosal fibers and vessels are cut using the hook knife with dry cut mode (60W, effect 5)

Result

En bloc resection rate was 97.7%(424/434). The causes of failure were ulcer scars (six cases) and inadequate snaring (four cases). 2. The rate of complete en bloc resection is 91.2%(396/434). The cause of failure was inadequate diagnosis of lateral extension. 3. The mean size of tumors was18mm (3-110mm) and the mean size of specimens was 35mm(14-146mm). 4. Complications: Perforation rate was 0.92%(4/434) and every case could be treated by clip.

Discussion

There were many EMR techniques, but the sizes of the specimens resected by EMR method were almost 2cm. So, piecemeal resection should be performed to resect large cancers.

The incidence of lymph node metastasis correlates closely with the invasion depth. Therefore, a precise pathological examination of resected specimen is very important to decide whether the patient needs additional treatment or not. A precise histological examination may be difficult with piecemeal-resected specimens removed by EMR. Moreover specimens resected with EMR method are sometimes damaged by forceps or aspiration retrieval. These drawbacks led to the development of ESD with the hook knife.

The needle knife, IT knife, flex knife and hook knife was reported as useful device for gastric ESD. The needle knife and flex knife could cut the mucosa and submucosal fibers for any direction but if the top of these knives contacted to the proper muscular layer it might cause perforation. IT knife was developed to prevent perforation and has an insulated tip at the top of the knife. Hook knife is useful to dissect submucosal fibers from both vertical and horizontal approach.

The major complication of ESD is perforation, but there have been only a few perforations in our

experience. The most important point to avoid perforation is to keep clear visual field of the submucosal layer and to control the direction of the hook knife parallel with the proper muscle.

Conventional EMR is an easy and safe method for small lesions. However, if the lesion is 10mm or more, ESD with the hook knife should be selected to prevent piecemeal resection that is liable to insufficient pathological diagnosis and increases the risk of local recurrence.

ENDOSCOPIC AND SURGICAL INTEGRATED APPROACH OF GI LESIONS

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OMED Treasurer

Having been trained as surgeon in so-called pre-endoscopic era, i have no doubt that the impact of endoscopy on digestive surgery has been tremendous.
In fact the same principles of endoscopy have ispired the diffusion of "minimal access surgery" via laparoscopy, wich represents a great progress in G.I. surgery.
The multidisciplinary approach to the G.I. patient's care management must be represented by the specialists who retain the highest clinical knowledge on digestive diseases, as hepato-gastroenterologist, digestive endoscopist, pathologist and digestive surgeon.
As far as my personal experience in this field is concerned I always believed that laparoscopy is an exceptional tool in clinical practice for diagnostic and therapeutic purposes. For this reason I have organized in my Unit from the beginning of the 70' a laparoscopic center in a surgical surrounding.
It is my personal view that flexible endoscopy performed by surgeons is essential in traditional surgery and in minimally invasive surgery for the following reasons: timing, decision making, and need for surgery, expertise in the management of surgical patients (including complications), the combined approach flexible and rigid in the operating room.
In the early days, surgery was used to recover any trouble from endoscopy or interventional radiology ...we soon learned that some complications of surgery could be effectively treated by endoscopy or interventional rx.
The results of the combined approach in the treatment of some G.I. lesions are reported and discussed.

Laparoscopy assisted partial resection of early gastric cancer

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Introduction: Owing to successful surveillance for gastric cancer, about half of gastric cancer cases are detected at early stage in Japan, therefore long prognosis are expected after treatments for many patients with gastric cancer. However most patients have been suffered from post gastrectomy disorder after surgical treatment, such as damping syndrome, iron deficient anemia, bile reflux esophagitis, and so on. We have made effort to improve quality of life of patients with gastrectomy. For early gastric cancer limited in mucosal layer, we perform local resection with lymph node dissection if it is out of indication for endoscopic mucosal resection. For preventing bile reflux esophagitis, we perform pylorus-preserving gastrectomy instead of distal gastrectomy with Billroth I or II reconstruction when a distance between a pylorus ring and a cancer edge is more than 4.5 cm. Moreover pylorus-preserving gastrectomy is expected to prevent carcinogenesis of remnant stomach for preventing bile reflux.
Recently laparoscopic technique has been progressed remarkably. At our institution Laparoscopic technique has been introduced to surgery for gastric cancer from 1996 for lees invasive surgery. At first we have introduced laparoscopic technique to local resection. From 2000, laparoscopic assisted distal gastrectomy (LADG) and pylorus preserving gastrectomy (LAPPG) has been performed at our institution. Indication for local resection is cancer in mucosal layer without ulcer scar and less than 4 cm in diameter. Local resection is accompanied with dissection of lymphatic basin. Indication of LAPPG and LADG is cancer at early stage and clinically N0. Laparoscopy assisted gastrectomy are performed for most of all early gastric cancer cases now. To reveal the advantages of laparoscopy assisted gastrectomy, we compared LAPPG with PPG in open surgery.
Material and Method: PPG in open surgery were performed for 60 cases from 1993 to 2000 at our institution and LAPPG were performed for 51 cases from 2000 to 2003 at the same institution. We investigated operation time, amount of bleeding, number of dissected lymph nodes, incidences of complications, incidences of recurrences and cost performance. For proving less invasiveness at laparoscopy assisted gastrectomy, we examined endotoxin, IL1-beta and IL-6 in portal venous blood and systemic venous blood using pigs.
Results: There was significant difference in operation time (LAPPG; 301±84 min vs. PPG in open surgery; 246±57 min). There was no significant difference in amount of bleeding and number of dissected lymph nodes (240±235 gram vs. 187±86 gram in amount of bleeding, 32±14 vs. 30±18 in number of dissected lymph nodes, respectively). About incidence of complications after surgery, ileus was observed in cases of PPF in open surgery much more than in cases of LAPPG with significant difference. Through the experiment using pigs, it was revealed that IL-6 and endotoxin in portal and systemic venous blood were higher with significant difference in cases of PPF in open surgery than in cases of LAPPG. There were no cases of recurrence in both groups.
Conclusion: Although LAPPG has disadvantages in surgical time and cost, it has advantages at incidence of complications and surgical stress. We have to make an effort to depress the cost and shorten surgical time still, however LAPPG can be thought to be a standard method for early gastric cancer.

MAGNIFYING ENDOSCOPY FOR EARLY COLORECTAL CANCER

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Recently Japanese Society for Cancer of the Colon and Rectum (JSCCR) proposed new histological criteria for curability of submucosal invasive colorectal cancer resected endoscopically. In brief, colorectal cancer with submucosal invasion can be cured by complete EMR on conditions that the depth of submucosal invasion is within 1,000 ?m and histological grade is well/moderately-differentiated adenocarcinoma, if there are no vessel involvements. It is important to diagnose the precise invasion depth of submucosal cancer (submucosal invasion depth: deeper than 1,000 ?m or not) prior to endoscopic treatment.

Pit patterns diagnosis is now routinely available under colonoscopic examination. Pit pattern classification of colorectal neoplasia, based on stereomicroscopy, as reported by Kudo & Tsuruta, includes I and II type pit patterns showing non-tumors, and IIIs, IIIL, IV, and V type (VI & VN) pit patterns showing neoplastic tumors. In this presentation, we will show the accuracy rate of submucosal deep invasion (>1000?m) diagnosis in colorectal adenoma and early cancer using magnifying observation. Our results show that the accuracy rate of VN pit pattern for submucosal deep invasion (> 1000?m) diagnosis in colorectal adenoma and early cancer is 97 to 100% in each gross appearance, which is significantly higher accuracy rate than the diagnosis by standard colonoscopic examination.

Magnifying findings and histology/depth of invasion in colorectal adenoma and early cancer

Magnifying findings	*Histologic grade · invasion depth*				*Total*
	adenoma	*m-ca*	*sm <1,000μm*	*sm ≥1,000μm*	
II	*70 (89)*	*9 (11)*			*79 (100)*
IIIL	*232 (69)*	*96 (29)*	*7 (2)*	*1 (1)*	*336 (100)*
IIIs	*35 (56)*	*17 (30)*	*4 (7)*		*56 (100)*
IV	*32 (45)*	*34 (48)*	*5 (7)*		*71 (100)*
VI	*24 (13)*	*76 (41)*	*48 (26)*	*36 (20)*	*184 (100)*
VN			*2 (3)*	*69 (97)*	*71 (100)*
Total	*393 (50)*	*232 (29)*	*66 (8)*	*106 (13)*	*797 (100)*

ca : carcinoma *Hiroshima University : 1996.4 ~ 2003.12* *( ):%*

On the other hand, although most of cases with VI pit pattern were early carcinoma, cases with VI pit pattern showed various invasion depth (mucosal 41%, submucosal shallow 26% or deep invasion 20%).

In conclusion, VN pit pattern is a useful diagnostic indicator for submucosal deep invasion (>1000?m) in early colorectal cancer prior to endoscopic treatment. Cases with VI pit pattern should be examined by an additional modality, such as endoscopic ultrasonography or fluoroscopic examination.

ENDOSCOPIC MANAGEMENT OF THE BILIOPANCREATIC MALIGNANCIES

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Endoscopic retrograde cholangiopancreatography (ERCP) has been an important tool in the diagnostic and management of biliopancreatic cancer. Although during the last years other less invasive techniques (Magnetic resonance MR, Endoscopic ultrasound EU) have been proved useful in the diagnostic and staging of those cancers, ERCP still has its place in the therapeutic management of those diseases.

(ERCP) permits the visualization of the biliary neoplasms while providing the opportunity to obtain tissue samples and to perform therapeutic maneuvers (such as biliary decompression) when necessary. Thus, it continues to have a central role in the diagnosis and management of biliopancreatic neoplasms.

Cholangiographic findings during ERCP can help distinguish benign from malignant neoplasms. Biliary neoplasms typically appear as a stricture during ERCP. However, strictures caused by benign processes can have the appearance of malignancies and vice versa. In addition, a neoplasm can develop in a long-standing benign stricture and its recognition may be difficult, such as in patients with primary sclerosing cholangitis and chronic pancreatitis. Some of the characteristics of the stricture suggestive of malignancy include a length of more than 10 mm, a ragged contour, and the presence of a fixed filling defect and/or an abrupt transition from relatively normal to the stricture. Strictures involving the hilum should also raise concerns of malignancy. Tissue confirmation should be sought in the majority of patients. The clinical setting, radiographic appearance, and cholangiographic findings may be sufficient to establish the diagnosis of malignancy in patients in whom tissue sampling is not feasible.

CHOLANGIOCARCINOMA

General features

Cholangiocacinoma is a malignant neoplasm of the biliary tract epithelium. Its clinic, pathologic and therapeutic features differ according to the site of origin: The Ampulla of Vater, common bile duct, common hepatic duct or the small intrahepatic bile ducts. Tumors arising at the intrahepatic bile ducts have been classified in four groups depending on localization, with specific clinic and handling characteristics: (1) a) peripheric cholangiocarcinoma grows in the small ducts and it is placed by the portal area; b) Cholangiocarcinoma of the intrahepatic ducts; c) Hilar cholangiocarcinoma, Klatskin's Tumor (2); d) papillar intraductal cholangiocarcinoma, with or without association to intraductal papillomatosys. Sometimes, differential diagnosis is difficult (3) especially at the hilum, with metastatic nodes, sarcoidosis, primary sclerosing cholangitis localized at the common hepatic duct or upper third of the common bile duct, post surgical stenosis and cholecystitis. The use of different image explorations such as ultrasound, CT, MR with needle punction, ERCP with biopsy or brushing and endoscopic ultrasound, allows the final diagnosis in a high percentage of patients, but in several others, surgery or nechropsy is needed. These considerations are important to decide the right therapy for the patients that very often have similar clinic manifestations. Diagnosis is less difficult when cholangiocarcinoma appears at mid or distal common bile duct or at the Ampulla of Vater.

Epidemiology

Risk factors

Inflammatory bowel disease associated with primary sclerosing cholangitis is a preneoplastic condition for cholangiocarcinoma. In Oriental countries, clonorchis or opistorchis infestation, and hepatic and biliar congenital cystic malformations (Caroli's disease, congenital hepatic fibrosis, choledocal cyst

and von Meyenberg complexes) are also associated with cholangiocarcinoma. Its Incidence is smaller than Hepatocarcinoma's and represents the 9.5% of all the hepatic neoplasms and 0,5% of necropsies

Carcinoma of the gallbladder is generally silent until jaundice appears provoked by a common bile duct or common hepatic duct invasion. Its clinical features are the same as in cholangiocarcinoma of the hepatic ducts confluence and its therapy, in most cases, is just palliative in order to by-pass the bile duct obstruction. There seems to be a causal relationship between gallstones and gallbladder carcinoma. Cholecystectomy has been recommended for all patients with gallstones in an effort to prevent its development.

Choledochal carcinoma may develop under two other conditions: Choledochal cyst and papillomatous choledoch. Both pathologies are uncommon, but if they appear, choledochal resection must be performed to avoid malignisation. In both cases, the only therapy for prevention is resection of the cyst, papillomas and choledoch, altogether. Differential diagnosis must be done, especially with pancreatic carcinoma causing stenosis of lower and middle third of the common bile duct.

The tumor of the ampullla is usually adenocarcinoma that comes from previous adenoma. So as with colonic cancer, the adenoma-carcinoma sequence would be the origin. A major incidence of ampulloma has been found in patients with familiar colonic polyposis and gastrointestinal polyposis. Clinical features are insidious, such as anemia, abdominal pain and loss of weight and jaundice when obstruction is achieved, which may be intermittent because of partial obstruction or tumoral nechrosis. Generally, prognosis is not bad because complete resection can be attempted by performing a cephalic pancreatico-duodenectomy. When tumor is localized in ampullary area, five year-survival rates are high.

Histopathologic diagnosis

Histologic diagnosis is difficult and its accuracy is only high when tumors are near duodenum (ampulla or low third of common bile duct); in such cases, positivity in biopsy carried out with conventional forceps is 70 to 95%. Difficulties are higher when tumor arises at mid or upper common bile duct, common hepatic duct or intrahepatic ducts. In these occasions diagnostic sensitivity of the endoscopic methods is poor, around 50%. Sherman and col. (table 1) (1) checked three diagnostic methods: brushing, needle aspiration and conventional biopsy forceps, when performed altogether, achieved an increase in diagnostic sensitivity from 63 to 81%

Table 1

	Pancreatic cancer	Cholangio-carcinoma	Metastatic disease	All
Brush	45%	44%	33%	43%
Needle aspiration (NA)	34%	41%	33%	37%
Biopsy forceps (BF)	42%	59%	33%	47%
Brush + NA	45%	59%	33%	47%
Brush + BF	58%	74%	58%	64%
NA + BF	55%	74%	58%	62%
Brush + NA + BF	63%	81%	75%	71%

Table 2

Hall (1978)	25.0%
Walsh (1982)	50.0%
Blackman (1985)	82.3%
Yamaguchi (1987)	89.0%
Sastre (1987)	41.0%
Moreira (1991)	70.0%
Armengol-Miró (1994)	96.4%
Global	67.9

Histologic diagnosis is higher in tumors of the ampullary area due to an easy accessibility, either with conventional biopsy forceps or macrobiopsy. When endoscopic ampullectomy is carried out, sensitivity is 100%.

TREATMENT

Surgical treatment

The best therapy is resection ,which is only possible between 15 to 20% of cases, being 50.9% (18) the highest rate.

In recent series with 125 patients (Mayo Clinic) (19) only 22 (18%) could be treated with curative resection; the remaining 82% underwent palliative resection. The results are comparable with other highly experienced Centers (20,21).

The palliative surgical treatment (insertion of an endoprosthesis or biliary-enteric anastomoses), which allows histologic diagnosis has a high mortality rate: 33% (22).

In a wide series from one single Center (Pilchmayr) (23) including 249 patients with proximal biliary carcinoma, only exploring laparotomy was performed, 50% underwent surgical by-pass and 10% liver transplant. Mortality rate was 10.5%, 30 days after surgery; 12.7% after excision and hepatectomy and 12% after liver transplant. Comparing patients who underwent palliative surgical and no surgical treatment, there was no statistical significance either at 30-days mortality, 17.4% vs. 10.7%; 1-year survival, 27.5% vs. 45.2%, or 3-year mortality, 3% vs. 7.5%, with an average of 6.3 to 6.7 months.

For this reason, less aggressive non-surgical methods could be the choice in many patients.

Table III

Percutaneous metal self-expanding stent insertion. Results (36)

Author (ref.)	Patients number	Hilar number	Grade	Drainage %	imm. complications	Late	Follow-up
Neuhaus(6)	7	2	?	100.0	--	--	3
Gillams(7)	45	22	?	91.0	6(13)	24(57)	8.5
La Berge (8)	20	20	II-III	100.0	4(20)	2(10)	2.00
Lammer(9)	61	4	II-III	95.0	3(5)	8(13)	4.53
Adam(10)	44	24	?	91.0	4(9)	3(7)	5.5
Lameris(11)	69	284	I-III	100.0	?	8(28)	8.10
Gordon(12)	50	26	II-III	100.0	13(26)	12(24)	15.80
Nicholson(13)	77	?	?	98.7	6(7.8)	7(9)	?
Coons(15)	46	46	I-III	100.0	?	7(15)	14.00
Wagner(16)	5	11	II-III	100.0	1(9)	2(18)	5.9

Nonsurgical palliative treatment

The difficulties of surgery, poor results and because many of the patients are in bad condition, implementation of permanent or removable stents to improve patient's quality of life, endoscopically or percutaneously (6-16). In cases with great infiltration, the use of self-expandable metal stents (6,13,15,16) (Table III).

Endoscopic treatment

At the beginning, endoscopic treatment was the placement of a naso-biliary drain to decompress the stricture, before surgical treatment or to avoid infection. The insertion of a plastic prosthesis, single or multiple, to drain intrahepatic dilated ducts was first introduced by Soehendra in 1979, and its results oscillated between more than 85% (3) of success and a lower rate of 53% (27). Drainage was best achieved in Bismuth I (91% and 71%) than in Bismuth II and III. The success in plastic stents insertion varies between 90 and 74% (25-26), being very difficult or impossible to place two or more prosthesis to reach

a complete drainage in Bismuth type II and III; normally partial drainage is achieved by placing just one stent. Another disadvantage is the common obstruction of the plastic stents (42-45%), which requires its replacement in a short period of time. (25-37). The obstruction of Teflon stents in the 3 months next to insertion oscillates between 20 and 30% (26).

Administration of antibiotic, ursodeoxycholic acid, aspirin and other drugs that can modify bile composition, do not prevent blockage due to fibrine and other materials.

Plastic stents usually used measure 10 F. Comparing 10 F and 11.5 F stents, there was no statistical significance in insertion success, biliary drainage, jaundice disappearance, time of permeability and migration. However, there was a big difference when comparing 8F and 10F stents (31,32). Endoscopes have an operative channel of 4.2 mm allowing insertion of 10 F. stents. The suppression of the stent holes was thought to enhance permeability time, but has not been useful (34).

The way to drain the biliary obstruction, by ERCP, consists in filling the bile duct with contrast in order to show the stricture and dilate it. Then, obtain specimen with a brush, a biopsy forcep or a needle, using a Teflon, hydrophilic guide wire that will help to insert the stent. Prosthesis election will depend on the kind of stricture, length, and grade of stenosis. Usually, a small sphincterotomy is performed before insertion: this allows better manipulation over the stricture and also afterwards, in case removal or reinsertion is required. When guide wire cannot pass through the stricture, rendez-vous technique is needed: a guide wire is introduced percutaneously and it is recovered through the Ampulla of Vater, allowing retrograde insertion. In case drainage is not enough, a percutaneous trans-hepatic drainage is needed.

Expandable metal mesh endoprosthesis is easy to introduce and its patency is significantly longer than plastic type, increasing success in endoscopic drainage to 95%, even in Bismuth type II and III. The metal type is more expensive and it cannot be removed, so, when blockage occurs, another metal or plastic prosthesis must be placed inside.

Materials used in endoscopic treatment do not differ from the ones used percutaneously, and sometimes both types might be needed in parallel technique (i.e. endoscopic drainage of the right side and percutaneous drainage of the left side) or in rendez-vous technique.

In a recent publication from Peters and cols. (35), 17 patients with positive diagnosis or suspected cholangiocarcinoma, with Bismuth II or III stenosis, were successfully treated. Insertion of a metal stent (Wallstent) was reached in all of them. Drainage was achieved in 15 patients (88%). Cholangitis occurred only in one patient (6%), late complications in 41%, obstruction in 4 patients and, in 3 patients duodenum compression. Average stent permeability was 12 months (between 1.5 to 24 months) in patients with more than 6 months survival. Average survival was 10 months (from 1 to 48 months), all patients died in follow-up period.

The insertion of the stent in the right or the left hepatic duct has shown no difference in terms of permeability (38). The insertion of two metal stents instead of one decreases early cholangitis, but late complications may increase (39). Finally, multicenter randomized trials of wider series have shown bigger effectiveness in quality drainage and permeability, and less number of therapeutic procedures by using metal stents , thus, final costs are similar. (40-42). There is no doubt that the number of cholangitis in patients with metal stents is lower during the follow-up than the ones with plastic stents, but obstruction also occurs when follow-up is long. The introduction of covered metal stents may be the solution.

A new technique for bilateral metal mesh stent insertion to treat hilar cholangiocarcinoma has been described; it allows introduction of two stents and a Y drainage by fenestration of one of them (36).

Brachytherapy with Iridium needles introduced in the bile ducts, previous to stricture dilatation, has been tested by Pakisch (43,44) and Costamagna (45-46) with no concluding results. In 112 patients with cholangiocarcinoma, success in procedure is achieved in 94.5%, biliary drainage in 99%. In 5 patients (4%) rendez-vous technique is used and, in 15 patients, stent is associated to intraluminal high dose rate 192Ir brachytherapy. Morbidity due to the procedure is 13% and mortality at 30 days is 11%. 26% of patients underwent surgery with curative intention. Survival rate for the endoscopic treatment alone was 208-281 days; survival rate for the combined treatment was 357 days (statistical significance $p< 0.05$).

MALIGNANT TUMORS OF THE AMPULLA OF VATER

Surgery is the treatment for ampulloma, pancreatico-duodenectomy: 5-year survival is 80%, if tumor is localized without invasion of nearby structures.

Endoscopic treatment is usually palliative to solve obstruction, pancreatitis or anemia in bleeding

tumors.

There are two endoscopic treatments: Stent drainage, which has the same complications as in cholangiocarcinoma, but blockage is easier to solve because direct visual control is possible. This treatment is recommended in patients with infiltrating ampullary or intraductal growing tumors. The second one is a variation of palliative local resection: Ampullectomy with fulguration (?) of the resection base. This therapeutic modality of which we are pioneers, needs a later drainage procedure when tumor relapses and only a few patients had to undergo surgery. Haemorrhage is unusual and can be controlled with electrocoagulation (Argon beam coagulation or laser).

When pancreatico-duodenectomy is developed, 5-year survival is higher in ampullary tumors than in pancreatic carcinoma. Morbidity decreases, although it may vary depending on age, histologic diagnosis, invasion and patient's conditions.

Since 1984 to 1997, 43 patients (28 males and 15 females), with ages between 71 and 98, were treated with tumoral resection after ERCP was carried out. Patients were selected using several criteria (risk, age, associated disease, no duodenal or pancreatic invasion). In 34 of them, sphincterotomy was performed before tumorectomy, and in 9 patients it was performed during tumor resection. Electrocoagulation of the tumor base was performed the following days in 29 patients.

At the present time, 12 patients are still alive; 9 patients needed plastic or metal stent insertion. Global survival is 708 days. No important complications occurred (any patient needed surgery), and late complications such as obstruction due to tumoral growth or stones were treated endoscopically.

Local resection of ampullary tumors has been widely used in conventional surgery: Endoscopic ampullectomy as an alternative treatment, has several advantages, and according to our experience, results are similar.

PANCREATIC CANCER

The median survival is 8 to 12 months for patients with locally advanced, unresectable disease and only 3 to 6 months for those with metastatic disease at presentation. Surgical resection offers the only chance of cure. However, only 15 to 20 percent of patients have resectable disease at initial diagnosis; the majority have either locally advanced or metastatic cancer. The prognosis of pancreatic cancer is poor even in those with potentially resectable disease. Despite potentially curative resection, the five-year survival following pancreaticoduodenectomy is only about 20 percent.

The surgical options for achieving biliary decompression include an anastomosis between the gallbladder and jejunum (cholecystojejunostomy) or common bile duct and jejunum (choledochojejunostomy). A cholecystojejunostomy should only be considered if the cystic duct enters the common bile duct at a site distant from the tumor. A choledochojejunostomy should only be performed if the common duct is >1 cm in diameter. Drainage is successful in returning the serum bilirubin concentration in approximately 90 percent of patients; in the remainder persistent hyperbilirubinemia may be seen due impaired hepatic function.

One advantage of surgical bypass is the ability to perform prophylactic or therapeutic gastrojejunostomy to avoid gastroduodenal obstruction, and celiac plexus block for pain control (see below). However, the risk associated with surgery in these typically debilitated patients is not small. In one report, the postoperative mortality and perioperative morbidity rates were 3.1 and 22 percent, respectively, and the median survival was 6.5 months.

Expandable metal stents — Endoscopically placed expandable metal stents can provide minimally invasive effective palliation of jaundice. Randomized trials have shown no difference in survival between endoscopic stent placement and surgical bypass for malignant obstructive jaundice; stented patients have more frequent re-admissions for stent occlusion, recurrent jaundice, and cholangitis, but lower morbidity and procedure-related mortality .

Although metal stents can also be placed percutaneously, at least one controlled trial that included 75 patients with malignant bile duct obstruction demonstrated that patients treated with an endoscopic stent had a higher success rate for relief of jaundice (81 versus 61 percent) and a significantly lower 30-day mortality rate (15 versus 33 percent). Metal stents are preferred compared to plastic stents because they are much less likely to become clogged by debris or tumor in growth.

ENDOSCOPIC MANAGEMENT OF SURGICAL FAILURE AND SURGICAL MANAGEMENT OF ENDOSCOPIC FAILURE

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OMED Treasurer

Since its introduction into clinical practice, diagnostic and therapeutic fiberoptic endoscopy and later, electronic flexible endoscopy, has been associated to surgery in the management of some G.I. patients.
In particular, endoscopic management of surgical failure and surgical management of endoscopic failure have been used to solve complications which could emerge during an endoscopic procedure and/or a surgical operation.
The success of ercp + related interventional procedures (es-nb drain - stents) has reduced the role of open surgery in the early and late management of biliary injuries.
Once diagnosis is made simultaneous treatment is possible in the majority of cases.
Ercp should to be preferred to ptc.
Combined radio-endoscopic approach is often usefull and seems to be promising according to our experience (need for long therm follow-up).
New techniques that will allow trans luminal intrabdominal surgery are in development.
The endoscopic and surgical integrated approach is feasible and effective respecting the guidelines wich regulate both the op. room and the G.I. endoscopic suite.
This integrated approach can be used to solve some problems which could affect the esophagus, gastro-esophageal junction, stomach, gallbladder, biliary tract, pancreas, rectum and colon.
The results of this experience are reported and discussed.

The Paris endoscopic classification of superficial neoplastic lesions : esophagus, stomach, and colon.

November 30 to December 1, 2002

VOLUME 58, NO.6 (SUPPL),2003 GASTROINTESTINAL ENDOSCOPY

Participants in the Paris Workshop

Paris,France

In Japan, neoplastic lesions of the stomach with a "superficial" endoscopic appearance are classified as subtypes of *"type 0."*[1,2] The term *"type 0"* was chosen to distinguish the classification of "superficial" lesions from the Borrmann classification, proposed in 1926 for "advanced" gastric tumors, which included *types 1 to 4*.[3] Within *type 0*, there are polypoid and non-polypoid subtypes. The non-polypoid subtypes include lesions with a small variation of the surface (slightly elevated, flat, and slightly depressed) and excavated lesions. The Japanese Gastric Cancer Association (JGCA) also added a *type 5* for unclassifiable advanced tumors. The complete modification for gastric tumors becomes:

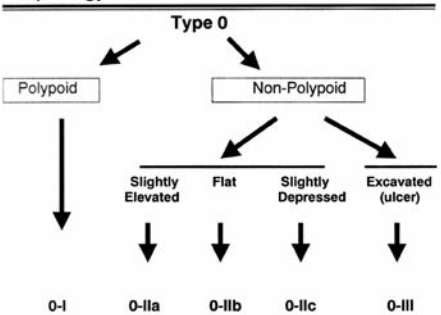
- *type 0* - superficial polypoid, flat/depressed, or excavated tumors
- *type 1* - polypoid carcinomas, usually attached on a wide base
- *type 2* - ulcerated carcinomas with sharply demarcated and raised margins
- *type 3* - ulcerated, infiltrating carcinomas without definite limits
- *type 4* - nonulcerated, diffusely infiltrating carcinomas
- *type 5* - unclassifiable advanced carcinomas

Table 1. Revised Vienna classification of epithelial neoplasia for esophagus, stomach, and colon[5,13]

Negative for IEN	
Indefinite for IEN	
Low-grade IEN	
Adenoma/dysplasia	
High-grade neoplasia (intraepithelial or intramucosal)	
Adenoma/dysplasia	(4-1)
Noninvasive carcinoma	(4-2)
Suspicious for invasive carcinoma	(4-3)
Intramucosal carcinoma (lamina propria invasion)	(4-4)
Submucosal carcinoma	

IEN, Intraepithelial neoplasia.

Table 2. Neoplastic lesions with "superficial" morphology



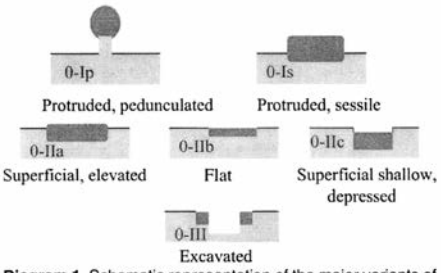


Diagram 1. Schematic representation of the major variants of *type 0* neoplastic lesions of the digestive tract: polypoid *(Ip and Is)*, non-polypoid *(IIa, IIb, and II c)*, non-polypoid and excavated *(III)*. Terminology as proposed in a consensus macroscopic description of superficial neoplastic lesions.[15]

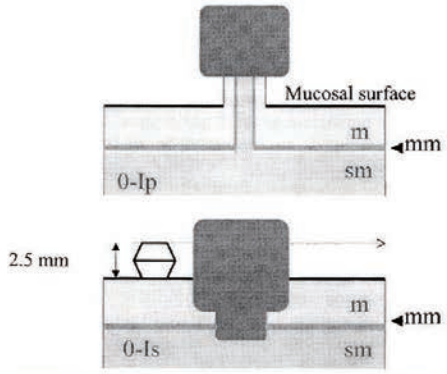


Diagram 2. Neoplasia in the columnar epithelium (Barrett's esophagus, stomach, colon, and rectum): *types 0-I*: pedunculated *(Ip)* or sessile *(Is)* in transverse section. In *0-Is* the protrusion of the lesion *(dark)* is compared with the height of the closed cups of a biopsy forceps (2.5 mm); the dotted arrow passes under the top of the lesion. *m*, mucosa, *mm*, muscularis mucosae; *sm*, submucosa.

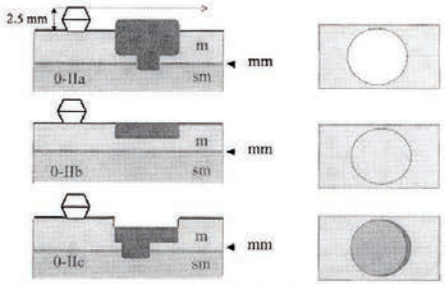


Diagram 3. Neoplasia in the columnar epithelium (Barrett's esophagus, stomach, colon, and rectum): *types 0-II* elevated *(IIa)*, completely flat *(IIb)*, or depressed *(IIc)*. In the transverse section, the lesion is compared with closed cups of a biopsy forceps (2.5 mm); the *dotted arrow* passes above the top of the *IIa* lesion. In the frontal view, the elevated, flat, or depressed zones of the mucosa are presented in distinct shading.

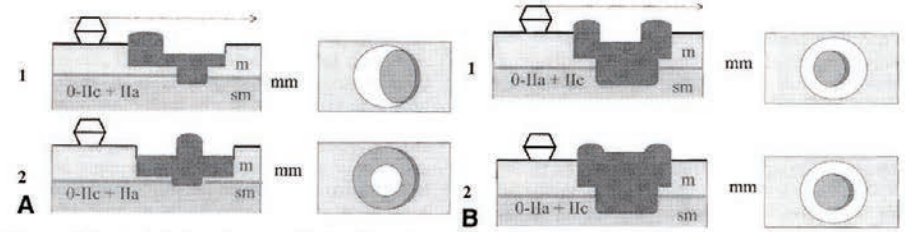


Diagram 4. Neoplasia in the columnar epithelium (Barrett's esophagus, stomach, colon, and rectum): combined *types 0-IIa and 0-IIc*. In the transverse section, the lesion is compared with the closed cups of a biopsy forceps (2.5 mm). In the frontal view, the elevated and depressed zones are presented in distinct shading. **A**, Types *IIc + IIa*: elevated area in a depressed lesion. **B**, Types *IIa + IIc:* depressed area in an elevated lesion. Two variants are shown in transverse section and frontal view. In variant 2, the depressed area at the top does not reach the level of the surrounding mucosa; this is a relatively depressed lesion.

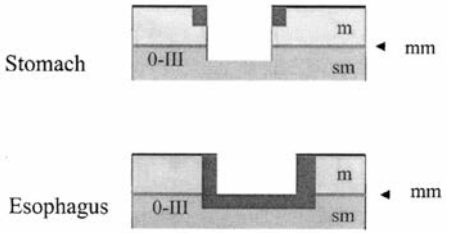


Diagram 5. Neoplasia in the columnar epithelium (Barrett's esophagus and stomach): type *0-III* excavated. In the stomach, the bottom of the lesion is non-neoplastic. In Barrett's esophagus, the neoplastic area covers the entire surface of the lesion.

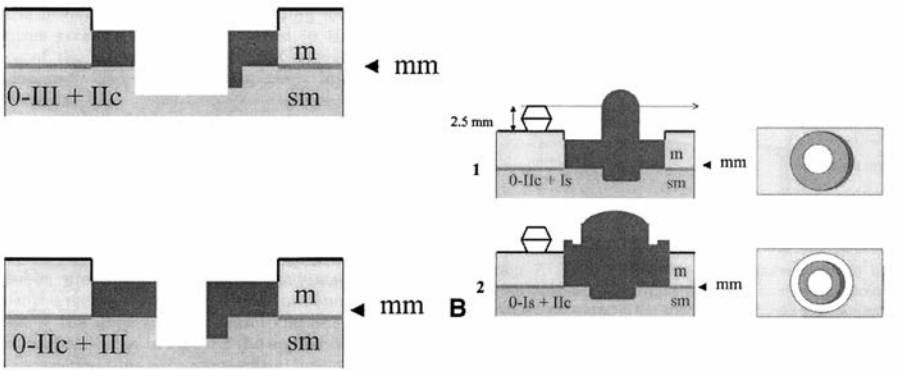


Diagram 6. Neoplasia in the columnar epithelium (Barrett's esophagus, stomach, colon, and rectum): in the transverse view, the lesion is compared with the height of the closed cups of a biopsy forceps (2.5 mm). In the frontal view, the elevated, depressed, or relatively depressed zones of the mucosa are presented in distinct shading. **A**, Combined *types 0-III and 0-IIc. Type III + IIc*: a large excavated lesion in a depressed zone. Type *IIc + III*: a small excavated zone in a depressed lesion. **B**, Combined types *0-Is and 0-IIc. Type IIc + Is*: the *dotted arrow* passes under the elevated zone. *Type Is + IIc*: the depressed zone is more elevated than the adjacent mucosa; this is a relatively depressed lesion.

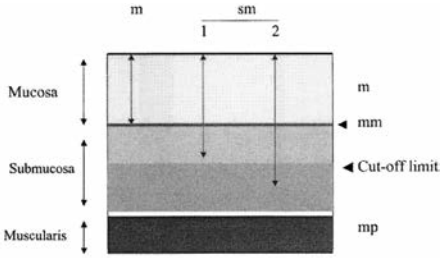


Diagram 7. Depth of invasion of the submucosa in the columnar epithelium (Barrett's esophagus, stomach, colon, and rectum) assessed in the specimen obtained after surgery. Depth of submucosal invasion is divided into two groups: superficial (sm1) and deep (sm2) with respect to a cutoff limit determined on a micrometric scale (500 μ in the stomach, 1000 μ in the colon).

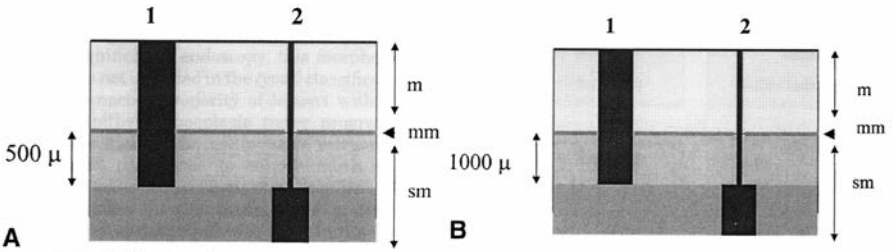


Diagram 8. Depth of invasion of the submucosa in the columnar epithelium, assessed for the clinical relevance of EMR and for the risk of nodal metastases. Group 1 (m and sm1): EMR is possible. Group 2 (sm2): surgical treatment is preferred. **A**, Barrett's esophagus and stomach: the cutoff limit between sm1 and sm2 is 500 μ. **B**, Colon and rectum: the cutoff limit between sm1 and sm2 is 1000 μ.

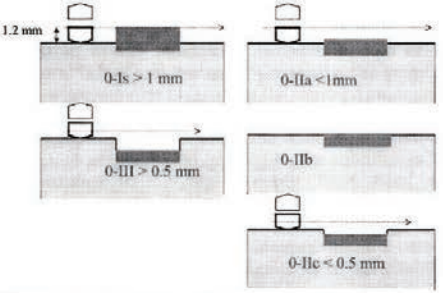


Diagram 9. Squamous cell neoplasia in the esophagus. Adapted scale of thickness in transverse section for the major subtypes: polypoid, non-polypoid, and excavated. The m and sm are represented as a single layer. The protruding lesions are compared with one open cup of a biopsy forceps (1.2 mm); the *dotted arrow* passes above the top of the *Is* and *IIa* lesions. The depressed lesions are compared with half the height of an open cup.

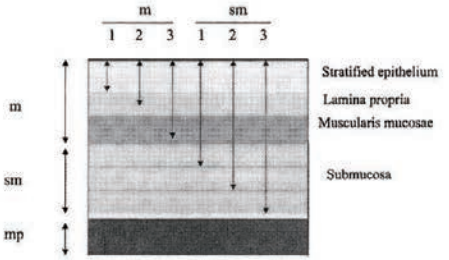


Diagram 10. Depth of invasion of squamous cell neoplasia in the esophagus. Mucosal carcinoma is divided into 3 groups: m1 or intraepithelial, m2 or micro-invasive (invasion through the basement membrane), m3 or intramucosal (invasion to the muscularis mucosae). The depth of invasion in the submucosa is divided into 3 sections of equivalent thickness: superficial (sm1), middle (sm2), and deep (sm3).

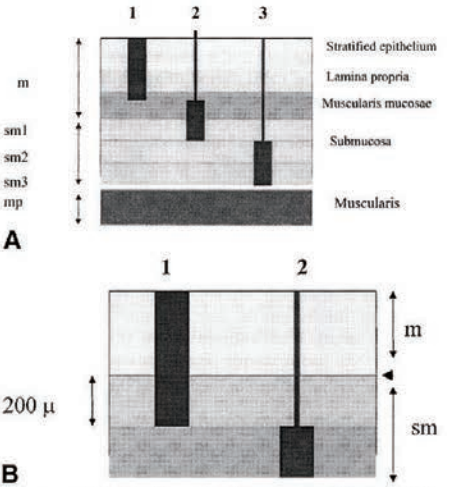


Diagram 11. Depth of invasion of squamous cell neoplasia in the esophagus adapted for relevance to EMR and the risk of nodal metastases. **A**, Full-thickness specimen. Group 1 (m and sm1): EMR is possible. Group 3 (sm2 and 3): surgical treatment. Group 2 (m3 and sm1): uncertain indications. **B**, Specimen obtained after EMR: the cutoff limit between sm1 and sm2 is 200 µ EMR is adequate for sm1.

In conclusion, the classification of *type 0* neoplastic lesions requires more attention to detail from the operator at each step of endoscopy, which then ensures the best outcome for diagnosis and treatment of those lesions.

OMED news

On the occasion of the 2nd World Congress of Gastroenterology in Munich 1962, the establishment of the International Society of Endoscopy was discussed. In 1964, the official constitution of the International Society of Endoscopy was approved. In accordance with the constitution, the International Society of Endoscopy was organized in 1966, and the 1st International Congress of Endoscopy held in Tokyo 1966.

A congress, the principal function of the International Society of Endoscopy, was decided to be held every 4 years. To show that the society is a world-wide operation, the name was revised to the World Organization for Digestive Endoscopy (OMED) as of July 3, 1976. OMED are organized from 3 zones, that is Asian-Pacific, European and Inter-American zone. Each zone has its own Society at the same time.

Member of OMED is the national digestive Endoscopy Societies or national gastroenterological societies with clearly defined endoscopy section or subcommittee. At present, there are 78 member Societies.

The purposes of OMED are worldwide promotion of the study and advancement of GI endoscopy, promote the education and training of young endoscopists, the arrangement of the World Congresses in conjunction with OMGE and so on. The 13th world Congress of Gastroenterology in Montreal is also the 11th Congress of OMED.

Almost three and half years have passed since I took over the presidency of OMED from the former president Professor Machado, and now my term is going to expire soon. Next president will be Prof. Axon from Great Britain.

I would like to look back the OMED activities that I have engaged in during my term.

The education committee has been very active in cooperation with OMGE. The "Train The Trainer" project is highly successful under leadership of Dr. Schapiro. Many young endoscopists took part in this event and gave us valuable comments hoping to develop this committee furthermore. The joint education committee of OMED and OMGE has been cooperatively engaging in various activities, and their most important challenge in the future is to grow educational institutes in the countries where endoscopy is in the course of development right now.

As a part of educational activity, OMED presented an endoscopy system last year to the teaching center in Argentina. This contribution program will be continued, and the next plan is to present an endoscopy system to a teaching center in an African country. As a matter of fact, we have had to face a tough financial situation due to these contributions. However, we have made effort to cut and contrive with the limited budget, hoping for global development of endoscopy in the future.

As for other educational activities of OMED, a small group ERCP hands on training was carried out in Thailand last year in cooperation with the Asian Pacific Society for Digestive Endoscopy, which made a great success. We have a plan to have similar courses in other Asian countries. An ERCP and therapeutic endoscopy training was held in Shanghai, China, too. China-Japan joint endoscopy workshop and Korea-Japan joint endoscopy symposia were also held in cooperation with OMED for these three years. Prof. Crespi and Prof. Montori carried out same programs in other European countries, too.

The Committee for Colorectal Cancer Screening, led by Prof. Rozen, has grown to be a significant meeting and played an important role in preventing colorectal cancers. And other committees such as minimal invasive surgery, information committee, research committee and others have done great contribution for OMED activity. The activities of these Committees will be reported in Governing C. and General assembly in Montreal.

As for other major OMED meetings, we were able to have the first OMED Spring Meeting in Rome last year, and the second meeting in Yokohama Japan this year, thanks to great support of Prof. Crespi, Technical Secretary and Prof. Montori, Treasurer. I hope this meeting will maintain the significance and continuously be held at the same time as the International Gastric Cancer Congress in the future.

The History and Archive Committee that had formerly been chaired by Dr. Nagy was taken over to me due to his will to retire because of his advanced age. Hoping to wrap up the history and archive of endoscopy as an achievement of the committee, I have requested each committee member to write the drafts. The fruit of their effort will be published as a supplement of 'Digestive Endoscopy', the official journal of Japan Gastroenterological Endoscopy Society and Asian Pacific Society for Digestive Endoscopy.

One of important jobs of OMED was establishment of an endoscopy museum. Because there were many who supported the idea of establishing it in Japan, I decided to open the endoscopy museum in the same building where the office of Japan Gastroenterological Endoscopy Society is located. Various old instruments have been presented from Japanese and overseas doctors including rigid gastroscopes, flexible gastroscopes, gastrocameras, fiberscopes, gastrocameras with fiberscope, videoendoscopes, ultrasonic endoscopes, proctosigmoidoscopes, Bronchoscopes, laparoscopes and endoscopes for other organs and so on. We are in the process of organizing these valuable items to make an excellent endoscopy museum.

Thanks to proactive encouragement of Prof. Lambert, we were also able to complete 'the Paris Endoscopic Classification of Superficial Neoplastic Legions: Esophagus, Stomach and Colon', in cooperation with OMED. The achievement of this project was published as a supplement of Gastrointestinal Endoscopy Vol. 58, No. 6, 2003. 'The Paris workshop on columnar metaplasia in the esophagus and the esophago-gastric junction' met in Paris last year and in Tokyo this year, the result of which will be published by Prof. Lambert as the proceedings soon in cooperation with OMED. It requires a substantial budget to carry on these projects.

Donation from BMI is made for OMGE and OMED combined, so the portion of OMED is very limited. Therefore, I had to rely heavily on Japan Gastroenterological Endoscopy Society to continue OMED activities. Finding a solution for the financial difficulty is one of the most important issues of OMED in the future. Although it was impossible to increase donations from the current amount during my term, I hope there will be some solution to be found by the next president in cooperation with OMED members.

Lastly, I would like to offer my greatest gratitude to everyone who supported and helped me during my term, including Prof. Crespi and Prof. Waye, the president advisers; Professor Montori who managed severe financial situation as the Treasurer; Dr. Chao, the Vice president of OMED from Asian- Pacific Zone and the president of Asian Pacific Society for Digestive Endoscopy; and everyone else who were involved in management of OMED throughout my term.

I sincerely hope further development of OMED in the future.

Thank you.

President Niwa looks back on past year

OMED President Niwa looks back on past year

Almost three-and-a-half years have passed since I took over the presidency of OMED, and now my term is going to expire soon. I would like to look back the OMED activities that I have engaged in during my term.

The education committee has been very active in cooperation with OMGE. The Train the Trainer project is highly successful, as many young endoscopists took part in this event and gave us valuable comments. The joint education committee of OMED and OMGE has cooperatively engaged in various activities, and their most important challenge in the future is to grow educational institutes in countries where endoscopy is in the course of development.

As a part of educational activity, OMED presented an endoscopy system last year to the teaching center in Argentina. This contribution program will be continued, and the next plan is to present an endoscopy system to a teaching center in an African country. A small ERCP hands-on training was carried out in Thailand last year in cooperation with the Asian Pacific Society for Digestive Endoscopy. We plan to have similar courses in other Asian countries. Other workshops tool place in Shanghai, China, and Europe, and joint endoscopy workshops were put on with China and Japan as will as Korea and Japan.

The Committee for Colorectal Cancer Screening has grown to become a significant meeting and played an important tole in preventing colorectal cancers. Other committees, including the Minimal Invasive Surgery, Information Committee, Research Committee and others made great contributins on behalf of OMED. The activities of these committees will be reported Montreal.

As for other major OMED meetings, we were able to have the first OMED Spring Meeting in Rome last year, and the second meeting in Yokohama, Japan, this year. I hope this meeting will maintain the significance and continuously be held at the same time as the International Gastric Cancer Congress.

With regard to the History and Archive Committee, we are working toward publishing the history and archive of endoscopy as a supplement of Digestive Endoscopy, the official journal of the Japan Gastroenterological Endoscopy Society and the Asian Pacific Soceity for Digestive Endoscopy.

One of the important jobs of OMED was the establishment of an Endoscopy Museum. With so much support for placing it in Japan, we opened the museum in the same building as the office of the Japan Gastoenterological Endoscopy Society. Japanese and overseas physicians have provided various instruments, including rigid gastroscopes, flexible gastroscopes, gastrocameras, fiberscopes, gastrocameras with fiberscope, videoendoscopes, ultrasonic endoscopes, proctosigmoidoscopes, bronchoscopes, laparoscopes and endoscopes for other organs and so on. We are in the process of organizing theres valuable items to make an excellent Endoscopy Museum.

We also were able to complese the Paris Endoscopic Classification of Superficial Neoplastic Legions: Esophagus, Stomach and Colon in copperation with OMED, the Paris workshop on Comumnar Metaplasia in the Esophagus and the Esophago-Gastric Junction in Paris last year and in Tokyo this year.

Finding a solution for the financial difficulty is one of the most important issues of OMED. Although it was impossible to increase donations from the current amount during my term, I hope that there will be some solution to be found by the next

PORTRAIT OF COUNCILLORS

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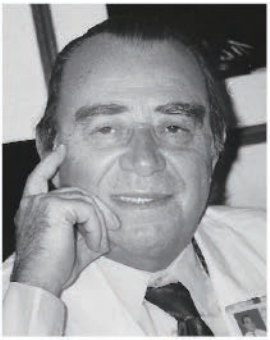

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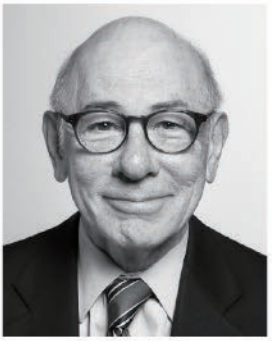
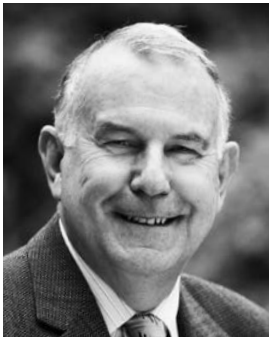


J.D. Waye



G. Young

ACKNOWLEDGMENTS

Honorary President's Address

Hirohumi Niwa

Very long time has passed since I took over the presidency of OMED from the former president Professor Glaciomar Machado.

I would like to look back OMED activities that I have engaged in during my term. My first job as the president was to attend the first meeting of IDCA that took place in Rome. OMED is supporting IDCA and the general secretary Professor Rikiya Fujita participates in it as one of the councilors to manage the activities of this organization.

It is my pleasure to finally publish this Bulletin No. 7 in which correspondence, clerical matters such as business meetings and details of OMED congresses during my term of office are recorded.

In fact, it was supposed to be published immediately after the end of my term, and Professor. Fujita, the Secretary General, and I were preparing for its publication steadily. However, Professor Machardo, the previous President of me, had not published his Bulletin No. 6 to report the details in his term yet, so I was reluctant to publish my version ahead of his, and was waiting for it for a long time. That is why the publication of Bulletin No. 7 was delayed. Now, the Bulletin No. 6 of Professor Machardo still has no likelihood of publication. Professor Axon who took the place of me as the President already ended his term, and the term of new President Professor. Waye has already started. Further postponement may deprive Professor. Axon's chance to publish his Bulletin No. 8 timely, so I decided to publish the Bulletin No. 7 to record OMED activities during my term of office without waiting for the one of Professor. Machardo. Taking this

opportunity, I apologize that the unavoidable postponement of this Bulletin No. 7 caused so much trouble to everyone concerned.

Bulletin No. 6 will be prepared in favor of Professor Machardo.

The activities of OMED are done through various committees, so I would like to describe the task of each committee during my term.

The Education Committee has been very active in cooperation with OMGE. "Train The Trainer" project is highly successful under leadership of Dr. Melvin Schapiro. Two Japanese doctors, Professor Kitano and Professor Tajiri, took part in this event and gave us valuable comments hoping to develop this committee furthermore.

As a part of educational activity, OMED presented an endoscopy system to the teaching center in Argentina. This contribution program will be continued, and the next plan is to present an endoscopy system to a teaching center in and African country. As a matter of fact, we have had to face a tough financial situation due to these contributions, because monetary donations for OMED from endoscopy manufacturer was reduced by the equivalent amount to their product donations. However, we have made effort to cut and contrive with the limited budget, hoping for global development of endoscopy in the future.

As for other educational activities of Educational Committee, a small group ERCP hands on training was carried out in Thailand, Vietnam and China in cooperation with the Asian Pacific Society for Digestive Endoscopy (APSDE), which made a great success. An ERCP and therapeutic endoscopy training was held in Shanghai, China, too. Japan-Sino Workshop on Endoscopy and Gastroenterology and Korea-Japan Joint Symposium on Gastrointestinal Endoscopy were also held in cooperation with OMED and APSDE for those years.

We have also been holding mini-lectures of endoscopic therapy at every general congress of Japan Gastroenterological Endoscopy Society. Supported by endoscopy manufactures, we have provided mini-lectures on ERCP or other biliary and pancreatic treatment. These mini-lectures received very good reactions from those who attended. It is highly desirable that these activities will expand to European and Inter-American countries.

The Committee for Colorectal Cancer Screening, led by Professor Paul Rozen, has grown to be a significant meeting and played an important role in preventing colorectal cancers. I will give a detail of activities of other committees in other chapters of this publication.

As for major OMED meetings, we were able to have the first OMED Spring Meeting in Rome in 2003 and the second meeting in Yokohama Japan in 2005, thanks to the great support of Professor Macssimo Crespi, Professor Alberto Montori, and Professor Kitajima, Japan. I hope this meeting will maintain the significance and continuously be held at the same time as the International Gastric Cancer Congress in the future.

The History and Archive Committee that had formerly been chaired by Dr. Gabriel Nagy was taken over to me due to his retirement. Hoping to wrap up the history and archive of endoscopy as an achievement of the committee, I have requested each committee member to write the drafts, and almost all drafts were collected. The fruit of their effort will be published as a supplement of "Digestive Endoscopy" in this year.

One of my promises when I assumed the presidency of OMED was establishment of an endoscopy museum in Japan. Because there were many who supported the idea of establishing it in Japan considering the past process of this project, I decided to open the endoscopy museum in the same building where the office of Japan

Gastroenterological Endoscopy Society is located. Various old instruments have been presented from Japanese and foreign doctors including rigid gastroscopes, flexible gastroscopes, gastrocameras, fiberscopes, videoscopes, ultrasonic endoscopes, endoscopes for other organs and so on. We are in the process of organizing these valuable items to make an excellent endoscopy museum.

To gather information on the old instruments to be exhibited in the new endoscopy museum, I sought for cooperation of the Nitze-Leiter Endoscopy Museum at the Medical University of Vienna and other overseas museums. I am thinking of exhibiting the information materials in the museum, too, so that the visitors can consult with them freely. I would like to take this opportunity to offer my deepest gratitude to Professor Manfred Skopec of the Nitze-Leiter Endoscopy Museum and the Museum of Medical History at the Medical University of Vienna for his kind help. Thanks to proactive encouragement of Professor Rene-Lambert, we were also able to complete "the Paris Endoscopic Classification of Superficial Neoplastic Lesions: Esophagus, Stomach and Colon", in cooperation with OMED. The achievement of this project was published as a supplement of Gastrointestinal Endoscopy Vol. 58, No. 6, 2003. "The Paris workshop on columnar metaplasia in the esophagus and the esophago-gastric junction" held in Paris and Tokyo, the result of which has been published by Professor Lambert as the supplement of the journal.

In addition, as I already mentioned, monetary donation from endoscopy manufacturer solely for OMED was decreased by the amount of their product donations that we presented for the educational institutes, which is making our financial situation very severe to carry out various activities and projects.

Therefore, I had to rely heavily on Japan Gastroenterological Endoscopy Society to

continue OMED activities. Finding a solution for the financial difficulty is one of the most important issues of OMED in the future. Although it was impossible to increase donations from the current amount during my term, I hope there will be some solution to be found by the next presidents in cooperation with OMED members.

Lastly, I would like to offer my greatest gratitude to everyone who supported and helped me during my term, including Professor Crespi, Dr. Jerry Waye, the present president, Professor Montori who managed severe financial situation as the Treasurer, Dr. William S. C. Chao, the president of Asia-Pacific Society for Digestive Endoscopy, and everyone else who were involved in management of OMED throughout my term.

I sincerely hope further development of OMED in the future. Thank you.