ISDE ORGANIZATION

PART 1: MEET WITH YOUR EXECUTIVE COMMITTEE MEMBERS
INCUMBENT 13 MEMBERS SERVING A 3 YEARS (1989.9—1992.9)

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Structure of the ISDE

Executive Committee

- Membership C.
- Scholarship C.
- Newsletter C.
- Journal C.

Council

Central Research C.
- TPH Classification Research Committee
- Barrett's Esophagus Research Committee
- New Classification for reflux hiatal hernia Research Co.
- Cricopharyngeal Function Research Committee

General Assembly
RECENT ORGANIZATION DEVELOPMENT

Message from Prof. Stipa,
NEW EDITOR IN CHIEF OF JOURNAL

The last Journal Committee meeting was held in Rome on March 24-25, 1990. The following members were present: Prof. K. Nabeaya, Prof. G. Stipa, Prof. A. Peracchia, Prof. G. Zaninni, Prof. G. Pappalardo, Dr. F. S. Carroniti and Dr. P. Trentino were included as Assistant Editors of "Diseases of the Esophagus".

Economical balance of the journal was presented by the Assistant Editors and discussed as the first step. For 1988, 1989 and 1990 the situation was satisfactory and all the members agreed on the good obtained results.

Afterwards, Prof. S. Stipa was appointed as the new Editor-in-Chief. Prof. A. Peracchia was added as Associate Editor, together with previous Prof. Inokuchi, Sievert and Skinner.

Unanimously, the Committee decided to renew the contract with Masson firm up to the end of 1993.

NEWS FROM THE EXECUTIVE COMMITTEE MEETING

Prof. Stipa elucidated a program to ameliorate both redactional and scientific aspects of the Journal. Some of the next issues will contain also selected topics, (achalasia, Benign tumors of the esophagus, Barrett's esophagus, gastroesophageal reflux) with famous colleagues as Guest Editors. Prof. Stipa underlined the contribution by all the members of the Society as the basic point to ameliorate the scientific level of the Journal. It is desirable, members to send their original papers to "Diseases of the Esophagus".

Thank you for your cooperation (S. Stipa)

c)Contents:
To improve the quality of the Journal, along with good free papers of high quality, Stipa said some review of special topics will be included in each issue. Two topics "Achalasia" and "Benign Esophageal Tumor" were Committee:

d)Future of the Journal Committee:
Concerning this point there were several opinions, and it was decided that the Journal Committee would be a standing committee of the ISDE.

Report(1) Research Committee
1)TNM Classification Research Committee:
TNM Research Committee actively circulated the revised registration form and Executive Committee endorsed those forms.

2)New Classification of Reflux Hiatal Hernia:
The so-called APP Classification (anatomy, function, pathology) was proposed by Matthews and others. At present members of the committee and trying to evaluate the classification at their own institutions and a decision will be made at a later date.

3)Barrett's Esophageal Research Committee and Cricopharyngeal Function Research Committee:
There has been little progress here.

Report(6) Discussion
1)The 5th World Congress of the ISDE:
A description of the preparations was made by President President Nabeaya.

2)The 6th World Congress - President and site:
It was decided that Prof. Sievert, Prof. Skinner, Prof. Peracchia and Prof. Inokuchi will take office of the associate editors.

(Ando)
Esophageal cancer was classified and included in the first edition of TNM classification published by UICC in 1968, and this classification was revised three times and the fourth fully revised edition was published in 1987. In this edition, T was classified according to the depth of invasion, and the regional node included not only mediastinal but also paraaortic lymph nodes. These changes were proposed by Japanese Research Committee based on the data compiled as a nation wide registration of the patients.

ISDE’s TNM Classification research Committee was established on July 21, 1988. Propagation of this classification was the main purpose of this research, and examination of its usefulness is another object. So we started collect the patients with esophageal carcinoma for investigation of this classification. Registration forms were made based on this classification, and the patients treated in 1988 was collected first. The part of the results of collected patients were presented at the meeting of Research Committee held at Chicago on September 5, 1989. Results showed about 60% of registered patients had positive lymph nodes. This indicated about 60% of patients were in the advanced stage. At that time, Registration forms are said to be too complicated, and new simplified one was presented, and they were approved by members of Research Committee. New forms are printed and distributed for registration of the patients. You can find a new simplified registration forms in separate paper.

Now I am collecting the registration forms of the patients treated in 1988 and 1989 with this simplified form. I hope many members of ISDE participate the registration of the patients. The results of this study will be useful to compare the location of the tumor, lymph node metastasis, and stage of the patient according to the countries participate to the registration.

The third meeting of Research Committee is going to hold on July 18th, 1990 at Kurume, Japan. New collected data will be shown in this meeting. I am expecting hot discussions at this meeting.

(F. Izuka)
RExIONAL ACTIVITY

P.R.C.

The Second National Congress of the China Anticancer Association on Esophageal Carcinoma, with Professor Yu De Zhang as the President, was held in Nan'Anhuang, Hubei Province, on Oct. 10-13, 1989. Over 380 participants from all over the country attended the Congress, to which 289 original papers, mostly on the etiology, carcinogenesis, cytology, other basic researches, surgery, radiotherapy, chemotherapy, and combination therapy of esophageal carcinoma were submitted. At the general assembly 25 papers, including that by Dr. Toshiki Matushara, an invited speaker from Japan, were presented with good attention. A collective review of approximately 24,000 patients with esophageal carcinoma treated surgically from a number of medical centers across the country showed operative mortality rates of around 3% (ranging from 1.5% to 6.5%) and overall 5- and 10-year survival rates of 25%-36% and 17%-21% respectively. A report on the highlights of the Fourth World Congress of the ISDE on Diseases of the Esophagus held in Chicago, USA, in September 1989 was given by Dr. Liang Jun Wang, who and professor Guo Jun Huang were the two thoracic surgeons from China invited to participate in the Congress.

It was decided that the next Congress will be held in 1992, in either Qingdao or Yantai, two of the beautiful seaside resorts, of Shandong Province, with new advances in the etiology, collaboration between basic research and clinical practice, and therapy of carcinoma of the esophagus as main themes. (G. J. Huang)

U.S.A.

Three papers of interest to esophageal surgeons were presented at two recent major national surgical meetings in the United States. Dr. DeMeester and his group presented a paper entitled, "Surgery in the Management of Barrett's Esophagus." While the paper itself did not present any new advances regarding the management of Barrett's esophagus, it did reinforce a number of previously held beliefs. Seventy-eight per cent of the 74 patients with the disease who were treated by the authors had significant complications including stricture, ulcer, dysplasia, and carcinoma. Those with benign disease, had a markedly defective sphincter with intraabdominally located areas often complicated with shortening of the high pressure zone. Even more significantly, the contractile features of the lower esophageus were markedly diminished in the symptomatic patients presumably resulting in increased reflux and diaphragm against gastric juice. Of interest was the fact that 48% of the patients had excessive exposure to an alkaline pH. These patients were more likely to develop complications than were those without alkaline reflux. Antireflux surgery was successful in most patients but as others have noted, the abnormal mucosa and the presence of dysplasia were not favorably affected.

Only 14 patients with adenocarcinoma were considered to have curable surgical lesions and while an actuarial survival of five years of 46% was reported, validity of this statistical calculation is questionable since it is based on an extraordinarily small group of patients. Nonetheless, they concluded that with early tumors can be cured by surgical resection emphasizing the importance of close surveillance of patients with Barrett's esophagus.

At the annual meeting of the American Association for Thoracic Surgery held in Tokyo, there was an interesting paper presented by Dr. Rice and associates from Cleveland on the use of Esophageal Ultrasound in the Preoperative Staging of Carcinoma of the Esophagus. This is a technique which has not been widely employed in the United States but others on the continent and in Asia have had considerable success with its use. This particular report reflected the learning curve of the participants for accuracy in the assessment of both T and N subgroups being 59 and 70 respectively. The authors were of the conclusion, however, that, this rather mediocre result could be improved by further experience and technical innovations in their equipment so that an 85 to 90% accuracy could be achieved. Clearly, more experience with the technique is needed in the United States. Dr. Ginsberg of Sloan Kettering mentioned in the discussion, that this technique is assuming increasing importance in the assessment of the stage of the tumor before therapy, particularly neoadjuvant therapy is being so widely employed. Only with the use of this technique, can a reasonably accurate preoperative assessment of stage be made and the affect of neoadjuvant therapy on the stage assessed. Those of us in the United States await with interest the presentation of further reports on the technique from this country.

An innovative modification of the transthoracic resection for carcinoma of the esophagus was presented by Dr. Saidi of Tehran a technique which he calls the "endoluminal" pull-through operation." According to him, it is applicable to lesions at any location and involves resection of the tumor as well as the esophageal mucosa leaving a muscular esophageal tube in place through which the esophageal substitute, either stomach or colon, can be advanced into the neck to facilitate a cervical esophagostomy. The discussers of the paper pointed out that the mortality rate and Anastomatic leakage rate were somewhat excessive and the three-year survival rate of only 13% suggested that maybe the extent of the resection was being compromised by leaving so much of a muscular tube in place. A potential hazard of bringing the esophageal substitute through a residual esophageal muscular tube might be impairment of function of the substitute due to spasm of the esophageal muscle. No nonmetastatic studies were performed, however, to prove or disprove this potential criticism. (H. Elite)

U.K.

In the U.K. we already have two forums for discussing exclusively onoesophageal topics. The first of these is the British Oesophageal Group, which is a small group of surgeons and membership that has an annual meeting once a year in March for informal discussion of oesophageal topics. Visitors are welcomed but have to be introduced by a member.

The second forum is the British Society of Gastrouterology which has recently established an Oesophageal Section for those with this particular interest. At present membership is open to all who are interested in the B.S.G., but discussions are underway as to whether there can be limited membership of the Oesophageal Section in the future.

Because we already have these organizations, we have not felt it appropriate to arrange any separate meeting for U.K. members of the ISDE, but I think we could do quite a lot more to recruit additional members from the U.K. (R.T. Matthews)
The 44th scientific meeting of Japan Society for Esophageal Diseases was held under the chairmanship of Professor Koichi Isono, Department of Surgery, School of Medicine, Chiba University in Chiba on June 14 and 15, 1990. Six hundred members attended from 145 institutions and discussed the following topics.

Topics 1: Substantial figures of lymph node metastasis and treatment results of the esophageal cancer. This included the metastatic according to the location and depth of invasion of the cancer, preoperative diagnosis, complications, relapse rate and long-term results. The treatment results of the three field lymph node dissection of neck, mediastinum and abdomen were compared with those of the two-field lymph node dissection of the mediastinum and abdomen.

Topics 2: Special characteristics of multiple development of esophageal carcinomas were discussed.

Topics 3: Cases required reconsideration after esophageal cancer operation regarding operative procedures, complications, postoperative cares and indications. The followings were also performed during the meeting:

1. Education corner with the video and movie.
2. Photo-exhibition of new classification of histologic and endoscopic findings.
3. The results of the questionnaire regarding topics collected from the nationwide institutions was shown by Isono, Congress Chairman.

The topics described above were extensively discussed during the meeting. Many important points were elucidated and resolved. Thus, new directions of the future researches were indicated.

(K. Isono)
STUDIES ON THE CHARACTERIZATION OF A MURINE MONOCLONAL ANTIBODY (KYM-1) TO A CELL SURFACE ANTIGEN ON ESOPHAGEAL CARCINOMA

We produced a murine monoclonal antibody, KYM-1 (ImmunoGlobulin M) by immunizing mice with esophageal cancer cell line (KE-1) at our Laboratory. KE-1 was derived from a metastatic supraclavicular lymph node of a patient with esophageal squamous cell carcinoma and maintained into BALB/c male nude mice. There are few reports concerning monoclonal antibodies produced by esophageal carcinoma in the immunogen. Interestingly, many monoclonal antibodies against human tumors have recognized a mucin glycoprotein antigen or glycolipid antigen. In this report, the distribution of antigen detected by KYM-1 were investigated immunohistologically and immunocytoologically. The biochemical property of antigen defined by KYM-1 were also investigated at the Biomembrane Institute.

By immunohistochemical staining, 43 out of the 53 human esophageal cancer (81.1%) showed a distinguished reaction to KYM-1. Against to this result, only one of the 3 gastric cancers were positive in this staining, and all of 5 colon cancers and 3 cell lines of adenocarcinoma were negative in this staining. In addition, KYM-1 slightly reacted to the basal cell membrane of non-cancerous esophageal mucosa. On the other hand, fresh-frozen cryostat tissue sections fixed with acetone were stained by KYM-1, while on reactivity of KYM-1 was observed in formalin-fixed and paraffin-embedded sections, suggesting that antigenic substances were disrupted by this procedure. By immunostaining on thin-layer chromatography (TLC) plates, glycolipid antigens extracted from gastric cancer, colon cancer and melanoma with isopropanol-hexane-water were not bound by KYM-1. These findings indicated that an epitope of KYM-1.

Furthermore, studies on the usefulness of KYM-1 as a diagnostic tumor marker and on the basic question of protein are in progress at our Laboratory. Finally, I would like to thank Prof. bent: irish Hakomori, for giving me this great opportunity to work in his cancer research. I am also grateful to the ISDE for giving me the opportunity to study in the Biomembrane Institute at the University of Washington, which is the most famous for glycolipid of cancer in the world. (G.Shiboru)

K. Jadivala, 
Bombay Hospital

I worked for three months in the department of Thoracic Surgery, Hotel Dieu De Montreal. This is the oldest Hospital in Montreal affiliated to the University of Montreal.

The thoracic surgery is headed by Dr. Andre Duranceau, who is not only the master in his work but also very kind hearted. When I left Bombay for Montreal, I had a lot of apprehension but as soon as I met him, I was at home. Dr. Duranceau has done plenty of pioneering work in esophageal motility disorders. He has established a very good esophageal laboratory. Manometry, esophageal manometry & 24hrs pH monitoring are done in this laboratory. I used to work in esophageal laboratory learning the techniques & interpretations of manometry, 24 hrs pH monitoring and endoscopy. The manometry & 24 hrs pH monitoring is done in our country and so I was probably the first to learn them. I also saw and assisted in the various surgeries of the esophagus like total esophagectomy, anti-reflux procedures, cricomyotomy with suspension of the Zenker’s diverticulum etc. procedures, cricomyotomy with suspension of the Zenker’s Diverticulum etc.

Under the guidance of Dr. Andre Duranceau & Dr. Raymond Taillefer from Nuclear Medicine department, I undertook two studies which are as follows:

(1) COMPARISON BETWEEN MANOMETRY & RADIOISOTOPIC ESOPHAGEAL TRANSIT STUDY (RETS) IN DETECTION OF ESOPHAGEAL MOTILITY DISFUNCTION.

101 consecutive patients without previous esophageal surgery and with symptoms referable to esophagus underwent both RETS & esophageal motility studies (EMR) within one month of each other. Analysis of the results revealed that (1) RETS is a useful noninvasive test for screening of patients with symptoms thought to be of esophageal origin.

(2) RETS is useful to quantitate esophageal emptying abnormalities in patients with reflux disease, motor disorders and other conditions affecting esophageal function.

(2) COMPARISON OF SLEEVE & CONVENTIONAL MANOMETRY FINDINGS IN THE ASSESSMENT OF UPPER ESOPHAGEAL SPHINCER DISORDERS.

In twenty-four patients with oropharyngeal dysphagia, manometry of the pharynx and upper esophageal sphincter was done using both conventional technique using a triple lumen esophageal motility tube & Don sleeve tube.

In pharynx, both the methods gave identical abnormalities but in upper esophageal sphincter the recorded resting pressure showed a significance difference between both methods with higher pressure recorded by sleeve sensor. Similarly, the pressure gradient between the sphincter during relaxation and upper esophageal was also higher with sleeve than with the conventional method.

Finally I appreciate and thank Dr. Andre Duranceau for giving me an opportunity to come to Montreal and share this extensive knowledge with me. It was also very interesting to know from him about this great country and her people. I also thank Dr. Edwin Laffontine, Associate Thoracic Surgeon, Dr. Raymond Taillefer - Dept. of Nuclear Medicine, Miss Esther Pellerin - Esophageal Laboratory and Mrs. Gisele Bergeron, Secretary to Dr. Duranceau for their help and kindness.

But for ISDE Scholarship, I could not have dreamt of going to Canada at this stage of my career. It is indeed very helpful for youngsters like me to go to renowned centres of the world and gain advanced knowledge in esophageal diseases.

(K.Jadivila)
FUNCTIONAL DISORDERS OF THE LOWER ESOPHAGEAL Sphincter and Cardia

—Dr. A. Yasai & Prof. T.R. DeMeester—

The body of the esophagus function as a worm drive propulsive pump, initiated by the pharyngeal phase of swallowing, and is responsible for transmitting a bolus of food from the distal esophagus into the stomach. Motility disorders of the esophageal phase of swallowing are due to failure of the esophageal pump and/or valvular functions of the distal esophageal sphincter. They were classified as Table 1.

The manometric abnormalities seen in diffuse esophageal spasm usually occur in the distal two-thirds of the esophagus. The proximal segment is normal, but as the distal esophagus is involved to a lesser degree. In diffuse spasm the response of the distal portion of the body of the esophagus to a single swallow is characterized by the occurrence of several nonsequential repetitive pressure peaks which may be of abnormally high amplitude and long duration. However, the esophagus usually retains some degree of peristaltic performance, which is not true in achalasia. A minority of patients can show impaired relaxation of the lower esophageal sphincter similar to that seen in achalasia with or without increased sphincter pressure. In most patients the distal esophageal sphincter relaxed completely. The advent of ambulatory motility has allowed sampling the esophageal contractions over a longer period and during various physiological states of activity. These studies have shown that patients with a disorder of the esophageal phase of swallowing have more difficulty than normal subjects in organizing their esophageal activity into peristaltic waves which results in a sense of fullness, i.e., sleep, awake, and focused on eating. Scoring systems based on variables of the motility pattern differentiate patients from normals and quantitates the severity of the disorder. These findings may be identified with greater specificity and sensitivity primary esophageal motility disorders.

The usual surgical procedure for treatment of dysphagia secondary to achalasia or diffuse spasm is an esophageal myotomy of the distal sphincter and body of the esophagus to just above the level of motility abnormality. The destruction of the distal esophageal sphincter relaxes the fundus to help prevent an antireflux procedure of low outflow resistance, i.e., a partial fundoplication. Better results are better for classic achalasia than diffuse spasm (92 to 77%) mainly because of the difficulty in diagnosing the latter. In the treatment of esophageal motor disorders there comes a time when improvement can only be achieved by esophagectomy. The question is when should one revert to an esophagectomy as the solution? There is no absolute answer to this question: The decision must be based on the surgeon’s individual experience and confidence in constructing a durable esophageal substitute that functions well. From our own experience, the following guidelines have been helpful in making this decision:

1. When previous esophageal procedures to correct a motility disorder have resulted in reflux and subsequent stricture of the distal esophagus, extirpation should be seriously considered.
2. When the disease has progressed, in spite of multiple therapeutic procedures, to where the esophagus is dilated and tortuous and contractions in the body are nonexistent, extirpation should be seriously considered.

TABLE 1

<table>
<thead>
<tr>
<th>PRIMARY ESOPHAGEAL DISORDERS</th>
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<tbody>
<tr>
<td>1. Achalasia</td>
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<tr>
<td>2. Diffuse spasm</td>
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<td>3. Nonspecific motility disorder</td>
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<tr>
<td>4. Hypotensive lower esophageal sphincter(GERD)</td>
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<table>
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<tr>
<th>SECOND ESOPHAGEAL DISORDERS</th>
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<tbody>
<tr>
<td>1. Scleroderma</td>
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<tr>
<td>2. Myositis</td>
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<tr>
<td>3. Myasthenia gravis</td>
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</tbody>
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**RECENT PUBLICATION**

Surgery for Cancer of the Esophagus By Hiroshi Akiyama
Williams & Wilkins, 1990

The author is world famous esophageal surgeon representative of Japan. He was elected Honorary Fellow of the Royal College of Surgeons of England in 1989, as described in the last ISDE News. He has experienced many cases of esophageal cancer and has written intensively and exclusively on the basis of his personal experiences, clinical date and results.

In this book, cancer of the esophagus is divided into three main categories: (1) carcinoma of the thoracic esophagus; (2) carcinoma of the hypophrynx and cervical esophagus (3) carcinoma of the lower esophagus and caries of gastric origin. The most up-to-date basic operative principles with detailed illustrations and through pathological studies effectively clarify the author’s operative methods. To make the reader in a series of logical steps. Significant description is devoted to the technique of lymph node dissection for radical surgery. A practical and clinical guide for surgeons who intend to operate on esophageal cancer. This work will serve as a textbook for surgeons and postoperative and postoperative care and surgical strategy and adjuvant therapy. After finishing the book, one will understand the author’s surgical philosophy and will have obtained much information. (R. Yoshino)

**CONGRESS NEWS**

**COLLEGIUM INTERNATIONAL CHIRURGIAE DIGESTIVAE**

Site: New Delhi, India
Date: Nov 3-7, 1990
President: M. J. Joshi (India)
Secretariat: 1194/23 Chole Road, Pune 411 005, INDIA
Tel: 212-53698 Fax: 2300-0600 Hrs

**INTERNATIONAL SURGICAL SYMPOSIUM**

Site: Hong Kong
Date: Dec. 14-16, 1990
President: Arthur R.C. Li (Hong Kong)
Coordinator: Secretariat
99 Wilson TE Wang International Surgical Symposium
San Francisco Travel Ltd., Suite 504-5 South Tower, World Finance Centre, Harbour City, Kowloon, Hong Kong
Tel: 735-0033 Fax: 735-0262
Deadline for abstracts: July 31, 1990
Topics: Gastric Cancer, Peptic Ulceration, Head and Neck Trauma and Reconstruction, Orthopaedic Injuries, Chest and Abdominal Injuries

**European Congress of Surgery**

Site: Paris, France
Date: Oct. 2-5, 1990

**ASIAN SURGICAL ASSOCIATION, 8TH CONGRESS**

Site: Pukouka, Japan
Date: Mar. 19-23, 1991
President: Dr. Fumio Nakayama

**INTERNATIONAL COLLEGE OF SURGEONS (17TH EUROPEAN FEDERATION CONGRESS)**

Site: Amsterdam, Holland
Date: June 23-26, 1991
President: Dr. W. R. Siabbeles
Deadline: Topics: Education and training, Surgical nutrition, Gastro-intestinal surgery, Surgical oncology, etc.

The first circular is scheduled to be distributed this autumn. Many participants are anticipated.

**NEXT WORLD CONGRESS OF ISDE, THE FIFTH WORLD CONGRESS OF THE INTERNATIONAL SOCIETY FOR DISEASES OF THE ESOPHAGUS**

Site: Kyoto International Conference Hall Kyoto, JAPAN
Congress Chairman: Ken-ichi Nabe\a Professor of the Second Department of Surgery, Kyorin University Sch. of Med.
Congress Office: Kyorin University Sch. of Med. 6-20-2 Shinkawa, Mitaka-shi Tokyo 181, JAPAN
Tel: 0422-47-5511(ext. 2603) Fax: 0422-45-3576

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We will be pleased to accept news items, Congress or Meeting information from members for publication. Suggestions for projects and programs will also be welcome. Please send any such information to the Secretariat.
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