GASTROINTESTINAL PATHOLOGY SOCIETY NEWSLETTER

Summer 1998

1998-1999

OFFICERS AND EXECUTIVE COMMITTEE OF THE GASTROINTESTINAL PATHOLOGY SOCIETY

Past President	Cecilia Fenoglio-Preiser
Incoming President	Brian West
Secretary/Treasurer	Audrey Lazenby
Education	Joel Greenson
Membership	Mary Bronner
Training	Marie Robert
Publications/Newsletter	Robert Odze
Senior Advisor	Klaus Lewin

EDITORIAL COMMENT

Dear GIPS Members,

For better or for worse, the millennium is drawing nearer, so it's entirely apropos that the executive committee of GIPS has decided to take the electronic plunge into the world of the internet. Yes it's true, by the time you receive this newsletter, the final touches will have already been placed on the new GIPS web site. The website will be easily accessible (even for those of us, including myself, who did not grow up in the computer age) with the use of your desk top computer via the Internet.

Enclosed in this newsletter is a sample layout of the introduction page of the GIPS web site which includes the various features and information that will be available. Included is a page regarding who and what GIPS represents, how to contact and join GIPS, membership list, events page, as well as a list of GI fellowship programs and announcements. The web site will include features that enable viewers to access other GI-related societies (i.e., AGA) web sites. Furthermore, all information that is normally transmitted in the newsletter will be available in one or another page of the web site, which will be continually updated twice per year. In addition, the newsletter will be able to be accessed, and downloaded as a hard copy. For those of you either unable (lack of computer access to Internet), unwilling, or just plain scared of electronic gadgets (yes, we do still exist and are doing quite well, thank you), the newsletter hard

copy will still be sent to you by mail. Please inform us of your preference in this regard on the next dues notice, if you haven't already done so. Alternatively, you may contact me at the address listed below. Finally, if any of you have any ideas or features that you think may enhance this web site, please feel free to let me know.

One final note, I wish to thank Pat Dean, the previous editor of the newsletter, for making the transition for me as easy, and fun, as possible. I also would like to thank Audrey Lazenby, Dr. Fenoglio-Preiser, Brian West, Bob Pascal, Amy Noffsinger, Gerry Turner and Jim Crawford for their contributions to this newsletter. That's all folks, so enjoy what will probably turn out to be the last newsletter published in this format (you may hold onto it for posterity, but I don't think it will become a collectors item). All feedback is encouraged.

-See you in San Francisco

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PUBLICATIONS COMMITTEE UPDATE

Negotiations are presently being conducted on behalf of GIPS to develop sponsorship in Modern Pathology. The initial plan is to utilize a separate GI Associate Editor, as yet to be named, who would have significant input regarding the acceptance of GI-related manuscripts in the Journal.

Details of this joint venture are not clear at the time of this writing, but should be in place by the beginning of the new academic year. See the Website for new developments in this regard!

Gastro-Intestinal Pathology Society

Welcome to the Gastro-intestinal Pathology Society Homepage.


About the Gastro-Intestinal Pathology Society


Preview the Gasto-Intestinal Society Newsletter


Read the Gastro-Intestinal Society Newsletter


Contact the Gasto-Intestinal Pathology Society


Realted Sites


Members' List


Events Page


Gasto-Intestinal Pathology Fellowship Programs

ANNOUNCEMENTS

Congratulations to the following individuals for acceptance into GIPS:

For regular membership:

*Elaine R. Alt, MD (sponsor: Henry Appelman)

*Thomas McColl Chesney, MD (sponsor: Rodger Haggitt)

*Franz Fogt, MD (sponsor: Harvey Goldman)

*So-Young Jin, MD (sponsor: Cecilia Fenoglio-Preiser)

*Husain Ali Saleh, MD (sponsor: Henry Appelman)

For associate membership:

*Richard N. Fredricks, MD (sponsor: Henry Appelman)

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Congratulations to Dr. Kanishka Sircar, MD for winning the GIPS prize at the recent USCAP meeting in Boston. The title of the winning abstract was "Most Gastrointestinal Stromal Tumors (GIST) Arise from Intestinal Cells of Cajal (ICC)".

Four additional presentations were considered outstanding and are listed here:

Jonathan Glickman, MD "Lymph Node Micrometastasis in Esophageal Carcinoma Has No Prognostic Significance".

Niall Mulligan, MD "Predictive Value of K-ras Codon 12 Mutation in Ductal Proliferative Lesions of the Pancreas".

Shaun Walsh, MD "Allergic Esophagitis in Children: A Clinicopathological Entity".

Bin Yang, MD "Overexpression of p53 Protein Associated with Decreased Response to Chemotherapy in Esophageal Carcinoma".

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GIPS TRAVEL AWARD

The GIPS Training and Awards Committee would like to take this opportunity to remind its members that the GIPS awards a prize of $500.00 for the best poster or platform presentation in the area of gastrointestinal pathology presented by a pathologist-in-training at the annual meeting of the USCAP. To be considered for this award, applicants should sent a copy of their accepted abstract with a cover letter from their mentor indicating that the abstract represents the work of the applicant. These documents should be sent to Marie Robert, M.D., by February 20th preceding the meeting.

Marie E. Robert, M.D., Department of Pathology, Yale University School of Medicine, 310 Cedar Street, PO Box 2080203, New Haven, CT 06520-8023.

Announcement of GIPS Travel Award

The Training and Awards Committee Wishes to announce the institution of the Gastrointestinal Pathology Society Travel Award to the membership. This award will replace the microgrant program which will no longer be active. The GIPS Travel Award is a **$500.00 stipend** to help support a pathologist-in-training to spend a one month rotation with a gastrointestinal pathologist at another institution. Applicants should sent their CV and a cover letter describing their interests in gastrointestinal pathology and whom they propose to work with to the chair of the Training Committee.

We strongly encourage our membership to convey this information to interested residents or fellows at their institutions.

Send applications to Marie E. Robert, M.D., Department of Pathology, yale University School of Medicine, 310 Cedar Street, PO Box 208023, New Haven, CT 06520-8023.

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A slide seminar on gastrointestinal polyps will be held at the IAP Congress in Nice, France, on Thursday, October 22, 1998, from 2:30 to 6:00 PM. The participants are:

*Dr. Jeremy R. Jass, Queensland, Australia
Course Director)

*Dr. Robert R. Pascal, Atlanta, GA, USA

Course Director)

*Dr. Donald A. Antonioli, Boston, MA, USA

*Dr. Henry D. Appelman, Ann Arbor, MI, USA

*Dr. Claus Fenger, Odense, Denmark

*Dr. Harvey Goldman, Boston, MA, USA

*Dr. Pentti Sipponen, Espoo, Finland

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Armed Forces Institute of Pathology - 9th Annual Review Gastrointestinal Surgical Pathology and Endoscopic Biopsies of the GI tract and 19th Annual Course Hepatopathology '98, The Interpretation of Liver Biopsies. August 17-19, 1998, Hyatt Regency Bethesda, Bethesda, Maryland. Course Director: Leslie H. Sobin, M.D. For further information, please contact the Course Coordinator, Stephen Huntington, Center for Advanced Medical Education, Armed Forces Institute of Pathology, Washington, DC 20306-6000. Telephone (202) 782-2637; Toll free (800) 577-3749 (U.S. only); Fax (202) 782-5020.

FELLOWSHIP PROGRAMS IN GASTROINTESTINAL PATHOLOGY
ECFMG requirements for approval of non-accredited Fellowship

Programs: International medical graduates who have completed five years of an AP/CP training program, and wish to spend a sixth year doing a Fellowship program in gastrointestinal pathology (technically an "unaccredited" program because there are no subspecialty Boards in GI pathology) now are required by the ECFMG to provide evidence that the program is recognized by the Board or appropriate professional society. The American Board of Pathology does not recognize (for this purpose) Fellowship programs in Surgical Pathology and other subspecialities in which there is no Board certification. Experience in 1997 has indicated that listing of Fellowship programs in Surgical Pathology by the Arthur Purdy Stout Society has met this requirement. It seems likely that a copy of the listing of programs in the Gastrointestinal Pathology Society Newsletter, in the American Journal of Surgical Pathology and in Gastroenterology, would suffice in the case of a Fellowship program in gastrointestinal pathology. However, the criteria for acceptance by the ECFMG are not clear, and as increasing restrictions are placed on training of foreign medical graduates, these may change. It would seem advisable for directors of Fellowship programs to offer Fellowship positions to foreign medical graduates contingent upon meeting the ECFMG requirements (which include a letter from the home country Minister of Health stating that there is a need for such expertise in that country), and to initiate the process of meeting those requirements as early as possible.

FELLOWSHIP PROGRAMS IN GASTROINTESTINAL PATHOLOGY

Institution	Duration [a]	Prerequisites [b]	Salary Source [c]	Program Director(s) & Adress	Comments
UCLA Center for Health Sciences	1 yr	AP or AP/CP complete and California license	Institution or Outside	Lewin, Klaus J. MD Dept Pathology 10833 Le Conte Ave Los Angeles, CA 90024 fax: (310) 206-5178 klewin@ucla.edu	Service responsibility and clinical research in GI and liver pathology.
Yale University School of Medicine	1-2 yrs	3 yrs AP or AP/CP	Institution or Outside	Crawford, James, MD, PhD Robert, Marie MD Dept Pathology 310 Cedar Street New Haven, CT 06520-8023 ph: (203) 785-5486 fax: (203) 737-1064 marie.robert@yale.edu Jamesmac.crawford@yale.edu	Specialized training in GI and liver pathology. Clinical and/or basic research experience.
Armed Forces Institute of Pathology	1 month	2 yrs AP or GI Fellowship	Home Institution	Sobin, Leslie H. MD Ishak, Kamal MD, PhD AFIP Dept Hepatic & GI Pathology Washington, DC 20306-6000 ph: (202) 782-2880 fax: (202) 782-9020 sobin@email.afip.osd.mil	
Armed Forces Institute of Pathology	1 year	Pathology training complete	American Registry of Pathology	Sobin, Leslie H. MD Ishak, Kamal MD, PhD AFIP Dept Hepatic & GI Pathology Washington, DC 20306-6000 ph: (202) 782-2880 fax: (202) 782-9020 sobin@email.afip.osd.mil	Callender-Binford Fellowship
Emory University School of Medicine	1 yr	AP or AP/CP	Institution	Pascal, Robert R. MD Dept Pathology & Lab Medicine 1364 Clifton Road, NE Atlanta, GA 30322 ph: (404) 712-7099 fax: (404) 712-4454	1 yr program in Surgical Pathology with emphasis on GI pathology and research.
Louisiana State University Medical Center	1 yr	Pathology training complete	Contact Dr. Correa	Correa, Pelayo MD Dept Pathology 1901 Perdido St New Orleans, LA 70112	Research in GI pathology and epidemiology.

[a] Fellowship is defined as an organized training program lasting for one or more years.

[b] Minimum completed training necessary for participation in Fellowship. Anatomic Pathology (AP) may be specified. Some programs are open to gastroenterologists, internists, and surgeons.

[c] "Institution" means salary is available via institution. "Outside" means salary must come from outside source (application or otherwise by the candidate).

[d] Programs are combined.

FELLOWSHIP PROGRAMS IN GASTROINTESTINAL PATHOLOGY

Institution	Duration [a]	Prerequisites [b]	Salary Source [c]	Program Director(s) & Adress	Comments
The Johns Hopkins University School of Medicine	2 yrs	2 yrs AP	Institution or Outside	Hamilton, Stanley R. MD Yardley, John H MD Dept Pathology Ross 632 720 Rutland Avenue Baltimore, MD 21205-2196 ph: (410) 955-3511 fax: (410) 614-0671	Experience in diagnostic GI/liver pathology both at Fellow and Attending level, combined with applied and/or basic research.
[d] Beth Israel & Childrens Hospitals, Harvard Medical School	1 yr	AP or AP/CP	Institution	Antonioli, Donald MD Dept Pathology 330 Brookline Avenue Boston, MA 02215	Includes general service responsibility in AP and specific training in adult and pediatric GI pathology.
Brigham & Women's Hospital, Harvard Medical School	1 yr	AP training or AP/CP	Institution or Outside	Odze, Robert D. MD Dept Pathology 75 Francis Street Boston, MA 02215 ph: 617-732-7549 fax: 617-277-9015	Combined diagnostic GI, Liver, and Pancreatic pathology with clinical based research.
[d] New England Deaconess Hospital, Havard Medical School	1 yr	3 yrs AP or AP/CP	Institution	Goldman, Harvey MD Dept Pathology 1 Deaconess Rd Boston, MA 02215 ph: (617) 632-9037 fax: (617) 632-0300 hgoldman@nedhmail.nedh.harvard.edu	Includes general service responsibility in AP and specific training in adult and pediatric GI pathology.
Mayo Clinic	1-2 yrs	3 yrs AP or 4 yrs AP/CP	Institution	Carpenter, Herschel MD Dept Pathology & Lab Medicine 200 First St, SW Rochester, MN 55905 ph: (507) 284-0697 fax: (507) 284-1599 hcarpenter@mayo.edu	Combines diagnostic GI and liver pathology with general AP and research. Over 12,000 GI and liver biopsies.
Long Island Jewish Medical Center	1 yr	3 yrs AP or 4 yrs AP/CP	Institution	Kahn, Leonard B. MD Dept Pathology 270-05 76th Street New Hyde Park, NY 11040	

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FELLOWSHIP PROGRAMS IN GASTROINTESTINAL PATHOLOGY

Institution	Duration [a]	Prerequisites [b]	Salary Source [c]	Program Director(s) & Adress	Comments
The Mount Sinai Medical Center	1-2 yrs	2 yrs AP or 3 yrs AP/CP	Institution	Harpaz, Noam MD, PhD Dept Pathology One Gustave Levy Place New York, NY 10029 nharpaz@smtplink.mssm.edu	Combines diagnostic pathology and research.
University of Cincinnati	1-2 yrs	AP/CP Complete & Eligible for Ohio License	Institution or Outside	Fenoglio-Preiser, Cecilia M MD Noffsinger, Amy MD Dept Pathology 1207 Medical Sciences Bldg 231 Bethesda Venue PO Box 670529 Cincinnati, OH 45267-0529 ph: 513-558-4500 fax: 513-558-2289 cecilia.fenoglio-@UC.edu	
Brown University	1-2 yrs	2 yrs AP or 3 yrs AP/CP	Institution	Lev, Robert MD Dept Pathology Roger Williams General Hosp 825 Chalkstone Avenue Providence RI 02908 ph: (401) 456-2162 fax: (401) 456-2131	Combines diagnostic pathology and research.
Baylor College of Medicine	1-2 yrs	1-2 yrs AP	Institution or Other	Lechago, Juan MD, PhD Dept Pathology 6565 Fannin Mail Station 205 Houston, TX 77030 ph: (713) 793-1189 fax: (713) 793-1473	Flexible, combines diagnostic pathology and research.
University of Washington	1-2 yrs	2 yrs AP or 2 yrs GI Fellowship	Institution or Outside	Haggitt, Rodger C. MD Div. Hosp Pathology, RC-72 1959 NE Pacific St Box 356100 Seattle, WA 98195-6100 ph: (206) 548-6404 fax: (206) 548-4928 rhaggitt@u.washington.edu	

[a] Fellowship is defined as an organized training program lasting for one or more years.

[b] Minimum completed training necessary for participation in Fellowship. Anatomic Pathology (AP) may be specified. Some programs are open to gastroenterologists, internists, and surgeons.

[c] "Institution" means salary is available via institution. "Outside" means salary must come from outside source (application or otherwise by the candidate).

[d] Programs are combined.

FELLOWSHIP PROGRAMS IN GASTROINTESTINAL PATHOLOGY

Institution	Duration [a]	Prerequisites [b]	Salary Source [c]	Program Director(s) & Adress	Comments
McMaster University	1 yr	2 yrs AP	Institution	Riddell, Robert H. MD 1200 Main Street West Hamilton Ontario L8N 3Z5 Canada ph: 905-521-2100/521-6341 fax: 905-577-0198 riddellr@fhs.mcmaster.ca	
Vancouver General Hospital, University of British Columbia	1 yr	4 yrs Pathology	Institution	Owen, David A. MD Dept Pathology 855 West 12th Avenue Vancouver British Columbia V5Z 1M9 Canada	Includes research, pediatric GI pathology experience.

[a] Fellowship is defined as an organized training program lasting for one or more years.

[b] Minimum completed training necessary for participation in Fellowship. Anatomic Pathology (AP) may be specified. Some programs are open to gastroenterologists, internists, and surgeons.

[c] "Institution" means salary is available via institution. "Outside" means salary must come from outside source (application or otherwise by the candidate).

[d] Programs are combined.

GASTROINTESTINAL PATHOLOGY SOCIETY NOMINATING INFORMATION

The Gastrointestinal Pathology Society was founded in 1979 as the Gastrointestinal Pathology Club with the objectives of disseminating and increasing knowledge about pathology of the gastrointestinal tract and of encouraging the development of gastrointestinal pathology as a subspecialty. At present the Society meets once a year immediately preceding the annual March meeting of the United States and Canadian Academy of Pathology. Further activities include the distribution of a newsletter, a scientific session in May at the American Gastroenterological Association annual meeting, and participation in the cooperative projects.

The Society exists to unite persons with an interest in the pathology of the gastrointestinal tract and liver. An exclusive involvement in hepatopathology will not ordinarily be considered adequate for membership.

Two categories of membership are available: regular membership and associate membership.

Regular Membership: This is open to individuals holding an M.D., Ph.D., or equivalent, and is not restricted to persons who are board certified in Anatomical or Clinical Pathology. The principal criterion for admission is evidence of active involvement and commitment to the pathology of the gastrointestinal tract. This may include diagnosis, education, and research but is not intended to encompass persons with only a vague general interest. Scholarly achievement in the form of publications relevant to G.I. pathology is required for admission, but special note will also be taken of other activities, especially regular educational efforts such as undergraduate or postgraduate lecturing. Annual dues for regular members are $40 U.S., payable after formal acceptance.

Associate Membership: This category is open to persons holding an M.D. or its equivalent, who have an interest in G.I. pathology. This membership is limited to five years and cannot be renewed. it is intended that persons in this category will have a developing interest in G.I. pathology, but less documented experience and involvement. This type of membership is most suited to residents and fellows, but is not restricted to them. Associate membership may be converted to regular membership after five years, or sooner if the individual meets the criteria outlined above. Annual dues for associate members is S10 U.S., payable after formal acceptance.

Nomination Form: Applications for membership should be made on the attached form. It is particularly important that a full bibliography be included in applications for regular membership. This information is used for more than establishing grounds for membership. The Society needs a comprehensive picture of the background and capabilities of its members in order to develop its programs.

Applicants for Associate membership need only fill out items 1 through 9 and

obtain a nominator's signature.

Applicants who do not personally know a member of the Society who will act as sponsor, should contact the Secretary-Treasurer who will provide name(s) of potential sponsors.

Normally it is sufficient for the nomination to be signed by any regular Society member. Nominators are used, however, to provide a letter of recommendation or amplification if there are any special or unusual aspects of the application which need to drawn to the attention of the Membership Committee.

Identifying information about all members including address and phone numbers will be listed in the Society Directory and submission of this nomination will be construed as permission to list such information. The directory will be distributed to the members annually.

The original application together with seven completed copies should be mailed to:

******** Audrey Lazenby, MD
Secretary/Treasurer
Kracke 526, Pathology
UAB School of Medicine
619 S. 19th Street
Birmingham, AL 35233

Applications should be received by the Secretary-Treasurer by January 15th. Applicants should expect to receive information concerning their membership after the GIPS annual meeting which is held during the March meeting of the United States and Canadian Academy of Pathology.

GASTROINTESTINAL PATHOLOGY SOCIETY

Nomination for Membership
(Use Typewriter Only)

1. Type of Membership: ___ Regular ___ Associate Date _____

2. Nominee's Name in Full _____
Last First Middle

3. Office Address _____

_____
City State Zip Code

4. Telephone numbers: Office ( ) _____ Home ( )_____

FAX: ( ) _____

5. Date of birth _____ Place _____

6. EDUCATION Name of Institution Degree Year Graduated

Academic or College _____

Medical School _____

Other _____

_____

7. POST DOCTORAL TRAINING (Housestaff and other. List chronologically)

Name of Institution Field Inclusive Dates

_____

_____

_____

_____

_____

8. TRAINING IN G.I. PATHOLOGY (Brief summary. Include any special coruses, post-doctoral training, etc., give names of teachers. If none, write "none."

_____

_____

_____

9. ACADEMIC APPOINTMENTS (past and present). Mark the present ones with asterisk.

Name of Institution	Title	Inclusive Dates

10. HOSPITAL APPOINTMENTS: (Non-housestaff, past and present). Mark present with asterisk.

Name of Institution	Title	Inclusive Dates

11. MEMBERSHIPS (past and present)

Medical and Scientific Societies: _____

_____

_____

_____

Other: (Editorial Boards, Advisory Groups, Study Sections, etc.): _____

_____

_____

_____

12. BOARD CERTIFICATION:

American Board of Pathology: Anatomic (Date) _____

Clinical (Date) _____

Other [Type, date(s)] _____

13. PROFESSIONAL ACTIVITY:

a. What proportion of <u>total</u> time is spent in:

Practice ____% Teaching ____% Research ____% Other ____%

(Nature?) _____

b. Percentage of total time in GI pathology: _____%

C. Nature of activities relating to GI disease. (Give basic details about activities, including types of diseases, disease mechanisms, and organ systems dealth with, methodology used, etc.):

Diagnostic: _____

_____

_____

_____

_____

Teaching: _____

_____

_____

_____

_____

_____

Research: _____

_____

_____

_____

_____

14. PUBLICATIONS: Attach your <u>complete</u> bibliography. Mark each GI-related publication with an asterisk in the left margin.

15. NOMINEE (Signature): _____

16. NOMINATOR (Signature): _____

Name (typed): _____

NOTE: When this form has been signed by both nominee and nominator, the original and 7 copies should be returned to:

Audrey Lazenby, M.D.
Secretary/Treasurer
Kracke 526, Department of Pathology
610 South 19th Street
Birmingham, AL 35233

BY-LAWS OF THE GASTROINTESTINAL PATHOLOGY SOCIETY

Revised December 7, 1995

Article I

Name: The name of the organization shall be the Gastrointestinal Pathology Society, herein abbreviated as GIPS.

Article II

Objectives: The objectives of the GIPS are to disseminate and to increase knowledge about pathology of the gastrointestinal tract and to encourage the development of gastrointestinal pathology as a subspecialty.

Article III

Membership:

A. Categories of Membership -

1. Regular Member - Any individual who has completed postdoctoral medical training with demonstrated interest and involvement in the field of gastrointestinal pathology as determined by the Membership Committee.

2. Associate Member - Any person holding a doctorate (or doctorate-equivalent degree) with an interest in gastrointestinal pathology. This membership is limited to five years and cannot be renewed. Associate members may apply for Regular membership in the usual way at any time if postdoctoral medical training has been completed.

3. Emeritus Member - Any regular member who, upon reaching the age of 65 years, has requested this status by letter to the Secretary-Treasurer, and whose request has been approved by the Executive Committee.

4. Inactive Member - A member can become "inactive" by requesting this status in writing to the Secretary-Treasurer. This status would be considered appropriate for a member who has become ill or incapacitated and is not presently actively practicing pathology. An inactive member would be excused from paying annual dues, but would maintain the full benefit of society membership.

This status can change by request to the secretary treasurer.

B. Conferring of Membership -

Nomination of an individual to Regular membership can be made by any Regular member. An application form (designed by the Membership Committee) must be countersigned by the sponsoring Regular member and then sent to the Secretary-Treasurer. The Membership Committee will review the applications and recommend approval or disapproval by the Executive Committee of the GIPS.

Nomination for Associate membership can be made by any Regular member. Applicants for Associate membership will not need to provide evidence of their involvement with GI pathology in their application. Such decision of involvement will rest with the sponsoring regular members. The procedure for application, review, and conferring of Associate Membership is otherwise identical to that for Regular Membership.

Membership can be terminated by written resignation addressed to the President or Secretary-Treasurer.

D. Right of Members -

Only Regular members will have the right to hold office and to vote. Each Regular member has one vote.

All members have the right to participate in the scientific sessions and in deliberations and discussions at the business meeting.

No member shall use the name, property, or the organization of the GIPS for personal benefit.

Only currently elected officers shall represent the GIPS in official business.

Article IV

Governing Body:

A. Elected Offices -

1. President: term of office one year.

2. Vice-President/President-Elect: serves on year as Vice-President and the next year as President.

3. Secretary-Treasurer: term of office three years.

B. Election of Officers -

Any Regular member of GIPS is eligible to hold office. Nominations will be recommended by the Membership Committee and may be offered from the floor by a Regular member at the Annual Business Meeting, or by mail ballot if the election is so held. Election ordinarily will be held at the Annual Meeting, or by mail ballot if deemed necessary by the Executive Committee. When the election is held at the Annual Business Meeting, a simple majority vote of the Regular Members in attendance is required to elect the officer. A simple majority vote of the Regular members in case of a mail ballot, is required to elect the officer.

C. Duties of Each Officer -

1. The President shall be the principal executive officer of the GIPS. The President shall preside at all meetings, serve as chairman of the Executive Committee, and take responsibility as a representative of the GIPS. The President officially receives donations, bequests, or gifts to the GIPS on behalf of the GIPS. The President shall make all appointments to the Standing Committees, as described in Article V. The President will also appoint a members of the GIPS to complete the term of any member of a Standing Committee whose position on that Committee is vacated. Ad hoc committees are appointed by the President as needed. The President will appoint the Editor of the Newsletter.

2. The Vice-President, in absence or incapacity of the

President, shall perform the duties of the President. The Vice-President shall serve on the Executive Committee.

3. The Secretary-Treasurer shall keep minutes of the Annual and Executive Committee meetings, distribute notices to members of GIPS, keep custody of documents of GIPS, including mortgages, deeds, and contracts that the Executive Committee has approved, serve on the Executive Committee, receive membership applications and dues, keep records of financial documents for governmental agencies, banks or other financial institutions with approval of the President for expenses used solely for the GIPS. All such disbursements will be reported at the Annual Meeting, as part of the financial report of the Secretary-Treasurer.

D. An Officer may not succeed him/herself in office.

Article V

Standing Committees:

A. Executive Committee.

1. The Executive Committee shall consist of the current officers, the past president, and chairman of the standing committees.

2. The Executive Committee shall:
   a. Represent the GIPS in official business.
   b. Carry out the directives and policies approved by the membership.
   c. Approve or disapprove all requests for change in membership status.
   d. Organize and coordinate all meetings of the GIPS.
   e. Exert leadership in the development and implementation of scientific programs according to the above stated objectives of the GIPS.
   f. Deal specifically with matters related to the incorporation of the GIPS.

B. Membership and Nominating Committee

1. The Membership and Nominating Committee shall consist

E. Training Programs and Awards Committee. The Training Programs and Awards Committee shall consist of six members appointed by the President. The term of office will be three years, with terms staggered so that two members are appointed each year. One member of the Committee will be appointed or reappointed each year by the President to serve as Chairperson. This Committee will:

1. Encourage organized graduate training programs in Gastrointestinal Pathology, and will collect and disseminate information about such programs, and will identify and assist in the development of sources of support for trainees.
2. Review all applications for Microgrants, and recommend to the Executive Committee, recipients of the GIPS Microgrants for research in Gastrointestinal Pathology.
3. Select the recipient of the annual GIPS prize for the most meritorious platform or poster presentation by a pathologist-in-training, on a subject of Gastrointestinal Pathology, at the Annual Meeting of the United States and Canadian Academy of Pathology.

Article VI

Scientific and Business Meeting.

This meeting shall be held annually. The time and place will be determined by the Executive Committee. A quorum must be present to conduct business, but the scientific meeting can proceed in absence of a quorum.

Article VII

Amendments:

Amendments to the by-laws may be suggested in writing to the Secretary-Treasurer by any Regular member at least two months prior to the Annual Meeting. If approved by the Executive Committee, these amendments need to be accepted by a two-thirds majority vote of the Regular members at the Annual Meeting.

Article VIII

of six members appointed by the President. The term of office will be three years, with terms staggered so that two members are appointed each year. One member of the Committee will be appointed or reappointed each year by the President to serve as Chairperson.

2. The Membership and Nominating Committee shall annually prepare a slate of nominations for officers of the GIPS to be presented to the membership at the Annual Business Meeting, or by mail ballot, if deemed necessary by the Executive Committee.

C. Education Committee. The Education Committee shall consist of six members appointed by the President. The term of office will be three (3) years, with terms staggered so that two members are appointed each year. The President will appoint one member of this Committee to serve as Chairperson for three (3) years. This Committee shall plan all scientific meetings of the GIPS, and will prepare the programs for such meetings to be distributed by the Secretary-Treasurer and by the appropriate officials of any other organization sponsoring such programs. The Executive Committee will provide the Education Committee with an annual budget to defray costs of invited speakers as deemed appropriate by the Education Committee and as approved by the Executive Committee.

D. Publications Committee. The Publications Committee shall consist of the Editor of the Newsletter, and the GI Section Editor of the American Journal of Surgical Pathology, whose terms shall coincide with their editorial appointments, a Senior Advisor, appointed by the President for a term of three (3) years, and one member-at-large, appointed by the President for a term of three (3) years. The Editor of the Newsletter shall serve as Chairperson of the Publications Committee. The Publications Committee shall review all material to be submitted for publication in the name of the GIPS, and will make its recommendation to the Executive Committee regarding the submission of such material for publication. Final approval for submission of material for publication will rest with the Executive Committee. Once approval is granted by the Executive Committee, the Publications Committee will coordinate the arrangements for submission, and publication with the appropriate publisher(s) and editor(s).

Dues and Assessments:

The amount of annual dues shall be determined each year by the Executive Committee. Special assessments may be made by the Executive Committee. New applicants shall be subject to assessments and dues if they participate in GIPS activities while being considered for membership.

After acceptance, new applicants shall be required to pay an initial fee not to exceed that of the annual dues.

Any member in arrears of dues for more than one year, failing satisfactory explanation, shall be dropped from membership. Such member may be reinstated on approval of the Executive Committee.

Article IX

Sunset Provision and Liquidation:

A. Sunset Provision.

Every five (5) years the President shall appoint an ad hoc committee to review the GIPS and its bylaws, and will, within the following year, prepare, and present to the membership its findings and recommendation concerning the continuation of the Society. If this does not occur the GIPS will be dissolved automatically. The ad hoc committee shall consist of the current President, the immediate Past-President, the President-Elect, and two members-at-large.

B. Liquidation.

Motion for liquidation must be made in writing to the Executive Committee at least two months prior to the Annual Meeting. A 2/3 vote of Regular members present at the annual meeting is required. In the event of liquidation, after payment of obligations, all remaining assets pass to the United States and Canadian Academy of Pathology (changed from the International Academy of Pathology, March 15, 1992).

Literature Review

1. Dr. Jerry Turner - Morphology Related Manuscripts:

Diverticular Disease-Associated Chronic Colitis

Prevalence and Significance of Pancreatic Acinar Metaplasia at the Gastroesophageal Junction.

The Biopsy Diagnosis of Gastroesophageal Reflux Disease, "carditis," and Barrett's Esophagus, and Sequelae of Therapy.

Classifications and Grading of Gastritis. The Updated Sydney System.

Recommendations for the Reporting of Resected Large Intestinal Carcinomas.

Lymph Node Recovery from Colorectal Resection Specimens Removed for Adenocarcinoma. Trends Over Time and a Recommendation for a Minimum Number of Lymph Nodes to be Recovered.

2. **Dr. Robert Pascal - Surgical/Clinical GI Manuscripts:**

Apoptosis is Inhibited Early in the Dysplasia-Carcinoma Sequence of Barrett's Esophagus.

Surgical Treatment and Outcome for Node-Negative Gastric Cancer.

Clinicopathologic Features of Superficial Squamous Cell Carcinoma of the Esophagus.

Granulomatous Appendicitis: Crohn's Disease, Atypical Crohn's Disease, or not Crohn's Disease at All?

3. **Dr. Amy Noffsinger - Molecular Biology and GI Pathology:**

Somatic Frameshift Mutations in the BAX Gene in Colon Cancers of Microsatellite Mutator Phenotype.

High Frequency of K-ras Mutations in Human Colorectal Hyperplastic Polyps.

K-ras Mutations are Found in DNA extracted from the Plasma of Patients with Colorectal Cancer.

A Juvenile Polyposis Tumor Suppressor Locus at 10q22 is Deleted from Nonepithelial Cells in the Lamina Propria.

1. Makapugay, L. M.; Dean, P. J. 1996. Diverticular disease-associated chronic colitis. Am J Surg Pathol. 20: 94-102.

This study serves to highlight the pathologic features of diverticular disease-associated chronic colitis. Makapugay and Dean have carefully described the pathologic features in 23 patients diagnosed with sigmoid chronic colitis associated with diverticulae. The presence of diverticulae were documented in all cases by either endoscopic visualization of diverticular ostia or by barium enema. and all cases had undergone fiberoptic colonoscopy in order to ensure complete macroscopic evaluation of the mucosa. An increase in lamina propria mononuclear cells (defined as readily evident plasmacellular, lymphocytic, and eosinophilic infiltrate of sufficient quantity to splay the crypts), basal lymphoid aggregates, and active cryptitis were present in all 23 cases. Notably, crypt architectural distortion (defined as loss of parallelism of crypts with crypts being branched, irregular, or bifid) was present in 20 of 23 cases (87%). Other features variably associated with chronic colitis, including Paneth cell metaplasia, villiform configuration, basal plasmacytosis, crypt abscesses, and granulomatous cryptitis were also identified in cases of diverticular disease-associated chronic colitis. Although diverticular disease-associated sigmoid colitis does appear to be a distinct entity, 3 patients in the study were diagnosed with ulcerative proctosigmoiditis 6, 9, and 17 months, respectively, after the onset of diverticular disease-associated chronic colitis. This may cause one to wonder whether some cases of sigmoid diverticular disease-associated chronic colitis are really a forme fruste of ulcerative proctosigmoiditis.

One significant point differentiating diverticular disease-associated chronic colitis from simple diverticulitis is the extensive involvement of surface mucosa by inflammation in the former. Makapugay and Dean evaluated the pathologic features of 151 sigmoid colons resected for diverticular perforation and found colitis of the luminal surface mucosa in only 2 cases (1.3%). Histopathologic features of chronic colitis were found within the orifices of an additional 5 of 151 cases (3.3%), but did not involve surface mucosa.

2. Wang, H. H.; Zeroogian, J. M.; Spechler, S. J.; Goyal, R. K.; Antonioli, D. A. 1996. Prevalence and significance of pancreatic acinar metaplasia at the gastroesophageal junction. Am J Surg Pathol. 20: 1507-10.

Since the initial description of gastric pancreatic acinar metaplasia by Doglioni et al. (Am J Surg Pathol. 1993. 17:1134-1143), many have made this diagnosis with increasing frequency. The clinical significance attached to the presence of pancreatic acinar metaplasia has varied. Some have cited the original study, which found chronic gastritis to be significantly associated with pancreatic acinar metaplasia, and considered pancreatic acinar metaplasia evidence of chronic gastritis. Others have been less certain.

In their study, Wang et al. have prospectively evaluated the presence of pancreatic acinar metaplasia of the gastroesophageal junction in 155 patients. Strikingly, they found pancreatic acinar metaplasia in 37 patients (24%). There was no association of pancreatic acinar metaplasia with active esophagitis, intestinal metaplasia at the gastroesophageal junction, active and chronic gastritis, gastric intestinal metaplasia, or the presence of *H. pylori*. Thus, Wang et al. have concluded that pancreatic acinar metaplasia is a congenital heterotopia, and not a reactive metaplasia. It should be noted that some degree of carditis was present in 92% of the patients with pancreatic acinar metaplasia and 86% of patients without pancreatic acinar metaplasia. Although Wang et al.'s study focused on biopsies of the gastroesophageal junction, one biopsy did show pancreatic acinar metaplasia beneath squamous mucosa. This suggests that, in some cases, pancreatic acinar metaplasia may be a true heterotopia of the esophagus. However, pancreatic acinar metaplasia has been described in Barrett's esophagus (Krishnamurthy and Dayal. Am J Surg Pathol. 1995. 19:1172-1180) and the clinical significance of esophageal pancreatic acinar metaplasia may deserve further study.

3. Riddell, R. H. 1996. The biopsy diagnosis of gastroesophageal reflux disease, "carditis," and Barrett's esophagus, and sequelae of therapy. Am J Surg Pathol. 20: S31-50.

This article is a comprehensive review of physiologic, endoscopic, and histologic criteria for the diagnosis of gastroesophageal reflux, Barrett's esophagus, and carditis. While no original data are presented, opinions are expressed along with recommendations and rationale of biopsy sites when evaluating for gastroesophageal reflux disease and Barrett's esophagus. In addition to being a useful review, this summary might be worthwhile for non-GI pathologists, pathology residents, and gastroenterologists.

Riddell summarizes data from 24 hour pH monitoring, endoscopic features of esophagitis, as well as the familiar histologic features of gastroesophageal reflux (basal cell hyperplasia, papillary elongation, balloon cells, neutrophils, eosinophils, T-lymphocytes). The discussion of these features includes commentary on their relative specificity, sensitivity, and differential diagnosis with other lesions (e.g. glycogenic acanthosis vs. balloon cells). Additionally, changes in gastric mucosa, including parietal and ECL cells, associated with gastritis and therapy are reviewed.

Riddell also tackles currently controversial issues in the definition of Barrett's esophagus and short-segment Barrett's esophagus. Included in this discussion is the presence of goblet cells in cardiac-type mucosa in biopsies taken at the Z-line. Riddell suggests that Barrett's esophagus be redefined as intestinal metaplasia in the lower esophagus. Unfortunately, such broadening of the definition of Barrett's esophagus may result in significant realignment of the clinical significance of that diagnosis. This is clearly an issue in need of further study before a consensus opinion can be reached.

4. Dixon, M. F.; Genta, R. M.; Yardley, J. H.; Correa, P. 1996. Classification and grading of gastritis. The updated Sydney system. Am J Surg Pathol. 20: 1161-81.

This article is a reappraisal of the histologic arm of the Sydney system for classification of gastritis (J Gastroenterol Hepatol. 1991. 6:209-222). The treatment is comprehensive, thoughtful, and detailed. Drawings showing the consensus impressions of normal, mild, moderate, and marked for semi-quantitative grading of *H. pylori*, neutrophilic infiltration, mononuclear infiltration, antral atrophy, corpus atrophy, and intestinal metaplasia complement the text nicely. Additionally, issues of topography, atrophic and nonatrophic gastritis, and distinctive forms of gastritis are addressed in detail. Final recommendations for reporting, example cases, and a detailed glossary are also provided.

5. Riddell, R.H.; Haggitt, R.C.; O'Brien, M.J.; Pascal, R.R.; Snover, D.C. 1996. Recommendations for the reporting of resected large intestinal carcinomas. Association of Directors of Anatomic and Surgical Pathology. Hum Pathol. 27: 5-8.

6. Goldstein, N. S.; Sanford, W.; Coffey, M.; Layfield, L. J. Lymph node recovery from colorectal resection specimens removed for adenocarcinoma. Trends over time and a recommendation for a minimum number of lymph nodes to be recovered. Am J Clin Pathol. 1996. 106: 209-16.

The first article is part of a series being issued by the Association of Directors of Anatomic and Surgical Pathology with recommendations for the reporting of common malignant tumors. The introduction to this article states that the recommendations are intended as an educational resource rather than a mandate. The recommendations are divided into (a) items that provide an informative gross description, (b) additional diagnostic features that are recommended to be included in every report, (c) optional features that may be included in the final report, and (d) a checklist. Many oncologists prefer a checklist, as it simplifies their ability to compare specific features between patients being treated under various investigational

protocols. A standardized intradepartmental checklist may also simplify interpretation of reports issued by different pathologists.

Features recommended to be reported include:

A. Gross description. 1. How the specimen was received, 2. How the specimen was identified, 3. Part(s) of intestine received, 4. Tumor description, 5. Presence of features of obstruction, 6. Presence of perforation, 7. Status of residual bowel, 8. Lymph nodes identified, 9. Tissue submitted for special investigation.

B. Diagnostic Information. 1. Site of tumor and part of bowel resected. 2. Histological type, 3. Histological grade, 4. Depth of infiltration, 5. Lymph node metastases, 6. Presence of mesenteric deposits, 7. Other sites biopsied for metastatic disease, 8. Adequacy of local excision, 9. Other significant disease, 10. State specifically if critical information is not available or cannot be adequately assessed.

C. Optional Features. 1. Stage, 2. Results of ancillary investigation, 3. Specific lymph nodes, 4. Nature of advancing edge, 5. Inflammatory infiltrate, 6. Lymph vessel infiltration, 7. Perineural infiltration, 8. Venous infiltration, 9. Residual adenoma at edge of the carcinoma.

The second article, also published in the past year, provides significant information regarding the evaluation and reporting of colon cancer. It is a retrospective and statistical analysis of lymph node recovery in colorectal cancer resection specimens. The general conclusion is that at least 17 lymph nodes should be recovered for optimal assessment of the presence of lymph node metastases. This represents a break from the oft-quoted minimum of 12 lymph nodes. The 12 lymph node number was obtained in previous work (Br J Surg. 1989. 76:1165-1167) which grouped specimens by number of lymph nodes required as 1-5, 6-11, 12-20, or >20. That study found increased detection of metastases in the 12-20 lymph node group (vs. the 6-11 group), but not in the >20 lymph node group (vs. the 12-20 group). In the 1996 study, Goldstein et al. have essentially performed a higher resolution analysis by dividing specimens according to 1-4, 5-8, 9-12, 13-16, 17-20, or >20 lymph nodes. Each group had metastases in a greater number of cases than the group before until the >20 lymph node range. Thus, as stated above, Goldstein et al.'s data suggest that 17 is a more appropriate minimum number of lymph nodes. However, the authors do state that this is a minimum, and that their opinion is that all lymph nodes should be recovered. Obviously, the ability to recover 17 or more nodes in a given specimen will depend on the site and extent of resection.

Katuda, N., Hinder, R.A., Smyrk, T.C., Hirabayashi, N., Perdikis, G., Lund, R.J., Woodward, T., Klinger, P.J. Apoptosis is inhibited early in the dysplasia-carcinoma sequence of Barrett's esophagus. Arch. Surg. 132: 728-733, 1997.

From the Dept. of Surgery, Creighton University, Dept. of Pathology, Clarkson Hospital, Omaha, NB, and Dept. of Surgery, Mayo Clinic, Jacksonville, FL.

Eighty-five mucosal samples from 58 patients undergoing esophagoscopy were studied for apoptotic activity and *bcl-2* overexpression. The distribution of histologic interpretations was; normal=10, reflux esophagitis=12, Barrett's metaplasia=21, Barrett's with low-grade dysplasia (BLGD)=17, high-grade dysplasia(BHGD)=5, well-to-moderately differentiated adenocarcinoma=10, and poorly differentiated adenocarcinoma=10. Apoptosis was detected by the terminal deoxynucleotidyl transferase-mediated deoxyuridine triphosphate-biotin nick-end (TUNEL) labeling method (see Gavrielle, Y., Sherman, Y., Ben-Sasson, S.A. in J. Cell Biol. 119:493-501, 1992). The *bcl-2* proto-oncogene was visualized immunohisochemically and roughly measured, because it is a principal inhibitor of apoptosis. The results showed many apoptotic cells on the surface of mucosae with reflux esophagitis, but very few in all other groups. Among normals, there was weak *bcl-2* expression in basal cells, but overexpression in 72% of Barrett's, 100% of BLGD, 25% of BHGD, 40% of W-MD carcinoma, and 20% of PD carcinoma. The authors conclude that apoptosis may be a protective effect in esophagitis, counteracting the proliferation accompanying regeneration. Inhibition of apoptosis, measured by *bcl-2* overexpression, in Barrett's esophagus occurs early and may allow for greater cell proliferation, which progresses to neoplasia.

Maehara, Y., Tamoda, M., Tomisaki, S., Ohmori, M., Baba, H., Akazawa, K., Suginachi, K. Surgical treatment and outcome for node-negative gastric cancer. Surgery, 121: 634-639, 1997.

Dept. of Surgery II, Kyushu University, Fukuoka, Japan.

Among 1,797 patients undergoing gastric resection for primary adenocarcinoma during the years 1965 to 1990, there were 730 without metastasis to perigastric lymph nodes, or other sites. The 5-year and 10-year survival in this group was 91.7% and 79%, respectively. The following parameters were examined for relevance to 10-year survival. All histologic parameters were determined by routine H&E examination only. For those factors of significance, the p-value was 0.01 or less.

PARAMETER	10-YR SURV (%)
Age under 70	91
Age 70 and beyond	79
Sex	NS
Tumor size <10 cm	82-94
Tumor size >10 cm	46
Histologic grade and type	NS
Serosa not invaded	93
Serosa invaded	66
Lymphatics uninvolved	92
Lymphatics involved	77
Veins involved	NS
Non-infiltrative pattern	91
Infiltrative pattern	77
Postop. chemotherapy	NS

This study provides parameters for pathologic examination and reporting of gastric cancer resections, especially those that prove to be node-negative, that may be of prognostic benefit for the patient.

Tachibana, M., Yoshimura, H., Kinugasa, S., Hashimoto,N., Dhar,D.K., Abe,S., Monden, N., Nagasue, N. Clinicopathological features of superficial squamous cell carcinoma of the esophagus. Am. J. Surg. 174: 49-53, 1997.

From the 2nd Department of Surgery, Shimane Medical University, Izumo, Japan.

Among 203 patients with squamous cell carcinoma of the esophagus, 165 underwent esophagectomy. Of these, 30 were found to have superficial SCC, defined as tumor limited to the mucosa and submucosa. 15 had malignancy confined to the mucosa. Symptoms referable to the tumors were absent in 24, and the lesions were detected as flat or depressed areas during upper endoscopy for gastric complaints. 8 cancers were multicentric, but the largest lesion always had the deepest invasion. Only those with submucosal invasion had lymphatic involvement (9), venous invasion (5), or nodal metastases (8). The mean size of the carcinomas was 29 mm, with a range of 4-58 mm. The histologic grade (5 WD tumors, 16 MD, and 9 PD) did not influence survival. The 3 and 5 year survival for patients with mucosal tumors was 86.7% each, and for those with submucosal lesions, 72% and 65%. The detection and diagnosis of superficial SCC of the esophagus produces results similar to the patient salvage in early gastric cancer, but such lesions can only be found with mass screening programs.

Richards, M., Aberger, F.J., Landerscaper, J. Granulomatous appendicitis: Crohn's disease, atypical Crohn's disease, or not Crohn's disease at all? J. Am. Coll. Surg. 185: 13-17, 1997

From the Departments of Surgery, Gastroenterology, and Pathology, Gunderson/Lutheran Medical Center, LaCrosse, WI.

Of 1,133 consecutive appendectomy specimens, 9 were diagnosed as having isolated granulomatous appendicitis. 156 additional cases were found in the world literature. These patients suffered fro indolent RLQ pain, fever, and anorexia. The absence of fistulae or other evidence of Crohn's disease, over a 7.3 year mean follow-up (authors' series), helped establish isolated granulomatous appendicitis as a distinct entity. Although 20-25% of patients undergiong laparotomy for CD are found to have appendiceal involvement, the discovery of granulomatous appendicitis does not necessarily establish a diagbosis of CD in other individuals. In contrast to appendiceal involvement by known CD, in which distinct granulomas are found in only 60%, the number of granulomas is greater in isolated granulomatous appendicitis (mean=19.7 vs. 0,3 in CD-associated appendicitis). The differential includes yersiniosis, tuberculosis, blastomycosis, schistosomiasis, actinomycosis, histoplasmosis, and Campylobacter jejunii infection. Caution should be exercised, and clinical parameters applied, before making a diagnosis of Crohn's disease in a patient with granulomatous appendicitis.

LITERATURE REVIEWS

Rampino N, Yamamoto H, Ionov Y, Li Y, Sawai H, Reed JC, Perucho M. Somatic frameshift mutations in the *BAX* gene in colon cancers of the microsatellite mutator phenotype. Science 275:967-969, 1997.

The microsatellite mutator phenotype (MMP) is observed in colon cancers with defects in DNA mismatch repair mechanisms. MMP positive colon cancers demonstrate widespread genetic instability, particularly in simple DNA repeat sequences. MMP positive tumors most likely develop through a genetic pathway which differs from that of MMP negative tumors. For example, MMP positive tumors often fail to demonstrate mutations in the p53 gene, while MMP negative tumors commonly contain mutant p53. One important function of p53 is to initiate the apoptotic pathway in response to DNA damage. p53-mediated apoptosis is carried out, at least in part, through transactivation of the *BAX* gene, a member of the *BCL-2* gene family. Interestingly, exon 3 of *BAX* contains a sequence of 8 consecutive deoxyguanosines. This type of simple repeat sequence is a likely target for mutation in MMP positive cancers. The authors examined various MMP positive tumor cell lines as well as a series of MMP positive and negative colon cancers for alterations in the $[(G)_8]$ sequence of *BAX* using PCR and DNA sequence analysis. More than 50% (21 of 41) MMP positive colon cancers demonstrated frameshift mutations in the $[(G)_8]$ sequence of *BAX*. No mutations were observed in MMP negative cancers. Frameshift mutations were present in both *BAX* alleles in some MMP positive tumor cell lines, as well as in some primary tumors. The data suggest that loss of *BAX* function is an important factor in colorectal carcinogenesis, and underscore the importance of the control not only of cell proliferation, but also of cell death in tumorigenesis. Additionally, these results may explain why MMP positive tumors typically do not contain p53 mutations. Mutations in the *BAX* gene may be selected for during tumorigenesis in MMP positive cancer cells. MMP positive cells are mismatch repair deficient, and therefore, produce thousands of DNA mismatches with each replication cycle. Cells with sufficient DNA mismatches trigger the p53-mediated apoptotic pathway. However, those cells which develop *BAX* mutations may escape programmed cell death since *BAX* is a vital link in the apoptotic pathway, and in this way gain a selective advantage.

Otori K, Oda Y, Sugiyama K, Hasebe T, Mukai K, Fujii T, Tajiri H, Yoshida S, Fukushima S, Esumi H. High frequency of K-ras mutations in human colorectal hyperplastic polyps. Gut 40:660-663, 1997.

Hyperplastic polyps are commonly encountered colonic lesions. Although they are commonly found in colons of individuals harboring carcinomas, they are generally considered benign, with little, if any, malignant potential. This study examined 28 colorectal polyps (19 hyperplastic and 9 adenomatous) for genetic alterations commonly identified in colorectal neoplasia. K-ras gene mutations were identified by mismatched primer mediated-PCR followed by restriction fragment length polymorphism (RFLP) analysis, and p53 alterations were identified using immunohistochemistry. Seven hyperplastic polyps were also examined for APC mutations, although the method for this procedure is not detailed. Mutations in K-ras were found in 9 (47%) of 19 hyperplastic polyps, and in 5 (56%) of 9 adenomas.

Mutations were present primarily in codon 12, although one hyperplastic polyp also harbored a mutation in codon 13. p53 protein accumulation occurred in 2 adenomas, but in none of the hyperplastic polyps. None of the hyperplastic polyps demonstrated APC mutation. This study is of significance in that it is the first to identify genetic alterations in hyperplastic polyps of the colon. K-ras plays an important role in the adenoma-carcinoma sequence, and is an alteration which is thought to occur early in neoplastic progression in the colon. Mutations in this gene are found with nearly equal frequency in both hyperplastic and adenomatous polyps, suggesting that hyperplastic polyps, like adenomas, may represent precancerous lesions. However, differences exist between the two types of lesions. Hyperplastic polyps showed no evidence of APC gene mutations, nor did they show evidence of p53 overexpression by immunohistochemistry. APC alterations are common in adenomas, and are thought to occur very early in their development. p53 alterations generally occur later in colorectal carcinogenesis. The absence of other genetic alterations commonly encountered in adenomas may account for differences in malignant potential between hyperplastic and adenomatous polyps.

Anker P, Lefort F, Vasioukhin V, Lyautey J, Lederrey C, Chen XQ, Stroun M, Mulcahy HE, Farthing MJG. K-ras mutations are found in DNA extracted from the plasma of patients with colorectal cancer. Gastroenterology 112:1114-1120, 1997.

Genetic alterations are common in human tumors, and have been found in DNA recovered from lymph nodes, sputum, urine, pancreatic juice and feces from patients with various forms of cancer. Recently, genetic alterations have been identified in DNA recovered from blood of patients with known cancer. Small amounts of circulating DNA are present in the plasma of healthy as well as diseased subjects, with the highest circulating DNA levels being found in cancer patients. Since it is known that K-ras mutations occur in a large proportion of colorectal cancers, the authors of this study hypothesized that K-ras mutations would be detectable in the plasma of patients with colon cancers harboring K-ras mutations. Blood from both patients with colon cancer and healthy subjects was examined. In addition, the status of K-ras was characterized in the primary tumors of the colon cancer patients for comparison with the plasma studies. The K-ras gene was detected in plasma by a highly sensitive method referred to as polymerase amplification of sequence specific primers (PASA-PCR). This technique is capable of specifically detecting wild-type and/or mutant K-ras sequences from genomic DNA. Analysis of the colorectal cancers demonstrated K-ras mutations in 7 of 14 tumors (50%). Among the 7 patients with K-ras mutations in their tumors, 6 had the same mutation detectable in plasma. None of the colon cancer with K-ras mutation negative tumors or the healthy controls had wild type K-ras in the plasma. The PCR techniques used in this study were 86% sensitive and 100% specific. However, since K-ras mutations were found in only 43% of all tumors, a significant number of patients with colon cancer would potentially be missed with this technique if only K-ras mutations were sought. The findings of this study confirm the feasibility of detecting molecular genetic alterations in the blood of cancer patients, and suggest that in the future this sort of analysis might be useful for clinical follow-up of cancer patients or for screening programs. The addition of assays for other genetic abnormalities might someday make this technique clinically useful.

Jacoby RF, Schlack S, Cole CE, Skarbek M, Harris C, Meisner LF. A juvenile polyposis tumor suppressor locus at 10q22 is deleted from nonepithelial cells in the lamina propria. Gastroenterology 112:1398-1403, 1997.

Juvenile polyps are the most common gastrointestinal polyps diagnosed in children. They are characterized by dilated, mucin-filled glands within an expanded lamina propria. In addition to sporadic juvenile polyps, a rare autosomal dominant juvenile polyposis coli (JPC) syndrome exists. The authors of this paper identified a unique patient with juvenile polyposis coli and multiple congenital anomalies who, on cytogenetic analysis, demonstrated a small deletion of 10q22.3-q24.1. This abnormality was present on only one homologue of chromosome 10, and did not affect either of the patient's parents, both of whom were unaffected by JPC. A genetic map of this deletion was then defined by comparing the patient's genotype with those of the parents using 41 informative microsatellite markers on chromosome 10. The patient did not inherit any parental alleles for 5 contiguous markers, a span of approximately 17 cM. This observation suggested that loss of this portion of chromosome 10 might play a role in the development of sporadic juvenile polyps. Interestingly, Cowden's disease, a disease associated with polyps which are phenotypically similar to juvenile polyps has recently been mapped to the same region of chromosome 10. The microsatellite satellite markers which were deleted in the index patient were then used to perform loss of heterozygosity (LOH) studies in a group of 47 juvenile polyps from 16 patients. In addition, interphase cytogenetic using FISH were performed on paraffin-embedded sections from the juvenile polyps to determine in which cell population loss of the chromosome 10 marker occurred. LOH was observed in 39 (83%) of 47 juvenile polyps. The results of the LOH studies were confirmed in most cases by FISH. Interestingly, FISH demonstrated that the population of cells showing 10q22 loss were located exclusively in the lamina propria of the polyps. The epithelial cells, smooth muscle cells, fibroblasts and neutrophils all showed two copies of the chromosome 10 marker. The cells affected by the 10q22 loss appeared to be histiocytic or lymphocytic cells, suggesting that abnormalities in mucosal immunity may play a role in the genesis of juvenile polyps.