THE GASTROINTESTINAL PATHOLOGY CLUB
NEWSLETTER

VOLUME 3, NUMBER 2

SPRING-SUMMER, 1985

CONTENTS

EDITORIAL

As of the current issue, the editorship of this August publication shifts from East Coast to the West. Readers will soon note that the old traditional staid style has gone, to be replaced by trend-setting layed back journalism. Since we have close connections with Hollywood and the movie business, we are in a position to bring you the G.I. gossip of the stars. In fact, this Newsletter might be renamed "National Flatulence Inquirer".

New features are planned including some G.I. soap operas. Instead of "Dallas" starring J.R., we will bring you "Villus" starring H.A.; instead of "Dynasty", you will soon be reading about "Dysentry"; perhaps, instead of "Lovers", we might interest you in "Livers", a production of J.P.

Seriously, though, we are both looking forward to the challenge of keeping our membership informed and up to date with the Club activities. And a challenge it is, indeed, as we look back with admiration and some trepidation to the high standards set by our predecessors, Don Antonioli and Henry Appleman, and hope that such standards will be maintained. Well done and thank you guys! Finally, and most important, a plea to all Club members to write to us with ideas and contributions. We need your help as only your unwavering support will make this News-letter a continuing success.

Juan Lechago

David A. Owen

GASTROINTESTINAL PATHOLOGY CLUB
MINUTES OF THE EXECUTIVE COMMITTEE MEETING
SHERATON CENTRE - TORONTO, ONTARIO, CANADA
MARCH 10, 1985

The meeting was called to order at 9:10 AM by Dr. Yardley in the Elgin Room of the Sheraton Centre, Toronto. Members in attendance were: Drs. Antonioli, Appelman, Fenoglio-Preiser, Goldman, Lechago, Lewin, Madara, D. Owen, Phillips, Rickert, Riddell and Yardley.

I. Financial Report : presented by Dr. Rickert

A. Financial Summary - see item 4

B. Delinquent Dues - Five (5) regular members have not paid the 1984-85 dues as yet and one associate and one regular member have not paid 1984-85 or 1983-84 dues. All will be notified by phone. According to the By Laws, any members in arrears for more than one year, failing satisfactory explanation, shall be dropped from membership.

C. Annual Dues Amount - The Executive Committee approved maintaining dues at $25.00 and $10.00 for Regular and Associate Members respectively.

II. Appointments - Dr. Yardley presented the G.I.P.C. Committee membership and other Appointments for 1986. - see minutes of Business Meeting.

III. Committee Activities:

A. Education - Drs. Fenoglio and Madara

1. Programs:

a. IAP (March 1985). Will try and hold distribution of handouts until the end of the GIPC Scientific Session in order to meet the CME requirements of the IAP.

b. AGA (May 1985). GIPC presentation will be on Esophageal Disease and there will be a new format with use of slides, microscope and T.V. monitor.

c. IAP (1986). Program at present is undecided. Details will be worked out by Education Committee.

d. Student/Trainee Award - The possibility of developing an award for students/trainees will be considered by the education committee and discussed at the next Executive Committee meeting.

2. Research Symposium: a lengthy discussion took place concerning possibility of incorporating a research symposium into our annual Scientific Session. Among formats considered were separate clinical and research portions of the annual program, presentation of club sponsored projects by the principle investigator, a thematic session or an interwoven clinical and research program.

Examples of research topics suggested were: a) Experimental Models of G.I. Disease; b) Cytoskeleton Modulation; c) Macromolecule Transport in the G.I. Tract. Suggestions for topics of the 1986 GIPC Meeting were: a) G.I. Hormonal Disorders; b) Drug-induced Liver Disease; c) Viral Hepatitis; d) Biliary Tract Disease.

It was further suggested that for meetings of the A.G.A., the club can sponsor research and clinical programs alternately on a yearly basis.

The details of these questions will be discussed by the Education Committee and recommendations will be developed.

B. Membership/Nomination: Dr. Phillips

1. The following were recommended for membership by the Executive Committee:
Regular Members: Drs. Kenneth Barwick, David Bostwick, Karl Perzin, Scott Saul and Daniel Sheahan.
Associate Members: Drs. Douglas Levine, Helen Wang and Miche Haddad.
In addition there were several applications received too late for consideration by the committee. These will be submitted to the new Membership Committee for permanent action prior to the next meeting. However, the Executive Committee temporarily recommends approval as Associate Members until Membership Committee considers these applications. (for names, see Business Meeting Minutes).

2. Vice President - The Committee recommended Dr. Donald Antonioli for the next Vice President. Recommendation was enthusiastically approved by the Executive Committee.

C. Publications: Drs. Riddell and Appelman

1. American Journal of Surgial Pathology - Dr. Riddell reviewed the proposed relationship between the GIPC and the AJSP Final details including the tying together of dues with subscription rate will be worked out and reported in the Newsletter when complete.

2. Standing Committee Status. It was recommended that the Publications Committee be changed to a Standing Committee. Bylaws change will be submitted to Membership at Business Meeting for approval.

3. Future Charge and Activities. Dr. Yardley described the role of the committee which will include review and recommendations regarding type of involvement with AJSP. The Committee will not function as an editorial board.

4. Atlas of G.I. Pathology - Dr. Appelman reported on conversations with a publisher concerning development of an "Atlas" of G.I. Pathology. It was recommended that Dr. Appelman continue discussions concerning this project which could involve the entire membership. Dr. Appelman will report back to the membership through the Newsletter.

D. Training

1. Standing Committee Status. It was recommended that the Training Program Committee be changed to a Standing Committee. Bylaws change will be submitted to membership through the Newsletter.

2. Future Charge and Activities - Dr. Yardley will report to the membership.

E. Newsletter - Drs. Lechago and D. Owen will become new editors with Drs. Antonioli and Appelman remaining on the Editorial Board.

IV Other Business

A. International Liaison and Cooperation - Dr. Goldman reviewed his discussions at Miami Beach concerning an international "union" of G.I. pathology groups. This concept was endorsed by the Executive Committee.

B. Co-operative Projects - Dr. Yardley reviewed his comments from the Newsletter editorial.

C. Specialty Conference Schedule - beginning next year the evening specialty slide conferences will rotate yearly so that we will not be "fixed" in the Thursday evening slot.

D. New business - Bylaws amendments on new Standing Committees were approved and will be presented to the membership at the Business Meeting.

V. There being no further business, the meeting was adjourned at 12:30 PM.

Respectfully submitted,

Robert R. Rickert, M.D.
Secretary-Treasurer

RRR/th

GASTROINTESTINAL PATHOLOGY CLUB
MINUTES OF THE ANNUAL BUSINESS MEETING
SHERATON CENTRE - TORONTO, ONTARIO, CANADA
MARCH 10, 1985

The meeting was called to order at 5:15 p.m. by Dr. Yardley in the Ballroom East of the Sheraton Centre, Toronto. Members Present: Drs. Antonioli, Appelman, Barr, Chejfec, Cooper, Dahms, DeSchryver, Fenoglio-Preiser, Frei, Goldman, Gourley, Hamilton, E. Kahn, Kay, Kelly, Keren, Lance, Lechago, Lev, Madara, Manley, Marcial, Mitros, Nassar, Norris, D. Owen, Petras, Phillips, Ray, Rickert, Riddell, Rotterdam, Schenk, Schuffler, Snover, Sobin, Sternberg and Yardley.

1. Approval of minutes of Annual Business Meeting of March 11, 1984 - the minutes were approved as distributed.

2. Financial Report - Presented by Dr. Rickert, showed an ending balance of $5,571.87 as of February 28, 1985 - details in item 4 of the Newsletter.

3. Committee Reports

A. Education

1. Dr. Fenoglio reviewed the decision to withold the handouts from today's program until the end, in order to comply with the IAP's CME credit policy requiring evaluation forms. Will take another look at this problem for next year and probably return to distribution at the beginning of the meeting.

2. Dr. Lewin described the program for the May AGA program in New York.

3. Dr. Madara discussed the issue of introducing a research oriented segment into the annual scientific program. The membership indicated a preference for keeping the clinical and research portions separate. Dr. Madara also indicated that the GIPC segment at the AGA will have research and clinical topics alternate on a yearly basis.

B. Membership/Nomination - Dr. Phillips announced the following names of new members: Regular- Drs. Kenneth Barwick, David Bostwick, Karl Perzin, Scott Saul and Daniel Sheahan. Associate: Drs. Douglas Levine, Helen Wang and Miche Haddad.
Also recommended at this time for Associate Membership were Drs. Carlos Cortes, Ervin Essenfeld, Ermes Alverez Garnica, Roncalli Massimo and Thomas Ulrich. These five applications were received very near the deadline for the meeting and membership status may change to "Regular" pending more complete reviews by the Committee.

C. Training Programs: Dr. Yardley indicated that the questionnaire will be redistributed to collect additional information from those who have not responded.

D. Publications. Dr. Riddell's discussions with the American Journal of Surgical Pathology were reviewed. Details including tie-in between dues and subscription will be worked out and reported in the newsletter. Dr. Appelman reported on conversations he has had with a publisher interested in development of an "Atlas" of gastrointestinal pathology. After considerable discussion, he was encouraged to continue discussions and will report back to the membership in the Newsletter.

E. Newsletter - Dr. Yardley reported that Drs. Lechago and D. Owen have been appointed the new editors of the Newsletter.

4. Committee Structure Changes:

A. GIPC Committee Membership - Dr. Yardley announced new members of various committees. The names are given in item 5 of the Newsletter.

B. New Standing Committees - Dr. Yardley proposed that the Publications and the Training Programs Committees each be changed to standing committees. Upon motion by Dr. Lechago and second by Dr. Keren, the bylaws will be amended to reflect these changes.

C. Sunset Review of Bylaws - According to our Bylaws the Gastrointestinal Pathology Club and its bylaws must be approved every three years. Upon motion by Dr. Appelman and second by Dr. Lechago both were unanimously re-approved.

5. Future Meetings and Inter-organizational Activities

A. The meetings of the AGA (program on esophageal disease) in May 1985 and the next GIPC (New Orleans, 1986) were announced.

B. Dr. Goldman discussed our relationships with other G.I. pathology groups. The concept of an informal "union" with other groups was endorsed. We have been asked to participate with the British and German-Austrian groups in September 1986. Dr. Goldman will continue discussions and report back to the membership.

6. Old Business

A. Cooperative Research Projects:

Dr. Cooper reported on his efforts to develop a cooperative project on "Malignant Polyps". Progress in obtaining case material has been slower then anticipated. After considerable discussion, it was decided that additional communication with the membership would be helpful.
Dr. Frei spoke about his proposed project on dysplastic Barnett's epithelium. He also will be sending additional information to the membership.

7. New Business

Two items of new business discussed were the possibility of a change in the club name and the development of a club logo. Both of these will be explored further.
Concerning the specialty slide conference, it was announced that a rotating schedule will now begin. Consequently, for 1986, the G.I. Specialty Conference will be held on Wednesday evening.

8. Election of Officers:

Upon recommendation of the Membership/Nomination Committee and endorsement by the Executive Committee, Dr. Donald Antonioli was proposed as the next Vice President. No additional nominations were made and Dr. Antonioli was elected by acclamation.

9. Announcement of New Members

The names are included in report of the Membership/Nomination Committee

10. Induction of New President

Dr. Yardley introduced Dr. Klaus Lewin as the new President of the Gastrointestinal Pathology Club. Dr. Lewin made some brief remarks, including commendation for the fine job done by Dr. Yardley during his term as President.

11. There being no further business, the meeting was adjourned at 6:10 PM.

Respectfully submitted,

Robert R. Rickert, M.D.
Secretary-Treasurer

RRR/th

GIPC FINANCIAL SUMMARY FOR 1984 - 1985

Balance as of February 29, 1984	$3697.43
Receipts, March 1, 1984 - February 28, 1985 (Dues)	2119.47
Receipt, (IAP International Congress)	1000.00
Interest earned March, 1984 - February 28, 1985	382.67
Total	7199.57

Expenses, March 1, 1984 - February 28, 1985

1984 GIPC Meeting Expenses	$ 750.55
1984 AGA Meeting Expenses	411.31
1984 IAP International Congress Expenses	355.12
1984 - 85 Newsletters	104.00
Bank charge	6.72
Total	$1,627.70

Balance as of February 28, 1985 . . . . . $5,571.87

GIPC COMMITTEE MEMBERSHIP AND OTHER APPOINTMENTS

1985 - 1986

Education Committee	Term Ends
J. Madara (Chairman)	1986
W. Weinsten	1987
C. Fenoglio	1986
H. Rotterdam*	1987
H. Cooper*	1988
R. Owen	1988

Membership/Nomination Committee	
L. Kahn (Chairman)	1987
G. Abrams	1986
S. Sommers	1986
P. Manley	1987
B. Dahms*	1988
D. Snover*	1988

Publications Committee (Ad Hoc. Proposed standing. Appointed annually)

H. Appelman* (Chairman)
R. Riddell
J. Madara* (Ex officio
S. Sternberg (Ex officio

Training Programs Committee (Ad Hoc. Proposed standing. Appointed annually)

J. Yardley (Acting Chairman)
R. Haggitt
K. Lewin
H. Goldman
J. Frei*
K. DeSchryver*

Newsletter Editors

J. Lechago*
D. Owen*

International Liaison

H. Goldman*

* New Appointments

REVIEW OF GI PAPERS AT THE 1985 IAP MEETING IN TORONTO

As has been the trend for some years now, the IAP meeting in Toronto produced a bumper crop of papers relevant to GI Pathology. These were so numerous that your editors had difficulty in keeping tract of them all. We had to forgo our "siestas", and there was a lot of coffee that (mercifully?) we didn't have time to drink. One whole afternoon session was devoted to liver diseases and both a morning and an afternoon session were dedicated to the glorious hollow tube.

As usual, specialists in several other systems tried to muscle in on our act. For example, there were the mandatory papers by the "lymphomaniacs". It was quite reassuring to note that these guys often have as much trouble as we do in distinguishing gastric lymphomas from pseudolymphomas. Of course, with the new monoclonal antisera it is now easier to distinguish short, fat, well-cleaved lymphoma from petite, aggressive, not so prominently cleaved lymphoma. Primary lymphomas of the liver introduced by Osborne et al. (Houston and Orlando) were, to us at least, a somewhat exotic topic. The main message is that they occur, and that with appropriate therapy survival is better than in other primary liver malignancies. The "baby doctors" also got in their 5c worth of GI pathology. Bove and co-workers (Cincinnati, Spokane, San Antonio and Seattle) reported the presence of unusual liver lesions, leading to liver and renal failure, in premature infants given intravenous Vitain E/Polysorbates. The etiopathogenesis of this condition is not understood. Pseudomembranous colitis occurs in the pediatric age group according to Qualman et al. (Columbus, Toronto, and Baltimore) bearing a significant relation to clostridial infection, but seemingly unrelated to antibiotic therapy.

The papers on liver disease were appropriately scheduled as an afternoon session, by which time of the day your editors livers had recovered from the previous evening stress. With our SGOT slowly dropping back to normal values, we heard two papers on the immunology of alcohol-induced liver disease. Swerdlow et al (Chicago) showed that the lymphocytes of alcoholic rats could produce chronic persistent hepatitis when injected into syngeneic non-alcoholic rats. Mills et al (Augusta, Warsaw, Poland and London, England) showed reduced sinusoidal macrophages in alcoholics and postulated that impaired clearance of IgA deposits may potentiate fibrogenic activity.

The accuracy and specificity of histologic features in the liver biopsy diagnosis of graft-versus-host disease (GVHD) was discussed by Shulman and colleagues (Seattle). They concluded that changes seen in the bile duct epithelium were the most valuable. Changes in the hepatocytes, on the other hand, were of uncertain value. Also, it was not possible by any method to separate acute from chronic GVHD. Fukusato and colleagues (New York) determined that HLA I antigens, thought to be significant in viral induced lesions of the liver, can be induced in hepatocytes as an expression of hepatocellular injury from various factors, including hepatitis B viruses.

Snover et al (Minneapolis) investigated the appearance of CMV hepatitis in immunocompromised and immunocompetent individuals. Interestingly enough, the typical nuclear inclusions were present only in the immunocompromised patients, where they were often surrounded by an accumulation of neutrophils. Immunocompetent patients, in contrast, had only a non-specific mononuclear sinusoidal infiltrate.

A noteworthy concept was postulated by Wee and Ludwig (Rochester, MN). They observed 107 liver biopsies from patients with chronic ulcerative colitis and found that 35% had pericholangitis in association with scarring of bile ductules. These lesions appeared identical to those found in biopsies from another group of patients with documented sclerosing cholangitis. The authors concluded that pericholangitis might be regarded as an intrahepatic equivalent of sclerosing cholangitis and, in some instances, it may represent a precursor lesion. Simonton and coworkers (Rochester, MN) examined the inflammatory cell population of transplanted livers using monoclonal antibodies. The patients were divided into those with no rejection, with treated rejection, and with untreated rejection. It was concluded that there are differences among the different groups which may be of significance with respect to outcome or treatment.

Ansari and coworkers (Columbus and Toronto) presented material from 15 cases of cirrhosis occurring in patients with histiocytosis X. They concluded that most of thse represented a biliary-type cirrhosis secondary to scarring of periductular granulomas. Finally, Wanless et. al. (Toronto) presented convincing evidence that focal nodular hyperplasia is the result of increased local blood supply stemming from a primary vascular anomaly. Thus ended the live papers, just in time for your editors to adjourn to the bar for a well deserved Molson's or suitable equivalent.

The following day, there were GI pathology papers, morning and afternoon. Your faithful editors acquired a surfeit of digestive information, mercifully unaccompanied by indigestion. First off the mark, were the Hopkins group of Hamilton and Smith with their attempt to clarify the relationship between Barrett's dysplasia and cancer using criteria comparable to those utilized for chronic UC in the past. They looked at 29 esophagectomy specimens and found a significantly high association between high grade dysplasia and invasive adenocarcinoma. A firm recommendation followed that high grade dysplasia be a firm indication for esophagectomy. However, with lesser degrees of dysplasia no clear advice can yet be formulated.

Next came Wang and coworkers (Beth Israel, Boston) who looked for common features in esophageal, junctional and cardial adenocarcinomas. They found that clinically and histologically these formed a rather homogeneous group, and that many of the esophageal cancers were associated with demonstrable Barrett's metaplasia. The strong implication is that all thse tumors seem to share common etiologies (e.g. smoking and alcoholism) and perhaps should be grouped together.

The team of Szabo and colleagues (Harvard, Boston) presented experiemental evidence that acute alcohol and aspirin-induced gastric mucosal lesions are preceded by a rapidly developing vascular injury. This injury is significantly ecreased by the administration of prostaglandins or sulfhydrils.

Dayal and fellow "endocrinomaniacs" (Tufts, Boston) were next at bat, comparing duodenal carcinoids in patients with and without von Recklinhausen's neurofibromatosis (VRNF) On routine H&E sections, there was little difference detected, but immunocytochemically the VRNF tumors tended to be pure somatostatinomas, in contrast with the non-VRNF associated tumors which were multihormonal (calcitonin, gastrin, serotonin and ACTH).

To round out the morning's entertainment, West and colleagues (Trinity) presented interesting, albeit controversial, findings in acute appendicitis. The decided that the old dictum "most cases of acute appendicitis have no specific etiology" could be challenged. Accordingly, they collected 160 cases of garden variety acute appendicitis and tested serologically for evidence of Yersinia infection. Using currently accepted serologic criteria, fully 26% of patients had evidence of recent infection. These appendices were then reexamined histologically, but no diferences could be detected from the other 74% serologically negative cases. People in the audience were quick to point out that no cultures of the appendices had been performed. so we could not incriminate Yersinia for sure as the causative organism. People also questioned the specificity of the serological findings, but were assured (if not necessarily reassured) that the best brains available in infectious diseases had been consulted for the development of serological criteria of recent infection. It would appear that more work will be required before accepting Yersinia as a common cause of acute appendicitis.

The GI Pathology extravaganza continued after a brief break for lunch with a study by Hinnert and coworkers (Lennox Hill, New York) on CMV infections of the alimentary tract. The patients studied had either AIDS or lymphoma. The commonest site was the colon, the right colon in particular, while the upper digestive tract tended to show low counts. Most of the inclusions were in vascular cells of the lamina propria, with only about 3% being present in epithelial cells. There was no correlation between number of inclusion and severity of symptoms; however, patients with low counts tended to survive longer. As was to be expected, many of the patients had other GI infections, like shigellosis, candidiasis, mycobacteriosis, and cryptosporidiosis.

The following presentation was by Lev and colleagues (Providence and Buffalo) who looked at normal colonic mucosa and adenomas from both children (Gardner's syndrome) and adults. The mucin contents of goblet cells was examined using histochemistry and lectin binding techniques. They concluded that the adenomas in children tended to resemble small adenomas in adults in that they had little histologic atypia as well as little histochemical evidence of "premalignancy". They also noted that goblet cells in children, both in normal and adenomatous mucosa, tended to be less glycosylated when compared with adult colonic goblet cells.

A group headed by Farhood (George Washington University) reported on a study they made of colonic adenomas and adenocarcinomas. They found epithelium resembling that seen in hyperplastic polyps in the mucosa adjacent to 25% of the carcinomas and concluded that this indicates that hyperplastic polyps are involved in the polyp-cancer sequence! Considering that these conclusions are based on H&E observations only, and that no other studies have been carried out on this transitional epithelium, this appears to be an unconvincingly simplistic interpretation.

We also learned that Bob Riddell has become involved with DNA cytometry in a paper presented by Troncoso and coworkers (Chicago). They used a Taxonomic Intracellular Analytic System which uses Feulgen stained slides for analysis rather than fresh cell suspensions. With this method it is possible to analyze material retrospectively and easily separate euploid from aneuploid cell populations. This pilot study addressed the cancer of the colon, and it appears that useful and reproducible results were obtained. We look forward with a certain anticipation to a flood of data from Bob's new "toy". In the same vein, Scarpelli and collaborators (Northwestern, Chicago) utilized a somewhat different approach to study colon carcinomas, their distant metastases, and adjacent non-neoplastic mucosa. Flow cytometry was applied to tissues previously embedded in paraffin and different DNA contents as well as cell cycle distributions (CCD) were noted and correlated with the corresponding morphology.

EDITORIAL: A ROSE BY ANY NAME WOULD SMELL AS SWEET

As I was sitting down to write this editorial, a dermatopathologist who occupies the office next to mine was looking over my shoulder and commented that the above line surely could not be applied to G.I. pathologists. The aroma he associates with us is not, I'm afraid, that of the rose. Nevertheless, the immortal bard, William Shakespeare, must have known about the existence of the GIPC and our current dilemma when he penned Romeo and Juliet which is where the quotation is taken from.

Our dilemma is whether the GIPC should change its name by dropping "Club" in favor of "Group" or "Society" or more pompous still "International Society". At the last meeting in Toronto, this suggestion was raised by a number of Club members. They pointed out that to many people the designation "Club" suggests a group of amateurs involved in non-academic activities, such as collecting vintage cars or bird watching. Since one of the purposes of our organization is to establish G.I. pathology as a major subspecialty, perhaps we should project an image of dedicated professional enterohepatophiles. The argument for change is also strengthened by two practical considerations. The first of these is money! Some U.S. Club members have been claiming their annual dues as a tax deduction, and so far the I.R.S. has accepted this. However, this may be due to a lack of vigilance by Uncle Sam, who might in the future challenge the eligibility of a subscription to a "club". The second consideration is the recently concluded agreement between the Club and the American Journal of Surgical Pathology, which will result in: (1) The name of the Club appearing on the cover of the journal as a sponsoring society; (2) Publication of our announcements and scientific proceedings; (3) GIPC representation on the editorial board; (4) Possible reduced subscription to the AJSP for Club members. Since the AJSP is a highly prestigious publication, the publishers will naturally feel that sponsorship by a "club" is not as desirable as sponsorship by a "society".

WHAT SHOULD WE NAME THIS ROSE?

1. Do you favor keeping the present name, GIPC, or change it?

   Keep _____ Change _____

2. If you support change, what name do you favor?

   a) Gastrointestinal Pathology Society _____

   b) Other, Please, specify _____

Please, tear out and send responses to: Robert R. Rickert, M.D., Secretary-Treasurer, GIPC, Dept. of Pathology, Saint Barnabas Medical Center, Livingston, New Jersey 07039.

There are, however, arguments against change. Our name GIPC (affectionately pronounced like "gypsy" by some) is known and loved? by all. A "club" meeting suggests a warm and friendly convivial atmosphere. A "society" meeting suggests formality, pomposity, and even constipation. We may label ourselves a bunch of stuffed shirts if we opt to become a society. The last word is also William Shakespeare's: "To be or not to be a club: that is the question".

Having got this far in the editorial, you may feel that the discussion reminds you of a large pile of bovine guano. You have my sympathy, but remember that trivial discussions frequently provoke the strongest arguments. To fuel the flames we are asking all members to give the matter deep thought and complete the questionnaire that is enclosed with the Newsletter. If you don't like GIPC, then let us know what you prefer.

Having resolved the dilemma of a possible name change, the next logical step is to decide if the club also needs a logo and a motto. Now, I am not suggesting a specially designed coat of arms complete with lions, unicorn, or bald eagle, but today every self respecting hospital, corporation, or club seems to have a logo. Since I'm not an artist, maybe our centerfold expert (H.A.) could be asked to chair another subcommittee to work on this!! Budding logo artists are asked to send in designs along with their completed questionnaire.

A good motto should be in Latin, not English. English is acceptable, but Latin definitely adds a touch of class as well as being indecipherable by 95% of the general population. Don't think that Latin mottos are a peculiar British or Canadian habit: there are some perfectly good American ones (E pluribus unum, for example). When it comes to finding a suitable motto I can claim to be more of an expert than most because I received a classical education. Here are a few samples. How about "Ab esophago usque ad anam" (Everywhere from esophagus to anus), or "Semper intestinales biopsit" (Always biopsy the guts), or "Scientia, veritas, sapientia" (Science, truth, wisdom) or, best of all, "Omnes de intestinalibus acciperimus" (We know everything about guts)? Again, any of your suggestions will be gratefully accepted, but your editors do not wish to receive abusive letters

D. Owens, M.D.

THE QUESTIONNAIRE ON THE OPPOSITE PAGE IS ADDRESSED TO ALL GIPC MEMBERSHIP. SINCE ANY CHANGES IN THE NAME OF OUR GROUP SHOULD REFLECT THE THINKING OF A SUBSTANTIAL MAJORITY OF OUR MEMBERSHIP, WE URGE EVERYONE TO TAKE A FEW MINUTES AND ANSWER THE QUESTIONS. THIS IS ALSO AN INVITATION TO ARTISTICALLY INCLINED MEMBERS TO SUBMIT DRAFTS AND/OR IDEAS FOR A LOG THAT WOULD GO WITH OUR DENOMINATION, WHETHER THE SAME OR A NEW ONE.

MESSAGE FROM THE PRESIDENT

It is very gratifying to see how GI Pathology has gained the recognition from our colleagues, as a sub-specialty in its own right, catalyzed to a great extent by the successful scientific sessions organized by the club during the IAP meetings. The same is beginning to happen with our clinical colleagues as a result of symposia organized for the last two years for Digestive Disease Week. As the Club grows and matures, it is natural that we should try to better define our mission. Two important issues addressing that point were aired in our last newsletter, namely the responsibility of the membership in participating in cooperative studies and secondly the purpose of the "scientific" sessions.

As was stated in a previous editorial, the advantage of a national society of pathologists working in a specialized area, is clearly the opportunity for data collection on a scale impossible at any single member's institution. Yet, as several members who have initiated projects have experienced, getting these off the ground is not easy. One might mandate, as has been suggested, that membership in the GI Pathology Club carries with it an obligation to participate in Club sponsored projects. However, this opens us a Pandora's box. Some members may be too busy or simply not want to get involved in "another" project. What if one is already engaged in a similar study, as appears to be the case with Barrett's esophagus? Should one try and amalgamate with ongoing studies or alternatively discourage competing ones? Lastly, one might not want to get involved with a project that one perceives to be inadequately conceived. This brings up the question as to the mechanics whereby a project is officially sanctioned by the Club. Logically this should be done by a committee, but this is a time comsuming affair, especially difficult if most members only regularly meet once a year. Also in a small society like ours, peer review of projects might create divisiveness amongst the membership. Thus a point could be made in favor of encouraging projects amongst the membership, but not officially sponsoring any.

The second issue I would like to address is the purpose of our Scientific Sessions. To date we have organized sessions at the IAP and in the last two years at the annual meeting of the AGA. It is becoming evident that in this area we are involved in three main endeavors, namely:

1. Educating ourselves and the non specialist pathologist in GI Pathology

2. Educating gastroenterologists and especially the endoscopists in the interpretation of GI biopsies.

3. Serving as a forum for basic and applied research on gastrointestinal related topics.

So far we have been most successful in our educational mission but have somewhat neglected the research side of our interests. This has been predicated to some extent by our wish, during the formative years of our club, to attract as many of our pathology colleagues as possible by producing an educational program that would appeal to them.

In the coming year, Jim Madara is putting together a program for the IAP and the AGA that will address this imbalance. However, we need imput from our membership as to what format they would prefer and as to whether we should expand our teaching and research roles to other groups, for example the ASCP comes to mind. Lastly in this regard we also need to know what meetings our membership regularly attends, since it can be argued that if only a handful of individuals goes to say the AGA, then our function at that forum should be more educational, (i.e. for the gastroenterologists) than research.

Finally as the Club continues to expand we must be careful not to overcommit ourselves and, in so doing, dilute our efforts to the point of becoming ineffective.

Klaus Lewin, M.D.
President, GI Pathology Club

DR. MING's REPLY TO DR. YARDLEY'S EDITORIAL

In the last issue of the Newsletter (vol. 3, no. 1, Fall-winter, 1984-1985), Dr. J. Yardley and Jose Jessurun had a critical review of the paper on gastric dysplasia written by Dr. S. C. Ming for the Pathology Panel of the International Study Group on Gastric Cancer (ISGGC; Cancer, 54:1794, 1984). A reply by Dr. Ming follows. This is a welcome contribution, as we feel that a dialogue about important gastrointestinal pathology problems, such as gastric dysplasia, might be of interest to all Club members.

Dysplasia occurs in both colon and stomach, yet these two organs are different in many ways both in health and in disease. There is a consensus that dysplasia is bad in the colon and should be resected, based on the fact that colonic dysplasia occurs mainly in ulcerative colitis of long standing history and that cancer occurs frequently in such cases is high enough to warrant the generalization that dysplasia is neoplasia even though the incidence and latency period for malignant change in the dysplastic tissue is itself largely unknown.

The gastric dysplasia occurs in a different enviornment, usually in an intact, although often atrophic, mucosa. A few follow-up studies have shown that is is a reversible process and carcinoma occurs only after long periods of persistence and in a small percentage of cases (Oehlert W: Preneoplastic lesions of the stomach. In: Ming S, Ed., Precursors of Gastric Cancer, Praeger, N.Y., p 73, 1984). Therefore, gastric dysplasia is not a neoplasia. It should be followed but not resected unless carcinoma is present.

In spite of vast interest in gastric dysplasia, we confess ignorance in the biological natural history of this disturbing phenomenon. In order to gain better insight into it, some of us are ISGGC, pathologists as well as gastroenterologists (M. Crespi, listed in the protocol, is an endoscopist) under the auspices of WHO Collaborating Centers on Gastric Cancer are setting up a Registry to record the gastric dysplasia cases. We welcome the participation of GIPC members. Interested members should address the inquiries to me.

Si-Chun Ming, M.D.
Department of Pathology
Temple University
3400 N. Broad Street
Philadelphia, PA 19140

A copy of the protocol of the Registry for Gastric Dysplasia issued by the International Study Group of Gastric Cancer is reproduced at the end of this Newsletter.

COOPERATIVE MALIGNANT POLYP STUDY

An appeal directed to the members of the GIPC to participate in a cooperative study on malignant polyps of the colon has been submitted by Dr. Harry S. Cooper from the Department of Pathology of the Thomas Jefferson University Hospital in Philadelphia. Dr. Cooper's letter is reproduced below as a service of the Newsletter to the whole GIPC membership:

At the GIPC meeting at the 1984 IAP meeting (San Francisco), I was asked to chair a committee to study endoscopically removed malignant colorectal polyps. At that time, I announced that all members of the GIPC were invited to join this committee and take an active part in this study (i.e. actual review of slides and materials). At that time eight members of the Club expressed such interest. In August of 1984, I sent a letter to all GIPC members asking them to contribute cases to this study. From the comments I received at the GIPC business meeting in Toronto (1985) it appears there may have been some communication gaps in my letter of 8/84. It was our hope that all members of the Club would submit cases to our study, regardless of whether they were taking an active part or not in the study. It as our intention that "active study group members" would all be involved in a detailed histopathological and clinical study of these materials while those members of the GIPC who of their own volition did not want to "actively" participate in this study, would also contribute cases. When the GIPC was formed one of its goals was for members to provide materials for various future studies. The concept behind this was quite simple: as a group we would be able to collect many more cases for various studies than could any one individual. It was hoped that this cooperation would be fostered to benefit all members (or groups of members) in any studies they wished to undertake. We need the help of all members in order to collect enough cases to have a meaningful study. If half of the membership would contribute only 4 cases each, we would have approximately 200 cases in our study. We realize that this requires some effort; however, the quid pro quo is reciprocal cooperation in other studies which other individuals may wish to undertake. Those members who actively review slides for this study would all be coauthors of any papers that were generated. Those members who expressed no desire to review these materials, but were kind enough to provide materials would be acknowledged as contributors. Finally, we welcome with open arms any other GIPC members who wish to take an active role (review of materials) in this study, and express our gratitude to those Club members who would be so kind as to contribute cases. Below you will find an outline of our study and the type of cases we want to study.

We wish to study various histopathological parameters (grade, extent of cancer, margin of resection, lymphatic or venous invasion, % of cancer in the lesion, etc.) of endoscopically removed malignant colorectal polyps. The object of the study is to define parameters which indicate adequacy or inadequacy of endoscopic polypectomy. The types of cases we are interested in studying are:

1. Any malignant polyp (defined as containing invasive cancer) which was initially removed endoscopically (polypectomy) and of which the patient subsequently underwent a definitive

surgical resection. This type of case is easy to retrieve since one may see these cases prospectively during one's routine service work.

2. Any endoscopically removed malignant polyp treated by polypectomy only, but with a minimum of a 5 year follow-up. If possible, we would also appreciate the post 5 year status of the patient (i.e. NED. DOD, etc.).

We would appreciate receiving representative H&E slides and copies of the pathology reports. Please send these materials to me at the following address:

Harry S. Cooper, M.D.
Surgical Pathology
Thomas Jefferson University Hospital
111 S. 11th Street
Philadelphia, PA 19107

All materials will be returned upon completion of the study. We thank you in advance for your help and cooperation in this study.

SCHEDULING OF THE ANNUAL BUSINESS MEETING

The following questionnaire is addressed to the whole GIPC membership concerning the scheduling of the Annual Business Meeting in conjuction with the Gastrointestinal Pathology Club Scientific Session.

1) Would you prefer to have the Annual Business Meeting before the Scientific Session or after, as it is now?

Before _____ After _____

2) Which would you be most likely to attend? _____

3) Do you have any other suggestions regarding scheduling of our Business Meeting?

_____
_____
_____
_____

Please, complete, tear out, and send responses to:

Robert R. Rickert, M.D.
Secretary-Treasurer, Gastrointestinal Pathology Club
Department of Pathology
Saint Barnabas Medical Center
Livingston, New Jersey 07039

Announcement: Education Committee, GIPC

This year at the IAP the GIPC Scientific Session will be split into two sessions: a topical session on G-I endocrine pathology, and a research session. Since one of the major goals of the research session is to familiarize ourselves with each others research, we would like to canvas the membership for potential participants in the session. Unfortunately, we will not be able to do this before the final program deadline of this years (March, 1986) IAP. But, given the early date of program deadlines, it is appropriate for the membership to start thinking about work they might want to present at this forum in the March 1987 meeting. If interested, members should submit a specific, but brief, outline of the material which they wish to present. The receipt deadline for outlines is February 28, 1986. I will then pass these outlines on to the new Education Committee Chairperson at the IAP in order that this committee be able to have a wide base from which to select the 1987 research session. Since this session is relatively brief, submission of an outline will not guarantee that it will be chosen for presentation. Furthermore, I imagine that the next education committee might, in part, select outlines for presentation on the basis of theme and/or compatibility with other presentations. Thus failure of a particular outline to make the final program should not, in any way, be construed as a negative comment on the scientific merit of the work described. Lastly, if chosen, the individual will be asked to later submit an updated abstract of the work to be published in the American Journal of Surgical Pathology.

Outlines should be mailed to:

Dr. James Madara
Department of Pathology
Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115

INTERNATIONAL STUDY GROUP ON GASTRIC CANCER

Dear Colleague:

In the course of practicing clinical gastroenterology, it is not unusual to encounter the diagnosis of dysplasia in a biopsy of the stomach. If it is associated with a carcinoma nearby or is found in an adenoma, it will not create too much concern because the lesion will be treated anyway. On the other hand, when dysplasia is found in a stomach without a lesion requiring surgery, the question of proper management becomes a major concern. At the moment there is no established guideline dealing with this question, because the natural history of the dysplastic epithelium is largely unknown. In order to solve the problem we propose the establishment of a Registry for the dysplastic cases with adequate follow-up data so that a better understanding of the dysplastic process may be achieved and a rational approach developed.

The attached statement explains the purposes and functions of the Registry and lists the simple procedures to be followed. We invite your participation in this project. Please fill out the form below and return it to either of us at your earliest convenience. You will be contacted when the Registry becomes functional. In the mean time, please feel free to send us comments and suggestions.

Massimo Crespi, MD
Centro Prevenzione Tumori
Instituto Regina Elena
Viale Regina Elena, 291
00161 Roma, Italy

Si-Chun Ming, MD
Department of Pathology
Temple University Medical School
3400 North Broad Street
Philadelphia, Pa 19140, USA

REGISTRY FOR GASTRIC DYSPLASIA

(Cross out the words which do not apply)

Interest in participating in the Registry project: yes no

Known cases of gastric dysplasia currently being followed: yes no
If yes, can they be entered into Registry? yes no
If yes, how many?

Physician's name and address:

REGISTRY FOR GASTRIC DYSPLASIA

Purposes

The Registry is aimed to record a sufficient number of cases of gastric dysplasia for a prospective study of its premalignant nature.

The specific aims are:

1. To study the natural history of gastric dysplasia which may occur in a flat gastric mucosa or as grossly distinct lesions.

2. To determine the incidence of malignant transformation in the dysplatic epithelium.

3. To determine the time trend and sequential changes in the transformation process.

4. To delineate the features of the dysplastic epithelium that are most relevant to malignant transformation.

5. To develop guidelines for the management of gastric dysplasia in light of the above findings.

Rationale

Gastric dysplasia has been considered to be a premalignant process. It is an essential feature of the adenomatous lesions of the stomach. Because of the high frequency of malignancy in them and their localized nature, the adenomas usually are excised. Dysplasia may also occur in the flat and grossly unremarkable mucosa. In this situation its premalignant nature has also been suspected because of its common association with carcinoma in the resected stomachs. The clinical importance of dysplasia in such cases is academic because the stomachs have already been resected.

Since the advance and availability of gastrocopic biopsy in routine clinical examination, gastric dysplasia has been found in many noncancerous stomachs. It is often multifocal and has no grossly distinctive features. In these cases gastric dysplasia has become an important problem in clinical gastroenterology. It is a problem because the available data are insufficient to answer clearly the questions such as: What will become of the dysplastic epithelium? Will a carcinoma develop in it? If it does, how often and how soon will it happen? On what basis can one predict which lesion will become malignant? How should such lesions be treated? Is a blind gastrectomy justified? Finally, does gastric carcinoma develop only in the dysplastic epithelium? If not, how important is dysplasia in gastric carcinogenesis? A systematic study may provide answers to these questions.

There have been a few prospective studies on gastric dysplasia. It appears that severe form of dysplasia is not common although minor aberrations are frequent. Carcinoma develops only in the severely dysplastic epithelium and such cases are few. In order to have a sufficient number of cases for evaluation, a multicenter collaborative endeavour is necessary. A registry center will serve this purpose. In

the registry, the cases with moderate to severe gastric dysplasia are recorded. They will be monitored at regular intervals (at least yearly) to determine the outcome, i.e. malignant change, stationary status or regression. To ensure the accuracy and uniformity of diagnosis, the pathological materials will be reviewed by a panel of experts periodically.

Procedures

1. Since the principal function of the Registry is to monitor malignant changes in the dysplastic epithelium, only cases with moderate to severe dysplasia which can be regularly followed up are recorded. A close partnership between the endoscopist and the pathologist is essential for proper documentation of the cases.

2. The prospective nature of the study requires that subsequent biopsies come from the same site as the original biopsy. In order to achieve maximal accuracy and reliability in this regard, the site of the biopsy must be precisely recorded. A simple pictorial drawing may suffice. A suggested report form is enclosed.

3. It is suggested that a repeat gastroscopic examination is performed in case of a diagnosis of severe dysplasia, in order to ascertain the diagnosis and to precisely record the requested data on the registry form.

4. There should be a description of the endoscopic view of the stomash including any visible lesion or abnormality together with the diagnosis and location, indicating whether the biopsy comes from such a lesion.

5. Since the biopsies may show different abnormalities and have different subsequent courses, each of the multiple biopsies should be individually identified and separately recorded on the diagram and legend on the registry form. The sourse of the biopsy and the nature of the biopsied lesion and other associated lesions should be recorded.

6. A brief history, the endoscopic and pathologic reports and, if available, duplicate sets of significant microscopic slides (one set of H&E stained slides and optional number of unstained slides) are sent to the Registry for recording and review. The unstained slides will be used for mucin and immune histochemical studies when indicated.

7. In order to have an uniform pathological diagnosis of gastric dysplasia, the participants are encouraged to apply the criteria developed by the Pathology Panel of the International Study Group on Gastric Cancer (Cancer 54: 1794-1801, 1984). Other criteria and grading of dysplasia may be used as long as they are clearly explained. See Pathological criteria of gastric dysplasia below for additional information.

8. The cases are reviewed by a committee of experts (3 endoscopists and 5 pathologists) annually. Their views will be passed on to the participatants of the program.

9. There will be an annual report on the progress of the activities of the Registry to the participants and a periodic report of the findings for publication.

10. In order to have as many cases as possible from the beginning, any suitable case with previous biopsies or follow-up materials, in which duplicate slides are available for evaluation, may be reported to the Registry.

11. If the stomach is subsequently resected or examined postmortem, a detailed histopathological workup of the whole stomach should be carried out and the results reported to the Registry.

Pathological criteria of gastric dysplasia

There have been several reports on the criteria and grading of gastric dysplasia. After examining many microslides together and a lenthy discussion, the Pathology Panel of the International Study Group on Gastric Cancer developed a set of criteria for the diagnosis of gastric dysplasia. Their views are published in a paper entitled "Gastric Dysplasia: Significance and Pathologic Criteria" in Cancer 54:1794-1801, 1984 and summarized as follows:

1. For clinical application as a premalignant lesion, the term "Dysplasia" applies only to moderately to severely abnormal gastric epithelium, including lesions which are possibly cancerous already but cannot be ascertained in the biopsy.

2. Pathological features of gastric dysplasia include: increased cell proliferation, abnormal cell morphology and pleomorphism and architectural derrangement, all of which should be beyond what may be seen during reparative regeneration.

When other grading systems or criteria are adopted, only cases with severe forms of dysplasia will be recorded. An explanation of the method used should be included to facilitate the understanding of the pathologic changes.

Analysis of data

The statistical evaluation of the results, in terms of stomach cancer incidence in cases of severe gastric dysplasia, will be performed with the life table method, in order to estimate the probability of malignant transformation in the dysplastic epithelium. This analysis will be performed in cooperation with Dr. E. Benhamou of the Department of Medical Statistics, Institute Gustave Roussy, Villejuif, France.

Location of Registry

The Registry will be located with Dr. Si-Chun Ming, Department of Pathology, Temple University School of Medicine, 3400 North Broad Street, Philadelphia, Pa 19140, USA, until a more suitable place is found at a later time. For the time being all records will be kept at the above address.

Gastric Dysplasia Protocol

(Please use one report for each examination. If the diagnosis of dysplasia was reached before the beginning of the study, previous data should be completed on additional forms.)

Specify: first report_____
or follow-up_____

Registration no. (by Registry):
First_____Follow-up_____

Date of examination:_____

Institute, Hospital or Center:_____

_____

Gastroenterologist:_____Pahtologist_____

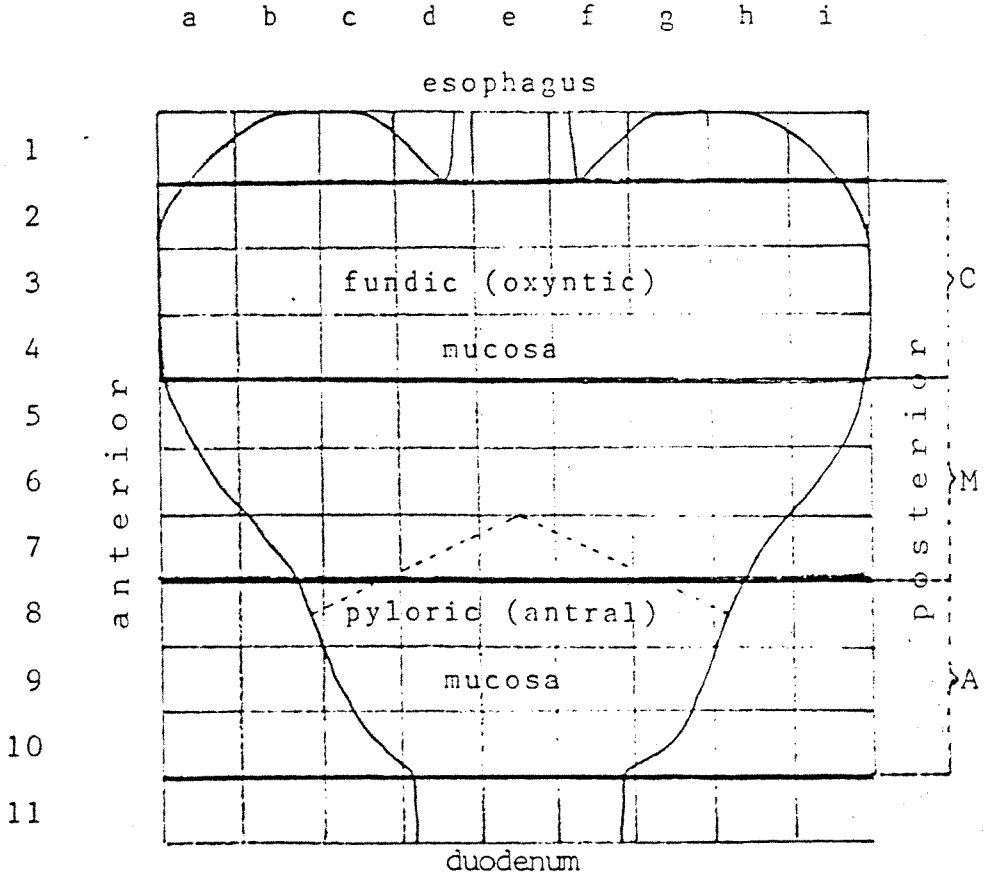
Patient's initials or number:_____Age_____Sex: M___F___

Place of Birth_____, of residence_____

Clininical diagnosis:_____

_____

Number of specimens:_____
Location of each bioptic specimen or lesion should be marked on the diagram below: specimen by X, lesion by O and, if the biopsied specimen is a gross lesion, by ●. Identify each specimen and gross lesion by a capital letter and record their endoscopic and histopathologic diagnose on the next page.



Gastric Dysplasia Protocol (continued)

Endoscopic and histologic diagnoses of each specimen or lesion:

Specimen or Lesion*	Location on diagram#	Diagnosis Endoscopic	Diagnosis Histopathologic
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			

* use the same code in the diagram.
# by number and small letters show at the margins of the diagram.

Remarks:

BY-LAWS OF THE GASTROINTESTINAL PATHOLOGY CLUB

(Including Ammendments through March 9, 1985)

Article I

Name: Gastrointestinal Pathology Club (GPC)

Article II

Objectives: The objectives of the GPC 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 training with demonstrated interest and involvement in the field of gastrointestinal pathology as determined by 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 post-doctoral training has been completed.

3. Emeritus Member. A member can become emeritus by requesting this status, in writing, of the Secretary-Treasurer anytime after age 65.

B. Membership Committee -

The President shall appoint five members and one Chairman to the Membership Committee. The term of office will be three years. The initial six appointees shall have their term staggered by lottery, two serving for one year, two serving for two years, and two serving for three years. The Chairman is appointed or reappointed each year by the President from among new and old appointees.

C. 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 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 GPC. Once conferred, membership may be retained even though the person discontinues active practice of gastrointestinal pathology.

Nomination for Associate membership can be made by a Regular member. Applicants for Associate membership will not need to provide evidence of their involvement with G.I. pathology in their application. Such decision of involvement will rest with the sponsoring, regular members.

All Charter members (persons listed in minutes of the organizational meeting held on March 7, 1979) will automatically become Regular members following approval of the By-laws. However, to retain their Regular membership, Charter members must submit a Regular membership application form within 3 months after receiving the form from the Membership Committee.

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

D. Rights 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 meetings.

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

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

E. Attendance Requirement -

Regular members should attend one annual meeting every three years. Any regular member absent for three successive years will be removed from membership. Reinstatement can take place on written request to the Secretary-Treasurer and approval of the Executive Committee.

Article IV

Governing Body:

A. Elected Officers -

1. President: term of office one year.

2. Vice-President/President-Elect: serves one 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 GPC is eligible to hold office. Nominations will be recommended by the Membership Committee and may be offered from the floor by any Regular member. Election ordinarily will be held at the Annual Meeting, or by ballot if deemed necessary by the Executive Committee. A majority vote of the Regular members present, or of all 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 GPC. He shall preside at all meetings, serve as chairman of the Executive Committee, and take repon-sibility as a representative of the GPC. The President officially receives donations, bequests, or gifts to the GPC in behalf of the GPC. The President shall appoint all standing committees for a term of one year, except for the Membership Committee, as indicated above. Ad hoc committees are appointed by the President as needed.

2. The Vice-President, in the absence or incapacity of the President, shall perform the duties of the President. Further, the Vice-President shall serve on the Executive Committee.

3. The Secretary-Treasurer shall keep minutes of the Annual and Executive Committee meetings; distribute notice to members of GPC; keep custody of documents of GPC, includ-ing mortgages, deeds and contracts that the Executive Committee has approved; serve on the Executive Committee; receive membership application and dues; keep records of financial documents for governmental agencies, banks or other financial institutions, with approval of the Presi-dent, for expenses used solely for the GPC. All such disbursements will be reported at the Annual Meeting.

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

Article V

Executive Committee:

A. The Executive Committee shall consist of the currently elected officers, the past president, and chairman of the standing committees.

B. The Executive Committee shall:

1. Represent the GPC in official business.

2. Carry out the directives and policies approved by the membership.

3. Organize and coordinate all meetings of the GPC.

4. Exert leadership in the development and implementation of scientific programs according to the above stated objectives of GPC.

5. Deal specifically with matters related to the incorporation of GPC.

Article VI

Meetings:

A. 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.

B. Special meetings may be called as deemed necessary by the Executive Committee.

C. Quorum* = 1/5 of total Regular members.

Article VII

Standing Committees (to be appointed by President):

A. Education and Specialty Conference. This Committee shall be responsible for design, organization and conduct of scientific meetings and other educational efforts of GPC.

B. Membership (see article III).

C. Training Programs. This Committee shall encourage broader availability of organized training opportunities in gastrointestinal pathology and help to upgrade their quality. Committee activities shall include collection and dissemination of information about training programs and identification and development of sources of support for trainees.

D. Publications. This Committee shall review and coordinate arrangements for all publishing activities of the GIPC. Final approval of publishing activities will rest with the Executive Committee.

* Only regular members are included in quorum.

Article VIII

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, this amendment needs to be accepted by a two-thirds majority vote of the Regular members at the Annual Meeting.

Article IX

Order of Business at Annual Meeting:

A. Scientific program.
B. Business meeting. Determination of quorum.
C. Previous minutes - Secretary-Treasurer.
D. Financial report of Secretary-Treasurer.
E. Reports of Committees.
F. Old business.
G. New Business.
H. Election of officers.
I. Announcement of new members.
J. Induction of officers.

Article X

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 GPC activities while being considered for membership.

After acceptance, new applicants and charter members shall be required to pay an initiation 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 members may be reinstated on approval of the Executive Committee.

Article VI

Liquidation and Sunset Provision:

A. Liquidation -

Motion for liquidation must be made in writing to the Executive Committee at least 2 months prior to the Annual Meeting. A 2/3 vote of Regular members present at the annual meeting is required.

B. Sunset Provision -

Every three years, the GPC and its By-laws must be re-approved by a majority of Regular members present at the annual meeting. If this does not occur, the GPC will be dissolved automatically.

C. In the event of liquidation, after payment of obligations, all remaining assets pass to the International Academy of Pathology.

Approved: December 15, 1979
Amended: February 28, 1982
Amended and Approved: March 10, 1985