THE 1st KURE INTERNATIONAL MEDICAL FORUM (K-INT) IN 2008

第1回呉国際医療フォーラム

TOPICS ON VASCULAR SURGERY IN ASIA
WITH SATELLITE SYMPOSIUM "CANCER CYTOLOGY IN ASIA"

July 25, 26, 27

AT National Hospital Organization

Kure Medical Center / Chugoku Cancer Center

●会　　長：佐治 文隆（院長）
●開催期間：2008年7月25・26・27日
●開　　催：国立病院機構呉医療センター・中国がんセンター
●会　　場：呉医療センター 4F 地域医療研修センター

Program and Proceedings

【問い合わせ先】
〒737-0023 呉市青山町3−1
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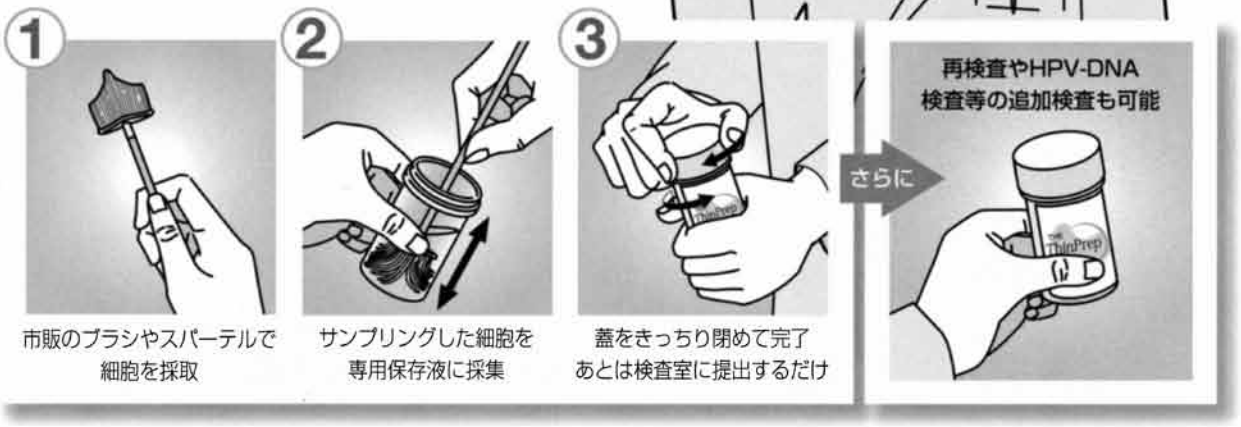

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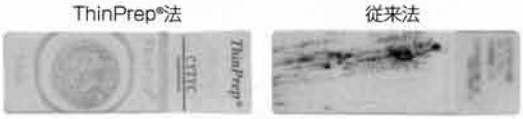

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Program and Proceedings

THE 1st KURE INTERNATIONAL MEDICAL FORUM (K-INT) IN 2008

"Topics on vascular surgery in Asia"

With satellite symposium

"Cancer Cytology in Asia"

July 25, 26, 27, 2008

At National Hospital Organization

Kure Medical Center / Chugoku Cancer Center

President of the 1st *K-INT*

Fumitaka Saji, M.D., Ph.D.
Clinical Profess

Message from the President

On behalf of the Organizing Committee, it is a privilege and a pleasure to invite you to the first Kure International Medical Forum, K-INT, to be held in Kure, Hiroshima, Japan, on July 25-27, 2008, in conjunction with the satellite symposium, Cancer Cytology in Asia. The meeting is scheduled to take place at the convention hall of National Hospital Organization Kure Medical Center/Chugoku Cancer Center, overlooking Kure Bay and Inland Sea. The Organizing Committee, in collaboration with our International Advisory Board, is making every effort to put together an exciting program covering important achievements in vascular surgery. The program includes the topics of intravascular neurosurgery and cardiovascular surgery in Asia. The Organizing Committee hopes that the participants will create a mutual network for future cooperation on topics of common interest.

Kure, located near the world-famous city of Hiroshima, will welcome you with scenic views and historical places such as Kure Chinjufu, Imperial Navy Base. Kure Maritime Museum, Yamato Museum, will introduce you to the history of Kure and technological achievements in shipbuilding and steelmaking which have contributed to the modernization of Japan. You may also visit Miyajima, a world cultural heritage site where the people and the gods live together.

We hope to have the pleasure of your company in Kure and are looking forward to a pleasant and fruitful meeting.

Kure International Medical Forum

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Ms. Negumi Irie, Mr. Ryoji Fujisawa
Kure International Medical Forum at Kure Medical Center and Chugoku Cancer Center
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Phone: 0823-22-3111 Fax: 0823-21-0478

Home page: http://www.kure-nh.go.jp/english/index.html

General Information

Access to Kure City and Kure MC/Chugoku CC

Fukuoka International Airport
to
JR Fukuoka Station
10 min by Taxi

JR Fukuoka Station
to
JR Hiroshima Station
70 min by Shinkansen (Nozomi)

Hiroshima JR Station
to
JR Kure Station
40 min by Local Train

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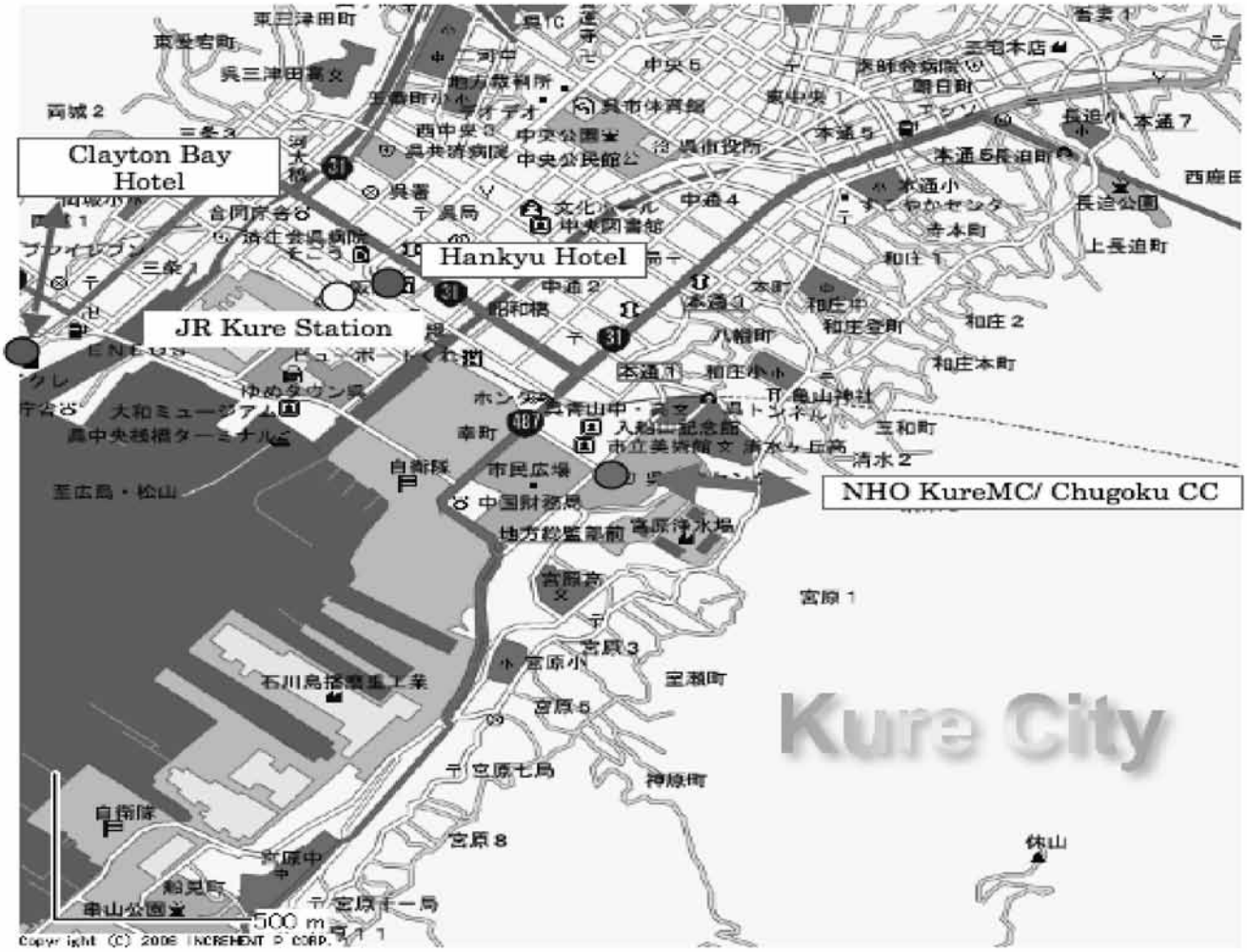
to
JR Kure Station
90 min by Limousine Bus



Attendance Fee; ¥3,000

Registration; E-mail to <irie@kure-nh.go.jp>

Early Bird Registration; until July 1st

Program and Proceedings

July 25 Friday, 2008

17:30-17:40
Welcome Address

Kiyomi Taniyama, M.D., Ph.D.
Executive Director of the 1st *K-INT*

Satellite Symposium
17:40 – 20:00
CANCER CYTOLOGY IN ASIA

Chaired by Kiyomi Taniyama, M.D., Ph.D.
NHOKureMC/ChugokuCC

Speakers

1. Aileen Wee, MB,BS, FRCPA, FRCPath National University Hospital, Singapore
   Fine needle aspiration biopsy of liver malignancies: Emerging trends

2. Thiti Kuakpaetoon, M.D., B.Sc. (Med.Sc.), FIAP,FRCPath Rajavithi Hospital, Thailand
   Cancer Cytology in Thailand

3. Hironori Katayama, C.T., FITC. Nippon Medical University, Japan
   Management of cytological specimens

4. Yosuke Kawakami, M.D., Ph.D. Kure MC/ Chugoku CC, Japan
   Liquid-based cytology and HPV typing of uterine cervical diseases in Japan

Discussion

July 26 Saturday, 2008

TOPICS ON VASCULAR SURGERY IN ASIA

Morning Session

9:15 - 9:30 Opening Address

Fumitaka Saji, M.D., Ph.D.
President of the *1st K-INT*

9:30 - 9:40 Introduction of the 1st *K-INT*

Kiyomi Taniyama, M.D., Ph.D.
Executive Director of the 1st *K-INT*

9:40 – 11:30 Symposium 1
NEUROSURGERY IN ASIA

Chaired by Kaoru Kurisu, M.D., Ph.D.
Professor and chairman, Department of Neurosurgery
Graduate School of Biochemical Sciences, Hiroshima University

Speakers

1. Sinji Ohba, MD, PhD. Kure MC/Chugoku CC, Japan
   Recent advancement in endovascular treatment of intracranial aneurysms

2. Zainal Muttaqin, Sp.BS., Ph.D. Diponegoro University, Indonesia
   Cerebrovascular Surgery in Indonesia: Semarang Experience
   Management of SAH: Indonesian Experience

3. Pravit Prachasilpchai, M.D. Rajavithi Hospital, Thailand
   Lateral Sylvian Cistern Dissection in Cerebral Aneurysm Operation and Rajavithi-design Suction

Discussion

12:00 – 13:00 Luncheon Seminar (in Japanese) Sponsored by WakoTsushinKogyo Co.,Ltd.

Chaired by Minoru Takebayashi, M.D., Ph.D.
Chief, Department of Psychiatry, Kure MC/Chugoku CC

Toshihiro Nagai M.D. Director of Minami-stress-naika clinic, Hiroshima and Director of preparatory school "Nagai Zemi", Japan (Regular commentator on Hiroshima TV program)

How to deal with troublesome patients and depressive patients.

13:20 – 13:30 Photograph

July 26 Saturday, 2008

Afternoon Session

13:30 – 17:00 Symposium 2

CURRENT AND FUTURE ISSUES IN THE CARDIOVASCULAR SURGERY

1) Current status and recent progresses

2) Surgery for elderly patients

Chaired by Taijiro Sueda, M.D., Ph.D.
Professor and Chaiman, Department of Cardiovascular Surgery
Graduate School of Biochemical Sciences, Hiroshima University

Speakers

1. Hironori Izutani, M.D., Ph.D. Rinku General Medical Center, Japan
Heart valve surgery for patients aged eighty years and more

2. Takeshi Shichijo, M.D. Kure Kyosai Hospital, Japan
Aortic surgery for elderly patients

3. Masafumi Sueshiro, M.D., Ph.D. Chugoku Rosai Hospital, Japan
Cardiovascular surgery for aged patients in Chugoku Rosai Hospital

4. Kenji Okada, M.D., Ph.D. Hiroshima University Hospital, Japan
Cardiovascular surgery for aged patients in Hiroshima University.

5. Teruya Nakamura, M.D., Ph.D., Kure MC/ Chugoku CC, Japan
Surgical ventricular restoration for ischemic cardiomyopathy

6. Chuen Neng Lee, M.D. MBBS, MMed, FRCS (Glas), FRCS (Edin), FRACS, FAMS
Singapore University Hospital, Singapore
The Future of Cardiac Surgery

Discussion

17:00 – 17:10 Closing Address.

Wataru Kamiike, M.D., Ph.D.
Vice President of the 1st *K-INT*

17:30 – 18:00 Celebration on the 1st *K-INT*

Nurse Unit and Student Nurses
NHOKureMC

18:30 – 20:30 Banquet

July 27 Sunday, 2008

Morning Session

10:00 – 12:00 Free discussion on the future of medicine in Asian countries

Afternoon Session

13:00 – 17:00 Inspection of domestic hospitals in Kure and Hiroshima cities

18:00 – 20:00 Discussion for the 2nd *K-INT*

(Appendix)

(Miyajima Shrine in the inland sea)

Excecutive Director of the 1st *K-INT*

Kiyomi Taniyama, M.D., Ph.D.
Clinical Professor

Introduction of the *K-INT*: How was the *K-INT* formed ?

I am the executive director of the first Kure International Medical Forum (*K-INT*) and have arranged it with the great help of many friends. I would like to explain how the K-INT came about.

Japan's training and education system for medical doctors has dramatically changed in recent years. Young doctors have started to select the hospital in which they will learn medical techniques. Smaller cities now have fewer of these younger doctors than large cities do. Kure MC/Chugoku CC has the disadvantage of being located in one of Japan's less urban regions. I believe that Kure MC/Chugoku CC has to do more to attract young doctors.

My idea was to sponsor an international event that would showcase the hospital. I consulted two of my best friends in the cytopathology field, Prof. Wee in Singapore and Dr. Kuakpaetoon in Thailand, and both gave me very warm support to connect to Singapore University Hospital and Rajavithi Hospital in Thailand, respectively. Prof. Lee, Prof. Wee's husband, gave me excellent advice on building the *K-INT.* Therefore, these two hospitals and Kure MC/Chugoku CC have become the core of the *K-INT.* Those friends are the guest speakers at the first *K-INT.*

K-INT is still in its formative stage. Although its influence is now limited to Kure and Hiroshima, it has great potential to introduce younger doctors to participation in international medical activities. I hope that medical activities in Kure and Hiroshima will increase as the *K-INT grows*.

<TOPICS>

CANCER CYTOLOGY IN ASIA

Pathological diagnosis is the gold standard for cancer diagnosis. Recent cancer treatment often requires the histological diagnosis before initiating therapy. These therapies have been developed on the new molecular findings, which can be demonstrated visually on the specimens by histological examination. Since the cytological diagnosis has been considered less reliable than pathological diagnosis, especially for assessing the characteristic expressions relating to the molecular abnormalities, the significance of cytological diagnosis for the neoplasm is decreasing. For example, core needle biopsy, instead of fine needle aspiration cytology, has been used worldwide to diagnose breast carcinoma. However, cytology is still a cost-effective and benign procedure versus needle biopsy for histological diagnosis. In this symposium, we will describe the current situation and new trials of cytology in each hospital / country and discuss the future of cytology in Asian countries.

NEUROSURGERY IN ASIA

Rupture of aneurysm is one of the leading causes of death elsewhere of the body. Treatment of aneurysms differs depending on the patient's condition and size or localization of the aneurysms. Over the years, aneurysm clipping in the intracranial region has become a relatively common procedure. However, in recent years, new procedures for the intracranial aneurysms have been developed, which have lowered the recurrence risk and the risk of accidental death during the procedure. In the neurosurgical session, we will discuss the advances in cerebrovascular surgery, particularly in the treatment of cerebral aneurysm in Asian countries.

CURRENT AND FUTURE ISSUES IN THE CARDIOVASCULAR SURGERY

1) Current status and recent progresses

The amount of cardiovascular surgery in Japan has increased over the last twenty years. Yearly, more than 50,000 operations have been performed for last five years. However, the yearly total number has plateaued and recently the number of isolated coronary artery bypass grafting has decreased. Japanese surgeons are facing issues of a small number of patients, high risk patients, and elderly patients. Recent surgical progresses and technologies are attractive for both patients and physicians. Off-pump bypass surgery, valve repair technique, and catheter based operations are such examples. We will focus on the facing subjects and recent progresses overcoming the issues.

2) Surgery for elderly patients

Because Japanese society is aging, more surgical patients are presenting for cardiovascular surgery. Surgery for octogenarians can be performed safely but the surgical outcomes and postoperative quality of life are still not satisfactory. Recent advances such as less invasive surgery, surgical management, postoperative care, and rehabilitation, can yield better outcome and satisfaction for cardiovascular surgery patients. We will discuss the existing and prospective concerns in elderly patients with cardiovascular disease.

<ABSTRACTS>

Fine needle aspiration biopsy of liver malignancies: Emerging trends

Aileen Wee, MB,BS, FRCPA, FRCPath
Department of Pathology, Yong Loo Lin School of Medicine, National University of Singapore, National University Hospital

Tissue confirmation is generally considered mandatory for institution of appropriate therapy for patients with malignancy. Malignant lesions occurring in the liver comprise primary cancers, namely, hepatocellular carcinoma (HCC) and cholangiocarcinoma (CC) and their variants; and metastases, particularly, adenocarcinomas. The diagnostic issues are distinguishing: (i) Well differentiated hepatocellular nodules, which comprise early well differentiated HCC, high- or low-grade dysplastic nodule, focal nodular hyperplasia, liver cell adenoma and macroregenerative nodule; (ii) Hepatocellular carcinoma (HCC) and its variants from metastases; (iii) Cholangiocarcinoma (CC) and its variants from metastases; (iv) Poorly differentiated HCC from poorly differentiated CC; and (v) Unusual neoplasms.

The role of computerized tomography (CT)-guided transabdominal (percutaneous) fine needle aspiration (FNA) biopsy is gradually being replaced by core needle biopsy (CNB), at least in some countries. Advantages and disadvantages of both exist. FNA is a safe and cost effective technique. It is less risky in patients with poor liver function and coagulation defects. It can access deep-seated lesions. The main advantage of CNB is the availability of tissue for histologic evaluation and ancillary studies, such as special stains, immunohistochemistry, flow cytometry and molecular studies. Disadvantages such as seeding of needle tract and bleeding can occur in both situations. The suboptimal amount of material in FNA can be overcome by using needles with dual aspiration and cutting mechanism and by ensuring that particulate tissue fragments are retrieved from the smears and made into cell blocks for histologic examination; microbiopsy cores of tissue are sometimes available.

FNA of hepatic lesions has been given a new lease of life through the emergence of endoscopic ultrasound-guided FNA (EUS-FNA). Early experience suggests EUS-FNA is comparable to CT-guided FNA in terms of diagnostic utility for hepatic lesions. EUS-FNA of the liver appears to be a safe, accurate and versatile procedure. EUS can better detect small focal liver lesions that are not visible at CT. Through EUS, FNA can access the left lobe of the liver, hilum and the proximal biliary tract as well as the gallbladder, extrahepatic biliary system and perihilar lymph nodes. Findings of EUS-FNA can confirm a cytologic diagnosis of liver metastases that are left-sided and / or lower than CT resolution, and establish a definitive M stage that

may alter or expedite clinical management. Likewise, EUS increases the accuracy of intrahepatic staging of HCC by delineation of lesions, which are missed by CT and magnetic resonance imaging (MRI).

EUS-FNA should be considered (i) when a liver lesion is poorly accessible to US- or CT-guided FNA, such as left-sided liver lesions, as well as biliary tract mass lesions, such as, hilar CC, gallbladder cancers, lymphomas and biliary strictures. (ii) when US- or CT-guided FNA fails to obtain diagnostic material; (iii) when a liver lesion/s is detected de novo by EUS, (iv) for staging of metastatic malignancy in accessible areas of the liver; (v) evaluation of suspected HCC, particularly in cases that are being considered for liver transplantation where the number of tumor nodules are crucial for the selection criteria; (iv) and for investigation of possible gastrointestinal primary tumors in the setting of liver metastases. The diagnostic difficulties in separating benign from malignant hepatocellular nodular lesions, however, remain.

So what does the future hold for FNA biopsy of hepatic lesions? Both FNA and CNB complement each other. EUS-FNA has given FNA a new lease of life. EUS-FNA is the latest diagnostic and staging tool with high specificity and sensitivity. Sensitivity of EUS-FNA for the diagnosis of malignancy ranges from 82% to 94%. Whether FNA, CT-guided transabdominal or EUS-guided, or CNB is used depends on operator comfort and skill, cost constraints, availability of sophisticated imaging modalities and lesion / tumor parameters. Whichever diagnostic tool is employed, on-site operator-cytopathologist teamwork with close communication and trust is mandatory. In the near future, EUS-FNA may be followed by introduction of targeted therapy through the same route after on-site cytologic confirmation of the nature of the tumor

AILEEN WEE, MB,BS, FRCPA, FRCPath

Professor and Senior Consultant Pathologist
Department of Pathology, Yong Loo Lin School of Medicine, National University of Singapore, National University Hospital

Professional Qualifications

- M.B.,B.S.(1975), University of Singapore
- FRCPA (1981), The Royal College of Pathologists of Australasia
- MRCPath (1982), The Royal College of Pathologists, United Kingdom
- FRCPath (2005), The Royal College of Pathologists, United Kingdom

Award: Teaching Excellence Award (1997-98)

Career History

- 1975-76 Houseman - Medicine, TTSH; Obstetrics & Gynaecology, TPH
- 1976-84* Lecturer – Dept of Pathology, NUS
- 1985-90 Senior Lecturer
- 1991-99 Associate Professor
- 1999-present Professor
- *[1983-84] Visiting Clinician in Pathology (*with Dr Jurgen Ludwig*) – Mayo Clinic, Rochester, Minnesota, USA

Cancer Cytology in Thailand

Thiti Kuakpaetoon, M.D., B.Sc. (Med.Sc.), FIAP, FRCPath
Cytopathology Division, Rajavithi Hospital,and Faculty of Medicine,
Rungsit University Bangkok, Thailand

For the theme of The Concurrent Cytopathology Workshop of The First Kure International Medical Forum (KINT), 2008, of Cancer Cytology in Asia. The current status and the opinion of the future of cancer cytology in Thailand will be shared with related information.

Cytology in Thailand plays the role principally in the diagnosis of malignancy of varying sites, ultimately positive or negative for malignancy. Diagnosis of infection is another important advantage. Unfortunately, the leading cancers in Thailand in female are cervical cancers and breast cancers, 24.7% and 25%, meanwhile in Male the ranking are liver and lung cancers, 33.4% and 24.6% respectively. Cytology is the method of diagnosis of those cancers as following, 1.0%, 5.5%, 7.5% and 22.5% while histology is the method of diagnosis as 98.6%, 90.8%, 15.4% and 61.7%. For liver cancers, endoscopy and radiology take more role of diagnosis type, 65.8%. Overall, histopathology shows 84.2% and 65.0% for cancer diagnosis in female and female while cytology shares 5.3% and 9.9%. However, for the local health problem of cervical cancers, conventional gynecologic cytology is so suitable for the screening test of cervical cancer control and prevention program of the country. In contrast with the diagnosis in clinical practice of cancer center, cytology is more helpful in the cancers of lung, liver and breast than that of cervix uteri. Cytology for pulmonary system has been renowned

From countries to countries, pathological practice and research are moving toward molecular paradigm more and more. So, the role of cytological diagnosis for the neoplasm is concerned to be decreased than before because the cytological specimen has been so-claimed as less suitable than histopathological one, especially for assessing the characteristic expressions relating to the molecular abnormalities. However, there are many other factors to be considered in the practical level before such conclusion.

Regarding UN HDI (Human Development Index), countries are classified to developed, developing and emerging or underdeveloping countries. In my experience, cytology is very helpful in some locations, not really emerging countries but also in developed or developing countries themselves in special areas may be high lands or regions which the health care is so difficult to access by natural obstacles for transportation and else. Therefore, significance of cytology application varies from places to places.

Cytology and molecular techniques are, on the other hand, subjective and objective. Subjective is more artistic and perceptive skilful while objective is more reproducible and logistic or reasonable. The possulate is not depending on reason. On one's opinion, cytology makes doctors more pride and dignity than depend on the machine and fixed software. We need machine in courtesy of inventors. Some seek for flexible while some need fixed reliability. I think many of you, as well as me, have ever experienced the experts, and may be senior teachers, so-called "Sensei" in Japanese and "Guru"

in Thai, who can have the correct cytological diagnosis, proofed by follow up, the real gold standard, which need only two hands and only the particular brain. Cytology aim is eventually for positive or negative for malignancy, not in the level of cell type, which may achieve by more sophisticate techniques. So, cytology will not be obsolete but will be their own usefulness, as well as many more ancient techniques, for example plain film or even H&E glass slides.

THITI KUAKPAETOON M.D., B.Sc. (Med.Sc.), FIAP, FRCPath (Thailand)

1985	4th grade physician, Department of Pathology, Rajavithi Hospital, Bangkok, Thailand.
1986	5th grade physician, Department of Pathology, Rajavithi Hospital
1990	6th grade physician, Department of Pathology, Rajavithi Hospital
1993	7th grade physician, Department of Pathology, Rajavithi Hospital
1997	8th grade physician, (Medical Expert in Pathology) Department of Pathology, Rajavithi Hospital
2001 –	Present 9th grade physician, (Special Medical Expert in Pathology) Department of Pathology, Rajavithi Hospital, Bangkok, Thailand.
1994	Chief of Department of Pathology (in lieu of), Rajavithi Hospital
1995	Chief of Department of Pathology (in lieu of), Faculty of Medicine, Rung sit University, Bangkok, Thailand.
1994 – 2001	Medical Advisor in Pathology of Ministry of Public Health
1998 – 2003	Medical Inspector of Ministry of Public Health, Region 8, 9 and 12
2001 - 2003	Registrar of Medical Society Organization of Rajavithi Hospital
2002 - 2004	President of International Academy of Pathology, Thailand Division

The management of cytological specimens

Hironori Katayama[1],Shotaro Maeda[1], Zenya Naito[2]

1) Department of Pathology, Tama-Nagayama Hospital, Nippon Medical School

2) Department of Pathology, Nippon Medical School

The results of cytological studies are dependent upon the collection, processing, and management of specimens. Currently, immunocytochemical staining and *in situ* hybridization are carried out using specimens obtained by cytological methods. The results obtained by cytodiagnosis are used to determine primary lesions, and as the basis for the selection of appropriate treatment. In the current study, we examined (1) the dependence of diagnostic findings of breast tumor on the processing of specimens obtained by fine needle aspiration (FNA); and (2) the dependence of (a) a definitive diagnosis of mesothelioma on body fluid cytology, and of (b) the detection of *HER2* in breast carcinoma on the processing of specimens obtained by cell transfer and/or cell block methods.

Methods/Results for Objective #1: Sixty cases (19 benign and 41 malignant tumors) were studied at our institution. Smears were prepared from samples collected using aspiration holders by the following four methods: a) Push method: after aspiration, cell samples collected in the needle were pushed onto a glass slide; b) Press method: cell materials were pressed between two slides that then were pulled apart; c) Sliding method: cell materials were lightly pressed between two slides that then were gently slid apart; and d) Crush method: cell materials were pressed firmly between two slides that then were slid apart. Characteristic cytological features were observed in specimens obtained by each method. It was found to be desirable to select the aspiration method most suitable for specific diagnostic purposes, by considering the characteristics of each method.

Methods/Results for Objective #2: For the study of body fluid cytology, we prepared numerous specimens using cell transfer and cell block methods, and then conducted immunocytochemical staining with antibodies. High-quality immunostaining results were obtained to diagnose mesothelioma definitively. Anti-calretinin, anti-CK5/6, anti-D2-40, anti-thrombomodulin, and anti-p-53 antibodies were particularly useful for the definitive diagnosis of mesothelioma. For the detection of *HER2* in breast carcinoma, specimens obtained by FNA from patients with the same type of carcinoma were examined. Among the patients, 10 were determined to carry the HER2 at 3+ and five the HER2 at 2+ in the tissue of invasive ductal carcinoma, as determined by the Hercep test. The specimens were subjected to direct smearing or washing/smearing. After the specimens were fixed in 95% alcohol, tumor cells were identified by Papanicolaou staining. In addition, a region containing several tumors was selected by the cell transfer method, and the cancer gene detected by chromatographic *in situ* hybridization (CISH) using a HER2-CISH kit (ZYMED Company). Hybridization signals were detected in samples collected from all 10 patients carrying the HER2 at 3+, and the amplification of *HER2* was observed. Signals were detected in samples collected from all five patients whose carcinoma cells were determined to carry HER2 at 2+; moreover, amplification of the *HER2* was observed in only three of these patients.

Conclusions: CISH of FNA cytological specimens enables the determination of the presence or absence of *HER2* amplification by light microscopy, and the permanent preservation of specimens. We consider the management of cytological specimens vital for accurate cytodiagnosis, prognosis, and selection of appropriate treatment.

Hironori Katayama, C.T., FITC

Education:

1979 ~ 1982 Department of Medical Technologist, TOYO Pablic Health College.

Employment Record :

1982-1994(June) ; Department Pathology, Nippon medical school institute of gerontology.

1994(July)-present; Department Pathology,Nippon medical school Tama-Nagayama hospital.

Present Position: Chief of Medical technologist and Cytotechnologist, Department Pathology,Nippon medical school Tama-Nagayama hospital.

Certification :

1. 1982,Apr. Medical Technologist, Ministry of Health, Labour and Welfare,Japan (Assurance: #75359.)
2. 1984,Aug. Qualified Class 2 Laboratory Technologist in Pathology (QTPat2), College of Laboratory Medicine of Japan, Japan. (Assurance: #13847 A.)
3. 1992, Dec. Cytotechnologist, The Japanese Society of Clinical Cytology, Japan. (Assurance: #4004.)
4. 1999, Dec. Cytotechnologist, International Academy of Cytology .(Assurance: #8487.)
5. 2006, Dec. Qualified Class 1 Laboratory Technologist in Pathology (QTPat1), College of Laboratory Medicine of Japan, Japan Assurance: #43,

Activity:

1) Councilor of The Japanese Society of Clinical Cytology.
2) Committee member of Committee of Internal Affairs of the Japanese Society of Clinical Cytology.
3) Committee member of Committee of Internal Affairs of the Japanese Society of Clinical Cytologist.
4) Committee member of of annual Thai-Japanese workshop in diagnostic cytopathology
5) Committee member of steering committee of Japanese Society of Pathological Technology

Liquid-based cytology and HPV typing of uterine cervical diseases in Japan

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[Objectives] The Bethesda System (TBS) for reporting cervical cytology and HPV testing have not been accepted widely in Japan. The authors have started a new survey for liquid-based cytology (LBC) with ThinPrep and TBS in conjunction with a novel one-step HPV typing method by multiplex PCR.

[Materials and Methods] Ten hospitals or institutes have joined in this survey. Cervical cytology samples were examined by a split-sample method using the ordinary Pap and ThinPrep methods. When positive findings obtained, the LBC samples were examined for the HPV typing.

[Results] A total 471 cases (mean ages, 47.9 years old) have been analyzed. Positive findings were observed in 66 (14.0%) cases by the Pap method and in 45 (9.6%) cases by the ThinPrep method. Up-grading by the ThinPrep method was detected in 7 (1.5%) cases. HPV typing was performed in 53 (11.3%) cases. Positive and negative HPV prevalence were detected in 33 (62.3%; mean age, 38.3 years old) and 20 (37.7%; mean age, 42.2 years old) cases. HPV types were 52 in 10, 16 in 9, 51 in 6 and 56 in 4 cases.

[Conclusion] LBC with TBS and HPV typing may be useful for detecting cervical cancer and choosing the follow-up durations.

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Professional Experience

1991 - 1991	Resident, Department of Obstetrics and Gynecology, Hiroshima University Hospital, Hiroshima, Japan
1991 – 1993	Resident, Department of Obstetrics and Gynecology, Hiroshima General Hospital of West Japan Railway Company, Hiroshima, Japan
1997 - 2000	Clinical and Research Fellow, Department of Gynecology and Clinical Research, National Shikoku Cancer Center, Matsuyama, Japan
2000 - 2000	Medical Staff and Research Associate, Department of Obstetrics and Gynecology, Hiroshima University Faculty of Medicine, Hiroshima, Japan
2000 - 2004	Post doctoral fellow, Department of Medicine, Division of Human Gene Therapy, University of Alabama at Birmingham, Birmingham, AL, USA
2004 - 2005	Research Associate, Department of Medicine, Division of Human Gene Therapy, University of Alabama at Birmingham, Birmingham, AL, USA
2005 -2006	Visiting Scientist, Department of Obstetrics and Gynecology, Hiroshima University Graduate School of Biomedical Sciences, Hiroshima, Japan
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Recent advancement in endovascular treatment of intracranial aneurysms

Shinji Ohba, M.D.,Ph.D.
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In recent years, endovascular surgery of intracranial aneurysms has garnered greater attention. Endovascular treatment has evolved since the Japanese Ministry of Health, Labour and Welfare had approved the Guglielmi detachable coils (GDC) in 1997. Presently, we can treat almost any aneurysm successfully due to the development of endovascular technology and instruments, such as guiding catheter, microcatheter, delivery wire, embolic materials, and others.

Eighty patients underwent surgical treatment of aneurysms in Kure Medical Center and Chugoku Cancer Center between January 2007 and June 2008. Coil embolization was attempted in 51 patients (64 %) and surgical clip occlusion in 29 (36 %). Endovascular surgery in this hospital has always been performed without general anesthesia. All surgical procedures were completed without intraoperative complications. In this way, making proper use of the two different therapeutic strategies, coiling or clipping, led to good outcomes with low morbidity and mortality in the treatment of cerebral aneurysms.

Coil embolization of intracranial aneurysms in awake patients appears surgically feasible and safe. In this presentation, I will show our procedural protocol and patient selection criteria for endovascular surgery of intracranial aneurysms.

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Education:

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Professional Experience:

1997-2004	Assistant professor of Neurosurgery Department, Hiroshima University Hospital.
2005-2006	Associate professor of Neurosurgery Department, Hiroshima University Hospital
2007-Present	Director of Neurosurgery Department, Kure MC/Chugoku CC Clinical professor of Neurosurgery, Hiroshima University

1. Cerebrovascular Surgery in Indonesia: Semarang Experience
2. Management of SAH: Indonesian Experience

Zainal Muttaqin, Muhamad Thohar Arifin
Dept. of Neurosurgery, Medical Faculty, Diponegoro University, Indonesia

1. Cerebrovascular diseases are a major global health problem, result in high morbidity and mortality, and are the leading cause of disability. Surgery on cerebrovascular disease in the developing countries, if they exist at all, is the result of the individual efforts of a small number of physicians who were fortunate enough to receive their training abroad. Patient needs are the same everywhere, but resources are not. In addition, such physicians often have to perform all aspects of patient care and preoperative evaluation by themselves. In the other hand, some levels of medical infrastructure (i.e. insurance provider) are not yet aware to identify patients remediable by surgery, or ensure surgery will cure the patients with cerebrovascular disease.
Over the past few years, developments in endovascular treatments for cerebrovascular diseases have expanded the horizon of treatment by use of minimally invasive techniques, although still in its infancy, have realized dramatic result.
We reported our experience in surgery on cerebrovascular disease and our new developing modality endovascular surgery.

2. Management of 35 SAH patients admitted to Diponegoro University Hospital (pre- endovascular intervention period) were evaluated. WFNS grading showed 3 grade I (headache only), 6 grade II, 10 grade III, 8 grade IV (decreasing level of consciousness), and 8 grade V (comatose patients). Fisher's CT criteria showed 15 group IV, 7 group III, 10 group II, and 2 group I. Intracerebral and/ or cisternal clot found in 14, while ventricular enlargement was found in 17, 12 of them was severe or VCR (ventriculo-cranial ratio) of > 0.26
The aneurysms were managed conservatively for the first 2 weeks. Ventricular drainage or ventriculo-peritoneal shunting was performed in 5 patients with acute ventricular enlargement during this period. There were 14 survivors after this 2 weeks, 12 of them underwent angiography and aneurysms were revealed in 10. Clipping were performed in 6 patients with good results. Two patients died from rebleeding after the angiography.
The outcome showed that all 100% grade V patients died, so did 62.5% of grade IV and 60% of grade III patients. Good outcome were found in 9 patients, 8 of them (88.9%) were alert on admission. Fisher's CT grading showed that mortality reached 80% in group IV, and 71.4% in group III. The presence of ICH or cisternal clot

worsens patients clinical condition at onset, as shown by more patients admitted with WFNS grade IV and grade V (71.4%), compared to only 25% without it. In consequences, good outcome were seen in 1/14 (7.1%) in those with ICH/ cisternal clot, compared to 8/20 (40%) for those without it.
Number of cases managed with endovascular intervention were reported but stastical evaluation were not performed

Zainal Muttaqin, M.D., Ph.D.

Education

1983	Graduated from Medical Faculty, Diponegoro University, Semarang
1987 – 1994	Ph.D. Degree in Neurosurgery, and Neurosurgical Trainingat Department of Neurosurgery, Hiroshima University School of Medicine, Hiroshima, Japan
1994 – Present	Several trainings and courses in Skullbase Dissection and Epilepsy Surgery
2000 – Present	Developing Epilepsy Surgery in Indonesia/ Semarang

Working Experiences

1984 – 1987	Teaching Neurophysiology at Medical Faculty, Diponegoro University
1995 – Present	Teaching Neurophysiology, Neuroradiology, and Neurosurgery at Medical Faculty, Diponegoro University, Semarang

Special Interest

Epilepsy, Neuroimaging, Transcranial Doppler Sonography, Skullbase Tumors

Lateral Sylvian Cistern Dissection in Cerebral Aneurysm Operation and Rajavithi-design Suction

Pravit Prachasilchai, M.D.
Neurosurgery Division, Rajavithi Hospital, Thailand

Cerebral aneurysms are more common in Thailand since the improvement of vascular imaging techniques. The urgent surgery to relief time bomb needs fine and smooth operation for avoiding the complication of rupture. In the operation of cerebral aneurysms, the important things to be concerned are the way of arachnoid cistern opening and how to decrease manipulation or minimal retraction of the brain parenchyma. The dissection of the lateral sylvian cistern consumes less operation time and takes the brain tissue less injured by physical retraction than medial sylvian dissection. The satisfactory operative outcomes are achieved by this approach with special-design suction in our experience. The Rajavithi-design suction and the lateral sylvian cistern dissection in the case of cerebral aneurysm will be presented with motion pictures. Comment and open discussion of the participants would be appreciated.

Pravit Prachasilchai, M.D.

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1980	M.D., Mahidol University
1986	Neurosurgical Board, Mahidol University
1990	Fellow in Neurosurgery, Nagoya University School of Medicine, Japan
1996	Certificate in Gamma Knife, Karolinska Hospital, Stockholm, Sweden
Present	Government Service

Heart valve surgery for octogenarian patients

Hironori Izutani, M.D[1,2]., Takanori Shibukawa, M.D[2]., Jun Kawamoto, M.D[2]., Shingo Mochiduki, M.D[2]., Dairoku Nishikawa, M.D[2].
[1]Cardiovascular Surgery, RINKU GENERAL MEDICAL CENTER
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Open heart surgery for octogenarians with valvular heart disease has recently been performed. However several issues surround outcomes, length of hospital stay, postoperative quality of life, and activities of daily living. One fifth of patients who underwent open heart surgery at our institute in Kure, an advanced aging city, was eighty years old and more. We examined the characteristics of the elderly patients underwent valve surgery for preoperative status, surgery, postoperative course.
Consecutive surgery patients who underwent valve surgery from 2004 to 2007 were reviewed.
Conclusion

1. Many elderly patients with severe valvular heart disease tend to visit emergency department with advanced heart failure, thus requiring extended length of hospital stay for treatment.
2. Elderly patients who expect valve surgery in near future should consider surgery before their heart failure worsens.
3. Most elderly patients tolerate concomitant valve surgery with coronary artery bypass grafting and MAZE procedure.
4. Some patients require postoperative rehabilitation because of compromised preoperative condition and complications.

Hironori Izutani, M.D., PhD.

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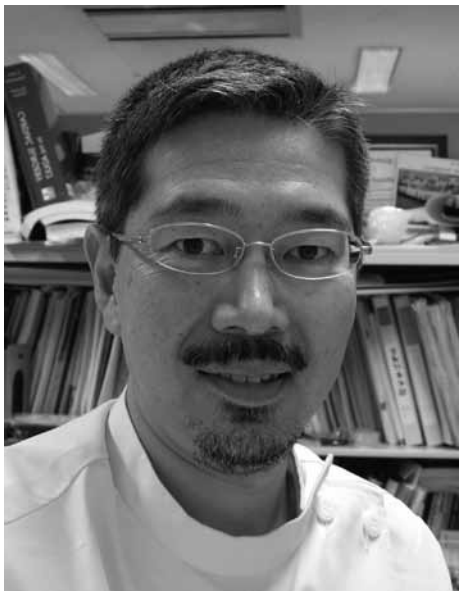
Medical School:

1988	M.D., University of Occupational and Environmental Health, Japan
1996	PhD., Graduate School of Medicine, Osaka University

Training & Professional Career:

1988	Resident, First Department of Surgery, Osaka University Hospital
1989	Resident, Department of Surgery, National Kure Hospital
1991-1992	Staff in the Department of Cardiovascular Surgery, Osaka Rosai Hospital
1996	Clinical Research Fellow, Division of Cardiothoracic Surgery, Loma Linda University Medical Center, Loma Linda, California, USA.
1999	Staff, Department of Cardiovascular Surgery, Osaka Police Hospital
2001	Clinical Fellow, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation, Cleveland, Ohio, USA.
2004- 2007	Chief, Cardiovascular Surgery, National Hospital Organization Kure Medical Center and Chugoku Cancer Center
2008- Present	Chief, Cardiovascular Surgery, Rinku General Medical Center



Aortic surgery for elderly patients

Takeshi Shichijo,M.D.,Shu Yamamoto, M.D.
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Due to the steadily increasing number of elderly individuals in Japan, many elderly patients are recently being referred to cardiovascular surgeons to undergo surgical treatment. Between January 2003 and May 2008, eighty-six patients underwent abdominal aortic surgery (AAA group) while 51 patients underwent either thoracic or thoracoabdominal aortic surgery (TAA group) at our institute. In the AAA group, 54 (63%) patients were 75 years of age or older, including 27 (31%) patients who were 80 years of age or older. In the TAA group, 20 (39%) patients were 75 years of age or older, including 9 (18%) patients 80 years of age or older. There were two postoperative deaths among the 86 patients in the AAA group. These two patients underwent an emergency operation for a ruptured abdominal aortic aneurysm. No perioperative deaths were observed among the patients who underwent elective surgery. In the TAA group, 10 patients died after surgery. There was no difference in the mortality between the younger and older patients. Although the operative risks are greater for elderly patients, thoracic aortic surgery should not be ruled out based on age alone.

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Training&Professional Career:

1980-1982	Resident, Department of Surgery, Kagawa Prefectural Central Hospital
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1984-1988	Research Fellow: Second Department of Surgery, Okayama University Medical Scool
1988-1992	Staff, Department of Thoracic and Cardiovascular Surgery, Kure Kyosai Hospital
1992-2003	Staff, Department of Cardiovascular Surgery, Hiroshima City Hospital
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Cardiovascular surgical approach for elderly patients

Masafumi Sueshiro, M.D., PhD.
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In the field of vascular surgery, we will be able to reduce invasive Surgery by combining traditional open surgery with endovascular surgery. As a result, we can provide minimally invasive surgical treatment for elderly patients who recently underwent surgery and have many complications. Last year, our hospital was the only one facility in Kure, which was certified to perform stent grafting of abdominal aortic aneurysms.
Then in the field of cardiac surgery, the number of cases of coronary artery bypass surgery is decreasing according to the PCI technology and product improvements. As a result, the aging of surgical patients after PCI progresses, and many cases have serious complications (head neck vascular disease). Considering the material cost, we use On-pump beating method without stapler in coronary artery bypass.

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Training & Professional Career
Staff, Department of Cardiovascular Surgery, National Hospital Organization Higashi-Hiroshima Medical Center
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Strategy for Elderly Patients in Cardiovascular Surgery

Kenji Okada, M.D., Shinya Takahashi, M.D., Taiichi Takasaki, M.D., Katsutoshi Sato, M.D., Tatsuya Kurosaki, M.D., Katsuhiko Imai, M.D., Kazumasa Orihashi, M.D. and Taijiro Sueda, M.D.

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As the number of elderly patients undergoing cardiovascular surgery (coronary artery bypass and peripheral artery bypass) continues to increase, evidence seems growing that they can do so with improved health status, functional status, longevity, and life quality. Our strategy for elderly patients is (1) Off-pump coronary artery bypass grafting (OPCAB) for coronary artery disease (CAD), (2) reconstruction under local anesthesia for peripheral artery disease (PAD) . In this article, we evaluated our results with CAD and PAD in recent two years. In CAD, standard combination were left internal thoracic artery (LITA) to left descending artery (LAD), and saphenous vein graft (SVG) to the others. Proximal anastomoses were often performed using PAS-port aortic connector devices. The graft patency rate was 100%. Two patients were died with MOF. Both were transferred to our hospital with IABP and intubation after resuscitation. The other patients were doing well without cerebral infarction, pneumonia, and cardiac events. OPCAB is safe and feasible in elderly patients. In PAD, at iliac and femoral arterial lesion, cross-over femoro-femoro artery bypass or cross-over femoro-profound femoro artery bypass were performed respectively. AS just two 4cm-incision in inguinal lesions were necessary, these two bypass could be done under local anesthesia. Preoperative condition, such as respiratory dysfunction, cardiac and renal failure was not issues. Conclusion: OPCAB for CAD, reconstruction under local anesthesia for PAD were alternative.

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Surgical ventricular restoration for ischemic cardiomyopathy

Teruya Nakamura, M.D.[1], Koji Takeda, M.D.[2,3], Goro Matsumiya, M.D.[2,3], Shigeaki Otake, M.D.[3], Kazuhiro Taniguchi, M.D.[3], Takafumi Masai, M.D.[3] and Yoshiki Sawa, M.D.[2,3]

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Background

Surgical treatment of patients with congestive heart failure has been challenging. Although ventricular assist devices and heart transplantation are universally applied as the treatment of choice, limitation exists such as device complications and shortage of donor hearts. Surgical procedures that potentially prevent or delay the progression of congestive heart failure have been recently emerging. Surgical ventricular restoration (SVR) has been drawing more attention amongst cardiac surgeons in Asian countries, where cardiac transplant is even more limited. We sought to examine our outcome of SVR for congestive heart failure secondary to ischemic cardiomyopathy (ICM) and risk stratification affecting long-term outcome.

Patients and methods

We analyzed 72 patients of ICM (left ventricular ejection fraction of less than 40%) who underwent SVR from 1999 to 2007. All the patients had anteroseptal myocardial infarction previously. Different types of SVR were performed: Dor procedure, 49 (68%); Septal and anterior ventricular exclusion, 12(17%); Overlapping, 11 (15%). Mitral valve operation and/or coronary artery bypass (CAB) were performed as adjunctive procedures in 35 cases (49%) and 55 cases (76%), respectively. Primary endpoints were death and major adverse cardiac events (MACE). Left ventricular function was assessed by cardiac catheterization and echocardiography. We determined pre- and post-operative NYHA functional class 3 years after the operation.

Results

Operative mortality was 2 (2.8%). Late death and MACE were 16 (22%) and 22(31%), respectively. Overall actuarial survival at 1 year and 5 years were 95.3% and 71%, respectively. Left ventricular function as represented by left ventricular end-diastolic volume index (148±47 vs. 94±31ml/m^2, $p<0.0001$), end-systolic volume index (112±46 vs. 60±25 ml/m^2, $p<0.0001$) and left ventricular ejection fraction (25±7.0 vs. 38±11%, $p<0.0001$) were significantly improved after SVR. NYHA functional class was significantly improved postoperatively (2.8±0.9 vs. 1.6±0.7, $p<0.0001$). Multivariate analysis showed that preoperative increased left ventricular dimension of greater than 65mm and association of severe mitral regurgitation were independent predictors of late cardiac death.

Conclusion

Our result suggests that SVR is an excellent treatment option for ICM, providing low operative mortality and good long-term outcome. Especially, it seems more reasonable option in Japan and other countries where the limited number of transplants take place due to lack of donor heart. Patients with preoperative mitral regurgitation and extensive ventricular remodeling had worse prognosis than those without them. We thus advocate that mitral valve operation is important as a conjunctive procedure of SVR.

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Education

2002	PhD at Osaka University of Graduate School of Medicine, Suita, Japan
1992	M.D. at University of Ryukyus Medical School, Nishihara, Japan

Licenses and Certificates

2007	Board Eligible Cardiovascular Surgeon in Japan
2006	Wisconsin State Medical License
2005	Passed USMLE Step 3
2004	ECFMG Certificate
1996	Board Certification of General surgery in Japan
1992	Licensure of Physician/Surgeon in Japan

Clinical Experiences

2007-2008	Staff surgeon, Sakurabashi-Watanabe Hospital, Osaka, Japan
2006-2007	Faculty/Clinical instructor, Department of Surgery-Cardiothoracic University of Wisconsin Hospital and Clinics, Madison, WI
2004-2006	Clinical fellow in Division of Thoracic and Cardiovascular Surgery, LDS Hospital, Salt Lake City, UT
1995-1998	Thoracic surgery resident at Osaka University Affiliated Hospitals
1992-1995	General surgery resident at Osaka University Affiliated Hospitals

Research Experiences

2001-2004	Research associate at Baylor College of Medicine, Houston, TX
1998-2001	Graduate student at Osaka University of Graduate School of Medicine

Awards

* 2002	Baylor College of Medicine Best Basic Research Award
2001	Research Award from Mochida Memorial Foundation
2001	Research Award from Uehara Memorial Foundation

*** 1999 YIA from Japanese Thoracic and Cardiovascular Society**

The Future of Cardiac Surgery

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Head, Dept of Surgery, Yong Loo Lin School of Medicine, National University of Singapore
Chief, Dept of Surgery & Dept of Cardiac, Thoracic & Vascular Surgery, National University Hospital, Singapore

There had been pessimism about the future prospect of cardiac surgery, particularly from effects of "disruptive technology".
Cardiac surgery's future is in fact, bright.

Data supports increasing volume of coronary surgery particularly with an ageing population. There is a trend towards reducing rates of percutaneous interventions. Different parts of the world will be affected differently. The future for Asia appears brighter than in western countries, given the lower base of cardiac surgery. Countries that had excessive numbers of surgeons (eg. Japan) may need to rationalize towards an optimal number to maintain high level of expertise.
We do need to seek new areas for cardiac surgery: particularly surgical options for heart failure and lone atrial fibrillation. Current regulations may hinder innovations in surgery. Innovation and collaborative research with engineers and scientists will be key to the future.
It is also important to review training programs in cardiac surgery, to acquire and incorporate percutaneous techniques into our training systems. Facilities like intraoperative angiosuite should be incorporated in expansion plans. Future practice of cardiac surgery would be radically different from current pattern.
Leaders in cardiac surgery will need to inspire and systematically plan for the long term, recruit the best to join our profession and provide for an atmosphere of academic, high integrity, long term result based surgical endeavor.

Lee Chuen Neng

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Professional Qualifications

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- M.MED 1980 School of Postgraduate Medicine, National University of Singapore
- FRCS (Glasgow) 1980 Royal College of Surgeons of Glasgow
- FRCS (Edinburgh) 1980 Royal College of Surgeon of Edinburgh
- FRACS 1982 Royal Australasian College of Surgeons
- FACC 1993 American College of Cardiology
- FCCP 1993 American College of Chest Physician

Career History

1975-76	Houseman - Surgery, SGH; Obstetrics & Gynaecology, TPH
1976-78	Medical Officer – Singapore Armed Forces
1978-80	Trainee – Singapore General Hospital
1980-83	Lecturer in Surgery – Singapore General Hospital
1983-85	Fellow and Resident - Mayo Clinic and Mayo Graduate School of Medicine Rochester, Minnesota, USA
1985-86	Senior Lecturer and Consultant – University Department of Surgery, SGH
1986-90	Senior Lecturer and Consultant Cardiovascular and Thoracic Surgeon – University Department of Surgery, National University Hospital
1990-92	Associate Professor and Consultant Cardiothoracic and Vascular Surgeon, Head of Cardiothoracic Surgery – University Department of Surgery
2002-present	Professor – Department of Surgery – Yong Loo Lin School of Medicine, NUS

Vice-President of the 1st *K-INT*
Wataru Kamiike, M.D., Ph.D.
Clinical Professor

Closing Address: The Purpose of the *K-INT*

The task of cultivating internationally valuable medical professionals has traditionally been the responsibility of Japan's large universities. At the same time, new technology has enabled us to create an international network. Our hospital, Kure MC/ Chugoku CC, is one of the leading hospitals in the western part of Japan and has started to train medical professionals although we are not affiliated with a university. The Kure International Medical Forum (*K-INT*) is a resource for doctors in the Kure and Hiroshima areas. Its purposes are to give younger or less-experienced medical staff an opportunity to participate in international activity, form friendships, and exchange ideas in an international forum. The first *K-INT* focused on vascular surgery, and the second one, to be held in 2009, will have neonatology as its theme. By changing the theme each year, we hope that more staff members will join the *K-INT* and encourage it to grow. I sincerely hope that new medical staff will find inspiration in the *K-INT* and play an active part in the world of international medicine. I look forward to seeing all of you again next year.

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処方せん医薬品注)

注射用オノアクト®50

注射用塩酸ランジオロール　ONOACT®

注）注意－医師等の処方せんにより使用すること。　薬価基準収載

〔禁忌（次の患者には投与しないこと）〕

(1)心原性ショックの患者〔心機能を抑制し、症状が悪化するおそれがある。〕
(2)糖尿病性ケトアシドーシス、代謝性アシドーシスのある患者〔アシドーシスによる心筋収縮力の抑制を増強するおそれがある。〕
(3)房室ブロック(II度以上)、洞不全症候群など徐脈性不整脈患者〔刺激伝導系に対し抑制的に作用し、悪化させるおそれがある。〕
(4)肺高血圧症による右心不全のある患者〔心機能を抑制し、症状が悪化するおそれがある。〕
(5)うっ血性心不全のある患者〔心機能を抑制し、症状が悪化するおそれがある。〕
(6)未治療の褐色細胞腫の患者（「用法・用量に関連する使用上の注意」の項参照）
(7)本剤の成分に対し過敏症の既往歴のある患者

■効能・効果

1.手術時の下記の頻脈性不整脈に対する緊急処置：
心房細動、心房粗動、洞性頻脈　＊2.手術後の循環動態監視下における下記の頻脈性不整脈に対する緊急処置：
心房細動、心房粗動、洞性頻脈

〈効能・効果に関連する使用上の注意〉
(1)本剤は、予防的には使用しないこと。
(2)洞性頻脈においては、その原因検索及びその除去が重要であることに十分留意するとともに、本剤の効果が心拍数の減少作用であることを踏まえて、本剤は緊急処置として必要に応じて使用すること。（「重要な基本的注意」の項(3)参照）
＊(3)手術後の使用においては、ICU、CCU及びそれに準じた全身管理が可能な施設において、循環動態の評価、不整脈診断及び呼吸・循環等の全身管理の十分な経験を持つ医師のもとで、心電図モニターを用い、心拍数の監視、血圧測定を原則として5分間隔で、必要ならば頻回に行うこと。（「重要な基本的注意」の項(1)、(2)参照）

■用法・用量（抜粋）

1.手術時　塩酸ランジオロールとして、1分間0.125mg/kg/minの速度で静脈内持続投与した後、0.04mg/kg/minの速度で静脈内持続投与する。投与中は心拍数、血圧を測定し0.01～0.04mg/kg/minの用量で適宜調節する。＊2.手術後　塩酸ランジオロールとして、1分間0.06mg/kg/minの速度で静脈内持続投与した後、0.02mg/kg/minの速度で静脈内持続投与を開始する。5～10分を目安に目標とする徐拍作用が得られない場合は、1分間0.125mg/kg/minの速度で静脈内持続投与した後、0.04mg/kg/minの速度で静脈内持続投与する。投与中は心拍数、血圧を測定し0.01～0.04mg/kg/minの用量で適宜調節する。

〈用法・用量に関連する使用上の注意〉
(1)目標とする心拍数に調節した後は、循環動態、特に血圧低下に注意し、本剤を心拍数の維持に必要な最低の速度で持続投与すること。
＊(2)手術後の使用においては、本剤投与により血圧低下（収縮期血圧90mmHgを目安とする）あるいは過度の心拍数減少（心拍数60回/分を目安とする）が生じた場合は、減量するか投与を中止すること。
(3)本剤を再投与する際の投与間隔は5～15分間を目安とすること。なお、再投与は用法・用量に従って実施すること。（添付文書の「臨床成績」の項4.、「薬物動態」の項参照）
＊(4)手術時と手術後の用法・用量が異なることに留意すること。
(5)褐色細胞腫の患者では、本剤投与により急激に血圧が上昇するおそれがあるので、α遮断剤を投与した後に本剤を投与し、常にα遮断剤を併用すること。
(6)本剤投与に際しては、添付文書の体重別静脈内持続投与速度表を参考にすること。

■使用上の注意（抜粋）

1.慎重投与（次の患者には慎重に投与すること）(1)左室収縮機能障害のある患者 (2)気管支痙攣性疾患の患者 (3)コントロール不十分な糖尿病患者 (4)低血圧症の患者 (5)重篤な血液、肝、腎機能障害のある患者 (6)末梢循環障害のある患者（壊疽、レイノー症候群、間歇性跛行等）＊(7)大量出血や脱水症状等により循環血液量が減少している患者　2.重要な基本的注意 (1)心電図による監視、血圧の測定等、心機能をモニターしながら投与すること。血圧低下又は徐脈を認めた場合等は減量あるいは投与を中止し、必要に応じて適切な処置を行うこと。また、PQ時間が過度に延長した場合、投与を中止すること。＊(2)大侵襲手術後等の心拍出量が低下している患者に本剤を投与する場合、本剤投与開始前の心機能を慎重に観察するとともに、心電図による監視、血圧の測定に加え、心拍出量及び血液ガス等の心機能をモニターし、患者の全身状態を十分管理しながら投与すること。＊(3)洞性頻脈に対して本剤を投与する場合は、心筋虚血や心不全等の発生及びその悪化のおそれのある患者における頻脈処置の必要性を十分考慮し、患者の基礎疾患、合併症の内容、手術前の状態及び手術内容等の事前の患者情報を精査した上で、頻脈の治療が必要とされる場合にのみ適用を考慮すること。＊(4)心筋虚血のリスクのある患者では、心拍数減少の有益性が血圧低下の危険性を上回ると判断された場合にのみ適応を考慮すること。＊(5)心不全の徴候又は症状が見られた場合は本剤を直ちに中止し、適切な処置を行うこと。また、本剤投与前に適切な緊急措置が可能となるように準備しておくこと。必要に応じてアトロピン、β1刺激剤、輸液や昇圧剤等を準備しておくことが望ましい。(6)狭心症の患者で類似化合物（塩酸プロプラノロール）の投与を急に中止したとき、症状が悪化したり、心筋梗塞を起こした症例が報告されている。本剤の投与を中止する場合においても観察を十分に行うこと。＊(7)心房細動及び心房粗動に対する使用に際しては、本剤の効果が心拍数の減少であることに留意し、頻脈性（型）であることを確認すること。(8)手術時の使用においては、本剤は緊急治療を要する場合に短期間のみ適応すること。患者の状態を十分観察し、緊急治療の必要がなくなった場合は、漫然と継続投与しないこと。また、本剤投与5～10分を目安として、目標とする心拍数の低下が得られない場合は、適切な処置を行うこと。＊(9)手術後の使用においては、本剤は緊急治療を要する場合に短期間のみ適応すること。患者の状態を十分観察し、緊急治療の必要が無くなった場合は、漫然と継続投与しないこと。また、本剤投与5～10分を目安として、目標とする心拍数の低下が得られない場合は、最大用量に増量するか、本剤投与を中止し、適切な処置を行うこと。(10)本剤の心拍数の減少効果は、投与終了後、速やかに減弱するものの、この効果の消失には投与終了後30～60分を要することに留意すること。

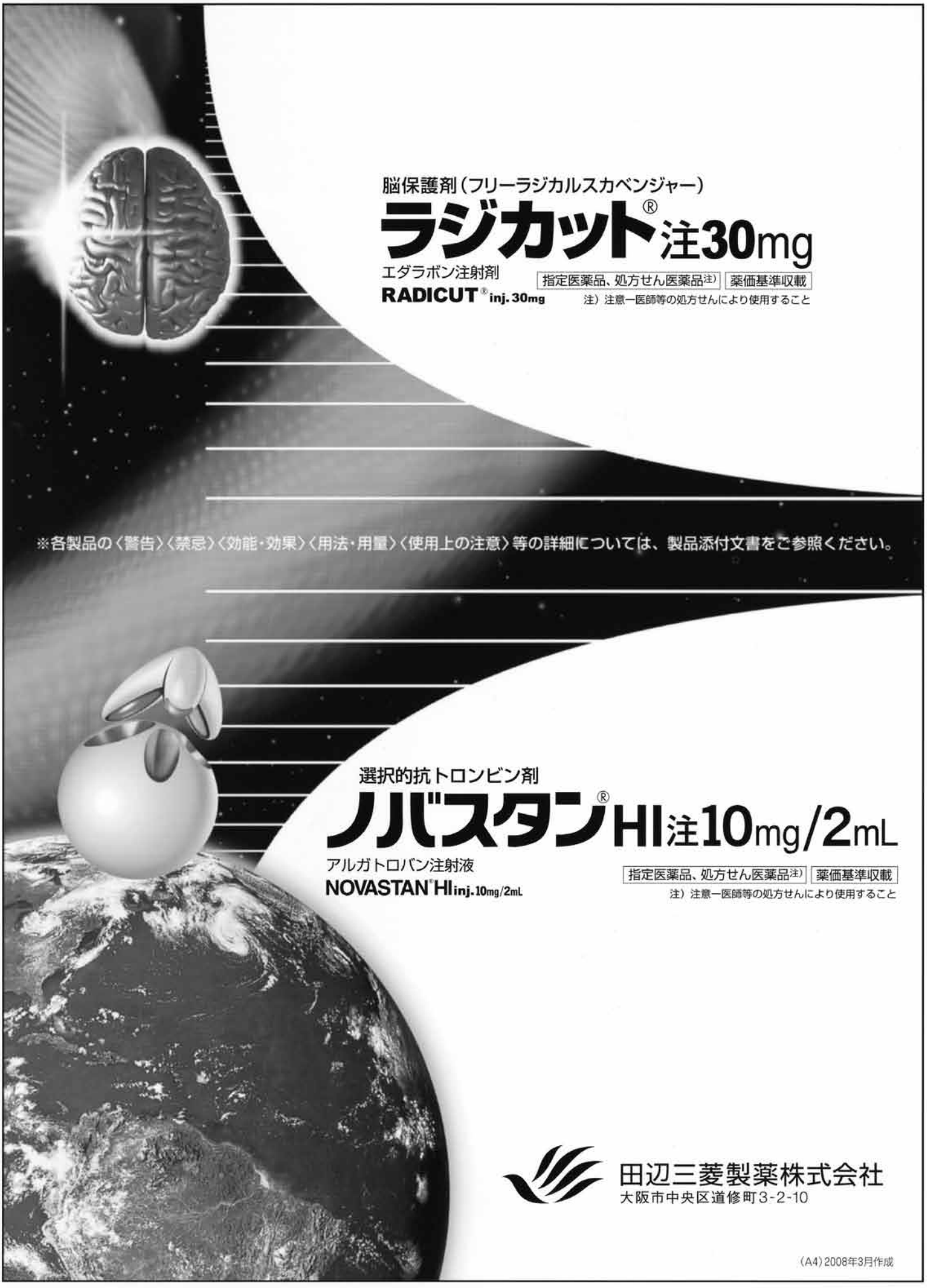
3.相互作用（抜粋）併用注意（併用に注意すること）　薬剤名等　交感神経系に対し抑制的に作用する他の薬剤（レセルピン等）、血糖降下剤（インスリン等）、カルシウム拮抗剤（ベラパミル、ジルチアゼム等）、ジギタリス製剤、クラスI抗不整脈剤（ジソピラミド、プロカインアミド、アジマリン等）、クロニジン、交感神経刺激剤（エピネフリン等）、コリンエステラーゼ阻害剤（ネオスチグミン、臭化ジスチグミン、塩化エドロホニウム等）、クエン酸フェンタニル、プロポフォール、プロカイン、スキサメトニウム　4.副作用〈手術時〉承認時までの調査における513例中80例(15.6%)に副作用（臨床検査値の異常を含む）が認められた。主な副作用は血圧低下60例(11.7%)、徐脈3例(0.6%)、ST低下2例(0.4%)、ショック1例(0.2%)、肺動脈圧上昇1例(0.2%)、喘息1例(0.2%)、低酸素血症1例(0.2%)、白血球増多2例(0.4%)、ALT(GPT)上昇4例(0.8%)、AST(GOT)上昇3例(0.6%)、総ビリルビン上昇3例(0.6%)、LDH上昇2例(0.4%)等であった。（承認時）＊〈手術後〉承認時までの調査における239例中66例(27.6%)に副作用（臨床検査値の異常を含む）が認められた。主な副作用は血圧低下38例(15.9%)、徐脈（心停止）1例(0.4%)、低酸素血症1例(0.4%)、血小板減少2例(0.8%)、ALT(GPT)上昇7例(2.9%)、AST(GOT)上昇6例(2.5%)、総ビリルビン上昇8例(3.3%)、γ-GTP上昇7例(2.9%)、アルカリホスファターゼ上昇5例(2.1%)、LDH上昇4例(1.7%)、BUN上昇3例(1.3%)、尿酸上昇2例(0.8%)、クレアチニン上昇2例(0.8%)等であった。（承認時）(1)重大な副作用　1)ショック　ショック（過度の血圧低下）があらわれることがある(0.1%)ので、異常が認められた場合には投与を中止し、適切な処置を行うこと。2)心停止、完全房室ブロック　心停止(0.1%)、完全房室ブロック（頻度不明）があらわれることがあるので、異常が認められた場合には投与を中止し、適切な処置を行うこと。

●その他の使用上の注意等、詳細は製品添付文書をご参照ください。

（＊2006年10月改訂）

資料請求先
小野薬品工業株式会社
〒541-8564 大阪市中央区久太郎町1丁目8番2号

071001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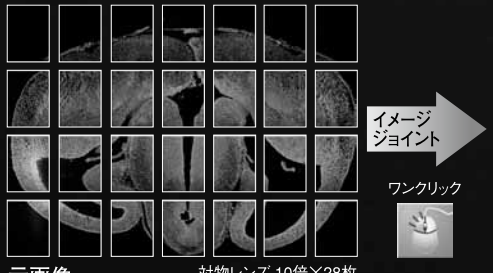

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【データセンタ】札幌、仙台、館林、東京、川崎、横浜、長野、名古屋、大阪、明石、広島、福岡

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ネオパレン® 1号

*注意—医師等の処方せんにより使用すること

【警告】

ビタミンB_1欠乏症と思われる重篤なアシドーシスが発現した場合には、直ちに100～400mgのビタミンB_1製剤を急速静脈内投与すること。また、高カロリー輸液療法を施行中の患者では、基礎疾患及び合併症に起因するアシドーシスが発現することがあるので、症状があらわれた場合には高カロリー輸液療法を中断し、アルカリ化剤の投与等の処置を行うこと。

〔禁　忌(次の患者には投与しないこと)〕

(1)電解質代謝異常のある患者　①高ナトリウム血症の患者　②高クロル血症の患者　③高カリウム血症(乏尿、アジソン病、高窒素血症等)の患者　④高リン血症(副甲状腺機能低下症等)の患者　⑤高マグネシウム血症(甲状腺機能低下症等)の患者　⑥高カルシウム血症の患者　(2)重篤な肝障害(肝性昏睡又は肝性昏睡のおそれ等)のある患者　(3)重篤な腎障害のある患者　(4)アミノ酸代謝異常のある患者　(5)本剤又は本剤配合成分に過敏症の既往歴のある患者　(6)血友病の患者

【効能・効果】

経口・経腸管栄養補給が不能又は不十分で、経中心静脈栄養に頼らざるを得ない場合の水分、電解質、カロリー、アミノ酸、ビタミン補給

【用法・用量】

ネオパレン1号

本剤は経中心静脈栄養法の開始時で、耐糖能が不明の場合や耐糖能が低下している場合の開始液として、あるいは侵襲時等で耐糖能が低下しており、ブドウ糖を制限する必要がある場合の維持液として用いる。

用時に上下2室の隔壁と上室内にある黄褐色の小室を同時に開通し十分に混合して、開始液又は維持液とする。

通常、成人には1日2000mLの開始液又は維持液を24時間かけて中心静脈内に持続点滴注入する。

なお、症状、年齢、体重に応じて適宜増減する。

ネオパレン2号

本剤は経中心静脈栄養法の維持液として用いる。

用時に上下2室の隔壁と上室内にある黄褐色の小室を同時に開通し十分に混合して、維持液とする。

通常、成人には1日2000mLの維持液を24時間かけて中心静脈内に持続点滴注入する。

なお、症状、年齢、体重に応じて適宜増減する。

指定医薬品、処方せん医薬品* 薬価基準収載

ネオパレン® 2号

*注意—医師等の処方せんにより使用すること

【使用上の注意】　一抜粋一

1.慎重投与(次の患者には慎重に投与すること)

(1)菌血症の患者 (2)脱水症の患者 (3)肝機能障害のある患者 (4)腎障害のある患者 (5)重症熱傷のある患者 (6)心不全のある患者 (7)閉塞性尿路疾患により尿量が減少している患者 (8)糖尿病の患者 (9)尿崩症の患者 (10)高度のアシドーシスのある患者 (11)膵障害(膵炎、膵硬化症、膵腫瘍等)のある患者 (12)本人又は両親、兄弟に気管支喘息、発疹、蕁麻疹等のアレルギーを起こしやすい体質を持つ患者 (13)薬物過敏症の既往歴のある患者 (14)妊婦 (15)小児

2.重要な基本的注意

(1)高カロリー輸液療法用の栄養輸液として組成を固定しているので、重篤な肝障害、腎障害等の特殊な輸液組成を必要とする疾患には使用しないこと。 (2)高血糖、尿糖があらわれるおそれがあるので、ネオパレン1号から開始するなど、ブドウ糖の濃度を徐々に高めること。 (3)ネオパレン2号の急激な投与の中止により低血糖を起こすおそれがあるので、投与を中止する場合には、糖濃度を徐々に下げること。 (4)ネオパレン1号は高カロリー輸液療法の開始時で、耐糖能が不明の場合及び病態により耐糖能が低下している場合の開始液として、あるいは侵襲時等で耐糖能が低下しており、熱量制限の必要がある場合には高カロリー輸液療法の維持液として用いる。ネオパレン2号は通常の熱量が必要な患者の維持液として用いる。

3.相互作用(併用に注意すること)

パーキンソン病治療薬レボドパ、ワルファリン、ジギタリス製剤ジゴキシン等

4.副作用

消化器(胃又は大腸)手術の術後患者を対象とした総症例47例の臨床第Ⅲ相試験において医学的に有害であると判断された副作用は、5例(10.6%)で、発現件数は8件(血清ALT(GPT)上昇、血清Al-P上昇が各2件、血清ビリルビン上昇、血糖上昇、そう痒感、発疹が各1件)であった(【臨床成績】の項を参照)。(承認時:2004年)

(1)重大な副作用

1)アシドーシス

重篤なアシドーシスがあらわれた場合には、【警告】の項を参照し、適切な処置を行うこと。

2)ショック注)、アナフィラキシー様症状注)

ショック、アナフィラキシー様症状を起こすことがあるので、観察を十分に行い、血圧低下、意識障害、呼吸困難、チアノーゼ、悪心、胸内苦悶、顔面潮紅、そう痒感、発汗等があらわれた場合には、直ちに投与を中止し、適切な処置を行うこと。

注)高カロリー輸液用総合ビタミン液でみられる副作用

3)高血糖

本剤は高濃度のブドウ糖含有製剤なので、過度の高血糖、高浸透圧利尿、口渇があらわれるので、このような症状があらわれた場合には、インスリン投与等の適切な処置を行うこと。

(2)その他の副作用

副作用が認められた場合には、投与を中止するなど適切な処置を行うこと。

◇その他の使用上の注意等は、製品添付文書をご参照ください。

Otsuka

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('08.01作成)

*グランシリンジには、注射針は付属しておりませんので、別途ご用意ください。

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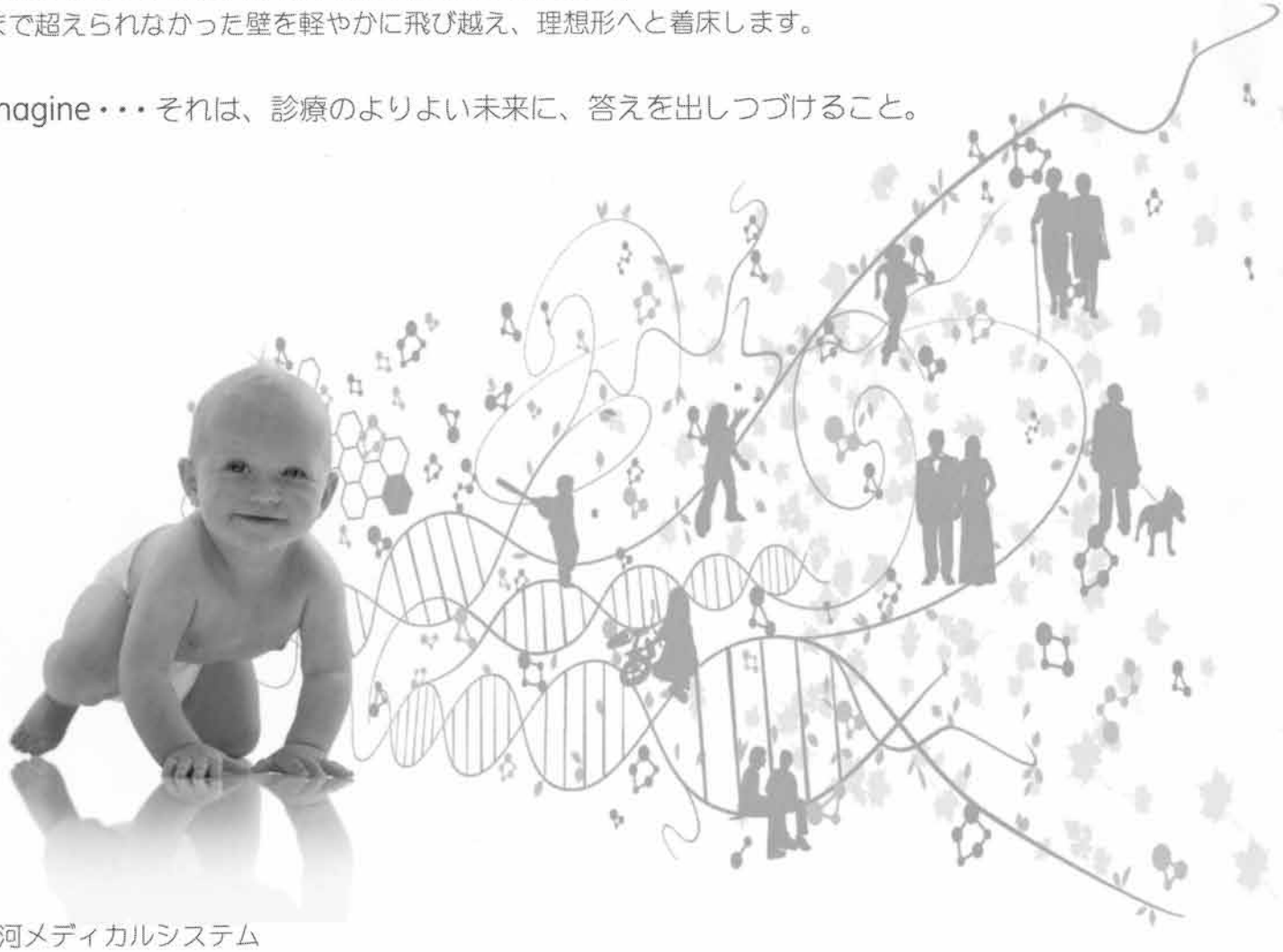

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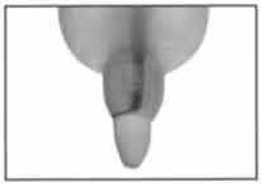

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PT0702-12 2007年2月作成

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日本初、禁煙治療に経口剤誕生。

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新発売

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【禁忌(次の患者には投与しないこと)】
本剤の成分に対し過敏症の既往歴のある患者

【効能・効果】
ニコチン依存症の喫煙者に対する禁煙の補助

【効能・効果に関連する使用上の注意】
(1)ニコチン依存症の診断については、ニコチン依存症に係わるスクリーニングテスト(TDS)により診断すること。(2)本剤の使用にあたっては、患者に禁煙意志があることを確認すること。

【用法・用量】
通常、成人にはバレニクリンとして第1～3日目は0.5mgを1日1回食後に経口投与、第4～7日目は0.5mgを1日2回朝夕食後に経口投与、第8日目以降は1mgを1日2回朝夕食後に経口投与する。なお、本剤の投与期間は12週間とする。

【用法・用量に関連する使用上の注意】
(1)本剤は原則として、他の禁煙補助薬と併用しないこと。[本剤の有効性及び安全性は単剤投与により確認されており、他の禁煙補助薬と併用した際の有効性は検討されておらず、安全性についても経皮吸収ニコチン製剤との併用時に副作用発現率の上昇が認められている(「薬物動態」の項参照)。] (2)患者が禁煙を開始する日を設定すること。その日から1週間前に本剤の投与を始めること。(3)本剤による12週間の禁煙治療により禁煙に成功した患者に対して、長期間の禁煙をより確実にするために、必要に応じ、本剤をさらに延長して投与することができる。その場合にはバレニクリンとして1mgを1日2回、朝夕食後に12週間投与すること。[「臨床成績」の項参照] (4)最初の12週間の投与期間中に禁煙に成功しなかった患者や投与終了後に再喫煙した患者で、再度本剤を用いた禁煙治療を実施する場合には、過去の禁煙失敗の要因を明らかにし、それらの要因への対処を行った後のみに、本剤の投与を開始すること。(5)本剤の忍容性に問題がある場合には、0.5mg1日2回に減量することができる。(6)重度の腎機能障害患者(クレアチニン・クリアランス推定値：30mL/分未満)の場合、0.5mg1日1回で投与を開始し、その後必要に応じ、最大0.5mg1日2回に増量すること。[「薬物動態」の項参照]

【使用上の注意】
1. 慎重投与(次の患者には慎重に投与すること)
(1)重度の腎機能障害のある患者[重度の腎機能障害のある患者では血中濃度が高くなるおそれがある(「用法・用量に関連する使用上の注意」、「相互作用」及び「薬物動態」の項参照)。] (2)血液透析を受けている患者[十分な使用経験がないため、本剤を投与する際には十分に観察を行うこと(「薬物動態」の項参照)。]
2. 重要な基本的注意
(1)医師等により、禁煙治療プログラムに基づいた指導の下に本剤を適切に使用すること。(2)禁煙は治療の有無を問わず様々な症状(不快、抑うつ気分、不眠、いらだたしさ、欲求不満、怒り、不安、集中困難、落ち着きのなさ、心拍数の減少、食欲増加、体重増加等)を伴うことが報告されており、基礎疾患として有している精神疾患の悪化を伴うことがある。本剤を使用して禁煙を試みた際にも、因果関係は明らかではないが、抑うつ気分、不安、焦燥、興奮、行動の変化、自殺念慮及び自殺が報告されているため、本剤を投与する際には患者の状態を十分に観察すること。(3)めまい、傾眠等があらわれることがあるので、自動車の運転等危険を伴う機械を操作する際には注意させること。(4)本剤の投与の有無にかかわらず、禁煙により生じる生理的な変化のため、下記のような薬剤の薬物動態や薬力学が変化し、用量調節が必要になる場合がある。 テオフィリン、ワルファリン、インスリン等　また、喫煙によりCYP1A2の活性が誘導されるため、禁煙を開始後、CYP1A2の基質となる薬剤の血漿濃度が上昇する可能性がある。
3. 相互作用
併用注意(併用に注意すること)　シメチジン
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※その他の使用上の注意等については添付文書をご参照ください。

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資料請求先：製品情報センター

2008年4月作成

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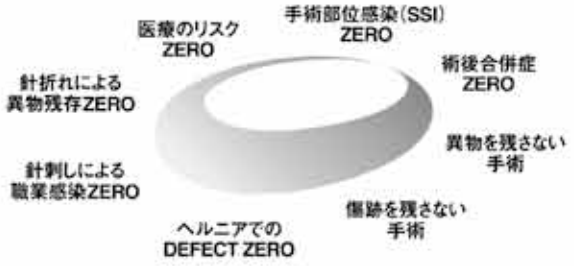

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