ACP American College of Physicians Leading Internal Medicine, Improving Lives | Japan Chapter

November 2016

Governor's Newsletter for All ACP Members

Governor: Fumiaki Ueno
MD, MACP

Governor's Newsletter

Fumiaki Ueno, MD, MACP
Governor, ACP Japan Chapter

I was in London on 23 June 2016, the day of the UK' s referendum. The city center was quiet and nothing unusual was happening. The result of the referendum, however, was astonishing! UK decided to leave from EU. Two years ago, Scotland finally remained in UK by their referendum, but the vote was very close. Balkanization is a term to describe division of a multinational state into smaller ethnically homogeneous entities. These decisions might be due to today's wind of Balkanization.

Globalism is a keyword for today. Many people in many countries can share culture, science, economics, industrial products by virtue of developed transportation and information technology. While in Japan, we can share information for health care instantly with other countries, and we can enjoy most of technology and products for health care from overseas, and vice versa.

My point is that Balkanization of nations is a reflection of globalization. Even though we live in certain country, we feel borderless and enjoy almost everything from outside. Then, why not to establish a nation with historical and ethnical homogeneity? We do not know about future health care policy of the next president of USA, but globalization is by no means retractable, particularly in health science. All members of ACP Japan Chapter will continue to enjoy many benefits for members, including excellent resource for internists. Invite your friend to join ACP, in order to become a global internist!

◯ Message from ACP Leaders

An American General Internist's Engagement with the American College of Physicians Japan Chapter Meeting in Kyoto.

Thomas S. Inui, ScM, MD, MACP

Professor of MedicineIndiana University School of Medicine

On the 4th and 5th of June 2016, it was my distinct pleasure and privilege to be a participant in the activities of the American College of Physicians Japan Chapter Annual Meeting held at the Kyodai Clock Tower Centennial Hall in Kyoto (1). The topic of the JACP meeting was one that would have resonated strongly within my own professional home Society of General Internal Medicine (SGIM) in North America – "Raising Generalist Medicine: To Improve Health and Health Care in Japan." My gracious hosts were Dr. Fumiaki Ueno, MD, MACP, MACG, AGAF, Governor of the ACP Japan Chapter and Dr. Yugo Shibagaki, MD, FACP, Chairman of the 2016 Annual Meeting.

My personal contribution to the meeting was a plenary address on residency reform changes now taking place in the People's Republic of China ("Residency Reform in China: Major Developments in Asia's Largest Health Care System," (2) available on the Japan ACP meeting program website). These reflections on graduate medical education in China were intended to highlight parallels in Japan's and China's educational program reforms, underlying challenges driving these changes, and the relevance of changes in China to the evolving health workforce issues in Japan. Some of the medical workforce challenges these two countries have in common are a deficiency of well-trained primary care physicians in rural settings, lack of a consensus on general medicine core knowledge/skills/competencies, and the need for public and professional policies to enhance the careers of generalist physicians everywhere, but in rural areas in particular. If Japan and China can learn from one another's approaches as well as consider policy changes in their two different environments that are affordable and sustainable, the health of the two most powerful countries in Asia will thereby be improved. Other countries in the world will be interested in progressive actions taken in Japan and China because these two countries are certainly not the only nations globally who face maldistribution and absolute deficiencies in primary care workforce to serve the needs of aging societies.

I should highlight other elements of the meeting as ones I greatly enjoyed. A "Learning Clinical Reasoning in English" (3) diagnostic case discussion presided over by Harumi Gomi and Noriaki Santo and was fascinating and mystified all participants until the chest x-ray with a widened mediastinum was revealed in the late stages of the patient's evaluation. A Nihongo session on the first North American internist Sir William Osler, with comparisons to Shigeo Okinaka at the University of Tokyo, provided a historic platform for a broader discussion of the place of generalism past, current, and future in Japan (4). This presentation dealt in an excellent fashion with site-based, relational (patient-centered, community-centered), and population-focused medical and health care dimensions of practice that will require new emphasis going forward. A third session in which I participated was "End-of-Life Discussions: Japan's New Challenge" by Drs. Shadia Constantine, Sandra Moody, Ryuichi Sekine, and Koichi Kuramoto (5).

This extraordinary, lecture and small group-based session used a Nihongo version of "Go Wish" cards, materials used to facilitate discussions about values near the end of life now in active use in my home state of Indiana in North America.

It was good to see resident physicians be very active participants in the JACP meeting. A vigorous "Doctor' s Dilemma" competition featured their knowledge and abundant enthusiasm. Their poster sessions were a spectacularly successful element of the meeting. These sessions were enormous and generated vigorous participant discussion at many posters. I loved seeing the young presenters explain and defend their work. All posters were in English. so I was able to get a glimpse of the diversity of the work, including applications of new technology, clinical epidemiology, health services research, case discussions, and still others. I would have personally given a "humor in medicine prize" to the poster that summarized resources needed for successful tourist medicine in Sapporo – (1) trauma management knowledge, (2) gastrointestinal disease knowledge, and (3) Chinese language interpreter (6) !

Photo by Dr Inui

This brief description of the Japan ACP Chapter annual meeting is merely a glimpse of the richness of activities within the meeting. I encourage all my internist colleagues in Japan to attend these meetings, make your voice heard in the affairs of internal medicine in japan, and contribute your own presentations to the meeting next year!

<Reference>

(1) ACP Japan Chapter Annual Meeting 2016, available at http://acp2016.org/index.html

(2) Thomas S. Inui, "Residency Reform in China 2016: Major Developments in Asia' s Largest Health Care System" ACP Japan Chapter Annual Meeting 2016, Kyoto, 4 June 2016, available at http://acp2016.org/pdf/program/Plenary.pdf

(3) Harumi Gomi, "Learning clinical reasoning in English" ACP Japan Chapter Annual Meeting 2016, Kyoto, 4 June 2016, available at http://acp2016.org/pdf/program/1-6-1b.pdf

(4) Hiroyasu Ishimaru, "Generalism and Internal Medicine past, present, future - From the perspective of hospital based generalist" ACP Japan Chapter Annual Meeting 2016, Kyoto, 4 June 2016, available at http://acp2016.org/pdf/program/1-6-2.pdf

(5) Shadia Constantine, Koichi Kuramoto, Sandra Moody, Ryuichi Sekine, "End of Life Discussions: Japan' s New Challenge" ACP Japan Chapter Annual Meeting 2016, Kyoto, 4 June 2016, available at http://acp2016.org/pdf/program/1-7-3c.pdf

(6) Nobutaka Masui, Shoji Onishi, Tomimichi Matsuda, Kentaro Tamiya, Kenji Taki, "Outcomes of Medical Emergencies About Foreign Tourists in Sapporo" ACP Japan Chapter Annual Meeting 2016, Kyoto, 4 June 2016

◯ Recipients of Best Abstract Award of Japan Chapter Meeting 2016

Many thanks to all involved in the study!

Toshihiko Takada, MD, MPH, PhD

Assistant Professor, Department of General Medicine
Shirakawa Satellite for Teaching And Research (STAR), Fukushima Medical University

Acknowledgement

It is a great honor for me to receive the Best Abstract Award in ACP Japan Chapter Annual Meeting 2016. This research was supported by so many people. I really appreciate all of their cooperation.

Background

Shirakawa STAR is an endowed department jointly founded by Fukushima Medical University and Fukushima Public Welfare & Agricultural Cooperatives Association. Its clinical activities and education are based at Shirakawa Kosei General Hospital. Japan Agricultural Cooperative Shirakawa branch and Shirakawa Kosei General Hospital periodically hold projects for health promotion in our local community. I am grateful for being able to receive this kind of opportunity.

We decided the theme of our project as salt reduction, which we considered the most relevant issue in our community.

We corporated with Ms. Miyuki Imamoto, associate professor, Department of Food and Nutritional Science, Kobe Women' s Junior University. She planned the contents of salt reduction cooking classes. The research design was cluster randomized trial, for investigating the effect of cooking classes for housewives on salt reduction in family members. We emphasized that giving feedback of the project to particpants.

Randomized Controlled Trial

We made our best effort for providing participants with sufficient information about aim of the project, to avoid annoying them with experimental design of the study. For cooking classes, three dietitians gave us their support. Ms. Masako Uchida, Ms. Yumiko Miura (Nutrition Division, Institute for Biomedical Research and Innovation Hospital)and Ms. Sayuri Yamada (Shirakawa Kousei General Hospital). For research design and statistical analysis, we were supported by Dr. Sho Sasaki (Center for Innovative Research for Communities and Clinical Excellence (CIRC2LE), Fukushima Medical University), Dr. Shingo Fukuma, Dr. Yosuke Yamamoto, and Prof. Shunichi Fukuhara (Department of Healthcare Epidemiology, Kyoto University). We really appreciate their cooperation. And we also thank the Japan Agricultural Cooperative Shirakawa branch and the Administration Division, Shirakawa Kousei Hospital for the management of the project; all participating housewives and their family members involved in the study.

Future Prospects

While our result revealed significant effect of the cooking classes in 2 months, the effect for longer term

Introduction

- Sodium reduction is very important in the prevention of cardiovascular diseases.[1]
- Salt reduction programs often target housewives.
- It is unclear whether such programs can reduce salt intake in both the housewives as well as their family members who did not participate programs directly.
- We investigated whether cooking classes focusing on salt reduction for housewives affect their own salt intake and that of their family members.

Methods

- Design: Cluster randomized trial
- Setting: Japan Agricultural Cooperative Shirakawa branch.
- Participants
  35 housewives and 33 family members (40 years old or older).
- Randomization
  Stratified by number of family members
- Intervention
  Housewives in the intervention group participated in cooking classes focusing on salt reduction in September and October 2015.
- Tips:
  - ✓ Applying flavors other than saltiness
  - ✓ Contrasting the saltiness of various dishes
- Control
  Lectures about healthy living
- Main outcome measures
  Difference in daily salt intake estimated by the spot urine method 2 months after intervention between groups.
- Statistical analysis
  ITT analysis using linear mixed models with subjects nested within family units.
- Approved by Ethics Committee of Kyoto Univ.

Results 1. Baseline characteristics of study participants

	control N=32	Intervention N=36
Age mean (SD) years	64.8 (11.5)	63.0 (10.3)
Female no. (%)	20 (62.5)	22 (61.1)
Family member no. (%)	15 (46.9)	18 (50.0)
Self reported hypertension no. (%)	7 (19.4)	16 (44.4)
Baseline systolic blood pressure (SD)	131.9 (18.7)	135.6 (18.5)
Baseline diastolic blood pressure (SD)	74.1 (10.3)	74.6 (11.4)
Baseline estimated daily salt intake g/day (SD)	10.00 (1.75)	9.57 (2.45)

SD=standard deviation

Results 2. Pre- and post- intervention estimated daily salt intake by spot urine and blood pressure measurement

	Control			Intervention			Adjusted difference* (intervention vs control) (95% CI) *P* value
	Baseline (SD)	Post-intervention (SD)	Change from baseline (SD)	Baseline (SD)	Post-intervention (SD)	Change from baseline (SD)	
All participants							
Estimated daily salt intake g/day	10.00 (1.75)	10.30 (1.78)	0.37 (2.39)	9.57 (2.45)	8.95 (2.45)	-0.57 (2.43)	**-1.19 (-2.29, -0.09) 0.034**
Housewives							
Estimated daily salt intake g/day	10.00 (2.13)	10.02 (1.67)	0.21 (2.55)	9.58 (2.74)	8.97 (2.20)	-0.74 (2.87)	-1.07 (-2.64, 0.50) 0.500
Sytolic blood pressure mmHg	131.9 (18.7)	140.3 (11.3)	7.88 (11.01)	135.6 (18.5)	138.0 (17.6)	5.05 (12.75)	-3.57 (-11.7, 4.56) 0.371
Diastolic blood pressure mmHg	74.1 (10.3)	78.7 (7.95)	3.81 (10.47)	74.6 (11.4)	76.8 (9.08)	2.91 (7.03)	-1.68 (-8.33, 4.97) 0.606
Members of participants' families							
Estimated daily salt intake g/day	9.99 (1.25)	10.68 (1.95)	0.59 (2.27)	9.56 (2.16)	8.93 (2.86)	-0.35 (1.82)	-1.12 (-3.09, 0.86) 0.249

SD=standard deviation, CI=confidence interval　　* Adjusted for age, sex, self-reported hypertension, baseline daily salt intake

Discussion

- Strength
  Our trial is the first study to suggest salt reduction intervention in housewives will affect not only their own salt intake but also that of their family members.
- Limitation
  1) External validity
  2) Spot urine method for estimating daily salt intake is less reliable than 24h collected urine though more convenient.[2]

References

1. Ikeda N, et al. What has made the population of Japan healthy? Lancet 2011; **378**: 1094-1105
2. Kawano Y, et al. Report of the Working Group for Dietary Salt Reduction of the Japanese Society of Hypertension: (2) Assessment of salt intake in the management of hypertension. Hypertens Res 2007; **30**: 887-893.

Conflict of interest
None of the authors have any conflicts of interest.

Role of the funding source
This report had no funding.

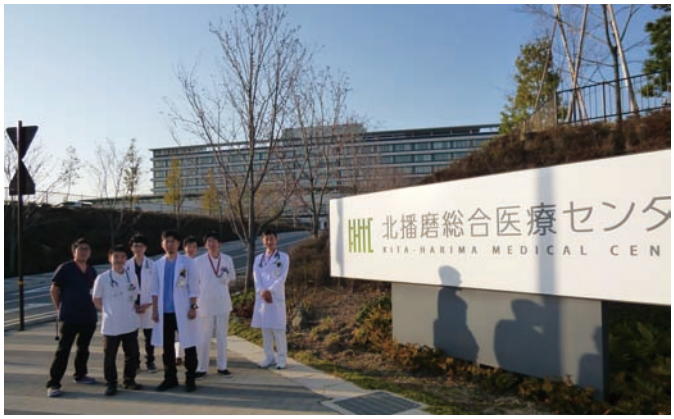
◯ Recipients of Best Abstract Award of Japan Chapter Meeting 2016

Very honored to receive the Best Abstract Award at the ACP Japan Chapter 2016 Annual Meeting

Tomofumi Takayoshi, MD
Kita-Harima Medical Center

I' m most grateful to the ACP Japan Chapter for giving me the very exciting experience for me.

I received the information about the ACP Japan Branch annual meeting through Facebook by chance, and a supervisory doctor recommended me to submit an abstract. Since it was the first experience for me to write an abstract in English, it was a very tough work. With support of my supervisory doctors, I was finally able to finish writing the abstract before the extended deadline. Though I had thought that I just had to write the abstract and making a poster in English, unexpectedly, I got an opportunity to the present my data in English. Since I had never had the chance to perform presentation in English, I became very nervous about that. I' m not sure whether I got along well, however the English presentation in a big hall became a valuable experience for me.



As for the theme of my presentation; "Hyperglycemia and 30-days mortality in patients admitted through emergency department: retrospective observational study" , I was very fortunate to receive training in Kita-Harima Medical Center in Ono-shi, Hyogo. The hospital is an ideal workplace for young physician, because every resident is allowed to get training at any department, if he or she wants. Therefore, I had an opportunity to get training in emergency department for two months, even though I was a resident in the department of diabetes and endocrine disease. Thus, we got interesting in the relationship between stress-induced hyperglycemia and mortality in our hospital. We happened to find that stress-induced hyperglycemia was associated with the increased risk of 30-days mortality whereas known diabetes was not.

I was very impressed by a variety of stimulating lectures and useful discussions in the ACP meeting which I attended for the first time. I' m thinking to attend the meeting with younger new residents in our hospital next time.

In closing, I' d like to express my sincere appreciation to the ACP Japan branch for giving me such a valuable experience, and to my supervisory doctors, Dr. Yoshiro Yasutomo, Dr. Kenta Hara, Dr. Arai Takashi, and many staffs in out hospital for supporting me in many ways.

Hyperglycemia and 30-days mortality in patients admitted through emergency department: retrospective observational study

Dept. of Internal and Geriatric medicine, Kitaharima medical ecnter[1)]
Dept. of Diabetes and Endocrine disease, Kitaharima medical center[2)]
Tomofumi Takayoshi[1)], Kenta Hara[2)], Takashi Arai[1)], Tetsuya Kawase[2)], Yuka Kimura[2)], Yasushi Nakagawa[2)], Toshimasa Takahashi[2)], Katsuhito Nishiyama[1)], Yoshiro Yasutomo[1)], Koichi Yokono[1)]

Introduction

It has been reported that hyperglycemia with or without known diabetes is associated with the increased risk of mortality.

Kathleen MD. *et al.* Lancet 2009;373: 1798-807

The gap between admission glucose and A1c-derived average glucose level can be used to assess the severity and prognosis.

Wen-I. Liao, MD. *et al.* Medicine 2015;94(36): e1525

Aim

We assessed whether hyperglycemia and glycemic gap could be predictors for 30-days mortality, in patients admitted to our hospital through emergency department.

Methods

Study Design: retrospective observational study

Patients: Admitted to our hospital through the emergency department between October 1 2013 and August 31, 2015 were enrolled.

Exclusion criteria：Age ≦ 14 years
Serum glucose levels ≦ 69 mg/dl
Data was not available

Definition：
Hyperglycemia： admission glucose ≧ 200 mg/dl
Glycemic Gap： the gap between admission glucose and A1c-derived average glucose
(A1c-derived average glucose ＝28.7×HbA1c－46.7)

Statistical Analysis：(EZR Version 1.32)
Cox proportional hazard regression analysis
Mann-Whitney's U test
Fisher's exact test

Results

Enrolled patients with or without hyperglycemia

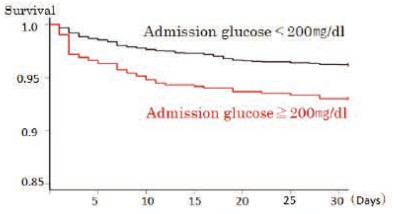
2740 patients were admitted
381 were excluded
Age ≦ 14 74
Glucose ≦ 69 mg/dl 39
Data not available 268
2359 patients were eligible
Glucose < 200 mg/dl n=1995
Glucose ≧ 200 mg/dl n=364
Death n=101(5%)
Death n=49(13%)

Patient characteristics with or without hyperglycemia

	PG<200mg/dl N=1995	PG≧200mg/dl N=364	p-Value
30-days mortality	101(5%)	49(13%)	<0.01[1)]
Age	69.2±17.7	74.4±12.1	<0.01[2)]
Sex(M:F)	1196:799	230:134	0.27[1)]
Known diabetes	661(33%)	189(52%)	<0.01[1)]
MBP(mmHg)	93.9±21.7	89±28.5	0.01[2)]
HR(/min)	86±25	90±32	<0.01[2)]
WBC(/μl)	9240±5670	11200±11300	<0.01[2)]
Hct(%)	36.6±6.8	35.7±6.7	<0.01[2)]
Na(mEq/l)	138.7±4.4	137.6±4.8	<0.01[2)]
K(mEq/l)	4.0±0.6	4.2±0.8	<0.01[2)]
Cre(mg/dl)	1.0±1.1	1.1±0.8	<0.01[2)]

1) Fisher's exact test, 2) Mann-Whitney's U test

Survival curves with or without hyperglycemia



	HR	95%CI	P-Value
Glucose≧200mg/dl	1.83	1.29-2.59	<0.01

Enrolled patients with Glycemic Gap lower or higher than 120 mg/dl

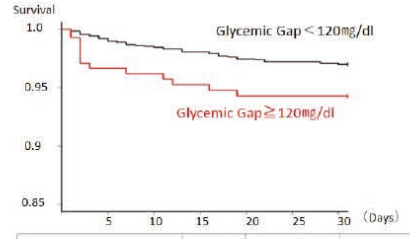
2740 patients were admitted
1679 were excluded
Age ≦ 14 74
Glucose ≦ 69 mg/dl 39
Data not available 1566
1061 patients were eligible
Glycemic Gap < 120mg/dl n=966
Glycemic Gap ≧ 120mg/dl n=95
Death n=40(4.1%)
Death n=14(14.7%)

Patient characteristics with Glycemic Gap lower or higher than 120 mg/dl

Glycemic Gap	<120mg/dl N=966	≧120mg/dl N=95	p-Value
30-days mortality	40(4.1%)	14(14.7%)	<0.01[1)]
Age	71.8±14.0	73.2±13.7	0.07[2)]
Sex(M:F)	605:361	65:30	0.37[1)]
Known Diabetes	369(38%)	53(56%)	<0.01[1)]
MBP(mmHg)	95.9±22.8	85.5±35.2	0.01[2)]
HR(/min)	86.3±25.8	91.2±37.0	<0.01[2)]
WBC(/μl)	9320±6990	13700±20400	<0.01[2)]
Hct(%)	37.0±6.8	34.6±6.9	<0.01[2)]
Na(mEq/l)	138.8±4.5	137.7±5.1	<0.01[2)]
K(mEq/l)	4.0±0.6	4.3±0.8	<0.01[2)]
Cre(mg/dl)	1.1±1.0	1.3±0.7	<0.01[2)]

1) Fisher's exact test, 2) Mann-Whitney's U test

Survival curves with Glycemic Gap lower or higher than 120 mg/dl



	HR	95%CI	p-Value
Glycemic Gap≧120mg/dl	2.08	1.11-3.89	0.02

Discussion

Comparison among new hyperglycemia, known diabetes, and normoglycemia

Our results

	New hyperglycemia	Known diabetes	Normoglycemia
No. of patients	175	850	1334
No. of 30days death	30	51	69
30days mortality	17.1%	6.0%	5.2%

Previous report

	New hyperglycemia	Known diabetes	Normoglycemia
No. of patients	223	495	1168
ICU admission	29%	14%	9%
No. of death	36	15	20
Total mortality	16%	3%	1.7%

New hyperglycemia：Diabetes mellitus(-), Hyperglycemia(+)

Known diabetes：Diabetes mellitus(+)

Normoglycemia：Diabetes mellitus(-), Hyperglycemia(-)

Why did new hyperglycemia show the highest mortality?

There is a report showing that 60% of patients with admission hyperglycemia was diagnosed as diabetes within 1 year.

Greci Ls, *et al.* Diabets Care 2003; 26: 1064-68

The group of new hyperglycemia may include diabetic patients without diagnosis, resulting in the increased risk of mortality.

It has been suggested that chronic hyperglycemia sets up a pattern of cellular conditioning that might actually be protective of acute hyperglycemia-mediated damage during critical illness

Kathleen M dungan, *et al.* Lancet 2009; 373: 1798-807

Higher glycemic gap is associated with higher mortality

Previous report

Our results

Wen-I. Liao, M D. *et al.* Medicine 2015;94(36): e1525

Conclusion

Hyperglycemia and glycemic gap are associated with 30-days mortality in patients admitted through emergency department.

○ Recipients of Best Abstract Award of Japan Chapter Meeting 2016

The Quick Induction of Remission with Trans-anal Administration of 5-Amino Salicylic Acid in Ulcerative Colitis: systematic review

Hirotaka Mori

Undergraduate student, Shinshu University of Medicine

It is a great honor for me to receive this award in ACP Japan Chapter.
I am grateful to Dr. Junichiro Mori and Dr. Ikuo Shimizu, teachers of medical education center of Shinshu University, for devoting a lot of times to help me with the presentation.

Abstract submission was recommended by Dr. Mori.

I was greatly impressed when I first saw him in an interview at the entrance exam.After some interviewers asked me some stereotyped questions, he gave me a difficult question. I had difficulty in expressing myself but it was original and stimulating my intellectual curiosity.

He seems to me to be a severe teacher. When I discuss with him, he demands me to express myself in my own words and will not allow me to use the words of others. But his severity is connected with his passionate love of truth and one aspect of his educational honesty.

Six years after first seeing him, I am glad to receive this award and to say to him ' thank you.'

I conducted a systematic review of the therapy for ulcerative colitis and the conclusion is that trans-anal administration of 5-Amino Salicylic Acid (5-ASA) induces the quick induction of remission.

Ulcerative colitis is clinically characterized by abdominal pain, diarrhea, blood stool, and diarrhea and decreases the quality of life. In patients with mildly or moderately active left-side colitis, the standard therapy is the combination therapy with oral and rectal 5-ASA. But in fact, rectal 5-ASA is underused and frequently stopped partly because according to a previous systematic review, rectal 5-ASA were no more effective than oral 5-ASA at 8 weeks although it is hard for patients to use rectal administration. But I doubted this result because rectal 5-ASA can be delivered site-specifically at high concentrations. So my research question was 'Does rectal administration induce early remission?' Therefore the purpose of this systematic review is to evaluate the difference in the time course effects between trans-anal and oral administration of 5-ASA at several time points unlike the previous study only at 8weeks.

I searched MEDLINE and Cochrane until February this year. The selection criteria were as follows. The severity was mild or moderate because 5-ASA is first-line treatment. A distal disease margin was less than 60 cm from the anal verge or distal to the splenic flexure, because 5-ASA can also be administered rectally as a suppository, enema or foam. Outcome is remission. The purpose of this study is to evaluate not only at 8weeks but also at several time points. Therefore there was no limitation of observation time.

A total of 304 studies were retrieved and assessed for eligibility. Of these studies, 3 studies fulfilled the inclusion criteria. The duration of follow up ranged from two to eight weeks. 2 studies including 95 patients evaluated at 2 weeks. After 2 weeks, 3 studies including 174 patients were evaluated. Rectal 5-ASA was superior to oral 5-ASA for inducing remission, with risk ratio two point ninety-nine. Rectal 5-ASA was no more effective than oral 5-ASA from 2 weeks. But this study shows that rectal 5-ASA provides earlier remission than oral 5-ASA.

I want to talk about the conclusion. Rectal 5-ASA induces earlier remission than oral 5-ASA at 2 weeks. As I already talked, the standard therapy is the combination therapy with oral and rectal 5-ASA. In fact, patients prefer oral administration. And rectal administration is frequently stopped over the therapy period. But this study showing the time when rectal 5-ASA induces earlier remission is likely to be helpful in encouraging patients to use rectal 5-ASA and result in maintaining the combination therapy And general conclusion is that it is important to report the time course effects in systematic reviews.

I have a hypothesis that like this study, to consider the time course effects in a treatment may make it possible to find a new combination therapy.

If you are interested in me, please contact me anytime.

Morihasdream@gmail.com

My Research Question

Rectal 5-ASA is likely to induce earlier remission than oral 5-ASA

Background

1. Ulcerative colitis is clinically characterized by diarrhea, blood stool, and abdominal pain and decreases the quality of life.
2. The standard therapy for inducing remission of mild to moderate active distal ulcerative colitis (UC). is the combination therapy of oral and rectal 5-Aminosalicylates(5-ASA).
3. In fact, rectal therapy are underused and frequently stopped[1] partly because according to a previous systematic review, rectal 5-ASA were no more effective than oral 5-ASA[2,3] at 8 weeks although it is hard for patients to use rectal administration.
4. But my research question was that rectal 5-ASA was likely to induce earlier remission than oral 5-ASA because rectal administration is site-specific at high concentrations in the left-side colitis.

Object

This systematic review was undertaken to evaluate the difference in the time course effectives between rectal and oral 5-ASA.

Search methods for identification of studies

1. MEDLINE and the Cochrane Library. were used to perform electronic searches (inception to February, 2016).
2. The search strategies used the Boolean operator 'OR' and 'AND' to create and combine the patients and intervention groups of medical subject headings (MeSH) (table1).

Search criteria (Type of studies, patients, interventions, and outcome)

1. Randomized trials comparing rectal 5-ASA to oral 5-ASA,
2. The distal disease margin less than 60 cm from the anal verge or distal to the splenic flexure, because rectal 5-ASA can be delivered as a rectal suppository, foam, or liquid enema.
3. The active severity was mild to moderate because 5-ASA is first-line therapy for mild to moderate active UC.
4. Outcome was remission defined by the scores that disease activity index (DAI) or a clinical portion of DAI was equal to 0 or Rachmilewitz crinical activity index (CAI) scale was less than or equal to 4.

Data collection and analysis

1. Risk ratio (RR) for the clinical remission was calculated using an intention to treat principle.
2. Heterogeneity was assessed using the chi-squared test. Fixed-effect model ($P > 0.10$ for χ^2) or a random-effects model ($P < 0.10$ for χ^2) was used. Review manager 5.3 was used.

Table 1

• MeSH for ulcerative colitis
ulcerative colitis, proctocolitis, proctosigmoiditis, rectocolitis, rectosigmoiditis, ulcerative rectocolitis, ulcerative proctocolitis, hemorrhagic ulcerative, hemorrhagic proctocolitis and proctitis.

• MeSH for 5-aminosalicylic acid
5-ASA, 5-aminosalicylate, mesalamine, Asacol, Pentasa, Rowasa, Salofalk, Mesasal and olsalazine.

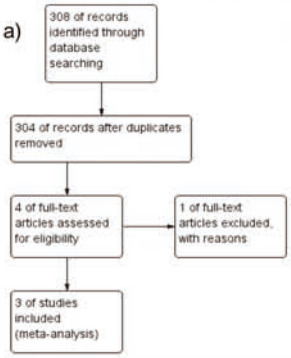
• MeSH for form of intervention
topical administration, topical drug administration, suppository, rectal instillation rectal administration, rectal drug administration, anal drug administration, foam and enema.

Reference
1. Seibold, F. 2014
2. Marshall, JK. 2010
3. Ford, A.C. 2012

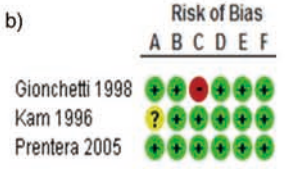
Result : Rectal 5-ASA induces earlier remission at 2 weeks

although the results after 2 weeks were same.

a)



b)

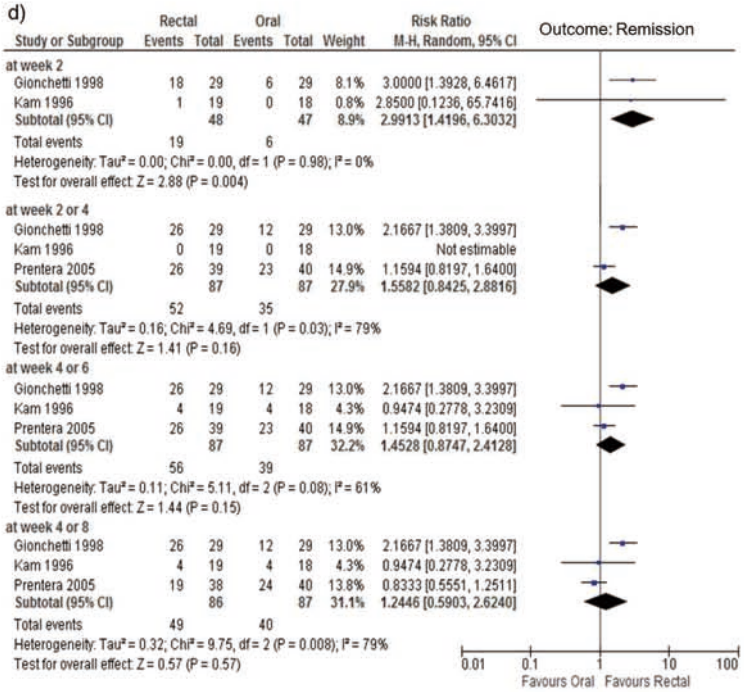


(A) Random sequence generation
(B) Allocation concealment
(C) Blinding of participants
(D) Blinding of outcome assessment
(E) Incomplete outcome data
(F) Selective reporting

c)

Author year	Form & Dose	Remission	week
Gionchetti 1998	5-ASA Suppository 400mg three times daily 5-ASA tablets 800mg three times daily	The clinical portion of DAI = 0	2 and 4
Kam 1996	5-ASA Suppository 4g once daily SASP 1g four times daily	complete remission: DAI=0	2 and 6
Prentera 2005	5-ASA Suppository 4g once daily 5-ASA Multi-Matrix 1.2g three times daily	Rachmilewitz CAI scale </= 4	4 and 8

d)



Note
a) A literature search flow diagram:
b) The Cochrane risk of bias summary:
One study was rated as high risk of bias doe to single-blind.
One study did not describe the Random sequence generation
c) The characteristics of included studies tables
d) Forest plot of comparison: Rectal 5-ASA vs Oral 5-ASA,

Conclusion

This study showing the time when rectal 5-ASA induce earlier remission is likely to be helpful in encouraging patients to use rectal 5-ASA and result in maintaining the combination therapy.

Limitation

The weight at 2 weeks was lower than the others.
Further studies should compare rectal 5-ASA to oral 5-ASA.

Feasible = Background 2	Modifiable = Result
Interesting = Background 4	Novel = Object
Relevant = Background 1,3 Conclusion	Ethical = Background 3
Measurable = Serection criteria 4	Specific = Selection criteria 1,2,3,4

Fukuhara, S. : Rinsyoukenkyu no michishirube 2013

Please feel free to contact me anytime : morihasdream@gmail.com

○ Winner of Dr's Dilemma of Japan Chapter Meeting 2016

Getting through Dr's Dilemma

Masaaki Sugino

Matsunami General Hospital General Internal Medicine

I had the unique opportunity to participate in Dr's Dilemma of ACP Japan chapter annual meeting 2016 held at Kyoto University on June 4th and 5th. I had heard that it was a quiz tournament where various hospitals compete against one another to answer quiz questions. This time I had been chosen to participate as my hospital's representative and at first although I was hesitant, several senior doctors encouraged me and my colleague Dr. Naganawa to take part in the event, so we did.

On the first day I arrived at a hall in the morning. Various teaching sessions were held and I learned a lot from these. Dr's Dilemma started at night and I remember that I was feeling very tense. It was time and we climbed on the stage. We watched questions projected on a screen and answered them. I could only marvel at the depth of other contestants' knowledge. However, by sheer luck and collaborative team work, our team was able to get a number of correct answers and as a result, we qualified to participate in the final round in the United States as a championship team.

The honor is more than I deserve, but we owe our success to the senior doctors who teach us many important things in the hospital every day. I really appreciate them. Not only the medical knowledge but also the language ability is necessary for us in the final round in San Diego. I'll try my best for the senior doctors I'm greatly indebted to including Dr. Sobajima and the kind staff who continue to assist us in making adjustments prior to the final round in the United States.

○ Winner of Dr's Dilemma of Japan Chapter Meeting 2016

Taking part in Doctor's Dilemma, an inter-facility medical quiz competition

Tatsuaki Naganawa, MD

Department of General Internal Medicine Matsunami General Hospital

My coworkers and I took part in Doctor's Dilemma, an inter-facility medical quiz competition during the American College of Physicians (ACP) Japan Chapter Annual Meeting 2016 held in May. With numerous well-known hospitals taking part in the competition, our team was able to take first place, thereby becoming eligible to enter the San Diego competition to be held next year as national champions. I am extremely happy with this successful outcome.

At our hospital, general internists are usually placed in charge of patients admitted to the department of internal medicine, except when specialized interventions such as those by the cardiovascular or gastrointestinal department are called for. Because of this approach, general internists must possess multiple skills and capabilities to promptly recognize a patient' s pathophysiology. At our department, we work and study under Dr. Masanori Murayama, who advocates a Problem Oriented System. When a new patient is admitted to the department of internal medicine, an internal physician draws up a problem list based on the patient' s history, physical findings and laboratory test data. This list is then managed by this primary physician, who analyzes each problem anatomically and physiologically to clarify its etiology, make a diagnosis and provide treatment. Although diagnostic procedures and therapeutic interventions by specialized departments may come into play as needed, our General Internal Medicine Department functions as the central hub of the Department of Medicine and every physician has the opportunity to encounter and experience a wide range of diseases from diagnosis through treatment. The latter half of the Doctor's Dilemma quiz focused on questions based on clinical cases, which enabled us to make use of our daily clinical experience, rapidly gain points, catch up with the frontrunners, and finally to win the competition! Our success would not have been possible without the outstanding support provided by Dr. Masanori Murayama, who's daily instruction provided underlying insights and skills in the practice of internal medicine, and Dr. Takeshige Kunieda, who encouraged keeping global standards in mind and aspiring to higher levels. I express my heartfelt gratitude to both of these outstanding physicians.

In closing, I would like to thank all of the members of the ACP Japan Chapter, including Dr. Kiyoshi Kurokawa, Dr. Shotai Kobayashi and Dr. Fumiaki Ueno, for giving us the opportunity to have this valuable experience. Taking part in Doctor' s Dilemma during the ACP Japan Chapter Annual Meeting 2016 was made possible by the tremendous efforts of Dr. Hideaki Shimizu, Dr. Shunpei Yoshino and all of the other doctors who provided their support. I extend my heartfelt gratitude to them all.

Internal Medicine 2016 (Washington DC) Report

Kenji Maeda, MD, FACP

The IM 2016 was held in the US capitol, Washington DC. It was a very practical meeting as always, and it's truly the most comprehensive live educational event in internal medicine as ACP itself states in the homepage. I wrote about the sessions I attended in the Japanese language version of the newsletter – I won't translate them here but please take a look at the newsletter if you're interested.
http://www.acpjapan.org/wpapp/wp-content/uploads/2016/08/gnewsJ_Aug2016.pdf

To follow is the list of the sessions I attended:

Thursday 5th:
(1) Antibiotics Prophylaxis and Screening for Infections – Current Concept and an Evidence-based Approach
(Dr. Trish M. Perl, MD, FACP)
(2)Evolving Paradigms in Chronic Hepatitis
(Dr. Dawn McDowell Torres, MD)
(3)Opening Ceremony
(Keynote lecture given by Sylvia Mathews Burwell- US Secretary of Health and Human Services (HHS))
(4)News You Can Use: Current Clinical Guidelines
Moderator: Dr. Amir Qaseem, MD, PhD, MHA, FACP、panelists: Dr. Michael J. Barry, MD, MACP, Dr. Nick Fitterman, MD, FACP, SFHM,Dr. Devan L. Kansagara, MD, MCR, FACP)
(5)Update in General Internal Medicine
(Moderator: Dr. Robert K. Cato, MD, FACP, co-moderator: Dr. Matthew H. Rusk, MD, FACP)

Friday 6th:
(1)AFib – Latest Choices
(Dr. Jordan M. Prutkin, MD, MHS)
(2) Clinical Triad: Screening for GI Malignancies-Esophagus, Pancreas, and Colon
(Moderator: Dr. Brooks D Cash, MD, FACP, panelists: Dr. Vinay Chandrasekhara, MD & Dr. Joel E. Richter, MD, FACP)
(3)Thieves' Market
(Dr. David R. Scrase, MD, FACP)

(4)Clinical Care and Research During the West African Ebola Outbreak
(Moderator: Dr. Robert Fowler, MD, MDCM, MSc, panelist: Dr. David Brett-Major, MD, MPH, FACP, FRCP (Edin))
(5) Multiple Small Feedings of the Mind: Gastroenterology, Psychiatry, and Osteoporosis
(Moderator: Dr. Sabina M.Lee, MD, FACP, panelists: Dr. Manal F. Abdelmalek, MD, MPH, FACP, Dr. Jeffrey M. Levine, MD, FACP & Dr. Thomas J. Weber, MD)

Saturday 7th:
（1）Colorectal Cancer Screening: Current Standards of Care
(Dr. Joseph C. Anderson, MD)
（2）Clinical Triad: The Top Three – What the Internist Needs to Know About Breast, Prostate, and Lung Cancer Screening
(Moderator: Dr. Peter W. Marks, MD, PhD, FACP, panelists: Dr. Marc B. Garnick, MD, FACP, Dr. David E. Midthun, MD, FACP, & Dr. Kevin Oeffinger, MD)
（3）Update in Geriatric Medicine
(Dr. David B. Reuben, MD, FACP)
（4）Thumbnail Rheumatology: Overview of Monoarthritis, Polyarthritis, Polymyalgia, and Giant Cell Arteritis
(Dr. Antoine G. Sreih, MD)
（5）Outpatient Diabetes Management
(Dr. Joseph A. Aloi, MD, FACP, FACE)
（6）Reducing Risk of Acute Kidney Injury in High-Risk Patients
(Dr. Joseph A. Vassalotti, MD)
（7）Internal Medicine Meeting 2016 Highlights: Key Messages You'll Want to Take Home and Doctor's Dilemma: The Finals

I hope many members will participate in the IM2017 which will be held in San Diego from Thursday March 30th until Saturday April 1st 2017.

◯ Convocation Ceremony

A new stage in my carrier as an FACP after attending the 2016 American College of Physicians meeting in Washington, D.C.

Satoru Joshita, MD, PhD,FACP

Shinshu University School of Medicine Department of Medicine
Division of Gastroenterology and Hepatology

It was a great personal and professional honor to obtain ACP Fellowship last year, for which I would like to deeply thank all members who supported my selection. Specifically, I want to express my heartfelt appreciation to Dr. Fumihiro Ishida (FACP) of Shinshu University School of Health Sciences, Matsumoto, Japan, and Dr. Hiromi Ishibashi (MACP) of International University of Health and Welfare, Fukuoka, Japan, both of whom encouraged me towards ACP membership and FACP promotion.

I attended the 2016 ACP meeting in Washington, D.C., to receive the honor of ACP Fellowship. Although it was my second time attending an ACP meeting, I remained impressed with so many ACP members, undergraduate students included, engaged in active discussion and sharing. I also spent several memorable days around Washington with my Shinshu University colleague, Dr. Tadanobu Nagaya, who is now working at NIH as a third year postdoctoral fellow. After walking around the city, I took him to the ACP meeting in hopes of him joining the organization as well. His energetic reaction to the experience indicates he will be applying soon.

Upon my return from the meeting to Japan, I happened to meet another colleague, Dr. Ikuo Shimizu, who mentioned that he would apply for promotion to FACP in a couple of years. It is a source of great joy to hear my colleagues aiming for ACP membership and Fellowship, and I will help them as much as possible to achieve their goals. I sincerely hope even more internists in Japan, including those with sub-specialties, will become interested in ACP activities in the name of better medical service to their patients and communities.

Lastly, I would like to thank Dr. Soichiro Ando for giving me the opportunity to write this letter. I will do my very best to uphold the ideals and standards of the ACP.

◯From Members

Rise Up Kumamoto!

Hiroshi Ono, MD, PhD,FCCP, FACP

Physician-in-Chief of Div. Respiratory Medicine, National Hospital Organization Kumamoto Medical Center

I was focusing on my research while at The cancer Institute of JFCR in Tokyo, when at 2:46 PM on March 11, 2011, I experienced the Great East Japan Earthquake. The hotel next to facility that could be seen from my window began to violently shake like an eraser, and black smoke rose from the construction site behind it. I saw a flock of people scatter and rush to the Kokusai-Tenjijo Station, but they were turned away at the gate.

I heard information coming in from the radio, and because my house in Suginami-ku was somewhat far from Koto-ku where the research facility was, the situation of being unable to contact my family and the continuous news of destroyed houses and patients with cardiopulmonary arrest being transported to hospitals caused me to feel a sharp pain in my chest. I found myself as a refugee who had great difficulty going home and continued to walk back home. The Tokyo sky as seen from the bridge of the Kokusai-Tenjijo Station appeared to become dark as evening as black smoke rose from the area; strange shadows covered the area as thick clouds of smoke spread.

"Are my family members safe?" This was the only thing that went through my mind. Due to fatigue, it felt as if my feet were shackled as I took each step forward, but my feeling remained as anxious as ever. On the way, I saw the situations of various people, and I finally reached home after a walk that took about 8 hours. Fortunately, all of my family members were safe, but a third of the windows in the 47-year-old house had shattered, so I entered the house with my shoes on because the floor needed to be cleaned. Luckily, we had prepared for earthquakes, and the damage that we experienced was small, and I thought that the psychological fear that I experienced could be easily wiped away...

Leaving Saitama, I came to Kumamoto on March 24, 2016 to search for a new ground. On the weekend, we unpacked the moving boxes and I went with my family to a local restaurant to enjoy authentic Kumamoto cuisine. While enjoying the truly delicious cuisine, we reminisced of our 16 years living in the Kanto region as a fond memory of the past. From the bottom of my heart, I felt that I was living a happy life. I started working at National Hospital Organization Kumamoto Medical Center in April. Before attending to my duties as head physician of the respiratory center, I was busy becoming used to the hospital. My previous nervousness gradually melted away as the hospital culture was welcoming and the workers warmly accepted me, even though I was previously based in Tokyo Medical and Dental University.

On April 14, from the window of my house, I could see Kumamoto Castle, which looked so dignified as it was bathed in beautiful light. The children were already asleep in their futons, and I was talking to my wife about the work events of the day while holding a glass of liquor in my hand. Suddenly, I felt an unnatural shaking, as if I were in an earthquake simulator. The children awoke from their deep sleep and fell into a panic; they cried as they desperately attempted to understand what was happening around them. I calmed my children by having them hide in their futons, and as we lived on the 8th floor of the condominium, the cupboards, refrigerator, and piano greatly shook, and our home was filled with broken furniture and scattered luggage. Being worried if we would be thrown out of our condominium, if the earthquake resistance of our home was safe, and what would happen in the future, while being attacked by an unceasing sense of anxiety, I cleaned up after the earthquake and worked to collect information.Water

and gas stopped, and there was a temporary blackout, but the power soon came back on again. The loud sirens of the emergency vehicles could be heard from my window.

Meanwhile, about 350 staff members had gathered at the hospital, where disaster headquarters were set up and we changed to disaster relief mode. The next day, the local disaster headquarters of the National Hospital Organization that was overseen by the National Hospital Organization Kyushu group was set up in our hospital, and medical teams from various fields rushed in to assist. We staff members also convened in the conference room and discussed a number of times about status reports and the future of the work system. As a newcomer, I had little knowledge of the internal system of the hospital, and was not completely sure how to use the electronic patient record system, but I performed my duties as I was told and remained busy to respond to the patients who lost their homes in the earthquake and had no place to go after being discharged.

On April 16, I came home late after a busy day of work at the hospital, and was enjoying a peaceful conversation with my wife about the events of the day while having a meal close to the middle of the night. I prayed that this peace would continue. However, it was 1:25 in the morning. Once again, along with the tremors, there was the sound of shaking and utensils breaking, disturbing the peace; I could hear the sound of furniture around me hitting the walls, and as if deja vu of experiencing a large earthquake, my children jumped up and shook in fear. We could only feel anger as the unforgiving continuous earthquakes did not give us time even to evacuate. There was nothing to do but shout "Enough already! “while withstanding the shaking and trying to prevent the damage from further spreading. Water and gas were stopped. We experienced a blackout. The loud sirens of emergency vehicles outside could be heard from the window, and the sky was filled with flying helicopters. I immediately guessed that extraordinary grave damage must have occurred. With my family members, we took refuge in a local elementary school; because of the cold of night, we took some cardboard boxes in the garbage dump

and used them to stay warm. While feeling angry at the repeated tremors, I shared information with other evacuees and thought about my future life in Kumamoto. Later, I sent my family members to take refuge back home that was comparatively undamaged by the earthquake, and I returned to my hospital to work. The next day, I saw on television that Kumamoto Castle had been cruelly changed, and was no longer in its previous majestic condition.

As we also had the cooperation of DMAT from across the country, there was no noticeable confusion in hospital medical care, however, all staff members were struggling with the fear of the earthquake while continue working without having time to care not only for their own families but also for themselves. My mind and body had already exceeded their peak level of fatigue with more than 50 ambulances and numerous walk-in patients came to the emergency room; we struggled to meet the demand. The full-time physicians also worked in three shifts to provide emergency care. An evacuation center for family members of workers was set up in the hospital, and there were also many staff members who were sleeping in their cars. The workers did not show any sign of the difficult situation they were facing as they cared for patients with a smile; this was the essence of professionalism. As an acute care hospital, we faced a critical situation due to the collapse of large neighboring hospitals, backlog of patient admissions and discharges due to dysfunction of the hospital management system, etc. The hospital chief gave everyone a word of encouragement: "We are the last line of defense and the last hope for everyone!"

It is true that I felt paralyzed because of the countless aftershocks, but at the same time, I had a fear that another large earthquake would occur sometime. There are patients who are suffering mental anguish and are brought to the emergency department, patients who restarted smoking in the wake of the earthquake, patients who drown their troubles in liquor, and patients who attempted suicide...Thus, the wounds of the disaster have not completely healed, but hope for the future has gradually increased, and Kumamoto is regaining its lost vitality.

Despite the unprecedented two seismic intensity 7 earthquakes and numerous aftershocks of maximum intensity of 6, Kumamoto Castle, which was heavily damaged to the point of collapse and many roof and decorative tiles had fallen off, seemed to have firmly withstood the disaster. It appears in poor condition to residents in the prefecture who knew the castle in its former glory, but I think that it is important to not look only at its poor condition but rather see that we can still recognize the site as "Kumamoto Castle." About a third of surrounding stone fence was broken, and we were faced with scientifically assessing each individual part as we moved toward the daunting task of "restoring" the castle. It was said that it would take several decades to complete restoration, and I heard some of the people in Kumamoto say that they would not be able to visit it in its previously magnificent condition within their lifetimes. And now repair of tower of Kumamoto Castle is scheduled to begin.

As a person who was a victim of the disaster, and not just as a health care practitioner, I have the deepest desire for the speedy recovery of the region and that the castle will become a beacon of light to guide the people in the prefecture and those who have experienced the disaster. Its path is hoped to lead to a wonderful future as we gaze at Kumamoto Castle, which once again shines brightly in the light.

○ Student Committee

Through participation in "ACP Japan Chapter Annual Meeting 2016"

Sho Fukuoka
Fujita Health University, the 6th year medical student

My name is Sho Fukuoka, a chairman of the student's committee of ACP Japan Chapter.
I participated in "ACP Japan Chapter Annual Meeting 2016" on June 4-5th. The subject of meeting this year was "Raising Generalist Medicine".

In recent Japanese society, the number of the senior who suffers many physical problems keeps increasing rapidly, therefore I think that an ability of the examinations from multiple points of knowledge, not from single view of a specific organ, becomes more important in any medical departments in all respects.

Because I have aspired to be a general physician, I had the good fortune to attend the meeting. I attended only some among many sessions nevertheless through my experiences from participations, I have learned a lot and am still eager to join them again next year. Also I would like to recommend this great annual meetings and ACP Japan Chapter to all of my friends and juniors.

"Transforming medical education through student leadership - experiences in Self-Directed Learning"

In ACP Japan Chapter Annual Meeting 2016, we held the session entitled "Transforming Medical Education through Student Leadership - experiences in Self-Directed Learning (SDL)", where we focused on considering the medical education in view of medical students and the method of each study.

Recently, through popularity of the SNS and so on, it becomes much easier for medical students to go beyond the boundaries of individual university or meeting together in the room for the activity of each group.

However due to the deficiency of active networks among studying groups, there is quite a few chance to know about the other activities of different groups at the moment. For such simple reason, it is still difficult to look over the prime target of study, as it is no chance to share methods of achieving goals of each study efficiently among groups.

In the subject session, two student groups of the "PRIME" where students learn regarding clinical reasoning and the "WiNG" where students study social problems, both participated the session to have considerations about the solutions through seminars and field studies, mounted the platform. While presenting various opinions of existing medical education problems founded by the two different groups of activities, we cached up the general situation of medical education at the moment.

Through this fruitful discussions during the meeting, we considered how to improve the quality of each SDL.

○ International Exchange Program Committee

Clinical observership at Olive View Medical Center, University of California, Los Angeles, USA.

Harumi Gomi, MD, FACP
Chair, International Exchange Program Committee
American College of Physicians Japan Chapter
Mito Kyodo General Hospital, University of Tsukuba

This letter is a follow up information on our committee' s educationally highly valuable exchange program for the ACP members and associate members in Japan.

International Exchange Program (IEP) Committee, American College of Physicians (ACP), Japan Chapter was founded initially as ad hoc committee in 2011. Since 2012, clinical observership at Olive View Medical Center, University of California, Los Angels has been initiated and developed. ACP Japan Chapter Governor and Former IEP Committee Chair Dr. Shotai Kobayashi, and the California Governor Dr. Soma Wali had made significant efforts to make this happen. In this valuable exchange program, ACP members and/or associate members are eligible to apply. Below is the website for the application details (in Japanese).
http://www.acpjapan.org/info/20160525_145/

At Olive View Hospital, a maximum of twelve observers can be accepted each year.
If you or your colleagues are interested in making the best of this opportunity, please contact the ACP Japan Chapter, International Exchange Program Committee. The Committee will try our best to support the applicants for their request and wishes.

Since 2012, there have been five observers in Year 2012-13, five in Year 2013-14, and two in Year 2014-15, one in Year 2015-16, and three in Year 2016-17 so far.

Below is the list of all clinical observers at Olive View Medical Center, University of California, Los Angeles, USA

Candidate No.	Last name	First name	日本語名	Specialty		Month	Year
2012-13				General Medicine Wards	Consultation service		
1	Uemura	Takeshi	植村健司	Internal Medicine	No	September	2012
2	Shimamura	Shonosuke	嶋村昌之介	Internal Medicine	Infectious Diseases	February	2013
3	Minobe	Shoko	美濃部祥子	Internal Medicine	Hematology/Oncology	February	2013
4	Isohisa	Ai	磯久愛	Internal Medicine	Rheumatology	May	2013
5	Cho	Narhiro	張成浩	Internal Medicine	No	May	2013
2013-14							
1	Tsuda	Moe	津田萌	Internal Medicine	Hematology/Oncology	January	2014
2	Muranaka	Emily	村中絵美里	Internal Medicine	Infectious Diseases	May	2014
3	Soma	Shinko	相馬真子	Internal Medicine	Cardiology	May	2014
4	Sato	Ryota	佐藤良太	Internal Medicine	Critical care	June	2014
5	Tanaka	Takamasa	田中孝正	Internal Medicine	Hematology/Oncology	June	2014
2014-15							
1	Kuriyama	Akira	栗山明	Internal Medicine	Critical care	November	2014
2	Makishi	Tetsuya	牧石徹也	Internal Medicine	Nephrology	November	2014
2015-16							
1	Ishitobi	Natsuko	石飛奈津子	Internal Medicine	Critical care/ Emergency medicine	May	2016
2016-17							
1	Shiroshita	Akihiro	城下彰宏	Internal Medicine	Infectious Disease	November	2016
2	Yamamoto	Takeru	山本たける	Internal Medicine	Infectious Disease	November	2016
3	Hiroki	Nishiwaki	西脇宏樹	Internal Medicine	Nephrology	April	2017

Program Director of the Clinical observership:
Dr. Soma Wali
Professor, Director
Department of Medicine
Olive View Medical Center, University of California Los Angels, USA

Here we are pleased to share the essay of the clinical observers Dr. Natsuko Ishitobi.

◯ International Exchange Program Committee

Break Through!

Natsuko Ishitobi, MD

Physician in ChiefDepartment of Critical and Emergency Care Medicine
Shimane Prefectural Central Hospital

I found this international exchange program when I was concerned about my future. I work as an emergency physician and intensivist in a Japanese rural area; thus, I manage many kinds of underlying diseases and social problems. Some years have passed since I finished my residency program, and I currently am responsible for not only our patients and the education of residents but also for my two children. My daily routine was too busy to ponder my current role and future career aspirations. One day, however, I read something that moved me to apply immediately for participation in this program.

My boss supported my desire to take part in this program fully; I should not have worried at all. My husband also encouraged me to participate. The major difficulty associated with this endeavor was arranging childcare for our two children aged four years old and two years and one month because both my husband and I were working full-time without any support from our families. We talked many times about making choices that would also be good for our children. I believed that I should participate in this program THIS YEAR, as I was strongly motivated and enthusiastic, even though some people said I should not have left my family in Japan. However, my husband' s boss and teachers at the nursery school where our children attended understood our circumstances and assisted in providing a comfortable situation for them.

A half-year and a difficult routine flew by from the day my application was accepted and the date of my departure to the U.S. I was able to enjoy a productive time at Olive View-UCLA Medical Center (OVMC) from May 5 to June 3, 2016.

My aims in participating in this program were as follows: 1. to learn how to manage patients more capably, 2. to identify innovative concepts to share with my residents, and 3. to improve my English skills.

In the U.S., patients' rights seem to be ensured; thus, they are encouraged to acquire an accurate understanding of their diseases and bodies. I was impressed that people could receive medical translations at any time no matter what language they spoke; further, patients and physicians had ease of access to bioethics consultations as needed. In our hospital, as in OVMC, some patients who are not fluent in Japanese come for medical treatment. Moreover, a developing social problem is in what manner patients without the ability to make decisions for themselves—such as individuals with advanced dementia or those in deep comas—should be cared for when they face the end of their lives. These points caused me to consider what we should present to such patients and their families to ensure mutual satisfaction regarding medicine and treatments.

I also observed that there were many low-income or uninsured patients at OVMC because it was a county hospital. Complicated social or financial conditions often caused physical problems. Not only physicians but also other healthcare workers respected each other and sought the best ways to help patients; they demonstrated enthusiastic professionalism, despite differences in occupations and years of experience. In other words, every OVMC staff member seemed to be recognized as a professional by his or her colleagues. In Japanese culture, younger physicians are often hesitant to state their opinions to their superiors because of seniority. Nevertheless, I wish to obtain the opinions of my colleagues, whether or not they are younger than me, in order to ensure the best outcomes for our patients.

As for educating residents, it is an important task for senior staff members to instill among our residents a respect for others. I found it interesting that senior residents at OVMC asked their interns "What's your decision?" It made me consider asking my residents "how they think and why" rather than fostering the impression that they need to give "right answers."

Regarding my English skills, I believed I could improve technically. This program motivated me to study English. Until the end of the second week of the program, I was a bit depressed owing to difficulties understanding what people meant and expressing my opinions in English. Friendly people (including alumni of this program) and my family encouraged me and helped me achieve my aims for participating.

I was truly impressed that physicians at OVMC struck a healthy balance between work and their personal lives; thus, they were able to enjoy both. My family may have had a hard time during our month apart, but we had many precious experiences and challenges as a result. My task for the future is how to retain my motivation and take advantage of my experiences.

I sincerely appreciate the incredible support from Dr. Soma Wali and Mr. Norman Belisle at OVMC and from Dr. Harumi Yano, Dr. Tetsuya Makiishi, and other alumni in the ACP Japan chapter. I also wish to extend my gratitude to my boss, colleagues, and family in Shimane.

◯ Committee Members

Credentials/Membership Committee	Chairperson	Eiji Shinya
	Vise-chairperson	Koichiro Yuji
		Katsuhisa Banno
		Hideto Watanabe
		Hitoshi Sawaoka
		Shunji Yasaki
		Keiko Arai
		Minako Tojo
		Jotaro Ohno
		Yusaku Kajihara
		Satoru Joshita
		Nobuhito Hirawa
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	Vise-chairperson	Masao Nagayama
		Toshihiko Hata
		Takafumi Ito
		Masaya Yamato
		Kazuhiro Yasuo
Scientific Program Committee	Chairperson	Yugo Shibagaki
	Vise-chairperson	Teruhisa Azuma
		Noriaki Kurita
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		Yasuhiro Akai
		Masako Utsunomiya
		Hideaki Shimizu
		Mikio Hayashi
		Shumpei Yoshino
		Sugihiro Hamaguchi
		Atsuko Mori
		Shungo Yamamoto
Finance Committee	Chairperson	Yukari Shirasugi
	Vise-chairperson	Yuko Takeda
Health and Public Policy Committee	Chairperson	Yuhta Oyama
	Vise-chairperson	Hiroshi Ono
		Hiroshi Yoshida
		Hitomi Miyata
		Yohei Goto
		Iwao Gohma
		Takashi Nishida
		Yasuharu Tokuda
		Masato Ito
Public Relations Committee	Chairperson	Soichiro Ando
	Vise-chairperson	Yasuo Oshima
		Hiroshi Bando
		Soichi Nakata
		Naoki Inoue
		Masaya Hirano

Public Relations Committee		Koichi Ono
		Yuko Morishima
		Masatoshi Kawana
		Shuichi Kawata
		Katsunori Suzuki
		Masumi Hara
		Masanobu Aramaki
		Mitsunaga Nishimura
		Mayumi Miyaji
Young Physicians Committee	Chairperson	Noboru Hagino
	Vise-chairperson	Masanori Mori
		Yuka Kitano
		Takahiko Fukuchi
		Akihito Kawashima
		Katsuhiko Morimoto
		Nobuaki Mori
International Exchange Program Committee	Chairperson	Harumi Gomi(Yano)
	Vise-chairperson	Tetsuya Makiishi
		Mamiko Ohara
		Toru Sasaki
		Naohiko Imai
		Takahiro Tsutsumi
		Miho Tagawa
		Mitsuyo Kinjo
Resident Fellow Committee	Chairperson	Tomohiro Kozuki
	Vise-chairperson	Akiko Hanamoto
		Tomoki Tagaya
		Shoko Soeno
		Yuto Unoki
	Adviser	
		Hideaki Shimizu
		Shumpei Yoshino
		Yuki Kataoka
		Responsible Director
		Shunichi Fukuhara
Student Committee	Chairperson	Sho Fukuoka
	Vise-chairperson	Natsumi Momoki
		Yoshihiro Fukuchi
		Shuhei Wada
		Yomei Sakurai
		Takahiro Akimoto
	Adviser	
		Yuko Takeda
		Yukari Shirasugi
		Fumiaki Ueno
		Kazuo Takahashi
		Noriyuki Koibuchi (Non-member)

◯International Exchange Program Committee

Chairperson

Harumi Gomi, MD, MPH, FACP, FIDSA

Professor of Medicine
Director, Center for Global Health
Mito Kyodo General Hospital, University of Tsukuba

Follow your passion and make your own niche.Education will change the globe.

Mamiko Ohara, MD, PhD, FACP, FASN

Director, Internal Medicine Education
Chief, Department of Nephrology
Kameda Medical Center

My message to the doctors in early career. You can accomplish more than 80 percent of what you think you can't achieve, with your earnest effort."

Naohiko Imai, MD, FACP, FASN

Division of Nephrology and Hypertension
St. Marianna University School of Medicine

See one, do one, teach one.

Miho Tagawa, MD, ACP Member

Medical Staff,First Department of Medicine,
Nara Medical University

I hope I can be of some help to members of ACP.

Vise-chairperson

Tetsuya Makiishi, MD, FACP,FASN

Chief,
Division of Nephrology, Department of Internal Medicine
Saiseikai Shiga Hospital

I'm thrilled to help you connect with valuable programs that ACP offers.

Toru Sasaki, MD, PhD, ACP member

Chairman,Sasaki Medical Clinic

To lose your money is bad.To lose your honor is worse.To lose your courage (hope) is worst, because it means you lose everything.
I love this phrase very much, but I have forgotten the original source of it. "

Takahiko Tsutsumi, MD, ACP Member

Chief of General Internal Medicine, Akashi Medical Center

My message to young doctors. Keep on moving forward!! We can do better. "

Mitsuyo Kinjo, MD, MPH, ACP member

Chief, Division of Rheumatology, Okinawa Chubu Hospital

Ambition and dream will guide your path.

◯ Finance Committee

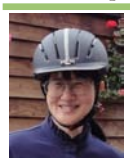
Chairperson

Yukari Shirasugi, MD, PhD, FACP

Associate Professor,Director of outpatient chemotherapy center Division of Hematology and Oncology
Department of Internal Medicine

"The art of practice of medicine is to be learned only by experience; 'tis not an inheritance; it cannot be revealed. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become expert. "-----William Osler

Vise-chairperson



Yuko Takeda, MD, PhD, FACP, MSc

Professor of Medicine
Division of Medical Education
Juntendo University School of Medicine

Education is an investment in the future; for you to receive and for the next-generation that you can provide.

○ Public Relations Committee

Chairperson

Soichiro Ando, MD, PhD, FACP

CEO of Ando Clinic

Love your patients as you love yourself.

Hiroshi Bando, MD, PhD, FACP

Director, Medical Research

Medicine and Art are broadly necessary, including primary care medicine, integrated medicine, music, sports and so on.

Naoki Inoue, MD, PhD, ACP member

Bouve College of Health Sciences,
Northeastern University

Hope to contribute to ACP as a member of PRC

Koichi Ono, MD, PhD, FJCC, FACC, FAHA, FESC, FJSIM, FACP

Vice Director, Rikita Hospital

I'd like to do this work as much as possible in the reach of my ability while utilizing the former ACP public relation committee's experience.

Shuichi Kawata, MD, PhD, FACP

Director, Kawata Mecical Clinic

Masumi Hara, MD, PhD, ACP member

Professor and Chairman of Internal Medicine
Mizonokuchi Hospital, Teikyo University School of Medicine

"Where observation is concerned, chance favors only the prepared mind."
--- Luis Pasteur

Masatoshi Kawana, MD, PhD, FACP, MBA

Associate director of Tokyo Women's Medical University Hospital
Director, Clinical Residency Training Program, Professor, Chief of General Medicine,Professor, Department of Cardiology.

My message to the doctors in early career. Specialist and professional are quite different. The former is quite competent to perform missions under the prior conditions, while the latter can challenge without any preconditions. Of course, you need to aim the professional in the 21st century.

Mayumi Miyaji, M.D, Ph.D, ACP member

Chief of Mami naika clinic

Engrish is not so good yet, but I am looking forward to studying with you.

Vise-chairperson

Yasuo Oshima, MD, PhD, FACP

Medical AdvisorNovartis K.K.
Visiting Scientist,
The Institute of Medical Science, the University of Tokyo

Sincerely is my personal motto.Joy and sorrow are today and tomorrow. Persistence pays off.

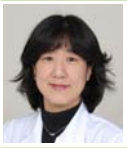
Soichi Nakata, MD, PhD, ACP member

Director, Nakata Clinic

Without haste, but without rest.

Masaya Hirano, MD, PhD, ACP member

Hirano clinic



Yuko Morishima, MD, PhD, FACP

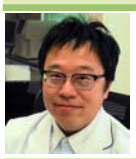
Associate Professor, Department of Respiratory Medicine, Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba

My message to the doctors in early career.
Challenge yourself and try various things in courageous manner.

Katsunori Suzuki, MD, PhD, ACP member

Assistant Professor,Division of Infectious Control and Prevention University of Occupational and Environmental Health, Japan

See one, do one, teach one



Masanobu Aramaki, MD, PhD, ACP member

Director of Aramaki Internal Medicine Clinic

Let 's learn the latest medical knowledge together. Knowledge is power.

Mitsushige Nishimura, MD,ACP member

Nishiizu Kenikukai Hospital, department of internal medicine

Personally, I propagate the utility of ACP to our residents. (Dynamed plus, ACP journal club, In the clinic etc) And I, myself, solve MKSAP questions every day with collegue.From this April, I join in the PR committee of ACP Japan chapter and appreciate this chance of joining. I will do my best to act as PR committee!!

＊Profiles of other Committee members will be present in the next issue.

Editor's Postscript

Mr Donald J. Trump was elected to become the next US President. He insisted to deliver a repeal of Obama care in his campaign. Healthcare system in the US might be reformed soon. On the other hand, the system of Japan is on the verge of collapse. Drastic reform has been postponed.

Regardless of health care system, our top priority is patient and we want to devote ourselves to deliver the most beneficial care for patients.

In this issue, young physicians and students, who will be leaders of Japanese medical community, contribute enthusiastic reports. You must believe in the bright future. (SA)