ECCO NEWS 2007

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- Report from UEGW in Paris
- Annual SciCom Report
- Report from ESCP Meeting in Malta

ECCO NEWS

The Quarterly Publication of ECCO
European Crohn's & Colitis Organization

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LETTER FROM THE PRESIDENT

President
MIQUEL GASSULL
Badalona, Spain

Dear ECCO friends,

Once more I want to update you about the activities carried out in ECCO since my last letter in the ECCO News.

ECCO has already become a modern and well settled organisation. During the last UEGW, the Governing Board met with the Council of National Representatives, and presented to them the proposed changes in our constitution in order to allow the open membership and, at the same time, by keeping the Council of National Representatives as a consulting body for the Governing Board. These modifications allow both free access to ECCO to those clinicians and scientists interested in IBD, while maintaining ECCO as the umbrella organization of the IBD National Groups. Also changes in the election procedures and definition of candidates for positions in the ECCO committees, the role of YECCO within ECCO and its participation in the committees and activities were also presented. The proposed changes, together with other changes related to treasury management, administration, organisation, etc, were approved by the Council.

The General Assembly of ECCO met after the meeting of the Council of National representatives and the Governing Board. All decisions were explained with special emphasis on the way the National Representatives are elected, and the role of the General Assembly. Please go the ECCO website where you will find detailed information about these issues.

Both the Council and the General Assembly were informed about the activities of ECCO between congresses. ECCO has taken a policy of organising regular workshops during the year to regularly update specialists on different items of importance in managing IBD. These workshops take place across Europe and are either organised and financed by ECCO itself or fully organised by ECCO (total independence in the contents) and financed by an unrestricted grant from one of our corporate members. Two types of these workshops have been carried out during this year. The first entitled "*Optimising Biological Therapy: practical considerations and future prospects*", has been organised by ECCO with an unrestricted grant from UCB. Three of these workshops have already been carried out (Prague, Stockholm and London) and successfully attended; the last one is taking place in Barcelona on the 20th of January 2008. The second type is the "ECCO Workshop: Implementing ECCO guidelines". This is done with only ECCO Educational Grants and are directed to General Gastroenterologists interested in the treatment of IBD. One of these workshop was held in Zagreb in early November with a wide attendance and successful evaluation, and the second one will take place in Vienna mid December.

Preparations for the ECCO Annual Congress: IBD 2008 to be held in Lyon are well advanced and with your contributions (papers and attendance) it will be also a great success and a good chance to meet and interchange important information.

During the General Assembly in Lyon detailed information about the consolidation of ECCO as a Scientific Society and the progress made since last year will be given. There Jean Frédéric Colombel will take over as new President of ECCO, while I will step down after 2 years of exciting changes and progress of our society, mainly thanks to the fantastic help and hard work of all members of the Governing Board, Scientific Committee and Educational Committee. Jean Fred is a very capable and wise man and a remarkable scientist. I am sure that with the help of all members of the Board and Committees, he will increase the visibility and prestige of ECCO to very high levels. The chairmen of the Scientific and Educational Committees will also leave their jobs. Both Boris Vucelic and Daan Homes have worked very hard these years to grow ECCO prestige in Education and Science to a remarkable high level.

A very important figure will leave the Governing Board – Renzo Caprilli. We all know what Renzo means to ECCO; founder and President for the four initial years, the most difficult ones. He has found the way to make ECCO progress to where we are today. Probably the word *thanks* may not express the gratitude that we all feel, but it is the best I can say in a language that it is not my mother tongue.

Also during the Lyon Meeting the new President Elect together with other positions in the committees will be elected. The procedure is explained on our website.

There will be changes as for the persons holding positions in ECCO. The new officials, I am sure, will improve very much the performance of our society. However, I am sure that the objectives, and most important, the spirit built during all these years will remain.

UEGW in Paris 2007

The 15th United European Gastroenterology Week was held in Paris, October 27–31.
More than 11 000 participants were registered, which was an all time high, and no less than 2 868 abstracts were received – which also was a record number.
IBD was one of the main topics at the Congress.

The first in a long line of speakers in the Scientific Programme was Jean-Frédéric Colombel, France. His lecture had the title *Is there a cure for IBD on the horizon?*

Focus on the early years

Initially, Dr Colombel in his speech pointed to the fact that IBD is spreading over Europe.

The natural history of both Crohn's disease and ulcerative colitis can be schematised as a multi-step process progressing from sub-clinical inflammation to intestinal disability.

Over the past decade, treatment of IBD has been revolutionised by the introduction of biologic therapy with anti-TNF agents above all. This therapy has greatly improved the impact of the treatments allowing clinical remission instead of mere response, smaller use of corticosteroids, mucosal healing and decreased need for surgery.

Many other biologics inhibiting cell adhesion and other pro-inflammatory cytokines or blocking T-cells may complement this approach in the near future.

– But today we target late disease – maybe we should focus on the early years?

Dr Colombel referred to the BeST-study, which concerns rheumatoid arthritis and in which the endpoint is simple: To avoid bone destruction by using immunosupressants.

– We must do the same, and that means that we must try to heal the mucosa, he said.

A potential cure?

Dr Colombel talked about shifting the paradigm – reinforcing the intestinal barrier and modulating the luminal side using probiotics and antibiotics.

– The traditional treatment paradigm for IBD still involves a step-up approach in which new therapies are introduced as "lesser" therapies fail. This may lead to long periods of uncontrolled inflammation which results in symptoms that impair quality of life and often lead to complications of the disease.

Jean-Frédéric Colombel

– It now seems that early aggressive therapy for various auto-immune illnesses provide an opportunity for real disease modification or possibly disease reversal – perhaps a potential cure?

Gastroenterologist as preventionist

To sum up his lecture, Dr Colombel stated he wanted to see the Gastroenterologists

of the future act more as preventionists, by using genomic information, serum and fecal markers and family history among other things, in order to create an "IBD risk index".

– This is a hope, perhaps it will be too late for me to see it realised, he concluded.

Dr Colombel rounded off his highly appreciated lecture by inviting everyone in the audience that is interested in IBD, to the ECCO Congress in Lyon at the end of February 2008.

Gut microbiota in phyla appears to be under genetic determination, said Patricia Lepage.

Bacteria and stem cells

The Opening Session also had four presentations of the chosen *Best Abstracts*. Two of these concerned IBD.

Patricia Lepage, Germany, talked about an analysis of gut microbiota in discordant monozygotic twins with IBD. Their aim was to search for bacterial species protecting the healthy twin or, alternatively analyse bacterial dysbiosis in the diseased one.

One of the findings she accounted for was that several species of the Clostridia class were more prevalent in healthy siblings of IBD twin pairs than in both diseased siblings and healthy twin pairs and might have a protective role at a mucosa level.

One of her conclusions was that involvement of bacterial microbiota in IBD was more obvious in ulcerative colitis than in Crohn's disease, even though some bacterial species could be protective against both diseases.

The other *Best Abstract* concerned an update on the findings on stem cell transplantation in refractory Crohn's disease. The conclusion was that unselected CD34+ cell transplantation appears to be safe overall and can induce and maintain both clinical and endoscopic remission in refractory CD.

Lunch buffet and UC

Every day several lunch sessions were held. These included a lunch buffet, and participants had to register for these separately on a first come – first served basis. The maximum number of participants was strictly limited. 20 such sessions were spread over three days.

One of these sessions had the title *Management of severe ulcerative colitis*. The Chairs were held by Boris Vucelic, Croatia, and Subrata Ghosh, UK.

It turned out to be a highly interactive discussion between the Chairpersons and the participants. No technical aids – such as slides or overhead projectors were used. According to Dr Vucelic, this was a deliberate decision in order to create an atmosphere that stimulated debate and discussion.

Dr Vucelic began by presenting a case of a man just admitted to hospital due to UC, and asked this question: How do we decide *how* severe it is?

This immediately led to a discussion about indexes. The "Golden rule" is: Remember to think of *other* possible causes!

– You have to work with that uncertainty – infections etc – to begin with. It's mandatory to exclude these possibilities, but it takes a couple of days, said Dr Ghosh.

Either or – not one after another

The case continued. Dr Vucelic said that after initial evaluation, we now know that the patient has a flare up of UC.

– When is the time to decide to treat the patient with something other than steroids, he asked.

A new discussion about Cyclosporine and Infliximab started. Dosages were discussed, and Dr Ghosh pointed out that 2 mg per kg bodyweight of Cyclosporine equals 4 mg per kg, but will give less side effects.

The questions and answers were many, and the debate intense during the session. Dr Vucelic referred many times to the ECCO consensus.

– First: Assess the patient properly – is it an acute attack, or chronic disease with a flare-up? Support the patient with high doses of steroids. If the response is good, then continue.

– If the patients fails to respond, on the fourth day you should step up the treatment with Cyclosporine or Infliximab. *Either or*! Not one after the other. After 4–5 days you have to decide whether to carry on with the treatment, or if to call the surgeon, he summarised.

The *Timing of surgery in IBD in the era of biologicals* was the title of another Lunch Session, chaired by Iris Dotan, Israel and Tom Öresland, Norway.

At this, the view that it sometimes takes too long before the patient is referred to the surgeon was expressed by several of the participants.

Successful combination

But there are good guidelines concerning this, available in ECCO Consensus.

Marc Lemann, France, presented the following statement, regarding intravenous-steroid resistant UC of any extent:

"Surgical options should be considered and discussed at this stage or earlier… If there is no improvement within a further 4–7 days, colectomy should usually be recommended."

The title of the symposium was *New therapeutic approaches in IBD*. In his lecture *The role of immunomodulators and biologics in ulcerative colitis*, Dr Lemann also said that studies show that Infliximab is efficient for UC in the long term.

– But Azathioprine is not so efficient for UC, he added and continued by quoting the Consensus again:

"Azathioprine/mercaptopurine is recommended for patients who have expe-


Daan Hommes


Peter Lakatos


Marc Lemann


Tom Öresland


Subrata Gosh

rienced early or frequent relapse while taking 5-ASA at optimal dose, or who are intolerant to 5-ASA."

The first rule of severe UC is simple, he stressed.

– No death! And mortality rate *has* gone down to almost zero.

Dr Lemann also said that Cyclosporine and Azathioprine could successfully be combined.

– Most of us use this combination today, in order to avoid relapse.

He pointed out that the most severe complications of Cyclosporine are nephrotoxicity, hepatotoxicity, diabetes and arterial hypertension. Adverse effects are less frequent with the lower 2 mg/kg/day dose, though.

Extinguish the inflammation

At the same symposium Geert D'Haens, Belgium, talked about *The evidence for early aggressive treatment in Crohn's disease*. He described it himself as "The case for top-down strategy".

Dr D'Haens started by talking about the long term effects of steroids.

– The steroid is a friend at the beginning, but turns into an enemy!

He carried on by back-tracking the history of immunomodulators. It turned out that these patients got to the same endpoint – surgery.

– They were treated *too late* in the course of their disease with immunosupressants, was Dr D'Haens conclusion.

He listed the most important concerns of patients with IBD. According to this, patients want to avoid surgery, having an ostomy bag, hospitalisation, side effects of drugs, uncertain evolution of the disease and cancer. On the topic of lymphoma in biological therapy of IBD, he thought that it probably was the older treatment that is the cause.

Dr D'Haens mentioned several studies that indicate that early treatment with immunomodulators gives better results. Hence his view was to reverse the treatment pyramid, i.e. start with the most efficient drugs to extinguish the inflammation and then step down the treatment.

– Should we use aggressive histological immunosupressants for IBD, he concluded by asking and gave the answer himself:

– Yes, for a majority of patients!

Which one to use

There are several of these to choose from, so *What anti TNF to use – is there any difference* was the title of a lecture from Walter Reinisch, Austria.

Infliximab, Adalimumab and Certolizumab pegol differ in molecular characteristics, immunogenicity, in vitro activities and pharmacokinetic profiles. However, they have broadly similar efficacy for induction and maintenance of remission in active Crohn's disease.

Caution should be exercised when comparing clinical trial results, because of variations in study design and patient selection, according to Dr Reinisch.

Other parameters such as mode of administration (intravenous vs. subcutaneous) compliance or health economics might be taken into account when considering the best strategy for using anti-TNF agents, was his conclusion.

Targets inflammation

The three anti-TNF:s were also the main topics of a Symposium entitled *Advancing the treatment of CD*.

Subrata Ghosh, UK, talked about the properties of PEG and PEGylated molecules.

– It stays longer in inflamed tissue, he said and explained:

PEG is a branched polyether with variable chain length. It is heavily hydrated which increases the hemodynamic radius of PEGylated proteins. This characteristic means that PEGylated proteins tend not to diffuse well into normal tissue and are retained in the blood. Inflamed tissue is more permeable and does not have the same barrier to diffusion.

– The clinical relevance of this finding needs to be further investigated, Dr Ghosh concluded.

11 000 participants was an all-time high for the 15th UEGW in Paris.


Just how often endoscopes are now used is shown by current figures from France – data shows that more than 2,5 million endoscopies are performed per year in the country.

Need for new treatment algorithms

There were several symposiums and sessions about IBD in Paris. Daan Hommes, The Netherlands, had a talk entitled *Biologics: At the edge of knowledge?*

– We can see a shift in the paradigm: From symptom orientated care to prevention orientated care, Dr Hommes said.

He quoted a survey that said that 87% of the patients say they are willing to try a new drug in order to avoid surgery.

– And in short – the three drugs we work with today are the three anti-TNFs. Before deciding on which one to use, make sure to identify the proper target and that the drug is delivered to the right place!

He reminded the audience that there still is a high risk of recurrence after long term treatment. Technology has given us new knowledge during the last 15 years, but not changed the treatment very much, according to Dr Hommes.

– So we need new treatment algorithms. And the "Top-down" approach is a "direct hit" therapy, and it is superior for mucosal healing.

He concluded by stressing that we need to rethink our research agenda, which includes the rethinking of our care process and a high level of co-operation in the future.

In search of markers

IBD is not one disease. The phenotype is complex, and there is not an ultimate test to predict the outcome in IBD, said Peter Lakatos, Hungary.

He talked about *New insights into serological markers in IBD*.

– Although there is no such thing as an ultimate test, serological markers can be used, or be of additional value, to a clinical, endoscopic and histological panel of tests.

– Serological markers – conventional as ASCA or OmpC, or new as gASCA or AMCA – may be useful in further differentiation of patients for which there is doubt about the diagnosis of IBD. However, the distinction between Crohn's disease and ulcerative colitis can not be made.

Dr Lakatos said that available data – partly prospective – suggests that serological markers are valuable in predicting progressive disease.

– As a consequence, they can be used to predict the need for surgical intervention.

Minimal invasive surgery

Tom Öresland, Norway, held a lecture on *Laparoscopic surgery in IBD*.

The first laparoscopic cholecystomy took place in 1987. Today almost every abdominal type operation has been done with minimal invasive technique. Dr Öresland described many different examples of minimal invasive surgery:

Laparoscopic assisted resection – resection and anastomosis undertaken extra corporeally using the incision needed to remove the specimen. Hand assisted laparoscopic surgery – one hand inserted through a wide port gives tactile input. Total laparoscopic bowel surgery – mobilisation of the bowel, vascular division and anastomosis inside abdominal cavity.

– Laparoscopic surgery causes fewer traumas to the abdominal wall, it gives an intact interior environment, less desiccation, normal temperature and gives potentially better visibility, Dr Öresland said.

The reports on minimal invasive IBD surgery have shown longer operation times, shorter scars, less pain and faster recovery, among others.

– But the studies are not randomised – it is very hard to do – and stems from highly selected patients, Dr Öresland added.

– The more you refine measures, the less difference between conventional and laparoscopic surgery you'll find!

According to Dr Öresland the main achievement it has had so far, is the impact on conventional surgery in regards of more accuracy and better analgesia.

Compliance

The patients perspective on ulcerative colitis was described by Rod Mitchell, Chairman of EFCCA (European Federation of Crohn's and Ulcerative Colitis Associations).

Mr Mitchell described what it is like to live with this disease, the practical problems and the challenges confronting the patients and their families.

One of the major concerns is the fact that patients compliance for taking their medication is low.

Pali Hungin, UK, showed data that indicated that the compliance is 80% in studies and that community based compliance is estimated to 40–60%.

There are three major reasons for this: 50% of the patients that didn't take their medicine simply "forgot to do so", 30% said they *choose* not to do so because they "took too many pills", and 20% said they "did not need that much medicine".

5-ASA is normally the option to treat mild to moderate UC. They act topically – the more the better. Hence, large doses are required, which in turn means more tablets – which means less compliance!

In Paris a new tablet, the Mezavant XL was presented. It is taken in one daily dose of two to four tablets, and is designed to provide prolonged release of mesalazine throughout the colon.

– This is a new treatment option for UC, said Stefan Schreiber, Germany.

Three posters presented at the UEGW documented the effect, and it is believed that the once daily dosage will lead to much better compliance.

PER LUNDBLAD
Senior Writer

The Annual Report of SciCom: 2006–2007

It has been a great year for ECCO! We as scientific committee of ECCO have also experienced the previous academic year as very successful and … great fun! We started the new academic year with high spirits in July 2006 with a number of new targets and ideas, most of which have been accomplished or are going well. This article summarizes our efforts of the previous year.

In addition, we will present our future directions including the *institutionalization* of our initiatives. This is an essential part of the SciCom process now that Walter Reinisch and myself will be stepping down during the upcoming Lyon congress, followed by Severine Vermeire and Yehuda Chowers over the next two years. Our efforts have been successful largely because we have received an overwhelming support from the current Board members, as well as from many other members from the IBD community. The much appraised "ECCO-spirit" is truly fuel for our engines, and will continue to inspire us in executing our mission within ECCO.

This article summarizes the official Annual Report of Scicom that has been presented to the Governing Board during our annual summer meeting in Vienna.

ECCO has clearly entered a new phase driven by the success and the hard work of a large number of enthusiastic and highly supportive European IBD colleagues in the previous years. This new era requires modernization and transformation of the structures of ECCO and preparing for the challenges of tomorrow. Along these lines, the SciCom needed to restructure in order to face up to its ambitions for the upcoming academic years. Consequently, SciCom will restrict itself more and more to a limited set of activities, a clear focus on "core-SciCom business". In doing so, several "historic" activities had to be transferred to other domains of the ECCO organization in order to ensure high quality.

The key focus of the SciCom is facilitation of science in the field of inflammatory bowel diseases. The committee has chosen a well defined strategy:

1) *Promoting scientific IBD projects* via ECCO Fellowships, ECCO Grants and YECCO support;

2) *Ensuring a high level of scientific exposure* via responsibility in preparing the scientific programs for the Annual ECCO Congress;

3) *Facilitating and assisting in scientific projects and programs* initiated by individual research groups/consortia or the biomedical industry;

4) Continue to be a *think-tank* for optimizing scientific progress through new concepts in organization, translation of basic science, and personalized approaches for IBD patients.

Cumulative overview of previous SciCom activities

1. Who-is-Who in ECCO; first and second edition
2. First ECCO Congress, Amsterdam 2006
3. ECCO Fellowship 2006: Fabian Schnitzler
4. PDL BioPharma: Visilizumab Phase III Program
5. UCB: Expert Workshops on biologicals in IBD
6. EMEA consultancy
7. Ocera Therapeutics consultancy
8. Merger EC-IBD
9. Facilitating ECCO projects
   a. Pregnancy study
   b. ASTIC: autologous stem cell transplantation
   c. METEOR
10. Quarterly contribution to ECCO Newsletter
11. Introduction ECCO Grant
12. Partnership with IBDIS
13. Partnership application EU Framework 7 Program: "Protease call"
14. Merger YECCO

Organizational structure of the SciCom

❋ *Number of members:* The Scientific Committee consists of a minimum of four and a maximum of six members, one member is the representative of the former EC-IBD organization. One member is the representative of YECCO. Each member will serve in the committee for a minimum of two and a maximum of six years. During Lyon 2008, the Chair position will change. Simon Travis will become the new chair. Walter Reinisch and Daan Hommes will leave SciCom. During the summer 2007 meeting of the ECCO Board two candidates have been selected who will be installed during the ECCO Congress of 2008: Silvio Danese (Italy) and Matthieu Allez (France).

❋ *The chair of the Scientific Committee:* The chair of the Scientific Committee is appointed by the ECCO Board for a period of two years, and is selected from the Scientific Committee after serving in this committee for at least one year. The ECCO Board needs to approve the candidacy during the Board meeting preceding the Annual ECCO Congress.

❋ *SciCom Election process*: SciCom ranks applicants for election. The ranking acts as a recommendation to the ECCO Board, who make the final decision. Criteria considered:

- ✳ Scientific achievement (publications, scientific initiatives)
- ✳ Declaration of intent (statement of contribution the individual is able to make to SciCom)
- ✳ Age (one member elected from YECCO, thus ECCO member <35 year)
- ✳ Experience (programme development, project development)
- ✳ Location (unusual, but not impossible, to have more than one member from a single country; SciCom members are excluded from voting for applicants from their own country. Scores are averaged)

❋ *Accountability:* During each ECCO Board meeting, the chair of the SciCom will update the Board on its activities. A summary of the activities will be published in the ECCO newsletter. All contracts prepared by the SciCom will have to be approved by the Board and signed by the president of ECCO and the chair of the SciCom. The annual SciCom report will be presented during the summer ECCO Board meetings.

❋ *SciCom meetings:* Meetings are planned and prepared by the general ➥

ECCO secretariat. Four times per year, the members meet in Vienna. In addition, telephone conferences are held on a monthly basis.

❋ *Assistance:* Financial affairs within SciCom are managed by the treasurer of ECCO. Legal affairs are carried out by the legal aid to the ECCO. The SciCom is assisted in their corporate affairs by the industry liaison officer to the ECCO. Secretarial aid is provided by the general ECCO secretariat.

ECCO Working Group on Epidemiology (EWGE)

The EC-IBD (European Community – IBD study group) was founded in 1989. The main aim of the group was to investigate various aspects of IBD inception cohorts. Twenty centres from twelve countries have been participating in common projects across Europe. In September 29th 2006, Prof. Dr. Reinhold Stockbrügger from University of Maastricht, The Netherlands, handed over the leadership to Pia Munkholm, MD, DMSci from Herlev University Hospital in Copenhagen, Denmark. Very soon thereafter, during restructuring of the SciCom, the ECCO Board agreed to merge ECCO and EC-IBD and Pia was added as a 6th member to the SciCom. As result of that the EC-IBD study group became formally a part of ECCO.

Just six months later the first meeting of EWGE has been organized by Pia and the secretary of epidemiology group Margarita Elkjaer, MD. The meeting was held in Copenhagen April 16th 2007. The subject of the meeting concerned two important questions:

1. The old EC-IBD cohort 1991–93 follow-up till 2003. What have been done already and what can we do more?

2. The new cohort East-West gradient in IBD. Incidents, prevalence, environmental factors, defensins and genetic.

The idea to carry out a new European project has been supported by twenty countries including Russia, Czech Republic, Croatia, Hungary, Lithuania, Moldavia and Belarus.

The Dublin research group, supervised by Colm O'Moran, is in the progress of finalising a protocol concerning the new study. This new initiative could potentially team up very well with an IOIBD inception cohort initiative led by Jürgen Schölmerich.

The EWGE will conduct two annual meetings. One will be held in spring in Copenhagen and another will be in connection with UEGW in autumn (Sunday before opening of UEGW).

ECCO Fellowships and funding opportunities

The **ECCO Fellowships** were established to encourage young physicians in their career and to promote innovative scientific research in IBD in Europe and are now in their second year. The ECCO Fellowship supports junior research fellows with a special interest in the field of IBD in their career to work in foreign dedicated IBD labs or departments on innovative scientific IBD projects. The duration of the award is one year. ECCO announced an increase in the number to two each year. Fellowships are created for younger individuals (age <40 years), who submit an original research project which they wish to undertake abroad in a European hosting laboratory and/or department that has accepted to host and guide the Fellow for the duration of the fellowship (one year). The host department is responsible together with the Fellow for the successful completion of the project. Fellowships are awarded a total amount of 30,000 Euros. The submission deadline for the ECCO Fellowship is announced six months in advance, through the newsletter, the ECCO Congress flyer and the ECCO website (annual deadline will be Dec 1st of each year, all applications to be sent to the ECCO Secretariat). Fellows will be expected to present the results of their work during the annual ECCO Congress and acknowledge ECCO as their funding source on every publication resulting from the project.

All projects are selected by the SciCom according to the following criteria: 1) The importance and feasibility of the scientific project and its relevance to IBD 2) The curriculum vitae of the applicant 3) The track record of the hosting laboratory or department. The SciCom will make recommendations to the ECCO Board, who makes the final decision.

A very original initiative by YECCO was implemented during the Board meeting in July: the **ECCO Travel Grant**. This will facilitate young researchers to visit a clinic or laboratory within Europe. Application for this grant is done via the ECCO website, and should be in before December 1, 2007. A total amount of 1500 Euro will be awarded per Travel Grant.

2005–2006 ECCO Fellow:
Fabian Schnitzler (München, Germany)
Hosting department:
Dept Gastroenterology, Leuven, Belgium (Prof Dr S. Vermeire)
Project: Apoptotic and immunological genetic polymorphisms as markers to predict short term outcome to infliximab therapy in Crohn's disease.
Term: December 2005–December 2006, presentation Innsbruck 2007
Delivered: Project and results were presented during the ECCO Congress 2007 in Innsbruck.

2006–2007 ECCO Fellow:
Kostas Karmiris (Greece)
Hosting department: University Hospital of Leuven, Belgium
Project: Pharmacokinetic study on clinical outcome and immunogenicity of anti-TNFα agents (infliximab, adalimumab and certolizumab pegol) effective in inflammatory bowel diseases.
Term: December 2006–December 2007, presentation Lyon 2008
Delivered: Project and results will be presented during the ECCO Congress in Lyon 2008.

Besides the Fellowships, ECCO now also announces **ECCO Grants**, to support good and innovative scientific, translational or clinical research in Europe. The guidelines of ECCO grants are very similar to those of the Fellowships, with the exception that the research is typically undertaken in the own institution of the applicant. ECCO grants are awarded 15.000 Euros each and will also be given during ECCO's annual congress. The deadline for submission of the Fellowships and the grants is December 1st, 2007.

In addition to ECCO Fellowships and ECCO Grants, the Board agreed to periodically consider the so-called **ECCO Privium Grants**. These are large grants (not exceeding € 100,000) for European multicenter studies with an exceptional relevance for IBD. The review process will be stringent, and the number or Privium Grants will also be dependent on the financial status of the ECCO Society.

YECCO

This rapidly growing group of IBD junior experts will be extremely important for

our society. The idea of Young ECCO was born during the fourth ECCO IBD Course in Amsterdam (February 2006) where young fellows, residents and investigators from several European countries and Israel met each other. The initial dreams and imaginations on continued collaboration became more concrete during our first official meeting in Berlin during UEGW 2006. Young ECCO aims to become a platform for friendship and collaboration between young clinicians and young investigators interested in IBD.

YECCO has been discussed in previous issues of the ECCO Newsletter. SciCom has sought to find the most optimal way on merging YECCO and ECCO further, without the risk of creating two separate societies. In short, any ECCO member <35 years of age can also belong to YECCO without specific actions. The daily activities of YECCO are supervised by the YECCO Chair and Vice-Chair (currently Gionata Fiorino and Marc Ferrante). They are elected by YECCO members for a term of two years. In addition, one member of YECCO will be elected to ECCO SciCom (Silvio Danese) and one to EduCom (to be determined). YECCO can propose to ECCO SciCom and EduCom specific activities of particular interest for YECCO members. These activities will be organized under the umbrella of these committees. YECCO members will meet biannually during the ECCO and UEGW Congress. Also, YECCO members will be actively involved in ECCO scientific projects, co-chair during sessions at ECCO congresses and will be given opportunities to present at ECCO Congress and UEGW.

Ensuring a high level of scientific exposure via responsibility in preparing the scientific programs for the Annual ECCO Congress

In general, the *Organizing Committee* of the annual ECCO congress is responsible for the scientific contents of the congress. The Organizing Committee will always consist of 7 members who will be selected from the SciCom (2 members), the EduCom (2 members) and local members from the hosting country (of whom one acts as CHAIR of the Organizing Committee), and finally the president of ECCO. The role of SciCom focuses on both the scientific content of the program and the review of abstracts.

Facilitating and assisting in scientific projects and programs initiated by individual research groups/consortia or the biomedical industry.

ECCO Consultancies

The unique, multinational structure of ECCO, founded on rotational membership and responsibilities, has created a powerful and diverse professional organization that represents collective opinion rather than that of influential individuals. Consultancy services are available to ECCO member countries free of charge, as well as regulatory agencies, pharmaceutical companies and biotechnology firms through appropriate contractual agreement.
Through its established professional collective expertise, SciCom offers:

- Consultancy in the planning phase of clinical trials
- Independent evaluation of protocols and research strategies
- Assistance in the conduct of clinical trials
- Assistance in establishing dedicated IBD departments or laboratories
- Independent evaluation of drug development programmes
- Programme planning for scientific workshops and meetings.

Consultancy in the *planning phase* may include:

- Advice in clinical trial design
- Advice in related basic research issues
- Advice in areas of unmet needs in which specific development is required.

This interaction with ECCO is not meant to jeopardize any relationship between consultants that a company hires according to specific needs, but to augment it with a collective, independent view to contrast with that of influential individuals.

SciCom is able to facilitate the *conduct of clinical trials* as a consequence of ECCO's wide geographical distribution. The interaction is meant to enhance and not to replace the role of a CRO. It can include:

- **Selection of clinical trial sites,** recommended by national ECCO representatives based on pre-defined criteria that will be standardized by the ECCO scientific committee.
- **Aid in recruitment of patients** during the trial. Predefined ECCO members will hold regular personal communication with site investigators to identify problems that occur during the trial that may be inhibiting patent recruitment.

There is recognisable value of independent appraisal or endorsement of scientific endeavours by ECCO that goes beyond conventional Advisory Boards. It is likely that ECCO endorsement of the design and conduct of clinical trials will be viewed constructively by the regulatory authorities, with whom ECCO is also in contact. Remuneration for these services is for the benefit of ECCO and not for individual members of SciCom. Any individual conflict of interest (such as might happen through independent consulting arrangements) will be avoided by precluding that individual from the process, or other appropriate measures according to the project.
The **process** by which this interaction occurs is:

I. initial contact through a member of SciCom to the Chair.
II. informal discussion of needs, goals and costing of services between the proposer and the Chair.
III. formal proposal with specific goals and timeline for the involvement of SciCom.
IV. contractual agreement through ECCO Secretariat legal services and proposer.
V. nomination of an individual member of SciCom by the Chair to collate contributions and monitor the timeline to ensure delivery.
VI. Outcomes will represent the collective views of SciCom on behalf of ECCO and be signed off by the Chair.

Current consultancies:

1. PDL BioPharma:
Visilizumab Phase III Program

PDL has requested that ECCO supervise their Phase III RESTORE Programme of visilizumab (anti-CD3 antibody, Nuvion®) in Europe. National coordinators of this program have been appointed by PDL, the SciCom discusses outstanding issues and problems on a regular basis and seeks to resolve them in collaboration with the PDL study team (supervisor Dr. Tom McIntyre, Paris). For the duration of this program (in total 4 clinical studies), PDL will

pay ECCO an annual fee. The deliverables of both parties have been outlined in the contract, which was signed early 2006. To date, the programme is running extremely well, and meets all its targets.

2. Ocera
The development programme for AST-120 (carbon microspheres for the treatment of Crohn's fistulas, among other indications) was evaluated by SciCom, before submission by Ocera to EMEA for programme approval. The report was submitted to Ocera within 6 weeks.

3. Given Imaging Ltd (Israel)
Given Imaging Ltd contacted ECCO in 2006 to develop a European landmark study to evaluate their Given® Diagnostic System and PillCam™ in Crohn's disease patients. The primary objective was to show superiority of VCE over the current diagnostic workup of suspected small bowel activity. Contact with SciCom remains open pending a specific protocol, but contracts have not been signed.

4. EMEA
The aim of the initiative with EMEA is a vision that ECCO can offer independent scientific advice on the development of novel IBD-related drugs, as opposed to that presented by individual rapporteurs. ECCO represents the leading IBD specialists in Europe. ECCO avoids the potential conflicts of interests of individuals, which benefits the regulatory process. In turn, involvement in the approval process enables ECCO to aid the Agency in determining study design or endpoints that matter to patients and evaluate objective benefits of therapy.

Preliminary contact was established in February 2006, and followed up during a meeting between SciCom representatives and the Agency in November 2006. A formal response to the Agency's guidance on clinical studies of new therapies for UC has been sent (May 2007). ECCO currently has no official position with EMEA, but is recognized as an interested and expert party, so will continue to develop links with EMEA. A seminar is planned at the ECCO Congress in Lyon in 2008. An additional approach with EMEA, planning to establish a durable presence in an IBD working party is planned following the final submission of the comments.

Facilitating
ECCO Investigator-Initiated Studies
The role of SciCom is to ensure the scientific quality of ECCO-approved or-funded studies rather than to act as Trial Sponsor. SciCom will facilitate the conduct of studies from inception to completion. At the very least, independent appraisal of a project can be expected to improve the scientific content and outcome of the study. Endorsement of a protocol by ECCO can be expected to increase the chance of successful grant application for funding and ethics' approval, which both require independent appraisal.

The **process** by which SciCom appraises and potentially endorses Investigator Initiated studies is:

I. informal discussion of aims, methods and endpoints between the investigator and the Chair.
II. protocol appraisal by all members of SciCom; an individual member of SciCom will be nominated by the Chair to collate views and draft the response, including recommendations of ways that ECCO can facilitate recruitment.
III. response by the investigator to the comments from SciCom with appropriate protocol amendments.
IV. recommendation by SciCom to ECCO Board for endorsement of the protocol if appropriate, including the timeline for report on the progress of the study and funding support if any.

Partnering in EU Framework Programs
The FP7 IBD call heralds a start of a new ECCO era for collaborative research among ECCO member states. In light of potential competition, it is essential that ECCO creates a stronger link between individual IBD investigators and research institutes in Europe. This will not only allow synergism driving new ideas into excellent research programmes, but also will greatly accelerate harmonization of procedures relevant to translational and innovative health care. Although each individual researcher will be acknowledged for his/her unique contribution, the traditional walls between different member states and institutions can be dismantled. FP7 will provide ECCO access to an extraordinary level of funding and continuity. It serves to provide an ECCO research platform for its member states.

Current projects

1. *Title*: **Pregnancy project**
Principal investigator: **Aurora Bartoli** (Italy)
Summary: In December 2006 Aurora Bortoli provided time lines on the ECCO pregnancy study. All IBD-pregnant patients have been enrolled. The last patient will undergo her last visit by March 2008. The final statistical analysis is projected for June 2008.

2. *Title*: **ASTIC** (Autologous Stem Cell Transplantation International Crohn's Disease Trial)
Principal investigator: **Chris Hawkey** (United Kingdom)
Summary: The aim is to evaluate the potential clinical benefit of hematopoietic stem cell mobilisation followed by high dose immuno-ablation and autologous stem cell transplantation versus hematopoietic stem cell mobilisation only followed by best clinical practice in patients with Crohn's disease. The protocol has been finalized, and is in the process of being submitted by ECCO members to the IRBs in different ECCO countries.

3. *Title:* **METEOR**
Principal investigator: **Franck Carbonnel**, Besançon (GETAID)
Summary: A 36 months phase II multicenter RCT, aiming to show superiority of methotrexate over placebo in inducing steroid-free remission within 16 weeks in 110 steroid-dependent ulcerative colitis patients. Through contacts of Pierre Michetti, this study will be financial supported by ECCO.

The Scicom acted immediately to the IBD "protease" call, which was posted on December 22, 2006. We identified EU research groups with special interest in proteases, and organized a February meeting with all interested investigators, supported by ECCO at Schiphol Airport (Amsterdam). One group was merged with an existing consortium. Subsequently, a SciCom review committee critically appraised two FP7 applications. In addition, a dissemination plan was developed by SciCom with help of Yellow Research (Dutch company with Framework expertise). To date, no official reply has been received from the EU. The Scicom is actively preparing a future Framework strategy to launch new EU initiatives. ➥

To be a think-tank for optimizing scientific progress through new concepts in organization, translation of basic science, and personalized approaches for IBD patients

1. IBD Information System – IBDIS

In 1999, Walter Reinisch from the General Hospital in Vienna and Nikolaus Pedarnig, founder and owner of UNIDATA GEODESIGN, started to outline the concept of a standardized documentation of IBD patients. A close co operation between science and technology was established to realize a project, which aims to result in the development of a validated and reliable catalogue of parameters relevant for scientific approaches and daily practise in inflammatory bowel diseases. The creation of a European IBD documentation standard in mind, the parameter catalogue was subjected to an inter-observer assessment study and succeedingly implemented by UNIDATA GEODESIGN into a web-based software. By using the worldwide web as the communication forum, code-controlled access is granted and broad availability to the community enabled.

During the ECCO-Congress 2007 in Innsbruck the governing board of ECCO and UNIDATA GEODESIGN signed a contract about a close cooperation in future projects. IBDIS® is now a ready to use service free of charge for all ECCO members. Third parties will pay a full commercial Project Fee to UNIDATA GEODESIGN and ECCO.

The potential applicability of IBDIS is manifold, reaching from an electronic patient record form for clinical routine to a scientific tool for standardized patient documentation and phenotyping within the scope of clinical studies or registries. A collaboration between UNIDATA/IBDIS and UCB Pharma has been outlined about the development and implementation of an electronic IBD-register. This register is based on the IBDIS parameter catalogue and monitors the use of Certolizumab/CIMCIA on IBD patients in Europe, USA and Canada.

The implementation of an IBDIS based inception cohort raised to evaluate the national course of IBD and to establish a control group for sponsored registries on new biologics in Europe should be explored in collaboration with the epidemiologic group within ECCO under leadership of Pia Munkholm. A decision on the performance of an inter-observer agreement study on IBDIS for which patient charts have been already is pending, but may best be performed with the help provided by YECCO.

2. Biobanking

Background: Biobanking optimizes research in large, well defined cohorts of patients, using high throughput analysis of biomaterial which is processed using standardized operational procedures.

Aim: To develop a standard for multicenter disease specific biobanking to allow future implementation across Europe.

Planning: A program for a national IBD Biobank is under development in the Netherlands. Using an IBM platform for data integration, an IBD-module has been implemented in the Academic Medical Center (Amsterdam). The IBD-module consists of a dedicated electronic patient file which is connected to all other databases in the hospital (lab, pathology, etc). Biomaterial (DNA, serum, biopsies, resection material), collected under an approved written informed consent, is stored in dedicated LIMS freezers. Molecular data extracted from biomaterial is integrated with the abovementioned clinical data. Using a query builder tool (IBM), data can be extracted for research purposes. Governmental support will allow replication of this model in all seven other University Medical Centers across the Netherlands in 2006–2007. The expected number of patients during the initiating years is 15,000, and estimated to exceed 20,000 in 4 years. Upfront investments approximate € 7 million, operational costs will amount to € 2 million/year. The business case for this national IBD Biobank foresees a breakeven point in year 4.

Relevance to ECCO: The generic solutions can be made available to the ECCO, for development and implementation in ECCO affiliated countries. Funds will be raised through national health care programs and the EU Framework Program.

Conclusion

Since we started as SciCom, the six of us became a strong team and really good friends. We have continuously sought to strengthen each other to make our efforts work. It is through the vision of Renzo Caprilli and the strong support of the ECCO Board members that we are where we are today. It is now time to refresh the team with new friends, goals and ambitions. The acceptance to join SciCom of two exceptional talents in the IBD field, Matthieu Allez and Silvio Danese means that the SciCom will further grow and deliver the coming years. Simon Travis, our new chair, has already (unofficially) taken over most of the running SciCom affairs in a splendid manner, in order to guarantee a swift transition. With the extraordinary skills of Severine Vermeire, Pia Munkholm and Yehuda Chowers, we have definitely secured our bright future.

On behalf of the SciCom
DAAN HOMMES

Next issue of ECCO News

Reports from:

Inflammatory Bowel Disease 2008
Lyon, France

ECCO MEMBERSHIP APPLICATION FORM

[please fill in legibly]

❑ **2008** [1.1.2008 – 31.12.2008] Member no./member id: _____ [provided by ECCO]

TYPE OF MEMBERSHIP [**§**: Bylaws & Rules of the European Crohn's and Colitis Organisation, **www.ecco-ibd.eu**]
Please check a category

❑ Regular member*	€uro 100.00 (as of 2009)	[Doctors, scientists interested in IBD, completed university degree]
❑ IBD Nurse	€uro 25.00 (as of 2009)	[registered nurse interested or working in the field of IBD]

[* includes subscription to the Journal of Crohn's and Colitis (JCC) for one year]

PERSONAL DATA

❑ Prof. ❑ Dr. ❑ Mrs. ❑ Ms. ❑ Mr. ❑ Other title: _____ Gender: ❑ female ❑ male

Profession: ❑ Physician ❑ Scientist ❑ IBD Nurse ❑ Other: _____

First name : _____ Middle name: _____

Family name: _____

Date & Year of birth: _____

Institute: _____

Department: _____

Street: _____

Zip Code: _____ City: _____

Country: _____ Phone: _____

Fax: _____ Email: _____

ADDITIONAL INFORMATION – YECCO

Members under 35 years of age will become YECCO (Young ECCO) members automatically. If you do not wish to become a YECCO member, you have the option to indicate so below:

❑ I am under 35 and **do not** wish to become a YECCO member

Please return the completed form to the ECCO Secretariat by mail or by fax: +43 (0) 1-212 74 17 – 49

Fee 2008 = 0,00	**EURO 0,00**
TOTAL TO BE PAID 2008	**EURO 0,00**

European Crohn's and Colitis Organisation
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ECCO GOVERNING BOARD 2007

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Inflammatory Bowel Diseases 2008

Congress of the European Crohn's and Colitis Organization (ECCO)

Congress Lyon, France, February 28–March 1

Scientific Programme

Thursday, February 28, 2008

13:00–13:10
Welcome
Miquel Gassull, President
Jean-Frédéric Colombel, President-elect

13:10–17:00 Scientific Session 1

PATHOGENESIS OF IBD: WHAT'S NEW AND WHAT'S THE RELEVANCE TO CLINICAL PRACTICE?

Chairs: Stefan Schreiber, Kiel, Germany
Christian Mottet, Lausanne, Switzerland

13:10–13:55 Tandem Talk 1
New Discoveries in IBD Genetics and Insights into Therapeutic Development
Miles Parkes, Cambridge, United Kingdom
Séverine Vermeire, Leuven, Belgium

13:55–14:40 Tandem-Talk 2
Of Mice and Men: Relevance of Animal Studies to Human Research
Fabio Cominelli, Charlottesville, Virginia, USA
Silvio Danese, Milan, Italy

14:40–14:55 Oral presentation
Best Abstract 1

14:55–15:10 Oral presentation
Best Abstract 2

15:10–15:30
Defensins: What's their Role in Crohn's Disease?
Eduard Stange, Stuttgart, Gemany

15:30–16:00 **Coffee Break**

16:00–17:00 Scientific Session 1 continued
Chairs: Daan Hommes, Leiden, The Netherlands
Shomron Ben-Horin, Ramat-Gan, Israel

16:00–16:30
T-Cell Co-stimulation and Therapeutic Implications
Marcus Neurath, Mainz, Germany

16:30–16:45 Oral presentation
Best Abstract 3

16:45–17:00 Oral presentation
Best Abstract 4

20:00 **ECCO Welcome Reception**

Friday, February 29, 2008

08:30–12:00 Scientific Session 2

LIVE ENDOSCOPY

08:30–10:00
Live Demonstrations via Satellite from Lille to Lyon (1)

Experts in Lille:
International Experts:
Brian Saunders, London, United Kingdom
Markus Neurath, Mainz, Germany
Gert van Assche, Leuven, Belgium

GETAID Experts:
Jean-Marie Reimund, Caen, France
Bernard Duclos, Strasbourg, France
Yoram Bouhnik, Clichy, France
Philippe Marteau, Paris, France

Endoscopic team from Lille:
Philippe Bullois
Jeanne Boitard
Vincent Maunoury

Chairs in Lyon:
Jean-Frédéric Colombel, Lille, France
Guido Tytgat, Amsterdam, The Netherlands
Geert D'Haens, Bonheiden, Belgium

10:00–10:30 **Coffee Break**

10:30–12:00
Live Demonstrations via Satellite from Lille to Lyon (2)

12:00–12:30
Current Concepts on Cancer in Ulcerative Colitis
Guido Tytgat, Amsterdam, The Netherlands

12:30–14:00 **Lunch** and
Poster Session in the Exhibition Area

14:00–17:00 Scientific Session 3 – Panel Discussion:

PATHOLOGY, RADIOLOGY, AND SURGERY IN ADULT AND PAEDIATRIC IBD: WHAT THE GASTROENTEROLOGIST NEEDS TO KNOW

Moderator: Marc Lémann, Paris, France
Panel Members: Robert Löfberg, Stockholm, Sweden
Gert de Hertogh, Leuven, Belgium
Andre D'Hoore, Leuven, Belgium
Andreas Schreyer, Regensburg, Germany
Robert Heuschkel, London, United Kingdom

Case Presentations:
14:00–14:30 **Case 1: Longstanding UC with Dysplasia**
Stephan Vavricka, Basel, Switzerland

14:30–15:00 **Case 2: Refractory Pouchitis**
Marc Ferrante, Leuven, Belgium

Inflammatory Bowel Diseases 2008

Congress of the European Crohn's and Colitis Organization (ECCO)

Congress Lyon, France, February 28–March 1

Scientific Programme

15:00–15:30 **Case 3: Extensive Small Bowel Crohn's Disease in an Adolescent**
Laurent Peyrin-Biroulet, Nancy, France

15:30–16:00 **Coffee Break**

16:00–16:30 **ECCO Fellowships & Grants**
Moderators: Miquel Gassull, Badalona, Spain
Simon Travis, Oxford, United Kingdom

16:00–16:15 **ECCO Fellowship 2007**
Konstantinos Karmiris, Heraklion, Greece

16:15–16:30
Announcement of ECCO Fellowships & Grants 2008

16:30–16:50 **Historical Perspectives of the Management of Severe Colitis**
Renzo Caprilli, Rome, Italy
Chairs: Miquel Gassull, Badalona, Spain
Simon Travis, Oxford, United Kingdom

20:00 **ECCO IBD Party**

Saturday, March 1, 2008

08:30–11:00 Scientific Session 4

RISKS ASSOCIATED WITH IBD

Chairs: Boris Vucelic, Zagreb, Croatia
Martin Bortlik, Prague, Czech Republic

08:30–09:00
Malignancy and Lymphoma in IBD
Larry Egan, Cork, United Kingdom

09:00–09:15 Oral Presentation
Best Abstract 5

09:15–09:30 Oral Presentation
Best Abstract 6

09:30–10:00
Opportunistic Infections in IBD: Diagnosis and Prevention
Jean-Frédéric Colombel, Lille, France

10:00–10:15 Oral Presentation
Best Abstract 7

10:15–10:30 Oral Presentation
Best Abstract 8

10:00–11:00 **Coffee Break**

11:00–13:00 Scientific Session 5

MANAGEMENT OF IBD

Chairs: Pierre Michetti, Lausanne, Switzerland
Walter Reinisch, Vienna, Austria

11:00–11:10 Case Presentation
Complex Fistulizing Crohn's Disease
Marijana Protic, Belgrade, Serbia

11:10–11:30
The Evaluation of Fistulizing Perianal Crohn's Disease
Andre D'Hoore. Leuven, Belgium

11:30–11:50
The Combined Management of Fistulizing Perianal Crohn's Disease
Remo Panaccione, Calgary, Ontario, Canada

11:50–12:05 Oral Presentation
Best Abstract 9

12:05–12:20 Oral Presentation
Best Abstract 10

12:20–12:50 ECCO Lecture:
Flexible Therapy in IBD: Is It Possible?
Paul Rutgeerts, Leuven, Belgium

12:50–13:00
Concluding Remarks
Jean-Frédéric Colombel, Lille, France

Congress information

Congress Venue
Lyon Convention Centre
50, quai Charles de Gaulle
69463 Lyon Cedex, France
www.ccc-lyon.com

Congress Office and Registration Desk
The congress office as well as the registration desk at the Lyon Convention Centre will be open:
Wednesday, February 27, 2008 07:30–18:00
Thursday, February 28, 2008 07:30–19:00
Friday, February 29, 2008 07:30–19:00
Saturday, March 01, 2008 07:30–13:00

Congress language
The official language of the congress is English.
No simultaneous interpretation will be provided.

Abstract submission, Registration, Accommodation
All registration procedures for the ECCO'08 congress will be conducted online.
In case you have no access to the internet please contact the ECCO Secretariat indicated below. They will gladly forward the necessary registration forms to you.

Certificate of Attendance
Upon arrival all registered delegates will receive a certificate of attendance together with their delegates' bag (registration kit).

ECCO Secretariat
Hollandstrasse 14/Mezzanine
1020 Vienna, Austria
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ESCP Meeting in Malta

During the end of September the European Society of Coloproctology – ESCP – held its Second Scientific and Annual Meeting in Malta. Surgeons from all over Europe came to this tiny island south of Sicily to attend.

The ESCP congress has witnessed a progressive increase in participants, which in Malta were more than 700.

ESCP was founded only a short time ago, in Bologna 2005 due to the merge of ECCP and EACP. The first meeting of the new Organisation was held in Lisbon 2006.

Four pillars

Professor Lars Påhlman, Sweden, has been President of ESCP for the first year. In his welcoming address, he was very pleased with the high attendance. He also pointed out the fact that more than 400 abstracts had been sent to the Congress.

ESCP rests on four pillars, says Professor Påhlman.

– The first three are: Cancer (colorectal), Proctology, Function (incontinence and constipation). The fourth pillar is IBD, he explains.

Professor Påhlman's opinion is that it is very important for surgeons and medical Gastroenterologists to cooperate for the benefit of the patients.

– All cancer should be treated multidisciplinary, and the same goes for IBD. In IBD we must have a dialogue, and I think we have that today in most hospitals.

Video sessions

After the official opening, a session on Surgical Technique followed. Video presentations, delivered by invited presenters with interactive chairmanship and discussions from the floor, were used.

This was a new feature, and it replaced the live surgery demonstrations of last years meeting in Lisbon. The reason for this was that it allowed more operations to be included, and enabled a greater scope of procedure type.

Many of these demonstrations concerned anal fistulas.

Sign of Crohn's fistula

A new diagnostic tool for perianal Crohn's disease was reported by Antoni Zawadki, Sweden.

Anal fistula is the first clinical manifestation of Crohn's disease in 20–40% of cases, and may proceed the diagnosis by years, Dr Zawadki said.

– We have noticed that Crohn's fistulas manifest specific ultrasound characteristics on 3D ANU (Anorectal Endoscopic Ultrasonography), he continued.

The aim of their study was to determine the prevalence of these features in a consecutive series of patients with anal fistula, to analyse the interobserver agreement on this finding and to relate the findings to the presence of Crohn's disease.

The Crohn's fistula is different from cryptoglandular fistula and transsphinctric abscess in the way that Crohn's fistula's has cavities filled with inflammatory tissue.

57 female and 100 male patients with anal fistula, mean age 48 years and range 15–87, were examined. The 3-D volumes were retrospectively analysed by two independent examiners who were blinded for the diagnosis of the patient.

14 new cases of Crohn's were discovered – in spite of the fact that these patients had already been examined.

– The "sign of Crohn's fistula" is easy to recognise with substantial interobserver agreement, and high specificity and sensitivity. One may consider sending patients with anal fistula and 3D ANU showing the "sign of Crohn's fistula" for further examination to exclude Crohn's disease, Dr Zawadki concluded.

Infliximab and surgery

Current guidelines for the treatment of complex Crohn's anal fistulas emphasise the importance of a long-term draining seton.

Julio Leite, Portugal, presented a study in which all consecutive patients with complex Crohn's anal fistula from 2002 to 2006 at Coimbra Hospital, with or without active proctitis, were treated with Infliximab.

After the second or third infusion definitive surgery was undertaken and maintenance immunosuppressive treatment was given. The patients with active proctitis failed, and were subsequently treated by proctectomy and defunctioning.

– Infliximab + aggressive surgery + maintenance immunosuppressive treatment is safe and short-term effective for complex Crohn's anal fistulas without active proctitis, was Dr Leite's conclusion.

Stem cells

Another interesting way of treating complex anal fistulas was presented at the meeting by Damian Garcia, Spain. It concerned using stem cells. ➥

Justin Davies | Ulf Lundstam | Mattias Block | Damian Garcia | Julie Cornish | Richard Lovegrove | Lars Påhlman

Dr Garcia spoke about a phase II clinical trial for Cx401 – expanded adipose-derived stem cells – for the treatment of complex perianal fistula.

– Cx401 is activated in an inflamed environment, and then suppresses the proliferation of lymphocytes and suppress the inflammation, Dr Garcia explained.

In local treatment of inflammatory diseases with tissue damage/wounds, Cx401 acts at the source of the inflammation and establishes an environment that will permit healing.

In systemic treatment of diseases with acute inflammatory component, Cx401 migrates to the inflammatory environment and suppresses inflammation, avoiding tissue damage.

– It is an effective treatment for complex fistula for both Crohn and non-Crohn patients. The probability of healing was more than four times greater in patients given Cx401. There was a statistically significant difference in terms of physical functioning, so Cx401 treatment seems to improve the Quality of Life (QoL) of the patient, Dr Garcia said.

Improved sexual function

Pouch surgery was another topic that was discussed in many sessions.

Justin Davies, Canada, presented some interesting data from a study concerning the QoL following Ileal Pouch-Anal Anastomosis (IPAA).

IPAA is the procedure of choice for patients with ulcerative colitis and familial adenomatous polyposis. Often a young and active patient population is operated upon, and – following pelvic surgery – a risk of sexual dysfunction exists, Dr Davies pointed out.

– Therefore, the aim of our study at Mount Sinai Hospital in Toronto, was to prospectively evaluate sexual function and QoL in patients undergoing IPAA, using validated instruments, he continued.

All patients undergoing IPAA between February 2005 and June 2006 were asked to participate. They completed questionnaires in pre-operative assessment clinic, and were then mailed at 6 and 12 months post-operative. 59 patients of 110 having IPAA surgery agreed to participate.

The result was that QoL-score improved for both male and female patients after surgery. In females, both sexual function and QoL were improved after 12 months.

These findings were confirmed by Julie Cornish, UK. She presented a study of QoL, sexual and urinary function in females after restorative proctocolectomy (RPC).

In her summary she pointed out that females undergoing RPC are likely to have improved sexual function. This she defined as increased sexual activity, orgasm and arousal compared with patients with medically treated IBD.

Patients accept reoperation risk

Is the Continent Ileostomy an option today?

The question was asked by Ulf Lundstam, Sweden.

– There are a few indications, he said.

– Patients, who after proctocolectomy, don't have sufficient sphincter capacity for IPAA or ileorectal anastomosis (IRA), can benefit from the procedure.

He presented a study that was carried out by data retrieved retrospectively, and reported activity related continent ileostomies 1998–2005.

There is a high frequency of reoperations. But Dr Lundstam pointed out that in order to avoid a terminal ileostomy, patients seems to accept the high reoperation risk.

– You have to discuss this risk with the patient, he emphasised.

His conclusion was that the Continent Ileostomy is an important reconstruction in a limited number of patients.

– Since the procedures are rare, the patients should be referred to centres with special interest and experience, he added.

K-pouch or J-pouch?

IPAA is the principal reconstructive alternative after proctocolectomy for ulcerative colitis. The functional outcome after IPAA depends on reservoir-volume and age of the patient.

– I do suggest that pouch design also affects long term functional outcome after IPAA, said Mattias Block, Sweden.

He presented a study that had compared patients with a K-pouch and a J-pouch. The K-pouch is named after Professor Kock, in principal it's a double folded J and it has the shape of a sphere compared with the cylindrical J-pouch.

The functional outcome was evaluated by the Öresland score. A comparison between handsewn pouch and stapled anastomosis were also made in the study. In total, 389 patients operated on between 1982 and 2004 participated. Of these, 120 had a J-pouch and 269 had a K-pouch. All pouches were made of 2 x 15 cm.

– We could see that the pouch design *is* of importance for functional outcome, Dr Block stated.

– The K-pouch is associated with a better long-term functional outcome than the J-pouch. There was no difference between stapled and manual anastomosis. It might be that using the same bowel length, the K-pouch achieves a larger volume.

Long study awarded

At the end of the Congress, ESCP had chosen the six best papers that were presented by the authors at a separate session. After this, the Colorectal Disease Prize was awarded to the winner.

Richard E Lovegrove, UK, was the winner of the Prize for the study *Quantification of long-term ileal pouch function following restorative proctocolectomy (RPC): a multifactorial model of 4013 patients.*

The study did not only concern an impressive number of patients, it also covered a long period of time – 4 013 patients undergoing restorative proctocolectomy

ESCP MEETING IN MALTA

A new non-surgical treatment option for patients with fecal incontinence – Solesta – generated a lot of interest in Malta.

at two tertiary centres between 1977 and 2005 were analysed.

The conclusion was that accurate prediction of functional outcomes following RPC is feasible, and may help in preoperative counselling of patients. Functional impairment occurs early on during follow up in patients whose ileal pouch ultimately fails.

Don't forget the Surgeon

At ESCP Annual General Meeting, Andrew Shorthouse was elected as the new President for the organisation. One of his first tasks was to present the Prize to Richard Lovegrove.

For *ECCO News* Lars Påhlman stressed the fact that the Surgeon must not be forgotten when it comes to treatment of IBD patients:

– We see IBD patients today that are medically treated and they can neither work or study. We Surgeons can cure many of these patients. But sometimes a Gastroenterologist regards it as a *failure* if a patient is colectomized.

– And there are a lot of patients who still think that we Surgeons "mutilate" our patients. We don't do that! We don't create any short bowel syndromes any longer – just to take one example.

Professor Påhlman believes in laparoscopy as a way of treatment in the future.

– Especially for patients with Crohn's Disease, because they will require several operations.

PER LUNDBLAD
Senior Writer

IBD CONGRESSES 2008

Congress	Date	Venue	Further information
International- Europe			
ECCO	28 Feb–1 March, 2008	Lyon, France	www.ecco-ibd.org
European Society of Coloproctology (ESCP)	24–27 September 2008	Nantes	www.escp.eu.com
16th UEGW	18–22 October, 2008	Vienna	www.uegw.org
IOIBD	3–6 April,2008	Kyoto, Japan	www.ioibd.org
42nd ESPGHAN	3–6 June, 2009	Budapest, Hungary	www.espghan.org
ASNEMGE 5th Summer School of Gastroenterology	June, 2008	Prague, Czech Rep	www.asnegmge.org
Falk 163	14–15 March, 2008	HangZhou, China	www.falkfoundation.com
Falk 164	2–3 May, 2008	Budapest, Hungary	www.falkfoundation.com
DDW	17–22 May, 2008	San Diego, USA	www.ddw.org
Germany			
38. Kongress der Deutschen Gesellschaft für Endoskopie & Bildgebende Verfahren e.V.	27 Feb–1 March, 2008	Mannheim	www.dge-bv.de
France			
GETAID Seminar	January, 2008		www.getaid.org
Journées Francophones de Pathologie Digestive	8–12 March, 2008	Paris	www.snfge.org
Finland			
XXXIX Nordic Meeting of Gastroenterology	4–7 June, 2008	Helsinki	http://www.terveysportti.fi/kotisivut/sivut.koti?p_sivusto=170
Hungary			
Colon Section of the HGS	18–19 January, 2008	Balatonalmadi	www.agnusmed.hu
50th Annual Meeting of Hungarian Society of Gastroenterology	7–11 June, 2008	Tihany	www.gastroent.hu
Sweden			
Swedish Gastroenterology Congress	7–9 May, 2008	Jönköping	Magnus.simren@medicine.gu.se
Switzerland			
9th Alpine Colorectal Meeting	27–29 January, 2008	Verbier	www.alpinecolorectal.org
United Kingdom			
British Society of Gastroenterology	10–13 March, 2008	Bimingham	www.bsg.org.uk
Association of Coloproctology of GB & Ireland	21–23 May, 2008	Harrogate	www.acpgbi.org.uk

Falk Symposia in Dresden

40 years ago, Herbert Falk arranged the first Falk Symposium in Freiburg in Germany.
Since then quite a few of these meetings have taken place, in different locations in Europe and the rest of the world.
162 to be more precise. In Dresden, Germany Falk Symposia 160–162 were held in October. The three symposia were held in sequence, and they all had a Gastroenterological perspective.

The first of these was called *Mechanisms of Intestinal Inflammation*. In general it covered aspects of disease pathogenesis, including its genetic, and the role of epithelial cells in the prevention or facilitation of inflammation.

When lifestyle meets environment

The first speaker was Stefan Schreiber who spoke about *New genetic defects in IBD and their relation to epithelial barrier function.*

In his talk Dr Schreiber pointed to the fact that IBD is often found in several members of a family, and there is a high concordance between monozygotic twins. This suggests heritable components.

– We vary a lot individually when it comes to the genome. The winners of yesterday, could be the losers of today, he said.

Dr Schreiber exemplified this with the fact that individuals that are genetically disposed to store fat, once benefited when food was rare and hard to get. Today the situation is the opposite: Individuals with this disposition develop problems instead.

Crohn's disease has become an example of successful molecular exploration of a polygenic etiology. The disease was not known before 1920. Since then, incidence has increased and now there is a lifetime prevalence of up to 0.5% in Western industrialised countries.

– If lifestyle meets environment – then we will see the disease, said Dr Schreiber.

Search for genes in Quebec

He returned to the fact that we vary a lot when it comes to the genome.

– There are 13 million variations! Most of these are meaningless. Some are triggered by environmental factors.

– Therefore it's important to look at the context: We must identify factors behind civilisation diseases like Crohn's disease – *which* factors trigger the disease?

It appears that increased expression and production of TNF, and an enhanced state of activation of the NF_KB system are main drivers of the mucosal inflammatory reaction.

The exploration of inflammatory pathophysiology of Crohn's disease using full genome, cDNA and oligonucleotide based arrays, respectively, has generated large sets of genes that are differentially expressed between inflamed mucosa and normal controls.

– One of the biggest studies was carried out in Quebec. The reason for choosing


Stefan Schreiber


Warren Strober


Jürgen Riemann

this Canadian town was that the population there was started by a few hundred people that originally came there. Genetically there are ten variations only. This makes it easier to define genes for disease, Dr Schreiber continued.

Fishing

Dr Schreiber made a comparison with fishing in the ocean.

– You cast a net. You see what fish you can get – sometimes you won't catch any fish at all, sometimes you do. But you'll never catch *all* the fish.

Although that is what researchers of the genome now are trying to do, using mounting technology.

– You expect on a fishing expedition to catch different sorts of fish, and in Quebec we did. But we also caught a big fish – that is the gene IL-23R! The same "fish" also came up in other studies.

The protein encoded by this gene is a sub-unit of the receptor for IL23A/IL23. This protein pairs with the receptor molecule IL12RB1/IL12Rbeta1, and both are required for IL23A signalling.

Dr Schreiber stressed the fact that there are more genes associated with Crohn's disease and that these are being discovered right now in different studies.

– The bottom line is: There are different genes – they evolve differently and do not always look the same. Instead they are *variations* of the main gene. Therefore comparative knowledge of the genomic sequence in *all* patients and controls is of key importance. That is a challenge for the future.

– The most important thing is to make sense of it – so we can translate it into medicine. The creation of a medical systems biology of the disease will lead to new models – and eventually to new therapies.

New way to treat Crohn's disease

Next symposium – number 161 – had the title *Future Perspectives in Gastroenterology*.

In 1996 this was first held in Leipzig, Germany. Leading scientists in the field then presented recent findings, and also speculated about future directions. Many of them were also present here in Dresden eleven years later.

Warren Strober, M.D, USA, spoke about *Major trends in immunologic therapy of Crohn's disease*.

– Only by studying mouse models, can we get a firm grip on human disease, he said.

Dr Strober talked about antibody targeting IL-12p40 treatment of Crohn's disease. The antibody in question blocks two related cytokines, IL-12 and IL-23.

– This is the new way to treat Crohn's disease, he continued.

He also mentioned interleukin-23 and interleukin-17 that also have been suggested as the next therapeutic targets for IBD, and was hesitant about that.

– I don't think that is going to be the case, he said.

There is a delicate balance between effector cells and regulatory cells required for mucosal homeostasis. If this balance is disrupted, we get mucosal inflammation.

There are many new possibilities for treating IBD, and the community of IBD scientists and clinicians are now working on establishing which of the new treatments will prove most beneficial, Dr Strober summarised.

Endoscopy – the future

Jürgen Riemann took a peek in the crystal ball in a Key Note Lecture titled *The future of endoscopy in gastroenterology*.

When introducing him, Dr Classen, Germany, reminded the audience that in 2007 we celebrate the 75th year of the flexible sigmoidoscope. Dr Classen continued:

– Endoscopy has come a long way since then. The small bowel – the final frontier – has now been reached, by capsules and balloons.

In a riveting and interesting lecture Dr Riemann took the audience on a tour of endoscopy related aspects such as technology, prevention, research and others. He demonstrated the latest technology, aided by films, photos and graphics.

The incidence of CRC is increasing, but screening by colonoscopy is stagnating, despite good results. Dr Riemann presented a survey from 2007 that listed the reasons for non-attendance of screening. At the top (73%) was the lack of knowledge – no information.

He gave many examples of what is coming in the future: The Aer-O-Scope is self propelling and self navigating and gives a 360 degrees Omni-view, and that was just one example.

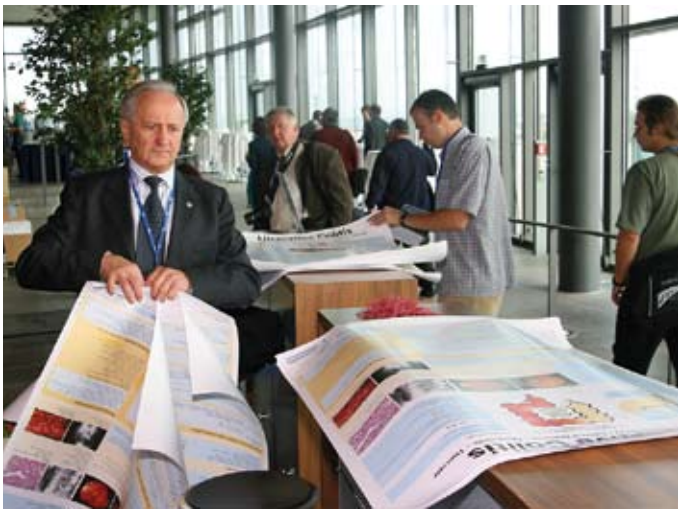
Virtual Colonoscopy via CT was another.

– The first results from this point to the fact that the detection is excellent – even better than colonoscopy, he said.

New tools

When it comes to interventions we will have a variety of new techniques: New stents (for example for oesophagus and bilary tract), endoscopic myotomy and ➥

The meetings are very international – also when held in Germany. R.B. Sartor, M.D. who held the Chair for this meeting, comes from North Carolina, USA.



Falk Foundation organises the infrastructure for the meetings.

improved management of complications due to new suturing techniques.

He demonstrated the ERBE Hybrid knife – that cuts and injects at the same time – and other examples of new tools for Endoscopists.

The interdisciplinarity between Gastroenterologists and Surgeons has a key role in the future, according to Dr Riemann.

– Endomicroscopy has taken us to the point where we now can *see* the helicobacter pylori!

New ways

Together with endocytoscopy and molecular imaging, endomicroscopy forms a new discipline that Dr Riemann called endopathology.

He also described NOTES (Natural Orifice Translumenal Endoscopic Surgery) in which surgery is carried out by endoscope only using the natural openings in the body.

– The benefits are: Fast recovery, no hernia or infection of the abdominal wall and flexible access to intraabdominal areas which are laparoscopically difficult to reach or unreachable. It also leaves no scar, which is an attractive cosmetic result.

So far the NOTES procedures has been carried out transgastrically, transcolonically and – in 2007 for the first time – transvaginally.

– All that I have shown you is only possible if we have qualified Endoscopists, Dr Riemann concluded. Therefore he stressed the need for standardised education, training centres and improved simulators among other things.

> “The idea is to bring together basic science on one side and clinical science on the other side.
>
> Martin Falk

Trusted partnership

Martin Falk is the General Manager and Chairman of the Falk Foundation.

– My father started his company on a small scale in 1960, Dr Falk says to *ECCO News*.

– At the time he realised that many physicians and scientists were interested in a platform to exchange new knowledge. That is the reason why he initiated the first Falk Forum in 1967. That first Forum was about icterus (also known as jaundice).

Dr Falk explains that the idea then was – and still is today –to bring together basic science on one side and clinical science on the other side.

Falk Foundation sponsors the Forums, but at these none of the Company's products are promoted.

– No, we organise the infrastructure. Then we ask physicians and scientists to form a committee, in order to select topics and to invite speakers, says Dr Falk.

– It's like a trusted partnership, but naturally it reminds physicians of our name.

International

Today these Forums attract between 400 and 1200 attendees.

– Normally they come from 40–50 countries, so it's a very international group. This is also reflected in the locations. Obviously a lot of them are in Germany – but the next one is going to be in China, Dr Falk reveals.

– Last year we were in Moscow and Sydney, and earlier this year we have had Forums in Turkey, Spain and Slovenia.

Dr Falk is very impressed by the meeting in Dresden.

– It has been an excellent abstract of the research and the treatment today!

And that is a perfect way to sum up the days *ECCO News* spent in Dresden.

PER LUNDBLAD
Senior Writer

How to chair a scientific session?
A YECCO interview with some experts


Geert D'Haens


Simon Travis

The ECCO Scientific Committee has selected four YECCO members to participate in the ECCO congress in Lyon as co-chairmen during one of the scientific sessions. In the future, other Young ECCO members will be involved. Since many of us do not have any experience with chairing a scientific session, we asked some ECCO experts for their point of view and suggestions concerning this matter.

Silvio Danese, the YECCO representative in the ECCO Scientific Committee, interviewed both Dr. Geert D'Haens and Dr. Simon Travis on this subject. Dr. Geert D'Haens works in the Imelda Hospital in Bonheiden (Belgium) and is strongly affiliated with the University of Leuven. He was one of the founders of ECCO and currently he is the ECCO Secretary. Dr. Simon Travis works at the University of Oxford (United Kingdom). Currently, he is member of the ECCO Scientific Committee and the Chairman Elect of the Committee itself.

Underneath you can find a report of this interview:

When was the first time you chaired for an international meeting?
D'Haens: If I remember correctly it was at AGA, I must have been 35 (in 1997 or 1998).
Travis: A couple of years after becoming a consultant.

Do you generally study the abstracts before chairing a session?
D'Haens: Yes
Travis: Rarely, but I do look at the titles, consider the theme and gauge my impression: this allows brief comments from the Chair at the beginning of the session to put it in context for the audience, and allows linking comments to subsequent talks in the session.

Should a chairman contact the presenters some weeks/months before the meeting and give some guidelines (for example allocated time)?
D'Haens: Not for original abstracts; the time is given by the organizers; for a symposium it is important to touch base in order to avoid overlap.
Travis: No (never, life is too short!). This is the organiser's responsibility – to emphasise the time allocated for the talk and the time for questions. When inviting speakers I increasingly (but politely!) draw attention to the time available, especially if it is shorter than usual, reminding the speaker that a 20min talk means 15 (talk) + 5 (questions) and does not mean a 30min talk squashed into 20mins!

Should a chairman try to meet the presenters in person before the start of the session and reassure the inexperienced ones?
D'Haens: In big meetings you often do not meet them before; in smaller meetings you can have a few words. Personally I have never been reassured.
Travis: Yes, if at all possible – simple courtesy and to introduce him or herself as well.

Should a chairman repeat the guidelines (for example allocated time) at the beginning of the session?
D'Haens: Yes he should say when people can ask questions (after every presentation or at the end of the whole session). And urge people to respect time constraints.
Travis: No, not in public, but definitely to the individual speakers if the programme is (or in danger of) running late.

How to share the microphone with your co-chair?
D'Haens: Never speak together. This is discussed before you start.
Travis: Agree before the start (!) who is going to introduce which talk; it is customary for the person who introduces the speaker to manage the questions from that talk and customary to alternate the introductions between the chairs. However, there is no rule – and the chair who knows the speaker best is the person best placed to do the intro.

Is punctuality crucial?
D'Haens: To my feeling YES, YES, YES.
Travis: No, it is essential.

How to arrange that the presenter sticks to his/her time limit?
D'Haens: Warn him/her in time.
Travis: If a speaker is known to have a habit of including too many slides (you get to know!), then a brief word emphasising time keeping before the symposium is important. There are electronic gadgets used by some congresses that give a green/amber/red warning light which often causes entertainment and consternation (if the powerpoint goes off when the red light shows!), but this is not widespread. If someone is talking well over time, then the chair should interject to say something 'I have to ask you to sum up in the interests of time': the timing of this is difficult and often embarrassing, but it is discourteous to the other speakers if someone runs over substantially. The number of questions are in the hands of the chair.

How many questions should every presentation receive?
D'Haens: Depends on the content.
Travis: Guided by time and the topic. If the topic is controversial, then keep questions going and say something like 'brief questions, brief answers, please'. The chair's weapon if a speaker has grossly exceeded their time is to say 'I'm afraid there is no time for questions'! Do remind the questioner to give their name and say where they are from. If the questioner is well known, then by all means mention them by name – but beware starting to identify questioners from the chair and then forgetting the name of a very well known figure! You get round this by saying 'microphone at the back' (or whatever). If there are more questioners than there is time for, then say 'we have time for just two more questions' and then 'Last question'. If there is someone well known waiting to ask a question who is likely to make a substantial contribution, then wait for that – but always keep a watch on the clock. The best chair's will generate discussion by putting speakers on ➥

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the spot: this can only be done if they know the topic and each other well.

What to do if nobody asks questions from the audience?
D'Haens: Chairmen should always have 1 or 2 questions ready.
Travis: The Chair who introduces the speaker must always think of one question during the talk: that means paying attention! It may need a question from the Chair to start the ball rolling ('while people are coming up to the microphone, can I ask...'), but be prepared for 'if there are no further questions, that leads us onto the next speaker who ....'

Should a chair always prepare questions?
D'Haens: Yes
Travis: Yes

Should a chair always ask (his prepared) questions?
D'Haens: No, the audience should have priority.
Travis: Definitely not. Some chairs abuse the privilege of their position by always asking their own question, but the chair's job is to generate interaction with the audience and that means questions from the audience take precedence. The chair should only ask their question if there is nobody getting up to ask a question (sometimes lecture theatres are very large and it takes time to get a microphone) or if there is no danger of running over time.

What to do if the presenter does not understand the questions from the audience?
D'Haens: Repeat and clarify by the chairmen.
Travis: The chair should paraphrase the question (that means you have to be paying attention, which can be difficult if distracted by an aside to/from your co-chair!) or ask the questioner to repeat it.

What to do if the presenter can not respond to a question from the audience?
D'Haens: Sometimes call upon his mentor if in the room, sometimes suggest an answer, sometimes leave it as such.
Travis: Be kind to the presenter and bale him/her out at an early stage: it is fortunately very rare that a questioner sets out to belittle a speaker, but it is embarrassing for everyone when this occurs. Simply take charge, redirect the question to a more authoritative source ('I see Professor Z in the audience and it would be interesting ...') or say something like 'It is a difficult area and I think we should move on ...'

What to do if the presenter does not understand English?
D'Haens: I would no allow questions in that case.
Travis: This is difficult, especially if someone is giving their talk from a prepared text. Imagine how frightening that is. The chair's job is to help the speaker through their ordeal: gently rephrase the question and perhaps suggest an answer ('What the questioner is asking is whether you think that...') so that the speaker only has to nod or say 'Yes'...and then the Chair should rapidly wrap up the questions!

Can you heavily criticize the content of a presentation?
D'Haens: Yes, if major scientific errors are evident.
Travis: Only if it is outrageously poor science. This does happen occasionally (miserably under-powered study, or gross misinterpretation) and in those circumstances a questioner from the audience will usually point out the shortcomings. However, it may be so poor that no one speaks – and then the chair should say something like 'It is of course important not to over interpret the results because...' , but don't humiliate the speaker.

Should you (try to) give a positive comment at the end of each presentation or at the end of each discussion?
D'Haens: If it is appropriate yes – we live in a hard world so only express your genuine feelings!
Travis: At the end of the symposium it is helpful (but not always possible) for the chair to sum up the key points in a very few words, because this brings closure. Then to highlight the timing of the start of a further session... it is just a matter of thinking what you as a member of the audience would like to know. We've all been there!

What to do if the speaker does not show up?
D'Haens: Allow more questions and entertain an interesting discussion.
Travis: Rearrange the order of speakers in the hope that they will turn up late, call the speaker on their mobile (had to do this more than once... 'stuck in traffic!') and apologise if there really is a no show. This is very exceptional and is the conference organiser's role as a rule – if a speaker hasn't handed in their talk 15mins before the symposium, then start thinking of contingency plans.

What to do at the beginning of a session?
D'Haens: Welcome the audience and give an idea of what to expect + outline timelines.
Travis: Decide which of the chairs is going to introduce the session, then say a few words that puts the topic of the session into context by mentioning some of the controversies in the area. Keep it very brief – the audience have come to hear the speakers, not the chair! Thank the organisers, mention house keeping points (the organiser will have alerted you to these) and ask people to switch off their mobile phones. Remember to switch yours off as well!

What to say at the end of a session?
D'Haens: Thanks for being here.
Travis: Thank the speakers with a very few words about the key points discussed, thank the organisers/sponsors, remind about housekeeping ('please compete your feedback forms and hand them into..') and the time of the start of the next session if appropriate.

Any other tips or tricks for inexperienced future co-chairs?
D'Haens: Read and study the abstracts, sometimes read background literature from the same group
Travis: No tricks – just speak to your co-chair, decide how you are going to play it and make sure you know a couple of things about the speakers who are giving invited talks that you are introducing (Dr X is from Y hospital and has a particular interest in Z...).

In the end, we would like to thank both Dr D'Haens and Dr Travis for their precious time.

SILVIO DANESE

ECCO Activities and deadlines 2007/2008

December 13 & 14, 2007
Nice, France
Workshop and Consensus Conference on Opportunistic Infections in IBD
Organiser: Jean-Frédéric Colombel
This meeting is made possible by an unrestricted educational grant from Abbott

December 15, 2007
Vienna, Austria
ECCO Educational Workshop
Organiser: ECCO Education Committee

December 15, 2007
Nice, France
Meeting of the ECCO Scientific Committee

January 19, 2008
Barcelona, Spain
Meeting of the National Representatives of ECCO
IBDIS System Teaching Workshop

January 19, 2008
Barcelona, Spain
IBDIS System Teaching Workshop
For more information please contact the ECCO Secretariat: ecco@vereint.com

January 20, 2008
Barcelona, Spain
Optimising biological therapy: practical considerations, current practice and future prospects – Final Workshop
Organiser: Simon Travis
This meeting is made possible by an unrestricted educational grant from UCB

February 27, 2008
Lyon, France
YECCO Workshop
Organisers: Marc Ferrante, Gionata Fiorino
This meeting is made possible by an unrestricted educational grant from Schering-Plough
Deadline for applications: December 31, 2007

February 27–28, 2008
Lyon, France
6th IBD Intensive Advanced Course for Junior Gastroenterologists
Organiser: ECCO Education Committee
Deadline for applications: December 15, 2007

February 27, 2008
Lyon, France
IBD Nurses Network Meeting
Organiser: Nurses Steering Committee

February 27, 2008
Lyon, France
METEOR Investigator's Meeting
Contact: Frank Carbonnel and Matthieu Allez, Pierre Michetti

February 28, 2008
Lyon, France
EpiCom Meeting
Contact: Pia Munkholm

February 28, 2008
Lyon, France
Meeting of the ECCO Governing Board

February 28, 2008
Lyon, France
ECCO Assembly Meeting

February 28–March 1, 2008
Lyon, France
Inflammatory Bowel Diseases 2008
3rd Congress of ECCO

March 1, 2008
Lyon, France
Pathogenesis Workshop
Organiser: ECCO Scientific Committee

The ECCO Scicom is launching an initiative of IBD pathogenesis workshops. These workshops will focus on key issues related to IBD pathogenesis and therapy and are intended to be used as a platform for initiating collaborative studies between interested ECCO members. A few selected topics will be discussed in each meeting. Participants will be asked to prepare and present predetermined topics for the meeting. The presentations will be followed by discussions and resolutions for carrying out the studies.
A first preliminary meeting will take place in Lyon, during which interested members will have a chance to contribute suggestions for topics and form of future meetings.
If you would like to contribute, please send your suggestions to the ECCO Secretariat at ecco@vereint.com **by January 15, 2008**.

For more information on all ECCO activities please visit the ECCO website www.ecco-ibd.eu

The ECCO Education Committee and Young ECCO are pleased to announce the first

YECCO Workshop
Lyon, 27th February 2008
Presentation Skills

Main objectives:
Developing an identity as a presenter
Coping with stress and anxiety
Improving delivery to greater effect
Handling questions and comments

General outline:
The sessions will combine the understanding of the required skills, as well as the experience of putting these skills into practice.
Participants will be motivated to role play, stand up and present to a group of maximum 8 YECCO members.
The program will provide 1-on-1 interaction between YECCO participants and professional speaker coaches.

Venue:
Centre de Congrès, Lyon (France)
Wednesday 27th February 2008 from 2.00 till 6.30 pm

Target group:
All ECCO members younger than 35 years
Note: ECCO membership is currently for free: www.ecco-ibd.eu

Applications:
Please send a formal request to ecco-congress@vereint.com
Deadline: Monday 17th December 2007
The number of participants is limited. Please register early!

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