Dear National Representative of ECCO!

First of all, we want to thank you for your active participation and your valid contributions to the ECCO activities in the past. The involvement of National Representatives is critical to the development of ECCO and will continue to be so even after the transition to individual membership. You are the driving force! Consider yourselves the ambassadors of ECCO – a role which brings much honour, but naturally also many duties.

Just as ECCO is a steadily growing association, so are the duties of the ECCO National Representative! The Governing Board relies on the National Representative to be the liaison to the National Societies as well as the ECCO individual members of your country. The extent of this growth can be seen below where we try to help you gain an overview of the benefits and duties of the ECCO National Representative.

**ELECTING THE GOVERNING BOARD**

According to the ECCO statutes, only the Council of National Representatives and the members of the Governing Board are entitled to vote for the President-elect, Secretary and Treasurer. Please also consider that a nomination by a National Representative greatly helps to increase the visibility of a potential candidate! The elections take place during the ECCO Congress and will be announced in due time by the ECCO Secretariat.

**ECCO CONGRESS**

The annual ECCO Congress in February provides ample opportunity for exchange of thoughts, networking with colleagues and industry or just socializing with friends during the ECCO Party. Here are some of the benefits to your country, which you as National Representatives can help to promote:

- The ECCO Governing Board has decided to give the National Representatives the opportunity to elect the next ECCO Congress destinations. The Governing Board will provide a pre-election of 3 countries, and all National Representatives present at the meeting may vote on their country of choice (anonymously). The first election of this kind will take place at the meeting during UEGW in London 2009.

- The National Representatives of the country which hosts the annual ECCO Congress, automatically obtain a seat in the Congress Organising Committee.

- National Representatives are invited to function as speakers and chairs for the scientific sessions or are called upon to propose new speakers.

- Participate in the annual meeting with the ECCO Industry Partners.

**ECCO IBD INTENSIVE COURSE**

As a National Representative you are in a position to nominate 3 students for the Course. However, you are also charged with the responsibility of the attendance of these students. Based on past experience of this sort, ECCO had to implement a strict procedure: Should student(s) of your country be absent from the course without an acceptable excuse, your country will not be allowed to send as many students in the next year. The free seat(s) will be given to another country for that year.

As of ECCO’10 in Prague, the IBD Course Programme will take a different shape. Because of the growing demand and to satisfy all levels of trainees, ECCO will offer two parallel courses: A **Basic Course** for trainees (currently known as the IBD Intensive Course), which consists of 3 selected students of each member country and a parallel **Advanced Course** for fellows and young gastroenterologists with open registration. National Representatives will be vital in the organisation, chairing as well as the promotion in their countries. Details will be provided under separate cover.

**ECCO EDUCATIONAL WORKSHOPS**

The first ECCO Workshop took place in Zagreb, Croatia in November 2007 and...
many other ECCO countries have since applied as hosts for 2008 and 2009. National Representatives of a hosting country are actively involved in the organisation of these workshops. It is their role to select and act as local speakers and chairs. Please feel free to contact the ECCO Secretariat for application guidelines if you want to be a host.

**ECCO Fellowships and Grants**

Please pay attention to the calls sent out by the ECCO Secretariat and actively promote interest within your country. In the future, you will also be called upon to function as (or suggest) a reviewer for the selection process of awarding fellowships and grants. The ECCO SciCom will set up an external reviewers’ committee for this purpose.

**ECCO Guidelines on CD and UC**

As you know, one of the main aims of ECCO is the publication of guidelines for the treatment of CD and UC. All National Representatives are invited to facilitate this important approach. Currently, ECCO is working on the update of the CD Consensus Guidelines. Please look out for the calls of the Consensus Panel for future updates or new guidelines.

**Meetings of National Representatives**

Each National Representative is expected to participate in the two annual meetings of the National Representatives, one at the ECCO Congress and one at UEGW.

The meeting at the ECCO Congress is dedicated to elections of Governing Board members, practical information for country members and, time-permitting, discussions on topics raised by the National Representative on behalf of his/her country.

The meeting at UEGW is dedicated to the presentations of new country members and country reports on ECCO related activities.

**Membership Recruitment**

Over 1000 members have already followed the call to become individual members. In order for this number to continue to grow and to reach more and more IBD specialists all over the world, ECCO needs the help of the National Representative to actively participate in the recruitment of members within your country. Membership forms can be obtained from the ECCO Secretariat or applications can be made online if you follow this link: [http://www.ecco-ibd.eu/about_ecco/membership.php?navId=18](http://www.ecco-ibd.eu/about_ecco/membership.php?navId=18)

Until 2010, the country membership fee will stay in place (reduced for 2009). The National Representative is in charge of paying this bill to ECCO.

**Reporting on Your Country’s Activities**

Please share new developments within your country or your Society with the ECCO Members. You may do so via the ECCO Newsletter, the Journal of Crohn’s and Colitis (JCC) as well as the ECCO Website. Another tool which is at your disposal to use for free is IBDIS, Category 1. Please find out more information on [http://www.ibdis.net/](http://www.ibdis.net/). For deadlines and contribution guidelines, please contact the ECCO Secretariat at ecco@vereint.com.

**ECCO Newsletter Sponsoring**

The ECCO Newsletter is put together at no cost to ECCO through the selling of ad-space. The Newsletter team around Olle and Per Lundblad from Mediahuset in Sweden may approach you with help of finding local sponsors. Please assist them wherever you can.

**NECCO and YECCO**

Another group in need of help are the ECCO Nurses (NECCO). In order for Nurses to be able to participate in international meetings, they need help from local sponsors or from their department. If an ECCO Nurse of your country or your region approaches you, please help her (or him) to get the connection they need.

And, last but not least, there is YECCO, this highly motivated and active group of young doctors who grew out of the first IBD School meetings. Please keep a close look on the developments of the young colleagues in your country and help them to become aware of ECCO and its activities.

The above list should give you a good overview of ECCO and especially of your important part in it. Only with the active participation of each National Representative will we be able to continue on this successful road.

We conclude with a quote by Jean Bodin, the French philosopher (1536–1596), whose maxim that all wealth can be found within mankind we strongly believe in as well. « Il n’est de richesse que d’hommes ».

Thank you very much for your attention!

If you have any questions, please don’t hesitate to contact us or the ECCO Secretariat (ecc@vereint.com). We are here to assist one another.

Warm regards,

JEAN-FRÉDÉRIC COLOMBEL
ECCO President

WALTER REINISCH
ECCO Secretary

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**ECCO’S website**

Find out more about ECCO on the web. Please note the address – [www.ecco-ibd.eu](http://www.ecco-ibd.eu)

Here you can find useful information about many details concerning ECCO. It’s easy to navigate via menus which can be found to the left and at the top of the page. E-mail links to the Governing Board are provided.

The website also contains many other links, both internal and external. Documentation for ECCO projects can be downloaded and links to partner organizations can also be found here.

On the website there are also links to forthcoming and past events, and links leading to information on trials about IBD in Europe.

The history of the organization itself can also be downloaded. In order to keep yourself updated – don’t forget to add [www.ecco-ibd.eu](http://www.ecco-ibd.eu) to your Favourites!
THE ECCO IBD FORUM:
Towards higher standards of care in IBD

On 20–21 June 2008 in the beautiful city of Budapest, participants from 22 countries gathered to discuss the measurement of outcomes and optimization of care in Crohn's disease. The focus of the meeting, chaired by Simon Travis, was on day-to-day management of Crohn's disease, through a combination of lectures, small-group break-out sessions with case studies, and roundtable discussions.

Understanding how patient goals sometimes differ from physician goals is important when working towards higher standards of care.

Gert Van Assche (Leuven) presented the epidemiology, pathophysiology and genetics of Crohn's Disease (CD) in the context of what questions patients ask and what we tell them. When bringing knowledge from bench to bedside, we can tell our patients that we still do not understand the precise cause of CD, but that in predisposed people a disturbed composition of gut microbes triggers inflammation that damages the gut lining when it is not sufficiently controlled. Moreover, it helps patients to understand that they are not alone: between 1/500 to 1/1000 people have CD, depending on the geographical region, with around 690 000 people in Europe being affected. By spending time discussing potential causes and consequences, we can help patients better understand the disease course and possible complications, which hopefully results in better adherence to therapy. As CD is at present a lifetime condition requiring medical attention, patients and physicians need to work together to ameliorate its course.

The next session addressed the diagnosis of IBD and disease measurement in new patients.

Elena Ricart (Barcelona) described the strengths and limitations of diagnostic tests used in the work-up of patients with suspected CD. She also discussed the practical utility and shortcomings of indices such as the Crohn's Disease Activity Index or the Harvey Bradshaw Index. Almost no one in the audience used a disease activity index outside clinical trials, although some were beginning to use the HBI and CRP as part of their standard follow-up of patients on biological therapy. Rheumatologists more frequently use activity indices, because the prognostic significance of rheumatological indices have been established, while the remuneration of expensive therapy may be contingent on objective measures of activity.

Peter Lakatos (Budapest) continued by asking how we optimize disease control, including: What are the definitions? Where do the goals of physicians and patients differ? Can we predict disease course and complications? There are no definitive answers to any of these questions, but in the subsequent breakout sessions a case discussion among smaller groups led to general agreement about our approach to managing patients.

The plenary feedback session held by Jullian Pànes (Barcelona), James Lindsay (London), Fabiana Castiglione (Naples), Andreas Sturm (Berlin) and Janneke van der Woude (Rotterdam) concluded that physicians need to build a better relationship with their patients by exploring their goals; agreeing (and, if necessary, managing) their expectations; and discussing different therapeutic options. After all, we as specialists are merely navigators and not the captain of the ship. The approach to diagnosing CD should strive for complete intestinal imaging, although the most suitable modality still needs to be defined as
imaging techniques evolve. Monitoring is still done by clinical assessment and biochemical measurement, with very few people using activity indices; mucosal healing was not a monitoring tool used by most participants. This was largely due to the lack of evidence of the effect of mucosal healing on disease outcome, yet some participants used endoscopic evidence of mucosal healing to help make decisions about when to stop immunomodulator or biological therapy.

Edouard Louis (Liege) discussed setting strategic goals after diagnosis by taking patients’ expectations and predictors of disease progression into account, as well as treatment success. The general feeling when discussing treatment strategy in the breakout sessions was that improved identification of high-risk patients at diagnosis is needed. This would allow the selection of patients for a more proactive approach (such as primary prophylaxis with immunomodulators) and to optimize ‘bottom-up’ (conventional) therapy in other patients, in search of better outcomes. Just which parameters could be used to identify patients eligible for stopping therapy was discussed at length and is a continuing debate.

On the second day, Matthieu Allez (Paris) discussed safety considerations associated with treatment. In the special circumstances of patients needing immunomodulator or biological therapy, these included indicators to monitor infections and recommended management approaches to vaccinations and pregnancy. The participants agreed with the forthcoming ECCO Consensus on Opportunistic Infections in IBD in that hepatitis serology and, potentially vaccination against HBV, was appropriate before starting immunomodulators. This is best planned and discussed with the patient before initiating such therapy. Pregnancy is considered to be safe in quiescent CD and anti-TNF therapy (possibly except in the third trimester) or azathioprine can continue during pregnancy and lactation.

This first ECCO IBD Forum confirmed that throughout the world we are confronted with similar questions and difficulties when managing our IBD patients. On a case by case basis, by discussing with patients their realistic and shared goals, we can optimize our standard of care for our patients.

The next IBD Forum, delivered by ECCO and supported by an unrestricted educational grant from Abbott, will be on 14–15 November in Istanbul.

JANNEKE VAN DER WOUDEN Rotterdarn
**New SciCom Member**

It is a pleasure to welcome Andreas Sturm from Berlin as the new member of SciCom, to succeed Yehuda Chowers when he steps down in February 2009. Andreas is just 40 years old, trained in Aachen and Essen, then did a 3 year Research Fellowship with Professor Claudio Fiocchi at the Cleveland clinic. He was appointed to the Charité in Berlin in 2004. His current research interests are in mucosal immunology, with a particular focus on apoptosis, epithelial restitution and repair in wound healing, intestinal barrier function and T-cell interaction with non-immune cells. He has published widely, including PLoS-one, Gastroenterology, Gut, Journal of Immunology and the Journal of Molecular Medicine. Current research funding comes from the German Research Council, the Federal department of Education and Research and the Broad Foundation.

**Elections to SciCom**

SciCom ranks applicants for election. The ranking acts as recommendation to the ECCO Board, who make the final decision. This is to be read in conjunction with the information on the role of SciCom. As with other committee members in ECCO, the normal term is two years. It is possible for a member to serve a part or all of a second term, especially if too high a proportion of the committee (>50%) might otherwise change in any one year.

**Criteria considered for election to SciCom**

- Scientific Achievement (publications, scientific initiatives)
- Declaration of intent (including a statement of the contribution that the individual is able to make to SciCom)
- Age (one member is elected from YECO, age under 35)
- Experience (for instance in programme development, project development)
- Overview (to take into account the balance between location, gender, age, the degree that the person will contribute to SciCom tasks, team spirit, commitment, familiarity with ECCO, prior contribution to ECCO and future potential). As far as location is concerned, it would be unusual, but not impossible, for more than one member from a single country.

SciCom members are excluded from voting for applicants from their own country. SciCom was hugely encouraged by the excellence, talents and overt enthusiasm of the 16 applicants this year. It is hoped that unsuccessful applicants will not be discouraged from applying again. The next call will be in Spring 2009 for two people to replace Severine Vermeire and Simon Travis. The application process is on the ECCO Website.

**Pathogenesis Workshop on Loss of Response to anti-TNF-α agents**

ECCO Pathogenesis Workshops are a new initiative that will be launched to form discussion and research forums for topics of interest in IBD during UEGW 2008 in Vienna. Each Workshop will include working groups, a systematic review of the literature, agreement on the questions to be answered and appropriate approaches to answering these questions, with a view to establishing collaborative research. There will be a new topic each year. This year the topic will be **Loss of response to anti-TNF-α agents.** The programme is outlined below.

A call has been made through the ECCO website (www.ecco-ibd.eu) to plan the meeting, so that ECCO members wishing to participate can sign up. Participants will be distributed in four working groups. Each working group will have to prepare a systematic review in advance and present their review of the literature during the Workshop in October 2008.

- Loss of response to anti-TNF-α antibody therapy, often with the evolution of intolerance over time, is an appreciable problem for patients. The objectives of this workshop are to better understand this phenomenon, to define its frequency, to identify and define the mechanisms of loss of efficacy and to focus on questions which demand further research.

**Four working subgroups will address the following questions:**

1. **Definitions of the problem:**
   - The background
     - To define primary failures, loss of efficacy and intolerance to each of the anti-TNF-α agents
     - To specify how frequent is the phenomenon of loss of response (LOR)
   - Specific questions
     - Are there differences between anti-TNF-α agents?
     - What are the data on the approaches to and outcome of switching?
     - What is the safety? Which switch? Back switch?
     - Should we measure surrogate markers for monitoring switching? Which ones?

2. **Mechanisms of action of anti-TNF-α agents**
   - A better understanding of the mechanisms of action of anti-TNF-α agents would help to identify the mechanisms leading to LOR.
   - The background
     - To review data on the pharmacology of anti-TNF-α agents
     - To compare putative mechanisms of actions of anti-TNF-α agents
   - Specific questions
     - Do pharmacokinetic considerations explain efficacy/LOR of anti-TNF-α agents?
     - What are the most relevant assays in vitro/ex vivo to assess the efficacy of anti-TNF-α agents?
     - What is the functional role of different antibody fragments of anti-TNF-α agents?
     - Is there a role for interactions between Fc fragments and their receptors?
     - Can these interactions explain clearance mechanisms and cell depletion?
     - Can signaling through Fc receptors contribute to efficacy, side effects and/or LOR?
3. Role of immunogenicity in the LOR

Immunogenicity to infliximab is associated with development of hypersensitive reactions and loss of efficacy. All biological agents are immunogenic in a proportion of individuals, including humanized or ‘fully human’ therapeutic monoclonal antibodies.

Specific questions

- To review data on immunogenicity to anti-TNF-α agents
- To review the evidence for immunogenicity as a cause of LOR

4. Changes in inflammatory pathways induced by anti-TNF-α agents

Anti-TNF-α agents have the ability to modify the excessive immune response and inflammatory pathways, to modify the cytokine profile and/or induce changes in T cell profiles. Such changes in inflammatory pathways could be associated with efficacy or LOR.

Specific questions

- Are there inflammatory pathways, promoted or induced by anti-TNF-α agents, which are correlated with efficacy or LOR?
- Are there inflammatory pathways, promoted or induced by anti-TNF-α agents, which are correlated with side effects (such as psoriasis-like skin inflammatory disorders or hypersensitivity reactions)?

- Can co-treatment (with steroids, thiopurines or other immunomodulators) modify or reverse these phenomena?
  - Through which mechanisms?
  - For how long?
- Should we switch to specific other treatments in these situations?

Establishing ECCO Pathogenesis Workshops is an ambitious initiative and the topic of loss of response to anti-TNF-α agents has suitably ambitious goals. The questions are germane to everyday practice and to industry, but the funding for the Workshops comes directly from ECCO and not from the industry. We believe by formulating the relevant questions through this approach will enhance collaboration between laboratories, which will initiate research into the mechanisms and be more likely to generate clinically-relevant answers. Following the Workshop in Vienna there will be a consolidation meeting at the ECCO Congress in Hamburg, work initiated and a progress report at the 2010 Congress in Prague. The aim is to sustain a cycle of a topic, working groups, consolidation meeting and progress report at UEGW and ECCO meetings.

Clinical Trial Advisory Group (CTAG): a new proposal

ECCO is rapidly growing and has well demonstrated its ability to stimulate educational programs and scientific exchanges on IBD in Europe, but ECCO could play a much more active role for supporting academic clinical trials in IBD.

Consequently Marc Lémann has proposed the creation of a Clinical Trial Advisory Group as part of SciCom, which is supported by the ECCO Governing Board. The principal purpose is specifically that of a resource to provide expert advice on the design and conduct of clinical trials, either for investigator-initiated trials, or industry.

The role of the CTAG would be to

- Review priority, originality, methodology, feasibility of the project
- Provide counselling about design, endpoints, regulatory aspects
- Help to enhance and adjust the project in a European perspective
- Help to implement the project
- Follow-up the project: an update would need to be submitted by the authors at agreed intervals.

Recommendations on design or principles of conduct would be the remit of CTAG and projects for clinical trials that are submitted for ECCO support or funding would go through CTAG. These projects (and their funding) will be subject to the approval process through SciCom (on which the Chair of CTAG will sit) and the Governing Body, as indicated on the SciCom page of ECCO website.

There will be a call for membership of this new group of 5–6 persons, including a biostatistician, through the ECCO website. Criteria will be solid experience in conducting academic multicentre clinical trial in IBD during the recent years, knowledge and interest in the methodology of clinical trials or regulatory aspects and special interest in therapeutic strategies for IBD.

Programme for Hamburg

Includes outline of talks and keynote speakers.

Difficult cases in IBD

During Hamburg 2009, SciCom will run a short session on unsolved, challenging cases in IBD with a multidisciplinary faculty. The key criterion is that the cases are unresolved, presenting a management dilemma on what to do next. Cases suitable for inclusion can be sent to Professor Matthieu Allez via ecco-congress@vereint.eu. There will be a call for cases in December (any earlier would mean that resolution was likely before the Congress in February) and the cases will be selected by Matthieu Allez, Yehuda Chowers and Willem Bemelman.

ECCO Fellowships, ECCO Grants and ECCO Travel Awards

Check out the ECCO website (www.ecco-ibd.eu) for details and application forms! ECCO Fellowships are designed to encourage and help young individuals in their career through travel abroad to another centre and promote innovative scientific research in the area of IBD in Europe. ECCO Grants are designed to promote research in IBD within the individual’s own country.
The concept and the past
After having successfully completed the huge effort of developing guidelines for the diagnosis and treatment of IBD, ECCO realized that the next crucial step was to implement these guidelines in the whole of Europe and Israel. Since adherence to guidelines by practitioners implies that physicians and surgeons are fully educated, ECCO EduCom (ECCO Education Committee) was asked to develop a program of educational workshops to be organized in different regions of Europe and focusing on the IBD guidelines. The effort was coordinated by Prof. Boris Vucelic and Dr. Gert Van Assche, with an important input from all members of EduCom, and with logistic support from Vereint.

First, crucial statements and therapeutic areas were selected from both the UC and CD guidelines, with the intention to cover most of the different ‘faces’ of IBD. Next, members of EduCom were asked to select a patient case illustrating the guideline and assemble the evidence defending the guideline statement. These cases were collected, edited by EduCom, and streamlined in a slide deck.

From day one the workshop program was aimed to be maximally interactive. To test the ability of the selected cases and of the slide deck to trigger discussion, two trial sessions were organised. At the first event, in Zagreb, Croatia, physicians from South-eastern Europe were invited. Cases on new onset ileocecal CD, fulminant and left-sided UC, pouchitis, endoscopic surveillance, pediatric and fistulising CD were presented. A few weeks later in Vienna, Austria, the same cases were offered to an audience of Austrian and Hungarian gastroenterologists. Members of EduCom served in the faculty. The trial workshops were greatly appreciated by the audience and proved to be both interactive and on target. In all cases the ECCO guideline statement served as the backbone and reference.

After the ‘proof of concept’ workshops, the first real ECCO guidelines workshop was hosted by Prof. Limas Kupcinskas in Kaunas, Lithuania, with local faculty from Lithuania and two ECCO representatives, Dr. Pia Munkholm and Dr. Konstantinos Karmiris. This very successful workshop was attended by 115 doctors from the Baltic states and Poland, and will be discussed later.

The future
It is ECCO’s ambition to host over the next two years at least 5 guideline workshops every year in different geographical regions of Europe and in Israel. A call was sent to all national representatives to probe their interest in hosting a workshop. For fall 2008, workshops are being organized in Athens, Warsaw, Istanbul and Oporto. The concept of these workshops will be identical to the first three. A well defined program constructed around the approved slide deck. One day interactive workshops open to doctors working in the region and hosted by 2 ECCO faculty and 2 to 3 local faculty. Since the workshops are targeted at a regional audience ECCO

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<thead>
<tr>
<th>Workshop Number</th>
<th>Location</th>
<th>Date</th>
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<tbody>
<tr>
<td>4th</td>
<td>Athens, Greece</td>
<td>September 13, 2008</td>
</tr>
<tr>
<td>5th</td>
<td>Warsaw, Poland</td>
<td>September 27, 2008</td>
</tr>
<tr>
<td>6th</td>
<td>Istanbul, Turkey</td>
<td>November 8, 2008</td>
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<tr>
<td>7th</td>
<td>Oporto, Portugal</td>
<td>November 15, 2008</td>
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Table 1. 2008 ECCO Educational Workshops and Dates.

Figure 1. Map of Europe with 2008 ECCO Educational Workshops and tentative locations for 2009.
is only covering costs for logistics and the scientific program. Travel costs and overnight stays are not reimbursed. For 2009 target areas are being selected. These may include Israel, Romania, Russia/Ukraine, Norway and Germany. Also in 2009 the concept of the workshops will prevail and additional cases may be added to the slide deck. EduCom is determined to strictly adhere to the ECCO guidelines and the current evidence. Therefore, presenters are urged to only use the validated slide deck, which will be updated if novel important data appear.

We aim to have spread out to most regions of Europe by the end of 2010, allowing doctors with an interest in IBD from all areas to increase their knowledge of the ECCO IBD guidelines.

The ultimate goal of this effort is to spread the knowledge of evidence based guidelines throughout Europe and to implement their use in order to optimize the care of patients with IBD. This huge undertaking is only possible with the voluntary support of ECCO EduCom and SciCom members, of ECCO National Representatives, of local faculty and of Vereint for the logistics. ECCO is greatly indebted to all of them.

GERT VAN ASSCHE

The 6th edition of the ECCO IBD Intensive Course for Junior Gastroenterologists met once again a frank success. Both the faculty and the students praised the organisation and the value of the course. The efforts of EduCom, and of the Course director Boris Vucelic, were thus rewarded. This edition was notable for the finalization of a complete text-based syllabus, and for the confirmation of new trends in the attendance to the course. The EduCom offer in terms of postgraduate education in the context of the annual congress is bound to evolve to respond to an increasing demand, not only from trainees, but also from gastroenterologists interested in postgraduate education in the field of IBD.

The 6th ECCO IBD Intensive Course for Junior Gastroenterologists took place in Lyon in February 2008, during one and a half day, just before the 3rd ECCO congress. As usual, the participants to the Course had been selected in their country, by a national system left to the responsibility of the national representatives of each ECCO member country. Two to three students can be sent by each country each year, leading to the assembly of a multi-national class of highly motivated and selected students. Participation to the course is entirely free, as travel costs are covered by the national IBD groups while ECCO provides the course, accommodation and meals to the participants, including a reduced fee registration to the congress. This year, the course was attended by 63 junior gastroenterologists issued from the selection conducted by the national ECCO representatives. This group should have been larger, however, as we unfortunately had to record that 17 selected students failed to show up at the course. Unexpectedly, their absence was compensated by the presence of 15 uninvited participants, who spontaneously joined the course, despite that the ECCO congress program specified that attendance to the course was by invitation only.

According to the usual practice of the course, the students were first submitted to a pre-course test, which is administered again at the end of the course. This technique – brought in by Pr M. Gassull who had used it in Spain for many years – allows the organisers to measure the progression of the students as a result of the teaching provided by the faculty during the course. In addition, as the very same questions have been administered during the last 4 editions of the course (the faculty and the students ignored this information!), a few comparisons between the results obtained each year is now possible. First, the overall level of education about IBD increases in Europe over time, as the pre-course level of the students progressively increased. Second, the progression of the student knowledge exceeds 20% each year, a notable result in a limited period of time. Third, the importance of
selecting students with the right level of education is important, as the best progression is observed among students in the middle range of the pre-test result scale. Thus students with very little pre-existing knowledge about IBD appear to benefit less (suggesting that the course is gauged to pediatric or adult gastroenterology fellows rather than to pediatricians or internal medicine residents) and that very advanced students (like junior GI faculty) may benefit more from other IBD-oriented postgraduate education rather than from this intensive course.

Qualitatively we have always been pleased to note the responses to the course evaluation questionnaire distributed to the students. Almost uniformly, the students ranked the ECCO intensive course among one the best course they ever attended, praising in particular the fact that the lectures are presented by those experts who published the landmark studies in each topic. This unique opportunity to interact and discuss with experts of such level is, of course, recognized by the students. This unique feature of our course has, of course, to be maintained, a challenge for the time needs to be carefully planned. A first step will be a questionnaire added to next year’s congress material, to confirm the interest of the congress participants for a postgraduate course. Furthermore, the destiny of the Congress is to develop its role of major IBD research forum, leaving less time available in its core program for lectures aimed at fulfilling the medical education needs of the broader audience. As the development of such a course will increase the overall length of the ECCO Congress with obvious major logistical implications, this potential development needs to be carefully planned. A first step will be a questionnaire added to next year’s congress material, to confirm the interest of the congress participants for a postgraduate course and to help define the content that the attendees to the congress may wish to receive. In parallel to this novel offer, the 7th IBD Intensive Course for Junior Gastroenterologists 2009 will take place on February 4 (all day) and February 5 (1/2 day), 2009, in Hamburg, just prior to the ECCO Congress. Jannecke van der Woude, Paolo Gionchetti, Pierre Michetti (new chair of EduCom) and Boris Vucelic will be in charge of the course program. The core curriculum of the course will remain unchanged, but attention will be put in the development of the interactivity in the course as well as in incorporating YECCO in the course program. In this regard, additional seminars, conducted by YECCO members, will be added to the course program and YECCO members will be systemically invited as co-chairs of the session, to give voice to course alumni, rich of their recent past experience of students.

The success and the increased awareness of the course among practising gastroenterologists that its association to the congress generated since 3 years, make obvious that ECCO should develop a continuous education offer for the physicians participating to the congress. The rapid development of the ECCO congress, which attracts larger and larger strata of practising gastroenterologists, not all traditionally interested or trained in IBD, further increases the demand for a postgraduate course. Furthermore, the destiny of the Congress is to develop its role of major IBD research forum, leaving less time available in its core program for lectures aimed at fulfilling the medical education needs of the broader audience. As the development of such a course will increase the overall length of the ECCO Congress with obvious major logistical implications, this potential development needs to be carefully planned. A first step will be a questionnaire added to next year’s congress material, to confirm the interest of the congress participants for a postgraduate course and to help define the content that the attendees to the congress may wish to receive. In parallel to this novel offer, the 7th IBD Intensive Course for Junior Gastroenterologists 2009 will take place on February 4 (all day) and February 5 (1/2 day), 2009, in Hamburg, just prior to the ECCO Congress. Jannecke van der Woude, Paolo Gionchetti, Pierre Michetti (new chair of EduCom) and Boris Vucelic will be in charge of the course program. The core curriculum of the course will remain unchanged, but attention will be put in the development of the interactivity in the course as well as in incorporating YECCO in the course program. In this regard, additional seminars, conducted by YECCO members, will be added to the course program and YECCO members will be systemically invited as co-chairs of the session, to give voice to course alumni, rich of their recent past experience of students.

Travel Grant

During my 3-month stay as a visiting fellow at the Department of Abdominal Surgery, University of Leuven, Belgium, under the supervision of Prof. Freddie Penninckx and Dr. André D’Hoore, I actively assisted in numerous surgical procedures of both Crohn’s disease and ulcerative colitis which markedly contributed to my surgical training and experience. I came into contact and discussed IBD topics with the gastroenterological team (Prof. Rutgeerts and colleagues). I also reviewed the medical records of fifty-two patients treated for rectovaginal fistulas in Crohn’s disease comparing the outcome of those treated with surgery alone and combined with anti-TNFalpha therapy. I prepared a draft of this subject for possible publication in an international peer reviewed journal. Furthermore, I prepared a protocol for a prospective study to be performed in collaboration with the University of Padova on local cytokine profile in patients with perianal Crohn’s disease as part of my PhD thesis.

CESARE RUFOLO

M.D.
PhD student in Surgical Sciences and Technological Applications
Department of Surgical and Gastroenterological Sciences
University of Padova, Italy
THEME FOR ECCO 2009: UNMET THERAPEUTIC NEEDS IN IBD

Thursday, February 5

13.00–13.10   Welcome
13:10–13:50   IBD: an Inflammatory barrier disease? (tandem talk)
13:50–14:00   Oral Presentation 1
14:00–14:10   Oral Presentation 2
14:10–14:30   The unmet therapeutic need in IBD: the Japanese perspective
14:30–15:00   Coffee Break
15:00–15:40   How do anti-inflammatory therapies work? – Back from the bedside to the bench (tandem talk, clinical)
15:40–15:50   Oral Presentation 3
15:50–16:00   Oral Presentation 4
16:00–16:40   Changing gut flora: aetiologic & therapeutic implications (tandem talk)
16:40–16:50   Oral Presentation 5
16:50–17:00   Oral Presentation 6

Friday, February 6

08:30–10:30   Live Demonstration via Satellite from Kiel to Hamburg
10:30–11:00   Coffee Break
11:00–11:30   OMED-ECCO consensus report: small bowel endoscopy in IBD
11:30–11:50   Difficult Cases in IBD
12:20–14:00   Lunch and Guided Poster Session in the Exhibition Hall
14:00–14:20   Immunomodulators in IBD: is there a price to pay?
14:20–14:30   Oral Presentation 7
14:30–14:40   Oral Presentation 8
14:40–15:00   Stress in IBD: the overlooked villain
15:00–15:10   Oral Presentation 9
15:10–15:20   Oral Presentation 10
15:20–15:50   Coffee Break
15:50–16:05   ECCO Fellowship 2008
16:05–16:20   Announcement of ECCO Fellowships & Grants 2009
16:20–16:40   The right use of diagnostics: how not to harm the patient
16:40–16:50   Oral Presentation 11
16:50–17:00   Oral Presentation 12
19:30   ECCO Party

Saturday, February 7

08:30–09:00   Crohn’s disease: Where it all started and where it’s all going
09:00–09:20   The unmet therapeutic need in IBD: a European regulatory view
09:20–09:30   Oral Presentation 13
09:30–09:40   Oral Presentation 14
09:40–10:20   Optimizing IBD management: Case-based discussion: TBA
10:20–10:50   Coffee Break
10:50–11:30   Optimizing IBD management: Case-based discussion: TBA
11:30–11:40   Oral Presentation 15
11:40–12:10   ECCO lecture: the unmet therapeutic need in IBD: a clinician’s perspective
12:10–12:20   Concluding Remarks
Epidemiological Trends of Inflammatory Bowel Disease in Russia

Elena Belousova on behalf of the Russian IBD Study Group

Inflammatory Bowel Disease is an extremely serious problem in Russia as well as in many other parts of the world. Owing to the importance of the problem, the Russian IBD Study Group, established in 2002, set as an objective to evaluate the IBD epidemiological situation in different regions of Russia, to compare the data obtained with the same epidemiological parameters from other countries and to assess the correspondence between the epidemiological situation in Russia and common world trends such as geographical, demographic, socioeconomic and temporal (1-14).

Five regions from different areas of Russia were included in this study: the Moscow region (Moscow excluded), the Krasnojarsky region (chief city – Krasnojarsk), the city of Novosibirsk, the Nizhni Novgorod region (chief city – Nizhni Novgorod) and the Rostov region (chief city – Rostov-on-Don). (Fig.1, table 1).

The following parameters were studied: prevalence, incidence, age of disease onset, mortality, female/male ratio, urban/rural ratio in both diseases. It was a population-based study performed on adults according to the common protocol. The study was retrospective and/or prospective concerning different periods of time.

Results

The prevalence of UC in three of five regions (the Krasnojarsky, the Nizhni Novgorod, and the Rostov region) turned out to be very much the same and fluctuated within the interval of 12.6–14.6/10^5 inhabitants. The sole exception is the Moscow region where the UC prevalence forms 28.3/10^5 inhabitants which is more than twice as high as in other regions (table 2). Almost the same trend in the regions mentioned is noted for CD, but the prevalence of the latter is 3.5–4.2 times higher than that of UC (table 2). In our opinion, this fact may be explained by the proximity to Moscow and the influence of the megalopolis on the lifestyle of the regional population.

The prevalence of IBD in chief cities of the regions, as well as in the Moscow region turned out to be not significantly different from each other and fluctuated within 22–31.1/10^5.

Compared with the present data from the majority of countries, the prevalence of UC and CD in Russia is 3–8 times lower (1-10), but similar to the early epidemiological findings obtained in Italy, Spain, Portugal and Norway as well as in Japan (14, 20-24) (Table 2).

There was no defined trend of female/male ratio in UC (it was 1.0–0.8–1.4 in different regions). More clear-cut regularity was revealed in CD in all regions, with higher prevalence among females (f/m ratio = 1.2–1.7). The age of disease onset both in UC and CD corresponded to the world trends (1,2). The incidence peak in all regions was fixed at the age span 20–40 years.

The difference between urban and rural population in UC and CD was noted in the Rostov and Nizhni Novgorod regions (UC: u: r = 6 and 2 correspondingly, CD: u: r = 3.4 and 5.1). In the Moscow region, both UC and CD prevalence among urban individuals slightly exceeded that among rural individuals, U/R ratio for both diseases was 1.1. Despite the differences mentioned, the common trend in the regions conformed to that in other countries: predominance of UC among females.

### Table 1. Epidemiological study of IBD in Russia.

<table>
<thead>
<tr>
<th>Region</th>
<th>Geographical location</th>
<th>Period of the study</th>
<th>Population</th>
<th>Number of IBD patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moscow region (Moscow excluded)</td>
<td>Center of Eastern part of Russia</td>
<td>1981–2005</td>
<td>5 140 000</td>
<td>UC 1453 CD 416</td>
</tr>
<tr>
<td>Nizhni Novgorod region</td>
<td>Center of Eastern part of Russia</td>
<td>2005</td>
<td>3 500 000</td>
<td>UC 410 CD 121</td>
</tr>
<tr>
<td>Rostov-on-Don region</td>
<td>South</td>
<td>2004–2005</td>
<td>4 340 000</td>
<td>UC 578 CD 145</td>
</tr>
<tr>
<td>Krasnojarsky region</td>
<td>Western Siberia</td>
<td>2000–2005</td>
<td>2 960 000</td>
<td>UC 292 CD 69</td>
</tr>
<tr>
<td>City of Novosibirsk</td>
<td>Western Siberia</td>
<td>2003–2005</td>
<td>1 405 600</td>
<td>UC 308 CD 131</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>UC 3041 CD 932</td>
</tr>
</tbody>
</table>
Inflammatory Bowel Diseases 2009

CCH Congress Center Hamburg, Germany
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4th Congress of ECCO – the European Crohn’s and Colitis Organisation
of IBD among urban population as compared to rural one (3,6).

UC and CD incidence was studied in three regions. In the Krasnojarsk and Rostov regions incidence increased during the past five years from 0.2 to 0.5/10^5 inhabitants. The most remarkable was the data in the Moscow region for the 25-year-long period of time (table 2). The UC incidence rate increased 2.8 times and the CD incidence rate 5.4 times. The CD incidence increased faster than the UC one and the UC/CD ratio decreased from 6 (1989–1996) to 2.4 (2005). Incidence rates were very low for both diseases in all regions. Mortality in both UC and CD varied within 0.1–0.4/10^5.

There was no difference in UC/CD prevalence/incidence depending on geographical location of the regions: neither North-South nor East-West direction. Both the Moscow and the Nizhni Novgorod regions in the centre of the European part of Russia, as well as Krasnojarsk and Novosibirsk in Western Siberia, are located between the 55th and the 56th parallels. Thus, four of the regions studied are in the same geographical latitude, and the prevalence in UC and CD in these regions being the same. (Copenhagen is situated on the same latitude as Moscow, Nizhni Novgorod, Novosibirsk, and Krasnojarsk but the IBD incidence in Copenhagen is one of the highest in the world). European countries with low UC and CD incidence (Italy, Spain, and Portugal) are located south of the most southern region examined in Russia – Rostov-on-Don. In spite of this fact, IBD incidence in these countries is higher than in the Rostov region.

Conclusion
As shown above, the prevalence and incidence of UC and CD in all regions examined are approximately equal (except the Moscow region) and 3 to 8 times lower than that in Europe, USA, and Canada. These parameters in Russia correspond more or less to the early data from Southern Europe (Spain, Portugal, Italy), Norway and from Japan. In the Moscow region the prevalence of both diseases is twice as high as in other regions, and the urban/rural prevalence does not differ from each other. It may reflect the influence of the Moscow megalopolis and the urbanization of the population around Moscow. The prevalence in the regions studied is very much the same, despite the difference in geographical location. Low IBD prevalence and incidence in Russia may reflect the real trend due to ethnic or genetic features, as well as it may be a result of poor diagnosis.

Other parameters such as the age of UC and CD onset, urban/rural ratio and female/male ratio correspond to the world trends.

Acknowledgements
The author thanks all members of the Russian National IBD Study Group who took part in this study.
Bibliography:
Lisa Younge
Chair of the Steering Committee of NECCO

Lisa Younge works as an IBD Nurse Specialist at St Mark’s Hospital in Harrow, London. She also holds the Chair on the Steering Committee of NECCO – the Nurses section of ECCO. The name NECCO is new, taken earlier this year. Before then they were known as the ECCO IBD Nurses.

Lisa was elected to this position at the Nurses Meeting which was held a day before the IBD conference in Lyon earlier this year.

We meet Lisa in her office at the hospital. It is a national and international referral centre for intestinal and colorectal disorders. She is part of a team that work closely together in order to deliver the IBD clinical service.

**Nurse-led activities**

There are two IBD nurses at the hospital at present, but Lisa reveals there is soon going to be a third.

– We have a telephone helpline service for IBD patients, Lisa explains.

– It gives the patients a direct access to us. We can offer advice on the telephone, or – if needed – arrange an early clinical review.

They also run a nurse-led biological service.

– We assess the patient and administer the drugs and manage infusion reactions. And we also teach patients to administer the drugs themselves – we make sure they know how to do it, and that they are happy with that, she continues.

**Access and continuity**

Lisa has been working as an IBD Nurse Specialist for more than ten years.

– During my training as a nurse, I was placed on a gastroenterology ward. I found it interesting. I saw many patients, and I noticed that several of them came back – they were familiar faces on the ward.

That’s how I really realised that IBD was a chronic disease, she recalls.

– I also realised that nurses with understanding and competence were very important for these patients. Therefore I decided to work as a Gastroenterology specialist nurse, and I was eventually employed as such. I learned endoscopy, and was allowed to create the rest of the post myself. I decided there and then to create access and continuity for IBD patients.

After setting up a service within her previous hospital, Lisa moved to St Mark’s in 2001 to do the same there.

One of the physicians working in the IBD team at St Mark’s in 2006 was Professor Michael Kamm. That was also the year when the idea of a nurses’ section of ECCO was born. 
INTERVIEW WITH LISA YOUNGE

Increase networking
The initiative originally came from the Scientific Committee and Educational Committee in ECCO.

– It was during the summer of 2006. The main goal then – and it still is – was to put together formal training, even a school, for nurses working with IBD patients, Lisa continues.

A number of nurses, including Lisa, were approached.

– It was Professor Kamm who came up with my name. You could say I got “drafted”!

A meeting was held in London shortly after, and Dr Simon Travis from Sci-Com and Dr Vucelic, EduCom, were also present with the invited nurses.

– There we discussed the aims of a nursing section. These aims, which can be sorted into three items on our programme, still stand, says Lisa.

The first item is to increase networking for all nurses working with IBD patients. That includes – obviously – the specialist nurses, but also ward nurses, endoscopy nurses and outpatient nurses.

The second item is to find out more about the current practices of nurses working with IBD patients.

The third is to create an IBD nursing school and help to standardise care for IBD patients in Europe.

New technology
These aims were agreed upon at the meeting two years ago. We ask Lisa what the results have been so far.

– We have had two successful networking meetings since then. One in Innsbruck 2007 and one in Lyon this year. They have been attended by approximately 60 nurses from different countries across Europe – although not from all of the countries.

These meetings deliver an educational programme as well. ECCO News were present at the meeting in Lyon, and among many interesting lectures we listened to Rosalinde Van Helden, Network Meeting Officer in NECCO, talk about Home care of IBD patients.

Rosalinde demonstrated the hand held “Lab on a chip,” that enables the patient to perform certain tests at home. A prick on the finger, a drop of blood on a stick and then connect it to the USB on a computer. Via Internet the results of the test are relayed to the patient’s file at the clinic.

There Rosalinde will check the files every day and act on it directly when necessary.

She pointed out to the audience that although they are going to start this as only a limited trial, lots of patients had volunteered.

– They really like the idea, she said.

There were many more interesting talks held during the meeting in Lyon. They concerned – among other things – the use of biologics, and updates on therapies, psychological issues and nutrition.

Formal part of ECCO
The Committee sets the agenda for the meetings, although Lisa is keen to point out that from Lyon and onwards this programme is based on feedback and requests taken from the evaluation forms completed by delegates at the meetings.

– The educational content deals with current issues and development in the field of IBD – it’s not to be confused with the future IBD school for nurses, which will provide a comprehensive overview of the care and management of IBD patients, she points out.

The Steering Committee itself consists of seven highly skilled IBD Nurses from five countries. They meet in person twice a year, and Lisa tells us that they now are going to try Tele-conferencing for the third.

– And of course we stay in touch with each other and discuss different topics via email, she adds.

The very first Nurses Meeting in Innsbruck was sponsored by a grant from Abbott.

– But since the next one in Lyon, they are now a formal part of ECCO itself. The aim is to continue to organise Nurses Meetings which will run alongside the main ECCO congress, and the next one will occur in Hamburg 2009.

Representatives in 13 countries
So what about the second item on the NECCO agenda – current practise?

– We have undertaken and circulated surveys – we sent questionnaires to the national representatives of ECCO. These

At present we have representatives from 13 countries, and hopefully this number will soon increase. We are hoping to use these representatives to further explore current practise, funding, barriers for further education etc.
are concerned with the current practise of IBD nurses – what they currently are doing in the different countries. But also to find out what kind of education is available, and how this is being accessed: We’re also interested in funding accessibility for education – is it funded by the hospitals, or do the nurses have to pay for it themselves etc.

Lisa tells us that they have just gathered a lot of information on this issue, and hopefully they will be able to present it in ECCO News, issue 4, later this year.

– And we have identified nursing national representatives for NECCO. At present we have representatives from 13 countries, and hopefully this number will soon increase, Lisa continues.

– We are hoping to use these representatives to further explore current practise, funding, barriers for further education etc. Finally we hope to use them for input in order to shape the school for IBD nurses – content, delivery and method.

**Train the trainers**

This school was the third item on the list, and Lisa reveals that they hope to get it off the ground in 2009.

– We have identified the problem of language – this is going to be more difficult when it comes to the nurses. Not all of them speak English.

This problem affects both the future school and the Nurses Meetings.

– For the meetings, we are going to arrange for participants to write question cards in their own language, that will be translated by the national representative – who also will be translating key slides, Lisa explains.

– The current thought when it comes to the school is to train the trainers (i.e. the national representatives) that will attend the school. Then they will go back and train their colleagues – with support from NECCO!

**Many factors affects the condition**

Lisa set up the nursing service for IBD patients at St Mark’s nearly six years ago, and now she is going to do it once again, but in another hospital – St Bartholomew’s and Royal London Hospital in London.

– I like the challenge it means to do it all over again, she explains.

– There are initiatives in the UK concerning chronic disease – to try and bring the care of chronic diseases closer to the patient. I think these initiatives are admirable, and I can see the opportunities in it.

This also means she has to leave St Mark’s in Harrow, and go to Whitechapel instead. This transition also means she has to change from the car to the constantly crowded Underground in order to get to work, but she thinks it’s worth the trouble.

– IBD is a relapsing and remitting disease – independently of the patients taking their medicine or not. Many factors affect their condition. When setting up local services, we need to make sure that patients know and understand their condition – and how to manage it. And also that they know when and how to access appropriate health resources that are available to them!
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FALK SYMPOSIUM IN BUDAPEST

IBD on the agenda at Falk Symposium in Budapest

In the beginning of May, more than 1400 Gastroenterologists from all parts of the world gathered for a meeting in the World Trade Centre in Budapest. It was Falk Symposium 164 – Intestinal Disorders – and the sessions were devoted to different areas of this subject. One of these was called Novel concepts in IBD.

This session was moderated by B Vucelic and J Schölmerich. The first lecture was held by G Rogler, Switzerland, and his talk had the headline Defective barrier – Therapeutic implications?

**Barrier integrity**

Dr Rogler started by stating that the epithelial cells in the human body cover a surface of two tennis courts.

– We have learned a lot about epithelial cells in the last decade, he continued.

– But we still don’t know how many different bacteria there are in the gut. It’s somewhere between 60 and 450, Dr Rogler said.

The barrier function of the intestinal mucosa has come into focus in IBD research, as it has been shown that an intact barrier is of great importance for the prevention of permanent and chronic inflammation as a reaction to the commensal intestinal flora.

The maintenance of the barrier integrity is carried out by gut mobility, secretion of mucin, the luminal flora and defensine and cytokine production.

– Then in 2001 the NOD2/CARD15 gene was identified, The mutation concerns the recognition of bacterial invasion into the mucosa. There is a strong bacterial colonisation – and an accumulation of endotoxin – in the intestinal mucosa in Crohn’s disease.

– Luminal bacteria colonising the mucus in CD-patients are able to cross the para-epithelial barrier through modified cell-to-cell contacts.

Intracellular bacterial stimulation results in activation of the inflammasome and multiple inflammatory reactions.

– Therapies that improve intestinal barrier function or bacterial recognition are now needed and have to be further explored, Dr Rogler said and added that he was not too sure about the value of antibiotics in this context.

Probiotics seems to play a role in improvement of the mucosal barrier. Lipids such as phosphatidylcholine may have a role.

– They may mediate their positive therapeutic effect via improvement of the barrier function of the mucosa layer. The antimicrobial defense function of the mucosal barrier needs to be improved. Further developments may include induction of local expression or substitution, Dr Rogler concluded.

**TLR**

Dr Elke Cario, Germany, also talked about the intestinal mucosa. Her lecture had the title The innate immune system as a therapeutic target.

Recently, much progress has been made in defining the mechanisms through which the gastrointestinal innate system mediates recognition and sorting of the broad luminal spectrum of diverse microbial products, Dr Cario said.

Toll-like receptors (TLR:s) have evolved as one major innate immune surveillance system which is central to efficient host defence and homeostasis of the intestinal mucosa.

Current therapies for IBD mostly aim to interrupt the inflammatory cascade through agents that regulate TH1- or TH2-cytokine responses. But there is a growing recognition that TLR dysfunction may play a role in IBD pathogenesis. TLR:s could provide another valid interventional target for novel therapy development.

**Classify IBD**

The topic for the next talk, held by Dr C Gasche, Austria, was Crohn’s disease is divided into several subgroups – but are there therapeutic differences?

– Good afternoon, ladies and gentlemen, Dr Gasche started his lecture and continued:

– By saying so I classify. We classify all the time – lady, gentleman, blonde, redhead and so on.

Dr Gasche then rhetorically asked why we classify, and talked about phenotype.

– The phenotype of an individual is not only the expression of the genotype, but
also affected by the environment – such as smoking as one example. The phenotype is actually the outcome of genotype – environment interactions on the expression of certain biological signs or symptoms. The phenotype is a classifiable biological group.

So why should we classify Crohn’s disease?

– Because of distinct biological characteristics with diagnosis and outcome, was Dr Gasche’s own answer.

He then continued with how we can classify IBD: By biological characteristics and phenotype, by disease activity and severity, by response to therapy and finally by genotype.

– When someone is under 20 years of age at the time of diagnosis the genetic is strong – the environment is less important.

Hence the therapeutic differences.

– Age affects surgical procedures (and cancer development). The location of the disease affects surgical procedures and postoperative recurrence. And behaviour of the disease – such as perforation or non-perforation – affects postoperative recurrence and need for reoperation.

Dr Gasche finished his lecture by stating that there unfortunately is not a single prospective study on therapeutic differences available.

**Genetic factors influence drug outcome**

Therapeutic response is multifactorial.

**Prediction of treatment success – will there be genetic or serological markers?**

This question was the headline for the last talk during the session. It was held by Dr Severine Vermeire from Belgium.

– At the moment we have a multitude of drugs to treat our patients with IBD, Dr Vermeire initially stated.

– But we can see a variable response to these drugs: Refractoriness in 20–30% of the cases, side effects and toxicity.

– Among many factors, our individual genetics determine how we will respond to a drug, she continued.

Therefore there is a need for personalised medicine and drugs. This calls for a selection of patients likely to benefit from the drug. It also prevents patients from undergoing unnecessary treatment (which also is cost effective – unnecessary and often expensive drugs can be avoided).

But it requires identification of modifiable factors associated with response. The only discovery translated until now into daily practice is the relation between thiopurine S-Methyltransferase (TPMT) gene polymorphisms and haematological toxicity of thiopurine treatment – i.e. TPMT testing.

– But TPMT-testing can never compete with your blood check-up: The monitoring of blood counts and liver transaminases remains necessary in all patients!

20–25% of patients do not respond to Infliximab. Dr Vermeire told the audience that in the first study they had carried out in Belgium they found that high CRP is a predictor for response.

– Then we saw other trials that confirmed this. If patients have a high CRP they are likely to respond better. Therefore they have now started a study of genetic factors that will influence an outcome of a drug. Pharmacogenetics is a promising field, although there are difficulties in identifying casual variants which affect drug response.

– Therefore, what is needed are studies in well organised patient cohorts, uniformly treated and systematically evaluated to quantify drug response more objectively. We have to make an effort to collect DNA from all patients enrolled in clinical trials.

– In the future I think we will have personalised medicine, tailored to the patient based on genetic profile, Dr Vermeire envisioned.

**Operate or not?**

Next session concerned Cases and controversies. During this, Boris Vucelic, Croatia, talked about obstruction in Crohn’s disease.

– Rule number one: Never operate, Dr Vucelic said and then continued:

– Rule number two: Always operate! He clarified these contradictory rules by explaining that there are two different scenarios in which patients present with obstructive manifestations of CD:

The first occurs during the acute flare-up of CD. In this situation, obstructive manifestations may be accompanied by a “string sign”, with no significant prestenotic dilatation.

The radiological “string sign” of a markedly narrowed bowel segment amidst widely spaced bowel loops does not reflect fixed stenosis caused by fibrous stricture, but is an acute manifestation of oedema, active inflammation and spasm.

These patients will recover after a few days of a clear liquid diet or i.v. fluids, combined with anti-inflammatory therapy.

– Therefore – never operate! The exception to that rule are patients who experience an acute, severe, complete, strangulating, adhesive obstruction – and they need prompt surgical intervention, Dr Vucelic said.

By contrast, fixed fibrosteotic obstruction with chronic prestenotic dilation occurs in patients who are chronically obstructed and suffering repeated attacks. They are afraid to eat, and lose weight. Their problem is mechanical, and does therefore need a mechanical, rather than medical, solution.

– The physician must not attempt to manage such a problem with medical therapy, and later send a patient who is malnourished and debilitated to a surgeon, Dr Vucelic continued.

– That is rule number two: Always operate for chronic obstruction in CD!
Pouch surgery

Bruce George, UK, had a talk titled \textit{Ile-oanal pouch solves the problem}.

– Sometimes it does – but not always, he admitted.

Key issues in pouch surgery are, among many, selecting the right patient and giving the patient realistic expectations, according to Dr George.

The arguments for pouches for CD are: Recurrence rates are no worse than IRA, around 75% of patients avoid stoma, failures are not disasters and function is equivalent.

– The personality is a predictor of quality of life after pouch surgery. A coping personality will probably have a good outcome, but a patient with anxiety or poor socialising skills will probably have a poor outcome.

The quality of life issues that the patient often wants to debate are impotency for males and fertility for females.

– But 76% of women who wanted to get pregnant after pouch surgery did so – naturally, Dr George pointed out.

Balloon dilatation

Milan Lukas, Czech Republic, talked about duodenal strictures. They are an important problem in patients with CD, and these patients are often referred for surgical therapy. But endoscopic and drug treatment may be successful, he said.

– To solve the patients’ problem effectively, TTS (“through the scope”) balloons are needed for dilatation of the small bowel strictures. The optimal therapeutic approach includes biologicals, because they work fast and have a powerful effect, Dr Lukas said.

Pooled data including 112 patients who underwent small bowel dilatation in a few clinical studies have shown that nearly 70% were free of symptoms until the end of follow-up (39 months), he continued.

– In 50% of patients a single dilatation is usually enough for long term effect!

Dr Lukas also presented a list of Crohn’s strictures which may be a “trap for the unwary endoscopist”. It included strictures length more than 50 mm, angulated stenosis, multiple and deep ulceration, strictures with the fistulas and finally mezenterial or retroperitoneal extension of inflammation.

Strictureplasty

The traditional surgical treatment of CD was in the beginning a wide resection, which is used to remove diseased sections of the bowel.

A new development in surgical treatment is strictureplasty, which opens up a narrowed section of the bowel. Tom Øresland, Norway, talked about this in his lecture \textit{Surgical bypass as a long-term solution}.

Using illustrations he described the method. The non-conventional strictureplasty encompass a division of the bowel in the middle of the diseased segment. The ends are cut open along the antimesenteric aspect of the bowel all the way through the diseased segments. These open ends are then joined together using a long suture line on both sides of the longitudinally opened bowel ends, thus in fact making the bowel wider and shorter – but not resecting it.

There are some indications that the mucosa will heal, as is often seen after a conventional strictureplasty.

– Conventional surgery bypasses are generally not a good solution in CD, the exemption is in gastroduodenal disease. Modern non-conventional strictureplasties might be the way forward, Dr Øresland summed up his lecture – and also the entire session.

With that a very interesting afternoon – that also included case reports and several short debates – was over.
Election of new YECCO representatives

For the first time since the official inclusion of YECCO in the ECCO family, YECCO members are going to choose their new representatives for the two coming years. The ECCO Secretariat is going to organize an electronic secret ballot according to the following timeline:

Call for nominations: November 6, 2008
Deadline for nominations: December 4, 2008
Start of online voting: December 15
Closure of online voting: January 8, 2009
Announcement of the new Chair and Deputy Chair: January 20, 2009

Official start of term: YECCO meeting in Hamburg

Coordinating so many people – we are running to 200 members – can be a hard job indeed. However, the enthusiastic participation of so many members and the large number of new proposals and ideas makes everything more easy.

The approval of the new ECCO statutes in October 2007 was a key date for the role of YECCO Chairs. Before that, due to lack of a YECCO Representative in the ECCO Committees, YECCO Chairs coordinated all scientific and educational proposals. Since last October, YECCO has a representative in the ECCO Scientific Committee and will soon have a representative in the ECCO Education Committee. Both representatives are chosen by the committees themselves.

In contrast to these two EduCom and SciCom representatives, the YECCO members themselves have to elect the YECCO Chair and Deputy Chair. These representatives will have to work together in collecting ideas and proposals and organizing meetings as well as YECCO driven activities. The main role of the two representatives is of course representing YECCO in the ECCO family and promoting an active role of YECCO members in all ECCO activities.

Finally, what are the new Chairs going to do? The Chair is the main representative of YECCO: he reports once a year YECCO activities and YECCO proposals to the ECCO Governing Board. He also chairs the YECCO meetings which are organized once a year during the ECCO congress. Both Chair and Deputy Chair organize the YECCO Workshop in collaboration with the Education Committee. They chair the discussion among YECCO members on new proposals, coming from the members themselves or from the ECCO Committees. They update the YECCO webpage on the ECCO website and communicate with ECCO members by the ECCO Newsletter. They are always in contact with SciCom and EduCom, directly or by the YECCO representatives in these committees.

Every YECCO member is warmly invited to present his/her candidacy to become the next Chair or Deputy Chair of our group. It’s important for our organization to have new ideas, new faces, new representatives... The YECCO future is bright!

GIONATA FIORINO

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NECCO MEETINGS

**NECCO National Nurse Representative Meeting, UEGW 2008 Vienna, October 18, 2008**

The NECCO Steering Committee led by the chairperson Lisa Younge, are organising a meeting with all the National Nurse Representatives in Vienna on October 18 to coincide with start of UEGW.

All of the 16 National Nurse Representatives have been invited, and are representing the following countries: Denmark, France, Netherlands, UK, Germany, Czech Republic, Norway, Portugal, Sweden, Italy, Latvia, and Lithuania.

The aim of this meeting is to:
- To present the results of the Questionnaire completed last year
- To understand the educational needs of nurses within each country
- Update you on the progress of NECCO with the meeting in Hamburg in 2009 and the school
- To consider the issue of finance, particularly in relation to getting nurses to attend meetings like ECCO
- To consider expanding the National Nurse Representatives from countries not already represented in Europe.

Once this meeting has been held, a full report will be produced for the ECCO Governing Board and a summary will be published in the ECCO News. This meeting will kindly be sponsored by industry and ECCO.

**NECCO Network Meeting, ECCO’09 Hamburg Congress, February 4–5, 2009**

NECCO Steering Committee kindly wants to take the opportunity to announce the 3rd NECCO Network Meeting taking place prior to the 4th Congress of ECCO in Hamburg in February 2009. Please feel free to participate and refer to the ECCO website www.ecco-ibd.eu for detailed information on the programme and registration.
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