ECCO NEWS

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

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EDITORIAL

IBD at UEGW 2008 Vienna

UEGW in Vienna was a stunning success for IBD. There were 103 key note lectures on IBD, 15 IBD sessions, 345 IBD abstracts out of a total of 119 sessions and 3,131 abstracts in total.

This is a tribute to the vigour of IBD in Europe and ECCO (through Severine Vermeire, Walter Reinisch and Yehuda Chowers) proposes the IBD programme to the scientific committee of UEGW. Incidentally, Professor Michael Farthing stepped down from chairing this influential committee at UEGW and Professor John Atherton, who will be a friend to IBD and also from the UK, elected in his place. UEGW was also the venue for updating the ECCO Consensus on Crohn's disease (see later in this issue), organised by Axel Dignass and Gert van Assche. An interesting aside was that ECCO was the most active of all the individual societies and organisations that constitute UEGF and this must reflect the way it gives opportunities to young clinicians and scientists.

The plenary session saw the presentation of the SONIC data, comparing azathioprine with infliximab and the combination of both for maintaining remission in relatively early Crohn's disease. The results have the potential to change practice: it is clear that at 6 months, the combination is better than either drug alone. This raises all sorts of questions about safety (although no new signals were identified in the programme), durability of response and whether it changes the behaviour of disease – but these questions will be at the forefront of discussion for years to come. Preliminary results from an interesting new CCR9 inhibitor for small bowel Crohn's disease were also presented at the plenary session, although it was disappointing that the placebo-controlled results were not available. After the plenary session there was an excellent session on translating IBD science into clinical practice. Edouard Louis, Liege, gave valuable clinical insights into managing individual patients with a poor prognosis and Jan Wehkamp, Stuttgart, addressed the epithelial-bacterial interface and potential for therapy.

The IBD sessions were the best attended, reflecting the interest in the field among some 11,876 delegates (incl. exhibitors, press, accompanying persons). Sessions included the epidemiology of IBD, use and misuse of IBD therapies, free paper sessions on genetics, drug mechanisms, anti-TNF therapy, and consequences of IBD, as well as lunchtime seminars on colorectal cancer surveillance and clinical cases. The range of the posters was enormous – from clinical observations on colectomy, to novel insights into the pathogenesis and the Th17-IL23 pathway in particular, a meta-analysis on colorectal cancer complicating Crohn's as well as UC, studies on the role of faecal biomarkers and a potential herbal remedy (*Andrographis paniculata*). There was enough to suit the tastes of the most eclectic of delegates, but still only serves as an hors'douvres to the ECCO Congress in Hamburg 2009!

So what were the messages for IBD from UEGW? The dominant theme was therapeutic strategy and allied to this were the data on predicting poor outcome to help select the optimal strategy. Gradually – and oh so slowly has the need been recognised! – we are getting closer to defining which patients might do well and which are likely to do badly so that clinicians can be proactive with treatment. UEGW 2009 took us further on this journey.

SIMON TRAVIS
SEVERINE VERMEIRE
JEAN-FRÉDÉRIC COLOMBEL

Inflammatory Bowel Diseases 2009

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

CCH Congress Center Hamburg, February 5–7 2009

Scientific Programme

Thursday, February 5, 2009

13.00–13.10 **Welcome**
Jean-Frédéric Colombel, President

13.10–14.30 Scientific Session 1
Chairs: Axel Dignass (Germany), Tibor Hlavaty (Slovakia)

13.10–13.50 Tandem Talk
IBD: an inflammatory barrier disease?
Stefan Schreiber (Germany), Pierre Michetti (Switzerland)

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**
Toshifumi Hibi (Japan)

14.30– 15.00 **Coffee Break**

15.00–17.00 Scientific Session 2
Chairs: Giovanni Monteleone (Italy), Charlie Lees (UK)

15.00–15.40 Tandem Talk
How do anti-inflammatory therapies work? – Back from the bedside to the bench
Julian Panes (Spain), Britta Siegmund (Germany)

15.40–15.50 Oral Presentation 3

15.50–16.00 Oral Presentation 4

16.00–16.40 Tandem Talk
Changing gut flora: aetiologic & therapeutic implications
Patricia Lepage (Germany), Herbert Tilg (Austria)

16.40–16.50 Oral Presentation 5

16.50–17.00 Oral Presentation 6

Friday, February 6, 2009

08.30–10.30 Scientific Session 3
Live Demonstration via Satellite from Kiel to Hamburg
Chairs in Hamburg: Markus Neurath (Germany), Stefan Schreiber (Germany), Marc Lémann (France)
Endoscopic team in Kiel: Susanna Nikolaus (Germany), Laurence Egan (Ireland), Andreas Sturm (Germany), Marco Daperno (Italy)

10.30–11.00 **Coffee Break**

11.00–12.20 Scientific Session 4
Chairs: André van Gossum (Belgium), Jean-Frédéric Colombel (France), Willem Bemelman (The Netherlands), Lloyd Mayer (USA), Simon Travis (United Kingdom)

11.00–11.30 **OMED-ECCO Consensus report: small bowel endoscopy in IBD**
Arnaud Boureille (France), Ana Ignatjovic (United Kingdom)

11.30–11.50 **Difficult Cases in IBD**
Yehuda Chowers (Israel), Matthieu Allez (France)

11.50–12.20 **State of the art lecture (endoscopy): Optimal endoscopic techniques in 2009**
Ralph Kiesslich (Germany

12.20–14.00 **Lunch and Guided Poster Session in the Exhibition Hall**

14.00–15.20 Scientific Session 5
Chairs: Elena Belousova (Russia), Konstantinos Papadakis (Greece)

14.00–14.20 **Immunomodulators in IBD: Is there a price to pay?**
Gert Van Assche (Belgium)

14.20–14.30 Oral Presentation 7

14.30–14.40 Oral Presentation 8

14.40–15.00 **Stress in IBD: the overlooked villain**
David Rampton (United Kingdom)

15.00–15.10 Oral Presentation 9

15.10–15.20 Oral Presentation 10

15.20–15.50 **Coffee Break**

15.50–17.00 Scientific Session 6
Chairs: Simon Travis (United Kingdom), Jens Dahlerup (Denmark), Laurent Peyrin-Biroulet (France)

15.50–16.05 **ECCO Fellowship 2008**
Alessia R Grillo (Italy)

16.05–16.20 **Announcement of ECCO Fellowships & Grants 2009**
Simon Travis (United Kingdom)

16.20–16.40 **The right use of diagnostics: how not to harm the patient**
Edouard Louis (Belgium)

16.40–16.50 Oral Presentation 11

16.50–17.00 Oral Presentation 12

19.30 **ECCO Party (different venue)**

Saturday, February 7, 2009

08.30–09.40 Scientific Session 7
Chairs: Michael Kamm (Australia), Miquel Sans (Spain), Alastair Windsdor (United Kingdom)

08.30–09.00 **Crohn's disease: Where it all started and where it's all going**
Lloyd Mayer (USA)

09.00–09.20 **The unmet therapeutic need in IBD: A European regulatory view (EMEA talk)**

09.20–09.30 Oral Presentation 13

09.30–09.40 Oral Presentation 14

09.40–12.20 Scientific session 8
Chairs: Geert D'Haens (Belgium), Sanja Kolacek (Croatia), Laurent Beaugerie (France), Oded Zmora (Israel)

09.40–10.20 **Optimizing IBD management: Case-based discussion: Limited ileocaecal Crohn's disease with a simple pereanal fistula at presentation**
Gianluca Sampietro (Italy)
Fistulising CD – Dario Sorrentino (Italy)

10.20–10.50 **Coffee Break**

10.50–11.30 **Optimizing IBD management: Case-based discussion: Top down and then develops severe skin lesions**
Pieter Stokkers (The Netherlands)
Acute severe UC in 16 year old female
Franck Carbonnel (France)

11.30–11.40 Oral Presentation 15

11.40–12.10 **ECCO Lecture: the unmet therapeutic need in IBD: A clinician's perspective**
Michael Kamm (Australia)

12.10-12.40 **ECCO Consensus Update on Crohn's Disease**
Chairs: Eduard Stange, Simon Travis
Speakers: tba

12.40–12.50 **Concluding Remarks**
Jean-Frédéric Colombel

ECCO Scientific Committee Report

SIMON TRAVIS, YEHUDA CHOWERS, SEVERINE VERMEIRE, MATTHIEU ALLEZ,
SILVIO DANESE, PIA MUNKHOLM, ANDREAS STURM

Fellowships and Awards

One of the pleasures and pivotal activities of SciCom is to present two ECCO Fellowships (each worth €30 000), four ECCO Grants (€15 000) and five ECCO Travel Awards (€1 500). As with most pleasures, there is a price to pay – and for this it is the disappointment in being unable to offer more awards to the many deserving applicants. The selection process is rigorous, with both internal and external peer review according to six defined criteria (see ECCO website, *www.ecco-ibd.eu*). We are particularly grateful to the time and effort from our external reviewers for their expertise and contribution to the appraisal process. Results will be announced at the ECCO Congress in Hamburg.

This year we have received six applications for **ECCO Fellowships**, the main purpose of which is to enhance the fabric and scientific contribution of ECCO by providing an opportunity for a young trainee in IBD (age <40yr) to work in a laboratory or department outside one's own country. Exceptional circumstances such as an ECCO member from an ECCO member state travelling to a non-member state will be considered, but such an application is likely to receive a lower priority than an ECCO member from a non-European country visiting Europe.

ECCO Research Grants are designed to support IBD research within the country of origin. We have received seventeen high quality applications for 2009. As with ECCO Fellowships, successful it is expected that when the results of the project are presented or published, then the name and logo of ECCO will be presented on all printed matter or slide presentations by way of acknowledgement to ECCO as their funding source. If the full paper is not published in *JCC* or *Gut*, then a synopsis of the paper from the work supported by the Fellowship should be submitted to *JCC* for publication as a "selected summary" of ECCO publications.

Applications for ECCO Fellowships 2009:

Applicant	Title of Project	Country of Origin
Francesca Fava	Measuring the impact of anti-tumour necrosis factor-alpha (TNF-α) treatment on the faecal microbiota in Inflammatory Bowel Disease (IBD)	Italy
Varun Kesherwan	Epigenetic (Methylation) and Transcriptomic profiling CD14+ and CD14- macrophages in Crohn's disease (CD) and Ulcerative colitis (UC) to identify, their phenotype in context of M1 and M2 Macrophages	Malaysia
Hajnalka Szabó	A new biological activity marker of Inflammatory Bowel Disease? Studying serum and faecal levels of long pentraxin PTX3 in Crohn's disease (CD) and Ulcerative colitis (UC) for evaluating its utility as non-invasive biological marker of disease activity and prognostic factor of relapse	Hungary
Mohamed El Nady	Parasitosis and Crohn's Disease - Pathogenesis of Immun-Modulation	Egypt
CT Kumarappan	Stem Cells and Inflammatory Bowel Disease	India
Sofia Maria Buonocore	Identification of IL-23 dependent effector pathways in colitis	Italy

ECCO Travel Awards are an opportunity for young investigators to visit different ECCO centres in Europe, to learn scientific techniques or to be a clinical observer. Applicant should be ECCO members, not older than 40 years and need to provide a letter of permission from the Head of Department of the hosting centre. The scientific purpose for travelling to an ECCO member country needs to be stated in detail. ECCO members are not limited to the 31 ECCO member countries and can apply from non-European countries, but the benefit to ECCO has to be clearly stated. Awards are not designed to support travel to congresses or meetings. Exceptional circumstances such as an ECCO member from an ECCO member state travelling to a non-member state will be considered, but such an application is likely to receive a lower priority than an ECCO member from a non-European country visiting Europe. Members of ECCO committees are excluded from applying.

Hamburg programme

Please see page 2.

EpiCom

By Pia Munkholm, Herlev Hospital, Denmark & Selwyn Odes, Soroka Hospital, Israel.

EpiCom is the Epidemiological Committee and a subcommittee within SciCom. The first European Epidemiological Inception Cohort in EpiCom is now under planning and construction. It will address the issue: "Is there an East-West gradient in IBD in Europe caused by differences in environmental factors or epithelial-bacterial interaction assessed by defensin expression, 2010–2012?".

We are aiming at defined areas in East and West Europe each having about

Applications for ECCO Grants 2009:

Applicant	Title of Project	Country of Origin
Romualda Wojczys	Cancer and carinogenesis in ulcerative colitis in patients treated surgically by restorative protocolectomy	Poland
Gianluca Sampietro	Expression of T-reg lymphocytes in ulcerative colitis-associated colorectal cancer. Comparison with sporadic neoplasia and impact on patients survival	Italy
Debby Laukens	Quantification of metallothioneins and their regulatory molecules in a gut biopsy collection of IBD patients	Belgium
Anders Eriksson	Addition of Hyperbaric Oxygen Treatment in Severe Ulcerative Colitis	Sweden
Rui-Dong Duan	The inhibitory effects of intestinal alkaline sphingomyelinase on ulcerative colitis	Sweden
Johanna C. Escher	Liquid diet therapy in paediatric Crohn's disease: plain or tasty?	The Netherlands
Jan Wehkamp	WNT transcription factor Tcf-1 and ist role in protective innate immunity in inflammatory bowel diseases	Germany
Stefania Vetrano	The protein C pathway in inflammatory bowel disease: a novel mediator of cross-talk between dendritic and epithelial cells	Italy
Stavroula Koilakou	Interobserver Study of Ulcerative Colits, Endoscopic Indices	Greece
Chiara Martinoli	The role of triggering receptor expressed on Myeloid cells-2 (TREM-2)	Italy
Javier Perez Gisbert	Implication of Angiogenic/Lymphangiogenic Factors in IBD	Spain
Seamus Murphy	A historical cohort study of early life events and their influence on future risk of development of inflammatory bowel disease	Ireland
Maria Papp	The possible role of von Willebrand factor and its cleaving protease (ADAMTS-13) in the vascular pathogenesis of inflammatory bowel disease	Hungary
Margarita Elkjaer	Virtual Hospital System in IBD: Patient centred monitoring and web-guided therapy with 5-ASA in ulcerative colitis "Constant-care": Impact on quality of life and cost benefit	Denmark
Jean-François Rahier	Use of confocal endomicroscopy in early diagnosis of post operative ileal recurrence in Crohn's disease – A pilot study	Belgium
Andrea Cassinotti	Association of RAC2 gene single nucleotide polymorphisms in northern and southern European countries	Italy
Severine Vermeire, Miles Parkes	Detailed Characterization of the Molecualr Genetic Architecture of Crohn's Disease: the International Inflammatory Bowel Disease Genetics Consortium Study	Belgium, United Kingdom

Applications for ECCO Travel Awards 2009:

Applicant	Country of Origin
Richard Gearry	New Zealand
Floreta Kurti	Albania
Michael Dam Jensen	Denmark
Joana Maria Tinoco da Silva Torres	Portugal
Mohamed Aly Alboraje	Egypt
Annalisa Crudeli	Italy
Davide Checchin	Italy

250,000 inhabitants in the background population. The study will include a new inception cohort of IBD patients that fulfill international diagnostic criteria, over 2 years from 1.01.2010 to 31.12 2011. GPs and specialists in the areas will be contacted to inform them about the registration of all IBD patients in the area, so that maximum inclusion can be attained. The protocol and the EpiCom Epidemiological Database constructed by EpiCom members , PhD student Johan Burisch, working at Herlev Hospital, Denmark and the web-master Birger Dinesen at *http://epicom.winlog.biz*, were presented at the EpiCom meeting during UEGW, Vienna, 19.10.2008.

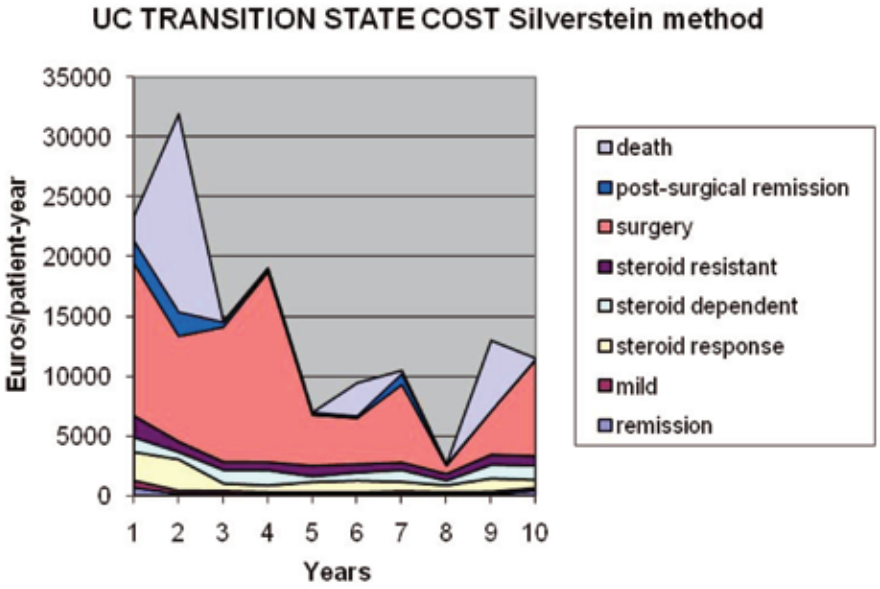
Bio-banking of blood and intestinal biopsies of selected patient groups in Europe will be stored by Professor Marieke Pierik at the bio-banking facility in Maastricht, the Netherlands. The intestinal biopsies will be examined for defensin expression, in collabration with Professor Eduard Stange, Robert Bosch Krankenhuis, Stuttgart.

History of EpiCom: EpiCom was intiated by the Head of SciCom Dan Hommes in 2006. Ass. Professor Pia Munkholm was elected first head of EpiCom and merged with EC-IBD on 28th September 2006, when Professor Reinhold Stockbrügger's tenure as chairman of EC-IBD completed. Pia Munkholm merged the Epidemiological group and the former EC-IBD database into ECCO 2007 and EpiCom, the Epidemiological Committee, became a reality.

Transition probabilities of IBD disease courses: Since 2007 Professor Selwyn Odes and Hillel Vardi, with members of the EC-IBD group, have been working with Markov transition probabilities of the pattern of IBD in the EC-IBD inception cohort 1991–1993, with follow-up over 10 years. Results are still being analysed, but preliminary data on patients with ulcerative colitis (UC), using a method adapted from the population-based model of Silverstein et al. (*Gastroenterology* 1999;117:49), are illustrated (see diagram on next page).

ECCO Projects

ECCO Projects are major initiatives that are facilitated by ECCO. They represent collaborative research across national boundaries.



Preliminary calculations of cost analysis in UC patients; 1991–1993

METEOR:
European extension through ECCO

METEOR is a randomized, controlled, double-blind, multicentre trial comparing methotrexate (MTX, intramuscular 25mg/week) and placebo in steroid-dependent ulcerative colitis. The objective is to compare rates of steroid-free remission.

Data on the efficacy of MTX in ulcerative colitis (UC) are controversial, although its efficacy is well established in Crohn's disease. In UC, negative trails have used oral or low dose (12.5mg/week). MTX appears to be active at a dose of 20–25 mg per week. The goal of this study is important: if successful, another effective medication will be available for the treatment of persistantly active, steroid-dependent UC.

This trial, launched by the GETAID, is independent of industry. It has started recruiting in France, Switzerland, Italy, Israel, Austria and Belgium. For more information about this trial, please contact: Franck Carbonnel *(fcarbonnel@chu-besancon.fr)*, Pierre Michetti *(Pierre.Michetti@chuv.hospvd.ch)*, or Matthieu Allez *(matthieu.allez@sls.aphp.fr)*..

ASTIC Stem Cell Trial:
Open for Recruitment

The ASTIC Trial is a collaborative (European and Canada) trial sponsored by the European group for Bone Marrow Transplantation (EMBT), and supported by ECCO. The ASTIC trial is now recruiting patients in the UK, Spain, France, Italy, Switzerland, Czech Republic and Canada. The trial has a small executive steering committee who can be contacted for advice (Chris Hawkey, *cj.hawkey@nottingham.ac.uk*; Silvio Danese, *sdanese@hotmail.com*; Matthieu Allez, *matthieu.allez@sls.aphp.fr*) and there are also Country Chief Investigators. All can offer advice and help to get an initial assessment of the patient. You can find more information on the website *(www.astic.eu)*. Think of a suitable patient!

***Clostridium difficile* IBD and immunomodulation**

An international retrospective study examining the impact of immunomodulators on the outcome of patients with *Cl difficile* as well as IBD has recruited more than 100 patients from centres in Israel, Greece, Belgium, France, Serbia, Austria and the UK. This is largely through the efforts of YECCO members. Results are in the process of being analysed and will be submitted for publication.

SciCom and Industry

SciCom offers consultancy services to third parties including individuals from ECCO member countries, regulatory agencies, pharmaceutical companies and biotechnology firms.

Services include:

* Independent evaluation of protocols and research strategies (a Clinical Trials Advisory Group is in the process of being established: see ECCO News October 2008)
* Assistance in setting up or executing clinical studies
* Assistance in establishing dedicated IBD departments or laboratories
* Drug developmental programmes
* Programme planning for scientific workshops and meetings

There is recognisable value of independent appraisal or endorsement of scientific endeavours by ECCO that goes beyond conventional Advisory Boards. 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.

A full list of interactions between ECCO and Industry is published on the website.

UEGW 2008 in Vienna

Situated on the shores of the Danube, the modern architecture of Danube City constitutes a striking contrast to the classic buildings in the Austrian capital Vienna. In October, in this ultra-modern environment, 12 000 Gastroenterologists from all across Europe and the rest of the world gathered for their annual European Conference. It was the 16th UEGW, held at Austria Center Vienna.

The chairman of UEGF, Professor Juan-R. Malagelada, stated in his opening speech that he thought that they had accomplished all their goals with the excellent scientific programme laid out for the Vienna conference.

The meeting started on Monday the 20th, but the weekend prior to this, postgraduate courses were held. These had attracted many participants, which Professor Michael Farthing was very pleased to state in his welcoming address.

– You voted with your feet, by turning up in such large numbers, he said.

Opening plenary session

Then the sessions were started. The following three days consisted of – among other activities – 97 sessions, plus 21 lunch sessions, 5 breakfast meetings and 6 satellite symposiums. UEGW just keeps getting bigger and better.

IBD was one of the core subjects in Vienna. In the opening plenary session – the only one during the three days that didn't have parallel sessions running at the same time – Professor Jean-Frédéric Colombel, President of ECCO, presented the SONIC Study.

– The study concerns what drugs to use in refractory Crohn's disease as first line of therapy, Dr Colombel explained, and continued:

– Basically there has been two possibilities: Azathioprine, or – at the other end – anti-TNF.

Single or combination therapy?

The study design, which is the first of its kind, was to compare the efficacy and safety when treating with Remicade or with Azathioprin – or with a *combination* of both. It's a multicenter, phase 3, randomised, double-blinded, controlled clinical trial in which 508 patients with mild to severe Crohn's disease were included. All patients were naive to immunomodulating or biological drugs.

The conclusions were that Infliximab/AZA combination therapy, when started together, was superior to AZA alone. It was also superior to Infliximab monotherapy. This result is statistically significant.

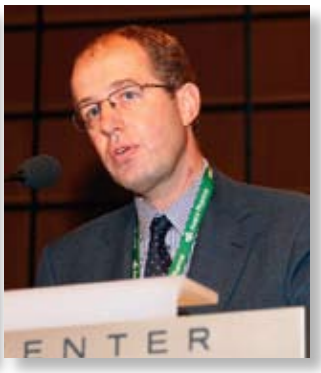
Infliximab monotherapy was superior to AZA monotherapy. Patients with high baseline CRP (60% of the patients in the SONIC study) and/or ulcers at baseline colonoscopy had a particularly strong benefit from early Infliximab.

Safety was similar in all three arms – and there was no trend toward an increased risk of serious infections with Infliximab.

Jean-Frédéric Colombel


Matthieu Allez


Edouard Louise


Magnus Simrén

– SONIC has shown that, in patients with objective evidence of active disease, we should use Infliximab first, said Professor Colombel.

– Whether we should use Infliximab alone, or together with Azathioprine, could still be a case by case discussion, he concluded.

Therapy according to stage of disease

At the following session *IBD: Translating science into clinical practice*, Matthieu Allez also touched on combination therapy in his lecture *New targets, new horizons*. He pointed out that IBD is characterised by activated T-cells.

– Why? Is it a secondary phenomenon, or defects in innate immunity? he asked rhetorically.

Dr Allez continued by stating that advances in the understanding of the pathogenesis suggests new targets. The timing is important – there are distinct immunological phases, and therefore perhaps therapies should be adapted to the stage?

– Combination therapy *may* be dangerous, he warned at the end of his lecture.

Intervene early

Edouard Louise talked on the subject under the headline *Tailoring therapy to the individual*.

– In UC the tailoring may be based on disease location, severity, past treatment, pharmacogenetics and microarrays. In CD it may be based on all those components – but also disease complications and predictive factors for severe disease, Dr Louise started his talk.

The risk of complicated disease in CD are as follows:

Ileal CD is associated with the risk of stricturing and penetrating disease – and surgery. Extensive small bowel disease with the risk of malnutrition.

> “Well informed patients have a significantly better prognosis. They consult their doctors at an earlier stage, and play a more active role in their treatment.

Severe upper GI disease is associated with the risk of major upper GI surgery. Rectal disease with the risk of stoma and perianal disease.

Smoking is associated with complicated disease.

– Clinical, demographic and biological characteristics may help and predict varying degrees of Crohns disease severity, he said.

– We should intervene early: At least with optimised bottom up, and maybe top down, was his conclusion.

Link with IBS?

An interesting talk about new findings that linked IBD with IBS (Irritable Bowel Syndrome) was delivered by Dr Magnus Simrén, Sweden.

– Many IBD patients show symptoms of IBS between their flare-ups, Dr Simrén revealed.

He pointed out that as many as one third of all UC patients in remission are suffering from IBS symptoms. These patients have an increased number of mast cells – especially those that are located near the nerves.

He reported that at present several studies on anti-inflammatory treatment of IBS symptoms are taking place. So far they have shown that Prednisolone did not improve in IBS patients, but Mesalazine has been proved to be superior to placebo.

– Low graded inflammation with increased levels of mast cells, enterochromatin cells and lymphocytes, seem to be of importance for symptom generation in a subgroup of IBS in patients, said Dr Simrén.

Need to inform the public

IBD was, as already stated, an important topic in Vienna.

– All sessions here on IBD were packed, Professor Colombel told ECCO News.

– UC and CD are not rare diseases. The epidemiology is changing – some countries did not have it, but now they are experiencing the disease.

He also stressed that biologics – antibodies for TNF-alpha – are a revolution in therapy, but they are no *cure*.

– These drugs will reverse the disease. A cure is our ultimate goal, but we're not there yet.

A high concern for Dr Colombel is the rise of incidence of IBD in children.

– It is rising not only in the countries where IBD generally is increasing, but also in the already high-incidence countries.

At the UEGW Professor Reinisch and Professor Colombel demanded that considerably more information on chronic IBD be made available to both the general public and the medical community.

– It is very important to raise the level of information available to the general public, Dr Colombel said.

– Well informed patients have a significantly better prognosis. They consult their doctors at an earlier stage, and play a more active role in their treatment.

According to the experts, there is increasing evidence of the effectiveness

of biologics in positively influencing the natural course of the more serious cases of disease, so that – at least in CD – the concept of applying these medicines from an early stage should be pursued. To be able to achieve this, the disease must be diagnosed early on and properly treated – which still does not happen often enough.

IBD Research Foundation

EFCCA is an European-wide umbrella organisation for patients suffering from IBD.

– Having put together so many different experiences and backgrounds, has enabled EFCCA to represent different aspects of patients lives, also considering different cultures and approaches, said Marco Greco, the new EFCCA Chairman.

In January, the IBD Research Foundation was founded. Powered by patients, its purpose is to raise funds in order to support scientific research that will help improve IBD patients lives. It is led by former EFCCA Chairman Rod Mitchell, and the foundation was presented at the UEGW in Vienna.

Asked whether there exists regional foci in Europe, regarding illness rate and burden of IBD, Marco Greco answered:

– Some areas are traditionally considered to have a higher incidence. These are the Nordic countries, UK and in general well developed and industrialised areas. But progress in diagnostics and recent studies put some doubt on traditional statements concerning illness rates.

Consensus on opportunistic infections

Professor Jean-Frédéric Colombel, was pleased to announce that the final work on ECCO Consensus on Opportunistic Infections was done.

– It consists of 100 pages, said Dr Colombel and showed the audience a massive pile of papers that he held in his hand.

– We're using IFX more and more in patients with IBD – and infections are now a cause of death in IBD. There's a clear message here: We shouldn't neglect the risk of infections, he continued.

The Consensus highlights definition of infection, risk factors such as age, comorbidity and malnutrition.

Definitions

Dr Colombel showed the audience examples from the Consensus which is going to be published in full in Journal of Crohn's and Colitis (JCC) later this year. A quote from ECCO Statements Definitions follows:

- The immunomodulators commonly used in IBD and associated with an increased risk of infections include corticosteroids, thiopurines, methotrexate, calcineurin inhibitors, anti-TNF agents and other biologics.
- For corticosteroids, a total dose equivalent to ≥ 20 mg of prednisolone for ≥ 2 weeks is associated with an increased risk of infections.
- Those particularly at risk for opportunistic infections are patients with combinations of immunomodulator therapies and those with malnutrition, which may be linked to disease severity. In addition, comorbidities should be considered. Age may be an independent risk factor for opportunistic infections.

The patient must be educated

Before you start treatment with immunosupressants, you should perform a detailed interview, Dr Colombel continued.

– This should concern:

- History of bacterial infections and fungal infections.
- Risk of latent or active tuberculosis.
  - date of last BCG vaccination.
  - potential contact with patients having TB,
  - country of origin, or prolonged stay in an area endemic for TB,
  - history of treatment for latent or active TB.
- History of varicella-zoster virus infection (chickenpox / shingles) and of herpes simplex virus infection.
- Immunisation status for hepatitis B.
- History of travel and/or living in tropical areas or countries with endemic infections.
- Future plans to travel to endemic areas.

– We must also perform a physical examination and laboratory tests (VZV serology and hepatitis B and C), Dr Colombel said, and continued by talking of ECCO Statements of vaccine.

– We should educate our patients, and make sure that they have an 24-hour per day access to a clinic, Professor Colombel concluded.

PER LUNDBLAD
Senior writer

New – and updated – ECCO Consensus

At the UEGW the ECCO Consensus on Crohn's disease was updated and many speakers referred to one on Opportunistic Infections in IBD. So what are all the Consensus meetings and how many are there? *ECCO News* talked to the Chair of ECCO's Scientific Committee, Dr Simon Travis, UK, about the work in progress.

The idea of having a European Consensus of Crohn's disease started in 2004.

– The purpose was to reach common agreement across Europe, Dr Travis explains.

It was Professor Eduard F. Stange, Stuttgart, who came up with idea of having a formal process in order to get agreement. A masterstroke, according to Dr Travis.

– The process was so formalised that it gives a capital C to Consensus. It was an attempt to quantify opinion where evidence for decisions was lacking.

Defined in real time

It was this formality to the process that contrasted to the conventional approach of guidelines often written by self-appointed opinion leaders sitting around a table. This process is still used today.

First a systematic review of literature is performed by separate working parties, addressing different topics, and defining the evidence level according to the Oxford Centre for Evidence Based Medicine.

The working groups then produce a questionnaire of clinically relevant questions that have insufficient evidence to support an unequivocal answer, which they circulate to all members of the Consensus panel.

The working groups then write a first draft of statements on their topic. These are discussed and revised by the working groups into concise statements that answer the clinically relevant questions in their topic.

A plenary session is then held, in which the Consensus of final statements is agreed in real time. In order to reach agreement, 80% of the people present have to be in favour of the content. Each word and implication is scrutinised.

– This means that everybody owns the final statements. And besides the common ownership, the process also leads to great insight and knowledge. It also dilutes the influence of opinionated individuals – and of course it is independent of industry, Dr Travis continues.

– The final statements that are the result of the plenary session become the ECCO Consensus. They are cast in stone! Not to be changed without the formal process.

The last task of the working group before the statements can be published, is to write the supporting text that puts them into context.

Update

But statements have of course to be updated, and the first Consensus – on Crohn's disease – that was originally published in 2006, was updated at a new plenary session that was held the weekend before the UEGW in Vienna.

– All statements were updated, Dr Travis reveals.

The process for this update followed the same procedure as described above. 53 delegates from all of ECCO's membership countries were present at this session, where they were agreed in real time.

– The update includes the view on anti-TNF therapy, the SONIC study, re-evaluation of the role 5-ASA, and treatment of pregnant women and children affected by Crohn's disease.

The work on the updated Consensus for Crohn's disease has been very ably led by Dr Axel Dignass, Germany, and Dr Gert van Assche, Belgium.

– The chairs of the working groups will be editing the text for their section, which will be collated and edited for style and consistency. The statements will then be presented at the ECCO Congress in Hamburg in February 2009, says Dr Travis.

Infections and small bowel endoscopy

There is also a new Consensus – on Opportunistic Infections – and this was cited by Professor Colombel in Vienna.

– The plenary session to establish the statements was held in Nice in December 2007. The text of eight chapters, running to 100 pages of manuscript and 400 references, has been written and is now being sent out for peer-review for publication in Journal of Crohn's and Colitis (JCC) at the end of 2008.

Simon Travis,
Chair of ECCO's Scientific Committee

This project has been driven by Jean-Francois Rahier, together with Jean-Frédéric Colombel and Simon Travis himself.

– It contains guidance on evaluating patients before starting immunomodulator therapy, including vaccination policy and tips to patients with IBD travelling abroad. There are sections on specific viral, fungal and parasitic infections, as well as on tuberculosis.

There is also a further Consensus in conjuction with the global endoscopy organisation, OMED – on the role of small bowel endoscopy in IBD– in progress.

– This includes a global group of investigators. The plenary session to establish statements will be held in December in Brussels and is being lead by Andre van Gossum (Belgium) from OMED. In keeping with the principles of ECCO, two young specialists, Arnaud Bourreille (France) and Ana Ignjatovic (UK) are on the organising committee and the results too will be reported in Hamburg and at the World Congress in London 2009.

PER LUNDBLAD
Senior Writer

7th IBD Intensive Advanced Course for Junior Gastroenterologists

Hamburg, Germany, February 4–5, 2009

Course Program Overview

February 4th, 2009

08:00–08:15	Opening remarks	J.F. Colombel, P. Michetti
08:15–08:45	**Pre-course test**	P. Gionchetti

I. General Session

Chairs: P. Michetti, T. Hlavaty

08:45–09:15	Pathogenesis and therapeutic targets in IBD (lecture)	Y. Chowers
09:15–09:45	The Genetics of IBD (lecture)	T. Ahmad
09:45–10:15	Drugs for IBD: Mechanisms of Action (lecture)	D. Hommes
10:15–10:45	**Coffee break**	

II. Seminar Session

10:45–11.15	***Seminar I.***	
	IBD and Pregnancy	J. van der Woude
11:30–12:00	***Seminar II.***	
	Biological agents in IBD, Present & Future	G. Van Assche
12:00–13:00	**Lunch break**	

III. Ulcerative Colitis Session

Chairs: B. Vucelic, C. Lees

13:00–13:30	Mild to moderate ulcerative colitis	W. Reinisch
13:30–14:00	Refractory ulcerative colitis	M. Lémann
14:00–14:30	Fulminant colitis	S. Travis
14:30–15:00	Cancer Surveillance and chemoprevention	H. Tilg
15:00–15:30	Pouch, early and late complications	P. Gionchetti
15:30–16:00	Coffee break	

IV. YECCO Workshop

16:00–19:00	See separate program
19:00	End of Day 1 program

February 5th, 2009

V. Crohn's Disease Session

Chairs: P. Gionchetti, L. Peyrin-Biroulet

08:00–08:30	Persistent diarrhea	M. Gassull
08:30–09:00	Mild-to-moderate Crohn's disease	M. Lukas
09:00–09:30	Fistulizing disease	B. Vucelic
09:30–10:00	**Coffee break**	
10:00–10:30	Stenotic disease	P. Michetti
10:30–11:00	Pediatric Crohn's disease	S. Kolacek
11:00–11:30	Post-course test	P. Gionchetti
11:30–11:45	Closing remarks	P. Michetti
11:45	End of the course	

ECCO participating in the FUN RUN at UEGW 2008 Vienna

On October 19, 2008 the second UEGW Fun Run took place. Delegates from 39 countries participated in the run to promote a healthy lifestyle and raise money for the European Federation of Crohn's and Ulcerative Colitis Association (EFCCA). 4,000 euros in entry fees were donated to the patients' organisation. Among the nearly 400 participants 10 ECCO members were taking part in this charity event. Their names and running time can be found in the table below.

Place	Race Number	Name	Country	Time
28	176	Gert D'Haens	Belgium	20:25,7
39	173	Jean-Frédéric Colombel	France	21:05,8
58	324	Gert van Assche	Belgium	22:20,7
71	329	Colm O'Morain	Ireland	22:56,0
73	21	Anders Paerregaard	Denmark	23:02,9
85	346	Davor Stimac	Croatia	23:56,9
137	198	Ingrid Gisbertz	The Netherlands	27:34,4
144	308	Arne Wilskow	Norway	29:00,4
156	289	Leana Sits	Estonia	31:19,1
Did not finish	267	Konstantinos Papamichael	Greece	Did not finish

ECCO Travel Grant in Oxford

My 3 months visit in Oxford started in April at the John Radcliffe Hospital. The "mythical" Dr Simon Travis was my mentor and I joined him in all clinical and numerous educational activities, acquiring more critical awareness to reorganize my clinical practice. I also undertook a project comparing the IBD care in Oxford and Milan using the National UK IBD Audit tool. I had also the opportunity to visit the laboratory of immunology at the Sir John Dunn School of Pathology of the Oxford University, directed by prof. Fiona Powrie. Thanks to the work (and kind patience…) of my "teachers" (in particular dr Alessandra Geremia, Carolina Arancibia, Margherita Coccia and Andrew Johnson) I get familiar with their projects on the role of the IL23/IL17 pathways, T-regs and innate immunity in IBD. The overall experience in Oxford was absolutely stimulating and I advise it to other young ECCO members.

ANDREA CASSINOTTI
"Luigi Sacco" University Hospital, Milan, Italy

In the meeting on October 19, 2008, the ECCO Education Committee proposed 3 new EduCom candidates, which were approved by the Governing Board. The new EduCom members will start their term on January 1, 2009 for a duration of 2 years.

Axel Dignass, Germany
Gerassimos Mantzaris, Greece
Charlie Lees, UK

ECCO welcomes its new functionaries!

In the meeting on July 3, 2008, the ECCO Scientific Committee proposed a new SciCom candidate, who was approved by the Governing Board. The new SciCom member will start his term on February 5, 2009 for a duration of 2 years.

Andreas Sturm, Germany

ECCO welcomes its new functionary!

Report from 4th ECCO Educational Workshop in Athens, Greece

On September 13, 2008 the 4th ECCO Educational workshop took place in Athens at "The Margi" Hotel in the seaside resort of Vouliagmeni.

The workshop was organized by ECCO with the collaboration of the Hellenic IBD Study Group (EOMIFNE), the local IBD Society in Greece.

The venue offered excellent meeting facilities which were enjoyed by all participants.

The workshop was well attended with a final number of 75 participants. This number could be considerably higher if the usual overlapping with other scientific activities on the same day didn't have occurred.

However, most important was the very active and vivid participation of almost all attendees in the case discussions for the entire duration of the workshop.

The case discussions were exhaustive allowing an in depth analysis of the cases which helped to clarify several controversial issues in the management of either simpler or more complicated cases of both Ulcerative colitis and Crohn's disease. The cases presented were carefully selected to be instructive, educational and didactic, covering a variety of several commonly encountered challenges in routine clinical practice.

At the conclusion of the workshop all participants were very satisfied with both the content and the format of the workshop and admitted that it was of great value in their decisions of IBD clinical management.

Some minor criticism was mainly about the very tight time schedule of the workshop and that, in a few cases, the discussion was very prolonged. However, all would attend a similar workshop in the future and would highly recommend it to their colleagues. So, we mostly welcome further organization of similar workshops in our country in the future.

Many thanks in particular to Marc Lémann, Janneke van der Woude and to the local participants Demetrios Karamanolis, Gerassimos Mantzaris, Nikos Viazis and Maria Mylonaki for their excellent moderation of the sessions and case-presentations.

Congratulations to ECCO (and the EduCom in particular) for initiating this educational activity which helps a lot in incorporating ECCO IBD guidelines throughout Europe (at the moment).

Last, but not least, many thanks to Nicole Eichinger, the Congress Secretary of ECCO for her indispensable contribution in the workshop organization.

JOHN A. KARAGIANNIS
DEMETRIOS G. KARAMANOLIS
ECCO National Representatives (Greece)

Report from 5th ECCO Educational Workshop in Warsaw, Poland

The first ECCO workshop in Warsaw was held on September 27 th 2008 in the Intercontinental Hotel.

There were 92 local attendants mainly recruited from the Intestinal Section of Polish Society of Gastroenterology. The Faculty included Pierre Michetti and Paolo Gionchetti from the ECCO Educational Committeee, the two Polish National ECCO Representatives: professor Grazyna Rydzewska, who is also the leader of National Crohn's Registry project in Poland and professor Jaroslaw Regula, the chairmen of the Intestinal Section of Polish Society of Gastroenterology and two other members of the Section board: professor Eugeniusz Butruk and professor Witold Bartnik.

The workshop was truly interactive; each case presentation was followed by a stimulating discussion with the audience interested in clarification of many clinical issues where the optimal management is still under debate. The feedback was very positive; the audience valued good communication with the speakers and enough time for discussion after each case, the practical aspects dominating in each presentation and good organization including the translation of slides into Polish. The negative aspects of the meeting included too intensive schedule; several participants proposed to add some topics and split the workshop into two days. It is obvious that this kind of meetings is a very good educational offer to trainees but also to specialists interested in expanding or sharing their experience.

EDYTA ZAGOROWICZ

Inflammatory Bowel Diseases 2009

CCH Congress Center Hamburg, Germany
February 5 – 7, 2009

Register online now!

www.ecco-ibd.eu

ECCO

4th Congress of ECCO – the European Crohn's and Colitis Organisation

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

YECCO Workshop
Hamburg, 4th February 2009

Howtosetupandperformaclinicaltrial

Time	Session Title	Lecture
16:00–16:15		Welcome & Short overview of the program and the clinical research question
16:15–16:35	Study Goals	Defining study goals and study endpoints
16:35–16:55	Statistical Issues	How to calculate a sample size?
16:55–17:15	Ethical Issues	Ethical issues in randomized trials
17:15–17:45	Break	
17:45–18:15	Basics to good clinical practice	CRF, study monitoring, data verification, European clinical trial directive, EMEA
18:15–18:50	Putting Theory into Practice	Interactive discussion with the participants to develop a study proposal: For example, use of an anti-TNF agent in refractory pouchitis
18:50–19:00	Concluding Remarks	
19:30	Dinner for all participants of the YECCO Workshop, the ECCO IBD Curse and the NECCO Network Meeting	

Main objectives:
Introduction to the basic steps required to plan a clinical research trial.
Defining clear goals and study endpoints.
Dealing with statistics, ethics and other regulatory issues.
Learning the importance of good clinical practice.

General outline:
Participants will have to prepare a short study proposal.
Throughout the workshop participants will learn how to deal with different aspects necessary to set up a solid clinical research trial.
At the end of the workshop theoretical knowledge will be put into practice during an interactive session.
The workshop will be followed by a free dinner for all participants.

Venue:
CCH Congress Center Hamburg (Germany)
Wednesday 4th February 2009 from 4.00 till 7.00 pm

Target group:
All ECCO members younger than 35 years
Please register as an ECCO member at www.ecco-ibd.eu

Applications:
Please send a formal request to ecco@vereint.com
Deadline: Saturday 20th December 2008
The number of participants is limited. Please register early!

Sponsored by an unrestricted educational grant from Schering-Plough.
For travel and accommodation issues, please contact your local SP representative.

IBD Sessions in Vienna

In the impressive scientific programme at the UEGW, there was always a symposium or session devoted to IBD being held. *ECCO News* sat in on several of these, and in this report we will give you a few examples of what was on the agenda.

Mucosal healing

A session, concentrating on nine short talks was devoted to *Mucosal healing & disease outcome in IBD*. P. Marteau and R. Eliakim held the Chairs.


I.C. Solberg

I.C. Solberg, Norway, had investigated if mucosal healing after initial treatment of IBD may characterise a subgroup of patients with a better prognosis. She showed that this indeed continued to be a marker for less need of surgery in both UC and CD when the follow-up was extended to 10 years.


D. Esser

The impact of mucosal healing (MH) on the economic burden of CD was the subject for D. Esser, USA. Achieving MH is associated with a tangible clinical benefit for the individual patient, as well as an economic benefit of reduced health care utilisation. However, country-specific cost structures may influence the outcome of the model, used in the study, was his conclusion.


F. Schnitzler

How do we achieve MH? According to F. Schnitzler, Belgium, initiation of Infliximab therapy in patients with CD is associated with MH in 67.8% of responders with complete MH in 45% of patients.

Certolizumab pegol (CZP) has been approved for the treatment of IBD in the USA, and in Switzerland – but not in the rest of Europe as of yet.

X. Heburtene, France, presented data from the MUSIC study, the first prospective study designed to investigate endoscopic improvement in CD with a biologic compound. The data presented in Vienna


X. Heburtene

demonstrated the efficacy of CZP in improving endoscopic and histological changes in patients with severe endoscopic disease and confirmed the clinical efficacy.

Infliximab and UC

TNF-alpha is a key proinflammatory cytokine in patients with CD, but is also found in increased concentrations in the blood, colonic tissue, urine and stools of the patients with active UC, according to O.C. Fratila, Romania.


O.C. Fratila

Infliximab binds with high affinity and specificity to the soluble form of tumour necrosis factor (TNF) alpha, preventing it from binding to cellular receptors. But when it comes to more detailed information about IFX action and efficacy in patients with UC, data are scarce. Hence their study on this subject.

The study revealed important intracellular alterations of the UC mucosa that can be restored after IFX therapy. Therefore IFX may be considered as a remission-inducing agent in patients with moderate to severe UC. Data are limited, though, and Dr Fratila called for future randomised trials to further help clarify the definitive role of IFX in the therapeutic plan for UC.

Pulmonary embolism and venous thromboembolism


M. Grainge

The risk of deep vein thrombosis and pulmonary embolism is markedly increased for patients with IBD, Dr M. Grainge, UK, initially stated in his talk. But does it *remain* high during periods of relative inactivity of the disease process?

According to Dr Grainge, the increased risk for those in remission is modest. Further research is needed to establish how much of this effect can be accounted for by hospitalisation – which often accompanies an IBD flare-up. But his study showed a need for optimising thromboprophylaxis in IBD.

G. Novacek, Austria, touched upon the same subject in his talk. In the study he presented data showing that IBD patients also have a high risk of *recurrent* venous thromboembolism. This highlights the need for optimising thromboprophylaxis in patients with IBD.


G. Novacek

Through the scope

Endoscopic dilatation of CD strictures is a safe and efficacious alternative to surgical resection in selected patients. But the influence of disease activity and medical therapy on the outcome of this procedure is largely unknown.


C. Thienpoint

C. Thienpoint, Belgium, therefore presented a study of the long term safety and efficacy of CD stricture dilation. This largest series ever reported, confirms that the long term efficacy of endoscopic CD stricture dilation outweighs the complication risk. Active disease at time of dilation, or medical therapy, does not predict recurrent dilation or surgery.

Through-the-scope (TTS) dilation is a safe and effective treatment of CD strictures, V. Kessler Brondolo, Switzerland, confirmed in her talk. The aim of the study she presented was to evaluate safety of repeated TTS balloon dilations in CD strictures.


V. Kessler Brondoli

Her conclusions were also that this approach can be used to treat anastomotic as well as disease-related strictures, independently of local inflammation. The low complication rate suggests that a diameter increment of less than 10 mm by dilation is a good safety rule. Multiple TTS balloon dilations of the same stricture are often required to improve symptoms, but these repeated dilations do not increase the complication rate.

Mesalazine more relevant then ever

Another symposium had the title *Use and misuse of therapies in IBD*. This was chaired by G Mantzaris, Greece, and Herbert Tilg, Austria.


M. Kamm

Michael Kamm, Australia, gave a lecture on *5-ASA: Past it or more relevant than ever?* According to Dr Kamm, it's still very relevant to treat UC patients with 5-ASA.

– In mild to moderate disease, Mesalazine is a useful acute therapy, and therefore more relevant than ever, he said.

– But some patients improve *gradually* with Mesalazine – in some cases it could take up to eight weeks.

A study on 312 patients has shown that 60% achieved clinical and endoscopic remission after eight weeks. In active, extensive colitis, combined oral and rectal Mesalazine could be used.

– So 5-ASA is the first line therapy for mild to moderate colitis. 90% will be in remission after one year!

Combined oral and rectal therapy offers advantage, especially if oral therapy has not induced remission.

– Compliance is very important. If the patient doesn't take the drug, the risk of not achieving remission is increased five times. So if you prescribe 5-ASA three times a day, you're a dinosaur. Therefore remember this poem: "Five-ASA – once a day", Dr Kamm said.

He finished his talk by pointing out that regular use of 5-ASA also significantly reduces the risk of colorectal cancer.

Monotherapy

At the same symposium, Walter Reinisch, Austria, talked about *The timing and choreography of biological therapies.*


W.Reinisch

– The biologicals that we have in Europe are infliximab, adalimumab and certolizumab pegol – the latter is approved in Switzerland, said Dr Reinisch.

The three drugs have broadly similar clinical efficacy for maintenance of remission in patients with active luminal CD, failing immunosupressants.

Dr Reinisch also mentioned the SONIC study:

– In patients with luminal CD, naïve to immunosupressants, IFX monotherapy is superior to AZA monotherapy, and IFX/AZA combination therapy superior to IFX.

In UC IFX is third line treatment, but should, when indicated, be used early.

– If we stick to biologics, we should try to keep it as a monotherapy, Dr Reinisch concluded.

Gert van Assche, Belgium, talked about drug interactions in IBD. Is there a dose related toxicity with combined anti-TNF and immunosupressants, he asked.


G. Van Assche

– None of the clinical trials with infliximab or adalimumab has shown dose/interval related increase of serious adverse events, was his own answer.

– And remember – opportunistic infections are also a risk with steroids, Dr Van Asche added.

Mirror in the East

The Epidemiology of IBD was at the center of the final of these sessions in Vienna.

B. Moum, Norway, had a talk titled *IBD on a global scale: Increase or steady state?*

– My task is to try to convince you that the incidence is changing, Dr Moum said.


B. Moum

He presented a map of high incidence areas in the world.

– We know that the incidence in Eastern Europe has been very low, but it is changing!

He drew attention to the fact that the old north-south gradient in Europe seems to be declining.

– This might be an illustration of what will happen when society gains affluence. It is therefore of extreme interest to follow the temporal trends for IBD in Eastern Europe.

By referring to figures from Dr Lakatos, he pointed to the fact that there is a striking elevation of incidence in Hungary.

– We can see a mirroring of what we have seen in Europe.

He also showed Professor Colombel's figures from Northern France (*presented in ECCO News 2/08, editors comment*) on the local differences in the evolution of CD and UC.

In North America there is a rising incidence that has been going on since the sixties – and here, there still is a north-south gradient to be found.

– The further north we go – the higher incidence we find. The highest is in Nova Scotia.

In Korea the incidence is also rising, but it is still much lower. In Hong Kong it also very low – but rising.

Dr Moum also talked about a paediatric trend.

– In Norway we now have data that shows a three-fold increase for IBD in children in the last ten years!

What doesn't kill you…

One theory that has been presented to explain this rise, is the "hygiene hypothesis". So does it stand up to scrutiny? This was the topic of C. Bernstein's, Canada, talk.

– Something in the environment triggers the disease. The theory suggests that in our new environment – in "clean countries" – we may have lost some "old friends", innocuous environmental micro-organisms, Dr Bernstein explained.


C. Bernstein

Everywhere in the world when children are affected with IBD, CD is more common than UC.

– If the body at an early stage is confronted with the bad bugs (mumps, measles etc), the body learns to deal with them. If it doesn't kill you, it makes you stronger.

– We found that if a child grew up with a pet cat, it is protective against CD.

Is it the antibiotics? If so, perhaps not all antibiotics.

– A high prescription of Sulphonamide can be connected to CD, Dr Bernstein continued.

He added that he couldn't find that vaccine means an increased risk.

One thing that speaks for the theory is that developing countries are adapting a westernised lifestyle, which includes getting "cleaner" – and we can now see IBD emerging in these countries. So does the theory stand up to scrutiny?

– I think it makes sense. We have lost one essential microbe somewhere, was Dr Bernsteins conclusion.

In the Questions and Answers that followed his talk, he added that we also need to learn more about diet.

Smoking can be a benefit

There is a significantly lower risk of colectomy for UC patients that smoke. But for CD the situation is reverse.


J. Cosnes

J. Cosnes, France, told the audience that smoking cessation is associated with decreased activity of CD. The benefit is significant from one year after the quit date and is long-lasting.

– But UC patients that quit smoking have a more active disease, compared to those who don't quit, he said.

Gender modulates the response to smoking. In UC, smoking delays disease onset and improves UC activity in men but not in women. In CD, women are more affected by smoking (i.e. need for immunosupressants and post-op recurrences).

Dr Cosnes also said that nicotine enemas had been given to CD patients, and a positive effect has been shown.

– Nicotine is not the bad guy here! But there are so many substances in cigarettes. We don't know *which* one it is that makes it beneficial for UC and the reverse for CD.

Fast food can increase CD

Studies show that children eating more vegetables, fruit and dietary fibre, have a lower risk of developing CD, said Dr Gassull, Spain, in the final talk that was held on IBD in Vienna.


M. Gassull

He presented a slide that proved the relationship between changes in dietary habits and incidence of UC and CD in Japan.

So is it fast food that we should blame? Fast food is claimed to have high (saturated) fat and meat content, but is low in fruit, vegetable, fibre and fish content.

– Fat accumulation can increase CD. Obese patients have more active disease and are more often hospitalised, Dr Gassull continued.

Oxidation of dietary saturated fat is reduced in CD, thus favouring its accumulation. Fat content in the enterals diets appear to be a key factor in their primary therapeutic effect in active CD.

Increased visceral fat (creeping mesenteric fat) is a common feature in CD, with an important role in regulating the inflammatory response.

– The type of diet can increase CD, Dr Gassull concluded.

And then three hectic days, packed with interesting lectures and lots of other activities in Vienna, was over.

Next year London will be the host for the UEGW – Europe's biggest congress for diseases in the gastrointestinal tract.

PER LUNDBLAD
Senior writer

ADVANCED FELLOWSHIP IN IBD 2010 (Toronto, Ontario, Canada)

Apply for a fellowship in Canada for 2010 now!!!

A training fellowship in inflammatory bowel disease is offered at Mount Sinai Hospital and the University of Toronto in Toronto, Canada. The position involves a combination of clinical and research training with the goal of preparing individuals for an academic or private practice career with a focus on IBD. Research topics include: mucosal immunology, genetics, serology, clinical outcomes, clinical trials, pathology, advanced imaging and pediatrics. Eligible candidates must have already completed their core gastroenterology training by the start date of the fellowship. The position begins in July of each academic year and applications can be submitted anytime but by August 15 of the year prior to start at the latest. Funding is guaranteed for a minimum of one year with future years possible if candidate is successful in securing external funding. The fellowship is supported by an unrestricted educational grant provided by Schering Plough Canada.

In order to learn more about this fellowship, please contact the ECCO Secretariat at ecco@vereint.com

NOTICE OF FORTHCOMING ELECTIONS

Dear Colleagues!
Notice is hereby given that the following position on the ECCO Governing Board is open for election:

ECCO Treasurer

The ECCO Governing Board is implementing § 5.2.2. of the ECCO Statutes by giving notice prior to the General Assembly Meeting, Thursday, February 5, 2009 at the CCH Congress Center Hamburg, Germany, where the election will take place.

Candidates for election to the Governing Board are nominated by any ECCO member. Candidates have to be regular ECCO members of more than two years. The nominee must agree to her/his nomination. All nominations must be sent in writing to the ECCO Secretary, stating the name and affiliation of the person proposed, the office, the name and affiliation of the proposer and two seconders, who must all be from different nations represented in the Council of National Representatives. Voting will be by ballot, by simple majority rule.

According to the ECCO Statutes, the ECCO Treasurer serves a term of 2 years, starting on March 1, 2009 and ending on February 28, 2011.

Deadline for receipt of all nominations is December 8, 2008.

Please include
- One A4 page Curriculum Vitae and
- A 1500 word mission statement

The details of the nominations will be circulated prior to the General Assembly Meeting.

Forms for proposing and seconding a candidate can also be obtained from the ECCO Secretariat or downloaded from the ECCO website www.ecco-ibd.eu.

In case you need any assistance please do not hesitate to contact the ECCO Secretariat.

With best regards,

Jean-Frédéric Colombel
ECCO President

Walter Reinisch
ECCO Secretary

ECCO
European Crohn's and Colitis Organisation

www.ecco-ibd.eu

ECCO MEMBERSHIP APPLICATION FORM

[please fill in legibly]

❍ **2009** [1.1.2009 – 31.12.2009] no. / member id: _____ [provided by ECCO]

TYPE OF MEMBERSHIP [§ 4 Statutes of the European Crohn's and Colitis Organisation, www.ecco-ibd.eu]

Please check a category

❍ Regular member*	€uro 100.00	[Doctors, scientists interested in IBD, completed university degree]
❍ IBD Nurse	€uro 25.00	[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: _____

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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

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Name of Cardholder: _____ Signature: _____

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

EUROPEAN CROHN'S AND COLITIS ORGANISATION
Hollandstrasse 14, 1020 Vienna, Austria, Tel. +43-(0)1-212 74 17, Fax +43-(0)1-212 74 17 – 49, E-Mail: ecco@vereint.com, URL: www.ecco-ibd.eu

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The John Radcliffe Hospital, Oxford (Photo: Per Lundblad)

HOW WE DO IT:

The anti-TNF prescription… …so then what happens?

Delivering anti-TNF therapy in Oxford

LYDIA WHITE, SARAH CRIPPS, SATISH KESHAV, SIMON TRAVIS

Lydia White is one of two IBD Specialist Nurses, Sarah Cripps is an independent prescriber and Specialist GI Pharmacist; Satish Keshav and Simon Travis are Consultant Gastroenterologists, all at the John Radcliffe Hospital, Oxford.

In the Summer Issue of ECCO News (ECCO News 2 2008), we described what we told patients about anti-TNF therapy before they started treatment. There is nothing special about the Oxford way; we simply hope that describing what we do will strike a resonance and that others will contribute their way of doing things to ECCO News.

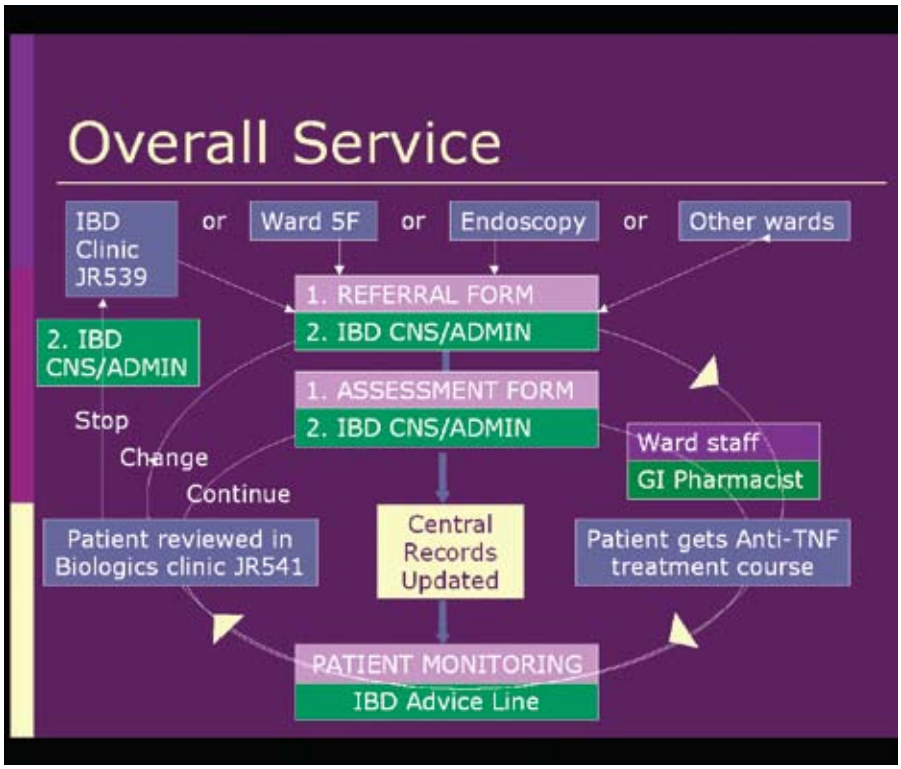
Having made the decision to start anti-TNF therapy with an appropriately informed patient (ECCO News 2 2008), everyone faces the practical process of making it happen. No guidelines govern the set up of a biologics' service, but it is common sense to surmise the aims:

1. The safe assessment before therapy
2. Starting and continuing treatment
3. A safety net for patients between treatments
4. Timely review for strategic decision making

These four factors do not happen in harmony or by chance without design. Thinking about this has led to a review of our service.

Background

In many UK hospitals, the advent of anti-TNF therapy has been the catalyst for creating the post of an IBD Specialist Nurse post. Treatment, monitoring, and appropriately timed decision-making has been co-ordinated by that person, allowing for a centrally managed service. In Oxford, however, this has not been the case. The service initially evolved through the Gastroenterology ward, where infliximab infusions were given, re-infusion appointments made and patients trained to administer adalimumab. There was no grand design, simply a system of working together. Decision-making was done by consultant gastroenterologists at out-patient clinic reviews, assisted by the specialist GI pharmacist who procured the medication, monitored prescriptions and worked with the gastroenterologists to provide patient information. The budget was agreed at a Unit level and practice audited internally,



but without external checks on prescribing or practice.

Change

As need and demand grew, this arrangement became less sustainable and the accuracy of a central registry difficult to maintain.

When Oxford appointed its first clinical IBD nurse specialist in June 2007, funded through Primary Care as a means of reducing annual follow up appointments, coordinating the anti-TNF service became part of her remit to improve patient care and safety. Fortunately, no major adverse event from anti-TNF therapy has triggered change, but the argument that the hospital was at risk without transparent co-ordination of a service that was costing £500000 in drug costs alone, was compelling and, incidentally, will support the case for a further post. The central registry is now held by the IBD CNS.

A further organisational change was initiated after internal audit found that patients had variable assessment and monitoring of outcome, leading to the creation of a clinic purely for patients on anti-TNF therapy alongside the regular IBD clinic. This was achieved simply by reassigning patients from the regular IBD clinic to a specific clinical fellow already working in the clinic. By removing access to these bookings from the regular appointments system and making them the responsibility of the IBD specialist nurse, the slots have been protected. Since the biologics clinic is co-located with the main IBD clinic, the clinical fellow has immediate access to consultant guidance for strategic decision-making. The segregated clinic has allowed for better continuity of doctor-patient care, as well as access to protected clinic slots so that clinic capacity does not dictate review dates above clinical need.

Referral and assessment forms ensure that clinical decision-making is based on current guidelines, that monitoring is standardised and follow-up organised. These forms facilitate audit, which is a crucial part of protecting the service when exposed to external scrutiny.

New Service Structure

With these new measures in place, the process for the service has been clarified. The decision to start, continue, or stop anti-TNF therapy remains that of a Consultant Gastroenterologist, but there are now only two things that a clinician needs to do to initiate and continue anti-TNF therapy.

1. Inform the IBD clinical nurse specialist
2. Complete the referral or assessment paperwork

This then feeds into the whole service (diagram). The IBD clinical nurse specialist liaises with the Gastroenterology ward staff, who book and arrange with the pharmacist for the prescription and administration of the medication. Follow-up is arranged to evaluate the initial response to treatment, as the assessment form indicates, so that there is timely review to govern the next step, which mean decisions about continuing, changing, or stopping anti-TNF therapy.

There is a safety net between doses and clinical reviews in the form of a written reminder about the IBD advice line run by the IBD specialist nurse, who can alert the clinician to any problems that need earlier review. This is especially important where patients are administrating adalimumab at home, who may need to be reminded to consider the contraindications (such as infection) prior to their dose.

The Future

An emerging problem for the anti-TNF service is ward capacity. Growing numbers of patients are making it difficult for therapy always started in a timely manner, whether for teaching self-administration of adalimumab, or day case admission for infliximab infusion.

The model of service whereby the IBD clinical nurse specialist gives the medication as well as facilitating the process is an alternative, but would require additional IBD specialist nurses and runs the risk of de-skilling the ward team who have provided an excellent service including weekend appointments that often suit patients. The current process seems to allow for the safe assessment and induction of treatment, provides a safety net for patients between treatments and timely review for strategic decision-making.

However it will evolve further and given increasing patient numbers with changing guidelines is unlikely to stay the same for long! If people want to translate our practice, assessment forms, or information sheets to their own circumstances, that's absolutely fine. We simply ask that the source is acknowledged and that you let us know, so that we can improve our own practice! We want this to be a catalyst for better practice.

Referral Form

Oxford Gastroenterology Unit

REFERRAL FORM FOR INFLAMMATORY BOWEL DISEASE BIOLOGICS CLINIC

ALL BOXES TO BE COMPLETED

Date..... *Form completed by* .....

Affix sticker here

NHS ☐
Private ☐

SEX	Male	☐	Female	☐		
DIAGNOSIS	Crohn's disease	☐	Ulcerative colitis	☐		
AGE AT DIAGNOSIS	<16	☐	17-40	☐	>40	☐
CROHN'S DISEASE DISTRIBUTION	Ileal	☐	Colonic	☐	Ileo-colonic	☐
	Isolated upper GI	☐	Peri-anal	☐		
CROHN'S DISEASE BEHAVIOUR	Inflammatory	☐	Stricturing (obstructing)	☐	Penetrating (fistulating)	☐
	Date _____		*Date* _____		*Date* _____	
UC DISTRIBUTION	Proctitis	☐	Left-sided	☐	Pan-colitis	☐

INDICATIONS FOR INFLIXIMAB – Tick all that apply

CROHN'S DISEASE

- ☐ Induction of remission in severe active Crohn's disease (Licensed indication; NICE approved)
- ☐ Maintenance treatment of Crohn's disease (Licensed indication; currently not approved by NICE)
- ☐ Fistulating Crohn's disease. (Licensed indication; NICE approved only in the presence of co-existing severe active CD).
- ☐ Treatment of EIMs (unlicensed) – specify _____

ULCERATIVE COLITIS

- ☐ Induction of remission in out-patient refractory ulcerative colitis (Unlicensed indication)
- ☐ Induction of remission for steroid-refractory severe ulcerative colitis (Unlicensed ind.)
- ☐ Maintenance of remission in severe active ulcerative colitis (Licensed indication)
- ☐ Treatment of EIMs (unlicensed) – specify _____

INDICATIONS FOR ADALIMUMAB - Tick all that apply

- ☐ Primary or secondary non-response to infliximab (Delete as appropriate) (Unlicensed indication)
- ☐ Immediate or delayed hypersensitivity to infliximab (Unlicensed indication)
- ☐ Patient preference to receive adalimumab at home, rather than infliximab in hospital (Unlicensed indication)

POOR THERAPEUTIC RESPONSE TO PREVIOUS TREATMENTS?

							Comment
Corticosteroids:	Refractory disease	☐	Dependence	☐	Intolerance	☐	
Azathioprine:	Refractory disease	☐	Dependence	☐	Intolerance	☐	
6-mercaptopurine:	Refractory disease	☐	Dependence	☐	Intolerance	☐	
Methotrexate:	Refractory disease	☐	Dependence	☐	Intolerance	☐	
Ciclosporin:	Refractory disease	☐	Dependence	☐	Intolerance	☐	

INFLIXIMAB - DOSE AND SCHEDULE REQUESTED

SEVERE ACTIVE CROHN'S DISEASE AND SEVERE ACTIVE ULCERATIVE COLITIS

Induction ☐ 5 mg/kg

Re-treatment
- ☐ Do not repeat if no response within first 2 weeks.
- ☐ *On demand:* 5mg/kg if signs & symptoms return
- ☐ *Maintenance*: 5mg/kg at week 2 & 6, followed by infusions every 8 weeks.

FISTULATING, ACTIVE CROHN'S DISEASE

Induction
- ☐ Week 0: 5 mg/kg
- ☐ Week 2: 5 mg/kg
- ☐ Week 6: 5 mg/kg

Re-treatment
- ☐ Do not repeat if no response within first 2 weeks.
- ☐ *On demand:* 5mg/kg if signs & symptoms return
- ☐ *Maintenance*: 5mg/kg every 8 weeks.

ALL PATIENTS

- *Pre-dose with hydrocortisone 200mg iv unless established on azathioprine/methotrexate for 3 months*
- *Dose escalation 10mg/kg. Consider for initial responders who lose response.*
- ***Check** concomitant immunosuppression (optimal dose and duration)*
- *Round doses up or down to the nearest whole 100mg vial – discuss with pharmacist if >1 patient per session*

ADALIMUMAB – DOSE AND SCHEDULE REQUESTED

SEVERE ACTIVE CROHN'S DISEASE

- ☐ Week 0 — **160 mg s/c**
- ☐ Week 2 — 80 mg s/c
- ☐ Week 4 and alternate weeks thereafter — 40 mg s/c

- *Review treatment after 4 weeks*
- *Review treatment if no response after 12 weeks (Licensed)*
- ***Check** concomitant immunosuppression (optimal dose and duration)*
- *First dose given in hospital. Subsequent doses can be administered by patient at home following appropriate training and should be labelled with instructions*

ANY CONTRAINDICATIONS TO BIOLOGIC THERAPY? – DEFINITE – "STOIC"

Yes ☐	No ☐	Sepsis or infection, including pelvic or perianal sepsis
Yes ☐	No ☐	Tuberculosis
Yes ☐	No ☐	Optic neuritis (or other demyelinating disorders)
Yes ☐	No ☐	Infusion reaction (previous sensitivity to either agent or murine products)
Yes ☐	No ☐	Cancer (past or present), or Cardiac failure, moderate to severe (NYHA III or IV)

ANY CONTRAINDICATIONS TO BIOLOGIC THERAPY? – RELATIVE

Yes ☐	No ☐	Pregnancy or breastfeeding
Yes ☐	No ☐	Stricturing disease with obstruction
Yes ☐	No ☐	Chronic HBV or HCV carriers
Yes ☐	No ☐	Primary failure (after 2 doses) or loss of response
Yes ☐	No ☐	Absence of inflammatory activity (as suggested by normal CRP in Crohn's)

COUNSELLING AND FOLLOW-UP

- ☐ Method of delivery, monitoring and risks / benefits discussed by doctor
- ☐ Infliximab / Adalimumab information sheet given to patient
- ☐ CXR ordered
- ☐ Follow-up appointment requested – specify clinic code JR 541 on OPD request form
- ☐ IBD CNS informed (1088) and given patient notes **OR** in absence Ward Snr Nurse informed and given patient notes
- ☐ Copy in **1.** IBD CNS **2.** GI Pharmacist **3.** Ward 5F Sister to clinic letter / documentation

ENSURE PATIENT IS BOOKED INTO THE IBD BIOLOGICS CLINIC – SPECIFY CLINIC CODE JR 541

Assessment Form

Oxford Gastroenterology Unit

IBD BIOLOGICS CLINIC ASSESSMENT FORM

ALL BOXES TO BE COMPLETED

Date..... *Form completed by* .....

Affix sticker here

NHS ☐
Private ☐

CURRENT ANTI-TNF AGENT: INFLIXIMAB *or* **ADALIMUMAB** (delete as appropriate)

Infusion number: **Date of last administration:** **Patient weight:**

CLINICAL NOTES

RELEVANT MEDICINES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES?

CROHN'S DISEASE ACTIVITY – HARVEY BRADSHAW INDEX (circle each item as required)

Item \ Score	0	1	2	3	4	Score
General well-being	Well	Below par	Poor	V poor	Terrible	
Abdominal pain	None	Mild	Moderate	Severe	-	
Abdominal mass	None	Dubious	Definite	Tender mass		
Number of stools/day	Score 1 point for each liquid stool per day					
Extraintestinal manifestations	Score 1 each for (circle as required) arthralgia, uveitis, pyoderma, erythema nodosum, aphthous ulcers, fissure, new fistula, abscess					
					Total	

ULCERATIVE COLITIS ACTIVITY– MONTRÉAL CLASSIFICATION OF DISEASE ACTIVITY

Circle disease activity	Remission (S0)	Mild (S1)	Moderate (S2)	Severe (S3)
Number of stools/day	Asymptomatic	<4	4-6	>6
Rectal bleeding		May be present	Present	Present
Pulse		All normal	Minimal or no signs of systemic toxicity	>90 BPM *or*
Temperature				>37.5°C *or*
Haemoglobin				<10.5 g/dL *or*
ESR				>30 mmHg
EIMS? Specify:				

INFLIXIMAB - DOSE AND SCHEDULE REQUIRED

SEVERE ACTIVE CROHN'S DISEASE AND SEVERE ACTIVE ULCERATIVE COLITIS

Induction ☐ 5 mg/kg

Re-treatment
- ☐ Do not repeat if no response within first 2 weeks.
- ☐ *On demand:* 5mg/kg if signs & symptoms return
- ☐ *Maintenance*: 5mg/kg at week 2 & 6, followed by infusions every 8 weeks.

FISTULATING, ACTIVE CROHN'S DISEASE

Induction
- ☐ Week 0: 5 mg/kg
- ☐ Week 2: 5 mg/kg
- ☐ Week 6: 5 mg/kg

Re-treatment
- ☐ Do not repeat if no response within first 2 weeks.
- ☐ *On demand:* 5mg/kg if signs & symptoms return
- ☐ *Maintenance*: 5mg/kg every 8 weeks.

ALL PATIENTS

- *Pre-dose with hydrocortisone 200mg iv unless established on azathioprine/methotrexate for 3 months*
- *Dose escalation 10mg/kg. Consider for initial responders who lose response.*
- ***Check** concomitant immunosuppression (optimal dose and duration)*
- *Round doses up or down to the nearest whole 100mg vial – discuss with pharmacist if >1 patient per session*

ADALIMUMAB – DOSE AND SCHEDULE REQUIRED

SEVERE ACTIVE CROHN'S DISEASE

Induction
- ☐ Week 0 — **160 mg s/c**
- ☐ Week 2 — 80 mg s/c
- ☐ Week 4 and alternate weeks thereafter — 40 mg s/c

- *Review treatment after 4 weeks*
- *Review treatment if no response after 12 weeks (Licensed)*
- ***Check** concomitant immunosuppression (optimal dose and duration)*
- *First dose given in hospital. Subsequent doses can be administered by patient at home following appropriate training and should be labelled with instructions*

Re-treatment
- ☐ Alternate weeks (every two weeks) — 40mg s/c
- ☐ Other:

COUNSELLING AND FOLLOW-UP

- ☐ Follow-up appointment requested: If continuing: specify clinic code JR 541 (Biologics clinic) on OPD request form
  If discontinuing: specify clinic code JR 539 (IBD clinic) on OPD request form
- ☐ Copy in **1.** IBD CNS **2.** GI Pharmacist to clinic letter / documentation
- ☐ If continuing on Infliximab patient notes given to IBD CNS **OR** in absence Ward Snr Nurse

COMMENTS

PRESCRIBE TREATMENT ON ORH TRUST IN-PATIENT DRUG CHART

ENSURE PATIENT IS BOOKED INTO THE IBD BIOLOGICS CLINIC – SPECIFY CLINIC CODE JR 541

The ECCO Education Committee and NECCO Steering Committee
are pleased to announce the third

NECCO Network Meeting in Hamburg, Germany

4th February 2009 from 08:00–16:00
5th February 2009 from 08:00–11:45

Venue:
4th Congress of ECCO
CCH Congress Center Hamburg (Germany)

Target group:
All Nurses with an interest in IBD who are members of ECCO
Please register as an ECCO member at www.ecco-ibd.eu

Applications:
Please send a formal request to ecco@vereint.com
Or apply online at http://ecco09.ecco-ibd.eu when you register for the congress
Deadline: Saturday 20th December 2008
The number of participants is limited. Please register early!

Wednesday, February 4, 2009

	Welcome Coffee		
09:30–09:40		Introduction by Pierre Michetti (Switzerland)	
09:40–10:00		Welcome, introduction and update of the NECCO activities	Lisa Younge (UK)
	SESSION 1	**Epidemiology & the management of IBD**	Chairs: Patricia Geens (Belgium) and Lotte Hansen (Denmark)
10:00–10:30	Talk 1	Epidemiology	Karin Menzel (Germany)
10:30–11:00	Talk 2	Recent advancement in the safety in IS and Biologics treatment	Jean-Fréderic.Colombel (France)
11:00–11:30	*Coffee Break*		
11:30–12:00	Talk 3	Surgery	Bert Bonsing (Netherlands)
12:00–12:30	Talk 4	New and upcoming techniques of blood cell removals in the treatment of IBD	Christian Felley (Switzerland)
12:30–13:00	Panel discussion	Preceded by a 10 minute brainstorm to allow for written questions	
13:00–14:00	*Lunch*		
	SESSION 2	**Patient Care**	Chairs: Karin Menzel (Germany) and Patricia Detré (France)
14:00–14:30	Talk 5	IBD transition to adult health care	Janneke van der Woude (Netherlands) and Merel van Pieterson (Netherlands)
14:30–15:00	Talk 6	IBD and IBS	Dominiek De Wulf (Belgium)
15:00–15:30	Talk 7	Fatigue in IBD patients	Liesbeth Moortgat (Belgium)
15:30–16:00	*Coffee Break*		
16:00–16:30	Talk 8	About disease outcome measurements and diaries used in IBD patients	Lone G. M. Jørgensen (Denmark)
16:30–17:00	Panel discussion	Preceded by a 10 minute brainstorm to allow for written questions	

Thursday, February 5, 2009

	SESSION 3	**Trial related issues in IBD**	Chairs: Marian O'Connor (UK) and Liesbeth Moortgat (Belgium)
09:00–09:35	Talk 9	The role of the IBD study nurse	Patricia Geens (Belgium)
09:35–10:00	Talk 10	ICH-GCP	Marianne Lasailly (France)
10:00–10:15	*Coffee Break*		
10:15–10:45	Talk 11	Endoscopic measurements	Geert D'Haens (Belgium)
10:45–11:15	Talk 12	Clinical Research Training	Patricia Détré (France)
11:15–11:45	Panel discussion	Preceded by a 10 minute brainstorm to allow for written questions	
11:45–12:00		NECCO closing remarks	Lisa Younge (UK)

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