ECCO NEWS

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

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LETTER FROM THE PRESIDENT

Dear friends,

You have just opened the last issue of *ECCO News* in 2010, and I would like to begin expressing our gratitude to the ECCO News crew, especially the two brothers **Per and Olle Lundblad**, for their outstanding job all these years! The 'Impact Factor' ECCO News has skyrocketed since its introduction. In 2011, we are going to further perfect its content and looks: the cover of both ECCO News as well as JCC will be restyled according to the **ECCO stylechange** that was introduced last summer. Not only our logo, but all publication materials were recently redesigned and this operation will be finalised prior to our Congress in Dublin with restyling our ECCO website.

Looking back unto 2010, I think that ECCO successfully underwent the necessary changes that fully prepare us for the road ahead. The year 2010: a most successful Prague Congress with a record of attendees, numerous ECCO Workshops around the world, novel guidelines, setting up our own ECCO Office in Vienna, a new marketing communication strategy (*ECCOmmunications*), the first pathogenesis workshop, and many more activities including of course the amendment of the ECCO Statutes to allow a **new structure** of our organisation. This was completed during the well attended Extraordinary General Assembly at the UEGW in Barcelona. After careful preparation and involving many ECCO friends, we sketched and proposed the new structure that will allow us to more effectively face the challenges of a growing organisation. This issue contains an article that details the organisational changes that were made.

So that takes us to closing the books on 2010 and opening up for 2011: our **10th Anniversary Year**! Much has happened since that day in a Viennese hotel in March 2001 when ECCO was founded. We would like to invite you for celebrations during our **Dublin Congress** in February. This issue of ECCO News includes an article on the events you can expect during the congress. Our Irish hosts and Organising Committee will welcome us in the most spectacular Congress Centre I have ever seen (Convention Centre Dublin)! The Wednesday will be scheduled around the IBD Advanced Course, the Nurses Network Meeting, the N-ECCO School, ECCO meets the Industry Meetings and many more interactions. In addition, Wednesday evening the Anniversary Reception is scheduled with the presentation of the **10 Year Anniversary Book**. Thursday through Saturday the Organising Committee managed to schedule a state-of-the-art programme that will educate you in all aspects of IBD. The satellite symposia, poster sessions, industry exhibitions and anniversary activities including the notorious Friday night ***ECCO Hearts and Minds*** will guarantee you to have a memorable time among friends!

Finally, I would like to take a moment to invite those of you that are not yet a paying member to join our ECCO family and those of you who are loyal members to make use of all the benefits included with **Regular Membership**. We continuously seek ways to involve you in our mission to increase the wellbeing of IBD patients, and can only do so if you are willing to continue your membership obligations. Please enjoy this issue of ECCO News, and see you in Dublin!

Warm regards on behalf of Jean Fred, Simon, Severine, Herbert, Janneke and Mathieu.

DANIEL HOMMES

More good news: Our Journal, JCC, has just been accepted into Medline! Please continue to send in your best papers!

IBD – a hot topic at the UEGW

UEGW is the largest European congress of Gastroenterology in Europe. For the 18th meeting that took place in Barcelona at the end of October 2010, more than 14 000 delegates were registered. IBD had a key position in the scientific programme.

The venue for the congress was Centre Convencions Internacional in Barcelona. It is situated just by the sea in Barcelona's new seafront area, Diagonal Mar.

It's one of the city's best-developed urban areas. The venue itself is one of the largest convention centres in Southern Europe.

Roof top of La Pedrera in Barcelona after reopening to the public. It is part of the UNESCO World Heritage Site "Works of Antoni Gaudí". (Photo: iStockphoto.com)

Optimise treatment strategies

After the Opening Plenary Session the scientific programme was divided in up to 14 parallell lectures and talks, covering several different topics and areas of Gastroenterology. There were symposias, free paper sessions, clinical case sessions, workshops and even lunch sessions.

IBD was constantly on the agenda somewhere.

Paul Rutgeerts was the first speaker of them all. His talk *New Therapeutic Strategies for IBD* came directly after that Rolf Hultcrantz, President of UEGF, and John Atherton, Chair of the Scientific Committee, had greeted all the delegates welcome to Barcelona.

– It is clear from recent studies that anti-TNFs are the mainstay of biological therapies, both for CD and UC, and that treatment strategies should be optimised, said Dr Rutgeerts.

For optimal use of current anti-TNF agents, one should use combination therapy (Azathioprine). Anti-IL12/23, and selective anti-migration therapies will expand our treatment options, he continued.

Dr Rutgeerts talked briefly about a new technique that's around the corner: Vaccination against TNF.

– It's very interesting. Large phase II studies are now starting, he said.

The goals for treatment for IBD are steroid-free remission and mucosal healing. The advancing treatment strategies for CD is treating *earlier* by identifying those who need it – i.e. patient identification.

For UC the strategy is accelerated step-up.

A new approach to treat CD

Herbert Lochs then stepped up to the Speakers Chair, and he had an exiciting message:

– You can treat CD with an antibiotic!

Dr Lochs talked about the RETIC-03 study about the efficacy and tolerability of Rifaximin-EIR (Extended Intestinal Release) tablets in the treatment of moderately active CD.

– In CD there is an adherence of bacteria to the mucosa. As a consequence the body fights this bacteria. The solution so far to treat this – classic immuno suppression therapy – has been to manipulate the immune system to tolerate these bacteria.

Antibiotics have earlier been evaluated as therapeutic agents for active CD in a limited number of trials, but their efficacy is controversial.

In RETIC, 400 patients were randomised to four groups – 400 mg, 800 mg and 1200 mg dose of Rifaximin-EIR, and one placebo group. The results show that patients in all rifaximin groups more often reached remission, compared to the placebo group.

– The study indicates that the dose of 800 mg was the most effective. It shows that changing the gut flora might be a new approach to treat CD, Dr Loch concluded.

He also said that they will follow up the results in a second study.

The battle of the biome

Scientists from throughout Europe are investigating new approaches to succesful treatment of IBD, as well as the cause of the disease, said Simon Travis.

– The inflammatory process is attributable to a troublesome combination of genetic (mis)information and environmental factors – most probably by an influence on gut bacteria.

Research has shown that human intestines harbour several hundered – and possibly over 1000 – types of bacteria.

– We might all just be 10% human, because there are ten times more bacteria in the gut than *all* other cells in the body put *together*, Dr Travis continued.

The intestinal mucosa is what separates gut bacteria from the rest of the body, so it is in effect the battleground between this microbial flora and the body – which then suffers collateral damage when signals between bacteria and the body provoke inflammation.

– I call this "the battle of the biome", because it's the new frontier in Gastroentereology and IBD, he explained.


Herbert Lochs


Sami Karoui


Emma Eshuis


Sanne Bartels


Christoph Gasche

The inflammation that drives CD is not present if the bacteria is not present in the gut. This has been proven in mouse models.

Study events that precede disaease

Disturbance of the gut bacteria (intestinal dysbiosis) is thought to precede the onset of CD, but no studies have examined events that precede disease onset.

A host of genes associated with CD have been discovered, yet genes alone can not account for the rapid increase in the number of people with CD.

– We need to know what goes on *beforehand*, Dr Travis said.

Therefore he presented a research project – European ORIGIN project. (**O**bserving **R**elatives, **I**mmunity, **G**enetics and the m**I**crobiome before the onset of Croh**N**'s disease). Over a period of five years, 6 500 healthy first-degree relatives of patients with CD will be examined and interviewed.

– We expect approximately 40 of these individuals to go on and develop CD. The samples, collected before the onset of the disease, will put events that precede CD under the microscope.

The study is managed by Dr Colombel and Dr Gower-Rousseau in Lille, France. At UEGW in London last year, Dr Colombel was awarded the UEGF research prize to support the start of this research.

Dr Travis finished his talk by explaining two ways of manipulating the microbiota – by using antibiotics and probiotics.

– We hope that the 21st century will be the era of probiotics, he said.

Predict risk for surgery

Surgery in IBD was the topic for one of the sessions during the first day.

– We can see a dramatic increase in the use of immunosuppressants, but no decrease in intestinal resections despite this, said Eduard Louis, who together with Andre D'Hoore held the chairs.

– Although surgery can cure UC, by removing the disease, there are drawbacks: Peri-operative morbidity, risk of infertility and impotence and risk of pouchitis and pouch dysfunction, Dr Louis said.

Sami Karoui then talked about a study on whether the risk for surgery in CD can be predicted according to the phenotype of the disease.

– The Montreal classification allows repartition of CD into several phenotypes. Our study's conclusion is that this can predict the recourse of surgery in patients with CD. Patients with A1, L1 and B3 phenotypes should be closely followed up, in order to avoid mutilant intestinal resection, he said.

Alessandro Armuzzi accounted for a study on the effect of anti-TNF treatment on short-term post-operative complications in patients with IBD.

– Pre-operative treatment with moderate to high dose of corticosteroids increase the risk. But anti-TNF agents do not seem to be associated with an increased risk, was his conclusion.

No difference for fecundity

A proctocolectomy with ileum pouch anal anastomosis (IPAA) can be performed in a one-stage, or a two-stage, procedure.

Emma Eshuis presented a study in which they had made a comparison of complication rate in UC patients after proctocolectomy with IPAA with and without infliximab (IFX) therapy, separately analyzing the one-stage and two-stage procedures.

– We found that IFX did not influence the total number of complications. The data in our small study supports the performance of a two-stage procedure in all patients with prior IFX therapy, she summaried.

Sanne Bartels talked about the female fertility after IPAA. The study she presented had investigated if pregnancy rate is higher after laporascopic IPAA, compared to open surgery.

– Our conclusion is that there is no significant difference in fecundity between the two. However, pregnancy rate is lower for *both* groups, compared to the general population, she said.

There *is* a difference after IFX

Farshid Araghizadeh presented a study that had compared the overall incidence for surgery in IBD and disease related complication in general practise from 1991 to 2006. The incindence of these procedures was grouped between 1991–1998 and 1999–2006 to correlate with the FDA approval of IFX as a therapeutic option in patients with IBD

– The incidence of surgical procedures *were* lower in the eight year period after 1999, as compared to the two year period before this, he stated.

– Disease related complications seemed to be decreasing during the same time span, Dr Araghizadeh added.

He also reported that important comorbid diseases, like neurological disease and lymphoma – which may in part be related to toxicity from IBD therapies – have *increased* over the same interval.

– A further study is required to evaluate what contribution the advent biologic therapies has had on these trends, he said.

Pay attention to joint complaints

In a symposium titled *Tricky topics in IBD*, chaired by Jonas Halfvarson and Zuzana Zelinkova, Antonio López San Román talked on *Management of IBD arthropathies*.

– We have to pay attention to extratestinal manifestations. One in three IBD patients will at some time experience them, he pointed out to the audience.

The majority of these manifestations are joint complaints/conditions. They are more frequent whenever colon is affected.

– We don't have to disturb asymptomatic patients – no intervention has been clearly shown to *alter* the progression of joint disease. We have only to *pay attention* to any complaints of swollen or painful joints, stiff joints in the morning, paresthesias and impaired gait.

It is very important to also consider drug-induced arthralgia – azathioprine, according to Dr San Román .

– The patients will benefit from general physical measures such as warm pads, guided exercises and physiotherapy.

NSAID-related adverse effects include lesions in small and large bowel that can mimic IBD. They are a mainstay in Rheumatologic therapy, but their use in IBD patients is controversial.

– The studies on whether NSAIDs influence IBD are not coherent, Dr San Román said, and continued to quote several studies that show *no* correlation.

– In my opinion, any patient with inflammatory back pain, that does not respond promptly to NSAIDs, has to be managed by a Rheumatologist!

Worst complication of IBD

Arthur Kaser talked about anaemia and IBD. He referred to a study that looked at 263 IBD-patients with IBD – 65% of these were anaemic at diagnosis.

And *after* treatment, 35% were *still* anaemic!

– It appears to be the worst complication in IBD. It also has a substantial impact on the patients' QoL, said Dr Kaser.

Primarily the patients suffer from iron-deficiency anemia. The symptoms are well known, among them are reduced functional capacity, fatigue, headache and vertigo.

– But we should also consider impaired cognitive function, restless legs syndrome, impaired thermoregulation, impaired immune function and hair loss, said Dr Kaser.

Jonas Halfvarson and Zuzana Zelinkova.

Oral iron substitution may be effective, but is not always well tolerated – i.v. iron substitution might therefore be preferred.

– Treatment of underlying inflammation is important. And remember that recurrence of anemia will come rapidly without continued iron supplementation, he summarised.

Better compliance with simplified dosing

An interesting poster on the subject of anemia was presented by Christoph Gasche.

The study presented showed that there is a greater improvement in the correction of haemoglobin levels, replenishment of iron stores (correction of serum ferritin level) and transferrin saturation rates with the new Ferinject dosing regimen, than with a standard treatment.

– Patients report that fatigue and symptoms associated with iron deficiency anaemia can be as debilitating as their IBD symptoms of abdominal pain and diarrhoea, and we need new effective strategies to treat it, said Dr Gasche.

The simplified dosing regimen uses a simple scheme based on haemoglobin levels and bodyweight of the patient, and can be given in a standardised total of 1000, 1500 or 2000 mg of iron. This should make it easier for patients to adhere to their treatment.

– As this study shows, a convenient and simplified Ferinject dosing regimen could result in better outcomes for patients and fewer visits to the hospital.

– This could allow clinics to be run more efficiently, with more patients seen and treated, said Dr Gasche.

Odormeter

A device to sniff out stomach bugs was presented in a session on *Prediction of cause and outcome in IBD,* by Iftikhar Ahmed.

The hypothesis behind the device is that patients with IBD will have a different pattern and range of volatile organic compounds (VOC) in their faeces, when compared to healthy individuals. VOC are chemicals, and an analysis of these may provide a non-invasive way to predict the clinical course and behaviour of IBD.

In the study Dr Ahmed presented, the device – which he jokingly referred to as the "Odormeter" – had been tested on 205 individuals.

– 75 patients with active IBD, 70 with disease in remission and 60 healthy controls, he explained.

The large bowel involvement both in CD and UC gave a similar pattern of faecal VOC, but different to small bowel CD.

– This technique is fast and convenient. It has the potential to provide a much needed reliable real-time and point-of care diagnosis and monitoring of various gastrointestinal disorders, Dr Ahmed concluded.

Model for prediction of colectomy in UC

Camilla Solberg presented data from the IBSEN study. The aim was to develop a prediction model assessing risk of colectomy within ten years of diagnosis of UC. Also to create a risk matrix model.

– Early prediction of severe outcome of UC could help physicians to provide more

European
Crohn's and Colitis
Organisation

Inflammatory Bowel Diseases

Dublin, Ireland

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10 year ECCO anniversary

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efficient treatment and reduce the risk of complications, she explained.

A population based inception cohort of 519 patients in Norway between 1990 and 1994 had been followed for ten years. After excluding 55 cases due to missing data, 464 cases remained for analysis. 45 of these patients had a colectomy.

– The overall risk for colectomy was low. Our model predicted correctly in 90.3% of the cases, said Dr Solberg.

High risk of being operated within ten years was significantly associated with age under 40, use of steroids, an extensive colitis and with erythrocyte sedimentation rate equivalent of, or higher, than 30.

– The risk for this patient group was 29.9%. This concept of a model based prediction matrix could be helpful in stratifying risk groups requiring more aggressive treatment, said Dr Solberg.

Similarities and differences

The first case of UC was described in 1859. The first case of CD was described in 1932.

– In the journals, the majority of articles on IBD concern CD. There are much fewer articles on UC, Silvio Danese pointed out in his talk on *A pathogenic approach to IBD*.

Why so little attention to UC pathogenesis, he wondered.

– UC was discovered more than 70 years before CD, and UC has higher prevalence than CD.

He continued his lecture by looking at the similarities and differences between the two diseases. First he turned his attention to the intestinal flora.

– It's difficult to study, and still undefined in human IBD. Dysbiosis seems to be linked to both CD and UC, but in CD several specific strains seems to play a pathogenic – or protective – role.

Then Dr Danese continued with innate immunity.

– This is a "hot area". CD is characterised by broad defects in innate immunity. The defects are both NOD2-dependent and independent. But no specific alterations of the innate immune system are at the moment described in UC.

He then talked about adaptive immunity.

– CD has traditionally been categorised as a Th1 disease, UC as a Th2 disease. The cytokine patterns vary according to the state of the disease, and its progression. This leads to an important therapeutic implication: Targeting the right cytokine at the right stage of the disease!

The barrier integrity is also a very important point, said Dr Danese.

– Both diseases display decreased barrier function. UC has unique alterations of PPAR-gamma expression (*PPAR = peroxisome proliferator-activated receptor*). Humoral immunity towards epithelial antigens seems to play a key pathogenic role in UC, he said.

– Inflammation is complicated – because *life* is complicated, Dr Danese summarised his lecture.

Networking

What *ECCO News* has referred to above, is just a pick of all the lectures on IBD that were given during the three days in Barcelona.

But the UEGW is not *all* about lectures and sessions – it's also an important place for networking.

An example of the latter was given by the Swedish IBD-nurse Susanna Jäghult:

– There is a Danish IBD-nurse, Palle Bager, who is doing research. He has taken an initiative for a network for nurses in Scandinavia who are also doing research on their own. We had a meeting down here – eight nurses who described their research projects for each other.

– At that meeting we instantly found possibilities for future co-operation. We will therefore continue to stay in contact with each other, says Susanna Jäghult.

And that is another good way to sum up the experience of going to the UEGW.

Next year the conference is going to be held in Stockholm, Sweden.

PER LUNDBLAD
Senior Writer

A new structure for ECCO approved in Barcelona

All ECCO Members were invited to an Extraordinary General Assembly that was held during the UEGW in Barcelona.

Normally, the General Assembly takes place at the annual ECCO Congress. The reason to call for an *Extraordinary* General Assembly was explained by ECCO's President Daniel Hommes.

– Every growing organisation has to change its structure, he said and explained that in order to add momentum, this decision couldn't wait until next year in Dublin.

– The General Assembly is ECCO's highest organ, and it will remain so. The changes concern the Governing Board and its committees. It's all about *optimising* ECCO, he continued.

But before he started his presentation of the new structure, he introduced the staff at the new ECCO Office – Nicole Eichinger, Barbara Schmid, Stefanie Hartmann and Melanie Pissarius (see picture).

– The ECCO Office is the core of our *organisation*. The National Representatives are also an integral part of *ECCO*, Professor Hommes said.

And then the time had come for him to present the Governing Board's suggestion for a new structure (see page 11).

Guiding ECCO to the Next Level

The recently approved new structure of ECCO will allow the organisation to advance towards accomplishment of its mission. A closer look...

DANIEL HOMMES, President of ECCO

"A look at my watch told me it was time. A bit nervous, I took the stand as I was about to open the Extraordinary General Assembly during the UEGW in Barcelona.

This has never been done before, I thought as I looked for support to the table where my Governing Board was sitting. Their looks confirmed that the time had come to present and justify the details of the ECCO Roadmap and the major revisions of the traditional structure we became to know so well and that proved to be so successful.

All of us had prepared so well, discussed matters with great care, sought advice from our senior IBD friends during the last months. But nothing would nor could happen unless the Extraordinary General Assembly would vote and approve!

Nervous but ready, I felt strong and checked the microphone. Nicole gave me a smile. That helped. 'Dear Friends, on behalf of the Governing Board I would like to welcome you..."

Founding an organisation requires defining a mission, one that is not in the clouds but one that all of its members can relate to on a day to day basis. For NASA it is: 'Taking people to the moon', for ECCO it is: 'Improving the well-being of IBD patients'. Very straightforward, very honest. Hence, all objectives and activities of an organisation must be directly linked to its mission. Progressing from an idea and a piece of paper in Vienna in 2001 to building an organisation that can truly contribute in the field of IBD implies a continuous flexible adaptation of the organisation.

In general, there are different stages of development of any growing organisation. Although the speed by which organisations develop varies, the quality and success is largely dependent upon the principles that an organisation is willing to adhere to. These principles are not altered by the rapidly changing world around us, nor by politics nor any other transitory disruption. No, those principles are natural laws that will lead anyone into passionate execution of the tasks that are defined. Within ECCO, we have formulated these principles among each other, we share these principles with our friends and colleagues within the IBD community and beyond. These principles motivate us to inspire others around us. These principles are often referred to as "*The ECCO Spirit*".

Two of those principles that ECCO adheres to are 1) seeking constant innovation and 2) building trust and friendship. Progress and growth of an organisation means innovation, innovation means adaptation and change. Lack of continuous innovation means standing still. Standing still (sometimes referred to as consolidation) means stepping back, giving up, moving back from the path to one's mission. Innovation is exciting, fun and very motivating! Innovation means involvement of everyone with a good idea. It is exactly this that has brought ECCO so much prosperity. We can enjoy the interest and commitment of young people, nurses, experts, scientists, pediatricians, new industry, surgeons and so on from so many different regions of the world.

Next, how do you build trust? Very simple: by avoiding (too much) politics, by ignoring personal agendas, by always considering win/win transactions, by authentic behaviour. For example, take our National Representatives. Why would a country be interested in ECCO when its National IBD Group is doing well? First, ECCO tries to analyse the aims of National Groups, then we seek complementary deliverables. In other words, ECCO wants to strengthen National Groups on one hand by offering products and services and on the other hand ECCO wants to collaborate on a much larger scale since ECCO believes in synergistic collaboration beyond borders. Further to this, a formidable exciting new step will be the **ECCO Biobank Initiative** which is currently being prepared for an official launch in February during the Anniversary Congress. In accord with its principles, ECCO will not own the data and the outcomes, but merely serves as a platform for collaboration, its own framework programme if you will.

"I have presented these slides so many times during the last months, they don't look very professional to me. The audience is so quiet, is that a good sign? Is anyone sleeping? My English comes out poorly tonight. I am halfway through presenting the statute amendments, my mouth is dry. I could do with a beer. My God, Stefan Schreiber enters the room! He is always late, sits in the front row and hammers his computer without paying attention. Although we love him, I haven't seen him in ECCO meetings for ages; will he step up to the microphone and cause trouble? Mmmm, let's try to get through this last bit, the final vote, the GRAND FINALE..."

So what is this new structure about? Well, the new structure is about building infrastructure, working according to standards, securing the economic position and, most importantly, involving more kindred spirits, people that bring specific expertise and ideas to the table. The new structure is about allowing the ECCO Spirit to further grow and develop our organisation, about preparing for future challenges.

The answers you need to know:
Q: Why is this the proper time to change the structure of ECCO, everything seems to be going so well?
A: ECCO is growing considerably both in number of members and number of stakeholders. In addition we have started our own ECCO Office that will build a modern

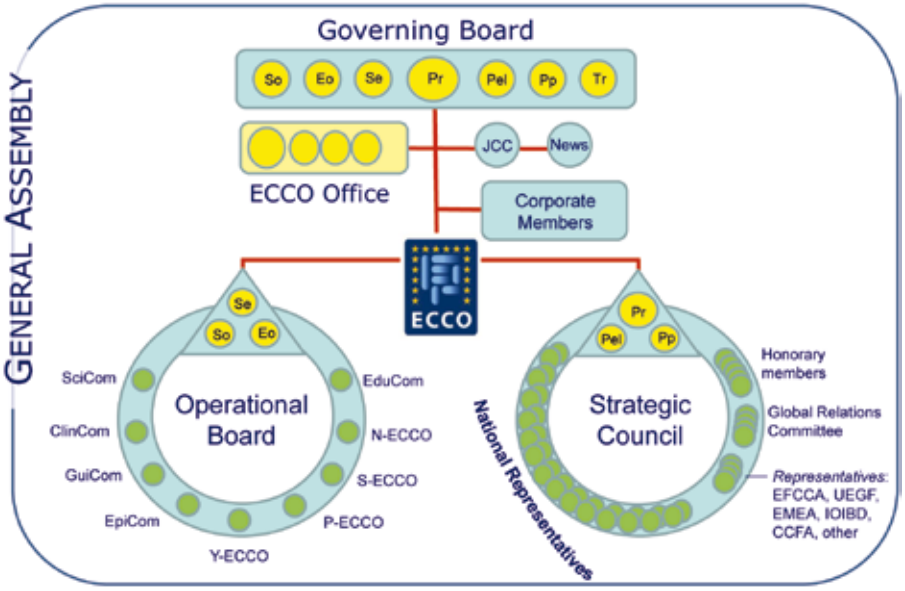
infrastructure around ECCO. This means that all of our operations need to be managed as effectively as possible, in separate committees, where the Governing Board needs to restrict itself to *governance*, *strategy* and *innovation*.

Q: So what does the new ECCO Organogram look like?

A: As you can see in the **Figure**, the structure of the Governing Board does *not* change. On a day-to-day basis we are in contact with the ECCO Office, as well as with our medical journal, JCC, and ECCO News.

On the left side, you can see that all operations are organised into our nine committees: SciCom, EduCom, GuiCom, EpiCom, ClinCom, Y-ECCO, N-ECCO, S-ECCO and P-ECCO. This **Operational Board** is a round table construction chaired by the Secretary and co-chaired by the Education Officer as well as the Scientific Officer, thereby linking ECCO operations directly to the level of the Governing Board. Ideas are brought to the table, and proposals are forwarded directly to the Governing Board level.

On the right side, the former Council of National Representatives is replaced by the **Strategic Council**, allowing our Honorary Members to stay in the loop for advice and guidance. In addition, we will invite representatives from non-EU countries to our inner core. Some non-EU countries are eager to collaborate with us, and naturally ECCO embraces this. Also, we will invite other stakeholders into this council including patient organisations, regulatory agencies, and other IBD communities to share our common vision.



Organogram showing the new structure of ECCO.

Q: What do you mean by infrastructure and standards?

A: First, ECCO will present its new IT infrastructure in Dublin in February. The new ECCO datawarehouse will be a highly secure, fully equipped megastorage, high processing power database with an ECCO Web portal, and applications like a Client Management System, Content Management System, Abstract Handling application, eLearning modules and a lot more. Using state of the art applications and so called *business intelligence* (BI) tools for ECCO datasets (members, relations, activities etc) we will be able to install efficient decision support tools allowing us to operate ECCO very effectively. In addition, we will be able to create a platform for our ECCO Community to interact, to share datasets, to use analysing- and statistical tools and to freely use highly secure eCRFs for clinical studies. Again, ECCO wants to facilitate not to own the data! The opportunities seem endless, and I am sure that a new generation of young ECCO experts will start using the ECCO platform to its fullest potential.

Second, we have started introducing Standard Operational ECCO Procedures to serve as a framework for all our ECCO activities. An example: each of the nine Operational Committees is required to submit their annual plans in a highly formatted way along with budget and timelines.

The vote on the amended statutes was unanimous.

Q: Is ECCO's ambition to be the global IBD organisation?

A: No, on the contrary! Europe including Israel is our playing field, but we are looking forward to working with the Americas, Africa, Russia, Asia and the Pacific because collaboration and sharing knowledge will greatly enhance the overall outcomes which serve to improve the wellbeing of IBD patients, our Mission. We hope to form sister organisations on a global scale.

Q: The industry is mentioned often in the new structure, will ECCO not be influenced by all this interaction?
A: Not at all! This is a common misconception. The industry is essential for any medical society or organisation. I have an aversion to the simplistic view on how the industry is perceived.

The industry is the key for development of new drugs, new devices, nutritional products, cellular therapies and much more. Where would we, and more importantly our patients, be without the industry? We are not, and never will be in a position to develop these innovations. However, we will always adhere to the principle of an unbiased choice with only the benefit of our patients in mind. Within our ECCO family, the industry is very welcome to become Corporate Member, albeit without voting rights in our General Assembly, again translating the ECCO principles into practice. A full disclosure of interest of all members of the Governing Board and Committee members can be found on our website. Indeed, we should advice and assist the industry in their developmental programmes to maximise the endproduct. Also, it is difficult to generalise the industry into one group. We invite not only the traditional big pharma with already marketed drugs but also the small start-up company which will greatly benefit from our guidance and network. In February, we will have an interaction with our (potential) Corporate Members to offer a more differentiated package tailored to individual firms.

Q: When will we know if the new structure worked?
A: I really don't know. For now, we gave it everything we got. Let's talk again next year…

"What was it, room 1219? I pushed the "12" button and waited for the elevator door of the AC Barcelona Hotel to close. Well passed midnight, I ran the film of the last 18 hours in my head on my way to my room. The vote on the amended statutes was unanimous, the relief enormous, the ECCO dinner intimate, the friendship and sense of purpose phenomenal, and… the ECCO Spirit tangible. Let's sleep for a couple of hours and start focussing on our Anniversary Congress in Dublin, a lot of work ahead." ■

The 2011 annual plans of the ECCO Committees

After the unanimous vote on the new ECCO Statutes, a representative from each of the nine Operational Board Committees gave a short presentation of its annual plan for 2011. They are summarised here:

SciCom
Is responsible for the scientific programme for ECCO Congress and IBD programme for UEGW. Also for the realisation and management of one scientific workshop. *SciCom* manages the promotion of scientific IBD projects: Fellowships, grants and travel awards. It has a strong interaction with ClinCom, EpiCom and Operational Board (OB).

EpiCom
Works with inception cohorts (evaluating gradients in East-West-South-North Europe). Also on the agenda are the study of environmental factors (differences throughout Europe) and a nurse project on quality of care in Europe. *EpiCom* will also work with cancer, mortality, surgery and treatment modalities in Europe.

ClinCom
After the tragic death of Marc Lemann, Gert D'Haens has taken over the chair in *ClinCom*. After establishing the group, they are going to work with promotion and support of academic multicenter clinical trials in Europe. Also they are going to work with consultancy, regarding assessment of projects, and they will interact with European Medicines Agency (EMA).

EduCom
Will be involved in the realisation and management of four European and one or two overseas workshops in 2011. They will organise the annual ECCO Course. *EduCom* is going to develop an innovative post-graduate programme for S-ECCO and P-ECCO, and also a concept for an e-learning format.

GuiCom
Is responsible for the update of the UC Guideline 2010/2011. They are going to establish a database with relevant references for guideline development, and an electronic guideline portal to enable interaction between guideline and consensus panellists. With paediatricians, surgeons and ESPEN they are going to participate in Guidelines on Nutrition in IBD. *GuiCom* will interact with RAND (Lausanne) for joint UC project, and expect to finalise Imaging Guidelines.

N-ECCO
On the agenda for 2011 is N-ECCO School: education, networking and training. Naturally also is the N-ECCO Network Meeting – education and networking. The aim is to improve nurse education and nursing quality throughout Europe, and work with linking nurses to patient education. Finally they are going to work with international IBD Nurses Guidelines.

Y-ECCO
In 2011 for the first time, an IBD literature review will be published in *ECCO News* (four issues per year). The Y-ECCO Workshop, which is integrated in the ECCO IBD Course at the annual ECCO Congress, will remain the most important educational tool in the year. Moreover, the integration of Y-ECCO in other activities of ECCO will be reinforced. Contact with the Y-ECCO Members will be ensured at the annual Y-ECCO Members meeting.

S-ECCO
The organisation of a Surgical IBD Course 2012 is on the agenda for 2011. They are also going to work on surgical guidelines, and will work for the integration of surgical topics in ECCO Congress.

P-ECCO
A paediatric IBD Course and paediatric guidelines are on their agenda. So is the organisation of a P-ECCO symposia.

14th ECCO Educational Workshop – Donetsk, Ukraine

The 14th ECCO Educational Workshop took place in Donetsk, Ukraine on September 17, 2010. The workshop was organised by ECCO in collaboration with the Ukrainian IBD Society.

The faculty included Vito Annese (Italy) and Milan Lukas (Czech Republic) from ECCO, as well as the two Ukrainian National Representatives of ECCO – Andrey Dorofeyev and Tatiana Zviagintseva as local chairs and speakers plus Michail Zakharash and Mykola Kucher as speakers.

The workshop was attended by 132 participants from different regions of Ukraine. The participants were represented by gastroenterologists and surgeons with special interest in IBD.

The programme of this one day workshop was based on the discussion of clinical cases. This type of communication was very useful due to the detailed explanation of selected cases and implementation of ECCO Consensus in routine clinical practice. ECCO Guidelines statements formed the base and reference in all presented cases.

In the long run, this educational event should lead to the optimisation in the care of IBD patients in Ukraine.

The workshop was highly interactive with participation of most of the audience. All participants gave positive impressions from the meeting and had clarified standpoints on treatment of IBD patients to improve their quality of life.

On behalf of the Ukrainian IBD Society and all participants we would like to thank ECCO, especially EduCom and SciCom members, for the chance to host this Educational Workshop in Ukraine. Many thanks in particular to Vito Annese, Milan Lukas and the local speakers for their excellent moderation of the sessions and case-presentations. We are especially grateful to Nicole Eichinger and Barbara Schmid, from the ECCO office, for their professionalism and contribution in the organisation of this successful workshop.

ANDREY DOROFEYEV
TATIANA ZVIAGINTSEVA
ECCO National Representatives, Ukraine

15th ECCO Educational Workshop – Budapest, Hungary

The 15th ECCO Workshop took place in Budapest, Hungary, on September 18, 2010. It was organised by ECCO in collaboration with Peter Lakatos and the Hungarian Inflammatory Bowel Disease (IBD) Study Group, as local organisers.

The meeting was preceded by the yearly IBD Update Meeting organised by Ferring Hungary discussing the topic of colorectal cancer in IBD.

The ECCO Workshop was an excellent educational opportunity to discuss and implement the latest ECCO Guidelines on Crohn's disease and ulcerative colitis in a friendly atmosphere. The faculty included Janneke van der Woude, the Chair of ECCO EduCom, from the Netherlands and Daniel Ginard from Spain as well as Pal Miheller, Peter Lakatos and Tamas Molnar as local faculty speakers. The official language of the workshop was English and hence all presentations were given in English.

The workshop programme was following the structure of previous meetings. The main topics covered patient management strategies, treatment and surveillance. Each topic was illustrated with a clinical case and interactive discussion. The workshop started with an introduction of ECCO by Janneke van der Woude explaining the objectives of the association and highlighting the aim and structure of guidelines. This part was followed by six case presentations covering different, partly controversial aspects of IBD, and a state of the art lecture on pregnancy in IBD given by Janneke van der Woude.

The interaction among participants and faculty was profound. This collective effort was very helpful to deliver the most important take home message of the meeting, which was to draw attention to the importance of standardised patient care throughout Europe including the former Eastern European countries by implementing the guidelines on diagnosis, treatment and follow-up in IBD.

The workshop was very successful and was attended by 68 participants, mainly gastroenterologists, covering all primary and referral IBD centres in Hungary. The meeting was highly appreciated by the audience and hence positive feedback was received at the end and after the meeting. The primary aim of ECCO of spreading evidence based guidelines and implementing their use to optimise patient care was accomplished in Hungary.

PETER L LAKATOS & PAL MIHELLER

16th ECCO Educational Workshop – Riga, Latvia

The 16th ECCO Workshop on IBD was held in Riga this year late autumn.

Despite fantastic weather outside about 100 professionals gathered in the heart of Riga on October 9, 2010 in one of the major business and educational centres of the city, Radisson Blu Hotel Latvia. The event was organised by ECCO in collaboration with Juris Pokrotnieks and Jelena Derova, ECCO National Representatives of Latvia, and endorsed by UEGF (United European Gastroenterology Federation).

Excellent faculty of 5 experienced ECCO and local lecturers delivered latest up to date information on IBD. The faculty consisted of the ECCO speakers Boris Vucelic and Axel Dignass as well as of the local speakers, Juris Prokotnieks, Jelena Derova and Aldis Pukitis from Latvia.

General topics on Ulcerative Colitis and Crohn's Disease were presented via case reports which are based on the ECCO Guidelines. Participation from the audience was encouraged by the speakers and hence, due to the different pharmacological possibilities there where many questions raised about TNF agents.

The programme covered the topics: Surveillance and Chemoprevention, Fistulizing Disease, New Onset Ileocecal CD, Left-sided Colitis, Pediatric CD and Fulminant Colitis. In addition, a special state of the art lecture on Pregnancy and IBD was given. Especially the last two topics Fulminant Colitis and Pregnancy and IBD caused lively discussion. Moreover, questions from the audience were raised on topics like: endoscopic surveillance and number of biopsy to take pharmacological and surgical approach in severe UC. These questions where competently answered by faculty.

In general, the ECCO Workshop held in Riga was a very successful step towards a continuous education in IBD. The meeting was highly appreciated by the participating audience and the local organisers and ECCO received throughout positive feedback.

JURIS POKROTNIEKS
ECCO National Representative Latvia

17th ECCO Educational Workshop – Galway, Ireland

The first ECCO Guidelines Workshop on the British isles was hosted really out West in Galway, Ireland.

This lively city is breathing the Atlantic breeze and embraced ECCO with all of its Irish charm on October 15, 2010. Only a few months away from the ECCO 2011 Dublin Congress, this workshop almost felt as a rehearsal for the big venue.

The workshop blended into the Galway IBD Study Day and the local host, Prof. Laurence Egan, spared no efforts to turn this symposium into a stimulating learning experience. The faculty was completed by Dr. Glen Doherty, of St. Vincent's Hospital, Dublin, Ireland and Dr. Matthieu Allez and Dr. Gert Van Assche, as ECCO faculty. However, for the first time the real performers of the ECCO Workshop, those presenting the cases, were all IBD fellows and registrars from the major teaching hospitals in Galway and Dublin. ECCO is therefore very grateful to Anthony O'Connor, Eoin Slattery, Wael Elfazari, Raja Affendi, Abobakr Shadad and Brian Egan for entertaining the cases.

In the morning the workshop started with an introduction to ECCO by Dr. Matthieu Allez, followed by four cases. None of the slide decks were carried all the way through to the end thanks to a vividly interactive audience. The faculty and the participants exchanged thoughts on diagnosis and management of IBD all morning. After lunch, the ECCO State of the Art Lecture doubled as the Medical Grand Round led to the fact that the audience more than tripled. In this lecture, Dr. Gert Van Assche highlighted the most important aspects of the ECCO Guidelines on the diagnosis and management of opportunistic infections in patients with IBD. This lecture was followed by two afternoon case presentations on the management of pouchitis and on perianal fistulizing Crohn's Disease. Prof. Laurence Egan closed the workshop with concluding remarks and words of gratitude towards the faculty, the participants and Melanie Pissarius and Barbara Schmid from the ECCO Office who brilliantly orchestrated the meeting.

This ECCO Workshop was supported by Shire Ireland and was attended by approximately 60 highly interested and predominantly young and emerging Gastroenterologists. Evaluations from the audience were throughout positive and the participants really enjoyed the interactive format of the workshop. Hence, the overall impressions of this workshop were clearly positive.

The Gastroenterology community in Ireland operates at a high and evidence based level, but is still eager to absorb suggestions from the combined ECCO Guidelines. After a full but rewarding day the ECCO faculty, Matthieu Allez and Gert Van Assche left the most Western part of Europe from Galway airport, where passengers are called to the gate by the local bartender while a tractor is fuelling the turbo-prop airplane bound for Dublin.

GERT VAN ASSCHE

Nordic Symposium to share clinical experiences on anti-TNF treatment

Essentials of anti-TNF Therapy (EaTT) is a cross-disciplinary symposium where Gastroenterologists share clinical experiences with Rheumatologists and Dermatologists.
In late September it was held in Copenhagen. 125 delegates from the three specialties came to participate.

The aim of the symposium is to share and discuss more than ten years clinical experience of anti-TNF treatment.

– It's very rare with a conference with three different specialties present, Professor Pia Munkholm stated in her welcoming speech.

Mutual and separate sessions

The delegates came from the Nordic countries. Gastroenterology was the largest specialty present, followed by Rheumatology in second place.

The conference was sponsored by MSD and Centocor, but the programme was designed and planned by an independent scientific steering committee – both in regard to content and choice of speakers.

During the three days the conference lasted, the programme was divided in two categories. Partly in plenary sessions, in which all three specialties participated, and in breakout sessions where they were divided.

A determinant for cancer risk

Professor Anders Ekbom talked about the epidemiological aspects of TNF-meditated chronic inflammatory disorders during the first plenary session.

– The lifetime risk of IBD for patients born 1940 or later is approximately 0.5 to 1%, he said.

The incidence curve on a graph for both CD and UC is rising, and is now approximately the same in most countries.

– The incidence is stable in western countries now – but the number of *patients* is rising, he pointed out.

Inflammatory activity is a determinant for cancer risk.

– The risk is increased in target organs. For psoriasis it is skin cancer, for UC it is colon and rectum and for CD it is the colon, rectum and small intestine. But there is a *decreased* risk for breast cancer in rheumatoid arthritis (RA) and UC. We have no idea why that is so, Professor Ekbom continued.


Anders Ekbom

His conclusion was that there are certain epidemiological characteristics that are the same for IBD, RA and psoriasis.

One of the questions he was asked after his talk, was if anti-TNF in itself is cancerogenic?

– We have *so far* not been able to see that. So the answer is no in the short term. But we need more long-term data before we can be positive, was his answer.

Poetry

The next lecturer, Per Brandtzaeg, started in an unusual way – he described inflammation by using verse!

"Inflammation is meant to be good, that's the way it would be if it would
remain in proportion, avoid all distortion,
resolve at the time that it should.
Inflammation may last and turn chronic,
situation that is most ironic
Instead of defending, result is offending,
protractive destructive demonic"

– That sums it all up, he said.

He continued by talking about the innate immune cells and the adaptive immune cells. These cells need to be activated, so Dr Brandtzaeg described the signal transduction from all surface receptors – that he called "antennas".


Per Brandtzaeg

– They give regulated activation – DNA-binding and transcription factors. All of this is the target of biologicals, he explained.

Anti-TNF therapy was first developed for RA, but is now an approved treatment for several immune-mediated chronic inflammatory disorders.

– But a challenge to the scientists is that the mechanist action of anti-TNF treatment is unclear.

Inefficient regulatory T cells and a defective intestinal barrier function may constitute a common pathogenic basis for the initation of both IBD and RA, and the variables of the adaptive and innate immune defense may be strengthened by probiotics and prebiotics, were two of his conclusions.

Combination therapy

The question of how to start therapy – step-up or top-down – was the topic for the first breakout session. In the Gastro group, Professor Björn Moum talked about the subject.


Björn Moum

– It is much more difficult to stop than start TNF-alpha inhibition, he said.

After establishing IBD diagnosis, there are several management goals. They start with symptom relief and clinical remission and strive for mucosal healing and to prevent further disease.

– We learned in the nineties that immunosupressant (IS) therapy works. But how *long* does it work? A French study shows no reduction in surgery, although increased use of AZA.

Combined treatment – AZA and anti-TNF – has in the SONIC study shown a significantly higher outcome for steroid-free remission.

– It therefore seems that combo-therapy is to be preferred for newly diagnosed CD-patients.

If using the step-up approach, one has to look at the course of the disease, and high-risk patients should receive early optimised treatment, were among his conclusions.

After the breakout session, all delegates gathered to give their conclusions and summaries in plenary.

Checklist in JCC

Professor Jens Dahlerup talked about the benefit and risks of anti-TNF treatment in Gastroenterology. He started by asking how many IBD patients there are in anti-TNF treatment today.


Jens Dahlerup

– A study has estimated this figure to one of four patients, he said.

Professor Dahlerup then talked about how to *define* benefit.

– The benefit is in the eye of the beholder – who can be the patient *or* the physician. It's a change in the quality of life, few or no side effects and prolonged remission or cure. But there are some *markers* of benefit: Response/remission frequencies, frequency of hospital admissions and the patient being able to stay employed are some of these.

Risk is a function of: The probability of an event (threat), the consequence (the impact) and the vulnerability of the person in question. An example of the latter: A patient during anti-TNF treatment may be more vulnerable to opportunistic infection if concomitant treated with one, or to more, immunomodulators.

Professor Dahlerup therefore presented an extensive checklist on what to do before anti-TNF therapy, in order to reduce the risk.

Obtain the patients history regarding previous bacterial, fungal and viral infections. Be aware of endemic opportunistic infections relevant to the geographic location of the patient. Check hepatitis B serology, and – if the history of chicken pox is unclear – varicella serology, were some of the items on the list.

– The full checklist is just published in Journal of Crohn's and Colitis (JCC), he pointed out to the audience.

A meeting for clinicians

The reason to organise EaTT is to benefit from three specialties that use anti-TNF treatment, Professor Pia Munkholm told *ECCO News*.


Pia Munkholm

– Of these three, the Rheumatologists have used these drugs longer than the Gastroenterologists, she pointed out.

The diseases differ, but there are many things the three can learn from each other, Dr Munkholm continued.

– We can learn about risk – benefit and step-up versus top-down. We can also see through our joint discussions we are able to better contribute to quality of life, workability, longer remission and lower surgery rates in IBD and RA.

The Scientific Steering Committee started to plan this meeting a year before it took place.

The programme was designed by Dr Munkholm, and several colleagues from the three specialties.

– It's a bit easier to do this in Scandinavia, where there are only 15 million inhabitants. We *know* each other well, she said.

Dr Munkholm pointed out that it's a meeting for *clinicians*.

– In the audience we had clinicians, and they benefited from the science presented her today, she summarised the congress.

PER LUNDBLAD
Senior Writer

Inflammatory Bowel Diseases

Lisbon, Portugal

7th Congress of ECCO

February 23-25, 2012

Register at the 6th Congress of ECCO in Dublin!

www.ecco-ibd.eu

Inflammatory Bowel Diseases 2011

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

Dublin, Ireland February 24–26, 2011

Preliminary Scientific Programme

Don't miss the 6th Congress of ECCO!

The 6th ECCO Congress will take place in the Convention Centre of Dublin from February 24 to 26. On this occasion the 10th anniversary of ECCO will be celebrated.

The programme has been finalised and many activities are planned, from the traditional ECCO Advanced Course for junior gastroenterologists to the N-ECCO school.

The first congress session will deal with the importance of bacterial-epithelial interactions and how this is relevant to intestinal homeostasis. In addition, the second pathogenesis workshop will report in a comprehensive manner all the aspects related to mucosal healing.

A special session dedicated to paediatric IBD will be held on Friday morning, and this will be followed by an IBD-related surgical session. A translational session will assess the futuristic targets for innate immunity and autophagy. Throughout the congress, the new UC Guidelines will be reported, as well as the Imaging Guidelines.

The traditional appointment with challenging cases and difficult IBD is scheduled for Saturday morning and will be followed by an entire session dedicated to IBD and cancer.

The last session on Saturday includes the presentations of the ECCO Fellowships and Grants. The Lémann lecture on 'Understanding clinical trials in IBD' will be given by Jean- Frédéric Colombel.

Finally, this year's ECCO Interaction Hearts and Minds will be absolutely great. Still the embargo policy does not allow revealing the location, but for sure lots of Guinness will make the evening pleasant.

Silvio Danese, SciCom

THURSDAY, FEBRUARY 24, 2011

11:30 – 12:30 **Satellite symposium**

12:45 – 13:00 Opening and Welcome
Daniel Hommes, Leiden, Netherlands
Colm O'Morain, Dublin, Ireland

13:00 – 14:40 **Scientific session 1: Microbiome meets the epithelium**
Jean-Frédéric Colombel, Lille, France
Laurence Egan, Galway, Ireland

13:00 – 13:20 Concept and importance of mucosa-associated bacteria
Arlette Darfeuille-Michaud, Clermont-Ferrant, France

13:20 – 13:30 Oral presentation 1

13:30 – 13:50 Metabolic functions as sensor for the microbiome
Dirk Haller, Munich, Germany

13:50 – 14:00 Oral presentation 2

14:00 – 14:10 Stressed out!
Arthur Kaser, Innsbruck, Austria

14:10 – 14:20 Oral presentation 3

14:20 – 14:40 Microbial manipulation for IBD in practice
Eamonn Quigley, Cork, Ireland

14:40 – 15:10 Coffee break

15:10 – 16:40 **Scientific session 2: Intestinal healing: 2nd ECCO Pathogenesis Workshop**
Florian Rieder, Cleveland, Ohio, United States
Gigi Veereman, Antwerp, Belgium

15:10 – 15:20 Overview
Andreas Sturm, Berlin, Germany

15:20 – 15:35 Mechanisms of intestinal healing
Miquel Sans, Barcelona, Spain

15:35 – 15:50 Measures and markers for monitoring intestinal healing
Marco Daperno, Torino, Italy

15:50 – 16:05 Impact of intestinal healing on the course of IBD
Laurent Peyrin-Biroulet, Vandeouvre Les Nancy, France

16:05 – 16:20 Therapeutic strategies to enhance intestinal healing
Geert D'Haens, Bonheiden, Belgium

16:20 – 16:30 Oral presentation 4

16:30 – 16:40 Oral presentation 5

16:40 – 17:00 **Mini-session 2: ECCO Guidelines 1: The ECCO Consensus process and future prospects**
Gert van Assche, Leuven, Belgium

17:15 – 18:15 **Satellite symposium**

FRIDAY, FEBRUARY 25, 2011

07:15 – 08:15 **Satellite symposium**

08:30 – 10:00 **Scientific session 3: The age of innocence: IBD in children**
Sanja Kolacek, Zagreb, Croatia
Tom Øresland, Lorenskog, Norway

08:30 – 08:50 IBD in the very young – insights into pathogenesis
Frank Ruemmele, Paris, France

08:50 – 09:00 Oral presentation 6

09:00 – 09:20 IBD surgery in children: indications and outcome
Paolo Lionetti, Florence, Italy

09:20 – 09:30 Oral presentation 7

09:30 – 09:40 Oral presentation 8

09:40 – 10:00 Management of IBD in adolescence
Robert Heuschkel, Cambridge, United Kingdom

Inflammatory Bowel Diseases 2011

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

Dublin, Ireland February 24–26, 2011

Preliminary Scientific Programme

10:00 – 10:20 **Mini-session 3a: ECCO Guidelines 2: Paedriatic Acute Severe Colitis**
Dan Turner, Jerusalem, Israel

10:20 – 10:50 Coffee break

10:50 – 12:20 **Scientific session 4: Targets in IBD: Lost and found**
Silvio Danese, Rozzano, Milano, Italy
Charlie Lees, Edinburgh, United Kingdom

10:50 – 11:10 TLRs as therapeutic targets
Luke O'Neill, Dublin, Ireland

11:10 – 11:20 Oral presentation 9

11:20 – 11:40 Past and future of T cell-directed therapies
Yehuda Chowers, Haifa, Israel

11:40 – 11:50 Oral presentation 10

11:50 – 12:00 Oral presentation 11

12:00 – 12:20 Therapeutic implications of autophagy and apoptosis
Stefan Schreiber, Kiel, Germany

12:20 – 13:15 **Lunch and guided poster session in the exhibition hall**

13:15 – 13:30 **Poster award ceremony**

13:30 – 15:00 **Scientific session 5: Optimising surgical outcomes in IBD**
Johan Söderholm, Linköping, Sweden
Ronan O'Connell, Dublin, Ireland

13:30 – 13:45 Nutrition and medication: Preparation for surgery
John Hyland, Dublin, Ireland

13:45 – 13:55 Oral presentation 12

13:55 – 14:25 Tandem Talk: Treating ileocaecal Crohn's Disease: Resect or medicate?
Julian Panes, Barcelona, Spain
André D'Hoore, Leuven, Belgium

14:25 – 14:35 Oral presentation 13

14:35 – 14:45 Oral presentation 14

14:45 – 15:00 Improving outcomes of Pouch surgery: Raising the bar
Nick Carr, Swansea, Wales, United Kingdom

15:00 – 15:30 Coffee break

15:30 – 17:00 **Scientific session 6: Daily challenges in IBD**
Hülya Ôver-Hamzaoglu, Istanbul, Turkey
Harald Peeters, Gent, Belgium

15:30 – 15:50 Report of the ECCO Guidelines on reproduction and IBD
Janneke van der Woude, Rotterdam, Netherlands

15:50 – 16:00 Oral presentation 15

16:00 – 16:20 Optimising conventional therapies for IBD
Peter Irving, London, United Kingdom

16:20 – 16:30 Oral presentation 16

16:30 – 16:40 Oral presentation 17

16:40 – 17:00 Tailoring anti-TNF therapy in CD
Edouard Louis, Liège, Belgium

17:00 – 17:20 **Mini-session 6: Imaging in IBD**
Simon Jackson, Plymouth, United Kingdom

17:35 – 18:35 **Satellite symposium**

19:00 **ECCO Interaction: Hearts and Minds**

SATURDAY, FEBRUARY 26, 2011

07:15 – 08:15 **Satellite symposium**

08:30-10:00 **Scientific session 7: Challenging cases**
Willem Bemelman, Amsterdam, Netherlands
Eugene Domenech, Badalona, Spain
Michael Kamm, Melbourne, Australia
Siew Ng, Hong Kong, China
Joseph Keane, Dublin, Ireland

10:00 – 10:30 Coffee break

10:30 – 12:00 **Scientific session 8: Cancer and IBD**
Gijs van den Brink, Abcoude, Netherlands
Dino Tarabar, Belgrade, Serbia

10:30 – 10:50 Inflammation and cancer: Partners in crime
Florian Greten, Munich, Germany

10:50 – 11:00 Oral presentation 18

11:00 – 11:20 Needle in a haystack: Strategies to detect cancer
Ralf Kiesslich, Mainz, Germany

11:20 – 11:30 Oral presentation 19

11:30 – 11:40 Oral presentation 20

11:40 – 12:00 Extraintestinal cancer in IBD
Corey Siegel, Dartmouth, United States

12:00 – 13:00 **Scientific session 9**
Daniel Hommes, Leiden, Netherlands
Simon Travis, Oxford, United Kingdom

12:00 – 12:10 ECCO Fellowship 2010: Presentation 1
Emanuela Sala, Rozzano, Milano, Italy

12:10 – 12:20 ECCO Fellowship 2010: Presentation 2
Caterina Strisciuglio, Naples, Italy

12:20 – 12:30 Announcement of ECCO fellowships and grants 2011
Matthieu Allez, Paris, France

12:30 – 13:00 Marc Lémann Lecture: Understanding clinical trials in IBD
Jean-Frédéric Colombel, Lille, France

13:00 – 13:10 Closing remarks
Daniel Hommes, Leiden, Netherlands

Please find the preliminary programme of the following educational activities online at www.ecco-ibd.eu:

■ **ECCO IBD COURSE**
9th IBD Intensive Advanced Course for Junior Gastroenterologists (February 23-24, 2011)

■ **N-ECCO**
2nd N-ECCO School (February 23, 2011)
5th N-ECCO Network Meeting (February 24, 2011)

■ **Y-ECCO**
Y-ECCO Workshop (February 23, 2011)

ECCO 10 Year Anniversary Congress

February 24 – 26, 2011

The Convention Centre Dublin (CCD)

Dear Friends,

On behalf of the Organising Committee we would like to welcome you to our **10 Year Anniversary Congress** in Dublin! The usually cold and wet February days will become warm and pleasurable because you will be among friends enjoying the main State-of-the-Art IBD Programme (*no parallel sessions*), interactive poster presentations, Satellite symposia, great industry exhibitions, and a range of Anniversary activities. These days will further educate you in IBD to the highest standards of today, allowing face-to-face meetings with Key Opinion Leaders from all over the world. You are able to enrich your network, recruit young talents, initiate exchange programmes, start research collaboration and much more!

The Anniversary activities include the presentation of the 10 Year Anniversary Book and Anniversary products, a Treasure Hunt, a Soccer Tournament, and of course the already notorious Fridaynight ECCO Anniversary **Hearts and Minds** in the Guinness Factory. Please don't miss out and register today!

The Organising Committee

Register Now!!
www.ecco-ibd.eu

10 YEARS
ECCO

Tribute to Marc Lémann

Marc Lémann, was born June 27, 1956 in Paris and died suddenly August 26, 2010, while on a beach on Reunion Island.

Marc gained his baccalauréat at the age of 17 in Marseille and undertook his medical studies in Paris, in the university hospital of Pitié-Salpêtrière (1973–1979). He became an intern at the age of 24. He accomplished his military duty at Saint-Denis de La Reunion. He specialised in Hepatogastroenterology during his internship (1981–1985). After one year as an assistant at Antoine Béclère hospital, he turned to research for two years (1986–1988) in the INSERM unit U290 headed by Professor JF Desjeux, at Saint-Lazare hospital. He went back to clinical gastroenterology at Saint-Lazare hospital as an assistant and then moved to Saint-Louis hospital (1988–1991), where he became teaching practitioner (1992–1995), hospital practitioner (1995–2000) and ultimately University Professor – Hospital Practitioner (2000–2010). When Robert Modigliani retired in 2003, Marc Lémann was appointed as his successor as Head of the Hepatogastroenterology department.

This succinct outline belies the many dimensions, great breadth and substantive achievements of his career, touched always with a personal concern for his colleagues and patients that made him unique. Marc Lémann put his medical duties before all others. He combined intuition and high quality clinical reasoning. He treated patients as people, always sparing them time, so it is no surprise that many became attached to his care. Inflammatory bowel disease (IBD) was his main clinical focus and with it, his concern to raise the standards of care for these conditions. Marc developed clinical and translational research with his team participating in many trials of novel therapy. He was an expert investigator and creative thinker, driving many investigator-initiated trials and excelling at collaboration. The activity of translational research in IBD was supported by the recent development of the INSERM "Avenir" team, managed by his colleague, Matthieu Allez, at Saint-Louis Hospital. Gastrointestinal oncology became a new field of interest for his team,

this activity being developed by his collaborator, Jean-Marc Gornet.

Marc Lémann and Emile Sarfati, Head of General Surgery at Saint Louis Hospital, created an exemplary and amicable medical and surgical cooperation, essential for the optimal management of IBD and GI cancers. In partnership with Emile Sarfati and Christophe Hennequin (radiotherapy), a committee of gastrointestinal oncology was created at Saint-Louis. Marc was the head of the group that brought together endocrinology, urology, nephrology, medical and surgical gastroenterology.

He was involved in University education, teaching in his department and at his University (Denis Diderot). He participated in several inter-University programs (IBD, surgical coloproctology) and in postgraduate teaching for gastroenterologists. His department was recognised as a training ground and centre of excellence, becoming a preferred choice for residents in Hepatogastroenterology.

His teaching and scientific lectures, always prepared with care, were crystal-clear. He was a warm and humorous speaker, conveying serious message with a friendly tone, smiling lips and twinkling eyes. He never missed a paradox or the irony of a situation. Colleagues at all levels of expertise and seniority looked forward to his talks and attended them assiduously, knowing that they would find helpful ideas and original insights.

The fundamental research of Marc Lémann focused first on gastrointestinal motility and then IBD immunology. Marc's achievements will, however, be principally remembered for his clinical research on IBD through GETAID, created in 1983 by Robert Modigliani. He initiated or participated in many clinical trials evaluating immunosuppressant drugs and biological therapy, which have revolutionised the care of patients with IBD. He was a major player in international trials testing new molecular targets for the treatment of these diseases. He also recognised the need to define the cumulative burden of IBD and developed new indices, one of which has been named the Lémann Score and quantifies the extent of intestinal damage in Crohn's disease.

However, his pre-eminent and favourite field was that of trials addressing therapeutic strategy. These trials were simple in concept in that they tested clinical practice, but they were robust in design and demonstrated a clear and practical vision of the disease. When two-arm randomised controlled trials were considered the state of the art, Marc designed and lead therapeutic strategy trials that became the principal engines for changes in practice.

Marc Lémann became GETAID chairman in 2002 and still assumed this charge in 2010. His chairmanship gave an extraordinary impetus to the group increasing and diversifying national and international studies that lead to high-impact publications. GETAID is now considered a major vehicle for investigator-initiated clinical or therapeutic research on IBD throughout the world. It has become a force for progress and a model that international colleagues strive to emulate. Marc achieved this influence by his personality, seeking always to find the common ground for collaboration, motivating colleagues and resolving tension... His technique was disarming; when asked to explain his se-

cret, Marc used to answer that it was the coupling between physicians and biostatisticians, internal democracy and mixing this all with friendship. He did not need to be more precise. He knew, quite simply, how to make different people work together in a friendly atmosphere; he knew how to bring out the best of everyone.

Marc was a member of European and International organisations dedicated to IBD. He contributed to the European Crohn's and Colitis Organisation (ECCO) from its inception and was an elected member of the International Organisation for the Study of Inflammatory Bowel Diseases (IOIBD). Apart from being a major contributor to consensus documents on ulcerative colitis and Crohn's disease, he was the spearhead for a Clinical Trials Committee in ECCO. Yet above all, it was his engaging personality that resolved disagreements and contributed so much to the spirit of ECCO, encouraging young people and promoting collaboration. As a leading international expert on IBD and often invited to speak at conferences, his work resulted in 160 peer-reviewed publications, many published in major journals and others in the process of publication that will preserve his memory among his many friends and generations to follow.

That Marc was an exceptional practitioner, a brilliant teacher and speaker, a productive researcher and an outstanding organiser is not a formula for posthumous praise, but a faithful, first-hand reflection of the man with whom we worked. His sharp intellect, open-mindedness, powerful capacity for work and remarkable efficiency were his conspicuous and widely-recognised qualities. The man was an active pessimist with a lucid irony. He cultivated and maintained friendship with the same rigorous warmth that he displayed in his work, making everyone feel like a special friend. It was his great store of medical and general knowledge that underpinned his penetrating and original thought. It is worth reading the many tributes recorded on the ECCO website (www.ecco-ibd.eu).

The sudden death of Marc, in the middle of his life, is a terrible bereavement for his father, his children Raphaelle and Stanislas, his brothers and sisters Frederic, Isabelle and Florence, and all his family. It is the loss of a very dear friend to all who worked with him. His death leaves a sorrowful void. He is sadly missed at Saint-Louis Hospital, in the Faculty of Medicine, in French gastroenterology and in the entire world of IBD. He was to become the next President of the French National Society of Gastroenterology, just one of many reminders of his presence, which stir sadness and regret, but also admiration and affection.

May his children, family, friends, colleagues and everyone know how much we loved him. He has left an indelible footprint.

JEAN FRÉDÉRIC COLOMBEL • MATTHIEU ALLEZ
FRANCK CARBONNEL • PATRICIA DÉTRÉ
YORAM BOUHNIK • ROBERT MODIGLIANI
and the **GETAID**

NOTICE OF FORTHCOMING ECCO ELECTIONS

Dear Colleagues!
Notice is hereby given that the following positions are open for election:

ECCO Treasurer (ECCO Governing Board)
ECCO ClinCom Member (ECCO Clinical Trial Committee)
3 ECCO EpiCom Members (ECCO Epidemiology Committee)
3 Y-ECCO Committee Members (Young ECCO Committee)

Submission of applications:
Applications need to be received by the ECCO Office at least 6 weeks prior to the General Assembly taking place in Dublin on February 24, 2011. The details of the nominations will be circulated prior to the General Assembly Meeting.

The following documents need to be submitted:

- Two A4 page Curriculum Vitae and
- A mission statement of up to 1000 words

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

Deadline for receipt of all nominations is December 19, 2010.

For detailed information about the open positions please visit the ECCO website at www.ecco-ibd.eu.

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

With best regards,

Daniel Hommes *ECCO President*
Séverine Vermeire *ECCO Secretary*

ECCO GOVERNING BOARD 2010

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d.w.hommes@lumc.nl

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Progress of the Second Scientific Workshop of ECCO on Intestinal Healing

With the subgroups and general meeting at UEGW 2010 in Barcelona on October 23, the second Scientific Workshop of ECCO has entered its final phase.

After a very substantial work of literature search, synthesis and writing, the 4 subgroups of the workshop have met first for a subgroup meeting aiming at finalising the key issues and statements of their topic and second for a general discussion with the whole group to allow interaction and further brainstorming.

The group leaders, topics covered and lists of key questions for each subgroup are described in the enclosed-table.

The general discussion has emphasised the lack of unique and broadly accepted definition for intestinal healing. In the literature, intestinal healing has been defined either by the absence of any abnormality (even histologic), a normal appearance of the mucosa, the absence of active lesion, the absence of ulcer or more precise thresholds using various endoscopic scores of activity. These different definitions have been associated with different disease outcomes. Hence, in their last working phase the different subgroups will have to clearly define how they precisely define intestinal healing each time they address a specific question. One of the deliverables of this workshop could be to come-up with a series of standardised definitions of different levels of tissue healing to be used in future studies.

The subgroups must now finalise both a synthetic manuscript describing the key questions related to their topic, the key statement or unsolved issues for each of these questions and the future studies that could be launched in the field. Meanwhile they will also prepare the presentations to be given at the ECCO 2011 Congress in Dublin.

EDOUARD LOUIS

Topic	Mechanism of intestinal healing	Imaging and biomarkers to monitor mucosal healing	Impact of intestinal healing on the course of IBD	Therapeutic strategies to enhance intestinal healing
Group leaders	Miquel Sans and Florian Rieder	Marco Daperno and Edouard Louis	Laurent Peyrin-Biroulet and Andreas Sturm	Geert D'Haens, Gert Van Assche and Axel Dignass
Key questions	– Definition of and players in intestinal wound healing generation – Early events in healing – Late events in healing – Variation of intestinal healing – What technical tools are neede to address the future questions – …	– How to define mucosal healing in CD and UC – How to assess transmural healing in DC – How to assess pathological healing in CD -What is the role of blood and stool markers in intestinal healing assessment – …	– What is the impact of different degrees of intestinal healing – What is the importance of the length of intestinal healing – When to assess intestinal healing – What to do when one has reached mucosal healing – …	– What is the level of tissue healing reached by different drugs – Impact of co-treatment on the level of intestinal healing reached – What is the influence of disease duration on the ability to heal intestine – …

Call for the 2011 Scientific Workshop and calling the price

➤ Second ECCO Scientific Workshop on Mucosal Healing

In its purpose to foster IBD-related scientific research in Europe and beyond, ECCO launches yearly scientific workshops (SWS)(formally called pathogenesis workshops).

After the first SWS "mechanisms of anti-TNF failures" in 2009 and the second SWS "intestinal healing" in 2011, SciCom is now calling for proposals for its third SWS which will be launched at the ECCO meeting in February 2011.

Every ECCO member is invited to propose until December 31 2010 a respective important topic related to IBD. This topic has to deal with pathogenic and basic science features but must be clinically relevant and make a link between basic and clinical research.

The proposal should not exceed one page, must clearly indicate in what way this topic is important to the IBD community, and should be sent before the deadline by email to the ECCO Office.

Starting in 2011, ECCO will not only encourage the submission of Grants and Fellowship demands based on researches approaching unsolved questions raised in the SWS, but even more, designate one of its grants related to the previous SWS topics.

Andreas Sturm

Dear friends of Y-ECCO,

The ECCO Congress in Dublin is approaching fast. Therefore, it's time to inform you about some important Y-ECCO issues.

During our Y-ECCO Members' meeting in Dublin on Wednesday, February 23, 2011 we will inaugurate **our new Y-ECCO Committee**. This committee will exist of 3 people who will deal with the organisation of Y-ECCO and its activities in the future. In contrast to the electronic voting procedure in the past, the committee members will choose a Y-ECCO Chair among themselves and this chair will represent Y-ECCO within the ECCO structures. The new Y-ECCO Chair and the other committee members will start their term during the ECCO meeting in Dublin. All Y-ECCO Members have the possibility to apply for a position within the Y-ECCO Committee. More details on this procedure can be found in this issue of ECCO News and on the ECCO website. We truly hope that a lot of enthusiastic young scientists and clinicians want to build further on the future of Y-ECCO.

If you want to learn more about the tasks and activities of the committee members, please feel free to contact one of us.

On Wednesday, February 23, 2011 we will also organise the fourth **Y-ECCO Workshop**. Charlie Lees, Jan Wehkamp and Marjolijn Duijvestein set up a tremendous programme with the title "How to pursue a career in IBD". Several outstanding speakers will share their ideas on networking, gender issues, fund raising, and dealing with pharma. All Y-ECCO Members are more than welcome to participate in this interactive workshop. The **Preliminary Programme** of the Y-ECCO Workshop can be found online at www.ecco-ibd.eu.

Finally, we have decided to start a **literature review** in the future ECCO News issues. To make this possible, we are looking for some Y-ECCO Members who want to collaborate with a senior ECCO Member in writing a two page review of the 3 most import IBD related papers in the last trimester. This might be a nice opportunity for you to work together with some IBD opinion leaders. If you are interested, please inform us or the ECCO Office asap.

See you all in Dublin!

Key meetings:

Wednesday, Feb. 23, 2011 from 16:00 to 18:00: **Y-ECCO Workshop.**

Wednesday, Feb. 23, 2011 from 18:15 to 19:15: **Y-ECCO Members' Meeting.**

Friday, Feb. 25, 2011 from 19:00 onwards: **ECCO Interaction Hearts and Minds** (don't forget to register).

MARC FERRANTE
(Y-ECCO Chair, Leuven, Belgium)
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JAN WEHKAMP
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Call for N-ECCO National Representatives

N-ECCO is looking for N-ECCO National Representatives to promote its educational programmes and its endeavour to improve IBD-nurse education in Europe and beyond in the following countries: Bulgaria, Greece, Hungary, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Turkey, and Ukraine.

Please submit your CV and a one-page mission statement by December, 19, 2010 to ecco@ecco-ibd.eu.

If you have any questions with regard to the duties and responsibilities of an N-ECCO National Representative please contact Ms Melanie Pissarius (m.pissarius@ecco-ibd.eu) to provide you with further information.

N-ECCO National Representatives will be elected by the N-ECCO Steering Committee and will be inaugurated during the next N-ECCO National Representative Meeting on February, 24, 2011.

N-ECCO National Representatives 2010

Austria	Monika	Reimitz	monika.reimitz@gmail.com
Belgium	Valerie	Wambacq	valerie.wambacq@erasme.ulb.ac.be
Croatia	Vesna	Oroz	vesna.oroz1@zg.t-com.hr
Czech Republic	Ludmila	Prochazkova	Ludmila.Prochazkova@seznam.cz
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Denmark	Lotte Julin	Hansen	lkjh@rn.dk
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United Kingdom	Karen	Kemp	Karen.kemp@cmmc.nhs.uk

Experience the ECCO spirit:
Become a member!

Become member or renew your ECCO membership for 2011 and profit from a reduced registration fee for the ECCO Congress in Dublin, February 24 – 26, 2011

Being a member of ECCO you will experience a range of benefits:

- ✔ Reduced registration fee for the annual ECCO Congress for the year of membership
- ✔ Free subscription to JCC - The Journal of Crohn's and Colitis (6 issues/year and online access)*
- ✔ Monthly eNewsletter on all ECCO activities and latest news in IBD
- ✔ Free subscription to the quarterly ECCO News - the society's magazine
- ✔ Membership login to www.ecco-ibd.eu (member search, reports of the General Assembly, etc.)
- ✔ Free use of IBDIS (category 1)
- ✔ Special educational and networking activities for graduates, fellows, and nurses
- ✔ Access to a large network of young and inspired IBD specialists
- ✔ Free copy of the ECCO anniversary book (only for members in 2011)

ECCO

Please use the ECCO membership form or simply apply online at www.ecco-ibd.eu.
For any questions regarding ECCO or ECCO membership please contact the ECCO Office in Vienna:
Tel: +43-(0)1-710 22 42, e-mail: ecco@ecco-ibd.eu

*) For regular members only

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MMPs and ADAMs in inflammatory bowel disease: preliminary results

Introduction: Matrix metalloproteinases (MMPs) are zinc-dependent endopeptidases, capable of degrading different extracellular matrix proteins. MMPs are inhibited by specific endogenous tissue inhibitors of metalloproteinases (TIMPs). The ADAM (a disintegrin and metalloproteinase) protein family are transmembrane glycoproteins known to be involved in cell adhesion and proteolytic ectodomain processing of cytokines and adhesion molecules.

MMPs, TIMPs and ADAMs have been shown to play a role in the inflammatory and repair cascade in the inflamed intestine. Evidence exists for expression and activity of these enzymes in inflammatory bowel disease (IBD), but no study has systematically delineated the deferential expression of the different MMPs and ADAMs in different disease manifestations.

Aims: The aim of our current study is to map the differential expression of MMPs, TIMPs and ADAMs in the terminal ileum and colon of IBD patients.

Methods: Biopsies from the terminal ileum, left colon and right colon of IBD patients and controls are collected during colonoscopy. The mucosal macroscopic appearance, disease classification and demographic details are noted. Real Time PCR using selected primers and probes for indentifying a range of MMPs, ADAMs and TIMPs is used.

Results: Preliminary results indicate differential expression of MMPs and ADAMs in Crohn's disease as compared to ulcerative colitis, colon as compared to ileum location, and inflamed mucosa as compared to healthy mucosa.

Conclusions: If validated, these results will allow us to focus on therapeutic implications of differential MMP expression. Cell lines and animal models using specific MMP inhibitors will initially be used. The proposed studies may enable to develop novel therapeutic approaches for IBD, extending the spectrum of responding patients and affecting mucosal healing and fibrosis.

YOAV MAZOR
Rambam Health Center
Internal Medicine B
Haifa, Israel

Modulating primary intestinal epithelial defence and immune response in inflammatory bowel disease – Development of integrated inducible epithelial gene transfer and expression system

Recent genome-wide association studies have revealed significant insights into the pathogenesis of inflammatory bowel disease. With more than 50 susceptibility genomic loci identified, the major challenge has shifted the focus to understanding rather than characterising the genetic architecture of IBD. Emerging data implicates the importance of the intestinal epithelial cells (IEC) as critical participants in the immune response and the maintenance of intestinal homoeostasis. Of interest, a number of genes directly involved in intestinal epithelial function and integrity (PTGER4, ITLN1, DMBT1, XBP1, ECM1 for examples) have been identified by GWA studies. In this context, this project aims to design an experimental system that would allow us to develop a human intestinal epithelial model with a gene transfer system that allows precise control of gene expression and function. This will enable the study of directional modulation of epithelial components of the primary gut barrier defence and innate immunity along with the recent key susceptibility genes involved in the epithelial integrity. Briefly, we will integrate our current method for generating stable mammalian expression cell lines by Flp Recombinase-Mediated Integration with an inducible system based upon the insect hormone ecdysone or its analog ponasterone A (ponA), which can activate transcription in mammalian cells harboring both the gene for the Drosophila melanogaster ecdysone receptor and a promoter containing a binding site for the ecdysone receptor. 3 intestinal epithelial cell lines (HT29, HCT116 and T84 epithelial monolayer) with a receptor site for which genes of interests can be cloned into and subsequently activated by ponasterone A, which has no known measurable effect on mammalian physiology. If successful, this system will allow epithelial targets to be tested directly with a view to identify and understand new pathways that can be translated into potential new avenues of therapy in IBD.

DR GWO-TZER HO
Gastrointestinal Unit
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The role for Protein tyrosine phosphatise N2 in the regulation of cytokine-induced apoptosis in the intestinal epithelium

During IBD the rate of apoptotic events in intestinal epithelial cells (IEC) is significantly increased while their number in mucosal immune cells is tremendously decreased. A reduced apoptosis rate in immune cells plays a crucial role for the pathogenesis of IBD and recent studies suggest hereby a causal role for TNF and IFNg. The gene locus of PTPN2 has been associated with IBD and my recent data demonstrate that PTPN2 is activated by TNF and IFNg and regulates cytokine-induced signalling and effects in IEC.

Our hypothesis is that PTPN2 regulates cytokine-induced apoptosis in IEC and monocytes. We will investigate whether loss of PTPN2 affects the extent of apoptosis in our cell lines using molecular approaches and by visual imaging. We will determine the activity of apoptosis effector molecules, such as certain caspases, in PTPN2-competent as well as PTPN2-deficient cells in response to TNF and/or IFNg. We will identify the signalling intermediates that are targeted by PTPN2 in the respective cellular context using pharmacological inhibitors and by genetic studies. We speculate that PTPN2 targets, among others, ERK1/2, STAT1 and AKT. We will also investigate the respective effects of TNF-blockers, such as Infliximab, in vitro. Further, we will incubate human intestinal biopsies from IBD and non-IBD patients with TNF-blockers and assess the extent of apoptosis, expression and activity of PTPN2 as well as of signalling intermediates and apoptosis effector molecules in ex vivo.

These findings will define the role for PTPN2 in the pathogenesis of chronic intestinal inflammation. They will reveal new insights in the pathophysiology of IBD and might help to identify new targets for the treatment not only of IBD but also of other diseases featuring a chronic inflammatory state.

MICHAEL SCHARL
University Hospital Zürich
Clinic for Gastroenterology and Hepatology
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Toll-Interacting Protein Deficiency Increases Susceptibility to Acute and Chronic Colitis

M. Maillard[1], E. Bernasconi[1], Holm Uhlig[2], C. Pythoud[1], D. Bachmann[1],H. Bouzourène[3], K. Burns[4], P. Michetti[1,5], D. Velin[1]
[1]Service de gastroentérologie et d'hépatologie, CHUV-UNIL, Lausanne, [2]Kindergastroenterologie, Leipzig, Germany, [3]Institut de pathologie, CHUV-UNIL, Lausanne [4]Institut de Biochimie, Lausanne, [5]Gastro-entérologie La Source-Beaulieu, Lausanne.

Background: Sensing of bacterial products via Toll-like receptors is critical to maintain gut immune homeostasis. The Toll-Interacting Protein (Tollip) inhibits downstream signaling through the IL-1 receptor, TLR-2 and TLR-4. Here,we aimed to address the role of Tollip in acute and chronic inflammatory responses in the gut.

Material and methods: WT or Tollip-deficient mice were exposed to dextran sulfate sodium (DSS) 1.5% in the drinking water during 7 days. To generate bone-marrow chimeras, WT or Tollip deficient mice were 900-rads irradiated, transplanted with WT or Tollip deficient bone-marrow cells and challenged with DSS 2-3 months after transplantation. IL-10 deficient mice were bred with Tollip deficient mice and colitis was compared at various time points. Bone-marrow cells from WT or Tollip deficient mice were in vitro differentiated in macrophages (BMDM) using M-CSF and stimulated with LPS in vitro. NFκB activity was determined by Western Blot and pro-inflammatory gene expression by RT-qPCR analysis. Caco-2 cells were knocked-down using a Tollip-specific siRNA and IL-8 was measured in culture supernatant after in vitro challenge with peptidoglycan.

Results: Upon DSS exposure, Tollip-deficient mice had increased body weight loss and increased pro-inflammatory cytokine expression compared to WT controls. Challenge of bone-marrow chimeras showed that colitis susceptibility was also increased when Tollip deficiency was restricted to non-hematopoietic cells. DSS-exposure lead to a disorganised distribution of zona-occludens-1, a tight junction marker and increased number of apoptotic, cleaved caspase 3 positive, epithelial cells in Tollip-deficient compared to WT mice. In vitro stimulation of Tollip deficient BMDM or intestinal epithelial cells showed increased NFkB activity and pro-inflammatory cytokines secretion. Chronic colitis was also affected by Tollip deficiency as Tollip/IL-10 deficient mice had more severe histological stigmata of colitis and higher IL-17 expression than IL-10 deficient controls.

Conclusion: Tollip in non-hematopoietic cells is critical for adequate response to a chemical-induced stress in the gut and to hamper chronic bacteria-driven colitis. Modulation of epithelial cell integrity via Tollip likely contributes to the observed defects.

MICHEL MAILLARD
CHUV
Division of Gastroenterology and Hepatology
Lausanne, Switzerland

Travel Award Report – Zoran Milenkovic

From April 1 to June 29 2010, supported by the ECCO Travel Award, I had the possibility to visit one of the leading IBD centres in Europe as a clinical observer, Hospital Claude Huriez in Lille. That was a great opportunity for me as a young gastroenterologist interested in the area of IBD, to experience different strategies in the treatment of IBD patients (hospitalised and outpatients), especially in administrations of different anti-TNF agents, as well as therapy regimens for most severe and complicated clinical cases.

Mostly, I worked together with Professor J.F.Colombel, observed examinations during IBD consultations, where I had been introduced to the implementation of guidelines in treatment regimens of IBD patients. In addition, we collaborated in literature search, paper analysis and discussions of diverse subjects related to IBD, which for me a was quite a new experience and challenge in following the path of IBD science. From that, many ideas for possible projects and papers came into existence.

During everyday visits at departments of the Gastroenterology Clinic in Hospital Claude Huriez (Nutrition and Endoscopy), I faced great hospitality from all of the staff members and experienced very good communication among doctors in sharing knowledge and practice in the IBD area. I had the chance to observe implementation of advanced diagnostic procedures with which I had not been familiar before and which are not presented in routine practice in my country and institution (like e.g. endomicroscopy and capsule endoscopy).

I emphasise excellent organisation and technical support in the everyday work at the hospital. I would rate my stay in Lille as excellent, productive and challenging by all means.

For that reason I can say: ECCO mission accomplished!

ZORAN MILENKOVIC
Military Academy
Department of Gastroenterology
Belgrade, Serbia

Travel Award Report – Ana-Maria Catuneanu

For two months, I have had the privilege to visit the Gastroenterology Unit at the John Radcliffe Hospital, Oxford. Besides being involved in the teaching programme, challenging multidisciplinary meetings, ward rounds and interactive IBD clinics, the most fascinating aspect was the crossover between clinical activity, translational research and basic science.

I brought home many valuable lessons: From Dr. Simon Travis, a most welcoming host and mentor, the importance of clinically-driven medicine, cooperation and joint management and a deep understanding of the patients and their disease. Dr. Alison Simmons introduced me to research on NOD2-mediated autophagy, Dr. Satish Keshav to the captivating concept of targeting the chemokine system to modulate intestine-specific immune responses.

Helping with the project on 'Prognostic factors in CD' and reading the medical notes, was a learning experience in itself.

To sum it up, I strongly recommend applying for a Travel Grant; it is about getting an education in IBD and creating links that may help you contribute to the field.

ANA-MARIA CATUNEANU
Elias University Hospital
Gastroenterology
Bucharest, Romania

Treatment and care – why IBD specialist nurses are essential

EFCCA is a Federation of 25 IBD patients associations, across 24 countries, representing over 100,000 active members, and a wider community of about 2.2 million people with IBD in Europe. There is great diversity – the largest national IBD association within EFCCA is 150 times the size of the smallest. Some associations concentrate on lobbying for health service change or funding research, others focus on providing information and hosting events. EFCCA seeks to connect these associations, across common themes such as access to treatments, equity of treatment across Europe, patient rights and choices, lifestyle topics such as employment, education, travel, relationships, and showcase events such as the annual General Assembly, youth group meetings, and summer camp for children with IBD.

Despite this diversity, one thing is consistent – people with IBD universally and vocally tell us that the role of the specialist IBD nurse, where present, is an essential part of their care, and that including a specialist nurse in the IBD team is a tangible and pragmatic means of increasing quality of care, and ultimately supporting better patient outcomes or reducing morbidity.

The root of this could be the difference between concepts of 'treatment' and 'care'. 'Treatments' (perhaps medication, a surgical intervention, an investigation or test), are necessary in IBD, but not sufficient. 'Care' must also be provided, and this involves a much wider, holistic assessment of the true impact of IBD on the patient's health, with detailed consideration of lifestyle factors, quality of life, and discussion around patient choice.

This concept of 'care', as provided by specialist nurses, encompasses many further elements. The specialist IBD nurse is often **highly accessible to patients**, and can be their first point-of-contact. Nurses tend to encounter their patients more frequently, and earlier, and can therefore effectively treat, or sign-post patients to the service they need from an appropriate specialist, with appropriate urgency. This **accessibility** and **speed of treatment and referral** is associated with improved outcomes, and is reassuring to patients – especially since IBD is often an isolating and emotive illness. **Referrals can also be reduced**, as nurses can provide pragmatic advice and reassurance which may mean admission or consultation is not needed. This provides a better patient experience, and also reduces service pressure and costs.

> "IBD specialist nurses provide exceptional support to enable informed patient choice and shared decision-making.

The specialist IBD nurse often has **greater time per patient**, compared to hospital specialists or family doctors. The specialist nurse, if well resourced, can provide information and practical advice; discuss co-morbidities and complications more fully; explain risks and benefits; explore lifestyle and social factors; refer to patient information or patients' groups for mutual support; co-ordinate with colleagues from, for example, rheumatology, dermatology, immunology, paediatrics, nutritional and diet departments, and ostomy services, to ensure well co-ordinated holistic care is provided; and provide a range of other essential roles and functions which may be omitted from a consultant or family doctor consultation due to time constraints.

IBD specialist nurses provide exceptional support to **enable informed patient choice** and **shared decision-making**. In the 21st century, patients must be involved in treatment decisions which affect them, as national and European standards and legislation are beginning to require. The specialist nurse often has greater expertise, understanding, and experience, to ensure that patients can accurately interpret and appraise their options, and arrive at the best and most appropriate decision for them. This control over one's own treatment and condition is often empowering and liberating.

Ultimately, IBD specialist nurses decrease fear and anxiety, increase confidence and choice, and offer both 'treatment' and 'care' – and this is of the most tremendous value to patients.

Despite all this, as you know, it is often difficult to persuade healthcare commissioners, managers, and government to fund and sustain the essential work of specialist IBD nurses, especially with increasing health service demand and economic pressures. For example, our members tell us that there is only a single IBD nurse in Northern Ireland, for a population of 1.8 million, and some countries have no official specialist nurses at all.

The outcomes and benefits of this specialty are difficult to measure – quality of life and good care are often qualitative, whereas quantitative measures and metrics may be required to argue for improved resourcing and provision of funding. However, working together, specialist nurses and EFCCA can hopefully begin to change this.

For example, November 2010 – January 2011, EFCCA will run the 'IBD IMPACT survey', which aims to highlight the broader impact of IBD, not merely within the traditional medical model. Perhaps an association between outcomes and the role of the specialist nurse will be found, which we can use to make the case for improved support for IBD specialist nurses – in terms of commissioning this role, and providing training such as that received at the NECCO IBD school. With this, we can provide the improved and complete care that we know is possible.

BEN WILSON
EFCCA

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