ECCO NEWS

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

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LETTER FROM THE PRESIDENT

Dear friends,

A seasonal update from the bowels of ECCO. After a harsh winter and a cool spring, summer is definitely approaching. The winter gave us a fantastic annual congress in Prague. The spring has given us new blossom by ways of our **new ECCO Office** in Vienna. Let me tell you a little bit more about what happened and start by using a metaphor. Consider ECCO to be an Olympic team, and why not. All of you, our *paying* individual members, are its Olympic star athletes. So far, we have been training hard and have won several prizes. But we want to proceed to Olympic levels and consequently need better training facilities. This is why we have improved our staff and Olympic facilities. We are all set for new Olympic records!

Our new ECCO Office is located near the beautiful Stadtpark in Vienna, and situated in a wonderful old building in the Ölzeltgasse (check on Google Maps). In the first week of May, Nicole Eichinger moved in with our ECCO gear together with our new staff member Melanie Pissarius. Melanie has recently joined us and will be responsible for both association management and congress management. Our scientific and educational activities have increased substantially over the last years. A major task of the current Governing Board is to adapt to these increasing demands. One element with which we began this process was with the installation of our ECCO Office. We will further professionalise and improve our services to all our stakeholders as well as improve the management structure around our organisation and annual congress. In a later issue of *ECCO News*, we will give you an in depth overview.

Following the installation of our ECCO Office, we have now begun to develop ideas about restructuring ECCO in a way that it can meet the challenges of tomorrow. The drivers for change are 1) an increase in the number of ECCO stakeholders (i.e. nurses, surgeons, paediatricians, non-EU countries, patient organisations, corporate sponsors ect) 2) a sharp increase in scientific and educational activities 3) the need to improve our financial situation 4) the changing relationship between academia and the biomedical industry. In the summer months we will work hard to turn our ideas into a proposal which we like to present to you. Therefore, I would like to invite you all to attend the ***extraordinary General Assembly*, on Sunday October 24 from 4.45 – 7pm during the UEGW 2010 in Barcelona**. Please reserve this time in your agenda because we really need you there! Further details will follow. Along with a new governance structure come revised statutes which need to be approved during this extraordinary General Assembly. In the next ECCO Newsletter we will further inform you about our ideas, meanwhile we hope that you will approach us with your ideas and comments.

Our new ECCO Office in Vienna.

Melanie Pissarius and Nicole Eichinger at work.

Finally, I would like to share with you some exciting news. Our scientific journal, the JCC, will increase her issues from 4/year to 6/year! Thanks to the hard work of our Editor-in-Chief Miquel Gassull and Editor Eduard Cabré the number of submitted original articles doubled last year and is still increasing. Our journal is really becoming very popular around the globe, and in September we are hoping to be awarded a citation in PubMed. We will keep you posted.

Please enjoy this issue of ECCO News, and hope to see you soon!

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

DAAN HOMMES

Updated ECCO Guidelines

On the Diagnosis and Management of Crohn's Disease

By **GERT VAN ASSCHE** and **AXEL DIGNASS** on behalf of the ECCO working parties on the guidelines for the diagnosis and management of Crohn's disease.

In 2006, ECCO published its first set of guidelines ever. These guidelines covered the diagnosis and current management of Crohn's disease.

The guidelines were published in GUT and soon became a standard reference for the management of Crohn's disease in Europe and in other parts of the world. The fact that the article on Current management of Crohn's disease was one of the top cited papers GUT published in 2006, illustrates very well how these guidelines have impacted on the community of physicians caring for patients with IBD.

In the next years until 2010, ECCO has published guidelines on the diagnosis and management of ulcerative colitis and on various topics such as infectious disease associated with the use of immunosuppressives and novel imaging techniques. Since the statements that were the basis for the guidelines on Crohn's disease published in 2006 had been agreed upon in a consensus meeting in 2004, ECCO opted to revise the guidelines on Crohn's disease in 2008. Indeed, by then novel therapeutic options had entered clinical practice and new diagnostic tools had become available. The guidelines committee set out to call upon ECCO national representatives and other experts, to join working parties aimed at revising the statements of the original guidelines published in 2006. We aimed to respect the subsections of the Crohn's disease guidelines: Definitions and Diagnosis, Current management and Special situations. The three different sections were subdivided into 13 topics and 13 working parties were formed and asked to tackle a well defined set of statements. All working parties collected the new pieces of evidence that had appeared since 2004 through systematic literature search and developed proposals to change the guidelines with supporting evidence. Throughout, supporting levels of evidence and grades of recommendations were based on a scoring system developed by the Oxford Center of Evidence Based Medicine (For details see http://www.cebm.net/levels_of_evidence). This process was facilitated by a novel web-based discussion platform, ResearchGate.

By the end of September 2008 all working party proposals were gathered and summarized for the consensus meeting in Vienna. On October 18, 2008, during the weekend preceding the UEGW conference in Vienna, Austria, the working parties met in a general assembly and voted on all individual revisions of the guideline statements. Some proposals were further modified by the group but finally every individual statement was accepted by consensus. Consensus was defined as agreement by >80% of participants. Each recommendation was also graded (RG) according to the Oxford Centre for Evidence Based Medicine, based on the level of evidence.

The second phase of the process consisted of writing the supporting text for the guideline revisions. This task was performed by the working party leaders and supervised by Dr. Axel Dignass, Dr. Simon Travis and Dr. Gert Van Assche. Dr. James Lindsay not only took the responsibility to write the revised text on the management of Crohn's disease in children but also provided invaluable feedback on the accuracy of the English language and on the internal consistency of all three papers. By the end of 2009 all manuscripts had been peer-reviewed and revised and were ready for publication in Journal of Crohn's and Colitis.

The statements and accompanying texts were developed independently from any influence from the pharmaceutical industry and the whole process of guideline development was shielded from external influences. Before final submission, ECCO's corporate sponsors were invited to comment on the factual accuracy of the accompanying text and reference list of the Current management, without changing any of the statements or the content of the text.

In this contribution we will describe in further detail which of the revisions in the updated guidelines published in 2010, will impact on the daily management of patients with Crohn's disease. To this end and for reasons of clarity we will respect the three different sections published in JCC.

Definitions and Diagnosis of Crohn's disease

Overall the definitions of Crohn's disease remained unchanged. Disease activity grading and the section on microscopic diagnosis was not altered. However, for phenotypic classification of Crohn's disease the Montreal classification, a revised version of the Vienna classification was adopted. In this new version of phenotype definitions, the presence of perianal disease per se no longer drives the transition from inflammatory to penetrating Crohn's disease. Abdominal abscesses and fistulas originating from the colon and ileum define penetrating disease. In addition, the revised guidelines on diagnosis of Crohn's disease state that the genetic and serological markers should not be used in routine clinical practice yet due to the lack of consistent evidence to demonstrate that they predict the severity of the disease course or the need for intensified

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> “ The orchestrated work of all contributors and the stringent evidence based consensus process on which these guidelines have been constructed, will hopefully facilitate the implementation of the guidance in all countries.

medical or surgical management. Clinical features at diagnosis including young age, ileocolonic location and perianal disease, may predict the course of the disease and should be taken into account when planning the therapeutic strategy. The main changes in these sections are dealing with new imaging techniques. CT or MRI enterography/enteroclysis are named as the imaging tools with the highest diagnostic accuracy to detect extramural abdominal complications. Capsule endoscopy is placed in the assessment of patients with a high **suspicion of CD despite negative investigation by ileocolonoscopy and other imaging techniques.**

Current Management of Crohn's disease

In this section some important changes were made in the guidelines on the medical and surgical approach to patients with Crohn's disease, based on novel evidence from the literature.

First of all, the early use of azathioprine/mercaptopurine or methotrexate in combination with steroids is proposed as an appropriate option in moderately and severely active localised ileocaecal and colonic Crohn's disease. Also, anti-TNF therapy is advocated as an alternative for patients with objective evidence of active disease who have previously been steroid-refractory, steroid-dependent, or steroid–intolerant. Indeed anti TNF therapies are effective both to induce and to maintain remission and could spare steroids in patients with previous exposure to systemic steroids. However, for some patients who have infrequently relapsing disease, re-starting steroids with an immunomodulator is still proposed as a valid option. Major drivers for the choice between anti TNF agents are local availability, route of delivery, patient preference, cost and national guidelines, since all anti-TNF therapies currently available for the treatment of inflammatory (luminal) Crohn's disease appear to have generally similar efficacy and adverse-event profiles.

Finally, the guidelines specify that surgery should always be considered as an option in localised disease specifically in patients with no signs of active inflammation and with obstructive symptoms. Novel elements in the guidelines on surgical management of 'luminal' disease also include the statement that the unexpected finding of terminal ileitis suggestive of Crohn's disease at laparoscopy should not lead to resection. Finally, local expertise permitting, laparoscopy assisted ileocolonic resection should be preferred.

Special Situations

Novel statements on the follow up and management of patients with surgically induced remission were formulated. Ileocolonoscopy is recommended within the first year after surgery where treatment decisions may be affected. Also the cumulative evidence now indicates that thiopurines are more effective than mesalazine or imidazole antibiotics alone in postoperative prophylaxis.

For the management of fistulating perianal disease, anti TNF agents are positioned as a second line medical treatment after antibiotics or immunosuppressives have failed. The mainstay of the evidence for the use of anti TNF agents to induce remission of fistulating Crohn's disease lies with infliximab. The management of complex perianal fistulae should be a close collaboration between surgeons and physicians and seton placement should be recommended for complex fistulae.

The management of Crohn's disease in children and adolescents was revisited with the latest evidence. The revised guidelines now state that both exclusive enteral nutrition and corticosteroids are effective for induction of remission of Crohn's disease in children but enteral nutrition has fewer side effects and promotes growth. Multidisciplinary teams in pediatric gastroenterology centers are recommended for the care of children with CD. Also, the efficacy of Infliximab for induction and maintenance of remission in pediatric Crohn's disease is mentioned.

The main revision of the guidelines on pregnancy in women with Crohn's disease consists of the advice that medical therapy for Crohn's disease should generally continue during pregnancy as the benefits of controlled disease outweigh the risks of medication.

For articular manifestations the guidelines clearly state that arthropathy associated with Crohn's disease belongs to the concept of spondylarthrtitis. Also, the efficacy of anti TNF therapy for axial arthropathy resistant to NSAIDs or physiotherapy is well established and this treatment is clearly an option.

Finally the disappointing results of two large placebo controlled trials assessing the efficacy of omega-3-fatty acids for the treatment of Crohn's disease, illustrate that at present none of the alternative medicines has shown efficacy in randomized controlled trials for Crohn's disease.

Summary

The second ECCO guidelines on the diagnosis and management of Crohn's disease will provide an updated guidance for clinical practice in Europe and beyond. Some novel insights based on evidence from controlled trials and real life clinical practice became apparent after 2004 and therefore, we believe this was a timely effort. The orchestrated work of all contributors and the stringent evidence based consensus process on which these guidelines have been constructed, will hopefully facilitate the implementation of the guidance in all countries. Needless to say that we are greatly indebted to all members of the working parties for shaping these guidelines. ECCO is committed to update its core publications on a regular basis and the guidelines on the diagnosis and management of ulcerative colitis will be revisited in 2010. ■

The 5th International Meeting on IBD in Capri

The Capri Meeting has had increasing success, and is today ranked among the most outstanding meetings on IBD in the world.
In April 2010 the 5th Capri Meeting was held.

The first Capri Meeting took place in April 1996. The initiative was then taken by Professor Renzo Caprilli, who is also known as the "Founding Father of ECCO".

– I thought it would be interesting to gather all the major experts of the field in an international congress, restricted to a few, in order to discuss the major pathogenic and clinical aspects of ulcerative colitis and Crohn's disease. The island of Capri, with its climate and relaxing atmosphere seemed to me the ideal setting for this meeting, Dr Caprilli explains to *ECCO News*.

Invitation only

At the first meeting, the precise criteria that would be applied to the future meetings were established. The following requirements were fixed:

A Steering Committee made up of European and North American IBD leaders, renovated at every meeting, is going to establish the scientific program and select the speakers.

The meeting should be restricted to a small number of participants upon invitation only. About 120 participants – of which 40 speakers and chairmen, 40 "Early Careers" selected from the best submitted abstracts and 40 "Thought Leaders" of acclaimed international worth.

The meeting should be a regular event (every 3–4 years) and have only one sponsor.

The objectives for the Meeting shall be to update the key areas of IBD pathogenesis and to incorporate into IBD emerging scientific concepts from areas outside of IBD. Also to ponder about the future, and attract and retain the brightest Early Careers in IBD. There should be a residential and friendly atmosphere and no influence from the industry in the scientific program.

– Back then, I spoke to Giancarlo Naccari, manager of Giuliani, who was enthusiastic about the project. Together we obtained the support of Dr Gian Germano Giuliani, Dr Caprilli recalls.

Focus for 2010

Since 1996 there have been three more meetings prior to the 2010 meeting – 2000, 2003 and 2006.

– They were all organized on the basis of the guidelines above, Dr Caprilli continues.

For the Meeting in 2010, the structure basically followed the same structure as the previous, but greater attention was given to basic science aspects and to the integration of IBD with other disciplines.

– Specific attention has been given to the relationship between environment, genetic and disease pathogenesis. Various sessions were dedicated to the relationship between tissue homeostasis and inflammation, and to innate and adaptive immunity response. ➡

– From the clinical point of view, mainly the negative aspects of therapy were considered. These included the risks/benefits of biological drugs and reason of failure of medical treatment, says Dr Caprilli.

Genetics can't explain it all

In his opening remarks he recalled the main topics of the earlier Capri Meetings. He greeted everyone with a warm welcome, and thanked the Steering Committee and Germano Giuliani for their continued support.

Then the first session started. The first speaker in 2010 was E.V. Loftus; *Epidemiology of IBD* was the title of his talk.

– There is an age-related incidence of CD – it peaks between 20 and 29 years of age. This goes for UC too – but here we find one more peak between 50 and 59. This *could* come from the fact that several patients quit smoking during this age, but we don't know if that is the cause, Dr Loftus said.

He continued by pointing out that the incidence for IBD is rising – also in areas where the incidence already *is* high.

– The trend is that the more a country is being industrialized, we first see an increase for UC and ten years later for CD.

The well known north-south gradient is still there, but not only for IBD, Dr Loftus pointed out.

– The gradient goes for other immunodeficiency diseases also!

The genetics are important, but it can't explain it all. The prevalence of NOD2 mutations varies widely in populations.

– Don't forget the twin studies. There is a 20–50% concordance in identical twins – but never *more* than 50%.

Need to focus on early life events

The fact that incidence of immune-mediated diseases is rising in developed countries has resulted in the hygiene hypothesis.

– But the results from studies for IBD have been, at best, conflicting. In Manitoba case-control early childhood exposure to pets and being from larger families was protective – but in Montreal case-control owning a pet was a *risk* factor, and less crowding was protective.

But Dr Loftus thought that the hypothesis is still promising. He gave several examples on how modern lifestyle might alter the enteric microflora. Among these were improved sanitation, decreased exposure to soil microbes and Helicobacter and an increased antibiotic use.

All four ECCO Presidents – present and past. From left: Jean-Frédéric Colombel, Renzo Caprilli, Miquel Gassull and present President Daan Hommes.

– And there is an increased consumption of refined sugars and saturated fats.

Dr Loftus said that future studies might need to focus more on dietary patterns, rather than individual foods.

– We also need to focus more on early life events. We need more natural history studies to fine tune our "risk stratification", was one of his conclusions.

Collaboration with allergists called for

The session also included a talk on asthma and allergic diseases, given by S. Bonini from Italy.

– These diseases have a very high, and increasing, prevalence worldwide, Dr Bonini said.

Allergic diseases and IBD are heterogeneous conditions, including different phenotypes. Similarities observed in mechanisms and tissue remodelling occurring in some phenotypes of allergic diseases and IBD, strongly suggests the usefulness of a close collaboration between allergists and gastroenterologists in studying and fighting these diseases, were two of his conclusions.

The session continued with three more speakers, and afterwards a good amount of time was given for questions and debate. This was often lively, and more than once the debate continued over cups of coffee and tea during the break.

Genes affect environment

The development of genome-wide association scanning (GWAS) technologies has lead to huge acceleration in the rate of discovery of complex disease susceptibility genes in general, and nowhere more successfully than in IBD.

This was pointed out by M. Parkes in his talk on *Advances in CD genetics*.

– I want to remind you of the fact that *genes* affect *environment*. They have a big influence on the gut microbiota, he stated.

CD and UC are related polygenic diseases, which share some susceptibility loci but differ in others.

R. Duerr pointed out that there are now seven UC GWAS.

– The first was published in 2009. It's a tremendous progress – in just one year, he said.

Clinicians and investigators must identify distinct – sometime rare – phenotypes through a variety of approaches, including molecular and immunological. Microbiologic characterization of these phenotypes will be necessary, M.T. Abreu stated.

– To genetically confirm any suspected disease causing gene, one has to identify additional mutations in families with the same phenotype – and ideally have more than one pedigree, she concluded.

Dysbiosis of the gut microbiota

The gut flora was in focus for the next session. ➡

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Dr Gian Germano Giuliani

Oliver Brain was one of 14 chosen to present his abstract orally.

Daniel Podalsky talked about the paradigm shifts in future healthcare.

Vito Annese, Co-chairman, and Maria.T. Abreu, Chairman for the Session on Genetics and disease pathogenesis.

The rate of discovery of new bacteria of the microbiota remained low as long as culturing was the only method available. Culture-independent molecular tools have resulted in a complete reassessment of the microbial diversity of the gut, said J.Doré.

– The human intestinal microbiota is a true organ – geared to protect our health and well being, he continued.

A genetic predisposition can lead to a dysbiosis of the gut microbiota – or to a deregulation of the immune response. Both of the latter alternatives can in turn lead to the other alternative.

– The International Human Microbiome Consortium aims to give an unprecedented view of the gut microbiota, and validate microbial signatures of prognostic and diagnostic value. These approaches promise to identify the most redundant genomic traits of the human intestinal microbiota, thereby identifying the functional balance of this organ.

– Ultimately it will support the concept of a "functional core" within the intestinal microbiome, Dr Doré said.

ER stress and autophagy

The last session on the first day was dedicated to cell response in inflammation.

Primary (genetic) and secondary (environmental) factors can affect endoplasmic reticulum (ER) stress in the intestinal epithelium and consequently inflammation, said Dr R. Blumberg.

The secondary factors include bacteria, diet (fat and glucose) and drugs.

– ER stress is common in human IBD, he continued.

ER stress and unfolded protein response can lead to autophagy.

Dr R. Xavier talked on the subject.

– Autophagy degrades and recycles cellular contents. It also restricts bacterial access to cell cytoplasm, Dr Xavier explained.

One of the most unexpected findings that has come from CD GWAS is that autophagy has an important role in CD pathogenesis.

– Recently – in 2010 – two independent labs have linked NOD2 to autophagy, he told the audience.

Intestinal homeostasis – a balancing act

The mucosal dendritic cells control mucosal immune response. The dendritic cell migration connects mucosal immune compartments, said Dr H.C. Reinecker.

He added that dendritic cells and macrophages share function-associated surface markers.

Dr Reinecker described in detail – and with the aid of several slides – the antigen uptake in the small bowel.

– A more precise definition of the function of specialized dendritic cells in the regulation of mucosal T-cells is required for our understanding of the mechanisms that control intestinal inflammation, he said at the end of his lecture.

– The intestinal homeostasis is a balancing act between effector and regulatory T-cell responses, said Dr F. Powrie.

IL-23 promotes Th17 cells that play an important role in arthritis, MS and IBD.

– Th17 cytokines are increased in colon and blood of patients with IBD, and they drive T-cell dependent colitis, she continued.

IL 23 drives colitis – but not the system inflammatory response.

– Does IL-23 act directly on T-cells to promote colitis? The answer is yes, she stated.

The HMBG1/RAGE pathway

– Cancer itself is an inflammatory disease. The cancer rises from inflammation, M.T Lotze initially stated in his talk.

Pathogen or damage associated molecular pattern – Dr Lotze referred to them as PAMPs and DAMPs – molecules promote the inflammatory response. Circulating mitochondrial DAMPs cause inflammatory responses to injury.

– Some people show a strong DNA response to stress and sleep loss, he added.

Dr Lotze also talked about high mobility group B1 (HMGB1), an immunogenic stimulus causing release of inflammatory cells, and its activation of the induced receptor for advanced glycation end products – RAGE.

– The HMGB1/RAGE pathway regulates metabolism and autophagy in experimental colitis and cancer models.

Dr Lotze finished his lecture by describing the importance of zinc in the process of autophagy. Cancer cells have upregulated zinc importers and most frequently increased zinc levels.

NOD2 induces autophagy

Over 100 abstracts from Europe and North America were submitted to the Capri Meeting.

– They were all of extremely high quality, Professor Caprilli says to *ECCO News*.

– Of these 14 were chosen, integrated in the scientific program and orally presented, he continues.

One of these presentations was given by O. Brain. He presented a study of NOD2 mediated autophagy. The aim of the study was to define the molecular mechanism by which NOD2 induces autophagy in human cells. ➡

Dr Brain started by defining autophagy – which literally means "self-eating".

– We have established that NOD2 induces autophagy in primary human dendritic cells. CD patients expressing variant NOD2 – or ATG16L1 – associated with CD are unable to induce autophagy via NOD2, he summarized.

The extended abstracts of all the lectures and the 40 selected best abstracts have been published in a special supplement of the Journal of Crohn's and Colitis.

The Capri Lecture

The 2010 Meeting saw the introduction of the "Capri Lecture".

– This shall be a general knowledge lecture, given by an illustrious referent of the cultural world, Professor Caprilli explains.

The 2010 lecture had the title *From observation to discovery in art and science*, and was given by Prof. Carlo Croce, director of Institute of Genetics, Ohio State University, Columbus (USA).

– Prof. Croce, a very close friend of mine, is not invited on his merits on research of the genetics behind cancer only. He is invited also because he is an expert in Italian paintings. He will not talk only about science tonight – but on the *connection* between art and science, Professor Caprilli said when he introduced him to the audience.

Prof. Croce started his talk by describing his long successful journey of cancer research.

– You have to have an idea, be persistent – but also to have *luck*, he said.

Then he switched the subject of his talk from B-cell knockout mice to a painting he presented on a slide – a painting of a female artist painting a portrait.

– I fell in love with it, he explained.

Paintings and cancer

Via a lot of research – *and* luck – he described to the audience how he had acquired the painting and eventually, years later, been able to find out *who* the woman in the painting was.

The research he made in order to find this, paralleled his scientific cancer research.

In his riveting lecture, Dr Croce continued to combine his research in the cultural and scientific world. He showed an excerpt from a book to the audience, that described how a painter in the late 17th century was commissioned – and paid – for *three* church paintings, but today there were only *two* that existed.

– Everybody thought the third was destroyed, he said.

One day he found a painting at an auction. After buying and studying it, he sent a photograph to the author of the book – and today it is recognized as the missing third painting.

This story was intertwined with his description of how his researches lead to epigenic therapy for cancer. The stories followed the same paths.

The first Capri Lecture was a big success, and it set a high standard to follow for the future.

Trials do not reflect real life

Developments in clinical trials for IBD was the theme for the first session on the final day of the meeting.

M. Lemann opened the session, and pointed out that clinical trials don't reflect real life.

– They last a short time – even twelve months are short for the long term – and the endpoints are black and white, he said.

Clinical trials are mainly devoted to demonstrate efficacy and safety of new *products*. Other studies are needed – to define the best *strategies*.

– Therefore we need comparative studies and prospective cohorts. Also sequential or combined therapies and more practical endpoints, Dr Lemann concluded.

A delicate balance

G. D'Haens talked about risk/benefit analysis of biological therapy of IBD.

– It's a delicate balance – we must beware so we don't over treat, or under treat, our patients, Dr D'Haens said.

What sources of information do we have on the toxicity of biological therapy? When they are in controlled randomised trials, these are performed in small numbers on selected populations.

– When they later come on the market many more patients – not so selected – will receive them. That's when we see *new* side effects, Dr D'Haens continued.

The majority of these side effects are infections.

– Infections and sepsis is the "Killer #1" in IBD!

So what is an opportunistic infection?

– My feeling is that any infection that you would *not* have if not on a biological treatment is an opportunistic infection. It could be a flu, said Dr D'Haens.

He also talked about vaccination, and guided the audience through ECCO's recommendations.

A majority of patients on biologics experience adverse events. The efficacy of the treatment needs to be balanced against the severity of these. Also the presence – or absence – of therapeutic options needs to be taken into account.

– Perhaps there is no other alternative for your patient, Dr D'Haens underlined.

Monotherapy regimens usually give fewer adverse events in the long run.

– Prolonged corticosteroid use and deep immunosuppression should definitely be avoided, he concluded.

Changing paradigms

The final session had the headline *Integrating scientific knowledge.*

– The world is changing. This affects the paradigms of clinical care, the paradigms of research – and the border between the two, said D.K. Podolsky.

Dr Podolsky gave a long list of examples of this.

– Now care is *provider* centered. In the future it will *individual patient* centered. Today it is *cost* driven – tomorrow it will be *value* driven, were two of his points on his list.

Dr Podolsky talked about the new paradigms of research. These include collaborate research teams and are technology dependent.

– Though nothing will replace a creative investigator who is pursuing a good question, he added.

He left the podium with a final question to which he admitted he had no answer:

– Is being a clinician in the future the work of an artist – or a scientist?

Mutual bio-bank project

D. Hommes – President of ECCO – gave a talk on *Building an infrastructure for future care.*

He described a project in the Netherlands in which eight academic medical centres had joined in a mutual bio-banking network. It involves tissue repositories for eight disease phenotypes – IBD is one, CRC, stroke and diabetes were among the others.

Critical success factors for a project like this includes starting with a minimal standardized dataset and implementing strong decision support. Dr Hommes also stressed the need to introduce task differentiation – what should the patient, the secretariat, the nurse and the doctor do?

– Let's get organized! We need help – it's a lot of work to do. Who is better to provide that than the patients themselves?

In his talk Dr Hommes used a windmill as a metaphor for the efficacy of the academic world.

– Only 15% of the electricity it generates comes out of the socket at the other end. 85% is lost! The academic world is the same...

Closure

The meeting was closed by Claudio Fiocchi (USA), member of the Steering Committee, who highlighted the most significant news and the future perspectives that had emerged from the meeting.

Endorsement

Capri 2010 was endorsed by the four main international IBD societies (ECCO, CCFA, IOIBD, EFCCA).

Acknowledgements

– My sincere gratitude goes to the Giuliani family, who has generously supported these meetings without ever interfering on the choice of the scientific program, Professor Caprilli told *ECCO News* afterwards.

– My greatest thanks goes to all the members of the various Steering Committees, who have chosen topics and speakers, strictly conforming to the established scientific requirements. Among these, a special thanks goes to Claudio Fiocchi in Cleveland and Dan Podolsky in Houston, who have always helped me in the organization of the meetings with precious advice and enthusiasm.

– I would also like to thank Giovanni Latella, Giuseppi Frieri and Salvatore Sbellinvia who have always sustained me throughout the years, and shared with me all the difficulties encountered during the organization of the meetings, Professor Caprilli said.

– Lastly a thanks to Cristina Montori, Alessandra Fatigati and Sarka Taftova of the Endogroup International, Como (Italy).

PER LUNDBLAD
Senior Writer

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ECCO Pathogenesis Workshops

The first ECCO pathogenesis workshop focused on anti-TNF therapy failures in IBD. Several interactive sessions were organized in 2008 and 2009, with the participation of more than 60 ECCO members.

The overall objective was to better understand and explore primary non response and loss of response to anti-TNF agents in IBD. The outcome of this workshop is presented into two parts. This first section addresses definitions, frequency and pharmacological aspects of anti-TNF therapy failure, including pharmacokinetics of anti-TNF monoclonal antibodies and immune and non-immune mediated clearance of anti-TNF mAbs. This article is accepted for publication in Journal of Crohn's and Colitis (JCC). The second section concerns the biological roles of TNF and TNF antagonists, including mechanisms of action of anti-TNF agents, and discuss hypothesis regarding their failures and phenomenon of paradoxical inflammation, including the potential role of TNF independent inflammatory pathways. This second manuscript is in preparation and should be submitted soon to JCC.

In February 2010 the SciCom launched its second pathogenesis workshop: "Relevance of Intestinal Healing for the Disease Course of IBD". In this workshop experts first review mechanisms and relevance of intestinal healing, predictors and markers, and impact of intestinal healing on the course of IBD. The goal of the project is to identify future areas of interest leading to novel therapeutic strategies to enhance intestinal healing and develop a respective European study platform enabling a testing of the identified tools or mechanisms in patient populations.

After a call to all ECCO members, 51 participants from all over Europe, North America and Israel were selected to join one of the five distinct topic groups.

Florian Rieder and Miquel Sans, head a group focused on mechanisms of intestinal healing on a basic science level, identifying potential future therapeutic targets.

The second working group (chairs: Marco Daperno and Edouard Louis) aims at identifying tools to predict, detect and monitor intestinal healing. This includes techniques to image and monitor intestinal healing and its complications as well as surrogate and genetic markers.

Laurent Peyrin-Biroulet and Andreas Sturm chair a topic group assessing the impact of intestinal healing on the course of IBD. Criteria for intestinal healing, information on the impact of intestinal healing on the mucosal/systemic immune status and vice versa and on the impact of the mucosal/systemic immune status on intestinal healing will be discussed.

The fourth working group (chairs: Gert van Assche, Axel Dignass, Geert D'Haens): "Therapeutic strategies to enhance intestinal healing", aims at assessing how anti-inflammatory therapy influences intestinal healing. Within this group, questions such as mechanisms of treatment on intestinal healing or consequences of impaired intestinal healing will be discussed.

The first meeting of the different topic groups will be at the DDW in May 2010. Based on the identification of relevant key questions, a systematic review of the literature, and a critical discussion of the current knowledge, the different working groups will then prepare a joint workshop meeting to be held at the UEGW in Barcelona (October 2010). In a scientific session at the ECCO 2011 in Dublin, the results of the workshop will be presented and discussed.

Aiming to set the stage for future studies, this workshop will contribute to the prospective knowledge in the field of IBD and ideally lead to the formation of a multinational initiative and a European Interest Platform on 'Intestinal Healing'.

SciCom plans to launch an ECCO pathogenesis workshop every year. A call for topics for the third pathogenesis workshop will be sent by the end of this year.

MATTHIEU ALLEZ & **ANDREAS STURM**

Genetics

A large number (more than 50) of loci have now been definitely associated with Crohn's disease (CD) and ulcerative colitis (UC). Some of these loci are mainly associated with CD, others with UC and some with both diseases. While this represents a major step forward in the understanding of the pathogenesis of inflammatory bowel diseases (IBD), which are currently the best defined complex disease from a genetic point of view, there is still a lot of work to be done to fully make use of these discoveries. Particularly, the causal genes or genetic sequences (for gene deserts) have still to be determined on many of these loci, the functional significance of the variants associated with IBD has to be explored and finally the involvement of all these genes in subtypes of IBD must be assessed to understand and better defined the heterogeneity of IBD.

These researches are ongoing partly through an international IBD Genetics Consortium. ECCO has funded the European members within the International IBD Genetics Consortium to undertake a project aiming to identify genetic markers of Crohn's disease progression/clinical course. Extensive phenotyping of European patients who have been genotyped on Genome-Wide Association Studies arrays has been undertaken, and these data analysed. SNP markers which showed evidence of association with short time from diagnosis to surgery in the GWAS discovery panel are being genotyped in a replication panel which includes >10,000 European CD cases and similar number of controls.

This work is being done as part of a large international effort using a custom-designed microarray targeting this as well as several other objectives. Genotyping starts June 2010. Results are expected end of 2010/early 2011.

EDOUARD LOUIS

Inflammatory Bowel Diseases 2011

www.ecco-ibd.eu

The Convention Centre, Dublin, Ireland
February 24 – 26, 2011

6th Congress of ECCO – the European Crohn's and Colitis Organisation

Report for UEGF Partnerships with Monothematic Initiatives

IBD Intensive Advanced Course for Junior Gastroenterologists

Prague Congress Center, Prague, Czech Republic, 24–25 Feb 2010

This postgraduate course was initiated in 2003 with the general aim to provide advanced fellows and junior faculty in gastroenterology or visceral surgery with a multidisciplinary broad base of knowledge in inflammatory bowel disease.

This background information represents the knowledge base that experts integrate with the new data to provide the best possible care to their IBD patients.

The course also aims at harmonizing the level of knowledge and the quality patient care on IBD across Europe and to favor the development of a network of young IBD experts in Europe, as well exemplified by the rapid emergence of the Young ECCO group (YECCO).

The course starts and ends with a multiple choice test, allowing each student for him/herself to evaluate his/her own progression. The course is made as a series of case-based lectures interspaced with small group seminars given by most prominent European IBD experts. The course also integrates a YECCO workshop, planned and run by young alumni of the course.

The target audience of the ECCO IBD course is made of advanced fellows or junior faculty in gastroenterology and visceral surgery. The needs of pediatric IBD fellows are also addressed. The ECCO IBD course is open to students from the 31 countries that are current member countries of ECCO. Each member country can send up to 3 students per year to the course, selected by their national IBD or Gastroenterology society under the responsibility of the ECCO National Representatives.

Teaching objectives:

1. Describe and integrate the pathophysiological bases of IBD,
2. discuss with patients the implications of the genetic and environmental components of IBD for their care and for potential family planning,
3. diagnose and characterize Crohn's disease and ulcerative colitis and be fluent in their classifications in terms of disease behavior, location, severity and activity,
4. critically review laboratory, endoscopy and radiological imaging information relative to a patient with IBD and be aware of the severity criteria associated with this information,
5. list the potential drugs and their indications for specific IBD situations, their benefits, limitations, side effects and the monitoring procedures for patients under each therapy, and:
6. describe the various surgical interventions used in the care of IBD patients and to integrate medical and surgical care for given clinical situations.

In addition, the students should know about the structures of ECCO and YECCO and be aware of the various grants and funding opportunities of ECCO. They should also have had the chance to develop personal links with some other students and with members of the faculty. Dissemination of the course content has been performed by the production of a syllabus distributed to all participants. Each chapter covers a lecture, contains the key slides of each lecture and is fully referenced. The material of the course is further disseminated by all participants. This material has been shown and seen in many case discussions and presentations, used both by the faculty and the fellows that participated to the course.

Course Participants:
Eighty-nine participants joined the course, from all ECCO member countries, including 83 students issued from the selection performed by the ECCO countries and 6 walk-ins. Ten registered students failed to show up, excused for various reasons.

Course evaluation by participants:
The course was evaluated by a questionnaire distributed to all participants at the beginning of the course and collected at the end directly with the post-course test. Answers were evaluable for 86 participants who took the second test. The overall rating of the participants show that the course is very well considered, as much for its format as for the quality of the presenters and lectures.

Course Outcome and Conclusion:
ECCO Intensive Advanced Course for Junior Gastroenterologists has been conducted for the 8th time. It is the oldest teaching activity of ECCO. This year this course obtained the support of UEGF through a partnership with Monothematic Initiative. The support of 50,000 Euros of UEGF allowed ECCO to further develop the IBD Course, to maintain a free registration and housing for all students, and to produce teaching material of the highest standard. With the growing interest for research and patient care in IBD, the partnership between ECCO and UEGF represents a synergy that leads to a very fruitful teaching experience. The past experience of the IBD Course shows that many past students have become junior IBD faculty and researchers.

PIERRE MICHETTI

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ECCO'11 Dublin – Scientific Programme

Prepare for Dublin! The scientific programme is outlined below. Sessions will have a similar format, starting with the science that underpins the topic, then onto clinically relevant subjects and finally a session on clinical management, with an eye to current practice and the future. Speakers for the third talk are being asked to make it case-based, to bring the clinical relevance home. There is also a session on challenging patients and another on mimics of IBD, which will represent the daily dilemmas and pitfalls that we face in clinical practice. In addition there will be an entire session dedicated to the second pathogenesis workshop on mucosal healing. In Dublin there are more oral presentations of best abstracts than ever before (a total of 20). The Organising Committee has decided to keep the duration of abstract presentations to 10 minutes each, just as at DDW, rather than extend the time and reduce the number of presentations. Speakers will be required to restrict the presentation to just 7 minutes, which will mean pithy presentations with a vigorous 3 minutes for discussion.

We still think that combining abstracts with lectures is a good way of keeping the sessions a topical. The programme is different and diverse: Dublin will be a great event, so put the dates in the diary now (February 24–26, 2011) and keep a watch out for registration online.
(More information online at http://ecco11.ecco-ibd.eu)

Silvio Danese
SciCom

Thursday, February 24, 2011

11:15-11:30	**Training Sessions for Chairs**
13:00-14:30	**Scientific Session 1: Microbiota and epithelium**
13:00-13:15	Mucosa-associated bacteria
13:15-13:25	Oral Presentation 1
13:25-13:40	Microbes at the interface to metabolism
13:40-13:50	Oral Presentation 2
13:50-14:05	Stressed out
14:05-14:15	Oral Presentation 3
14:15-14:30	Probiotics for IBD: past hope, or future promise?
14:30-15:00	**Coffee Break**
15:00-16:30	**Scientific Session 2: Second ECCO Pathogenesis Workshop: Mucosal Healing**
15:00-15:10	Introduction
15:10-15:25	Mechanisms of Intestinal Healing
15:25-15:40	Measures and Markers of Prediction to achieve, detect, and monitor Intestinal Healing
15:40-15:55	Impact of Intestinal Healing on the Course of IBD
15:55-16:10	Therapeutic Strategies to enhance Intestinal Healing
16:10-16:20	Oral Presentation 4
16:20-16:30	Oral Presentation 5
16:30-16:50	**Mini-Session 2a: ECCO Guidelines 1**
	Second ECCO Consensus on the management of UC

Friday, February 25, 2011

08:30-10:00	**Scientific Session 3: The age of innocence: IBD in children**
08:30-08:50	IBD in the very young - new insight in the pathogenesis
08:50-09:00	Oral Presentation 6
09:00-09:20	Surgery in children: Indication and outcome
09:20-09:30	Oral Presentation 7
09:30-09:40	Oral Presentation 8
09:40-10:00	Management of IBD in adolescence

Inflammatory Bowel Diseases 2011

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

Dublin, Ireland February 24–26, 2011

Scientific Programme

10:00-10:20	**Mini-Session 3a: ECCO Guidelines 2**
	Paediatric acute severe colitis
10:20-10:50	**Coffee Break**
10:50-12:20	**Scientific Session 4: Targets in IBD: Lost and Found**
10:50-11:10	TLRs as therapeutic targets
11:10-11:20	Oral Presentation 9
11:20:11:40	Past and Future of T cell-directed therapies
11:40-11:50	Oral Presentation 10
11:50-12:00	Oral Presentation 11
12:00-12:20	Therapeutic implications of autophagy and apoptosis
12:20-13:40	**Lunch and guided poster session in exhibition hall**
13:40-15:10	**Scientific Session 5: Calling the surgeon**
13:40-14:00	Nutrition and medical therapy: preparation and planning for surgery
14:00:14:10	Oral Presentation 12
14:10-14:30	Medicine versus surgery for ileocaecal Crohn's disease
14:30-14:40	Oral Presentation 13
14:40-14:50	Oral Presentation 14
14:50-15:10	Outcomes of pouch surgery: raising the bar
15:10-15:40	**Coffee Break**
15:40-17:10	**Scientific Session 6: Daily challenges in IBD**
15:40-16:00	Report of the ECCO Consensus on pregnancy and breast feeding
16:00-16:10	Oral Presentation 15
16:10-16:30	Rescue therapy for acute severe colitis
16:30-16:40	Oral Presentation 16
16:40-16:50	Oral Presentation 17
16:50-17:10	IBS in IBD
17:10-17:40	**Mini-Session 6a: ECCO Guidelines 3**
	Guidelines on Imaging in IBD

Saturday, February 26, 2011

08:30-10:00	**Scientific Session 7: Challenging Cases**
10:00-10:20	**Coffee Break**
10:20-11:50	**Scientific Session 8: Cancer and IBD**
10:20-10:40	Inflammation and Cancer: Partners in crime
10:40-10:50	Oral Presentation 18
10:50-11:10	Needle in a haystack: diagnostic strategies to detect cancer
11:10-11:20	Oral Presentation 19
11:20-11:30	Oral Presentation 20
11:30-11:50	Extraintestinal Cancers in IBD
11:50-12:50	**Scientific Session 9: ECCO Lecture**
11:50-12:10	ECCO Fellowship 2010: two presentations
12:10-12:15	Announcement of ECCO Fellowships and Grants 2011
12:15-12:45	Timing of conventional and biological therapy in the management of IBD
12:45-12:50	Concluding Remarks

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IBD Conference in Miami

***The Keys to IBD 2010: Treatment, diagnosis and pathophysiology* – Falk Symposium 172 – was held during the end of March.**
The meeting was in Miami – close to the famous Florida Keys, and saw 300 participants from 32 countries.

William Sandborn

Gerhard Rogler

Professor William Sandborn, USA, and Professor Gerhard Rogler, Switzerland had put the scientific program together.

Dr Sandborn tells *ECCO News* that he and Dr Rogler were approached by Falk Foundation for this meeting approximately one year in advance. They formed the Scientific Organization and selected the topics and the speakers together.

– We also worked together with the GI Health Foundation (an US foundation) for this conference, Dr Sandborn continues.

New ideas

– We had two goals in mind: The first was the new boundaries of treatment, Dr Sandborn explains.

– Then we wanted new and young speakers. We wanted the next generation. The speakers were selected not only because they are young, but also because they are really doing new things.

He adds that the young speakers will not only find it exciting to meet others in their field – they also become a vitalising factor for the elder generation.

– I have been in this field for a long time, so it is good to hear some new ideas, Dr Sandborn says.

More than 40 disease genes – so far

New insights into IBD genetics was the topic for Stefan Schreiber's talk during the first session.

– We know that IBD is genetically dependent, he stated and continued to describe how to find a disease gene in a polygenic, complex disorder.

– When NOD2/CARD15 was found, we momentarily thought that we had the answer. Now we know that it is *one* strong gene – among many others.

For Crohn's disease more than 40 disease genes have been identified until today, which however still explain less than 30% of the total genetic risk. In addition to innate immune barrier genes, cytokine response genes and autophagy related genes have been identified.

In ulcerative colitis genome wide association scan (GWAS) studies are just in the beginning. The genetic further exploration of CD and UC will result in molecular risk maps that are presently completed with amazing speed.

– Outcomes research for individuals carrying risk genotypes is one necessity for future health-care. Genotype-based prevention is another, said Dr Schreiber.

The creation of medical systems of biology of disease will lead to new models– and eventually to new therapies, was one of his conclusions.

The relationship between the commensal microbiota and the immune system

The epidemiological evidence for genetic basis of IBD and the role of environment was the first topic in Richard Blumberg's State-of-the-art lecture.

– Studies of twins are the most important evidence for environmental importance, he said.

Dr Blumberg continued by talking on the commensal bacteria. The microbiota regulates development and differentiation of local and systemic immune and non-immune components.

– The microbiota is inherited from the mother, but is then modified by genetical and environmental factors.

He said that Paneth cells are critically important – they provide anti-bacterial protection in the small intestine.

Dr Blumberg also described many potential mechanisms for NOD2 in CD. They include mucosal tolerance to bacteria, regulation of autophagy – and regulation of Paneth cell function.

One bacterium – Faecalibacterium prausnitzii – is *protective* for CD.

– If a patient lacks it, the risk for post-op surgery increases!

Environmental factors that modify the risk for development of IBD have the common attribute of affecting the relationship between the commensal microbiota and the immune system – in a manner that intersects with the functionally relevant immunogenetic pathways that are uniquely operative within a particular context of IBD, Dr Blumberg said.

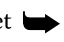
Changing gut immune response

Tobacco is the most consistent environmental risk factor identified, said Charles Bernstein.

– For CD the risk is twice to four times higher for individuals that smoke. But it's also obvious that it is protecting from UC.

Dr Bernstein presented a list of features in developing countries, including larger family size, more exposure to livestock, intestinal microbiota that are variable and transient and low antibiotic use.

– But in these countries we also see a change: A changing antibiotic use and diet



Marla Dubinsky

Gert D'Haens

give a changing gut flora and changing gut immune response. Perhaps with globalisation there comes a change of stress too, Dr Bernstein said.

The incidence of infectious diseases in these countries is decreasing – but the incidence of immune diseases is *increasing*, he pointed out.

Jacques Cosnes talked about the impact of physical activity for IBD patients.

– It improves quality of life without detrimental effect on disease activity. It's probably good for bone density in patients with CD, he said.

There is no clear evidence, according to Dr Cosnes, for diet as a therapy in IBD – except for enteral nutrition when needed.

– The role of refined sugar has been debated, but there are no clear findings.

Obesity was uncommon in CD, but the figure is now changing.

– There is a trend toward more severe CD in obese patients, said Dr Cosnes.

Many forms of IBD

Serologic markers were discussed in Miami.

– They are needed for diagnosis, to define the type of IBD and the severity of the disease, said Iris Dotan.

ALCA, ACCA, AMCA, gASCA, anti-L and anti-C are all new serologic markers. They are directed against glycans on microorganisms. They have improved CD diagnosis and differentiation.

– There are many forms of CD and UC, Dr Dotan reminded the audience.

The markers can be used to individualized drug therapy.

– There is not only one CD and UC, Marla Dubinsky agreed.

– We see the different phenotypes in our daily practise every day!

Dr Dubinsky suggested that we perhaps should not classify our patients in the categories of CD and UC – but instead classify them genetically and immunologically.

– That's what we will do in the future – therefore we need markers, she said.

All interventions – including inaction – carry risk.

– So risk-benefit discussions with patient are needed. They should be based on whether the patient is at high or low risk for complicating disease. Biomarkers and clinical parameters can predict CD recurrence and a more aggressive phenotype. Therefore we should use them to guide a much more targeted approach to therapy, Dr Dubinsky concluded.

A time window for maximal effect

Anti-inflammatory agents usually work better when started early in the disease course, i.e. in the absence of complications, said Gert D'Haens.

– But what *is* "early IBD"? We can't really ask that question. However, we *do* know that CD is characterized by relapse and remitting intestinal inflammation.

Dr D'Haens described several complications in CD. These included structural damage as fistulae/perforation and stenosis/fibrosis, metabolic complications such as iron deficiency, growth retardation and osteopenia. Extraintestinal manifestations include PSC and spondylarthritis.

– We don't have treatment for stricturing and penetration. We can only treat inflammation. But even so, a vast majority of CD patients will need surgery, he continued.

Dr D'Haens used a comparison with inflammation and a fire in the woods.

– When you see it, you want to extinguish it!

He returned to his opening question on how to define early IBD.

– It's the *time window* in which anti-inflammatory therapies exert a maximal effect. Before all these complications have occurred, he said.

Select for appropriate strategy

There are probably two types of errors in defining the treatment strategy for an IBD patient, said Remo Panaccione.

– Under-treating a patient who will develop disabling, complicated or severe disease. Or over-treating a patient with a benign course of disease, he said.

Dr Panaccione reminded the audience of the fact that the severity of IBD is determined by the general course of the disease, rather than the severity of a flare.

Selecting patients for an appropriate treatment strategy is critical to achieving optimal disease control. Therapeutic strategies should be tailored to the individual patient, with the goal of optimising outcomes.

– Employing strategies to identify patients early for treatment with effective therapy offer patients the best clinical outcomes – and will likely also change long-term outcomes, Dr Panaccione said.

Treatment goals have been redefined. Treating only *symptoms* leaves patients at risk of developing progressive disease – and therefore monitoring to detect and treat inflammation should be employed.

Need for sequential IBD therapy

– We should consider the complexity of IBD when we discuss paradigms and future treatment, said Jürgen Schölmerich in the second State-of-the-Art lecture.

The treatment has so far resulted in that IBD patients today do not have a higher

Iris Dotan

Eduard F Stange

mortality than the ordinary population. But are IBD-patients today treated *optimally*?

– In a study 64% of the patients were on a 5-ASA dose that was too low, 77% were on steroids for more than three months – and 78% of the patients on long-term steroids had no bone protection. It proves to us that there is still much we can improve, Dr Schölmerich said.

The intestinal symbiosis of host and flora is the key to IBD, according to Dr Schölmerich and – in his opinion – what we should study in the future.

– The function of our immune system depends in part on the intestinal colonisation. Genetic "defects", but in particular exogenous alterations disturb homeostasis, and are the cause of variable disorders – like IBD, asthma and sarcoidosis.

– We have since long had papers that suggest that IBD – and CD especially – is a consequence of immune deficiency.

Therefore we need *sequential* IBD therapy. First, during inflammation, the aim should be inhibition of inflammation. Next follows the healing phase, in which the aim of therapy should be restitution of epithelial integrity. The third step is stabilisation of the barrier where the aim of therapy is maintenance of mucosal barrier, Dr Schölmerich said.

Act like a unit

Does it make sense to avoid surgery in CD patients? was the headline for a talk given by Feza Remzi, a surgeon at the Cleveland Clinic, USA.

– I was given this title, and I thought that there is an easy way to state my opinion, he said and presented a slide in which the word NO was written in *very* large letters.

Dr Remzi showed with figures that surgery continues to have a critical role in the treatment of patients with CD.

– Refractory disease, or those who suffer adverse reactions with medications, should be considered as failure and referred to surgery.

A retrospective study on 2 573 patients had looked at the impact of the increasing use of immunosupressants in CD on the need for intestinal surgery. Although these drugs have been used more frequently over the last 25 years, there was no significant decrease of the need for surgery – or of the intestinal complications for CD, Dr Remzi continued.

He described the different techniques for bypass, resection and strictureplasty.

– Infliximab has delayed, but not avoided, the need for surgery. But there are some new promising data emerging. I hope this is true – I have so many *other* things to do in my surgical practice!

The patient's perceptions on surgery are the most frustrating aspect for the surgeon. This is unique to patients with IBD, according to Dr Remzi. But he also had the solutions for these problems:

– There must be an early discussion of surgical options versus immunomodulators and outcomes with the patient by both gastroenterologists and surgeons. In these discussions there should be a clear definition of the goals of continued medical therapy – *and* the criteria for referral to surgery. We must act as a *unit*, Dr Remzi concluded.

No interference

Eduard F Stange gave a talk on the options available for maintenance therapy for CD. He guided the audience through several ECCO Statements on the subject.

– Following medically induced remission, 5-ASA and steroids are ineffective in maintenance. Azathioprine and – if ineffective or poorly tolerated – methotrexate are the mainstay for maintenance treatment, he summarized.

Anti-TNF is an option if both are ineffective. In the postoperative patient metronidazol or azathioprine, if tolerated, are the best choices, he added.

ECCO News talked to Dr Stange after his lecture, and asked him why he took the time to travel all the way to Miami from Germany, where he lives.

– Because The Falk meetings are the best in the business. They always have the best speakers in the field, Dr Stange answers.

– There is a company behind these meetings with a long tradition of *not* interfering with the program. Whoever that is in charge, have their complete freedom in selecting topics and speakers. This way of organising events is a standout from many others.

Dr Stange adds that many other meetings sponsored by the industry use the content and topics for marketing use.

– But Falk meetings are different. It's fair to participate, and I feel comfortable since there is no interference in the content of my talk.

Different perspectives to take home

Professor Stange has another reason for coming to Miami.

– I also want to counter-balance the American view, which is extremely probiologic.

He thinks that during this meeting, the organisers have given the audience the chance to make up their own minds.

– This has been possible by having the speakers tackle their subject using the same studies – but from different perspectives. You get many views – and can make your own decision and take it home to your clinic and your patient.

In Dr Stange's opinion the overall quality of the Miami Symposium has been really good.

– There is no "golden therapy", by which I mean one that is right and all others are wrong. This is showed at this meeting, he says.

PER LUNDBLAD
Senior Writer

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NOTICE OF FORTHCOMING ELECTIONS

Dear Colleague in IBD!
Notice is hereby given, that the following positions on the Scientific Committee of ECCO are open for election:

1 ECCO Scientific Committee member, who is elected from YECCO or a young ECCO member under the age of 40

Candidates may be proposed by an ECCO Member in good standing or self-nominated. Self-nominations need to be seconded by an ECCO Member in good standing.

Deadline for receipt of all nominations is June 10, 2010.

A candidate for an office of ECCO must be an established specialist in the area of IBD. The candidate should submit a 2 page CV, a list of their 10 best publications, and a letter of intent, explaining his/her suitability for the office in question. The term for the Committee officers is three years and starts on January 1, 2011 and ends on January 1, 2014. The nominee must agree to his/her nomination.

The process of election is that candidates are ranked by SciCom on the following criteria:

1. Scientific Achievement (publications, scientific initiatives)
2. Declaration of intent (including a statement of the contribution that the individual is able to make to SciCom)
3. Age (this member is elected from YECCO or a young ECCO member under the age of 40)
4. Experience (for instance in programme development, project development)
5. Overview (to take into account the balance between location, gender, age, the degree that the person will contribute to SciCom tasks, academic expertise, team spirit, commitment, familiarity with ECCO, prior contribution to ECCO and future potential). As far as location is concerned, it would be unusual, but not impossible, for more than one member from a single country
6. SciCom members are excluded from voting for applicants from their own country.
7. Applicants are ranked on each criterion and the person(s) with the lowest score(s), depending on the number of positions open, recommended to the Governing Board for approval, with at least one reserve name (selected by rank order).

Scores are averaged and applicants ranked for election. The ranking acts as a recommendation to the ECCO Board, who make the final decision.

Election forms can be obtained from the ECCO Secretariat upon request at ecco@ecco-ibd.eu or downloaded from the ECCO website. Please send all forms to the ECCO Office via email to ecco@ecco-ibd.eu.

With best wishes,
Matthieu Allez
Chair ECCO Scientific Committee

PLEASE SEND BACK TO:

ECCO Office
Ölzeltgasse 1a/2
A-1030 Vienna, Austria
Email: ecco@ecco-ibd.eu

ECCO SCIENTIFIC COMMITTEE ELECTION 2011 **Deadline for nominating a candidate: June 10, 2010**

NOMINATION FORM FOR THE POSITION OF
ECCO Scientific Committee member (YECCO or a young ECCO member under the age of 40)

____
Name of candidate

____
Affiliation of candidate

____
Name of nominating ECCO National Representative (if applicable)

____
Signature of nominator

____
Date

Implementation of ECCO Consensus on Crohn's Disease and Ulcerative Colitis

2010 ECCO Educational Workshop

Spreading Standards in IBD
Your Presence counts!

13th Educational Workshop	São Paulo	Brazil	June 19, 2010
14th Educational Workshop	Donetsk	Ukraine	September 17, 2010
15th Educational Workshop	Budapest	Hungary	September 18, 2010
16th Educational Workshop	Riga	Latvia	October 9, 2010
17th Educational Workshop	Galway	Ireland	October 15, 2010
18th Educational Workshop	Sofia	Bulgaria	November 12, 2010

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or send an email to ecco@vereint.com

European Crohn's and Colitis Organisation

"YECCO" – Spread The Word

YECCO is the ideal platform for networking between young clinicians and investigators with a special interest in IBD

Dear ECCO Members,
With this article we would like to ask you, as ECCO member, to spread the word of the existence of YECCO. In this way we hope to reach more young colleagues who are currently not aware of the existence of YECCO but who we hope will benefit from the advantages that ECCO and YECCO provide to young clinicians and scientists. By bringing young people from all over Europe together we aim to open possibilities for future collaboration in educational and scientific projects along with exchange programs.

A core principal of ECCO has been to include young gastroenterologists, scientists and trainees in many key activities. In addition to the great success of the established intensive IBD school, the ECCO grants and fellowships are largely directed to young researchers. Furthermore, ECCO involves young people in many other regular activities, such as co-chairing at the IBD school and congresses. With YECCO we aim to provide additional activities including the successful YECCO workshops (see recent report in *ECCO News*) and, most importantly, opportunities for networking.

Scientific studies have been successfully performed by YECCO. Members previously collaborated in a project on Clostridium difficile in IBD which was recently published by Shomron Ben-Horin et al (*Clin Gastroenterol Hepatol* 2009; 7: 981-987). Currently, Jean-Francois Rahier (Belgium) is collecting the data on the safety of H1N1 vaccination in patients with IBD. Several YECCO and ECCO members, from larger but also from smaller European centers, have successfully participated in this trial.

Currently, we are looking forward to receive any ideas/proposals for new studies that could be performed primarily by YECCO members in the future.

Besides collaboration on the scientific level, YECCO and ECCO also give great possibilities for exchange programs. By getting in contact with young fellows from all over Europe – and this in a relaxed and informal atmosphere – one might easily inform him/herself about the possibilities in other IBD centers and work out a visit to one of these centers for a shorter or longer period.

In this perspective, ECCO has developed travel awards of 1.500 Euro each to facilitate such exchange programs. One might easily apply for these awards by sending a request to ECCO. Importantly, also very short visits of one or two weeks are applicable for this type of grant. More information is available on the ECCO website (https://www.ecco-ibd.eu/sci_comm/travel_grant_guide.php).

Besides, the ECCO Fellowships of 30.000 Euro each are awarded every year to one or two fellows who will perform an extensive research program in a foreign IBD center during a period of at least one year (https://www.ecco-ibd.eu/sci_comm/fellow_guide.php). In the future, we will invite past award winners to our YECCO meetings to explain their experiences to the other YECCO members.

Again, we think it's worthwhile for you, as IBD specialist, to motivate your younger colleagues in networking with fellows from all over Europe. By applying for the ECCO membership for only 100 Euro, people younger than 35 will automatically become YECCO member. This will give them access to YECCO activities such as the YECCO Workshop and the YECCO member's meeting, besides the common benefits as a reduced subscription fee for the ECCO congress and free access to the *Journal of Crohn's and Colitis*. Please have a look at the ECCO website for more details on the registration procedure (https://www.ecco-ibd.eu/about_ecco/membership.php).

Not only are we looking forward to welcome new YECCO members, but we will later this year be announcing elections for a new YECCO chair and co-chair (full details to follow in due course).

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Do you want a personal subscription to ECCO NEWS?

The aim of ECCO NEWS is to reach all doctors and nurses in Europe with an interest in IBD. ECCO NEWS is an important part of the European Crohn and Colitis Organisation's ambition to create a European standard of IBD care and to promote knowledge and research in the field of IBD. The newsletter is financed through advertisements and distributed free of charge. If you are yet not on the mailing list you can have a personal paper copy sent to your postal address 4 times a year. Just send an email to **ecco@mediahuset.se** stating your postal address. The information you give will not be used for any other purpose than distributing ECCO NEWS.

TOM ØRESLAND, Editor ECCO News

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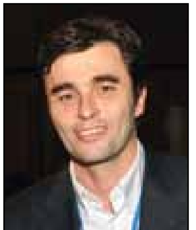

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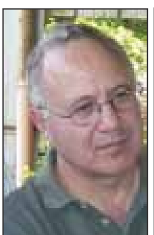

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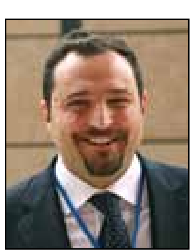

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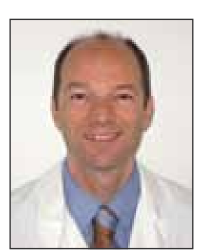

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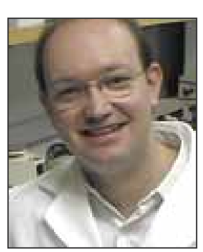

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Report from NECCO School

On the 24th of February, we had our first NECCO School in Prague.
It started early in the morning and lasted until 1 PM.
25 nurses from different European countries attended this NECCO School.

We prepared a nice program with good speakers for these enthusiastic nurses.

Our aim was to teach BASIC knowledge and in a CLEAR way. We wanted to improve nurse education throughout Europe. That day passed so quickly and luckily without major difficulties. But of course there is room for improvement. The evaluation form the nurses completed afterwards, were overall very positive, but showed that they appreciated mostly the fact that it was an interactive course. So, next year, if we can go on, we will strive for even more interaction and more case based sessions. We also found out that there was a language problem for some of the delegates. So, therefore maybe we can organise a kind of medical English training course especially for IBD nurses in the future!

I want to thank everyone who helped us with realizing this course, especially the ECCO Governing Board, who gave green light to start with the School. Then of course the whole Steering Committee for finalizing the program and Mika for her help, especially with the registration of the nurses. But, I also want to thank especially Charlie Lees and Fernando Magro, both members of Educom, for their presence. We really felt their support, which we need and appreciate a lot!

Again, we also thank EFFCA for their grant, and they have already promised to continue with helping the nurses.

Now, I will conclude this report with saying that we have done a great work and that we can be proud of what we, all together, have realised.

Kind regards to everyone!

PATRICIA GEENS

NEW ECCO OFFICE CONTACTS

Dear ECCO Friends,
I would like to take this opportunity to follow up on the announcements, made in Prague, that ECCO will proceed with our new ECCO Office. From May 1st we will operate under our own roof! Nicole Eichinger will supervise a new ECCO staff, responsible for the management of our association as well as of our congress. In the next ECCO Newsletter it would be my pleasure to present you with all the details.

We thus want to pay your attention to the following new contact details of the new ECCO office:

ECCO Office
Ölzeltgasse 1a/2, 1030 Vienna, Austria
Phone: 0043 (0) 680 1226553 (temporarily)
Email: n.eichinger@ecco-ibd.eu
Association affairs: ecco@ecco-ibd.eu
Congress affairs: ecco-congress@ecco-ibd.eu

As of May 3, 2010 you will be able to reach us at the new office.
Whenever you happen to be in Vienna, feel free to stop by!

Kind regards,
Daan Hommes

CALL FOR ECCO FELLOWSHIPS, GRANTS AND TRAVEL AWARDS APPLICATIONS

Deadline for ECCO FELLOWSHIPS, GRANTS and TRAVEL AWARDS: October 1, 2010

ECCO has established Fellowships, Grants and Travel Awards to encourage young physicians in their career and to promote innovative scientific research in IBD in Europe.

Fellowships are created for young individuals younger than 40 years, who submit an original research project, which they wish to undertake abroad in a European hosting laboratory and/or department that has accepted to host and guide the fellow for the duration of the fellowship (one year) and that is responsible together with the fellow for the successful completion of the project. Fellowships are awarded a total amount of €30,000.

Grants are created to support good and innovative scientific, translational or clinical research in Europe. The guidelines of ECCO Grants are very similar to those of the Fellowships, with the exception that the research is typically undertaken in the own institution of the applicant. ECCO Grants are awarded €15,000 each and will also be given during the ECCO annual congress.

The Travel Awards have been established in 2007 as an opportunity for young investigators to visit different ECCO centres in Europe, to learn scientific techniques or be a clinical observer.

For detailed information, eligibility and submission process on fellowships and grants please visit the ECCO Website:
https://www.ecco-ibd.eu/sci_comm/fellow_grants.php?navId=19.

We look forward to your application!

Kind regards,
Matthieu Allez
Chair, ECCO Scientific Committee

Advertisement

NECCO – Where are We Now?

I am delighted, as Chair of NECCO, to be able to report that our nursing community within ECCO is going from strength to strength.

A total of 150 nurses registered for our 4th NECCO Network Meeting in Prague, and it is likely that the actual number attending may have been even higher. This is a great achievement and is thanks to all the hard work put in by the NECCO Steering Committee in creating an interesting and varied programme (based on feedback from our delegates of course) and also to the work of the national representative of NECCO in helping to publicise and promote the event. I would like to extend my personal thanks to everyone involved.

As with previous meetings, we asked our delegates for their feedback and suggestions on how things could be improved. We received a high number of completed evaluation forms and these demonstrated overall satisfaction with the meeting, although there were some salient points raised both about the facilities and the programme which will definitely be taken into account by the committee. As always, we received a huge number of proposals for possible future topics. It is noteworthy however that some topics which have been covered in previous meetings continue to be requested, and this will prove a challenge for future meetings in terms of balancing new information with a perfectly reasonable request for some of the most relevant topics to perhaps feature on an annual basis. This will be the source of much discussion I suspect over the coming year. Thanks to all who provide us with feedback – it really does help to direct our focus for these meetings.

We are keen to ensure our nurses become members of ECCO and work continues to achieve this. As a result, the decision has been made by the Governing Board of ECCO that only nurses registered as ECCO members will be able to register for next years meeting, so this is a call to remind any of you reading this who may not yet be members to change that as soon as possible!

This year in Prague also saw our first intake of nurses registered specifically to attend an IBD nursing school. Once again, thanks to a fantastic effort from our national representatives, we were delighted to welcome 25 nurses to the 1st NECCO School, which ran for one half day parallel to the first morning of our Network Meeting. Attendees to the school were then invited to join the remainder of the Network Meeting. We were extremely grateful to EFCCA, who generously helped us with the sponsorship of a significant number of our school delegates to assist with accommodation and expenses for attending the school. This help was undoubtedly responsible for the high representation of nurses who might otherwise have struggled to attend.

The committee would like to thank all those who gave up their time to teach on this course, and also the ECCO Governing Board for giving us the green light to go ahead with this venture. Again, feedback from attendees was generally positive but crucially, makes suggestions for future developments. We recognise that language remains a major problem for us to tackle and will continue to try and overcome this, both within the NECCO School and the Network Meeting.

We await the decision from the Governing Board about the future of the Nurses IBD School as an ongoing project, but hope to have positive news to report soon. Further information as we receive it will of course be available via the national representatives as well as online at www.ecco-ibd.eu/necco.

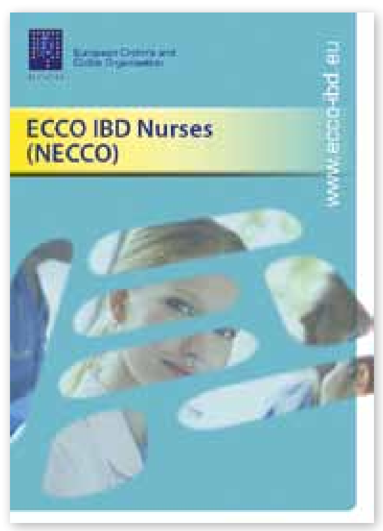
We have seen some changes to our committee members. After a long vacancy, we have been able to now welcome Janette Gaarenstroom (The Netherlands) as our new Networking Officer, who will work with Marian O'Connor to continue our attempts at identifying representatives from each of the member countries of NECCO, which will in turn improve our communication between meetings about the work of NECCO and ECCO.

In addition, we said goodbye and thank you to Rosalinde van Helden this year, who has been part of the committee since the beginning and indeed was our first NECCO chair. Her current role of Network Meeting Officer has been filled by Rina Assulin (Israel) who will take over the responsible position of developing future network meetings and will be working together with Liesbeth Moortgat. Thank you to all who nominated or were nominated for these positions; it was not an easy task to choose our successful candidates.

Finally, our NECCO brochure has been updated, and is available on the NECCO website at www.ecco-ibd.eu/necco for download and dissemination. We hope it will serve as a tool for publicising the work of NECCO and encourage everyone to take a look.

In summary – this year has been a really positive one for NECCO, and this is entirely down to the hard work and commitment of all involved, and the support of the ECCO Governing Board and the Educational Committee. I would like to take this opportunity to once again thank everyone for their input and look forward to a further year of hard but rewarding work as part of the NECCO Steering Committee.

LISA YOUNGE



Download the updated NECCO brochure at www.ecco-ibd.eu/necco

ECCO 2010

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