Dear ECCO friends,

Thank you for picking up our third ECCO News issue of 2011! We have so much to update you about, especially the outcomes of our strategic Summer Meeting, our new headquarters in Vienna, our ECCO publications and, of course, our upcoming ECCO Congress in Barcelona. This issue contains a collection of news facts from all of our ECCO Committees.

We have enjoyed our ECCO Office space in the Ölzeltgasse for just one year, but already we have had to seek an alternative since our office team is expanding so rapidly. My first visit to our new office, at Seilerstätte 7/3 in Vienna, was on Wednesday August 24. I was welcomed by Nicole, Barbara, Stefanie, Julia and Karoline amidst piles of boxes. Our new office is very spacious, offering both plenty of room for our new staff members as well as meeting rooms. Please stop by if you are in Vienna.

Each year, ECCO uses the summer months to refuel its batteries, reflect on the past year and brainstorm together about our next steps and opportunities. This year, our annual ECCO Summer Meeting took place at the end of June. Hosted by our ECCO Office ladies, it was a wonderful gathering of 34 of the brightest minds that make up the Operational Board of ECCO. Each of the nine committees took time to evaluate the past year and brainstorm about 2012. The outcomes of the Summer Meeting will be condensed into the Annual Plans 2012, which will be discussed by the Governing Board at the UEGW in Stockholm. The Annual Plans are the roadmaps for each of the ECCO Committees for 2012, all carefully balanced against the available budget. A detailed presentation will be given during the General Assembly at our ECCO Congress in Barcelona: don’t miss it! Our activities continue to expand, which means that we are calling upon you to join one of our committees. Please visit our website www.ecco-ibd.eu and review the current open positions; I am sure that there is one that will appeal to you!

During our Summer Meeting, the Elsevier team dropped in with news of our astonishing new Impact Factor for JCC: 2.628! We knew that all JCC indicators looked good but we did not realise that this performance would result in such a high impact factor after only four years. I hope that this will encourage you to keep submitting your original articles to the JCC. We envision an increase to a monthly issue within the next three years and are certain that our impact factor will flourish further. In addition, our ECCO News has been thoroughly restyled and its content improved. We aim to optimise the ECCO News so that it is both very attractive and keeps you constantly informed about all activities and other matters, including the further development of ECCO apps for mobile phones and tablet PCs. As of January, the management and publication of ECCO News will be incorporated into our ECCO Office. We thank Mediahuset for their immense support over the past years.

The leaves are turning colour again, which means that we have started to prepare for our ECCO Congress in Barcelona. This promises to become another milestone in ECCO history, with a very beautiful venue, IBD courses and workshops for young gastroenterologists, surgeons, paediatricians and nurses, and the introduction of a Masterclass in IBD Surgery by S-ECCO, a Clinical Trials workshop by ClinCom, an Epidemiology workshop by EpiCom and an IBD refresher course for our Corporate Partners. In addition, we shall organise a Global Forum on the Wednesday night for our sister organisations beyond Europe, and hope to welcome colleagues from Argentina, Australia, Brazil, Canada, China, Japan, Korea, Saudi Arabia and South Africa to share views on IBD and launch collaboration across the globe.

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

Warm regards on behalf of Jean Fréd, Simon, Séverine, Milan, Janneke and Matthieu,

DAAN HOMMES
In June, a conference on the topic *Mucosal healing and beyond* was held in Berlin. Jean-Frédéric Colombel chaired the symposium, and he welcomed 170 delegates from 20 different countries.

In his opening speech, Professor Colombel pointed out that the topic of mucosal healing has a significant importance in daily clinical practice.

The goals of treatment in IBD have changed; now we are focussing not only on treating symptoms but also on healing the mucosa – and even beyond, he said.

All therapeutic decisions in IBD – for instance when to start a treatment and when to stop it – are based on objective criteria, especially endoscopy and biomarkers, Prof. Colombel added.

**No international agreement on scoring UC**

Dr Ana Ignjatovic was the first speaker, and she talked on how to assess endoscopic activity and mucosal healing in ulcerative colitis (UC).

As a brief reminder, Dr Ignjatovic started her talk on the course of UC, pointing out that it is a chronic inflammatory condition and that the incidence varies between 0.5 and 24.5 per 100 000 per year. From 15% to 30% of patients will see progression in their disease, she said.

A population-based study has reported that if you look at the patients with UC who you see in the clinic, every year only 25% of them are in remission. Dr Ignjatovic said that 18% have persistent activity and more than half have intermittent relapses.

Currently there is no international agreement on scoring UC – clinically, endoscopically or histopathologically. We also know that there is a poor correlation between physician assessments of activity and endoscopy. What we do know is that for patients with UC there is a good correlation between endoscopic appearance and the patient’s symptoms, Dr Ignjatovic continued.

**UCEIS**

Various endoscopic scores are currently used for the assessment of UC. Dr Ignjatovic showed nine of them.

**Three scores for CD**

Professor Geert D’Haens then talked about the concept of mucosal healing.
“We speak about it all the time, but do we know what the concept is?” he began his lecture by asking.

He pointed out that no consensus exists on a single definition of mucosal healing. There are different scores; in Crohn’s Disease (CD) the absence of ulcers is frequently used as a definition, but the GETAID score does not only look for ulcers but also at other lesions such as erosions.

Prof. D’Haens described three scores for the measurement of endoscopic disease activity in CD: the Crohn’s Disease Endoscopic Index of Severity (CDEIS), the Simple Endoscopic Index for Crohn’s Disease (SES-CD) and the Rutgeerts score for postoperative recurrence. For CDEIS the scores range from 0 to 44; the higher the score, the more severe is the disease.

The good news is that CDEIS correlates well with SES-CD: “They’re probably interchangeable, and we can use them in parallel in studies,” Prof. D’Haens said.

The Rutgeerts score has been developed for lesions in the neoterminal ileum and at the ileocolonic anastomosis. It ranges from 0 to 4, the most severe type. This score has been useful for clinical trials on postoperative recurrence. It is also now being used in the PREVENT trial with infliximab post surgery.

**Useful marker**

Endoscopies are expensive, there are waiting lists, and patients don’t like them. Prof. D’Haens therefore asked whether we can replace the tests with surrogate markers of inflammation in the colon.

There are faecal markers — calprotectin and lactoferrin. Most studies have been performed on calprotectin.

Calprotectin is a protein that originates from granulocytes. Normally granulocytes are not present in the intestines. So if there is an elevated calprotectin in the intestine, it means something. It can be IBD, but it can also be an infection or diverticulitis, for example. Any inflammatory event in the GI tract gives rise to calprotectin.

Serum markers such as C-reactive protein and radiographic methods such as MRI can also be useful.

“For the small bowel there is today also capsule endoscopy; for the colon it is currently under development,” Geert D’Haens continued.

**Mucosal healing reduces the risk of relapse**

At present, there are a total of five drugs that gastroenterologists can use singly or in combination: aminosalicylates, corticosteroids, thiopurine, methotrexate and anti-TNF antibodies. Prof. D’Haens spoke in more detail of different trials on these.

Mucosal healing predicts the disease course in UC. Prof. D’Haens pointed out that data from the ACT 1 and ACT 2 trials indicate that when mucosal healing is induced early in treatment, the likelihood that the patient will continue to be in remission is five times higher.

The risk of colectomy is also significantly reduced. However, healing induced by steroids does not seem to have an impact on further clinical relapse. This is different from observations with the other drugs.

**Questions and answers**

Do we need to intensify treatment in order to achieve mucosal healing?

In CD this is still a matter of debate. There are no prospective data. The same uncertainty exists over whether we should include mucosal healing — or a certain degree of it — as an endpoint in trials. On the other hand, Prof. D’Haens said, for the question of whether we should introduce potent agents earlier in the disease, the answer is clearly ‘yes’ with regard to mucosal healing.

Do we need to do more frequent endoscopies? Probably yes. But we need further research into surrogate markers and MRI scores, and those efforts are currently ongoing.

Newer drugs and drug combinations induce mucosal healing to a variable extent, and such healing appears to be associated with better outcomes, was Prof. D’Haens’ conclusion.

He ended his talk by saying that the exact role of endoscopic assessments in daily practice remains to be established.

**Gut feeling for a gut disease**

A question from the audience afterwards concerned a patient who is clinically not active and has a normal CRP — but a mucosa that is sick. Should one then change the treatment in order to achieve mucosal healing?

Prof. D’Haens answered that we don’t have data to say that you should do that, but a trial is being launched on the subject.

In the meantime, however, we need some guidance, Prof. Colombel pointed out, and a debate followed.

Professor Jacques Cosnes suggested decisions need to be made on a case-by-case basis and that guidelines cannot be provided.

Professor Julian Panes had the following “gut feeling for a gut disease”:

“If a patient is doing fine, and I don’t have any evidence that would support a decision to intensify treatment, I don’t do it. But we need these studies before we can recommend anything.”

**The Lémann Score**

Professor Cosnes then talked about a new score for assessing bowel damage in CD.

“CD is a lifelong disease — and a destructive disease,” Dr Cosnes underlined. He reported that after 20 years, 80% of CD patients had been operated upon, and there is no evidence that this rate is decreasing.

Dr Cosnes described the PSHI (Post-Surgical Handicap Index) with a score from 0 to 100. The PSHI is the sum of the values attributed to each digestive segment removed. For example, a total proctocolectomy with permanent stoma gives a PSHI value of 42.

Although most CD patients will be operated on one day, assessment of surgical sequelae is too late a marker of disease severity.

Dr. Cosnes said that his friend Marc Lémann had therefore developed a score without the surgeons, namely the Lémann Score — a CD digestive damage score.

The score assesses digestive damage at a given time in a given CD patient. It needs to be borne in mind that damage is different from disease activity.

The score is also used to assess damage progression, to identify CD patients with a high risk of rapid damage progression, and to study the effect of early therapeutic intervention on damage progression.
The score is based on assessment of digestive damage including stricturing lesions, penetrating lesions and, of course, surgical resections, Dr Cosnes continued.

Ongoing study
The Lémann Score will have wide applicability, regardless of patients’ country of origin. It should also allow patients to be assessed at different clinical stages – in early or advanced CD – and can be used in both patients who have and patients who have not been operated on and in patients with either limited or extensive CD. The Lémann Score is “damage driven” (i.e. based on disease location and type of lesions) and not “method driven”. This is because the investigational method may change with time, said Dr Cosnes.

The score will vary from zero to a theoretical maximal value corresponding to the complete resection of the entire digestive tract. For each segment, severity will be scored on a scale ranging from 0 (normal) to 3 (maximal) for stricturing lesions, penetrating lesions and surgical resection or bypass of bowel.

A weighting coefficient will be applied to take into account the relative “importance” of the location of damage. The coefficient will be determined by experts in an on-going study performed by international experts (IPNIC), Dr Cosnes explained.

Clinicians need to interpret cross-sectional imaging
There are still things that need to be discussed and analysed – the process is not complete. The Lémann Score is, however, expected to be fully completed in autumn 2011 and will then be used in prospective randomised controlled trials.

Dr Cosnes underlined that the concept is very different. “Now we are treating lesions! This is completely different – we want to slow down very different: “Now we are treating lesions! This is a very important statement! We have to take the differential diagnosis and also UC versus CD – at this time we need a complete map of the lesions.”

Based on all this, he then establishes a prognosis based on disease extension, severity and the presence or absence of complications.

“For each patient we need to build a treatment plan,” he continued. In IBD, therapeutic decisions cannot be based on clinical symptoms only:

“We know that significant lesions may be present in the absence of symptoms, and there are other causes of symptoms in patients with IBD. Patients may have diarrhoea and abdominal pain because they develop complications as a consequence of surgical resection, concomitant infections or motility disorders. So we have to base our therapeutic decisions on biomarkers, imaging and endoscopy.”

Endoscopy or imaging required
Clinical activity does not correlate with mucosal lesions in CD.

This is a very important statement! We have to use objective measures. Imaging techniques are very good for this purpose, Prof. Panes continued.

MRI is not the only cross-sectional technique that is good; CT is, too, and also ultrasound, according to Prof. Panes:

“They also have high sensitivity and specificity for extramural complications such as fistulas and abscesses.”

“At first, for a patient with suspected IBD, a fecal biomarker could be very useful. But biomarkers have low sensitivity and correlate poorly with severity of lesions. We require endoscopy or imaging to prove activity; we cannot treat patients only on the basis of symptoms. One in five patients don’t have lesions, and they would be treated unnecessarily!”

Is it necessary to always check for healing of lesions?
“In practice I personally don’t do that with every patient because there is no proof that management based on mucosal healing leads to better outcomes compared to symptom-based management.”

Endoscopic lesions: one of many components
Prof. Panes’ final question was the following: Is endoscopic remission the door to an exit strategy?

For his answer, Prof. Panes showed the audience data from the STORI study concerning relapse upon discontinuation of infliximab.

The data showed that endoscopic lesions are only one of the components. Prof. Panes pointed out that we have to take into account other components, too: gender, whether the patient has had previous surgery, whether the patient has required steroid treatment during the last six months, and whether biomarkers have been used during the last six months.

Prof. Panes concluded that performing endoscopy is just one of the components of patient assessment for withdrawal of treatment.

After these four lectures, the clinical aspects were followed up in several case presentations. These were highly interactive, and the delegates were asked to vote and debate – and the debate was often lively.

“I think we have learned a lot,” Prof. Colombel said when he thanked all speakers and the audience for their participation.

He extended his thanks to Tillotts Pharma for organising the conference.

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

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*) For Regular Members only
7th Congress of ECCO
CCIB Barcelona
February 16-18, 2012

The major educational event in the field of Inflammatory Bowel Diseases in Europe – EACCME applied.

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Get ready for the 2012 ECCO Congress in Barcelona. Each year the ECCO Congress attracts more participants, and it is now the world’s largest IBD meeting, gathering doctors and nurses from around the world. The scientific programme is outlined below. In accordance with ECCO’s mission to provide broad and novel scientific information to everyone, all presentations will be held in the main auditorium, a unique approach for an international congress.

The sessions will have a similar format to that used in previous years, starting with the science that underpins the topic, then moving on to clinically relevant subjects and finally addressing clinical management with an eye to current practice and the future. Within the sessions, selected abstracts will be presented to provide a bridge from bench to bedside.

ECCO’12 will specifically focus on patient care. The congress will open with a “tandem talk”, an approach excellently received in preceding years. After setting the stage regarding the common ground across inflammatory disorders and their therapeutic options, the second session will focus on the impact of the disease on patients and the tools available to measure success and failure in IBD. A further session on the first day will cover the preliminary results from the 3rd Scientific Workshop, focusing in particular on malignancy in IBD. In addition, the new ECCO-ESPGHAN Paediatric Guidelines on UC will be presented.

The first session on the second day of the congress will consider imaging in IBD and will encompass the ECCO-ESGAR Imaging Guidelines. Further sessions will discuss practical tips and tricks for handling IBD complications and the impact of IBD on daily life, including the perspective of the patient. Related novel topics such as care pathways in IBD, organising care in IBD and E-Health will also be covered in a separate session.

As surgery is an important therapeutic approach in our patients, surgery in IBD, and especially the optimal timing for surgery, will be discussed on the third day of the congress. State of the art lectures will be delivered on genes, stem cell therapy and the microbiome, before the ECCO Lecture on personalised medicine concludes the meeting.

We hope that the diverse programme will appeal to many colleagues and will spread the current IBD-related knowledge far beyond Europe. As ECCO’12 will be a great event, please put the dates in your diary now (February 16–18, 2012) and register online today. More information is available online at http://www.ecco-ibd.eu/ecco12.

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**Preliminary programme overview (as of September 13, 2011)**

7th Congress of ECCO – “Breaking down barriers in IBD”

**Thursday, February 16, 2012**

**10:45-11:15** Top tips for chairs (Closed session)
Geert D’Haens, Amsterdam, The Netherlands

**11:30-12:30** Satellite symposium

**12:45-13:00** Opening & welcome
Miquel Gassull, Barcelona, Spain
Daniel Hommes, Los Angeles, United States

**13:00-14:20** Scientific session 1:
Common ground across inflammatory disorders
Miquel Sans, Barcelona, Spain
Jan Wehkamp, Stuttgart, Germany

**13:00-13:30** Tandem talk: Shared pathways in inflammation
Maria Abreu, Miami, United States
Fiona Powrie, Oxford, United Kingdom

**13:30-13:40** Oral presentation 1

**13:40-13:50** Oral presentation 2

**13:50-14:00** Oral presentation 3

**14:00-14:20** Inflammatory side-effects of biological therapy
François Aubin, Besançon, France

**14:20-14:50** Coffee break

**14:50-15:10** Predicting disease outcome
Siew Ng, Hong Kong, China

**14:50-15:10** Oral presentation 4

**15:20-15:40** Tandem talk: Scoring disease damage and disability
Benjamin Pariente, Paris, France
Laurent Peyrin-Biroulet, Vandoeuvre-lès-Nancy, France

**15:40-15:50** Oral presentation 5

**15:50-16:10** Assessing endoscopic and disease activity in practice
Gert van Assche, Leuven, Belgium

**16:10-16:30** Scientific session 3:
Preliminary results from the 3rd Scientific Workshop
Dana Duricova, Prague, Czech Republic
Pierre Michetti, Lausanne, Switzerland

**16:10-16:30** Malignancy in IBD
Silvio Danese, Rozzano, Milan, Italy

**16:30-17:00** Mini-session 3:
ECCO-ESPGHAN Paediatric Guidelines on UC
Dan Turner, Jerusalem, Israel

**17:15-18:15** Satellite symposium
Friday, February 17, 2012

07:15-08:15  Satellite symposium
08:30-09:30  Scientific session 4: Imaging in IBD
André D’Hoore, Leuven, Belgium
Simon Jackson, Plymouth, United Kingdom
Janneke van der Woude, Rotterdam, The Netherlands
Medical or surgical therapy for obstruction: Is imaging the key?
Casper Gijsbert Noomen, Amsterdam, The Netherlands
IBD facing surgery - Are you sure the small bowel is normal?
Ailsa Hart, London, United Kingdom
08:50-09:00  Oral presentation 6
09:00-09:20  ECCO-ESGAR Imaging Guidelines
Julian Panes, Barcelona, Spain
09:20-09:30  Case resolution
09:30-09:40  Scientific session 5:
Complications carousel: Management tips and tricks
André D’Hoore, Leuven, Belgium
Simon Jackson, Plymouth, United Kingdom
Janneke van der Woude, Rotterdam, The Netherlands
Anaemia
Christoph Gasche, Vienna, Austria
Osteoporosis
Ad van Bodegraven, Amsterdam, The Netherlands
Renal
Satish Keshav, Oxford, United Kingdom
Ocular
Luis Pablo, Zaragoza, Spain
Pulmonary
Franck Carbonnel, Besançon, France
Thromboembolism
Gerassimos Mantzaris, Athens, Greece
10:12-10:30  Discussion
10:30-11:00  Coffee break
11:00-12:20  Scientific session 6: Impact of IBD on daily life
Fernando Magro, Porto, Portugal
Fermin Mearin, Barcelona, Spain
11:00-11:40  Debate: IBD and IBS - Marriage or divorce?
Michael Kam, Melbourne, Australia
Giovanni Barbara, Bologna, Italy
11:40-11:50  Oral presentation 8
11:50-12:00  Oral presentation 9
12:00-12:20  The patient perspective
Ben Wilson, Newcastle, United Kingdom
12:20-13:15  Lunch and guided poster session in the exhibition hall
13:15-13:30  Poster award ceremony in the exhibition hall
13:30-14:30  Scientific session 7: Organising care in IBD
Francesc Casellas, Porto, Portugal
Mircea Diculescu, Bucharest, Romania
13:30-13:50  E-Health and home-testing: Ready for prime time?
Pia Munkholm, Copenhagen, Denmark
13:50-14:00  Oral presentation 10
14:00-14:10  Oral presentation 11
14:10-14:30  Care pathways in IBD
Daniel Hommes, Los Angeles, United States
14:30-15:00  Coffee break
15:00-15:50  Scientific session 8: ECCO Fellowships and Grants
Andreas Sturm, Berlin, Germany
15:00-15:10  Fellowship 1
Bénédicte Brounais-Le Royer, Geneva, Switzerland
15:10-15:20  Fellowship 2
Lael Werner, Berlin, Germany
15:20-15:30  Announcement of ECCO Fellowships and Grants 2012
Andreas Sturm, Berlin, Germany
15:30-15:40  Oral presentation 12
15:40-15:50  Oral presentation 13
15:50-17:25  Scientific session 9: Challenging Cases
Jürgen Schölmerich, Frankfurt am Main, Germany
Peter Irving, London, United Kingdom
16:50-16:10  Case 1
16:10-16:30  Case 2
16:30-16:50  Case 3
16:50-17:00  Oral presentation 14
17:00-17:10  Oral presentation 15
17:10-17:25  How I manage abnormal LFTs in IBD
Maria Esteve, Barcelona, Spain
17:40-18:40  Satellite symposium
20:00  ECCO Interaction: Hearts and Minds

Saturday, February 18, 2012

07:15-08:15  Satellite symposium
08:30-10:00  Scientific session 10: Surgery in IBD
Antonio Lopez San Roman, Madrid, Spain
Bjorn Moum, Oslo, Norway
08:30-08:50  Perianal CD
Bruce George, Oxford, United Kingdom
08:50-09:00  Oral presentation 16
09:00-09:20  Tandem talk: Find the best timing for surgery
Sandro Ardizzzone, Como, Italy
Antonino Spinelli, Milan, Italy
09:20-09:30  Oral presentation 17
09:30-09:40  Oral presentation 18
09:40-10:00  Managing complications
Emmanuel Tiret, Paris, France
10:00-10:30  Coffee break
10:30-11:50  Scientific session 11: Where are we heading?
Daniel Hommes, Los Angeles, United States
Simon Travis, Oxford, United Kingdom
10:30-10:50  Are gene hunting days over?
Miles Parkes, Cambridge, United Kingdom
10:50-11:00  Oral presentation 19
11:00-11:20  Are stem cells ready for clinical practice?
Gis van den Brink, Amsterdam, The Netherlands
11:20-11:30  Oral presentation 20
11:30-11:50  Are we ready to manage the microbiome?
Arlette Darfeuille-Michaud, Clermont-Ferrand, France
11:50-12:20  Scientific session 12: ECCO Lecture
Daniel Hommes, Los Angeles, United States
Simon Travis, Oxford, United Kingdom
11:50-12:20  Translating evidence from clinical trials into personalised medicine
Stephen Hanauer, Chicago, United States
12:20-12:30  Closing remarks
Simon Travis, Oxford, United Kingdom
Bone loss secondary to inflammatory bowel diseases (IBD) causes fragility fractures. This is largely explained by activated T cells producing cytokines that trigger osteoclastogenesis and accelerate bone resorption while inhibiting bone formation by osteoblasts, resulting in osteoporosis. In IBD, abnormal expression of interleukin (IL)-15 plays a central role in T cell activation, pro-inflammatory cytokine production and the development of colitis. Our laboratory reported that osteoclast development by the receptor activator of NF-κB ligand (RANKL) was impaired in bone marrow and/or spleen cell cultures from mice lacking the IL-15 receptor (IL-15Rα−/−). In turn, IL-15Rα−/− mice had higher bone mineral density and improved bone microarchitecture compared with wild-type mice. In addition to its effects on osteoclasts, preliminary results indicate that an IL-15 antagonist, CRB-15, significantly increases osteoblast number and bone formation in ovariectomised mice. Whether IL-15 can modulate osteoblastogenesis directly or indirectly through T cells remains to be investigated. Hence, we hypothesise that inhibition of IL-15 signalling may moderate the severity of colitis and prevent bone loss in mouse models of IBD by preventing T cell activation, osteoclast development and/or the inhibition of bone formation. To test this hypothesis, we shall first study the effects of CRB-15 in two mouse models of colitis, namely mice with chemically induced colitis and IL-10 knock-out mice. Finally, we shall assess the role of IL-15 on the in vitro differentiation of osteoblasts co-cultured with T cells. Thus we shall use a combined in vivo and in vitro approach to shed further light on the role of IL-15 and activated T cells in bone loss related to colitis.

Bénédicte Brounais-Le Royer, Service of Bone diseases, Department of Rehabilitation and Geriatrics, Geneva University Hospital, Geneva, Switzerland

Background and aims: TNFα inhibitors are frequently prescribed for inflammatory bowel disease (IBD). Despite the clinical success of TNFα inhibitors such as infliximab (IFX) and adalimumab (ADA), understanding of their physiological mode of action is still limited. Our study aims to further investigate anti-TNFα’s mode of action in IBD. Specifically, we hypothesised that Notch mediates anti-TNFα action and so aspired to identify Notch-1 as a link by which anti-TNFα antibodies mediate their inhibitory functions in IBD.

Methods: Freshly isolated T cells were isolated from normal or IBD patients. The influence of TNFα inhibitors on T cell function was analysed. For Notch studies, we compared mucosal Notch-1 levels in normal vs. IBD and examined the effects of ADA and IFX on Notch-1 expression. The regulatory role of Notch-1 was examined by blocking several Notch-1-mediated pathways.

Results: Both TNFα inhibitors induced T cell apoptosis, inhibited activation, reduced cytokine secretion and restricted cell cycling. TNFα blockade at several levels revealed that TNFα is responsible for inducing apoptosis by anti-TNFα, but not for cell cycle restriction. By linking Notch and TNFα pathways we have shown that (a) Notch-1 mucosal expression differs in inflamed and uninflamed mucosa, (b) Notch-1 function is activated by IFX and ADA, (c) Notch-1 binds to TNFα and (d) Notch-1 inhibition averts anti-TNFα-induced T cell cycle arrest.

Conclusions: IFX and ADA potently inhibited T cell activation, cell cycling and expansion in normal and IBD T cells. By demonstrating that Notch-1 mediates the inhibitory effects of ADA and IFX on T cell cycling, we have revealed not only a new mode of action, but also an underlying signalling pathway by which biological agents act in IBD.

Lael Werner, Department of Medicine, Division of Gastroenterology and Hepatology, Charité-Campus Virchow Clinic, Universitätsmedizin Berlin, Berlin, Germany
The main mission of GuiCom is to foster the development and implementation of guidelines.

Through these guidelines we hope to improve the diagnosis and treatment of IBD in all member countries of ECCO. ECCO has previously developed guidelines on the diagnosis and management of CD and UC, opportunistic infections and pregnancy problems in IBD. Due to technical and therapeutic developments in IBD, both new guidelines and updating of the “old” ones are needed. Furthermore, additional work is required to spread the guidelines in our community (ECCO Educational Workshops).

We are planning to develop eight new consensus guidelines and three guideline updates. Topics covered in the new guidelines will include imaging modalities, nutrition, IBD-related neoplasia, endoscopy, and histopathology in IBD and microscopic colitis. Interactions with other societies (e.g. paediatricians, surgeons, nutrition experts, radiologists, pathologists and the RAND panel) are being pursued with the intention of developing joint guidelines. With these initiatives we hope to ensure the development of guidelines with high standards of evidence-based medicine. A database with all references from all guidelines is now under development and a reference manager (EndNote) will be implemented. With this tool all ECCO Members will have easy access to the abstracts. An electronic guideline portal has also been established to enable interaction between guideline and consensus panelists, allowing online voting and discussion. We believe that these projects will assist in achieving the mission of GuiCom.

GuiCom
Axel Dignass, Fernando Magro, Abraham (Rami) Eliakim, Vito Annese

A new consensus is emerging…

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<th>Updates</th>
<th>Call</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative Colitis</td>
<td>2011</td>
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<tr>
<td>Opportunistic infections</td>
<td>2011</td>
<td>2012</td>
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<tr>
<td>Crohn’s Disease</td>
<td>2012</td>
<td>2014</td>
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</tbody>
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P-ECCO action plan

The Paediatric Committee of ECCO (P-ECCO) met in Vienna last June along with all other committees to work on the action plan for next year.

The P-ECCO mission is to improve knowledge on paediatric-specific IBD issues; to produce and promote paediatric-specific IBD guidelines; to publish consensus papers and statements; to initiate and coordinate clinical trials involving transitional and combined paediatric/adult aspects of IBD; to interact with the Porto IBD WG of ESPGHAN and to educate on adolescent-specific issues.

Currently we are working on combined ECCO-ESPGHAN Guidelines for the treatment of UC in children, which will be completed by the end of this year. A large group of people from Europe, the United States and Canada have been working enthusiastically on this project.

P-ECCO will actively participate in the scientific and educational activities of the next ECCO Congress in Barcelona in 2012.

P-ECCO will grow from three to five members next year. A call for applications has been made. The deadline for applications is September 19, 2011. This will certainly allow for more activities to be embraced and greater interaction with all those who care for children and adolescents affected by IBD.

Jorge Amil Dias
P-ECCO Committee Member

And the Winners are…

Free registration for the ECCO’12 Barcelona Congress

Feedback is highly valuable for ECCO in order to continuously improve our annual congress. As promised, three free registrations for the 7th ECCO Congress – the ECCO’12 Barcelona Congress – were drawn from among all the completed evaluation forms that were submitted at the ECCO’11 Dublin Congress.

We are happy to announce that the following delegates have won a free registration for the ECCO’12 Barcelona Congress: Norbert Busch (Germany), Marijke Paelinck (Belgium), Peter Barrow (United Arab Emirates)

Congratulations! We kindly ask the winners to contact the ECCO Office at ecco@ecco-ibd.eu.
10th ECCO Intensive Advanced Course in IBD, Barcelona 2012

The 10th ECCO Intensive Advanced Course in IBD for residents, fellows in gastroenterology and junior faculty will take place in Barcelona, Spain on February 15–16, 2012, just prior to the next ECCO Congress.

In great appreciation of the wide popularity that this course has now gained, the ECCO Education Committee is constantly striving to maintain its high standard and to develop further its attractiveness. In this context, the 10th ECCO Intensive Advanced Course will benefit from the following innovations:

- The call for nomination of participation has been advanced (with the deadline of September 15, 2011) so that the selection of participants can be completed before the early registration deadline for the ECCO Congress 2012 (November 9, 2011) – allowing participants to register in time to qualify for the reduced registration fees.
- With this course, ECCO is investing in the education of the IBD experts of tomorrow and at the same time aiming to engage them in the ECCO Family. Reflecting this rationale and fostering the inclusion of course participants in the community beyond the course itself, ECCO Membership has been introduced as an eligibility criterion for course participation.
- In order to enhance the didactic quality of the printed course syllabus, the 2012 edition will include learning objectives, key slides, key references and space for note-taking.
- Interaction is key in so many ECCO initiatives, and it is certainly a top priority in developing the course programme further: the upcoming course will foster active participation by the use of voting pads and considerable time will be dedicated to case-based discussions.

Preliminary Programme Wednesday, February 15, 2012 (as of September 13, 2011)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Activity</th>
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<tbody>
<tr>
<td>08:00-08:15</td>
<td>Welcome</td>
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<tr>
<td></td>
<td>Daniel Hommes, Los Angeles, United States and Janneke van der Woude, Rotterdam, The Netherlands</td>
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<tr>
<td>08:15-08:45</td>
<td>Pre-course test</td>
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<td></td>
<td>Charlie Lees, Edinburgh, United Kingdom</td>
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<tr>
<td>08:45-10:35</td>
<td>Session 1: Lecture session</td>
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<tr>
<td></td>
<td>Arthur Kaser, Cambridge, United Kingdom and Peter Lakatos, Budapest, Hungary</td>
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<tr>
<td>08:45-09:15</td>
<td>IBD: Epidemiology and environmental factors</td>
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<td></td>
<td>Pia Munkholm, Copenhagen, Denmark</td>
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<tr>
<td>09:15-09:45</td>
<td>The genetics of IBD</td>
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<td></td>
<td>Charlie Lees, Edinburgh, United Kingdom</td>
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<tr>
<td>09:45-10:35</td>
<td>Tandem Talk: IBD therapeutics targets and drugs: New and old</td>
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<td>Yehuda Chowers, Haifa, Israel</td>
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<td>Séverine Vermeire, Leuven, Belgium</td>
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<tr>
<td>10:35-11:00</td>
<td>Coffee break</td>
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<tr>
<td>11:00-12:25</td>
<td>Session 2: Seminar session</td>
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<tr>
<td>11:00-11:40</td>
<td>Seminar I: IBD and pregnancy</td>
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<td></td>
<td>Janneke Van der Woude, Rotterdam, The Netherlands</td>
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<td>Seminar II: Paediatric IBD</td>
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<td>Frank Ruemmele, Paris, France</td>
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<tr>
<td>11:45-12:25</td>
<td>Seminar I: IBD and pregnancy</td>
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<td>Janneke Van der Woude, Rotterdam, The Netherlands</td>
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<td>Seminar II: Paediatric IBD</td>
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<td>Frank Ruemmele, Paris, France</td>
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<td>12:25-13:15</td>
<td>Lunch break</td>
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<tr>
<td>13:15-15:35</td>
<td>Session 3: Ulcerative Colitis session</td>
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<td></td>
<td>Gerassimos Mantzaris, Athens, Greece and Andreas Sturm, Berlin, Germany</td>
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<tr>
<td>13:15-13:55</td>
<td>Case based discussion: The patient with bloody diarrhoea differential diagnosis and initial diagnostic work-up</td>
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<td></td>
<td>Case presentation: Marjolijn Duijvestein, Amsterdam, The Netherlands</td>
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<td></td>
<td>Discussion: Axel Dignass, Frankfurt am Main, Germany</td>
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<tr>
<td>13:55-14:20</td>
<td>Cancer surveillance and chemoprevention</td>
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<td>Matt Rutter, Cleveland, United Kingdom</td>
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<tr>
<td>14:20-15:10</td>
<td>Tandem Talk: Acute Severe Ulcerative Colitis: Management including medical and surgical rescue therapy</td>
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<td></td>
<td>Willem Bemelman, Amsterdam, The Netherlands and Simon Travis, Oxford, UK</td>
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<tr>
<td>15:10-15:35</td>
<td>Pouch, early and late complications</td>
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<td>Fernando Magro, Porto, Portugal</td>
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<tr>
<td>15:35-16:00</td>
<td>Coffee break</td>
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<tr>
<td>16:00-18:00</td>
<td>5th Y-ECCO Workshop</td>
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<td>See separate programme on page 29.</td>
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</tbody>
</table>
Preliminary Programme Thursday, February 16, 2012 (as of September 13, 2011)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
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<tbody>
<tr>
<td>08:00-10:00</td>
<td>Session 4</td>
<td>Crohn’s Disease session</td>
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<td></td>
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<td>Axel Dignass, Frankfurt am Main, Germany and Walter Reinisch, Vienna, Austria</td>
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<tr>
<td>08:00-08:40</td>
<td>Case based discussion: The patient with watery diarrhoea, abdominal pain and weight loss</td>
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<td>Case presentation: Franco Scaldaferri, Rome, Italy</td>
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<td>Discussion: Vito Annese, Florence, Italy</td>
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<tr>
<td>08:40-09:20</td>
<td>Case based discussion: The patient with severe Crohn’s Disease</td>
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<td></td>
<td>Case presentation: James Christoph Lee, Cambridge, United Kingdom</td>
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<td>Discussion: Rami Eliakim, Jerusalem, Israel</td>
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<td>09:20-10:00</td>
<td>Tandem talk: Fistulizing &amp; stenosing disease: medical and surgical approaches</td>
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<td>Pierre Michetti, Lausanne, Switzerland</td>
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<td>Tom Øresland, Lorenskog, Norway</td>
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<tr>
<td>10:00-10:20</td>
<td>Coffee break</td>
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<tr>
<td>10:20-11:35</td>
<td>Session 5: Drug therapy session</td>
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<td></td>
<td>Charlie Lees, Edinburgh, United Kingdom and Gert van Assche, Leuven, Belgium</td>
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<tr>
<td>10:20-10:40</td>
<td>Understanding clinical trials in IBD</td>
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<td>Geert D’Haens, Amsterdam, The Netherlands</td>
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<tr>
<td>10:40-11:10</td>
<td>Monitoring drug therapy with biomarkers, drug levels and antibody testing</td>
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<td>Edouard Louis, Liège, Belgium</td>
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<tr>
<td>11:10-11:35</td>
<td>Vaccinations, immunisations and opportunistic infections in IBD - A case-based guide</td>
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<td>Jean-Francois Rahier, Yvoir, Belgium</td>
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<tr>
<td>11:35-12:25</td>
<td>Conclusion</td>
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<td>11:35-12:00</td>
<td>Post-course test</td>
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<td></td>
<td>Charlie Lees, Edinburgh, United Kingdom</td>
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<tr>
<td>12:00-12:25</td>
<td>Course test feedback, marking &amp; questions</td>
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<td></td>
<td>Charlie Lees, Edinburgh, United Kingdom</td>
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<tr>
<td>12:25-12:30</td>
<td>Closing remarks</td>
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<td></td>
<td>Janneke van der Woude, Rotterdam, The Netherlands</td>
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</tbody>
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Preliminary Announcement of the ECCO IBD Intensive Advanced Course 2013 (as of September 13, 2011):

All potential candidates interested in participating in the 2013 course are highly encouraged to note the following timeline:

- Spring 2012: publication of preliminary programme on congress website.
- June 2012: call for nominations will be sent to National Representatives and published on the ECCO website.

Minimum criteria for nominees:
- ECCO Member status 2013.
- Trainees at least in their third year with preferably one year of GI experience.
- Demonstration of a sufficient level of English to follow the course.

Participants on this course will be selected in their country, by a national system left to the responsibility of the National Representatives of each ECCO Country Member. Two students can be sent by each country each year, leading to the assembly of a multinational class of highly motivated and selected students.

In order to register for the forthcoming IBD Course, please contact the ECCO National Representative of your country (contact details at www.ecco-ibd.eu).

- September 2012: deadline for nominations
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The 1st S-ECCO IBD Masterclass – a pioneering activity at the ECCO Congress – will be organised by the Surgeons of ECCO (S-ECCO). The aim of this Masterclass is to foster an appreciation of the results of a multidisciplinary approach to Crohn's Disease of the terminal ileum. The Masterclass will provide insights into the medical strategy and surgical techniques. Indications for surgery and the importance of timing will be extensively discussed.

Wednesday, February 15, 2012 Preliminary programme overview – 1st S-ECCO IBD Masterclass (as of September 13, 2011)

13:00-13:15 Welcome André D’Hoore, Leuven, Belgium
13:15-14:00 Session 1: Introduction André D’Hoore, Leuven, Belgium
  13:15-13:37 Have indications and need for surgery changed in the era of biologicals
      Bjørn Moum, Oslo, Norway
  13:37-14:00 How to evaluate inflammation and/or fibrosis: Serology, MRI enterography
      Julian Panes, Barcelona, Spain
14:00-15:30 Session 2: Ileocaecal resection Eloy Espin-Basany, Barcelona, Spain
  14:00-14:23 The open approach: Surgical details - Including complex cases (internal fistulae)
      Tom Øresland, Oslo, Norway
  14:23-14:45 Laparoscopic ileocaecal resection: A tailored approach
      Hermann Kessler, Erlangen, Germany
  14:45-15:07 Laparoscopic ileocaecal resection in complex cases and for recurrent disease
      Yves Panis, Clichy, France
  15:07-15:30 The anastomosis: Types – outcome
      Carla Coimbra, Liège, Belgium
15:30-16:00 Coffee break
16:00-16.45 Session 3: Strictureplasties André D’Hoore, Leuven, Belgium
  16:00-16:15 Rationale and outcome of classical types
      Neil Mortensen, Oxford, United Kingdom
  16:15-16:30 Isoperistaltic strictureplasty
      Fabrizio Michelassi, New York, United States
  16:30-16.45 Discussion
16:45-17:45 Session 4: Outcome Antonio Spinelli, Milan, Italy
  16:45-17:00 Postoperative morbidity: Do we have to blame the drugs ?
      Johan Soderholm, Linköping, Sweden
  17:00-17:15 Outcome after primary ileocaecal resection
      Willem Bemelman, Amsterdam, The Netherlands
  17:15-17:30 Outcome after conservative surgery
      Gianluca Sampietro, Milan, Italy
  17:30-17:45 S-ECCO clinical research lecture: Case matched comparison strictureplasty with ileocolic resection
      Anthony de Buck van Overstraeten, Leuven, Belgium
17:45-18:15 Session 5: Ongoing debate Julio Leite, Coimbra, Portugal
  17:54-18:00 Early versus late surgery
      Anders Tottrup, Aarhus, Denmark
  18:00-18:05 The LIRIC trial (an update)
      Tjibbe Gardenbroek, Amsterdam, The Netherlands
  17:15-17:30 Discussion

Thursday, February 16, 2012 Preliminary programme overview – 1st S-ECCO IBD Masterclass (as of September 13, 2011)

09:00-10:00 Session 6: Follow-up and adjuvant treatment Fabrizio Michelassi, New York, United States
  09:00-09:30 Classification of postoperative recurrent disease and intensity of follow-up
      Geert D’Haens, Amsterdam, The Netherlands
  09:30-10.00 Maintenance (prophylactic) treatment after surgery: Current evidence and ongoing trials
      Séverine Vermeire, Leuven, Belgium
10:00-10:30 Session 7: Brainstorm session: S-ECCO as a platform for international clinical research
      Willem Bemelman, Amsterdam, The Netherlands and André D’Hoore, Leuven, Belgium

Registration – 1st S-ECCO IBD Masterclass

The 1st S-ECCO IBD Masterclass in Barcelona is open to all members of ECCO (paid-up membership fee for 2012).

In this context, the S-ECCO Committee is looking forward to welcoming:

• all current ECCO Members
• new members (you can learn more about joining the ECCO Family or signing up for membership online at www.ecco-ibd.eu).

Registration for the 1st S-ECCO IBD Masterclass is accessible to paid-up ECCO Members 2012 within the online ECCO Congress registration at www.ecco-ibd.eu/ecco12.

The number of participants for the Masterclass is limited. Registration will be on a first-come, first-served basis.

For further information please contact the ECCO Office (ecco@ecco-ibd.eu).
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Tel: +43-(0)1-710 22 42, E-mail: ecco@ecco-ibd.eu
In the next issue of JCC (Journal of Crohn's & Colitis)

Volume 5, issue 5, October 2011 CONTENTS

**REVIEW**

Diagnostics anemia in inflammatory bowel disease: Beyond the established markers
P. Oustamanolakis, I.E. Koutroubakis, E.A. Kouroumalis 381

**REGULAR PAPERS**

Environmental factors in infancy and ulcerative colitis in the Central South of Chile: A case—control study
A. Boneberger, E.H. Weiss, M. Calvo, L. Torres, J. Wagner, M. Kobesch, K. Radon 392

Methotrexate in ulcerative colitis: A Spanish multicentric study on clinical use and efficacy
M. Marhosa, V. García, L. Castro, O. García-Bosch, M. Chaparro, M.B. Acosta, D. Carpio, M. Aguas 397

Serum levels of soluble receptor for advanced glycation endproducts (sRAGE) are higher in ulcerative colitis and correlate with disease activity
Y. Yılmaz, O. Yonal, F. Eren, O. Atug, H. Over Hamzooglu 402

Sexual function after failed ileal pouch-anal anastomosis
J. Bengtsson, E. Lindholm, S. Nordgren, I. Berndtsson, T. Öresland, L. Börjesson 407

Influence of ileal pouch anal anastomosis on bone loss in ulcerative colitis patients

C-reactive protein (CRP), erythrocyte sedimentation rate (ESR) or both? A systematic evaluation in pediatric ulcerative colitis

Cancer in inflammatory bowel disease 15 years after diagnosis in a population-based European Collaborative followup study

Nutritional problems in inflammatory bowel disease: The patient perspective
A. Prince, K. Wheelan, A. Moosa, M.C.E. Lomer, D.P. Reidlinger 443

**SHORT REPORTS**

IgG4-associated ampullitis and cholangiopathy in Crohn's disease
U. Navaneethan, X. Liu, A.E. Bennett, R.M. Walsh, P.G.K. Venkatesh, B. Shen 451

Stevens—Johnson syndrome with sulfasalazine treatment: Report of two cases

Concurrent small bowel adenocarcinoma and carcinoid tumor in Crohn's disease — Case report and literature review
D. Boltin, Z. Levi, M. Halpern, M.G. Fraser 461

Fulminant ulcerative colitis despite maximal immunosuppression following liver transplantation: A case report and literature review
A. Pan, M. Schlup, R. Lubcke, M. Schultz 465

Cytomegalovirus disease, haemophagocytic syndrome, immunosuppression in patients with IBD: A cocktail best avoided, not stirred
D.R. van Langenberg, G. Morrison, A. Foley, R.J. Buttigieg, P.R. Gibson 469

Comprehensive MRI diagnosis of sacral osteomyelitis and multiple muscle abscesses as a rare complication of fistulizing Crohn's disease
M. Tonolini, A. Ravelli, A. Campari, R. Bianco 473

**SPECIAL ARTICLES**

Results from the 2nd Scientific Workshop of the ECCO (I): Impact of mucosal healing on the course of inflammatory bowel disease

Results of the 2nd part Scientific Workshop of the ECCO (II): Measures and markers of prediction to achieve, detect, and monitor intestinal healing in Inflammatory Bowel Disease

**LETTERS TO THE EDITOR**

In-vitro dissolution testing of 5-aminosalicylic acid release from pH dependent mesalazine formulations
W. Kruis, R. Greinwald, T. Fingerhut 499

Reply to Dr. Kruis et al.’s letter
S. Tenjarla 501

Piercing and Crohn's disease
K.H. Katsanos, E.V. Tsianos 502

On the usefulness of small bowel capsule endoscopy in Crohn's disease
B. Rosa, M.J. Moreira, A. Rebelo, J. Cotter 504

Cigarette smoking in Crohn's disease: Can we do more?
E. Slattery, P. Mitchell, H.E. Mulcahy 505

A case of ulcerative colitis co-existing with pseudo-membranous enterocolitis
S. Kılıncalp, A. Altnbaş, Ö. Başar, M. Deveci, O. Yüksel 506
Influence of ileal pouch anal anastomosis on bone loss in ulcerative colitis patients

Navaneethan et al. performed a case control study comparing bone density as measured by dual–energy x-ray absorptiometry (DXA) in patients with ulcerative colitis (UC) with and without proctocolectomy and ileal pouch–anal anastomosis (IPPA). Their aim was to clarify whether IPPA alters the risk of bone loss in UC. Decreased BMD was found in a higher proportion of patients in the IPPA group (31.1%) than in the non-operated UC group (15.1%). Independent risk factors for low BMD were advanced age, low body mass index and IPPA. The IPPA cohort was significantly younger and more likely to have extensive colitis and a family history of osteoporosis. Fragility fractures were detected in 8.1% of patients in the IPPA group versus 2.5% of the control group. This study was cross-sectional and therefore not designed to compare preoperative versus postoperative BMD. However, among those patients for whom preoperative DXA scans were available, colectomy with IPPA had a tendency to improve BMD in 53.8% of cases (not significant). Time from diagnosis of UC to restorative proctocolectomy and IPPA was significantly longer in patients with low BMD than in those with normal BMD.

The study by Navaneethan et al. is in concordance with current knowledge. Kuisma et al. found osteopenia and osteoporosis in 26.1% and 2.3% of 88 UC patients with restorative proctocolectomy, respectively [3]. Shen et al. detected osteoporosis in 32.1% of 327 patients recruited from a pouchitis clinic [4]. The study at hand also reproduces previous results from smaller trials, which found IPPA to increase BMD postoperatively in more than half of the patients studied [5].

By including patients after IPPA, Navaneethan et al. have selected a cohort of UC patients with unfavourable disease course, extensive glucocorticoid exposure and an intense systemic inflammatory response, all established risk factors for bone loss [6]. Therefore unsurprisingly, the yield of diminished BMD was significantly higher in cases versus controls.

In conclusion, osteoporosis and an increased fracture risk were once again demonstrated in UC patients undergoing proctocolectomy and IPPA and should not go overlooked in the management of IBD. Furthermore, incomplete medical disease control in this subset of UC patients and therefore prolonged steroid use and unduly delayed referral to eventual proctocolectomy might contribute to further preventable bone loss with all its unsavoury consequences. This and the reported gradual recovery in bone mineral density after IPPA warrant further research and might add to the increasingly accepted notion that restorative proctocolectomy should not be considered our last resort in UC but is best used in a timely manner as a therapeutic option in patients refractory to medical therapy.
Mucus covers the intestinal epithelium along the entire gastrointestinal tract and is a central part of the intestinal barrier. Enteric mucus contains goblet cell-derived mucins, antimicrobial peptides and immunoglobulins and thus forms both a functional and a physical barrier that prevents the translocation of microbial organisms into the intestinal lamina propria [1]. The composition of mucus varies along the intestinal tract and increases in depth towards the distal colon, where an inner, sterile layer adjacent to the epithelium and an outer non-sterile layer can be distinguished [1, 2]. These structural features are dependent on mucins, a family of oligomerising and non-oligomerising heavily O-glycosylated glycoproteins [1, 2].

Given the central role of intestinal mucus in the prevention of uncontrolled microbial translocation into the lamina propria, it was hypothesised decades ago that inflammatory bowel diseases (IBD) are associated with alterations in the composition and structure of the intestinal mucus. Indeed, characterisation of the mucus layer in IBD revealed an inflammation-dependent decrease in mucus thickness, particularly in ulcerative colitis [3]. This is consistent with earlier reports on altered molecular mucus composition in IBD [4] and was shown to be in large part due to impaired O-glycosylation of mucins [5]. Subsequent mechanistic studies in mice indicated that altered expression of mucins might indeed play a primary, pathogenic role in IBD since genetic defects in mucin expression can lead to spontaneous intestinal inflammation [6, 7].

Fu et al. [8] have now highlighted the role of O-glycosylation of intestinal mucins in the pathogenesis of IBD. The authors generated mice with conditional, intestinal epithelial-specific deletion of core 1 (β1,3-galactosyltransferase (C1galt1)), an enzyme responsible for generation of the predominant form of O-glycans. Similar to previous reports on mice with mucin defects, C1galt1-deficient mice developed spontaneous colitis with histological features reminiscent of human ulcerative colitis such as epithelial ulceration and crypt abscesses. Mechanistic studies revealed that intestinal epithelial deletion of C1galt1 leads to a severely impaired mucus structure, reduced expression of mucins and unrestrained, direct contact between the intestinal epithelium and the microbiota that is associated with bacterial translocation into the lamina propria. In addition, Fu et al. demonstrated that spontaneous colitis in C1galt1-deficient mice is driven by myeloid cells in a TNF-α-dependent but not toll-like receptor-dependent manner and is independent of adaptive immune cells.

Several findings suggest that these observations might be relevant to human IBD. First, the authors demonstrated that intermediates of glycan biosynthesis, normally concealed by further glycosylation, can be detected in the intestinal mucosa of patients with ulcerative colitis (UC) but not controls, which indicates incomplete glycan synthesis in UC. In addition, initial genetic analysis of UC patients exhibiting defective glycosylation of intestinal mucins revealed the presence of missense mutations in a chaperone responsible for proper function of C1galt1 (core 1 β1,3-galactosyltransferase–specific chaperone 1), which suggests that primary genetic alterations in glycan pathways might contribute to the pathogenesis of UC.

Summary: The study by Fu et al. demonstrates that alterations in glycosylation of mucins are associated with impaired mucus production, increased bacterial translocation into the intestinal lamina propria and spontaneous colitis. In addition, the authors’ findings suggest that primary genetic alterations in glycan pathways might be associated with human UC. Finally, since defects in glycan biosynthesis similar to those observed in UC can also be detected in colorectal cancer, the study by Fu et al. raises the question of whether glycan alterations in UC might be related to the development of colitis-associated cancers.

References:
2. Johansson ME, Larsson JM, Hansson GC. The two mucus layers of colon are organized by the MUC2 mucin, whereas the outer layer is a legislator of host-microbial interactions. Proc Natl Acad Sci U S A 2011;108 Suppl 1:4659-65.

Visit the ECCO Booth at UEGW 2011
Come and find ECCO at UEGW 2011 on October 24–26, 2011 in Stockholm, Sweden. The ECCO Booth will be located in the brand new UEGF Association Village. The ECCO Office Team and ECCO Officers will be happy to provide you with information on ECCO’s activities and initiatives, as well as the Annual ECCO Congress. Signing up for or renewing your ECCO Membership is possible at the booth. The ECCO Office Team looks forward to meeting YOU!
Dr. Falk Pharma Benelux B.V. provides ECCO access to GE-trainee.

Dr. Falk Pharma specializes in pharmaceuticals used successfully to treat inflammatory bowel disease and cholestatic liver disease. With a focus on modern formulations and specially designed delivery systems targeted release of the active drug is ensured.

Since 1967 Dr. Falk Pharma has arranged internationally recognized scientific congresses, the Falk Symposia and Workshops. So far more than 200 events have been attended by some 100,000 participants from over 100 countries.

Continuing medical education events are sponsored and organized throughout Europe - to date over 13,000 seminars have been attended by over one million physicians and patients in Germany alone. With more than 200 publications, which are updated regularly, a comprehensive literature service is provided for healthcare professionals as well as for patients and their families.

Dr. Falk Pharma Benelux B.V. decided to strengthen this initiative on a local level by providing an ECCO membership to all about 135 Dutch GE-trainees, the future gastroenterologists. During the course of their training period, with a maximum of 6 years, the GE-trainee will be enabled to join (Young) ECCO and benefit from the advantages of the ECCO membership.

The Dutch GE-trainees will be informed personally, however if your trainee is not yet informed about this unique opportunity to join the ECCO, please have them contact Dr. Falk Pharma Benelux B.V. (+31-(0)76-5244200 or info@drfalkpharma-benelux.eu).
**5th Y-ECCO Workshop**

The 5th Y-ECCO Workshop is being organised by the Y-ECCO Committee. Y-ECCO Members as well as ECCO Course participants are invited to participate. The workshop is scheduled to take place immediately after the 10th IBD Intensive Advanced Course for junior gastroenterologists on Wednesday, February 15, 2011, 16:00–18:00.

Wednesday, February 15, 2012 Preliminary programme overview – 5th Y-ECCO Workshop (as of September 13, 2011)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers</th>
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</thead>
<tbody>
<tr>
<td>16:00-16:10</td>
<td>Welcome</td>
<td>Welcome and introduction Jan Wehkamp, Stuttgart, Germany</td>
</tr>
<tr>
<td>16:10-16:50</td>
<td>Session 1</td>
<td>Marjolijn Duijvestein, Amsterdam, The Netherlands, Florian Rieder, Ohio, USA</td>
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<td></td>
<td></td>
<td>Why bother doing research beside my clinical work? Gijs van den Brink, Amsterdam, The Netherlands</td>
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<td></td>
<td></td>
<td>How and where to get funding for research? Silvio Danese, Rozzano, Milan, Italy</td>
</tr>
<tr>
<td>16:50-17:30</td>
<td>Session 2</td>
<td>James Christopher Lee, Longstanton, Cambridge, United Kingdom, Franco Scaldaferrri, Rome, Italy</td>
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<td></td>
<td></td>
<td>How NOT to get your work published – Common mistakes made Miquel Gassull, Barcelona, Spain</td>
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<td></td>
<td></td>
<td>Dark and light of industry sponsoring – Chances and pitfalls from both perspectives Gerassimos Mantzaris, Athens, Greece, Giancarlo Naccari, Lainate, Italy</td>
</tr>
<tr>
<td>17:30-18:00</td>
<td>Discussion &amp; Y-ECCO Members’ Meeting</td>
<td>Join us for a visit in a nearby bar afterwards...</td>
</tr>
</tbody>
</table>

Registration – 5th Y-ECCO Workshop

The 5th Y-ECCO Workshop in Barcelona is open to all Y-ECCO Members (paid-up membership fee for 2012).

In this context, the Y-ECCO Committee is looking forward to welcoming:
- all current Y-ECCO Members
- new members (you can learn more about joining the ECCO Family or signing up for membership online at www.ecco-ibd.eu).

Registration for the 5th Y-ECCO Workshop is accessible for paid-up ECCO Members 2012 within the online ECCO Congress registration at www.ecco-ibd.eu/ecco12.

The number of participants is limited. Registration will be on a first-come, first-served basis.

For further information please contact the ECCO Office (ecco@ecco-ibd.eu).

Wonderful news!

Our Journal of Crohn’s and Colitis (JCC) just received its 2010 Impact Factor of 2.628! This is a 52% further increase from our 2009 Impact Factor. We are very thankful for all of the hard work by our JCC team headed by Miquel Gassull and Eduard Cabré, all our editors and of course all our authors who entrusted their research outcomes to be published in our Journal. We are seeing a tremendous growth of original manuscripts submitted to the JCC which has led us to decide to increase the number of annual issues from 6 in 2011 to 8 in 2012. We are anticipating having 12 annual issues in 2014. It is very exciting to see that papers are being submitted from all regions in the world. In addition, ECCO has greatly invested in the further development and growth of the number of IBD guidelines and guideline updates which will be submitted to the JCC.

We truly hope that the success of the JCC and the recognition of our journal as an authoritative platform for IBD science will encourage you to keep submitting your scientific work to the JCC. Our very rapid review time of only two weeks, our speedy online publication, our pubmed citation and the publication of the JCC Table of Content in the ECCO News are only some of the attractive features of our journal.

Thank you for your trust and support!
On behalf of the Governing Board of ECCO,
Daan Hommes, ECCO President
The 6th N-ECCO Network Meeting will take place on Thursday February 16, 2012 in Barcelona, Spain as part of the 7th Congress of ECCO.

This will once again be a one-day meeting for nurses from all over Europe with an interest in IBD. Candidates from the N-ECCO School, which will be held on Wednesday 15 February, will also be invited.

The selection of topics for the programme of the 6th N-ECCO Network Meeting is based on frequently requested subjects taken from the evaluations from the last network meeting in Dublin (February 2011) and updates on new developments in all aspects of IBD. In addition to a number of experienced nurse speakers, invited gastroenterologists and other professionals involved with IBD will be taking part in the meeting. During the sessions and the coffee breaks there will be opportunities to exchange experience and views and for networking with international colleagues.

The N-ECCO Network Meeting is already an established event for nurses working within the specialty of IBD and the number of delegates is increasing each year, with 240 nursing delegates from all over Europe in Dublin.

Thursday, February 16, 2012 Preliminary programme overview – 6th N-ECCO Network Meeting (as of September 13, 2011)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08:00-09:00</td>
<td>Breakfast satellite symposium</td>
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<tr>
<td>09:15-09:30</td>
<td>Welcome</td>
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<tr>
<td></td>
<td>Janneke van der Woude, Rotterdam, The Netherlands and Marian O’Connor, London, United Kingdom</td>
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<tr>
<td>09:30-12:30</td>
<td>Session 1: Understanding disease management</td>
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<td>09:30-09:50</td>
<td>Managing immunomodulators</td>
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<td></td>
<td>Franck Carbonnel, Besancon, France</td>
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<td>09:50-10:10</td>
<td>Tandem talk: Treating fistulae</td>
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<td>Yves Panis, Clichy, France and Lisa Younge, London, United Kingdom</td>
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<td>10:10-10:30</td>
<td>Going through transition (child to adult)</td>
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<td>Mary Hamzawi, Dublin, Ireland</td>
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<td>10:30-11:00</td>
<td>Coffee break</td>
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<tr>
<td>11:00-11:30</td>
<td>Diagnostics in IBD: When, what &amp; why</td>
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<td></td>
<td>Julian Panes, Barcelona, Spain</td>
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<tr>
<td>11:30-12:00</td>
<td>Management during pregnancy/fertility</td>
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<td></td>
<td>Janneke van der Woude, Rotterdam, The Netherlands</td>
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<tr>
<td>12:00-12:30</td>
<td>Abstract session</td>
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<td>12:30-14:00</td>
<td>Lunch break (including poster round)</td>
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<tr>
<td>14:00-15:20</td>
<td>Session 2: Issues affecting quality of life in people with IBD</td>
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<td>14:00-14:20</td>
<td>Work and IBD</td>
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<td></td>
<td>Tineke Markus, Heverle, The Netherlands</td>
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<td>14:20-14:40</td>
<td>Fatigue: What can we do?</td>
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<td></td>
<td>Lauran Vogelaar, Rotterdam, The Netherlands</td>
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<td>14:40-15:00</td>
<td>IBD &amp; smoking</td>
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<td>Andreas Sturm, Berlin, Germany</td>
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<td>15:00-15:20</td>
<td>Advice on sexuality &amp; body image</td>
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<td>Rina Assulin, Haifa, Israel</td>
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<tr>
<td>15:20-15:40</td>
<td>Coffee break</td>
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<tr>
<td>15:40-16:45</td>
<td>Session 3: Comparing &amp; sharing nursing practice</td>
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<tr>
<td>15:40-15:55</td>
<td>The IBD Nurse in Europe: Finland</td>
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<td></td>
<td>Marika Susanna Huovinen, Joensuu, Finland</td>
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<td>15:55-16:10</td>
<td>The IBD Nurse in Europe: Spain</td>
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<td></td>
<td>Antonio Torrejon Herrera, Barcelona, Spain</td>
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<td>16:10-16:25</td>
<td>The IBD Nurse in Europe: Italy</td>
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<td></td>
<td>Matteo Martinato, Padua, Italy</td>
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<tr>
<td>16:25-16:45</td>
<td>N-ECCO: Spreading the knowledge</td>
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<td>Janette Gaarenstroom, Utrecht, The Netherlands</td>
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<tr>
<td>16:45-17:00</td>
<td>Closure</td>
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<td></td>
<td>Marian O’Connor, London, United Kingdom</td>
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<tr>
<td>17:15-18:15</td>
<td>Afternoon satellite symposium</td>
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</table>

The 6th N-ECCO Network Meeting in Barcelona is open to all nurses who are members of ECCO (paid-up membership fee for 2012). In this context, the N-ECCO Network is looking forward to welcoming:
- all current IBD nurse members
- new members (to learn more on joining the ECCO Family please go to http://www.ecco-ibd.eu/index.php/membership/individual-membership)

Registration for the N-ECCO Network Meeting is accessible for paid-up IBD nurse members 2012 within the online ECCO Congress registration: https://www.ecco-ibd.eu/ecco12/index.php/register/registration-fees-and-payment
Early Registration Deadline: November 9, 2011
For further information please contact the ECCO Office (ecco@ecco-ibd.eu).
### ECCO Governing Board 2011

<table>
<thead>
<tr>
<th>Country</th>
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<td>Walter Reinisch, Gottfried Novacek</td>
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