ECCO NEWS

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

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**Production:**
Mediahuset i Göteborg AB, Sweden
www.mediahuset.se

**Printing:**
Åkessons Tryckeriaktiebolag,
Emmaboda, Sweden

ISSN 1653-9214

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# Dear Friends,

Improving the outcome for individual patients suffering from inflammatory bowel diseases is our greatest challenge. Looking at all the steps that lie between the work of ECCO and daily patient care, we have to conclude that there is still a long way to go. Guidelines, educational programmes, scientific publications and all our current ECCO work are of great value in changing the way that doctors and nurses manage their patients. However, how do we know whether, at the end of the day, this leads to improved clinical outcomes? Most of our practices are not organised to look at that. What should we measure? When should we measure it? What is of value for individual patients? Often I think I have managed my patient faultlessly, only to find that he or she is still immensely burdened by the disease. I could look at endoscopy and CRP and be content with normal results, but my patient could still be miserable because of a low quality of life due to joint pain or inability to work optimally.

***So, I am wondering:*** Is this an area on which we need to focus? Can we do that within ECCO? Great work is already being performed on work disability, and we do interact with patient organisations. However, we may want to consider putting all of this into a larger, well-organised framework, defining patient value for IBD and finding smart ways to incorporate assessment and management tools into daily practice. We have to be very aware not to increase the administrative burden for care givers, and not to further increase costs or rely too much on the promise of IT technology. It will take years (!) before current electronic medical records can be tailored towards the specifics of IBD.

***Having said this,*** I realise that it will be a new ECCO team that will decide on the direction of our organisation. This is my last foreword for ECCO News since I shall step down in February. It is difficult to put into words the joy and excitement I have felt in helping ECCO to grow and advance towards achievement of its mission. This was and will always be a team effort driven by the "ECCO Spirit"! Our team has expanded rapidly, with new committees and colleagues, young and old, interested in working with us. I have to mention Nicole Eichinger, our chief of operations with her ECCO Office team in Vienna. Nicole started in an empty office space with a pen and her old laptop computer. Her extraordinary talent and skills have been essential in the success of ECCO, and we owe her much gratitude for this.

***I would like to conclude*** by inviting you to visit our Barcelona Congress, to be held on February 16–18, 2012. The programmes, courses, workshops and other activities really are going to be superb this year! We are seeing new records in all areas, with more than 600 abstract submissions and a new record for pre-registrations as well as the number of IBD friends and colleagues coming from all regions of the world. We hope that the combination of education, science and social activities in the beautiful city of Barcelona will convince you to make the trip. We look forward to welcoming you!

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

**DAAN HOMMES**


# IBD at UEGW 2011 in Stockholm

**For the first time ever, Europe's largest conference on gastroenterology was held in the Swedish capital. About 12,000 participants from 122 countries attended the conference. IBD was – as usual – one of the core topics in the scientific programme.**

At the Opening Plenary Session, Anders Ekbom, Sweden, gave a talk entitled, *What can epidemiology teach us about IBD and other diseases*?

### *First documented case of CD in Sweden*

He presented an old case report from Sweden, a male born in 1905. The first journal entry concerning this patient was made in 1918, from which Dr Ekbom quoted: *Stenotic inflammation in distal ileum – not tuberculosis*.

"51 years later this man reappears. In 1969 he is diagnosed with Crohn's Disease (CD). This is the first documented case of CD in Sweden", he said.

So what can we learn from this? Dr Ekbom continued: "Our previous colleagues understood that IBD is an entity of its own, and that the natural history is lifelong. We can also learn that smoking aggravates CD."

It seems that prevalence of Ulcerative Colitis (UC) precedes that of CD in all populations – at least where we have data.

"Populations with a high incidence or mortality of CD have a high incidence or mortality of UC", he pointed out.

### *Need for new ideas*

Clinical characteristics and extent at diagnosis have changed over time. For CD in children in Sweden the incidence was 1.2 per 100,000 in 1984–85, while by 1999–2002 the incidence had risen to 8.2.

"Paediatric CD possibly represents a new clinical entity", said Dr Ekbom.

Appendectomies (the surgical removal of the vermiform appendix) seem to be protective against UC. In Sweden the number of appendectomies peaked in the 1950s and has since declined.

According to Dr Ekbom there is a need for new ideas: "We should study the colonic flora and its determinants. Remember *Helicobacter pylori*."

### *PSC-IBD: a specific phenotype*

One symposium concerned primary sclerosing cholangitis (PSC) and IBD. Annika Bergquist asked in her talk whether PSC-IBD is a specific diagnostic entity.

"Five percent of IBD patients also have PSC, but in the northern countries this figure is much higher. So if you have a PSC patient, always perform a colonoscopy to exclude IBD", was her advice.

There is an increased risk for IBD in first-degree relatives to PSC patients. This indicates shared genetic susceptibility factors for PSC and IBD.

"The overlap is not only for CD and UC, but also for other diseases", Dr Bergquist continued.

She added that we have little – or no – evidence that PSC-IBD represents a specific genotype.

"But we have evidence for PSC– IBD being a specific *phenotype*!"

According to studies, there is an increased risk for dysplasia in UC patients with PSC. Therefore these patients need surveillance. Inflammation is often situated on the right side in these patients, so most findings of tumours are on the right side. ▶

Advertisement


Annika Bergquist


Curt Tysk


Sanne Bartels


Matti Waterman


Alicia Maria Sambuelli

### *Laparoscopic or open surgery IPAA?*

The outcome of medical and surgical therapies in IBD was the topic for a Free Paper Session.

Dr Sanne Bartels presented a study on female fertility after laparoscopic surgery.

Restorative proctocolectomy with ileal pouch anal anastomosis (IPAA) is associated with tubal factor infertility in female patients.

"Although studies have shown that there is less adhesion formation after laparoscopic colectomy, it is unknown what the clinical consequences of this observation are", she said.

Dr Bartels described IPAA in more detail. It is a standard surgical treatment for UC and familial adenomatous polyposis (FAP) and is often performed on relatively young patients, in their reproductive years.

"It causes a reduction in fertility, so the aim of this study was to determine whether the pregnancy rate after laparoscopic IPAA was higher than after open IPAA", Dr Bartels explained.

The study was cross-sectional, and was carried out in three university hospitals in the Netherlands and Belgium. All female patients over 18 years who underwent IPAA under the age of 41 and between 1993 and 2009 were eligible, and were sent a questionnaire addressing medical and fertility history.

In total there were 60 patients, 89% of whom returned the questionnaire.

"Our conclusion was that patients who had a laparoscopic IPAA had significant higher pregnancy rates compared to those who had an open surgery IPAA. The approach in IPAA must therefore be laparoscopic in women who desire to have children", Dr Bartels summarised.

### *Infliximab as rescue therapy for UC: a retrospective study*

The long-term outcome after infliximab (IFX) rescue therapy for UC is not very well described.

"The studies that exist are small and heterogeneous", Curt Tysk said.

Therefore he presented a retrospective study, carried out by the Swedish Organisation for the Study of IBD (SOIBD), of hospitalised patients who received IFX as rescue therapy due to a steroid-refractory, acute attack of UC.

Primary end-points were colectomy-free survival at 3 and 12 months.

"We included 212 patients over a 10-year period. 129 were male, and the patients were between 26 and 45 years of age with a median age of 35. The patients were hospitalised between 1999 and 2010 due to a moderate to severe attack of UC that was unresponsive to intravenous corticosteroids and received IFX 5 mg/kg as rescue therapy", Dr Tysk continued.

The study found that IFX is an effective rescue treatment in a moderate to severe attack of steroid-refractory UC.

"This large study shows that 63% of the patients had a colectomy-free survival and 53% were in steroid-free remission at 12 months. This supports the long-term benefit of IFX rescue therapy. The risk of serious complications, including deaths, is low, but not negligible. Six patients died during follow-up, and three of these deaths had a possible connection to IFX rescue treatment", Dr Tysk concluded.

### *Infliximab as rescue therapy for UC: a prospective study*

The next speaker addressed the same topic.

"The value of IFX as rescue therapy in severe UC has been scarcely studied and short- and long-term clinical outcomes are controversial", said Alicia Maria Sambuelli.

"We aimed to study the efficacy of IFX in acute severe UC", she continued. "Here we are reporting an observational prospective study conducted in two Argentine centres in Buenos Aires and Mendoza".

After IFX approval in Argentina, 70 patients resistant to one week of IV steroid were treated with IFX as an alternative to colectomy. The Truelove and Witts criteria and also the Mayo score determined the severity of the disease.

"Our results suggest that IFX seems to be an effective rescue therapy in this highly severe group of UC. Early use of thiopurines may have been the factor that improved clinical response in this cohort of patients", was Dr Sambuelli's conclusion.

### *Do not delay surgery after biologics*

While biological therapy in IBD is highly efficacious, its use is not without risks. The relative risk for serious infections associated with all biologics is increased two- to threefold.

This was pointed out by Matti Waterman, who talked about a study that had investigated the 30-day complication rates in IBD patients who underwent abdominal surgery and had recent exposure to IFX or adalimumab (ADA).

"The aim was to see if it was good to save the patient from the surgeon", he jokingly explained.

The study also aimed to determine the influence of the time interval from exposure to biological therapy to surgery on early postoperative complications.

In order to do this, they identified all patients who had abdominal surgery and recent exposure to biological therapy. A retrospective chart review was performed. Patient demographics, concomitant corticosteroid and azathioprine use, type of surgery and date of last dose of biologics before surgery were recorded. Overall, 173 procedures were studied.

Dr Waterman summarised the findings as follows: "We found that only surgical wound infections, re-admission and a combination of postoperative leak and need for re-operation or percutaneous drainage are associated with preoperative biologics. A shorter time interval between the last pre-operative dose of biologics and surgery is not associated with increased complications".

The implications are that surgery should not be delayed to increase the time interval between the last dose of biologics and surgery and that appropriate biological treatment may be continued peri-operatively.

### *Ileal disease a key predictor of need for surgery in CD*

More surgery: Anne Phillips talked about surgery in CD.

"CD patients are at high risk of surgical resection, with at least 40% of patients needing one resection by 5 years. A subset of patients will require multiple resections, but little is known ▶

about the phenotype of those requiring multiple resections", she said.

Therefore the study she presented had analysed the risk of first and subsequent resections in a well-documented CD cohort comprising no fewer than 1,155 patients assessed in teaching hospitals in Edinburgh and Dundee, Scotland.

She told the audience that disease location, especially ileal CD, is a key biological predictor of need for initial surgery and need for multiple resections. Isolated colonic disease is less likely to need resection or resections.

"Additionally, we observed a shorter time to resection in patients diagnosed before the 1990s, consistent with surgical and medical practice in recent years", Dr Phillips said.

### *Surgery in children with CD*

Early surgery is considered a predictor of poor outcome in patients with CD who present with complications at diagnosis.

Medina Boualit presented a study that aimed to describe the long-term evolution and to determine predictors of outcome in paediatric-onset CD patients after a first resection.

"52% of the patients had a growth or nutritional deficit. Ileocolectomy was the first resection in 82 patients (69%) while a second resection was performed in 25% of them. Probability of second resection was 8%, 17% and 29% at 2.5 and 10 years", Dr Boualit stated.

In univariate analysis, catch up of weight and height was significantly better in patients who had early surgery than in those with delayed surgery.

In multivariate analysis adjusted for gender, age and complicated behaviour at diagnosis, catch up of height remained significantly better in patients with early surgery. The same trend was found for catch up on weight.

*Anne Phillips*

*Brian Feagan*

*Rayko Evstatiev*

"The long-term outcome after first resection in paediatric-onset CD is similar to what has been observed in adults. Early surgery (within 3 years of diagnosis) was not associated with a worse prognosis, and allowed a lower use of immunosuppressants and anti-TNF treatment – and a better growth and nutritional catch up", she concluded.

She added that these data might be worth considering when taking therapeutic decisions in children.

### *Adalimumab for UC*

Brian Feagan ended the session by talking on adalimumab (ADA) therapy for UC. He presented data from two double-blind, placebo-controlled trials.

"The number of hospitalisations was significantly lower for ADA-treated patients, compared with placebo-treated patients. The colectomy rate was also numerically lower", Dr Feagan pointed out.

"The overall low colectomy rate may have been due to the allowance for open-label rescue therapy", he added.

"This analysis is the first to report that an anti-tumour necrosis factor agent reduced all-cause hospitalisation risk in patients with moderate to severe UC. These data support a favourable benefit/risk profile of ADA in UC", Dr Feagan concluded.

The Oral Free Paper Prize was introduced at the UEGW in Stockholm. It was awarded to one presenter in each Free Paper Session by the chairs, who had to take into consideration the quality of the research, originality and execution of presentation.

The chairs of this session, Tom Øresland and David Lahaire, therefore called Medina Boualit, who they had chosen, back to the podium to receive this award – a Certificate of Excellence.

### *Maintenance treatment for anaemia*

The last session in Stockholm had the title *Drug therapies in intestinal inflammation*.

Here Rayko Evstatiev talked on iron deficiency anaemia (IDA) in IBD.

"Early recurrence of anaemia is frequent in IBD patients and this calls for maintenance therapy", he said.

Dr Evstatiev presented a study on maintenance treatment with intravenous ferric carboxy maltose (FCM).

It demonstrated that FCM is effective in preventing recurrence of anaemia. However, the trigger to treat (s-ferritin less than 100 µg/L) seems insensitive, as more than 35% of the patients still developed IDA despite apparently sufficient iron stores.

"My take home message is: Anaemia can be prevented! Things have improved in recent years. You don't *see* anaemia, but it's becoming stronger on the gastroenterologists' agenda. Maintenance treatment is important", Dr Evstatiev concluded.

He was the final speaker, so after his talk the UEGW in Stockholm was over. Next year the congress will take place in Amsterdam.


*Tom Øresland, David Lahaire and Medina Boualit.*

**PER LUNDBLAD**
Senior Writer

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# 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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# ECCO Grant 2011 Synopses

**A principal function of SciCom is to promote European research into IBD and scientific integration. ECCO Grants are important components in achieving this goal. In 2011, ECCO Grants have been awarded to Stefania Vetrano, Franco Scaldaferri, Arie Levine and Catherine Reenaers.**

*Catherine Reenaers, Stefania Vetrano, Franco Scaldaferri, Arie Levine and Matthieu Allez.*

## GROWTH (**G**rowth, **R**elapse, **O**utcomes **W**ith **Th**erapy) Study

### Factors predicting relapse and adverse outcomes early in the disease in newly diagnosed paediatric Crohn's disease – a prospective, multicentre prognostication study by The ESPGHAN Porto group

Principal Investigator: Arie Levine, Tel Aviv, Israel

The treatment paradigm for treating Crohn's Disease (CD) is changing owing to the recognition that previous treatment strategies have been associated with poor outcomes. At present, the major known risk factor for a complicated course is duration of disease, and thus children are at the highest theoretical risk both for disease and for treatment-associated complications. Most of the data sets analysed to date have been retrospective; furthermore, endpoints for clinical intervention studies are often short term and do not monitor inflammation as an end point. Therapy is currently not tailored to individual risk for complicated disease, primarily because we do not have prospectively validated biomarkers.

We hypothesise that persistent inflammation after induction of remission will be associated with early relapse and a more complicated disease course; this is related to the primary end point. Having the ability to predict which patients are more likely to relapse, to be refractory to therapy or to develop complications might enable physicians to treat these subsets more aggressively at disease onset, or early in the course of the disease, without exposing all paediatric patients to medications that increase the risk for adverse effects and specifically neoplasia (tailored therapy). This would avoid delay in instituting more aggressive maintenance therapy for patients prone to complications. There are no prospective studies that have evaluated this issue in new-onset, treatment-naive paediatric CD.

The ESPGHAN Crohn's Disease (CD) *GROWTH* study is an ongoing prospective multicentre framework project that will try to identify easily applicable clinical and laboratory parameters that will enable modelling of disease-associated risk for early complicated disease. During phase 1, the *GROWTH* study will identify factors associated with early adverse outcomes (within the first 24 months of disease). This framework study will generate several studies (eight are currently planned) geared to identify clinical and therapeutic parameters predictive of disease relapse, growth retardation, penetrating or stricturing disease and requirement for early surgery. The study will enrol *newly diagnosed untreated* patients with a diagnosis of CD using the Porto criteria. After disease location and anthropometry and disease severity have been established by a paediatric CD disease activity index (PCDAI), patients will receive one of the treatments for induction of remission, using a standardised treatment protocol accepted by all participating centres. This project is ongoing in 17 centres in Europe and Israel, with more than 110 patients already enrolled as of June 2010. The treatment will be allocated at the physician's discretion. Patients will be monitored for weight, height, PCDAI, faecal calprotectin, CRP and serological markers (antiglycan antibodies, ImmunArray chip), as well as other unvalidated potential markers, at standardised visits (at 0, 8, 12, 26, 52 and 78 weeks).

The *primary* endpoint of the first phase (GROWTH 1) is time to relapse based on initial and post-treatment measures of inflammation.

The *secondary* endpoints will include relapse (defined on the basis of initial and post-treatment serological markers), presence of strictures or fistulae and need for surgery (based on antiglycan profiles and inflammatory markers), and growth retardation (based on initial biomarker profile and type of treatment with steroids or exclusive enteral nutrition at 12 weeks and 18 months). Early adverse outcomes will be modelled independently and in combination Early adverse outcomes will be modelled independently and in combination.

It is our belief that the data generated will broaden our understanding of the relationships between various clinical and subclinical parameters and disease outcomes, as well as the influence of treatments on these parameters. Greater knowledge of the relationship between inflammation biomarkers, markers, and treatments chosen, along with CD outcome, will improve disease control in the future and may offer insights as to how to modify the natural history of the disease.

**ARIE LEVINE**
Wolfson Medical Center, Tel Aviv University
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Tel Aviv, Israel

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# The role of the chemerin/ChemR23 axis in the pathogenesis of IBD

Although the aetiology of inflammatory bowel disease (IBD) is still unknown, the abnormal immune response to the gut flora appears to play a pathological role in both forms of IBD, being characterised by the excessive activation of macrophages, dendritic cells and T cells and the secretion of high amounts of pro-inflammatory mediators, leading to chronic gut destruction.

***Chemerin is a chemoattractant protein*** for ChemR23-expressing cells such as dendritic cells, macrophages and natural killer cells. It is synthesised as an inactive protein (prochemerin) and its activation occurs upon cleavage by serine proteases. Once activated, chemerin plays an important role in the recruitment of plasmacytoid dendritic cells (pDCs) and macrophages to the lymphoid organs and sites of tissue injury, thereby participating in the initiation of the inflammatory process.

Platelets, fibroblast cells, adipocytes, epithelial cells of the small intestine and inflamed endothelial cells have been identified as sources of chemerin, while its receptor is expressed by several cell types, including macrophages, monocytes and pDCs. High amounts of chemerin have been found in various inflammatory conditions, as has high expression of ChemR23-expressing cells. Moreover, it has been demonstrated that chemerin not only acts as a strong chemoattractant to antigen-presenting cells but also displays potent ChemR23-dependent anti-inflammatory properties. The proteolytic cleavage of the C-terminal portion of the mature chemerin leads to the synthesis of several chemerin peptides with different biological activity. The dual chemoattractive and anti-inflammatory functions of chemerin appear to be due to its proteolytic cleavage by different serine proteases.

***Because some serine proteases*** are derived from neutrophils present during the beginning (acute) phase of inflammation, it is plausible that the activation process of chemerin takes place at sites of inflammation and that its biological activity depends on proteases. Elevated levels of serum chemerin and serine protease activity in the inflamed intestinal mucosa have been observed in IBD patients, suggesting a possible involvement of chemerin in IBD. Currently there are no studies describing the link between the chemerin/ChemR23 axis and intestinal inflammation. Since the ChemR23 receptor is expressed by DCs and macrophages, it is plausible that recruitment of these cells in the inflamed lamina propria could also be regulated by chemerin. Furthermore, increased angiogenesis in IBD mucosa could be favoured by the local release of chemerin conferring a pro-inflammatory effect. Chemerin also exerts anti-inflammatory activities in many inflammatory models, but there is no evidence of this function during intestinal inflammation.

***Given the involvement*** of the chemerin/ChemR23 axis in both the initiation and the resolution of inflammation, the aim of this project will be to study the functional role of chemerin as a new potential player in IBD pathogenesis. Its manipulation could represent a novel therapeutic approach for the treatment of IBD.

**STEFANIA VETRANO**
Instituto Clinico Humanitas
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# The role of adipose tissue-derived mesenchymal stem cells in chronic colitis and colitis-driven colon cancer progression

Mesenchymal stem cells (MSC) are potent immune regulators that have been proposed for local and systemic use in human and experimental IBD. They can be derived from several organs and are usually derived from bone marrow (BM-MSC) or, more easily, from adipose tissue (AMSC). Only a modest number of studies have assessed the role of MSC (usually BM-MSC or AMSC) in experimental IBD, despite interesting data regarding efficacy from clinical sources. Still fewer papers have assessed the effect of AMSC on chronic colitis. On the other hand, cancer studies have found stem cells to be involved in the mechanisms of cancer induction and progression, warning against the use of stem cells in clinical conditions associated with increased cancer risk, such as ulcerative colitis. Despite this, very little information exists on whether and how the use of MSC influences cancer induction in chronic colitis. For this reason, the aims of the present project will be *to explore the efficacy of AMSC in chronic murine colitis, to investigate the effect of AMSC on colon cancer development in the context of chronic colitis and to identify the mechanisms of action of AMSC in curing chronic colitis and in limiting cancer development*.

***To this end***, AMSC will be isolated from adipose tissue of C57BL/6 mice expressing green fluorescent protein (GFP+) and analysed for MSC markers and for adipocyte and osteogenic differentiation. The DSS model of acute colitis will be used to access the clinical efficacy of AMSC, administered by intraperitoneal injection. The DSS-azoxymethane (AOM) model of colon cancer in chronic colitis will then be used to assess the effect of AMSC on cancer development. In vitro AMSC will be exposed to inflammatory stimuli and will be analysed for surface marker expression and chemokine production. The effect of AMSC supernatants on intestinal epithelial cell proliferation will also be assessed.

***In vitro experiments*** are intended to identify the mechanisms of immune regulation adopted by AMSC in response to inflammation. Preliminary data and literature data indicate that AMSC have an anti-inflammatory and immune regulatory role. Understanding these mechanisms would be the first step in finding new approaches to enhance the action of resident AMSC in the intestinal mucosa. The potential exists to reinforce the use of MSC in treating IBD, individuating new mechanisms of mucosal regeneration which could be used even without MSC transplantation. This approach will need to better clarify the potential role of MSC in inducing colitis-associated colon cancer.

***In conclusion***, it is to be borne in mind that a regenerative approach able to cure IBD should be not only efficacious but also safe, considering that IBD patients are very often young and are already exposed to a higher risk of developing colon cancer.

**FRANCO SCALDAFERRI**
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# ECCO'12 Barcelona Congress – Scientific programme

Aiming to bridge bench to bedside, this year's programme opens with a translational session providing an overview of common mechanisms across inflammatory disorders and inflammatory side-effects of biological therapy. The second session discusses tools to measure success and failure in IBD and how to predict disease outcome, which have been identified as relevant issues in daily practice.

Further sessions are dedicated to providing answers to questions relevant to daily patient care. The advantages and use of different imaging modalities in IBD will be covered, as will the medical and surgical consequences of inflammation and its complications. The scientific programme will additionally include the presentation of challenging cases, discussion of various IBD-related complications and, of course, the oral presentation of the best scientific abstracts.

As announced in the earlier ECCO News, the programme will also include presentation of the preliminary results from the 3rd Scientific Workshop, Malignancy in IBD, and the new ECCO-ESPGHAN Paediatric Guidelines on UC and ECCO-ESGAR Imaging Guidelines.

On the second day, talks will focus on the impact of IBD on daily life and how to organise IBD care and will include a lecture on E-Health and care pathways in IBD. Following the preceding discussions on several important issues in IBD care, the last session will provide an overview of new trends in the management of IBD and their possible implementation in daily routine.

Barcelona'12 will close with the ECCO Lecture, entitled "Translating evidence from clinical trials into personalised medicine", which will be given by Stephen Hanauer from Chicago, United States.

We are sure that the diverse and challenging scientific programme will attract a growing number of IBD experts from Europe and all over the world. If you haven't done so already, please register at http://www.ecco-ibd.eu/ecco12, where you will find more information.

We look forward to seeing you soon.

**ANDREAS STURM**
SciCom Chair

## *Preliminary programme overview (as of november 14, 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***

**14:50-16:10** ***Scientific session 2: Measuring success and failure in IBD***
Dana Duricova, Prague, Czech Republic
Pierre Michetti, Lausanne, Switzerland

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

15:10-15:20 ***Oral presentation 4***

15:20-15:40 ***Tandem talk: Scoring disease damage and disability***
Benjamin Pariente, Paris, France
Laurent Peyrin-Biroulet, Vandœuvre-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***
Laurent Beaugerie, Paris, France
Silvio Danese, Milan, Italy
Laurence Egan, Galway, Ireland

**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

08:30-08:35 ***Medical or surgical therapy for obstruction: Is imaging the key?***
Casper Gijsbert Noomen, Amsterdam, The Netherlands

08:35-08:40 ***IBD facing surgery - Are you sure the small bowel is normal?***
Ailsa Hart, London, United Kingdom

08:40-08:50 ***Oral presentation 6***

08:50-09:00 ***Oral presentation 7***

09:00-09:20 ***ECCO-ESGAR Imaging Guidelines***
Julian Panes, Barcelona, Spain

09:20-09:30 ***Case resolution***

**09:30-10:30** ***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

09:30-09:37 ***Anaemia***
Christoph Gasche, Vienna, Austria

09:37-09:44 ***Osteoporosis***
Ad van Bodegraven, Amsterdam, The Netherlands

09:44-09:51 ***Renal***
Satish Keshav, Oxford, United Kingdom

09:51-09:58 ***Ocular***
Luis Pablo, Zaragoza, Spain

09:58-10:05 ***Pulmonary***
Franck Carbonnel, Besançon, France

10:05-10:12 ***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 Kamm, 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, Barcelona, Spain
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 ***The IBD care pathway***
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

15:50-16:10 ***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
Bjørn 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 Ardizzone, 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?***
Gijs 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-Ferrant, 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

# Findings of the 2nd Scientific Workshop of ECCO on intestinal healing

**The 2nd ECCO Scientific Workshop, organised by Edouard Louis, Florian Rieder and Andreas Sturm, took place from February 2010 to February 2011.**

It focused on the relevance of intestinal healing for the disease course of inflammatory bowel disease (IBD). The objective was to better understand basic mechanisms, markers for disease prediction, detection and monitoring of intestinal healing, impact of intestinal healing on the disease course of IBD and therapeutic strategies. IBD experts from Europe and the United States worked intensely together in four groups to first review the current literature and define the 'state of the art' in each IBD field. The goal of the discussions and working groups was then to generate a list of open questions that would help the IBD community with a framework for future studies.

***The group on basic mechanisms*** of intestinal healing addressed key findings in mucosal injury but also discussed early and late events in the intestinal wound healing response. Striking differences in wound healing between different IBD patients can be observed, which can be explained by genetic differences, alterations in the intestinal luminal components or distinct responses to drug therapies. The most prominent open questions were the identification of factors intersecting or separating inflammation and wound repair, the role of environmental and microbial factors, and epigenetic alterations that influence wound healing.

***The group on biomarkers*** and imaging tools to predict and monitor intestinal healing worked on a series of seven questions encompassing the definition of mucosal healing in Crohn's Disease and Ulcerative Colitis, the assessment of transmural and pathological healing in Crohn's Disease, the association with serological and genetic markers, and the potential role of blood, stool and alternative biomarkers. Main areas for future research were identified as better assessment of inter-individual agreement and reproducibility of endoscopic scoring systems as well as the validation of thresholds for response and healing, the definition and clinical relevance of transmural healing according to ultrasound or cross-sectional imaging and finally the validation of blood or faecal surrogate markers of intestinal healing, with relevant cut-off levels.

***The third group*** worked on the impact of mucosal healing on the course of IBD. In particular, this group reviewed the published evidence regarding the impact of mucosal healing on the clinical remission of IBD, the risk of complications, the frequency of hospitalisations, the need for surgery and the risk of cancer. They also reviewed the impact of different levels of endoscopic or histological healing on these outcomes. Main questions for future research were whether mucosal healing should be systematically assessed to improve disease outcomes, whether therapies should be optimised on the basis of endoscopic findings to change the disease course and what would be the optimal timing of endoscopic evaluation.

***Finally, the fourth group*** worked on the ability of available treatments to achieve mucosal healing. They reviewed the literature on this topic and identified the main open questions to be ways of improving tissue healing by more appropriate and timely use of anti-metabolites and/or anti-TNF, by treatment optimisation aiming at tissue healing and tight disease control and finally by potentially developing new drugs with higher healing ability.

***The results of this workshop*** are presented in four separate manuscripts, two of which have already been published in the *Journal of Crohn's and Colitis*. A final workshop meeting is going to take place at the ECCO Congress in Barcelona in February 2012 with the aim of establishing collaborations to tackle the most relevant research questions.

**FLORIAN RIEDER**
**EDOUARD LOUIS**
**ANDREAS STURM**
Scientific workshop steering committee

# Kick-off meeting of the 3rd Scientific Workshop on IBD and neoplasia in Stockholm

**The 3rd Scientific Workshop on "IBD and neoplasia" had its first meeting during UEGW in Stockholm in October 2011.**

The workshop, led by Silvio Danese, Laurent Beaugerie and Laurence Egan, has been launched for the next 2 years. More than 20 IBD experts and ECCO Members held an extensive start-up meeting aimed at selecting the main topics. The study group agreed to create three subgroups based on the three main selected topics: (1) colorectal cancer; (2) other non-colonic IBD-associated intestinal cancers and (3) extraintestinal neoplasia, including inflammation and/or drug-associated lymphoma, uterine cervix dysplasia and cancer, and non-melanoma skin cancers.

Common framework topics include a deep literature review on pathogenesis, epidemiology, clinical presentation and diagnosis, prevention, treatment and outcomes, and surveillance.

Coverage of these topics is expected to lead to the typical high standard review articles that are now a characteristic of the ECCO Pathogenesis Workshop. Moreover, key knowledge gaps will be identified. The next step will be preparation of reference lists after literature searches, and planning of a meeting update during the ECCO Congress in Barcelona.

On this occasion, a time slot in the programme was allocated in order to present the preliminary work update.

Furthermore, all members of the study group agreed that maximum effort would be made to identify unanswered questions in the literature in order to pave the way for ambitious ECCO collaborative studies across Europe.

**SILVIO DANESE**
**LAURENCE EGAN**
**LAURENT BEAUGERIE**
Scientific workshop steering committee

# In the next issue of JCC (Journal of Crohn's & Colitis)

## Volume 5, issue 6, December 2011



# Building an IBD conference programme

**Creating a programme for an IBD meeting, symposium or conference is always a challenge. Sometimes the idea takes hold at another meeting and sometimes you are invited to develop a programme within the department, by a society or by industry. But there are many questions to consider once the idea has been born: Where do you start? When do you start and what should be taken into consideration? What are the pitfalls?**
***ECCO News* talked to Dr Simon Travis and Dr Séverine Vermeire on the subject, both of whom have vast experience of arranging successful meetings.**

### *When you decide upon arranging an IBD meeting, what are the first things you have to consider?*

***Travis***: The theme of the meeting.
***Vermeire***: I agree. But you also have to consider the audience: Will it consist of doctors and nurses? Who are you going to aim at? The budget is also important from the beginning.
***Travis***: Add the timeline to that – how long you have to plan in advance. It is crucial to think ahead. For international meetings it has to be 12 months, but for regional meetings 4 months may be enough. The logistics (date, venue, duration) have to be decided before you start working on the content, because the programme needs to be adapted to the framework.
***Vermeire***: You need a difference to your meeting. Think: "Why would I go to this meeting?".
***Travis***: Give the meeting a novel identity; make sure it has a focus. That's part of the key to getting the delegates. If you are not excited by your own programme, don't expect anyone else to be!

### *The title of the meeting – how do you pick that?*

***Vermeire***: Sometimes from your mind. Make it attractive; use your imagination. Then it needs to mature for a while: don't instantly cast it in stone.
***Travis***: Discuss the title with others: the organising committee needs to discuss the title and content, best done over a glass of wine – not just by e-mail!
***Vermeire***: Meet and talk, then you can finalise via e-mail.
***Travis***: Meetings stimulate lateral thinking.

### *What topics do you select?*

***Vermeire***: That depends on the theme – and the audience. For instance, the ECCO Congress, for IBD specialists, and UEGW, for a more general audience, differ from each other.
***Travis***: There are some principles: Novelty should be balanced with familiarity. If you have the "usual" speakers on the "usual" topics, the meeting will become boring.
***Vermeire***: You need a fresh wind, but also the basic ingredients.

### *How do you choose new people as speakers?*

***Vermeire***: If you go to a meeting and hear a good speaker, write the name down.
***Travis***: Keep notes from every meeting you go to. Ultimately it is the organisers who have to

*Two experienced conference builders – Simon Travis and Séverine Vermeire.*

have the knowledge and awareness of good speakers.
***Vermeire***: Sometimes you can promote your own young people.
***Travis***: But take care to avoid being seen to be too partial to your own institution or country. Be prepared to experiment, or phone a friend if unsure.

### *How do you ensure that speakers accept their invitation?*

***Travis***: This is best done by a personalised e-mail, or a phone call, from the organiser. The personal contact is important: don't delegate that task.
***Vermeire***: I fully agree. And in that e-mail, reassure them that logistics and travel arrangements will be taken care of.
***Travis***: Give as much notice as possible and ask the major names first.

### *How do you synchronize the speakers, i.e. avoid overlap in their talks?*

***Travis***: Ensure that titles on the programme don't overlap, but complement each other. The titles should guide the person reading the programme. This allows the speaker to understand where his or her talk fits into the programme. The organiser should then write specific guidance for each speaker after the invitation has been accepted, explaining what the talk is to be about and pointing out what other people will talk about.
***Vermeire***: You can check the slides in advance – but everyone makes changes at the last minute. Check for too many slides, and content.

### *How do you plan the timing for the speakers?*

***Travis***: Discuss the timing. Be very careful to time the talks and include time for questions. Once a speaker has accepted, the follow-up letter should emphasise the time available for the talk and the questions (e.g. 20 min = 15+5 min for questions. Please don't try and squeeze a 30-min talk into 20 min).
***Vermeire***: Be very specific about time in the planning.

> "Discuss the timing. Be very careful to time the talks and include time for questions."

### *How do you handle sudden, late drop-outs?*

***Travis***: You need a back up, especially for high-profile speakers.
***Vermeire***: You have to be flexible. If there is no-one to step in, allow the speaker prior to the missing one to continue a little longer and extend the discussion. Re-organise the session.
***Travis***: A useful tip: Have a draft programme, and only distribute the final programme on the day.
***Vermeire***: Make sure you have a cell-phone contact number for all speakers.

### *Contacts with industry – how should they be handled?*

***Travis***: Industry support for meetings is often fundamental. Single company meetings are best avoided, unless there is a totally independent organising committee. The organising committee best use their senior colleagues to solicit support from industry.
***Vermeire***: I agree. You should ensure transparent agreement from the beginning. If you feel too much pressure from the company and this pressure is affecting the programme, be prepared to withdraw.

### *What pitfalls are there?*

***Travis***: The date: if it clashes with another meeting for the same audience or a major sporting event, it's not going to work.
***Vermeire***: Too much on the programme. Include some down time in the programme; allow more than just sufficient time for coffee (30 min, not 20!) and lunch (60 min, not 45!), and remember an afternoon break. Allow some "time out" during a 2-day meeting.
***Travis***: Lack of funding, and delegates or speakers who call off the week (or day!) before.
***Vermeire***: Half the delegates will leave before the close on the final day. Therefore keep the best speakers till last – but beware the problem of them speaking to a half-empty auditorium!
***Travis***: Speakers who have too many slides and speak for too long.
***Vermeire***: Choose a good chair to introduce the session, invite questions and keep the speaker to time.

### *How do you ensure a good attendance?*

***Travis***: Advertising is part of it: make sure the ad reaches the target audiences.
***Vermeire***: Limit the audience – play on psychology with a limited meeting. Have an early registration fee that is less costly than the late registration fee.
***Travis***: Advertise it on social networks.
***Vermeire***: Think of sending speakers a slide promoting your meeting, and ask them to put it at the end of other talks they are giving.

### *Is there a "recipe" for a good meeting?*

***Travis***: Yes: high-quality ingredients.
***Vermeire***: Ensure slow cooking.
***Travis***: Flavour it with appropriate spices.
***Vermeire***: Sometimes add exotic spices.
***Travis***: Create the right ambience: although the hard work goes on in the kitchen, think of the "candles" that make a dining experience special.
***Vermeire***: Carefully choose the location.
***Travis***: Have a social interaction with faculty.
***Vermeire***: Ensure a friendly atmosphere.

### *What do you do for a follow-up?*

***Travis***: A thank you letter and personal present to the speakers.
***Vermeire***: Include anonymised evaluations of the talks as feedback in this letter.

### *What's the worst thing you have done wrong in a meeting?*

***Vermeire***: Since we're both obsessed with detail it hasn't happened. So consider an element of obsession a good thing!

**PER LUNDBLAD**
Senior Writer

# Experience the ECCO Spirit:
# Become a member!

***Become member or renew your ECCO Membership for 2012 and profit from a reduced registration fee for the ECCO Congress in Barcelona, February 16 – 18, 2012***

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

- ✔ Reduced registration fee for the annual ECCO Congress for the year of membership (according to congress website)
- ✔ Free subscription to JCC - Journal of Crohn's and Colitis (6 issues/year and online access)*
- ✔ Monthly eNewsletter on all ECCO activities and latest news on IBD
- ✔ Free subscription to the quarterly ECCO News - The society's magazine
- ✔ Membership login to www.ecco-ibd.eu (reports of the General Assembly, media streaming, etc.)
- ✔ Free use of IBDIS (category 1)
- ✔ Educational and networking activities for graduates, fellows, and nurses
- ✔ Free participation in ECCO Educational Workshops (excluding members affiliated with industry)
- ✔ Access to a large network of young and inspired IBD specialists

ECCO

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

*) For Regular Members only

# 1st ClinCom Workshop at ECCO'12 Barcelona Congress

**Almost every attendee at the ECCO Congress has an interest in clinical trials as a reader of scientific articles or as an investigator in industry or academic-driven clinical trials. Some of us are also (or will be) involved in the conception of clinical trials.**

In many cases, this begins with an idea or a conversation after having seen a patient, attending a congress or reading a paper. And then many questions arise: What is the correct formulation of the hypothesis? Is the study feasible? What should be the primary endpoint? What are ideal and reasonable criteria of inclusion and exclusion? How many patients should be included? Etc.

The first workshop of the ECCO ClinCom will provide many clues as to how these questions may be appropriately answered. It will be held in Barcelona on Wednesday, February 15, 2012. The workshop will have no more than 50 attendees and will be solely dedicated to the successful management of clinical trials in the field of IBD (in Europe).

The workshop is open to all Regular Members of ECCO (paid-up membership fee for 2012). ClinCom particularly invites those clinicians (gastroenterologists, surgeons, paediatricians) who are (or wish to be) involved in clinical trials.

### *Registration – 1st ClinCom Workshop*

**The 1st ClinCom Workshop in Barcelona is open to all paid-up Regular Members 2012.** In this context, ClinCom is looking forward to welcoming:

- all current ECCO Members
- new members (to learn more on joining the ECCO family please sign up for membership online at www.ecco-ibd.eu).

**Registration is accessible to paid-up ECCO Members 2012 within the online congress registration at www.ecco-ibd.eu/ecco12 at educational activities.**

The workshop will be held in a friendly and interactive manner and will not be a formal course. There will be round table discussions with up to eight speakers visiting each table for a 15- to 20-minute conversation about a specific aspect of the design, practical setup and monitoring of a clinical trial, from the very beginning to publication and beyond. Financial and regulatory aspects will also be covered.

The subjects and experts are as follows (as of November 14, 2011):

### *1. Biostatistics in IBD trials, common errors. Review of CONSORT guidelines*
Jean Yves Mary, Paris, France

### *2. Doing translational research surrounding clinical trials*
Yehuda Chowers, Haifa, Israel

### *3. How to write the perfect protocol for different types of trials*
Walter Reinisch, Vienna, Austria

### *4. Choosing the best endpoints for your trial*
Geert D'Haens, Amsterdam, The Netherlands

### *5. Financial and regulatory issues in IBD trials*
Franck Carbonnel, Besançon, France

### *6. Feasibility and patient selection*
Laurent Peyrin-Biroulet, Vandeouvre les Nancy, France

### *7. Quality requirements and assurance in IBD trials. Is GCP evolving?*
Ailsa Hart, London, United Kingdom

### *8. Investigator-initiated studies in IBD: real life experience and common errors*
Brian Feagan, Ontario, Canada

Without any doubt, this will be an attractive and fruitful meeting. We hope it will help clinicians to conceive and develop future trials for IBD patients. Full programme can be found online at *www.ecco-ibd.eu/ecco12*.

**GEERT D'HAENS**
ClinCom Chair

# Paediatric Committee (P-ECCO)

Members from both ECCO and the IBD Working Group of the European Society of Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) have actively worked together during this year to prepare an evidence-based guideline on the Diagnosis and Treatment of Ulcerative Colitis in Children and Adolescents. In previous ECCO guidelines, statements on paediatric IBD have been incorporated in a section on "special situations" [1,2], which does not seem justified as more than 25% of IBD patients present before the age of 18 years. This ECCO-ESPGHAN guideline project is being chaired by Dan Turner (Jerusalem, Israel) and Frank Ruemmele (Paris, France). The group has successfully produced a pre-final document, which was discussed during the October 2011 UEGW meeting in Stockholm. All issues related to paediatric UC, such as diagnosis, disease activity scoring, medical treatment modalities, surgery, nutrition and transition will be addressed in this first ECCO guideline solely dedicated to children and adolescents with UC. The guideline will be finalised by the end of this year and will be presented during the February 2012 ECCO Congress in Barcelona.

P-ECCO will also be involved in the organisation of the 3rd international paediatric IBD meeting, which will be held on September 10–13, 2014 in Rotterdam, the Netherlands. After successful meetings in Rome (2006) and Paris (2009), the Rotterdam PIBD 2014 will be chaired by Hankje Escher, who expects to welcome about 600 participants from all over Europe as well as the United States. The international scientific committee is dedicated to organising a programme that incorporates both clinical innovation and exciting news on immunopathogenesis, genetics and biomarkers in this unique group of patients. For inspiring cross-talk, PIBD 2014 aims to attract clinicians and researchers in both paediatric and adult IBD. So, ECCO Members: mark your calendars!

**HANKJE ESCHER**
P-ECCO Committee Member


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2. Biancone L, Michetti P, Travis S, Escher JC, Moser G, Forbes A, Hoffmann JC, Dignass A, Gionchetti P, Jantschek G, Kiesslich R, Kolacek S, Mitchell R, Panes J, Soderholm J, Vucelic B, Stange E; for the European Crohn's and Colitis Organisation (ECCO). European evidence-based Consensus on the management of ulcerative colitis: Special situations. J Crohns Colitis 2008;2(1):63-92.
3. Turner D, Travis SP, Griffiths AM, Ruemmele FM, Levine A, Benchimol EI, Dubinsky M, Alex G, Baldassano RN, Langer JC, Shamberger R, Hyams JS, Cucchiara S, Bousvaros A, Escher JC, Markowitz J, Wilson DC, van Assche G, Russell RK; European Crohn's and Colitis Organization; Porto IBD Working Group, European Society of Pediatric Gastroenterology, Hepatology, and Nutrition. Consensus for managing acute severe ulcerative colitis in children: a systematic review and joint statement from ECCO, ESPGHAN, and the Porto IBD Working Group of ESPGHAN. Am J Gastroenterol 2011;106:574-88.

# The 20th ECCO Educational Workshop – Helsinki, Finland

**The 20th ECCO Educational Workshop took place in Helsinki, Finland on August 26, 2011.**

A kind invitation to organise an ECCO Workshop in Finland had been received from the Educational Committee about one year earlier. On a beautiful late summer morning, colleagues interested in IBD gathered at the Rake Meeting Hall in the heart of Helsinki. Of the 58 participants, 49 were Finnish, 5 were from Estonia, 3 from Latvia and 1 from Norway. The majority of the participants were gastroenterologists. This time the ECCO Faculty included both a gastroenterologist and a surgeon: Gert van Assche (Leuven, Belgium) and Willem Bemelman (Amsterdam, The Netherlands). The Finnish National Representatives, Martti Färkkilä and Taina Sipponen from Helsinki, were local chairs. Local speakers were Kaija-Leena Kolho, Clas-Göran af Björkesten from Helsinki and Jouni Silvennoinen from Joensuu. All presentations were given in English.

***The workshop programme*** followed the structure of previous meetings: It started with a short introduction about ECCO presented by Gert van Assche. The morning session was reserved for Crohn's Disease: The first case was about new-onset ileocecal Crohn's Disease, and was followed by cases of fistulising, paediatric and recurrent complicated ileocecal disease. Especially the case of fistulising disease presented by Willem Bemelman caused lively discussion.

The afternoon session began with a State of the Art Lecture about pregnancy and IBD presented by Gert van Assche. Acute severe colitis and pouchitis were chosen as topics about Ulcerative Colitis. The Workshop was interactive and was highly appreciated by participants, who offered positive feedback throughout.

***The meeting would not have been possible*** without the professional contribution of Workshop Project Manager Barbara Schmid from the ECCO Office. We are grateful to ECCO for the chance to host this important event in Helsinki.

**TAINA SIPPONEN**
ECCO National Representative, Finland

# The 21st ECCO Educational Workshop – Opatija, Croatia

**The 21st ECCO Educational Workshop took place in Opatija, Croatia on September 17, 2011. It was organised by ECCO in collaboration with Boris Vucelic and the IBD Section of the Croatian Gastroenterological Society as local organisers.**

The idea of organising ECCO Educational Workshops arose from a need to improve and harmonise the quality of patient care throughout Europe. This educational activity has been based on the ECCO Guidelines on Ulcerative Colitis and Crohn's Disease, using slide decks based on clinical cases with supporting literature data. The first ECCO Workshop took place in Zagreb, Croatia in November 2007. Croatia became the first ECCO Member to be given the opportunity to organise a second workshop in the country, this time in the beautiful city of Opatija on the Adriatic coast.

***The faculty consisted of*** two ECCO chairs, Rami Eliakim from Israel and Fernando Magro from Portugal, and two local chairs, Boris Vucelic and Brankica Sincic. Presentations were given by ECCO Faculty (Rami Eliakim and Fernando Magro) and local speakers (Silvija Cukovic Cavka, Brankica Sincic and Zeljko Krznaric). The official language of the workshop was English.

Six cases out of the pool of slide decks and one State of the Art Lecture were presented by the faculty. The workshop started with a presentation about ECCO by Boris Vucelic. The topics covered were: paediatric Crohn's Disease (CD), pregnancy and inflammatory bowel disease, fulminant colitis, surveillance and chemoprevention, imaging and new diagnostic steps in CD and fistulising CD. The State of the Art Lecture given by Rami Eliakim was on opportunistic infections.

***The workshop was regional*** in character, with 72 participants from Croatia, Bosnia and Herzegovina and Slovenia. The majority were physicians, but there were also paediatricians and other specialists. Based on impressions from faculty and feedback from participants, the 21st ECCO Educational Workshop was perceived to have been very successful. The participants liked the structure and quality of the programme since they had the opportunity to clarify a number of issues through lively discussion with the faculty during scientific sessions.

ECCO support staff onsite, Nicole Eichinger and Karoline Graf, were exceptional as usual.

We all feel that the workshop accomplished its primary goal of disseminating evidence-based guidelines in this region of Europe.

**BORIS VUCELIC**
**SILVIJA CUKOVIC CAVKA**
ECCO National Representatives, Croatia

# Standard operating procedures for ECCO authorised guidelines

**In 2009 and 2010 standard operating procedures (SOPs) for the development of guidelines were developed by the Consensus panel of ECCO's Education Committee (within a new structure transformed into the Guidelines Committee, GuiCom), coordinated by Gert van Assche and Axel Dignass and supported by Simon Travis, Marc Lémann, Séverine Vermeire and Eduard Stange. These guidelines were subsequently approved by ECCO's Governing Board (GB) in 2010.**

### *The aims of these SOPs are:*

1. To facilitate and coordinate the selection of guideline projects by ECCO.
2. To streamline the consensus process for guidelines.
3. To increase the transparency of the entire process, leading to novel guidelines.
4. To prevent delays in the process by implementing predefined timelines and by facilitating review and approval.

These SOPs have been used since 2010 for the development of all ECCO guidelines, i.e. all consensus guidelines and position statements on the diagnosis, classification or management of inflammatory bowel diseases or related topics that are authorised by ECCO. The most important aspects of the SOPs are summarised below.

### *Submitting a proposal to develop ECCO guidelines*

Unsolicited proposals may be submitted to GuiCom by an individual ECCO Member or by a group of individuals of whom at least one is an ECCO Member using a standard form supplied by the ECCO Office. If the proposal is a group effort, then one responsible member of ECCO should be appointed. The proposal should describe (1) a short rationale, (2) all topics that will be covered, (3) the members of the initial task force, (4) the timelines for the Consensus and for the final publication and (5) the budget for the Consensus.

### *Selection of working parties*

A call will be sent to all ECCO Members announcing the guideline project. This call will be written by the responsible ECCO Member, approved by the GuiCom Chair and distributed via e-mail and website through the ECCO Office. All interested members should respond within 2 weeks to the ECCO Office, providing a rationale explaining their expertise (maximum 10 lines, supported by a maximum of 5 key references). The selection of working party members (ECCO Members and external experts) and working party leaders is the combined responsibility of GuiCom and the ECCO Member responsible for the project. They have the right to call upon external experts (also from outside of ECCO Member States) provided they submit their conflict of interest (COI) declaration *before* the start of any working party activities and account is taken of extraneous expenses. Advice can be sought through the ECCO Committees or GB. Criteria for the selection of working party members will primarily depend on academic expertise, but appropriate consideration of gender balance and geographical location is expected to avoid the perception of bias. Inclusion of Y-ECCO Members in working groups, or as drivers for the project under appropriate senior guidance, is encouraged. Employees of the pharmaceutical industry are explicitly excluded from the systematic literature review or meetings of the consensus, even as observers. Any industry support for the logistics of a consensus meeting can only be made through an unrestricted grant to ECCO and should be agreed with the GB prior to any commitment. If the guideline project is an orchestrated effort involving ECCO and other scientific societies/organisations, the selection process only applies to the contribution of ECCO to the project. Other societies and organisations should follow their own procedures.

### *Literature search and consensus procedure*

The development of guideline statements and the supporting text should always include a systematic literature search with the appropriate key words using Medline/Pubmed and the Cochrane database. The evidence level (EL) and grades of recommendation (RG) are attributed, according to the Oxford Centre for Evidence Based Medicine (http://www.cebm.net/levels_of_evidence.asp#refs). Working parties may wish to circulate carefully worded questions to quantify opinion on topics for which there is insufficient evidence from clinical trials, or where there is variation in practice. These questionnaires should only be circulated to those who have completed a COI declaration and non-response to an invited questionnaire may be used as a criterion to exclude a person from further involvement in the Consensus process. A consensus should be sought for every single guideline statement. The final publication should explain how the consensus was reached and how this was defined. The set of guideline statements, once accepted, is final and is not open to further change by any process other than reconvening the consensus panel. More specifically, guideline statements cannot be changed afterwards and no statements can be added or deleted.

### *Supporting text*

A supporting text based on the detailed evidence from the literature is composed by every working party or by the entire group if working parties were not formed. The final editing of the text is done by the responsible member of the guideline project. It has become customary for the responsible member to be either the first or the last author, with the person who has contributed most to the writing of the paper being the first author; where two people have contributed equally, this can be denoted by an asterisk. Leaders of working groups can then be listed in order of the sections or listed in alphabetical order, as decided by the working group.

### *External review and publication policy*

The guideline statements are not eligible for external review, either by peer reviewers or by ECCO Corporate Members. These statements remain the property of ECCO or shared property with the co-authoring organization (in the case of jointly sponsored guidelines). Prior to final submission, the manuscript should be sent to GuiCom and to the GB for review, with a review time limited to one week. The final manuscript should normally be sent to JCC for publication, unless guidelines are jointly sponsored, in which case another journal is acceptable as long as the name of ECCO is included in the title. The editor of JCC will send the manuscript for peer review to external referees according to JCC procedures.

**AXEL DIGNASS**
GuiCom Chair

**GERT VAN ASSCHE**
EduCom Chair

# Surgical Committee (S-ECCO) – ready to go!

**Surgical ECCO (S-ECCO) has progressed significantly.**

During the last congress of the European Society of Coloproctology (ESCP) in Copenhagen, Ronan O'Connell (Dublin, Ireland) presented S-ECCO to the ESCP council. S-ECCO was embraced and in the near future will obtain the full endorsement of the ESCP. S-ECCO therefore will have the official mandate to liaise between ECCO and ESCP. This is very important in avoiding the creation of a parallel ESCP-IBD working group.

Furthermore this acceptance was a sine qua non for S-ECCO to start the process of developing specific evidence-based guidelines for surgery in Ulcerative Colitis and Crohn's Disease. Tom Øresland (Oslo, Norway) and Alastair Windsor (London, United Kingdom) will take the lead in this project and will present the framework during the next ECCO Congress in Barcelona.

The first Masterclass in IBD Surgery will take place in Barcelona and will cover all aspects of surgery for terminal ileal Crohn's Disease. The Masterclass aims to be interactive and all dedicated surgeons and gastroenterologists will be welcomed. A panel of world-recognized specialists in the field will guarantee the quality of this educational programme and it is foreseen that ample time will be available for exchange of expertise.

Outcome data from different European centres will be jointly presented. We also hope to present data from an international clinical research project comparing resectional surgery with strictureplasty (cohort data from Amsterdam, The Netherlands; Leuven, Belgium and Milan, Italy).

This Masterclass should be as attractive for surgeons with longstanding experience as for novices. Gastroenterologists are also warmly invited to participate.

### *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 (to learn more on joining the ECCO Family please sign 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).

## *Preliminary programme 1st S-ECCO IBD Masterclass (as of November 14, 2011)*

### *Wednesday, February 15, 2012*

***13:00-13:15*** ***Welcome***
André D'Hoore, Leuven, Belgium

***13:15-14:00*** ***Session1: 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***

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***
Fabrizio Michelassi, New York, United States

16:00-16:15 ***Rationale and outcome of classical types***
Neil Mortensen, Oxford, United Kingdom

16:15-16:30 ***Isoperistaltic strictureplasty***
André D'Hoore, Leuven, Belguim

***16:30-16.45*** ***Discussion***

***16:45-17:45*** ***Session 4: Outcome***
Antonino Spinelli, Milan, Italy

16:45-17:00 ***Postoperative morbidity: Do we have to blame the drugs?***
Johan Söderholm, 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 of strictureplasty with ileocolic resection***
Anthony de Buck van Overstraeten, Leuven, Belgium

***17:45-18:15*** ***Part 5: Ongoing debate***

17:45-18:00 ***Early versus late surgery***
Anders Tottrup, Aarhus, Denmark

18:00-18:05 ***The LIRIC trial (an update)***
Tjibbe Gardenbroek, Amsterdam, The Netherlands

***18:05-18:15*** ***Discussion***

### *Thursday, February 16, 2012*

***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
André D'Hoore, Leuven, Belgium

***Session 8: S-ECCO guideline for surgery UC***
Tom Øresland, Oslo, Norway

In the future S-ECCO might offer a platform to facilitate surgical research in the field of IBD. In addition, the surgical faculty for ECCO Educational Workshops can be recruited via S-ECCO. Informal meetings during the next ECCO Congress should enhance this process.

I look forward to meeting you all during the next ECCO Congress and, who knows, at our first Masterclass.

**ANDRÈ D'HOORE,** S-ECCO Chair
On behalf of W. Bemelman and T. Øresland

# The IBD 10 Conference in Vienna

**550 delegates from more than 40 countries had come to the Austrian capital to participate in the 10th anniversary meeting *IBD 10*.**
**The theme of the Meeting was *Knowledge & Expertise: Working together in IBD*.**
**The Conference was supported with an educational grant from Ferring.**

The first lecture was called *Epidemiologic clues to IBD*, and it was given by Siew Ng, China.

"Epidemiologic studies across time and geography highlight environmental factors", she said.

## Changes in diet

She started her talk by showing a map of the global epidemiology. IBD is spreading in Asia, and we see – as we did in the West – the pattern that ulcerative colitis (UC) first predominates. Crohn's disease (CD) has at first a low incidence, but then UC stabilises and is overtaken by CD. This development can now be seen in Asia.

"In these countries we see a change in hygiene level, in diet, in stress level and also in antibiotic use", Dr Ng pointed out.

Early life events may hold the key to aetiological clues, and gut microbiota is the epicentre of the pathogenesis.

"One of the things that change the microbiota is what we eat, and we can see changes in the diet in Japan", she continued.

Epigenetic epidemiology (EWAS) may unravel genetic-environmental contribution to the disease. Dr Ng also reminded the audience of helicobacter pyroli and peptic ulcer disease.

"The solution to some human disorders cannot be solved by only looking at the human host. Rather we need to study the *interface* of the host with the microbial environment."

She finished her talk by stating that one day we hopefully will have an answer – not only clues.

## The genes were there – but not IBD

The Conference's Keynote Lecture had the title *IBD in the next ten years* and was given by Claudio Fiocchi, USA.

"We're still looking at parts of the puzzle", he stated.

Dr Fiocchi then looked back on IBD in the last ten years. He concluded that the same key components of IBD pathogenesis that we today believe to be essential were already recognised then. These include the environment, the genetic make up, the gut microbiota and the immune response.

"Genetic heterogeneity in IBD appears to be overwhelming, at least at the moment. Novel technologies are needed to learn how each genetic variation – alone or in combination – contributes to IBD pathogenesis", he said.

He reminded the audience that IBD is progressively spreading in the world. But 100 years ago the same genes were there – but not IBD.

"So what is different now? The answer is the environment".

Dr Fiocchi pointed out that there is a worldwide change in the prevalence of obesity – it has doubled between 1980 and 2008.

"Obesity itself is a risk factor for immunological diseases".

Of all the complex environmental changes that IBD is unequivocally linked to, the diet and the intestinal microbiota offer the most promising possibilities for future therapeutic intervention, he stated.

## IBD a dynamic condition

The immune/inflammatory process that mediates IBD involves more components than previously anticipated. Both immune and non-immune cells are involved in innate and adaptive responses, and both could be targeted for therapeutic purposes, Dr Fiocchi continued.

"Additional components of IBD pathogenesis are being constantly recognized. At the same time new pathophysiology-based molecular therapies are being developed".

IBD can no longer be seen as a condition with a fixed set of pathogenic events and clinical manifestations.

"On the contrary, IBD is a dynamic condition with a time-dependent evolution of disease mechanisms and clinical expression".

The complex physiological networks that keep cells running have evolved over billions of years to withstand all manners of disruption.

"Rather than focusing exclusively on single proteins, or individual biochemical pathways, we should look at the bigger picture and target the myriad networks of interactions between the molecules in our cells", Dr Fiocchi ended his highly appreciated talk.

## Not a barrier for treating cancer

Patients with colonic CD and UC are at increased risk for development of colorectal cancer (CRC). One session was dedicated to this topic.

Gijs van den Brink, The Netherlands, asked what causes IBD related CRC – and what can we do about it?

He described the critical role of NF-kappaB signalling in inflammation driven carcinogenesis in the intestine as a probable answer to the first question. ▶


Siew Ng


Claudio Fiocchi


Pradeep Bhandari


Michael Kamm


Simon Travis

"Colonoscopy screening and medical therapy are the answers to the second", Dr van den Brink continued.

Thiopurines *prevent* advanced colorectal neoplasia in patients with IBD.

"The more we strive for mucosal healing, the higher decrease for CRC will we see in our patients", he said.

Laurence Egan, Ireland, then talked about the cancer risk related to drug therapy.

"You can minimise that risk by patient selection – male or female, age and prior cancer treatment are factors to be considered", he said.

For 5-ASA drugs, a modest *protective* effect for CRC is possible, but of limited duration. Also a similar effect for steroids can be seen. This is probably related to the inhibition of inflammation. Aspirin and NSAIDs have the strongest protective effects, Dr Egan summarised.

"A population study in Ireland suggests that IBD in itself is not a barrier for *treating* CRC. The outcome for these patients was the same as the normal population", he added.

## Non-resectable lesions might harbour cancer

It is widely accepted that poor quality bowel preparation leads to significant lesions being missed. Pradeep Bhandari, UK, demonstrated this by showing pictures from different colonoscopies.

"Poor bowel preparation is common – and half of these patients are not re-scoped!" he said.

In a study referred to by Dr Bhandari, morning preparation for afternoon colonoscopy gave higher mucosal visibility. Patients also preferred it, compared to split 2-day preparation.

Colonoscopy may have a protective effect on development of CRC, according to Raf Bisschops, Belgium.

He talked on endoscopic removal of dysplastic lesions. Chromo-endoscopy has become the new gold-standard in screening for IBD colitis, and Dr Bisschops showed several examples of endoscopic pictures with this technique.

"Endoscopic resection of well delineated lesions is possible and safe, but needs to be balanced against surgery – taking all patient related factors into account", he continued and showed movies demonstrating techniques for endoscopic resection.

"If the lesion is *not* resectable there is a high chance that it harbours cancer. Then send the patient to surgery", Dr Bisschops concluded.

## New strategy to patient empowerment

Axel Dignass, Germany, had a talk on 5-ASA.

For CD, Mesalazine has moderate efficacy for the treatment of active disease and maintenance of mild to moderate CD. But for UC it is standard of care for the treatment and maintenance of mild to moderate disease – which are the majority of UC patients.

"I believe that 5-ASA is the optimal drug for patient empowerment", Dr Dignass said.

He explained this by showing data on once-daily dosing, and how this increases patients' adherence to the drug – by self-guided therapies. Non-adherence is proven to be associated with worse outcome.

"It matters what formulation you choose – granules or tablets. Granules are better", Dr Dignass continued.

He described the PODIUM study that shows that once-daily dosing of slow release Mesalazine is efficacious as maintenance therapy in mild to moderate left-sided UC.

"We can use once-daily dosing even in acute disease", he added.

Dr Dignass ended his talk with describing an E-health project in Denmark and Ireland. Patients were guided on the web, and the median relapse duration in this group was 18 days – to be compared with 77 days in the control group. No difference in relapse frequency, hospitalisation, surgery or adverse events was observed between the two groups.

"This may be a new strategy to patient guidance and empowerment", he said.

## Treating severe UC is a skill

Michael Kamm, Australia, referred to a clinical case discussion held earlier at the Conference and pointed out how *different* the choices we make are.

He continued by describing a case of a 19 year old male who had been previously well and on no medication – and didn't have a family history of gut disease. After seeing his doctor for frequent bloody stools, he was admitted to hospital.

Dr Kamm recapped the story as it went, and it ended with colectomy on day 34.

The management of a sick patient with UC is one of the best tests of a physician's clinical skill, according to Dr Kamm.

"We have to recognize new onset acute colitis – excluding infection only takes two days", he said.

Timing is of essence. Antibiotics are ineffective – and there is no place for weak oral or rectal therapies.

"Ensure that the patient is getting cyclosporin. Treating severe UC is a skill: Keep your focus and don't make any interruptions. Don't pause until full remission is achieved", was his message.

## Don't duck difficult decisions

Simon Travis, UK, then talked on rescue therapy for acute severe colitis (ASC).

"The principal pitfall is failure to think that an acute presentation might be UC – treat *both* ASC and infection if in doubt", Dr Travis said.

Make contingency plans on day 3: Discuss medical strategy, consider pattern of disease, request surgeon's opinion and introduce the stoma therapist.

"Make a *decision* about rescue therapy!", he urged the audience.

Then *act* on day 3 criteria.

"Give cyclosporin if the patient is likely to undergo colectomy, infliximab if the disease is less severe. But *don't* use both cyclosporin and infliximab! And most important: Don't duck difficult decisions – if in doubt, phone a friend. You can do that wherever you are", was Dr Travis message to the audience.

**PER LUNDBLAD**
Senior Writer

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**Further contacts of ECCO Officers can be found online at www.ecco-ibd.eu**

# Personal picks – **Literature Reviews** from Young-ECCO Members

**Dear colleagues,**
**In this issue we have a special literature review section containing personal manuscript selections of Y-ECCO Members. The heterogeneity of the authors – three women and two men; one psychologist, one biologist, one surgeon and two gastroenterology trainees – reflects the different backgrounds and interests in the field of inflammatory bowel disease (IBD) that are represented in Y-ECCO. The topics covered are similarly diverse. The role of infliximab in postoperative complications in Ulcerative Colitis (UC) and its long-term effect on the disease course of UC are discussed. An investigation into the outcome of Crohn's Disease after cessation of infliximab, including related risk factors for early relapse, is considered. Fatigue and sleep difficulties – a very common but largely uninvestigated problem in IBD – are brought to our attention, and finally cutting-edge results on the role of IL-35 in intestinal mucosal immune regulation are presented.**

**This selection does not depict an objective ranking and is not intended to be comprehensive. Rather it represents individual selections, allowing the statement of personal opinions. We continue to look forward to suggestions for the next series. If you have ideas or would like to submit a review, please contact: riederf@ccf.org or ecco@ecco-ibd.eu.**

**Florian Rieder**
**On behalf of the Y-ECCO Committee**

## A population-based study of fatigue and sleep difficulties in inflammatory bowel disease

Graff LA, Vincent N, Walker JR, Clara I, Carr R, Ediger J, Miller N, Rogala L, Rawsthorne P, Lix L, Bernstein CN
Inflamm Bowel Dis 2011;17:1882-9

Fatigue has long been linked to inflammatory bowel disease (IBD) and is frequently reported by patients. This symptom has been commonly explained as a consequence of chronic inflammation, anaemia, prevalent sleep problems and psychological co-morbidities such as anxiety and depression.

To date, only a few studies have explored fatigue in IBD and those available have largely involved small samples, in particular hospitalised populations, and have focussed on either active or inactive disease only.

As part of their ongoing Manitoba IBD cohort study, Graff et al. conducted the first comprehensive investigation on fatigue in IBD. Their sample of 318 participants was representative of the larger local IBD population, with a mean age of 43 years (SD=14.06), an average disease duration of 6.4 years (SD=2.1), 51% of participants having Crohn's Disease (CD) and 46% having current active disease.

### *Key findings*

In this investigation, disease activity was measured using the Harvey-Bradshaw index for CD and Powell-Tuck index for Ulcerative Colitis (UC). Clinically significant fatigue was highly prevalent in IBD participants (both with CD and with UC) who had active disease (72%). However, surprisingly, 30% of those with inactive disease also reached the clinically significant threshold for fatigue. With respect to sleep difficulties, 77% of those with active disease reported poor sleep as did approximately 50% of participants in remission.

In a multivariate analysis, fatigue was found to be highly correlated with poor sleep quality (OR=4.0, 95% CI: 1.9-8.6), active disease (OR=4.2, 95% CI: 2.2-7.8) and high perceived stress (OR=4.2, 95% CI: 2.2-8.1). However, no relationship was found between fatigue and haemoglobin and CRP levels.

In participants with inactive disease, multivariate analysis showed poor sleep quality (OR=4.4, 95% CI: 1.5-13.3) and psychological factors (OR=4.4, 95% CI: 1.7-11.5) to be strongly associated with fatigue.

### *Why is this study important?*

In the presented manuscript, fatigue was shown to be highly prevalent in IBD participants, with nearly 75% of patients with active disease and 30% of patients with inactive disease reporting this symptom. In comparison, only 5% of healthy subjects report fatigue [1]. Importantly, fatigue was not shown to be a simple consequence of elevated CRP and anaemia and thus more attention should be directed to other contributing factors. For example, fatigue is a common symptom of depression, as identified by a number of previous studies. High stress levels were associated with a four-fold likelihood of fatigue and thus psychological status may be an important factor in explaining this symptom in IBD. Sleep problems were also found to be highly prevalent, with up to 82% of patients with active disease and up to 51% of subjects with inactive disease reporting difficulties in sleep, indicating the need for more focus on strategies to improve sleep quality.

The authors recommend that fatigue and associated factors (psychological distress, stress and sleep quality) should be assessed in standard care to optimise IBD treatment. Psychological therapies such as cognitive-behavioural therapy could help manage fatigue and associated psychological co-morbidities and improve sleep quality. However, the lack of availability and the high costs of psychological help are not mentioned. Thus better access to psychologists or online psychological resources for IBD patients is warranted in order to better manage fatigue, sleep problems and psychological difficulties.

Reference:

1. Minderhoud IM, Oldenburg B, van Dam PS et al. High prevalence of fatigue in quiescent inflammatory bowel disease is not related to adrenocortical insufficiency. Am J Gastroenterol 2003;98:1088-1093

**ANTONINA MIKOCKA-WALUS**
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*Antonina Mikocka-Walus is a Research Fellow at the University of South Australia. She is a psychologist with an interest in psychological therapies to manage IBD.*

# Infliximab and complications after colectomy in patients with ulcerative colitis

Brengbak D, Mortensen C, Bendtsen F
J Crohns Colitis 2011 doi: 10.1016/j.crohns.2011.08.014

There is no known cure for Ulcerative Colitis (UC), but several agents are frequently used for control of inflammation. High doses of corticosteroids (CS) are administered in acute flares of UC and achieve a high response rate, but this success has the trade-off of a higher risk of complications after surgery. The anti-tumour necrosis factor (TNF)-α antibody infliximab (IFX) is now used in both induction and maintenance therapy for moderate to severe UC. The number of UC patients undergoing surgery after treatment with IFX is increasing. It has been hypothesized that IFX treatment may increase the risk of postoperative complications in patients with UC. Recent investigations have tried to assess this dilemma, with conflicting conclusions. A study on a 10-year experience from Belgium concluded that use of CS, but not IFX, increases the risk of early postoperative complications [1]. On the other hand, two large series globally comparing 132 patients who received IFX as a treatment before surgery with 692 who did not, found that IFX was associated with a higher rate of complications post surgery [2,3].

## *What are the key findings?*

In the presented work Brengbak and colleagues performed a retrospective analysis of a database of patients undergoing surgery for UC within a 5-year period. They compared 20 patients who received IFX prior to surgery with 51 who were not treated with biologic agents. The main outcome measure was complications occurring within 30 days after surgery. The authors found no correlation between treatment with IFX 12 weeks prior to surgery and infectious postoperative complications. Interestingly, these were more likely to occur in patients receiving CS.

## *What is of interest in this study?*

Even if the study design does not allow definitive conclusions to be drawn, preoperative patient assessment – which is a weakness of all previously published studies – is very well described.

The two groups were homogeneous as patients were selected using stringent criteria. A cut-off value of 90 days (12 weeks) between the last IFX infusion and primary surgery was chosen. Endoscopy was not performed to assess the Mayo score, resulting in a "partial Mayo score". However, the authors sufficiently explain their conduct in the text and also point out the weaknesses of the report. Two authors disclose a conflict of interest with an IFX distributor in Denmark; nevertheless, the study is well conducted and described, and the conclusions seem genuine, prudent and justified.

Although not included in the authors' aims, a longer follow-up period could be of interest to examine the long-term effect of IFX in patients undergoing surgery for UC. This investigation could take into account infectious as well as non-infectious complications.

References:

1. Ferrante M, D'Hoore A, Vermeire S et al. Corticosteroids but not infliximab increase short-term postoperative infectious complications in patients with ulcerative colitis. Inflamm Bowel Dis 2009;15:1062-70.
2. Selvasekar CR, Cima RR, Larson DW et al. Effect of infliximab on short-term complications in patients undergoing operation for chronic ulcerative colitis. J Am Coll Surg 2007;204:956-62.
3. Mor IJ, Vogel JD, da Luz Moreira A et al. Infliximab in ulcerative colitis is associated with an increased risk of postoperative complications after restorative proctocolectomy. Dis Colon Rectum 2008;51:1202-7.

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*Gianluca Pellino is currently performing his Residency in General Surgery at the Second University of Naples, Italy. He is member of the surgical team of Professor Francesco Selvaggi, a general surgeon with extensive experience in IBD surgery. Gianluca is interested in instrumental imaging, endoscopy, surgery of IBD and research activity.*

*Characteristics of studies investigating the association between Infliximab (IFX) and postoperative complications (source: G. Pellino).*

| STUDY | YEARS | PATIENTS | CONCLUSIONS | PRO & CON |
|---|---|---|---|---|
| **Schluender et al** *Dis Colon Rectum* 2007 | 2000-2005 | 17 IFX<br>134 NO IFX | IFX = NO IFX | - no preoperative assessment of disease activity |
| **Selvasekar et al** *J Am Coll Surg* 2007 | 2002-2005 | 47 IFX<br>254 NO IFX | IFX increases the odds of postoperative pouch related and infectious complications | - IFX group received higher dose of ASA, CS, 5-ASA |
| **Mor et al** *Dis Colon Rectum* 2008 | 2000-2006 | 85 IFX<br>438 NO IFX | IFX increases the risk of postoperative complications | - median last IFX infusion 13.5 wks → unlikely to mantain response > 12 wks |
| **Ferrante et al** *Inflamm Bowel Dis* 2009 | 1998-2008 | 22 IFX<br>119 NO IFX | IFX = NO IFX | + 10-year survey<br>- no preoperative assessment of disease activity |
| **Couquet-Reinier et al** *Surg Endosc* 2010 | 1999-2008 | 13 IFX<br>13 NO IFX | IFX = NO IFX<br>Laparoscopy feasible after IFX | - small sample size<br>- case-matched controls |
| **Yang et al** *Aliment Pharmacol Ther* 2010 metanalysis | 1993-2008 | 132 IFX<br>553 NO IFX | IFX increases short-term total postoperative complications | - no associations between IFX and infectious or non-infectious complications when analysed separately |
| **Gainsbury et al** *J Gastrointest Surg* 2011 | 2005-2009 | 29 IFX<br>52 NO IFX | IFX = NO IFX<br>hand-assisted laparoscopy feasible after IFX | - hand-assisted laparoscopy, failure of medical therapy, CS dose, MTX use, 6-MP use unequally distributed |
| **Present study** *J Crohns Colitis* 2011 | 2005-2010 | 20 IFX<br>51 NO IFX | IFX = NO IFX<br>CS increase the risk of infectious postoperative complication | + homogeneous groups<br>+ nice pre- and post-operative assessment<br>+ & - infectious ≠ non-infectious complications differences<br>- partial Mayo score (endoscopy not routinely performed)<br>- conflict of interest |

# Interleukin-35 mediates mucosal immune responses that protect against T-cell-dependent colitis

Wirtz S, Billmeier U, McHedlidze T, Blumber RS, Neurath MF
Gastroenterology 2011;141:1875-86

The IL-12 family of cytokines plays an important role in the pathogenesis of IBD. It consists of pro-inflammatory cytokines enhancing inflammation by induction of Th1/Th17 responses, like IL-12 and IL-23, but also of members with an immunosuppressive function, like IL-27 and IL-35.

Interestingly, the IL-12 family consists of heterodimeric cytokines composed of two subunits, some of which are shared amongst family members. IL-27 is composed of EBI3 (Epstein-Barr virus-induced gene 3) and the IL-27p28 subunit, whereas IL-35 is composed of EBI3 and IL-12p35. In contrast to the well-defined function of IL-12 and IL-23 in IBD, the function of IL-27 and IL-35 is still unclear. In particular, functional studies of IL-35 are hampered by the current limitations in our ability to detect it and the fact that knock-out of the EBI3 subunit will also affect IL-27 expression and knock-out of the IL-12p35 unit will also affect IL-12 expression.

Wirtz et al. elegantly circumvented this problem by using mice deficient in both EBI3 (lacking both IL-27 and IL-35) and IL-27p28 (lacking only IL-27) to gain insight into the role of IL-35. The differences between the EBI3 and IL-27p28 deficiency were studied in a variety of established mouse colitis models, using state of the art imaging tools, i.e. murine endoscopy and bioluminescence, to assess colonic inflammation *in vivo*.

## *Key findings*

Both the EBI3 and the IL-27p28 deficiency trait were crossed into mice lacking STAT3 signalling in their myeloid cells (STAT3 model of spontaneous enterocolitis). Compared to control mice in the STAT3 model, EBI3-deficient mice showed an earlier onset and a more severe phenotype of enterocolitis, whereas IL-27p28-deficient mice did not display any noticeable difference in disease. Similar results were obtained when EBI3 and IL-27p28 deficiency was studied in the T cell-dependent adoptive transfer model of colitis. Although the IL-27p28-deficient mice seemed to have a slightly enhanced transfer colitis, none of the differences reached statistical significance.

The enhanced intestinal inflammation in EBI3-deficient mice using the STAT3 model coincided with an increased mRNA expression of pro-inflammatory mediators. In addition, stimulation of lamina propria mononuclear cells from these mice showed increased production of pro-inflammatory cytokines.

To investigate the therapeutic potential of IL-35, the authors constructed an IL-35 expression vector where the EBI3 gene was fused into the 3' end of the IL-12p35 subunit. Administration of this IL-35 expression vector inhibited dextran sodium sulphate (DSS)-induced colitis in mice in both a preventive and a therapeutic setting.

## *Overall conclusion*

The authors conclude that the EBI3 subunit of the immunosuppressive cytokine IL-35 plays an important role in the regulation of the mucosal immune response. Accordingly, IL-35 may have therapeutic potential in IBD patients.

## *Critical remarks*

In this paper, EBI3- and IL-27p28-deficient mice were used to study the role of IL-35. Although this provided insight into the role of IL-35, it fails to tell us anything about the immunoregulatory role of IL-27.

Since most of the evidence for the regulatory function of IL-35 was based on the STAT3 and transfer colitis models, it was surprising that the authors used DSS-induced colitis to show the therapeutic potential of IL-35. A set of experiments using IL-27 expression vectors to rescue the EBI3-deficient mice in the different colitis model would have been a crucial addition to this paper in order to assess the function of IL-27.

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# Maintenance of remission among patients with Crohn's disease on antimetabolite therapy after infliximab therapy is stopped

Louis E, Mary JY, Vernier-Massouille G, Grimaud JC, Bouhnik Y, Laharie D, Dupas JL, Pillant H, Picon L, Veyrac M, Flamant M, Savoye G, Jian R, Devos M, Porcher R, Paintaud G, Piver E, Colombel JF, Lemann M; Groupe D'etudes Thérapeutiques Des Affections Inflammatoires Digestives
Gastroenterology 2011 Sep 22 [Epub ahead of print]

## *Introduction*

Infliximab (IFX) has dramatically changed the approach to the management of patients with Crohn's Disease (CD) [1]. IFX induces rapid and profound endoscopic healing, improves quality of life and allows patients to avoid hospitalisation and surgery [2]. The ACCENT I [3] and ACCENT II [4] trials have shown that scheduled maintenance therapy with IFX is superior to episodic therapy in maintaining response and remission both in luminal and in fistulising CD. Nonetheless, approximately 60% of patients cannot reach remission and 25–40% of patients on an IFX maintenance regimen experience a loss of response to the drug [5].

It has been demonstrated that the combination of IFX and azathioprine is more effective than IFX alone in inducing steroid-free remission and mucosal healing of the bowel in luminal CD in patients not treated previously with azathioprine. The Study of Biologic and Immunomodulator Naive Patients in Crohn's Disease (SONIC) also showed that IFX monotherapy is significantly better at inducing steroid-free remission and mucosal healing than azathioprine alone in azathioprine-naive patients [6].

It is important, however, to determine whether IFX therapy can be safely interrupted in patients with CD who have undergone a period of prolonged remission, and the timing of IFX withdrawal in patients who receive combination therapy is one of the most controversial topics in IBD management. ▶

### *What this paper is about*

This interesting prospective multicentre cohort study included 20 centres in France and Belgium between March 2006 and December 2009. The paper analyzed the time to relapse after IFX discontinuation in CD patients who achieved a corticosteroid-free remission for at least 6 months as a result of the combination of IFX and antimetabolite therapy (azathioprine, 6-mercaptopurine, methotrexate). In addition, the authors identified factors associated with a low risk of relapse. 115 CD patients of the GETAID cohort were treated with scheduled IFX and antimetabolite for 1 year. In patients achieving steroid-free remission (CDAI <150) for at least 6 months, IFX was stopped and patients were followed up for 2 years thereafter. After 2 years of follow-up 51 of the 115 patients had a confirmed relapse (CDAI >250 or between 150 and 250 with a 70-point increase from baseline over two consecutive weeks), with a total relapse rate of 43.9% +/- 5% and 52.2% +/- 5.2% in the first and second year, respectively.

The following were identified as relapse risk factors: male sex, the absence of surgical resection, leucocyte counts >6x10$^9$/L, levels of haemoglobin <145 g/L, CRP >5 mg/L and faecal calprotectin >300 µg/g. Patients were graded according to the risk of relapse: patients presenting no more than two of the above risk factors had a 15% likelihood of relapse within 1 year. 40 patients who relapsed were also re-started on IFX therapy and were assessed for response to treatment 30 days after the first IFX re-treatment up to the third infusion. Therapy was effective in inducing remission in 37/40 (93%) and 39/40 (98%) showed a clinical response. IFX re-treatment proved itself to be safe and was well tolerated by all patients.

### *Conclusion*

The study shows that approximately 50% of patients with CD who were on an antimetabolite agent and IFX for 1 year and in corticosteroid-free remission for at least 6 months experienced a relapse within 2 years after discontinuation of IFX. However, patients with a low risk of relapse can be identified using a combination of clinical and biological markers.

The study group under examination was characterised by extremely heterogeneous risk factors for debilitating disease, from endoscopic grading to smoking. However, those features seemed not to represent risk factors for relapse. Finally, a control group of patients continuing combination therapy is needed.

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# Early mucosal healing with infliximab is associated with improved long-term clinical outcomes in ulcerative colitis

Colombel JF, Rutgeerts P, Reinisch W, Esser D, Wang Y, Lang Y, Marano CW, Strauss R, Oddens BJ, Feagan BG, Hanauer SB, Lichtenstein GR, Present D, Sands BE, Sandborn WJ
Gastroenterology 2011;141:1194-201

In terms of the number of investigations into the use of biologics to induce and maintain clinical remission, Ulcerative Colitis (UC) has been a 'neglected cousin' to Crohn's Disease. ACT-1 and ACT-2 [1] assessed the efficacy and safety of infliximab versus conventional treatment in patients with moderately to severely active UC. UC patients in the infliximab arm were more likely to achieve clinical response, remission or mucosal healing at weeks 8, 30 and 54 than those receiving conventional treatment. In addition, maintenance infliximab reduced the risk of colectomy in this UC patient population [2]. Colombel et al. have undertaken a subgroup efficacy analysis of ACT-1 and ACT-2 to evaluate a possible correlation between endoscopy subscores at 8 weeks of treatment with infliximab or placebo and subsequent long-term clinical outcomes at week 54. The outcomes assessed included colectomy rates, commercial infliximab use, symptomatic remission (Mayo Stool Frequency of 0 or 1 and a rectal bleeding subscore of 0), corticosteroid-free symptomatic remission, corticosteroid-free status and sustained mucosal healing. In effect they asked the question: Does the patient's response at 8 weeks predict what will happen in a year's time?

ACT-1 and ACT-2 [1] enrolled UC patients with moderately to severely active colitis despite conventional treatment and placed them into one of three arms: placebo, infliximab (5 mg/kg) and infliximab (10 mg/kg). Colombel et al. separated each of these arms into their Mayo endoscopy subscores at week 8.

***The results at face value*** appear intuitive: UC patients who achieved mucosal healing (subscore 0 or 1) at 8 weeks in the infliximab arms had a lower colectomy rate (p=0.0004), a lower commercial infliximab use (p<0.0001), an increased likelihood of being in symptomatic remission (p<0.0001) and corticosteroid-free symptomatic remission (p<0.0001), a reduced need for corticosteroids (p<0.0001) and an increased rate of sustained mucosal healing (p<0.0001) at 54 weeks.

No trend towards improvement was seen in the placebo arm for the endpoints of colectomy and commercial infliximab use until 54 weeks. At 54 weeks, UC patients receiving placebo who had a low endoscopy score at week 8 were more likely to be in symptomatic remission and corticosteroid-free symptomatic remission, to be corticosteroid free and to exhibit sustained mucosal healing, though the percentages achieving these outcomes were lower compared to the infliximab-treated patients. It has to be borne in mind, however, that the numbers of patients were small, especially in the subgroup that had achieved mucosal healing at 8 weeks, and therefore caution should be exercised in interpretation of these data.

Why is this important? Infliximab has previously been shown to improve mucosal healing in UC. This study adds support to the growing evidence that achievement of early mucosal healing may

lead to improved long-term clinical outcomes. In addition, these results emphasize the value of endoscopically detected mucosal healing in predicting outcome versus facilitating the clinical response only. However, formal randomized controlled trials need to be undertaken to compare the long-term outcome in patients with symptomatic clinical remission versus mucosal healing.

***ECCO editor's comment from the original article*** "this study was designed and conducted by the ACT-1 and ACT-2 Steering Committees, Centocor Research & Development, a division of Johnson & Johnson Pharmaceutical Research & Development, LLC and Schering Corporation (a subsidiary of Merck & Co, Inc) who jointly analyzed and interpreted the data, and contributed to the manuscript"

References:

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# Invitation to the Y-ECCO Members' Meeting 2012

**All Y-ECCO Members (paid-up Membership fee 2012) are cordially invited to the Y-ECCO Members' Meeting, which aims to involve all Y-ECCO Members in shaping Y-ECCO initiatives further:**

**Y-ECCO Members' Meeting**
**February 15, 2012, 17:30-18:00**
**ECCO Congress 2012, CCIB Barcelona**

**This meeting will follow the Y-ECCO Workshop 2012 – which will focus on inspiring the career development of all Y-ECCO Members:**

*Wednesday, February 15, 2012 Preliminary programme overview – 5th Y-ECCO Workshop (as of November 14, 2011)*

| "How to pursue a career in IBD" | | |
|---|---|---|
| **16:00-16:10** | ***Welcome and introduction***<br>Jan Wehkamp, Stuttgart, Germany | |
| **16:10-16:50** | **Session 1**<br>Marjolijn Duijvestein, Amsterdam, The Netherlands<br>Florian Rieder, Ohio, United States | |
| | 16:10-16:25 | ***Why bother doing research beside my clinical work?***<br>Gijs van den Brink, Amsterdam, The Netherlands |
| | 16:25-16:50 | ***How and where to get funding for research?***<br>Silvio Danese, Milan, Italy |
| **16:50-17:30** | **Session 2**<br>James Christopher Lee, Cambridge, United Kingdom<br>Franco Scaldaferri, Rome, Italy | |
| | 16:50-17:05 | ***How NOT to get your work published – Common mistakes made***<br>Miquel Gassull, Barcelona, Spain |
| | 17:05-17:30 | ***Dark and light of industry sponsoring – Chances and pitfalls from both perspectives***<br>Gerassimos Mantzaris, Athens, Greece<br>Giancarlo Naccari, Lainate, Italy |
| **17:30-18:00** | ***Discussion & Y-ECCO Members' Meeting*** | |
| *Join us for a visit in a nearby bar afterwards...* | | |

## *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).

# N-ECCO National Representatives Revival & N-ECCO Network Meeting

**As part of N-ECCO's renewed engagement with our National Reps, the N-ECCO Committee met with a small number of the Nursing National Representatives in Stockholm on Sunday October 24, 2012. There was representation from France, Italy, Germany and Austria.**

The meeting was productive and provided an opportunity to recap on the plans for the N-ECCO School and N-ECCO Network Meeting due to be held in Barcelona on February 15 and 16, 2012. There is ongoing interest from nurses from around Europe in attending the N-ECCO School, which provides foundation training in the management of Crohn's Disease and Ulcerative Colitis. EFCCA (European Federation for Colitis & Crohn's Associations) has kindly provided financial support to each nurse attending the N-ECCO School. This support from EFFCA is invaluable and without it, the nurses who most need to access this training would be unable to attend. As a result, N-ECCO remains committed to supporting EFCCA and to forging ongoing links between ECCO and N-ECCO. The N-ECCO Network Meeting continues to be a tremendous means of networking and sharing experience throughout Europe. The National Reps have been pivotal in the success of previous meetings, with 43% of attendees at the N-ECCO meeting in Dublin 2011 reporting that they knew about the meeting from them.

***As part of the meeting*** in Stockholm, there was an excellent opportunity for National Representatives to provide an update on the developments in IBD nursing and education within their own country. It is very rewarding and encouraging to hear of such developments, some of which are detailed below for information.

***Austria:*** A. Beyer reported that in Austria, IBD nurse education has already been established – with the help of industry sponsorship. In September 2011, 85 nurses participated in the autumn educational programme; and 25 nurses participated in the most recent national meeting in spring 2011.

In addition, a consensus guideline about IBD nursing is currently drafted. It is also planned for publication – once the respective legal aspects have been clarified.

***Germany:*** P. Hartmann reported that in Germany, too, courses are held on IBD nursing. From 2008 to 2010, nearly 500 nurses participated in these courses, which are organised by the "Kompetenz-Netzwerk Darmerkrankungen". However, no practical training is included. Since 2011, the course consists of 2 parts – a basic level and an advanced level. Hence, in 2011, an advanced course has been introduced for IBD nurses who previously participated in the basic course.

Furthermore, there is a new society in Germany called "FA-CED" (Fachgesellschaft für Assistenzpersonal – Chronisch Entzündliche Darmerkrankungen), which held a meeting in June in Hannover. For this meeting, 60 participants were budgeted, but 90 candidates were interested in participating.

> "There is ongoing interest from nurses from around Europe in attending the N-ECCO School, which provides foundation training in the management of Crohn's Disease and Ulcerative Colitis."

***Italy:*** M. Martinato reported that two pharmaceutical companies in Italy are starting to invest in IBD nurse education in cooperation with gastroenterology societies.

The starting project includes 6 days of school (theory) and 6 days of stage (practical training) and is taking place in two hospitals in Northern Italy. Participants are fully sponsored by the pharmaceutical companies for travel, accommodation and registration fees. The end of the project and its evaluation will take place in mid December 2011 and if it is successful, this initiative will be implemented on a national basis starting in 2012.

In addition, another project will try to put in place the results of a recent consensus meeting focused on "Planning the Education for IBD Nurses". It will start in spring 2012 and probably will be held under the patronage of IG-IBD, the Italian scientific society for IBD. This project aims to create a national network for IBD nurses based on the model of N-ECCO and the N-ECCO Network Meeting; it will be a two day intensive course/congress.

Moreover, "Gastro Care" – a society of gastroenterology physicians and nurses, has started to work on a "shared profile for IBD nursing" taking into account the interests of the Italian patients' society AMICI. The project started in mid October 2011 and is focussing on patient needs.

***France:*** S. Ostrec pointed out that due to the shortage of nursing staff, there is as yet no IBD nurse network yet. GETAID however has started a project on therapeutic education for IBD patients. Today, about 40–50 nurses and 20 patients (200 during the study) are involved. There are two groups of patients: since its inclusion, one group receives patient information (nurses educate the patients individually) and has to score questions about quality of life (those issues which the patients want to improve like knowledge about his/her pathology, the treatment,...) 6 months and 12 months later. The other group also has to score the questions after 6 and 12 months of the project timeline, but is educated only after the first 6 months have passed. After 12 months the results will be compared with the hypothesis that education is good for the patients. The results will be available approximately in 2 years.

## *N-ECCO Network Meeting*

We welcome all nurses with an interest in inflammatory bowel disease to the next N-ECCO Meeting, due to be held in Barcelona on February 16, 2012. The full details of the programme are available online at www.ecco-ibd.eu. The programme provides a good mix of presentations from both nursing and medical staff, with attention to new developments in the field and practical management of care and with oral presentation of the top three N-ECCO abstracts. Furthermore, the afternoon session will demonstrate nursing practice with regard to telephone helplines (advice lines) in three countries, Finland, Spain and Italy. This session, entitled 'Comparing and sharing nursing practice', will make comparisons and highlight similarities between these countries in respect of the management of such services by nurses for patients with inflammatory bowel disease. The session will conclude with the current chair of N-ECCO, Marian O'Connor, underlining the importance of the differences and similarities and demonstrating how N-ECCO considers that we as a group can resolve these issues to the benefit of all nurses working in the field across Europe.

**MARIAN O'CONNOR**
N-ECCO Chair

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