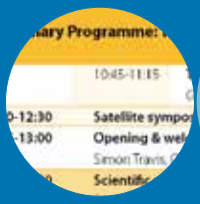
European
Crohn's and Colitis
Organisation

Volume 7 | Issue 3 | 2012

ECCO News AUTUMN



ECCO'13 Vienna Congress: Preliminary scientific programme

Page 8

The history of Crohn's Disease: From the earliest days (Part 1)

Page 4

Editing ECCO News: The match must go on...

Page 6

www.ecco-ibd.eu

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

President:
Simon Travis
Gastroenterology Unit
John Radcliffe Hospital
Oxford, United Kingdom
simon.travis@ndm.ox.ac.uk

Editor:
Silvio Danese
Head of IBD Center
Instituto Clinico Humanitas
Rozanno, Milano, Italy
sdanese@hotmail.com

Associate Editor:
Johan Burisch
Herlev University Hospital
Copenhagen, Denmark
burisch@gmail.com

Production and Advertising:
OCEAiN GmbH (ECCO Office)
Seilerstätte 7/3
1010 Vienna, Austria
ecco@ecco-ibd.eu

Printing:
Druckerei Ferdinand Berger
& Söhne GmbH
Horn, Austria

Illustrations:
Martin Melcher (ECCO Photographer)

ISSN 1653-9214

Content:

Missed an ECCO News issue?
Please scan this code
(ecco-ibd.eu/ecco-news)

ECCO goes to work

ECCO's purpose is to improve the care of patients with IBD. A key element in achieving this goal has been the development of guidelines through a robust consensus process that has become a benchmark for practice. Nevertheless, transferring guidelines from screen to practice is a constant challenge. ECCO embarked upon this journey by initiating ECCO Workshops with case-based discussion of guidelines at a regional level, primarily in Europe but also in Brazil, United Arab Emirates, Japan, South Africa and (next year) China. However, we need to continue to move forwards.

ECCO now plans to bridge the gap between guidelines and best practice. Guidelines are a tool for physicians and can provide information for patients, but revisions become repetitive. ECCO needs to step up to another level. It will do this in two ways: through e-CCO and by developing toolkits for best practice.

e-CCO (Learn@e-CCO) is our e-learning platform, led by Janneke van der Woude, the driving force behind the project, with Charlie Lees and Stephan Vavricka, who have taken up the baton following the pioneering work of Gert van Assche and Larry Egan. e-CCO will be launched at ECCO '13 in Vienna, transforming the current workshop cases based on guidelines into interactive modules and integrating pre-, interim and post-module assessments with selected cross-references to an ECCO e-Library. A further exciting development within e-CCO will be iPad modules based on guidelines and clinical challenges – such as peri-anal Crohn's Disease – that can be used in real time in clinics in order to provide patients with clear explanations (transforming specialist evidence into patient information at a click) and that offer interactive pathways for planning a therapeutic strategy. The prototype has been developed by Marcus Harbord and colleagues (Ailsa Hart and Siew Ng). Look out for calls to help.

Toolkits for best practice will harness the expertise within each committee and specialist community of ECCO. Collectively the toolkits will be the benchmark for centres of IBD excellence. ECCO is a facilitator, not a regulator, so the toolkits will be just that: tools for the job, not the job itself. They will address the questions, frequently asked, regarding how best to improve care for patients. These questions can be grouped into five areas: clinical care pathways, integration of science and practice, information technology, ethical and legal framework, and finance. Although for most of us our comfort zone is clinical care, we all grapple with the other areas every working week. These toolkits will be building blocks for best practice, easy to understand and easy to use, rather than standards. Centres will be able to take the toolkit to their own institution and see where they are performing well and where improvement might be needed, using the ideas and framework to re-evaluate their care for patients. It's the sort of thing that we all sense the need to do from time to time (since there can be no institution that feels it cannot improve patient care), but for which we have no model in IBD. We are naturally cautious about generic management solutions, so the ECCO toolkits will be IBD specific and collate the know-how of specialist practice in our institutions for our institutions. That means 'How to' toolkits for establishing an advice line, biobank, electronic care, multidisciplinary meeting, registry or whatever: we have ECCO Members who have the knowledge and experience and we need to mobilise this in the interests of our patients.

This goes to the core of ECCO: improving the care of patients with IBD. It means a different emphasis to what ECCO is doing today, but innovation is what ECCO is about.

Simon Travis © Simon Travis

SIMON TRAVIS
ECCO President

The history of Crohn's Disease: from the earliest days

The year 1932 (MCMXXXII) was a leap year, starting on a Friday in the Gregorian calendar (www.wikipedia.com).

What did the world look like at that time?

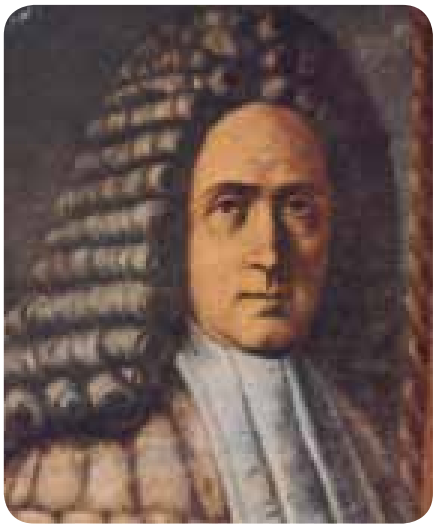
The USA was at the peak of the Great Depression *(source: www.thepeoplehistory.com)*. A quarter of the population was unemployed: *"Thousands of people lived in cars moving from place to place looking for a job. Homeless people were creating shanty towns by building houses with whatever material was available."* In Washington, General Douglas MacArthur led troops using tear gas, but no shooting, to clear the campgrounds of the Bonus Army, which comprised thousands of demonstrators, including 17,000 World War I veterans, who marched to the capital and set camp, demanding early payments of cash bonuses to help them survive. The Revenue Act of 1932 raised USA tax rates, with the rate on top incomes rising from 25% to 63%. Wage cuts of up to 30% were implemented. Working hours were cut for employees in the hope of providing more jobs for the unemployed. Tuberculosis surged due to malnutrition and poor health. American loans to Germany ended. Franklin D. Roosevelt won the presidential election on November 8, 1932.

Meanwhile in Canada, unemployment rose to 29% and a strict immigration policy was imposed. In the UK, "…unemployment reached 30% in areas reliant on heavy industry. People were forced to search old slag heaps hoping to find coal to use for heating." Wages were cut by 10%. Income tax was raised to 25% and 70,000 policemen used force to disperse the largest National Hunger March to London in September of 1932. Some 200,000 unemployed men were sent to work camps. Germany, devastated by the ending of American aid, witnessed unemployment rates above 30% and the rise of the Nazi Party to power. On the other side of the planet, Australia's economy, dependent upon exports, was severely affected by import taxes imposed in countries around the world. Unemployment reached 29% and civil unrest occurred in Sydney.

So, the world was gloomy in 1932, and in a condition not without echoes today, 80 years later.

Yet 1932 was a 'quantum leap' year in the history of IBD (Janowitz, 1985). On May 2, Leon Ginzburg and Gordon Oppenheimer, surgeons at the Mt. Sinai Hospital New York, in conjunction with Burrill Bernard Crohn (1884-1983), presented a paper entitled "Non-specific granulomata of the intestine" to the American Gastroenterological Association meeting. Eleven days later, on May 13, Dr. Crohn delivered on behalf of his associates a monumental lecture entitled "Terminal ileitis: a new clinical entity" to the American Medical Association Meeting in New Orleans (Baron JH, Mt Sinai J Med 2000;67:174). This lecture summarised the results of their collaborative work on 14 patients with non-specific granulomatous inflammation of the distal ileum. During the discussion, Dr. Bargen from the Mayo Clinic suggested that 'regional ileitis' was a more appropriate eponym as 'terminal' implied a lethal outcome which was incorrect, since some patients survived after ileocaecal resection. This proposal was accepted and the final manuscript was published with the title 'Regional ileitis: a pathologic and clinical entity' (JAMA 1932;99:1323-9). This landmark article led to the apparently new clinical entity being named 'Crohn's Disease'.

Burrill B. Crohn (1884-1983) © The Mount Sinai Archives



Giovanni Battista Morgagni (1682-1771)

Was Dr. Crohn or the Crohn-Ginzburg-Oppenheimer (CGO) trio the first to describe the disease?

The answer is an unequivocal 'No'!

Although the cause of Crohn's Disease is generally considered to be related to the major environmental and life-style changes imposed on the western world by the Industrial Revolution, there is evidence that cases of apparent Crohn's Disease date back to around 870 AD. Alfred the Great, 'England's Darling' and King of Wessex, born in Wantage, Oxfordshire in 849 AD, developed at the age of 19 years an unremittingly active intestinal and perianal disease that plagued his life 'by causing pain and abdominal discomfort on eating and diarrhoea'. What was considered at the time to be 'witchcraft' or a 'punishment of God for the King's sins' (tobacco had not yet been imported into Europe!), is today thought by some medical historians to have been Crohn's Disease (G Craig, J R Soc Med1991;84:303).

Additional evidence comes from an autopsy report on a young boy in 1612 which described intestinal ulceration pretty similar in description to the features of Crohn's Disease (Fabry 1682, cited by J.F. Fielding in *J Clin Gastroenterol* 1982;10:279). Furthermore, Giovanni Battista Morgagni (1682-1771) attributed the death of a young man to small intestinal perforation due to granulomatous enterocolitis after a period of disease that was characterised by colicky abdominal pain and protracted, occasionally bloody, diarrhoea.

Joseph B. Kirsner, who sadly passed away early this year at the age of 102, cited another three cases that were published in the early years of the nineteenth century (Inflammatory Bowel Diseases, 3rd ed., 1988). The famous case of Isabella Bankes, which is often cited as the index description of 'Ulcerative Colitis' in 1859 by Dr. S. Wilks, was later re-classified as Crohn's ileocolitis. According to J.B. Kirsner, Dr.

Wilks (later President of the Royal College of Physicians in London) described how:

"…The ileum was inflamed for three feet from the ileocaecal valve, though otherwise the small intestine looked normal. The large intestine was ulcerated from end-to-end with ulcers of varying size, mostly isolated though some had run together… inflammation was most marked at the proximal colon and the caecum appeared to be sloughing, causing the peritonitis…."

According to Kirsner (1988) and J. Alexander-Williams (Inflammatory Bowel Diseases, 3rd ed., 1997), several additional cases were published during the late years of the nineteenth and early in the twentieth century by Moore (1892) and Fenwick from London (1889), Berg from Stockholm (1898), De Groot from the Netherlands and Lesniowsky from Warsaw (1904). Fenwick described Fistulising Disease between adherent loops of the small intestine and the caecum as well as between the sigmoid colon and the rectum, and stenosis of the ileocaecal valve with dilated terminal ileum. In addition, British, French and German physicians reported cases of apparent Crohn's Disease presenting with fever, diarrhoea and a mass lesion at the right iliac fossa masquerading as 'untreated malignancy' (Kirsner 1988). Most recently (2011) a strong case has been made by the British historian Helen Rappaport that Prince Albert, Consort to Queen Victoria, suffered from Crohn's Disease (Magnificent obsession: the death that changed the monarchy. Hutchinson 2011; appendix on 'what killed Prince Albert' with advice from Simon Travis, Chris Conlon and Neil Mortensen).

However, the first well-documented case series was published in 1913 in the British Medical Journal by the Scottish Surgeon, T. Kennedy Dalziel (pronounced Dee-yell). Dalziel was born in Merkland, Penpont, Dumfriesshire in 1861 and graduated from the Edinburgh Medical School in 1883 (ref. Prof. D.G. Young). He studied experimental surgery and pathology in Berlin and Vienna and was subsequently appointed assistant to Mr. H.C. Cameron at the Western Infirmary (1889), visiting surgeon at the Glasgow Royal Hospital for Sick Children (1892) and Professor of Surgery (1895). In his article, Dalziel reported on the treatment of nine patients with chronic enteritis leading to intestinal obstruction. At autopsy all had discontinuous and transmural inflammation in the jejunum and ileum and some also had such inflammation in the right colon. Although very similar to intestinal tuberculosis, Dalziel strongly believed that the new disorder closely resembled Johne's disease of cattle because, *"The histological characters [of Johne's disease] and naked-eye appearances are as similar as may be to those we have found in man." Although the absence of acid-fast bacilli "would suggest a clear distinction", the histological characteristics were sufficiently similar "to justify a proposition that the disease may be the same".*

As an interesting aside, the cause of Johne's disease, Mycobacterium ssp. paratuberculosis, was described in the same year, in 1913.

However, physicians were not so receptive at that time. World War I was ante portas, and publicity was insufficient to draw the attention of the medical profession. Furthermore, contrasting reports by Ignard claimed that in many cases of hyperplastic intestinal tuberculosis neither tubercles nor giant cells nor bacilli could be identified. As a result, Dalziel's report was forgotten and a new eponym, 'hyperplastic tuberculosis', was given to this unusual non-specific granulomatous intestinal disease, in which acid-fast bacilli could not be identified. It was only a decade later that physicians gradually rejected the belief that intestinal tuberculosis could exist in the absence of acid-fast bacilli or granulomata without caseating necrosis. At that time, cases of non-specific granulomatous disease of the intestines were being reported with increasing frequency, predominantly in young adults presenting with symptoms of 'chronic' appendicitis: crampy abdominal pain, fever, diarrhoea and weight loss. Several reports from America and some European countries linked this disorder to Ashkenazi rather than Sephardic Jews "irrespective of native birth, immigrant history, or orthodoxy" (Kirsner 1988). Dalziel's disorder was now re-named as 'non-specific granulomatous enteritis'. This, then, was the background to the new condition of 'Crohn's Disease'.

The second part of this article in the next issue of ECCO News will describe how doctors from Mt. Sinai Hospital, and more particularly Crohn, Ginzburg and Oppenheimer, were involved in the research into this condition and why this disease was named after Crohn.

GERASSIMOS MANTZARIS
Gerassimos Mantzaris© ECCO Photographer
Evangelismos Hospital, Athens, Greece
Department of Gastroenterology

Visit the ECCO Booth at UEGW 2012

Come and find ECCO at the UEGW 2012 on October 22-24, 2012 in Amsterdam, The Netherlands. The ECCO Booth will be located in the UEGF Association Village.

The ECCO Office Team and ECCO Officers will be happy to provide you with information on ECCO's educational and scientific activities and initiatives, ECCO's publications and the annual ECCO Congress. Signing up for or renewing your ECCO Membership is possible at the booth.

ECCO Booth at UEGF Association Village
© European Crohn's and Colitis Organisation

The ECCO Office Team looks forward to meeting YOU!

Goodbye and "kiitos"– Tom Øresland

As time rushes past, we continually see new people stepping into the organisation and successfully contributing to ECCO. At the same time we see others leaving. Their departure provides the opportunity for new talents to flourish, but we miss our friends who have contributed so much.

ECCO wants to thank Tom Øresland, Founder and Editor of ECCO News, for his message of continuing support. He launched ECCO News in 2007 in a highly professional way as a first class society magazine.

Having Tom on board as a key member of the ECCO Family has been great. As a surgeon, he is used to making things happen: he established ECCO News and contributed substantially to ECCO's success. Tom's broad medical knowledge and expertise in writing scientific articles and managing editorial duties was a bonus for ECCO, and we appreciate all his hard work, his support and his motivation.

Tom's departure opens the way for the new generation of ECCO News, with Silvio Danese (Secretary of ECCO) as Editor and Johann Burisch (Member of EpiCom) as Associate Editor. ECCO News is your magazine, your News, your opportunity to profile your IBD organisation: so please send in the news (ecco@ecco-ibd.eu).

We thank Tom for being part of the ECCO team from the beginning and for his innovative spirit in creating ECCO News. We wish him all the best for the future and hope that he will always have a place in his heart for ECCO, as ECCO will for Tom.

Kiitos, Tom, kiitos.

SIMON TRAVIS
President of ECCO

(kiitos = many thanks in Norwegian)

The match must go on…

Some moments in life appear to resemble soccer games. They provide something exciting, something unique; they offer some reasons for cheering and some for sadness; and they can even take the breath away for a second or two. Above all, soccer games involve a coming together of different characters with different motivations and different expectations, but all with the aim of kicking the ball in such a way as to ensure success.

Kicking the ball further is exactly what Tom Øresland, creator and former chief Editor of ECCO News, has done. Now we welcome Silvio Danese and Johan Burisch as the new Editorial Team of ECCO News and as Tom's successors.

For Silvio this will be a completely new challenge in addition to his work as ECCO Secretary, but he was immediately highly enthusiastic about the idea of working as a team player for ECCO News: "When I was asked to become one of the Editors I said yes immediately, because every time I receive the journal in my mail, I am sooo… happy to open it and to go through it right away." Johan's chief motivation in becoming Associate Editor of ECCO News was to extend his involvement in the work of ECCO: "I think this is a good example of how ECCO involves its younger and inexperienced members in its work." Johan's ECCO News career dates back a little longer than Silvio's as he already became associate editor at the beginning of this year. Writing articles for ECCO News is not the only support that we luckily receive from him, as Johan is also an active member of EpiCom and is in charge of the EpiCom study on the incidence of IBD in Europe. In addition, he is working on his PhD thesis on this subject at the University of Copenhagen.

We asked Silvio and Johan about their plans and expectations for ECCO News and in which direction they would like to head. Silvio explained that ECCO is a very sparkling society with an extremely high number of diverse activities. Therefore he wants to report on all kinds of ECCO activities, the workshops, the meetings and the congresses. In addition, the content of ECCO News is never simply related to the main activities and achievements; rather, much is coloured by the personal style and views of the writers and this is what makes ECCO News so unique.

Kicking the ball to the new Editor and Associate Editor of ECCO News © ECCO Office

Johan agrees very much with Silvio's expectations. "I think we need to continue and improve the work already being done in letting all members know what is happening on the nine ECCO Committees and at the Congress and in informing them about additional ECCO activities and the more prominent ECCO figures and writers." In the future, Johan would like to place the focus a little more on the participating countries by providing them with more room in ECCO News. A step in this direction has already been taken with the introduction of the ECCO Country Member profiles; eight Country Members have already participated in this initiative, and hopefully more will take the chance to present themselves and their work in combating IBD.

Beside their work for ECCO, Silvio and Johan share a love of playing soccer. Johan is still an active, fierce defender, playing for fun during his time off. Silvio experienced his peak playing days when he was a bit younger but unfortunately more or less gave up the game when he started to study in the United States. We very much look forward to seeing Silvio and Johan next to each other as team players and, who knows, perhaps not only for the purpose of ECCO News.

ECCO OFFICE

ECCO Fellowship Study Synopsis

An epidemiological study on the natural history of patients with Inflammatory Bowel Disease

Fellowship Awardee: Jessica C. Wilson

Recent studies have shown an increased risk of less commonly occurring extra-intestinal manifestations (EIMs) in patients diagnosed with Inflammatory Bowel Disease (IBD), such as autoimmune diseases, serious infections requiring hospitalisation (e.g. tuberculosis), cardiovascular diseases, pulmonary disorders and cancer. However, it is uncertain whether the risk of developing such diseases is associated with factors relating to IBD or to the therapies used in its treatment.

The current study seeks to examine this relationship, investigating whether factors relating to IBD (i.e. IBD type, IBD severity, duration since onset) or to therapies are associated with an altered risk of development of EIMs. We are conducting an initial cohort study which utilises data from the Clinical Practice Research Datalink (CPRD) and comprises patients with a first-time diagnosis of IBD, randomly matched to patients without an IBD diagnosis. Participants are followed up and incidence rates for the outcomes of interest (i.e. a first diagnosis of cancer, a diagnosis of serious infection requiring hospitalisation, a pulmonary or cardiovascular event or a diagnosis of an autoimmune disease) will be calculated and compared between the two groups. To examine the effect of IBD treatment, a matched case-control study will be conducted nested in the initial cohort, comprising those individuals with a first-time diagnosis of IBD. Cases will include IBD patients with a diagnosis of an outcome of interest (as detailed above); cases will be matched to four control patients. Using conditional logistic regression, risk estimates and 95% confidence intervals will be calculated for the outcomes of interest in relation to the exposures of interest, i.e. IBD type and severity, time since IBD diagnosis, and type and duration of IBD therapy.

This study aims to aid further understanding of the relationship between IBD, treatment regimens and the development of EIMs.

Jessica C. Wilson © ECCO Photographer

JESSICA C. WILSON
ECCO Fellowship Awardee 2012

ECCO Fellowship Study Synopsis

ER stress and autophagy in intestinal epithelial cell homeostasis and IBD

Fellowship Awardee: Timon Adolph

An altered ER stress response has been associated with Inflammatory Bowel Disease (Tréton et al., 2011) and animal models exhibiting ER stress specific to the intestinal epithelial compartment resemble human disease (Kaser et al., 2008). Today, genome-wide association studies have revealed genetic associations of nearly 100 risk loci in patients with Inflammatory Bowel Disease. From these studies, autophagy came to prominence in Crohn's Disease, with implication of disease susceptibility associated with genes within the pathway, including polymorphisms in ATG16L1 (Barrett et al., 2008). How these associations contribute to human disease is unknown. ATG16L1 hypomorphic mice do not develop spontaneous intestinal inflammation despite their altered Paneth cell morphology (Cadwell et al., 2008). To shed light on the interplay between autophagy and ER-stress and its role in IEC homeostasis, we shall generate an Xbp1 ATG16L1 IEC specific double knockout. Besides the histological evaluation (inflammation, Paneth and goblet cell morphology), we shall carefully study the NFκB cascade as a central pro-inflammatory and IEC homeostatic pathway. Further, we shall assess autophagy induction biochemically and evaluate vesicle formation based on electron microscopy. To investigate the interplay between autophagy and ER stress, we shall study the activation of ER stress branches.

What we have learned from earlier studies is that an altered autophagy pathway does not necessarily lead to inflammation on its own. In line with this, associated ATG16L1 polymorphisms confer only a low risk for Crohn's Disease with a high frequency in the population (risk allele frequency, 0.53). Nevertheless, autophagy may be crucial for IEC homeostasis under stressed conditions or in a genetically altered host. Our study aims at providing evidence that either so far unappreciated promoting event(s) or interplay with rare (or common) disease variants (which would not cause disease on their own) have an impact on the development of Crohn's Disease. In this context, we aim to emphasise the epithelial compartment as an originator of intestinal inflammation.

Timon Adolph © Foto Hübel GmbH

TIMON ADOLPH
ECCO Fellowship Awardee 2012

8th Congress of ECCO

Preliminary scientific programme (as of September 1, 2012)

The programme for the 8th Congress of ECCO, to be held on February 14-16, 2012 in Vienna, Austria, will follow the overarching theme of "New Concepts and Current Challenges in IBD". As at other Congresses in recent years, we have aimed to put together a programme that ranges from novel scientific insights to primarily educational elements. We are very hopeful that it will be attractive to our audience of clinicians, basic and clinical scientists, and trainees.

Each session will comprise two or three invited lectures presented by renowned leaders in the field, and a similar number of shorter scientific presentations that have scored top among the abstracts submitted and hence will give you a flavour of scientific excellence in the field.

The first two sessions of the meeting are dedicated to the early stage of IBD and to our options for preventing its progression, and will address in particular whether there is a 'therapeutic window of opportunity'.

Friday, February 15, 2013 will start with sessions on what is on the horizon scientifically and on specific aspects of clinical trials in Ulcerative Colitis. The next two sessions will deal with clinically very important aspects – IBD management in the context of reproduction and in adolescents – and will logically lead on to the opening sessions on the Saturday, focussing on IBD in the elderly and IBD management in the context of past or current malignancy.

We are delighted that, as the final highlight of the meeting, Sander van Deventer will present the ECCO Lecture celebrating the 20th anniversary of the very first report on anti-TNF treatment in IBD.

We hope you will be as excited about this meeting as we are, and we look forward to seeing you in Vienna!

ARTHUR KASER, MIQUEL SANS
On behalf of SciCom

Preliminary programme: Thursday, February 14, 2013		
	10:45-11:15	**Top tips for chairs (Closed session)**
11:00-12:00	**Satellite symposium**	
12:15-12:45	**Join the fight against IBD 2013:** **Panel discussion „Crohn's and Colitis in Europe:** **The burden of disease in young people"**	
12:45-13:00	**Opening & welcome** Simon Travis, Oxford, United Kingdom; Wolfgang Petritsch, Graz, Austria	
13:00-14:30	**Scientific session 1: Early stage IBD** Silvio Danese, Milan, Italy; Oliver Brain, Oxford, United Kingdom	
	13:00-13:20	**Does the pathogenesis change over the course of the disease?** Matthieu Allez, Paris, France
	13:20-13:30	**Oral presentation 1**
	13:30-13:50	**Is there a therapeutic window of opportunity?** Gert van Assche, Toronto, Canada / Leuven, Belgium
	13:50-14:00	**Oral presentation 2**
	14:00-14:10	**Oral presentation 3**
	14:10-14:30	**Acute presentation: New UC or non-IBD Colitis?** Peter Irving, London, United Kingdom
14:30-15:00	**Coffee break**	
15:00-17:00	**Scientific session 2: Preventing progression in IBD** Arthur Kaser, Cambridge, United Kingdom; Alexander Moschen, Innsbruck, Austria	
	15:00-15:20	**Fat and inflammation** Britta Siegmund, Berlin, Germany
	15:20-15:30	**Oral presentation 4**
	15:30-15:50	**Inflammation in IBD: Tissue repair or disrepair?** Florian Rieder, Cleveland, United States
	15:50-16:00	**Oral presentation 5**
	16:00-16:10	**Oral presentation 6**
	16:10-16:20	**Oral presentation 7**
	16:20-16:40	**Preventing cancer** Ian Lawrance, Perth, Australia
	16:40-17:00	**ECCO Guidelines on pathology** Arzu Ensari, Ankara, Turkey Fernando Magro, Porto, Portugal
17:15-18:15	**Satellite symposium**	

Preliminary programme: Friday, February 15, 2013

07:15-08:15	**Satellite symposium**	
08:30-09:30	**Scientific Session 3: What is on the horizon?** Herbert Tilg, Innsbruck, Austria; Siew Ng, Hong Kong, China	
	08:30-08:50	**Genomics in IBD: Who gets what and when?** Stefan Schreiber, Kiel, Germany
	08:50-09:00	**Oral presentation 8**
	09:00-09:10	**Oral presentation 9**
	09:10-09:30	**Therapeutic targets to hit or miss** Jean-Frédéric Colombel, Lille, France
09:30-10:30	**Scientific session 4: Clinical trials in Ulcerative Colitis** Franck Carbonnel, Paris, France; Alexander Eser, Vienna, Austria	
	09:30-09:50	**Pitfalls in design and practice** Brian Feagan, London, Canada
	09:50-10:00	**Oral presentation 10**
	10:00-10:10	**Oral presentation 11**
	10:10-10:30	**Long-term outcomes** Sandro Ardizzone, Milan, Italy
10:30-11:00	**Coffee break**	
11:00-12:20	**Scientific session 5: Reproduction and IBD** Sanja Kolacek, Zagreb, Croatia; Monica Cesarini, Rome, Italy	
	11:00-11:20	**Pharmacokinetics in pregnancy and lactation: Implications for drug efficacy & safety** Zuzana Zelinkova, Bratislava, Slovakia
	11:20-11:30	**Oral presentation 12**
	11:30-11:50	**Care from conception to delivery** Janneke van der Woude, Rotterdam, The Netherlands
	11:50-12:00	**Oral presentation 13**
	12:00-12:20	**Neonatal safety** Saskia de Wildt, Rotterdam, The Netherlands
12:20-13:30	**Lunch and guided poster session in the exhibition hall**	
13:30-14:50	**Scientific session 6: Adolescents with IBD** Frank Ruemmele, Paris, France; Kaija-Leena Kolho, Helsinki, Finland	
	13:30-13:50	**The adolescent phenotype** Gabor Veres, Budapest, Hungary
	13:50-14:00	**Oral presentation 14**
	14:00-14:20	**Organising care** Hankje Escher, Rotterdam, The Netherlands
	14:20-14:30	**Oral presentation 15**
	14:30-14:50	**Therapeutic strategies** Richard Russell, Glasgow, United Kingdom
14:50-15:20	**Coffee break**	
15:20-16:05	**Scientific session 7: ECCO Fellowships and Grants** Andreas Sturm, Berlin, Germany; Marie Joossens, Brussels, Belgium	
	15:20-15:35	**Outcomes from 2011-12 Fellowships** Timon Erik Adolph, Innsbruck, Austria; Jessica Claire Wilson, Belfast, Northern Ireland
	15:35-15:45	**Announcement ECCO Fellowships & Grants 2013** Andreas Sturm, Berlin, Germany
	15:45-15:55	**Oral presentation 16**
	15:55-16:05	**Oral presentation 17**
16:05-17:25	**Scientific session 8: Challenging Cases** Larry Egan, Galway, Ireland; Marilia Cravo, Lisbon, Portugal Walter Reinisch, Vienna, Austria; Al Windsor, London, UK	
	16:05-16:25	**Case 1**
	16:25-16:45	**Case 2**
	16:45-17:05	**Case 3**
	17:05-17:25	**ECCO Guidelines on endoscopy in IBD** Vito Annese, Florence, Italy Rami Eliakim, Jerusalem, Israel
17:40-18:40	**Satellite symposium**	
20:00	**ECCO Interaction: Hearts and Minds**	

Preliminary programme: Saturday, February 16, 2013

07:15-08:15	**Satellite symposium**	
08:30-10:30	**Scientific session 9: Course and treatment of IBD in the elderly** Mircea Diculescu, Bucharest, Romania Konstantinos Papadakis, Crete, Greece	
	08:30-08:50	**The natural history of IBD in the elderly** Corinne Gower-Rousseau, Lille, France
	08:50-09:00	**Oral presentation 18**
	09:00-09:20	**Medical management of IBD in the elderly** David Binion, Washington, United States
	09:20-09:30	**Oral presentation 19**
	09:30-09:40	**Oral presentation 20**
	09:40-10:00	**Minimising damage: Single incision surgery and enhanced recovery** Tonia Young-Fadok, Phoenix, United States
	10:00-10:10	**First N-ECCO Consensus on caring for patients with IBD** Marian O'Connor, London, United Kingdom
	10:10-10:30	**Opportunistic Infection Guidelines: The update** Jean-François Rahier, Yvoir, Belgium
10:30-11:00	**Coffee break**	
11:00-12:20	**Scientific session 10: Treating IBD in patients with past or current malignancy** Dino Tarabar, Belgrade, Serbia Ricardo Veloso, Gaia, Portugal	
	11:00-11:20	**The risk of extra-intestinal cancer in IBD** Tine Jess, Copenhagen, Denmark
	11:20-11:30	**Oral presentation 21**
	11:30-11:50	**Lessons from rheumatology** Georg Schett, Erlangen, Germany
	11:50-12:00	**Oral presentation 22**
	12:00-12:20	**Practical management of IBD with past or current malignancy** David Laharie, Bordeaux, France Jean-Fréderic Blanc, Bordeaux, France
12:20-12:50	**Scientific session 11: ECCO Lecture** Simon Travis, Oxford, United Kingdom Séverine Vermeire, Leuven, Belgium	
	12:20-12:50	**Where it all started and where it's going to: Biological therapy for IBD** Sander van Deventer, Leiden, The Netherlands
12:50-13:00	**Award and closing remarks** Organising Commitee Members Simon Travis, Oxford, United Kingdom	

European
Crohn's and Colitis
Organisation

ECCO Educational Workshops 2012

Spreading standards in IBD – Your presence counts!

For registration please visit **www.ecco-ibd.eu**

25th ECCO Educational Workshop – Athens, Greece

Athens was the host city for the very successful 4th ECCO Educational Workshop in 2008, when we were all very happy and honoured to have as ECCO Speakers Professor Janneke van der Woude and the beloved late Marc Lemann. Since then, numerous workshops have been organised in many member states of ECCO, always with great success thanks to the tremendous efforts and professionalism of the local National Representatives on the one hand and the Educational Committee (EduCom) of ECCO and the ECCO Office project managers on the other. This success prompted the Hellenic IBD club to re-apply in 2010 for a second Educational workshop. However, as the rule in the EduCom has always been that member states that have never hosted an Educational Workshop should be given priority, the application of the Hellenic IBD club was postponed until 2012.

At last, this Country Workshop was held on 7th July. We must now confess that we in the local faculty were very anxious regarding the level of participation in this workshop. One reason was that, according to the new Workshop regulations, only ECCO Members were eligible to participate. Participants from other Greek cities would have to cover their expenses for travel and accommodation, which increased further the financial burden against the backdrop of austerity measures imposed on our country. In addition, we had just held a very successful National IBD Meeting two weeks earlier and were already in the heart of the summer holiday period. The neighbouring beaches and the great weather were too seductive for it to be easy to resist the temptation of spending a Saturday on a beach rather than in a meeting room! Finally, a concurrently held, competing GI endoscopy event was taking place in the city centre. Despite these problems, on this early summer day, 57 Members of ECCO, including 56 colleagues from Greece (52 physicians including some nine Y-ECCO members, two paediatricians and two surgeons) and one colleague from Turkey, gathered in the Divani Apollon Palace Hotel in the beautiful seaside resort of Kavouri on the Athenian Riviera to the south east of the city in order to discuss with the local faculty and the ECCO representatives six selected workshop cases and to attend one state of the art lecture. It should be noted that while ten of the 55 colleagues who had been pre-registered for this Workshop (48 from Greece and seven from neighbouring and distant countries) did not show up, there were 12 on-site registrations!

Faculty at the 25th ECCO Educational Workshop, Athens, Greece, 2012 © ECCO Office

The local faculty consisted of the two Greek National Representatives, Professors Epaminondas Tsianos (as chairman) and John Karagiannis (as chairman and speaker), Professor John Koutroubakis (speaker) and Dr Gerassimos Mantzaris, EduCom Chair (speaker). ECCO representatives were Professors James Lindsay (gastroenterologist) and Dr Alastair Windsor (surgeon), both from London, UK. A very productive faculty meeting was held on site during the evening before the event and this helped enormously not only in deciding upon the duration and style of presentation but also in identifying missing points, potential slides for update and possible changes in the cases. These comments were recorded by the workshop project managers, Stefanie Hartmann and Sarah Essl, whose professionalism helped tremendously in ensuring the smooth running and success of the workshop. Actually, we were very happy to welcome Sarah on her virgin trip abroad the ECCO vessel and wish her every future success and similar joy to that which we have experienced in ECCO!

The morning session opened with a warm welcome from the local National Representatives and Dr Mantzaris on behalf of the EduCom. Professor Lindsay then led the discussion on the case concerning the management of treatment-refractory Ulcerative Colitis; this was followed by presentation of a case of Acute Severe Ulcerative Colitis by Dr Mantzaris, which concluded the first morning session. After the coffee break, Dr Windsor presented a case of recurrent complicated ileocaecal Crohn's Disease and this was followed by Professor Karagianni's case relating to imaging and new diagnostic steps in Crohn's Disease. In the afternoon, Dr Windsor presented the fistulising Crohn's Disease case, followed by presentation of the case concerning the management of infectious complications in IBD by Professor Koutroubakis. Professor Lindsay closed the afternoon session by delivering his state of the art lecture on 'Pregnancy and IBD', and Professor Tsianos then concluded by presenting the highlights of the 25th ECCO Workshop and addressing his farewell to the participants.

We in the faculty were excited by the level of interaction between the participants, especially the younger ECCO Members, and the speakers, especially the ECCO representatives. The charismatic presentation of the cases, the roving microphones and the gentle encouragement of the participants to express their views on the presentations, whether comments, objections or agreement (and always bearing in mind that the Consensus documents on which the ECCO Workshop cases were based are 'guidelines not rules'), assisted greatly in creating a fruitful environment for discussion. We believe that, as a consequence, the Workshop will have added to the knowledge of the participants, impacted on their daily clinical practice and achieved the ECCO Workshop mission of 'harmonising the practice of IBD among members of different ECCO Member States' with the aim of 'improving our patients' care'. The participants' level of satisfaction was reflected in their evaluation forms, where almost all aspects of the workshop, including the speakers, were highly rated. In fact, 48 participants stayed until the end of the workshop and handed back the evaluation forms.

We are grateful to invited speakers, Professor Lindsay and Dr Windsor, for their great presentations and the invaluable discussion and comments, which helped this Workshop to

accomplish its primary goal of disseminating the evidence-based ECCO Guidelines to our country. We also express our gratitude to the local tourist organisers in Triaena Tours and Congresses, the Workshop sponsors Abbott, MSD and Genesis, and the Members of ECCO who resisted the temptation of the great weather and decided to spend their Saturday with us by the beach and not on the beach! Last but not least, we are very grateful to Stefanie and Sarah for their professionalism in making this Workshop a successful event and to Nicole, Barbara and the rest of the ECCO Team in Vienna for conducting this event in their usual exceptional way.

GERASSIMOS J. MANTZARIS
Chairman of the Education Committee on behalf of the National Representatives of Greece and the local faculty

24th ECCO Educational Workshop – Tokyo, Japan

It's easier to get a double balloon enteroscopy in several hospitals in Japan than it is to obtain magnetic resonance enterography (MRE) – or so we heard at the 2012 ECCO Workshop in Tokyo. ECCO was there at the invitation of the Japanese Society of Inflammatory Bowel Disease (JSIBD), and the event was held in the superbly appointed Station Convention Centre, adjacent to the neoclassical Tokyo Station, modelled on Amsterdam's.

Faculty at the 24th ECCO Educational Workshop, Tokyo, Japan, 2012 © ECCO Office

There was a great turnout of 124 young – and less young – IBD specialists, who had come from throughout Japan and also from Taiwan. The President of JSIBD, Professor Toshifumi Hibi, hosted the meeting, aided by his colleague at Keio University, Dr Takanori Kanai. ECCO Workshops have developed a standard pattern: four case-based presentations out of the 14 written by EduCom, all illustrated by evidence-based practice from the ECCO Guidelines. The great value of the workshops lies not just in the dissemination of guidelines at a regional level, but also in the opportunity they afford to hear how regional practice varies according to health care system, disease prevalence and, yes, idiosyncrasy.

Learning is bilateral.

Professor Gert van Assche (in transit between Leuven and Toronto) opened with a case illustrating the imaging of Crohn's Disease. Small bowel barium radiology or CT enterography is commonplace in Japan, as it is in many areas of Europe (including the UK!), with limited access to MRE, even for young patients. Professor Takayuki Matsumoto from Hyogo University towards the south west of Japan then presented a case on complicated ileal Crohn's Disease. The timing of decision-making, especially with regard to radiological drainage of an abscess before surgery and staging through defunctioning ileostomy before re-anastomosis in a patient with an abscess on steroids, generated avid discussion that was greatly enhanced by the surgeons in the audience, particularly Professor Akahira Sugita from Yokohama and Professor Watanabe from the University of Tokyo.

Dr Kanai presented the case on treatment-refractory Ulcerative Colitis in outpatients. Of the treatments available before immunomodulators, apheresis was a choice for many – although not mentioned as a therapeutic option in the slides. Immunomodulators such as azathioprine cause appreciable anxiety among patients, not least because of potential myelotoxicity (linked in the minds of patients to radiation) and the stark declaration in drug information that they are not to be used in pregnancy, again quite contrary to the recommendations in ECCO Guidelines. Japanese IBD specialists may not share this anxiety, but practicalities make changing practice a challenge: when an individual specialist has more than 30 patients to see in a morning, there is time only for decisions, not for discussion. Their work might be aided by development of IBD nurse specialists and Sr Lydia White (Oxford) spoke from the audience about their role, particularly with regard to advice line and management of biological therapy. As many as 40% of patients with Crohn's Disease are treated with infliximab or adalimumab, although for some reason dose escalation is currently only allowed for infliximab. Simon Travis discussed the management of pregnancy in IBD, presenting the evidence supporting management decisions from the ECCO Guidelines on reproduction and IBD, written by Janneke van der Woude (Rotterdam) and colleagues.

Surveillance colonoscopy in Colitis was another area for education: not everyone was convinced of its value, although it is widely practiced, and only a minority as yet perform chromoendoscopy in every patient. Not even the Japanese report pit patterns routinely! Yet for surveillance to work, it has to be performed meticulously and with logistical arrangements for recall. Dr Hiroaki Ito went on to discuss Acute Severe Colitis, with discussion from Dr Ogata about his experience with tacrolimus.

The Workshop was an outstanding success, thanks in large part to the excellent coordination and logistical arrangements from Nicole Eichinger in the ECCO Office (who also mastered the Tokyo underground!) and Hitomi Mishige in Tokyo. ECCO is honoured and delighted that JSIBD is sponsoring five young JSIBD members to attend the ECCO Congress in Vienna, where they will be hosted by Y-ECCO.

SIMON TRAVIS
ECCO President

European
Crohn's and Colitis
Organisation

ECCO Educational Workshops – where we have been so far...

1st ECCO Workshop
Zagreb, **Croatia** - November 10, 2007

2nd ECCO Workshop
Vienna, **Austria** - December 15, 2007

3rd ECCO Workshop
Kaunas, **Lithuania** - May 10, 2008

4th ECCO Workshop
Athens, **Greece** - September 13, 2008

5th ECCO Workshop
Warsaw, **Poland** - September 26, 2008

6th ECCO Workshop
Istanbul, **Turkey** - November 8, 2008

7th ECCO Workshop
Oporto, **Portugal** - November 15, 2008

8th ECCO Workshop
Haifa, **Israel** - May 5, 2009

9th ECCO Workshop
Cluj Napoca, **Romania** - June 17, 2009

10th ECCO Workshop
Oslo, **Norway** - September 4, 2009

11th ECCO Workshop
Moscow, **Russia** - September 17, 2009

12th ECCO Workshop
Belgrade, **Serbia** - October 14, 2009

13th ECCO Workshop
Sao Paulo, **Brazil** - June 19, 2010

14th ECCO Workshop
Donetsk, **Ukraine** - September 17, 2010

15th ECCO Workshop
Budapest, **Hungary** - September 18, 2010

16th ECCO Workshop
Riga, **Latvia** - October 9, 2010

17th ECCO Workshop
Galway, **Ireland** - October 15, 2010

18th ECCO Workshop
Sofia, **Bulgaria** - November 11, 2010

19th ECCO Workshop
Dubai, **UAE** - April 29, 2011

20th ECCO Workshop
Helsinki, **Finland** - August 26, 2011

21st ECCO Workshop
Opatija, **Croatia** - September 17, 2011

22nd ECCO Workshop
Cordoba, **Spain** - November 12, 2011

23rd ECCO Workshop
Naples, **Italy** - December 1, 2011

24th ECCO Workshop
Tokyo, **Japan** - June 17, 2012

25th ECCO Workshop
Athens, **Greece** - July 7, 2012

26th ECCO Workshop
Durban, **South Africa** - August 10, 2012

27th ECCO Workshop
Sibiu, **Romania** - September 20, 2012

28th ECCO Workshop
Bratislava, **Slovakia** - November 16, 2012

Your destination could be next!
Find details on how to apply at **www.ecco-ibd.eu**

Stop by the ECCO Booth

UEG Week, October 22-24, 2012:
UEG Association Village, RAI Exhibition & Convention Centre, Amsterdam

ECCO Congress, February 14-16, 2013:
Austria Center Vienna

Would you like to...

... participate in "Face-to-face with ECCO" sessions at the ECCO'13 Vienna Congress?
... learn about/renew your ECCO Membership?
... find out more about the ECCO'13 Vienna Congress?
... learn about the ECCO Educational Workshops?
... inform yourself about the ECCO Committees & their activities?
... hear more about ECCO's educational and networking activities for graduates, fellows and nurses?

"Face-to-face with ECCO" sessions at the ECCO Booth are scheduled throughout the ECCO'13 Vienna Congress in the coffee breaks. Please drop by at our booth to meet the ECCO Officers to have a nice chat in an informal atmosphere or engage in lively discussions about IBD.

The ECCO Office team looks forward to meeting you!

11th IBD Intensive Advanced Course

The 11th IBD Intensive Advanced Course is a 1.5-day programme for junior gastroenterologists scheduled prior to the official start of the ECCO Congress. The core curriculum of the course will consist of lectures, case-based discussions and seminars encouraging the audience to participate actively and to interact. The course is organised in conjunction with Y-ECCO, who hold their dedicated seminar during the programme. Y-ECCO Members will also be invited as course faculty to participate in the clinical case discussions.

In recognition of the wide popularity of the course over the last few years, the ECCO Education Committee aims to maintain its high standard whilst continuing to develop the content for the future. In this context, the 11th ECCO Intensive Advanced Course will benefit from the following modifications:

- The call for nomination of participants has been brought forward (with the deadline of September 7, 2012) so that their selection is completed before the early registration deadline for the ECCO Congress 2013 (November 7, 2012) – allowing course participants to register in time to qualify for the reduced registration fees.
- With this course, ECCO is investing in the education of IBD experts of tomorrow and at the same time aiming to engage them in the ECCO Family. As a reflection of this desire to engage participants in the community beyond the course itself, ECCO Membership has been introduced as an eligibility criterion for course participation.
- In order to enhance the didactic quality of the printed course syllabus, the 2013 edition will include learning objectives, key slides, key references and space for note-taking.
- Interaction is key to many ECCO initiatives, and is also a top priority in the development of the course programme: the upcoming course will encourage active participation by the use of electronic voting pads and considerable time will be dedicated to case-based discussions.

Preliminary programme (as of September 1, 2012): Wednesday, February 13, 2013

07:30–08:00		**Arrival and distribution of voting pads**
08:00–08:15		**Welcome** Simon Travis, Oxford, United Kingdom Janneke van der Woude, Rotterdam, The Netherlands
08:15–08:45		**Pre-course test** Charlie Lees, Edinburgh, United Kingdom James Lindsay, London, United Kingdom
08:45–10:45		**Session I: Lecture session** Lead discussant: Peter Lakatos, Budapest, Hungary
	08:45–09:15	**IBD: Epidemiology and environmental factors** Pia Munkholm, Copenhagen, Denmark
	09:15–09:45	**The genetics of IBD** Charlie Lees, Edinburgh, United Kingdom
	09:45–10:45	**Tandem Talk: IBD therapeutic targets and drugs: New and old** Yehuda Chowers, Haifa, Israel Gert van Assche, Toronto, Canada / Leuven, Belgium
10:45–11:15		**Coffee break**
11:15-12:40		**Session II. Seminar session**
	11:15-11:55	**Seminar I: IBD and pregnancy** Janneke Van der Woude, Rotterdam, The Netherlands **Seminar II: Paediatric IBD** Frank Ruemmele, Paris, France
	12:00-12:40	**Seminar I: IBD and pregnancy** Janneke Van der Woude, Rotterdam, The Netherlands **Seminar II: Paediatric IBD** Frank Ruemmele, Paris, France
12:40–13:15		**Lunch break**
13:15–15:30		**Session III. Interactive case discussion and lecture session** Lead discussant: Stephan Vavricka, Zurich, Switzerland
	13:15–14:00	**Case-based discussion:** **The patient with watery diarrhoea, abdominal pain and weight loss** Case presentation: Franco Scaldaferri, Rome, Italy Discussion: Vito Annese, Florence, Italy
	14:00-14:30	**Cancer surveillance and chemoprevention in colitis** Matt Rutter, Cleveland, United Kingdom
	14:30–15:30	**Tandem Talk: Acute severe ulcerative colitis: management including medical and surgical rescue therapy** Willem Bemelman, Amsterdam, The Netherlands James Lindsay, London, United Kingdom
15:30–16:00		**Coffee break**
16:00–18:00		**Session IV. 6th Y-ECCO Workshop** (separate programme)

Preliminary programme (as of September 1, 2012): Thursday, February 14, 2013

08:00-10:20		**Session V. Interactive case discussion and lecture session** Lead discussant: Charlie Lees, Edinburgh, United Kingdom
	08:00-09:00	**Tandem talk: Fistulising & stenosing disease: Medical and surgical approaches** Pierre Michetti, Lausanne, Switzerland Tom Øresland, Lorenskog, Norway
	09:00-10:00	**Case-based discussion:** **The patient with severe Crohn's Disease** Case presentation: James Lee, Cambridge, UK Discussion: Rami Eliakim, Jerusalem, Israel
10:00–10:20		**Discussion**
10:20-10:45		**Coffee break**
10:45-12:15		**Session VI. Drug therapy** Lead discussant: Gert van Assche, Toronto, Canada
	10:45–11:15	**Endoscopy for Inflammatory Bowel Disease** Stephan Vavricka, Zurich, Switzerland
	11:15-11:45	**Monitoring drug therapy with biomarkers, drug levels and antibody testing** Peter Irving, London, United Kingdom
	11:45-12:15	**Vaccinations, immunisations and opportunistic infections in IBD – A case-based guide** Jean-Francois Rahier, Yvoir, Belgium
12:15-12:30		**Feedback and closing remarks** Charlie Lees, Edinburgh, United Kingdom James Lindsay, London, United Kingdom

Preliminary Announcement of the ECCO IBD Intensive Advanced Course 2014

(as of September 1, 2012)

All potential candidates interested in participating in the 2014 course are highly encouraged to note the following timeline:
Spring 2013: Call for nominations will be sent to National Representatives and published on the ECCO website
June 2013: Deadline for nominations (NEW!)
September 2013: Selection of waiting list candidates for left-over spaces

Minimum criteria for nominees:

- ECCO Member status 2014.
- Trainees at least in their third year, preferably with one year of GI experience.
- Demonstration of a sufficient standard of English to follow the course.

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

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

Imaging in IBD: ECCO–ESGAR consensus

Acknowledgment of the limitations of IBD assessment based on symptoms and biomarkers, along with acceptance of the need to objectively monitor therapeutic interventions, has fostered a growing interest in incorporating cross-sectional imaging techniques into the diagnostic armamentarium for IBD. Whereas endoscopy is a well-established and uniformly performed diagnostic examination, the implementation of radiological techniques for assessment of IBD still varies widely, with differences among European countries in respect of technical aspects, degrees of experience and preferences. This situation has led to a recognition among members of ECCO and ESGAR that practical guidance is needed regarding the use or cross-sectional imaging in IBD and that convergence of knowledge in the fields of IBD and radiology is necessary in order to provide the best evidence-based recommendations.

A joint ECCO–ESGAR project was therefore started in 2010, and further developed during 2011 and 2012, to generate a consensus on imaging in IBD. The organising committee comprised members of both societies, providing a broad national diversity, and included Yoram Bouhnik (ECCO, Paris, France), Andrea Laghi (ESGAR, Rome, Italy), Julián Panés (ECCO, Barcelona, Spain), Walter Reinisch (ECCO, Vienna, Austria), Jaap Stoker (ESGAR, Amsterdam, the Netherlands) and Stuart Taylor (ESGAR, London, UK). Marc Lemann was instrumental in starting this project prior to his unfortunate death in August 2010.

The aim of the project has been to establish standards for imaging in IBD, covering magnetic resonance imaging (MRI), computed tomography (CT), ultrasound (US), and other radiological procedures such as conventional radiology and nuclear medicine examinations, but not endoscopy, although considerations on the relative value of endoscopy and radiology in different clinical settings are provided in the consensus.

Julián Panés, on behalf of ECCO, receiving a certificate from ESGAR in recognition of the collaboration
© ESGAR - European Society of Gastrointestinal and Abdominal Radiology

A call was issued to ECCO Members to participate in the consensus in January 2011, and experts were chosen in such a way as to ensure broad national representation. At the same time, ESGAR selected the participating radiologists. Seven working groups (WG) were established as follows:

- WG1: Overview. General principles. Technical aspects. Scores. Radiation safety.
- WG 2: Upper GI tract (including oesophagus, stomach, duodenum) and small bowel.
- WG 3: Colon and rectum, CD and UC including Severe Acute Colitis.
- WG 4: Perineum including anus, genital tract.
- WG 5: Liver and biliary tract.
- WG 6: Emergency situations (acutely ill patients to be treated/investigated within 24 h).
- WG 7: Special situations: postop, cancer surveillance, IA Pouch and stomas

Uniform questions were addressed by each working group, taking into consideration the procedures available; patient acceptance, tolerability and complications; costs in Europe; definitions of elementary abnormalities; value for diagnosis; value for detection of inflammation (activity) and bowel damage; value for detection of complications; value for therapeutic monitoring and prognostication; information needed for the gastroenterologist; and positioning of imaging techniques in a diagnostic algorithm.

Following the established standard operating procedures for the creation of a consensus from ECCO, each group performed an extensive literature search and summary, and generated a first draft for the statements. This draft was initially discussed on-line, and final discussion and approval of the statements took place at the consensus meeting in Vienna on January 25, 2012. Integration of the different areas of knowledge during this meeting resulted in constructive and fruitful discussions, leading to robustly based and practical recommendations for radiologists and clinicians involved in IBD care. All participants highly valued this exchange of expertise and the openness of the discussions.

The first public presentation of the consensus was on February 17 at the ECCO meeting in Barcelona, and this was followed by a presentation at the ESGAR meeting in Edinburgh on June 13. At the latter, ECCO was awarded a certificate for the ECCO–ESGAR joint session during the meeting. The publication is being finalised and is expected to be submitted by the fourth quarter of 2012.

JULIÁN PANÉS
Consensus Organising Committee Member

P-ECCO–ESPGHAN consensus statement on the management of Paediatric Ulcerative Colitis

P-ECCO, together with the IBD working group of the European Society of Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN), initiated the first international expert panel to produce evidence-based recommendations for the management of Paediatric Ulcerative Colitis (UC).

Paediatric UC shares many features with adult-onset disease but therapeutic approaches have to be adapted to the many particular age-related needs. A total of 27 paediatric IBD experts, gastroenterologists and surgeons developed the guidelines, based on tedious systematic literature review and an iterative consensus process (available online in the Journal of Paediatric Gastroenterology and Nutrition 2012). The guidelines include 40 formal recommendations enriched by 68 practice points and tables. Paediatric onset disease more often presents as extensive disease with a more aggressive course. Therefore, isolated topical therapy may be less efficacious than in adult patients, and higher 5-ASA doses may be needed. Despite the fact that paediatric-onset UC more often requires immunosuppressive therapy, 5-ASA remains the first-line agent for those with mild to moderate disease. Thiopurines are indicated after an acute severe attack, in frequently relapsing disease courses (more than 2-3 flare ups/year) or in steroid-dependent patients. Anti-TNF agents might be considered for treatment of children with persistently active or steroid-dependent UC that is not controlled by the appropriate use of 5-ASA and/or thiopurines. Unlike in adults, routine endoscopic assessment during flares cannot be recommended in children but is of vast importance in questionable cases. A practical, disease activity-based management flow chart provides concrete instructions for clinically relevant situations, based on the validated Paediatric UC Activity Index (PUCAI). The group is now in the midst of developing similar guidelines for Crohn's Disease.

FRANK RUEMMELE, DAN TURNER
On behalf of P-ECCO and ESPGHAN

Ileocaecal resection and strictureplasties for Crohn's Disease

Highlights of the 1st S-ECCO IBD Masterclass in IBD Surgery

Surgery for Crohn's Disease has been considered a challenge since the first successful treatment proposed by Albert Berg in the early 1930s. Berg, the surgeon who operated on all the patients reported by Burrell Crohn in his original article, proposed a staged procedure using exclusion bypass of the ileocaecal region (transecting the small bowel proximal to the ileal disease, oversewing the distal ileum and anastomosing the proximal ileal end to the transverse colon). The so-called Berg or Mount Sinai procedure was extensively used until the 1950s, as the mortality (at that time) of this technique was nearly zero compared to 30% after primary resection. An intriguing aspect of staged surgery was that when the experience of the Sinai surgeons increased, they noted that at the second stage the diseased segment of ileum seemed to have "healed" in many instances. Today, with improved perioperative care, most patients face a limited resection and primary anastomosis as the procedure of choice for ileocaecal and colonic Crohn's Disease. Implementation of laparoscopic techniques has reduced operative morbidity and resulted in a significant cosmetic benefit for the patient.

Long isoperistaltic strictureplasty © André D'Hoore

But what has been the destiny of those patients with duodenal or extensive jejuno-ileal disease in whom surgery is required? Multiple bypass surgery on request, with unpredictable functional results, and/or extensive resections, leading to short-bowel syndrome, has been the fate of a considerable number of patients.

On the basis of Indian surgeons' experience in bowel length preservation in patients with multiple tuberculous intestinal strictures, Emanoel Lee, a South African surgeon working in Oxford, performed in 1979 the first strictureplasty, in a 21-year-old female Crohn's patient with multiple jejuno-ileal strictures.

Today, the operation remains largely the same as originally described. However, a number of variations have been proposed for long segment strictures or particular locations (duodenum and ileocaecal region), with application of side-to-side (Finney), isoperistaltic side-to-side (Michelassi) and combination strictureplasty techniques. These techniques should be present in the armamentarium of the experienced IBD surgeon.

Almost all reports on strictureplasties attest to the efficacy and safety of the procedure. Although no randomised data are available, long-term follow-up studies after strictureplasty show an equal need for re-operation in comparison with resectional surgery. Intriguingly, disease recurrence almost never occurs on a previous strictureplasty site. This concept of sparing small intestine ranks as a major advance in the surgery of Crohn's Disease. However, only a small number of referral centres around the world make extensive use of these conservative techniques. The two main concerns for gastrointestinal surgeons when performing extensive strictureplasty relate to the technical difficulty of performing such complex sutures, with the potential for postoperative major leakage, fistula and abscess, and to the question of whether the diseased segment treated by strictureplasty can regain normal function.

The 1st S-ECCO IBD Masterclass organised by the Surgeons of ECCO (S-ECCO) focussed on these and other hot topics in surgery for Crohn's Disease and gave a detailed and exhaustive picture of how IBD surgery is performed in referral centres.

Bjorn Moum and Julián Panés lectured on the role of surgery in the era of biological therapy and the importance of collaboration between surgeons and physicians in deciding on the timing of surgery, as well as the crucial distinction between inflammation and fibrosis and how to achieve this distinction. Tom Øresland outlined the need for an open approach in the era of laparoscopy, while Hermann Kessler and Yves Panis showed how both primary (simple) and complex cases are technically manageable with a minimally invasive approach. Neil Mortensen and André D'Hoore highlighted the rationale for and the tips and tricks of classical and side-to-side strictureplasy, with the aid of an outstanding chair in Fabrizio Michelassi, inventor of the long isoperistaltic strictureplasty technique. Perioperative outcome, with particular attention to preoperative therapy, and long-term recurrence after ileocaecal resection and strictureplasty were addressed by Johan Soderholm, Willem Bemelman and Gianluca Sampietro. It seems clear that postoperative outcome has improved significantly in recent years and that long-term recurrence-free (and certainly surgery-free) survival can be obtained. Anthony de Buck Van Overstraeten presented the preliminary results of a multicentre comparative study on ileocaecal resections and strictureplasties among the centres of Leuven, Amsterdam and Milan, which showed comparable safety and long-term efficacy for resections and strictureplasties. Anders Tottrup discussed the early versus the late surgical approach, an ongoing debate in the era of biologicals, while Tjibbe Gardenbroek gave an update on the LIRIC trial. The classification of recurrent disease and the need for postoperative adjuvant therapy were addressed by Geert D'Haens and Severine Vermeire, and a very interesting discussion on this topic was stimulated by Fabrizio Michelassi.

Surgery for Crohn's Disease in the twenty-first century should no longer be considered a therapeutic failure but rather a valuable element within a long-term therapeutic strategy. Dedicated multidisciplinary teams including gastroenterologists, surgeons, radiologists, pathologists and stoma therapists should stipulate a tailored treatment plan taking into account the expectations of the patient. Limited and conservative minimally invasive surgical techniques combined with optimised pre- and postoperative medical therapy still have an important role to play.

At the end of the masterclass, André D'Hoore, Willem Bemelman and Tom Øresland made a proposal that S-ECCO should be used as a platform for international collaborative studies and invited all participants to help formulate first surgical guidelines on Ulcerative Colitis in collaboration with the European Society of Coloproctology.

ANDRÉ D'HOORE, GIANLUCA SAMPIETRO
On behalf of S-ECCO

An invitation to the 2nd S-ECCO IBD Masterclass on the treatment of Ulcerative Colitis

The 2nd Masterclass of the Surgeons of ECCO (S-ECCO) will certainly again attract both gastroenterologists and surgeons since all important aspects of UC will be addressed. Rescue medical treatment and timely referral for surgery in the setting of Severe Colitis unresponsive to steroids remains a clinical challenge and poses a potentially life-threatening situation. This topic will be discussed, as will the clinical dilemma of DALM and dysplasia in the subclinically inflamed colon. Minimally invasive ileo-anal Pouch surgery has become the treatment of choice in patients with UC who require surgery. However, important challenges remain: How can we minimise perioperative morbidity and how can we optimise functional outcome? What is the learning curve for this surgery? How should we score Pouch function and investigate and mitigate Pouch dysfunction? Cuffitis and pouchitis, especially refractory pouchitis, reduce the enthusiasm for such surgery. Could there be a new role for total colectomy and ileo-rectal anastomosis in UC? A panel of internationally recognised specialists in the field will guarantee a highly interactive and rewarding masterclass. We also invite you to send us some challenging clinical cases for discussion. A video forum of surgical techniques will precede the masterclass and will set the scene.

I hope to welcome you all.

ANDRÉ D'HOORE
On behalf of S-ECCO

European Crohn's and Colitis Organisation

Volume 6
Issue 9
October 2012

JCC

JOURNAL of CROHN'S & COLITIS

Read what the experts say on microscopic colitis

See article on page 932

www.ecco-ibd.eu

ELSEVIER

ELSEVIER

JOURNAL OF
CROHN'S & COLITIS

International Journal Devoted to Inflammatory Bowel Diseases
Official Journal of the European Crohn's and Colitis Organisation

Volume 6, issue 9 **October 2012**

CONTENTS

eLearning for ECCO Members

Learn@e-CCO: Interactive education accessible to all members of ECCO

e-CCO Library

- ✔ Congress presentation videos
- ✔ Congress abstracts
- ✔ Guidelines
- ✔ Literature reviews
- ✔ e-CCO learning points
- ✔ Selected JCC inventory
- ✔ Podcasts

e-CCO Courses

- ✔ Integrated pre, interim and post tests linked to CME accreditation
- ✔ Interactive case-based discussions
- ✔ Selected cross-references to e-Library

In order to become an ECCO Member and have access to eLearning, 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

European
Crohn's and Colitis
Organisation

ECCO Country Membership

ECCO is honoured to embrace 31 Country Members in 2012 - the driving force and ambassadors of ECCO.

www.ecco-ibd.eu

7th N-ECCO Network Meeting

The 7th N-ECCO Network Meeting will take place on Thursday, February 14, 2013 in Vienna, Austria as part of the 8th Congress of ECCO.

This annual, one-day event is open to all nurses who are members of ECCO and have a particular interest in Inflammatory Bowel Disease (IBD). As always, the content of the programme is based on popular suggestions and requests from delegates at the last N-ECCO Network Meeting, which in this case was held in Barcelona in February 2012. The focus for the coming Network Meeting is on issues that are important to our patients now and on developments which may become important to them in the future. The last session on comparing and sharing nursing practice will look at current developments in nurse-led research in IBD.

The invited speakers include nurse specialists, gastroenterologists and other professionals dedicated to the care of patients with Inflammatory Bowel Disease.

In addition to the programme, the N-ECCO Network Meeting provides an excellent opportunity to meet and interact with international colleagues. Participants are invited to exchange their experience and ideas with other delegates both during the breaks and at the end of each talk.

N-ECCO invites all nurses with a special interest in IBD to join us in Vienna. With the knowledge to be gained we may be in a better position to answer one of the most popular questions posed by our patients, namely, "Nurse, is there any news concerning the treatment of IBD or what I can expect in the future?"

JANETTE GAARENSTROOM
N-ECCO Committee Member

Preliminary programme of the 7th N-ECCO Network Meeting (as of August 2012): Thursday, February 14, 2013

08:00 – 09:00	**Breakfast satellite symposium**	
09:15 – 09:30	**Welcome and introduction** Janneke van der Woude, Rotterdam, The Netherlands Marian O'Connor, London, United Kingdom	
09:30 – 12:30	**Session 1 – Current issues in IBD care** Rina Assulin, Haifa, Israel Lisa Younge, London, United Kingdom	
09:30–09:50	**The risk of cancer in IBD** Shomron Ben-Horin, Tel Hashomer, Israel	
09:50–10:10	**Treating anaemia effectively** Guillaume Savoye, Rouen, France	
10:10–10:30	**Tandem Talk:** **Which surgery & when in IBD** Yves Panis, Clichy, France Bas Oldenburg, Utrecht, The Netherlands	
10:30 – 11:00	**Coffee break**	
11:00–11:30	**Psychological impacts of IBD:** **How can we help?** Janette Gaarenstroom, Utrecht, The Netherlands	
11:30–12:00	**Psychological interventions to aid the patient to cope with IBD** Julian Stern, London, United Kingdom	
12:00–12:30	**Abstract session**	
12:30 – 14:00	**Lunch break** **(self-guided poster round in the exhibition hall)**	
14:00 – 15:20	**Session 2 – IBD management: New horizons** Janette Gaarenstroom, Utrecht, The Netherlands Marian O'Connor, London, United Kingdom	
14:00–14:20	**Genetics in IBD** Charlie Lees, Edinburgh, United Kingdom	
14:20–14:40	**New therapies for IBD management** Andreas Sturm, Berlin, Germany	
14:40–15:00	**Stem cell therapy for IBD** Marjolijn Duijvestein, Amsterdam, The Netherlands	
15:00–15:20	**The IBD nurse tomorrow** Lisa Younge, London, United Kingdom	
15:20 – 15:40	**Coffee break**	
15:40 – 16:45	**Session 3 – Comparing & sharing nursing practice: Developing nurse-led research** Janette Gaarenstroom, Utrecht, The Netherlands Marian O'Connor, London, United Kingdom	
15:40–16:00	**Researching in nursing by nurses: Why & how to start** Christine Norton, London, United Kingdom	
16:00-16:10	**Nursing research in Norway** Lars-PetterJelsness-Jorgensen, Fredrikstad, Norway	
16:10–16:20	**Nursing research in The Netherlands** Maria van Vugt, Nijmegen, The Netherlands	
16:20–16:30	**Nursing research in Sweden** Lena Oxelmark, Gothenburg, Sweden	
16:30–16:45	**Themes and discussion** Janette Gaarenstroom, Utrecht, The Netherlands	
16:45 – 17:00	**N-ECCO in 2013 & Conclusion** Marian O'Connor, London, United Kingdom	
17:15 – 18:15	**Afternoon satellite symposium**	

Young ECCO (Y-ECCO)

Dear Collegues,

I hope you had a great summer.

A friendly and productive Y-ECCO Committee Meeting in Vienna lies behind us. We made progress on many issues raised by you during the past year.

The ECCO Operational Board and Governing Board agreed on changing the eligibility criteria for Y-ECCO from '≤35 years' to '≤35 years of age or in training'. This initiative was brought forward based on your requests. We wish to honour the longer training duration required by Y-ECCO Members owing to maternity/paternity leave or significant research activities. Please let us know if you fall into this category and we shall be glad to welcome you back or to keep you in our group.

We have elections coming up. Two seats will be available on the Y-ECCO Committee as of February 2013. Every Y-ECCO Member can apply and the positions will be filled on a competitive basis. An e-mail call was sent out to you earlier this summer. We would like to encourage you all to send in your applications and to take the opportunity to participate in Y-ECCO activities. The results of this election will be reported in an upcoming issue.

Please note the Y-ECCO Workshop programme in this issue. To ensure that delegates who register do indeed show up, the Governing Board has introduced a registration fee for all workshops. For the Y-ECCO Workshop this will be EUR 35 per participant. Advanced IBD Course participants can take part free of charge. We hope that these changes will meet with your understanding and feel strongly that our workshop is worth this investment. You are also invited to the networking event after the workshop, which proved a great success last year.

Y-ECCO congress awards 2012

750 Euro each for the best five abstracts of Y-ECCO Members submitted to the conference. These awards were announced at the plenary session and handed out during the poster award ceremony. Congratulations!

Pieter Dewint, The Netherlands
Melania Scarpa, Italy
Mirthe Van der Valk, The Netherlands
Michael Scharl, Switzerland
Cloé Charpentier, France

Please visit the new ECCO website with the new Y-ECCO pages. We are currently working on filling this space with useful information for you.

The interest in the Y-ECCO Literature review remains intense and we are again publishing five articles in this issue of ECCO News. Writing such a review allows you not only to state your opinion on a timely and relevant article but also to present yourself and your specialty. If you would like to submit a review, please contact ecco@ecco-ibd.eu.

For the next ECCO Congress in Vienna 2013, we are once again glad to be able to offer an award of EUR 750 for each of the five best abstracts submitted by Y-ECCO Members. You will be provided with more information when you submit your abstract. Please make sure that you are an active Y-ECCO Member at the time of submission.

Y-ECCO would like to build a database of Y-ECCO Members who are interested in acting as a session chair at ECCO Congresses. Please let us know if you would like to consider this option and stipulate your area of expertise. This is a great opportunity to learn an important part of an academic career with the help of an experienced co-chair.

Finally, as suggested by you in the Y-ECCO questionnaire survey, we have proposed a reduced conference fee for Y-ECCO Members. The Governing Board is currently considering this option and will decide on its feasibility later this year.

Enjoy the Y-ECCO section of this issue. As always, thank you for all you do for Y-ECCO.

FLORIAN RIEDER
Y-ECCO Chair
On behalf of the Y-ECCO Committee

Y-ECCO survey of research opportunities and intentions

A riddle for Y-ECCO Members: How can you contribute to an important piece of research and improve your CV by talking to your friends? Read on...

The future of academic medicine (or possible lack thereof!) is highly topical and is a major concern in many medical specialties. Currently, no-one knows how gastroenterology will be specifically affected by the global decline in doctors pursuing an academic career. However, thanks to its extensive links to trainees throughout Europe and beyond, Y-ECCO is ideally placed to try and answer this topical question.

To do this, we have set up a web-based survey for **gastroenterology trainees** (https://www.surveymonkey.com/s/YECCOsurvey) to establish their intention to undertake research, together with their motivation for doing (or not doing) so, and also to assess whether they have the necessary **opportunities** for this to be a realistic possibility. All participants in this short survey will be entered into a draw to win one of three free memberships to ECCO for 2014.

We hope that this will provide a snapshot of the potential future of academic gastroenterology in Europe and beyond, and clarify whether disparities exist between trainees' intentions and opportunities to undertake research.

We are currently looking for Y-ECCO Members who would be prepared to publicise this in their respective countries. If this is something that you might be interested in, please contact me drjameslee@gmail.com for further details. In the event that this work produces publishable data, we would also aim to allocate authorship slots on any manuscript to those individuals who have co-ordinated the most responses from their respective countries.

Even if you don't want to get involved in publicising this, why not fill it in when you next have a spare 5 minutes?

JAMES LEE
Y-ECCO Committee Member

Y-ECCO Membership criteria: 35 years or in training

You might not think that the addition of three small words to the ECCO Statutes would be particularly newsworthy, but the expansion of Y-ECCO Membership from a strict age cut-off of under 35 years to under 35 years OR IN TRAINING is certainly worth highlighting. Y-ECCO was always designed to offer trainees benefits above and beyond standard ECCO Membership, but it has become apparent that, increasingly, trainees are delaying their training to have families, undertake research, pursue subspecialty interests, explore opportunities outside of gastroenterology – or all of the above! Accordingly, it is now not uncommon to still be in training at the age of 35 – I, for one, am very likely to be! To reflect this, ECCO has amended the criteria for Y-ECCO Membership (which is automatically offered to any ECCO Member who meets these criteria). Y-ECCO Members receive all the same benefits as ECCO Members, but in addition are eligible to attend the Y-ECCO Workshop, the IBD Advanced Course and the Y-ECCO networking event, to receive funding (up to EUR 750) for the five best submitted abstracts and to contribute to the literature review in ECCO News. This change therefore ensures that these and other benefits of Y-ECCO Membership will remain for as long as you are in training – which means that we thought, on this occasion, three small words were definitely worth a mention!

JAMES LEE
Y-ECCO Committee Member

6th Y-ECCO Workshop

Dear Y-ECCO Members and friends,
The Y-ECCO Committee is proud to present to you the programme of the 6th Y-ECCO Workshop. As the workshop takes place after the IBD Intensive Advanced Course, we have chosen "light" and interactive topics that will certainly provide you with practical tips and tricks of value in pursuing your career in the IBD field. Several real-life questions will be addressed by experts: What are my career options? Should I go abroad? How can I combine this with my family?

After the workshop, everyone is invited to join us for an informal networking event in a nearby pub – the ideal opportunity to get in contact with IBD Fellows around the world.

See you all on February 13 in Vienna!

PIETER HINDRYCKX
Y-ECCO Committee Member

Preliminary Programme (as of September 1, 2012): "How to pursue a career in IBD"		
16:00-16:10	**Welcome and introduction** Florian Rieder, Cleveland, United States	
16:10-16:50	**Session 1** Franco Scaldaferri, Rome, Italy Pieter Hindryckx, Gent, Belgium	
	16:10-16:30	**Podium discussion: Career options as a gastroenterologist: The spectrum from academic clinical science through to private clinical practice** Gijs Van den Brink, Amsterdam, The Netherlands Florian Obermeier, Regensburg, Germany Asit Parikh, Cambridge, United States
	16:30-16:50	**How to combine an (academic) career in IBD with my family?** Ailsa Hart, London, United Kingdom
16:50-17:30	**Session 2** Marjolijn Duijvestein, Amsterdam, The Netherlands James Lee, Cambridge, United Kingdom	
	16:50-17:10	**Training in IBD: Home sweet home or better abroad?** Arthur Kaser, Cambridge, United Kingdom Catherine Reenaers, Liège, Belgium
	17:10-17:30	**Personal reflections on my curriculum vitae** Jean-Fréderic Colombel, Lille, France
17:30	**Y-ECCO Members' meeting & networking event in a nearby pub**	

The 6th Y-ECCO Workshop is being organised by the Education Committee and Young ECCO Committee (Y-ECCO). Y-ECCO Members as well as ECCO Course participants are invited to participate. The Workshop is scheduled to take place immediately after the 11th IBD Intensive Advanced Course for junior gastroenterologists on Wednesday, February 13, 2013, 16:00-18:00.

Registration – 6th Y-ECCO Workshop
The 6th Y-ECCO Workshop in Vienna is open to all Y-ECCO Members (paid-up membership fee for 2013). In this context, the Y-ECCO Committee is looking forward to welcoming:

- all current Y-ECCO Members
- new members (to learn more on joining the ECCO Family – please refer to page 2 or sign up for membership online at www.ecco-ibd.eu)

Registration fee for this course: EUR 35.-
Registration is possible online at www.ecco-ibd.eu/ecco13 (Deadline: January 31, 2012). The number of participants is limited. Registration will be on a first-come, first-served basis.

For further information, please contact the ECCO Office at ecco-congress@ecco-ibd.eu.

Switch to adalimumab in patients with Crohn's disease controlled by maintenance infliximab: prospective randomised SWITCH trial

Van Assche G, Vermeire S, Ballet V, Gabriels F, Noman M, D'Haens G, Claessens C, Humblet E, Vande Casteele N, Gils A, Rutgeerts P
Gut. 2012;61:229-34

Introduction

Infliximab (IFX) and adalimumab (ADA) are both effective in inducing and maintaining clinical and endoscopic remission in Crohn's Disease (CD) [1]. In the ACCENT 1 trial, patients who underwent IFX administration as maintenance therapy were more likely to sustain clinical remission until week 54 (28% and 38% at doses of 5 mg/kg and 10 mg/kg, respectively) compared with those receiving placebo (14%, p=0.007 and <0.001, respectively) [2]. In the CHARM trial, a greater percentage of patients who received ADA (36% and 41%, respectively, for administration every other week or weekly) were in clinical remission at week 56 compared with those who received placebo (12%, p<0.001) [3]. Similar results emerged from the CLASSIC II trial, in which 79% (ADA administration every other week) and 83% (ADA administration weekly) of patients were in remission at week 56 compared with 44% of patients receiving placebo (p<0.05) [4]. Switch to ADA has been evaluated in patients presenting with loss of response or intolerance to IFX. In this patient population, ADA induced remission in 21% of patients, while remission was observed in 7% in the placebo group (p<0.05); ADA thus represents a valid alternative if loss of response or intolerance to IFX occurs [5]. For practical and economic reasons, a switch from intravenous (IFX) to subcutaneous (ADA) administration has entered clinical practice and is being frequently requested by patients, who usually prefer self-administration at home.

What this paper is about

The SWITCH trial is an interesting open label randomised controlled single-centre trial prospectively evaluating the impact of elective switching of patients with CD well controlled with intravenous IFX to subcutaneous ADA. CD patients with ongoing response to IFX and in stable clinical remission (Crohn's Disease Activity Index, CDAI, <200) for at least 6 months were recruited. Seventy-three patients were randomised to continue IFX 5 mg/kg at the same interval as before randomisation (37 patients) or to switch to ADA 80 mg at inclusion and 40 mg every other week (36 patients) for one year. Dose optimisation or short courses of steroids were allowed in the event of disease flare. If complete loss of response or intolerance occurred, patients were allowed to cross over to the alternative treatment arm.

The study aimed to evaluate patients' preference for ADA over IFX as well as the proportion of patients requiring rescue therapy or discontinuation of therapy after switching.

As expected, throughout the study most patients preferred ADA over IFX, when taking into account different aspects such as efficacy, administration, side-effects and daily activities. Seventeen patients in the ADA group (47%) required dose intensification or early termination because of loss of response or intolerance, compared with only six patients in the IFX group (16%, p=0.003).

ADA dose optimisation and return to IFX were successful strategies in most patients (8/10) who became intolerant or lost response to ADA. Cross-over to ADA was successful in the patients who lost tolerance to IFX. All serious adverse events occurred in patients randomised to ADA and were related to complicated CD.

Conclusions

This study shows that approximately one-third of patients who switched to ADA returned to IFX within one year. In the event of intolerance or loss of response to ADA, return to IFX was a successful management strategy. ADA was less well tolerated than IFX, but this is probably attributable to the fact that only patients with a long-maintained response (and tolerance) to IFX entered the study. In conclusion, switch to another anti-TNF agent should not be advised for practical reasons alone, but only in the presence of loss of tolerance or response to the current anti-TNF agent. Given the small number of approved biological agents for CD, therapy optimisation still remains the best strategy.

References

1. Dignass A, Van Assche G, Lindsay JO, Lemann M, Soderholm J, Colombel JF, et al. The second European evidence-based consensus on the diagnosis and management of Crohn's disease: current management. J Crohns Colitis 2010;4:28-62.
2. Hanauer SB, Feagan BG, Lichtenstein GR, Mayer LF, Schreiber S, Colombel JF, et al. Maintenance infliximab for Crohn's disease: the ACCENT I randomised trial. Lancet 2002;359:1541-9.
3. Colombel JF, Sandborn WJ, Rutgeerts P, Kamm MA, Yu AP, Wu EQ, et al. Comparison of two adalimumab treatment schedule strategies for moderate-to-severe Crohn's disease: results from the CHARM trial. Am J Gastroenterol 2009;104:1170-9.
4. Sandborn WJ, Hanauer SB, Rutgeerts P, Fedorak RN, Lukas M, MacIntosh DG, et al. Adalimumab for maintenance treatment of Crohn's disease: results of the CLASSIC II trial. Gut 2007;56:1232-9.
5. Sandborn WJ, Rutgeerts P, Enns R, Hanauer SB, Colombel JF, Panaccione R, et al. Adalimumab induction therapy for Crohn disease previously treated with infliximab: a randomized trial. Ann Intern Med 2007;146:829-38.

CHIARA DE CASSAN
Department of Surgical and Gastroenterological Sciences, University of Padova, Italy

Chiara De Cassan
© Chiara De Cassan

Chiara De Cassan

Chiara De Cassan was born in 1983. She is a medical doctor and specialist in gastroenterology from the University of Genova. She spent one year at Hôpital Claude Huriez, Lille and she is currently working at the Department of Surgical and Gastroenterological Sciences, University of Padova. She is interested in endoscopy, nutrition and IBD management.

Risk of melanoma and nonmelanoma skin cancer among patients with Inflammatory Bowel Disease

Long M, Martin C, Pipkin C, Herfarth H, Sandler R, Kappelman M
Gastroenterology. 2012;143:390-9

Introduction

Inflammatory Bowel Disease (IBD) is characterised by a dysregulated immune system. Immunomodulating therapies [e.g. thiopurines and anti-tumour necrosis factor α (anti-TNF) agents] are widely used in the treatment of both Crohn's Disease (CD) and Ulcerative Colitis (UC). Patients with immune dysfunction and immunosuppressive therapies are at increased risk of developing neoplasia. Thiopurine use, especially when long term, has been associated with increased risk of non-melanoma skin cancer (NMSC), including in patients with IBD [1, 2]. Anti-TNF therapy is often used in combination with thiopurines to treat IBD, leading to an even more immunocompromised state. Little is known about the potential of anti-TNF drugs to promote malignancy when used alone or in combination with other immunosuppressants. Whether anti-TNF agents are associated with NMSC and melanoma is unclear. Some cases of basal cell carcinoma and melanoma have recently been reported in IBD patients treated with biologics [3, 4]. NMSC incidence was found to be raised in patients with CD on adalimumab therapy [5], especially those on prolonged treatment regimens [2]. However, a long-term safety report for adalimumab has shown overall malignancy rates to be comparable to those in the general population [5].

What this paper is about

A retrospective cohort study design was used to determine the overall risk of melanoma and NMSC in an IBD cohort in comparison to a non-IBD population. Secondly, a nested case-control study assessed the effect of different medications used in IBD treatment on skin neoplasia.

Patients with IBD, and particularly those with CD, had an increased risk of melanoma [incidence rate ratio (IRR) 1.29, 95% CI 1.09-1.53, and 1.45, 95% CI 1.13-1.85, respectively] but the risk was not significantly increased in patients with UC (IRR 1.13, 95% CI 0.89-1.42). However, both disease subtypes were associated with an increased risk of developing NMSC (IRR 1.64, 95% CI 1.54-1.74, and IRR 1.34, 95% CI 1.26-1.42, respectively).

It has to be stated that thiopurines and biologics were used more frequently in CD patients than in UC patients (15% with CD were treated with thiopurines vs 6.3% with UC; 5% of CD patients received anti-TNF drugs vs only 0.7% of those with UC). Furthermore, from 1997 to 2009 a slight increase in the risk of developing melanoma was observed among IBD patients (IRR rose from 1.1 to 1.5), simultaneously with increasing use of biologics.

With a nested case-control study the authors assessed:

1. The association of skin cancer with medication use
2. Whether the risk associated with medication use was related to therapy duration

They revealed that IBD patients with melanoma had a higher use of anti-TNF drugs and that biologics were associated with development of melanoma for both CD and UC [odds ratio (OR) 1.94, 95% CI 1.03-3.68, and OR 1.73, 95% CI 0.53-5.63, respectively]. Use of thiopurines was not linked to melanoma. Regarding NMSC, the use of thiopurines was related to increased risk in both CD and UC subgroups (OR 1.99, 95% CI 1.73-2.27 for CD patients and OR 1.63,

95% CI 1.36-1.94 for UC). This cancer type was not linked to biological therapy. Neither skin neoplasia was associated with 5-ASA treatment.
Concerning duration of therapy, long-term treatment with immunosuppression and/or biologics was associated with increased risk of skin cancer: risk of melanoma was related to prolonged anti-TNF use (OR 3.93, 95% CI 1.82-8.50) while the greatest risk of NMSC was associated with combined thiopurine and biological treatment (OR 3.89, 95% CI 2.33-6.46), followed by thiopurine single use (OR 2.72, 95% CI 2.27-3.26) and use of biologics alone (OR 1.63, 95% CI 1.12-2.36).

Conclusion

This study shows an increased risk of melanoma among CD patients, as well as an increased risk of NMSC in both CD and UC patients. The increased risk of melanoma is related to anti-TNF drug use and the risk of NMSC is associated with thiopurine therapy. The greatest risk factor for NMSC is long-term and combined treatment regimens with immunosuppressants and anti-TNF medications. Some further questions to be clarified are: (1) whether older age in combination with immunomodulating therapy contributes to risk elevation in skin neoplasias; (2) whether there are some common genetic mutations for IBD and skin cancer; (3) whether human papilloma virus infection is a co-factor in the risk of NMSC in immunosuppressed patients; and (4) whether patients with IBD are at increased risk for skin malignancies due to the immunomodulating medications alone or the immune dysfunction of the disease itself or a combination of both.

References

1. Setshedi M, Epstein D, Winter TA, Myer L, Watermeyer G, Hift R. Use of thiopurines in the treatment of inflammatory bowel disease is associated with an increased risk of non-melanoma skin cancer in an at-risk population: a cohort study. J Gastroenterol Hepatol. 2012;27:385-9.
2. Long M, Kappelman M, Pipkin C. Non-melanoma skin cancer in inflammatory bowel disease: a review. Inflamm Bowel Dis. 2011;17:1423–7.
3. Gaines-Cardone E, Hale EK. Infliximab (Remicade) and increased incidence of development of basal cell carcinoma. J Drugs Dermatol. 2012;11:655-6.
4. Ehmann L, Tillack-Schreiber C, Brand S, Wollenberg A. Malignant melanoma during ustekinumab therapy of Crohn's disease. Inflamm Bowel Dis. 2012;18:199–200.
5. Burmester GR, Panaccione R, Gordon KB, McIlraith MJ, Lacerda AP. Adalimumab: long-term safety in 23 458 patients from global clinical trials in rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, psoriatic arthritis, psoriasis and Crohn's disease. Ann Rheum Dis. 2012 Jul 6. [Epub ahead of print]

DOBRIANA PANOVA
Medical University – Sofia,
"St. Ivan Rilski" University Hospital, Clinic of Gastroenterology, Sofia, Bulgaria

Dobriana Panova
© Dobriana Panova

Dobriana Panova

Dobriana Panova was born in 1981 and lives in Sofia. She is now in her final year of training in Gastroenterology at the Medical University in Sofia. She is also at the very final stages of completing her PhD thesis regarding quality of life and personality traits in patients with inflammatory bowel disease.

Optimising outcome on thiopurines in inflammatory bowel disease by co-prescription of allopurinol

Smith MA, Blaker P, Marinaki AM, Anderson SH, Irving PM, Sanderson JD
J Crohns Colitis. 2012 Mar 3 [Epub ahead of print]

Introduction

The conventional thiopurines, azathioprine (AZA) and mercaptopurine (MP), are the cornerstone of immunosuppressive maintenance therapy in inflammatory bowel disease (IBD). Unfortunately, up to half of patients derive no overall benefit from this antimetabolite therapy, in part due to lack of efficacy but mainly because intractable side-effects develop [1]. The majority of these thiopurine-failing patients are subsequently treated using a step-up regimen with methotrexate (in Crohn's disease) or biologicals. The unfavourable outcome of thiopurine administration can in part be explained by the complex metabolism and its generated metabolites [especially the metabolites 6-thioguanine nucleotides (6-TGN) and 6-methylmercaptopurine (6-MMP)]. Thiopurine metabolism can be optimised by co-administration of allopurinol (a xanthine oxidase inhibitor regularly used in the treatment of gout), leading to a striking decrease in 6-MMP levels and mild increase in 6-TGN levels.
Several small-scale studies have previously demonstrated that low-dose thiopurine (approximately 25-33% of its original weight-based dosage) in combination with allopurinol (100 mg/day) can overcome several side-effects (especially those associated with high 6-MMP levels, like transaminitis) that may develop during regular thiopurine monotherapy. Moreover, combination therapy showed good clinical efficacy (2,3). The study by the Sanderson group provides essential data on safety and success in a large real-life cohort of 110 IBD patients using this combination therapy, with an average follow-up of 16 months.

Key findings

The results obtained in this series, the largest published to date, show that the majority of IBD patients who cannot tolerate monotherapy with AZA/MP do not develop side-effects during combination therapy with allopurinol. This remarkable result was observed not only in patients with (6-MMP-related) hepatotoxicity (20/25 patients tolerated combination therapy alongside normalisation of earlier liver test abnormalities), but also in those who had suffered atypical adverse events (such as GI disturbances, rash, flu-like symptoms, myalgia and alopecia) on preceding thiopurine monotherapy (24/28 patients). A total of 27 patients were switched to combination therapy due to partial or non-response on monotherapy. The administration of combination therapy for this novel indication showed promising results, as 65% of patients achieved clinical remission. Thirteen adverse events were reported during combination therapy, these being rash (mild and self-limiting), liver test abnormalities or GI complaints. Pharmacokinetic evaluation of combination therapy showed a decrease in 6-MMP and an increase in 6-TGN levels, confirming the results of earlier studies.

Why is this study important?

Although this retrospective study is not a randomised controlled trial, it clearly demonstrates the clinical value of combination therapy comprising allopurinol and thiopurine in IBD patients who develop adverse events during thiopurine monotherapy and in patients who do not achieve a proper clinical response to AZA or MP. This promising strategy to optimise thiopurine therapy may lead to an increase in IBD patients who can benefit from this first-line immunosuppressive therapy and may avoid or delay the use of alternative therapies, such as biologicals or surgery.

References

1. Jharap B, Seinen ML, de Boer NK, et al. Thiopurine therapy in inflammatory bowel disease patients: Analyses of two 8-year intercept cohorts. Inflamm.Bowel.Dis. 2010.
2. Sparrow MP, Hande SA, Friedman S, et al. Allopurinol safely and effectively optimizes tioguanine metabolites in inflammatory bowel disease patients not responding to azathioprine and mercaptopurine. Aliment.Pharmacol. Ther. 2005; 22: 441-446
3. Ansari A, Patel N, Sanderson J, et al. Low-dose azathioprine or mercaptopurine in combination with allopurinol can bypass many adverse drug reactions in patients with inflammatory bowel disease. Aliment.Pharmacol.Ther. 2010; 31: 640-647

NANNE DE BOER
Department of Gastroenterology and Hepatology
VU University Medical Center
Amsterdam, The Netherlands

Nanne de Boer
© Nanne de Boer

Nanne de Boer

Nanne de Boer is a gastroenterologist dedicated to clinical IBD care at the VU University Medical Center in Amsterdam, the Netherlands. He has a scientific interest in the pharmacology and toxicology of immunosuppressive drugs.

Loss of interleukin-10 signaling and infantile Inflammatory Bowel Disease – implications for diagnosis and therapy

Kotlarz D, Beier R, Murugan D, Diestelhorst J, Jensen O, Boztug K, Pfeifer D, Kreipe H, Pfister ED, Baumann U, Puchalka J, Bohne J, Egritas O, Dalgic B, Kolho KL, Sauerbrey A, Buderus S, Güngör T, Enninger A, Koda YKL, Guariso G, Weiss B, Corbacioglu S, Socha P, Uslu N, Metin A, Wahbeh GT, Husain K, Ramadan D, Al-Herz W, Grimbacher B, Sauer M, Sykora KW, Koletzko S, Klein C.
Gastroenterology. 2012 April 28 [Epub ahead of print]

Introduction

Although identification of a single cytokine responsible for the pathogenesis of a chronic inflammatory condition seems promising in terms of provision of targeted curative treatment, this cannot generally be achieved for Inflammatory Bowel Disease (IBD), with its complex and heterogeneous aetiology. However, for a particular subgroup of IBD patients – children with very early onset IBD – such a cytokine seems to be interleukin-10 (IL-10), known for its anti-inflammatory properties. First evidence for a role of IL-10 in IBD emerged nearly 20 years ago, when IL-10-/- mice were shown to develop severe enterocolitis [1], an effect that could be reversed by IL-10 gene therapy [2]. In 2009, three mutations in genes encoding for the IL-10 receptor (IL10R1 and IL10R2) were identified in children with early-onset IBD [3]. As a consequence, peripheral blood mononuclear cells (PBMCs) of affected children produced higher amounts of pro-inflammatory cytokines. As a proof of principle, one patient was successfully treated with allogeneic stem cell transplantation, and sustained remission was achieved.

Key findings of this article

Following up on these findings, the present study by Kotlarz et al. investigated the impact of mutations within the IL-10 pathway among children with IBD on the clinical disease course. Among 66 patients who had disease onset <5 years of age and a severe clinical course, 16 patients with loss-of-function mutations in IL-10-related genes were identified. In the majority of cases the IL-10 receptor was affected (five patients had mutations in the IL10RA gene and eight, mutations in the IL10RB gene), while three patients had mutations in the IL-10 gene itself. All of these patients presented with peri-anal disease and onset of symptoms within the first 3 months of life. Endoscopic and histopathological examination revealed close resemblance of these findings to Crohn's Disease. Despite multimodal therapy including immunosuppressive therapy, exclusive enteral nutrition and surgical procedures, in none of the patients could a sustained clinical response be achieved. In functional assays, defective response via the STAT-3 pathway was shown for mutations within the IL10R gene, resulting in diminished anti-inflammatory properties of IL-10 and thus production of high amounts of lipopolysaccharide-stimulated TNF-α by PBMCs. Haematopoietic stem cell transplantation (HSCT) was performed in five patients, four of whom achieved a sustained complete remission in terms of clinical and endoscopic response, with a median follow-up of 2 years. Functional assays confirmed reconstitution of the IL-10/STAT3 pathway.

Discussion

This study provides evidence for the importance of genotyping young children presenting with a severe refractory course of Colitis with peri-anal disease, in order to offer a curative approach in treating a defined immunodeficiency rather than IBD. Hereby, it is important to distinguish between defective IL-10 on the one hand and mutations within the receptor on the other. The minority of children in the study by Kotlarz et al. displayed loss-of-function mutations within the IL-10 gene. However, these patients would theoretically benefit from exogenous administration of functional IL-10. So far, this has only been examined in adult patients without prior genetic analyses, and has – understandably – not been shown to be effective [4]. With respect to mutations within the IL-10 receptor, further randomised trials are essential. One concern is that the induction therapy for HSCT, including chemotherapy and potent immunosuppressant drugs as well as gut decontamination, has contributed greatly to the clinical response, bearing in mind the possible uncontrolled immune response of IBD patients to normal gut flora. Besides IL-10, IL10R2 is a component of other receptors, namely IL-22, IL-26, IL-28 and IL-29 receptors. Thus, altered signaling in these pathways may equally contribute to the imbalance of pro- and anti-inflammatory signals.

According to the EUROKIDS register, only 1% of all paediatric IBD patients are diagnosed in infancy [5]. Kotlarz et al. found mutations within the IL-10 pathway in no more than one-third of such children. Thus, the reported important findings are merely applicable in a small, well-defined subgroup of patients. Nevertheless, for this group, defective IL-10-mediated immunomodulatory signaling is proven, and targeted curative therapy based on genetic findings is a promising option.

References

1. Kühn R, Löhler J, Rennick D, et al. Interleukin-10-deficient mice develop chronic enterocolitis. Cell 1993;75:263-74.
2. Lindsay JO, Sandison A, Cohen P, et al. IL-10 gene therapy is therapeutic for dextran sodium sulfate-induced murine colitis. Dig Dis Sci 2004;49:1327-34.
3. Buruiana FE, Solà I, Alonso-Coello P. Recombinant human interleukin 10 for induction of remission in Crohn's disease. Cochrane Database Syst Rev 2010;11:CD005109.
4. Glockner E, Kotlarz D, Boztug K, et al. Inflammatory bowel disease and mutations affecting the interleukin-10 receptor. N Engl J Med 2009;361:2033-45.
5. de Bie CI, Buderus S, Sandhu BK, et al. Diagnostic workup of paediatric patients with inflammatory bowel disease in Europe: results of a 5-year audit of the EUROKIDS Registry. J Pediatr Gastroenterol Nutr 2012;54:374-80.

DONATA LISSNER
Department of Gastroenterology
Charité - Universitätsmedizin Berlin
Berlin, Germany

Donata Lissner
Donata Lissner is currently performing her residency at Charité – Universitätsmedizin Berlin and is interested in the immunological aspects of IBD, particularly the role of the innate immune system.

Donata Lissner © D. BulaDonata Lissner © D. Bula

Visceral adipocytes: old actors in obesity and new protagonists in Crohn's Disease?

Zulian A, Cancello R, Micheletto G, Gentilini D, Gilardini L, Danelli P, Invitti C
Gut. 2012;61:86-94

Introduction

Crohn's Disease (CD) is characterised by the presence of expanded adipose tissue located at the mesenteric attachment around areas of inflamed intestine [1]. The inflamed adipose tissue marked by macrophage and T cell infiltration, endothelial cell activation and fibrosis is an active endocrine and immune organ and serves as a source of pro- and anti-inflammatory cytokines. Microscopically, mesenteric adipocytes in CD have been described as small with a fourfold increase in number compared to healthy controls [2]. Adipose tissue in obesity (visceral/omental and subcutaneous) also shows inflammation and is characterised not only by increased numbers of adipocytes but also by adipocyte enlargement [3].

What this paper is about

Using morphological and molecular-genetic methods the authors studied the subcutaneous and intra-abdominal fat tissue of morbidly obese (n=8) or stricturing CD patients (n=8) in comparison with healthy lean subjects (n=8) undergoing intra-abdominal surgery.

The fat compartments were divided into the following groups:

1. Subcutaneous adipose tissue
2. Visceral adipose tissue from the omentum
3. Adipose tissue from the mesenteric attachment close to:
   a. healthy intestine
   b. inflamed intestine in cases of CD

Key findings

The subcutaneous adipocytes in obese patients were significantly larger (hypertrophic) than those in CD patients and healthy controls. CD patients and lean controls had comparably sized subcutaneous adipocytes, without any morphological signs of inflammation. The mesenteric adipose tissue of healthy intestine in obese and lean controls showed no inflammatory cell infiltration. In CD patients there were fewer inflammatory and fibrotic changes of mesenteric fat tissue close to healthy sections of the CD intestine compared to the fat tissue attached to the inflamed CD intestine. However, there was a clear difference in the size of adipocytes: visceral adipocytes in CD were smaller than those in obese individuals and CD mesenteric adipocytes close to the inflamed intestine. In summary, the morphological analyses showed that adipocytes of CD patients had a significantly smaller diameter in all adipose tissue compartments compared to adipocytes of obese subjects. In comparison to lean individuals, this difference was only detectable in the intra-abdominal fat compartment.

In a second step, the authors studied the inflammatory changes of adipose tissue by micro-array analysis. Considering the global gene expression of whole adipose tissue compartments in CD, the subcutaneous fat tissue formed an expression cluster that was independent of the other intra-abdominal adipose depots. The visceral and mesenteric adipose tissue, located close to the affected intestine, showed an upregulation of inflammatory genes. Looking more closely, the global gene expression of isolated visceral adipocytes in CD formed an independent branch in clustering analysis, suggesting a distinct function of visceral and mesenteric adipocytes. Isolated visceral adipocytes in both CD and obese patients revealed an upregulation of genes related to inflammation/immune response and downregulation of genes required for mitochondrial function. By proper characterisation of involved genes, visceral adipocytes in CD were shown to exert a greater upregulation of anti-inflammatory genes compared to those in obese patients. The most marked difference was in respect of the expression of prokineticin 2, with showed much higher expression in CD patients.

Conclusion

This is the first study to compare adipose tissue in CD versus obesity, both of which are characterised by accumulation and inflammation of the intra-abdominal fat tissue. Previous studies directly examining the creeping fat in CD described morphological changes and altered expression of some pro- and anti-inflammatory cytokines/adipokines in comparison to healthy controls or patients with diverticulitis [4-6]. The authors showed a clear difference between the two diseases with respect to the morphological picture of adipose tissue compartments. In fact, the visceral adipocytes of CD and obese patients share 40% of the expressed genes. An upregulation of anti-inflammatory genes in visceral adipocytes was detected. The authors therefore suggest a protective role of visceral fat tissue in CD.

In this study the authors have not depicted the gene expression of adiponectin. Previously adiponectin was shown to be downregulated in obesity [7] but upregulated together with leptin, TNF-α and CRP in mesenteric adipose tissue in patients with CD [4-6, 8, 9]. Therefore it would have been interesting to study the expression of adiponectin in CD compared to obesity.

Prokineticin 2 is expressed by macrophages and neutrophils infiltrating the damaged tissue, but its expression on adipocytes has not yet been described. This finding might be explained by the changed expression pattern and function of immunologically activated pre-adipocytes and adipocytes under inflammatory conditions in CD [10]. Interacting with its receptors, prokineticin 2 can induce visceral pain [11]. Its markedly higher expression in CD may explain the clinical differences in pain perception in CD and obesity. The proper function of prokineticin 2 in the creeping fat, however, needs to be further clarified.

References

1. Crohn BB, Ginzburg L, Oppenheimer GD. Landmark article Oct 15, 1932. Regional ileitis. A pathological and clinical entity. By Burril B. Crohn, Leon Ginzburg, and Gordon D. Oppenheimer. JAMA 1984;251:73-9.
2. Peyrin-Biroulet L, Chamaillard M, Gonzalez F, et al. Mesenteric fat in Crohn's disease: a pathogenetic hallmark or an innocent bystander? Gut 2007;56:577-83.
3. Maury E, Brichard SM. Adipokine dysregulation, adipose tissue inflammation and metabolic syndrome. Mol Cell Endocrinol 2010;314:1-16.
4. Paul G, Schäffler A, Neumeier M, et al. Profiling adipocytokine secretion from creeping fat in Crohn's disease. Inflamm Bowel Dis 2006;12:471-7.
5. Desreumaux P, Ernst O, Geboes K, et al. Inflammatory alterations in mesenteric adipose tissue in Crohn's disease. Gastroenterology 1999;117:73-81.
6. Barbier M, Vidal H, Desreumaux P, et al. Overexpression of leptin mRNA in mesenteric adipose tissue in inflammatory bowel diseases. Gastroenterol Clin Biol 2003;27:987-91.
7. Maury E, Ehala-Aleksejev K, Guiot Y, Detry R, Vandenhooft A, Brichard SM. Adipokines oversecreted by omental adipose tissue in human obesity. Am J Physiol Endocrinol Metab 2007;293:E656-65.
8. Yamamoto K, Kiyohara T, Murayama Y, et al. Production of adiponectin, an anti-inflammatory protein, in mesenteric adipose tissue in Crohn's disease. Gut 2005;54:789-96.
9. Peyrin-Biroulet L, Gonzalez F, Dubuquoy L, et al. Mesenteric fat as a source of C reactive protein and as a target for bacterial translocation in Crohn's disease. Gut 2012;61:78-85.
10. Cousin B, Munoz O, Andre M, et al. A role for preadipocytes as macrophage-like cells. FASEB J 1999;13:305-12.
11. Watson RP, Lilley E, Panesar M, et al. Increased prokineticin 2 expression in gut inflammation: role in visceral pain and intestinal ion transport. Neurogastroenterol Motil 2012;24:65-75.

KLÁRA FRIVOLT
Comenius University Medical School and University Children's Hospital, 2nd Department of Pediatrics

Klara Frivolt
© Foto Studio Sopko

Klára Frivolt

Klára is a resident at the University Children's Hospital in Bratislava. She is interested in paediatric IBD and is currently working on her PhD thesis at the Ludwig Maximilian University in Munich.

Dear Friends of ECCO News,

ECCO Membership in 2012 totals approximately 1,950, and we would like to thank each and every Member for his or her contribution to ECCO's success. We would be delighted to welcome even more members to the ECCO Family next year – so we invite you to apply now for your ECCO Membership 2013 and ensure your access to many ECCO initiatives.

We would like to highlight that as of 2013, **an online subscription only to the JCC – Journal of Crohn's and Colitis is included in the ECCO Membership fee (for Regular and Y-ECCO Members).** Print subscriptions will still be available for ECCO Members for an additional charge.

We are delighted to announce that **ECCO's eLearning (eCCO) with interactive IBD case-based courses, IBD eLibrary, IBD multimedia reference material and CME accreditation** will be going live after the ECCO Congress 2013 and will be available for ECCO Members only.

So apply for your membership now – more information as well as online application is available on the ECCO website (www.ecco-ibd.eu). If you have any questions with regards to Membership, please feel free to touch base with the ECCO Office at ecco@ecco-ibd.eu.

We are looking forward to welcoming you to the ECCO Family in 2013.

ECCO Country Member Profile

Dear ECCO Country Member,
Dear ECCO National Representative,

The original idea of the founders of ECCO was the constitution of an organisation of the National IBD Study Groups within Europe. After an initial membership of five countries in 2001, most European countries joined ECCO in the following years. Since its foundation, ECCO has been continuously supported by its national counterparts and ECCO is therefore honoured to embrace 31 Country Members, each of which is represented by two National Representatives – the driving force and ambassadors of ECCO.
In our upcoming issue of ECCO News we therefore want to introduce our ECCO Country Membes (National IBD Study Groups) based on a predefined questionnaire which has been answered by their ECCO National Representatives. Please get in touch with the ECCO Office (s.essl@ibd-ecco.eu) for contribution in the upcoming issues.

Identity card

- Country: **Serbia**
- Name of group: National Society for the Treatment of Inflammatory Bowel Diseases
- Number of active members: 50
- Number of meetings per year: 5-6
- Names of president and secretary: Njegica Jojic, Daniela Bojic
- Incidence of IBD in the country (if available): 1-2 per 1,000

Identity card

- Country: **Ireland**
- Name of group: N/A
- Number of active members: N/A
- Number of meetings per year: 1
- Name of president and secretary: N/A
- Incidence of IBD in the country (if available): Not known

Questionnaire – IRELAND

- ***How did your national group start?***
  For 5 years, Professor Egan has organised an annual IBD study day which is held at the University Hospital Galway.
- ***How is your group organised in terms of new members joining the group, meetings, election of president etc.?***
  We have an annual meeting which is multidisciplinary, including physicians, surgeons, nurses, radiologists and pathologists.
- ***When did your group join ECCO?***
  We have been members of ECCO since 2005.
- ***What are your main areas of research interest?***
  Cancer epidemiology in the IBD population.
- ***Does your centre or country have a common IBD database or bio bank?***
  No.
- ***What are your most prestigious/interesting past and ongoing projects?***
  We have compared at a population-based level in Ireland, the clinical features, diagnosis, treatment and survival of colorectal cancer patients who do or do not have IBD (Clin Gastroenterol Hepatol. 2011 Jul;9(7):584-9).

GI Study Day 2010, 17th ECCO Educational Workshop, Galway, Ireland, 2010 © ECCO Office

- ***Which ECCO projects/activities is the group currently involved in?***
  3rd scientific workshop.
- ***What are your aims for the future?***
  We aim to develop more collaborative multicentre prospective studies in Ireland.
- ***How do you see ECCO helping you to fulfil these aims?***
  ECCO provides a framework and point of reference that is invaluable for the conduct of high-quality research studies in IBD.
- ***What do you use ECCO for? Network? Congress? How do you use the things/ services that ECCO has to offer?***
  ECCO Congress and affiliated ECCO Workshops are the key advantages that the organisation provides to a country like Ireland. JCC is, of course, also a key benefit.

LARRY EGAN
ECCO National Representative, Ireland

Questionnaire – SERBIA

- ***How did your national group start?***
  It started among doctors dedicated to the treatment of IBD patients who recognised the need for such an organisation.
- ***How is your group organised in terms of new members joining the group, meetings, election of president etc.?***
  The group has all the structures found in similar organisations, and all GI doctors are free to join. Membership is also open to others involved in the treatment of such patients, e.g. surgeons, pathologists, radiologists and immunologists.
- ***When did your group join ECCO?***
  In 2005 or 2006 (we are not sure which!).
- ***What are your main areas of research interest?***
  There are many projects in progress, and it is impossible to list them all here.
- ***Does your centre or country have a common IBD database or bio bank?***
  We are in the process of establishing a national register which will actually be a database of all IBD patients.
- ***What are your most prestigious/interesting past and ongoing projects?***
  The national register.

Faculty at the 12th ECCO Educational Workshop, Belgrade, Serbia, 2009 © ECCO Office

- ***Which ECCO projects/activities is the group currently involved in?***
  None.
- ***What are your aims for the future?***
  To persuade more MDs to become involved in our national society and in more of our local projects. Also we wish to become involved in more ECCO projects.
- ***How do you see ECCO helping you to fulfil these aims?***
  Through cooperation to promote greater future involvement in ECCO projects.
- ***What do you use ECCO for? Network? Congress? How do you use the things/ services that ECCO has to offer?***
  So far we have mostly made use of ECCO's services during Congress activities, which is definitively not enough.

DANIELA BOJIC
Dino Tarabar
Njegica Jojic
ECCO National Representatives, Serbia

European
Crohn's and Colitis
Organisation

ECCO MEMBERSHIP APPLICATION FORM

please fill in, legibly

Member ID: _____

❍ **2013** (1.1.2013 – 31.12.2013)

(provided by ECCO)

TYPE OF MEMBERSHIP (§ 3 Statutes of the European Crohn's and Colitis Organisation, ***www.ecco-ibd.eu***)

Please check one of the following categories:

❍ **Regular Member*** (Doctors, scientists interested in IBD, completed university degree)	**€ 100.00**
❍ **Y-ECCO Member*** (Doctors, scientists interested in IBD, completed university degree, under 35 years of age or in training)	**€ 100.00**
❍ **IBD nurse/Affiliate Member** (Registered nurse or allied professional interested in the field of IBD)	**€ 25.00**

(* includes online access to the Journal of Crohn's and Colitis – JCC for one year; print subscriptions for ECCO Members are available for € 38.00, please contact K.Admiraal@elsevier.com)

PERSONAL DATA

❍ Prof. ❍ Dr. Please list your national professional registration number: _____

❍ Other university degree: _____ (please specify subject of degree)

❍ Other title: _____ Gender: ❍ female ❍ male

Profession: ❍ Physician ❍ Scientist ❍ IBD nurse ❍ Surgeon

❍ Paediatrician ❍ Industry ❍ Other: _____

First name: _____ Middle name: _____

Family name: _____ Date & Year of birth: _____

Institute address: Please indicate your institute address below.

Institute: _____

Department: _____

Street: _____ Zip code: _____

City: _____ Country: _____

Phone: _____ Mobile: _____

Fax: _____ E-mail: _____

ECCO Publications: The ECCO Publications will be sent to the address indicated above. If you want to have the publications delivered to a different address, please enter the shipping address below.

Street: _____ Zip code: _____

City: _____ Country: _____

❍ I acknowledge that ECCO obeys the international data protection guidelines; I agree that the above data may be used and processed by ECCO for the management of membership data as well as other ECCO purposes (e.g. distribution of newsletter and other ECCO information, promotion of ECCO Congress and educational/scientific activities) and may be forwarded to the publisher/distributor of ECCO publications.

MEMBERSHIP FEE

Fee 2013 = €

Total to be paid €

Credit Card: ❍ Visa ❍ Master Card

CC number: _____ Exp. date: _____ / _____

Place, date: _____ Card validation code: _____

Name of cardholder: _____ Signature: _____

Please return the completed form to the ECCO Office by e-mail to ecco@ecco-ibd.eu or by fax: +43-(0)1-710 22 42-001

ECCO – European Crohn's and Colitis Organisation
Seilerstätte 7/3, 1010 Vienna, Austria | Phone: +43-(0)1-710 22 42 | Fax: +43-(0)1-710 22 42-001 | E-mail: ***ecco@ecco-ibd.eu*** | Web: ***www.ecco-ibd.eu***

ECCO Governing Board 2012

President
Simon Travis
Oxford, United Kingdom
simon.travis@ndm.ox.ac.uk

Past President/Liaison Officer
Daniel Hommes
Los Angeles, United States
DHommes@mednet.ucla.edu

President-Elect
Séverine Vermeire
Leuven, Belgium
Séverine.vermeire@uzleuven.be

Secretary
Silvio Danese
Milan, Italy
sdanese@hotmail.com

Treasurer
Milan Lukáš
Prague, Czech Republic
milan.lukas@email.cz

Education Officer
Janneke van der Woude
Rotterdam, The Netherlands
c.vanderwoude@erasmusmc.nl

Scientific Officer
Matthieu Allez
Paris, France
matthieu.allez@sls.aphp.fr

ECCO Committees 2012

SciCom
Andreas Sturm, Germany
Miquel Sans, Spain
Edouard Louis, Belgium
Arthur Kaser, United Kingdom
Iris Dotan, Israel

SciCom Chair
Andreas Sturm
Berlin, Germany
a.sturm@waldfriede.de

ClinCom
Walter Reinisch, Austria
Franck Carbonnel, France
Jean-Yves Mary, France

ClinCom Chair
Filip Baert
Roeslare, Belgium
fbaert@hhr.be

EpiCom
Peter Lakatos, Hungary
Johan Burisch, Denmark
Tine Jess, Denmark
Matteo Martinato, Italy
Epameinondas Tsianos, Greece

EpiCom Chair
Peter Lakatos
Budapest, Hungary
lakatos.peter_laszlo@med.semmelweis-univ.hu

EduCom
Gerassimos Mantzaris, Greece
Charlie Lees, United Kingdom
James Lindsay, United Kingdom
Stephan Vavricka, Switzerland
Sandro Ardizzone, Italy

EduCom Chair
Gerassimos Mantzaris
Athens, Greece
gjmantzaris@gmail.com

GuiCom
Axel Dignass, Germany
Fernando Magro, Portugal
Vito Annese. Italy
Rami Eliakim, Israel

GuiCom Chair
Axel Dignass
Frankfurt am Main, Germany
axel.dignass@fdk.info

N-ECCO
Marian O'Connor, United Kingdom
Lisa Younge, United Kingdom
Patricia Détre, France
Rina Assulin, Israel
Janette Gaarenstroom, The Netherlands

N-ECCO Chair
Marian O'Connor
London, United Kingdom
marian.o'connor@nhs.net

Y-ECCO
Florian Rieder , United States
Marjolijn Duijvestein, The Netherlands
James Lee, United Kingdom
Franco Scaldaferri, Italy
Pieter Hindryckx, Belgium

Y-ECCO Chair
Florian Rieder
Ohio, United States
riederf@ccf.org

S-ECCO
André D'Hoore, Belgium
Willem Bemelman, The Netherlands
Tom Øresland, Norway
Alastair Windsor, United Kingdom
Gianluca Sampietro, Italy

S-ECCO Chair
André D'Hoore
Leuven, Belgium
andre.dhoore@uzleuven.be

P-ECCO
Frank Ruemmele, France
Hankje Escher, The Netherlands
Jorge Amil Dias, Portugal
Kaija-Leena Kolho, Finland
Arie Levine, Israel

P-ECCO Chair
Frank Ruemmele
Paris, France
frank.ruemmele@nck.aphp.fr

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

ECCO Governing Board 2012			
President	Simon Travis	Oxford, United Kingdom	simon.travis@ndm.ox.ac.uk
Past President/Liaison Officer	Daniel Hommes	Los Angeles, United States	DHommes@mednet.ucla.edu
President-Elect	Séverine Vermeire	Leuven, Belgium	Séverine.vermeire@uzleuven.be
Secretary	Silvio Danese	Milan, Italy	sdanese@hotmail.com
Treasurer	Milan Lukáš	Prague, Czech Republic	milan.lukas@email.cz
Scientific Officer	Matthieu Allez	Paris, France	matthieu.allez@sls.aphp.fr
Education Officer	Janneke van der Woude	Rotterdam, The Netherlands	c.vanderwoude@erasmusmc.nl

ECCO National Representatives 2012					
Austria	Gottfried Novacek	gottfried.novacek@meduniwien.ac.at	Norway	Ingrid Berset	Ingrid.Prytz.Berset@helse-mr.no
	Walter Reinisch	walter.reinisch@meduniwien.ac.at		Jørgen Jahnsen	jorgen.jahnsen@medisin.uio.no
Belgium	Denis Franchimont	denis.franchimont@erasme.ulb.ac.be	Poland	Grażyna Rydzewska	grazyna.rydzewska@cskmswia.pl
	Filip Baert	fbaert@hhr.be		Jaroslaw Regula	jregula@coi.waw.pl
Bulgaria	Zoya Spassova	zoya.spassova@hotmail.com	Portugal	Fernando Magro	fm@med.up.pt
	Iskren Kotzev	kotzev@mnet.bg		Luis Correia	laraujocorreia@gmail.com
Croatia	Boris Vucelic	boris.vucelic@zg.t-com.hr	Romania	Mircea Diculescu	mmdiculescu@yahoo.com
	Silvija Cukovic Cavka	silvija.cukovic@gmail.com		Adrian Goldis	goldisadi@yahoo.com
Czech Republic	Martin Bortlik	mbortlik@hotmail.com	Russia	Elena Belousova	eabelous@yandex.ru
	Tomas Douda	douda@fnhk.cz		Alexander Potapov	potapov@nczd.ru
Denmark	Jens F. Dahlerup	jensdahl@rm.dk	Serbia	Njegica Jojic	njegica@Eunet.rs
	Jens Kjeldsen	jakjeldsen@dadlnet.dk		Dino Tarabar	dino@tarabar.net
Finland	Martti Färkkilä	martti.farkkila@hus.fi	Slovakia	Milos Gregus	ghugregus@gmail.com
	Pia Manninen	pia.manninen@uta.fi		Martin Huorka	huorka@stonline.sk
France	Laurent Beaugerie	laurent.beaugerie@sat.aphp.fr	Slovenia	Ivan Ferkolj	ivan.ferkolj@kclj.si
	Franck Carbonnel	fcarbonnel7@gmail.com		Borut Stabuc	borut.stabuc@kclj.si
Germany	Andreas Sturm	a.sturm@waldfriede.de	Spain	Francesc Casellas Jorda	fcasellas@vhebron.net
	Torsten Kucharzik	torsten.kucharzik@klinikum-lueneburg.de		Fernando Gomollon G.	fgomollon@gmail.com
Greece	Ioannis Karagiannis	jakaragiannis@doctor.com	Sweden	Leif Törkvist	leif.torkvist@ki.se
	Epameinondas Tsianos	etsianos@uoi.gr		Hans Strid	hansrobertstrid@gmail.com
Hungary	Peter Lakatos	lakatos.peter_laszlo@med.semmelweis-univ.hu	Switzerland	Pierre Michetti	pmichetti@gesb.ch
	Tamas Molnar	molnar.tamas@med.u-szeged.hu		Frank Seibold	Frank.Seibold@spitalnetzbern.ch
Ireland	Colm O'Morain	colmomorain@gmail.com	The Netherland	Rinse Weersma	r.k.weersma@mdl.umcg.nl
	Laurence Egan	laurence.egan@nuigalway.ie		Herma Fidder	H.H.Fidder@umcutrecht.nl
Israel	Iris Dotan	irisd@tasmc.health.gov.il	Turkey	Murat Törüner	murattoruner@yahoo.com
	Selwyn Odes	odes@bgu.ac.il		Aykut Ferhat Celik	afcelik@superonline.com
Italy	Anna Kohn	akohn@scamilloforlanini.rm.it	Ukraine	Andrey E. Dorofeyev	dorofeyev@med.finfort.com
	Paolo Gionchetti	paolo.gionchetti@unibo.it		Tetyana Zviagintseva	zvyagintseva_t@mail.ru
Latvia	Juris Pokrotnieks	pokrot@latnet.lv	United Kingdom	James Lindsay	james.lindsay@bartshealth.nhs.uk
	Jelena Derova	jelena.derova@gastroenterologs.lv		Chris Probert	Chris.Probert@liverpool.ac.uk
Lithuania	Darius Kriukas	dakr@takas.lt			
	Limas Kupcinskas	likup@takas.lt			

N-ECCO National Representatives 2012					
Austria	Anita Beyer	anita.beyer@meduniwien.ac.at	Israel	Miri Ganon	miriamg@hadassah.org.il
Belgium	Valerie Wambacq	valerie.wambacq@erasme.ulb.ac.be	Israel	Olga Gourin	JRolgaGU@clalit.org.il
Bulgaria	Zoya Spassova	zoya.spassova@hotmail.com	Italy	Matteo Martinato	matteo.martinato@unipd.it
Bulgaria	Jasmina Andonova	jasi_andonova@yahoo.co.uk	Latvia	Valentina Lapina	valentina.lapina@inbox.lv
Croatia	Vesna Oroz	vesna.oroz1@zg.t-com.hr	Norway	Ellen Vogt	ellen.vogt@diakonsyk.no
Czech Republic	Ludmila Prochazkova	Ludmila.Prochazkova@seznam.cz	Portugal	Patrícia Silva	fnicolausilva@hotmail.com
Denmark	Dorrit Jakobsen	dorrjako@rm.dk	Serbia	Svetlana Rakicevic	ceca.rakicevic@gmail.com
Denmark	Lotte Julin Hansen	lkjh@rn.dk	Spain	Antonio Torrejón Herrera	tonith@gmail.com
Finland	Tuija Vilmunen	Tuija.Vilmunen@pshp.fi	Sweden	Ann Tornberg	Ann.tornberg@skane.se
France	Suzanna Ostrec	suzanna.ostrec@gmail.com	Switzerland	Christina Knellwolf	christina.knellwolf@kssg.ch
Germany	Petra Hartmann	praxis@gastroenterologie-minden.de		Rosmarie Junker	rosmarie.junker@spitalnetzbern.ch
	Karin Menzel	karin.menzel@mvz-portal10.de	The Netherlands	Marthe Verwey	m.h.verwey@lumc.nl
Greece	Helen Keimali	elkeim@hotmail.com		Henny Tomlow	henny.tomlow@mumc.nl
Ireland	Yvonne Bailey	yvonne.bailey@amnch.ie	United Kingdom	Karen Kemp	karen.kemp@manchester.ac.uk
				Jeanette Thompson	jthompson12@nhs.net

Corporate Members 2012

Abbott · Bristol-Myers Squibb · COSMO · Dr. Falk · FERRING · GIULIANI · janssen · MSD · Merck Serono · Otsuka · Shire · Millennium · TIGENIX · Tillotts Pharma · Vifor Pharma

ECCO Office

European Crohn's and Colitis Organisation
Seilerstätte 7/3
1010 Vienna, Austria
Phone: +43-(0)1-710 22 42
Fax: +43-(0)1-710 22 42-001
E-Mail: ecco@ecco-ibd.eu
Web: www.ecco-ibd.eu

The Austrian Ecolabel for printed products, UZ 24, UW 686 Ferdinand Berger & Söhne GmbH.