Inflammatory Bowel Diseases

9th Congress of ECCO
February 20-22, 2014

- Bella Center Copenhagen, Denmark
- EACCME applied
- Register online at www.ecco-ibd.eu/ecco14

Scan and contact the ECCO Office
www.ecco-ibd.eu
Dear ECCO Friends,

The results of an investigation into the burden of IBD in Europe are profiled in a report in this issue of ECCO News (p. 4-5) and are well worth the read: talks and slides will need updating so that we all speak with the same voice. This matters to the message for people with IBD. Enhancing understanding of the physical and socio-economic burdens of IBD was the aim of the Public Awareness Campaign earlier this year in Vienna [https://www.ecco-ibd.eu/jtf-2013.html]. The report on the burden of IBD has derived from major work by EpiCom, now published in the Journal of Crohn's and Colitis (the ECCO Journal – https://www.ecco-ibd.eu/publications/jcc.html), and highlights the facts that there are around 3 million people in Europe with IBD and that the direct costs of care are in the region of EUR 4.6–5.6 billion. The indirect costs of IBD, taking into account days lost to work, missed opportunities and the impact on family or friends, are several times this figure.

Quality of care for IBD is, however, the theme for the ECCO’14 Copenhagen Congress. The programme for Copenhagen is profiled in this issue of ECCO News (p. 6-7, 9-13) and the message is: be there. It is ECCO’s mission to improve care for patients with IBD. The need to anchor ECCO to patients always merits re-iteration, because it is in the care of patients, for people with IBD, where common ground is found whatever national differences exist. The Causes, Consequences and Quality of Care for IBD (ECCO’14) concern us all. Too often, however, academic programmes pay lip service to quality of care. Copenhagen will correct that, opening opportunities for us to scrutinise our own practice. This is uncomfortable. It involves measurement. The future, determined lest anyone doubt it, not by doctors but by payors and increasingly by patients, is auditable care. If you don’t measure, you can’t demonstrate improvement in your care.

Medicine has for too long hidden behind the ephemeral ‘art’ of medicine, as if it prevented analysis. I love the art of medicine: it is the essence of my practice, but systematic science is simple. We could all do it, now: simply recording, systematically, disease activity, days lost to work or principal occupation, and quality of life. We needn’t even do it ourselves! Patients could (would) do all of this, and are already doing so in some centres, where they are asked to record data as part of every outpatient appointment. Then all we (as healthcare professionals) need do is to add the timing of interventions. That is a practical step towards demonstrating achievement and improvements in the quality of care.

Think how powerful those data would be when persuading payors to pay up. Audit is more familiar to some countries than others: but whether care is Government, insurance or otherwise funded, payors are waking up to the costs of chronic disease. It is coming our way soon – and may already have arrived. ECCO has to be in the vanguard of setting standards and metrics, or others will set them. The Causes, Consequences and Quality of Care for IBD (ECCO’14) concern us all. Too often, however, academic programmes pay lip service to quality of care. Medicine has for too long hidden behind the ephemeral ‘art’ of medicine, as if it prevented analysis. I love the art of medicine: it is the essence of my practice, but systematic science is simple. We could all do it, now: simply recording, systematically, disease activity, days lost to work or principal occupation, and quality of life. We needn’t even do it ourselves! Patients could (would) do all of this, and are already doing so in some centres, where they are asked to record data as part of every outpatient appointment. Then all we (as healthcare professionals) need do is to add the timing of interventions. That is a practical step towards demonstrating achievement and improvements in the quality of care.

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The burden of Inflammatory Bowel Disease in Europe

The aim of this short report is to summarise the main facts on Inflammatory Bowel Disease (IBD) in Europe, focusing on the burden related to these conditions.

The highest incidence and prevalence rates are observed in northern European countries and these are highest in regions where the risk of cancer in IBD is highest. The reason for this is that IBD is a disease of the young, and in Europe IBD is commonly diagnosed in young adults. As compared to the general population, the absolute risk of colorectal cancer in patients with IBD is higher than in the general population but the relative risk of small bowel cancer in European patients with CD is increased. The only subgroup in which the absolute risk is lower than in the general population is CD patients who have been diagnosed in the first 5 years. However, recent data suggest a decrease in the risk of colorectal cancer in European patients with UC.

The burden of IBD in Europe is enormous: it is still the case that 20% of European CD patients will receive a disability pension, with an additional 10% facing unemployment and 25% part-time employment. Up to half of patients have to take sick leave and direct healthcare costs may average EUR 5,000 per year. The role of the IBD patient is to work towards and support the goal of self-management and to help prevent IBD complications. The burden of IBD is not only experienced directly by patients, but is also experienced by their families and their carers.

The economic impact is even higher because IBD is commonly diagnosed in young people. The burden of IBD in Europe varies from 80,000 new cases of CD and 178,000 new cases of UC each year, up to 10% development of extensive colitis within the first 10 years. However, recent data suggest a decrease in these rates. This decrease is probably multifactorial in origin, disease behaviour seems to be more mild, with a greater proportion of patients with inflammatory disease at diagnosis, which also appear likely to respond more readily to an improved medical management.

The risk of colorectal cancer is increased in IBD patients with CD, though the increased risk of colorectal cancer is greater in the general population than in IBD patients. However, the absolute risk is lower in IBD patients. In Europe, colorectal cancer patients have a better chance of survival. The overall risk of extra-intestinal manifestations of IBD is not markedly increased in European patients with CD but is increased in patients with UC, although the absolute risk of extra-intestinal manifestations is very low. The risk of colorectal cancer in IBD patients with UC is twice that among the general population, however, the absolute risk of colorectal cancer is only 1–2% after 20 years, and recent studies suggest a decrease in the incidence of colorectal cancer in IBD patients.

The overall risk of extra-intestinal manifestations is not markedly increased in European patients with IBD despite an increased risk of cancer of the upper gastrointestinal tract, lung and urinary bladder in CD and an increased risk of hepatobiliary cancer and trismus in UC (Schaaf et al. 2000). The risk of extra-intestinal manifestations is not increased in IBD patients with CD. However, the absolute risk of extra-intestinal manifestations is very low. The risk of colorectal cancer is increased in IBD patients with UC, although the absolute risk of extra-intestinal cancer is not increased in IBD patients with UC. The risk of colorectal cancer in IBD patients with UC is twice that among the general population, however, the absolute risk of colorectal cancer is only 1–2% after 20 years, and recent studies suggest a decrease in the incidence of colorectal cancer in IBD patients.

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New in 2014

- Digital posters
- Congress app
- New educational courses
- Half price on selected activities for Y-ECCO and IBD Nurse Members
- Extended e-COO Learning
- Increased number of oral presentations
Long-term outcome of tumor necrosis factor alpha antagonist's treatment in pediatric Crohn's disease


Clinical status, psychosocial impairments, medical treatment and health care costs for patients with inflammatory bowel disease: A systematic review and a meta-analysis


Increase in bone mineral density in strictly treated Crohn’s disease patients with concomitant calcium and vitamin D supplementation

S.F. Bakker, V.K. Dik, B.J. Witte, P. Lips, J.C. Roos, A.A. Van Bodegraven

The prevalence of inflammatory bowel disease in an Israeli Arab population


Evaluation of the risk of lymphoma and immunomodulators in patients with inflammatory bowel diseases: Results from a population-based cohort in Eastern Europe


YouTub® and inflammatory bowel disease

S. Mukewar, P. Mani, W. Wu, R. Lopez, B. Shen

Plasmogen activator inhibitor-1 is increased in colonic epithelial cells from patients with colitis-associated cancer


Bone loss and bone mineral density in patients with inflammatory bowel disease treated with anti-TNFα therapy

K. Greveson, J. Goodhand, S. Capoccia, S. Woodward, C. Murray, I. Cropsey, M. Hamilton, M. Lipman

The prevalence of inflammatory bowel disease in an Israeli Arab population

J. Zividi, G.M. Fraser, Y. Niv, S. Birkenfeld

Impact of inflammatory bowel disease on post-cholecystectomy complications and hospitalization costs: A Nationwide Inpatient Sample study

U. Navaneethan, S. Parasa, P.G.K. Venkatesh, T.T. Ganapathi, R.P. Kiran, B. Shen

Risk factors for peristomal pyoderma gangrenosum complicating inflammatory bowel disease

X.-r. Wu, S. Mukewar, R.P. Kiran, F.H. Remzi, J. Hammel, B. Shen

ECCO NEWS 2/2013
Preliminary programme: Wednesday, February 20, 2014

08:00-12:15 Session 1: Pathogenesis

- 08:00-08:45 Welcome
- 08:45-08:50 Introduction: Overview of ECCO
- 08:50-09:30 General overview of IBD
- 09:30-10:10 The genetic basis of IBD
- 10:10-10:50 The microbe and IBD
- 10:50-11:30 Coffee break

11:30-13:30 Session 2: Seminar session

- 11:30-12:30 Part I: Practical skills
- 12:30-13:30 Sonata del director: Practice: Practical guide to interpreting MRI
- 13:30-14:30 Part II: Specialist subject IBD and pregnancy

13:45-14:30 Lunch break

14:30-15:30 Session 3: Interactive case discussion and lecture session

- 14:30-15:10 Case-based discussion: IBD: Epidemiology and environmental factors
- 15:10-15:30 Tandem Talk: Acute Severe Ulcerative Colitis

10:30-11:10 Coffee break

11:10-12:10 Coffee break

Preliminary programme: Thursday, February 20, 2014

08:00-12:15 Session 1: Pathogenesis

- 08:00-08:45 Welcome
- 08:45-09:45 General overview of IBD
- 09:45-10:25 The genetic basis of IBD
- 10:25-11:15 The microbe and IBD
- 11:15-12:15 Coffee break

12:15-13:15 Session 2: Seminar session

- 12:15-13:30 Sonata del director: Practice: Practical guide to chromo-endoscopy
- 13:30-14:30 Part II: Specialist subject IBD and pregnancy

13:45-14:30 Lunch break

14:30-15:30 Session 3: Interactive case discussion and lecture session

- 14:30-15:10 Case-based discussion: IBD: Epidemiology and environmental factors
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Call for Nominations of Participants at the 5th N-ECCO School in Copenhagen

At the 5th Congress of ECCO in Copenhagen, the N-ECCO Committee will host the educational activity for IBD nurses. N-ECCO School, for the fifth time. ECCO intends to give young nurses, who might still be in training and have an interest in IBD, the possibility of attending an IBD-focused course. The aim of this programme ultimately is to improve nurse education throughout Europe.

Nomination process for candidates from ECCO Country Members

The call for nominations of participants is being sent out to all N-ECCO National Representatives in May 2013. Interested candidates are encouraged to apply for nomination via the N-ECCO National Representative of their country (see page 34). Places are limited to one nurse per country. If there is no N-ECCO National Representative in your country, please do not hesitate to contact Niels Nipenburg from the N-ECCO Committee (n.nipenburg@lumc.nl). Some financial support will be available to cover nurses’ costs incurred in attending the School. For further information, please visit www.ecco-ibd.eu.

Nomination process for candidates from outside of Europe:

For the second time, N-ECCO is delighted to announce that a certain number of course places will be reserved for IBD nurses from outside of Europe. Candidates who are interested should contact the ECCO Office (n-raynard@ecco-ibd.eu) well in advance.

Deadline for nominations: September 6, 2013

3rd ECCo membership 2014 required:

- Online registration
- ECCO membership 2014 required:
  - Regular/Y-ECCO/IBD nurse Member
  - Registration fee: EUR 80 (half price for Y-ECCO and IBD nurse Members)

Y-ECCO & IBD nurse Members)

7th S-ECCO IBD Masterclass

Date: February 18, 2014

Time: 09:00-12:00; Masterclass 13:00-18:00

Target audience: Surgeons, Physicians, IBD nurses

Registration: Online registration

ECCO Membership 2014 required:

- Regular/Y-ECCO/IBD nurse Member

Registration fee: EUR 150 (half price for Y-ECCO and IBD nurse Members)

Highlights:

- The 7th S-ECCO Masterclass will highlight the challenges of treating fistulating Crohn’s Disease. This not only includes internal (entero-enteric, enteroevrosidal) and entero-cutaneous fistulae, but also the problem of per-anal fistule in Crohn’s Disease.

Special attention will be paid to pre-operative Imaging, especially the current role of cross-sectional Imaging, and optimal pre-operative preparation of the patient as well as the problem of difficult abdominal closure. This will complement the main ECCO scientific programme, which will address the management of short bowel syndrome, intestinal failure and total parenteral nutrition. The main focus will be on the added value of a multidisciplinary approach and dedicated care to improve the outcome of these patients with the most challenging types of Crohn's Disease.

It is intended that all sessions will be interactive and will provide ample time for discussion. A panel of internationally recognised experts will be invited to guarantee the quality of this meeting.

The preliminary programme will be available online at www.ecco-ibd.eu/ecco14 by the end of June.
3rd IBD Refresher Course

**Date**: February 19, 2014  
**Time**: 08:00–11:30  
**Responsible Committee**: IBD Nurses  
**Target audience**: IBD nurses, Allied Health Professionals  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- Session 1: Welcome and Introduction  
- 10:00–10:30: Snaith and Clasen  
- Session 2: Hands-on open space in ultrasonography

3rd ClinCom Workshop

**Date**: February 20, 2014  
**Time**: 08:00–11:30  
**Responsible Committee**: ClinCom  
**Target audience**: Physicians, Surgeons, Paediatricians, Clinical Researchers, Industry Professionals  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 9:00–09:15: Welcome and introduction  
- 09:15–09:20: Coffee break and introduction  
- 09:20–09:30: Case study  
- 09:30–10:15: Session 1: How can we bridge the gap to real-life clinical practice?
- 10:15–10:30: Open label trials and registries: Can we improve or should we abandon them?
- 10:30–10:45: New outcome measures in IBD trials: (bismuth, deep remission, disability, bowel damage index) The emperor’s new clothes?
- 10:45–10:50: How to address special situations (pouchitis, fistulae, kids etc.): Mini versus mega trials

4th N-ECCo Network Meeting

**Date**: February 20, 2014  
**Time**: 08:00–09:15  
**Responsible Committee**: IBD Nurses  
**Target audience**: IBD nurses and Allied Health Professionals  
**Registration**: Upon invitation

**ECCo Membership 2014 required**: Corporate Member  
**Registration fee**: n.a.

**Preliminary programme**: Global IBD Forum on practicalities in biobanking
- 10:15–10:30: Welcome and introduction  
- 10:30–11:15: Ian Satsangi and colleagues  
- 11:15–11:20: Welcome and introduction  
- 11:20–11:30: Case 1: Patient with a previous cancer history  
- 11:30–11:40: Case 2: Colonic CD with a stricture: What’s the cancer risk?  
- 11:40–12:00: Case 3: Young CD patient with a stoma and disease progression. What are we anxious about: The disease or the cancer risk?

Preliminary programme: Ultrasound Workshop (Advanced level)

**Date**: February 20, 2014  
**Time**: 08:00–11:30  
**Responsible Committee**: Ultrasound  
**Target audience**: Physicians, Surgeons, IBD nurses  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 08:30–09:00: Case study  
- 09:00–09:15: Coffee break  
- 09:15–10:15: Session 1: Hands-on open space in ultrasound

Preliminary programme: Cancer in IBD

**Date**: February 20, 2014  
**Time**: 08:00–08:15  
**Responsible Committee**: IBD Nurses  
**Target audience**: Physicians, Surgeons, Paediatricians, IBD nurses  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 08:15–09:00: Welcome and introduction  
- 09:00–09:15: How BD associated with intestinal cancer: what is the baseline risk?  
- 09:15–09:30: Influence of age and gender on the risk of intestinal cancer  
- 09:30–09:45: Extra-intestinal cancer with focus on skin cancer  
- 09:45–10:00: How to manage patients with a previous cancer

Preliminary programme: Ultrasound Workshop (Advanced level)

**Date**: February 20, 2014  
**Time**: 08:00–11:30  
**Responsible Committee**: Ultrasound  
**Target audience**: Physicians, Surgeons, IBD nurses  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 08:30–09:00: Case study  
- 09:00–09:15: Coffee break  
- 09:15–10:15: Session 1: Hands-on open space in ultrasound

Preliminary programme: 7th Y-ECCo Workshop

**Date**: February 19, 2014  
**Time**: 10:00–10:30  
**Responsible Committee**: Y-ECCo  
**Target audience**: Paediatricians, Physicians, Surgeons, IBD nurses

**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 10:00–10:15: Welcome to Y-ECCo and Course introduction  

Preliminary programme: Update on Paediatric IBD

**Date**: February 19, 2014  
**Time**: 10:00–10:30  
**Responsible Committee**: IBD Nurses  
**Target audience**: IBD nurses and Allied Health Professionals  
**Registration**: Online registration

**ECCo Membership 2014 required**: IBD nurse Member  
**Registration fee**: tbc

**Preliminary programme:**
- 10:00–10:15: Welcome and introduction  
- 10:15–10:30: How children with IBD differ from adults. Phenotype and natural history

N-ECCo Research Networking Forum

**Date**: February 19, 2014  
**Time**: 08:00–12:00  
**Responsible Committee**: N-ECCo  
**Target audience**: IBD nurses and Allied Health Professionals

**Registration**: Online registration

**ECCo Membership 2014 required**: IBD nurse Member  
**Registration fee**: n.a.

**Highlights**
- During the ECCO’14 Congress in Copenhagen we are hosting the first meeting of the new N-ECCo research networking forum, identification of aims and objectives and a discussion/network to identify nurses’ needs.
- Perhaps in time develop collaboration on similar research issues.
- To succeed in academic medicine and perhaps in time develop collaboration on similar research issues.
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3rd ClinCom Workshop

**Date**: February 20, 2014  
**Time**: 08:00–11:30  
**Responsible Committee**: ClinCom  
**Target audience**: Physicians, Surgeons, Paediatricians, Clinical Researchers, Industry Professionals  
**Registration**: Online registration

**ECCo Membership 2014 required**: Regular/IIBD nurse Member  
**Registration fee**: EUR 80

**Preliminary programme:**
- 08:00–11:30: Session 1: How can we bridge the gap to real-life clinical practice?
- 11:30–12:00: How to address special situations (pouchitis, fistulae, kids etc.): Mini versus mega trials

8th N-ECCo Network Meeting

**Date**: February 20, 2014  
**Time**: 07:45–08:45  
**Responsible Committee**: IBD Nurses  
**Target audience**: IBD nurses, Allied Health Professionals  
**Registration**: Upon invitation

**ECCo Membership 2014 required**: Corporate Member  
**Registration fee**: n.a.

**Preliminary programme**: 8th N-ECCo Network Meeting
- 07:45–08:00: Morning satellite symposium (tbc)
- 08:00–08:15: Welcome and introduction
- 08:15–10:25: Session 1: Sexual and reproductive issues in IBD
- 10:25–11:00: Facilitating fertility and conception and pregnancy – An update
- 11:00–11:15: Coffee break
- 11:15–12:30: Session 2: IBD through the years
- 12:30–13:45: Lunch break (self-guided poster round in the exhibition hall)
- 13:45–14:15: Session 3: Clinical outcomes
- 14:15–14:45: Clinical history and physical examination
- 14:45–15:15: Radiology interpretation, options & exposure
- 15:15–15:45: Coffee break
- 15:45–16:45: Session 4: Addressing the patient’s priorities
- 16:45–17:00: N-ECCO on 2014 & Conclusion
- 17:15–18:15: Afternoon satellite symposium (tbc)
ECCO goes global  
Guidelines Committee (GuCoM)

1st CIMF - ECCO International Summer School (ISS) in IBD
Guangzhou, China, April 25-28, 2013

The first Chinese International Medical Foundation (CIMF)-ECCO Summer School (ISS) was held in April 2013. This 3.5-day programme was modelled on the ECCO Advanced Course in IBD, now entering its 11th year. Co-Hosts FH. Hu (Guangzhou, current Chair of the Chinese IBD Society) and ECCO President Simon Travis (Oxford) were joined by an expert faculty assembled from Guangzhou (Weihe Chen, Peng Lan and Pinghui Hu) and the other major centres in China (Bing Xa, Wuhan, Zhuhai Fan, Shanghai, Xuchan Wu, Nanjing website) and ECCO Officers Jannick de la Wurde (Rotterdam) and Charlie Lees (Edinburgh). An enthusiastic delegation of 40 IBD physicians (and even a couple of staff from various non-Medicine faculties) were all in the faculty in the majestic Jiaong Hu Princess Hotel for the duration of the meeting, allowing plentiful opportunity for interaction.

The Summer School covered all aspects of IBD, starting with epidemiology and pathogenesis and then ranging through clinical management of Crohn’s Disease and Ulcerative Colitis, special situations (pregnancy, paediatrics), disease and therapy, monitoring and practical aspects of setting up an IBD service and clinical trial design. All delegates were invited to submit a clinical case for discussion. An overwhelming response gave the faculty the opportunity for insight and discussion as from 30 excellent cases (all with high-quality imaging and pathology included) were selected for engagement and discussion by delegates of all ages and amongst faculty. This was particularly evident during the case session at the end. The use of voting pads ensured that all participants felt fully engaged in the learning process.

As has been tradition at the ECCO IBD Advanced Courses, the ISS was preceded and concluded by peer and post-test MOC tests. The e-voting system used to conduct the test allowed real-time visualisation of the test results, providing instant feedback to the participants and faculty as to the knowledge base and gaps to inform appropriately targeted teaching. Comparison of the results of the pre- and post-tests demonstrated a significant improvement in knowledge at the end of the course.

Early plans are evolving to host the 2nd CIMF-ECCO ISS in IBD in Beijing in 2014.

In the meantime, ECCO has developed and published additional guidelines related to various problems in IBD care, e.g. management of opportunistic infections in IBD, pregnancy and reproduction in IBD, imaging, endoscopy and histopathology in IBD and management of paediatric UC and CD.

As evidence and current practice of IBD management change over time, ECCO opted to revise its guidelines on a regular basis (usually every 4-5 years) and several guidelines have already been updated and revised.

The development of ECCO Guidelines has been further improved and standardised over recent years. The criteria for guidelines development is highlighted by the foundation of a committee (GuCoM) responsible for all the issues around ECCO Guidelines. Under the supervision of GuCoM, Standard Operating Procedures (SOPs) for ECCO Guidelines have been developed:

- to give the committee the opportunity for interaction
- to increase the transparency of the entire process, leading to novel guidelines or updates of established guidelines
- to facilitate and standardise the dissemination and publication of ECCO Guidelines.

ECCO goes global

ECCO has diligently maintained a disclosure policy for several years. ECCO Guideline manuscripts cannot be submitted for publication without the authors having submitted a Conflict of Interest form. The conflict of interest declaration is based on a form of the International Committee of Medical Journal Editors (ICMJE), which is widely accepted and used by numerous leading journals including JCC (Journal of Crohn’s & Colitis) and Gut. This policy is described in the ECCO Guidelines and is approved or rejected by ECCO’s Governing Board. The selection of guideline coordinators and participants involves open calls to all ECCO Members and any interested individual can become involved in the guideline project. The selection of working party members (ECCO Members and external experts) and working party leaders is a combined responsibility of GuCoM and the coordinating ECCO Members responsible for the project. They may call upon external experts (also from outside of ECCO Member states and outside IBD-related areas) provided that they submit their conflicts of interest (including before the start of any working party activities and accounts of their extraneous expenses). Criteria for selection of working party members will primarily relate to academic expertise, but appropriate consideration of gender balance, geographical location and participation in current or previous guideline projects is expected, to avoid the perception of bias. Inclusion of IBD Members in working groups, or as drivers for the project under appropriate senior guidance, is encouraged. Employees of the pharmaceutical industry are historically excluded from the systematic literature review or consensus meetings, even as observers.

The development of guideline statements and the supporting text always includes a systematic literature search with the appropriate key words using Medline/PubMed and the Cochrane database (Evidence levels (S) and grades of recommendation (R)) are attributed according to the Oxford Centre for Evidence-Based Medicine. To facilitate the discussion among different working groups and to quantify opinions among all working groups, an online e-voting platform is used for all guideline projects. Usually, two rounds of online voting are performed. The first round takes place after finalisation of the statements by the topic-focused working groups and involves all participants of the consensus project. The feedback from the first online voting is used to modify and improve the initial statements in order to reach the highest degree of acceptance at the second round. A second online voting round takes place after the revision of the statements, and in addition to all the consensus participants, all ECCO National Representatives and all ECCO Members who applied for this guideline but were rejected due to space limitations are involved. The feedback from the second online voting round is again used to modify and improve the statements in order to reach the highest degree of acceptance at the final consensus meeting. A final consensus meeting takes place after the second online voting round and all ECCO Members who were involved in the guideline should attend this meeting. All statements with more than 80% agreement in the second online voting round do not need any additional voting in the consensus panel meeting. All statements with less than 80% agreement will be voted upon and may be revised. If the consensus panel deems a statement with less than 80% agreement to be of sufficient quality and importance, the statement can be included in the final guidelines. A final consensus meeting takes place after the second online voting round, where the statements are accepted as final consensus statements. Those with less than 50% agreement in the final consensus meeting are rejected, as there has been no majority among the experts. Those statements with 50-80% agreement are regarded as having obtained a majority vote, which results in a downgrading of the recommendation grade. In the context of specific guideline projects, the full SOP document can be requested from the ECCO Office (ecco@ecco-ibd.eu).
The 29th ECCO Workshop, and the fifth international ECCO Workshop, was aligned with the National Gastroenterology and Inflammatory Bowel Disease meeting (Reunión Nacional en Enfermedad Inflamatoria Intestinal), hosted by Jesús Yamamoto and Francisco Bosques. The workshop attracted 120 gastroenterologists and surgeons from almost every state in Mexico (see the map). More participants applied than could be accommodated, giving an idea of the enthusiasm for the event.

Presentations were delivered by both the local faculty (José Luis Rocha, in addition to our hosts) and the ECCO Faculty (Simon Travis and Miquel Sans). There was much interaction, knowledgeable questions, and stimulating dialogue, with local experience informing ECCO Guidelines. The ratio of Ulcerative Colitis to Crohn’s Disease approaches 10:1 in rural Mexico (which does not include the 24 million people living in the megapolis of Mexico City – or is that Cities?). Here the admission rate for Acute Severe Colitis is around 9/100,000 population, which matches that of Oxford, but systematic data are scarce. Coccidioidomycosis is endemic in northern Mexico, in addition to endogenous TB, which raises the risks of immunosuppression. Combination therapy is therefore regarded with caution.

The feedback through keypads was overwhelmingly positive, since Mexican clinical practice often has more in common with European practice than with investigation-driven practice in the United States. There is an enthusiasm for European clinical training and we will see more Mexicans at ECCO. The enthusiasm for learning about IBD is palpable. Publication of the workshop cases in a Spanish supplement to the Review of Gastroenterology & Hepatology is coming. Translation of the ECCO Guidelines on Ulcerative Colitis, with publication in the Mexican Journal of Gastroenterology, is also now a project in hand. And for people yet to visit Mexico, you have to discover what, where and when to carajillo. Just try the Mexican version!

Call for ECCO Educational Workshop 2014 Destinations

The primary goals of these educational workshops organised by the ECCO Education Committee are the harmonisation of IBD practices within ECCO Country Members by spreading the ECCO Guidelines as well as the provision of continuous medical education with the ultimate aim of improving the quality of care for patients with IBD. The programmes of these one-day workshops are created around clinical cases, with the intention of ensuring that the workshop is as educational and proactive as possible and that participants can take an active part in the discussions. ECCO Educational Workshops are offered to large countries and in regional centres to smaller countries throughout Europe.

So far, 30 Educational Workshops have been organised, starting in 2007. A list can be found on the ECCO website (www.ecco-ibd.eu/Educational-Workshops/Where-we-have-been).

This call is specifically targeted at ECCO National Representatives with an interest in hosting such an Educational Workshop in their country or specific region during the year 2014. National Representatives who see this workshop as an opportunity to foster education in this particular field of expertise in their country are invited to apply for an ECCO Educational Workshop in their country/region.

The application should contain the following elements:

- Proposed dates stated in chronological order according to preference (max. 3 options)
- Possible venue/city
- Name of local organiser (contact person for ECCO Office)

How to apply:

Please submit your application, including an official letter of intention, by September 14, 2013 to the ECCO Office (p.judkins@ecco-ibd.eu). Kind regards,

ECCO Education Committee

Scan and contact the ECCO Office

www.ecco-ibd.eu
Deadline for applications for ECCO Fellowships, Grants and Travel Awards: October 1, 2013

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

Fellowships have been created for individuals younger than 40 years who submit an original research project which they wish to undertake abroad in a European hosting laboratory and/or department that has agreed to host and guide the Fellow for the duration of the Fellowship (one year) and that is responsible, together with the Fellow, for the successful completion of the project. Fellowships are awarded EUR 40,000 each and are given during the annual ECCO Congress.

Grants are created to support good and innovative scientific, translational or clinical research in Europe. The guidelines for ECCO Grants are very similar to those for the Fellowships, with the exception that the research is typically undertaken in the institution of the applicant. ECCO Grants are awarded EUR 20,000 each and will also be given during the annual ECCO Congress.

The Travel Awards were established in 2007 as an opportunity for young investigators to visit different IBD centres in Europe, to learn scientific techniques or to be a clinical observer. Incentives are available for applicants from Central and Eastern Europe.

IBD nurse members of ECCO can apply for the N-IBD Travel Award, which provides nurses with the opportunity to visit another European centre to observe nursing care, in recognition of the fact that observational learning is essential in enabling nurses to develop within a role.

How to apply:
For detailed information on Fellowships and Grants, including eligibility and the submission process, please visit the ECCO website (https://www.ecco-ibd.eu/science/fellowships-and-grants.html).

We look forward to your application!
Kind regards,

EDOUARD LOUIS
SciCom Chair

Call for applications for ECCO Fellowships, Grants and Travel Awards 2014

Introducing new SciCom Members

Find out more about the new SciCom Members, Laurence Egan, Julián Panés and Gerhard Rogler, who joined the Scientific Committee in February 2013, in their profiles below

Laurence Egan

Laurence Egan graduated from UCG in 1990 (MB, BCh), completed internships, house officer and registrar training based at University College Hospital Galway. He received Membership of the Royal College of Physicians in 1992 and a Masters in Medical Science from UCG in 1994. From 1994 to 1999, at the Mayo Clinic in Minnesota, he completed further training in Internal Medicine, Clinical Pharmacology and Gastroenterology, receiving American Board certification in those three disciplines. Mr Egan finished his MD in 1999. Laurence then undertook post-doctoral training from 2000 to 2002, in the Laboratory of Mucosal Immunology at the University of California, San Diego, before returning to the Mayo Clinic to take up a consultantcy in Gastroenterology, with joint appointment in the Department of Molecular Pharmacology and Experimental Therapeutics. His research focuses on molecular characterization of signalling pathways involved in intestinal epithelial cell stress, death and malignant transformation. In 2005, he was recruited by Mr Galway and the Health Service Executive Western Region as Professor of Clinical Pharmacology/Consultant Clinical Pharmacologist and Head of the Department of Pharmacology & Therapeutics, a position he took up in August 2005. Laurence has been an active individual member of ECCO since individual memberships first started. He has also had the honour of serving as National Representative of Ireland to ECCO, and in 2010 hosted an ECCO Educational Workshop in Galway. He was involved in the organisation of the 3rd ECCO Pathogenesis Workshop on Inflammatory Bowel Disease and Neoplasia, and as a member of the Organising Committee of the 6th Congress of ECCO in Dublin, 2011. He would like to make the following contributions to the ECCO-SciCom:
• Continue the outstanding work of the committee to date on the development of scientific workshops and scientific programmes.
• Establish new methods to translate outputs of ECCO Scientific Workshops into ECCO-funded research projects.
• Review the Fellowship, Grants and Travel Awards that have been so successful at ECCO to ensure that they are optimally meeting the organisation’s mission.
• Conduct market research among the IBD research community to identify the key challenges that we face in these diseases. That knowledge can be very useful in setting research priorities for ECCO, and in the organisation of our congresses.
• Seek opportunities to expand the research budget available within ECCO.

LAURENCE EGAN
SciCom Member

Julián Panés

IBD research and clinical practice is one of Julián’s passions, and he considers himself very lucky to work in the IBD Unit of the Hospital Clinic of Barcelona with a young and enthusiastic team of clinicians and basic scientists. The research interests of the Unit revolve around IBD pathophysiology, diagnostic methods with a special interest in imaging and new therapies, in particular oral therapy. Julián considers ECCO to be the most relevant international organisation in IBD because it has successfully encouraged the adoption of high standards of care in the field, based on fostering education and research that provides benefit to our patients. He has been involved in many of the past activities of ECCO, participating in the generation of consensus documents, reviewing abstracts and grants, and delivering talks at ECCO Congresses and educational meetings. Julián sees his mission on the Scientific Committee as making a contribution to research in IBD based on facilitation of integrative efforts between basic scientists, clinicians, patients, the pharmaceutical industry and payers. Integration of different areas of knowledge is an essential part of achieving excellence in research. Moreover, in recent years collaboration with the industry has made possible the development of studies that are having a major impact on our current practice, and these initiatives should be further pursued. Payers can also help us in fostering progression because they demand more effective medicines if higher reimbursements are expected. We face a still high number of unmet needs in the assessment and treatment of patients, and Julián expects SciCom to catalyse the interactions among all stakeholders in order to expand research and improve the lives of our patients.

GERHARD ROGLER
SciCom Member

Since March 2007, Gerhard Rogler has been Novartis Chair of Gastroenterology and Hepatology at the Medical Faculty of the University of Zurich, as well as senior physician in the Department of Gastroenterology and Hepatology of the University Hospital. He has built up a large research group there, with more than 30 MDs, PhDs and PhD students as well as technicians and study nurses focusing on clinical aspects and pathophysiology of Inflammatory Bowel Disease (IBD). Gerhard’s group has built up collaborations with other groups locally but also an excellent international group in Cleveland, San Diego, Stanford, Houston, Milan and Jena. Gerhard has authored and co-authored more than 370 PubMed-credited manuscripts, of which more than 180 are original manuscripts.

IBD has been Gerhard’s focus of research ever since 1995. He has pushed this priority especially since 2007, when he moved to Zurich. In May 2004 Gerhard became the principal investigator of the special research programme SBI of the German Science Foundation at the University of Regensburg ("Regulation of immune functions in the digestive tract"). Interdisciplinary scientific collaborations have always been a high priority among his interests. Through his work as a scientific coordinator of the BMBF “Competence Network Chronic Inflammatory Bowel Disease” and as the first chairman of the “Competence Network IBD”, he is well trained in institutional work and networking. Since 2011 he has been principal investigator of the Swiss IBD Cohort Study, a nationwide cohort project currently supported by the Swiss National Science Foundation with nearly CHF 5 million, which was initially established by Pierre Michetti. Since 2011 Gerhard has also been a panel member of European Research Council and in 2012 he was elected into the IOIBD. Gerhard looks forward to his work on SciCom and SWS 4 and hopes to cooperate closely with other ECCO Members.

GERHARD ROGLER
SciCom Member
The 2nd ClinCom Workshop was held on February 14, 2013 during the ECCo Congress and was entirely devoted to therapeutic trials. During the first session, Jakub Paneš recalled that suboptimal design of the initial phases 1 and 2 in drug development, with incomplete pharmacodynamic dose-response characterisation and imperfect pharmacokinetic profiling, may have caused the benefit of some drugs to be overlooked and led to remaining uncertainties on the optimal dosing of already marketed biologics. In parallel, two new aspects in the treatment of BD require a number of efforts to optimise therapies: the comparison of treatment or monitoring strategies and the proof that a certain therapeutic intervention may lead to a change in disease course (surgery, hospitalisation, disability etc.). Cluster randomised trials are particularly appropriate for the development of disease-modification trials.

Brian Feagan and Jean-Types Mary underscored that cohort studies and randomised clinical trials (RCTs) have complementary roles to play in the evaluation of BD research questions. The randomised design allows examination of treatment allocation, which helps to minimise bias, and, most importantly, random allocation of known and unknown confounders to treatment, which allows isolation of the treatment effect in the experiment. For these reasons the RCT has become the gold standard for evaluation of medical therapies. However, multiple challenges currently exist in the design and conduct of randomised controlled trials in BD. These include the choice of comparator (active vs. placebo), selection of patients (treatment naïve vs. failures) and selection of outcome measures (surrogates vs. clinical). In their pursuit form, prospective cohort studies allow for relatively unbiased assessment of pre-defined outcome and thus minimise the bias associated with retrospective designs. Furthermore, the cohort design allows prospective definition of and adjustment for known confounders. Accordingly, the cohort design is well suited to address questions of causation that cannot, often for ethical reasons, be evaluated by an RCT. Cohort studies have the limitation of requiring large sample sizes and often have a relatively long-term horizon.

The requirements for clinical trials in the two main areas of BD, Crohn’s Disease and Ulcerative Colitis, are summarised in two separate guidelines of the European Medicines Agency (EMA) for the development of new medicinal products. These two guidelines came into operation in the years 2008 and 2009. Elmer Schabel from EMA concluded his talk by stating that whereas guidance documents for the development of new therapeutics are able to give clear recommendations for the conduct of clinical trials, the reality, with previous acceptance of deviating development programmes, economic restrictions and the problems of day-to-day patient care, is imposing some flexibility on the overall requirements in drug regulation.

In his talk, entitled “How to avoid bias or mistakes in academic trials”, Stefan Schreiber reflected that academic trials should reflect the situation in clinical practice and that unfortunately they are often conducted to answer specific questions or to achieve the proof of efficacy required for approval of a drug by the authorities. This leads to compromises on several levels: limitations in patient selection through in/exclusion criteria and trial design, limitations in the choice of endpoints, inadequate statistical concepts for comparator studies, early choice of dosing levels and neglect of individual differences.

Overall, the workshop was highly interactive, with fruitful discussion throughout the sessions. Filip Baer as Chair of ClinCom closed this workshop by informing about the way to submit a study protocol to ClinCom for details on how to submit your study protocol, visit the ECC website at www.ecco-bd.org/ClinCom/SDP-Clinical-Study-Protocol). All ClinCom Members will be invited to send their comments on each study protocol in a timely manner, with the final aim of improving the likelihood of publication in a good journal and the clinical relevance.

The 2nd ClinCom Workshop © EECO Photographer

The risk of adverse outcomes in Paediatric IBD

A summary of studies evaluating treatment-associated risk in Paediatric IBD that were presented at the ECCo’13 Vienna Congress

The treatment of BD is always a balance between the beneficial outcomes of a given treatment and the risk involved in using it or not using a treatment modality. Since both Crohn’s Disease (CD) and Ulcerative Colitis (UC) entail a high risk of complications and need for surgery, the risk involved with immunosuppressive therapy is usually felt to be acceptable. Paediatric BD is characterised by more aggressive and extensive disease. This has led to more widespread use of immunomodulators (IMM) early in the disease. Recent data from multiple adult data sets have shown that IMM and biologics may be associated with treatment-associated cancers and mortality. While parents, patients and many physicians have become more wary of certain medications because of these data, others are concerned that the risk of cancer and mortality due to undertreatment may be overlooked.

Several studies presented at the ECCo’13 Vienna Congress provided novel data about the risks of disease- or treatment-associated complications in Paediatric BD.

Data from the 4,443 paediatric patients (2,263 of whom received immunosuppressants (IMM), involving 4,417 patient years) enrolled in the DEVELOP database (a Janssen-sponsored and -sourced database) gained sight on the risk of cancer from treatment or disease. DEVELOP is a prospective observational registry designed to study the long-term safety of IMM and other therapies in Childhood-onset BD (CD and UC). Data were obtained from 86 centres in North America and Europe from 2007 to 2012. Multiple cancers were observed in the DEVELOP cohort with similar risk profile compared with the expected event rates using the SEER database, adjusted for age, gender and race. The incidence rates of IMM (IR) were estimated by dividing the number of patients in whom malignancies were observed by the expected number of cancer events, according to the age-adjusted incidence rates in the United States based on SEER data. This study showed a lack of a control group made it impossible to quantify the true IBD and treatment-associated adverse outcomes, since both disease- and treatment- associated adverse outcomes increase over time and may appear when the children have become adults. Since the paediatric age group is an especially vulnerable group who will have a longer duration of disease as well as exposure to medications, we need even larger and better organised data sets targeted at identifying these outcomes.

On behalf of P-ECCO

ARIÉ LEVINÉ

Laurent Peyrin-Biroulet

On behalf of ClinCom

The ESPGHAN Porto group took a different approach. They attempted to perform a retrospective analysis of all causes of IBD-related mortality, including cancer. The survey was performed among paediatric gastroenterologists in 19 European countries and Israel. One representative from each country repeatedly contacted all paediatric gastroenterologists from each country and reported all Paediatric BD patient deaths. In total, 726 deaths were reported during the period 2006–2011. Data regarding the cause of death, prior treatment and type of cancer were registered. The group identified 18 cancers and/or 32 deaths among Paediatric BD patients. For five deaths, no information was available (hepatosplenic and EBV associated lymphomas, was both responsible for 19% of deaths. The lack of a control group made impossible to elucidate how many of the cancer cases were disease specific but at least five lymphomas (hematopoietic and EBV associated) were first using were associated by virtue of their phenotype.

In the data presented, all cancers are reported with the information about the treatment-associated risk of IBD. However, it is clear that outcomes measured during childhood may under-report the true BD and treatment-associated morbidity and mortality. Since both disease- and treatment- associated adverse outcomes increase over time and may appear when the children have become adults. Since the paediatric age group is an especially vulnerable group who will have a longer duration of disease as well as exposure to medications, we need even larger and better organised data sets targeted at identifying these outcomes.

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Does an appendectomy have a therapeutic effect in UC patients?

Over the past few decades, various hypotheses have been proposed for the aetiology of Ulcerative Colitis (UC). The development of inflammation was suppressed in mice (Colitis mouse model) showed that the association between the appendix and UC. A recent study showed a significantly increased number of early activated CD4+ T cells in the appendix of UC patients, compared to the late activated CD4+ T cells seen in the inflamed intestinal mucosa, particularly the ileum.

Various epidemiological and case control studies have investigated the association between appendectomy and UC. A recent Australian study reported excellent outcomes in UC patients compared to an incidence of more than 3% in non-IBD controls from an orthopaedic clinic. They showed that a therapeutic effect in UC patients?

Our main goal is to establish a full understanding of the appendix and its role in UC on every level. If an appendectomy can protect UC patients from future use of medication or even surgery, the additional costs and potential side effects of appendectomy would be offset by substantial gain in health and reduction in costs later on. This is especially true for laparoscopic appendectomy, as this is a relatively simple procedure that can be performed in day care and easily incorporated into standard treatment regimens in UC patients.

References

William Beineman, S.ECCO Member

Dear colleagues,

We hope you are well and updated with all the news happening in our Y-ECCO Community.

Our educational programme is expanding! Starting this year, together with the Y-ECCO Committee and the team discussion, we chose the timely topic "Presentation, networking and negotiation skills" – all very important competencies for your career. Supported by our renewed collaboration with the ECCO Family and the ECCO Young Committee (Y-ECCO), the Y-ECCO Committee are working on developing a novel Y-ECCO Ultrasound Workshop in collaboration with the Educrom and ESGE. After a short theory section, Y-ECCO Members will have plenty of opportunities to practice on different ultrasound samples (see p. 11 for the preliminary programme). Both workshops are on the same day as the Y-ECCO Members’ Meeting and Networking Event, so you can come a day earlier to the ECCO Congress and participate in our great programme. You can register online for both workshops.

To further enhance possibilities for young gastroenterologists to participate in ECCO activities, Tim Raine is working on including interested Y-ECCO Members in the clinical case development process for the recently launched eCOC Learning platform. There is still a lot of room for new cases and other content, and your contribution will be more than welcome. Tim is also collaborating with SciCom to help launch the new online scientific platform – connecting all parts of the ECCO Family and different disciplines, ranging from location to scientific interest, mentorship and collaborations! You can continue to apply for the Y-ECCO Clinic programme for future ECCO activities, which provides the opportunity to chair a session alongside an experienced ECCO expert. Selections will be made on a competitive basis.

Y-ECCO maintains a strong presence in ECCO. Next to the previous work, we have decided to create a new edition of the Y-ECCO newsletter: the Young ECCO News: the Y-ECCO Conference report. You will hear about it shortly!

Ciao to all and do not hesitate to contact us for further details.

Y-ECCO Committee

Promoting collaborative clinical studies among “Young Europe”: a new task for Y-ECCO

Starting from this year, the Y-ECCO Committee, in collaboration with the YCHC, is offering the possibility of fostering collaborative studies proposed by Y-ECCO Members for clinical studies should follow the guidelines provided by ClinCom (available on the ECCO website: www.ecco-ibd.org/young-eccomembers/sponsored-studies). Although ClinCom supports and fosters the idea of Y-ECCO Members encouraging collaborative studies, our aim is to promote the availability of resources and knowledge at the best of our ability.

Briefly, whoever wants to propose a collaborative study in Europe (or worldwide, as ECCO is now worldwide) can simply write a study synopsis of a few pages (following ClinCom Guidelines), send it to his or her Y-ECCO representative and wait for initial feedback. After this step, a full application may be encouraged and discussed in depth within ClinCom, with the presence of a Y-ECCO Committee Member. Once the study has received a recommendation from ClinCom, Y-ECCO will decide whether to promote it using the available instruments (such as e-mail lists, website and workshops). All studies will receive constructive feedback independently of whether later Y-ECCO sponsorship is forthcoming or not.

Further good news is that the first Y-ECCO study has already been submitted! You will hear about it shortly!

Ciao to all and do not hesitate to contact us for further details.

Y-ECCO Committee

Submission of the proposal by Y-ECCO Member

Y-ECCO Committee

Send back the proposal not properly designed with comments for own use

Study not endorsed

Study endorsed

Forward and follow-up the proposal

Y-ECCO Committee

Young ECCO (Y-ECCO)

Y-ECCO Chair

Y-ECCO Members for revisions

ESCP (September 25-27, 2013, Belgrade) or ESGE (September 26-27, 2013, Berlin). We already have authors for DDW in Orlando, but we are still looking for Y-ECCO Members interested in writing on the ESPGHAN (May 8-11, 2013), LONDIS, ESGE (June 4-7, 2013, Barcelona), ECCO (September 25-27, 2013, Berlin) or ESGE (November 15-16, 2013, Budapest) meetings. If you are interested in any Y-ECCO related activities or if you have ideas for new projects, please let us know: contact ecco@ecco-ibd.eu.

We are looking forward to hearing from you.

As always, thank you for all you do for Y-ECCO.

Françoise Scaldaferri, Y-ECCO Chair

Young ECCO (Y-ECCO)

Young ECCO Committee renders decision on sponsoring the study (majority vote)

Young ECCO Members (using endorsement tools at the discretion of Y-ECCO Committee)

Steps for the review of studies © Franco Scaldaferri, Filip Baert
As of the Congress in Vienna, Marijolijn Duijvestein and James Lee have left the Y-ECCO Committee and have been replaced by Sebastian Zeissig and Tim Raine.

**MD & JL:** Hi and welcome to the best committee in ECCO! Tell us about yourselves.

**TR:** I'm a postdoctoral fellow at the University of Cambridge. I undertook my initial medical training and PhD in Cambridge, and subsequently continued my training in Yale, Connecticut, USA and at Guy's and St. Thomas' Hospitals, London, UK. After postdoctoral work at Kings College, London, UK, I returned to Cambridge for general internal medicine and gastroenterology specialty training. In 2011 I was awarded a research fellowship to examine the impact of genetic variants associated with Inflammatory Bowel Disease on the behaviour of gastrointestinal T cells.

**SZ:** I am a junior research group leader at the University Medical Center, Kiel, Germany. I graduated at the Charité (Berlin, Germany) in 2004 (M.D.) and following graduation, worked as a postdoctoral fellow at the Charité. Later, I joined the laboratory of Richard S. Blumberg at the Brigham and Women's Hospital (Boston, USA), where I studied the role of lipid antigen presentation in IBD and infectious hepatitis. In 2010, I joined the Department of Internal Medicine in Kiel, Germany, where I continue my GI training and lead a research group focused on the immunological mechanisms of intestinal inflammation and cancer.

**TR & SZ:** You have both spent the last two years working on the Y-ECCO Committee: What were the main highlights?

**MD:** The yearly Y-ECCO Workshop is truly my highlight. It has been great interacting with people from all around the world, and to reunite with them at the ECCO Congress. Furthermore, it was great working together with François, James, Peter, Florian and the whole ECCO Team.

**JL:** My main highlight has simply been the many conversations I have had with Y-ECCO Members. These have ranged from chatting idly over a beer at the Y-ECCO Networking Events while getting to know new members, to being asked for advice as young clinicians have to make difficult decisions over their futures. This has been hugely rewarding in terms of making new friends and contacts and a huge privilege.

**MD & JL:** Can you tell us what it was that made you want to join the Y-ECCO Committee?

**SZ:** During my training as physician-scientist in the field of IBD I have greatly enjoyed being a member of Y-ECCO and have, with great pleasure, participated in Y-ECCO activities such as the Y-ECCO Workshop. As a Y-ECCO Committee Member, I now look forward to organising these unique events for Young ECCO Members.

**MD & JL:** So what are you both most looking forward to?

**TR:** Meeting more of the Y-ECCO Members and really ECCO in action. Having the opportunity to look outside of national communities of clinicians and researchers and see cooperation across Europe in bringing forwards some of the goals of our organisation.

**SZ:** Y-ECCO is driven by extraordinarily talented young clinicians and scientists supported by a network that facilitates interaction. I very much look forward to further strengthening and expanding this outstanding and dynamic network and to interacting with all Y-ECCO Members.

**TR & SZ:** Now that you are both in a position to look back at your time in Y-ECCO, what do you see as its main relevance?

**MD:** I think it is unique that within such a great organisation as ECCO young people can meet and interact. It’s been great that so many Y-ECCO Members have contributed to the literature reviews published in ECCO News. The main relevance of Y-ECCO is that it provides a platform to any Y-ECCO Member with a good idea.

**JL:** For me, Y-ECCO is a bit like a greenhouse. It brings together young clinicians and scientists and promotes interactions between them, but it also provides the optimal environment for them to develop and grow. It also provides a unique opportunity to develop links with more senior figures who can facilitate movement within Europe. I also think it’s really important to remember that in 15-20 year’s time, the senior posts in ECCO will almost be all filled by people who are now in YEOCC.

**MD & JL:** Finally guys, can you tell us what you will be doing in Y-ECCO?

**SZ:** I am currently organising the Y-ECCO Workshop 2014, which we hope will repeat the immense success of this year’s workshop.

**MD:** I'm going to be continuing in my role as a Clinical Lecturer at the University of Cambridge for at least the next couple of years and then plan to apply for an Intermediate fellowship to continue my academic training, probably back to Cambridge for a time. Oh, but I'll still be at the ECCO Congress each year and can guarantee that I will always be found on the dance floor at the party! (It's not an ‘interaction’)

**JL:** Last year I obtained my MD. I've just finished two years of general internal medicine training and will now continue my GI training and research work. I'll also be back at the ECCO Congress in Copenhagen and am already looking forward to the next Y-ECCO Workshop!

**MD & JL:** What was the key step that allowed you to move forward in your career in IBD?

**SZ:** When I think back on what was really relevant, I feel that my career can be compared to the direction that I wanted and in the field that I had chosen IBD. My subsequent departure for the United States to work with Claudio Fiocchi for 3 years was crucial in starting my career in IBD research and enabling me to become very much involved in the IBD field. Working in the lab at the same time as Andreas Sturm, Miquel Sans and Florian Rieder was the next domino to fall into place. They were the first nodes in my network of colleagues across Europe. It is fun to look back and see that all of us who were the “post-docs” are now grown up PI’s: This is a journey that we have shared in many respects, such as fighting for funding or participating in common research programmes. Collaboration between IBD scientists is mandatory if one is to build a solid career in IBD and get the best results from one’s work. Nobody can reach the top of the mountain alone.

**MD & JL:** What suggestions can you give young doctors who want to work in IBD?

**SZ:** I think that it is key to have full commitment to patient care and to try to provide the best care to patients, based on the best evidence-based medicine. In addition, for young doctors interested in research, whether clinical or at the bench level, it is important to choose a good mentor. Having a guide who provides ‘great tips’ and ‘good timing’ is key, and meeting with a young spirit this makes a very good cocktail. Those willing to become involved in academic IBD must be prepared to accept a very large workload. Research is so called because it is RE-search: one must search and search again, until one finds something. Sometimes good research means many, many negative findings, and a lot of frustration, before good solid data are obtained. Finally, if a young doctor is interested in IBD, he or she must join Y-ECCO and ECCO.
Once-daily budesonide MMX in active, mild-to-moderate ulcerative colitis: results from the randomised CORE II study


Introduction

Corticosteroids are effective for inducing rapid remission in Ulcerative Colitis (UC), but due to their adverse effects they are usually reserved for patients who have failed mesalazine, patients who need a prompt response or those with severe disease [1, 2].

Oral budesonide is a topically acting corticosteroid with low bioavailability and few systemic side-effects [3, 4], and this local activity in the colorectum is the key to its efficacy. However, current oral p-methylated release formulations of budesonide are able to act only in the distal bowel and proximal colon and so are not optimally designed for the anatomical distribution of UC [5]. In fact, a recent study assessed that oral budesonide was significantly less effective than mesalazine for inducing clinical remission in active UC (P<0.05), and in some cases delivery to the entire colon, as supported by scintigraphic data [6]. On the other hand, the colorectal drug release system (MRX) has now been almost exclusively used successfully with oral mesalazine (mesalazine MMX) [7-9]. This technology provides better delivery to the entire colon, as supported by scintigraphic data [6].

Overall, budesonide coupled with the MMX colonel release system was very well tolerated and raised no new safety concerns, with an adverse event profile not clinically different from that observed with placebo.

Beyond the CORE I study, an almost identically designed CORE II study was conducted in the USA, Canada, Mexico and India and yielded very similar results [10].

What is of interest in this study?

The study shows that budesonide MMX 9 mg is safe and effective for induction of combined clinical and endoscopic remission in patients with active, mild-to-moderate UC. It was designed as a randomised, double-blind, double-dummy, placebo-controlled parallelogroup trial and was conducted at 69 centers in 15 countries in Europe, Asia, and Latin America between July 2007 and February 2009. An internal reference arm of oral budesonide controlled-release pellets (Entocort EC) was included as an active control, but the study was not powered to detect a statistically significant difference between the budesonide MMX and Entocort groups.

In total, 410 UC patients were evaluated for efficacy and received budesonide MMX 9 mg/day, budesonide MMX 6 mg/day, Entocort EC 9 mg/day or placebo, taken once daily for 8 weeks. The primary endpoint was a high goal Combination clinical and endoscopic remission at week 8, defined as UC Disease Activity Index score ≤ 1 with a score of 0 for rectal bleeding and stool frequency, no mucosal friability on full colonscopy, and a ≥3-point reduction in Endoscopy Index Score from baseline. The authors chose this definition partly to minimize the placebo response, but also as a strategy that could be clinically relevant.

Budesonide MMX 9 mg provided a statistically significant increase in the combined clinical and endoscopic remission rate compared with placebo (18.5% vs 4.0%, OR 4.04, 95% CI 1.47-11.32, p=0.0044). Furthermore, budesonide MMX 9 mg was associated with higher rates of clinical and endoscopic improvement (32.7% vs 33.7% and 42.2% vs 31.5%) compared with placebo, but these differences did not reach statistical significance. Nevertheless, the ratio of histological healing (16.6% vs 6.7%, p=0.0061), which appears to predict long-lasting remission, and the proportion of patients with symptom remission (23.9% vs 11.2%, p=0.0220) were significantly higher for budesonide MMX 9 mg than for placebo. Although numerically more patients achieved combined clinical and endoscopic remission with budesonide MMX 6 mg compared with placebo, this difference was not significant.

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Introduction
The development of perianal fistula is a common complication of Crohn’s disease (CD) and is a target for therapeutic intervention. Patients with perianal fistula have a long duration of disease, a range of medical and surgical options are available today, the treatment of perianal fistula remains challenging. Achieving complete closure of the fistula tract is a long process and relapses are common.

What this paper is about
In this multicentre randomised, double-blind, placebo-controlled trial, patients with active perianal fistulae in Crohn’s disease: a randomised, double-blind, placebo-controlled trial, patients with active perianal fistulae in Crohn’s disease were randomised to receive adalimumab (80 mg every 2 weeks) once weekly or twice daily was added to the adalimumab from week 4 until the end of follow-up at week 24. Placebo (n=36). All patients started at day 0 with adalimumab + ciprofloxacin (n=34) or adalimumab + placebo. In the adalimumab + ciprofloxacin group, the median Perianal Disease Activity Index (PDAI) decreased from baseline to week 12 (p<0.001), no difference in PDAI reduction was observed between the arms at week 12 or 24. (In the mean Crohn’s Disease Activity Index (CDAI) was significantly more reduced at week 12 and week 24 compared to baseline when combination therapy was prescribed. The decrease in Inflammatory Bowel Disease Questionnaire (IBDQ) from baseline to week 12, but not week 24, was significantly greater in the adalimumab + ciprofloxacin-treated patients than in those who received adalimumab monotherapy (p<0.009).

In the adalimumab group, 31/34 patients had no serious adverse events compared to 31/34 patients in the placebo group, three patients in the combination group and two patients in the monotherapy group experienced a serious adverse event. No differences in severity or frequency of adverse events between the arms were reported.

The most common adverse event was upper respiratory tract infection.

Conclusion
Although the calculated sample size was not reached in this study, the results clearly show that the combination of adalimumab and ciprofloxacin is superior to adalimumab monotherapy in the treatment of active perianal Fistulising Crohn’s Disease. However, this effect was not maintained after withdrawal of ciprofloxacin. Therefore, future studies should address whether long-term treatment with ciprofloxacin in addition to TNF is feasible and may delay or even avoid seton placement or more invasive surgery such as proctocolectomy in this patient population.

In this study, response and remission rates were higher with combination therapy compared to monotherapy (p=0.002). The frequency of serious adverse events in the high throughput subgroup was comparable to that among patients with low antibiotic concentrations. Infections occurred in seven patients treated with BMS-936557 as compared to two patients in the placebo arm. The authors refer to an earlier study investigating BMS-936557 in rheumatoid arthritis patients showing no increased infection rates as compared to the placebo group. In the present study, treatment for two patients recovering BMS-936557 was failed both primary and secondary endpoints due to lack of clinical response and remission rates. However, the trial population in this proof of concept study was rather small with 109 individuals and large study cohorts may delineate significant therapeutic effects from this compound. Furthermore, since higher through levels were clearly associated with clinical and histological improvement, the clinical benefit of increased dosages is potentially promising and is currently being investigated in another clinical trial (ClinicalTrials.gov identifier NCT01294240). Nevertheless, the significance of target R10 in the clinical management of UC is currently indeterminate, especially in the face of other promising agents with a targeted mechanism of action, such as tofacitinib and vedolizumab, which all are expected to become available soon.

References

ECCO Elections
Dear ECCO Friends,

Notice is hereby given that the following positions on the ECCO Governing Board and ECCO Committees are open for election:

ECCO Committees – open seats (2014-2016):
1. President-Elect, 2014-2016
2. 2 Y-ECCO Members (Young ECCO)
3. 2 P-ECCO Members (Paediatricians of ECCO)
4. 1 N-ECCO Member (Nurses of ECCO)

For details regarding the elections and to download the election forms, please visit the ECCO website (www.ecco-ibd.eu).

ECCO Governing Board:
1. 11. President, 2014-2016
2. 10. President-Elect, 2014-2016
3.  9. Vice President, 2017-2018
4.  8. Secretary, 2017-2018
5.  7. Treasurer, 2017-2018
6.  6. 2 Ex-officio Members (President-Elect and President)

ECCO Committees – open seats (2014-2016):
1.  1. 3 CmCom Member (Clinical Research Committee)
2.  2. 3 EducCom Members (Educational Committee)
3.  3. 2 EpCom Members (Epidemiological Committee)
4.  4. 2 GutCom Members (Gastroenterological Committee)
5.  5. 1 SciCom Member (Scientific Committee)
6.  6. 1 NECCO Members (Nurses of ECCO)
7.  7. 2 PECCO Members (Paediatricians of ECCO)
8.  8. 2 Ecco Members (Surgeons of ECCO)
9.  9. 2 Y-ECCO Members (Young ECCO)

Deadline for submission of applications for ECCO Committees is September 13, 2013 and for the ECCO Governing Board: December 13, 2013.

For details regarding the elections and to download the election forms, please visit the ECCO website (www.ecco-ibd.eu). Please send all forms to the ECCO Office via email to ecco-ibd@ecco-ibd.eu.

Kind regards,
ECCO Governing Board
The underlying aim is to integrate all IBD on Inflammatory Bowel Diseases (DACED) in Germany, under the title of the German in 1999. The common decision to establish a Competence Network IBD was established while joint study platforms on chronic IBD have implemented to provide sustained support study proposals will be jointly developed and are then reviewed and permitted by the steering committee. A special focus of the meeting was IBD beyond CD and UC, and state-of-the-art lectures on microscopic colitis and coeliac disease were given. Within the Competence Network IBD, two prospective 5-year studies are being undertaken on 1,500 CD and 1,000 UC patients (early disease and/or biologics).

What are your most prestigious/interesting past and ongoing projects?
At the 2012 DACED meeting in Mainz, chaired by Christian Maaser, 28 original IBD research projects were presented. The topics included genetics, pathogenesis of inflammation, signal transduction studies in cell lines and mouse models of IBD, as well as diagnostic and interventional trials in humans.

Chairmen of the competence network IBD are elected every 2 years. The GISG structures are depicted in the graph above.

When did your national group join ECCO?
Immediately after the foundation of ECCO (about 10 years ago) The German GI Association (DGVS), in conjunction with its IBD organisation (DACED), was one of the founding societies of ECCO and also belongs to the group of first paying members after the introduction of country fees (in 2000). Since 2010 the Competence Network IBD has been the German ECCO Country Member and elects the National Representatives jointly with DACED.

What are your main areas of research interest?
In Germany several IBD research groups are active, focusing on nearly all fields of IBD and covering epidemiology, health services research, and basic and clinical sciences. GISG promotes studies aimed at answering questions relevant to research into the causes, epidemiology, diagnostics and therapy of Crohn’s Disease (CD) and Ulcerative Colitis (UC).

How do you see ECCO helping you to fulfil these aims?
ECCO’s wide calls for networking using ECCO newsletters, mailing of newsletters to the Competence Network IBD and distributing these newsletters via their email list, involving German National Regs in ECCO strategies.

What do you use ECCO for? Network?
Congress? How do you use the things/services that ECCO has to offer?
Network, data presentation and update on all issues relevant for IBD, formation of international networks, planning of research projects and clinical trials, developing international projects, health care politics, meeting reps from industry, meeting patient associations.
When did your national group join ECCO?

From the start of ECCO in 2005.

What are your main areas of research interest?

Strategic clinical trials.

Does your centre or country have a common IBD database or bio bank?

This is now being set up.

How do you see ECCO helping you to fulfill these aims?

ECCO is a forum for the exchange of ideas: people beyond our borders. It helps in developing cooperation with other national groups, such as GETECCU (in Spain) and IBRD (in Belgium), in respect of trials/projects.

Which ECCO projects/activities is the group currently involved in?

METECOR is an ECCO project. GETAD members have been/are involved on the Governing Board, ClinCom, EpCom, GuCom etc.

What are your aims for the future?

To increase the number of ECCO Members in France and to continue to perform good strategic studies.

How do you see ECCO helping you to fulfill these aims?

By inviting members of the group specifically to join research projects in the field of epidemiology and through cooperation regarding our upcoming national registry.

What do you use ECCO for? Network? Congress? How do you use the things/services that ECCO has to offer?

To establish closer connections with ECCO and its members. Dr. Prytz-Johansen is attending the ECCO Congress instead of the IBD group meetings.

From the Nordic countries, this is a great opportunity to get to know ECCO and its members. Dr. Prytz-Johansen is attending the ECCO Congress instead of the IBD group meetings.

What are your main areas of research interest?

Epidemiology (IBDEN group), biologics registry (NOKBIL).

What are your aims for the future?

To establish closer connections with ECCO and to cooperate more in research activities.

ECCO Committees 2013

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**Corporate Members 2013**

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<th>Cosmo</th>
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