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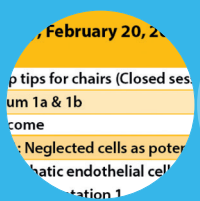

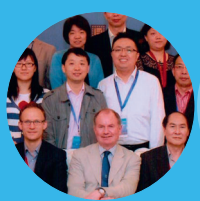

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European Crohn's & Colitis Organisation

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Content:

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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 for us. Don't be frightened by this: it is an opportunity for IBD specialists to show that they contribute added value and enhance the care for our patients with IBD. Come to Copenhagen for IBD and find out more.

Come to Copenhagen for IBD
ECCO'14

Simon Travis © Simon Travis

SIMON TRAVIS
ECCO President

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, focussing on the burden related to these conditions

Current and former EpiCom Members (Peter Lakatos, Matteo Martinato, Corinne Gower-Rousseau, Dana Duricova, Johan Burisch; not on picture: Tine Jess) © ECCO Photographer

This issue has recently been addressed in a review article published in JCC by the ECCO Epidemiological Committee (EpiCom) (Burisch J, Jess T, Martinato M, Lakatos PL. The burden of Inflammatory Bowel Disease in Europe. J Crohns Colitis. 2013 May 1;7:322-37).

IBD, i.e. Crohn's Disease (CD) and Ulcerative Colitis (UC), are chronic inflammatory disorders of the gastrointestinal tract of unknown aetiology that are thought to be the result of an immune response to gut microbiota in genetically susceptible individuals. IBD has a severe impact on patients' quality of life because of its commonly early onset, the lack of a cure and its relapsing–remitting nature. CD and UC also account for high costs for both health care systems and society.

This report presents the main European data on the incidence and prevalence of IBD, the related risk for surgery, the rate of hospitalisation, cancer and mortality risks, and patients' disability and work impairment.

Incidence and prevalence of IBD

The highest occurrence of UC and CD is found in the developed countries (North America and Europe) but with high variations between countries in these continents. In Europe the highest incidence and prevalence rates are found in northern countries and the lowest in eastern ones, but increasing incidence rates are reported from previously low-incidence areas, including Eastern Europe and Asia, even if observed differences between regions might be due to differences in the methodology used in different studies.

The incidence of CD in Europe ranges from 0.5 to 10.6 cases per 100,000 person-years while the estimates for UC range from 0.9 to 24.3 per 100,000 person-years, with a north-west/south-east gradient in IBD incidence. Among the total European population (731 million in 2006), this would indicate a maximum of 78,000 new cases of CD and 178,000 new cases of UC each year, i.e. 256,000 new cases of IBD per year.

The prevalence of CD in Europe varies from 1.5 to 213 cases per 100,000 persons, whereas the prevalence of UC in Europe varies from 2.4 to 294 cases per 100,000 persons. In the total European population there may be up to 1.6 million persons with CD and 2.1 million persons with UC, i.e. 3.7 million persons with IBD. The prevalence of IBD is expected to increase due to the early age of onset, the low mortality of IBD patients and the increasing incidence of both CD and UC in virtually every region of the world; furthermore, the emergence of IBD in traditionally low-prevalence regions will further contribute to this increase.

The current inception cohort study coordinated by ECCO EpiCom is investigating the East–West gradient in the incidence of IBD, as well as differences in potential environmental risk factors between Eastern and Western Europe, and is providing an interesting update on the incidence of IBD across Europe.

Disease phenotype, overall disease course and relapse rates

One of the most important parameters associated with long-term outcomes is the disease phenotype, currently assessed by the Montreal classification in both CD and UC.

In CD, the distribution of location is relatively homogeneous and stable with the exception of the reported variance in the frequency of the upper GI location, especially in paediatric-onset populations. In addition, the proportion of isolated colonic disease has been increasing during the past decade. Up to one-third of European patients present with a complicated disease phenotype at diagnosis, with stricturing or penetrating disease, and a similar proportion of patients develop complications over the next 10–15 years of follow-up. Disease location remains relatively stable during follow-up. The rate of peri-anal complications varies between 10 and 20% at presentation.

In UC, the distribution of the disease extent at diagnosis is variable, with increasing rates of proctitis. Of the patients initially diagnosed with proctitis, up to one-third show progression and up to 10% develop extensive Colitis within the first 5 years.

Few data are available from Europe on the relapse rates and overall disease course in IBD, most of the data having been derived from the Nordic countries. The majority of patients with IBD in Europe experience a relapsing disease course, with 20–25% experiencing chronic continuous symptoms.

Hospitalisation rates and surgery

Relatively few data are available on hospitalisation rates in patients with IBD and data vary between European countries. In the past the diagnostic work-up was performed during hospital admissions, leading to fairly high hospitalisation rates. Nowadays hospitalisation rates are still high, but they are slowly decreasing in patients with CD, with approximately 50% of European patients requiring hospitalisation within the first 10 years after diagnosis. In UC, hospitalisation rates are stable and seem to be linked to both disease severity and risk of colectomy.

While the main aim of surgery in CD is to eliminate the complications, the indication for colectomy in UC is usually the failure of medical therapy, which leads to chronically active disease. Another indication for surgery is Fulminant Colitis. The overall cumulative surgery and re-operation rates in CD are still high in Europe, with 30–50% of patients needing a surgical intervention and up to 20% needing a re-operation due to disease recurrence in 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, but other factors also appear likely to be responsible, including a revised follow-up strategy and increased and earlier use of immunosuppressants, leading to an improved medical management.

The risk of colectomy in UC is approximately 10% by 10 years from diagnosis. Colectomy rates are lower in Southern and Eastern Europe even if disease severity (assessed by disease location, extension, or episodes of Acute Severe Colitis) is not necessarily milder in these regions. However, this unexplained geographical variation in colectomy rates has been diminishing in recent years.

Extra-intestinal manifestations

IBD is associated with a large number of extra-intestinal manifestations (EIMs), joint manifestations (peripheral or axial arthropathies) being the most common. Peripheral arthropathies can be divided into two subgroups: type 1 arthritis (an acute, self-limiting, pauci-articular arthropathy, typically affecting large joints, associated with other EIMs and linked to intestinal disease activity) and type 2 arthritis (a chronic, bilateral, symmetrical, polyarticular arthropathy affecting five or more small joints, independent of the course of intestinal disease).

Other EIMs are: axial arthropathies (sacroiliitis and ankylosing spondylitis), erythema nodosum, pyoderma gangraenosum, aphthous stomatitis, uveitis, episcleritis and primary sclerosing cholangitis. In European studies, EIMs have been found to be present in as many as 20–40% of patients with CD and 15–20% of patients with UC.

Disability and economic burden

Few data are available on disability in patients with IBD and, unfortunately, an unequivocal definition of disability is difficult and available assessment tools measure different aspects of disability. However, a huge variation is reported in the disability rates across the world, with an overall disability rate of 25%, ranging from 20% in the United States to 34% in Europe, possibly reflecting differences in disease severity, local socioeconomic and societal factors and insurance policies.

The health economic burden and permanent work disability in IBD are high in Europe, with a total yearly direct healthcare cost of EUR 4.6–5.6 billion. Unemployment (10%), sick leave (3–6 weeks/year) and permanent work disability (two-fold increase) are more common in patients with IBD than in unaffected individuals. The economic impact is even higher because IBD is commonly diagnosed in young people.

Cancer and mortality

The risk of colorectal cancer in European patients with CD is close to that among the general population, but the relative risk of small bowel cancer in European patients with CD is increased severalfold, though this is in general a very rare disease and the absolute risk is low. On the other hand, the risk of colorectal cancer in European patients with UC is twice that among the general population; however, the absolute risk is only 1–2.5% after 20 years, and recent studies suggest a decreasing risk.

The overall risk of extra-intestinal cancer is not markedly increased in European patients with IBD despite an increased risk of cancer of the upper gastrointestinal tract, lung, skin and urinary bladder in CD and an increased risk of hepatobiliary cancer and leukaemia in UC (counterweighted by a decreased risk of lung cancer). Thiopurines may increase the risk of lymphoid tissue cancer and non-melanoma skin cancer among European IBD patients, but drug effects are to some extent difficult to differentiate from the baseline increased risk of these cancers.

As compared to the general population, mortality is increased by up to 40% in European patients with CD but is not increased in those with UC.

Summary and conclusion

The incidence and prevalence of IBD are increasing in Europe. The current prevalence of IBD may be estimated to be approximately 0.3% of the European population, but there is significant geographical variation (North/West to South/East gradient). An ECCO EpiCom initiative is in progress to further explore this gradient and to assess the environmental factors associated with or responsible for the variation.

IBD, affecting mainly young individuals, impacts all aspects of the patients' life and is responsible for high direct and indirect costs to societies, including health care systems. The health economic burden and permanent work disability due to IBD are high in Europe, with a total yearly direct healthcare cost of EUR 4.6–5.6 billion.

Half of the patients have frequent relapses or chronically active disease and are exposed to the risk of extra-intestinal manifestations.

Up to two-thirds of patients with CD develop complications requiring hospitalisation and/or surgery, though some recent studies have suggested a decrease in the surgical rates. Surgical rates have also decreased in UC, to 10–15%. However, there is an unexplained geographical variation in colectomy rates between North/West and South/East Europe.

Advanced patient monitoring (more complex, tight patient control) and an optimised, tailored treatment strategy including more systematic use of biologicals may be responsible for the decreasing need for surgery, but studies are needed to determine whether these drugs can further improve long-term disease outcomes.

The risk of colorectal cancer is close to that in the general population in CD and is about twofold higher (1–2.5% after 20 years) in UC, but the risk of extra-intestinal cancers is not markedly increased in European patients.

Nonetheless, the long-term disability rate is high and the economic and social impact of IBD in Europe is enormous: it is still the case that 20% of European IBD 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 health care costs may average as much as EUR 3,000.

The role of tight control and early patient profile stratification in disease management (hopefully leading to better long-term outcomes, improved quality of life and decreased disability rates) should be assessed in further pan-European epidemiological and follow-up studies. Disease-modifying trials are also needed.

MATTEO MARTINATO
Former EpiCom Member
On behalf of EpiCom

9th Congress of ECCO

Preliminary Programme (as of April 11, 2013)

The ECCO Congress is the largest meeting for IBD specialists in the world. In 2013 it was the Best Congress Ever, attended by over 4,500 people. ECCO'14 in Copenhagen (February 20-22, 2014) will be even better. Make sure these dates are in your diary. It will be wonderful to be in maritime Copenhagen.

The theme for ECCO'14 Copenhagen is **"The Causes, Consequences and Quality of Care for IBD".** Improving the care of patients with IBD is at the core of ECCO, but quality of care is rarely addressed at academic meetings. ECCO'14 will rise to the challenge, placing quality at the forefront of care within the context of the latest advances in understanding the pathogenesis of Ulcerative Colitis and Crohn's Disease. All patients and their physicians live with the consequences of IBD, so the ECCO'14 Copenhagen Congress will also focus on the management of daily clinical dilemmas, the prevention of complications and the strategic management of such complications should they occur. The ECCO'14 Copenhagen Congress is a world class meeting that will appeal to clinicians in all disciplines caring for people with IBD, scientists, surgeons, trainees, nursing specialists and industry.

Uniquely for such a large international meeting, the programme is linear, with no parallel sessions. This means that delegates can go to everything. Each session has two or three state of the art lectures by renowned leaders in the field, interspersed by short presentations of the very best abstracts, selected from the thousand submitted. ECCO is now favoured as the prime meeting to present the newest research in IBD.

The meeting starts with neglected cells in IBD: Are the multitude of lymphatics, mast cells and stroma innocent bystanders or are they pivotal in the pathogenesis? The very next session addresses quality: How is it defined? How do you cope when choice is limited? What are the tricks for getting the best out of biological therapy? And how do you enable patients to reach their horizons?

The cost of therapy and burden of care is the next topic, with a focus on biosimilars and the dilemmas of how, whether or when to stop therapy. The newest medical and surgical advances will be discussed, before state of the art talks on how to avoid or cope with complications. There will be the latest guidelines from ECCO (five are previewed at the ECCO'14 Copenhagen Congress, before publication in the Journal of Crohn's & Colitis, free to Congress delegates for 6 months after the ECCO'14 Copenhagen Congress). There will also be more oral presentations of the latest research than ever before, a completely new digital poster session and all the educational events to sign up to. The academic part of the ECCO'14 Copenhagen Congress concludes with preventive strategies, challenging conventional care – and then the ECCO Lecture on The Causes of Crohn's Disease by Professor Tony Segal, who knows.

ECCO is a family and the congress is a window on the world of IBD. The "ECCO Interaction: Hearts and Minds" is a key part of that family atmosphere, so join this – and look out for the closing ECCO Video 2014: watch ECCO'13 (www.ecco-ibd.eu/congresses/ecco-video-2013). The plot thickens… so register here soon: www.ecco-ibd.eu/register-2014.html

The Organising Committee for the ECCO'14 Copenhagen Congress:
Simon Travis
Séverine Vermeire
Silvio Danese
Iris Dotan
Stephan Vavricka

SIMON TRAVIS
ECCO President

Preliminary programme: Thursday, February 20, 2014		
	10:45-11:15	**Top tips for chairs (Closed session)**
11:30-12:30	**Satellite symposium 1a & 1b**	
12:45-13:00	**Opening and welcome**	
13:00-14:30	**Scientific session 1: Neglected cells as potential targets**	
	13:00-13:20	**Lymphatic endothelial cells as mediators and targets**
	13:20-13:30	**Oral presentation 1**
	13:30-13:50	**Mast cells at the leading edge**
	13:50-14:00	**Oral presentation 2**
	14:00-14:10	**Oral presentation 3**
	14:10-14:30	**Stromatic cells: innocent bystanders or regulators?**
14:30-15:00	**Coffee break**	
15:00-17:00	**Scientific session 2: Optimisation of therapy**	
	15:00-15:20	**Defining quality**
	15:20-15:30	**Oral presentation 4**
	15:30-15:50	**Maintaining quality when choice is limited**
	15:50-16:00	**Oral presentation 5**
	16:00-16:10	**Oral presentation 6**
	16:10-16:30	**Biologic drug levels in practice**
	16:30-16:40	**Oral presentation 7**
	16:40-17:00	**Travel with IBD: Climb high, dive deep**
17:15-18:15	**Satellite symposium 2a & 2b**	

Preliminary programme: Friday, February 21, 2014		
07:15-08:15	**Satellite symposium 3a & 3b**	
08:30-09:30	**Scientific session 3: Cost of therapy, burden of care**	
	08:30-08:50	**Biosimilars - straight ahead or off at a tangent?**
	08:50-09:00	**Oral presentation 8**
	09:00-09:10	**Oral presentation 9**
	09:10-09:30	**Exit strategies**
09:30-10:30	**Scientific session 4: Tomorrow's therapy**	
	09:30-09:50	**It's decision time: Anti-TNF vs anti-integrin therapy**
	09:50-10:00	**Oral presentation 10**
	10:00-10:10	**Oral presentation 11**
	10:10-10:30	**Tomorrow's surgery**
10:30-11:00	**Coffee break**	

9th Congress of ECCO - Preliminary scientific programme

Preliminary programme: Friday, February 21, 2014		
11:00-12:20	**Scientific session 5: Fibrosis as a complication**	
	11:00-11:20	**Intestinal fibrogenesis**
	11:20-11:30	**Oral presentation 12**
	11:30-11:50	**Imaging: inflammation vs fibrosis**
	11:50-12:00	**Oral presentation 13**
	12:00-12:20	**Stricturelysis: potential and practice**
12:20-13:30	**Lunch and guided poster session in the exhibition hall**	
13:30-14:50	**Scientific session 6: Intestinal failure**	
	13:30-13:50	**Physiology and consequences of short bowel syndrome**
	13:50-14:00	**Oral presentation 14**
	14:00-14:20	**Surgical quality: timing of decision-making**
	14:20-14:30	**Oral presentation 15**
	14:30-14:50	**Intestinal transplantation: just the end, or the end of the beginning?**
14:50-15:20	**Coffee break**	
15:20-16:00	**Scientific session 7: ECCO Fellowships and Grants**	
	15:20-15:35	**Outcomes from the 2012-13 Fellowships**
	15:35-15:40	**Announcement of ECCO Fellowships and Grants 2014**
	15:40-15:50	**Oral presentation 16**
	15:50-16:00	**Oral presentation 17**
16:00-17:00	**Scientific session 8: Challenging cases**	
	16:00-16:20	**Case 1: Ileal Crohn's Disease (is therapeutic choice making decisions more complex?)**
	16:20-16:40	**Case 2: Acute Severe Colitis (the stakes are high!)**
	16:40-17:00	**Case 3: Recurrent pouch dysfunction (pouches behaving badly)**
17:00-17:45	**Scientific session 9: What's new on the guideline front**	
	17:00-17:15	**ECCO Guidelines: Reproduction and IBD**
	17:15-17:30	**ECCO Guidelines: ECCO-ESGPHAN Guidelines in Paediatric CD**
	17:30-17:45	**ECCO Guidelines: The Crohn's Disease Consensus**
18:00-19:00	**Satellite symposium 4a & 4b**	
20:00	**ECCO Interaction: Hearts and Minds**	

Preliminary programme: Saturday, February 22, 2014		
07:15-08:15	**Satellite symposium 5a & 5b**	
08:30-10:20	**Scientific session 10: Colitis under the microscope**	
	08:30-08:50	**Pathogenesis of collagenous colitis**
	08:50-09:00	**Oral presentation 18**
	09:00-09:10	**Oral presentation 19**
	09:10-09:20	**Oral presentation 20**
	09:20-09:40	**Treatment-refractory microscopic colitis**
	09:40-09:50	**ECCO Guidelines on Anaemia in IBD**
	09:50-10:00	**Oral presentation 21**
	10:00-10:20	**ECCO Guidelines on Surgery in Ulcerative Colitis**
10:20-10:50	**Coffee break**	
10:50-12:20	**Scientific session 11: Preventative or pre-emptive care?**	
	10:50-11:10	**What triggers relapse?**
	11:10-11:20	**Oral presentation 22**
	11:20-11:40	**Post-operative prevention - offence or defence?**
	11:40-11:50	**Oral presentation 23**
	11:50-12:00	**Oral presentation 24**
	12:00-12:20	**Challenging conventional pathways of care**
12:20-12:50	**Scientific session 12: ECCO Lecture**	
	12:20-12:50	**The causes of Crohn's Disease?**
12:50-13:00	**Awards, closing remarks and the ECCO Film 2014**	

New in 2014

- **Digital posters**
- **Congress app**
- **New educational courses**
- **Half price on selected activities for Y-ECCO and IBD Nurse Members**
- **Extended e-CCO Learning**
- **Increased number of oral presentations**

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

Volume 7, issue 5 **CONTENTS** **June 1, 2013**

Educational Programme at ECCO'14

The educational programme of the 9th Congress of ECCO is scheduled to take place prior to the official start of the ECCO Congress and will cover activities for ECCO's different interest groups, including young gastroenterologists, surgeons, paediatricians, IBD nurses and allied health professionals and scientists.

An overview of these activities can be found below. Please note that some of these courses/workshops run in parallel and that some have a limited capacity – please do register at your earliest convenience.

We look forward to seeing you in Copenhagen!

Wednesday February 19, 2014			**Thursday** February 20, 2014		**Friday** February 21, 2014	**Saturday** February 22, 2014
12th IBD Intensive Advanced Course				Scientific programme Poster exhibition		
	3rd S-ECCO IBD Masterclass			Industry exhibition		
5th N-ECCO School		N-ECCO Research Networking Forum	8th N-ECCO Network Meeting		ECCO Interaction: Hearts & Minds	
	Ultrasound Workshop (Basic level)	7th Y-ECCO Workshop	Ultrasound Workshop (Advanced level)			
		Updates on Paediatric IBD	3rd ClinCom Workshop			
	PSC Update Forum	3rd IBD Refresher Course	2nd EpiCom Workshop			
		Global IBD Forum				
ECCO Business meetings						

Educational programme Scientific programme

12th IBD Intensive Advanced Course

Date: February 19-20, 2014
Time: Feb 19: 08:00-15:30; Feb 20: 08:00-12:30
Responsible Committee: EduCom
Target audience: Junior Gastroenterologists
Registration: upon invitation
(please see official call on the right side)
ECCO Membership 2014 required:
Regular/Y-ECCO Member
Registration fee: n.a.

Call for Nominations of Participants at the 12th IBD Intensive Advanced Course

The **12th ECCO Intensive Advanced Course in IBD for residents,** fellows in gastroenterology and junior faculty will take place in **Copenhagen, Denmark from February 19–20, 2014,** just prior to our next congress. We are pleased to inform you that the preliminary programme of this course is already available (see below).

ECCO wants to make this course as attractive as possible for participants. We are therefore limiting the general number of participants from each ECCO Country Member to 2 in order to provide for a more interactive atmosphere. Three seats will be open for countries with a population of over 50 million people (this includes: Italy, France, Germany, Russia, United Kingdom and Turkey).
Minimum criteria for nominees:

- ECCO Member status (2014)
- Trainees at least in their third year with preferably one year of GI experience (NOT for established gastroenterologists)
- Should demonstrate a sufficient level of English to follow the course

Nomination process for candidates from ECCO Country Members:

Candidates who are interested should contact their National Representatives well in advance.
Participants are selected in their country, by a national system left to the responsibility of the National Representatives of each ECCO Member Country.
The National Representatives submit their nominations with a CV (containing full contact details, position and information about hospital affiliation) and a letter of intent for each candidate:
Deadline for receipt of nominations from ECCO National Representatives: **September 6, 2013**
Nominated candidates will be informed about the status of their application by the beginning of October 2013.

Nomination process for candidates from outside of Europe:

As in past years, 10 seats in total will again be reserved for candidates from outside of Europe.
Candidates who are interested can apply directly to the ECCO Office (j.gabriel@ecco-ibd.eu).
Application deadline: **September 6, 2013**
In order to apply, candidates need to submit:

- a CV (containing full contact details, position and information about hospital affiliation) and
- a letter of support from a senior IBD expert.

Participants are selected by representatives of the Governing Board & EduCom on the basis of qualification and country balance.
Nominated candidates will be informed about the status of their application by the beginning of October 2013.

12th IBD Intensive Advanced Course (continued)

Preliminary programme: Wednesday, February 19, 2014		
07:30–08:00	Arrival and distribution of voting pads	
08:00–08:15	Welcome	
08:15–08:40	Pre-course test	
08:40–11:30	**Session 1: Pathogenesis**	
	08:40–09:00	**IBD: Epidemiology and environmental factors**
	09:00–09:20	**The genetics of IBD**
	09:20–09:40	**The microbiome and IBD**
	09:40–10:00	**Discussion**
10:00–10:30	**Coffee break**	
	10:30–11:30	**Tandem Talk: IBD therapeutics targets and drugs: New and old**
11:30–13:45	**Session 2: Seminar session**	
	11:30–12:30	**Part I: Practical skills** Either: Role of bowel ultrasonography in intestinal disease or Practical guide to interpreting MRI or Practical guide to chromo-endoscopy
12:30–13:00	**Lunch break**	
	13:00-13:45	**Part II: Specialist subject IBD and pregnancy** Seminar I & Seminar II
13:45–15:30	**Session 3: Interactive case discussion and lecture session**	
	13:45–14:30	**Case based discussion:** **Investigation and management of mild IBD**
	14:30-14:45	**Discussion**
	14:45–15:30	**Tandem Talk: Acute Severe Ulcerative Colitis:** Management including medical and surgical rescue therapy

Preliminary programme: Thursday, February 20, 2014		
08:00–10:20	**Session 4: Interactive case discussion and lecture session**	
	08:00–09:00	**Tandem Talk:** **Fistulising & stenosing disease: Medical and surgical approaches**
	09:00–10:00	**Case-based discussion:** **The patient with severe inflammatory Crohn's Disease**
	10:00–10:20	**Discussion**
10:20–10:45	**Coffee break**	
10:45–12:15	**Session 5: Special scenarios**	
	10:45–11:15	**Vaccinations, immunisations and opportunistic infections in IBD - A case-based guide**
	11:15–11:45	**Monitoring drug therapy with biomarkers, drug levels and antibody testing**
	11:45–12:15	**Endoscopy for Inflammatory Bowel Disease**
12:15–12:30	Feedback and closing remarks	

5th N-ECCO School

Date: February 19, 2014
Time: Satellite symposium (tbc) 07:15-08:15; N-ECCO School 08:30-15:35
Responsible Committee: N-ECCO
Target audience: IBD nurses – new to the specialty
Registration: upon invitation
(please see official call on the right side)
ECCO Membership 2014 required:
IBD nurse Member
Registration fee: n.a.

Call for Nominations of Participants at the 5th N-ECCO School in Copenhagen

At the 9th 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-focussed 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 nomination 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 Nienke Ipenburg from the N-ECCO Committee (n.ipenburg@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.weynandt@ecco-ibd.eu) well in advance.

Deadline for nominations: **September 6, 2013**

5th N-ECCO School (continued)

Preliminary programme		
07:15–08:15	Morning satellite symposium (tbc)	
08:30–08:45	Welcome and opening remarks	
08:45–09:15	Welcome get together with coffee	
09:15–12:00	**Session 1: Diagnosis and assessment**	
	09:15–10:00	**Diagnosing IBD and assessing disease activity**
	10:00–10:30	**Anatomy and physiology of the GI tract – Pathophysiology of IBD**
10:30–11:00	**Coffee break**	
	11:00–11:30	**Overview medical treatment**
	11:30–12:00	**Surgery in IBD**
12:00–14:30	**Session 2: Case studies - Disease Management**	
	12:00–12:45	**Workshop 1 – UC Management**
12:45–13:45	**Lunch break**	
	13:45–14:30	**Workshop 2 – CD Management**
14:30–15:30	**Session 3: General Management in IBD**	
	14:30–15:10	**Nutritional aspects in IBD**
	15:10–15:30	**Nursing roles in IBD management**
15:30–15:35	Closing remarks	

3rd S-ECCO IBD Masterclass

Date: February 19, 2014
Time: Feb 19: Sat. symp (tbc): 11:45-12:45; Masterclass: 13:00-18:00
Feb 20: Sat. symp (tbc): 07:15-08:15; Masterclass: 08:30-12:00
Responsible Committee: S-ECCO
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 3rd S-ECCO Masterclass will highlight the challenges of treating fistulating Crohn's Disease. This not only includes internal (entero-enteric, enterovesical) and enterocutaneous fistulae, but also the problem of peri-anal fistulae in Crohn's Disease.
Special attention will be paid to pre-operative imaging, especially the current role of cross-sectional imaging, and optimal preoperative 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 intestinal transplantation.
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.

Ultrasound Workshop (Basic level)

Date: February 19, 2014
Time: 13:00-15:30
Responsible Committee: Y-ECCO in collaboration with EduCom and ESGAR
Target audience: Young ECCO
Registration: Online registration (max. 40 participants)
ECCO Membership 2014 required:
Exclusive to Y-ECCO Members
Registration fee: EUR 40

Preliminary programme		
13:00–13:05	Welcome & Course Introduction	
13:05–13:35	**Session 1**	
	13:05–13:20	**Intestinal ultrasonography: Basic principles**
	13:20–13:35	**IBD pathology in intestinal ultrasonography**
13:35–15:30	**Session 2: Hands on open space in ultrasonography** **Clinical cases and exercises**	

PSC Update Forum

Date: February 19, 2014
Time: 13:00-15:30
Responsible Committee: SciCom in collaboration with IPSCG
Target audience: Physicians, Surgeons, Paediatricians, Scientists
Registration: 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)

Preliminary programme	
13:00–13:05	Welcome & Course Introduction
13:05–13:30	**Liver disease in IBD – update on diagnosis, therapies and follow-up**
13:30-14:00	**PSC-associated malignancies –** **pre- and post-transplant implications for patient management**
14:00-14:30	**Immune regulation in PSC – where are the potential treatment targets?**
14:30-15:00	**Bile acid therapy in PSC – relevance and opportunities for novel treatment options**

7th Y-ECCO Workshop: Practical skills to succeed in academic medicine

Date: February 19, 2014
Time: 16:00-18:00
Responsible Committee: Y-ECCO
Target audience: Paediatricians, Physicians, Surgeons, IBD nurses
Registration: 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)

Preliminary programme: 7th Y-ECCO Workshop	
The programme will focus on soft skills in academic medicine and will feature two outstanding speakers, Tony Lingham and Eric Dixon, who are internationally renowned experts in the fields of management and communication.	
16:00–16:10	Welcome to Y-ECCO and Course Introduction
16:10–17:00	**Session 1:**
	Learning Styles, Networking, and Negotiation. Tips for daily practice. (Group A)
	Presentation skills: How to deliver a clear message? (Group B)
17:00–17:50	**Session 2:**
	Learning Styles, Networking, and Negotiation. Tips for daily practice. (Group B)
	Presentation skills: How to deliver a clear message? (Group A)
17:50–18:00	Y-ECCO Abstract Awards
18:00	Y-ECCO Networking Event

Updates on Paediatric IBD

Date: February 19, 2014
Time: 16:00-18:00
Responsible Committee: P-ECCO
Target audience: Paediatricians, Physicians, Surgeons, IBD nurses
Registration: 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)

Preliminary programme: Updates on Paediatric IBD	
16:00–16:05	Welcome and Introduction
16:05–16:25	**How children with IBD differ from adults. Phenotype and natural history**
16:25–16:50	**Why are Paediatric GI doctors obsessed with nutrition?**
16:50–17:15	**Combo or not: Treatment strategies for kids with CD**
17:15–17:40	**Challenges in treating Paediatric UC**
17:40–18:00	**Growth and bones matter – treatment strategies for IBD**

N-ECCO Research Networking Forum

Date: February 19, 2014
Time: 16:00-18:00
Responsible Committee: N-ECCO
Target audience: IBD nurses and Allied Health Professionals
Registration: Online registration
ECCO Membership 2014 required: IBD nurse Member
Registration fee: tbc

Highlights

During the ECCO'14 Congress in Copenhagen we are hosting the first meeting of the new N-ECCO Research Forum for nurses. The first meeting will involve a presentation as an introduction to the forum, identification of aims and objectives and a discussion/network to identify nurses' needs regarding research. It is hoped that this new group, under the N-ECCO Committee, will create a forum for IBD nurses undertaking research across Europe through which they will gain support and direction and perhaps in time develop collaboration on similar research issues.

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: 16:30-18:00
Responsible Committee: Governing Board
Target audience: Corporate Members
Registration: Upon invitation
ECCO Membership 2014 required: Corporate Member
Registration fee: n.a.

Preliminary programme: 3rd IBD Refresher Course	
16:30–16:35	Welcome and introduction
16:35–16:50	**Causes of IBD: Current concepts**
16:50–17:05	**Classifying IBD: How do you do it?**
17:05–17:25	**Management overview**
17:25–17:40	**Future approaches to therapy**
17:40–18:00	**Question and answers**

Global IBD Forum

Date: February 19, 2014
Time: 18:15-19:15
Responsible Committee: Governing Board
Target audience: IBD Organisation representatives, ECCO Officers, Corporate Members
Registration: Upon invitation
ECCO Membership 2014 required: n.a.
Registration fee: n.a.

Preliminary programme: Global IBD Forum on practicalities in biobanking	
18:15–18:20	Welcome and introduction
18:20–18:40	**What data should we all be collecting?**
18:40–19:00	**Biobanking: practicalities and pitfalls**
19:00–19:15	**Discussion**

9th Congress of ECCO – Educational programme

2nd EpiCom Workshop

Date: February 20, 2014
Time: 08:00-11:30
Responsible Committee: EpiCom
Target audience: Physicians, Surgeons, Paediatricians, IBD nurses
Registration: Online registration
ECCO Membership 2014 required: Regular/Y-ECCO/IBD nurse Member
Registration fee: EUR 80
(half price for members of the EpiCom cohort study, for Y-ECCO and IBD nurse Members)

Preliminary programme: Cancer in IBD		
08:00–08:10	Welcome and introduction	
08:10-09:50	**Session 1**	
	08:10–08:30	**Is IBD associated with intestinal cancer: what is the baseline risk?**
	08:30–08:50	**Influence of age and gender on the risk of intestinal cancer**
	08:50–09:10	**Extra-intestinal cancer with a focus on skin cancer**
	09:10–09:30	**Extra-intestinal cancer with focus on lymphomas**
	09:30–09:50	**How to manage patients with a previous cancer**
09:50–10:10	**Coffee break and interaction**	
10:10-11:30	**Session 2**	
	10:10–11:30	**Practical workshop on how to interpret the risk of cancer** **Case 1: Patient with a previous cancer history** **Case 2: Colonic CD with a stricture: What is the cancer risk?** **Case 3: Young CD patient with a stoma and disease progression.** **What are we anxious about: The disease or the cancer risk?**

3rd ClinCom Workshop

Date: February 20, 2014
Time: 08:00-12:30
Responsible Committee: ClinCom
Target audience: Physicians, Surgeons, Paediatricians, Clinical Researchers, Industry
Registration: 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)

Preliminary programme: 3rd ClinCom Workshop	
08:00-12:30	**Randomised controlled trials challenged**
Part 1	**Biosimilars: Are we ready to change our practice?**
	What is the best study design: Non-inferiority or equivalence trials?
	Can we switch our patients safely?
Part 2	**How can we bridge the gap to real-life clinical practice?**
	Open label trials and registries: Can we improve or should we abandon them?
	New outcome measures in IBD trials (biomarkers, deep remission, disability,
	bowel damage index): The emperor's new clothes?
	How to address special situations (pouchitis, fistulae, kids etc.): Mini versus mega trials

Ultrasound Workshop (Advanced level)

Date: February 20, 2014
Time: 08:30-11:30
Responsible Committee: EduCom in collaboration with ESGAR
Target audience: Physicians, Surgeons, Paediatricians
Registration: Online registration (max. 40 participants)
ECCO Membership 2014 required: Regular/Y-ECCO Member
Registration fee: EUR 80

Preliminary programme: Ultrasound Workshop (Advanced level)		
08:30–08:40	Welcome & Introduction	
08:40–09:30	**Session 1**	
	08:40–09:05	**How to use bowel ultrasonography in patients with IBD**
	09:05–09:30	**Bowel ultrasonography in clinical practice – Case presentations**
09:30–11:30	**Session 2: Hands-on open space in ultrasonography**	

8th N-ECCO Network Meeting

Date: February 20, 2014
Time: Sat. symp (tbc): 07:45-08:45; N-ECCO Network Meeting 09:00-17:00
Sat. symp (tbc): 17:15-18:15
Responsible Committee: N-ECCO
Target audience: IBD nurses – advanced level
Registration: Online registration
ECCO Membership 2014 required: IBD nurse Member
Registration fee: EUR 25

Preliminary programme: 8th N-ECCO Network Meeting		
07:45–08:45	Morning satellite symposium (tbc)	
09:00–09:15	Welcome and introduction	
09:15–10:45	**Session 1: Sexual and reproductive issues in IBD**	
	09:15-09:45	**Sex and IBD**
	09:45-10:15	**Fertility, conception and pregnancy – An update**
	10:15-10:45	**Case study**
10:45–11:15	**Coffee break**	
11:15–12:30	**Session 2: IBD through the years**	
	11:15–11:45	**IBD in the growing child**
	11:45–12:10	**Transition and transfer**
	12:10–12:17	**Oral presentation 1**
	12:17–12:24	**Oral presentation 2**
	12:24–12:30	**Oral presentation 3**
12:30–14:00	**Lunch break (self-guided poster round in the exhibition hall)**	
14:00–15:15	**Session 3: Clinical assessment**	
	14:00–14:25	**Clinical history and physical examination**
	14:25–14:50	**Radiology interpretation, options & exposure**
	14:50–15:15	**Endoscopy & Histopathology**
15:15–15:40	**Coffee break**	
15:40–16:45	**Session 4: Addressing the patients' priorities**	
	15:40–16:00	**Fatigue**
	16:00–16:20	**Pain**
	16:20–16:40	**Urgency**
16:40–17:00	N-ECCO in 2014 & Conclusion	
17:15–18:15	Afternoon satellite symposium (tbc)	

1st CIMF - ECCO International Summer School (ISS) in IBD

Guangzhou, China, April 25-28, 2013

Faculty and participants of the 1st CIMF-ECCO International Summer School in Guangzhou, China © CIMF

The first Chinese International Medical Foundation (CIMF)–ECCO Summer School in IBD was held in Guangzhou in April 2013. This 3.5-day programme was modelled on the ECCO Advanced Course in IBD, now entering its 11th year. Co-hosts P.J. Hu (Guangzhou; current Chair of the Chinese IBD Society) and ECCO President Simon Travis (Oxford) were joined by an expert faculty assembled from Guangzhou (Minhu Chen, Ping Lan and Pingin Hu) and the other major centres in China (Bing Xia, Wuhan; Zhihua Ran, Shanghai; Kaichun Wu, Xian; Weiming Zu, Nanjing) and ECCO Officers Janneke van der Woude (Rotterdam) and Charlie Lees (Edinburgh). An enthusiastic delegation of 40 IBD physicians (and even a couple of surgeons) from around China stayed alongside the faculty in the majestic Jiulong 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 plenty of food for thought and discussion as from 30 excellent cases (all with high-quality imaging and pathology included) five were selected for presentation on the final morning. The teaching format and style of the Summer School encouraged and allowed frequent opportunities for engagement and discussion involving 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 Intensive Advanced Course, the ISS was preceded and concluded by 'pre' and 'post' MCQ 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.

CHARLIE LEES
Former EduCom Member

Preliminary programme:
CIMF-ECCO International IBD Summer School
April 2014, Beijing, China

Case selection made on evening of arrival.

Thursday		
08:30		Welcome
08:45		**Session 1: Pre-course test / epidemiology / pathogenesis / genetics**
	08:45	**Pre-course test**
	09:30	**Pathogenesis and genetics (ECCO)**
10:30		**Coffee**
	11:00	**Epidemiology of IBD in the West (ECCO)**
	11:20	**Epidemiology of IBD in the East (CIMF)**
	11:40	**Epidemiological research in IBD – challenges and opportunities (CIMF)**
	12:00	**Discussion**
	12:30	**Introduction to ECCO Guidelines (ECCO)**
12:45		**Lunch**
13:30		**Session 2: Diagnostics/differential diagnosis/endoscopy/radiology**
	13:30	**Case presentation from delegate #1**
	14:00	**Diagnostic work-up – clinical features, including differential diagnosis (CIMF)**
	14:30	**Diagnostic work-up – biomarkers (ECCO or CIMF)**
	15:00	**Diagnostic work-up – endoscopy, including UCEIS, CDEIS and SES-CD (ECCO)**
	15:30	**Diagnostic work-up – radiology (CIMF)**
16:00		**Tea**
	16:30	**Setting up an IBD clinical service (ECCO)**
	17:15	**Case presentation from delegate #2**
18:30		**Welcome Dinner**
20:00		**Q&A session #1**
Friday		
8:30		**Session 3: Crohn's Disease**
	08:30	**Predicting prognosis in Crohn's Disease (ECCO)**
	09:15	**Management of mild-moderate Crohn's Disease (CIMF)**
	10:00	**Management of severe inflammatory Crohn's Disease (ECCO)**
10:45		**Coffee**
	11:15	**Management of fistulating Crohn's Disease (CIMF)**
	11:45	**Management of stricturing Crohn's Disease (CIMF)**
12:30		**Lunch**
13:30		**Session 4: Complications and drug therapy of IBD**
	13:30	**Case presentation from delegate #3**
	14:00	**Extra-intestinal manifestation in IBD (CIMF)**
	14:30	**Anaemia in IBD (ECCO)**
	14:50	**Opportunistic infections and vaccinations (CIMF)**
15:15		**Tea**
	15:45	**Monitoring drug levels for immunosuppressants & biologics (ECCO)**
	16:15	**Managing loss of response to anti-TNF therapy (ECCO)**
	16:45	**Clinical trials for IBD – design, interpretation and practice (ECCO)**
	17:15	**Case presentation from delegate #4**
18:30		**Dinner**
20:00		**Q&A session #2**
Saturday		
8:30		**Session 5: Ulcerative Colitis**
	08:30	**Mild-moderate UC (CIMF)**
	09:00	**Acute Severe UC (ECCO)**
	09:45	**Surgery for Ulcerative Colitis and Crohn's Disease (CIMF)**
10:30		**Coffee**
	11:00	**Case presentation from delegate #5**
	11:30	**Cancer chemoprevention and surveillance (CIMF)**
	12:00	**Novel therapies for IBD (ECCO)**
12:45		**Lunch**
		Session 6: Special situations
	13:30	**Case presentation from delegate #6**
	14:00	**Reproduction in IBD (ECCO)**
	14:30	**Paediatric IBD and transitional care (ECCO)**
	15:00	**Nutritional support and therapy (CIMF)**
	15:30–1700	**Options: Workshop on biostatistics, Quality of life and how to measure it, Minimum data sets**
19:30		**Gala Dinner (no Q&A session)**
Sunday		
9:00		**Session 7: Cases / post-course test**
	09:00	**Case presentation from delegate #7**
	09:30	**Case presentation from delegate #8**
	10:00	**Post-course test**
10:45		**Coffee**
	11:15	**Spare lecture slot/Case presentation from delegate #9**
	11:45	**Keynote talk - The future of IBD care in China (CIMF)**
12:30		**Closing remarks**
12:45		**Lunch and departures**

Standard Operating Procedures (SOP) for ECCO Guidelines

In 2006, ECCO published its first set of guidelines ever

These guidelines covered the diagnosis and current management of Crohn's Disease (CD) and were followed by guidelines on the diagnosis and current management of Ulcerative Colitis (UC) in 2008. The guidelines were initially published in Gut, before they were moved to ECCO's own journal, JCC. These guidelines soon became standard references for the management of IBD in Europe and in other parts of the world. The articles on current management of UC and CD are among the top-cited papers published in Gut and JCC, illustrating how the ECCO Guidelines have impacted on the community of physicians caring for patients with IBD.

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 importance of guidelines for ECCO is highlighted by the foundation of a committee (GuiCom) responsible solely for all the issues around ECCO Guidelines. Under the supervision of GuiCom, Standard Operating Procedures (SOPs) for ECCO Guidelines have been developed

- to facilitate the selection and preparation of guideline projects by ECCO,
- to increase the transparency of the entire process, leading to novel guidelines or updates of established guidelines, and
- to facilitate and standardise the dissemination and publication of ECCO Guidelines.

ECCO Guideline proposals may be submitted by any individual ECCO Member. Every proposal will be reviewed by GuiCom and ultimately approved or rejected by ECCO's Governing Board. The selection of guideline coordinators and participants involves open calls to all ECCO Members via ECCO eNewsletters announcing the guideline project. The selection of working party members (ECCO Members and external experts) and working party leaders is a combined responsibility of GuiCom 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 (COI) before the start of any working party activities and account is taken of 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 Y-ECCO Members in working groups, or as drivers for the project under appropriate senior guidance, is encouraged. Employees of the pharmaceutical industry are explicitly excluded from the systematic literature review or 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 (EL) and grades of recommendation (RG) 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 guideline 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-focussed 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 final consensus meeting. 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 those 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 aim to 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 modified according to the feedback from the consensus panel members in order to achieve a higher degree of agreement. Statements with more than 80% agreement in the final consensus meeting or the second online voting round 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.

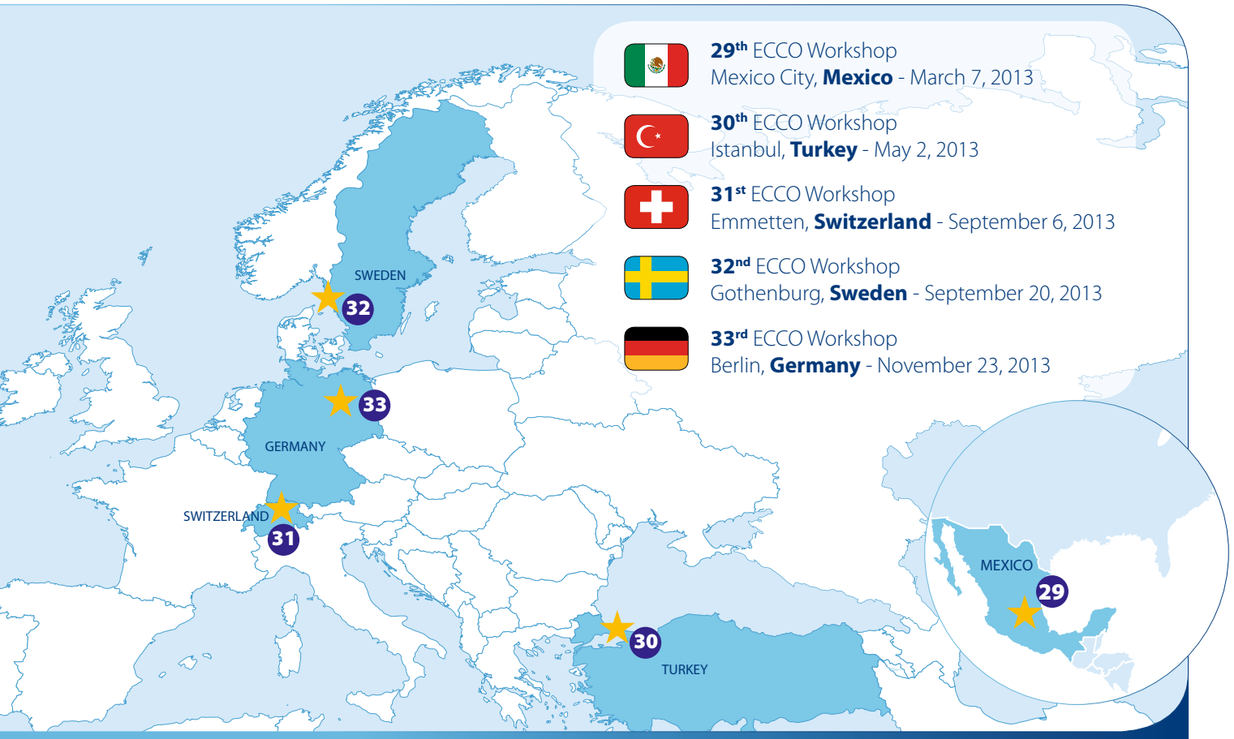
In the context of specific guideline projects, the full SOP document can be requested from the ECCO Office: ecco@ecco-ibd.eu.

AXEL DIGNASS
Education Officer

ECCO has diligently maintained a disclosure policy of potential conflicts of interests (CoI) for several years: ECCO Guideline manuscripts cannot be submitted for publication without all authors having submitted a CoI 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). The CoI statement is not only stored at the ECCO Office and the editorial office of JCC but also open to public scrutiny on the ECCO website providing a comprehensive overview of potential conflicts of interest of the consensus participants and guideline authors. As ECCO experts are increasingly involved in several activities such as the ECCO Congress, ECCO Workshops, ECCO Guidelines, or other projects, including publications of papers in JCC throughout one year, ECCO now collects one completed CoI form from experts in line with the respective Congress business year (updated every autumn). These forms are publically accessible through the ECCO website (https://www.ecco-ibd.eu/about-ecco/ecco-disclosures.html).

European
Crohn's and Colitis
Organisation

ECCO Educational Workshops 2013



29th ECCO Workshop
Mexico City, **Mexico** - March 7, 2013

30th ECCO Workshop
Istanbul, **Turkey** - May 2, 2013

31st ECCO Workshop
Emmetten, **Switzerland** - September 6, 2013

32nd ECCO Workshop
Gothenburg, **Sweden** - September 20, 2013

33rd ECCO Workshop
Berlin, **Germany** - November 23, 2013

Spreading standards in IBD - Your presence counts!

Scan and contact the ECCO Office

www.ecco-ibd.eu

29th ECCO Workshop in Mexico City

March 7, 2013 – ECCO in Mexico!

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 Inflammatoria Intestinal), hosted by Jésus 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.

Faculty and attendees of the 29th ECCO Workshop © local organisers

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!

SIMON TRAVIS
ECCO President

MIQUEL SANS
Former ECCO SciCom Member

Origin of attendees of the 29th ECCO Workshop © local organisers

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

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

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-ECCO 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

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 (M.B., B.Ch., B.A.O.), and completed internship, house officer and registrar training based at University College Hospital Galway. He received Membership of RCPI 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. NUI Galway conferred an 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 consultancy in Gastroenterology, with joint appointment in the Department of Molecular Pharmacology and Experimental Therapeutics. His research focusses on molecular characterisation of signalling pathways involved in intestinal epithelial cell stress, death and malignant transformation. In 2005, he was recruited by NUI 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 IBD 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 the 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 © ECCO Photographer

LAURENCE EGAN
SciCom Member

Julián Panés
IBD research and clinical practice is one of Julián Panés' 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 cell 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.


Julián Panés © ECCO Photographer

JULIÁN PANÉS
SciCom Member

Gerhard Rogler
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 focussing 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, Horsham, Milan and Jena. Gerhard has authored and co-authored more than 270 PubMed-cited 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 speaker and principal investigator of the special research programme 585 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 © ECCO Photographer

GERHARD ROGLER
SciCom Member

Report on the 2nd ClinCom Workshop

The 2nd ClinCom Workshop was held on February 14, 2013 during the ECCO Congress and was entirely devoted to therapeutic trials

2nd ClinCom Workshop © ECCO Photographer

It was very successful, with 41 attendees. This year, the ClinCom Members (Chair, Filip Baert) developed a programme composed of two different but complementary sessions, one entitled "Therapeutic trials in IBD at the turning point" and a second entitled "Academic trials in IBD: a user's guide". The best international experts in the field of clinical trials in IBD were invited to give a talk on a specific topic.

During the first session, Julián Panés 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 IBD 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-Yves Mary underscored that cohort studies and randomised clinical trials (RCTs) have complementary roles to play in the evaluation of IBD research questions. The randomised design allows concealment 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 IBD. 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 purest form, prospective cohort studies allow for relatively unbiased ascertainment 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 IBD, 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.

The first talk of the second session was given by Walter Reinisch and was entitled "From idea to a sound protocol". He first highlighted that the key elements to be considered in development of a high-quality protocol may be summarised by the PQRST rules, including the population, the question, the relevance, the study design and variables and the time frame. He concluded by telling us his own experience in developing a study protocol: "Writing of a protocol is an iterative process of drafting and redrafting from repeated discussions with clinical collaborators and statisticians before it is granted a go".

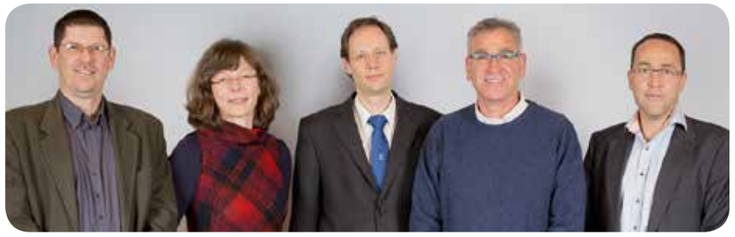
In his talk, entitled "How to avoid bias or mistakes in academic trials", Stefan Schreiber recalled that academic trials should reflect the treatment situation in clinical practice and that unfortunately they are often conducted to answer specific questions or to achieve the proof of efficacy required 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, this workshop was highly interactive, with fruitful discussion throughout the sessions. Filip Baert 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 ECCO website at www.ecco-ibd.eu/ClinCom/SOPs-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.

LAURENT PEYRIN-BIROULET
ClinCom Member
On behalf of ClinCom

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



P-ECCO Members (Dan Turner, Kaija-Leena Kolho, Frank Ruemmele, Arie Levine, Gábor Veres) © ECCO Photographer

Treatment of IBD is always a balance between the beneficial outcomes of a given treatment and the risk involved in using 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 IBD 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 patients, parents 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 IBD.

Data from the 4,343 paediatric patients [2,503 of whom received infliximab (IFX), involving 4,347 patient years] enrolled in the DEVELOP database (a Janssen-sponsored and -controlled database), shed light on the risk of cancer from treatment or disease. DEVELOP is a prospective observational registry designed to study the long-term safety of IFX and other therapies in childhood-onset IBD (CD and UC). Data were obtained from 86 centres in North America and Europe from 2007 to 2012. Malignancy event rates from DEVELOP were compared with the expected event rates using the SEER database, adjusted for age, gender and race. Standardised incidence ratios (SIRs) were estimated by dividing the number of patients in whom malignancies were observed by the expected number of patients with malignancies according to the age-adjusted incidence rates in the United States based on SEER data. This study also evaluated associations of serious infections with treatment.

The study identified seven malignancies. Four patients were exposed to IFX prior to a malignant event, comprising one basal cell carcinoma, one malignant melanoma, one acute monocytic leukaemia and one adenocarcinoma of the parotid gland. Three patients exposed to non-biologic treatments developed haematopoietic malignancies: Haematophagic histiocytosis, Hodgkin's disease and malignant lymphohistiocytosis. The incidence of malignancies was similar among all three exposure cohorts, each with an event rate of 0.09 per 100 patient years. All patients had prior exposure to IMM [one to azathioprine (AZA), six to 6-mercaptopurine (6-MP) and two to methotrexate (MTX)]. Comparisons between DEVELOP and SEER data yielded a SIR of 4.96 (95%CI 1.35, 12.69) for IFX-exposed patients, 4.77 (95%CI 1.30, 12.20) for anti-TNF-exposed patients and 5.09 (95%CI: 1.05, 14.86) for patients exposed to non-biologic therapies. Among those who were also exposed to IMM, an increased SIR was observed: IFX (n=1,973), 5.98 (95%CI 1.63, 15.31); anti-TNF (n=2,042), 5.73 (95%CI 1.56, 14.67); non-biologics (n=1171), 7.12 (95%CI: 1.47, 20.79). Data regarding combination therapy were not made available.

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 IBD patients (diagnosed prior to the age of 19 years) with any cancer and/or mortality after diagnosis of IBD, 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 IBD patients. Causes of mortality were primarily infectious (n=15, 47%), uncontrolled disease activity of IBD (e.g. toxic megacolon) (n=6, 19%), cancer (n=6, 19%), other non-IBD-related diseases (n=3, 9%) and unknown (n=2, 6%). The most common malignancies were haematopoietic (n=11; 61%), of which three were hepatosplenic T cell lymphoma and two, EBV-associated lymphomas. One case each of colon adenocarcinoma and cholangiocarcinoma were identified, only one of which was associated with primary sclerosing cholangitis. Medications used in the 3 months preceding the cancer cases included steroids (n=4, 22%), thiopurines (n=12, 67%), biologics (n=2, 11%) and calcineurin inhibitors (n=1, 6%). Combination therapy was used in only one patient (6%). The group concluded that mortality was primarily related to infections. Uncontrolled disease activity and cancer were both responsible for 19% of deaths. The lack of a control group made it impossible to elucidate how many of the cancer cases were disease specific but at least five lymphomas (hepatosplenic and EBV associated) were likely treatment associated by virtue of their phenotype.

In summary, the data presented at ECCO helped to provide more perspective on IBD and treatment-associated morbidity and mortality. However, it is clear that outcomes measured during childhood may under-report 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.

ARIE LEVINE
P-ECCO Member
On behalf of P-ECCO

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)

To date, however, no unequivocal cause has been found, UC being regarded as a multifactorial disease involving interactions between genetic and environmental factors that give rise to an inappropriate immunological response. Many researchers have evaluated this response and observed extensive infiltration of CD4+ T cells in the inflamed mucosa. Activated CD4+ T cells also show increased cytotoxic activity and secrete cytokines that enhance the inflammatory state. Over time, chronic inflammation destroys the mucosal architecture, leading to ulcers and scarring [1].

Although the human appendix is considered a vestigial remnant, recent research on the relationship between UC and appendectomy has gained widespread attention. Different studies suggest that the appendix is a priming site in the development of UC. A recent study shows 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 rectum [2]. Furthermore, it is proposed that the cytokine production within the appendix initiates an immunological cascade, leading to an imbalance in pro- and anti-inflammatory cytokines in the colorectum [3].

There is growing evidence in the literature linking prior appendectomy inversely with subsequent risk of the development of UC. This inverse association was first reported in 1987 as an unexpected finding in a study of childhood determinants of Inflammatory Bowel Diseases [4]. In 1994, a Belgian group evaluated this finding in a case-control study comparing UC patients with non-IBD controls from an orthopaedic clinic. They showed a low incidence, 0.6%, of appendectomy in UC patients compared to an incidence of more than 25% in the control group [5].

A recent Australian study reported excellent results in a prospective case series of 30 ulcerative proctitis patients who underwent an appendectomy. After appendectomy, 90% of the patients showed an improvement in their simple colitis activity index (SSCAI) score (median of 9 to a median of 2). In 40% of the patients a complete resolution of symptoms was achieved, such that no further pharmacological treatment was required [6].

Animal models of Colitis further emphasise the association between the appendix and UC. A study with T cell receptor (TCR) α-chain deficient mice (Colitis mouse model) showed that the development of inflammation was suppressed in those animals that underwent appendectomies, particularly at 3–5 weeks of age [7]. These findings suggest that an appendectomy could be beneficial early in the course of the disease.

S-ECCO Members (Gianluca Sampietro, Willem Bemelman, André D'Hoore, Alastair Windsor, Zuzana Serclova) © ECCO Photographer

The available evidence points towards a therapeutic effect of appendectomy in UC patients. However, the available studies are mostly of limited quality and confounded by many factors. A randomised study must overcome these methodological problems.

At the Academic Medical Center (AMC) in Amsterdam, we are conducting a multicentre randomised controlled trial to evaluate the short- and medium-term effectiveness of appendectomy in maintaining remission in patients with an established diagnosis of UC treated for a relapse (the ACCURE trial, trial register; NTR2883). In this study, patients who have (a) an established diagnosis of UC, made less than 1 year prior to randomisation (any extent of disease); (b) have suffered recent disease relapse less than 4 months prior to randomisation, medically treated until remission, and (c) have received treatment of UC only with 5-ASA (oral and/or topical) and/or a maximum of one steroid course will be randomised to laparoscopic appendectomy or to no appendectomy. Our primary outcome is the relapse rate. Patients will be followed for at least 12 months, or until relapse. UC patients treated with biologicals or refractory to medical treatment are excluded from the ACCURE trial.

Although we believe that the immune homeostasis of the mucosa is different in treatment-refractory patients compared to patients able to regain remission, appendectomy could still be beneficial. If an appendectomy can influence the disease course of treatment-refractory patients, thereby postponing or even preventing a colectomy, there will be a substantial gain in quality of life. In a pilot study, 30 patients with an established diagnosis of UC and with refractory disease after full medical treatment (5-ASA, corticosteroids, immunomodulators and biologicals) requiring a colectomy will be treated with appendectomy. Patients will be followed until 12 months after laparoscopic appendectomy to assess the patients' clinical condition and the full MAYO score (the PASSION study).

Furthermore, the appendicular tissues will be collected and investigated with respect to histological and immunohistochemical features. Appendicular tissue of both ACCURE and PASSION study patients will be compared to that from non-IBD (such as cancer) and acute appendicitis patients.

Although various epidemiological and case control studies have investigated the association between appendectomy and the risk of developing UC, strong evidence is still lacking.

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 initial additional costs and potential side-effects of appendectomy will 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 daycare and easily incorporated into standard treatment regimens in UC patients.

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WILLEM BEMELMAN
S-ECCO Member

S. SAHAMI, C.J. BUSKENS
Department of Surgery, Academic Medical Center, Amsterdam, The Netherlands
On behalf of S-ECCO

Dear colleagues,

We hope you are well! Let us update you on the recent happenings in our Y-ECCO Community:

Our educational programme is expanding! Sebastian Zeissig together with the Y-ECCO Committee is currently planning the Y-ECCO Workshop programme for the ECCO Congress in Copenhagen in 2014. Based on your feedback and the team discussion we chose the timely topic: "Presentation, networking and negotiation skills" – all very important competencies for your career. In addition, Franco Scaldaferri and the Y-ECCO Committee are working on developing a novel Y-ECCO Ultrasound Workshop in collaboration with the EduCom and ESGAR. After a short theory section, Y-ECCO Members will have plenty of opportunities to practice on different ultrasound simulators (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 eCCO 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 the ECCO Family on different topics, ranging from location to scientific interest, mentorship and collaborations! You can continue to apply for the Y-ECCO co-chairing 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 News! Pieter Hindryckx is the new editor of the literature review section. The reviews have been a huge success for Y-ECCO Members, enabling them to inform the ECCO Family about recent publications of relevance and to gain visibility. Please note his address and the articles on the following pages. Monica Cesarini publishes her second Y-ECCO Interview, this time with Silvio Danese. We will start a new item in the next issue of ECCO News: the Y-ECCO Conference report. We already have authors for DDW in Orlando, but we are still seeking Y-ECCO Members interested in writing on the ESPGHAN (May 8-11, 2013, London), ESGAR (June 4-7, 2013, Barcelona), ESCP (September 25-27, 2013, Belgrade) 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.

FLORIAN RIEDER
Y-ECCO Chair

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

Starting from this year, the Y-ECCO Committee, in collaboration with ClinCom, is offering the possibility of fostering collaborative studies proposed by Y-ECCO Members.

Applications for clinical studies should follow the guidelines provided by ClinCom (available on the ECCO website: www.ecco-ibd.eu/ClinCom/SOPs-Clinical-Study-Protocol), but Y-ECCO Members are encouraged to apply through Y-ECCO in order to have the option of Y-ECCO study sponsorship and promotion.

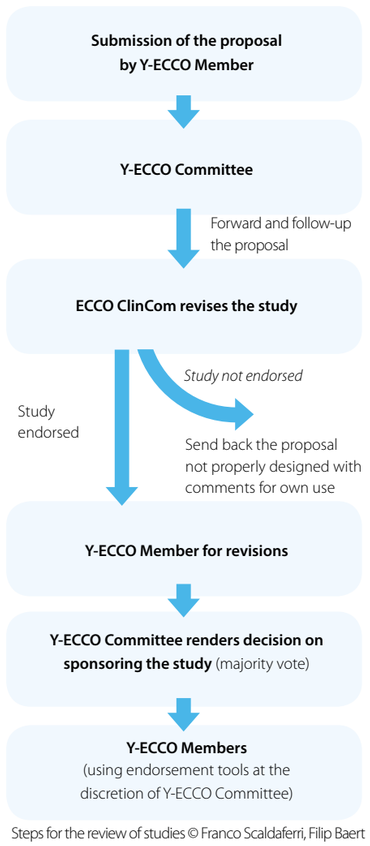
Briefly, whoever wants to propose a collaborative study in Europe (or worldwide, as ECCO is now worldwide!) can simply write a study synopsis of a few pages (following ClinCom Guidelines), send it to his or her Y-ECCO representative and wait for initial feedback. After this step, a full application may 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 workshop). 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.

Franco Scaldaferri © ECCO Photographer

FRANCO SCALDAFERRI
Y-ECCO Member



Steps for the review of studies © Franco Scaldaferri, Filip Baert

Introducing new Y-ECCO Members

As of the Congress in Vienna, Marjolijn Duijvestein and James Lee have left the Y-ECCO Committee and have been replaced by Sebastian Zeissig and Tim Raine

Here we use a discussion among the four to tell you more about what has been happening and what is to come.

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 focussed 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 Franco, James, Pieter, 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.

TR: I think ECCO is an absolutely terrific organisation, and something that colleagues in other specialties and disease areas look on with envy. Young ECCO, in particular, is a brilliant way to create opportunities for clinicians and clinician-scientists at an early stage in their careers, in particular by providing a link with more senior figures across the globe, and to overcome past barriers of geography and local politics. I think that to be able to facilitate that sort of interaction is tremendously exciting.

TR & SZ: What will you both be doing now that you've left?

JL: 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 away from 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! (Er, I mean "Interaction".)

MD: Last year I obtained my PhD. 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: 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 years' time, the senior posts in ECCO will almost all be filled by people who are now in Y-ECCO.

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.

TR: I'm working closely with the EduCom to help develop an online learning platform based around case reports and expert commentary. We are very much hoping that Y-ECCO Members will come forward to help write some of the case reports – it's a fantastic opportunity.

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Sebastian Zeissig © ECCO Photographer

TIMOTHY RAINE, SEBASTIAN ZEISSIG
Y-ECCO Members

MARJOLIJN DUIJVESTEIN, JAMES LEE
Former Y-ECCO Members

Y-ECCO Interview corner

Dear Y-ECCO Members,

It's a pleasure to introduce the second "Y-ECCO Interview corner" interview, with Silvio Danese.

The rationale of the "Interview corner" is to perform a short interview with a senior ECCO Member, in order to provide advice to young doctors on how to pursue a career in IBD.

The next interviewee will be Séverine Vermeire. Please feel free to suggest questions of interest and send them to the ECCO Office under ecco@ecco-ibd.eu. We can't wait to hear from you.

Yours sincerely,

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Monica Cesarini
@ Monica Cesarini

Monica interviews Silvio Danese

Silvio Danese ©
ECCO Photographer

What was the key step that allowed you to move forward in your career in IBD?

When I think back on what was really relevant, I feel that my career can be compared to the game involving a row of dominoes, in which after the first piece starts to fall, all the others fall in sequential order.

The Italian academic system is sometimes rigid, and it might be hard to find a good mentor: for me, finding the right mentor for my MD thesis was the key. Professor Gasbarrini was very supportive and let me take my career in 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 around Europe. It is fun to look back and see that all of us who were then "post-docs" are now grown-up PIs. 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.

Is it possible to be a good clinician and a good scientist at the same time?

I think it is very difficult to be very good in both basic science and clinical medicine, but I also feel that IBD is the perfect example of a disease area in which interactions between the bench and bedside are possible. I know many colleagues who are very good clinicians and also very good scientists. The most common problem is lack of time. Being both a researcher and a clinician is like having two jobs, and it is sometimes difficult to give optimal time to both patient care and research. Actually, if the work environment were not protective and supportive, patient care would receive the bulk of available time and research time would be reduced. It is up to a very well-motivated clinician and researcher to find the best mix between good patient care and high-quality research.

What suggestions can you give young doctors who want to work in IBD?

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 "imprinting" is key, and mixed 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 work load. 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!

MONICA CESARINI
Y-ECCO Interview corner Admin

Dear Y-ECCO Members,

During the last few years, the Y-ECCO Literature reviews have become a fixed and well-received part of ECCO News and we are happy to continue with them. The purpose of the literature reviews is to highlight the most recent landmark articles within the field of IBD.

We offer every Y-ECCO Member the opportunity to participate in this Y-ECCO initiative. After choosing a timely and relevant article, you summarise the key findings and relevance of the paper in one page. Your review will then be published together with a personal picture and a short self-description. This means it is the ideal way to introduce yourself to the ECCO Community!

If you are interested in writing a literature review or if you have any questions, please send an email to pieter.hindryckx@ugent.be.

PIETER HINDRYCKX
Y-ECCO Member
On behalf of Y-ECCO

Pieter Hindryckx © ECCO Photographer

Natural history of elderly-onset inflammatory bowel disease: a population-based cohort study

Charpentier C, Salleron J, Savoye G, Fumery M, Merle V, Laberenne JE, Vasseur F, Dupas JL, Cortot A, Dauchet L, Peyrin-Biroulet L, Lerebours E, Colombel JF, Gower-Rousseau C.
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Introduction

The incidence of Inflammatory Bowel Disease (IBD) is increasing worldwide. As the worldwide population is ageing, the proportion of elderly-onset IBD patients is also on the rise [1, 2]. The management of IBD in this population is complex because of problems with co-morbidities, polypharmacy, impaired mobility and cognition etc. The risk/benefit ratio of medical and surgical therapies should always be taken into account, especially in this fragile population [3, 4]. A better knowledge of the natural history and the further course of the disease at a population-based level could help in making therapeutic decisions and in improving the quality of care for these patients.

What this paper is about

This population-based cohort study of elderly-onset IBD recruited 841 [367 Crohn's Disease (CD); 472 Ulcerative Colitis (UC)] IBD patients >60 years of age at diagnosis from the EPIMAD registry [5] in northern France between 1988 and 2006. Median follow-up was 6 (2-11) years. Characteristics of the disease at diagnosis and during follow-up were described, and compared with younger populations. The therapeutic management and outcomes were analysed, and in addition, risk factors for surgery were identified.

At diagnosis, elderly-onset CD was characterised by the predominance of pure colonic disease (65%), with inflammatory, uncomplicated (non-stricturing non-penetrating) behaviour (78%). Disease location was stable with time in more than 92% of the elderly. At maximal follow-up, progression from uncomplicated to complicated disease had occurred in 9%, which is a significantly lower rate than that among younger patients. In UC there was a predominance of left-sided (45%) and extensive Colitis (26%) at diagnosis. Proctitis (29%) was less frequent than in other age groups (p<10-4). During follow-up, disease extension was rare (16%).

With regard to the therapeutic management and outcomes, almost all elderly IBD patients received 5-ASA and approximately 40% received systemic steroids. It is of note that fewer than 20% of the elderly patients received immunosuppressants and only 2% received anti-TNFα therapy. According to the authors, this might be because only 18% of the patients were steroid dependent, and because of fear of the side-effects in elderly people. In CD, cumulative probabilities of receiving corticosteroids (CS), immunosuppressants (IS) and anti-TNFα therapy were respectively 47%, 27% and 9% at 10 years. In UC, cumulative probabilities of receiving CS, IS and anti-TNFα therapy were 40%, 15% and <1%, respectively, at 10 years.

Only 16% of elderly-onset patients underwent surgery at 10 years from diagnosis. Cumulative probabilities of surgery at 1 year and 10 years were 18% and 32%, respectively, in CD and 4% and 8%, respectively, in UC. Surgery seems to be done earlier than in younger adults. The authors suggest that this can be explained by fear of misdiagnosis and by avoidance of immunosuppressive drugs when surgery is a reasonable alternative. In this study fewer than 10% of the UC patients underwent a coloprotectomy with ileoanal anastomosis, probably because of the worse pouch survival, functional outcomes and quality of life in elderly patients.

Conclusion

This study shows that the course of elderly-onset IBD is mild and less aggressive than in younger patients. There seems to be a quite unique pattern of disease presentation/course and of medical and surgical treatments. This is important information to take into account when discussing therapeutic strategies in a vulnerable population.

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Once-daily budesonide MMX in active, mild-to-moderate ulcerative colitis: results from the randomised CORE II study

Travis SP, Danese S, Kupcinskas L, Alexeeva O, D'Haens G, Gibson PR, Moro M, Jones R, Ballard ED, Masure J, Rossini M, Sandborn WJ
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Introduction

Corticosteroids are effective for inducing rapid remission in active 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 colonic mucosa is the key to its efficacy. However, current oral pH-modified release formulations of budesonide are able to act only in the distal ileum 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 (risk ratio 0.72; 95%CI 0.57–0.91) [6]. This lower effect may also be due to the altered intestinal pH of UC patients.

On the other hand, the colonic release multi-matrix system (MMX) has already been used successfully with oral mesalazine (mesalazine MMX) [7-9]. This technology provides targeted drug delivery to the entire colon, as supported by scintigraphic data [10]. Based on this, the current study assessed whether the use of this technology coupled with budesonide can help to improve the efficacy of corticosteroids while minimising systemic side-effects in UC patients.

Key findings

This phase III CORE II (COlonic RElease budesonide) study investigated the short-term efficacy (8 weeks) of once-daily budesonide MMX for the 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, parallel-group trial and was carried out at 69 centres in 15 countries in Europe, Russia, Israel and Australia between July 2008 and February 2010. An internal reference arm of oral budesonide controlled ileal-release capsules (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 set a high goal: Combined 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 colonoscopy, and a ≥1-point reduction in Endoscopy Index Score from baseline. The authors chose this definition partly to minimise the placebo response, but also to have an outcome 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 (17.4% vs 4.5%; OR 4.49; 95%CI 1.47–13.72; p=0.0047). Furthermore, budesonide MMX 9 mg was associated with higher rates of clinical (42.2% vs 33.7%) and endoscopic improvement (42.2% vs 31.5%) compared with placebo, but these differences did not reach statistical significance. Nevertheless, the rate of histological healing (16.5% vs 6.7%; p=0.0361), which appears to predict long-lasting remission, and the proportion of patients with symptom resolution (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.

Overall, budesonide coupled with the MMX colonic 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.

Besides the CORE II study, an almost identically designed CORE I study was conducted in the USA, Canada, Mexico and India and obtained very similar results [11].

What is of interest in this study?

The study shows that budesonide MMX 9 mg is safe and effective for the induction of combined clinical and endoscopic remission in patients with active, mild-to-moderate UC after 8 weeks. These data support the hypothesis that low bioavailability and targeted delivery of budesonide limit its side-effects without affecting its efficacy. Budesonide MMX may therefore be considered as an alternative to conventional corticosteroid therapy in these patients. While the absolute clinical and endoscopic remission rates assessed in the study are lower than the remission rates reported in several recent UC trials, the authors try to explain the potential reasons for these differences.

Of note, this paper highlights the importance of using robust endpoints and the crucial necessity of ensuring histological evidence of active disease prior to initiating studies with anti-inflammatory agents.

It will be interesting to design a study powered to compare colonic-release budesonide with conventional corticosteroid therapy for the treatment of active, mild-to-moderate UC patients. Finally, further studies should investigate the safety and efficacy of this formulation in those patients who could need a corticosteroid treatment lasting longer than 8 weeks.

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Adalimumab combined with ciprofloxacin is superior to adalimumab monotherapy in perianal fistula closure in Crohn's disease: a randomised, double-blind, placebo-controlled trial (ADAFI)

Dewint P, Hansen BE, Verhey E, Oldenburg B, Hommes DW, Pierik M, Ponsioen CI, van Dullemen HM, Russel M, van Bodegraven AA, van der Woude CJ
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Introduction

The development of perianal fistulas is a common complication of Crohn's Disease (CD), with a reported cumulative incidence of about 25% after a disease duration of 20 years [1,2]. Although a range of medical and surgical options are available today, the treatment of perianal fistulas remains challenging. Achieving complete closure of the fistulous tract is a long process and relapses are common.
Antibiotics such as ciprofloxacin and metronidazole are widely used as first-line therapy for perianal fistulas; however, re-exacerbations are common after discontinuation of this treatment [3]. Several trials have clearly demonstrated the benefit of anti-TNF for the induction and maintenance of remission in perianal Fistulising Disease [4,5,6].
West et al. [7] combined infliximab therapy with ciprofloxacin or placebo for 12 weeks and found a non-significant difference in response to the treatment in favour of the combination group.

What this paper is about

In this multicentre randomised, double-blind, placebo-controlled trial, patients with active perianal Fistulising Crohn's Disease were enrolled at eight sites in the Netherlands from September 2008 to March 2011. Patients were randomised between adalimumab + ciprofloxacin (n=34) or adalimumab + placebo (n=36). All patients started at day 0 with 160 mg adalimumab, received 80 mg at week 2 and were treated with 40 mg every other week from week 4 until the end of follow-up at week 24. During the first 12 weeks, ciprofloxacin 500 mg or placebo twice daily was added to the adalimumab treatment. The primary endpoint was a 50% reduction of draining fistulas from baseline at week 12. Secondary endpoints were the complete closure of all fistulas from baseline at week 12 and week 24. Baseline characteristics were similar between the two groups.

At week 12, 24/34 patients (71%) had a response (at least 50% reduction in number of draining fistulas) to the adalimumab + ciprofloxacin treatment compared to only 17/36 patients (47%) in the adalimumab + placebo group (p=0.047). Baseline characteristics did not influence fistula closure as shown by univariate analysis. Furthermore, significantly more patients achieved remission (100% closure of draining fistulas) at week 12 when allocated to combination therapy (65% vs 33%; p=0.009). However, at the end of follow-up (week 24), when ciprofloxacin had been stopped for 12 weeks, the difference in fistula response and remission between the two treatment arms was not maintained.
In both groups, 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 contrast, 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 and ciprofloxacin-treated patients than in those who received adalimumab monotherapy (p=0.009).
In the ciprofloxacin group, 31/34 patients had no serious adverse events, compared to 34/36 patients in the placebo group, i.e. 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 an 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 anti-TNF is feasible and may delay or even avoid seton placement or more invasive surgery such as a proctocolectomy in this patient population.
In this study, response and remission rates were determined by clinical investigation. A valuable addition for future studies could be the use of serial MRI to visualise the fistula tracts and determine the radiological healing.

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Anti-IP-10 antibody (BMS-936557) for ulcerative colitis: a phase II randomised study

Mayer L, Sandborn WJ, Stepanov Y, Geboes K, Hardi R, Yellin M, Tao X, Xu LA, Salter-Cid L, Gujrathi S, Aranda R, Luo AY
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Introduction

Ulcerative Colitis (UC) is a chronic relapsing disease, the pathogenesis of which is incompletely understood [1]; consequently, there is still a pressing need for a causal therapy. In 2006, infliximab, as the first anti-TNF antibody, extended the therapeutic armamentarium for UC after its efficacy was proven in both induction and maintenance therapy [2]. However, due to insufficient long-term response rates in the case of maintenance therapy and potentially severe side-effects associated with the use of anti-TNF antibodies, there is still an urgent need for new therapeutic approaches in UC. The ongoing search for new therapeutics beyond anti-TNF-based strategies is documented by the abundance of drugs currently being evaluated in a vast number of preclinical and clinical studies [3].
Interferon-γ-inducible protein-10 (IP-10; CXCL10) is a chemokine which both directly and indirectly participates in inflammatory cell migration (e.g. Th1 and Th17 cells, as well as monocytes) and epithelial cell survival through binding to the G protein-coupled CXCR3 receptor. High IP-10 expression levels were found in colonic biopsies and plasma from patients with active UC as compared to healthy controls. In addition, preclinical in vivo studies demonstrated therapeutic activity of anti-IP10 treatment in several murine models of colitis [4, 5].

What this paper is about

In this randomised, double-blind, placebo-controlled phase II study, 109 patients with active UC were treated intravenously with a fully human monoclonal antibody to IP-10 (BMS-936557, 10 mg/kg every other week) for 8 weeks. The primary study endpoint was the clinical response rate at 8 weeks; secondary endpoints were clinical remission and mucosal healing rates at that time point.
Results regarding the primary and secondary endpoints did not reveal significant differences between the BMS-936557 and the placebo group: 52.7% of BMS-936557-treated patients showed a clinical response as compared to 35.3% patients of the placebo group (p=0.083). In addition, clinical remission and mucosal healing rates were 18.2% vs 16.2% and 41.8% vs 35.2% (p=1.0 and p=0.556), respectively. Interestingly, higher trough levels (108-235 µg/ml) were clearly associated with both increased clinical response rates (p<0.010) and histological improvement rates (p=0.004), pointing at a dose-dependent mechanism of action. The frequency of serious adverse events in the high trough level subgroup was comparable to that among patients with low antibody concentrations.
Infections occurred in seven patients treated with BMS-936557 as compared to two patients in the placebo arm. The authors referred to an earlier study investigating BMS-936557 in rheumatoid arthritis patients showing no increased infection rates as compared to the placebo group [6]. In the present study, treatment for two patients receiving BMS-936557 had to be discontinued due to vasculitis and perforated appendicitis/appendiceal abscesses, both of which were considered to be unrelated to the study agent.

Conclusion

Since the current concept of precision medicine [7], including, for example, the individual assessment of T cell gene expression [8] and susceptibility loci of IBD [9], is still a futuristic vision of clinical management, evaluation of more general anti-inflammatory substances beyond anti-TNF pathways is needed. In the present study, BMS-936557 failed both primary and secondary endpoints due to low clinical response and remission rates. However, the trial population in this proof of concept study was rather small, with 109 individuals, and larger study cohorts may delineate significant therapeutic effects of this compound. Furthermore, since higher trough 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: NCT01294410). Nevertheless, the significance of targeting IP-10 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 [10] and vedolizumab [11] as well as biosimilars [12], which all are expected to become available soon.

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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 Governing Board:
- President-Elect, 2014-2016
- Treasurer, 2014-2017

ECCO Committees – open seats (2014-2016):
- 1 ClinCom Member (Clinical Research Committee)
- 3 EduCom Members (Educational Committee)
- 2 EpiCom Members (Epidemiological Committee)
- 2 GuiCom Members (Guidelines Committee)
- 1 SciCom Member (Scientific Committee)
- 1 N-ECCO Member (Nurses of ECCO)
- 2 P-ECCO Members (Paediatricians of ECCO)
- 2 S-ECCO Members (Surgeons of ECCO)
- 2 Y-ECCO Members (Young ECCO)

Deadline for submission of applications for **ECCO Committees** is **September 13, 2013** and for the **ECCO Governing Board** it is **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@ecco-ibd.eu.

Kind regards,
ECCO Governing Board

ECCO Country Member Profiles

Identity card
- Country: **France**
- Name of group: GETAID
- Number of active members: 70
- Number of meetings per year: 6
- Name of president and secretary:
  Edouard Louis (President),
  David Laharie (Secretary),
  Laurent Peyrin Biroulet (Vice President)
- Incidence of IBD in the country: 8.5

Identity card
- Country: **Norway**
- Name of group: NGF IBD interest group
- Number of active members: 8
- Number of meetings per year: 1 or 2
- Name of president and secretary:
  President: Ingrid Prytz-Berset, 2008–2013.
  From February 2013: Rasmus Goll.
  The group has no secretary.
- Incidence of IBD in the country:
  According to the IBSEN research group, approx 20 new patients with IBD per 100,000 per year.

Identity card
- Country: **Germany**
- Name of groups: Deutsche Arbeitsgemeinschaft für Chronisch Entzündliche Darmerkrankungen (DACED)
  Competence Network IBD
  German IBD Study Group (GISG)
- Number of active members:
  100 DACED members
  415 members in the Competence Network IBD
  130 GISG study centres
- Number of meetings per year: DACED and Competence Network IBD: twice a year
  GISG board or plenary assembly: six times a year
- Name of president and secretary:
  Oliver Bachmann (DACED speaker)
  Ulf Helwig, Christian Maaser and
  Britta Siegmund (GISG spokespersons)
  Bernd Bokemeyer
  (Competence Network IBD president)
- Incidence of IBD in the country:
  As in Western Europe

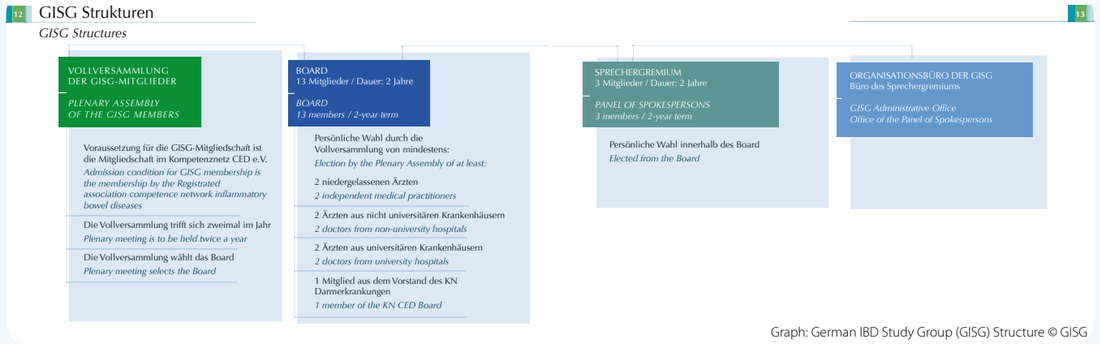
Questionnaire – GERMANY

How did your national group start?

DACED was founded in 1988 and the Competence Network IBD was established in 1999. The common decision to establish a study platform on Inflammatory Bowel Disease (IBD) in Germany, under the title of the German Inflammatory Bowel Disease Study Group (GISG), emerged in November 2008 from a joint initiative of the German Working Group on Inflammatory Bowel Diseases (DACED) and the Competence Network IBD (KN CED). The underlying aim is to integrate all IBD treatment centres, i.e. medical practices, clinics and universities, into the GISG. Individual study proposals will be jointly developed and implemented to provide sustained support for research and treatment in the field of IBD. While joint study platforms on chronic IBD have a longer tradition in a number of neighbouring European countries, GISG leads the way in Germany.

How is your group organised in terms of new members joining the group, meetings, election of president etc.?

DACED is open to all MDs and PhDs who are interested in IBD and based in Germany. There is no formal member status and no membership fee. A 1.5-day meeting of DACED takes place every June in Mainz. At this meeting, everyone can come and present his or her own scientific data. The wish to present data is expressed by informal submission following a call by the president of DACED in April. Presented data are supposed to be new and should represent work in progress. The second meeting in the autumn, in conjunction with the German GI meeting, focusses on clinical trials and the cooperation with the Competence Network. The president is elected annually by the members present at the main meeting in Mainz. GISG elects its speakers every 3 years, and the Board and



Graph: German IBD Study Group (GISG) Structure © GISG

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 2005). 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, focussing 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).

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

Within the Competence Network IBD a bio bank including serum as well as tissue samples is available. In order to access the bio bank, specific project grants have to be submitted and are then reviewed and permitted by the steering committee.

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. 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).

Group picture: Working Group Speakers and Governing Board © Competence Network IBD

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

Guidelines conferences and scientific workshops.
German representatives have been or are involved in various committees (SciCom, EduCom, GuiCom, Y-ECCO, Governing Board). Also, the first German Educational Workshop will take place this year.

What are your aims for the future?

One major aim is to achieve better linkage of ECCO projects into the German researcher horizon and vice versa. One aim is, for instance, to use ECCO-based Guidelines as a basis for German IBD guidelines. There is interest in getting involved in European-wide research projects (bio banking, genetics consortia, clinical trials beyond industry and improvement of care for IBD patients).
Establishing a European network will strengthen the national networks, and in the long term this will make possible the performance of studies at the European level.

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

Europe-wide calls for networking using ECCO newsletters; mailing of newsletters to the Competence Network IBD and distributing these newsletters via their e-mail list; involving German National Reps 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.

TORSTEN KUCHARZIK, ANDREAS STURM
ECCO National Representatives, Germany

Questionnaire – FRANCE

How did your national group start?
Robert Modigliani, gastroenterologist, and Jean Yves Mary, methodologist, formed the embryo of GETAID in the early 1980s. IBD specialists in university hospitals in France and Belgium joined and the group was formed. Paediatric and surgical GETAID were formed recently.

How is your group organised in terms of new members joining the group, meetings, election of president etc.?
New members may join the group and have to recruit patients in GETAID trials. The president is elected every 4 years.

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.

What are your most prestigious/interesting past and ongoing projects?

Franck Carbonnel @ Franck Carbonnel

Past: CDEIS description and validation, effect of steroids upon mucosal healing in Crohn's Disease, the azathioprine withdrawal trial, the azathioprine bridge trial, the STORI trial and the CYSIF trial. Ongoing projects: METEOR, CREOLE, ABIRISK

Which ECCO projects/activities is the group currently involved in?
METEOR is an ECCO project.
GETAID members have been/are involved on the Governing Board, ClinCom, EpiCom, GuiCom 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 fulfil these aims?

Laurent Beaugerie @ Laurent Beaugerie

ECCO is a forum for the exchange of ideas with people beyond our borders. It may help in developing cooperation with other national groups, such as GETECCU (in Spain) and BIRD (in Belgium), in respect of trials/projects.
European centres may recruit in GETAID trials (as has been the case in CYSIF and METEOR).

What do you use ECCO for? Network? Congress? How do you use the things/services that ECCO has to offer?
We use it for networking and congress. ECCO Guidelines are very important in France: they serve as the reference for IBD care.

LAURENT BEAUGERIE, FRANCK CARBONNEL
ECCO National Representatives, France

Questionnaire – NORWAY

How did your national group start?
The group was constituted at the National Gastroenterology Society (NGF) General Assembly in February 2008. The NGF elected eight members to the group.

How is your group organised in terms of new members joining the group, meetings, election of president etc.?
The group consists of six gastroenterologists, one gastrointestinal surgeon and one paediatric gastroenterologist. Members are elected for 4 years, with four being exchanged every second year to ensure better continuity. Every second year before the annual national NGF meeting, all members of NGF (i.e. all gastroenterologists in Norway) are asked by e-mail to propose the gastroenterologists who might become new members in the IBD interest group. The NGF Steering Committee then elects four new members to the IBD interest group for the next 4 years.

When did your national group join ECCO?
In 2008.

What are your main areas of research interest?
Epidemiology (IBSEN group), biologics registry (NOKBIL).

Does your centre or country have a common IBD database or bio bank?
Not yet, but work in this direction has been in progress for the last 2 years and we are close to establishing a common biologics registry (NOKBIL) for all types of biologic treatment in all medical disciplines. In addition to the common biologics registry, the NOKBIL project will include separate registries for the main disease groups, such as IBD, rheumatology and dermatology, where the plan is to include all patients diagnosed with these diseases from the time of diagnosis, before the start of treatment.

What are your most prestigious/interesting past and ongoing projects?
The NOKBIL registry (in progress) and the IBS research group (past and present: 20 years' data have now been collected).

Which ECCO projects / activities is the group currently involved in?
The group is not involved in any specific ECCO project, but former members of the group (Drs. J. Jahnsen and B. Moum) have been and are cooperating with ECCO in different projects through the IBS research group.

What are your aims for the future?
To establish closer connections with ECCO and to cooperate more in research activities.

How do you see ECCO helping you to fulfil 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?
ECCO is a valuable platform for networking, and both the IBD group members and many gastroenterologists in Norway prefer to attend the ECCO Congress instead of other conferences, because of its favourable programme and because it is a great way to get to know ECCO and its members. Dr. Prytz-Berset has also been participating in reviewing ECCO Guidelines during the past couple of years, which has been a good experience and an effective way of keeping up-to-date and thus being able to use current information to produce national guidelines on IBD management (first edition 2011, update due in 2013).

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