European
Crohn's and Colitis
Organisation

Volume 11 | Issue 4 | 2016

ECCO News WINTER

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Crohn's and Colitis
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To reach our objectives, our members can access the following ECCO Initiatives:

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- Monthly eNewsletter
- Access to online members' area
- Voting rights in General Assembly (President-Elect, Treasurer, Secretary)
- Quarterly ECCO News – The society's magazine
- Educational and networking activities
- Guidelines, ECCO Fellowships, Grants and Travel Awards
- Access to ECCO UR-CARE - United Registries for Clinical Assessment and Research

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

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Horn, Austria

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ISSN 1653-9214

Content:

Dear ECCO Friends,

We are approaching our central annual event, the ECCO Congress, which will on this occasion be held in the charming city of Barcelona, Spain, on February 15–18, 2017. This is already the 12th Congress of ECCO. Barcelona is a city of design and creativity, and these components are an essential part of our Congress programme for 2017. The Organising Committee has designed a programme that is attractive and indispensable for all professionals whose work relates to IBD. For 2017 the theme of the Congress is ***"Advancing knowledge, improving care"***. In Barcelona 2017, N-ECCO is offering an outstanding range of clinical, educational and research opportunities which will meet the wide range of needs of nurses. New editions of the N-ECCO School, N-ECCO Network Meeting and N-ECCO Research Forum will take place during ECCO'17. You will find more information on the Congress activities in this issue of ECCO News.

ECCO has a continuous active life outside the central event of the Congress. This includes **European** and **international workshops** aimed at spreading multidisciplinary IBD knowledge beyond the borders of Europe. Last trimester we organised the **2nd Paediatric IBD Workshop** in Helsinki, which was the **46th ECCO Educational Workshop** overall, and the **3rd S-ECCO International Workshop** in the city of Cancun, Mexico. We also had a joint symposium between ECCO and the **European Society of Pathology (ESP)**. All these activities raised interesting discussions that are summarised in this issue.

ECCO and N-ECCO are very pleased to announce that we are starting a programme of research grants specifically devoted to IBD nurses. All aspects of patient care are susceptible to improvement if the proper research is done. Given the key role of the nurse in our IBD multidisciplinary teams, it is also an ambition of ECCO and N-ECCO to foster research in this area. The new research grants will be added to the support that we already provide, including pioneering awards, fellowships and travel awards. **Do not miss the deadlines for these grants, and stay alert to our website and e-Newsletters!**

And there is much more in this issue of ECCO News, from counselling on how to overcome the difficulties of performing diet-related randomised controlled trials, to non-pharmacological ways to cure intestinal inflammation.

Enjoy!

Julián Panés © ECCO

JULIÁN PANÉS
ECCO President

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

European Crohn's and Colitis Organisation

Announcement 2018

Inflammatory Bowel Diseases

13th Congress of ECCO
February 14-17, 2018

- Reed Messe Vienna
- EACCME applied
- Register at the 12th Congress of ECCO in Barcelona

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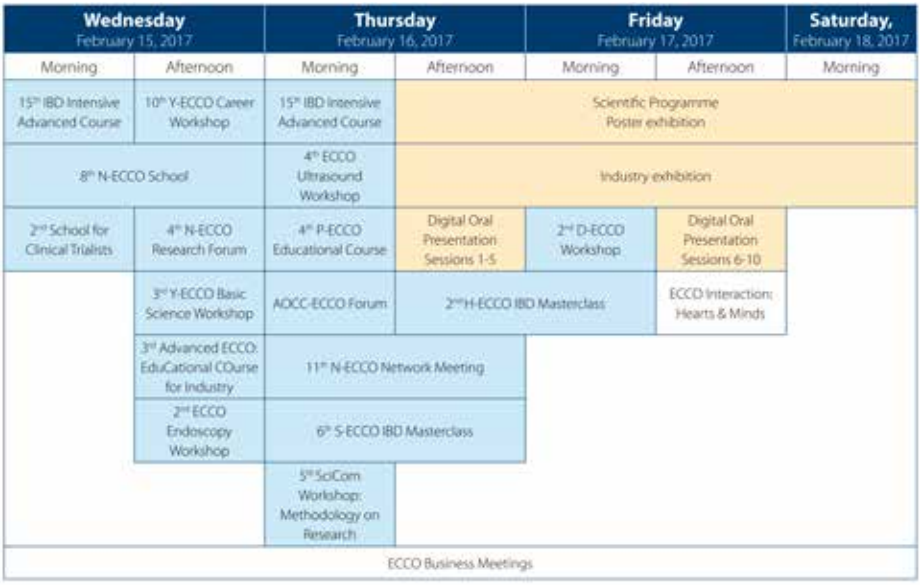
ECCO'17 – Come to Barcelona for IBD!

The 12th Congress of ECCO in Barcelona is coming closer and so is the late registration deadline. Benefit from the late registration and register by February 1st, 2017 (after this date the onsite registration fees apply).

Educational programme at ECCO'17:

Educational activities at the 12th Congress of ECCO will be held from Wednesday, February 15, 2017 to Saturday, February 18, 2016. The educational programme covers activities for ECCO's different interest groups, including young gastroenterologists, surgeons, paediatricians, histopathologists, dietitians, IBD nurses and allied health professionals and scientists. An overview of these activities can be found below. For the detailed final programme please refer to ***www.ecco-ibd.eu/ecco17***. Please note that some of these courses/workshops will run in parallel to the scientific programme and that some will have a limited capacity – please register by February 1st, 2017.



Look out for our digital oral presentations!

- The **38 best abstracts** (up from 30 in 2016) will receive an **oral presentation** slot in the scientific programme of the 12th Congress of ECCO.
- The **next best ~90 abstracts** will be **digital oral presentations**, with a 5-minute oral presentation on either **Thursday, February 16, 2017 from 17:45 to 18:45 or on Friday, February 17, 2017 from 17:20 to 18:20**. Due to the great success of the DOP sessions at the past two congresses, the presentations will be split over two days this year. This will give you the chance to attend more presentations!
- The remaining accepted abstracts will be displayed as **hard copy posters** throughout the Congress. Please do join our vivid **Guided Poster Session** on **Friday, February 17, 2017 in the lunch break**.

For further information, please refer to ***www.ecco-ibd.eu/ecco17***.

DOPs at ECCO'16, Amsterdam © ECCO

What's in store for ECCO Members at the ECCO Congress?

ECCO Members attending the 12th Congress of ECCO will enjoy a number of highly valuable privileges:

Special registration privileges:

- Payment of reduced registration fees, with a saving of EUR 300.- to 400.-
- Access to the educational programme (only for Members)

Onsite privileges:

- **General Assembly of ECCO Members**
  Thursday, February 16, 2017, 19:00–20:00, Room 112 (CCIB Barcelona)
  The Annual General Assembly of ECCO Members is ECCO's highest deliberative body and the embodiment of one of the association's most elementary member privileges: The right to vote and help form ECCO's future.

- **ECCO Members' Lounge**
  ECCO Members have the possibility to enjoy an informal atmosphere with their peers. Meet ECCO Officers and network with colleagues in our lounge, located in the entrance hall of the CCIB Barcelona.

Members Lounge at ECCO'16, Amsterdam © ECCO

ECCO Congress bags 2017

As in 2016, our ECCO Congress bags will be produced by Township Patterns®, a company supporting women's entrepreneurship in township communities outside Cape Town, South Africa. Hence, the ECCO Congress bags are more than just a stylish accessory – they are a means of improving the lives of the African women who produce them in their own sewing cooperatives.

Congress bag special: Every ECCO Congress bag will include a copy of JCC – Journal of Crohn's and Colitis, Issue 1/2017. Please do not forget to pick up your Congress bag!

Congress Bags ECCO'17, Barcelona © ECCO

ECCO Interaction: Hearts and Minds

"ECCO Interaction: Hearts and Minds" is THE event at ECCO to attend – to see and be seen, to network and to engage. Anyone who has been to a previous ECCO Congress knows that it is a must and everyone is welcome, but places are limited.

Date: Friday, February 17, 2017
Start time: 20:30
Venue: Museu Nacional d'Art de Catalunya, Museu Nacional, Palau Nacional, Parc de Montjuïc, 08038 Barcelona, Spain

This event is open to all congress delegates. The price of an entrance ticket purchased in advance is EUR 50.- for ECCO Members and EUR 95.- for Non-Members. **Please be informed that a three-course buffet dinner is included in the entrance fee.**
Tickets can be purchased during the online congress registration at ***www.ecco-ibd.eu/ecco17***. **Access to the event is strictly limited to those with ECCO Interaction tickets.**

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ECCO UR-CARE

Your IBD Database for patient records and research studies

What to expect

- Comprehensive registry capturing demographics, environmental factors, clinical characteristics, examinations and therapeutic interventions in IBD
- Ground-breaking cross-project cooperation and comparison of results
- Independent data management software offered to study groups
- Quality of care assessment
- High mobility & continuity of care for patients
- Retro- & prospective data collection and evaluation
- Sophisticated, user friendly data export and report function
- Precise data ownership rules

Scan and visit
www.ecco-ibd.eu/ur-care

UR-CARE: A great new tool for your centre, your study group and for IBD research throughout Europe

If you, your centre or your study group lacks a strong IBD Database, UR-CARE could be a great solution for you. If you already have a database, its data can be imported into UR-CARE, making it much more powerful and safe.

UR-CARE Dashboard © ClinicaaL

The United Registries of Clinical Assessment and Research (UR-CARE) platform is a digital registry capturing IBD patient records for clinical care and also clinical research studies across Europe. UR-CARE (facilitated by IBDIM – IBD in Motion Ltd., the Research Unit of ECCO) also works well as a database at a local and national level.

The first priorities when creating UR-CARE were safety, legal and ethical requirements: every centre remains the owner of the data they enter in UR-CARE. If the medical data of patients in UR-CARE are used in a retrospective study by another centre, they will be strictly anonymised. All data are stored in secure back-end servers located within the European Union. All sensitive information undergoes a multi-level cyphering process as soon as it is entered into the database. The IT company who designed and manage UR-CARE is compliant with all relevant EU Information Security Management System and Software standards and hold ISO 27001 and ISO 15504 certificates. Their safety systems are audited on an annual basis.

In order for a centre to join UR-CARE it will be required to adhere to a legal contract as well as a Framework of Rules that ensure responsible use of the platform and protect each centre's rights and data. A centre's application to join UR-CARE must be made by an ECCO Member who is part of the centre's staff. Existing databases can be imported into UR-CARE, thereby avoiding the loss of data already captured by your centre or study group.

Benefits for daily clinical practice

For daily clinical practice, UR-CARE is an intuitive tool that can be used easily by you and all of your team. UR-CARE provides an inventory of all of your individual patients and it is possible to download both short summaries and detailed customised reports of their data. These reports can be downloaded in either PDF or Word format. It is also possible to export your data from UR-CARE into an Excel or SPSS file.

Not all variables in UR-CARE are mandatory. So physicians can fill out the information that is most relevant for their patients. You can also draw a report showing the percentage of data completed at your centre. This provides a useful tool to conduct quality checks on your data, should you wish to.

Benefits for research

With respect to study projects, the platform offers clinical investigators the opportunity to easily cooperate across projects, using information captured in the database for multiple projects. It will be a fantastic resource for conducting research studies in the field of IBD.

UR-CARE can cater to both small and large IBD centres in Europe. To facilitate use of the data collected in UR-CARE by researchers for the purpose of international studies, we, the UR-CARE Steering Committee, have implemented a clear, three-stage study project proposal process. The preliminary stage is the feasibility query. The feasibility query will allow researchers to learn whether UR-CARE does in fact contain the sample size that they require to successfully carry out their project. Following a positive response to the feasibility query, researchers will be encouraged to take the next steps in the study project proposal process. The UR-CARE Steering Committee will only receive study project proposals intended for academic purposes. Any proposals received from industry will be rejected.

To complement the research potential of UR-CARE, strict and precise rules regarding authorship and publications have also been created. These rules are designed to encourage the acknowledgement of all active participants in a project and to foster the development of less experienced researchers. The Steering Committee has implemented authorship rules for UR-CARE that stipulate that as many authors as possible should be included in the list of authors. If there is a limit on the number of authors that appear on a paper, all centres that participated must be clearly included in acknowledgements.

The research being performed in your study group, however, can continue independently of the UR-CARE Steering Committee following certain legal requirements.

To provide more information on how UR-CARE can be used on a local level, a video and a demo version have been made available on the UR-CARE webpage of the ECCO Website: ***www.ecco-ibd.eu/index.php/science/ur-care***.

UR-CARE STEERING COMMITTEE

UR-CARE Steering Committee L-R: E. Langholz, F. Baert, B. Siegmund, J. Gisbert © ECCO

UR-CARE: Express info

Unique common international IBD database for daily clinical care and research purposes
Free and open to any doctor/researcher who is an ECCO Member
System works for centres or study groups of all sizes (no minimum number of patients required)
User-friendly, intuitive use; only some variables are mandatory
Short reports summarising the most important data can be created or data can be easily exported in a data file (e.g. Excel or SPSS)
For studies on a European level, there are strict, precise rules regarding publications and authorship
Acknowledgement of your name and your centre in all studies that are published
UR-CARE will be ready to receive data in early 2017

ECCO at UEGW 2016 – The 24th United European Gastroenterology Week

Committee Meetings

The Committee Meetings on the Sunday were a great opportunity to review and discuss all ongoing educational and scientific activities within ECCO! I can reliably inform you that the 11 Committees are very active all year long! Improving the quality of care worldwide should already be considered as a great achievement.

The **Educational Workshops** are increasingly popular and ECCO receives many requests from within and outside Europe. At UEGW, **EduCom** selected the new destinations for 2017 and worked on the development of the ECCO IBD Curriculum.

P-ECCO continues to work on developing standard references for paediatric IBD management: the Joint ESPGHAN-ECCO Paediatric UC Guideline and the Topical Review on Transition in IBD. Meanwhile **S-ECCO** is spreading excellence beyond Europe through the S-ECCO International IBD Masterclass.

GuiCom is publishing numerous papers: CD Consensus update, UC Consensus update, Topical Review on IBD in the Elderly, Environmental factors in IBD and several others that will be used to guide decision-making in daily practice. **Y-ECCO** is still very active in the field of basic research and in improving the career development of Young ECCO Members. Therefore their workshops during the ECCO Congress are always very well attended. Y-ECCO and **ClinCom** continue their collaboration to provide guidance to small research studies and surveys: a Y-ECCO/ClinCom Call was launched before UEGW, inviting Y-ECCO Members to propose a brief research study/survey that, if selected, will receive support from both Committees. **EpiCom** has recently published highly epidemiological papers, for example on the impact of new treatments on the outcome of disease, and have conducted the European-wide EpiCom Survey on registries across Europe.

Histological healing is emerging as a new therapeutic target in Ulcerative Colitis and the role of diet and nutrition is crucial in IBD management. **D-ECCO WG** and **H-ECCO WG** are working on new initiatives, such as the H-ECCO IBD Masterclass and D-ECCO Workshop at ECCO'17, and we can anticipate the launch of new and creative projects that will be in accordance with the ECCO Spirit!

Through the School for Clinical Trialists and the Advanced ECCO: **EduCational COurse for Industry**, ClinCom continues to support the improvement in the quality of clinical trials and research across Europe. In order to foster cooperation between European National IBD Study Groups, ClinCom will also organise, for the second time, an IBD National Study Group Meeting at ECCO'17.

SciCom continues to support European scientific projects. At UEGW, meetings of two of SciCom's scientific initiatives – the 6th Scientific Workshop and ECCO CONFER Cases – were held.

How can we treat an IBD patient without a nurse? We all know that it is impossible! **N-ECCO** is working in close collaboration with all the Committees to help countries that do not have national provisions of IBD nurses. N-ECCO and EduCom are in the process of developing an international IBD Nurse Education Programme, through which they will identify and support nurses to be involved in IBD care with the ultimate aim of improving quality of care. The N-ECCO School, the N-ECCO Network Meeting and the N-ECCO Research Forum demonstrate that N-ECCO has had a key role in the past and current success of ECCO.

Please view the podcast recordings with the Committee Chairs on the ECCO Website for more information on the activities of ECCO Committees.

ECCO Dinner

As always, the ECCO Dinner was a great success! Around 60 attendees shared beer and wine during a very good meal after a long day with all the Committee Meetings and Committee Podcasts and Talking Heads recordings. It was nice to see the ECCO Office relaxing (something that does not happen all that often!) after their hard work for each Committee Meeting and their work all year round. Without the ECCO Office, ECCO could not function as an organisation!

ECCO Booth

During UEGW, the ECCO Booth was situated in the Association Village very close to that of UEG, highlighting the strong links with the European Society of Gastroenterology. The ECCO Booth was staffed throughout the Congress day and was very welcoming to all visitors. It also hosted several face-to-face meetings between the UR-CARE Steering Committee and the heads of interested National Study Groups.

The ECCO Spirit was present during the entire UEGW meeting. Even though ECCO is now very famous worldwide, further promotion of ECCO during UEGW in a friendly manner is a mandatory step for us. This was also a great opportunity to foster the links between IBD physicians who are yet to join ECCO and existing ECCO Members. In summary, the ECCO Booth was the meeting point for all physicians with an interest in IBD!

ECCO Booth, UEGW 2016 © ECCO

New on e-Learning

New initiatives are always welcome at ECCO! Three new topics were recorded for Talking Heads, experts discussions on controversial topics in IBD. Furthermore the ECCO IBD Blue Book was expanded by two new videos, which will soon be available on the e-CCO e-Learning website.

Overall, all ECCO Activities during UEGW Meetings underscore three key elements of ECCO's success: innovation, creativeness and friendship.

See you all in Barcelona

LAURENT PEYRIN-BIROULET
ECCO Secretary

ECCO Dinner, UEGW 2016 © ECCO

Talking Heads filmed during UEGW 2016 © ECCO

ECCO Grant Study Synopses

Early microbial exposure and type 3 innate lymphoid cells in the pathogenesis of IBD and their value as therapeutic targets

Aim of research

The aetiology of Inflammatory Bowel Diseases (IBD) is not fully established. Increasing evidence supports the hypothesis that perturbation of the immune system before weaning may imprint the intestine with an increased susceptibility to IBD in adulthood. It remains unclear how perturbations in host–microbial symbiosis in childhood impact intestinal immunity later during adulthood. Given the pro-inflammatory profile of lymphoid cells expressing the transcription factor RORγt (retinoid-acid receptor-related orphan receptor gamma t) and their critical impact on microbiota, these cells are associated with the pathogenesis of IBD. Type-3 innate lymphoid cells (ILC3s) constitutively express RORγt and are the major subset of IL-17- and IL-22-expressing lymphocytes in the intestine before weaning, while at homeostasis, gut microbiota repress IL-22-producing ILC3s through epithelial expression of IL-25. Thus, we hypothesise that perturbation of symbiotic microbiota and/or ablation of RORγt lymphoid cells during weaning has a major impact on the development of the immune system, and increases the IBD susceptibility later in life.

The aim of the current proposal is to understand how perturbations in bacterial colonization and ILC3 response during weaning impacts on development of Colitis in adults.

Methodology

To address this question, we will use a novel transgenic mouse model, developed in our laboratory, that allows for the inducible (and reversible) ablation of all ILC3s without affecting their development later in life. ILC3 ablation will take place during weaning and Colitis susceptibility will be assessed in transgenic adult mice using the experimental Colitis model. Specific colonisation or antibiotic treatment in neonatal mice will be used to determine the bacteria that regulate ILC3-mediated response and Colitis development. Mechanisms involved in Colitis development will be explored at the cellular, molecular and epigenetic levels. This project will lead us to develop therapeutic strategies to maintain host–microbial symbiosis in childhood that protect against IBD development in adulthood.

ZIAD ALNABHANI
ECCO Grant Awardee 2016

Human ROR(γt)+ regulatory T cells in IBD

Aim

Regulatory T cells are well-known suppressors of immune responses to harmless antigens. In the periphery the regulatory T cell (Treg) pool consists of two subpopulations: One Treg subpopulation is derived from the thymus, while the other differentiates in the periphery in response to harmless environmental antigens. We intend to use the transcription factor ROR(γt) to assess the frequency of Tregs in humans that have differentiated in response to microbial colonisation of the gut. Murine studies indicate that ROR(γt) is a relatively good marker for identification of commensal-induced Foxp3+ Tregs and their genetic ablation indicates a critical role of ROR(γt)+ Tregs in the efficient suppression of excessive pathology in different Colitis models. However, human ROR(γt)+ Tregs remain poorly defined. A better characterisation of human ROR(γt)+ Tregs at steady state and during inflammation may be useful in order to identify novel therapeutic targets in IBD.

Methodology

We will establish a surface staining method in order to sort purify human ROR(γt)+ Tregs and assess their transcriptional profile. Interesting genes will be validated on the protein level by flow cytometry or other means dependent on the availability of reagents. Furthermore, we will try to correlate the relative frequency of these ROR(γt)+ Tregs from human biopsies with disease severity or manifestations. We are particularly interested in patients who suffer from Ulcerative Colitis because this disease may be associated with an exaggerated immune response to the intestinal microbial flora.

Proposed timing

A cell surface staining will be established during 2016 and we aim to sort purify the first Treg subpopulation by the end of 2016. In early 2017, we shall perform transcriptional profiling and identify interesting genes to further discriminate between ROR(γt)+ and ROR(γt)– Tregs. In parallel, human specimens from biopsies or surgeries will be processed and infiltrated Treg subpopulations analysed dependent on availability of samples.

CASPAR OHNMACHT
ECCO Grant Awardee 2016

MicroRNA profiling in tissues and primary intestinal epithelial cells of patients with active and inactive Ulcerative Colitis

Aim of research

The aim of this study is to determine the microRNA (miRNA) profile at the tissue and epithelial cell level in order to allow discrimination between patients with active Ulcerative Colitis (UC) and patients in clinical and endoscopic remission.

Methodology

The study will involve patients with active UC, patients with UC in remission and control subjects (approx. 20 individuals/group). Tissue samples from UC patients will be obtained during endoscopic procedures from the affected sites of the colon. Tissue samples from patients in clinical and endoscopic remission will be obtained from previously inflamed sites of the colon, while in control subjects samples will be taken from normal colon mucosa. Blood samples will be taken using vacuum tubes with separating gel. Primary human colonic epithelial cells will be isolated using the chelation method according to Seidelin et al. [1]. Isolation of intestinal myofibroblasts will be performed according to Pathak et al. [2]. Total RNA will be extracted from tissue, epithelial cell, myofibroblast and plasma samples using commercially available kits. The sequencing will be performed in tissue and cell samples using the next-generation sequencing technique on a HiSeq 2500 (Illumina) platform. Small RNA sequencing data will undergo filtering steps, normalization, quality control and statistical analysis (cutadapt, miRDeep2 software, DESeq2 package). Thereafter, the most differentially expressed miRNAs will be selected for expression analysis in blood plasma of patients (sample size approx. 80 samples/group). In this way, the suitability of the biomarkers for non-invasive diagnostics will be assessed. MiRNA profiling in plasma samples will be performed using Taq-Man low-density array analysis. Statistical analysis of differential miRNA expression will be performed using the HTqPCR package of Bioconductor.

Small RNA sequencing of UC tissue and epithelial cell samples will be carried out during the first year. During the second year, sequencing of the miRNA profile in intestinal myofibroblasts will be performed, as well as miRNA profiling in plasma samples.

References

1. Seidelin JB, Horn T, Nielsen OH. Simple and efficient method for isolation and cultivation of endoscopically obtained human colonocytes. Physiol Gastrointest Liver Physiol. 2003;285:G1122–8.
2. Pathak S, Grillo AR, Scarpa M, et al. MiR-155 modulates the inflammatory phenotype of intestinal myofibroblasts by targeting SOCS1 in ulcerative colitis. Exp Mol Med. 2015;47:e164.

JURGITA SKIECEVICIENE
ECCO Grant Awardee 2016

A multicentered analysis on the effect of eHealth and usual care in IBD patients with peripheral arthralgia

Aim of research

Treatment options for IBD patients with non-inflammatory (arthralgia) joint complaints are limited. Previous studies in patients with rheumatoid arthritis (RA) and fibromyalgia have shown that non-therapeutic interventions, such as cognitive behavioural therapy, are effective in reducing pain severity and also have a positive effect on coping and health status. In the past decade, the use of internet-based cognitive behavioural therapy has grown intensively. The objective of this study is to determine the effect of eHealth and usual care in IBD patients with arthralgia.

Methodology

Study design. This is a prospective randomised controlled trial comparing the effect of eHealth intervention and usual care in IBD patients with peripheral arthralgia. The effect will be determined by using the Visual Analogue Scale (VAS) to measure reduction in joint pain (0=no pain, 100=maximum pain) from baseline to the end of the study period in the eHealth and usual care arms. The change in coping with pain will be measured using the VAS (0= very bad, 100=very good) and the SF-36 questionnaire will be used to assess the impact of these joint complaints on daily life.

Study population. IBD patients in clinical remission with peripheral arthralgia for at least 3 months, aged from 18 to 70 years, will be included. Patients will be asked to complete VAS scores and the SF 36 questionnaire.

Intervention. In the control group, medication will be prescribed for the arthralgia according to the severity of the joint complaints. In the eHealth group (intervention group), patients will be offered internet-based cognitive behavioural treatments. Prior to starting this programme, patients will be seen by a therapist and a tailored therapy will be devised. Apart from this programme, patients will receive the same analgesic care as patients in the usual care group.

Proposed timing

We started our project in September 2016 at the Leiden University Medical Center. The three other participating centres will embark on the project in November and December 2016.

ANDREA VAN DER MEULEN-DE JONG
ECCO Grant Awardee 2016

Harnessing functional immune biomarkers to predict response to anti-TNFα therapy in Ulcerative Colitis

Aim of research

Ulcerative Colitis (UC) is a severe Inflammatory Bowel Disease with debilitating symptoms, and a significant proportion of patients will require surgery in their lifetime. Treatments with anti-TNFα drugs are effective but are expensive and carry risks of serious side effects; moreover, a significant proportion of patients do not respond. New ways of predicting therapeutic response to anti-TNFα drugs are urgently required to improve patient outcomes and cost effectiveness. This issue is becoming even more pertinent now that alternative biological agents acting via different biochemical pathways (e.g. vedolizumab, ustekinumab, tocilizumab) are already licensed or are undergoing phase II/III clinical trials.

Methodology

Patients with Ulcerative Colitis are identified at a clinic appointment as having severe disease requiring anti-TNFα at the behest of the treating gastroenterologist. Blood and colonic samples as well as clinical and demographic data are obtained at endoscopic evaluation before commencing anti-TNFα therapy. Patients are monitored and reassessed between week 12 and week 14 with endoscopic, biochemical and clinical scores to decide whether they are 'responders' or 'non-responders' under pre-approved criteria.

Blood and colonic samples are processed to isolate mononuclear cells and then stimulated with disease-specific cytokines as well as anti-TNFα. Subsequently a cytokine panel is performed on the supernatant and the cells are lysed and the RNA sequenced. Currently we are still recruiting patients to the study and will group analyse all the samples to avoid batch variability.

Conclusion

This scientific approach to establish an individual 'immunophenotype' heralds the start of personalised medicine in Ulcerative Colitis. With correct application, this technique could arm the clinician with a powerful tool to direct their patients to the correct biologic therapy first time, thereby improving cost effectiveness as well as reducing the risk of side effects and the time to remission.

JONATHAN DIGBY-BELL
ECCO Grant Awardee 2016

The role of T cell-derived cytokines in the pathogenesis of CD-associated fistulae

Aim of research

Fistulae represent a frequent complication in Crohn's Disease (CD), severely impacting the quality of life of affected patients. Nevertheless, our understanding of the pathophysiology of fistula formation in CD patients is still poor. Current hypotheses suggest that epithelial-to-mesenchymal transition (EMT) is the driving force behind the development of CD-associated fistulae. We have demonstrated that T cell-derived cytokines and their receptors are highly expressed in/around CD fistulae. These molecules seem to make an essential contribution to fistula development by orchestrating the onset of EMT and the activity of matrix metalloproteinases (MMPs) and TIMP1, which are molecules involved in remodelling events during fistula formation/progression.

Our hypothesis, based on our recent data, suggests that T cell-derived cytokines play a crucial role in the pathogenesis of CD-associated fistulae; hence we will address the following issues:

1. Do fistula-associated T cells contribute to the onset of EMT?
2. Do fistula-associated T cell cytokines regulate activity of MMPs/TIMPs?
3. Are there human-specific mechanisms underlying fistula formation and do fistulated human xenografts recapitulate the human disease?

Methodology

To address our aims, we will (1) isolate T cell subsets from surgical specimens of CD-associated fistulae, as well as intestinal specimens from CD patients and non-IBD controls, and co-culture them with intestinal epithelial cells (IECs); (2) analyse the expression of MMPs and TIMPs in IECs co-cultured with T cells as described above, and in fibroblasts isolated from the same tissue samples; and (3) use tissue samples from the human-to-mouse xenograft model of fistulising gut, established at the laboratory of Nahum Shpigel in Israel. In this model, we will analyse the expression/localization of T cell-derived cytokines and their receptors, and stain EMT markers, MMPs and TIMPs. To gain deeper insight into the mechanism underlying fistula formation in the xenograft model, we will further perform transcriptome analysis.

Proposed timing

The experiments will be conducted within 12 months.

MARIANNE SPALINGER
ECCO Grant Awardee 2016

Microbiota-mediated fine-tuning of the threshold of intestinal inflammasome activation in host-microbial mutualism

Aim of research

The aim of this project is to understand how and when the composition of the intestinal microbiota changes in the genetic absence of an intact inflammasome signalling pathway and the downstream impact of these changes on the development of intestinal inflammation and Colitis. Microbial dysbiosis has been proposed to contribute to the onset and severity of Colitis although the underlying trigger(s) and developmental window for microbial dysbiosis are not clear. Different inflammasome-deficient mice show reduced IL-18 levels and microbial dysbiosis as well as increased susceptibility to experimental chemical-induced Colitis.

My hypotheses are:

1. Mice harbouring genetic deficiencies in the inflammasome pathway will develop dysbiosis under steady state gnotobiotic hygiene conditions.
2 Inflammasome deficiency and altered microbiota will have an important downstream impact on intestinal epithelial cell function, triggering several inflammatory pathways leading to Colitis.

The results obtained by these experiments using gnotobiotic mice will pave the way for (a) a better understanding of the cause/effect of the dysbiosis in vivo in genetically predisposed situations and (b) discovery of future therapeutic targets in intestinal inflammatory disorders.

Methodology

To address the first hypothesis (objective 1), I will analyse the composition of the microbiota longitudinally and transversally in the gastrointestinal tract of wild-type, ASC- or IL-18-deficient mice that are colonised with a defined microbial consortia. I hypothesise that genetic deficiency in the inflammasome pathway will lead to microbial dysbiosis and that this will occur early in life when the microbiota is still very dynamic and sensitive to changes in the environment.

To address the second hypothesis (objective 2), I will perform transcriptome and proteome analysis at the level of intestinal epithelial cells under different gnotobiotic conditions and genetic backgrounds. Here I hypothesise that the role of the inflammasome in the gut could also play a role during steady-state conditions in maintaining homeostasis and not only in mediating secretion of protective or inflammatory mediators.

Proposed timing

Months	1–6	6–12
Objective 1	X	
Objective 2		X

FRANCESCA RONCHI
ECCO Grant Awardee 2016

Optimal use of immunomodulator and biological therapy in Inflammatory Bowel Disease

Aims of research

Immunomodulators (IM) and anti-TNFα therapies have proven efficacy in inducing and maintaining remission in IBD. However, overtime response can be lost. Loss of response (LOR) can occur for a number of reasons. Immunogenicity has been increasingly recognised as a main culprit in LOR. This is the formation of antibodies against anti-TNFα, leading to a reduction of anti-TNFα trough levels and subsequent treatment failure. Immunomonitoring involves the measurement of anti-TNFα trough and antibody levels, allowing doses of anti-TNFα to be adjusted in a treat-to-target fashion. This approach offers the potential to overcome LOR, reduce the risk of complications and help achieve mucosal healing.

The aims of this project are:

1. To determine whether a treat-to-target approach is more efficacious than the current standard approach.
2. To correlate a relationship between drug trough and antibody levels with clinical response rates, including mucosal healing and deep remission, and to explore the impact of therapeutic trough levels on response rates.

Methodology

Patients will be recruited from IBD clinics in our hospital (AMNCH Tallaght, Ireland). At the end of induction therapy, 6-TGN, anti-TNFα trough and antibody levels will be measured. Anti-TNFα trough and antibody levels will be measured using standard ELISA techniques. If levels are subtherapeutic, doses will be intensified, or if there is antibody formation, immunomodulators will be introduced. Alternatively, patients may be switched to alternative agents if there is a lack of response despite adequate trough levels. This treat-to-target approach will be compared to the standard approach, where doses are adjusted based on symptoms and biochemical markers alone. At completion of the study, patients will be re-evaluated, with assessment to check for evidence of mucosal healing.

Proposed timing

Clinical assessment will take place at 24 weeks, and endoscopic, clinical and biochemical assessment will take place at 52 weeks.

DONAL TIGHE
ECCO Grant Awardee 2016

Strategies for restoring loss of response to anti-TNF therapy in Inflammatory Bowel Disease

Aim of research

Loss of response (LOR) to anti-TNF therapy occurs in up to 50% of IBD patients. The reasons behind LOR in the context of adequate drug levels are poorly understood. We hypothesise that LOR to anti-TNF in the presence of adequate drug levels is mediated by breakthrough Th17 inflammation. Sandborn et al have demonstrated enhanced efficacy of ustekinumab (which binds to the common p40 subunit of IL-12 and IL-23, thus reducing Th17-mediated inflammation) in patients who have experienced LOR to anti-TNF medications. CD39 is thought to regulate intestinal inflammation and can restrain Th17-mediated inflammation. Our research group previously demonstrated relative deficiency of CD39 expression by FOXP3 regulatory T lymphocytes in Crohn's patients, which is restored specifically in IBD patients who respond to anti-TNF (when compared to non-responders). In addition, IL-6 may alter the ability of CD39 Treg to suppress IL-17-driven inflammation.

In our pilot prospective study, we aim to define immune mechanisms underlying LOR to anti-TNF drugs in IBD. Our focus is on the role of FOXP3+ Treg, their expression of CD39 and their role in preventing breakthrough Th17-mediated inflammation.

Methodology

We are recruiting IBD patients commencing treatment with anti-TNF medications. In addition to receiving standard care, patients will be evaluated using faecal calprotectin levels (obtained using home testing kits) and questionnaires (incorporating elements of the Harvey Bradshaw Index, Partial Mayo Score and Short Health Scale) completed via a mobile website at pre-specified timepoints. Blood samples will enable cytokine profiling and analysis of drug and anti-drug antibody levels. Using tissue samples obtained at colonoscopy/surgery, we will also employ an ex vivo biopsy culture model to examine the effect of IL-6 blockade and Th17-related cytokines on immune parameters.

MARGARET WALSHE AND GLEN DOHERTY
ECCO Grant Awardee 2016

ECCO EFCCA PATIENT GUIDELINES

BARCELONA February 2017
21st century challenge
autoimmune diseases

will be translated!

Global launch of the translations into the 29 languages of ECCO and EFCCA Country Members

Bosnian, Bulgarian, Croatian, Czech, Danish, Dutch, Estonian, Finnish, French, German, Greek, Hebrew, Hungarian, Icelandic, Italian, Latvian, Lithuanian, Norwegian, Polish, Portuguese, Romanian, Russian, Serbian, Slovakian, Slovenian, Spanish, Swedish, Turkish, Ukrainian

12th Congress of ECCO
CCIB Barcelona
February 15-18, 2017

United We Stand

ECCO
European Crohn's and Colitis Organisation

The challenge of ECCO Guidelines

GuiCom's mission is to foster the development and implementation of guidelines to harmonise and thus improve the management of IBD in ECCO and beyond.

The creation and updating of guidelines in an international context are challenging tasks and often way more difficult than expected. After having identified the need for a guideline or its update, and after designation of a steering committee of project coordinators and the issue of an open call, experts from all over Europe apply to participate. The selection of ECCO Members is done based on their CV and expertise, as well as their former involvement in projects of ECCO.

After division into several working groups, the participants in an ECCO Guidelines project perform a literature research to identify the current evidence regarding their particular topic. And this is where the trouble starts: What are the important questions that need to be answered and is there enough evidence to answer those questions? For example, our guidelines state that we should perform upper GI endoscopy in all newly diagnosed CD patients regardless of whether they are symptomatic. However, there has never been a study in adults showing that the procedure is beneficial or changes treatment, rather than simply generating costs and being potentially harmful. Randomised, placebo-controlled evidence is often only available for pharma-sponsored studies, conducted mostly with biologicals.

In addition, the existence of different national health systems all over Europe, with access to varying diagnostic tools and drugs and different cultural approaches to the same problem, makes it difficult to suggest one unifying answer to a given problem for the whole continent. For example, in some countries azathioprine must be given before the use of biologicals, while in many countries the use of biologicals is unrestricted. The list of differences seems endless and includes variation in the availability of expert ultrasound and MRI as well as discrepancies in the use of calprotectin to follow up patients.

Last but not least, reader-friendliness and practicability of the statements are often lacking. Patient expectations and histories vary, and the therapeutic targets shift over time to an even greater extent. Thus, recommendations given in guidelines can only provide broader guidance, a limitation which ECCO is overcoming with the development of the ECCO e-Guide (***www.e-guide.ecco-ibd.eu***) and the ECCO Toolkits (***www.ecco-ibd.eu/index.php/publications/toolkits.html***).

The next topics to be addressed in publications are Topical Reviews on Transition (a project of P-ECCO), Research Gaps in Diet in IBD (D-ECCO WG); Exit Strategies; Complementary Therapies and Psychological Therapies; update of the ESPGHAN-ECCO Consensus in UC; N-ECCO Consensus Update; the ECCO-ESCP Guidelines on Surgery in CD and, last but not least, the merged Guideline on Diagnostic Techniques & Monitoring.

ANDREAS STURM
GuiCom Chair

ECCO Guidelines and their Translation

In great anticipation of the upcoming ECCO-EFCCA Patient Guidelines Translations, this is an opportune moment to present a brief summary of: the Principles of Translation of ECCO Clinical Consensus Guidelines and the Principles of Use of ECCO Consensus Guidelines Statements in the original English version.

Principles of Translations for ECCO Clinical Consensus Guidelines

We are very happy that ECCO Consensus Guidelines have been so popular since their inception, and they certainly serve the purpose of being a freely accessible reference – also for National Guidelines. Moreover, they serve as a basis for the educational material of ECCO as well as of the National Societies. The very wide dissemination of the ECCO Guidelines means that ECCO receives a considerable number of translation requests throughout the year. In order to address these requests in a harmonised way, ECCO has long since established Principles of Translation.

A major principle has always been that translation must ensure the correct citation of the original publication and a "sub-heading" under the Guidelines title must indicate that it is an exact translation of the relevant ECCO Guidelines. Growing in size and professionality, ECCO faced the need to revise the workflow in 2014 – which was then approved in its current edition in order to make it more professional: According to these principles, a translation inquiry can be submitted either by a National Society, if an educational grant has been secured, or by a partner company offering an unrestricted educational grant to a specified translation project.. Such an unrestricted grant allows the contracting of a professional translator for the project. In all instances, the translation must be of the latest available version of the Guidelines. In order to avoid any possibility of Guidelines parts being taken out of context, the respective ECCO Guidelines must be completely translated. The copyright of the original and of the translated version remains with ECCO.

With the aim of ensuring the integrity of the translation, a steering group of at least three people, preferably proposed by National Representatives of the country concerned, is asked to supervise the translation project. National Representatives who feel unable to undertake this task should notify the ECCO Office. Delegation is possible, but only upon ECCO agreement. All statements will be checked completely for accuracy of translation. The accuracy of translation of a supporting text is established by comparison of a random sample of text in the original and the translated version by an independent evaluator selected by ECCO. Prior to publication, the final version is approved by ECCO based on a recommendation from the steering group for the project in question. The translation will then be made available on the ECCO Website, while the National Societies may additionally publish the translation in their national medical journal (on condition that the full original JCC citation is correctly indicated as the source) and/or on their National Society website.

Principles of Use of ECCO Consensus Guidelines Statements (original English version)

Nowadays physicians face an increasing need to be proficient in English in order to stay up to date in their subject. This situation has fostered the most recent ECCO approach, that translation of statements should not be necessary in order to reach the target audience for the ECCO Consensus Guidelines.

In line with this approach, the quotation of ECCO Consensus Guidelines Statements in the original English version is welcome as long as they are correctly cited and followed by a disclaimer saying that statements must be read in the context of the full Guideline in order to avoid misunderstandings.

JULIÁN PANÉS
ECCO President

LAURENCE EGAN
JCC Editor-in -Chief

ANDREAS STURM
GuiCom Chair

GERASSIMOS MANTZARIS
GB Education Officer

Investigating the disease course, prognosis and treatment of Inflammatory Bowel Disease in Europe – an update on the EpiCom Study Group

Based on the previous success in establishing the largest European epidemiological collaboration to date, the EpiCom Study Group will initiate a new cohort study in 2017 investigating bowel damage progression in Crohn's Disease. All are welcome to participate!

Epidemiological studies of Inflammatory Bowel Disease (IBD), taking in patients who exhibit the whole spectrum of disease severity, are crucial for our understanding of the "natural" course and prognosis of these diseases. Furthermore, such studies can elucidate the effectiveness of medication and surgery and the ways in which they are used in a community setting. In 2006, members of the then European Collaborative study group on Inflammatory Bowel Disease (EC-IBD) formed a new study group under the leadership of Pia Munkholm, Denmark, that included several new members with an interest in epidemiological research. The aim was to investigate and compare IBD incidence, clinical presentation, disease outcome, treatment choices and the impact of such choices on disease course across Europe.

The EpiCom Study group

A total of 31 centres from 14 Western and 8 Eastern European countries joined the EpiCom Study Group and formed two population-based inception cohorts: one of 1,500 IBD patients diagnosed in 2010 and another of 700 patients diagnosed in 2011. Summaries of the findings from the EpiCom cohorts can be found elsewhere [1,2], but to summarise, this collaborative epidemiological study has shown that the incidence of IBD in Western Europe is twice that in Eastern Europe, despite frequent use of, and easy access to, colonoscopy in Eastern Europe and similar diagnostic delays to those in Western Europe. Overall, in terms of socio-economic characteristics and clinical presentation at diagnosis, patients are comparable across Europe. However, treatment choices have been found to differ. For example, the use of biological therapy is significantly greater in Western Europe, while Eastern European centres use 5-ASA for most patients with Crohn's Disease (CD) or Ulcerative Colitis (UC). In both regions, patients were treated earlier and more frequently with immunomodulators compared with previous cohorts. But despite these differences in treatment, disease course – including hospitalisation and surgery rates during the first year of disease – were similar in both regions and the majority of patients were in clinical remission at follow-up. Currently, long-term follow-up data from the EpiCom cohort are being analysed in order to verify these findings.

New cohort study in 2017

Next year, several new initiatives will be started within the EpiCom Study Group and we invite everyone with an interest in IBD epidemiology to participate. The recognition that persistent bowel inflammation, even in periods of clinical remission, results in poor outcomes in IBD has led to a paradigm shift in treatment strategies, with an increasing focus on the early introduction of immunomodulators and/or anti-TNF agents. The goal is to induce both clinical and mucosal healing to limit the adverse effects of uncontrolled inflammation. However, the challenge remains to select patients who will benefit most from early intensive therapy, while sparing those who will derive minimal benefit from such treatment. In this context, it will be extremely valuable to be able to predict progression of disease, as well as to identify 'red flags' that could alert the clinician to an impending flare-up or relapse.

With this in mind, a new cohort will be launched within the EpiCom Study Group, in collaboration with North American centres, where newly diagnosed IBD patients will be closely followed in order to characterise the progression of CD over time, relying on the Lemann Index as an objective, reproducible measure. The goal of the proposed study is to promote a greater understanding of the long-term evolution of CD, to better elucidate the impact of different therapeutic strategies and to develop accurate predictors of bowel disease damage and disability.

If you are interested in joining the study or wish to know more about it, you are welcome to contact Johan Burisch (***burisch@dadlnet.dk***).

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1. Burisch J. Crohn's disease and ulcerative colitis: Occurrence, course and prognosis during the first year of disease in a European population-based inception cohort. Dan Med J. 2014;61:B4778.
2. Vegh Z, Burisch J, Pedersen N, et al. Incidence and initial disease course of inflammatory bowel diseases in 2011 in Europe and Australia: Results of the 2011 ECCO-EpiCom inception cohort. J Crohns Colitis. 2014;8:1506–15.

JOHAN BURISCH
on behalf of the EpiCom Study Group

ECCO Educational Workshops – where we have been so far…

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The 48th ECCO Educational Workshop

A report from the 48th ECCO Educational Workshop in Dubrovnik, Croatia – October 8, 2016

The organisers of the 48th ECCO Educational Workshop in Dubrovnik with some of the participants © O-Tours d.o.o., Croatia

Dubrovnik, the southern pearl of the Adriatic Sea and a well-known Croatian and European tourist destination famous for its Wall and Renaissance buildings, was the venue for the 48th ECCO Educational Workshop. The event was organised through the collaboration of the Croatian National Representatives, Brankica Mijandrušić Sinčić from the University of Rijeka and Željko Krznarić from the University of Zagreb. As an introductory event to the Workshop, the Meeting of the IBD Section of the Croatian Society of Gastroenterology was held a day beforehand.

The Workshop was attended by more than 80 participants, originating mostly from Croatia and the surrounding countries. Overseeing the Workshop were the ECCO expert faculty members Torsten Kucharzik from Lüneburg, Germany and Pascal Juillerat from Bern, Switzerland.

After the welcome speech by the Workshop hosts, Brankica Mijandrušić Sinčić and Željko Krznarić, the customary Introduction to ECCO and the History of the ECCO Workshop was presented by the doyen of Croatian IBD research and practice, Boris Vucelić. The introductory notes were followed by the main focus of the Workshop, the presentation and discussion of six IBD cases:

Case 1: Imaging and new diagnostic steps in CD – Torsten Kucharzik, Lüneburg, Germany
Case 2: New-onset ileocaecal CD – Pascal Juillerat, Bern, Switzerland
Case 3: Fistulising disease – Ante Tonkić, Split, Croatia
Case 4: Management of EIM – Brankica Mijandrušić Sinčić, Rijeka, Croatia
Case 5: Transition – Silvija Čuković-Čavka, Zagreb, Croatia
Case 6: Stopping drugs, exit strategy – Torsten Kuczarzik, Lüneburg, Germany and Pascal Juillerat, Bern, Switzerland.

The interactive discussion that followed each case presentation enabled the participants, namely aspiring young gastroenterologists, to share their thoughts on the topic under consideration and to communicate directly with some of Europe's finest IBD gastroenterologists. This opportunity was invaluable in shaping their thoughts and allowing them to deepen their understanding.

The first half of the case presentations concluded with a lecture given by Željko Krznarić regarding Biosimilars in IBD. Similarly, the second half was brought to a close by the State of the Art Lecture, on Epidemiology in IBD, given by Peter Lakatos from Budapest, Hungary. The end of this successful and productive Workshop in Dubrovnik was hosted by Boris Vucelić, who offered final remarks.

BRANKICA MIJANDRUŠIĆ SINČIĆ
ECCO National Representative, Croatia

The 46th ECCO Educational Workshop

Helsinki, Finland, September 2, 2016

The 2nd Paediatric IBD Workshop, the 46th ECCO Educational Workshop overall, was organised in Helsinki on September 2, 2016. The venue and date were decided upon only earlier this year but, thanks to ECCO's Phillip Judkins and Gabriele Mayr, the organisation worked superbly. The nature of the organisation of the practical matters testified once again to the good atmosphere characteristic of all events organised by ECCO.

The programme included invited keynotes, case presentations on difficult-to-treat paediatric Crohn's Disease and Acute Severe Colitis, and lectures on clinical progress on remaining challenges. The invited foreign speakers included paediatric gastroenterologists Dan Turner, from Jerusalem, and David Wilson, from Edinburgh, as well as paediatric surgeon Michael Stanton, from Southampton. Dan Turner, who is also P-ECCO Chair, gave a talk on recent research findings from a multicentre paediatric study involving detailed analysis of the clinical features of more than 400 IBDU patients. David Wilson (a P-ECCO member to be) provided an update on genetics and monogenetic disease underlying IBD – particularly important aspects when treating very early onset IBD patients. In his talk, Michael Stanton focussed on the age at which surgery should be performed in Crohn's Disease and on surgical techniques and outcomes specific to paediatric IBD.

Most of the other 38 participants were Finnish paediatric gastroenterologists, paediatric surgeons or other paediatricians caring for IBD patients but to our delight there were also participants from Estonia, Latvia and Russia. We forewarned our foreign speakers that we Finns often hesitate to open our mouths in Q&A. However, contrary to our tradition, the workshop was characterised by very lively discussion and input from the audience. Representatives of our corporate sponsors mingled with participants during breaks, discussing the latest pharmacological and nutritional updates with the participants. Upon questioning of the participants, it was clear that all were pleased with this ECCO Educational Workshop.

I cannot but warmly recommend that colleagues everywhere should consider applying to organise a Paediatric IBD Workshop or another ECCO Educational Workshop; for me, the experience was both fun and highly useful in terms of clinical and academic experience.

KAIJA-LEENA KOLHO
Workshop Chair

European Crohn's and Colitis Organisation

Volume 10
Issue 11
November, 2016

JCC

JOURNAL of CROHN'S and COLITIS

Food and IBD, see editors choice review article page 1351

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OXFORD UNIVERSITY PRESS

JOURNAL OF CROHN'S AND COLITIS

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

VOLUME 10, ISSUE 11
November 2016

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N-ECCO Activities at Barcelona 2017

ECCO and N-ECCO invite you to the beautiful, architectural and sunny city of Barcelona!

N-ECCO Network Meeting at ECCO'16 © ECCO

N-ECCO School at ECCO'16 © ECCO

It is with great pleasure that N-ECCO is once again offering nurses an outstanding range of clinical, educational and research opportunities that will meet their wide range of needs. The programme for all events has been developed taking into account the opinions previously expressed on the evaluation forms submitted by delegates.

This year the 8th N-ECCO School will again be joined by the dietitians. Some changes have been made to the agenda to include an emphasis on the nutritional needs of IBD patients. We shall once more be addressing the psychological implications of living with IBD and holding interactive workshops in the afternoon.

The 11th N-ECCO Network Meeting will once again consider a wide variety of subjects presented by expert speakers from centres across Europe. The theme of the morning session is 'Quality Care in IBD' and the session will include presentations covering remote monitoring, biomarkers and PROMs. This will be followed by an exploration of real clinical issues in IBD that continue to be matters of discussion: pregnancy, travel and the FODMAP diet. Following the oral abstract presentations, the agenda will focus on therapeutic patient algorithms: How do we step up to the next treatment? We shall also be building on past success in delivering lively debates by holding a further debate entitled 'Mono vs. Combo Therapy' – an ongoing question for all of us!

The 4th N-ECCO Research Forum, now an established aspect of the N-ECCO Activities, will offer a range of sessions. This will include an overview of real-life research experience in undertaking systematic reviews, developing questionnaires and measuring conditions. The aim of this 2017 Research Forum will be to examine how teams can come together to develop research applications that can be taken forward to funding. Led by senior researchers, breakout groups will each take a project and 'work this up' to a research application.

ECCO and N-ECCO are also pleased to announce that there will be a Research Grant of €20,000 for 2017, followed by a further Research Grant in 2018. A key feature of this award is to be the partnering of nurses new to IBD research with senior researchers to increase capability in IBD nurse research across Europe, led by N-ECCO.

The complete programmes for the N-ECCO School, N-ECCO Network Meeting and N-ECCO Research Forum are available on the ECCO'17 Congress Website (***www.ecco-ibd.eu/ecco17***).

The aim of N-ECCO remains to provide educational opportunities and to create opportunities for networking. The N-ECCO Travel Award offers any nurse who is a member of ECCO the opportunity to visit an established nursing service either in another European country or in their own country. Please look out for the call for this in 2017.

There are several other workshops which can be attended by nurses at ECCO Barcelona in 2017, such as the D-ECCO Workshop on the Friday morning, as well as, of course, the main Scientific Programme of the ECCO Congress throughout the rest of the week.

At the ECCO'17 Barcelona Congress, one N-ECCO Committee Member will be stepping down, Karen Kemp, the current Chair. Karen has been part of N-ECCO since 2013, helping to build its profile and portfolio of clinical, educational and in particular research activities. Karen will be replaced by Palle Bager as Chair, and replacing Palle on the main N-ECCO Committee is Susanna Jäghult from Sweden.

N-ECCO is going from strength to strength, building IBD nursing education and research across Europe. We very much look forward to seeing you in Barcelona for another excellent educational event and an ideal opportunity to network with colleagues from around the world.

Karen Kemp © ECCO

KAREN KEMP
N-ECCO Chair, On behalf of the N-ECCO Committee:
Palle Bager, Kay Greveson, Usha Chauhan, Kathleen Sugrue

Considerations in the performance of diet-related randomised controlled trials

The randomised controlled trial (RCT) is the gold standard scientific experiment, its aim being to reduce bias when testing a specific treatment (intervention) against a control. However, when the intervention is a specific dietary treatment or dietary component, a number of factors need to be taken into account during the study design. Furthermore, many RCTs do not consider diet as a potential source of bias that may affect an outcome. It is in fact necessary to engage with experts in diet and nutrition from the planning stage until study completion to ensure that the complexities of dietary studies are not overlooked.

Study design

When designing a diet-related RCT, bear in mind that you need to carefully design your control. For any RCT where the intervention is a drug or dietary component, a placebo may contain confounding ingredients that are possible dietary triggers in your patient population (e.g. lactose, wheat). Tolerance to the placebo and the intervention in terms of appearance, smell, taste and the ability to swallow (e.g. capsules/tablets) should be considered in relation to the drop-out rate, especially in long-term studies.

Feeding studies

In feeding studies, some or all food is provided for the intervention and control arms so the exact diet constituents can be carefully managed. Where only some food is provided, the remaining part of the diet will need to be carefully controlled and monitored for adherence. Feeding studies are time intensive for the researcher. The 'dos' and 'don'ts' of foods included and excluded in the intervention arm of a feeding study are fixed and will not reflect day-to-day dietary challenges (e.g. food -related social activities), so the study results may be difficult to replicate in clinical practice.

Habitual diet as a control

An intervention can be controlled using a habitual diet. This is usually done so that members of the control group continue with their usual diet for the duration of the trial period and are given the active intervention at the end of this period. However, the control group would not be receiving any dietary treatment, so it is biased from that perspective.

Waiting list

Waiting list as a control arm of an RCT is where treatment is delayed and subjects are not advised on their diet until the end of the intervention period. With no dietary advice given to patients in the control arm, patients may seek alternative ways of altering their diet in an effort to gain symptom control or may continue to follow their habitual diet: either course of action may affect the outcome. It can be argued that delaying a treatment in the control arm removes the researcher contact that the intervention arm will receive, which may in itself have a treatment effect.

Standard dietary treatment

A novel dietary intervention can be compared to standard or routine dietary treatment (control). This type of study design is relatively easy to plan but large sample sizes may be required to demonstrate a difference in outcome, and such sample sizes may not be feasible.

Sham diet

The ideal dietary RCT involves providing dietary advice on either the intervention or a placebo (sham) diet whereby the control is a dummy intervention that is similar in nutritional profile except for the dietary component of interest used as an intervention. Design of a sham diet needs careful planning and testing to ensure that other nutrients/dietary components are not altered in a way that could have an effect on the outcome.

Measurement of dietary bias

Diet affects gastrointestinal physiology and the gastrointestinal microbiota. Therefore, it may be important to evaluate diet as a potential source of bias in RCTs and this can be done by measuring background dietary intake at baseline and endpoint.

Many tools are available and diet cannot be measured with absolute accuracy. The advantages and disadvantages of each method need careful consideration. Methods employed should ideally be validated, preferably using an external measure, such as a biochemical marker, or at least an internal measure, whereby an individual is asked for the same information in different ways. When choosing an assessment tool, it should be rigorously tested to ensure that questions and expectations are clear, such that the information obtained specifically answers the questions posed.

Food frequency questionnaires (FFQ)

The FFQ is a popular dietary assessment tool often used to assess usual dietary habits or validated to measure a specific nutrient or dietary component. An FFQ comprises a list of questions that aim to identify foods and, therefore, nutrients of interest in the diet. FFQs ask subjects to recall how often and in what quantity they typically consume a food item. FFQs tend to be cheap and easy to use, but require careful development and validation, and often are still imprecise.

Diet history

A diet history is generally conducted by a trained interviewer who obtains information on the foods usually consumed, the portion sizes, the recipes used and the frequency of foods consumed recently. It tends not to be used in research but mainly in clinical dietetics, due to the necessity for face-to-face interviews and has limitations in terms of memory and recall bias.

24-hour recall

The 24-hour recall method depends upon the previous day's intake and is commonly used in cross-sectional studies rather than RCTs. It is cheap and easy to administer, but it does not provide a reliable estimate of an individual's intake due to day-to-day variation.

Weighed intake

A weighed intake is considered the 'gold standard' reference technique. Subjects weigh food as it is served and record any wastage after consumption. Several different weighing methods are available but they can be complex for some individuals, so compliance may be affected. This technique is time consuming and usual dietary intake can be misrepresented if some foods are less easy to weigh than others, which may alter usual dietary habits. However, when properly carried out, this method tends to be used as an important internal validation tool.

Diet record

Diet records of up to 7 days are often used in RCTs at baseline and endpoint to measure dietary intake. Subjects record an estimate of the weight, by household measures, volume models, photographs, average portions or pack sizes of each food and drink consumed. This method is useful in RCTs but is time intensive for both researchers and subjects although dietary measurement using modern technology (e.g. a smartphone app) is available.

Dietary adherence

Adherence rates in dietary RCTs are important and should be defined at the outset and monitored throughout.

MIRANDA LOMER
D-ECCO WG Member

3rd S-ECCO International IBD Workshop 2016

Cancun, Mexico, September 6, 2016

On September 6, 2016, the 3rd S-ECCO International IBD Workshop took place in the beautiful city of Cancun, in Mexico. The meeting was held a full day before the National Congress of Colorectal Surgery, with the support of the Mexican College of Coloproctology and its president, Miguel Blas Franco. This was the 3rd international workshop to be organised outside of Europe by S-ECCO with ECCO Endorsement (the previous two were held in Brazil).

S-ECCO was represented by its two founders, André D'Hoore (Belgium) and Willem Bemelman (The Netherlands), as well as our current chair, Oded Zmora (Israel), and Paulo Kotze (Brazil). The gastroenterologists from ECCO were excellently represented by Geert D'Haens (The Netherlands) and Matthieu Allez (France). The faculty was completed by Amy Lightner (Mayo Clinic, USA), Fabio Teixeira (Brazil) and Steven Wexner (Cleveland Clinic, USA). Mariana Berho, a pathologist from the USA, and local Mexican physicians also contributed effectively to the programme.

The scientific modules explored the multidisciplinary approach to IBD, with surgical and gastroenterological topics being discussed interactively. Several sessions were held on an extremely high level, demonstrating the excellent knowledge of Mexican physicians in the field of IBD.

Highlights of the day were the presentation by Geert D'Haens regarding how to manage secondary loss of response without access to serum levels and antibodies, a reality in Latin America. The video session was also an enjoyable part of the meeting. Pouch techniques to be performed laparoscopically were described by Steven Wexner, the transanal approach for pouches in Ulcerative Colitis was detailed by Bemelman and a case of transanal proctectomy in Crohn's Disease was also brilliantly presented by André D´Hoore, in a very technical session.

Case discussions also contributed greatly to the success of the meeting, moderated by Matthieu Allez (CD) and Geert D'Haens (UC). Debates were one of the highlights, with Paulo Kotze and Matthieu Allez fighting to define the real impact of anti-TNF therapy in the perioperative period in CD patients. Other very well attended lectures on hot topics in IBD also emphasised the need for a personalised approach to CD and UC in 2016.

3rd S-ECCO International IBD Workshop 2016 © Paulo Kotze

3rd S-ECCO International IBD Workshop 2016 © Paulo Kotze

The closing remarks, by Oded Zmora, emphasised the spirit of S-ECCO and ECCO: To hold high-level interactive scientific discussions, characterised by real friendship, with the aim of achieving what really matters, namely to improve the quality of our patients' lives.

One of S-ECCO's aims is to spread surgical and multidisciplinary IBD knowledge beyond the borders of Europe. The next S-ECCO International IBD Workshop is already scheduled for Florianopolis, Brazil, in October 2017, where we shall be aiming to continue the improvement in meeting quality. We shall await you there and will take great pleasure in your attendance!

Paulo Kotze © ECCO

PAULO GUSTAVO KOTZE
S-ECCO Member

The non-pharmacological way to cure intestinal inflammation

Epidemiological data indicate a recent dramatic increase in the incidence of so-called non-communicable diseases (NCDs) in Western countries, i.e. chronic disorders in which an abnormal interplay between genetic predisposition and immunity on the one hand and environmental factors on the other plays a crucial role in their mechanisms [1]. Among NCDs, Inflammatory Bowel Diseases (IBD) have been extensively investigated with respect to their pathogenetic aspects. In particular, gut microbioma and nutrition, as environmental variables, have attracted great interest from the scientific community [2].

It is known that IBD are more common in people who consume a Western diet, essentially consisting of animal protein and fats, sugar, and a low content of fruits and vegetables. The Western diet is also characterised by an unbalanced ratio of the two types of polyunsaturated fatty acids (PUFA) (n-3/n-6 ratio). An increased risk of developing IBD, in particular Ulcerative Colitis (UC), has been found in large consumers of linoleic acid, an n-6 PUFA detected at high concentrations in cooking oils, red meat and margarine [3].

Robust studies in animal models have illustrated the link between specific nutrients and the occurrence of gut inflammation, mainly focussing on macronutrients that include fats, proteins, carbohydrates, minerals, vitamins and phytochemicals. In a mouse model, macronutrients seemed to affect inflammation by interacting with the different players of the intestinal innate immunity, which is a sort of first-line response of the gut epithelium cross-talking with intraluminal and mucosa-associated microbioma [4]. Macronutrients can influence the intestinal immune response by regulating expression and function of different pattern recognition receptors (e.g. NOD2, TLR family members), by neutralising the formation of the inflammasome (which is a multimolecular complex) but also by promoting formation of antimicrobial peptides such as defensins and, finally, by changing the composition and the metabolic activity of the gut microbiota.

Briefly, while red meat and high saturated fat diets worsen inflammations in rats, olive oil, n-3 PUFAs, resistant starch, amino acid mixture, curcumin, green tea and other polyphenols improve colitis and decrease molecular expression of pro-inflammatory signals.

The effects of foods on gut inflammation could, however, also be due to other food components, such as emulsifiers (e.g. carboxymethylcellulose, polysorbate-80) and additives (e.g. carrageenan), that are typically present in food undergoing industrial processing. These components act primarily by disrupting the integrity of the intestinal epithelium, with consequent bacterial translocation across the gut mucosa.

Based on experimental data on the link between nutrients and inflammation, a nutritional non-pharmacological approach to treat IBD has been repeatedly suggested. Several reports emphasise the usefulness of special diets in controlling symptoms and in promoting mucosal healing [5]. These diets mainly consist of a polymeric formula given as a sole meal during the day for several weeks (exclusive enteral nutrition, EEN) or as a prevailing meal covering >50% of the required calories daily, while the rest of the calories are provided by a low-antigenic controlled oral diet (partial enteral nutrition, PEN). Nutritional therapy of IBD has been investigated more in paediatric than in adult IBD, and Crohn's Disease (CD) shows a greater benefit than UC; however, the latter has been more rarely studied. Other studies in CD have included the use of the so-called specific carbohydrate diet, which restricts all carbohydrates except monosaccharides (e.g. glucose, fructose, galactose), with beneficial results on symptoms and lesions [6]. A low-FODMAP (fermentable oligo-, di- and monosaccharides and polyols) diet also seems to be promising. Recently, two small placebo-controlled trials in UC patients have shown that the addition of curcumin to pharmacological therapy is superior to placebo in inducing and maintaining remission [5].

The mechanisms underlying the effect of dietary interventions in IBD are still unsettled and under investigation. It is conceivable that the benefit derived from them may be attributed to different factors: (1) low food antigenic load; (2) low content in fats (which promote the inflammatory signals); (3) lack of emulsifiers and additives that damage the gut epithelial integrity; (4) absence of gluten and complex sugars in many dietary protocols (gluten is known to damage the intestinal epithelial barrier while polysaccharides have been shown to promote epithelial invasion of pathobionts such as some strains of E. coli); (5) changes in gut microbioma profile and metabolic function following prolonged refined diets; (6) the use of home-prepared fresh meals, eliminating industrially prepared food: this is common in many food protocols for IBD so far reported.

While the research agenda will be focussed on highlighting the role of the above-mentioned mechanisms, robust and large sample size clinical trials in IBD, in different settings (induction of remission, maintenance, postoperative recurrences), are awaited. There is a widely held view that nutritional intervention will have increasingly more weight in the management of IBD, in both adults and the paediatric age group. It will be crucial to provide treatment protocols with scientifically proven efficacy, thus avoiding empirical eating patterns that entail the risk of deficiencies in nutrients that can negatively affect the disease course.

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Salvatore Cucchiara © ECCO

SALVATORE CUCCHIARA
P-ECCO Member

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12th Congress of ECCO
EDUCATIONAL SYMPOSIUM

MILD-TO-MODERATE IBD MANAGEMENT: CHALLENGES BEYOND INFLAMMATION

Chairman: Prof. Gerhard Rogler (Zurich, Switzerland)

CCIB Barcelona, Spain
Parallel Hall, Room 116 & 117

Friday, February 17, 2017

07:15-08:15 am

07:15 - 07:25
Welcome and Introduction
Chairman: Prof. Gerhard Rogler, Zurich, Switzerland

07:25 - 07:45
Treatment of mild to moderate IBD in the elderly
Dr Ian Arnott, Edinburgh, Scotland

07:45 - 08:05
The relevance of PROs and biomarkers in clinical practice
Prof. Jonas Halfvarson, Orebro, Sweden

08:05 - 08:10
Panel discussion/Q&A
All

08:10 - 08:15
Closing remarks
Prof. Gerhard Rogler, Zurich, Switzerland

Breakfast will be provided

This programme is not affiliated with ECCO

PM-Til-ALL-00008_1

Report on the joint symposium between ECCO and the European Society of Pathology (ESP)

The 28th Annual Congress of the European Society of Pathology (ESP) was held in Cologne, Germany, from September 25 to 29, 2016.

For the first time, the meeting included a joint symposium organised by the Digestive Disease Pathology Group of the ESP in conjunction with ECCO, entitled: 'The interdisciplinary approach to Inflammatory Bowel Disease'. The session occupied one morning, and was chaired by a pathologist (Cord Langner from Austria) and a gastroenterologist (Marco Daperno from Italy). The symposium was arranged as seven talks given by distinguished European and international experts who have a special interest in the pathogenesis, diagnosis and management of Inflammatory Bowel Disease. Two of the speakers were gastroenterologists, four were pathologists and the seventh was a research-orientated gastroenterologist with an interest in molecular pathology. The mixture of speakers acted as a reminder that the management of IBD and understanding of its behaviour are optimised by positive interactions between different disciplines.

The opening lecture, delivered by Roger Feakins from the United Kingdom, reviewed the basic pathology of IBD and its histological differential diagnosis. The discriminatory value of specific pathological features and the importance of correlation with the clinical picture were discussed, and the audience was reminded of the many potential histological impersonators of IBD.

The second talk explored the features of Inflammatory Bowel Disease in children. It included a review of the clinical and pathological differences between childhood and adult IBD, and a summary of potential pitfalls when these differences are forgotten. This talk was delivered thoughtfully and engagingly by Paula Borralho Nunes from Portugal and was followed by a coffee break, allowing delegates to ask questions and to meet lecturers.

The third and fourth talks together comprised a Tandem Talk on the topical and sometimes controversial subject of mucosal healing in IBD. They were delivered by a gastroenterologist and a pathologist, both from Italy (Marco Daperno and Vincenzo Villanacci). This was a comprehensive and entertaining review with plenty of new information and some thought-provoking ideas about the importance and assessment of mucosal healing.

The fifth lecture was delivered by Simon Leedham from the United Kingdom, a gastroenterologist who has an interest in IBD-related colorectal neoplasia and an excellent record of research in this area. The audience was brought up to date by his well-organised and clear presentation of the latest advances and a summary of some of his group's recent findings.

The last two lectures also comprised a Tandem Talk and were delivered by Rami Eliakim from Israel and Cord Langner. The subject was dysplasia in IBD. Professor Eliakim discussed endoscopic and clinical aspects, including a very helpful outline of the changing and complex management protocols for dysplastic lesions, while Professor Langner reviewed the pathological features thoroughly, including a discussion of the difficulties of distinguishing between sporadic and IBD-related lesions.

The symposium covered an appropriate range of related topics and was well received by an attentive audience who interacted well with the speakers. Informal feedback was also good. We hope that there will be further positive interactions with the ESP resulting in similar activities.

Roger Feakins © ECCO

ROGER FEAKINS
H-ECCO WG Chair

ESP-ECCO Joint Symposium at the 28th Congress of the ESP © Jan Pauls/ESP/IAP

Dear Y-ECCO Friends,

It was a real pleasure to see so many Y-ECCO Members at the UEG Week in Vienna. It was a fantastic meeting, and the range of IBD talks and data presented was staggering. The Y-ECCO Committee worked hard to tweet news from the meeting via our Twitter account (***@Y_ECCO_IBD***) and it was hugely rewarding to see us listed by an independent data analytics firm as one of the top influences for #UEGweek, ranking behind only the UEG team themselves, Nature and the Lancet! The Twitter feed is a new innovation for us, but we aim to use it to keep our Members, and anyone who is interested in IBD, up to date with ECCO Activities and news about IBD in general. Do follow us, and encourage your friends and colleagues to do so, too.

The deadline for abstract submission for the 2017 ECCO Congress is drawing near – do remember that there are dedicated Y-ECCO Abstract Awards for the top five ranked abstracts from Y-ECCO Members, including two awards specifically for basic science abstracts. And Y-ECCO Members who submit a basic science abstract will also have the opportunity to be invited to present at the Y-ECCO Basic Science Workshop, moderated and led by Miles Parkes and Gijs van den Brink.

Following on from the success of our ACCID survey last year, we ran an open competition for Y-ECCO Members to propose their own small studies or surveys. From some excellent submissions, in collaboration with members of ClinCom we have selected an outstanding proposal from Laura Kim and Rupert Leong for a survey of attitudes to treatment of IBD in elderly patients that we will be promoting at the educational programme of the 2017 ECCO Congress to allow for sampling of congress attendees. We continue to receive proposals for small studies from our members, some more complex than others, and will always do our best to support such member-initiated projects.

We had a really large number of applications to join the Committee and it is always hard to say no to so many excellent and committed individuals. I shall be stepping down at the next ECCO Congress and I am delighted that Isabelle Cleynen (Belgium) will be taking over as Chair. A new Member will also join the Committee. I wish them both, the whole Committee and the Y-ECCO community well.

Timothy Raine © ECCO

TIMOTHY RAINE
Y-ECCO Chair

Y-ECCO Interview corner

Dear Y-ECCO Members,

The Y-ECCO Interview Corner aims to interview IBD specialists and enthusiasts in order to gain insights into their career paths and benefit from their vast experience. We have previously included interviews with non-European high-profile colleagues who have been major contributors to ECCO. In this issue we are delighted to present to you the first Y-ECCO Interview with a very well-known North American gastroenterologist, Professor William Sandborn, who is Director of the IBD Center at the University of California, San Diego and who is one of the global opinion leaders in the field of clinical trials related to IBD.

Yours sincerely,

DOMINIK BETTENWORTH
Y-ECCO Member

Dominik Bettenworth © ECCO

Dominik Bettenworth interviews William Sandborn

Professor Sandborn, thank you very much indeed for taking the time to give your point of view on some of the current challenges in IBD research and daily clinical management of IBD patients.

The pathogenesis of IBD is believed to be multifactorial. Do you think a single "Helicobacter pylori" of IBD aetiology will ever be identified?

I suspect no. The heterogeneity of anatomic involvement, age of onset, development of complications, etc. suggests that there is not a single aetiologic agent. Similarly, the heterogeneity of gene associations argues against a single aetiologic agent.

With the advent of new treatment options such as anti-integrins, JAK-kinase inhibitors, cytokine inhibitors and others, the choice of first- and second-line treatment regimens is becoming more and more complex. What is your current strategy to facilitate clinical decision-making and what innovative approaches do you expect for the future?

For Ulcerative Colitis, mesalamine remains the first-line therapy for both induction and

maintenance, and steroids remain the second-line therapy for induction. For Crohn's Disease, steroids remain the first-line therapy for induction. I believe that the preponderance of the data does not support a robust effect of azathioprine/6-mercaptopurine as monotherapy in either Ulcerative Colitis, so I tend to go from steroids to biologics, usually administered as combination therapy with azathioprine or methotrexate. The choice of first-line biologic class is complex, taking into account speed of onset, route of administration, safety considerations, etc. In general, I prefer anti-TNF agents for more severely ill and hospitalised patients who are steroid refractory or who have fistulas, and anti-integrin agents in those who are more moderately ill and are steroid dependent. The positioning of anti-interleukin 12/23 therapy with ustekinumab is not entirely clear but this may be the preferred treatment for patients with Crohn's Disease who have failed an anti-TNF agent. The role of tofacitinib and other JAK inhibitors in Ulcerative Colitis remains to be defined.

It seems unlikely that all relevant clinical questions regarding the treatment of IBD patients can be answered by clinical trials; what alternative approaches could overcome this limitation?

Increasingly the medical record is migrating to electronic medical records (EMRs). The use of EMRs allows the use of templates, order "smart sets", ability to monitor populations of patients, etc., all of which can lead to standardisation of clinical data collection and care. Application of "big data" bioinformatics to data collected from clinical practice in standardised ways has enormous potential to supplement the results of randomised clinical trials in informing the care of patients.

If you compare clinical management of IBD patients in North America and Europe, what are the most striking differences and what might European gastroenterologists learn from the North American approach?

The use of biomarkers (CRP and faecal calprotectin) is much more widespread in Europe to guide the care of patients. European gastroenterologists appear to "de-escalate" therapy in patients who are initially receiving combination therapy with an anti-TNF agent and azathioprine, stopping one of the two drugs. North American gastroenterologists are more likely to start monotherapy with a biologic agent and then just continue the biologic.

As the clinical duties for young doctors appear to have become more time consuming in recent years, only a minority of doctors actively perform research or are involved in clinical studies. Do you consider personal experience in research to be a prerequisite for becoming a good "IBDologist"?

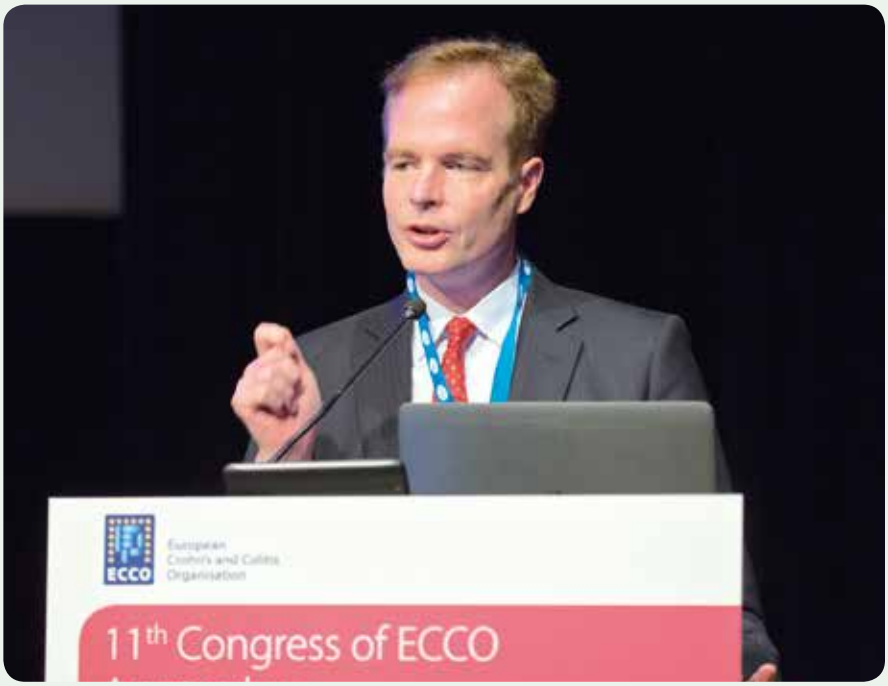
I think that involvement with research is important for the training and development of sub-subspecialists in IBD. The field is moving fast, IBD specialists are required to keep up with and understand the rapid advances, and some background in research is necessary to understand the newly generated data and apply it quickly to clinical practice.

What would be your most important advice to young gastroenterologists who aim to become successful in the field of IBD?

Spend at least one year post GI fellowship obtaining specialised advanced training in IBD. Acquire training and expertise in the care of severely ill hospitalised patients with IBD, patients with fistulas, patients with ileoanal pouches, and IBD endoscopy including pouchoscopy, chromoendoscopy and balloon dilation of Crohn's Disease strictures. Become knowledgeable about the extra-intestinal manifestations of IBD, the natural history and epidemiology of the disease, and the clinical pharmacology of the drugs used to treat IBD. Commit to lifelong learning, and stay abreast of new advances.

When you reflect on your own career, what were the crucial steps in becoming one of the global opinion leaders in the field of IBD?

Pick areas to be an expert in, and then evolve your interests over time. I began my career focused on clinical pharmacology (cyclosporine, azathioprine, nicotine, methotrexate), pouchitis and epidemiology. I evolved to biologic therapy, clinical trial design and development and refinement of outcome measures. Currently I am further evolving to translational research. You can see themes in my publications from the 1990s to the 2000s to the 2010s.



William Sandborn © ECCO

Modern communication channels such as Twitter etc. provide an increasing amount of data combined with a decreasing half-life period. What is your personal opinion on work–life balance and how do you secure sufficient time for your family and interests?

Balance has been a lifelong struggle for me. I enjoy my work, but I also recognise that ultimately family, friends, relationships and living life is what brings happiness and satisfaction in life. Find a way to do what you love and then love what you do. Make time to do the things that matter. Time and relationships are the things that are most valuable in life.

We would like to thank Professor Sandborn very much for sharing these valuable insights into his world. We would like to invite Y-ECCO Members to suggest any other high-profile IBD specialists they would like us to interview by emailing nuhasurgeon@gmail.com. We would also like to invite our Y-ECCO Members to follow us on Twitter @y_ecco_ibd for more news of our activities. We look forward to seeing you in Barcelona.

Y-ECCO Literature review

Dear (Y-)ECCO Members,

We are happy to welcome you to the Y-ECCO Literature Review section of ECCO News. In this section, Y-ECCO Members highlight and summarise recent landmark articles within the field of IBD. The articles cover different topics, including basic science, epidemiology, clinical phase 3 trials, endoscopy, surgery, etc.

We are always looking for people who want to participate in this initiative, and Y-ECCO members who are interested can contact Isabelle (***isabelle.cleynen@kuleuven.be)***. The idea is that you choose a recent article and summarise the key findings and importance of the paper in a maximum of 1,000 words. Together with the review, a short self-description and picture will be published in ECCO News. In addition, we are happy to announce that the literature reviews will also be included in the ECCO e-Library.

Isabelle Cleynen © ECCO

ISABELLE CLEYNEN
Y--ECCO Literature Review Admin

Interleukin 1β mediates intestinal inflammation in mice and patients with interleukin 10 receptor deficiency

Shouval DS, Biswas A, Kang YH, Griffith AE, Konnikova L, Mascanfroni ID, Redhu NS, Frei SM, Field M, Doty AL, Goldsmith JD, Bhan AK, Loizides A, Weiss B, Yerushalmi B, Yanagi T, Lui X, Quintana FJ, Muise AM, Klein C, Horwitz BH, Glover SC, Bousvaros A, Snapper SB

Gastroenterology. 2016 Sep 28. pii: S0016-5085(16)35035-1. doi: 10.1053/j.gastro.2016.08.055. [Epub ahead of print]

Introduction

The anti-inflammatory cytokine interleukin-10 (IL-10) plays a key role in regulating immune cells in IBD [1]. The significance of IL-10 became clear when IL-10-deficient mice were shown to develop spontaneous enterocolitis [2] and loss of IL-10 and its receptor were shown to cause severe infantile IBD, predominantly unresponsive to immunosuppressive medication [3]. Whilst administration of IL-10 might therefore have been expected to ameliorate this inflammatory cascade, previous work involving administration of IL-10 actually resulted in upregulation of pro-inflammatory mediators such as interferon gamma (IFN-γ) [4]. Further work has since confirmed an association between enterocolitis and IL-10 receptor alpha (IL-10Rα) and IL-10 receptor beta (IL-10Rβ), which are coded for by IL10RA and IL10RB respectively [5]. Although the exact mechanism and pathways involved are yet to be fully determined, recent work has shown that loss of IL-10R signalling results in increased interleukin 1 beta (IL-1β) [6]. In this study, Shouval et al. further define the role of IL-1β in mediating Colitis, target this pathway with an IL-1 antagonist and aim to further define the role of the inflammasome in IBD [7]. This study contributes to our understanding of the IL-1 and IL-10 signalling pathways and these could represent potential targets for novel therapeutics.

Methods and key findings

1. Loss of IL-10 receptor signalling is associated with increased IL-1β-mediated Colitis

Firstly, the authors conducted experiments with a model using Rag1-/- and Rag1-/-Il10rb-/- mice. Recombinase activating gene (RAG) plays a key role in lymphocyte development; therefore if knocked out, there is an absence of lymphocyte development. Wild-type (WT) unfractionated CD4+ T cells were then transferred to each of these two groups of mice. Weight was measured, histological examination of colonic sections performed and IL-1β levels measured in colonic tissue. The IL-10RB knockout mice were shown to develop Colitis and significant weight loss and had significantly increased levels of IL-1β.

These same mice then had adoptive transfer of either IL1r-/- CD4+ T cells or WT CD4+ T cells. Compared with mice that received WT CD4+ cells, the mice receiving IL-1 knockout cells showed an attenuated course of Colitis and had a higher weight, larger colons, less histological evidence of inflammation and lower levels of pro-inflammatory cytokines. These cytokines were measured from colon specimens and included tumour necrosis factor-alpha (TNF-α), IFN-γ and interleukin 17-A (IL-17A).

2. Anakinra reduces inflammation in patients with IL-10 receptor deficiency

Although a previous study had demonstrated lack of efficacy of anakinra in an IL-10R deficient patient [8], the authors next assessed whether the above-described Colitis and pro-inflammatory cytokine changes could be reduced by neutralising IL-1 in vivo. Two patients aged 2 and 28 years, with a history of fistulising Colitis secondary to IL10RA mutation, were treated with the IL-1R antagonist, anakinra. Following treatment, both patients showed marked clinical, endoscopic and histological response to treatment after 4–7 weeks. Subsequent analysis of pro-inflammatory cytokines showed reduction in TNF-α, IFN-γ, IL-17A and IL-17F. This was the first use of anakinra in such a patient group and both patients were subsequently evaluated for haematopoietic stem cell transplantation (HSCT).

3. IL-10 receptor signalling regulates inflammasome-dependent IL-1 production in macrophages

Next, the authors sought to outline the importance of the inflammasome and derived macrophages from control patients and IL-10R-deficient patients, and bone marrow-derived macrophages (BMDM) from WT and Il10rb-/- mice. For inflammasome activation, classical descriptions have been of a primary signal involving toll-like receptor (TLR) activation, and a secondary signal provided by electrolyte flux and adenosine triphosphate (ATP). Lipopolysaccharide (LPS) is a TLR4 stimulator, commonly used as a model of inflammation, and was used to provide a primary signal of activation in these macrophages. A second signal for inflammasome activation was given by administering ATP. In these macrophages, LPS + ATP was shown to trigger increased IL-1β and the presence of IL-10 suppressed production of IL-1β. In human macrophages, LPS stimulation alone, without ATP, still resulted in increased IL-1β.

Nod-like receptor protein 3 (NLRP3) and apoptosis-associated speck-like protein containing CARD (ASC) are considered to be key components of the inflammasome. LPS stimulation was shown to upregulate NLRP3 but with no effect on ASC. NLRP3 was then found to be inhibited by IL-10, an effect confirmed by the amelioration of this effect with an IL-10R1 antibody. The mechanism through which IL-10 abrogates the inflammasome effect was shown to be, at least partly, through increased K48-linked polyubiquitination of the NLRP3 complex.

Conclusions and commentary

This study further defines the processes through which IL-10R deficiency and signalling loss result in inflammation. IL-10 seems to play a key role in regulating NLRP3-mediated inflammasome activation and subsequent development of Colitis. This process appears to be driven by IL-1β production from innate immune cells, which subsequently activates CD4+ T cells and results in production and release of pro-inflammatory cytokines. IL-1 blockade, using anakinra and similar agents, may be a potential treatment or bridge to HSCT, particularly for those with IL-10R deficiency or defects within the IL-10 signalling pathway.

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Nuru Noor © Nuru Noor

Nurulamin Noor

Nurulamin Noor is an Academic Clinical Fellow in Gastroenterology currently completing his specialist training at the University of Cambridge and Addenbrooke's Hospital (Cambridge, United Kingdom). His interest is in applying the use of biomarkers to predict prognosis and helping develop the use of personalised medicine for patients with IBD.

Expanded allogenic adipose-derived mesenchymal stem cells (Cx601) for complex perianal fistulas in Crohn's disease: a phase 3 randomised, double-blind controlled trial

Panés J, García-Olmo D, Van Assche G, Colombel JF, Reinisch W, Baumgart DC, Dignass A, Nachury M, Ferrante M, Kazemi-Shirazi L, Grimaud JC, de la Portilla F, Goldin E, Richard MP, Leselbaum A, Danese S, for the ADMIRE CD Study Group Collaborators
Lancet. 2016 September;388:1281–90

Introduction

In this article, the ADMIRE CD group report the keenly anticipated outcomes of their multicentre double-blind randomised controlled trial (RCT) of allogenic adipose-derived mesenchymal stem cell (MSC) treatment for Crohn's perianal fistula. A short, supportive review published alongside the article discusses the proposed mechanism of action of MSCs [1].
The trial agent, Cx601, was a product of the TiGenix company and this study was funded by them.
Perianal fistula in Crohn's Disease remains a challenge to patients and clinicians. The best medical treatments produce fistula closure in around half of patients, a third of whom will maintain closure at one year of maintenance treatment [2]. Definitive surgical procedures have generally been inadequately studied in the Crohn's population, representing small subgroups in small studies.
This trial is one of very few high quality studies of surgical intervention in Crohn's anal fistula and represents a benchmark for the future, particularly because of its size, stratified randomised controlled design, carefully selected outcome measures, clearly defined inclusion and exclusion criteria and rigorous surgical protocol.

Methods

Included patients had mild or inactive luminal disease, a strictly defined complex perianal fistula and a history of failed medical treatment for it. Patients were excluded if they had anorectal stenosis, severe proctitis, a stoma or large undrained sepsis (also well defined) or had undergone previous definitive surgery. The study population therefore included patients with complex, untreated perianal disease but without factors thought to inhibit successful treatment.
Randomisation was stratified in order to eradicate the effect of concomitant medical treatment. Blinding was carefully performed and outcome measures clearly defined. In particular, the combined primary outcome measure at week 24 included both clinical remission (closure of all treated baseline external openings) and the absence of collections greater than 2 cm in at least two of three dimensions on magnetic resonance imaging (MRI). Although clearly defined, this endpoint raises questions about true fistula healing in response to treatment, discussed below. Nevertheless, use of the combined endpoint is a particularly valuable and unusual feature of this study.
Surgical technique was also carefully designed to assess the true benefit of the addition of MSC. At an initial procedure, patients in both arms underwent examination under anaesthesia (EUA), fistula curettage and seton placement. At least 2 weeks later, all patients had a further EUA, seton removal and closure of the internal opening. The study group then had 120 million stem cells injected along the track according to a carefully prescribed technique. Saline was used as placebo.

Key findings

Baseline characteristics were similar in the two groups. Some 81% of patients completed 24 weeks of follow-up.
In the intention to treat (ITT) group (all randomly assigned patients), more patients treated with Cx601 versus placebo achieved the primary endpoint of combined remission [53 of 107 (50%) vs. 36 of 105 (34%)] at 24 weeks.
Findings were similar in the modified intention to treat (mITT, all randomly assigned patients who received study treatment and had at least one efficacy assessment after baseline) and per-protocol (PP) populations.
In the mITT and PP populations, clinical response (closure of at least 50% of treated baseline external openings) was greater (ca. 70% vs. 55%) in the treatment group at 24 weeks.
Clinical remission and response were also achieved faster in the treatment group and PDAI scores were lower at 6, 12 and 18 weeks but similar at 24 weeks.
Adverse events were mostly similar in the two groups, including the development of perianal abscess. Thirty-four percent of a subset of treatment group patients developed HLA class I antibodies at week 12 with no apparent ill-effect or impact on outcome.

Conclusion

This high-quality study with careful and effective design has demonstrated an improved outcome in patients with complex perianal fistulas in Crohn's Disease when MSCs are added to a rigorous technique of track preparation. It represents a benchmark in Crohn's fistula research in terms of the combined endpoint, careful methodology and innovative intervention.
The primary outcome itself bears closer examination. A short follow-up interval such as this one attracts criticism since recurrence often occurs later. The addition of MRI assessment to the clinical endpoint seeks to limit this criticism by demonstrating that the tracks have healed throughout their length rather than simply at the level of the skin and that late recurrence is therefore unlikely. This requires a rigorous radiological assessment capable of demonstrating complete track healing, which is not currently defined in the literature.
The radiological element of the combined outcome used here, the absence of collections greater than 2 cm in at least two of three dimensions, means that a significant volume of undrained sepsis might have been present but described as remission in this study.
The authors are to be congratulated for trying to limit the impact of the unavoidably loose clinical definition of remission but without longer follow-up data, the MRI-based corroboration used is perhaps insufficient to allay fears of late recurrence.
It could be argued that the definitions apply equally to the two groups and therefore any difference remains relevant. However, the placebo success rate is higher than that seen in most studies and so it may be the case that the threshold used for defining remission is too low.
The high placebo rate may instead be due to the rigorous surgical technique used prior to treatment with Cx601 or placebo. Curettage followed by a short period of seton drainage is thought to prepare the track for treatment by removing granulation tissue and epithelium and allowing adequate drainage of sepsis. Closure of the internal opening disconnects the track from the gut and in some ways the placebo arm in this study employs similar principles to some techniques of definitive fistula surgery, such as the over-the-scope clip or mucosal advancement flap closure.
Logistical issues such as the short shelf life, need for maintenance treatment and cost of Cx601 need exploration in further studies which examine efficacy in larger groups and at longer follow-up.
These criticisms notwithstanding, this well-designed and rigorous double-blind placebo-controlled trial demonstrates that locally injected MSCs improve remission and response in complex Crohn's perianal fistula. There are two important outcomes. First, this treatment appears to be safe and whether alone or in combination with other modalities, may generate improved healing and symptomatic relief for these patients in the future. Second, a new benchmark for studies of surgical (and medical) intervention in perianal Crohn's fistula has been set.

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Phil Tozer © Phil Tozer

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Gut and liver T-cells of common clonal origin in primary sclerosing cholangitis-inflammatory bowel disease

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J Hepatol. 2016 Sep 16. pii: S0168-8278(16)30503-7. doi: 10.1016/j.jhep.2016.09.002. [Epub ahead of print]

Introduction

There is a strong association of PSC and IBD, with 60%–80% of PSC patients having coexisting IBD [1]. Even though the exact pathogenesis remains unclear, it was recently demonstrated that PSC livers express an aberrant level of gut-specific endothelial adhesion molecule MAdCAM-1 and CCL25 chemokine, the binding sites of α4β7+CCR9+ gut-specific effector T cells [2,3]. Furthermore, recent studies have shown that in PSC patients approximately 20% of the liver-infiltrating lymphocytes are α4β7+CCR9+ effector memory T cells [2]. Murine studies have further demonstrated a migration of gut-associated lymphoid tissue-primed T cells to the liver, where they recognise the same antigen on bile ducts, leading to cholangitis [4].
Based on these findings, Henriksen and co-workers hypothesised that recruitment of gut-derived memory T cells to the liver drives hepatic inflammation in PSC as a potential underlying pathological mechanism. As this mechanism has not yet been investigated in human PSC, the authors used paired gut and liver tissue from PSC-IBD patients to assess whether gut and liver T cells are clonally related.

Methods

Paired liver tissue, colonic biopsies and peripheral blood samples were obtained from PSC-IBD patients (nine with Ulcerative Colitis and one with Crohn's

Disease). As a control group, matched normal gut and liver tissue from patients with colon cancer and liver metastasis was used (n=10). cDNA was extracted from gut and liver tissue as well as from blood samples, rearranged TCRβ complementarity-determining region 3 was amplified, and TCRβ repertoires were sequenced in all sample types. T cell clonality and the proportion of liver and gut memory T cells carrying overlapping gut-liver memory clonotypes were calculated and scored.

Key findings

As a rearranged TCRβ nucleotide sequence (nucleotide clonotype) is generally unique to each T cell clone (in the antigen-experienced memory T-cell repertoire) [5,6], the authors investigated the overlap of nucleotides in paired gut and liver samples to establish whether gut- and liver-infiltrating T cells are clonally related in PSC-IBD. Nucleotide clonotypes of gut and liver memory TCRβ repertoire revealed an overlap of 9.7% in paired PSC-IBD affected gut and liver samples, after clonotypes present at similar frequencies in blood (greater than 0.1%) were excluded. Further analysis revealed that gut-liver memory clonotypes were carried by 16% of the liver memory T cells and by 15% of the gut memory T cells. Upon analysis of the overlapping clonotypes, the authors furthermore identified amino acid clonotypes previously reported to recognise epitopes of polyomavirus BK, cytomegalovirus and Epstein-Barr virus.

Next, the overlap of nucleotide clonotypes of paired normal gut and liver tissue samples (n=10) with colon cancer and liver metastasis was investigated. After normalising the tissue samples by down-sampling to the same number of beads, paired normal tissue revealed a nucleotide clonotype overlap of 3.6% of gut and liver TCRβ repertoires, while paired PSC-IBD affected gut and liver tissue showed a clonotype overlap of 8.7%. Thus, the overlap of TCRβ repertoires in PSC-IBD affected gut and liver tissue is significantly higher than in normal gut and liver tissue. These data clearly demonstrate that paired PSC-IBD affected gut and liver tissue has a significantly higher sharing of TCRβ repertoires compared to paired normal gut and liver tissue. Concerning previously identified PSC-associated amino acid clonotypes [7], the authors were further able to prove the presence of these PSC-associated clonotypes in the Norwegian PSC-IBD population.

Investigating the clonality, the authors observed similar scores for TCRβ repertoires in affected gut and liver tissue and blood samples of PSC-IBD patients and in normal tissue samples, indicating a similar T cell diversity.

Conclusions

This study demonstrates that memory T cells of common clonal origin are present in paired gut and liver tissue of PSC-IBD patients, with significantly higher clonotype overlap in paired affected gut and liver samples of PSC-IBD patients than in paired normal gut and liver tissue.

Based on the aberrant expression of gut-specific molecules in the inflamed livers of PSC patients, it is hypothesised that an enterohepatic migration of T cells might participate in the pathogenesis of PSC [2,3]. The authors support this hypothesis by demonstrating an overlap of nucleotide clonotypes in 16% of liver memory T cells and 15% of gut memory T cells, supposedly leading to a recognition of the same antigens or the same structural similarities by a high amount of the memory T cells in gut and liver. However, this study was unable to identify in which compartment or tissue the T cells were initially activated. In order to resolve this question, it would be necessary to sample each tissue at multiple time points, which is ethically inappropriate.

Summing up, these data provide the first evidence that memory T cells of common clonal origin are present in PSC-IBD patients. This presence is supposedly linked with PSC-IBD pathogenesis, and supports the hypothesis of memory T cells with shared antigenic drivers in PSC patients. Even though the compartment of initial activation of these memory T cells remains unclear, these data could be of importance for therapeutic strategies such as targeting of memory T cells in PSC-IBD patients.

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Dear ECCO Friends,

We are pleased to invite you to the

ECCO General Assembly

at ECCO'17 Barcelona, at the CCIB, Room 112 (Level 1).

When?
Thursday, February 16, 2017 - 19:00-20:00

General Assembly at ECCO'16 © ECCO

Voting at the General Assembly at ECCO'16 © ECCO

- Don't miss the opportunity to come cast your vote for the future ECCO Treasurer and Internal Auditors
- Come watch the ECCO Outlook 2017 (video), and what all 9 Committees and 2 Working Groups have planned as their future projects
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ECCO Country Member Profiles

Identity card

- Country: **Latvia**
- Name of group: Gastroenterology Support Society
- Number of active members: 15
- Number of meetings per year: 1-2
- Name of president and secretary: Juris Pokrotnieks (Head of the Board), Jelena Derova (Secretary, Treasurer)
- National Representatives: Aleksejs Derovs, Jelena Derova
- Joined ECCO in: 2004
- Incidence of IBD in the country (if available): Not available

Identity card

- Country: **Slovakia**
- Name of groups: Slovak IBD Working Group
- Number of active members: 35
- Number of meetings per year: 2-3
- Name of president and secretary: Martin Huorka – President, Miloš Greguš – Secretary
- National Representatives: Marika Zakuciova, Martin Huorka
- Joined ECCO in: 2004
- Incidence of IBD in the country (if available): as in Europe generally, there are about 13,000 patients with IBD per 5,000,000 inhabitants.

Identity card

- Country: **Turkey**
- Name of group: Turkish IBD Society
- Number of active members: 420
- Number of meetings per year: one each year/IBD School
- Name of president and secretary: Aykut Ferhat Celik , Elif Saritas Yuksel
- National Representatives: Aykut Ferhat Celik, Yusuf Erzin
- Joined ECCO in: 2007
- Incidence of IBD in the country (if available):
  Estimated Prevalence: 60/100,000
  Incidence: 3–4/100,000

Questionnaire – LATVIA

What has changed since your society became an ECCO Country Member?
Regular local meetings, participation in ECCO Courses and Workshops, participation at ECCO Congress, local studies in IBD field, adaptation and informational support of ECCO Guidelines in local medical societies
What are the benefits to you of being an ECCO Country Member?
Opportunity to be involved in ECCO scientific and educational activities in Europe and locally
Is your society making use of the ECCO Guidelines?
Yes (see above).
Have you developed research projects with other countries through your ECCO Country Membership?
Started recently
Have you developed educational activities with other countries through your ECCO Country Membership?
ECCO Workshops, Latvian Gastroenterology Congresses with International participation (every 2 years)
Has your country been involved in a fellow exchange through ECCO?
Planned
What are your main areas of research interest?
Clinical application of novel IBD drugs, Diagnostic and treatment challenges in IBD
Does your centre or country have a common IBD database or bio bank?
No
What are your most prestigious/interesting past and ongoing projects?
ESBL producing Enterobacteria in patients with UC and CD: clinical peculiarities

Jelena Derova © Jelena Derova

Aleksejs Derovs © Aleksejs Derovs

Which ECCO Projects/Activities is the group currently involved in?
Not at the moment
What are your aims for the future?
Local IBD database for country, solving of reimbursement problems of biologics
How do you see ECCO helping you to fulfil these aims?
ECCO Research Grants, opinion leaders comments, ECCO Guidelines
What do you use ECCO for? Network? Congress? How do you use the things/services that ECCO has to offer?
1. Participation in ECCO events
2. Clinical Guidelines
3. Collaboration with other ECCO delegates for scientific and clinical trials

ALEKSEJS DEROVS
JELENA DEROVA
ECCO National Representatives, Latvia

Questionnaire – SLOVAKIA

What has changed since your society became an ECCO Country Member?
We can see a greater interest in the topic of IBD among the professional community, and there have been increases in the numbers of publications, lectures and local postgraduate courses in Slovakia.
What are the benefits to you of being an ECCO Country Member?
There is greater accessibility of information, and the possibility for young fellows to participate in congresses and explore opportunities for cooperation.
Is your society making use of the ECCO Guidelines?
Yes, including those on Reproduction and Pregnancy.
Have you developed research projects with other countries through your ECCO Country Membership?
Yes, with the Czech Republic (regarding epidemiology, pregnancy and IBD, and the creation of a register of IBD patients).
Have you developed educational activities with other countries through your ECCO Country Membership?
Yes, we have developed educational activities with Czech Republic and Hungary. In particular a one-day symposium, the "Czech and Slovak IBD Day", is held once a year with alternation of the hosting country. Postgraduate courses are also organised between the republics.
Has your country been involved in a fellow exchange through ECCO?
No

Slovakian IBD Working Group © Martin Huorka

Martin Huorka © Martin Huorka

What are your main areas of research interest?
Epidemiology, IBD in special situations, vitamin D and IBD, follow-through levels of biologicals, endocrine diseases and IBD
Does your centre or country have a common IBD database or bio bank?
Our centre has a common IBD database and we are currently preparing a bio bank for the whole country.
What are your most prestigious/interesting past and ongoing projects?
A map of the epidemiological situation regarding IBD in Slovakia, an evaluation of surgical treatment of IBD in Slovakia, and efforts to increase the use of endoscopic indexes of disease activity in daily practice.
Which ECCO Projects/Activities is the group currently involved in?
Pregnancy and IBD
What are your aims for the future?
To complete a register of IBD patients, to extend our working group, to form committees and identify members responsible for individual IBD topics, to cooperate with neighbouring countries and to produce national guidelines for therapy of IBD
How do you see ECCO helping you to fulfil these aims?
ECCO will perhaps provide some "know how" with respect to the database of IBD patients and especially on creation of the biobank.
What do you use ECCO for? Network? Congress? How do you use the things/services that ECCO has to offer?
Both for networking and for the Congress

MARTIN HUORKA
MÁRIA ZAKUCIOVÁ
ECCO National Representatives, Slovakia

Questionnaire – TURKEY

What has changed since your society became an ECCO Country Member?
More attention is now paid to IBD. Regulations and Guidelines of ECCO have made people more confident in applying their personal decisions, made after checking ECCO's suggestions. This is especially important in obscure fields of IBD, where expert opinion is essential.
Each year the need to prepare for the ECCO Congress has made people more productive.
What are the benefits to you of being an ECCO Country Member?
Major benefits are greater awareness of what is happening in the field of IBD, appreciation of Turkey's standing among the ECCO Member Countries with respect to IBD and organisation of workshops on IBD in Turkey.
Is your society making use of the ECCO Guidelines?
One year ago a special meeting was organised to assess and encourage the use of ECCO Guidelines.
Have you developed research projects with other countries through your ECCO Country Membership?
Not as yet
Have you developed educational activities with other countries through your ECCO Country Membership?
This is in our future plans, especially with East European and Balkan countries.
Has your country been involved in a fellow exchange through ECCO?
We are awaiting suitable candidates at present.
What are your main areas of research interest?
As a country with no firm up-to-date epidemiological data, our aim is to try to establish the current prevalence and incidence through an initial IBD registry which has been in use for more than a decade.
Does your centre or country have a common IBD database or bio bank?
We have an initial IBD registry which is more than 10 years old. However, a new modern online registry that will facilitate follow-up will be completed within the next few months.
What are your most prestigious/interesting past and ongoing projects?
1) The ongoing new online registry project.
2) The Turkish IBD society has now reached a level of economic stability sufficient to provide travel and short stay grants to suitable young candidates.
3) Joint meetings with other inflammatory disciplines, like Rheumatology, Ophthalmology and Dermatology, to identify the overlaps regarding both pathogenesis and treatment.


Left: Aykut Ferhat Celik; Right: Yusuf Erzin © Yusuf Erzin

Which ECCO Projects/Activities is the group currently involved in?
None as the whole Turkish IBD Society, but the Turkish National Representatives are involved in many secondary assessment projects relating to the ECCO Guidelines.
What are your aims for the future?
- To create a standard registry file and an endoscopic report page
- To extend the meaning of IBD by including other inflammatory conditions of bowel in the same registry (first step, already taken in a few centres)
- To create a bridge with other inflammatory disciplines and, later, a multidisciplinary Inflammatory Disease Group (second step, in ca. 10 years)
- To function, as far as possible, as an independent society that deals with most of its own requirements

How do you see ECCO helping you to fulfil these aims?
Not too much help is really to be expected from ECCO, as the scope of ECCO's interests does not extend to the future of inflammatory diseases (by which I mean inflammatory diseases beyond IBD!)
What do you use ECCO for? Network? Congress? How do you use the things/services that ECCO has to offer?
ECCO is used mainly for meetings with other IBD experts and exchanges of opinion regarding new follow-up and treatment modalities.

AYKUT FERHAT CELIK
YUSUF ERZIN
ECCO National Representatives, Turkey

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European Crohn's and Colitis Organisation

Announcement 2017

Inflammatory Bowel Diseases

12th Congress of ECCO
February 15-18, 2017

- CCIB Barcelona, Spain
- EACCME applied
- Register at www.ecco-ibd.eu/ecco17

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www.ecco-ibd.eu