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In this issue

Message from the WDHD Chair

World Digestive Health Day (WDHD) 2011: Enteric Infections: prevention and management

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"Nearly one in five child deaths – about 1.5 million each year – are due to diarrhea. Today, only 39 per cent of children with diarrhea in developing countries receive the recommended treatment, and limited trend data suggest that there has been little progress since 2000."[1] Enteric infections, however, occur not only in developing countries. In the United States it is estimated that children less than five years in age will have 2.2 episodes of diarrhea per year; in those above the age of 16 years this rate is still 1.7. German sources describe that one third of the total population will have diarrhea at least once annually. There were some 16,000 deaths from diarrhea recorded in Europe in 2002.[2] Lastly, travelers originating in industrialized countries must expect an incidence rate of travelers' diarrhea in the order of magnitude of 20 to 30% during a two week stay in a developing country.[3]

Enteric infections associated with a variety of pathogens thus are a global problem, no country being unaffected. As gastroenterologists anywhere have to deal with such diagnoses, the objective of the WDHD 2011 is to focus attention on the prevention and management of diarrheal diseases. We will tend to improve child survival in developing countries and also to reduce morbidity and mortality in the industrialized world. Special attention will be given to at risk travelers. Obviously the strategies will vary in different parts of the world.

For instance clean water, clean food and clean environment initiatives will play a greater role in less developed, low resource countries. Improvement of the infrastructure will reduce the risk of children

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developing the disease in the first place. The World Gastroenterology Organisation selection of the topic for the WDHD is timely: On July 28, 2010 the United Nations General Assembly declared access to clean water and sanitation a human right. Also vaccines will increasingly play a role in prevention. Still, reducing deaths "depends largely on delivering life-saving treatment of low-osmolarity oral rehydration salts and zinc tablets."[1]

While sanitation is not perfect everywhere in industrialized countries, even greater emphasis will be given here on the option of diarrheal prevention by vaccines, e.g. the recently introduced one against rotavirus, sometimes also by medication. Therapeutic guidelines will be propagated, and appropriate travel kits will be recommended to those planning to visit high-risk countries. A broad range of agents including anti-motility agents, systemic and non-absorbed antibiotics, probiotics, absorbents, antisecretory agents, etc. need to be discussed along the principles of evidence based medicine.

Thus, gastroenterologists worldwide as 'Global Guardians of Digestive Health' are expected to greatly contribute to the global fight against enteric infections on May 29, 2011 and throughout next year.

Water well in Lamu, Kenya – how safe?

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2010 World Digestive Health Day

IBD Task Force Meeting Proceedings

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Throughout 2010 e-WGN has brought various articles and scientific information on Inflammatory Bowel Disease from around the world to its readers. In this issue we look at the IBD task force meeting that occurred during Digestive Disease Week 2010 in New Orleans, Louisiana, USA, where leading international researchers and specialists gathered to share their view on the disease. The meeting was also used to plan an IBD Symposium which was held October 24, 2010 at the United European Gastroenterology Week in Barcelona, Spain (please see the recap on page 9). A total of six experts from various countries gave presentations with Dr. Charles Bernstein, Chair of the WGO IBD Task Force moderating and several other experts from Austria, Brazil, Canada, France, Germany, Ireland, Israel, Japan, Malaysia, Mexico, Norway, Pakistan, Philippines and the USA engaged in a lively discussion. A brief summary of points from each presentation follows.

NORWAY

The presentation began with Dr. Morton H. Vatn of Norway. He summarized major epidemiological reports from both North American and European groups, discussing incidence rates and their increase in Western societies since the mid-1970s as well as peak incidence in the third decade. Dr. Vatn also emphasized the inverse relationship between the high incidence of CD and low frequency of NOD2 polymorphisms in Northern Europe.

JAPAN

Dr. Toshifumi Hibi of Japan spoke second and noted that according to the Japanese Ministry of Health, Labor and Welfare the total number of people affected with IBD is thought to be more than 100,000. He emphasized that there is almost no association between Korean and Japanese IBD populations in regard to most identified genes. This leads to the fact that the genetic risk of IBD varies greatly between Japanese and Western IBD populations. Dr. Hibi ended by giving an overview of the Japanese management guidelines for UC and CD.

LATIN AMERICA

Presenting on the epidemiology of IBD in Latin America was Dr. Flavio Steinwurz of Brazil. He noted that the areas limited applicability to the populations within respective countries is a major problem when discussing epidemiological data and Latin America. Two more key points brought up by Dr. Steinwurz was that UC associated cancer is not seen in Brazil at all, and those that are insured have access to almost all diagnostic modalities and drugs.

PAKISTAN

Dr. Zaighaim Abbas of Pakistan stated in his presentation that Pakistanis along with other South Asians who live in Europe tend to be more likely to develop IBD than those living in their home countries. He discussed there being a resemblance in various aspects of UC in Pakistan as there is in Western IBD and a noticeable male dominance. It was also mentioned that patients in Pakistan that are insured receive access to a majority of approved Western drugs.

PHILIPPINES

A challenge in the Philippines, as Dr. Jose Sollano reported during his presentation is the limited amount of access to specialized care. An interesting fact he brought up is that a majority of those with IBD have traveled abroad, whereas those that haven't tend to be healthy. This leads to the idea that a non-Philipino style of life or perhaps other infections could be possible factors.

CLOSING REMARKS

The Task Force meeting ended with a final panel discussion which included an overall conclusion that IBD is in fact an issue globally, training and education should continually be supported and national registries promoted. Events around the world have continued throughout 2010 which promote IBD education and awareness to both physicians as well as to the general public. The WGO continues to support this by frequently seeking updated information to the IBD Guideline via Graded Evidence and offering information on its 2010 World Digestive Health Day page.

The full report appeared in: Inflamm Bowel Dis. 2010 Aug 19. [Epub ahead of print] http://dx.doi.org/10.1002/ibd.21409

IBD Research Review

As part of the WGO's campaign to raise awareness about inflammatory bowel disease (IBD) throughout 2010, an IBD expert will be recommending and highlighting a "gold standard" article on IBD, with a direct link to the original source, in each issue of e-WGN this year.

ARTICLE

Teruel C, López-San Román A, et al. Outcomes of pregnancies fathered by inflammatory bowel disease patients exposed to thiopurines. Am J Gastroenterol 2010 Sep;105(9):2003-8 (PMID: 20700117)

IBD EXPERT: PROF. JESÚS K. YAMAMOTO-FURUSHO M.D., PH.D., M.SC.

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Professor Yamamoto-Furusho's comment on the article: This paper provides novel and important information about the safety of thiopurines at the time of conception in male patients with IBD suggesting that it is not recommendable to interrupt this kind of treatment when they want to conceive.

Introduction to Professor Yamamoto-Furusho: Professor Yamamoto heads the IBD Clinic in Mexico City – the only IBD Clinic in Latin America with a sizeable publications programme in the IBD area.

Click here to view his extensive output in IBD research. ■

Idiopathic Chronic Pancreatitis in India and West: Differences and Similarities

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Chronic pancreatitis is characterized by irreversible damage to the pancreas that eventually leads to pain and/or exocrine and endocrine insufficiency. In spite of large number of reports on chronic pancreatitis, it remains a fascinating disease of uncertain pathogenesis, unpredictable clinical course and unclear treatment. While alcohol is an important and major cause of chronic pancreatitis worldwide, the cause remains unidentified in a large number of patients. Chronic pancreatitis of unknown etiology has been labeled as idiopathic chronic pancreatitis (ICP) which includes a number of disease entities like early and late onset idiopathic chronic pancreatitis, minimal change chronic pancreatitis, small duct chronic pancreatitis and tropical pancreatitis.

Ever since its first description in the 1950s, tropical pancreatitis has continued to fascinate and challenge the pancreatologists in India and world, alike. A case of classical tropical pancreatitis was a young patient who had pot belly, clinical signs of malnutrition and deficiency. Plain radiograph of abdomen revealed the pancreas studded with large intraductal calculi. Such patients often developed an accelerated course of the disease leading to diabetes and/or steatorrhea, and a higher susceptibility to pancreatic cancer. Physicians attempted to find the underlying cause of such intriguing presentations, which tended to be more common in a specific geographical area of India (south India).[1] Various hypotheses like malnutrition, oxidant stress hypothesis, trace elements deficiency or cassava ingestion (Tapioca, *Manihot esculenta*) were proposed as etiopathogenesis, but have not been proven.[1]

Limited studies have looked into the profile of ICP in North India and most suggested that ICP of North India is similar to tropical pancreatitis of South India. However, recent anecdotal observations suggested that ICP of North India is probably different. In our daily clinical practice over the last decade, at a major tertiary health care center in North India, we have encountered patients with classical tropical pancreatitis only infrequently.

With a goal to dissect the differences between ICP within India, we undertook a study on clinical profile of patients with ICP at our centre.[2] Of 155 patients with chronic pancreatitis (CP), ICP was the most common form of CP (41.3%) (Fig 1). When we compared the clinical profile of our patients of ICP with the profile of classical tropical pancreatitis (as revealed by published reports in 1990s from various centers in South India), various interesting differences were noted. In contrast to 'classical' tropical pancreatitis, where most of the patients were between 10 to 30 years of age at the time of diagnosis, the mean age at presentation in our series of idiopathic pancreatitis was 33 years. Patients with 'classical' tropical pancreatitis were usually malnourished and emaciated and abdominal pain was seen in 30 to 90% of the patients. Majority of our patients with ICP had normal mean body mass index and 96.9% of the patients had abdominal pain as one of the presenting clinical feature. More than 90% of the patients of tropical pancreatitis had pancreatic calcification and diabetes whereas in our study, the frequency of pancreatic calcification and diabetes was 46.9% and 23.4% respectively. Majority of patients with tropical pancreatitis frequently had large intra-ductal calculi whereas calculi were noted in only 9/64 (14%) of our patient population. Also, none of our patients had history of ingestion of cassava. In contrast to high risk of pancreatic malignancy in tropical pancreatitis, none of our patients with ICP had pancreatic cancer.

Another study from North India on idiopathic chronic pancreatitis reported that classical tropical pancreatitis was uncommonly seen with only 5.8% of the patients fitting into the standard criteria for diagnosis of tropical pancreatitis.[3] The patients

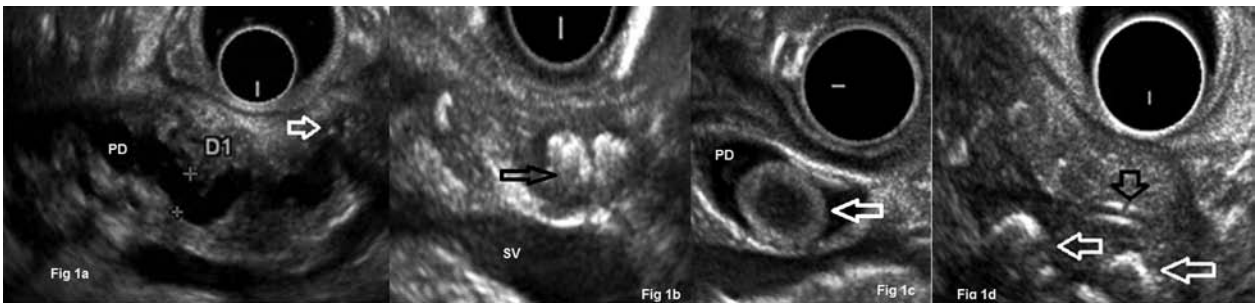

Figure 1: EUS images of patients with idiopathic chronic pancreatitis
1a: Dilated pancreatic duct (between the marks +) with small ductal calculi (arrow); 1b: Large ductal calculi in body of pancreas (arrow); 1c: Dilated pancreatic duct with large ductal calculi in head of pancreas (arrow); 1d: Parenchymal calcification (white arrows) with stent in the pancreatic duct (black arrow). SV: splenic vein, PD: pancreatic duct

with ICP presented at a later age than the classical tropical pancreatitis, were not malnourished and diabetes was also uncommon at presentation, seen in only one third of the patients with ICP. Midha et al also reported better survival for patients with ICP with a 35 year probability of survival being 85%. This is in contrast to earlier studies on 'classical' tropical pancreatitis which had shown it to be an aggressive disease with many patients dying early in the course of disease. These observations from two large tertiary care centres in North India make us wonder whether the ICP of North India is different from the classical tropical pancreatitis described earlier, or is this indeed the same disease that has changed its' phenotypic expression over a period of time? To get closer to the answer of this intriguing question, let us see what has happened to tropical pancreatitis in South India, the part of India from where a large number of studies on tropical pancreatitis have emanated.

Balakrishnan et al[4] in 2006 compared a cohort of 220 patients with ICP studied in 1984 with another cohort of 244 patients seen in 2004. These authors from Kerala in South India reported that the clinical profile and presentation of the disease has changed over a period of time. They reported that ICP in the recent group (2004) of patients occurred in older people with the mean age at onset of disease being 30.6 years in contrast to 20.7 years in the 1984 cohort. The frequency of pain was higher and that of diabetes was lower in the recent cohort (95.9% vs. 81% and 59.7% vs. 77%, respectively). Only 10%-15% of patients presented with the classical features of tropical pancreatitis. A recent prospective multicenter study from India involving 1086 subjects from all parts of India including South India also reported that only 3.8% of the patients with chronic pancreatitis were diagnosed as having classical tropical pancreatitis.[5] We then looked at patients with early onset ICP in our study to see if there were any cases that resembled classical tropical pancreatitis. Even cases that appeared to be classical tropical pancreatitis had a lower incidence of diabetes, ductal calculi and less dense calcifications.

Let us have a look at the profile of ICP in the West. Layer et al[6] reported two distinct forms of ICP in the West: early and late onset ICP. Early onset idiopathic chronic pancreatitis was characterized by a long course of severe abdominal pain with calcifications. The exocrine and endocrine insufficiency also developed more slowly than in late onset idiopathic chronic pancreatitis. When compared with early onset idiopathic chronic pancreatitis of the West, our North Indian patients had a significant higher male preponderance and lower frequency of exocrine insufficiency. Also, our patients with late-onset idiopathic chronic pancreatitis all had pain that was absent in a significant number of cases from the West. Exocrine insufficiency was seen in significantly greater number of patients with late onset ICP of West in comparison to late onset ICP at our centre. Thus, the ICP of our population has started to resemble ICP of West, but there are still persistent pertinent differences in the clinical profile of the two.

The cited studies above suggest that classical tropical pancreatitis is now seen uncommonly both in North and in South India. It also appears that over a period of time the profile of tropical pancreatitis/ICP in India has changed. So what has happened over the last two decades that has changed the profile of tropical pancreatitis? ICP is a complex polygenic disorder with interaction of genes with environment determining the phenotypic expression of the disease. It is unlikely that the genetic profile of the population is going to change in few decades. It seems that this change in profile of ICP may be due to the changes in the environment, diet, and nutritional status brought about by the economic progress of India in the past two decades.

Genetic studies have been con-

ducted to unravel the mystery of this intriguing disease. Gain-of-function mutations of the cationic trypsinogen (PRSS1) gene are associated with hereditary chronic pancreatitis and idiopathic chronic pancreatitis of West.[7,8] However, studies from India have not found its association with tropical pancreatitis.[9,10] Instead, SPINK 1 mutation is reported to be more commonly associated with tropical pancreatitis.[3,9-11] There have been attempts to identify other genetic mutations that can explain the pathogenesis of tropical pancreatitis or idiopathic pancreatitis of India. Cystic fibrosis transmembrane regulator (CFTR) mutations and polymorphisms in cathepsin B (*CTSB*, OMIM 116810) have also been shown to be associated with tropical pancreatitis. Recent studies have identified chymotrypsin C (*CTRC*, OMIM 601405) as a new pancreatitis-associated gene. This mutation has been reported in Idiopathic chronic pancreatitis of both West and India.[12,13]

In conclusion the several studies discussed in this summary indicate: 1) Classical tropical pancreatitis is being seen less and less, even in India; 2) ICP of North India differs from classical tropical pancreatitis with a higher frequency of pain, lower frequency of: diabetes, pancreatic calcification and intra-ductal calculi.[2,3,14] This disease has better prognosis compared to classical tropical pancreatitis with improved survival rates; and 3) ICP of our population in North India has started to resemble ICP of the West but there still exist differences in the clinical profile of ICP of North India compared to that of the West. We expectantly look forward to genetic and other studies that hopefully will unravel the mystery that idiopathic pancreatitis of North and South India and that of the West are either 1) the same disease with different presentations and manifestations; or 2) different diseases altogether. Until such time we will continue to designate these mysterious and challenging diseases by latitudes, longitudes and/or geographical boundaries. ■

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WDHD 2010: The year of IBD

A Recap of the 2010 IBD Symposium

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This past year the WGO has devoted much time and energy toward promoting knowledge about inflammatory bowel diseases (IBD) for an international audience. We have aimed to reach both patients and health care providers with information about diagnostic and management issues.

At the Digestive Diseases Week in New Orleans in May, 2010 we convened a meeting of IBD experts from around the world including Austria, Brazil, Canada, France, Germany, Ireland, Israel, Japan, Malaysia, Mexico, Norway, Pakistan, Philippines and the USA to discuss issues germane to managing IBD in different cultures, different economies, different counties. Proceedings of this meeting are published in the journal *Inflammatory Bowel Diseases* as well as on page 4.

Another goal of this meeting was to lay the groundwork for the kind of issues we wanted discussed at an international symposium to be held at the United European Gastroenterology Week, Barcelona in October, 2010. The meeting was held on October 24 and several hundred attendees were treated to three superb presentations by Ernest Seidman, MDCM, FRCPC, FACG, Professor of Medicine & Pediatrics, Canada Research Chair in Immune Mediated Gastrointestinal Disorders, Bruce Kaufman Endowed Chair in IBD at McGill University Health Center, Montreal General Hospital, Canada; Geert D'Haens, MD, PhD, Professor of Medicine, Academic Medical Centre, Section of Gastroenterology, Amsterdam, The Netherlands, Director, Imelda GI Clinical Research Centre, Bonheiden, Belgium; and Iris Dotan, MD, Head of IBD Service, Department of Gastroenterology and Liver Diseases, Tel-Aviv Sourasky Medical Centre, Israel.

Dr. Seidman reviewed nutritional issues as they may pertain to disease etiology as well as key nutritional issues therapeutically. Dr. D'Haens reviewed diagnostic issues in IBD from blood testing to endoscopy to imaging. Dr. Dotan reviewed the complex issues of deciding on surgery versus advanced immunomodulatory therapy in patients with complicated disease. During the panel discussion audience participants raised such issues as the emergence of IBD in developing countries and distinguishing Crohn's disease from tuberculosis.

The WGO considers our "WDHD 2010: year of IBD" a success in that we were able to generate increased interest in IBD. For example, our "10 tips for patients" was translated into multiple languages and our "cascades" guidelines for diagnosis and management in countries of different resource capabilities was published in the journal *Inflammatory Bowel Diseases*. However, the real measure of success will come if in fact practitioners and patients alike in developing countries feel that there is greater clarity in approaching the management of IBD and if we have raised awareness so that their local health care providers, governments, and pharmaceutical industries will have recognized the importance of IBD as an emerging and costly clinical problem.

To view the full scope of the 2010 WDHD Campaign and to access IBD resources and information regarding the broad range of events held globally, please visit http://www.worldgastroenterology.org/wdhd-2010.html.

The Inflammatory bowel disease: a global perspective guideline can be downloaded for free here: http://www.worldgastroenterology.org/inflammatory-bowel-disease.html. ■

(from left to right) Charles N. Bernstein, MD, Iris Dotan, MD, Geert D'Haens, MD, PhD and Ernest G. Seidman, MDCM, FRCPC, FACG were the panel of experts during the IBD Task Force Symposium, Barcelona, Spain

WGO Train the Trainers: Trial Design Workshop

Athens 2010

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In collaboration with the Hellenic Society of Gastroenterology (HSG), WGO is proud to have successfully completed its 2nd annual Train the Trainers: Trial Design Workshop, which took place on November 11th and 12th 2010 in Athens, Greece.

Like the standard TTT this workshop, developed by WGO, exposes clinical investigators in gastroenterology and GI surgery to current trial design techniques and philosophies. It brings together faculty and participants from across the globe in an intensive and interactive workshop. The workshop is characterized by hands-on sessions and ample opportunity for discussion and interchange. The workshop syllabus includes: types of clinical trials, data analysis and statistics, grant writing, data interpretation and ethical considerations.

On behalf of WGO, our most sincere appreciation goes to the host coordinator, Dr. John Karagiannis of the HSG, as well as all of the local facilitators and international faculty who contributed to the successful outcome of the program.

The Trial Design Workshop consisted of 19 participants and seven faculty members representing countries from all over the world, including Greece, Australia, Ireland, USA, Nigeria, Syria, Colombia, China, Brazil and Cameroon.

One of the highlights throughout this workshop were the breakout sessions, which allowed for participants to work with local facilitators in developing small group presentations on topics discussed during the lectures. Based on the feedback from Dubrovnik in 2009, faculty decided that it was important to incorporate additional time for participant engagement. With this in mind, a new element to this course was introduced which provided participants with the opportunity of developing a clinical study relevant to their region's needs prior to the commencement of the workshop.

Topics which were tendered for discussion included: Study of Anti-HIV seroprevalence in Deirezor Province, Syria; Comparing conventional light endoscopy (CLE) versus FICE for diagnosis of esophageal minimal lesions in patients with gastroesophageal non-erosive reflux disease; The Prevalence of Pancreatic Intraductal Papillary Mucinous Neoplasm (IPMN) by EUS evaluation in Greek population concerning ages between 25 and 60 years old; Defining Criteria For Upper Gastrointestinal Endoscopy In Nigerians; Large Balloon Papillary Dilation vs. Mechanical Lithotripsy for the Treatment of Difficult Common Bile Duct Stones; Inflammatory Bowel Diseases, Trends and Pattern of Admission in Major Referral Hospital, Dammam Medical Complex, in Eastern Province in Kingdom of Saudi Arabia; Antimicrobial resistance incidence among adult patients with dyspepsia *Helicobacter pylori*-infected: A prospective and multicenter, Colombian trial; and EUS-guided Ablation of Mucus Cystic Neoplasms of Pancreas using P131 Brachytherapy in Liquid formulation.

WGO Faculty front row, left to right: Nicoletta Mathou, Greece; Adam Adamopoulos, Greece; John Karagiannis, Greece. **Back row:** Eamonn Quigley, Ireland; Spyros Michopoulos, Greece; Jim Toouli, Australia; David Bjorkman, USA.

The sessions provided participants with the research tools and references needed in conducting these diverse studies. In addition the workshop discussed ways of publishing the data and discussed mechanisms for obtain-

ing funding which allows the conduct of the studies.

Following the workshop, participants were encouraged to provide feedback both openly and using an evaluation form. One participant wrote that, "You gave us good examples …., very good." Many felt that the "faculty provided exceptional presentations," and that the "report-back session was very interesting and useful." Furthermore, participants expressed their interest in participating in future TTTs and requested that additional days be added to the Trial Design Workshop.

With one workshop ending successfully, we begin the process of preparing for the upcoming Train the Trainers workshop. 2011 will mark the 11th year anniversary of Train the Trainers! This TTT, in collaboration with the Indian Society of Gastroenterology, will take place in Chennai, India, from April 11-14, 2011. A recap of the TTT will be reported in the June issue of e-WGN following the Chennai workshop.

For more information on WGO's Train the Trainer Workshops visit http://www.worldgastroenterology.org/train-the-trainers.html

WGO Train the Trainers: Trial Design Workshop. *The photo was taken at Eleftherias Park in Vasilisis Sofias Avenue.*

Promoting Digestive Health

The World Gastroenterology Organisation and the WGO Foundation thank the following 2010 donors for their generosity and support to further global training and education:

The WGO Executive also thanks those who provided support directly to the WGO Training Centers and to the WGO Foundation. Recognition for that support is provided by each individual center as well as on the WGO and WGOF websites.

Asian Pacific Digestive Week 2010

"Gastroenterology in the Asia-Pacific- Excellence in the New Decade"

Professor Dr KL Goh

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The APDW 2010 was successfully organized from 19th-22nd September 2010 in Kuala Lumpur, Malaysia.

It was the first time that this premier event was held in Malaysia and it was indeed heartening to receive a record crowd of 2,661 registered delegates coming from 59 countries, including 31 Asian countries and 28 outside Asia including from Africa, the USA, Slovakia, Russia and Sweden. We had a formidable line-up of 143 internationally renowned speakers and 83 moderators. Ten special lectures, 33 symposiums, two days of live endoscopy workshop, a post-graduate course, two special OMED endoscopy course/courses and 12 focused research meetings were successfully held at APDW 2010. Thirty-eight biomedical companies, utilizing 102 unit booths participated in a truly beautiful trade exhibition and we also held nine pharmaceutical sponsored satellite symposiums. A record 583 original scientific submissions for oral and free paper presentations were received, as well as two Young Investigator Awards sessions. The record does speak for itself.

Apart from the four host societies: Asian Pacific Association of Gastroenterology, Asian Pacific Society of Digestive Endoscopy, Asian Pacific Association of Study of Liver Disease and the International Society of Digestive Surgery, we had participation from eight sister GI organizations: World Endoscopy Organization (OMED), International Organization of Inflammatory Bowel Disease (IOIBD), European Association of Gastroenterology (EAGE), International Digestive Cancer Alliance (IDCA), The International Working Group for the Classification of Esophagitis (IWGCO), Asian Neurogastroenterology Motility Association (ANMA), Japan Society of Gastroenterological Endoscopy, and the American Society of GI Endoscopy (ASGE).

Professor Neville Yeomans delivering the Marshall and Warren lecture at APDW 2010

Professor Fock opening the APDW 2010

The APDW 2010 was truly a top-class event which the Malaysian Society of Gastroenterology and Hepatology was proud to host and organize. It was landmark event for us and we are grateful for its huge success. I wish to thank everyone who had participated in the meeting and hope that you have benefited scientifically, professionally and socially from it and have brought back home fond memories of the APDW 2010. ■

Professors Ken McColl and Mrs. McColl. Pali Hungin and Peter Malfertheiner

The Rome Foundation and WGO Announce Joint Symposium

IBS – The Global Perspective Prevalence, Pathophysiology, Presentation and Management

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The Rome Foundation along with the World Gastroenterology Organisation will be holding a symposium titled *IBS – The Global Perspective*. The meeting, co-directed by Dr. Ami Sperber (Rome) and Dr. Eamonn Quigley (Ireland, WGO) will be held for one-and-a-half days on April 6-7, 2011 in Milwaukee, Wisconsin, USA. The symposium will be held just prior to the 9th International Symposium on Functional GI Disorders (April 8-10, 2011).

This will be an exciting and stimulating meeting, which will provide a new perspective on IBS and other functional GI disorders that is relevant to clinicians and academicians alike.

The faculty will include a stellar group of speakers from the areas of functional GI disorders, medical anthropology, health and culture, and psychopathology, as well as representatives of regulatory agents from the US, Europe and Japan.

THE PROGRAM WILL INCLUDE THE FOLLOWING SESSIONS:

Epidemiology and Socio-Cultural Issues

- Culture and Symptom Reporting
- Interpretation and Reporting of GI Symptoms, Differential Diagnosis and Diagnostic Work-up Around the World

Culture, Health and FGIDs

- Culture and Health
- Explanatory Models of Health and Illness, Impact of Culture on Physicians' and Patients' Explanatory Models

Mechanisms and Pathophysiology

- A Global Perspective on the Effect of Genetics and Ethnicity on Pathophysiology and Management
- GI Microbiology: Pathogens, Exposure Patterns and Immune Responses
- Geographical and Cultural Food-Related Symptoms, Food Avoidance and Elimination
- Worldwide Differences in Psychopathology and the Interpretation and Effects of Stress

Patient Care in Different Geographical Areas and Cultural Settings

- Practicing in a Multicultural Milieu: Physician Competence
- Practicing in a Multicultural Milieu: Patient Health Literacy
- Folk Remedies, Self-Medicating, and CAM Around the World
- Impact of Local Regulations and Healthcare Organization on Management Options
- Effect of Religious and Cultural Beliefs on Healthcare Around the World

Conducting Multinational Drug Trials

- Unique Problems in Multi-National Studies: Organizational and Regulatory Issues
- Unique Problems in Multi-National Studies: Ethical Issues and Recruitment Problems
- Unique Problems in Multi-National Studies: Regional Perspectives on Inclusion Criteria, Endpoints and Outcomes

WORKSHOPS INCLUDE:

Clinical Competence Workshop

- Working in a Multiethnic Clinic
- Role Play with Professional Actors - Clinical Encounters with Cross-Cultural Issues

Research Competence Workshop

- Cross-Cultural, Multinational Research
- Examples of Cross-Cultural Studies
- Translation and Validation of Instruments for Cross-Cultural Studies

WHO SHOULD PARTICIPATE:

- Practicing gastroenterologists, primary care physicians, psychologists, sociologists, and other health care providers interested in IBS and the functional GI disorders at a global level
- Scientists and academicians interested in cross-cultural investigation of these conditions.
- Pharmaceutical company research, development and marketing managers interested in learning about cultural differences in attitudes and beliefs toward medical treatments
- Members of health policy and regulatory organizations

The scientific advisory and organizing committee is comprised of the following members:

Rome Foundation: Ami Sperber, Doug Drossman, Lin Chang, Max Schmulson

WGO: Eamonn Quigley, Richard Hunt, Kok-Ann Gwee, Carolina Olano

IFFGD:– Nancy Norton

All meeting information and registration is currently available at www.romecriteria.org/global_perspective. ■

Click Here to Register Now!

Centre International De Formation Post-Graduee En Hepato-Gastroenterologie

Celebration of the 10th Annual Course of WGO-Rabat Training Centre

The WGO-Rabat Training is proud to announce that in January of 2011, they will be celebrating the Tenth Gastroenterology and Hepatology Training Course at their training centre, Rabat, Morocco. The course, which will be held January 27 through February 5, 2011, will include:

CONFERENCES:

- News Hepatology
- Viral hepatitis (news)
- Cholestatic liver
- ACDI / Digestive Cancer
- Chronic diarrhea
- NSAIDs and gut
- Celiac disease
- Digestive Diseases and Nutrition, FI
- Proctology practice
- *Non-HP* gastritis
- Obesity

HELP WITH MEDICAL WRITING: ARTICLES AND CRITICAL READING

BIOETHICS

DISTANCE EDUCATION

PRACTICAL TRAINING:

- Endoscopy Workshop
- Ultrasound Workshop
- Animal Modles
- Simulator
- Video Corner
- Workshops
- Clinical Cases

At the end of the Tenth Training Course, the Third Symposium of the African Middle Eastern Digestive Cancer Alliance, the regional arm of the IDCA, will be held. This will be led by former WGO treasurer, Douglas LeBrecque.

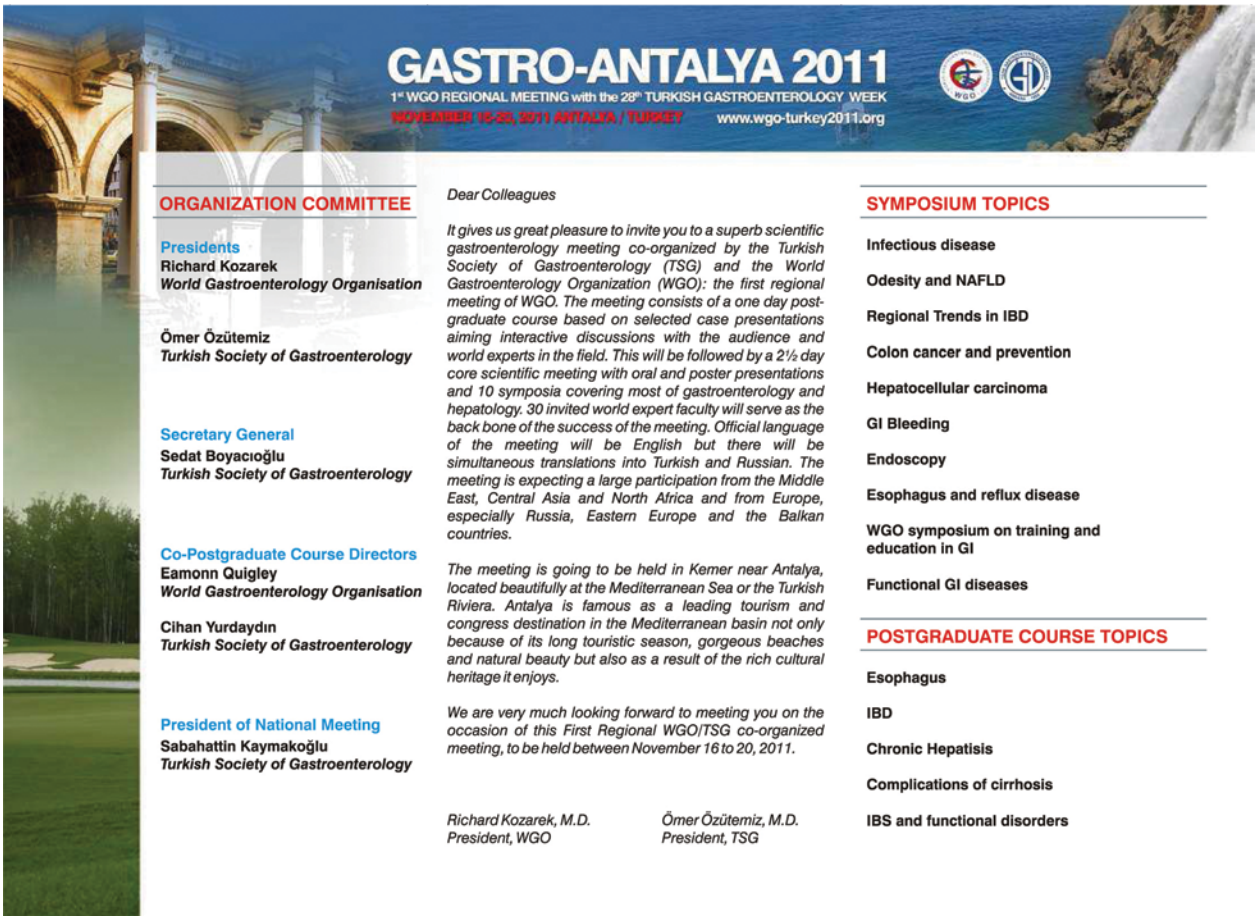
BACKGROUND

The Rabat Training Center was opened in January 2003. It is situated in the Faculty of Medicine and Pharmacy of the Mohammed V-Souissi University. It is open to all French speaking gastroenterologists, in particular from Africa, willing to improve their theoretical and practical knowledge, in the fields of hepatology and gastroenterology. Since its opening, the Center has organised regular training sessions ranging from 10 days to internships of 4 years. Attendees have come from all over French speaking Africa and the Indian Ocean Islands, and over 350 practitioners have already received training.

For more information, please visit www.centreomge-rabat.org.

GASTRO-ANTALYA 2011: Joint WGO-Turkish Society of Gastroenterology Meeting Announced

WGO and the Turkish Society of Gastroenterology are pleased to announce and invite you to the upcoming joint meeting, Gastro-Antalya 2011, November 16 to 20. This clinically-oriented congress will feature a two-day case-based postgraduate course, numerous symposia on critical issues in Gastroenterology, Hepatology and Endoscopy and ample opportunities for the presentation of original work. While the main languages of the meeting will be English and Turkish, simultaneous translation into Russian will also be available. Continue watching future issues of e-WGN for the latest updates on registration, abstracts and general information, throughout 2011. You may contact the secretariats at info@worldgastroenterology.org or valor@valor.com.tr, and visit www.wgo-turkey2011.org for more information.



Dear Colleagues,

The World Gastroenterology Organisation (WGO) and the International Digestive Cancer Alliance (IDCA), a division of the WGO, have mutually agreed that the IDCA will become an independent organization. Both WGO and IDCA will continue their interest and activities in GI oncology, with the special focus of the WGO being on those issues that are pertinent on a global basis to its primary goals of education and training.

Both organizations look forward to future collaborations based on issues of mutual interest and for the benefit of our patients around the world.

We realize that you may have questions regarding this decision and invite you to contact us at any time.

Thank you for your continued support of both the WGO and the IDCA.

Sincerely,

Richard Kozarek, MD
President, WGO

Sidney Winawer, MD
Chairman, IDCA

Eamonn Quigley, MD
Past President, WGO

Meinhard Classen, MD
Past Chairman, IDCA

Henry Cohen, MD
Vice President, WGO

Guido Tytgat, MD
Vice Chairman, IDCA

Cihan Yurdaydin, MD
Secretary General, WGO

Joseph Geenen, MD
Finance Officer, IDCA

Constipation – WGO's latest cascade-based global guideline featuring resource sensitive approaches to diagnosis and management

This article is an abridged version of WGO's new guideline on Constipation . It looks at its unique aspects – the Cascades for diagnosis and treatment developed by Professor Greger Lindberg and his Review Team

1. Introduction

Constipation is a chronic problem in many patients all over the world. In some groups of patients such as the elderly, constipation is a significant healthcare problem, but in the majority of cases chronic constipation is an aggravating but not life-threatening or debilitating complaint that can be managed in primary care with a cost-effective control of symptoms.

2. Cascades– a resource-sensitive approach

A gold standard approach is feasible for regions and countries where the full scale of diagnostic tests and medical treatment options is available for the diagnosis and management of all constipation (sub)types. But what can be the approach in a resource constrained setting? Enter WGO's unique 'Cascade' concept. Below we reproduce three resource sensitive approaches for the investigation and management of constipation.

CASCADE: A HIERARCHICAL SET OF DIAGNOSTIC, THERAPEUTIC AND MANAGEMENT OPTIONS TO DEAL WITH RISK AND DISEASE - RANKED BY RESOURCES AVAILABLE.

2.1 Cascade options for investigation of severe/therapy refractory constipation

Level 1 – *limited resources*

a. Medical history and general physical examination
b. Anorectal examination, 1-week bowel habit diary card

Table 1. Possible causes & constipation associated conditions

Mechanical obstruction	**Neurological disorder/neuropathy**
Colorectal tumor Diverticulosis Strictures External compression from tumor/other Large rectocele Megacolon Postsurgical abnormalities Anal fissure	Autonomic neuropathy Cerebrovascular disease Cognitive impairment/dementia Depression Multiple sclerosis Parkinson's disease Spinal cord pathology
Endocrine/metabolic condition	**GI disorders & local painful condition**
Chronic kidney disease Dehydration Diabetes mellitus Heavy metal poisoning Hypercalcaemia Hypermagnesaemia Hyperparathyroidism Hypokalaemia Hypomagnesemia Hypothyroidism Multiple endocrine neoplasia II Porphyria Uremia	Irritable bowel syndrome Abscess Anal fissure Fistula Haemorrhoids Levator ani syndrome Megacolon Proctalgia fugax Rectal prolapse Rectocoele Volvulus
Myopathy	**Dietary**
Amyloidosis Dermatomyositis Scleroderma Systemic sclerosis	Dieting Fluid depletion Low fiber Anorexia, dementia, depression
Miscellaneous	
Cardiac disease Degenerative joint disease Immobility	

Table 2. Medications associated with constipation

Prescription drugs	**Self-medication – over-the-counter drugs**
Antidepressants Antiepileptics Antihistamines Antiparkinson drugs Antipsychotics Antispasmodics Calcium channel blockers Diuretics Monoamine oxidase inhibitors Opiates Sympathomimetics Tricyclic antidepressants	Antacids (containing aluminium, calcium) Antidiarrheal agents Calcium and iron supplements Nonsteroidal anti-inflammatory drugs

c. Transit study using radio-opaque markers
d. Balloon expulsion test

Level 2 – *medium resources*
a. Medical history and general physical examination
b. Anorectal examination, 1-week bowel habit diary card
c. Transit study using radio-opaque markers
d. Balloon expulsion test or defecography

Level 3 – *extensive resources*
a. Medical history and general physical examination
b. Anorectal examination, 1-week bowel habit diary card
c. Transit study using radio-opaque markers
d. Defecography or magnetic resonance (MR) proctography
e. Anorectal manometry
f. Sphincter electromyography (EMG)

2.2 Cascade options for treatment of chronic constipation

The following cascade is intended for patients with chronic constipation without alarm symptoms and little or no suspicion of an evacuation disorder. The main symptoms would be hard stools and/or infrequent bowel motions.

Level 1 – *limited resources*
a. Dietary advice (fiber & fluid)
b. Fiber supplementation
c. Milk of magnesia (Magnesium hydroxide in aqueous solution)
d. Stimulant laxatives (bisacodyl better than senna) for temporary use

Level 2 – *medium resources*
a. Dietary advice (fiber & fluid)
b. Fiber supplementation, psyllium
c. Milk of magnesia, lactulose, macrogol
d. Stimulant laxatives for temporary use

Level 3 – *extensive resources*
a. Dietary advice (fiber & fluid)
b. Psyllium or lactulose
c. Macrogol or lubiprostone
d. Prokinetics (prucalopride)
e. Stimulant laxatives (bisacodyl or sodiumpicosulphate)

2.3 Cascade options for treatment of evacuation disorders

This cascade is developed for patients with chronic constipation without alarm symptoms but with suspicion of an evacuation disorder. The main symptoms would be prolonged straining, feeling of incomplete evacuation, thin stools, feeling of blockage, or failure of treatment for constipation with hard stools.

Level 1 – *limited resources*
a. Dietary and behavioural advice (fiber, fluid, timed bowel training)
b. Therapy for chronic constipation

Level 2 – *medium resources*
a. Dietary and behavioural advice (fiber, fluid, timed bowel training)
b. Therapy for chronic constipation
c. Biofeedback therapy

Level 3 – *extensive resources*
a. Dietary and behavioural advice (fiber, fluid, timed bowel training)
b. Therapy for chronic constipation
c. Biofeedback therapy
d. Surgical evaluation

THE CONSTIPATION GUIDELINE REVIEW TEAM

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Peter Malfertheiner (Germany)
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Luis Bustos Fernandez (Argentina)
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Alan Thomson (Canada)
Khean-Lee Goh (Malaysia)
Rakesh Tandon (India)
Suliman Fedail (Sudan)
Benjamin Wong (China)
Aamir Khan (Pakistan)
Justus Krabshuis (France)
Anton Le Mair (The Netherlands)