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VOL.14, ISSUE 2

Message from the WGO President

WGO 2005–2009—some thoughts

It has been my great privilege and honor to have served as President of the World Gastroenterology Organisation over the past 4 years and to have attempted to follow in the footsteps of my eminent predecessors and mentors, Guido Tytgat and Meinhard Classen. Thanks to their stewardship and the wise management of our finances by Joseph Geenen, my colleagues and I inherited an organization that was financially sound and whose governance was on a firm footing, ably supported by Bridget Barbieri and her staff at Medconnect.

In 2005, therefore, we had an opportunity to expand the activities of WGO. Recognizing the

organization's limited resources, we decided to concentrate on training and education. Furthermore, aware of the special needs of those areas of the world where gastroenterology is poorly developed, we sought to concentrate our efforts considerably, though not exclusively, on such areas. To serve these goals, we next came to define the Training Centers, the Train-the-Trainers (TTT) programs, the International Digestive Cancer Alliance, and our Global Guidelines as our flagship educational programs and sought to establish cohesion between them in order to pursue our central mission—training and education in gastroenterology. Other

supporting projects were developed or enhanced: the WGO website, *World Gastroenterology News*, the WGO e-newsletter, the “Ask a Librarian” service and, most recently, the tremendously successful World Digestive Health Day—each and every one of these activities promoting our message and disseminating important information on digestive health and disease worldwide.

I am proud of what we have achieved over these past few years, but it would be remiss if I did not acknowledge all who have supported these endeavors: from those who served on our Executive, Governing

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Treasurer's Report

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The past year has created financial challenges for everybody, from governments to individuals, and the WGO has also been affected by the global economic downturn. The WGO investment portfolio lost 12.3% of its value in 2008, compared to a 33.8% drop in the Dow Jones average. While our equity investments sustained substantial losses, these were partially offset by our diversification into fixed-income assets. In the first 5 months of 2009, the value of our equity investments has increased substantially in 2009. These investments are actively managed to enhance our financial position, but are subject to changes in the global markets.

In the past, the WGO has relied on income from each World Congress of Gastroenterology to provide the funds needed to support the WGO programs for the next four years. These funds have been supplemented by some contributions from industry. The past funding pattern, however, will not be viable for the future. We can no longer rely on conference revenues, and industry support for medical societies and programs has dropped precipitously. Like other organizations, the WGO must develop a new paradigm for long-term financial success.

In the short term, the WGO Executive Committee has looked at each of our programs and decreased the expenses. As a result, the WGO budget for 2009 has decreased 45% from 2008, and the draft budget for 2010 plans for another reduction of 30%. This budget reduction has been accomplished by closely evaluating each of our programs, economizing where possible, and decreasing the scope of some activities. For example, the number of Train-the-Trainers

workshops will be limited by lack of funding, but the quality of the workshops will remain high. Other WGO activities may be scaled back to maintain quality in the setting of limited resources.

In addition to decreasing expenses, the WGO is looking for additional funding opportunities. We do not feel comfortable increasing our dues to member societies, as they are facing the same difficult financial climate. The WGO Foundation has been launched under the direction of Dr. Bernard Levin with a dedicated board of directors. After consultation with fundraising experts, we are optimistic that the Foundation will be able to attract substantial philanthropic funding for the activities of WGO. We are continuing to look for opportunities and apply for funding from foundations and industry. We are very pleased with the partnerships we have developed with some member societies to support specific programs. We will be able to increase our activities in other areas where direct

sponsorship and support are available.

The net result is that the WGO has carefully evaluated its financial situation and has made changes necessary to maintain its financial strength in these difficult economic times. As we have seen with governments and individuals, this has forced us to make difficult decisions to limit some WGO activities. We are confident, however, that Gastro 2009, in partnership with UEGF, will be an extremely successful World Congress. Our share of the proceeds from this meeting, along with the success of the WGO Foundation and direct programmatic sponsorship, will allow us to continue the programs critical for the WGO mission. We are also confident that as the global economy rebounds, the WGO will realize additional revenues that will allow us to expand our programs.

We look forward to continuing to work with our member societies to meet their needs and promote the digestive health of people around the world.

Cont. Message from the WGO President

Council, committees, working groups, editorial boards, guideline groups and other groups, to those who volunteered of their time and talents to teach at a Training Center, a TTT, an IDCA symposium or other teaching activity, to the national and regional societies that so actively joined with us in supporting training centers, TTTs, and IDCA, and to all of those who so readily provided invaluable input, whether as organizations or as individuals. As I have often said, “WGO is *your* society!”

Highlights: witnessing the wonders that you perform in the Training Centers, sharing in the unique spirit of learning and comradeship that is TTT, seeing the impact on the world literature and medical practice of our unique Global Guidelines, knowing of the importance that the Declarations of Brussels and Rabat will have in the fight against digestive cancers, and feeling the enthusiasm generated around the world by WDHD topics such as inflammatory bowel syndrome, nutrition and hepatitis. These are some of the headlines, but the memories that I will retain will be more personal and will be my own recollections of people met, topics discussed, and experiences shared with you as individuals and with your patients and colleagues.

As I come towards the end of my Presidency, I can marvel on the one hand at how WGO has progressed to assume the rightful place it now has as “the global guardian of digestive health,” but on the other I must also admit to having concerns for our future. We must recognize that WGO has not been immune to the financial crisis that has enveloped the globe

and to the particular challenges that face gastroenterology. WGO has traditionally benefited either directly or in a number of indirect ways from the largesse of the biomedical industry; indeed, none of our programs would be possible without such support, and for that we are most grateful. For a variety of reasons, industry support for educational events in gastroenterology has begun to wane. WGO is facing this challenge by establishing a Foundation under the chairmanship of Bernard Levin to develop a broad base of support for WGO and thereby secure the organization’s future. We look forward to your enthusiastic support for WGO!

Finally, a word of thanks to my immediate colleagues—David Bjorkman, Henry Cohen, Michael Farthing, Michael Fried, Richard Kozarek, Douglas Labrecque, Bernard Levin, Guido Tytgat, and James Toouli—who have given so much of their time and wisdom; to Bridget Barbieri, Molly Fassbender, Heather Wynn, Rachel Fischer, Michael Roberts and all the staff, current and past, at Medconnect; and to Justus Krabshuis at Highland Data; these are the people who actually got the job done.



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The serrated pathway to colorectal cancer



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Introduction

Carcinomas of the serrated pathway are now thought to account for 15–20% of all colorectal cancers. They usually present in the eighth decade of life, are more common in women, and are found predominantly in the proximal colon. These cancers may also be disproportionately represented among carcinomas overlooked at screening or surveillance colonoscopy (interval carcinoma). One reason that has been put forward for this is that, in addition to being located in the less accessible proximal colon, the precursor serrated lesions (and in many cases the end-point superficial carcinomas) of this pathway are nonpolypoid or flat and they are therefore more easily overlooked at endoscopy.

Superficial lesions of the colorectal mucosa

The Paris classification will be applied to the current discussion of serrated lesions. Both serrated and nonserrated lesions of the colorectal mucosa are called superficial when there is no invasion, or when invasion is present but limited to the mucosa or submucosa. The morphology of a lesion is determined by the predominant direction of growth: upward for polypoid and nondepressed lesions;

transverse for lesions of the laterally spreading type (LST); downward for nonpolypoid depressed lesions. The Paris classification, briefly, is as follows: type I, polypoid lesions, with subtypes Ip (pedunculated) or Is (sessile); type II, nonpolypoid lesions, with subtypes IIa (slightly elevated), IIb (flat) or IIc (depressed). Ulcerated (type III) lesions are never superficial [5,6].

High-resolution video colonoscopes, which provide magnification and image-enhancement techniques such as narrow-band imaging (NBI), increase the ability to analyze the surface of superficial lesions, whether they belong to the serrated pathway or to the conventional adenoma–carcinoma sequence. The surface microarchitecture or *pit pattern* is assessed optimally on magnification combined with dye chromoscopy, or with image processing. A type I pit pattern refers to small and regular pit openings, as in the normal mucosa. Type II indicates large and regular stellate pit openings, as found in most serrated lesions, which also may show a mosaic of pit patterns. Types III_L, III_S, IV, V_r and V_N with sinuous short, long, or branched crypts are seen in dysplastic lesions, serrated or conventional. Types V_I and V_N in carcinoma have a degree of irregularity that suggests invasion into

the submucosa, under or above the limit of 1000 μm, respectively. There has also been a recent trend to use magnification and NBI in transparency to analyze the network of superficial capillaries or the *vascular pattern*, classifying lesions into categories that have been shown to have a predictive value for the risk of malignancy and/or the extent of invasion into the submucosa.

Serrated lesions

Nondysplastic serrated lesions. This category consists of mucosal lesions, previously known as hyperplastic polyps (HPs) or metaplastic polyps, representing the great majority of serrated lesions or polyps. Most are small, less than 5 mm in diameter, with nonpolypoid morphology, slightly elevated or even flat, and classified as subtypes IIa or IIb (Paris classification). Small HPs are found mainly (at least 80%) in the distal colon and rectum. Larger HPs, over 10 mm in diameter, are less frequent and are preferentially located in the proximal colon; their morphology is often nonpolypoid, flat, slightly elevated, or even polypoid and sessile. The surface microarchitecture or pit pattern of HPs is usually classified as category II, with large stellate pit openings, but large, normal-appearing round pits with an increased

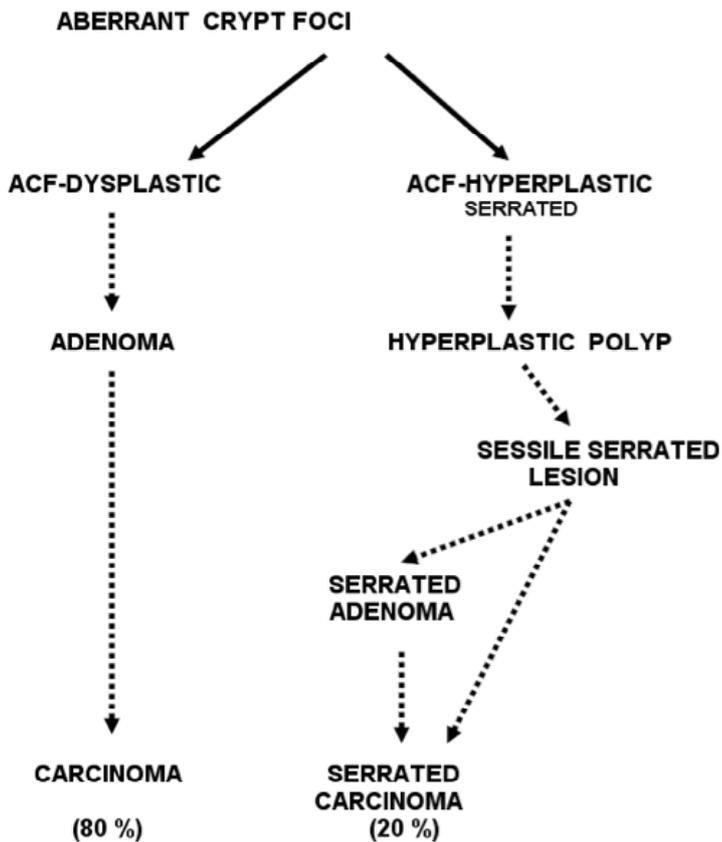


Fig. 1 The initial rupture of homeostasis occurs in aberrant crypt foci (ACFs). The dysplastic type of ACF is the origin of the nonserrated adenoma–adenocarcinoma sequence. The hyperplastic serrated type of ACF is the origin of nonneoplastic serrated lesions and of the traditional serrated adenoma–adenocarcinoma sequence.

pericryptal zone are characteristic of the goblet cell serrated polyp (GCSP) variant (see below).

In the past, HPs were viewed as a homogeneous histological category. Through the work of Torlakovic and Snover [7], it is now recognized that there are three distinct histological subtypes: microvesicular serrated polyp (MVSP), goblet cell serrated polyp (GCSP), and sessile serrated lesions (SSL; also known as sessile serrated adenoma, SSA), each with its own molecular-genetic profile and biological characteristics. A fourth type, mucin-poor hyperplastic polyp (MPHP), appears to be extremely rare and is currently considered likely to represent a variant of MVSP.

Microvesicular serrated polyps (MVSPs) occur predominantly in the distal colon and rectum and

represent the most frequent subtype of HPs. The architecture of the crypt is serrated, particularly in its upper and middle thirds. The component cells of the upper crypts show abundant enlarged microvacuolated columnar cells, mixed with scattered goblet cells. An activating mutation of the *BRAF* oncogene is found in up to 80% of these polyps.

Goblet cell hyperplastic polyps (GCSP) are typically diminutive, less than 5 mm, and represent less than 10% of proximal hyperplastic polyps and 25% of distal hyperplastic polyps. The crypts are enlarged, but show little or no serration. The mature cells of the upper crypt are mainly large goblet cells. An activating mutation of the *KRAS* gene is found in 50% of these polyps. Both the microvesicular cells of MVSPs and the goblet cells of GCSPs are

thought to represent hypermature or senescent cells that acquire this phenotype as an adaptive response to the activating mutations of *KRAS* or *BRAF* kinases. These kinases act in tandem as part of a highly conserved growth-controlling intracellular signaling pathway known as the RAS-RAF-MAPkinase pathway. The adaptive signaling that ensues may explain why these lesions are not transformed or dysplastic as in a conventional *APC*-mutated small adenoma; nonetheless, many now consider that they represent true early neoplasms rather than “hyperplasia.” The progression to more advanced neoplasia or dysplasia in small hyperplastic polyps is uncommon in the distal colon, but is more likely to occur in proximal lesions.

Sessile serrated lesion (SSL) is a histologically atypical variant of hyperplastic polyp, and as such it is at the nexus in the progression from a unicryptal aberrant crypt focus (ACF) to a dysplastic serrated polyp. It usually displays a nonpolypoid morphology and is classified as IIa, or IIa + Is. The surface is frequently covered with a plaque of yellow mucin; when this is rinsed, it may be difficult to identify an underlying serrated lesion without chromoendoscopy and/or magnification under NBI to reveal the abnormal surface microarchitecture—mainly a type II or mosaic pit pattern.

There is substantial evidence that *sessile serrated lesions* are successor lesions of typical hyperplastic polyps. Most occur in the proximal colon, and the presence of the characteristic histology correlates strongly with size and location. The histology is essentially that of a hyperplastic polyp, with superimposed alterations of the crypts that indicate disordered growth. These include irregularity of the crypt bases, with irregular branching and horizontal elongation producing T-shaped and boot-shaped crypts. Other features include crypt dilation and abundant mucus production. These lesions do not show cytological

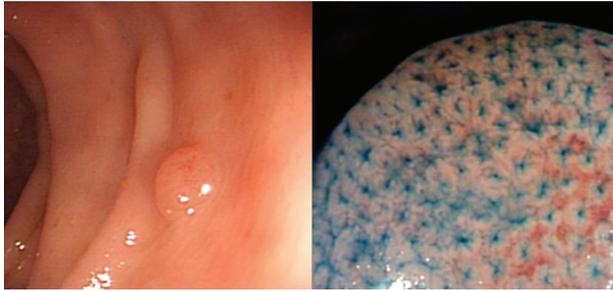


Fig. 2 A small hyperplastic polyp (0-Is) . Left: standard vision. Right: magnification and chromoscopy with indigo carmine, pit pattern II with large stellar pit openings.

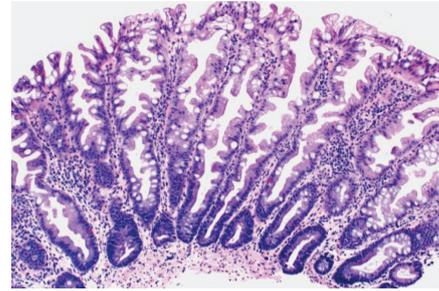


Fig. 3 Histopathology of hyperplastic polyps. This is a microvesicular serrated polyp—the most prevalent variant of hyperplastic polyps. There is serration in the upper and mid-crypts. The base of the crypts has a simple tubular shape. The upper crypts mainly consist of vacuolated columnar cells (microvesicular cells) and scattered goblet cells.

dysplasia, by definition, but their potential for further progression is indicated by the high frequency with which contiguous SSLs are found in resected dysplastic serrated adenomas (so-called “mixed polyps”).

Reflecting their presumed origin, 75% of SSLs show *BRAF* mutations and 10% have *KRAS* mutations. A notable feature of *BRAF*mut SSL is a high level of CpG island methylation, a finding that indicates a proclivity to inactivation of mutator and suppressor genes. Inactivation of the mismatch repair gene *hMLH1* by methylation of the CpG islands of its promoter region is the molecular signature of *BRAF*mut microsatellite instability (MSI) colorectal carcinoma, the major end point carcinoma of the serrated pathway.

Dysplastic serrated lesions.

Dysplastic serrated polyps also encompass several histological subtypes and synonyms—SSL with dysplasia, serrated adenoma, not otherwise specified, traditional serrated adenoma, and mixed polyps. Serrated polyps with dysplasia appear to represent the penultimate stage before the emergence of carcinoma in the serrated pathway, although some have proposed (with little supporting evidence) that the atypical hyperplastic polyp variant SSL can progress to carcinoma via a minor or short-lived dysplastic

component. Mixed polyps (SSL with an adjacent adenoma component) capture the transition from disordered crypt architecture of SSL to a dysplastic (adenomatous) serrated polyp.

Dysplastic serrated polyps are much less common than nondysplastic variants. In a survey of 10,532 polyps in Japan by Iwabuchi et al. [8], the proportion of lesions classified as serrated adenomas (dysplastic serrated polyps) was 1.8%. By contrast, SSLs have been estimated by Spring et al. [9] to represent 9% of all polyps.

For clinical decision-making, dysplastic serrated polyp (or serrated adenoma) is a sufficient term, and the nature and biology of these advanced serrated polyps may be more accurately revealed by their molecular profile rather than by morphological variations. Approximately 70% of dysplastic serrated polyps have a *BRAF* mutation, and these include the precursors of CpG island methylator phenotype (CIMP)-High and MSI serrated carcinoma; 20% show a *KRAS* mutation, and these are the presumptive precursors of *KRAS*mut serrated carcinomas, a group of cancers that are more distally distributed in the colon and rectum and show microsatellite stability (MSS), aneuploidy (indicating chromosomal instability) and frequent p53 mutations.

In all these respects, these *KRAS*mut serrated cancers resemble conventional adenocarcinomas of the adenoma–carcinoma sequence .

Clinical significance of sessile serrated lesions

Given its high prevalence and demonstrated potential for progression to more advanced dysplastic serrated polyps, SSLs are an important focus for intervention in the prevention of serrated pathway cancers. There are several issues of clinical importance related to this lesion: detection and removal, accurate pathologic classification, risk assessment, and surveillance. The dependence of the rate of detection of nondysplastic serrated hyperplastic polyps (HPs) on the endoscopist has been shown by Chen and Rex [10], who demonstrated that among 10,034 colonoscopies in 1999–2004 conducted by nine endoscopists at Indiana University Hospital, the prevalence of these lesions varied by endoscopist from 11.8% to 34.9%. In addition, a number of studies have indicated low reproducibility among pathologists in the distinction between HPs and SSLs. It appears, however, that reproducibility in classification can be significantly improved by using agreed prospective criteria.

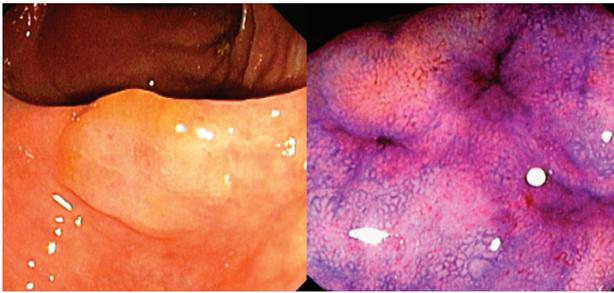


Fig. 4 A sessile serrated lesion (O-IIa). Left: standard vision. The lesion is larger than 10 mm and is located in the ascending colon, with an irregular surface. Right: magnification and chromoscopy with crystal violet. Pit pattern II with very large pit openings is visible in the lower right quadrant of the image. There is no adenomatous pit pattern.

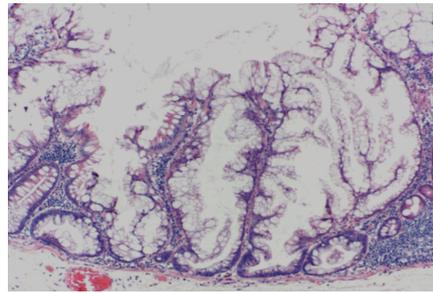


Fig. 5 Histopathology of a sessile serrated lesion (also known as sessile serrated adenoma). This hyperplastic polyp variant shows a complex crypt architecture, particularly in the basal crypts. Serration is prominent and extends to the base. This example shows numerous goblet cells, and there is markedly increased mucin production.

As a practical matter, proximal HPs—particularly if they are large—should perhaps be regarded as SSLs unless proven otherwise. Finally, in terms of risk assessment and the need for surveillance, associated factors such as multiple additional serrated or conventional adenomas, a family history of colorectal cancer, older age, and the possibility of hyperplastic polyposis syndrome need to be evaluated when planning a surveillance strategy.

Endoscopic assessment of serrated lesions

The diagnosis of lesions of the colorectal mucosa with a superficial appearance at endoscopy is conducted in two distinct steps: detection of an area of suspicion, followed by characterization of the abnormal area with respect to the risk of malignancy. The detection step is conducted with standard white-light endoscopy and requires training for the application of criteria other than visible shapes, elevations, or depressions. New criteria include a change in the color of the mucosa or an interruption of the course of superficial capillaries. The purpose of characterization is to predict the histology from the endoscopic appearance. Chromoscopy with indigo carmine solution or NBI helps disclose

the morphology of the anomaly in the subtypes of the category 0 of the Paris classification and the surface microarchitecture (pit pattern or vascular pattern).

Small nodules or papules on the surface of SSLs may indicate the presence of a mixed polyp. These small nodules frequently present areas containing dysplastic tubular or tubulovillous structures depicting a pit pattern type IIIIL and most frequently type IV at magnifying endoscopy. The presence of type IIIIL and IV pit patterns through the whole lesion predicts a more advanced form with considerable dysplastic change.

The topographic distinction between proximal and distal lesions is relevant to the efficacy of complete colonoscopy in screening protocols. There is no doubt that large and nonpolypoid lesions, both serrated and nonserrated lesions, are often missed in the cecum and ascending colon during colonoscopy. The proximal colon, the preferential site for poorly visible and large nonpolypoid serrated lesions, requires special attention and careful washing of any mucus covering the mucosa. Lesions missed in the proximal colon are a relevant cause of the preferential localization in the proximal colon of interval cancer detected within 5 years after a negative screening colonoscopy.

This also explains the lack of protection from colorectal cancer mortality afforded by complete colonoscopy in the Ontario population-based study conducted by Baxter et al. [11]. The occurrence of a previous complete colonoscopy was investigated in the history of patients who had died of cancer and of control individuals who had no cancer. A previous colonoscopy was strongly associated with fewer deaths for left-sided CRC (OR 0.33), but not for right-sided cancer (OR 0.99). The difference was attributed to poor detection of lesions in the proximal colon.

Assessment of the risk of malignancy in serrated lesions

Scale of risk. The endoscopic evaluation of the nature of a mucosal lesion can be summarized in a pragmatic classification that applies to serrated as well as to nonserrated lesions and estimates the risk of malignancy. This pragmatic classification supports treatment decisions, which should of course be controlled by the results of histopathology after treatment. There are five categories of risk.

1. *No risk in nondysplastic serrated lesions.* This corresponds to categories 1 and 2 in the Vienna classification



Fig. 6 A sessile serrated lesion (O-IIa) . Left: standard vision; the lesion in the transverse colon is larger than 10 mm, with multiple nodules, corresponding to an adenomatous transformation. Right: chromoscopy with indigo carmine enhancing the nodular surface.

of neoplasia in the gastrointestinal mucosa and applies to small hyperplastic polyps less than 10 mm, located in the distal colon and with a type II pit pattern at magnifying endoscopy. At lower magnification with high-resolution endoscopes, the pit pattern appears as small dots evenly distributed throughout the lesion. No endoscopic treatment is necessary; biopsy and decision of local surveillance is optional.

2. Low risk in nondysplastic serrated lesions. Some potential for progression to carcinoma may exist in large hyperplastic polyps > 10 mm, proximally located hyperplastic polyps, and in SSLs usually presenting a type II pit pattern. Endoscopic resection with histopathologic validation of the resected specimen is recommended.

3. Low risk in dysplastic serrated or nonserrated lesions. This corresponds to categories 3 and 4-1 to 4-4 of the Vienna classification and concerns adenomas classified as low-grade intraepithelial neoplasia (IEN), adenomas with noninvasive high-grade IEN, and also well-differentiated intramucosal carcinoma with low-grade cell atypia. These lesions at endoscopy frequently present pit patterns type III-L and IV. The risk for lymph-node

metastasis is low and endoscopic resection is recommended, as well as surveillance after treatment (advanced adenoma protocol).

4. Intermediate risk in dysplastic serrated or nonserrated lesions. This corresponds to category 4-4 in the Vienna classification and to category 5; it concerns differentiated intramucosal carcinoma with high-grade cellular atypia, poorly differentiated intramucosal carcinoma with signet ring cells, and differentiated submucosal carcinoma with low histological grade and a depth of invasion in the submucosa < 1000 μ m. The majority of these lesions at endoscopy present a type V_I (irregular) pit pattern at magnifying endoscopy. The optional decision between endoscopic resection and surgical treatment can be revised after pathologic examination.

5. High risk in neoplastic serrated or nonserrated lesions. A high risk of progression corresponds to poorly differentiated carcinoma with invasion of the submucosa, and to well-differentiated submucosal carcinoma with high-grade histology or invasion over 1000 μ m. The majority of these lesions present a type V_N (nonstructured) pit pattern

at magnifying endoscopy. There is a high risk for lymph-node metastasis. Surgical treatment is required.

Surveillance strategy in the serrated pathway

In current practice in the United States and other Western countries, hyperplastic polyps are usually removed when encountered at colonoscopy. It is probably unnecessary to attempt to remove every small hyperplastic polyp found in the distal sigmoid and rectum. Proximally located serrated polyps, even those with endoscopic features reported to be highly predictive of hyperplastic histology, should be completely removed if possible, since they are likely to represent SSLs and the probability of a finding of dysplasia in such lesions, according to a study by Rex et al. [12], is approximately 4%. East et al. [13] urge the colonoscopist to weigh up the risks and benefits of immediate polypectomy of large flat lesions, especially in the thin-walled proximal colon, against observation with biopsy to confirm SSL and/or allow resection at a later date.

Surveillance of patients following removal of SSLs is warranted, especially if there are additional risk factors such as large size and multiple additional serrated or other polyps, or if there is a family history of colorectal carcinoma

or features that suggest hyperplastic polyposis syndrome. The time frame for progression of SSL to dysplasia and ultimately to carcinoma is not known and the appropriate frequency of surveillance colonoscopy has not been evaluated, but guidelines similar to those that apply to conventional adenomas may be appropriate. Assuming a prevalence of 10% of SSL in the U.S. population over 50 years, the risk of CRC development can be calculated on the basis of estimates of the annual incidence

of serrated carcinomas (15% of the total incidence) and the number of patients in the population over 50. This calculation yields a risk of cancer by year in individuals harboring any SSL as 0.25%/year—a value very similar to the estimate of the risk for CRC developing in an individual with any conventional adenoma, as calculated by Eide in 1986 using autopsy prevalence rates and the known CRC incidence [14]. For the purposes of a surveillance strategy, it may therefore be reasonable to assign

a single SSA without dysplasia the status of a small tubular adenoma and to regard the more advanced dysplastic serrated polyps as the equivalent of advanced adenomas. Finally, the mean age of SSL patients appears to be approximately 20 years lower than that of patients with incident MSI carcinomas. This suggests that the time frame for progression and the window of opportunity for intervention in the serrated pathway may be as long as, or longer than, that in the conventional APC adenoma–carcinoma sequence.

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IBD guidelines—an interview with the editors of *Inflammatory Bowel Diseases*

The World Gastroenterology Organization (WGO) is proud to have had its recent Guideline on inflammatory bowel disease (IBD) published in the world's leading journal on the condition, *Inflammatory Bowel Diseases* (published by Wiley, www3.interscience.wiley.com/journal/113307010/home). IBD is to be the focus of World Digestive Health Day (WDHD) in 2010. We are pleased that the WGO's focus on "resource-sensitive" solutions in the management

of IBD has been so enthusiastically received by the journal's editors, Dr. Richard MacDermott and Dr. Robert Burakoff.

WGN's interview with the editors shows that IBD is a global problem that requires local solutions. While gold standards are important in the ideal situation, there are wide variations both between countries and even within countries, and WGO is proud to have the journal's support for its concept of "cascades"—resource-

sensitive options for diagnosis and management. The guideline was produced by a global team headed by Dr. Charles Bernstein from Canada. Versions are also available in French, Portuguese, Mandarin, Russian and Spanish from the WGO web site (www.worldgastroenterology.org).

The IBD journal version is available for download worldwide through academic institutions and libraries.

WGN: Is a special focus on IBD needed in developing countries? To what extent is IBD a problem in developing countries, and is it growing?

MacDermott and Burakoff:

Ulcerative colitis and Crohn's disease are steadily increasing in incidence and prevalence around the world. In most countries, the incidence and prevalence of IBD are greater in urban, as opposed to rural, areas. A leading potential cause of IBD includes an alteration in intestinal bacteria. This may be due to diet or the use of some medications such as antibiotics. It may also be that IBD is emerging in developing countries because of the adoption of a Western lifestyle.

WGN: Are there ethnic or cultural issues in the global epidemiology of the conditions?

McD & B: The worldwide increase in IBD is occurring among a variety of ethnic groups. Hence, there may be many different genes that predispose to ulcerative colitis and Crohn's disease, but since the gene pool is not changing

Editors of the journal *Inflammatory Bowel Diseases*:



Richard P. MacDermott, MD

The Thomas Ordway Endowed Chair, Division of Gastroenterology, Albany Medical College, Albany, New York, USA



Robert Burakoff, MD, MPH

Clinical Chief, Associate Professor of Medicine, Harvard Medical School; Division of Gastroenterology and Hepatology, Brigham and Women's Hospital, Boston, Massachusetts, USA

as rapidly as IBD is emerging in developing nations, this points to the importance of environmental factors.

WGN: What are the issues and challenges involved in IBD throughout the world—in connection with financial concerns and resources, for example?

McD & B: The diagnosis and treatment of ulcerative colitis and Crohn's disease is particularly challenging if resources are limited. Therefore, the approach to diagnosing and treating IBD needs to be adjusted depending on the resources available and the patient population being evaluated.

WGN: How can the WGO and its guideline on IBD be helpful here?

McD & B: The World Gastroenterology Organisation's "Global Guidelines for the Diagnosis and Management of IBD" are the first IBD guidelines to take account of the available resources and the way in which resource availability affects diagnosis and treatment around the world.

WGN: The IBD guideline is unique in including resource-sensitive options, designed by Dr. Charles Bernstein, which we call "cascades."

McD & B: The cascade options outlined in the WGO's IBD guidelines make it possible to take scarce resources into consideration. Some people may think that resource-sensitive guidelines would be most applicable to countries that have fewer financial resources. However, resource-sensitive guidelines are in fact applicable in all countries around the world due to the increasing costs of health care, which are making budget constraints necessary in health-care systems all over the world.

WGN: Do you think all guidelines should take account of such resource-sensitive management options, or should guidelines simply present the available "gold standard" recommendations?

McD & B: "Gold standard" guidelines are important for the ideal situation. However, there is wide variability within each country, depending on the medical budget available in each individual region or district. Although it is important to be aware of ideal gold standards, the long-term (1–2-year) remission rate obtained with biologic drugs is less than 40%, and not every IBD patient will benefit from more costly biologics. It is in fact appropriate

to use less expensive and equally well-established medications, such as immunomodulators, first. Furthermore, major side effects can occur due to biologics. In the future, therefore, guidelines for the diagnosis and treatment of ulcerative colitis and Crohn's disease in all countries will need to take the availability of resources and the cost of medications into consideration.

WGN: Why did you see your journal, *Inflammatory Bowel Diseases*, as a suitable vehicle for disseminating the world guidelines?

McD & B: The journal *Inflammatory Bowel Diseases* is dedicated to the publication of articles concerning ulcerative colitis and Crohn's disease, with regard to every aspect of IBD patient care, clinical research, and basic research. The journal is available for download worldwide through academic institutions and libraries and has an impact factor of 4.975. *Inflammatory Bowel Diseases* is therefore proud and delighted to have had the opportunity to publish the World Gastroenterology Organisation's global guidelines on the diagnosis and management of IBD.



Interview conducted by
Justus Krabshuis, Highland Data,
Tourtoirac, France

Mentoring for residents

Roque Sáenz

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Introduction: benefits of mentoring, definition

Everyone needs to know where they are and where they are trying to get to—especially on the first rungs of a career in medicine. When we are looking for a way forward, it's often helpful to have guidance from someone more experienced whom we can respect and admire. Just as an average mountaineer couldn't get to the top of K2 without a Sherpa, people starting on medical careers can find it difficult to scale the peaks and fulfil their potential without guidance and assistance from more experienced practitioners. A skilled guide can point you in the right direction, help you avoid obstacles, and point out alternative routes—in a word, can be a mentor. Able and dedicated clinical teachers willing to act as mentors are difficult to find, however.

Teachers, role models, and mentors (Figs. 1, 2)

Teaching staff can sometimes become mentors and role models without realizing it—finding ways of passing on values, attitudes and ways of behaving. But mentors can also take an active role in guiding their colleagues—a role that requires training, time, and mutual trust.

Why should resident physicians need mentoring? The process can make residency periods more rewarding, hospital departments better, and perhaps even the medical specialty

as a whole stronger. The benefits of mentoring for individuals in the short term and for large organizations in the longer term have long been recognized in the business world. In medicine, however, mentoring is typically undervalued and is not associated with any financial reimbursement or academic recognition for the time invested. As a result, it is

aimed at achieving specific career goals for the mentee.

Mentors can be assigned to residents as part of a formal program, but mentoring relationships based on free choice tend to be more satisfactory, with more frequent communication and a greater contribution to the residents' personal growth and career development being reported. A mentor

“The greatest good you can do for another is not just to share your riches but to reveal to him his own.”

— Benjamin Disraeli

becoming increasingly difficult to obtain nowadays. The benefits of the mentoring relationship for mentors themselves may be entirely subjective, with successful mentors being largely motivated by the opportunity to have a positive and substantial effect on another person's life and career.

Mentoring versus teaching

Being a mentor to a resident is different from being a teacher. Teachers' contacts with residents are episodic and focused on imparting medical knowledge. Mentoring involves the development of a personal relationship and mutual understanding, with interactions

can have more than one protégé (or protégée), but generally there should not more than two or three at once due to time constraints. Conversely, mentoring is not an exclusive relationship, and residents can benefit from having several different mentors. Residents' needs vary at different stages of training, and several mentors may therefore be needed.

The three main components of successful mentorship are accessibility, interpersonal chemistry, and expertise.

The resident's point of view

Residents can have a wide variety of different mentoring needs during training. They should choose mentors



Fig. 1 Professors Jerry Wayne and Nib Soehendra—valuable mentors for the author and for many other gastroenterologists all over the world. Recognized for their input as the mentors at the WGO Training Center in Santiago de Chile.

with whom they feel they have the right connection, to whom they have easy access, who are generous with their time and who can provide them with the opportunities they need to succeed in their goals.

As residents progress through their training, their mentoring needs evolve as well. Early on during training, residents need to learn how to succeed in the department they are working in. As residency also coincides with child-rearing years, many can benefit from mentors who are also familiar with balancing career and family needs. Women are under the greatest stress in coping with career and family roles, and many lack adequate role models or mentors who can offer advice on finding the right balance.

Department

At the departmental level, faculty members and residents can discuss their expectations before moving forward and investing



Fig. 2 Mentees Claudio Navarrete and Roque Sáenz (the author), who are now passing on their experience by serving in turn as mentors for the next generation.



Fig. 3 Mentoring in endoscopy.

time in setting up a mentoring relationship and research project. It is the responsibility of mentors to match residents to projects that are appropriate to their needs and abilities. Residents need to be aware that mentorship is available.

However, a number of barriers can arise that prevent residents from seeking mentors:

- Fear of approaching someone
- Feeling there's no one you can trust
- Not having considered seeking out a mentor

Departments should cultivate a mentoring culture in order to minimize these barriers. Mentors need to receive information about what makes for successful mentorship—including respecting confidentiality, focusing on how to identify protégés' needs and how to help them achieve their goals. In successful mentoring relationships, both parties will enjoy the interaction. Protégés should feel that their mentors are genuinely interested and have time for them. Mentors should feel that their advice is being considered thoughtfully and their time respected.

To improve mentoring services in endoscopy residence programs (Fig. 3), departments should consider setting up a separate award for

mentoring. The existence of the award will emphasize the importance of mentoring to the entire department and it also indicates that mentoring is seen as being different from teaching.

Conclusions

Key points for mentees:

- The process should be fun
- Be honest with the mentor
- Follow through on lessons learnt
- Do not become friends with the mentor
- Do not be afraid to ask questions

Tips for mentors:

- Ensure a positive learning environment
- Try to understand the trainee's point of view
- Identify common problems
- Direct the trainee toward learning resources
- Encourage reflections
- Teach by example
- Give frequent feedback
- Seek comments from the trainee

In conclusion, mentoring helps ensure the trainee's future success, and the relationship is an essential aspect of career development. Successful mentoring of residents is crucial, as the entire specialty depends on the way in which today's residents face tomorrow's challenges.

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Unprecedented success in 2009



The WGO celebrates World Digestive Health Day (WDHD) every 29th May, initiating a worldwide public health campaign through its 110 national and regional societies and over 50,000 members. Each year focuses on a particular digestive disorder in order to increase general public awareness of prevention, early diagnosis, and optimal therapy. World Digestive Health Day has grown into an event that is celebrated in every part of the globe.

In 2009, World Digestive Health Day tackled a global problem that reportedly affects the life of millions—irritable bowel syndrome (IBS). WGO recognizes that in spite of all the volumes of research published on the prevalence and impact of IBS worldwide, there is a real unmet need to bring the latest information on IBS to

medical practitioners, other health-care professionals, and the general public. 62 events for World Digestive Health Day were held this year in over 40 countries.

India

India was one of the most active countries taking part in World Digestive Health Day in 2009. In Bhubaneswar (Fig. 1), a community meeting was held on IBS, and educational materials about IBS were published in Hindi and Oriya for the first time. In Kerala, continuing medical training was given at Calicut Medical College. In Nagpur, free consultations were made possible for the local population, and an article about IBS was published in the local newspaper. Finally, in Pune, a local and national media campaign about IBS was launched, leading to an IBS

article being published in the *Times of India*, one of world's largest-circulation English broadsheet newspapers.

USA

The initial meeting of the WGO IBS Task Force Summit, held in Cincinnati, Ohio (Fig. 2), brought together leading IBS experts from around the world to assess the global status of IBS prevalence, impact, and management. To address various aspects of IBS in different parts of the world, the similarities and differences in the presentation and management of IBS between various regions and the development of strategies for diagnosis and treatment were considered as the main objectives for the work of this group of experts. The Task Force findings will be presented at a special



Fig. 1 A community meeting on IBS held in Bhubaneswar, the capital of the state of Orissa on the eastern coast of India.



Fig. 2 The initial meeting of the WGO IBS Task Force Summit in Cincinnati.



www.worldgastroenterology.org

www.wgofoundation.org

satellite symposium at Gastro 2009 in London on 22 November 2009 at 18:00–19:30 at the Excel Conference Centre (N7/8).

Sudan

WDHD was marked in Sudan with eminent local gastroenterologists giving lectures on IBS for medical students, physicians, and gastroenterologists (Fig. 3). A guest lecturer from England, Peter Cartwright, adopted a unique approach to IBS and WDHD by speaking about new perspectives on IBS in war regions.

Argentina

In Argentina, WDHD was observed with unprecedented media impact: public awareness about IBS was increased all around the country through educational materials, and a prominent press conference dedicated to IBS resulted in numerous articles in some of Argentina's largest newspapers (Fig. 4). Altogether, six events were held all around Argentina, and WGO is pleased to announce that the *Sociedad Argentina de Gastroenterología* (SAGE), one of South America's national gastroenterology societies, has also

translated into Spanish the IBS tools that WGO developed for WDHD 2009 in cooperation with Danone.

Pakistan

In Pakistan, WDHD events were held in three parts of the country—Lahore, Karachi, and Peshawar. In Peshawar, a large symposium with lectures and a public awareness session was organized to highlight IBS (Fig. 5). A lively discussion followed lectures by an expert panel, with doctors and the general public alike putting questions about IBS to some of Pakistan's most widely known gastroenterologists. The local media also joined the Pakistan Society of Gastroenterology in marking WDHD, with national and regional newspapers publishing articles about IBS.

Spain

The Spanish Federation of Gastroenterology organized an open day focusing on IBS, held in the Science Park in Granada on World Digestive Health Day 2009 (Fig. 6). During this special event, members of the general public were able to find out more about the condition as IBS specialists



Fig. 3 Eminent local gastroenterologists gave lectures on IBS at a symposium in Khartoum.



Fig. 5 The IBS symposium in Peshawar.



Fig. 4 Argentina: an article published the Bahía Blanca newspaper La Nueva Provincia.

discussed this global problem. The WGO “Global Guideline on Irritable Bowel Syndrome” was also presented to the public for further information.

Slovakia

Thanks to the provision of unrestricted educational funds by Danone to national gastroenterology societies in Europe, South America, and Africa in order to raise awareness about IBS, several events were held all over the world, IBS information was translated into local languages, and press conferences and symposia were held.

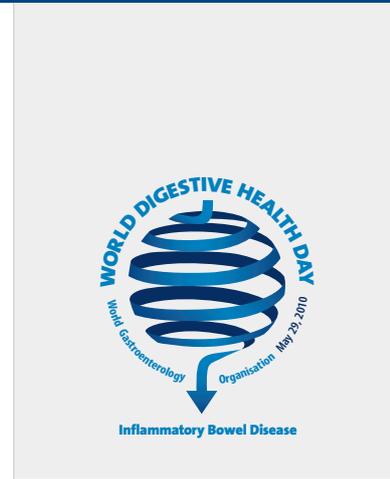
For example in Slovakia, various hospitals were provided with IBS educational materials and information about the condition in Slovak for patients (Fig. 7). The President of the Slovakian Gastroenterology Society also gave a radio interview to inform the public about IBS, and a nationwide public awareness campaign was launched.

Unprecedented success

It is clear that World Digestive Health Day 2009 was an unprecedented success. WGO would like to extend its warmest thanks to all of the national gastroenterology societies and other event organizers who joined us in raising global awareness and informing the general public about IBS. It is the generous and committed work of these volunteers that makes WDHD an event with a truly global impact.

WDHD 2010: inflammatory bowel disease

The next challenge for national societies and industry partners will be World Digestive Health Day 2010—focusing on inflammatory bowel disease. Next year, WGO will be concentrating its efforts on informing the general public and gastroenterologists alike about inflammatory bowel disease (IBD) under the guidance of the WDHD 2010 campaign leader, world-renowned



IBD expert Dr. Charles Bernstein. Throughout the year, the focus will be on issues such as general awareness of IBD, the importance of accurate IBD diagnosis, and assessment and appropriate therapy—critical issues for the millions of people all over the world living with IBD. World Digestive Health Day 2009 amply illustrated the way in which a WGO-led global campaign on digestive health can truly make a difference. Looking ahead to 2010, WGO invites all national societies and other WDHD partners to join us in raising IBD awareness to a new level.

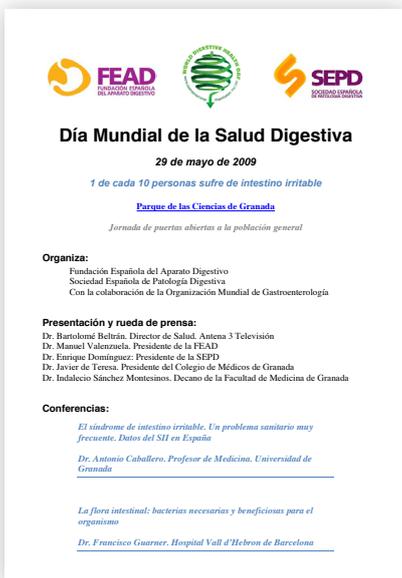


Fig. 6 WDHD event programme from Spain



Fig. 7 Educational material on IBS in Slovak.

Working Party reports: overview and summaries

The Gastro 2009 Working Parties will be presenting their results at the World Congress in London in November, and their reports will later be submitted for publication in peer-reviewed journals. The Working Party concept has been one of the real success stories of previous World Congresses and has resulted in the publication of important documents such as the “Sydney Classification” and “The LA Grading System.” For almost 2 years, the GASTRO 2009 Working Parties have been working on key global issues in gastroenterology. All of the topics have been reviewed and approved by the GASTRO 2009 Scientific Program Committee. We are confident that these reports will have a global and lasting impact on the management of important digestive disorders. An overview of the GASTRO 2009 Working Party reports is presented here.

Endoscopy guidelines for credentialing

Chair: Doug Faigel, USA; *Co-Chair:* Peter Cotton, USA. The London OMED guidelines for credentialing and quality assurance in digestive endoscopy emphasize the importance of both the professionalism of those who carry out endoscopic procedures and the need to consider quality assurance as a continuous process for measuring aspects of endoscopic performance, focusing on the endoscopy unit.

Guidelines for evaluation of new screening tests for colorectal and gastric cancers

Chair: Graeme P. Young, Australia; *Co-Chair:* Jack Mandell, USA; *Gastric Cancer Co-Chair:* Joseph Sung, Hong Kong. The goal of the Working Party has been to develop practical guidelines on how best to compare “new” with proven screening tests in terms of their clinical context, optimal end points, and appropriate study design. As a result, a four-phase approach to new test evaluation is proposed, which will allow efficient evaluation of new screening tests and ensure that their impact on population outcomes, including mortality, can be estimated relative to proven screening tests.

HCV genotypes 4, 5, and 6: the neglected genotypes

Chair: Nabil Antaki, Syria; *Co-Chair:* Patrick Marcelin, France. HCV genotypes 4, 5, and 6 represent 20% of all HCV infection cases worldwide. Their incidence in areas in which genotypes 4, 5 and 6 have traditionally been rare is changing, and as a result of this Working Party’s efforts, the impact of these changes has been evaluated and new recommendations for treatment are provided.

Continued on next page

Postinfective IBS: a global perspective

Chair: Robin Spiller, UK; *Co-Chair:* Paul Enck, Germany. About 10–20% of inflammatory bowel syndrome (IBS) cases are thought to start after a gastrointestinal infection. The Working Party set up a web-based survey for IBS patients to report the mode of onset of their IBS symptoms, which suggests that postinfective IBS accounts for 22% of all IBS cases and occurs throughout the world, with clinical features that are similar to non-postinfective IBS.

The London position statement on biological therapies in IBD treatment

Chair: Jean-Frédéric Colombel, France. Biological therapy is a significant advance in the management of inflammatory bowel disease (IBD), although it is only indicated for patients in whom conventional therapy has failed. This London position statement generates recommendations for when to initiate and when to end biological therapy in patients with IBD, and discusses the choice of drugs, the issue of adverse events, and the prediction of responses. Pregnancy and pediatric IBD are also taken into account.

Recent advances in the pathogenesis of gallbladder cancer and precancer

Chair: Robert Goldin, UK. In order to assess the level of agreement between histopathologists in classifying the preinvasive stages of gallbladder cancer, to describe clearly the individual histological features that contribute to the diagnosis, and then to develop a classification of the preinvasive stages of gallbladder cancer, this Working Party set up an exclusive web site for specialist input. On the basis of these interactive diagnoses and their evaluation, the London classification of preinvasive gallbladder cancer was developed.

Early recognition of Barrett's esophagus-related neoplasia: the BORN project

Chair: Prateek Sharma, USA. The BORN project team has worked closely during the past year and a half on a high-quality teaching tool for endoscopists for the recognition of early Barrett's neoplasia and on examining the ability of expert and nonexpert endoscopists to recognize early lesions.

Guidelines on histological techniques and reporting: the London classification of GI neuromuscular pathology

Chair: Charles Knowles, UK; *Co-Chair:* Roberto de Giorgio, Italy. The Working Party has already produced guidelines on histological techniques and reporting and is developing a contemporary classification of gastrointestinal neuromuscular pathology based on defined histopathological criteria and using the already created guidelines as a platform.

Working Party reports: The Working Parties will be representing their work at GASTRO 2009 at special sessions dedicated to the landmark results of the Working Parties' Research. For further information, please consult the congress website, www.gastro2009.org.

Histology for gastrointestinal neuromuscular pathology:

an interview with the chairs of the GASTRO 2009 Working Party, Charles Knowles and Roberto de Giorgio

WGN: When did your Working Party for the “Guidelines on histological techniques and reporting: the London Classification of GI neuromuscular pathology” start its work? Could you tell us a little about why you wanted to be involved in the Working Party?

Knowles and de Giorgio: The idea originated from informal discussions held at the *Festschrift* meeting for Prof. Peter Milla at the Institute of Child Health in London in March 2006. Prof. Milla and other colleagues had long wished to try and rationalize the practice of histological reporting and disease classification for gastrointestinal neuromuscular conditions. We agreed to try and push the process forward after his retirement. After a failure to formalize the process by other means, we applied for selection as a Gastro 2009 Working Party. Work started in earnest in July 2007 with the recruitment of other members.

The subject area was one for which all of the members recognized that there was an urgent need for standardization. From our own perspective, both of us are often faced with the dilemma of giving opinions on the results of histology to patients without a firm international consensus on the validity and interpretation of such results. The implications of this for the patient are serious.

WGN: Have the Working Party’s guidelines already been published?

K & deG: The detailed guidelines were published in the August edition of *Acta Neuropathologica*. This “opus” spans 31 pages of the paper journal and has 172 accompanying references, numerous figures and tables, as well as several key sets of reporting and referral recommendations to guide the general pathologist. Supplemental material is provided digitally. The full reference is given below [1]. Free reprints of the article will be available at the Working Party meeting on 23 November 2009.

WGN: Will you be developing a classification, and if so, does it have global applicability?

K & deG: We are in the process of developing a contemporary classification of gastrointestinal neuromuscular pathology based on defined histopathological criteria and

using the guidelines as a platform. In recognition of its origins and first presentation in London at the World Congress of Gastroenterology 2009, GASTRO 2009, it has been named the “London Classification.” The classification needs to be seen as a starting-point for future modification as new data become available. It will have global applicability. We anticipate publication of the classification later this year in a major general gastroenterology journal.

WGN: How do the Working Parties help improve patient care?

K & deG: With regard to our own Working Party, we believe that the process facilitated by the WGO will have significant benefits for patient care. The immediate implementation of the guidelines and classification

Interviewees



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should allow diagnostic standardization and provide useful prognostic and therapeutic information. As the classification develops further, it is envisaged that it will provide a firmer base for longer-term collaborative studies, with the development of databases leading to a better understanding of underlying disease mechanisms, developments in diagnostic biomarkers, and perhaps more effective (targeted) therapies.

WGN: What is the next step for your Working Party?

K & deG: The classification offers a provisional “snapshot in time” that uses the best available current evidence and a consensus of expert

opinion. Particularly relevant to future modification is the definition of quantitative normative data for gastrointestinal neuromuscular pathology that are specific for age, gender and region. The Working Party identified this as the area where there is a critical need for future research, as the histopathological phenotypes defined by the guidelines were deliberately kept highly conservative, due to the absence of adequate data to provide quantitative limits of normality in the individual. The Working Party has nevertheless suggested standards that might result in the establishment of normal values that would be applicable in different centers and regions. An international cooperative study group may be developed to pursue this research in

the future. We would like to thank all the members of the Working Party for all their hard work.

REFERENCES

1. Knowles CH, De Giorgio R, Kapur RP, et al. Gastrointestinal neuromuscular pathology: guidelines for histological techniques and reporting on behalf of the Gastro 2009 International Working Group. *Acta Neuropathol* 2009;118:271–301.

Learn more about this Working Party's results at GASTRO 2009:

- Working Party Report: Guidelines on histological techniques and reporting: the London Classification of GI neuromuscular pathology
- Date: Monday, 23 November 2009
- Time: 11:00–12:30
- Venue: Platinum 3/4

WGO highlights at GASTRO 2009

WGO is one of the host societies for GASTRO 2009 and together with United European Gastroenterology Federation (UEGF), the *Organisation Mondiale d'Endoscopie Digestive*/World Organization of Digestive Endoscopy (OMED) and the British Society of Gastroenterology (BSG) we have arranged a landmark meeting that will set the standard for future conferences. During GASTRO 2009, the WGO will be organizing symposia focused on education and training, following up on World Digestive Health Day 2009 with the latest news from the WGO IBS Task Force, and inviting all its members and partners to the WGO booth to meet world-renowned gastroenterology experts and exchange ideas with colleagues.

WGO booth

Find out what WGO can do for you and how you can join us in promoting global digestive health. As a world organization for gastroenterologists, we are delighted to be able to offer GASTRO 2009 attendees the chance to meet some of the leadership of both WGO and the WGO Foundation. During GASTRO 2009 exhibition days we are pleased to invite you to stop by the WGO booth and exchange ideas with our most prominent professionals. The WGO booth will be open on 20–25 November 2009 and the WGO leaders will be available on 23–25 November 2009.

The WGO expert on detailed medical literature searches, Justus Krabshuis, will also be available for questions and comments at the WGO booth during the exhibition hours.

WGO Symposia—the latest developments in gastroenterology WGO IBS Task Force symposium.

New horizons in irritable bowel syndrome: developments in pathogenesis and a report from the WGO IBS Task Force. Irritable bowel syndrome (IBS) has long been recognized as a common and often very bothersome problem in North

America and western Europe, which in severely affected individuals can have a significant impact on work, family, and personal life. Management of the condition has traditionally posed challenges, related in part to a failure to understand its cause(s). Two recent developments require a more global approach to IBS: firstly, the recognition that IBS is common almost everywhere, but that there may be differences in its demographics and symptomatology in different parts of the world; and secondly, research that indicates potential roles for the gut flora and the host immune response in the pathophysiology of IBS. We all have much to learn from experience with IBS in different parts of the world. This is the essence of the WGO Global Task Force on IBS—to obtain a truly global picture of IBS, to appreciate similarities and differences in the presentation and management of IBS between various regions, and to develop strategies for diagnosis and treatment that are mindful of these issues.

WGO welcomes you to discover the findings of the WGO IBS Task Force at this special satellite symposium chaired by Professor Eamonn Quigley, the WDHD 2009 Campaign Leader



and WGO President. *Chair:* Eamonn Quigley, Ireland. Sunday 22 November 2009, 18:00–19:30, N7/8.

Global education for gastroenterologists.

As the global guardian of digestive health, WGO regards global training and education as part of its mission. This symposium offers an insight into the global impact of WGO's core educational initiatives: the Train-the-Trainers workshops and WGO Training Centers. *Chair:* Eamonn Quigley, Ireland. Monday 23 November 2009, 15:45–17:15, N11/12.

WGO Brohée Medal and Lecture:

Acid secretion in the developed world: now too much of a good thing? During every World Congress of Gastroenterology, WGO devotes two plenary lectures that are named after two of WGO's founding fathers, Georges Brohée and Henry Bockus, to the discussion of some of the latest and "hottest" topics in the field of gastroenterology. *WGO Speaker:* Kenneth McColl, United Kingdom. Tuesday 24 November 2009, 08:30–09:00, S4/5.

WGO Henry L. Bockus Medal and Lecture:

Science, society and the gastroenterologist: the influence of politics, pharma and professors. *WGO Speaker:* Richard Hunt, Canada. Tuesday 24 November 2009, 14:00–15:30, N9/10.

UEGF/IDCA/ESDO/IARC:

European Guidelines for quality assurance in colorectal cancer screening – network meeting and UEGF workshop. *Organising committee:* C. O'Morain, M. Classen, S. Madai, J. Patnick, N. Segnan, L. Faulds Wood, L. von Karsa. Saturday 21 November 2009, 08–18:00, SG 26/26

WGO Training Centers: Enhancing education in the developing world through global collaboration

Dr. Des Leddin and Ms. Heather Wynn

The WGO Training Centers play a pivotal role in the delivery of gastroenterology care around the globe through direct patient care, honing the skills of established experts, and training the next generation of caregivers in areas where training in gastroenterology is not readily available.

The needs of the centers, and potentially the number of centers, are growing. While these centers benefit from many experts who donate their time voluntarily, there are costs

related to travel and accommodation, the provision of equipment and accessories, and to the development of effective communication between centers in order to enhance best practices and gain from each other's experiences.

The WGO cannot meet these needs on its own. However, the WGO is in the unique position of being able to provide a global framework to facilitate links between training centers and gastroenterology societies, to help coordinate the educational efforts at each center and between centers, and to provide direct teaching and technical support.

Training Center partnership agreement

An important part of this global framework is now complete. The WGO has developed a template agreement that defines the relationships between training centers, the WGO, and potential national society sponsors of the training centers. Under the terms of this agreement, each party is aware of its own roles and responsibilities. The challenge now is to encourage more national societies to lend their support to the training centers. This is already well under way. Societies from every region have shown enthusiasm, and we are confident that progress will accelerate with the new structure in place.

Telemedicine Network

With the invaluable assistance of Professor Shuji Shimizu, the WGO Training Centers are being linked electronically through the Academic Network for Research and Education. As the Training Centers are connected, they will have an opportunity to participate remotely in courses offered by the other centers, extending the reach of these courses and allowing real-time communication between the centers.

The network was presented to the



Ian Roberts-Thompson, Daniel Worthley and Tony Clark
with the donation shipment

Centers during DDW 2009 and met with unanimous enthusiasm. The first live broadcast between centers took place in October between the Mexico City Training Center, the Ribeirão Preto Training Center in Brazil, and the Seattle Science Foundation in the USA. The WGO hopes to use this network in the partnership program as well, allowing remote broadcasting of training courses from abroad into the Training Centers and enhancing the curriculum for WGO trainees through the ability to communicate with international experts.

Outreach program

In an effort to bring much-needed equipment to both WGO Training Centers and the home institutions of WGO trainees in areas of need, the WGO Outreach Committee has been established in order to solicit industry donations. The WGO would like to offer special thanks to Fujinon, Inc., for its generous donation to the WGO Suva Training Center in Fiji. Before the donation, the center in Fiji had only two gastroscopes, both more than 10 years old, and two serviceable colonoscopes. Thanks to Fujinon's donation, the WGO Suva Training Center is now better equipped to train gastroenterologists in the South Pacific region, where gastroenterology training had previously been unavailable, and to offer endoscopic services to a local population of nearly one million.

The equipment was received and



Units from the donated Fujinon equipment

installed immediately before the start of the Training Center's annual gastroenterology course, organized in collaboration with volunteers from the Gastroenterological Society of Australia (GESA) to the benefit of both trainers and trainees. The new endoscopy unit was inaugurated during the course, and the benefits of the donation are already being seen in the center.

Fujinon's generosity is also continuing—a donation to the WGO Ribeirão Preto Training Center in Brazil is currently underway. The WGO would like to express its thanks and recognition to Kurt Cannon,

Vice-President of Operations of the Endoscopy Division at Fujinon, for his pivotal role in bringing these donations to fruition.

Join the WGO in supporting the Training Centers

We welcome all those interested in assisting the WGO in supporting the Training Centers—e.g., from industry partners who wish to donate equipment to gastroenterology societies that want to become involved in centers' training programs. Please contact the WGO Executive Secretariat for further details.



A Message from the WGO Foundation



The WGO Foundation has been hard at work in 2009 trying to raise funds to support WGO's Training and Education programs and to ensure equal access to digestive health care.

WDHD 2009

The theme for World Digestive Health Day (WDHD) 2009 was irritable bowel syndrome (IBS). The condition reportedly affects millions of individuals (around one in 10) throughout the world and it has a significant influence on quality of life both in reported cases and in the unreported ones (around five in 10). There is an unmet need to bring the latest information on IBS to medical practitioners, other health-care workers, and the general public. The WGO Foundation was able to partner with industry sponsors such as Danone, Procter and Gamble Healthcare, and Boehringer-Ingelheim to focus attention on IBS. Many educational tools on IBS were developed for WDHD 2009, including a digestive health test, edu-lessons, and 10 tips for living with IBS. Further details are given on the Foundation's web site (www.wgofoundation.org).

WDHD 2010

For WDHD 2010, WGO has chosen to focus on inflammatory bowel disease (IBD). IBD represents a group of idiopathic chronic inflammatory intestinal conditions, the two main disease categories being Crohn's disease and ulcerative colitis.

Epidemiologic research is showing that IBD is having an increasing global impact. The WGO is honored to have Dr. Charles N. Bernstein of the University of Manitoba leading the WDHD campaign on IBD.

For WDHD 2010, the WGO Foundation is concentrating on developing relationships with a variety of sponsors, including Danone and Procter and Gamble, aiming to produce further educational tools and achieve increased awareness among both the medical community and the general public. We hope these and other similar initiatives will continue to enhance our collaborative relationships with nutrition companies and the pharmaceutical industry.

Fundraising initiatives

The WGO Foundation engaged CCS, an international professional fundraising group to conduct a feasibility study on the prospects for a major global fund-raising campaign. Over 75 individuals, including international leaders in gastroenterology, representatives from the instrument and pharmaceutical industries, and World Gastroenterology Foundation leaders were interviewed to ascertain their opinions concerning the Foundation and the feasibility of a campaign. Based on the results of the feasibility study, a fund-raising campaign will begin in January 2010. The success of this effort will depend heavily on the efforts of WGO

members worldwide.

The WGO Foundation is also proud to announce the Masters of the WGO Fundraising Campaign, described below by Richard Fedorak.

In these lean economic times, it is a challenge to raise the funds needed to support WGO's essential training and education programs focused on developing and low-resource countries. We are working diligently to support these programs, which have come to mean so much to doctors and their patients. Digestive disorders—from diarrhea to obesity to cancer—are ranked by the World Health Organization among the 10 leading causes of mortality, and gastrointestinal and liver malignancies are the single greatest cause of cancer mortality. Unfortunately, however, these common disorders rank disproportionately low in both public awareness and health-care priority in many countries.



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The Masters of the World Gastroenterology Organisation



Richard Fedorak, MD

Director, Division of Gastroenterology,
University of Alberta, Canada
E-mail: richard.fedorak@ualberta.ca

As part of the award, the WGO will create a WGO Training Center Fellowship or Studentship at a designated WGO Training Center, which will be permanently endowed in the Master's name. Each individual Master's fellowship or studentship will offer promising up-and-coming gastroenterologists from developing countries support in attending the designated WGO Training Center and furthering their education and training in digestive disease. The fellowship or studentship will be uniquely directed toward supporting those talented individuals who are committed to improving care for patients with digestive disorders in their home country. Their training at the WGO Training Center will be specifically designed to give them optimal preparation for this.

The Masters of the World Gastroenterology Organisation award is the highest honor the WGO can bestow, and the legacy of a dedicated Fellowship or Studentship will establish this honor for generations of gastroenterologists in the future. We will be honoring the 2009 Masters of

the World Gastroenterology Organisation during Gastro 2009 at the WGO General Assembly on 24 November 2009 at the Convention Centre in London. The 2009 Masters of the World Gastroenterology Organisation are:

Luiz P. de Paula Castro, MD

Suliman Fedail, MD

Joseph E. Geenen, MD

Solly Marks, MD

Melvin Schapiro, MD

Issy Segal, MD

Ziad Sharaiha, MD

Shu-Dong Xiao, MD

Rakesh Tandon, MD

Guido N. J. Tytgat, MD