You will all have caught those fragments of conversation wafting around wherever gastroenterologists gather that the BSG is really only a London Club, a Midlands Mafia or even a Coventry Cabal with no clear structure or strategy.

Review of the BSG archive challenges these views. A 10 year strategic plan for the BSG was created by Professor Ian Bouchier in 1995. This review prompted the creation of the Clinical Services and Standards and the Training Committees.

The 10 year strategy was revisited by Professor Leslie Turnberg and his colleagues in 1999 (four years later!). Extensive discussion was synthesised into a mission statement for the Society (current handbook page 12)

The key features are:

- to support the discovery of new knowledge, leading to prevention, treatment and cure of digestive diseases
- to promote high quality patient care by defining best clinical practice
- to ensure high quality training in gastroenterology
- to lead in the provision of continuing professional development for gastroenterologists and
- to develop an advocacy role for digestive health and for gastroenterology.

Other developments included the separation of the education and programme committee and the creation of the research committee. Improved links were forged between BSG and the DDF and between BSG and BASL. In addition an executive committee was established to consider BSG strategy including a formal annual strategy meeting.

Recent developments include the initiative of Professor Tony Axon to create the Digestive Cancer Appeal and Professor Derek Jewell in his support and promotion of research.

The links between the Society and the Royal College of Physicians have also been enhanced with a joint specialist committee of the BSG and the College for Gastroenterology and Hepatology. The College and the Society are now jointly reviewing the future delivery of GI services in the light of the likely concentration of acute medical and cancer services in larger hospitals.

The Society can only thrive with your support. How can you help? For those in training join and contribute to TIGS; a vigorous constructive forward looking group. For recently appointed consultants establishing a first class clinical service this has to be a priority, together with the development of research and education programmes. Publications from an active unit will readily be recognised through invitations to speak at local, regional and national society meetings. Endoscopic skills can be put to good use in developing Local and National Education and Training Centres. In addition, join a BSG section which particularly interests you, make a positive contribution and offer to act as secretary or chairman when the opportunity arises. Once established, stand for Council, offer your services as BSG secretary or chairman of one of the major committees.

The Society is only as active as its members’ contributions.

BSG Meeting: March 2003

Abstracts must be submitted electronically only on www.bsgabstract.org.uk

Case presentations must be submitted via email on Confrex@easynet.co.uk

Deadlines for both are 5 November 2002.
Hyperplastic polyposis: have you seen a case?

- Hyperplastic polyposis is relatively rare but under-diagnosed condition which is probably associated with an increased risk of colorectal cancer.
- We have ethical approval to examine the natural history and genetics of hyperplastic polyposis and have already collected 29 cases.
- Hyperplastic polyposis is defined by the WHO as ≥30 hyperplastic polyps (HP) throughout the colon or 5 HPs (two ≥1 cm) proximal to the sigmoid colon
- If you know of a case with multiple hyperplastic polyps, probably detected at colonoscopy, and think that the individual would be willing to help with research please kindly write to me at the following address:
  Dr Wendy Atkin, Colorectal Cancer Unit, Cancer Research UK, St Mark’s Hospital, Northwick Park, Harrow, HA1 3UJ. Tel: 0208 235 4279, fax: 0208 235 4277, wendy.atkin@cancer.org.uk

Guidelines database

The CEEU at the Royal College of Physicians have established a Clinical Effectiveness Forum in conjunction with the specialist societies and have compiled a central database of clinical guidelines, produced over the past 5 years, covering all areas of clinical practice that come under the RCP umbrella.

Please refer to Clinical Practice on the BSG website: www.bsg.org.uk to access the database.

Appointments

Dr YS Ang
Leigh Infirmary
Dr S Lewis
Derriford Hospital
Dr J Martin
Charing Cross Hospital
Dr P Mullins
East Surrey Hospital
Dr R Ransford
County Hospital Lincoln
Dr A Safe
Northern General Hospital
Dr D Sanders
Royal Hallamshire Hospital
Dr C Sheen
St Mary’s Hospital
Dr J Simmons
Royal Berkshire Hospital
Dr S Singhal
Sandwell District Hospital
Dr S Whalley
West Suffolk Hospital

Events

Email: espen@mci-group.com

4-6 September 2002.
3 day course for hepatology specialist registrars in training. University College London. Details from Natalie Day.Tel: 020 7679 6510, fax: 020 7380 0405, email: n.day@ucl.ac.uk

11/12 September 2002. BASL Meeting - University of Newcastle upon Tyne.
Details: Mrs J Carter. Tel: 0191 222 5640, fax: 0191 222 0723, email: j.a.carter@ncl.ac.uk


2-4 December 2002. 13th Annual Course in Paediatric Gastroenterology, Royal Free Hospital London. (CME approved) Details: Dr S Murch. Tel: (0044) 207 830 2779, fax: (0044) 207 830 2146, email: smurch@rfc.ucl.ac.uk web: www.royalfreepaedgastro.com

4-6 December 2002. 5th Masterclass in Modern Paediatric Endoscopy, Royal Free Hospital London. (CME approved) Details: Dr M Thomson. Tel: (0044) 207 830 2779, fax: (0044) 207 830 2146, email: m.thomson@rfc.ucl.ac.uk web: www.royalfreepaedgastro.com


Guidelines for the Management of Dyspepsia

A revised version of Guidelines for the Management of Dyspepsia are currently available on the BSG web site – www.bsg.org.uk (under Clinical Practice). These should be downloaded as hard copies are not held in the BSG Office.
The Department of Health are evaluating the feasibility of introducing a national population screening programme of asymptomatic individuals for colorectal cancer. The scheme is being evaluated in two pilot sites, one around Coventry & Warwickshire and the other in North East Scotland. The screening programme is based on FOB testing, leading to colonoscopy. The BSG has representation on the screening pilot steering group. Screening started in September 2000, for 2 years in the first instance, and an additional 6 month extension has just been granted. Therefore, a report should be available in February 2003. Two activities of the BSG may help direct progress from here. Firstly, I can report that the BSG has now received a full draft report of the National Colonoscopy Audit and hopefully will be published after peer review before too long. Clearly caecal intubation rates, complications and mortality will be critical data if the pilot is to be rolled out nationally. However, if the generally accepted mortality rate for colonoscopy is 1-3 per 10,000 (National Polyp Study USA) then potentially 5 patients may die every year as a result of national colorectal cancer screening.

Secondly, the BSG guidelines for colorectal cancer screening will be published this year and will be helpful to the Department of Health in deciding the way forward for national colorectal cancer screening. Data are eagerly awaited and over the next 12 months we should see evidence based BSG guidelines on colorectal cancer screening, the feasibility of a National Colorectal Cancer Screening programme and have published colonoscopy audit data.

Colorectal cancer screening will add an extra burden to colonoscopy services. In the pilot sites, screening has been funded in terms of extra endoscopy lists. However, some of the work that colonoscopy screening generates, e.g. polyp surveillance following screening colonoscopy, has not been funded and this needs to be addressed. Money is just one aspect of resource, another being skilled endoscopists. Alistair McIntyre, BSG Manpower co-ordinator, has been working with Rodney Burnham in the RCP Manpower Office to push for an expansion of NTNs in medical specialties as a whole and in particular for gastroenterology. A case has been made for expansion of some 50 NTNs in gastroenterology and an additional 14 in hepatology. Whilst the principle of expansion is accepted funding seems to be a problem. Furthermore, expansion in gastroenterology has been considered quite healthy and psychiatry, histopathology and radiology are considered a higher priority. All is not lost, however, the principle of the expansion of gastroenterology NTN posts is accepted if funding can be sought.

Duncan Loft

**Are you meritorious?**

**Discretionary Points**
Consultants at the top of the pay scale are eligible for points or additional points up to a maximum of 8. Eligible consultants should be considered annually by their local discretionary points committee. Individuals who feel they may have been overlooked should contact the chairman of their local discretionary points committee and obtain a CV questionnaire which should be completed and returned to the chairman with a request for a review.

**Higher Awards**
Higher awards (B and A) are competitive so that a B award under the age of 43 years is extremely unusual and an A award under 46 years of age is exceptional. While not essential nearly all eligible individuals already hold at least some discretionary points.

Each Trust has a local mechanism for making recommendations to the Regional Awards Committee (RAC) and in its turn the RAC makes its recommendations to the Central Committee.

Any individual who feels they have been overlooked should write to the chairman of their Trust Higher Awards Committee or the chairman of the RAC and obtain a CV questionnaire which should be completed and returned with a request for a review.

The Royal Colleges and the Specialist Societies among others also submit recommendations to the Central Committee. The BSG will write to all eligible members of the Society this autumn asking them to complete and return a current (year 2003) questionnaire which will be available on the Department of Health website.

Major changes are mooted within the new contract, but the current system is likely to remain in place for a further year. See Department of Health website at [http://www.doh.gov.uk/nhsexec/acda.htm](http://www.doh.gov.uk/nhsexec/acda.htm) for further information.
European Union of Medical Specialties (EUMS) & European Board of Gastroenterology (EBG)

Formed in 1958 the EUMS’ purpose was to be an organisation that could represent medical specialists. Out of this, the EBG was established in 1992 to represent ‘academic’ gastroenterology. In particular it was to define requirements for postgraduate training and ensure the quality of training establishments. Other areas of responsibility included workforce information, CPD and exchange visits between countries.

Although the section board has a more ‘political’ purpose and the board a more ‘academic’ emphasis, in practice both consist of the same people and neither section nor board have powers of compulsion. The aim is to lobby, persuade and encourage each country to pursue high standards of harmonisation within every member state. However, with the enlargement of the EU, its importance and that of the diploma it issues, may grow.

The Diploma of the EBG can be awarded 2 years after national accreditation. Individuals can receive this provided they have satisfied the regulations (http://www.uems.be) and may use the title ‘Fellow of the European Board of Gastroenterology’. Training institutions recognised by the board after inspection can be designated a European training centre in Gastroenterology.

Until 31 December 2005, gastroenterologists who began specialty training before 1 January 1994 and are actively practising, can have their training recognised (retrospective certificate). Candidates who began training after 1 January 1994 must either be trained in an EBG accredited training centre and/or have been trained fully according to the requirements - which includes ultrasound training. From 1 January 2006, all candidates must have been trained in accredited centres, have their training evaluated prospectively and comply fully with European training requirements. The details of these requirements are therefore a matter of great importance. There is a very strong case for the UK to include ultrasound training in its curricula, although not necessarily to the detailed level recommended by the Royal College of Radiologists1. This would strengthen our position in ensuring that training in other European countries Europe is of a high standard.

WR Burnham
(President; European Board of Gastroenterology)

Reference

Oesophageal section news

The Section Committee is concerned about the management of oesophageal cancer, particularly the recent guidelines for the management of gastro-oesophageal cancer. Whereas nobody would promote that oesophagectomy should be carried out on an occasional basis by a surgeon who rarely performs this operation, concern has been raised by the suggestion of the guidelines that oesophagectomy should be restricted to centers defined by their population rather than the skill and case mix of their surgeon. This is difficult as there is no appropriate evidence demonstrating that this strategy results in improved outcomes. If upper GI cancer surgery is to be restricted to geographically-defined centers, with the removal of upper GI cancer surgery from smaller centers with good outcomes, there will major implications for the delivery of all upper GI surgery in some areas. Hopefully this issue will be resolved satisfactorily.

The guidelines for the Management of Oesophageal Structures are currently in the hands of the Clinical Services and Standards Committee.

This year’s Autumn Symposium takes place on November 20th at the Royal College of Physicians. This is a joint venture with the Radiology and Pathology sections. The main topics to be discussed are the relationship between reflux disease and oesophageal cancer, the diagnosis of Barrett’s Oesophagus, oesophageal imaging and oesophageal motility.

Finally the UK Barrett’s Oesophagus registry continues to grow. There are now over 8,000 registrations to what is an extremely important database for the study of Barrett’s oesophagus. Any members who are interested but have not yet registered patients are encouraged to do so.

Chairman: Mr Bill Owen; Secretary: Dr Alan Ireland

BAPEN NEWS

We are saddened by the premature death of Chris Pennington, distinguished gastroenterologist and specialist in the field of nutrition. Chris was Chairman of BAPEN.

However, we are pleased to announce that Dr Alastair Forbes, Consultant Physician and Reader in Gastroenterology at St Mark’s Hospital, Harrow, and Secretary to the BSG 1996-2001 will be taking over as Chairman of BAPEN with immediate effect.

Log on to www.bapen.org.uk for further information on BAPEN.
Endoscopy Manpower Issues – a successful away day

My first newsletter set out a two year strategy for the endoscopy section which was broadly based upon manpower issues. The Endoscopy committee had an away day in Birmingham (with a forced interlude related to an important football game) and brainstormed the agenda. As you might expect from knowing the lively and disparate personalities involved, many issues were discussed and I think we have defined a way ahead. We intend to produce a paper looking at the manpower necessary for provision of an endoscopy service; who should do the work, how to manage the waiting list, what is a reasonable endoscopy workload, what are the implications of training etc. This is clearly opportune as we negotiate our new consultant contracts. A guideline will also be produced concerning urgent endoscopy, giving advice as to how to cope with the two week cancer rule and what is essential to run an emergency endoscopy service; perhaps we need to learn the lessons of our general surgical colleagues and develop endoscopy CEPOD lists for example.

An update of the Nurse Endoscopist guideline is being developed in conjunction with the Association of Coloproctology of GB and Ireland and the Association of Upper Gastrointestinal Surgeons. We had much discussion about ‘narrowing the gateway’ to ensure that only patients who have appropriate indications actually get endoscopy. We await NICE and SIGN guidelines devoted to the investigation of dyspepsia and would like to review these and ASGE guidelines before deciding how to progress.

The away day also confirmed that we would like to cement our close relationship with JAG and we are very pleased that Tony Morris has agreed to be co-opted onto our committee. Currently a series of courses devoted to basic and advanced endoscopic techniques and courses for training the trainers are being arranged by JAG - I can vouch first hand for their quality - interested parties should visit the JAG website.

I was fortunate to be nominated by the BSG to participate in the Young Clinicians Award Programme at the World Congress in Bangkok. This Congress-sponsored initiative is aimed at getting young international gastroenterologists together to foster new, mutually beneficial educational, research and professional relationships.

The Program included a whole-day workshop on evidence-based medicine and how to use clinical practice guidelines. I was able to learn from fellow delegates about many and varied topics. Those include: electrogastrography in functional dyspepsia in Chile, gastric-emptying in Belarus, health economic analysis of MRCP imaging in Canada, that less than 10% of PEGs are inserted for neurological dysphagia in Hungary, that HFE mutations are an uncommon cause of haemochromatosis in South America and that even in large US centres with 5 MRI scanners it can still take 3 days to get an MRCP done.

This was an extremely worthwhile experience, which I hope will be replicated by other major international meetings. I would like to thank the BSG and World Congress sponsors for the opportunity.

Ian LP Beales
Dr Nelson Coghill (1912–2002)

President 1969–70 (q Cambridge & Westminster 1937)

Nelson pioneered gastroenterology as a specialty in the DGH. With the advent of fibreoptic endoscopy he was quick to introduce this to West Middlesex, and established a purpose-built endoscopy unit there in 1967.

Nelson had a passionate belief in the newly established NHS and combined his clinical work with being physician to the nurses for his first 25 years. He also supervised the Infectious Diseases Unit at nearby South Middlesex Hospital.

His main research was gastric inflammation and he attracted research fellows from around the world. He studied physiological adaptation following colectomy and ileostomy and ran clinics for ileostomists. Another research area was the local epidemiology of acute viral hepatitis. He audited clinical outcomes years before such activity became commonplace.

Nelson Coghill believed that doctors should involve themselves in management. In his late eighties, with his brain as sharp as ever, he was still writing on medical management issues.

Dr Stephen Kane (West Middlesex University Hospital)

Dr Sidney Truelove (1913–2002)

President 1974–5; Founding president of the British Society for Digestive Endoscopy; (q. King’s 1938)

On April 19th 2002, we lost one of the ‘greats’ of British gastroenterology – Dr Sidney Truelove. Educated at Cambridge and at King’s College hospital he subsequently volunteered for the RAMC. While in Italy, he studied the epidemiology and control of infectious hepatitis in the troops. Returning to the War Office, he worked with the medical statistician, Lancelot Hogben, an experience which was fundamental to his subsequent interest in clinical trials and data analysis. His contributions to gastroenterology have been profound - the first to use a fibre-optic endoscope in the UK, the first major audit of upper gastro-intestinal bleeding (with Klaus Schiller and others), studies in coeliac disease, and above all his studies in inflammatory bowel disease. Describing the natural history of ulcerative colitis, the controlled trial of cortisone for active colitis, and the identification of 5-aminosalicylic acid as the active ingredient of sulphasalazine stand out as historical landmarks.

However, apart from these many achievements, he will always be remembered as a teacher of distinction, a stimulating and provoking intellectual, and an unconventional individual with great humanity. His ability to bring out the best in his trainees, even when their command of English was limited, is legendary and he had the same devotion and respect for his patients. He was at his best gathered with a just a few of us sleepy lesser mortals in the middle of the night when, interspersed with cigarettes and whisky, ideas would be developed with great logic and clarity. He will be greatly missed but for those fortunate enough to have been pupils, that experience will never be forgotten and the same approach to solving clinical problems will persist.

Professor Derek Jewell