That was the year that was

As I write, it is hard to believe that this is the last Newsletter to which I will contribute. The year has passed with alarming speed. No, a year is not long enough to be President, but perhaps no time would be long enough to achieve all one might wish.

I believe this has been a good year. The Society goes from strength to strength, membership increasing, attendance at annual meetings reaching record levels.

By Michael Hellier
President BSG

Highlights of 2004
What have been the highlights of the year? An outstanding September Scientific meeting in Oxford hosted by Simon Travis and Derek Jewell symbolised closer ties with the AGA and a formula for the future. The BSG spread its wings into Europe with a successful Joint meeting with the Romanian Society of Gastroenterology masterminded by Maggie Bassendine, next year the Czech Republic.

Auditing what we do is so important at a time when the profession is under such critical scrutiny. This has been an outstanding year in this respect with the ERCP Audit, funded by the BSG, led by Martin Lombard almost completed and on time. We have launched and jointly funded the co-operative BSG/National Blood Transfusion Service GI Bleeding Audit. We have just received the remarkable news of independent funding to the tune of £500,000 to start a truly national IBD audit which will involve all members of the Society and all Trusts. This is thanks to the initiative and drive of Jonathan Rhodes and his team.

We have established two new key groups within the Society, the Strategy group and the Public Relations/Communications group. These are up and running and I believe will be of fundamental importance to the future of the Society.

Challenges for 2005
And what are the challenges for 2005? Undoubtedly the completion and launch of the Society’s document “Strategy for the Next Millennium” is the major task which the Society must put at the top of its list and upon which it must focus its energies. Great progress has been made during the year and a huge amount of energy expended in pushing it forward. It is a monumental task!

The plenary session Spring meeting 2005, Birmingham
May I take this opportunity of flagging up this plenary session which I think will be very special. This will be a star-studded event with Peter Cotton, who has contributed so much to the Society and to World Gastroenterology, giving the Sir Arthur Hurst lecture and Professor Carol Black PRCP who is forging valuable new links between the College and the Specialist Societies, giving the New Perspectives lecture.

The launch will also take place of the Strategy document and the first half of the AGM which follows the plenary session will be given over to an open forum to which all are invited to discuss the document.

The future
The future is promising. We must use the Strategy document to promote and raise the profile of British Gastroenterology. Our journal, Gut, a jewel within the crown of the BSG will, we hope, become the official journal of the UEGF. As the British DDW concept has to go on hold we look forward to enticing more specialty groups back to the BSG meeting with more joint Symposia and an expansion of the meeting to five days.

Continued on page 4
Annual Scientific Meeting 14–17 March

Have you registered for the meeting yet? It’s not too late. Register on line at www.confrex-bsg-reg.co.uk to avoid having to queue at the Registration Desk on arrival. We look forward to seeing you in Birmingham.

28th King Faisal international prize for medicine

The British Society of Gastroenterology is happy to learn that Professor Sir Richard Doll has been co-awarded the 2005 King Faisal International Prize for Medicine for pioneering research into tobacco risks on human health.

Many congratulations.

Appointments

Dr S Cullen, Wycombe Hospital
Dr A Grant, Leicester Royal Infirmary
Dr N Hawkes, Royal Glamorgan Hospital
Dr J Lindsay, St Bartholomew’s Hospital
Dr S Mannnnjunatha, Manor Hospital
Dr L Wong, Walsgrave Hospital

‘Congratulations are in order’

The Society’s IT officer, Howard Ellison, has been awarded a Masters Degree – MSc – in Information Systems from the University of Greenwich. Well done Howard!

Diary Date

AGA-BSG Research Meeting on Upper Gastrointestinal Cancer, Oxford, 1 and 2 September 2005. Details of programme and abstracts will be posted on the website.

Events

2-8 April 2005.
‘Airways Diseases - A shared approach to management’, University of York.
Details: Tel. 01482 382860; email: conferences@technotics.com

5-8 April 2005.
Warwick University short course: ‘Techniques and applications of molecular biology: A course for medical practitioners’.
Details: Dr C Moonan, Dept of Biological Sciences, University of Warwick.
Tel : 024 7652 3540; email: Charlotte.Moonan@warwick.ac.uk

8 April 2005.
One day meeting ‘The Sick Liver Patient’, University College London. Further details: Danielle Brown. Email: Danielle.brown@ucl.ac.uk. Tel: 020 7679 9666.
http://www.ucl.ac.uk/medicine/intensive-care/courses.

13 April 2005.
Liver Tumour Symposium – A multi-disciplinary approach. (In association with the Wessex Region of the Royal College of Physicians.)
The Pelican centre in the Ark, Basingstoke. Details: Juliet Crawley, Pelican Centre, North Hampshire Hospital.
Tel 01256 314746; email: admin@pelicanancer.org or www.pelicanancer.org

4-7 May 2005.
6th International Gastric Cancer Congress, Japan. Details: email: igcc6@sc.itec.keio.ac.jp

18-22 June 2005.
Annual Practical Nutritional Support Course for clinicians. Chilworth Manor, Southampton. Details: Janice Taylor; tel. 023 8079 6317; email: iohn@soton.ac.uk

World Congress of the International Society for Diseases of the Oesophagus, Adelaide, Australia. Details: email: isde@sapmea.asn.au; Wed: www.sapmea.asn.au/isde; Fax: +61 8 8274 6000.
Honorary secretary's column

Tried and Failed

Firstly, may I wish you all a very Happy New Year and hope that 2005 will be a fine year for all members of the Society. And on the subject of members, the concern has been raised once again that Specialist Registrars are not becoming members despite the reduced rate and subscription to Gut. I suspect, to some extent, that the Society has relied for too long on the perceived honour that came with membership and we need to look and see how membership can be made more attractive to Trainees. However, the issue is also partly one of a lost habit and we would therefore ask all of our Consultant Members if they could encourage their SpR’s to become members (preferably not allow them to pass beyond induction without filing in the appropriate form!). This all sounds like decline which it isn’t – the membership is larger than ever, but it may, of course, not remain that way.

“Tried and Failed” refers to the saga of the British DDW. Regular readers of the Newsletter will have followed the upbeat reports of our moves towards a British DDW style meeting planned for 2008. The prime aim of this was to offer the attendee a really exciting and comprehensive program across many related disciplines that he/she would otherwise have to attend multiple smaller meetings to access. Unfortunately, and disappointingly, it has failed more through issues of identity of sub-speciality societies rather than actual feasibility. Whatever the reasons, it has failed and we are putting this one to bed. In fact, the Annual Meeting has continued to grow with 2005 offering even more parallel sessions and symposia and an excellent faculty. By continuing joint symposia, in particular, we would hope to achieve many of the aims set out in a British DDW. We have, also, brought back Satellite Symposia on site for the March meeting and the programs for these look excellent. We look forward to some feedback on these subsequently.

Work continues on formulating a Gastroenterology “Framework” document with the help of John Williams’ research group in South Wales. We are still on target to present the nuts and bolts of this at the Annual meeting in March and would welcome as much feedback as possible. With this in mind we are intending to hold an open forum during the meeting to allow members to come and have their say and will announce this nearer the time. However, at present we are on course to have the information on which to base a meaningful BSG strategy for delivery of GI services over the next 5-10 years.

Finally, I think this will be my last contribution to the Newsletter as my 4 years are now up. I would like to wish John de Caestecker good luck for his second 2 years and thank him for supporting me. I would also like to welcome Adam Harris to the fold who takes over as Junior Honorary Secretary in March.

That was the year that was

continued from page 1

One worry for the future is the fact that only 89 out of 500 trainees are members of the BSG.

Why is this? We must encourage our SpRs to join the Society. This is our Society, it is important that we are members and support it. We should be proud to do so.

This has been an exciting, challenging and busy year for me but great fun, great fun because of all those enthusiasts with whom I have had the privilege of working. I can’t thank all individually but thank especially the Officers who work so hard and give endlessly of their time and the Council who have given me such support. But where would we be without Di Tolfree, Chris Romaya and Howard Ellison who make it all work. My special thanks to them.

Hot news from the endoscopy section

The British Cardiac Society has made a small but endoscopically significant change to the guidelines on antibiotics prophylaxis. The Society now recommends that moderate risk patients are given antibiotic cover for endoscopic procedures. The prophylactic regime remains essentially the same and details of the document can be found on http://www.bcs.com/item/1749.

This website also contains evidence relating to the incidence of strokes to heavy drinking, which could serve as a warning to some!

Robin Teague
News

National Inflammatory Bowel Disease Audit Funded

The Health Foundation (the charitable arm of Private Patients Plan) has awarded a grant of £536,033 to fund a National Audit of IBD. The successful bid was initiated by the BSG but submitted by a consortium consisting of the BSG, the Royal College of Physicians, the Association of Coloproctology and the National Association for Colitis and Crohn’s Disease. Applicants of shortlisted bids were interviewed by a selection committee which included Professors of Health Services Research from Harvard and York plus representatives from the lay community and General practice. At the interview the BSG was represented by Jonathan Rhodes (Audit lead, IBD section) and Keith Leiper (the designated lead clinician for the national IBD audit) and the other interviewees were Prof Mike Pearson (representing the RCP), Asha Senapati (the audit lead of the Association for Coloproctology) and Richard Driscoll (the Director of NACC).

The audit will involve all UK Trusts and indeed all general hospitals where there are more than one per Trust and with 40 patients (20 UC and 20 CD) sampled per Trust/general hospital in the initial audit round. The audit will be led by a steering group representing all the applicants (BSG/RCP/ACP/NACC) who have joint “ownership” of the audit. The day to day/week to week management will be led by Keith Leiper working in close consultation with Mike Pearson (who led the very well received MINAP (Myocardial infarct) and Stroke Audits for the RCP). The target outcomes will be a mixture of clinical measures (mortality/morbidity etc) as well as measures of “process” – access to stoma care/specialist surgery/urgent clinic assessment etc) and will be substantially based on the recently published BSG guidelines. Funding will start from April 2005. The first 6-9 months will be spent developing contacts with all relevant hospitals (about 250) and piloting the audit in a small number of centres to assess reproducibility of the initially selected outcome measures. These measures will then be refined according to reproducibility and the main audit will commence. This should be complete within about 9-12 months and will be followed by regional feedback meetings (as well as presentations to the BSG etc). Action plans will then be established to address issues raised by this audit and the audit cycle will then be repeated to “close the loop”. A presentation will be given at the Spring 2005 BSG meeting to give further details of the audit process.

Although some of the issues raised by the Audit might be contentious, it should help substantially to improve quality of care (and funding) for IBD around the UK and with that should also help improve luminal medical and surgical gastroenterology with it, since some of the endpoints will include measures of service provision.

Manpower Update

As of 30/9/04 there were 826 Consultant Gastroenterologists across the UK, an increase of 7.1% during the last year. This continues the steady annual rate of expansion of around 7% over the last 5 years. The agreed long-term aim, with the Royal College of Physicians, is that there should be 6.1 whole-time equivalent gastroenterologists per 250,000, which equates to around 1900 consultant posts in the UK (1625 posts in England). Assuming continued growth at 7% it will take around 13 years to achieve these numbers. Within the UK there are 241 Non-consultant career grade gastroenterologists.

From the BSG annual census, there are currently 28 consultants working part-time and 118 academic gastroenterologists. Across the country a consultant gastroenterologist will typically serve a population of 72,000 but there is great variation with populations served by a consultant varying between 42,000 and 233,000.

There are now a total of 550 trainees in gastroenterology. Over the last year there has been an increase of 60 trainees - an increase of 12%. Approximately 27% of trainees are women and only 23 (4.1%) trainees are in flexible training. Currently, total training time is about 7.4 years and this has not changed significantly recently. Last September there were about 40 trainees who had had their CCST for 6 months but were not yet in a substantive consultant posts. Assuming a constant expansion of consultant posts of 7% per year it is likely that there will be a slowly decreasing, excess number of CCST holders for the next 7 years.

By Jonathan Rhodes

By Nick Thompson
In 1997, 1999 and 2000 the UK National Blood Transfusion Service was advised of donors who later developed variant CJD (vCJD). To date 9 UK plasma donors are known to have developed vCJD and collectively they have made 23 plasma donations. This plasma has been used to manufacture Factor 8, Factor 9, Antithrombin, IV immunoglobulin G, Albumen, Intramuscular Human Normal Immunoglobulin and Anti D.

In December 2003 a case of transfusion associated vCJD was announced and a second probable case of transfusion associated vCJD infection was reported in July 2004. Both patients had received non leukodepleted blood.

These are the only two incidents known to have accrued from blood transfusion by blood donated by a later vCJD sufferer and so far there have been no cases of vCJD developing as a result of the use of plasma products.

The likelihood of patients being at risk of vCJD for public health purposes following exposure to implicated plasma products has been categorised as:

i) High where the amount of potential vCJD infectivity in product batches is high enough for patients to be considered at risk of vCJD following the administration of a very small dose, (eg 1 treatment with Factor 8, Factor 10 or antithrombin where 1 vial used has been implicated).

ii) Medium, where the amount of potential vCJD infectivity in product batches is not low enough to be ignored, but substantial quantities of material in question would need to be administered for patients to be considered at risk of vCJD (eg several infusions of IV immunoglobulin or large doses of Albumin 4.5%).

iii) Low, where the amount of potential vCJD infectivity in product batches is so low that the likelihood of a patient being considered at potential additional risk of vCJD infection can be realistically ignored (eg Albumin 20%, Factor 8 products where the Albumin excipient and not the plasma concentrate itself has been implicated, intramuscular human normal immunoglobulin used for example for travel prophylaxis against Hepatitis A and anti D).

All these at risk patients have been informed and have been instructed to inform the doctor or nurse in charge of their care and an insertion in their notes should state that they are in an “At Risk” category. These are nearly all patients with haemophilia or immunodeficiency syndromes.

Endoscopy on this cohort of patients is thought to be low risk procedure unless a biopsy has been taken. If a biopsy has been taken there is the potential for prion contamination of the biopsy channel and risk to subsequent patients, so the endoscope in question has to be quarantined. Whether or not this instrument can then be used on other patients exposed to the same level of risk has not yet been determined or decided upon, but it is unlikely that this will ever be allowed.

Because of the retrospective nature of the investigations it may be found that quarantined endoscopes have been used on many subsequent patients before a risk was known. At the present time there are no plans to alert these patients as the risk is considered to be extremely low.

In summary, this is not a theoretical situation, and I myself already have had one endoscope in quarantine because of it. Fortunately, after consultation with the CJD Incidents Panel, the endoscope has now been returned to service as it had completed more than 10 cycles of standard decontamination since the index case Specific and up to date advice can be obtained from www.advisorybodies.doh.gov.uk/acdp/tseguidance/index.htm but in practical terms the message must be not to biopsy unless absolutely essential. If biopsy is essential withdrawing the endoscope with the biopsy forceps in full view and releasing the tissue before cutting off the end of the forceps may be acceptable practice. It is to be hoped that with this change of practice the country will not run out of endoscopes!

Scopes in Dock?

The Oesophageal Section has been busy!

The Oesophageal Section recently held its ever-popular 2-yearly symposium in London, this time in association with the Association of GI Physiologists. Over 100 people attended, to hear a widely varied programme. The real draw in the day was the presence of two major international speakers. John Dent came all the way from Adelaide to talk about exciting new potential ways of pharmacologically controlling reflux, based on his innovative animal work. Daniel Sifrim from Leuven addressed the topic of impedance measurement in reflux, which is now a ‘cutting-edge’ tool. We were particularly pleased to have the first Bill Owen Memorial Lecture, ably given by Dr Shaheen Hamdy from Manchester. Bill’s widow Wendy presented him with a certificate and cheque, and all were agreed that the talk was a very fitting tribute to a much loved man.
How You Can Use Your Will to Help Fund Gastro-intestinal Research

As you know, medical research is a long-term business. It takes many years for an inspired idea to develop into a new drug, treatment, or a preventive measure. Including CORE in your Will, helps ensure that funding will be in place in the long-term so that research can continue and further advances made.

Our current programme of Research Fellowships supports research at hospitals and universities throughout the UK. Current holders are investigating conditions such as pancreatitis, hepatitis, ulcerative colitis, crohn's disease and digestive cancers.

Three years ago, in partnership with the BSG, we launched the Digestive Cancer Campaign which has established four research centres, investigating different aspects of cancer of the bowel, oesophagus, pancreas and stomach.

We need to know that funds are in place so that the investments we are making today will result in the development of new managements tomorrow.

For more information, please contact Jo on 020 7486 0341 or by email to jo@corecharity.org.uk.