I view the business of the BSG as a tripod with equipoise between service delivery, training and academia.

Service delivery is the focus of the Strategy Document which Mike Hellier and Jeremy Sanderson have nurtured during its prolonged gestation. We aim to have a consensus view of how gastroenterology services should be provided in the next several years. We need to agree on defined minimum standards of care. When centralisation of complex cases yields better results we should support resourcing of specialised units. Equally we must fight against any erosion of standards that will result if concentration of certain resources is accomplished to the disadvantage of the feeder units. It seems to me that management of acute gastrointestinal haemorrhage is a tangible yardstick by which to gauge the performance of gastroenterology units across the country. If the number of gastrointestinal surgeons and therapeutic endoscopists is reduced by migration towards regional units or independent diagnostic centres, the provision of front line gastroenterology services is at risk of serious erosion. Without reciprocal concern one would fear that the number of lives saved by concentration of high risk surgery in a few large centres is in danger of being more than offset by the increased mortality from gi emergencies in the front line unit handling emergencies such as gi bleeding. The audit of gastrointestinal bleeding is an opportunity for us to document the impact that changing work patterns may have had on key aspects of our function in GI units.

It would be good to have greater communication between members. Howard has helped set up the Forum. It would be good to generate discussion and trade opinions on issues related to training, education and research. I would encourage you to visit our web-site and chip in to the debate that Roland Valori has sportingly kicked off with me.

Let us know your views on the Newsletter. Is there an energetic editor out there who relishes the prospect of taking it on as production editor?

Birmingham or Glasgow - it's your decision

The Executive had been discussing the venues for future scientific meetings of the Society. There is a vast difference in the cost of hiring these venues, with Birmingham being twice as expensive as Glasgow. However, there are really no other suitable venues in the UK. We would like your views, however, on which venue you prefer. Please let the Secretaries know your preference.

You have a choice:

- Birmingham every 2 years and Glasgow every third year
- Birmingham every year
- Glasgow every year
- Birmingham and Glasgow in alternative years
- A foreign venue
UK EUS Users Group

Are you performing or interested in developing EUS? The UK EUS Users Group is affiliated with the BSG Endoscopy Committee. It represents all issues relating to EUS and holds regular 2-day conferences and live meetings. If you’d like to join the Group or find out more, please contact either:

Dr Andrew Cole, Group Secretary (Derby City Hospital). andy.cole@derbyhospitals.nhs.uk or Dr Ian Penman, Group Chairman (Western General Hospital, Edinburgh). ian.penman@luht.scot.nhs.uk

Attention Researchers - The Blue Card is back!

The BSG will be re-launching the blue card system in electronic format. From 1997 to 2003 members were able to report cases of interest involving specific GI disorders to researchers. The system proved invaluable to a number of members and has aided research in gastroenterology and its related sciences. The BSG website will soon be able to accept returns based on the format of the old blue card. Members will be sent an email asking them to report specific disorders. A simple ‘yes’ or ‘no’ answer will be required. Any further data requested due to a positive response will also be entered via the website. We are currently looking for researchers who are interested in using the system on a six month’s trial, free of charge. It is anticipated that a charge will be made to researchers in the future for using this service. For more information on the project, please contact Howard Ellison (h.ellison@mailbox.ulcc.ac.uk)

BSG Handbook 2005

You will by now have received your membership book for 2005. Please check your entry carefully and let Di have any change in address or email. Email especially since we are planning to send out ballot and voting papers by email shortly. Please email changes to

www.bsg.org.uk

Appointments

Dr M Banks  Chelsea & Westminster Hospital
Dr A Bassi  Whiston Hospital
Dr G Constable  Princess of Wales Hospital
Dr A Gibbons  Hinchingbrooke Hospital
Dr C Lim  Good Hope Hospital
Dr M Teli  Nottingham City Hospital
Dr S Turner  Whiston Hospital
Dr S Weaver  Royal Bournemouth General Hospital

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Events

6-9 September 2005. 23rd Leeds Course in Clinical Nutrition. Details: School of Continuing Education, University of Leeds, Leeds LS2 9NG. Details: Tel: 0113 343 3241; email: c.would@leeds.ac.uk or s.armitage@leeds.ac.uk


17/18 November 2005. Inflammatory Bowel Disease and Colon Cancer – The State of the Art. RCP Edinburgh. Contact: Maregaret Farquhar. Details: Tel: 0131 245 3636; Fax: 0131 220 4393; email: m.farquhar@rcpe.ac.uk

18 January 2006. 2nd National Multidisciplinary meeting: radiotherapy-induced bowel damage: assessment, prevention, treatment, research. Royal Marsden Hospital, London. Abstracts invited. Details: email: j.l@andrejev.demon.co.uk


1-5 July 2006. 12th International Symposium on Viral Hepatitis and Liver Disease, Paris. Details: email: isvhld2006@mci-group.com
The Spring BSG meeting in Birmingham saw Jeremy Sanderson finish his 2 year term as senior secretary: he will be a hard act to follow. The secretary’s main function remains the organisation of the annual meeting: the last 2 meetings have delivered, to my mind, just about the right mix of science and clinical practice update. Some of the sessions reflect the BSG’s commitment to encourage debate and involvement in the dizzying spiral of modernisation and politically driven change. The unveiling of the endoscopy global rating scale and plans to accredit units and individual colonoscopists for the fast approaching start date for colorectal cancer screening was unfortunately inaccessible to a large number of delegates due to the small room allocated – a clear message to me of the issues engaging a large part of the membership which I will endeavour to take on board in planning next year’s meeting.

Jeremy and our outgoing president Mike Hellier have both worked hard to establish a basis for the BSG to put gastroenterology on the political map – a new External Relations Committee has been established and the Strategy document, the ‘brain child’ of Robert Allan and unveiled in its draft form at the Birmingham meeting, will be a cornerstone. Mike and Jeremy have agreed to continue to be involved in these endeavours for the next year, in order to provide continuity and the society is very grateful to them for their commitment.

I was disappointed but not entirely surprised that the move, suggested by Nick Wright when he was president, to develop a British DDW with sister societies (BASL, AUGIS, ACP, SIGGAR to mention a few) foundered. It is clear that many of these societies have developed an identity that they wish to preserve and nurture. My hope is that the BSG can continue to engage with these societies and encourage joint symposia at our annual meeting. There is no doubt that the downside of the success of the surgical and radiological societies is at the expense of the relevant sections of the BSG. While this is not necessarily a bad thing, I’m sure many will feel as I do that we want to attract the colleagues that we work increasingly closely with as GI physicians to join us for at least part of our annual meeting. This is something that I would like to work towards in my term as senior secretary: all disciplines involved in gastroenterology need to be speaking with one strong voice in the face of the many pressures facing us today.

Finally, many of you reading this will be aware that many gastroenterologists in training and newly appointed gastroenterologists are not members of the BSG: gastroenterology is expanding fast and in order for the BSG to be a representative body we need to encourage the majority of those remaining uncommitted to join. A provocative piece on this topic by a gastroenterology SpR is published in this issue of the newsletter – comments and other ideas would be welcomed.

By John de Caestecker, honorary secretary of the BSG

Council 2004–5

(⑷) Dr Chuka Nwokolo, Dr Richard Long, Dr John MacKenzie, Dr John de Caestecker, Dr Simon Trinci, Professor Andy Burnoughs, Dr Bryan Warren, Dr Jeremy Sanderson, Professor David Rampton, Dr Robin Teague, Professor Alistair Watson, Professor John Atherton, Dr John Bennett, Professor Howard Thomas, Dr Mike Hellier, Di Tolfree, Professor Tony Morris, Professor Elwyn Elias, Dr Tawfique Daneshmand, Dr Duncan Loft, Professor John Primrose
Care of patients with gastrointestinal disorders in the UK

You will all have received the “Progress Report” either with your ABM agenda or as a delegate at the March BSG Meeting.

The pressure is on us to bring this important document to fruition and your input is crucial. We want everyone to feel that they have had the opportunity to look at, criticise, add to or change the content so that the final document is right. It will be based not just on the wealth of hard data produced by John Williams’ team in Swansea but also the consensus view of all those involved in the delivery of GI Services.

The March BSG Meeting provided an ideal opportunity to bring everyone up to date with progress on the document. The Plenary session provided the chance to highlight the Progress Report to a large audience. Lively debate followed at the open session of the ABM, a rare happening! The special open house on Thursday lunchtime produced a good crowd with lots of helpful ideas. My thanks to all who took the trouble to come.

Disappointingly, following this surge of activity and interest, there has been little further feedback via the BSG website. The very detailed 180 page Swansea report is on the web and further copies of the progress report are available from the BSG. Please take the time to look at both and get back to us.

I have agreed to head up the strategy working group until completion of the document, hopefully this September. Please feel free to send comments to Di Tolfree or contact me direct.

Michael Hellier

Autumn neurogastroenterology and motility symposium psychoneuroimmunology and the gut

30 September 2005
Royal College of Physicians, London
Cost: £68/day
Full details are available from Professor Q Aziz, GI Sciences, Clinical Sciences Building, Hope Hospital, Salford M6 8HD.
Email: qaziz@hope.sman.nhs.uk

ADVANCED INFORMATION

The deadline for submission of abstracts for the Spring Meeting in 2006 (20 - 23 March) will be Tuesday 1 November. Submit on line at www.bsgabstract.org.uk after 1 September 2005.

‘Beware of LGV masquerading as proctitis - an alert from the Health Protection Agency Centre for Infections. Full details and useful web sites for further information posted on the British Society of Gastroenterology Web site.’
This house believes that Independent sector commissioning (+/- of endoscopy) will benefit patient care.

For

Most of us would choose who does their colonoscopy. Most people do not have such choice. Doctors and their relatives who need health care are in a privileged position. They can choose whom and where, jump queues and make sure they get their results on time. The average punter is not so lucky. Average folk, not doctors, determine the outcome of general elections and this is why the Government is fixated on waiting times and choice.

Patient choice requires a critical mass of providers. Thus a strong reason for independent commissioning is to have more providers. Choice encourages competition and competing services will think more carefully about what patients want — otherwise they lose business. Often we think we are providing a good service. However, when we look closely, and through the patient’s eyes, its not so great — phone a friend and ask for a recent NHS health care experience. More providers, more choice, better service - the patients win.

Independent providers bid for a fixed price contract. To make the most of the contract they will hone their processes to perfection. This means they can bid for work below NHS tariff prices and still make a profit. This drives down unit costs. In the NHS too little attention is paid to processes and costs per case are high. To compete effectively the traditional NHS will have to focus more on processes. When it does costs will go down and there will be more money to spend on other things - the patients win.

Against

Diversion of resources from hospitals to be invested in Independent Diagnostic Centres (IDC) will, overall, impair patient care, lessen training opportunities, and mitigate against the teamwork and continuity of care that underpins best practice. This will erode the standard of care which most critically affects key outcomes such as prevention of death and major avoidable morbidity.

Issues such as waiting times for diagnostic procedures are important but should not be considered as a driver of change with priority over other needs such as death defying management of g.i. bleeding. The Independent Provider will be recompensed at a profitable rate for performing low risk, low yield diagnostic procedures; the resource diverted would be much better spent strengthening the local NHS provider such that the resources endowed would be pooled to support management 24hrs/day for 365 days per year.

Competition works when there is excess of supply over...
Debate

Demand which gives the consumer choice. The current NHS is underfunded by any international comparison. Rather than address the shortfall in funding and thus improve standards of care within the NHS, creation of IDC’s will divert resources away from an already depleted service. The diminished workload that results from removing high volume, low risk diagnostic procedures to the private sector will hardly be noticeable whereas the effect of withdrawing the equivalent resource is likely to impair the residual service in the NHS.

If patients were truly informed they would opt for a 5 star service at their local DGH that provided expert care at all times and utilised the resources being siphoned into IDC’s to (a) provide early training opportunities for young trainee endoscopists and (b) ensured the presence of a critical mass of operators to guarantee an acceptable response to COG guidelines on the one hand and now by pillaging to form IDC’s on the other.

Having set off with good intent to bring health care funding up to European standards the government appears to have abandoned ship in favour of Mrs Thatcher’s puerile policy of playing shop (competition among providers) when what is needed is a continuing resolve to bring the core resource up to what is required. What effect will diverting this work have on training opportunities? We challenge the DoH to mount a national audit on the outcome of GI haemorrhage including correlation of outcome (survival) with local arrangements whether for an integrated service or the fragmented plurality of flawed political dogma.

———

Paul Brown travelling fellowship – Amsterdam EUS attachment 21-24 March 2005

| Day 1 |
| AM: Boston scientific sponsored pancreato-biliary disease live symposium; Pancreatic EUS; ERCP for Klatskin tumour; perforation from wire, even experts can do that! Talk on ERCP tools and technique; Gastric outlet obstruction |
| PM: EUS of cardiac cancer; diaphragm invasion clearly shown, useful skill; ERCP for CBD stone; EUS of a patient with obstructive jaundice - issue about CBD stents resulting in artefact at EUS, and discussion about the sequence of investigation in such patients i.e. CT followed by EUS and then ERCP rather than ERCP before EUS. Role of MRCP discussed; Interventional EUS - last case, CT 6 cm pancreatic cyst; EUS only 3 cm in size & interestingly in the duodenal wall; Fluid aspirated. What the fluid should be sent for was discussed; Lecture on role of EUS and its new developments in treating pancreato-biliary disease e.g. guided intra-pancreatic tumour injection of cytogenic therapy; Interesting point - EUS should not be called radial or linear; but called Diagnostic EUS to include FNA as well; and Therapeutic EUS or EUS-guided therapy rather than Interventional EUS. |

| Day 2 |
| AM: This was a training day for doctors and nurses and we joined the training session looking at various colonoscopy techniques, endo-loop which I have not used yet. PEG techniques with all instruments and in particular the push technique shown on a training mannequin. I will now alter my practice of the usual PEG insertion in that the guide wire that is pulled from the stomach out through the mouth will now be pulled with a stent forcep through the scope itself rather than with a snare through the oesophagus and mouth, preventing trauma to the oesophagus and mouth. |
| PM: Further training and EUS atlas pictures |

| Day 3 |
| AM: Two oesophageal EUS for cancers and two EMR (endomucosal resection). This was extremely useful, in particular the EMR as we are hoping to set up a service in Blackburn. |
| PM: Two EUS - pancreatic and oesophageal; an ERCP; EUS atlas. Overall the four days in Amsterdam University Hospital were extremely fruitful and has certainly helped me to change my practice with regards to EUS and establish certain other procedures which we have yet to commence in Blackburn. Please accept my sincere thanks for supporting me with the Paul Brown Fellowship. I can assure you this was utilized to its full extent. |

Difficult cases were discussed including interesting ones: Oesophageal EUS, discussion around T3 and T4 lesion; Two colonoscopies and an ERCP; Utilised time to look at EUS atlas by Professor Tytgat; finally an ERCP. |

PM: Interventional EUS for pancreatic cancer - difficulties in using a needle which frequently bend was seen; Oesophageal EUS T3 lesion; EUS of agastric cancer T3 lesion, limited to stomach unlike CT suggestion of cardia involvement. Useful as we do rare gastric Ca EUS.

Vishal Kaushik
Alcohol harm: Can the 2003 Licensing Act be used to protect the health of consumers?

By Dr Christopher Record

The BSG and BASL have made a joint response to the consultation document “Drinking Responsibly” with a consortium of parties including Alcohol Concern, The Medical Council on Alcohol and the City and Health Authorities of Newcastle Upon Tyne. The response urged HM Government to adopt the following measures by amendment of the 2003 licensing act or inclusion in the National Guidance Issued by the Secretary of State for the Department of Culture Media and Sport:

1. The display in licensed premises of information concerning responsible drinking and the unit content of the products sold along the lines recently proposed to the Portman Group.

2. Specific guidance on discounted drinks promotions, happy hours and alcohol awareness such as that published by Newcastle City Council on 5th January 2005 (www.newcastle.gov.uk).

3. The use of plasma televisions in licensed premises for the screening of videos (such as that recently launched by the Portman Group for use in cinemas) showing the adverse effects of alcohol excess upon their clients.

4. The power for local authorities to impose a supplement on Licence fees in respect of all licensed premises based on their rateable value to pay for the local policing and health measures required for controlling and treating the effect of alcohol abuse within their locality.

We await the result, which have been delayed by the General Election.
The staff of CORE and I enjoyed talking to many of you at the Birmingham meeting. When I presented the Research Essay Prize to Joe West, and in my brief presentation to the AGM, I made it uncompromisingly clear that I believe far more BSG members should become regular subscribers to CORE. Those of you who were at the meeting will subsequently have had a letter from me. I hope you’ll seriously think about filling in a direct debit form. With gift-aid supplementing what you give, and higher rate tax reclaimable by you it’s a cheap way to help g-I research forward.

Fund-raising from the public is gathering pace as our new Chief Executive applies his experience and expertise to it. While we wait to see the results we are heartened by having another new fellowship to offer. The pharmaceutical company Altana, encouraged by Professor Nick Wright, will support a one-year research fellowship in any branch of gastro-enterology. This will be particularly useful for someone currently doing a successful two-year project (not necessarily funded by CORE) who could extend the work for a third year and be accepted for a Ph.D. We’ll advertise it shortly and award it in the summer. Similar Altana/CORE awards will be available in 2006 and 2007.

Towards the end of April we awarded two new joint fellowships. The “Bret/CORE award” (jointly with the Foundation established in Rotherham by Chandu Bardhan) went to Dr. Daniel Gaya who will work in Edinburgh with Professor Jack Satsangi on the role of the MDR 1 gene in causing ulcerative colitis, with the hope that modulating its production of P-glycoprotein might have therapeutic potential.

The “RCS/CORE award” (jointly with the Royal College of Surgeons) was won by Mr. Richard Lindley who will be working in Liverpool using enteric nerve stem cells to regenerate the absent ganglion cells in Hirschprung’s disease, initially in mice. In each case competition was strong, as there were several good applications, all for worth-while projects by promising young researchers. All we need is more income . . .

You may have seen our new-style patient-information leaflets, and might even have ordered some. So far six are in the revised format, three more are ready for printing, and we have an agreed programme for having the full 25 in new form by next year. The old style ones are available on our website, as are a number of fact-sheets on (mostly) less common disorders which don’t justify a full print-run. You can print these off free. New leaflets will be on the web soon. To order printed leaflets simply contact our office.

We have decided to raise the price of the leaflets to hospitals. At present their production and distribution cost us a nett £100,000 a year – so while we recognize their value as a service to patients, reduction of that cost would leave us more to distribute as research funding.

calling all female gastroenterologists

We are constantly being contacted by doctors and members of the general public asking for the names of female gastroenterologists who do private practice. If any female members of the Society do undertake private practice and would be happy for their name/s to be passed on, would you please let me know. Di Tolfree

The Society is once again indebted to Carol Fletcher (l) and Anne Pearson (r) of Confrex for the smooth running of the annual scientific meeting.
Case of the Month presentations

The prizes for the two best Case of the Month presentations at the recent scientific meeting have been awarded to:

1. An unusual cause of back pain (Basavaraju KP, Keshav S, Keeling-Roberts CS, Hunt CR, Ahluwalia NK)

Poster ‘Sin Bin’

The following posters were not displayed at the recent scientific meeting:

- Plenary poster (missing both days): The intrinsic and extrinsic apoptotic pathways are rapidly activated in response to oxidative stress in pancreatic acinar cells (Baumgartner HK, Ashurst L, Sutton R, Tepikin A, Petersen OH, Watson AJM, Gerasimenko OV)
- Large series prospective experience with EUS for post-chemotherapy staging of oesophageal cancer (Doig L, Meenan J, Wu C)
- P27 is downregulated in gastric precancerous lesions and correlates with survival on gastric carcinoma patients (Anagnostopoulos GK, Stefanou D, Arkoumani E, Paraskeva K, Lakaniti K, Tsianos E, Agnantis NJ – introduced by Ragunath K)
- Can bowel ultrasound replace colonoscopy in diagnosing ulcerative colitis flare-up (Parente F, Greco S, Molteni M, Anderloni A, Pastore L, Ardizzone S, Sampietro GM)
- Direct access colonoscopy (Mulchandani M, Maruthachalam K, Jain RK, Stoker E, Morgan AF)

'This poor little soul isn’t allowed comics but has to make do with Guidelines' (Picture reproduced by kind permission of Jeremy Sanderson)
Endoscopy section

Endoscopy Certification and JAG visits

Certification for endoscopy

The SAC with approval from the Chairman of the JCHMT will administer certificates following completion of endoscopy modules. Thus, certificates for diagnostic Upper GI endoscopy, therapeutic Upper GI endoscopy, flexible sigmoidoscopy and colonoscopy will be given out and will be a mandatory requirement for achievement of CCST. Certificates will only be given when training is undertaken in JAG approved units. The award of the certificates will be recommended by the local Educational Supervisor using DOPS methodology. It is anticipated that certificates will also be given to nurses undertaking training in endoscopy and in the fullness of time we anticipate that this will also be taken up by surgical trainees.

JAG visits

Much thought has been given to the ways of re-accrediting JAG approved endoscopy units. JAG is purely an advisory group and does not have the financial resources to do this on a regular basis. We anticipate, however, that re-accreditation will be based upon a combination of written evidence (questionnaire) combined with visits supervised by representatives of the national and regional training centres, SHA leads and training committees. The criteria for assessment of the units will be updated and in due course it is anticipated that outcome measures including success of procedures and complications will be examined via the Global Rating Scale.

Encouraging trainees to become members of the Society

The following letter was received by the Gut office from an SpR in gastroenterology and we thought it worth publishing to stimulate discussion. The letter does not necessarily represent the views of the BSG or its officers. The Editor would be pleased to receive further comments and suggestions. Email: john.decaestecker@uhl-tr.nhs.uk

‘In the spring edition of their newsletter1 both the president and honorary secretary of the British Society of Gastroenterology (BSG) comment on the low number of gastroenterology trainees who are applying for BSG membership, the quoted figure being 89 out of 500 trainees.

There are several options that the BSG can pursue to encourage us to become members of the BSG:

(1) The application2 and sponsorship3 forms on the BSG website needs to be made more user friendly. These forms presently open as a web page rather than a word document and prove very difficult to type into, save or print. Trying to get one of these forms onto a disc and then to your sponsor can prove to be quite frustrating.

(2) Scrap the sponsorship part of the application process. Is it really necessary for a trainee with a national training number to have to prove his/her commitment to gastroenterology? These doctors have already spent considerable time and effort in applying for training posts and being grilled by senior gastroenterologists at interviews. The BSG should be willing to accept that trainees have committed to gastroenterology and thus decrease the work/time necessary in applying for membership. Membership should be offered automatically to anyone obtaining a training number and this could be co-ordinated via the Joint Committee for Higher Medical Training.

(3) Have an exhibition stand at the annual BSG meeting. Here the benefits of joining the BSG can be advertised and trainees can sign up for membership there and then.

(4) Consider making membership compulsory! All trainees are presently compelled to enrol with one of the royal colleges during their training period. Could this be extended to the BSG as well?’

References: