Looking to the future

Meetings
Well, we have made considerable progress as far as our ideas about meetings with the AGA are concerned. The September Council endorsed the proposal by the Education committee that the first joint meeting should be on inflammatory bowel disease, and we even have an enthusiastic suggestion for a very appropriate venue. In the next few weeks, we will be developing this concept with a view to having a programme and firm proposals for the meeting to take place in autumn 2004.

And speaking of meetings, the Council has been exercised over the summer about events which will happen in 2009. I know that this seems a long time away, but the decisions we make – or fail to make – could have considerable repercussions for the Society in that year. In 2009, the United European Gastroenterology Week is due to be in the UK, and the preferred site is London, rather than Birmingham where you will remember that we held the last successful European meeting. We have indeed identified a suitable venue – hoping that travelling in London will be improved by then(!). However, that year is also the year of the World Congress and it has been suggested that London hosts a joint meeting of the UEGW and the World Congress. While this is not a new concept – the 1997 Vienna meeting was a joint meeting of both organisations – such a proposal will of course have profound implications for the BSG and our Officers at that time. Moreover, in the aftermath of the Bangkok World Congress members of Council have expressed their reservations about involvement with this initiative.

However, there are a number of expressions of interest in holding the World Congress extant – I understand that no less than five of them come from Europe, and I suppose what would be a considerable worry is having two or more contemporaneous meetings in Europe in 2009, a scenario which we must avoid if at all possible. We understand, however, that preparations for the Montreal World Congress are going well and, after considerable discussion, Council has written to OMGE with a declaration of interest in holding the 2009 World Congress in London, possibly jointly with the UEGW. Of course, it goes without saying that any such agreement will be heavily contingent on the views of the European partners. In this respect, Peter Milla, the president, has told me about very recent discussions among their Council, in which they have agreed that such a meeting would indeed be in principle acceptable, although such discussions between the two bodies would not take place until 2005. With the thought that, if this joint meeting was a success, then this would reflect very well on our Society, let’s hope that this is possible. Of course, the converse is also true…….

Audit and research funding
Over the years the BSG has had many discussions about what to support, with its limited funds, and central to this has been its commitment to research and to the performance of audits. We have made a considerable contribution to the DDF which will continue for a number

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Email addresses
We are trying to build up a comprehensive list of reliable email addresses of the membership so that we can reduce the amount of paper mailings. If your email address in the handbook is either incorrect or absent please send it to the secretariat at BSG@mailbox.ulcc.ac.uk

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Editors needed for ‘Case of the month’

The BSG is looking for two young Consultants, one with interest and experience in luminal gastroenterology and one in hepatology to edit ‘Case of the month’ on the BSG website. The editors will vet and edit cases before they are published on the website, starting immediately, and will organise and judge (with a panel) the submission of case reports to the BSG meeting for computer presentation starting next year. The job will be supported by the current case report co-ordinator, Dr. Tim Jobson and by the BSG website co-ordinator, Howard Ellison. There will be no payment for this work!

Enquiries to John.Atherton@nottingham.ac.uk, chairman of the BSG Education committee.

Application by CV with brief covering letter explaining why you would like to do this job to Di Tolfree. Email: BSG@mailbox.ulcc.ac.uk

Appointments

Dr M Carter
Queen Elizabeth II Hospital, Welwyn
Dr U Dave
Morriston Hospital, Swansea
Dr S Jowett
Bradford Royal Infirmary
Dr D Rowlands
Lister Hospital, Stevenage
Dr M Rutter
University Hospital of North Tees

"En Vie" BUDD CHIARI WORKSHOP

(European Network for vascular disorders of the liver)

Prospective 9-nation study of Budd Chiari syndrome commencing October 2003.

A Workshop for co-ordinating the UK arm of this study will be held in Birmingham on Friday 14 November 2003. All those wishing to participate are invited to attend.

UK Co-ordinator: Elwyn Elias. Details available from elwyn.elias@uhb.nhs.uk

Events

1/5 December 2003.
14th Annual Paediatric Gastroenterology Course & 6th Live Paediatric Endoscopy Masterclass 2003. Royal Free Hospital, London. Details: Susan Hampson. Tel: 020 7830 2779, email: s.hampson@rfc.ucl.ac.uk

2 December 2003.
Recent advances in Hepatitis C virus. Royal Society of Medicine, London. Tel: 020 7290 3859, email: pathology@rsm.ac.uk

2-4 December 2003.
18th International Workshop on Therapeutic Endoscopy. Hong Kong. Details: Miss C Mak, Endoscopy Centre, Prince of Wales Hospital, Shatin, NT, Hong Kong. Email: info@hksde.org

An introduction to microarray technology & its applications. Warwick University. Details: sj.hicks@warwick.ac.uk

10th Royal Free GI Masterclass: The Foregut. Details: Gina Cripps, Sheila Sherlock Education Centre, Royal Free Hospital, London NW3 2QG. Tel: 020 7472 6294, email: gina.cripps@royalfree.nhs.uk

BSPGHAN Winter Meeting. Crieff Hydro Hotel, Scotland. Details: Carolyn Fraser. Tel: 0141 201 9264, email: cf24f@clinmed.gla.ac.uk

5th Annual Alpine Colorectal meeting, Verbier, Switzerland. Details: coloproctology@rsm.ac.uk

Colonoscopy Teaching Day, Luton & Dunstable Hospital. Details: coloproctology@rsm.ac.uk

An introduction to immunology. Warwick University. Details: sj.hicks@warwick.ac.uk

21/22 April 2004.
Consensus Conference on Hepatitis C. RCP Edinburgh. Abstract Deadline: 12 December 2003. Details: Margaret Farquhar. Tel: 0131 247 3636, fax: 0131 220 4393, email: m.farquhar@rcpe.ac.uk www.rcpe.ac.uk/events/hep_c_04.html

3-5 June 2004.
Honorary secretary’s column

Annual meeting to run Mon-Thurs from 2005

As a result of the recent questionnaire sent to members, from March 2005 the Annual meeting will change to hold the Postgraduate Course on Monday and run the meeting proper from Tuesday to Thursday. Views were obviously divided but this was the most popular format. The need for this change was certainly highlighted by the poor attendance at the Postgraduate Course in 2003 (which unfortunately coincided with the first warm sunny day of spring). This change is good in other respects, especially in view of the renewed move towards creating a British DDW aimed at bringing in a number of related Society meetings under one roof and providing a much more comprehensive programme for both trainees, consultants and scientists with an interest in GI disease.

The programme for 2004 in Glasgow is looking good. We have experimented a little by bringing back some ‘Meet the Expert’ breakfast meetings – although I think we will call them ‘Question the Expert’ meetings to emphasise that these will be very didactic and not lectures. There will be a charge but they are much cheaper than those at the AGA!

We have also tweaked the scoring system for abstracts to make it as fair and accurate as possible (FYI the abstracts are scored by the chairperson and 4 others from each relevant section and the scores averaged). A cut off level for acceptance is decided upon according to meeting space and, as mentioned in a previous newsletter, the top scoring abstracts will be selected as oral presentations.

Finally, the move towards increased public (or external) relations activity is progressing (slowed, I’m afraid, by obstetric events in the honorary secretarial household). The BSG finds itself in a situation where it needs to gather more data on, for example, exactly how best to deliver GI services and on the burden of GI disease such that the Society has something more concrete upon which to base an overall external relations strategy. Council has agreed to put money behind gathering this data rather than spend money straight away on external relations activity. However, our plan is to establish an External Relations committee to orchestrate these activities and, as you will see from the announcement in this newsletter, a chairman is needed for this proposed committee. He/she is going to be a very important person in the activities of the Society and it is envisaged that this would be a position for 3 years. Presidents come and go and influence the Society and specialty all too briefly – an External Relations chairperson will inevitably need to be a more continuous voice formulating the views of the president, council and sections into a consistent external relations strategy. Are you that person? Let us know.

Presidents column continued from page 1

of years, and have also been able to at least pump-prime a number of audits. It is a matter of record that DDF funding has led to the acquisition of further research funds from research councils and charities, but I wish we could say the same about funding for audit. This has recently reached a head with our wish to carry out an important audit on ERCP, for which our president elect, Mike Hillier, has really been putting himself about for provide funding. However, despite what was tantamount to a commitment from the DoH, they have reneged on this promise. No amount of appealing to a number of Government stakeholders seems to have any effect. It seems that the Department of Health want us to audit our work and to establish best practice, but are simply not willing to provide any funds for this important function, and have practically told us that we should fund it ourselves – which incidentally would drive the Treasurer into an early grave. Seeing that some 15% of the total NHS budget now goes into collecting data, it seems quite incredible that some of this money at least cannot be channelled into doing something important, instead of providing the mountains of questionable information about wait times in accident and emergency which we all know are cooked by cancelling leave and stuffing the place to the gunwales with staff on the observation week. While hospitals gain or lose stars on such ludicrous criteria, it simply beggars belief that we cannot get them to fund a vitally important audit in our field. Another job for the incipient PR machine? Perhaps we should be investing in a parliamentary lobbyist?

Pressure

Finally, you might recall my angst about the possibility that money would be withdrawn from RAE 4 departments, outlined in the Spring newsletter. I am moderately pleased to report that, as a result of extensive lobbying by a number of organisations, including ours, this is not going to happen. There will be no allowance for inflation, but such departments are OK until the next RAE at least (Hawkey, Watson, you owe me a pint). We now await the result of our representations on the Roberts report on the RAE and the OST consultation on the sustainability of university research (no hollow laughter, please).

See you in Madrid, hopefully.
Campaign for a health warning on alcohol products

In an interim analysis released by the Cabinet Office Strategy Unit on the 19 September (www.number-10.gov.uk) it was estimated that alcohol harm costs the nation £20 billion per annum. More importantly for doctors, £1.7 billion of this was for NHS treatment including the occupancy of one in every 26 bed days, while 40% of Accident and Emergency admissions and 150,000 hospital admissions were alcohol related. The Government is currently formulating a National Alcohol Harm Reduction Strategy (www.strategy.gov.uk), which is due to be published towards the end of the year. In March 2003, on behalf of the British Society of Gastroenterology, the British Association for the Study of the Liver and the British Liver Trust, 500 members signed a petition requesting the inclusion of the following health warning on all alcohol products:

HM Government Health Warning
This product contains x units of alcohol. Consumption of more than 21 units per week for men and 14 units per week for women can damage your health.

The petition was presented to Downing Street and The Department of Health in July by Professors Humphrey Hodgson, Roger Williams, Ian Gilmore and myself, and in a TV broadcast of the presentation, the Chief Medical Officer Sir Liam Donaldson expressed strong support for the project. The petition has subsequently been presented by Chris Babbs in Manchester to Hazel Blears, the Minister responsible for the National Alcohol Harm Reduction Strategy; by Adrian Hamlyn in Dudley to Ross Cranston, Chairman of the all party House of Commons Alcohol Committee; and by Jan Freeman in Derby to Margaret Beckett, Secretary of State for Environment. Presentations to Members of Parliament are shortly to take place in Reading, Oxford, London, Stoke, Swindon, Leeds, Darlington, Cambridge, Welwyn Garden City and are planned in many other centres, including all those with a District General Hospital.

Why act now?
Since 1987 the Medical Royal Colleges have recommended the safe limits for alcohol consumption to be 21 units of 8 grams or less per week for men and 14 units or less per week for women. Recognising the increasing culture of binge drinking, in 1995 the Department of Health recommended that the maximum daily intake should be no more than 3-4 units for men and 2-3 units for women. With two alcohol free days the weekly recommendations were unchanged. Unfortunately these safe limits are not widely known among the population at risk of alcohol harm. More importantly the strength of alcohol products has substantially increased over the years. Most table wines are now 12% or greater i.e. 1.9 units/125ml glass, beers around 4.5% (3.2 units per pint) while specialty bottled beers can be greater than 11% (3.5 units/250ml bottle). In 2001 in his annual report (www.doh.gov.uk), the Chief Medical Officer drew attention to the number of deaths from cirrhosis (4000 in 1999), the rise in death rates from cirrhosis since the early 1970’s (eight fold in men and seven fold in women aged 35-44) and binge drinking in the young. Gastroenterologists know from their own clinical practice that patients are now presenting with terminal liver disease in their twenties.

How can BSG members help?
With alcohol most of the damage happens before the patient seeks medical attention. Improved public education, especially the drinking population most at risk, is therefore paramount. While health warnings on alcohol products will be ignored by many, a small effect in the large population at risk should have substantial benefits and no members of the public will be able to claim ignorance of the dangers. Health warnings should also greatly strengthen the position of parents counselling their children. The alcohol industry is fiercely resisting health warnings. If the latter are not included in the strategy being formulated it is unlikely that any action will be taken for many years.

Use this window of opportunity and act now either alone or with your colleagues and make a publicised presentation of the petition or write to your Member of Parliament supporting the petition.

Nick Wright, President; Mike Hellier, President-Elect; Elwyn Elias, President-Elect; Robert Allan, immediate past President.. (Copies and tool kit available by post or email from jane.hogan@nuth.northy.nhs.uk, 0191 2824610).

Chris Record
Consultant Physician, Royal Victoria Infirmary and Freeman Hospital, Newcastle upon Tyne, NE1 4LP.

Chairperson of External Relations committee
Call for nominations

As part of the Society’s proposed increased external relations activity, we are seeking nominations for chairperson of a new External Relations committee. This person will chair a committee having broad representation within and outside the Society and will oversee the development, coordination and promotion of the Society’s External Relations Strategy.

A job description will be available from the BSG office. Nominations should be proposed by one Full BSG member.
NICE and SIGN guidelines – the demise of routine gastroscopy

The Scottish Intercollegiate Guideline Network (SIGN) have published guidelines for the investigation of dyspepsia and the BSG website currently displays an advanced draft of the NICE dyspepsia guidelines. Both SIGN and NICE have, of course, extensively analysed the relevant literature and taken informed advice from opinion leaders. One of the most important recommendations of both guidelines is that diagnostic upper GI endoscopy will be deemed unnecessary in the investigation of uncomplicated dyspepsia. This will apply across all ages, including patients over middle age, and a ‘test and treat’ policy for H. pylori eradication in positive patients and symptomatic therapy in negative cases will become standard care. These recommendations only apply to ‘simple dyspepsia’ (whatever that is) whilst the presence of alarm symptoms will warrant urgent endoscopy.

This policy has considerable implications for endoscopy units, particularly those undertaking a large volume of upper GI endoscopy as part of ‘Open Access’ lists. It may also disturb many GPs who currently refer patients with dyspepsia in order to rationalise prescribing, detect early, treatable cancers and, perhaps most importantly, reassure the patient and themselves that their symptoms are not life threatening. It is likely that referrals for H. pylori testing by breath test or serology will increase both in primary and secondary care. The recommendations will also impact upon the mind-set of many units who have trained non-medical practitioners to perform a large number of routine upper GI endoscopies to satisfy clinical demand.

What is the attitude of the BSG, particularly the endoscopy group to these guidelines? Some gastroenterologists are likely to express unease because a policy of not undertaking endoscopy will obviously result in early gastric cancers being undiagnosed; we are all aware of the increasing incidence of oesophageal and junctional adenocarcinomas in the West. Finally there may be implications for training as the number of routine gastroscopies will fall since only patients with alarm symptoms or those requiring endoscopic therapy will undergo endoscopy.

In response it is difficult to argue against the large evidence base which underpins both sets of guidelines. It is very clear that the yield of early gastric cancers discovered at open endoscopy lists is very small and patients who develop oesophageal or junctional tumours present with dysphagia or other alarm symptoms rather than uncomplicated dyspepsia. Moreover in an NHS with limited resources it can be argued that our capacity and energy should be directed towards investigation of the lower GI tract where the yield of pathology is higher and outcomes of surgical interventions are better. Many units currently offer lower GI endoscopy on an open access basis and the implications of these guidelines is that these are likely to develop further. The evidence that a normal endoscopy gives long term reassurance is lacking and logical prescribing does not require gastroscopy. To argue for continuation of high volume diagnostic endoscopy because it serves a teaching function is obviously untenable; practice moves on and once accepted standard procedures and policies become obsolete.

Whilst the SIGN guidelines have been widely accepted and applied with relatively little pain in Scotland, the final NICE document has not been produced and BSG members may still have time to influence the authors. Website ‘hits’ are relatively low and this is a plug for this communication forum; you will also see the recently completed endoscopy decontamination and disinfection guideline and updated recommendations for safe sedation. The website is an efficient vehicle for influencing the BSG and even this computer illiterate has learned to appreciate it!

The DDF president 2005-2008

The Charity wishes to identify appropriate candidates for the role of the next DDF president, to take office on 1 January 2005. Ideally, the new appointee would become a DDF Trustee in July 2004 and would serve as DDF president-elect.

At present, the chief executive and the DDF Trustees are consulting widely to identify potential candidates. The final decision is in the hands of the Trustees, but given the close and harmonious relationship between the BSG and the Charity, the views of the BSG Council on this matter are particularly important. The work of the DDF president (and indeed that of all the Charity’s trustees) is voluntary, although expenses are paid. Given that the job can be time-consuming, it is probably best suited for a senior and established member of the BSG who is approaching retirement, or who has recently retired from clinical and academic practice.

The post will be advertised.
What’s in a name: a time for change at the DDF?
Throughout the DDF’s 33 year history, there has been controversy about the best name for our Charity. When it began in 1970, the DDF’s founding fathers sought an all inclusive ‘descriptor’ that would satisfy all branches of the sub specialty. Initially, they chose the Digestive Diseases Foundation (DDF) – soon to be the Digestive Disorders Foundation Trust Fund. In 1974, they changed its name to the British Digestive Foundation (BDF). No sooner had we got used to this acronym than the name changed once more in 1999 – to the present title of the Digestive Disorders Foundation (DDF) again. Over the years, the Trustees have repeatedly tried to find a better name (and to choose an appropriate logo) that would capture the interest of the money donating public. However, the path of least resistance was to maintain the status quo – until, that is, we met more consistent criticism from distinguished friends who are helping with the Digestive Cancer Campaign, including Lord (Maurice) Saatchi, Lord (Peter) Carrington and Sir Alastair Morton. They pressed us to re-visit this problem and Lord Saatchi generously provided the services of his colleagues inform his world-famous PR company, M & C Saatchi. They encouraged us to consider a brief title (for example ‘Mind’ or ‘Scope’ used by other charities), combined with a descriptive strap-line. Possible suggestions included ‘The Swallow Fund’ (not to imply that we are confined to the oesophagus but rather to create a vague association with the world of gastroenterology), ‘The Gulliver Trust/Fund/Charity’ or even ‘Gull’ (neologisms based on both the Gut and the Liver). Possible strap-lines have included ‘Fighting Gut and Liver Disease through Research’, ‘Leading the Fight against Digestive Diseases’ or ‘the Gut and Liver Fund – Fighting Digestive Diseases’. So far, these ideas have been discussed in the DDF and by the BSG Council but we would welcome your views on this matter. Should we choose a new name and logo or maintain the status quo? Do you have alternative suggestions? Please contact us at the DDF office to give us your opinion.

Hermon Dowling, president of the Digestive Disorders Foundation

DIGESTIVE DISORDERS FOUNDATION
The Charity for Research and Information on All Digestive Disorders

The Raven Department of Education co-ordinates the following JAG approved endoscopy courses:

- Basic skills in flexible sigmoidoscopy
- Basic skills in colonoscopy
- Basic foundation course in GI endoscopy

The course level is suitable for SpRs, Research Fellows, SHOs, GPs and Nurse Endoscopists. Courses are held at various hospitals around England. For details of the courses including dates, locations, fees and curriculum please visit our website www.rcseng.ac.uk/surgical/gastro or contact Alex Jevons, Endoscopy Course Assistant on Tel: 020 7869 6335.