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Food safety: What is the Role for Gastroenterologists?

An Editorial from a WDHD 2011 Steering Committee Member



Dr. Yasmine Motarjemi

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From May to July 2011, two related outbreaks of Shiga-toxin producing *Escherichia coli* (O104:H4) occurred in Germany and in France, affecting the local population as well as international travelers (EFSA 2011). By July 27, a total of 4,075 cases and 50 deaths were reported from 16 countries in Europe and North America. 908 people had developed the severe and life-threatening hemolytic uremic syndrome, characterized by acute hemolytic anemia, thrombocytopenia, and renal insufficiency (WHO 2011). Studies on the causative agent of the outbreak in Germany showed the emergence of a new and highly virulent strain of *E. coli* now referred to as Shiga-toxin-producing enteroaggregative *E. coli* O104:H4 (Rasko et al. 2011). As to the origin of the outbreak, during the period in which the outbreak was investigated, different hypotheses were proposed, only to be subsequently withdrawn. Among these, cucumbers imported from Spain were first suspected. Finally, it was concluded that the two outbreaks were related to fenugreek sprout whose seeds were imported from Egypt (EFSA, 2011).

For the general public, the uncertainties in the source of the outbreak during the investigation in Germany and the explanations by public health authorities created a situation of insecurity, distrust and panic. The population in Germany and some other European countries boycotted cucumbers and other vegetables, particularly those imported from Spain. The economic losses for producers in Spain and in Europe in general were huge and amounted to several hundred million Euros (Motarjemi, 2012).

The general public and the media saw the outbreak as an extraordinary event and were surprised that food can be the source of such a massive and deadly epidemic.

For the food safety experts who had been sounding the alarm concerning the looming risk of foodborne pathogens, the incident was nothing out of the ordinary, except for its magnitude and its high degree of virulence: other outbreaks of foodborne illness, though often of smaller scale, do occur frequently in a society

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without much media attention and they are forgotten as soon as the investigation is over. Few, if any, remembered and/or mentioned that in the year 1996, Japan was hit by a series of similar outbreaks of Shiga-toxin producing *Escherichia coli* related to radish sprout and affecting almost 10,000 people, mostly children, and killing 11 people (WHO 1996). Other outbreaks of *E. coli* associated with sprout have occurred since that time, and the frequent reports of similar outbreaks have come from the US. Few people have questioned what lessons were learned from these outbreaks and what has been done to prevent their reoccurrence. In 1997, the World Health Organization developed specific recommendations for the control and prevention of shiga-toxin producing *Escherichia coli* (WHO 1997). The emergence of a new strain and virulent of *E. coli*, was nothing unusual either since molecular biologists know very well that the world of microbes evolves and that new strains with different pathogenicity and/or virulence are to be expected. The question is: what do we do to protect the population from well-established or emerging foodborne pathogens?

Outbreaks of foodborne illness, mostly inducing diarrhea, are a widespread public health problem and are more prevalent than most people, even the medical community, realize. As a result of different factors related to our modern food production, processing, distribution, and handling as well as to our lifestyle, including international travel and trade in food and feed, both the incidence and the scale of outbreaks of foodborne diseases have increased in recent years.

Each time outbreaks of foodborne illness occur, particularly those with the outcome and the scale experienced in Germany, consumers are understandably outraged as they are reminded that their food supply is not

as safe as they believe and/or expect. For the experts in food safety, the outrage comes from another front; they see that in spite of their know-how on the subject and technologies at hand to prevent foodborne illnesses, they fail to protect the population, particularly when they know that there is no reason for the world population to suffer or die from foodborne illness. Most foodborne diseases, if not all, are preventable. When they occur, they are the result of failures in implementing the preventive measures at a certain point in the food chain. The root cause of our failures lies in the lack of commitment of decision-makers, in the private or public sector, in making food safety a priority and employing all of our know-how and technologies, independent of political and economic considerations.

Despite the outcry of the food safety experts, there is still much misperception and ignorance among the public health and medical community about foodborne illnesses. Among these:

- i. Foodborne diseases are often seen as benign illnesses resulting in self-limiting diarrhea. Advances in the medical field have shown that many microbial infections can lead to long-lasting chronic health effects and in recent years, we have seen the emergence of pathogens such as EHEC, *Listeria monocytogenes* or *Cronobacter* spp. which can also be fatal, particularly for the increasing vulnerable segment of the population (Motarjemi 2002).
- ii. The magnitude of the illness is evaluated by the number of outbreaks. Cases of foodborne illness related to outbreaks are only the tip of the iceberg and outbreak data are not representative of the true magnitude of foodborne illness in the population. With the industrialization of the food

supply, most cases associated with processed or manufactured food will appear as sporadic cases, and therefore they will go undetected. Only a strong network of laboratory-based surveillance may be able to depict such outbreaks (WHO 1997, Borgdorff and Motarjemi 1997).

- iii. Traditionally, a number of illnesses, e.g. cholera or infant diarrhea, are associated with drinking water, and the role of food in their transmission is omitted. This is a fallacy that individuals with some common sense should realize, i.e. that any agent which can be transmitted through oral exposure or is associated with drinking water can be transmitted through food as well. Food, being a good media for the growth of bacterial agents, and some food being able to protect the bacterial agents against gastric acidity, can play an even greater role. Yet, even today, articles on infant diarrhea omit the role of food contamination.
- iv. Finally, there is a lack of understanding regarding food technologies, including food irradiation, and the role and potential of these in the prevention of foodborne illnesses.

The question that then comes to mind is that of the role that gastroenterologists play in the prevention of foodborne illnesses and diarrhea. Gastroenterologists are at the forefront of this public health problem. By observing the ill health of the population, diagnosing it, treating it, reporting it to public health authorities, and advising the general population on measures necessary for their future prevention, gastroenterologists play a pivotal role. They are best placed to raise awareness in the public health community and policy-makers of the ongoing problems, their magnitude and the severity of health

consequences so that they in turn can establish the necessary preventive programs. Today, there is still much ignorance about food safety and the risks associated with foodborne pathogens. An anecdotal case illustrates this point. Recently, a book on microbes was proposed to schools for promoting education of primary school children in food hygiene. It is known to all health education specialists that education and change of behavior is most effective when it is done at an early stage in life. The physician overseeing health programs in the schools declined the proposal. In his response, he wrote: pathologies related to too much hygiene is a bigger problem than foodborne illnesses. He added: during the last ten years, we had only some 100 outbreaks of foodborne illness; they are therefore not such a major health problem. It is to be noted that in 2009, the public health authorities in the country in question were reporting an annual incidence of over 8000 cases for a population of 8 million people (i.e. over 100 cases /100,000 population) (OFSP 2011). Considering the under-reporting factor, it can be assumed that the true incidence is several factors higher: yet, campylobacter is only one among some hundred of foodborne agents that we need to be concerned with. Shortly after the school physician's statement, Europe was hit by one its worst outbreaks of foodborne illness.

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Research Review



ARTICLE

Probiotics use in childhood acute diarrhea: A web-based survey
Weizman Z.

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EXPERT: A/PROF AAMIR GHAFUOR KHAN

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A/Prof Aamir Ghafoor Khan's Comment on the Article: This well conducted study is interesting from a WGO point of view just as we are revising and updating our Probiotics guideline.

Only 34% responded which is disappointing considering all of us have access to internet and it would have gone a long way in making the study more representative. The study shows clearly that probiotics are effective in Acute Diarrheal diseases in childhood with treatment being effective or very effective in 54% to 62% patients respectively – even though dosing and duration were very variable.

Importantly, adverse effects were very rare which is a big plus in a pediatric population. Similarly, there were few differences between the US and non-US populations ($P > 0.05$), which means it can be used in resource challenged countries where Acute Diarrhea is a major contributor to high Infant Mortality.

The main message coming out of this study is that we have a potentially easy to use and cheap therapy which could have worldwide benefits, but because of lack of worldwide guidelines, its efficacy and usage is not exploited in full. It is a challenge to the leaders in the field of Gastroenterology and leading professional bodies like WGO, WHO, AGA and ACG to come up with viable guidelines. The recent contribution by the WGO Guideline team will go a long way in helping and contributing in this regard and others should follow suit.

Introduction to A/Prof Aamir Ghafoor Khan: Professor Aamir Ghafoor Khan from Pakistan is a respected member of both the Acute Diarrhea and Probiotics WGO guideline teams and so he is a 'bridge.' His views from Asia and the UK represent key input for both of these guidelines. Although today few pediatric gastroenterologists prescribe probiotics for acute diarrhea in childhood, the new WGO guideline, co-authored by the world famous **Bangladesh International Centre for Diarrheal Diseases Research (ICDDR)**, may well begin to change this. The Weizman survey clearly shows the need for future guidance in this area.

How Does Language Affect the Impact of a TTT Course?

A comparison of English- and Spanish-language TTT's among those whose native language is Spanish



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Along with the Faculty of the Chilean Spanish Language TTT May 2010, Santiago, Chile.

Drs. Fernando Fluxá, Cecilia Castillo, Marisol Sirham, Zoltan Berger, Alex Navarro, Percy Brante, Victor Corzo, Ricardo Santander and Carlos Bustos

of experts originating from different parts of the world have been assembled over the years to present this program to trainees of multicultural and multiracial origin in English. By bringing together trainers and trainees from across the globe in intensive and interactive 4-day sessions dedicated to the development of teaching and training skills, WGO has developed a forum for interaction between world leaders in education, in order to share experiences and discuss common problems and solutions. The outcome of those TTT Courses has been outstanding.

The Organisation has realized that in some areas where English is not the first or even the second language, the impact of the course could be less than optimal. Indeed, in some regions, the delivery of these courses exclusively in English, (being fluent in English has been a prerequisite to be involved in the TTT courses) may limit the transmission of these teaching skills and may be a real issue in areas where they are most needed.

Recently, (May 2010) and for the very first time, a Spanish language TTT was organized in Chile. Two members of the WGO TTT Task Force were involved as faculty. The Chilean Society of Gastroenterology supported this TTT which proved to be a real success.

Summary

In order to evaluate the influence of language on the impact of WGO Train The Trainer (TTT) courses, we compared the English version (October 2009) and a Spanish version (May 2010), using a Likert scale administered to 10 Chilean gastroenterologists who attended the two TTT courses, the English language TTT as a faculty or student, and the Spanish language TTT as faculty. Their first language is Spanish. An English speaking person acted as leader in both versions and also participated in the comparative study.

The aim of the study was to evaluate the effect of the use of a foreign language in comparison to the mother tongue, on the outcomes of the Course.

The results show that the overall quality of the course, of its faculty, and its didactic content were similar in both versions. However, activities

which involved the direct participation of the attendees, such as the workshops, breakout and hands-on sessions, as well as the general level of involvement, were rated as better in the Spanish version.

Introduction

Adult education should be an important part of our daily work as gastroenterologists, but it is rarely a component of conventional training. It is not intuitive. Our specialty deals also with several skills that need to be learned. Generations of gastroenterologists in the world are in need of a variety of training resources to enable them to apply modern concepts of adult education.

The WGO, along with its National Member Societies, have for 10 years planned and delivered "Train the Trainers" (TTT) courses, which aim to improve the teaching skills throughout the world. A large panel

The rest of the Faculty comprised of 11 Chilean gastroenterologists involved in teaching, who had previously been part of the regular English TTT (October 2009) also held in Santiago, Chile and which also was a great success.

A comparison of these two experiences only 7 months apart, was performed in a retrospective analysis, considering the “pros and cons” of conducting the TTT in English versus the Spanish version.

Methods

The courses compared were A) The TTT course, held in Santiago, October 2009, with an international faculty lead by Eamonn Quigley using English as the sole language; and B) The TTT course held also in Santiago, but with a Chilean faculty lead by Eamonn Quigley using Spanish as the main language. The entire faculty has a good knowledge of English.

The survey was taken by an 11 faculty team, with at least two different TTT experiences, one as students and the other as a faculty. Some of them had more than one TTT experience as faculty. Two of the WGO Task Force (Eamonn Quigley and Roque Sáenz) were part of the courses and the survey.

A five point Likert type scale was developed for 29 questions covering the main TTT course items. Questions were designed to give quantitative comparison of each item using addressing the relative merits of the English and Spanish-language versions.

The Scale was created in an Excel electronic worksheet, cleaned, and then transformed to the Stata 9.0 package for statistical analysis. Descriptive statistics and non-parametric comparative analysis were used, due to the small number of participants. Results were based on an α error of 0.05 and a β error of 0.2.

Results

Questionnaires were mailed to the 11 gastroenterologists with both TTT experiences. We received 10 answers back (91%).

There was an **agreement** with the following positive statements (means greater than 4, statistically significant differences compared with the correspondent negative statement):

1. Spanish version was easier to follow (p = 0.000)
2. Overall quality was similar in both versions (p = 0.001)
3. Quality of educational topics was similar in both versions (p = 0.000)
4. Quality of Evidence Based Medicine was similar in both versions (p = 0.000)
5. Quality in Leadership topics was similar in both versions (p = 0.000)
6. Break Out sessions were better in Spanish (p = 0.0003)
7. Workshop sessions were better in Spanish (p = 0.0003)

There was **agreement** with the following positive statements (mean greater than 3, statistically significant differences compared with the corresponding negative statements):

1. Hands on quality sessions were better in Spanish (p= 0.004)
2. Report back quality sessions were better in Spanish (p = 0.031)
3. Overall faculty quality was similar in both versions (0.004)

There was a **disagreement** with the following statements (mean less than 2, statistically significant differences compared with the corresponding positive statements):

1. Quality in Leadership topics better in English (0.000)
2. Quality in Hands on sessions better in English (0.000)
3. Quality of Breakout sessions was similar in both versions (p 0= 0.005)
4. Quality of Breakout sessions better in English (p = 0.0004)
5. Quality of Workshops sessions simi-

lar in both versions (0.0005)

6. Quality of Workshops sessions better in English (0.0005)

The following statements were **not conclusive** (any mean with no statistically significant differences with the opposite statement):

1. Overall quality of the Spanish version better (p = 0.55)
2. Quality Educational themes better in English (p = 0.55)
3. Quality of EMB better in Spanish (p = 0.07)
4. Quality of Leadership themes better in Spanish (p = 0.84)
5. Quality of Report Back themes better in Spanish (p = 0.81)

Discussion

To evaluate two different versions of the same course in different languages is not difficult in the case of prospectively designed and planned instruments. This was not the case here. The idea to evaluate both versions occurred following the development of the course and, therefore, a retrospective approach had to be invoked.

The initial experiences of the Spanish course, which were informally commented on during the course and later officially evaluated by the Faculty team, was that the participation of the trainees increased and the quality of their presentations improved when the course was presented in Spanish, their mother tongue, rather than in English version.

The logical reason behind these differences lays in the fact that despite a working knowledge of English by every student, some obstacles are to be expected, especially when which open discussion or presentations are required, which are essential components of TTT courses.

Despite the apparent logic of these observations, WGO support for TTT courses in a different language demands more than subjective impressions.

Building a TTT course in another language faces several difficulties: The quality of the local faculty must be at least as good as that of the international, experienced faculty, the didactical content should maintain the same standard; and all the material, educational techniques, papers, PowerPoint presentations, workshop material, break out and management of report-back sessions should be of similar quality to that that he been achieved in the English version of TTT.

The aim of presenting the results of this survey is to show, with some basic level of evidence, that the overall quality of the courses was similar but that those activities that required more and open trainee participation were rated as in the Spanish version due to fluency in Spanish of all the participants.

In this survey, an evident bias exists. Almost all the participant's surveyed speak Spanish as their mother language, and, therefore, may have a subconscious vested interest in demonstrating that the Spanish course is of similar quality. A non-biased survey could be one with similar density of Spanish and English speakers, evaluating the two courses. This was not the case, so, some bias has to be taken into account. However, for the researchers it has been very important that the solely English faculty opinions have been similar to the others. On the other hand, the statistical analysis shows strong consistency and a relatively narrow dispersion of the data.

Conclusions

There was agreement (with high statistical significance) among the participant's surveyed, in the following statements:

1. General quality of both courses (Spanish and English) was similar.
2. Quality of the general sessions of both courses was similar.

3. Quality of the Faculty of both courses was similar.
4. Quality of the sessions requiring active participation (Workshops, breakout and hands-on, and report back sessions) was better in the Spanish version.

Therefore, a Spanish TTT could be encouraged in other scenarios in Latin-America as well as in Spain in order to improve the teaching skills and the overall quality of Gastroenterology in areas of need.

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Survey scale

Estimado colega:

Ya que usted tuvo la oportunidad de asistir a dos cursos de TTT, uno de ellos en inglés y el otro en castellano, le queremos pedir unos minutos para que llene una encuesta con su opinión para poder tener un instrumento objetivo comparativo entre ambos, y de esta manera estudiar la factibilidad de seguir realizando los TTT en castellano.

Por favor conteste las siguientes preguntas de la forma más objetiva posible. A cada afirmación de la lista de 29, encierre en un círculo aquella que le parece la más adecuada a su parecer, de acuerdo a las siguientes categorías:

1. Muy en desacuerdo
2. Levemente en desacuerdo
3. Indiferente
4. Levemente de acuerdo
5. Muy de acuerdo

En esta escala no se puede mantener el anonimato, ya que le correo de vuelta identifica a la persona, pero si usted quiere, anote su nombre.

Nombre _____

En cuanto a mi experiencia en ambos TTT, dados en inglés o en castellano:

1.-	No tuve diferencias en mi participación en ambos, inglés o castellano.	1	2	3	4	5
2.-	El TTT en castellano fue más fácil de seguir y participar por la facilidad de comunicación.	1	2	3	4	5
3.-	La calidad general de ambos fue similar.	1	2	3	4	5
4.-	La calidad general del TTT en inglés fue superior.	1	2	3	4	5
5.-	La calidad general del TTT en castellano fue superior.	1	2	3	4	5
6.-	La calidad de los temas educativos de ambos fue similar.	1	2	3	4	5
7.-	La calidad de los temas educativos del TTT en inglés fue mejor.	1	2	3	4	5
8.-	La calidad de los temas educativos del TTT en castellano fue mejor.	1	2	3	4	5
9.-	La calidad de los temas de medicina basada en evidencia de ambos fue similar.	1	2	3	4	5
10.-	La calidad de los temas de medicina basada en evidencia del TTT en inglés fue mejor.	1	2	3	4	5
11.-	La calidad de los temas de medicina basada en evidencia del TTT en castellanos fue mejor.	1	2	3	4	5
12.-	La calidad de los temas de liderazgo y acreditación de ambos fue similar.	1	2	3	4	5
13.-	La calidad de los temas de liderazgo y acreditación del TTT en inglés fue mejor.	1	2	3	4	5
14.-	La calidad de los temas de liderazgo y acreditación del TTT en castellano fue mejor	1	2	3	4	5
15.-	La calidad y aprovechamiento de los talleres hands – on de ambos fue similar.	1	2	3	4	5
16.-	La calidad y aprovechamiento de los talleres hands – on del TTT en inglés fue mejor.	1	2	3	4	5
17.-	La calidad y aprovechamiento de los talleres hands – on del TTT en castellano fue mejor.	1	2	3	4	5
18.-	La calidad y aprovechamiento de los talleres de Break Out de ambos fue similar.	1	2	3	4	5
19.-	La calidad y aprovechamiento de los talleres de Break Out del TTT en inglés fue mejor.	1	2	3	4	5
20.-	La calidad y aprovechamiento de los talleres de Break out del TTT en castellano fue mejor.	1	2	3	4	5
21.-	La calidad y aprovechamiento de los talleres en pequeños grupos de ambos fue similar.	1	2	3	4	5
22.-	La calidad y aprovechamiento de los talleres en pequeños grupos del TTT en inglés fue mejor.	1	2	3	4	5
23.-	La calidad y aprovechamiento de los talleres en pequeños grupos del TTT en castellano fue mejor	1	2	3	4	5
24.-	La calidad, participación y aprovechamiento de los report back de ambos fue similar	1	2	3	4	5
25.-	La calidad, participación y aprovechamiento de los report back del TTT en inglés fue mejor.	1	2	3	4	5
26.-	La calidad, participación y aprovechamiento de los report back del TTT en castellano fue mejor.	1	2	3	4	5
27.-	La calidad del Faculty en ambos fue similar.	1	2	3	4	5
28.-	La calidad del Faculty en inglés fue mejor.	1	2	3	4	5
29.-	La calidad del Faculty en castellano fue mejor.	1	2	3	4	5

Gracias por su esfuerzo, por favor devolver este correo lo más pronto posible para su análisis a: edrios@adsl.tie.cl

Is Diet Related to IBS No Matter Where You Live or What You Eat?

Max Schmulson^a, Enrico Corazziari^b, Dan Dumitrascu^c, Carlos Francisconi^d, Shin Fukudo^e, Ami Sperber^f and the Rome Foundation International Liaison Committee.

Very interesting data about diet and IBS in different parts of the world were presented at the IBS Global Perspective Conference jointly organized by the Rome Foundation and the World Gastroenterology Organisation and at the symposium of the International Foundation for Functional Gastrointestinal Disorders, both of which took place in Milwaukee in April 2011. It has always been known that diet triggers IBS symptoms, but the idea that no matter what people eat, diet is always related to this disorder, is intriguing.

For example, in Asia, IBS patients have more irregular eating habits than individuals without bowel symptoms or even patients with other functional bowel disorders (1). Studies analyzing the relationship of IBS symptoms (2) and sensorimotor responses (3) to meals have provided strong evidence for this. However, analyses of possible associations between food contents and IBS symptoms are scant. Japanese cuisine is comprised primarily of rice, fermented soy bean, vegetables and fish. The Korean diet includes rice, baked beef, and spicy vegetables. Chinese cuisine varies depending on the specific district, but consists mainly of rice, pork, vegetables and sea foods fried with oil. In Southeast Asian countries the diet is based mainly on rice and spicy curry with fruits and meats, while in India wheat or rice, milk, spicy curry and meat are staples. Although there are no specific items of foods that can be associated with IBS symptoms, capsaicin-rich foods, oily foods, wheat, and alcohol are

considered to be aggravating factors. Studies from Japan have shown that, in IBS patients, complete fasting for 10 days induces symptom relief (4), as well as improvement in duodenal and colonic motility, visceral perception and mucosal inflammation (5).

In Israel, as in other geographical areas and cultural groups, IBS patients are often convinced that their abdominal symptoms are related to food and eating. The Israeli diet is a form of a Mediterranean diet with high amounts of salads and fruits as well as legumes such as chick peas and tahini, and dairy products. These are associated with the prevalence of complaints on bloating and flatulence. In addition, patients often ascribe their symptoms to spicy food. Friday evenings and Saturdays (the Jewish Sabbath) are days in which families gather and enjoy meals together. These are often heavy meals and people tend to overeat. As a result, it is commonplace to hear complaints about abdominal discomfort and aerophagia at the beginning of the week after the Sabbath, although this clinical impression has not been studied formally.

Israelis are avid Internet users. In terms of IBS and food, they are exposed to disinformation, which has led to the adoption of elimination diets, including the recent popularity of gluten-free diets in patients without any evidence of gluten intolerance. Patients often go to practitioners of naturopathy and are given recommendations for very strict diets, in some cases for supposed intestinal *Candida* infestation. The latter is encountered

often by physicians who treat IBS patients (personal communication), but has not been documented in formal research.

Food avoidance is also frequently reported by Italian patients with functional bowel disorders. The widespread use of dairy (mozzarella, ricotta, and cappuccino) and flour-based food (pasta, pizza) in a country with a high prevalence of lactose and gluten intolerance is an inevitable cause of food avoidance. The prevalence of lactose intolerance is 50% in northern Italy, and 70% in southern Italy, and the prevalence of celiac disease in Italy in general is about 7%. However, many other patients avoid lactose or gluten in the erroneous belief that they are intolerant to these food components. Only 75% of patients who claim that they are lactose intolerant have a positive lactose hydrogen breath test (6). Many other patients avoid lactose, gluten-based diets and other types of foods on the basis of unreliable intolerance tests that are popular and available in the country (7).

In central and eastern Europe the diet is traditionally and predominantly based on meat, bread, potatoes, saturated fat and vegetables. In southern areas of Eastern Europe (Greece, Croatia) the Mediterranean diet is common. In former communist countries, including Russia and other ex-USSR states, less antioxidants are consumed in comparison with western countries and the salt intake is high (8-9). This dietary pattern is reflected in high cardiovascular

mortality, but with respect to IBS, there are no scientific data that link symptoms to specific foods. Diarrhea and constipation are aptly attributed to the type of food consumed, to food intolerances, allergies, etc., but this refers to non-functional conditions such as lactose malabsorption, celiac disease, megacolon, etc. Some patients believe that food may trigger bloating and flatulence. Therefore, patients may also avoid specific food items that they consider responsible for their symptoms, but epidemiological data exist only for functional dyspepsia, not IBS.

In Greek-Orthodox populations, Russians, Romanians, Bulgarians, and Greeks observe the fasting period between Easter and Christmas. Their fasts are stricter than those of Catholics and may involve a totally vegetarian diet for several weeks. However, there are no studies to date that have looked at the effect of fasting on IBS symptoms.

Alcohol consumption in Eastern Europe is heavy, mainly among men. Although spirits with an alcohol content of 40 percent or more, as well as beer and wine, are frequently consumed, patients do not attribute their symptoms to alcohol.

IBS patients in Latin America also associate their symptoms to food ingestion. In México, for example, in a nationwide multicenter study designed to characterize the bowel habit subtypes, patients reported that fatty foods, spicy or highly seasoned foods, and legumes (beans), were most frequently associated with triggering or exacerbating IBS symptoms (10). No differences in food attributions were associated with bowel habit subtype. In contrast, artificial sweeteners do not appear to be related to symptom generation, in contrast to what has been reported from other parts of the world. Fermentable oligosaccharides (fructans and galactanes), disaccharides

(lactose), monosaccharides (fructose and polyols) (FODMAPs), the highly fermentable and poorly absorbed short chain carbohydrates that have been related to symptoms in patients with functional gastrointestinal disorders (11), have not been investigated in Latin America. Nevertheless, it is a common observation in clinical practice that patients who chew gum sweetened with fructose and sorbitol report symptom exacerbation, mainly bloating, cramps and diarrhea.

Lately, a blood test for “food intolerance” has become very popular in Mexico. Patients get a list of “foods to which they are intolerant” and follow very strict elimination diets, in accordance with the results. After a period of time they find that there is no improvement in their symptoms and abandon these diets. Celiac disease is very uncommon in Mexico, with a prevalence estimated at less than 1% in the general population so it is not cost-effective to investigate it in patients with IBS (12). In contrast, in other Latin American countries like Argentina where it is more common, it is worth investigating.

In Brazil, the largest country in the region, the food types most blamed for triggering IBS symptoms, vary by geographical region. For example, palm oil is culturally part of north-eastern Brazilian cuisine but is rarely used in the southern states because it is used to cook “heavy” foods. Many of these beliefs have their origin in taboos that have been passed on for generations. Examples of these are that older people cannot eat “heavy” foods, watermelon ingested with wine provokes “indigestion” (meaning severe dyspepsia), fried eggs at dinner are “dangerous” for the health (also implying GI symptoms), and fat, pork and chocolate are “bad for the liver”. It is worth mentioning that many IBS patients complain that everything they eat makes them feel sick to the

stomach and they attribute the subsequent “liver malfunction” as the cause of their functional symptoms (13).

In conclusion, no matter where you live or what you eat, diet is related to IBS symptoms. It is possible that food intolerance may play a role, but popular beliefs make a significant contribution to the phenomenon of food avoidance in these patients. Further studies are necessary to confirm possible associations between foods and IBS in all regions of the world. Optimally, a collaborative multinational study would provide the most interesting and reliable data.

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2011 WDHD Update

View the full 2011 report later this year

IRELAND

The Alimentary Pharmabiotic Centre held a Public Forum for World Digestive Health Day 2011. Professor Colin Hill, Professor of Microbial Food Safety at UCC and Principal Investigator at APC, discussed the concept of using beneficial bacteria to fight infection in the developing world. In his talk “Enteric pathogens and infections; what’s new and what’s to do?”, Prof. Hill noted that infectious disease continues to claim the lives of almost 10 million children every year, 2 million of them from the scourge of diarrhea and 3.5 million involving malnutrition. In addition to these deaths, diarrhea and malnutrition create a deadly cycle of infectious disease which has lifelong consequences for the survivors in terms of life expectancy, intellectual capacity and even adult stature and work productivity. WGO Past-President Professor Eamonn Quigley also spoke, about “Post-infectious IBS; what is it and who gets it?” and Dr. Orla Craig spoke on “IBS, food and stress: new insights, new approaches.”



IRAN

The Iranian Association of Gastroenterology and Hepatology held seminars for physicians, as well as programs in Radio and TV and articles in newspapers in 10 provinces of the country, which included Tehran, Qom, Kerman, Guilan, Golestan, Tabriz, Ahvaz, Mashhad, Mazandaran and Isfahan.



UKRAINE

In Ukraine, a scientific medical forum of 400 doctors was held, under the leadership of the National Gastro Association and National Dietitian society, on enteric infections. Seminars included Enteric Infections in Developing Countries, Children Rehabilitation Trends after Enteric Infections, and Helminths and Protozoa as Gastroenteritis Reason. Clean Water and Clean Environment as Prevention Base.



URUGUAY

The Sociedad de Gastroenterología del Uruguay celebrated Día Mundial de la Salud Digestiva - 29 de mayo 2011, with “Infecciones entéricas: prevención y manejo.” Various activities took place in both Salto and Montevideo, May 27-29, 2011.



Clinical Research Tools: Templates, Proposals, Methods and Statistics

An Interview with Richard Fedorak



Richard N. Fedorak, MD

Professor of Medicine
Associate Vice-President (Research)
University of Alberta, Zeidler Leducor Centre
Canada

Background

Two years ago, Professor Richard Fedorak (University of Alberta, Canada) led the Research Methodology Committee for the World Gastroenterology Organisation (WGO) in developing a guide for researchers and gastroenterologists interested in reporting their work through research protocols, abstract presentations and printed manuscripts. The members of the WGO Research Methodology Committee who contributed to this effort are listed at the end of this article.

With special regard for WGO's core mission to focus on the education and training of young clinicians and researchers in non-Western settings, the online WGO Clinical Research Tools is a "tool-kit" of information, templates, examples and "real time" assistance that will help colleagues with scientific writing of research protocols, abstracts and manuscripts.

Online Content of the WGO Clinical Research Tools

The guide, *WGO Clinical Research Tools: Templates, Proposals, Methods and Statistics*, contains information in the following sections and is available at <http://www.worldgastroenterology.org/research-methodology.html>.

1. Preparation Tools
 - 1.1 How to Write a Research Proposal
 - 1.1.1 Writing a Research Proposal
 - 1.1.2 Research Protocol Templates
 - 1.1.3 Clinical Trial Registration
 - 1.2 Sample Size Calculation
 - 1.3 How to Write an Informed Consent Document
 - 1.3.1 Writing an informed Consent Document
 - 1.3.2 Informed Consent Templates
 - 1.4 Statistical Tools
2. Presentation Tools
 - 2.1 How to Write a Quality Manuscript
 - 2.1.1 CONSORT Statement
 - 2.1.2 CONSORT Guidelines
 - 2.1.3 Journal Impact Factors
 - 2.2 How to Prepare a Well-Written Abstract
3. Abstract Assistance Service
 - 3.1 Submit an Abstract

WGO Clinical Research Tools is a valuable resource for researchers in the various phases of the preparation, registration and presentation of their investigative work, especially

in low-resource areas. Information is provided for both clinical research studies as well as observational and case studies.

The Abstract Assistance Service Section of the Online WGO Clinical Research Tools

Writing scientific abstracts is a challenge for non-native speakers. Poor English may be a barrier to getting an abstract accepted by major gastroenterology congresses like the DDW and the UEGW. The rejection rate is high. The latest UEGW congress for example received just over 3000 abstract submissions - 1991 abstracts were accepted (442 abstracts and 1549 as posters) giving a rejection rate of 65%.

This *WGO Clinical Research Tools* helps to smooth the path. Using the Abstract Assistance Service, a team of volunteer editors is available to help non-English speaking researchers write high quality abstracts for submission to the major Gastroenterology Congresses. This service is limited to abstracts and is not available for research protocols or manuscripts.

As outlined above, **The WGO Clinical Research Tools can be seen at <http://www.worldgastroenterology.org/research-methodology.html>**. There are 3 main sections: Preparation, Presentation and Abstract Assistance. Each section contains tools and guidelines. The Abstract Assistance Service section puts you in touch with the abstract writing service, where there is help with language, with format and with structure.

INTERVIEW

Professor Fedorak – thank you for taking the time to talk with us. Can you give a brief description of the project: *WGO Clinical Research Tools: Templates, Proposals, Methods and Statistics*?

The *WGO Clinical Research Tools* section is an online resource, aimed at gastroenterologists and gastrointestinal scientists around the world, but especially in developing countries, to assist them in constructing and writing a research proposal, patient consents and in preparing an abstract for presentation and a manuscript for publication.

In addition to all the online tools, this section provides a very unique feature - the online “real-time” help desk for abstract writing. This Abstract Assistance Service is designed to be accessed by gastroenterologists in developing countries who request assistance with formatting and English language and grammar of their abstracts.

Why did you start this? What evidence is there that this is an ‘unmet need’?

Yes, there is, in my opinion, an unmet need. There are many outstanding gastroenterologists and gastrointestinal scientists in the developing world. For many, English is not their first language, and thus constructing a scientific research proposal or manuscript or an abstract presentation for a major international meeting can be a challenge.

As a reviewer of manuscripts for journals and abstracts for major international meetings, it has become apparent to myself and my co-reviewers that the research proposals, manuscripts and abstracts from individuals in which English was not their first language, often received a ranking at a lower score because of this language

barrier being reflected in the scientific writings.

Do you think this ‘Tele-learning’ or ‘Distance-learning’ approach is better than organizing Scientific Writing Classes for Clinicians locally – for example as the BMA has been doing in Africa?

The online *WGO Clinical Research Tools* are complementary to on-site scientific writing classes. It is accessible day and night through the internet and can support individuals who may not be able to attend on-site classes or who want some extra support once the classes are completed. In addition, the Abstract Assistance Service is a unique tool not available elsewhere.

One of the key problems identified in helping budding scientists in developing countries is lack of mentoring (see for example Richard Smith’s BLOG).

I absolutely agree with this statement. Indeed, not only is the WGO developing the *Clinical Research Tools* to assist gastroenterologists and “budding scientists” world-wide but the WGO is also incorporating these research tools, templates, proposals, methods and statistics in its Train the Trainers courses which teach hundreds of “budding scientists” each year.

WGO is now an official HIFA2015 Supporting Organisation. A recent post by Dr. LaPorte argues for setting up a “Scientific Writers without Borders correspondence school.” Do you think this could be a useful further extension of your initiative?

Having scientific writers available through this section and the Abstract Assistance Service, to gastroenterologists and gastrointestinal scientists in developing countries will be invaluable.

Having the scientific writers and librarians from the Abstract Assistance Service to edit, critique and correct structure, format English and grammar of abstracts being submitted to major international meetings, will only enhance these scientific endeavours. It is important to note that the WGO Abstract Assistance Service will not be able to assist or alter the content of the abstracts. The content will be up to the researcher.

I understand you want to focus primarily on young non-western gastroenterologists who wish to submit abstracts to the DDW or UEGW congresses. Does good English guarantee the submitted abstract is accepted?

Good English will not guarantee acceptance of an abstract; even the best science, when poorly written and corresponded, will fail.

Congress abstracts are becoming more important in research increasingly driven by evidence based medicine. Do you think Non-Western research can leapfrog the slow and cumbersome process of publishing in scientific journals and report trials directly via congress abstracts only? Maybe with peer-review via social media?

Abstracts are an important communication of scientific knowledge. Almost every scientific discovery and advancement begins its knowledge transfer life as an abstract. It is important that gastroenterologist and gastrointestinal scientists in the developing world have the opportunity to disseminate their research findings through abstracts at national and international meetings. We believe the *WGO Clinical Research Tools* and Abstract Assistance Service will help achieve this goal.

More than 300,000 congress abstracts are published every year and the number is increasing. Is there a bias toward English, do you think? How many rejections are based on 'poor English'?

Most major scientific organizations require their scientific presentations and abstracts in English. A good solid command of the English language is important for the abstract to portray its results and conclusions. Poor English language and grammar will often result in rejection of the abstract because it does not properly portray the excellent science content.

Who will do this work? Will there be a fee to pay or is it 'free at the point of use'?

At this point, the Research Methodology Committee of the WGO has placed free online information, guides

and templates for research protocols, patient consents, manuscripts and abstracts on its website: <http://www.worldgastroenterology.org/research-methodology.html>.

In addition, the WGO Abstract Assistance Service will have "real-time" free assistance for WGO gastroenterologist and gastrointestinal scientist members in the developing world. Through this service these individuals will be able to submit their abstract for collection of English and grammar. The service will not alter or write the scientific content in the abstract but instead focuses on ensuring the research message is clear and conveyed with the best appropriate English and grammar.

The WGO thanks Professor Fedorak and the Research Methodology Project Participants for their time and dedication.

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UEGW 2011 Stockholm



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The United European Gastroenterology Week (UEGW) is arranged by the United European Gastroenterology Federation (UEGF) which is a federation made up by 16 specialized Gastroenterological associations. This is an annual meeting, which started in 1992.

The UEGW is the premier meeting of the UEGF and is held in a major European city each year in late fall. Recent venues have been Paris, Vienna, London and Barcelona, and **UEGW 2011 will be held from 22nd-26th October in Stockholm, Sweden.** Attendance has been increasing in recent years, and last year a total of 14,000 people were attracted from all around the world, but particularly from Europe and Asia. The main meeting takes place from Monday to Wednesday, and is preceded by the UEGF Postgraduate Course on Saturday and Sunday.

Scientific Program Highlights

UEGW 2011 will feature the latest advances in clinical management, translational and basic science and the best original research in GI and liver disease. UEGW's popular clinical symposia will be highly interactive with keypad voting, debates, tandem talks, case-based management sessions and questioning through text messaging. Highlights will include personalized medicine, live endoscopy, inflammatory bowel disease, GI and

liver oncology, viral hepatitis, nutrition and obesity.

The UEGW **invited program of parallel symposia** has traditionally been very strong. Top experts from all over the world are invited to speak at the meeting, including many from Asia and America, and a comprehensive range of topics in gastroenterology, hepatology, endoscopy and GI surgery is covered. The meeting uses a variety of formats, including live endoscopy all day Tuesday, tandem talks (for example scientist + clinician or physician + surgeon), debates, and case-based management discussions. Audiences have the chance to interact with speakers through encouraging questioning and debate and, in some rooms, using keypads or texting via mobile phone.

Recently more **parallel sessions on basic and translational science** have been added to the invited program, including dedicated single subject science workshops and a topic based meeting-within-a-meeting initiative called "**Today's science; tomorrow's medicine.**" This meeting of the top international basic and clinician scientists working in a specific field is open to all UEGW registrants; last year the topic was stem cells, and this year it is **bacteria in digestive health and chronic disease** co-organized and hosted by Joel Doré, Séverine Vermeire and Jean-Frédéric Colombel. This will feature the best microbial

scientists from around the world to discuss the current state of the art in bacterial research in the digestive tract.

The biggest recent advance in the UEGW has been the improved quality of the **original research** presented at the meeting; this is now truly world class. Last year 3,481 abstracts were submitted of which 64% were accepted. 481 abstracts were presented as oral free papers and 1,650 as posters. The original research sessions are exciting and also very interactive. Some of the best abstracts are integrated into invited symposia, and many abstract sessions have introductory overviews from expert chairs. In 2011, there will be even more prizes for original research, and the top 5 abstracts will win 10,000 Euros each to contribute towards the further research of the first author.

Live Endoscopy

Top international experts will demonstrate cutting-edge techniques during live endoscopy sessions in the Postgraduate Program as well as the main Scientific Program of UEGW 2011.

Postgraduate Teaching Program

The UEGW Postgraduate Course is growing in prestige and size year on year. There is a full two-day postgraduate program incorporating gastroenterology, hepatology, endoscopy, surgery, imaging and other diagnostic modalities. The Postgraduate Course has plenary sessions at the beginning and end (this year on IBD and acute pancreatitis) and 4 parallel courses in the middle: medical gastroenterology, surgical gastroenterology, hepatology and endoscopy. These are arranged so that attendees can move freely

between sessions. The PG Course is pitched at the level of cutting edge management and covers areas of changing practice; it is aimed at established clinicians and senior trainees. The endoscopy course includes a day of live interactive endoscopy teaching using feeds from a major European endoscopy center. Other courses also use highly interactive formats including, this year, keypad voting.

Plenary Session

The Monday morning Plenary Session is stand-alone and features the best UEGW has to offer. It is a fast-paced balance between invited talks and the top original research presentations. The UEGF **Research Prize Winner Pierre-Alain Clavien** (last year Hans Clevers for his work on GI stem cells) presents briefly here.

UEGW Grants

The UEGW encourages youth and awards travel grants covering expenses to 200 young clinicians and 140 young basic scientists. It also sponsors national scholars presenting high quality research from countries in and outside Europe and runs a competition for about 10 “Rising Stars” - the best young established researchers with the promise of becoming the next research leaders.

UEGW Public Events

Alongside the Scientific Program UEGW organizes a number of Public Events:

The **Charity Run** at UEGW Stockholm 2011 will take place on Sunday, October 23. The start will be at 9:00 and the 5km course will bring the runners around the congress venue Stockholmsmässan. The Swedish Patient Organization “Riksförbundet Mag-och Tarmsjuka, RMT” will benefit from the registration proceeds.

Members of the public are invited to attend the **2011 Public Health Day** that will be organized on occasion of UEGW Stockholm 2011 on Saturday, October 22. Representatives from local patient organizations and world renowned experts will discuss current issues in the field of alcohol related digestive diseases together with patients.

For the first time UEGF will host a Congress Party (**UEGW Rock the Congress**) in Stockholm’s leading Night Club Venue Café Opera on Sunday, October 23. There will be DJs, drinks and lots of opportunities for young delegates to meet and network with colleagues from around the world.

The UEGW is a dynamic, friendly, vibrant and interactive meeting, featuring the best GI and liver medicine and science from Europe and around the world. Find more information and browse the 2011 Stockholm program at <http://uegw11.uegf.org/>.

WGO Train the Trainers Workshop

Porto Alegre, Brazil 2011

The World Gastroenterology Organisation (WGO), in partnership with the Federação Brasileira de Gastroenterologia (FBG), is pleased to announce the successful completion of its first full length Spanish Train the Trainers (TTT) Workshop, which was held in Porto Alegre, Brazil from August 12-15, 2011.

This workshop represented 12 countries, consisting of 50 Portuguese and Spanish speaking gastroenterologists as well as 11 faculty members. The integration of both the Spanish and Portuguese language provided a complimentary fusion, resulting in not only the first Spanish TTT, but also the first to be exchanged in Português.



Gaudérios group during morning Breakout Session

Applying the English TTT model, this workshop is characterized by hands-on sessions with ample opportunity for the exchange of ideas and the establishment of contacts between various countries, in an environment which is conducive to learning and interaction. An essential component to the workshop criteria is that the delegates selected possess high academic experience and are leaders in their field of gastroenterology. The knowledge learned and shared throughout the workshop by participants is then implemented in their own respective countries, with the active support of their national society.

What makes Train the Trainers so unique is that it not only transmits knowledge in the classroom, but also represents a diversity of cultures and regions.



Participants given instruction by faculty, using Koken Models, during afternoon Teaching Procedural Skills Hands-on Session

TTT Porto Alegre was well represented by every region in Latin America, which included delegates from El Salvador and Paraguay, a first for Train the Trainers. The delegates' eagerness for learning, sharing, and spreading knowledge was evident from day one. By the final day of the workshop, the PowerPoint presentations during the report back sessions were nearly flawless. The teambuilding event provided participants and faculty with the opportunity to work together in a friendly tournament playing Bocce, while the Cultural Evening and dinner highlighted the cultures and traditions of those in attendance. Furthermore, the local tour and dinner provided an impressive introduction to the many splendors that Porto Alegre has to offer.

Faculty members commented that this was one of best TTT's that they had ever attended. Basic concepts were conveyed to the participants early on, and with this foundation in place, the participant's energy to perform and teach what they had learned from the workshop was very

high. In addition, it was apparent that the spirit of Latin America really brought the course to life, proving to be a fruitful experience for all those in attendance.

On behalf of the WGO, our most sincere appreciation goes to the FBG and its gracious host coordinator, Dr. Mario Reis, who, with their support, put his vision in motion and co-organized an exceptional course that has left lasting impressions. According to one participant, "Dr. Reis gave a lesson in the art of hospitality. Impeccable." Furthermore, WGO would also like to thank the local facilitators and faculty for their commitment and contribution to the successful outcome of the workshop.



Faculty and participants outside of the Museu da História da Medicina during the local tour of Porto Alegre

Highlighted below are further testimonials to the success of the workshop:

Thank you for enabling professional excellence for the good of humanity. – Participant, TTT Porto Alegre

Many years ago I had heard about the quality of this course, but the obstacle for me had been the language. I applaud the idea of having captured this TTT in Spanish, Portuguese, and Português,

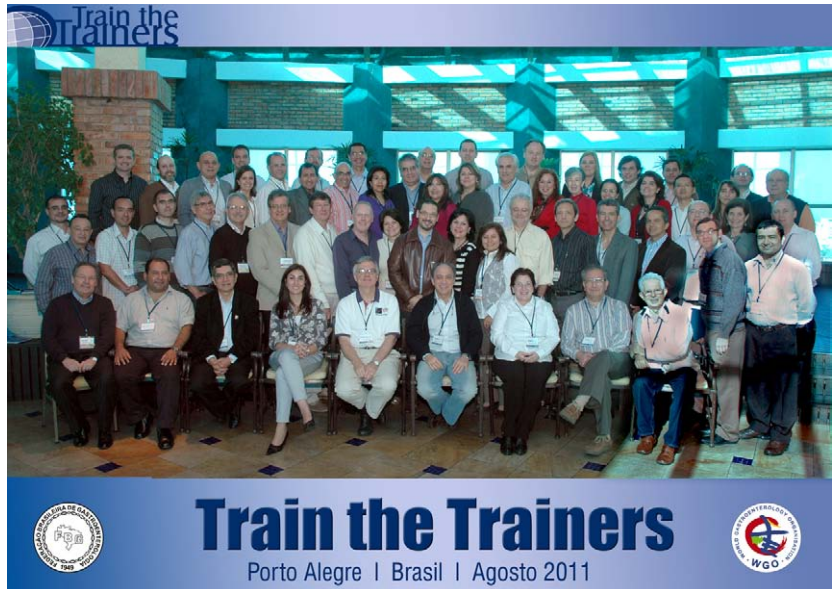
opening the door for many professionals to attend. I hope to see WGO continue with this idea. – Participant, TTT Porto Alegre

The TTT Porto Alegre was an unforgettable event. It was an enriching experience not only professionally, but personally. It was the best course I have ever attended in my profession. – Participant, TTT Porto Alegre

The dynamics of the course promoted learning with pleasure. The group work was a unique experience of “sharing the differences,” along with the interaction with colleagues of different nationalities in Latin America. – Participant, TTT Porto Alegre

The active participation, great blend of languages, and generous exchange of knowledge and culture are some of the things that have made this TTT unique. – Faculty member, TTT Porto Alegre

For more information on WGO’s Train the Trainer Workshops, please visit: <http://www.worldgastroenterology.org/train-the-trainers.html>



Faculty and trainees at the Sheraton Porto Alegre Hotel

WGO's Train the Trainers Workshop Held in India

“Academic and Cultural Experience Unlike Any Other”



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Attendees of the recent Train the Trainers workshop in Chennai, India.

The American College of Gastroenterology sponsored my recent trip to Chennai, India, where I attended Train the Trainers, an international workshop created and produced by the World Gastroenterology Organization. The Indian Society of Gastroenterology cosponsored this year's

workshop. Workshop is the key term in this extraordinary experience. Four days of “hands on” training by international experts that guide participants through a non-stop, all about training, intense see and do workshop. There are only 50 participants per workshop and further subdivision

into small groups leaves no room for wallflowers; everyone participates, and everyone is not only a trainee but a trainer.

A few of the topics of training included teaching procedural skills, interpersonal skills and team working, credentialing, critical appraisal of papers, trial design, presentations, and evidence-based medicine. But these topics are not just presented through lectures. The breakout sessions allow small groups to tackle an assigned task which is discussed, a consensus is reached on the solution, and a slide presentation is developed and then given...all in about an hour — the time flies by! Just when your brain is maxed out and you feel that you cannot absorb any more, the workshop takes a half day off to learn about the sponsoring country, in this case, India, with shopping, a trip to the sea and a seaside resort with Indian



Renee Young, MD, FACP (left) with several of the other workshop attendees.

hospitality. What makes this such a fantastic workshop? The faculty are polished teachers but they intermingle and also become participants. What an experience it is to get to know the participants — so many people from diverse countries and everyone there wants to train and wants to be better. Plus the WGO staff help solve any problem, and the conference is organized to a “T”.

As an added bonus, the country’s sponsoring group, The Indian Gastroenterology Society, gave us all a little look into their wonderful country and customs. Everything together makes this one of the highlights of my life and has revived my zest for training. Since my return, I have already tried training methods and trained others using the knowledge from this conference. I would encourage ACG members interested in training to apply with ACG for this workshop. This is an academic and cultural experience unlike any other conference. I would attend again in a heartbeat.

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One of the team building exercises attendees participated in.



Eamonn Quigley, MD, FCG with the host coordinator, Dr. KR Palaniswamy, during an evening social event.



Dear Colleagues,

The Turkish Society of Gastroenterology (TSG) and the World Gastroenterology Organisation (WGO) are pleased to announce the upcoming joint meeting, GASTRO-ANTALYA 2011, *1st WGO Regional Meeting with the 28th Turkish Gastroenterology Week*. The meeting will take place November 16-20, 2011 at the Rixos Sungate Hotel, Kemer in Antalya, Turkey.

REGISTRATION

Register now, by visiting <http://www.wgo-turkey2011.org>.

Gastro-Antalya 2011 will feature a one-day case-based postgraduate course, numerous symposia on critical issues in Gastroenterology, GI Oncology, Hepatology and Endoscopy and ample opportunities for the presentation of original work.

CLINICAL SYMPOSIA

- Hepatocellular Carcinoma
- Functional GID
- Variceal Bleeding
- Colon Cancer
- Biliary
- Regional Trends in IBD
- GI Infectious Disease
- Esophagus and Reflux

- Obesity - NAFLD
- Non-Variceal Bleeding
- WGO Symposium on Training and Education
- Endoscopic Ultrasonography (EUS)
- Mesenchymal Stem Cells in Treatment of GI Diseases

POSTGRADUATE COURSE

- Esophageal Disorders
- IBD
- Viral Hepatitis
- Complications of Cirrhosis
- IBS and Functional GID

The full program for Gastro-Antalya 2011 may be viewed by visiting <http://www.wgo-turkey2011.org>.

Gastro-Antalya has been organized by the following individuals and organizations:

PRESIDENTS

Richard Kozarek, *World Gastroenterology Organisation*
Ömer Özütemiz, *Turkish Society of Gastroenterology*

SECRETARY GENERAL'S

Henry Cohen, *World Gastroenterology Organisation*
Sedat Boyacıoğlu, *Turkish Society of Gastroenterology*

CO-POSTGRADUATE COURSE DIRECTORS

Eamonn Quigley, *World Gastroenterology Organisation*
Cihan Yurdaydin, *Turkish Society of Gastroenterology*

PRESIDENT OF NATIONAL MEETING

Sabahattin Kaymakoğlu, *Turkish Society of Gastroenterology*

Bangkok Training Center News & Highlights

The WGO Training Center in Bangkok, Thailand, opened March 20, 2006. The Center, based in Siriraj Hospital, is one of the largest facilities in the region with 2500 beds and a medical school. Associate Professor Sathaporn Manatsathit is the Managing Director of the Center.

The Center has four main goals and objectives:

- To train doctors and nurses from local and surrounding countries i.e. Thailand, Laos, Myanmar, Cambodia, Vietnam, Sri Lanka, Indonesia, Malaysia, Brunei, Singapore, etc, in GI Endoscopy and related fields (doctors from other regions are also welcome)
- To run Master Classes in GI Endoscopy and introduce new techniques to the region
- To assist local and regional Gastroenterology societies in training program
- To liaise with WGO in arranging international training on other aspects of Gastroenterology



Due to the fact that all trainees should have hands-on practice during their training period, several training sites within the Bangkok Metropolitan Area have been included so that an appropriate number of patients and endoscopic events can be accommodated. The major training site is in Siriraj Hospital (3rd floor of the 84th

Siriraj Anniversary Building). Satellite training sites are located in Chulalongkorn Hospital, Ramathibodi Hospital, King Mongkut Hospital, Rajavithi Hospital, Police Hospital, and King Bhumiphol Hospital, where endoscopic equipment and well trained endoscopy staff are available. In addition, further satellite training sites are available in the north of the country at Songkla Hospital, Khon Kaen Hospital and Chiangmai Hospital.



About the training process

The training process includes delivery of theoretical knowledge (in the form of lectures and video presentations) and hands-on practice under the trainer's supervision. Training faculty incorporates a panel of local experts which run most of the training program while a number of international experts from WGO join to advise and monitor the training program and curriculum. As the GI Endoscopy Society of Thailand usually arranges an annual conference with live demonstration in January or February, the center tries to schedule the Endoscopy Training Program so that it coincides with the Thai Endoscopic Annual Program and candidates may also benefit from the conference.

Year	BASIC	ERCP
2006	2	-
2007	1	
2008	2	2
2009	4	3
2010	2	3
2011	2	-
total	13	8

This chart shows the total number of attendees for Basic Upper and Lower GI and ERCP from 2006-2011, at Siriraj GI Endoscopy Training Center, Faculty of Medicine Siriraj Hospital, Mahidol University.

Attendees, their location, and dates attended at the Bangkok Training Center

- Dr. Thein Myint
Yangon General Hospital,
Myanmar
1 July – 31 December 2006
- Dr. Thann Souanntheth
Kampong cham provincial Hospital
Cambodia
1 July – 31 December 2006
- Dr. Kampasong Rattanavong
Mahosot Hospital
Laos PDR
1 November 2007 – 31 January 2008
- Dr. Dipesh L. Gurubachaya
Kathmandu Medical College
Nepal
Attended both courses:
Basic: 5 May – 31 July 2008
ERCP: 4 August – 31 October 2008
- Dr. Oukeo Khouthalyoung
Setthathirath Hospital
LAOS PDR
5 November 2008 – 31 January 2009
- Dr. Amedul Kabir
Dhaka Medical College
Bangladesh
5 November 2008 – 31 January 2009

Dr. Djamel Bouazza
Sunnybrook Health Sciences Centre
Canada
2 February – 30 April 2009

Dr. Shahram Ali Ibrahim
Rizgari teaching Hospital
Iraq
4 May – 31 July 2009

Dr. Bikash Adhikari
Bhaktapur Hospital
Nepal
3 August – 30 October 2009

Dr. Adegboyega Akere
College of Medicine, University of
Ibadan
Nigeria
2 November 2009 – 28 January 2010

Dr. Prashant Verma
Royal Melbourne Hospital
India
10 August – 10 November 2009

Dr. Gaurav Gandhi
Vinnysya City Hospital
India
10 August – 10 November 2009

Dr. Karem Tolan
Marmara University Hospital
Turkey
2 November 2009 – 28 January 2010

Dr. Asif Brohi Reza
Peoples Medical College Nawabshah
Pakistan
1 February – 30 April 2010

Dr. Atul Baid
Fortis hospital
India
3 May – 30 July 2010

Dr. Adegboyega Akere
College of Medicine, University of
Ibadan
Nigeria
1 February – 30 April 2010

Dr. Rajnish Verma
Deva Memorial Hospital
India
3 May – 30 July 2010

Dr. Lubna Kamani
Liadual National Hospital
Pakistan
1 November 2010 – 28 January 2011

Dr. Ajibola Aje
University College Hospital, Ibadan
Nigeria
1 February – 29 April 2011

Dr. Gamal Tohamy
Mouwasat hospital
Egypt
1 August – 30 October 2011



This year's hands Colonoscopy program featured two days of didactic lectures, introduction of colonoscopy simulators, and hands on experience for 40 attendees. Physicians from Burma, Laos, Cambodia, and as far away as Egypt attended the workshop that also featured live video case transmissions from Beijing, Seoul, and Tokyo. Dr. Richard Kozarek, WGO President, who was present for the initial Training Center inauguration in 2006, attended as faculty for this course and had the pleasure of meeting many of the trainees from around the region who have brought back the skill sets they learned in Siriaj to their respective countries.



Dr. Kozarek instructing colonoscopy during the 2011 program

The Latest News in WGO Global Guidelines and Cascades

This year so far has been a success for the Guidelines Program. The *Helicobacter pylori* and Constipation guidelines have been published in WGO's official Journal, the *Journal of Clinical Gastroenterology (JCG)*, the *Helicobacter pylori* Guideline was noted as one of the most cited articles in the JCG, and multiple guidelines both old and recently updated have been published in various National Society Members' journals. Look for these on the WGO Global Guidelines Homepage.

The **Probiotics-Prebiotics Guideline**, Chaired by Professor Francisco Guarner, Spain, has recently reached its final stages and is set to be released soon. This guideline features two important tables: *Evidence-based pediatric indications for probiotics and prebiotics in gastroenterology* and *Evidence-based adult indications for probiotics and prebiotics in gastroenterology*, and includes opinions and representation from Pakistan, Israel, South Africa, Austria, Canada, India, Turkey, South Korea, France, The Netherlands, along with outside experts from Uruguay, Argentina, Canada, Ireland, the USA and Poland.

The **NASH Guideline**, Chaired by WGO Foundation Board Member Professor Douglas LaBrecque, is also in its final stages and includes strong

feedback from Austria, Pakistan, USA, Malaysia, Russia, Venezuela, Colombia, Mexico, India, Croatia, Canada, France and the Netherlands.

With many other guideline updates in progress such as **Celiac Disease**, **Obesity** – with a special focus on the elderly and children, among others - and **Acute Diarrhea** – featuring a pediatric section - 2011 is sure to lead into a 2012 full of new, worthwhile educational resources by global experts, for gastroenterologists world wide.

WGO is also pleased to announce that the Guideline homepage will soon be available in Mandarin and Russian, so watch future issues of *e-WGN* as well as the new monthly *e-ALERT* for more news and updates on Global Guidelines and Cascades, and visit <http://www.worldgastroenterology.org/global-guidelines.html> to download any of the WGO guidelines for free, in six different languages including Spanish, Portuguese, English, French, Russian and Mandarin.

As always, WGO invites and encourages you to provide feedback on any of our Global Guidelines, by filling out the Guideline Feedback Form found here: <http://www.worldgastroenterology.org/wgo-guideline-feedback.html>.



A Resource Sensitive Solution