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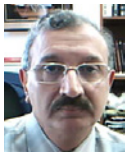


The WGO Guidelines Project

Past, Present, Future

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THE BEGINNING

Many years ago in the early nineties of last century in the corridors of the Amsterdam Academic Medical Hospital, Professor Guido Tytgat looked at a proposal to build a WGO Guidelines Project. Yes, he said, WGO could do what nobody was doing then – guidelines should be global and not just focus on the latest gold standards.

And so the early guidelines tried to take account of regional variation, of varying prevalence and incidence and ethnic issues. Three to four guidelines were produced per year and guideline review teams did not exist. Each guideline had a few authors only. These key opinion leaders were selected by the Guideline Chair and Professor Tytgat jointly. Often the first draft of the guideline was produced by a medical writer who summarized existing guidelines much like a systematic review today summarizes all randomized controlled trials. These were interesting times – one could argue that the wide variation in medical practice was a key factor in the world-wide growth of guideline making. But guidelines themselves also showed 'variation'. Major guideline making bodies like the ACG, AGA, SIGN, NICE and Canadian, Australian, New Zealand GI Associations occasionally showed a different approach to common digestive diseases even though the gold standard was always the goal.

As we realized this we knew our focus on content should be global. Whilst not forgetting the gold standard we knew we should try and concentrate on silver and bronze as it were. The gold standard would normally be sufficiently dealt with by the large 'Western Associations'. And furthermore, feedback from the National Societies also clearly showed our focus was helpful.

THE PRESENT

Introduction

In the late nineties Professor Tytgat moved on and the guidelines project acquired a new chair. Professor Michael Fried was the first more 'hands-on' chair-

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man. The world was changing and he clearly saw the need to organize production more strictly – Swiss precision and organization was introduced. The Guideline Committee expanded and WGO was keen to include representation especially from non-Western societies.

Professor Fried encouraged discussion on the role of evidence, about the importance of clinical experience and 'practice-variation' and – crucially – he developed and formalized WGO's global focus by introducing the 'Cascade' concept.

Each Guideline would henceforward not only have a chair but a specialist review team. The review teams always include a number of true experts and they always include gastroenterologists practicing in Asia, Africa and Latin America. Only in this way can we make sure that what we write has some use outside of the 'West'.

Each guideline should also always be translated into 6 languages to facilitate access and 'reach'. And a wise decision it was, as annual download statistics consistently showed that more than 50% of all guideline downloads concern non-English versions.

Team management became more professional. Teams were now supplied with key evidence through a number of 'evidence' initiatives such as Professor Elewaut's Graded Evidence (http://www.worldgastroenterology.org/graded-evidence.html), the Virtual Gastroenterology Library (http://www.labovirtual.com.ar/vrg.htm) and the WGO 'Ask a Librarian' service (http://www.worldgastroenterology.org/ask-a-librarian.html)

Workflow

WGO Guidelines are not Systematic Reviews of the evidence, gathering all relevant RCTs with carefully designed inclusion and exclusion protocols and then building strictly structured evidence tables from where we start the synthesis and then the recommendations and grading.

WGO guidelines do not present new evidence. Instead we identify the best available evidence from a variety of sources including existing systematic reviews and guidelines from the most authoritative and influential societies (usually North American) and we then try to summarize this in a new way taking account of available resources – that is to say, we built CASCADES. As a global society, WGO believes guidelines must not be resource-blind but instead sensitive to available resources and local culture and circumstances.

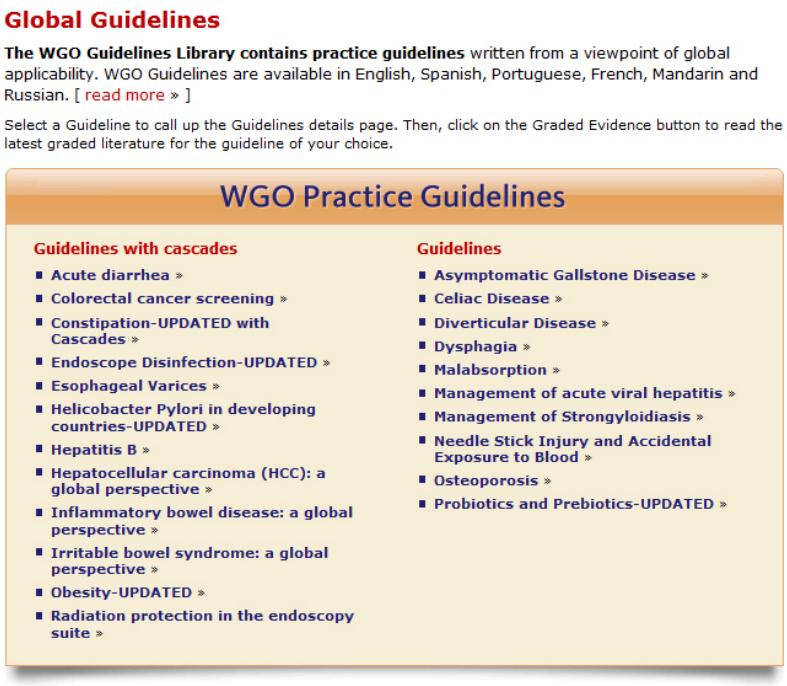
Thanks to the unique Cascades system, the WGO guidelines are applicable at every resource level. They offer adaptable solutions for the diagnosis and management of digestive disorders of global importance and are published on a bi-annual basis. WGO considers the dissemination and implementation of its Global Guidelines with Cascades as one of the organization's key educational goals.

By making the Cascades the new focus of the WGO's promotional efforts, by producing even more language versions of the Cascades with the help of the WGO National Societies and by disseminating them freely, true global ownership over the WGO Cascades can be given to the WGO membership. This will also encourage the WGO members and Training Centers to contribute to the production of the Cascades, which will then re-enforce the global nature of the Cascades and reassure the Cascades production team of the fact that the WGO offers solutions that truly cover each resource level.

What we are unique in

Our guiding philosophy is perhaps best illustrated by the thoughts of Tikki Pang (WHO Director) and others who, in The Lancet a few years ago, wrote that instead of focusing on

Current WGO Guidelines



new evidence, we can save millions of lives by trying to implement better what we know already.

(Pang, T., Gray, M. & Evans, T. (2006) A 15th grand challenge for global public health. Lancet, 367 (9507), 284–286. PMID 16443025.)

Our 'Evidence base'

We are very conscientious regarding gathering evidence, however the problem is that often there is very little evidence about diagnostic and treatment options that take account of limited resources. Clearly when trials are done they compare new treatment options with existing options (or against placebo) rather than older solutions or solutions based on locally available materials or resources.

We identify the gold standard – it is of course extremely important but it is the easy part and usually means referring to the relevant parts of an existing guideline from one of the top societies or perhaps a Cochrane review. For example, for our Hepatocellular carcinoma guideline, the gold standard was immediately available in the form of the recent HCC Guideline from the AASLD (American Association for the Study of the Liver) – written by Professor Morris Sherman (Canada) and Professor Jordi Bruix (Barcelona) – and both are on the review team for our WGO guideline. They are world leading experts and we are happy to refer to the AASLD guideline if we talk about a gold standard for HCC treatment.

What we need to do is to identify options available to those regions which do not have access to the resources you need when applying this gold standard. So we write for areas with fewer or even very few resources – we add global aspect data (prevalence and incidence worldwide if available) and we translate to make access easier for non-English speakers.

To have world experts like Morris Sherman and Jordi Bruix supporting such an approach is of course a great honor for us and not a little encouraging. But where is the evidence I hear you ask? Here I would refer you to the AASLD team.

Then, as far as our options for lower resource levels are concerned – here we can no longer use an evidence based approach – because there is no evidence – and for that we can present evidence.

WGO is currently working on two guidelines. Professor Hunt and his team are preparing a new guideline to mark this year's World Digestive Health Day (see: http://www.worldgastroenterology.org/world-digestive-health-day-year.html). Professor Umar from Pakistan will lead a team to produce our new guideline on hepatitis C – this is also a first for us and we are especially pleased to have major input from Asia.

The future

The future of guideline making needs to focus on improving the update process, creating better feedback mechanisms, and building structures that give better ownership to all WGO societies. Guidelines must not be top-down – they should be made by all of us for all us.

We will likely move from creating new guidelines to maintaining and updating already created guidelines and perhaps having them translated to more languages. Continuous feedback will be a great help when updating existing guidelines.

We are going for quality!

Acute Hepatitis E

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Background:

Hepatitis E virus (HEV) is associated with acute viral hepatitis E, an enterically transmitted hepatitis. HEV is becoming increasingly recognized in many parts of the world especially in developing countries like south Asia and Africa (1, 2). It is a significant worldwide public health problem with estimated infected cases of HEV amounting to about one third of the world population (3).

The first outbreak of HEV occurred in New Delhi (India) in 1955-56; this was retrospectively confirmed and reported that approximately 29,000 cases had jaundice (4). Subsequently, many epidemics have been reported from other parts of the world such as parts of Asia, Mexico and Africa (2). Moreover, a sporadic form of acute HEV infection occurred in developing parts of Asia and Africa as well as in developed nations (5).

Hepatitis E virus (HEV) is a non-enveloped, single-stranded, positive-sense RNA virus classified as a member of Hepeviridae family (6). This family also includes closely related viruses that infect pigs, rabbits, rats, deer and mongoose, which belong to the same genus as the human HEV genus (7). HEV genome is arranged in three overlapping open reading frames (ORF) i.e. ORF 1, 2, 3 (2).

Epidemiology:

There are at least four genotypes (1-4) found globally as shown in Table 1 and Figure 1 (8, 9). There are clear differences in the epidemic potential of various genotypes, and epidemics occur exclusively in underdeveloped regions where the predominant circulating human strain is HEV genotype 1 (Table 2) (2). Incubation period for HEV infection among human volunteers following oral ingestion has been 4-5 weeks; however, in actual epidemics where time of water contamination is known, incubation period varies from 2-10 weeks (9). There are at least four routes of transmission; fecal-oral transmission (most common), food-borne transmission, transfusion of infected blood products, and vertical transmission. The commonest is fecal-oral transmission (9, 10).

Table 1 Geographic distribution of HEV genotypes (8)

Geographic distribution of HEV genotypes

Genotype	Geographic region				
	Asia	Africa	America	Europe	Oceania
1	Bangladesh Cambodia China India Japan[a] Kyrgyzstan Myanmar Nepal Pakistan Uzbekistan Vietnam	Algeria CAR Chad Djibouti Egypt Morocco Namibia South Africa Sudan Tunisia	–	Russia UK[a]	–
2	–	CAR Chad DRC Egypt Namibia Nigeria	Mexico	–	–
3	Cambodia Japan Korea Kyrgyzstan Taiwan Thailand	–	Argentina Canada Mexico USA	Austria France Germany Greece Hungary Italy Netherlands Russia Spain UK	Australia New Zealand
4	China India Indonesia Japan Taiwan Vietnam	–	–	–	–

[a] Most likely imported from countries endemic for genotype 1 HEV.

Figure 1 Showing HEV endemic regions (9)

Table 2 Comparison of the Hepatitis E virus by select characteristics (2)

Characterstics	Genotype 1	Genotype 2	Genotype3	Genotype 4
Viral discovery	1983	1986	1995	2003
Geographic distribution	Developing countries	Mexico, West Africa	Developed countries	China, Taiwan, Japan
Food-borne transmission	No	No	Yes	Yes
Fecal-oral transmission	Yes	Yes	?	No
Water-borne transmission	Yes	Yes	?	No
Person-to-person transmission	Yes	Unknown	Yes	Unknown
Zoonotic transmission	No	No	Yes	Yes
Occurrence of epidemics	Common	Smaller scale epidemics	No epidemics	Uncommon
Highest attack rate	Young adults	Young adults	Persons ≥ 40 yr of age	Young adults
Gender	Male preponderance	Not discriminatory	Mostly male	Not discriminatory
Mortality rate	0.5%-3%	0.5%-3%	Not determined	0.5%-3%
Mortality among pregnant women	High	High	Not determined	High
Chronic infection	None	None	Yes	None
Severe disease among immuno-compromised	Not reported	Not reported	Yes	Not reported
Interspecies transmission	Only humans and non-human primates	Only humans and non-human primates	Humans Pigs	Humans Pigs
Subtypes	5	2	10	7

Table 3 Features of HEV infection in highly endemic and non-endemic countries (7)

Characteristic	Highly endemic Areas	Non endemic Areas
Human	Highly frequent, both sporadic and endemic cases	
Reservoir	Primarily Human; possibly environment	Zoonotic
Routes of transmission	Fecal oral; mainly through contaminated water	Ingestion of undercooked meat, possibly contact with animals
Characteristic of diseased person	Young healthy persons	Mostly elderly, with coexisting illness
Disease in pregnant women	High frequency of severe disease	Not reported
Prevalent genotype	1,2	3,4

The epidemiologic features of epidemic hepatitis E have remained unchanged since the first described outbreak from India; highest case rates among young individuals and a high fatality rate among pregnant women; the latter is characteristic of acute HEV infection (2). Different epidemiologic patterns (sporadic and epidemic) have been noted in countries where disease is either non-endemic or highly endemic; hence, these differ according to routes of transmission, affected population groups and disease characteristics (Table 3) (7, 10).

Highly Endemic Region:

This infection is endemic to tropical and subtropical countries in Asia, Africa and Central America. Outbreaks have been reported from Indian subcontinent including Pakistan mainly from northern areas (7, 11-13). These waves of HEV infections are related to contamination of drinking water with human wastes. Such epidemics had varied from unimodal epidemic lasting a few weeks to multipeaked epidemics which remained for many months with thousands of cases (11, 14). Rain leading either to floods or stagnation of water has been noticed as a main factor for drinking water contamination (14). In these areas, young adults are more affected than children who are mostly asymptomatic and male population is affected more than females. It had also been noted that there is predilection for pregnant women for HEV infection and causing higher mortality in this subset of patients. During pregnancy, HEV infection occurred usually in second or third trimester of pregnancy (7).

It has also been observed over the years that the sporadic form of hepatitis E infection occurs in high endemic areas with same characteristics of age, gender and severity and none of chronic sequelae (7).

From Pakistan two separate HEV isolates (87-Pakistan-A and B) were detected a few years ago (15). Recently an investigative report on an outbreak from southern part of Pakistan was presented, that showed new Pakistani strains (16). Our group has also reported HEV infection leading to acute liver failure in pregnancy in mid-1990's (17).

Low endemic regions:

These regions include primarily the developed world (including North America and Europe) and some countries of Asia Pacific regions (e.g., Japan, Taiwan, Hong Kong, Australia), where the incidence of HEV infection is quite infrequent. Until very recently it was considered that HEV infection is primarily imported to these places by travelers from high endemic areas to low endemic regions. But in recent past it has been shown that epidemics in low endemic areas like North America as well as in Europe are actually autochthonous as well (9, 18-20). Few observations have suggested that in these regions HEV infection is caused by zoonotic spread of infection from wild or home animals; in these observations, HEV isolate belong to genotype 3 or 4. These human isolates have been experimentally transmitted to non-human primates (7, 18). A report from Japan has also confirmed that few of the cases had consumed uncooked deer meat and isolates of HEV infection from these cases had similar genomic sequencing to those from wild hog and wild deer (21, 22). Recently from Korea a case series reported that only two patients had a history of travel to India while the remaining cases were supposedly autochthonous with isolation of genotype 4 (1).

Clinical manifestations:

The clinical features of HEV infection are similar to other acute viral hepatitides; however the majority of HEV infections are asymptomatic. HEV infection manifests in two distinct phases; initial preicteric phase lasting only for few days characterized by fever, loss of appetite, bad taste in the mouth, vomiting and abdomen pain and second icteric phase lasting for weeks that is marked by the disappearance of prodromal symptoms.

Few patients suffer a prolonged cholestatic phase marked by troublesome itching, though usually with good clinical outcome (7). Clinical outcome of HEV infection in patients with preexisting liver disease or any other comorbid is poor (23). Case fatality rate ranges from 0.5%-4% in hospitalized patients while community based surveys have shown a lower mortality rate (9).

It has also been observed that HEV infection in low endemic areas, usually affects somewhat older people mostly, males with a higher frequency of other comorbid conditions including liver disease and in these areas the outcome of HEV infection in pregnancies is better than that in high endemic areas (24).

Chronic HEV has been reported in the immunosuppressed (e.g. renal transplant, liver transplant) patients and may lead to cirrhosis (7, 25, 26).

Diagnosis:

Specific diagnosis of HEV infection is made on serologic tests for anti HEV antibodies (Ab). Detection of IgM anti HEV Ab suggests current infection while IgG anti HEV shows past exposure. HEV PCR based diagnosis is also available (26, 27). Liver injury is indicated by elevated liver enzymes including transaminases.

Treatment:

There is no specific treatment for HEV infection because it is self-resolving infection and only patients with acute liver failure require specific management especially intensive care unit that may require liver transplantation (7, 28).

Prevention:

The main mode of prevention would be to break the principal route of transmission (oral-fecal) by providing safe drinking water, proper treatment and safe disposal of human excreta and provision of health education (avoidance of uncooked food/meat, implementation of sanitary food handling practices) to endemic regions (7, 9). Vaccine is currently undergoing extensive trails for prevention and is showing promise (2).

Summary:

Initially it was thought that HEV infection is a disease of only underdeveloped countries but now it has been proven that this is also present in the developed world as well. As a consequence this has changed our understanding of its presence. Hence worldwide presence is a major concern because of its association with sporadic infections as well as epidemics. HEV infection has intricate epidemiology with water borne human to human contact and zoonotic transmission.

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Colorectal Cancer in More and Less Developed Countries

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The burden

The number of new cases of colorectal cancer (CRC) occurring in a year is expressed per 100,000 persons of the concerned population. The crude incidence rate, based on the actual age distribution in the population represents the actual burden of the disease in that country. However, the proportion of people in different age classes influences this rate and comparisons between countries require reference to a fixed standard (World Population in 1960). In each country, the incidence of CRC is expressed as the Age Standardized Rate (ASR)/100,000 persons. Similarly, the annual number of deaths from this cancer, occurring in a year, is expressed as ASR mortality/100,000 persons. Survival of CRC cases included in cancer registries is expressed at 5 years after detection and takes into account survival in a control population without CRC of the same country; this is the 5-year Relative Survival (5-yRS). Survival depends on the stage of the tumor at detection; in the period 1990-1999 the 5-yRS of colon cancer in the USA (SEER 12 registries), was 96% for Stage I localized cancer and only 6% for stage IV cancer.

Hereditary and sporadic cancer

In a small proportion, not over 5% of cases, CRC occurs as a hereditary disease, through genetic transmission by one ascendant. These include familial adenomatous polyposis (FAP) with transmission of a mutation on chromosome 5, and Lynch syndrome, a non-polyposis syndrome (HNPCC) with microsatellite instability (genes MSH2, MSH6) provoking secondary mutations in the original genome of the descendant. Usually CRC is a sporadic disease; then the risk is influenced by exogenous causal factors. Cases of sporadic cancer may occur under the influence of the same environmental causal factors in closely related parents, offering a similar multi-chromosomal genetic profile.

More and less developed countries

Countries are first classified in geographical regions of Africa, America, Asia, Europe and Oceania. With respect to human development, countries are more or less developed. More developed countries include North America, Europe, Australia and Japan; less developed countries are predominant in Asia, Africa, Latin America and the Caribbean. Those less developed countries showing rapid growth and industrialization are called "emerging"; this applies to Brazil, Russia, India and China, called the BRICs. In complement, a classification of the Gross National Income (GNI) per capita is published for each country by the World Bank and based on the final income (in US Dollars) of each country during one year, divided by the number of the population. According to the most recent (2011) estimations, the GNI per capita is $1,000 or less, for countries in the group Low Income; $1,000 to $4,000 for countries in the group Lower Middle Income; $4,000 to $12,000 for countries in the group Upper Middle Income; and more than $12,000 for countries in the group High Income.

Factors influencing the burden

The risk of sporadic CRC increases with age and is influenced by smoking and by other diseases such as inflammatory bowel disease and diabetes. Causal factors linked to the style of life and to the global resources and economics, differ between more and less developed countries with an impact on incidence (and correlative mortality) of CRC: Incidence is higher in countries classified in the Upper Middle and in the Upper Income groups:

1. A diet rich in calories of animal origin, including red and processed meat and poultry, is a source of overweight, resistance to insulin and production of insulin-like growth factors like IGF-1 which stimulate the proliferation of intestinal cells. In addition, aromatic polycyclic molecules with a carcinogenic impact develop within meat directly grilled on the flame at a high temperature.
2. The lack of physical activity and sedentary style of life is another causal factor. Multiple publications have confirmed the significant role

of physical activity and amount of daily walking, in the prevention of colorectal cancer.

3. Screening protocols based on the Fecal Occult Blood Test or colonoscopy are offered to asymptomatic persons, in the age range 50-70 years, in many developed countries. As a consequence, survival after detection of CRC, is higher in relation to the diffusion of early diagnosis and correct treatment, in those countries with higher resources.

Impact of the country development on incidence

In volume IX of the I.A.R.C. database "Cancer Incidence in Five Continents" the ASR incidence/100,000 of CRC is estimated in the period 1998-2002 in multiple registries of the world. For men incidence is high in developed countries: 37.4 in Japan (Osaka), 38.4 in the USA (SEER 9 registries), 48.7 in France (Bas Rhin); for women the respective figures are slightly lower: 21.7, 28.4 and 26.1, respectively. The incidence is much less in countries with low income in Sub-Saharan Africa, like Zimbabwe (Harare): 7.4 in men and 6.3 in women. In emerging countries, a high incidence is expected in urbanized areas like in Singapore in Asia: 40.1 in men and 29.3 in women. However, in India, figures remain low in urban registries (5.9 in men and 4.4 in women in Mumbai) and in rural registries (4.1 in men and 3.6 in women in Karuganappally). This can be explained by the general life style in this country where a vegetarian diet and practice of enough physical activity ensures a spontaneous primary prevention.

Impact of the country development on survival

In cancer registries with a correct follow-up the survival of CRC depends on the proportion of cases detected at an early, curable stage through population based screening protocols. The 5-y RS of CRC is high in more developed countries, as stressed in the CONCORD study for the period 1990-1994. In that study the respective figures in men were: 51.9% in USA registries, 45.3% in European registries and 61.1% in Japanese registries. For women the respective figures were 60.2%, 48.1% and 77.3%, respectively.

High figures still occur in cancer registries of urban areas in "emerging" countries: 54.0% for colon, both sexes, e.g., in China (Shanghai, 1992-95). Lower figures for colon, both sexes, occur in India: 30.3% in Mumbai (1992-1999) and only 7.0% in Bhopal (1991-2000). Low figures also occur in countries of Sub-Saharan Africa like in Uganda: 7.4% for colon, both sexes (Kampala, 1993-1997).

Temporal trends in incidence

The temporal trend on incidence of CRC is available through comparison of registries in 2 distinct periods; this trend can be compared to the development of the country during the same period. Incidence is expected to be stable if socio-economic factors do not change, or to increase if the level of development increases. In developed countries with a high incidence of CRC, the trend to increase is modulated towards decrease by the diffusion of the endoscopic resection of precursor adenomatous polyps during colonoscopy. In the USA, after a period of increased risk, a slight and steady decline occurred in the incidence of CRC, in relation to the practice of polypectomy, in the last 3 decades. As shown in the SEER 9 registries, the ASR incidence/100,000 for CRC, both sexes and all races, decreased from 64.2 in 1985, to 60.6 in 1990 and 49.5 in 2003.

The variation in the incidence of CRC between two periods is confirmed in many countries in the successive volumes of the IARC database "Cancer Incidence in Five Continents". In Japan, a developed country, the ASR incidence/100,000 of colon cancer in men, increased from 8.3 in 1973-1977 to 36.0 in 1998-2002. The respective figures for women increased from 7.3 to 21.5. This change correlates with an increase of risk factors associated with CRC, like a high calorie intake, reduced fruit and vegetable intake, increased consumption of fat with excess body weight and reduced physical activity. In India, an emerging country, the incidence of CRC remained low and stable during the same period, even in urban areas. In the Mumbai registry the ASR incidence/100,000 of colon cancer in men was at 3.5 in 1973-1977 and 3.0 in 1998-2002. The respective figures for women were 3.5 and 2.4, respectively. This stability, equivalent to a primary prevention, is likely to be due to a traditional life style with a diet rich in vegetables and occupational physical activity. In urbanized regions of other emerging countries the incidence of CRC increased during the same period as in the Singapore registry for the Chinese population where the ASR Incidence/100,000 of colon cancer increased from 14.9 to 26.5 in men and from 12.7 to 20.8 in women.

Conclusions

In countries with a high incidence of colorectal cancer, where the 5-y survival of this tumor is relatively high, the health authorities and general practitioners should still develop primary prevention through diet and physical exercise. A major advantage of colonoscopic exploration in screening protocols, in addition to detection of cancer, is the direct treatment of precancerous adenomatous lesions aiming at reduction of CRC incidence.

In less developed countries with a lower burden of cancer, a large

proportion of deaths are caused by infectious diseases. The priority in the management of CRC should be given to quality control in the course of early diagnosis and to improvement of survival after detection, rather than to mass screening.

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2012 World Digestive Health Day

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University College Cork
Cork University Hospital
Ireland
Co-Chair, WDHD 2012

Richard Hunt, FRCP, FRCP(C), FACG, FAGA

Farncombe Family Digestive Disease Research Institute
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Canada
Co-Chair, WDHD 2012

The goal of the WDHD 2012 advocacy and public health awareness campaign, "**From Heartburn to Constipation – Common GI Symptoms in the Community: Impact and Interpretation**", is to help health care providers and sufferers alike to understand these common symptoms, what they may mean and how they should be appropriately and effectively managed. WDHD 2012 will endeavor to engage with and inform the health care provider – physicians, pharmacists and allied health professionals – and the community at large. WDHD will seek to encourage dialogue on these GI issues and to facilitate interaction between the sufferer and health care providers involved in the management of these and related symptoms.

Special attention will be given to the influence of culture, ethnicity and language on the expression and interpretation of these symptoms and to the development of diagnostic and management algorithms appropriate to various settings and circumstances.

HERE IS A PREVIEW OF EVENTS THAT ARE ALREADY PLANNED FOR THIS YEAR!

INDIA

Date: May 29-June 3, 2012
The event is a CME for postgraduate students, family physicians, internists and gastroenterologist. In addition, there will be an awareness campaign for the general public.

KAZAKHSTAN

Date: May 30-31, 2012
An event for the Republic Kazakhstan Ministry of Health, National Gastroenterologists Association in collaboration with WGO will be held.

MALAYSIA

Date: May 29-June 3, 2012
2012 will be the fourth year World Digestive Health Day is celebrated in Malaysia. WDHD Malaysia was inaugurated in the year 2009. Each year, an official ceremony of WDHD Malaysia is held on May 29 in a high-

This important initiative could not have been done without the hard work of the WDHD 2012 Steering Committee. WGO sincerely thanks the following volunteers for their time and dedication to this important campaign:

- Dr. Richard Hunt, WDHD 2012 Co-Chairman, Division of Gastroenterology, Canada
- Dr. Eamonn Quigley, WDHD 2012 Co-Chairman, Alimentary Pharmabiotic Centre, University College Cork, Cork, Ireland
- Dr. Monica Acalovschi, University of Medicine and Pharmacy, Cluj-Napoca, Romania
- Dr. Naima Amrani, Faculté de Médecine et de Pharmacie, UM5S - Rabat, Morocco
- Dr. Dan Dumitrascu, University of Medicine and Pharmacy, Cluj-Napoca, Romania
- Dr. Kwong Ming Fock, Changi General Hospital, Singapore
- Dr. Amy Foxx-Orenstein, Mayo Clinic, Arizona, USA
- Dr. Francisco Guarner, University Hospital Vall d'Hebron, Barcelona, Spain
- Dr. John Horn, University of Washington, Department of Pharmacy, Seattle, USA
- Dr. Pali Hungin, Durham University, UK
- Dr. Govind Makharia, All India Institute of Medical Sciences, New Delhi, India
- Dr. Carolina Olano, Gastroenterology Department. Universidad de la República. Montevideo, Uruguay

traffic shopping mall, officiated by the Ministry of Health Malaysia. It aims to reach out to the public with the objective of creating awareness and educating the public and reducing the prevalence of digestive disease/ disorders in Malaysia. The official ceremony is followed by a 5-day road show.

PAKISTAN

Date: May 31, 2012
A one day Symposia for Awareness and Teaching will take place.

UKRAINE

Date: May 24, 2012
A Scientific Conference and healthy food exhibition under the support of the Health Ministry will be held.

ROMANIA

Date: June 14-16, 2012
The National Symposium of Gastroenterology will take place during these dates, and a Symposium on the common GI symptoms in the community will be organized. Presentations at other gastroenterology meetings will be organized during the year as well.

UNITED ARAB EMIRATES

Date: May 29, 2012
The event will be a CME event for General Practitioners.

Visit http://www.wgofoundation.org/wdhd-2012.html to view more information on the 2012 WDHD Campaign.

WGO Digestive Oncology Task Force

Chris JJ Mulder, MD

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The WGO is pleased to formally announce the creation of the new WGO Digestive Oncology Task Force. The Task Force membership is currently being confirmed and will meet for the first time at DDW in San Diego. The inaugural article from Professor Chris JJ Mulder, Chair of the Task Force, follows.

Until the late 1980's, Gastroenterology was considered a subspecialty of Internal Medicine. We incorporated Hepatology and now train Hepatogastroenterologists (HGE-specialists). Since 2000 the HGE- societies do extend more and more GE training to 4 years, with a common trunk of Internal Medicine of 2 years. In the final 4th year, fellows subspecialize, if possible/desirable in advanced endoscopy, motility/nutrition, hepatology or oncology. Training in advanced endoscopy or hepatology has been well defined. Proper curricula for Digestive Oncology (DO) have been published and are well developed in Germany, Belgium and France. The major challenge in current training is the language. Where to train HGE-specialists in English speaking countries in sufficient numbers?

The WGO task-force for Digestive Oncology will discuss the local possibilities and develop a strategy to implement this training in the HGE-specialisation.

DIGESTIVE ONCOLOGY

HGE- specialists are often the first to see the patient with digestive cancers. They are increasingly resisting the paradigm in which only HGE-specialists play a diagnostic or technical role in the care of digestive tumors. A new HGE-generation seeks to assume a more central role in the multidisciplinary care of our patients. A subgroup of HGE-specialists wants to deliver anti-cancer therapies in the future.

Thereby HGE-specialists are competent to organize supportive care for DO-patients. We have the immense advantage as HGE-specialists, that we can both diagnose malnutrition or obstructing symptoms and can resolve such devastating situations.

Despite modern down staging anti-cancer drug therapy, (intra-operative) radiofrequent ablation, high dose radiotherapy or combined treatment modalities, the need for optimal surgery has not been eliminated. More and more surgeons develop the necessary skills to operate highly pre-treated tumors. Induction chemo(radio) therapy for oesophageal, gastric and rectal tumors is expanding. The role of surgery by resection of cancers previously considered incurable, is centralized in low-volume, high complex referring centers.

Future Digestive Oncologists must be skilled HGE-specialists capable in modern diagnostic and staging procedures as well as anti-cancer therapy. The goal of advanced training in Digestive Oncology is to enhance knowledge and skills beyond the expertise obtained during a normal HGE residency program.

Training programs in Germany, Belgium and France are organized to provide a structural educational experience at an advanced level to ensure that those trainees acquire the knowledge and skills necessary to gain this.

We are now in a process of implementing such a curriculum in the East and in the West. In Europe we advise candidates for Digestive Oncology to do one more year of oriented oncology training during the last year of formal HGE-training and one additional year to be spend in a Medical Oncology Department combined with advanced HGE-oncology care. In the East some suggest to spend already 6 months on an oncology ward during the basic trunk of 2 years of Internal Medicine, to spend during this Internal Medicine, followed by 2 years of gastroenterology in a regular HGE-training setting. The final 2 years should be spent on advanced endoscopy focusing on tumor staging and palliative endoscopic tumor care and out-clinic oncological medical therapy in close cooperation with medical oncologists.

The published curriculums of Clinical Oncological Societies should provide the main framework for this

training. No compromise in training duration should be made to ensure an adequate level of competence. Chemotherapy ordering, preparation and administration are part of this. Rapidly developing countries like India and China can integrate this management of digestive cancers by HGE-specialists in their public and private hospitals to keep these treatments in one hand.

More prevalent tumors from the East like HCC's are ideal to start as our hepatologists are already skilled in very complicated logistic medical treatment in Hep B and Hep C. Our IBD-ologists do treat, for more than a decade, their patients with complicated immunochemotherapy with monoclonal antibodies, thiopurines and methotrexate. In year 3-5 our trainees are being trained in these competences. A differentiation in year 6 for Digestive Oncology is not a major threshold for them anymore.

It is this idea of expansion of the scope of the HGE-units that will necessitate advanced Digestive Oncology training for a minority of HGE-specialists. Some HGE-specialists trained as sub specialists in Internal Medicine administer chemotherapy in their countries (Middle-East/Africa/South America). Maintaining the continuity of patient care is a worthwhile goal.

The scope and personalization of the HGE-curriculum is WGO's major challenge, it will change HGE once again in the coming decade.

The proper positioning of Digestive Oncology is an important part for this WGO Task-Force. We hope that the WGO can encourage a new generation of HGE-specialists to join us and take over our initiative.

After prevention, screening and surveillance, staging, endoscopic treatment and supportive care some of us are joining internists again in medical oncological treatments. In the East and West Digestive Oncology Societies have been established. Of interest, the African Middle East Society for Digestive Oncology was formally founded in Khartoum Sudan on 12th February 2012. Their first goal is to organize primary medical care for HCC and adjuvant CRC treatment based on competence.

The next years will boost improved DO care by HGE-specialists. WGO is supportive of these efforts, as well as increased training in GI oncology for all GI and hepatology trainees and practitioners.

WGO 2012 Calendar of Events

Endo Live Roma 2012
When: April 12-13, 2012
Location: Università Cattolica del Sacro Cuore
Address: Policlinico A. Gemelli, Aula Brasca, Largo A. Gemelli, 8 – 00168 Rome, Italy
Organizer: Gruppo Sc Studio Congressi
E-mail: info@endoliveroma.it
Website: www.endoliveroma.it

10th International Symposium on Functional Gastrointestinal Disorders
When: April 12-14, 2012
Location: Pfister Hotel, USA
Organizer: University of Wisconsin School of Medicine and Public Health, Office of Continuing Professional Development and the International Foundation for Functional Gastrointestinal Disorders (IFFGD)
Telephone: +1 414-964-1799
Fax: +1 414-964-7176
E-mail: symposium@iffgd.org
Website: http://www.iffgd.org/symposium

CH-EUS - Symposium Contrast Harmonic – Endoscopy Ultrasound Kontrastmittelgestützte Endosonographie
When: April 13, 2012
Location: Hamburg, Bethesda Krankenhaus Bergedorfl
Address: COCS GmbH - Congress Organisation C. Schäfer Rosenheimer Str. 145c, 81671 Munich, Germany
Organizer: Tagungsleitung: Dr. med. Dr. habil. Martin Keuchel, Hamburg, COCS GmbH - Congress Organisation C. Schäfer
E-mail: info@cocs.de
Website: www.cocs.de

Endoskopie-Live Berlin 2012
When: April 27-28, 2012
Location: MARITIM proArte Hotel
Address: Friedrichstrasse 151, 10117 Berlin, Germany
Organizer: Congress Organisation C. Schäfer
E-mail: info.bpa@maritim.de
Website: www.cocs.de

9th Congress of the Jordanian Society of Gastroenterology
When: May 3-5, 2012
Location: Le Meridien Hotel, Amman
Address: Queen Noor Street, Shmeisani, Jordan
E-mail: medical@jordan-valley.com
Website: http://www.jgsociety.com/

Digestive Diseases Week 2012
When: May 19-22, 2012
Location: San Diego Convention Center, San Diego, CA
Address: 111 West Harbor Drive, San Diego, USA
Contact Page: http://www.ddw.org/wmspage.cfm?parm1=714
Website: http://www.ddw.org/

Gastro-intestinal Models for the Study of Probiotics and Prebiotics - Pre-conference Satellite Symposium
When: June 11, 2012
Location: Kosice
Address: Doubletree by Hilton, Kosice, Slovakia
Organizer: The International Scientific Conference on Probiotics and Prebiotics
E-mail: info@probiotic-conference.net
Website: www.probiotic-conference.net/Symposium

Digestive Disorders Federation 2012 Meeting
When: June 17-20, 2012
Location: Arena Convention Centre
Address: Monarchs Quay, Liverpool, L3 4FP, United Kingdom
Organizer: COCS GmbH
E-mail: DDF2012@mci-group.com
Website: http://www.ddf2012.org.uk

8th International Endoscopy Workshop
When: September 12-15, 2012
Location: The 8th International Endoscopy Workshop's venue will be located at Cipto Mangunkusumo National General Hospital and Indonesian Digestive Disease Week (IDDW) 2012'S venue will be located at Borobudur Hotel, Jakarta, Indonesia
Organizer: Indonesian Society of Gastroenterology and Indonesian Society for Digestive Endoscopy
E-mail: gitipdui@cbn.net.id

IV Advanced Theoretical-Practical Course on Endoscopic Submucosal Dissection in Animal Model
When: September 14-15, 2012
Location: Cáceres
Address: Centro de Cirugía de Mínima Invasión Jesús Usón - Carretera N-521, km 41,8 10071 Cáceres, Spain
Organizer: Minimally Invasive Surgery Centre Jesús Usón
E-mail: ccmi@ccmijesususon.com
Website: www.ccmijesususon.com

UEGW Amsterdam 2012

When: October 20-24, 2012
Location: Amsterdam RAI Convention Centre
Address: Europaplein, NL 1078 GZ Amsterdam, The Netherlands
E-mail: office@uegf.org
Website: http://uegw12.uegf.org/

American College of Gastroenterology Annual Scientific Meeting

When: October 19-24, 2012
Location: The Venetian, Las Vegas, Nevada, USA
Address: 3355 Las Vegas Boulevard South, USA
Website: http://www.acgmeetings.org

13th World Congress of the International Society for Disease of the Esophagues

When: October 15-17, 2012
Location: Venice Lid, Italy
E-mail: isde2012@keycongress.com
Website: http://www.isde2012.org/

6th AMAGE Congress

When: November 22-24, 2012
Location: Calabar, Nigeria, a peaceful and quiet area with beautiful scenery and many tourist attractions to enjoy during your stay
Hosted by: the African Middle East Association of Gastroenterology (AMAGE) in collaboration with the Nigerian Society of Gastroenterology (SOGHIN)
Organizer: Arab Organizers Company, Dr. Ibrahim Farouk, araborganizers@hotmail.com
President: Hussein Abdel-Hamid (Egypt)
Email: hussein.egypt22@gmail.com
Telephone: 0202 01006602429
Founding President: Ziad Sharaiha (Jordan)
Email: z_ash@hotmail.com
Vice President for Middle East: Siavosh Nasseri- Moghaddam (Iran)
Vice President for Africa: Ronald Ndoma (Nigeria)
Secretary General: Olusegun Ojo (Nigeria)
Email: segun.ojo@gmail.com
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Treasurer: Reda Elwakil (Egypt)
Email: wakil_md@yahoo.com
Treasurer: Edith Okeke (Nigeria)
Website: http://www.sixthamagecongress-calabar.com/

Highlighted events represent WGO member events. For a full listing of events happening in 2012, visit http://www.worldgastroenterology.org/major-meetings.html

The Latest News in WGO Global Guidelines and Cascades

WGO IS PLEASED TO ANNOUNCE THE CREATION OF THE GUIDELINES HOMEPAGE, IN MANDARIN!

The Mandarin page is currently available at http://www.worldgastroenterology.org/global-guidelines-mandarin.html. Watch *e-WGN* for news on the Russian version of the Guidelines homepage, coming soon!

GLOBAL GUIDELINES AND CASCADES — WGO

A Resource Sensitive Solution

RECENT GLOBAL GUIDELINE NEWS!

Obesity

The Obesity Guideline has now been released! The English version, now available for download at http://www.worldgastroenterology.org/obesity.html, has been updated to include five appendices: Nutrition, Pharmacotherapy, Lifestyle Changes, Surgery, and Obesity and the Elderly.

Probiotics

Originally created in 2008, the 2011 updated version is now available in English, Spanish, Portuguese, Mandarin and French. The Probiotics Guideline will soon be published in WGO's official Journal, the *Journal of Clinical Gastroenterology*.

Download the newest version now! http://www.worldgastroenterology.org/probiotics-prebiotics

WHAT TO LOOK FOR IN 2012!

NASH

The NASH Guideline, a brand new WGO guideline, is chaired by WGO Foundation Board Member Professor Douglas LaBrecque, and is in its final stages. It features cascade options for diagnosis in patients with suspected NAFLD/NASH as well as a therapy cascade for extensive, medium, and limited resources. A special section lists specific bibliographies for epidemiology, pediatric epidemiology, non-

invasive diagnosis, hepatitis C and NAFLD/NASH, pathophysiology, and treatment. The NASH guideline incorporates strong feedback from Austria, Pakistan, USA, Malaysia, Russia, Venezuela, Colombia, Mexico, India, Croatia, Canada, France and the Netherlands.

Celiac Disease

Under the direction of Professor Julio Bai, the updated Celiac Disease Guideline will feature a cascade for the diagnostic management of Celiac disease. This cascade focuses on resource constraints when diagnosing the condition – with limited resources for example, a simple antiTG IgA could be considered to diagnose Celiac Disease.

Acute Diarrhea

The Acute Diarrhea Guideline, led by Professor Michael Farthing, now features specific information on pediatric aspects of acute diarrhea. This aspect has been built by special advisor Dr. Mohammed Abdus Salem of the ICDDR-Bangladesh. The guideline has a cascade for acute, severe, watery diarrhea – cholera-like with severe dehydration. There is also a cascade for acute, mild/moderate, watery diarrhea – with mild/moderate dehydration and, finally, the guideline has a third cascade for acute bloody diarrhea – with mild/moderate dehydration.

Along with the release of these Guidelines comes the creation of two very important Guidelines: A guideline on hepatitis C, led by Professor Umar of Pakistan, and a special guideline focused on this year's World Digestive Health Day, led by Professor Richard Hunt, Canada.

Watch future issues of *e-WGN* as well as the 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.