

# e-WGN

## WORLD GASTROENTEROLOGY NEWS

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Graeme Young, MD

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## The New e-WGN After Four Years



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e-World Gastroenterology News (e-WGN) was established by the World Gastroenterology Organisation (WGO) at the time of the last World Congress of Gastroenterology (WCOG) in November 2009 in London. Its mandate was to carry on the mantle of World Gastroenterology News (WGN) that had been published and distributed in a print version for many years. Henry J. Binder, Professor of Medicine at Yale University, USA and Greger Lindberg Professor of Gastroenterology at Karolinska Institute, Sweden, were appointed as its initial Co-Editors. Over the past four years e-WGN has been published four times each year and distributed to gastroenterological societies around the world that constitute WGO for dissemination to their respective members.

e-WGN has provided a mix of scientific articles together with news of activities and accomplishments of WGO. The Co-Editors decided that the scientific articles

(usually two in each issue) would concentrate on diseases that either had significant differences in prevalence in different areas of the world (e.g., gastric carcinoma) or had significant changes in prevalence over time (e.g., Celiac Disease). These articles have provided a continuum of new information of such diseases to our readership.

e-WGN has also included summaries of the major activity of WGO – the multiple regional Training Centers and the Train the Trainer workshops that are held each year. Highlights of these critical WGO activities have been outlined in each issue of e-WGN.

Another activity of WGO that has been emphasized in e-WGN has been World Digestive Health Day (WDHD) which is held on 29 May – the day that WGO was originally incorporated in 1958. Over the past several years WDHD has evolved into a year-long event in which the member organizations hold multiple events to highlight and publicize the specific disease

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entity that has been identified for that year's WDHD. These have included: Inflammatory Bowel Diseases (IBD); Irritable Bowel Syndrome (IBS); Enteric Infections; Common Gastrointestinal Symptoms; and in 2013 Liver Cancer (HCC).

The activities of the Global Guidelines Committee whether launching new guidelines or updates of existing guidelines have been highlighted in *e-WGN*. Particular emphasis has been on the use of cascades for creating resource sensitive guidelines. WGO Global Guidelines are now available in six languages including Mandarin and Russian with separate homepages in the latter two (see The Latest News in WGO Global Guidelines and Cascades in this issue of *e-WGN*).

Over almost 60 years the only meeting that WGO has held has been its quadrennial meeting – the

World Congress of Gastroenterology (WCOG). Changes have occurred during the past few years: Starting in 2009 WCOG was held in London, in conjunction with UEGW (United European Gastroenterology Week) and was a great success. In 2011 a regional meeting, Gastro Antalya, was held (between WCOG meetings) in Turkey as an additional educational event. This meeting in Antalya was deemed very successful such that the Executive Committee of WGO decided to hold additional events between the quadrennial meeting. The next WCOG meeting will be held in collaboration with the Asian Pacific Digestive Week Federation (APDWF), the Chinese Societies of Digestive Diseases (CSDD), and the World Endoscopy Organization (WEO) in Shanghai from 21-24 September. In this issue of *e-WGN* as well as in the two prior

issues, considerable information about the coming joint meeting – Gastro 2013 – has been provided.

Finally, with the next WCOG and the end of this calendar year the Editorship of the two present Co-Editors of *e-WGN* will end and the mantle of *e-WGN* will be passed to two new editors – Dr. Christina Surawicz from Seattle, Washington, USA, and Professor Enrique Dominguez-Muñoz from Santiago de Compostela, Spain. We are confident that Professors Surawicz and Dominguez-Muñoz will successfully continue *e-WGN* that was initiated by the two retiring Co-Editors in 2009. We look forward to future issues of *e-WGN*!



## Adenocarcinoma at the Esophago-Gastric (EG) Junction



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### Morphology of the esophago-gastric junction

Esophageal and gastric tumors are often classified in a single group because they are detected in the two steps of the same diagnostic procedure: upper GI endoscopy.

Adenocarcinoma at the EG junction, is located in the distal third of the esophagus (C15.5 in the ICD classification of tumors) or in the proximal part of the stomach or cardia (C16.0). In most countries, there are much more cases at the cardia, than in the distal esophagus. Siewert classified cancer at the EG junction in 3 groups with respect to the central point of the tumor: Group I with an esophageal origin; Group II with an origin in the gastric cardia; and Group III with a sub-cardial origin. The esophagus joins the stomach at the level of the diaphragmatic pinch, when there is no

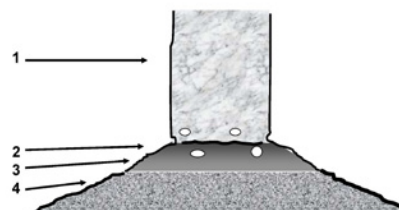


Figure 1: Anatomical sectors at the esophago-gastric junction: 1-distal esophagus, 2-esophago-gastric epithelial junction, 3-mucosa of the cardia, 4-mucosa of the fundus.

hiatal hernia. As shown in Figure 1, the EG region includes the distal part of the esophagus up to 2 cm above the squamo-columnar junction of the epithelium, just above the pinch of the diaphragm and also the proximal part of the stomach, or cardia, down to 2 cm below this epithelial junction. Above the epithelial junction, or Z-line, superficial and parallel epithelial capillaries offer an endoscopic landmark of the squamous epithelium. Below the Z-line, the upper pole of the longitudinal folds of the gastric mucosa is the endoscopic landmark of the proximal part of the stomach. The short segment of gastric cardiac mucosa is coated with cardiac epithelial cells organized in short pits and glands. This segment is in continuity with the fundic or oxyntic epithelium of the stomach where parietal cells are visible. The distinct epithelial types at the EG junction are shown in Figure 2. In addition, small islets of cardiac mucosa are often present in the squamous epithelium above the Z-line and islets of intestinal metaplasia may develop above or below this Z-line. If there is a hiatal hernia, the respective positions of the endoscopic landmarks are modified: the esophago-gastric junction moves to a position proximal to the pinch of the diaphragm and a segment of the stomach is located in the thorax. In the columnar lined, or Barrett's esophagus, the squamo-

columnar epithelial junction will ascend in the distal esophagus which is then lined by a segment of columnar metaplasia showing cardiac columnar cells and intestinal metaplasia. The length of this metaplastic segment is variable and very short segments (<1 cm) of columnar metaplasia are often misdiagnosed.

### Esophageal cancer

Squamous cell cancer is the most frequent type of esophageal tumor, and in many countries adenocarcinoma is relatively rare. The relative proportions of both types of esophageal tumor are shown in cancer registries with histological data. In the period 1993-97 the proportion of adenocarcinoma (both sexes) was only 4.2% in Japan (Osaka registry), 5.4% in Korea (Seoul registry), and 9.5% in France (Bas Rhin registry). Higher proportions of adenocarcinoma occur in the same period in Northern Europe with 27.0% in Sweden, (Country registry); 29.6% in Norway (Country registry), and 52.0% in the caucasian population of the USA (SEER registries). In Western countries the incidence of adenocarcinoma in the esophagus tends to increase. The annual variation during the period 1973-1993 in the SEER registries of the USA was +8.6% in males and +6.8% in females, in the white population.

### Stomach cancer

Stomach cancer is a frequent tumor: in the database GLOBOCAN the respective numbers of incident cases in more and in less developed countries were in 2002 207,000 and 439,000 in men, and 120,000 and 233,000 in women. The risk of stomach cancer in men is about twice that of women in both high and low-risk countries. It is

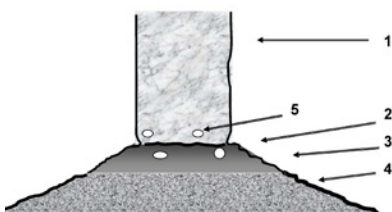


Figure 2: Epithelial types at the esophago-gastric junction: 1-squamous cell epithelium, 2-squamo-columnar epithelial junction, 3-columnar cardiac epithelium, 4-fundic epithelium with parietal cells, 5-islets of intestinal metaplasia.

estimated that gastric adenocarcinoma is located distally to the cardia in 82% of cases. In the Lauren classification, gastric adenocarcinoma is classified in 2 categories: an “intestinal” type with recognizable glands and a “diffuse” type without cohesion between the cells. Areas of highest incidence are found in Eastern Asia, Western South America, and Eastern Europe. In Japan, in 1999 an analysis of 11 population-based registries showed that stomach cancer accounted for 23% of cancer cases in men in 1999 and 15% in women. In the database GLOBOCAN, the age standardized incidence rate /100,000 of stomach cancer in Japan in East Asia was estimated in 2002 at 62.1 in males and 26.1 in females; the respective figures were much lower: 7.2 and 3.3 in the USA. However since the period 1963-65 there is a continuous decreasing trend for the incidence of stomach cancer in Asia.

#### Adenocarcinoma at EG junction, in the cardia

In a report from Parkin the respective numbers of adenocarcinomas classified at cardia or in distal esophagus in the SEER registries of the USA (1973-95) were 6,300 and 2,694 for the white population and 311 and 43 for the black population; the respective numbers were 2,203 and 358 in

the registries of 4 regions in France (in 1978-92) and 2,151 and 15 in the Osaka registry of Japan (in 1980-93). Adenocarcinoma at the cardia differs from adenocarcinoma in the distal esophagus in the profile of molecular markers: the ratio cytokeratins - CK7 high /CK20 low - is more frequent for tumors located at the cardia, and so is the TP 53 mutation, as shown at the Paris Workshop.

#### Adenocarcinoma at EG junction, in the esophagus

The tumor arises from an area with columnar metaplasia, which is a pre-neoplastic condition. The risk of malignancy in columnar metaplasia of the esophagus is estimated at 1 case for 200 patients followed during one year. The risk is higher in the male sex, with Caucasian ethnicity and a long history of reflux symptoms. The risk is lower in females and in people with Asian or African ethnicity. The risk of malignancy increases with the length of columnar metaplasia in the esophagus, but short segments at the EG junction deserve attention because they are more frequent. The mechanisms by which columnar metaplasia develops in the mucosa of the distal esophagus, exposed to irritation from acid and the injurious effect of bile acids and salts, are still debated. Western experts propose that, after destruction of the squamous epithelium by bile and acid stress, multipotent esophageal stem cells expressing cytokeratin, proliferate and differentiate into a columnar type. Eastern experts consider that there is a direct proliferation of the islands of esophageal cardiac mucosa, exposed to the same factors. In the sequence leading from inflammation to metaplasia and then cancer, the intraluminal generation of nitric oxide from dietary nitrate occurs at the EG junction with formation of carcinogenic N nitroso-compounds. Western experts consider that adenocarcinoma develops selectively from

areas with intestinal metaplasia. Most experts in Asia think that adenocarcinoma can also develop in the absence of intestinal metaplasia, from areas with metaplasia showing only columnar cardiac cells.

#### Causal factors for adenocarcinoma at EG junction

In the upper digestive tract, neoplastic lesions develop in a background of chronic inflammation of the mucosa and submucosa. Endogenous factors, in particular bile and acid from duodeno-gastric and gastro-esophageal reflux, have an irritative action, combined with multiple exogenous toxic and infectious agents like alcohol, tobacco, nitrites, food contaminants, *H. pylori* in the stomach and HPV in the esophagus.

**In the cardia:** chronic inflammation of the mucosa in the distal verge of the squamo-columnar epithelial junction, is frequent. Carditis is characterized by elongated pits, hyperplasia and islets of intestinal metaplasia. The prevalence of carditis in the adult population is high and intestinal metaplasia has been demonstrated at endoscopy in up to 25% of persons with, or without, reflux symptoms. Gastric carcinogenesis follows the pathway described by Correa - atrophic chronic gastritis - intestinal metaplasia - intraepithelial neoplasia. Atrophic gastritis increases the intraluminal pH with transformation of nitrites (NO<sub>2</sub>) in NO under the influence of the inducible nitric oxide synthetase (i-NOS). This chain reaction towards nitrosation results in the endoluminal formation of carcinogens and is inhibited by anti-oxidants (ascorbic acid). The etiology of carditis is multifactorial: contact with unbuffered acid, mechanical trauma and *H. pylori* infection. The causal factors linked to lifestyle in stomach cancer are linked to diet and tobacco: a high intake of mucosal irritants such as salt and nitrates causes chronic inflamma-

tion and superficial gastritis. In Japan, during the follow-up of a cohort of subjects with atrophic gastritis, the risk of stomach cancer increased 1.8-fold by the consumption of salty and spicy food. A high intake of fruit and vegetables is associated with a reduced risk of stomach cancer and anti-oxidants, such as beta-carotene, alpha-tocopherol (vitamin E), ascorbic acid (vitamin C), prevent the formation of carcinogens in the gastric lumen. The risk of stomach cancer also increases in both sexes with the duration of smoking and number of cigarettes smoked. These factors play a role altogether in distal stomach cancer and in proximal cancer at the cardia. *H. pylori*, an infectious agent, is another major causal factor in distal gastric cancer, but it plays a marginal role in proximal gastric cancer at the level of the cardia. The Helicobacter and Cancer Collaborative Group confirmed in prospective studies the association between *H. pylori* infection and the subsequent development of distal cancer (O.R. = 2.97), while there was no increased risk for the cardia site (O.R. = 0.99). The prevalence of *H. pylori* infection in humans is estimated at 74% in developing countries and 58% in developed countries. However, the incidence of stomach cancer is not high in African countries, in contrast to the very high prevalence of *H. pylori* infection. According to Parkin it can be estimated that in 2002 around 590,000 cases of gastric cancer were attributable to *H. pylori* infection. The cycle of infection is through oral contamination in childhood, increased contamination with age, possible sero-conversion after eradication and possible re-infection.

**In the esophagus:** Gastroesophageal reflux disease (GERD) is the cause of columnar metaplasia in the esophagus. The exact prevalence of Barrett's esophagus in the population is difficult to estimate because more

than 80% of those patients are asymptomatic. A recent survey of persons with, or without, reflux symptoms who had an indication of colonoscopy and have accepted a simultaneous upper GI endoscopy detected Barrett's esophagus in 6.8%; this is a disease of the white (Caucasian) and aged male persons. Alcohol consumption, smoking, and a diet poor in fruit and vegetable, are risk factors for development of cancer. The proportion of smokers in adenocarcinoma is higher (72%) at the esophageal site than in the cardia site (42%). In the distal esophagus several inflammation-related factors are overexpressed during the progression from metaplasia to neoplasia. Cyclo-oxygenase 2 catalyzes the production of prostaglandin E2, which activates the beta-Catenin growth-signaling pathway.

#### Endoscopic Diagnosis

The detection of adenocarcinoma at the EG junction occurs in 3 circumstances: in asymptomatic persons, in persons complaining from symptoms of gastro-esophageal reflux, and in persons with dysphagia. Diagnosis is based on upper GI endoscopy performed with a recent model of high-resolution video-endoscope, with optical magnification and image processing, like Narrow Band Imaging. The first step in the endoscopic exploration of the EG junction is assessment of the position of the epithelial squamo-columnar junction based on the top of gastric folds: a proximal migration of the epithelial junction suggests the presence of a segment with columnar metaplasia and the length of this segment should be estimated. A retroflexion in the stomach is performed to explore the EG junction from below, and attention is given to any irregularity in the mucosal surface and to changes in the clear pink color which can be more red or white. The exploration is completed by chromoscopy: the Lugol

Iodine dye stains only the squamous cell epithelium and may ensure a better delineation of metaplasia in the distal esophagus, the solution of acetic acid enforces the contrast at the junction of columnar and squamous epithelium, and the indigocarmine dye (0.1%) is sprayed onto the areas with suspicion of neoplasia. Magnification aims to analyze the variations in the pit pattern or in the epithelial crests at the surface of the mucosa and detect in the distal esophagus areas of intestinal metaplasia where large and long parallel grooves separate the epithelial crests. Below the epithelial junction and at the level of the cardia, the mucosa shows regular epithelial crests separated by narrow grooves.

Magnification offers the best approach to detect and characterize neoplastic lesions in their early stage. The strategy of endoscopic diagnosis is in 2 steps: detection at first, then characterization, allowing prediction and classification of neoplastic lesions as premalignant (low grade or high grade) or as confirmed cancer with evaluation of its depth as intra-mucosal, submucosal or deeper. The endoscopic prediction is then confirmed by biopsies. Endoscopic diagnosis is followed, when the diagnosis of neoplasia is confirmed at pathology, by other procedures including endosonography and CT scan. As a matter of fact, many premalignant lesions at the EG junction, can remain stable without progression to cancer for years; however their endoscopic resection is recommended as a rule.

#### Endoscopic treatment

After characterization of lesions located at the EG junction, and prediction of histology, treatment decision is between endoscopic resection or surgical treatment. Endoscopic resection, either in the distal esophagus or in the cardia, is proposed for low grade and high grade precancerous lesions, for intramucosal cancer and for

cancer with a superficial invasion of the submucosa. *En bloc* resection, in a single specimen, is always preferred to piece-meal resection in multiple fragments; therefore the conventional EMR (endoscopic mucosal resection) should be restricted to neoplastic areas up to 2 cm in diameter. Larger lesions should either be treated by endoscopic resection *en bloc* with the ESD (endoscopic submucosal dissection) method or transferred to surgical treatment. The *en bloc* endoscopic resection is particularly adapted for the treatment of early adenocarcinoma in the cardia; after a direct hemi-circumferential incision (and submucosal dissection) of the upper part visible in the distal esophagus; the distal part of the lesion is resected from the stomach, with the endoscope in retroflexion. Of course all tumors resected at endoscopy should be carefully stretched in a cardboard before fixation for study by the pathologist.

### Surgical treatment

The indications for surgery in the treatment of adenocarcinoma at the EG junction were described by Siewert with respect to 3 categories of tumors: type I for adenocarcinoma in the distal esophagus, type II for adenocarcinoma in the cardia, and type III for gastric subcardia adenocarcinoma infiltrating the EG junction. The treatment proposed varies with the type: transthoracic esophagectomy for type I, extended total gastrectomy for type II, and trans-hiatal extended gastrectomy for type III. Surgical treatment is proposed for a non-superficial, but localized, adenocar-

cinoma and for a large superficial carcinoma when the ESD technique of resection *en bloc* is not available.

### REFERENCES

1. Correa, P., Human gastric carcinogenesis: a multistep and multifactorial process - First American Cancer Society Award lecture on cancer epidemiology and prevention, *Cancer Res.* 1992; 52:6735-6740.
2. Curado MP, Edwards B, Shin HR, Storm H, Ferlay J, Heanu M, et al. eds *Cancer Incidence in Five Continents, Vol. IX*, IARC Scientific Publications No. 160, IARC, Lyon, 2007.
3. Ferlay J, Shin HR, Bray F, et al. GLOBOCAN 2008, *Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10*. IARC Lyon; 2010. Available from: <http://globocan.iarc.fr>.
4. Ferlay, F, Bray, P, Pisani et al. GLOBOCAN 2002. *Cancer Incidence, Mortality and Prevalence Worldwide IARC CancerBase No. 5*, version 2.0, 2004. IarcPress, Lyon 2004.
5. Osaka Cancer Registry. *Survival of cancer patients in Osaka (1975-89)*, 1998, Shinohara Publ, Tokyo.
6. Paris Workshop on Columnar Metaplasia in the Esophagus and the Esophagogastric Junction, Paris, France, December 11-12 2004. *Endoscopy.* 2005; 37:879-920.
7. Parkin DM, Whelan SL, Ferlay J et al. *Cancer incidence in five continents - IARC publ. N° 155*, 2002, IARC press, Lyon (distributed Oxford Univ Press).
8. Parkin M, Munoz M, Vizcaino P. Incidence time trends for cancers of the lung, esophagus and gastric cardia by histological type in the European community 1973-93. Final report to EU, 2000 (contract N° 97/CAN/33850).
9. Powell J, McConkey CC. The rising trend in oesophageal adenocarcinoma and gastric cardia. *Eur J Cancer Prev.* 1992; 1:265-9.
10. Siewert JR, Stein HJ, Feith M. Adenocarcinoma of the esophago-gastric junction. *Scand J Surg.* 2006; 95:260-9.
11. Taniere P, Martel-Planche G, Maurici D, et al; Molecular and clinical differences between adenocarcinomas of the esophagus and of the gastric cardia. *Am J Pathol.* 2001 Jan; 158:33-40.
12. Vizcaino AP, Moreno V, Lambert R, et al. Time trends incidence of both major histologic types of esophageal carcinomas in selected countries, 1973-1995. *Int J Cancer.* 2002; 99:860-888.
13. SEER Cancer incidence Public Use Database SEER Cancer Statistics Review. Bethesda, MD: National Cancer Institute, available at <http://www.seer.cancer.gov/>.
14. Parkin DM. The global health burden of infection-associated cancers in the year 2002. *Int J Cancer* 2006; 118:3030-3044.
15. Van der Burgh A, Dees J, Hop WCJ, et al. Oesophageal cancer is an uncommon cause of death in patients with Barrett's esophagus. *Gut*, 1996, 39, 5-8.

## From Obesity to Fatty Liver/NASH: Two Parallel Epidemics



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### ABSTRACT

Nonalcoholic fatty liver disease (NAFLD) is believed to be the most common form of chronic liver disease in Western countries. The clinicopathologic spectrum of NAFLD ranges from simple steatosis to non-alcoholic steatohepatitis (NASH). NAFLD is commonly associated with the components of the metabolic syndrome, including obesity. The prevalence of adult obesity and the metabolic syndrome, estimated at 34% in the United States, has reached epidemic proportions. NAFLD affects approximately 30% of general Western population and has obesity as an independent risk factor. There is however evidence that the epidemic of obesity may be stabilizing, so it is possible that also NAFLD/NASH and its complications may halt its progressive incidence in the near future.

This article reviews the epidemiology of obesity and NAFLD, including non-alcoholic steatohepatitis (NASH).

### INTRODUCTION

Nonalcoholic fatty liver disease (NAFLD) is one of the most common chronic liver disease in western countries and it is the leading cause of abnormal functional liver tests in the primary care setting [1]. The clinic-pathologic spectrum of NAFLD ranges from simple steatosis to non-alcoholic steatohepatitis (NASH). Whereas simple steatosis seems to have a relatively benign clinical course, patients with NASH can develop fibrosis, cirrhosis, and hepatocellular carcinoma (HCC) [2].

NAFLD is closely associated with the components of metabolic syndrome (MS), including obesity and Type 2 diabetes. Approximately 90% of NAFLD patients have more than one component of the MS and one-third has the MS. In addition, the risk of having NAFLD increases exponentially with the addition of each of the MS components [3]. The alarming epidemic of obesity has fuelled an increasing prevalence of

NAFLD, making NASH potentially the most common cause of advanced liver disease in coming decades [4]. At present, the real prevalence of NAFLD is still underestimated.

### EPIDEMIOLOGY OF OBESITY

Obesity is becoming one of the most serious public health problems worldwide and its prevalence has dramatically increased in the last few decades, reaching epidemic levels. According to the National Health and Nutrition Examination Survey (NHANES) data, prevalence of obesity in the U.S. was relatively low and stable between 1960 and 1980, but more than doubled among adults (from 15% to 32.9%) and tripled among children (from 5.5% to 17.1%) between 1980 and 2004. In 2003–2004, 66.2% of U.S. adults were either overweight or obese [5]. Furthermore, one in every 20 Americans had either morbid obesity (defined as a body mass index [BMI] > 35 kg/m<sup>2</sup> together with obesity-associated diseases or a BMI > 40 with or without obesity-associated diseases) [6]. In Europe, the prevalence of obesity is increasing too, and predictably will continue to increase [7]. However, in 2009–2010, the prevalence of obesity in the U.S. was 35.5% among adult men and 35.8% among adult women, with no significant change compared with 2003–2008, thus suggesting that the epidemic may be slowing or levelling off [8]. Also, recent studies suggest a leveling off of the epidemic in children and adolescents from Australia, Europe, Japan and the USA, with heterogeneity according to socioeconomic status [9].



Nonetheless, the World Health Organization (WHO) projects that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese.

## EPIDEMIOLOGY OF NAFLD

### Prevalence

The prevalence of NAFLD has not been well established. It varies with the study population and the modality used to establish the diagnosis (eg, liver enzymes, imaging, liver biopsy). In the USA, a study performed in an ambulatory clinic cohort, found the prevalence of ultrasonographic NAFLD to be 46%, with a high prevalence of diabetes and obesity (45%); when performing liver biopsy in ultrasound positive patients, it was found that 30% of patients with NAFLD (12% of the total cohort) had NASH [10]. Also, Younossi et al, when comparing three cycles of NHANES, from 1988 to 2008, found that NAFLD had been continuously increasing and was now the more frequent chronic liver disease in the USA, accounting for 75.1% of chronic liver diseases (CLD) in the 2005-2008 period. Importantly, obesity was an independent predictor of NAFLD in all periods [11].

### General population

Non-invasive radiological modalities applicable to large scale screening studies of NAFLD include ultrasonography, magnetic resonance imaging (MRI) and magnetic resonance spectroscopy (MRS). The DIONYSOS nutrition and liver study based on ultrasonography demonstrated that the prevalence of NAFLD in two communities of Northern of Italy, with and without suspected liver disease was 25% and 20%, respectively [12]. Another study based on ultrasonography, in a cohort of 35,519 Japanese individuals presenting for a

health check-up over 10 to 12 years, identified an increased prevalence of NAFLD from 13% to 30% [13]; in this study there were no clear exclusions of other liver diseases. Also, Caballeria et al. found in a Spanish cohort of 766 individuals, a prevalence of NAFLD of 25.8%, 33.4% men and 20.3% women [14]. A study from Dallas, Texas in 2004, using proton nuclear MRS, identified NAFLD in 31% of a multi-ethnic, population-based sample [15]. Hispanics had the highest prevalence of hepatic steatosis (45%), followed by Caucasians (33%) and African Americans (24%). Lastly, a study from Hong Kong, using proton nuclear MRS and transient elastography (TE), in 922 subjects from the general Chinese population, showed NAFLD in 27.3% of subjects and advanced fibrosis in 4% of NAFLD patients [16].

### Selected populations

In a series from obese, undergoing bariatric surgery, prevalence of NAFLD ranges from 74-98%, while that of NASH can be as high

as 37% [17-19]. The proportion of advanced fibrosis in NAFLD patients ranges from 2-9%. In morbidly obese patients, elevated AST, male gender and type 2 diabetes were found to be predictive of NASH [18]. In living liver donors, supposedly healthy, the prevalence of NAFLD ranges from 3% to 51% [20-22] and that of NASH from 1% to 15% [20,23]. In a Korean study in which liver biopsies were performed on 589 consecutive potential liver transplant donors, reported NAFLD prevalence was 51% [21]. In the United States, liver biopsies performed on potential liver donors revealed that 20% of donors were ineligible for organ donation based on the degree of the steatosis (>30%).

### Incidence

Data on the incidence of NAFLD in the general population are quite limited. However, the incidence seems to be rising as the obesity epidemic continues. In one Japanese study, the annual incidence of NAFLD was estimated to be about 10% [3]. Another

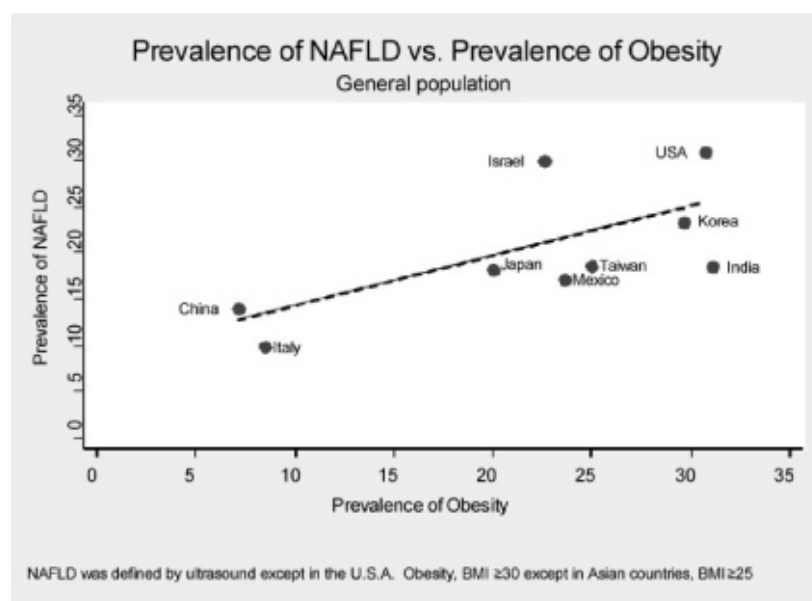


Figure 1: Correlation between prevalence of obesity and prevalence of NAFLD around the world Lazo M and Clark JM. "The Epidemiology of Nonalcoholic Fatty Liver Disease: A Global Perspective." *Seminars in Liver Disease*. 2008; 28(4). www.thieme.com (reprinted with permission).

Japanese study revealed an overall incidence of non-alcoholic hypertransaminasemia of 31 cases per 1,000 person-year [25]. In the 8.5-year follow-up of the DIONYSOS study, the incidence and remission of fatty liver detected by ultrasonography was 18.5 and 55 per 1,000 person-years [26]. A recent study of an outpatient hepatology clinic in England reported a referral incidence rate of 29 cases per 100,000 person-years [27]. Taking into account the discrepancy among these rates, further studies are needed to determine the true incidence of NAFLD.

### CONCLUSION

Given the parallel increase in prevalence of obesity and NAFLD, it is intuitive to correlate the two epidemics. Also, the fact that obesity is usually an independent risk factor for NAFLD supports this assumption. Furthermore, as shown in Figure 1, in each area of the world, there is a very strong correlation between the prevalence of NAFLD and obesity [28].

The recent evidence that obesity epidemics seems to be lowering or at least leveling off is good news. It is possible that the increasing self-consciousness of the risks of obesity, including fatty liver, may lead to improved lifestyle behavior, thus halting the continuous rising incidence of NAFLD/NASH and its complications, such as cirrhosis or hepatocellular carcinoma.

### REFERENCES:

1. Armstrong MJ, Houlihan DD, Bentham L, Shaw JC, Cramb R, Olliff S, Gill PS, Neuberger JM, Lilford RJ, Newsome PN. Presence and severity of non-alcoholic fatty liver disease in a large prospective primary care cohort. *Journal of Hepatology* 2012;56(1):234-240.
2. Farrell G, Larter C. Nonalcoholic fatty liver disease: From steatosis to cirrhosis. *Hepatology* 2006;43(2 Suppl 1):S99-S112.
3. Hamaguchi M, Kojima T, Takeda N, Nakagawa T, Taniguchi H, Fujii K, Omatsu T, Nakajima T, Sarui H, Shimazaki M, Kato T, Okuda J, Ida K. The metabolic syndrome as a predictor of nonalcoholic fatty liver disease. *Annals of Internal Medicine* 2005;143(10):722-728.
4. Agopian VG, Kaldas FM, Hong JC, Whittaker M, Holt C, Rana A, Zarrinpar A, Petrowsky H, Farmer D, Yersiz H, Xia V, Hiatt JR, Busuttill RW. Liver transplantation for nonalcoholic steatohepatitis: The new epidemic. *Annals of Surgery* 2012;256(4):624-633.
5. Ogden CL, Yanovski SZ, Carroll MD, Flegal KM. The epidemiology of obesity. *Gastroenterology* 2007;132(6):2087-2102.
6. Brzezinski S. Morbid obesity: Issues and challenges in home health. *Home Healthc Nurse* 2008;26(5):290-297.
7. Schneider H, Dietrich ES, Venetz WP. Trends and stabilization up to 2022 in overweight and obesity in Switzerland, comparison to France, UK, US and Australia. *International Journal of Environmental Research and Public Health* 2010;7(2):460-472.
8. Flegal KM, Carroll MD, Kit BK, Ogden CL. Prevalence of obesity and trends in the distribution of body mass index among US adults, 1999-2010. *JAMA* 2012;307(5):491-497.
9. Rokholm B, Baker JL, Sørensen TIA. The levelling off of the obesity epidemic since the year 1999 – a review of evidence and perspectives. *Obesity Reviews* 2010;11(12):835-846.
10. Williams CD, Stengel J, Asike MI, Torres DM, Shaw J, Contreras M, Landt CL, Harrison SA. Prevalence of nonalcoholic fatty liver disease and nonalcoholic steatohepatitis among a largely middle-aged population utilizing ultrasound and liver biopsy: A prospective study. *Gastroenterology* 2011;140(1):124-131.
11. Younossi ZM, Stepanova M, Afendy M, Fang Y, Younossi Y, Mir H, Srishord M. Changes in the prevalence of the most common causes of chronic liver diseases in the United States from 1988 to 2008. *Clinical Gastroenterology and Hepatology* 2011;9(6):524-530.
12. Bedogni G, Miglioli L, Masutti F, Tiribelli C, Marchesini G, Bellentani S. Prevalence of and risk factors for nonalcoholic fatty liver disease: The Dionysos nutrition and liver study. *Hepatology* 2005;42(1):44-52.
13. Kojima S-i, Watanabe N, Numata M, Ogawa T, Matsuzaki S. Increase in the prevalence of fatty liver in Japan over the past 12 years: Analysis of clinical background. *J Gastroenterol* 2003;38(10):954-961.
14. Caballería L, Pera G, Auladell MA, Torán P, Muñoz L, Miranda D, Alumà A, Casas JD, Sánchez C, Gil D, Aubà J et al. Prevalence and factors associated with the presence of nonalcoholic fatty liver disease in an adult population in Spain. *Eur J Gastroenterol Hepatol* 2010;22(1):24-32.
15. Browning JD, Szczepaniak LS, Dobbins R, Nuremberg P, Horton JD, Cohen JC, Grundy SM, Hobbs HH. Prevalence of hepatic steatosis in an urban population in the United States: Impact of ethnicity. *Hepatology* 2004;40(6):1387-1395.
16. Wong VW, Chu WC, Wong GL, Chan RS, Chim AM, Ong A, Yeung DK, Yiu KK, Chu SH, Woo J, Chan FK, Chan HL. Prevalence of non-alcoholic fatty liver disease and advanced fibrosis in Hong Kong Chinese: A population study using proton-magnetic resonance spectroscopy and transient elastography. *Gut* 2012;61(3):409-415.
17. Machado M, Marques-Vidal P, Cortez-Pinto H. Hepatic histology in obese patients undergoing bariatric surgery. *Journal of Hepatology* 2006;45(4):600-606.
18. Ong J, Elariny H, Collantes R, Younsozai A, Chandhoke V, Reines H, Goodman Z, Younossi Z. Predictors of nonalcoholic steatohepatitis and advanced fibrosis in morbidly obese patients. *Obes Surg* 2005;15(3):310-315.
19. Abrams GA, Kunde SS, Lazenby AJ, Clements RH. Portal fibrosis and hepatic steatosis in morbidly obese subjects: A spectrum of nonalcoholic fatty liver disease. *Hepatology* 2004;40(2):475-483.

20. Minervini MI, Ruppert K, Fontes P, Volpes R, Vizzini G, de Vera ME, Gruttad-auria S, Miraglia R, Pipitone L, Marsh JW, Marcos A, Gridelli B, Demetris AJ. Liver biopsy findings from healthy potential living liver donors: Reasons for disqualification, silent diseases and correlation with liver injury tests. *Journal of Hepatology* 2009;50(3):501-510.

21. Lee JY, Kim KM, Lee SG, Yu E, Lim YS, Lee HC, Chung YH, Lee YS, Suh DJ. Prevalence and risk factors of non-alcoholic fatty liver disease in potential living liver donors in Korea: A review of 589 consecutive liver biopsies in a single center. *Journal of Hepatology* 2007;47(2):239-244.

22. Tran TT, Changsri C, Shackleton CR, Poordad FF, Nissen NN, Colquhoun S, Geller SA, Vierling JM, Martin P. Living donor liver transplantation: Histological abnormalities found on liver biopsies of apparently healthy potential donors. *J Gastroenterol Hepatol* 2006;21(2):381-383.

23. Yamamoto K, Takada Y, Fujimoto Y, Haga H, Oike F, Kobayashi N, Tanaka K. Nonalcoholic steatohepatitis in donors for living donor liver transplantation. *Transplantation* 2007;83(3):257-262.

24. Wanless IR, Lentz JS. Fatty liver hepatitis (steatohepatitis) and obesity: An autopsy study with analysis of risk factors. *Hepatology* 1990;12(5):1106-1110.

25. Suzuki A, Angulo P, Lymp J, St. Sauver J, Muto A, Okada T, Lindor K. Chronological development of elevated aminotransferases in a nonalcoholic population. *Hepatology* 2005;41(1):64-71.

26. Bedogni G, Miglioli L, Masutti F, Castiglione A, Croce L, Tiribelli C, Bellentani S. Incidence and natural course of fatty liver in the general population: The Dionysos study. *Hepatology* 2007;46(5):1387-1391.

27. Whalley S, Puvanachandra P, Desai A, Kennedy H. Hepatology outpatient service provision in secondary care: A study of liver disease incidence and resource costs. *Clin Med* 2007;7(2):119-124.

28. Lazo M, Clark JM. The epidemiology of nonalcoholic fatty liver disease: A global perspective. *Semin Liver Dis* 2008;28(4):339-350.

## Just Two Months Until GASTRO 2013 APDW/WCOG SHANGHAI!



The World Gastroenterology Organisation (WGO) in partnership with the Asian Pacific Digestive Week Federation (APDWF), Chinese Societies of Digestive Diseases (CSDD), and the World Endoscopy Organization (WEO) warmly invite you to gather with us to participate in a dynamic, stimulating and varied scientific program of the highest quality. This premier global event will focus on gastroenterology, liver disease, endoscopy, GI surgery and related GI diseases.

### THE GASTRO 2013 PROGRAM AT A GLANCE

The Scientific Program, which combines a full one-day Postgraduate Course/Live Demonstration Endoscopy Program with the three day Main Meeting, will result in a golden opportunity to be informed of the latest scientific achievements, to discuss recent discoveries, and finally to renew both professional and personal friendships with peers from around the world. Participants are invited to the Opening Ceremony and Welcome Reception that will take place the evening of Saturday, 21 September, for lively discourse with friends and colleagues from around the globe.

Topics will cover new and cutting-edge information on the etiology, pathogenesis, diagnosis and treatment of the broad range of gastrointestinal,

liver and related disorders. Sunday through Tuesday, 22-24 September, symposia will be offered in four primary tracks: Endoscopy, Upper GI, Lower GI, and Liver Disease.

The Endoscopy track on 22-24 September will feature symposia reporting on a broad spectrum of current topics including two Working Party Reports that will be highlighted within these sessions. Also integrated into the Endoscopy track are Live Demonstration Endoscopy sessions where attendees will have the opportunity to observe experts as they guide delegates through a series of endoscopic techniques in real time.

The Upper GI, Lower GI and Liver Disease tracks will each feature nine symposia spread over the three days of the Main Meeting, 22-24 September, with seven Working Party Reports highlighted throughout these three tracks. Presentations will focus on the fusion of basic science and clinical practice with a spotlight on the Asian-Pacific region presented by faculty from all corners of the globe.

**Other key programmatic components offered during Gastro 2013 include:**

### NINE NAMED LECTURESHIPS

During every World Congress of Gastroenterology, WGO devotes two

### REGISTRATION

It's not too late to register for Gastro 2013! Regular registration is available until 15 August 2013. Onsite registration begins after 16 August 2013. Detailed Information can be found by visiting <http://gastro2013.org/online-registration/registration-online>.

Named Lectureships that are named after Georges Brohée and Henry L. Bockus, to the discussion of some of the latest topics in the field of gastroenterology. Additionally, the collaborating partners will also be presenting Named Lectureships, during the Plenary Sessions to be convened each morning of the Congress, 22-24 September.

- **JGHF Okuda Lecture:** *Immune disorders lead to liver damage and influence antiviral efficacy in patients with chronic HBV infection*  
Fu-sheng Wang, Beijing
- **JGHF Marshall & Warren Lecture:** *Adult tissue stem cell therapy for gastrointestinal diseases*  
Mamoru Watanabe, Tokyo
- **JGHF Emerging Leader Lecture:** *Involvement of luminal nitric oxide in the pathogenesis of gastro-esophageal reflux disease spectrum*  
Katsunori Iijima, Sendai

- **JGHF Emerging Leader Lecture:** *Dual HCV and HBV Infection: Resolved and unresolved issues*  
Chun-jen Liu, Taipei
- **WEO François Moutier Lecture:** *Innovations in diagnostic endoscopy*  
Thierry Ponchon, Lyo
- **WEO Sadataka Tasada Lecture:** *Recent advances in endoscopy in the Asian Pacific region*  
William Chao, Hong Kong
- **WEO Rudolf Schindler Lecture:** *Evolving endoscopic surgery*  
Paulo Sakai, Sao Paulo
- **WGO Henry L. Bockus Medal and Lecture:** *Research misconduct: A grand global challenge for the 21<sup>st</sup> century.*  
Michael Farthing, Brighton
- **WGO Georges Brohé Medal and Lecture:** *New views on pathogenesis of NASH and how it should inform management.*  
Geoffrey Farrell, Canberra

### Nine Quadrennial Working Party Reports

The Working Party Reports and Guidelines continue to be distinctive features of the World Congress of Gastroenterology and Asian Pacific Digestive Week meetings, respectively. All member societies and organizing partners were invited to submit proposals for topics for consideration. The following selected working party reports that will be presented during the Congress cover current areas in need of a “new look” or where real guidance is required on classification, diagnostic criteria or therapeutic strategies:

- Radiological exposure in gastroenterology  
Chair: Immanuel Ho, Philadelphia, USA
- Diagnostic approaches to chronic diarrhea  
Chair: Lawrence Schiller, Dallas, USA
- Celiac disease - an emerging epidemic in the Asian-Pacific region

and a global concern

- Chairs: Govind Makaharia, New Delhi, India, Chris Mulder, Amsterdam, The Netherlands
- Genetics of GI disease  
Chair: Janusz Jankowski, Plymouth, United Kingdom
  - Standardized endoscopy reporting  
Chair: Lars Aabakken, Oslo, Norway
  - Interval lesions in colorectal cancer screening and serrated polyps  
Chairs: Evelien Dekker, Amsterdam, The Netherlands, Silvia Sanduleanu, Maastricht, The Netherlands, Gerrit Meijer, Amsterdam, The Netherlands
  - A novel validated classification for perianal lesions and fistulas in Crohn’s disease  
Chairs: Geert D’Haens, Amsterdam, The Netherlands, Brian Feagan, London, Canada, Jean-Frédéric Colombel, Lille, France
  - Endoscopic management of early gastroenterology cancers  
Chair: Kenneth Wang, Rochester, USA
  - Definition of acute on chronic liver failure  
Chairs: Rajiv Jalan, London, United Kingdom, Patrick Kamath, Rochester, USA

### Masters of the WGO Awards

The highest recognition of lifetime achievement and contribution to Gastroenterology, the Masters of the WGO Award, will be presented at Gastro 2013. To view this year’s recipients, turn to page 18.

### Free Paper Sessions

Submitted abstracts will be reviewed by a panel of experts, and if an abstract is selected as an oral presentation, it will be allocated to a Free Paper Session.

### Nursing Program

A meeting for GI nurses and other allied health professionals will be

### WHY EVERYONE SHOULD ATTEND GASTRO 2013

- It is the World Congress of Gastroenterology and it comes to Asia only once every 12 years.
- First time ever in exotic China!
- This will be an incomparable celebration of the art and sciences of Gastroenterology, Hepatology, Endoscopy and GI Surgery.
- The Congress will offer a comprehensive and highly academic Scientific Program.
- Two days of Live Demonstration Endoscopy by the top experts from around the world.
- Experience an unbeatable social program in Shanghai with easy day-trips to beautiful Suzhou and Hangzhou!

organized by the Society of International Gastroenterological Nurses and Endoscopy Associates (SIGNEA) in collaboration with local and regional nursing bodies. It will be held 22-24 September at the Shanghai Convention Center in conjunction with Gastro 2013 APDW/WCOG Shanghai.

### WEO Learning Center

The WEO Learning Center will provide all Gastro 2013 delegates an opportunity to delve into the world of Endoscopy during the Congress through interactive lectures, video teaching and hands-on training on simulators.

### Young Clinicians Program

This unique program commences prior to the main meeting and continues throughout the core meeting. The YCP program will bring together trainees from around the world who clearly represent future opinion leaders in their respective countries. The program will incorporate formal

lectures and hands-on training sessions in various practical skills as well as provide opportunities throughout the Congress week for discussion and review of topics presented.

#### Poster Exhibition

Posters will be displayed daily during the Congress in the exhibition hall at the Shanghai Expo Center. All posters will be changed daily and will be on display for the full course of each day, with poster presentations scheduled during key viewing time opportunities.

#### Technical Exhibition

A technical exhibition will accompany the Congress at the Shanghai Expo Center. Further information about the technical exhibition and application requirements for participation are contained within the [Sponsorship & Exhibitor Prospectus](#).

#### Industry Sponsored Symposia

Breakfast, Lunch and Dinner Satellite Symposia will be organized by the biomedical industry and will be open to all Congress participants. Symposia will have timeslots of 60 minutes, running in parallel with others, and will take place Sunday through Tuesday, 22-24 September. Satellite Symposia will be announced in all Congress communications including announcements and the Final Program. Responsibility of the program content remains with the sponsors. Please note that – like any other sponsor item – timeslots for Satellite Symposia are sold on a “first-come, first-served” basis.

#### The WGO Booth

As a world organization for gastroenterologists, we invite you to learn more about the exciting initiatives happening around the world including the latest Training Centers,

Train the Trainers workshops, Global Guidelines and more in addition to how you can join WGO in promoting global digestive health, by visiting the booth! During the GASTRO 2013 exhibition days we are pleased to invite you to stop by the WGO booth to collect information on WGO's programs and initiatives. The WGO booth will be open from 21-24 September 2013, and we will inform you once the location is announced!

The organizing partners of Gastro 2013 look forward to offering you an outstanding and truly international program, and will be privileged to welcome you to the city of Shanghai – a first for the World Congress of Gastroenterology - this 21-24 September, for a WORLD CONGRESS IN ASIA!



## WDHD 2013 News

### CHILE

The University of Chile Clinical Hospital conducted different types of initiatives to spread the May 29 World Digestive Health Day celebration, established by the World Gastroenterology Organisation. The Hospital, as an entity providing health plus educational functions, has a commitment to inform the public about various topics related to health and quality of life. Therefore, this year they established the month of May as the period to talk about digestive health and bring people different information.

The Department of Communications created a special website ([www.redclinica.cl](http://www.redclinica.cl)), with eight articles on digestive health which discussed several issues of interest to the population. The subjects were selected from common concerns of users and had much impact on the social networks. In 20 days it was seen by 456 users. Content included:

- Liver Cancer: <http://bit.ly/17DOTD2>
- Recommendations for your health: <http://bit.ly/18CANLm>
- What is irritable bowel syndrome and what is its treatment: <http://bit.ly/137YKvZ>
- What are the inflammatory bowel diseases: <http://bit.ly/19sZ9MU>
- What is diarrhea: <http://bit.ly/11GWUUF>
- Why was WDHD for Hepatitis C: <http://bit.ly/Zyg1Qy>
- Gastric cancer: symptoms, diagnosis and prevention: <http://bit.ly/142XFH0>
- FAQ: <http://bit.ly/17DQKID>

In an effort to increase communication to allow more people to access highly relevant content, the Commu-

nications Department of the Hospital Clinic produced a video which involved leading experts on the topic of this year. Dr. Javier Brahm (Gastroenterology Section Chief), Juan Carlos Diaz (Head Transplant Unit), Ivan Gallegos (Head Pathology Service) appeared in the production, and spoke about HCC. In two days, the video had 171 views. To view the video, click here: <http://bit.ly/ZymgUw>

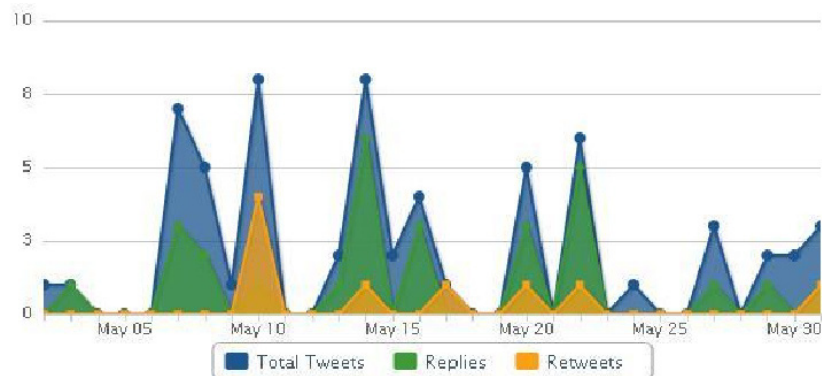
Considering the current communication platforms often used by the population, the University of Chile Clinical Hospital decided to innovate by sending cellular text messaging focused on liver cancer. The company in charge of sending messaging was MOB.ID, which assisted in getting the following May 29 message to 8,420 people: “U Chile Clinical Hospital reports: alcohol, obesity and certain viruses may cause cirrhosis and liver cancer. Live and watch your liver: <http://tiny.cc/hcuch>.”

The posts on Facebook and Twitter by the Hospital had a significant impact on the audience. The University of Chile Clinical Hospital Facebook ([www.facebook.com/redclinica](http://www.facebook.com/redclinica)) was seen by 2,308 people and the informative article on the day of May



29 had 2,137 total impressions. The “Our specialist answers” is a section which discusses digestive health, as the users can ask specific expert questions. In this case, it was a prominent gastroenterologist, Dr. Ana María Madrid who answered the doubts and concerns of about 20 people; an initiative that is highly valued by the public. This was the one activity that had the most impact in the history of the Hospital, as there were 3,823 people who participated.

The University of Chile Clinical Hospital Twitter account, ([www.twitter.com/redclinica](http://www.twitter.com/redclinica)) was used to disseminate the various publications about digestive health and liver cancer. There were 62 tweets, 29 answers or comments, and 9 retweets.



A chart showing activity on the University of Chile Clinical Hospital's Twitter account.

**CANADA**

Information on Hepatocellular Carcinoma (HCC) received a great amount of attention in the media in Canada, primarily due to the release of the Canadian Cancer Society's annual report on WDHD, with a special section recognizing the 3x increase in liver cancer in men and the 2x increase in liver cancer in women since 1970. Click here to view the report. The Canadian Cancer Society released a press release noting the World Digestive Health Day 2013 campaign, and the overall story made national TV and newspapers and was in the top news story on the Canadian Broadcasting Corporation (CBC) news.

**Media coverage links include:**  
<http://www.calgaryherald.com/health/Liver+cancer+continues+wreak+havoc/8447881/story.html>  
<http://www.cbc.ca/news/canada/calgary/story/2013/05/29/calgary-liver-cancer-increase.html>

During the same week, the University of Calgary Liver Unit launched their new automated HCC screening program. A postcard describing the program was mailed out to 5,000 physicians in Calgary, and a very successful CME event with the GPs of the Mosaic Primary Care Network took place earlier in the week. One third of the GPs that practice in North-East Calgary, where the majority of the immigrant population lives, attended this event. The meeting reviewed screening, diagnosis and management of both Viral Hepatitis and HCC, and soon a new outreach clinic will be launched to better serve the immigrant population, who has a high burden of viral hepatitis, but doesn't access the facilities at the University.

**INDIA**

The Indian National Association for Study of Liver (INASL), the highest body of liver specialists in the country,

has constituted the INASL Task Force on HCC to generate consensus on India-specific diagnosis and management of the cancer.

The Task Force has 18 members representing the major centers managing HCC with Head of Gastroenterology, AIIMS, New Delhi, Prof S. K. Acharya at the helm as chairman. The First Round table discussion on devising strategies for countering the surge of primary liver cancer in the population was held in Puri recently.

The Task Force would work towards defining the epidemiology of HCC in India, risk factors for the disease, while suggesting surveillance mechanisms and preventive measures.



Members of the INASL Task Force.

It will also strive to integrate screening mechanisms to detect HCC early while formulating guidelines for staging of the cancer along with management and therapeutic modalities.

The Tamilnadu Chapter of the Indian Society of Gastroenterology held a Public Awareness Programme, *Taking Steps for a Healthy Tomorrow*, on May 26. The program began with a walkathon followed by a public program with experts in the field of gastroenterology.



A newspaper article focusing on the walkathon held in India.

The experts included Drs. K. Raghuram, K.R. Palaniswamy, V. Balasubramanian, L. Thayumanavan, Mohammad Ali, Usha Srinivas, N. Murugan, K. Premkumar and Rajasundaram.



Dr. K.R. Palaniswamy speaks during a CME Programme on HCC.

**MOROCCO**

Within the framework of the celebration of the World Digestive Health Day, The Société Marocaine des Maladies de l'Appareil Digestif and the WGO Training Center of Rabat, organized a day of information and education on 1 June about the liver cancer under the aegis of the Fondation LALLA SALMA pour la Prévention et Traitement des cancers.



A copy of the 1 June Program in Morocco.



The program contained a scientific Round Table intended for the hepatogastroenterologists and a sensitization of the civil society on liver cancer, by insisting on the prevention of this disease. This raising awareness was assured by interviews of the SMMAD President Professor Rhimou Alaoui with five channels of National radios. Similarly a press release signed by the SMMAD was broadcasted by newspapers. A file of health on HCC is under press by the newspaper “ITTIHAD EL CHTIRAQUI” and will be published Monday, 24 June, 2013.



One of many newspaper articles published in Morocco, focusing on liver cancer.

The main recommendation adopted during this day was to create a register with special HCC index form according to the diagnostic specificities of this cancer. The SMMAD board makes a commitment to work with the Foundation for the implementation of the HCC register.

## WGO Announces Recipients of the Masters of the WGO (MWGO) Award

The Masters of the WGO (MWGO) Award is the highest honor WGO can bestow on a member and is granted only to those individuals who have provided outstanding dedication to the mission of the WGO and achieved distinction in such areas as scholarly research, teaching, service to WGO and the community at large. The Award was created to recognize these contributions and by this recognition provide incentive, encouragement and guidance for others to significantly

contribute to their fields. The Masters of the WGO Award is a capstone career award and is given in conjunction with each World Congress of Gastroenterology. The next awards ceremony will take place during the WGO General Assembly, at the upcoming World Congress, [Gastro 2013 APDW/WCOG Shanghai](#), in Shanghai, China, September 2013.

Recipients of the Masters of the WGO Award will receive an engraved

plaque to be presented at the time of the General Assembly at the 2013 World Congress in Shanghai and will receive recognition in WGO publications and on the website. All Masters of the WGO use the title of “Master of the WGO” and the letters “MWGO” in conjunction with their name.

Please join WGO in congratulating this year’s recipients on this prestigious award!

### Past recipients of the MWGO Award include:

Professor Luiz de Paula Castro, MWGO

Professor Suliman Fedail, MWGO

Professor Joseph Geenen, MWGO

Professor Solly Marks, MWGO

Professor Melvin Schapiro, MWGO

Professor Isidor Segal, MWGO

Professor Zeyad Sharaiha, MWGO

Professor Rakesh Tandon, MWGO

Professor Guido Tytgat, MWGO

Professor Shu-Dong Xiao, MWGO

## WGO is Honored to Announce This Year's Recipients



Professor Jean-Paul Galmiche



Professor Richard Hunt



Professor Bernard Levin



Professor Juan Malagelada



Professor Finlay Macrae



Professor Ibrahim Mostafa



Professor D Nageshwar Reddy



Professor Joseph Sung



Professor Guido Villa-Gomez

## WGO Announces the Establishment of The WGO, AGA and TSG Training Center

On behalf of Professors Henry Cohen, WGO President, Anil Rustgi, AGA President, and Nurdan Tozun, TSG President, we are pleased to announce the establishment of a new World Gastroenterology Organisation (WGO)-endorsed Training Center in Ankara, Turkey, in collaboration with the American Gastroenterological As-



The location of the new Training Center in Ankara, Turkey.

sociation (AGA) and Turkish Society of Gastroenterology (TSG). The Training Center, which will be called *The WGO, AGA and TSG Training Center*, will be under the direction of Professor Sedat Boyacioglu, Turkey, and will be located in the newly renovated building which also hosts the TSG. An area within the building will provide work stations and an area for trainees, and learning materials - provided by the AGA - as well as internet. In the future, there are plans to expand the Center to have endoscopy simulation equipment.

Currently, six trainees from Nigeria, Sudan, Kenya, Ukraine, Albania and Afghanistan have been chosen to attend the Center. They will first have a three month course of Turkish, followed by 12 month training in one



The area which would be used by trainees of the Center.

of the gastroenterology departments of three universities in Ankara. The travel and accommodation will be financed by biomedical industry and each trainee will be given a scholarship of \$500 per month.

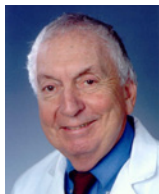
**New Educational Opportunity Available!**  
Thanks to the generosity of Dr. Alan Thomson, the WGO is pleased to offer free access to numerous GI & hepato-logy books. Visit [www.giand-hepatology.com/](http://www.giand-hepatology.com/) to begin downloading various books, & watch for future alerts as more books are released!

## A Tribute to Paul Rozen



**Bernard Levin,  
MD**

USA



**Sidney  
Winawer, MD**

USA



**Graeme  
Young, MD**

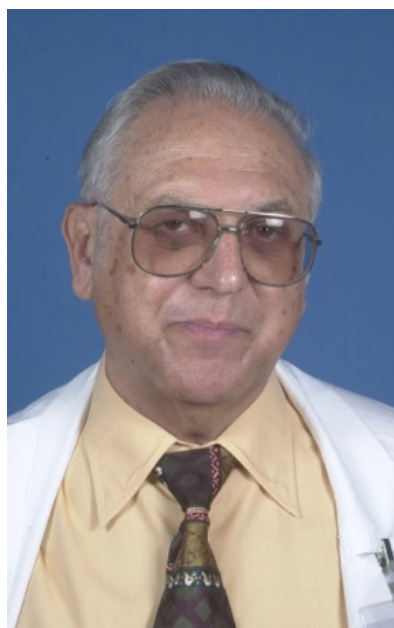
Australia

Paul Rozen, our beloved and respected colleague and friend, will be missed. We are writing this tribute to celebrate and commemorate his many personal and professional contributions. Paul was born in New Zealand in 1934 and attended medical school at Melbourne University, graduating in 1957. He then emigrated to Israel in 1959, and served in the Israeli Military Service from 1960 to 1961. Following his internal medicine residency at Shaare Tzedek and Hadassah Hospitals, he had further training in Chicago in Gastroenterology. Subsequently, he returned to Israel. Paul became Chief Physician at Bikur Holim and then Hadassah Hospital in Jerusalem and later Deputy Head of Cancer Prevention and Genetics at Tel Aviv Medical Center and Full Professor of Medicine at the Sackler School of Medicine.

Paul's many scientific contributions cannot easily be summarized, but they generally fall into three areas: genetics, primary prevention and secondary prevention of colorectal neoplasia. These include almost 200 publications in peer-reviewed journals and 49 book chapters. He was editor and/or co-editor of 14 books. Paul organized or actively participated in more than 125 scientific meetings, both in Israel and internationally. He was a member of the editorial boards of five international medical journals and served

as a peer reviewer for over 20 medical journals.

Paul received multiple research grants that funded his studies in colorectal cancer screening, familial cancer, evaluation of screening tests, and in primary prevention of colorectal cancer. He was a member of many Israeli, international, and U.S. gastroenterology, endoscopy, and oncology societies and was the recipient of several awards including from the Israeli Gastroenterology Association and the Cancer Research and Prevention Foundation in Washington D.C.



Dr. Paul Rozen.

Paul had a global perspective of the prevention of colorectal neoplasia with strong interests in both primary and secondary prevention. He was a pioneer in furthering our knowledge of epidemiology of colorectal cancer by studying the incidence of colorectal cancer in populations from different countries. He also systematically investigated the influence of diet and its relationship to colorectal cancer in various ethnic groups in Israel.

Paul had a passionate commitment to research into screening and early detection of early stage curable colorectal cancer in average risk patients. Some of his most recent work included the demonstration of the effectiveness of fecal immunochemical testing. As a further reflection of his international leadership in colorectal cancer screening, Paul was invited to organize and was the first chair of the WEO (OMED) Colorectal Cancer Screening Committee. This Committee has evolved into an outstanding annual forum for exchange of ideas and advances by world leaders in the field. Paul was also interested in various aspects of familial high-risk families and participated actively in the International Society of Gastrointestinal Hereditary Tumors.

Throughout Paul's professional life, he consistently demonstrated qualities of high integrity, intellectual curiosity, dogged pursuit of his goals and

courage in the face of adversity. A serious man of quiet dignity, he was always willing to stand up for his beliefs. He was not satisfied by glib answers, always demanding a deeper level of understanding. Paul was never constrained by conventional thinking. He was prepared to think laterally and imaginatively and then test these ideas in practice. Paul was a modern-day pioneer in medicine.

Paul's personal life was full. He was a wonderful and loving husband, father, and grandfather. His legacy

continues through his wife Etta, his daughter Shulamit, a pediatrician, Gideon, a medical instrument technician, Naimo, a dental hygienist, and 8 grandchildren. Paul was above all a dedicated and compassionate physician. His many patients, friends and colleagues throughout the world will sorely miss him.



## The WGO Train the Trainer (TTT) Workshop - A participant's perspective



### Kevin A. Waschke, M.D., C.M., FRCPC

Associate Professor  
Director of Therapeutic Endoscopy and Endosonography  
Division of Gastroenterology  
McGill University; McGill University Health Center

The World Gastroenterology Organisation (WGO) held a four day Train the Trainer (TTT) Workshop in Oporto, Portugal from March 18<sup>th</sup>-21<sup>st</sup>, 2013. This event was hosted by the Portuguese Society of Digestive Endoscopy and featured 10 faculty and approximately 50 participants from around the world. Each participant was nominated by their respective national societies and came to the meeting as clinical educators aiming to learn enhanced educational and training skills which could subsequently benefit their local programs. The goal of this article is to provide an overview of this course from a participant's perspective.

One of the biggest challenges facing an educator is dealing with learners of varying prior knowledge and skills, along with varying degrees of motivation. Add to this the influence of language and different cultures and a limited amount of time, and it is evident that the organizers of this workshop potentially faced a number of significant challenges to deliver a meaningful, interesting and personally relevant educational experience to each learner. Based on the feedback of my co-participants however, I can tell you that the TTT workshop succeeded in achieving a unique and highly stimulating educational experience that surpassed most, if not all, individuals' expectations. From

discussion with the course faculty and a perusal of the TTT website, it is obvious that this is a common reaction to this course, which has been running since 2001. For this reason I believe it is worthwhile to describe the process of this course and some of my observations and feedback from the participants of what makes this course such a success.

One of the earliest components of the course was an entry survey that was completed prior to arrival at the course in order to evaluate the participants' perceived needs and familiarity with the content of the course. Although this may not seem like a vital component, I mention this because it quickly became evident to the participants that the course faculty were making an enormous effort to continually evaluate and improve the course. The impact of these faculty efforts was clear from the questions and comments during the sessions. Each learner was encouraged throughout the course to reflect upon what their own learning goals were and what they could apply subsequently once they returned home after the course. Hearing each person discuss what was relevant to each of them really illustrated how much we have in common despite our different backgrounds, and yet how much variation in education and medical care delivery occurs around the world. Many aspects of

this workshop were not only extremely valuable to the participants, but were often novel, with numerous participants not having encountered this type of training previously, particularly not having had training coming from experienced educators with diverse and extensive backgrounds. This is an important point given that one of the WGO's stated goals is to improve the standards of training, education, and practice of gastroenterology and hepatology worldwide with a focus on low-resource nations.

The workshop was organised into a variety of modules that consisted of a large group didactic session with interactive components, followed by small group sessions that allowed participants to apply the various aspects of each session in more detail. Attendees were asked to put away laptops, tablets and smart phones during the didactic sessions, which facilitated engagement in the course. Thanks to a dynamic faculty and willing participants, each lecture component was accompanied by much discussion, interesting comments and questions and occasionally active debate. Following each session and a short break, participants broke out into small group sessions. The small groups were typically based upon challenging and relevant problems related to the previous session. Based on each task, groups were tasked with appointing a session chair, someone who would present the group findings back to the course and of working together on the problem. Interestingly, each group was able to observe over the four day course how much small group dynamics evolved over time, which was something that had been discussed in the education and team work modules.



In terms of content, there were numerous modules that were presented. The earliest module, Education, presented important educational principles along with elements of adult learning. For many in the audience this was new material, but it laid the groundwork for subsequent interactions, particularly with respect to the small groups and to the use of feedback. In fact, feedback was integrated throughout the course, facilitating everyone's active participation in the learning process. After being asked to present in front of the whole group and either receive or give feedback about the speaker's presentation skills, participants quickly learned that this was no ordinary training course. The next module, Teaching Procedural Skills challenged everyone to think differently about how they taught by breaking tasks into their smallest components and teaching each task individually, again using feedback and educational principles from the preceding session. Using simple tasks, learners saw how effective these methods could be and how easily they could be applied in a variety of sessions.

That evening everyone from the course gathered at the hotel pool and participated in a spirited water polo tournament. Despite a lack of prior experience for most people, this was a highly entertaining activity that helped "break the ice" so to speak and bring the groups closer together. Fortunately the only injuries were sore throats from all the cheering, and everyone made it to the subsequent group dinner! I will mention that the breaks between sessions and the meal times were an enjoyable part of the course for everyone for a number of reasons, particularly because of the opportunity to interact with people from different cultures and to informally discuss education and medicine in the various cultures. The meals also featured local Portuguese cuisine, which added to the flavour of the course. I would be remiss at this point however, in not acknowledging the role of the course hosts, the Portuguese Society of Digestive Endoscopy, in this workshop. Although the Portuguese are renowned for their hospitality, I had never experienced it first hand. It was clear from the start of the course that they went beyond

the call of duty to ensure an enjoyable experience for all. Visits to the city of Oporto and neighbouring towns, including architectural, cultural and World Heritage sites were a valuable and enjoyable experience and many participants planned to return on future occasions to see more of this beautiful country. It is difficult to describe how rich and varied interaction among participants and faculty was during the informal and formal components of the workshop, but there was no doubt that this is also another stated goal of the course that was clearly achieved thanks to thoughtful course planning and execution.

The next modules were Evidence Based Medicine, Critical Appraisal, Publications, Presentations and Trial Design. In these sessions, everyone was shown tools to be able to critique the literature, present this information in a scholarly manner and how they could potentially design studies that could be used at their institutions in the context of their local resources and skills. Again, each session was followed by small groups with relevant tasks to work on, with subsequent presentations to the whole group. As the workshop progressed, each group's presentations dramatically improved in quality. Many participants noted how rapidly everyone was able to apply the lessons learned in previous modules to good effect. Obviously a short course does not make experts of all the participants, but the nature of the sessions and tasks left no doubt in my mind that learning was taking place for all levels of learners and everyone who was seeing this for the first time was clearly motivated to learn more.

The next modules of the workshop were Assessment and Appraisal and Credentialing. For the majority of the trainees, this was new material and very eye opening. Hearing how these subjects are addressed in each



participant's context was interesting to everyone and valuable discussions followed. It was clear that the WGO's objectives to improve standards of care were shared by the participants following these sessions. Subsequent modules on Interpersonal skills and Teamwork also were highly educational, relevant and interactive. Given that everyone had actively participated in small groups and experienced the subject matter first hand over the preceding days, these sessions were particularly meaningful.

The workshop concluded with a course feedback session that closed the loop on previous discussions and allowed participants to actively reflect on the course, to see whether their learning objectives had been met and the opportunity for each learner to develop personal learning objectives going forward from the course. Following this, there was an enjoyable game show style quiz that also served as a review session which was highly entertaining and yet educational.

In summary, this WGO TTT is an

educationally sound, well organised and highly effective workshop that clearly meets the objectives set out by the WGO. Although its success is best judged on its future impact at the level of each learners' local contexts, I have no doubt that from what I have seen and heard from my fellow participants, it would be very difficult to imagine a course of this length accomplishing more for such a diverse and varied group of participants. ■

## Asian Pacific Digestive Week 2012 – WGO Global Lectureship Recap

During the most recent Asian Pacific Digestive Week (APDW), Professor K.M. Fock (Singapore), President of the Asian Pacific Digestive Week Federation, was selected as a speaker for a WGO Distinguished Global Lecture, for the first time at APDW in Bangkok, Thailand in December 2012. The theme of the conference was “Achieving Excellence in Gastroenterology and Hepatology”, and the title of Professor Fock’s lecture was “GI Cancer in the Asian Pacific Region-Implications to the Global Cancer Burden”.



Professor K.M. Fock of Singapore.

In addition to serving as the President of APDW, Professor Fock currently serves on the WGO Nominations and Outreach Committees and served in 2012 as a member of the World Digestive Health Day (WDHD) Steering Committee. He also attended a WGO Train the Trainers Workshop in Crete, Greece in 2004.

To learn more about Asian Pacific Digestive Week, please [click here](#). To read more about the Asian Pacific Digestive Week Federation, please visit their website, [www.apdwcongress.org](http://www.apdwcongress.org). In addition, APDW is also one of four organizing partners of Gastro 2013 APDW/WCOG Shanghai, which will take place in Shanghai, China, from 21-24 September 2013. To learn more about the upcoming quadrennial World Congress of Gastroenterology, please visit <http://www.gastro2013.org>.



(Left to right) Professor Udom Kachintorn, President, APDW 2012, Professor K.M. Fock, President of APDWF, and Professor Varocha Mahachai, Chairperson, Scientific Program Committee, APDW 2012.

# The Latest News in WGO Global Guidelines and Cascades

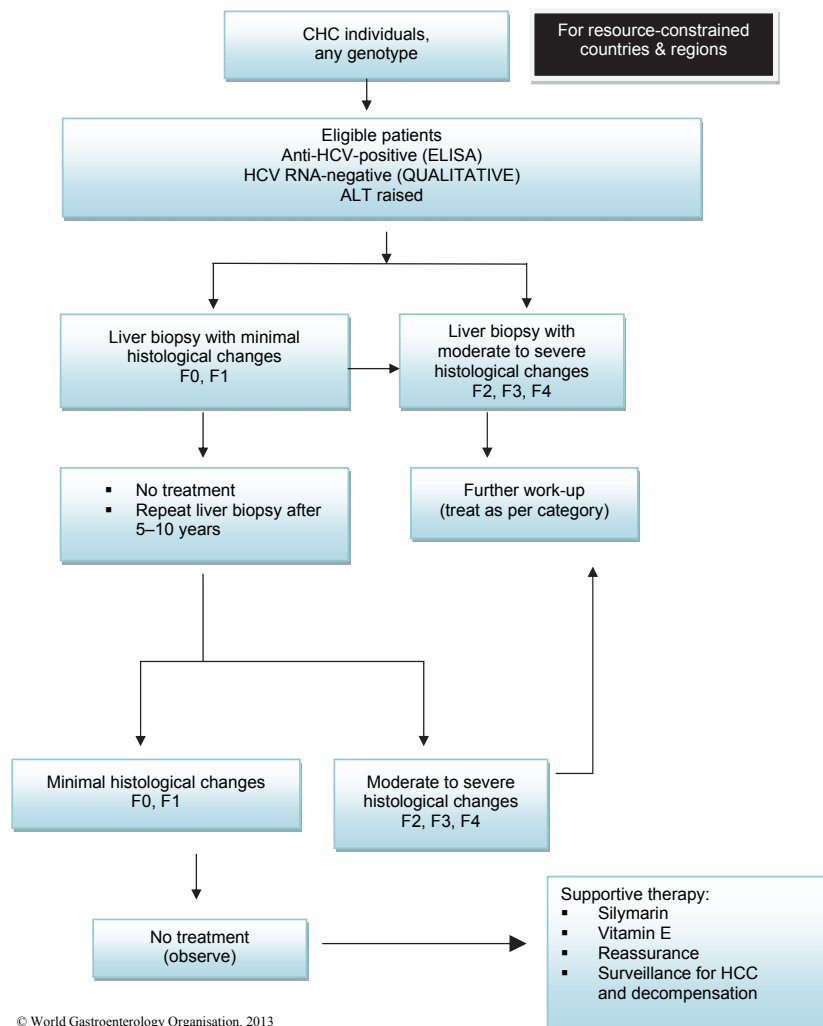


A Resource Sensitive Solution

## Two New WGO Guidelines Have Been Released!

The WGO is pleased to announce the release of its newest guidelines! The first, *Diagnosis, management and prevention of Hepatitis C*, led by Professor Muhammed Umar, Pakistan, will be of interest to all health professionals in primary and secondary care involved in the management of people with hepatitis C infection in different countries of the world. It covers all stages of the disease management pathway: screening, testing, diagnosis, referral, treatment, care, and follow-up of children and adults with, or exposed to, hepatitis C (HCV) infection. To download this brand new guideline, [click here!](#)

The second guideline, *Coping with common GI symptoms in the community; a global perspective on heartburn, constipation, bloating, and abdominal pain/discomfort*, led by Professors Eamonn Quigley and Richard Hunt, is the first to take four key gastrointestinal (GI) symptoms as its starting-point: heartburn, abdominal pain/discomfort, bloating, and constipation. It is also unique in featuring four levels of care in a cascade approach: self-care and “over-the-counter” aids; the pharmacist’s view; the perspective of the primary care doctor—where symptoms play a primary role in patient presentation; and the specialist. The aim is to provide another unique and globally useful guideline that helps in the management of common, troubling but not disabling GI complaints. [Download this new guideline, now!](#)



Sequential steps in the evaluation and treatment of chronic hepatitis C patients with mild disease (F0 and F1), based on liver histopathology (liver biopsy).

## RECENTLY UPDATED & RELEASED GUIDELINES!

### NAFLD-NASH

WGO's other new guideline, Non-alcoholic Fatty Liver Disease and Non-alcoholic Steatohepatitis (NAFLD-NASH) is now available for [download in various languages](#). The Guideline features cascade options for diagnosis in patients with suspected NAFLD-NASH as well as a therapy cascade for extensive, medium, and limited resources. NAFLD-NASH are now the number one cause of liver disease in Western countries, and play an equally important role in the Middle East, Far East, Africa, the Caribbean, and Latin America. Led by Professor Douglas LaBrecque, USA, this guideline was created with a global view with representation from Pakistan, Austria, Malaysia, Russia, Venezuela, Colombia, Mexico, India, Croatia, Canada, France and The Netherlands. Watch future issues of the monthly *e-Alert* as more languages are released!

### Obesity

The Obesity Guideline is now available in multiple languages! Available for download at <http://www.worldgastroenterology.org/obesity.html>, the Obesity Guideline can now be downloaded in English, Spanish, Mandarin, and Portuguese. Look for more languages, soon! The Obesity Guideline is unique in having been updated to include five appendices: Nutrition, Pharmacotherapy, Lifestyle Changes, Surgery, and Obesity and the Elderly. You may also view the [WGO Review Article on Obesity and the Elderly](#) written by co-author of the Obesity Guideline, Prof. Elisabeth Mathus-Vliegen, on the Journal of Clinical Gastroenterology's website.

### Acute Diarrhea

The Acute Diarrhea Guideline, led by Professor Michael Farthing, is [now available!](#) This guideline 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.

Begin downloading the updated version by [clicking here](#), and watch future *e-Alerts* for announcements on more available languages!

### Global Guidelines & Cascades Homepage in Russian and Mandarin

Don't forget to view the Global Guidelines and Cascades homepage in Russian and Mandarin! You may view the Russian page by visiting <http://www.worldgastroenterology.org/global-guidelines-ru.html> or the Mandarin page here: <http://www.worldgastroenterology.org/global-guidelines-mandarin.html>.



## WGO Calendar of Events

### 2013 SOGHIN Annual Meeting

**When:** August 1-2, 2013  
**Location:** Sheraton Hotel, Lagos, Nigeria  
**Organizer:** The Society for Gastroenterology and Hepatology, Nigeria  
**Website:** <http://www.soghin.org/new/login.php>

### National Congress Indonesian Society of Gastroenterology-Indonesian Society for Digestive Endoscopy-Ina ASL 2013

**When:** August 22-24, 2013  
**Location:** Hotel Aryaduta Manado, Sulawesi, Indonesia  
**Email:** [konasgastrohepatomanado2013@gmail.com](mailto:konasgastrohepatomanado2013@gmail.com)  
**Website:** [www.konasghmanado2013.com](http://www.konasghmanado2013.com)

### SAGES Annual Congress

**When:** August 15-18, 2013  
**Location:** Champagne Sports & Conference Centre, Drakensberg, South Africa  
**Organizer:** South African Gastroenterological Society  
**Email:** [sages@easternsun.co.za](mailto:sages@easternsun.co.za)  
**Website:** [www.sagescongress.co.za](http://www.sagescongress.co.za)

### GUT 2013 – Annual Scientific Meeting of MSGH

**When:** August 23-25, 2013  
**Location:** G Hotel, Penang, Malaysia  
**Organizer:** Malaysian Society of Gastroenterology & Hepatology  
**Email:** [secretariat@msgh.org.my](mailto:secretariat@msgh.org.my)  
**Website:** [www.msgh.org.my](http://www.msgh.org.my)

### OESO 12th World Congress

**When:** August 27-30, 2012  
**Location:** Paris, France  
**Address:** UNESCO, 125 Avenue de Suffren, 75005 Paris  
**Organizer:** World Organization for Specialized Studies on Diseases of the Esophagus (OESO)  
**E-mail:** [michele.liegeon@oeso.org](mailto:michele.liegeon@oeso.org)  
**Website:** <http://www.oeso.org>

### Argentine Congress of Gastroenterology

**When:** September 5-7, 2013  
**Location:** Cordoba, Argentina  
**Organizer:** Federacion Argentina De Gastroenterologia (FAGE)  
**Email:** [info@iescalada.com](mailto:info@iescalada.com)  
**Website:** <http://www.gastro2013.com.ar/>

### Conference of Lithuanian Gastroenterology Society "Reare Liver Diseases: Wilson Disease"

**When:** September 26, 2013  
**Location:** Kaunas, Lithuania  
**Organizer:** Lithuanian Society of Gastroenterology  
**Website:** [www.gastroenteologija.lt](http://www.gastroenteologija.lt)

### Swiss Annual Congress 2013

**When:** September 12-13, 2013  
**Location:** Basel, Switzerland  
**Organizer:** Swiss Society of Gastroenterology  
**Email:** [info@gkaufmann.ch](mailto:info@gkaufmann.ch)  
**Website:** [www.sgg-sgvc-congress.ch/](http://www.sgg-sgvc-congress.ch/)

### ILCA 2013 Annual Conference

**When:** September 13-15, 2013  
**Location:** Washington, D.C., USA  
**Organizer:** The International Liver Cancer Association (ILCA)  
**E-mail:** [info@ilca-online.org](mailto:info@ilca-online.org)  
**Website:** <http://www.ilca2013.org>

### Finnish Gastroenterology Autumn Meeting

**When:** September 19-20, 2013  
**Location:** Kuopio Music Center, Kuopionlahdenkatu 23, 70100, Kuopio, Finland  
**Organizer:** Finnish Society of Gastroenterology  
**Website:** [www.terveysportti.fi/gastroenterologiayhdistys](http://www.terveysportti.fi/gastroenterologiayhdistys)

### Gastro 2013 APDW/WCOG Shanghai

**When:** September 21-24, 2012  
**Location:** Shanghai, China  
**Address:** Shanghai Expo Center, 1500 Shibo Avenue, Shanghai, China  
**Organizers:** Asian Pacific Digestive Week Federation (APDWF), Chinese Societies of Digestive Diseases (CSDD), World Endoscopy Organization (WEO), World Gastroenterology Organisation (WGO)  
**E-mail:** [congress\\_international@gastro2013.org](mailto:congress_international@gastro2013.org)  
**Website:** <http://www.gastro2013.org>

### The 15th International Celiac Disease Symposium

**When:** September 22-25, 2013  
**Location:** Sheraton Chicago Hotel & Towers, USA  
**Address:** 301 East North Water Street, Chicago  
**Organizer:** Stefano Guandalini, MD/ The University of Chicago Celiac Disease Center  
**Email:** [icds2013@vista-ft.com](mailto:icds2013@vista-ft.com)  
**Website:** [www.icds2013.org](http://www.icds2013.org)

### The Viral Hepatitis Congress

**When:** September 26-28, 2013  
**Location:** Frankfurt Messe Conference Centre, Germany  
**Organizer:** KnowledgePoint360  
**Email:** [hep@kp360group.com](mailto:hep@kp360group.com)  
**Website:** [www.viral-hep.org](http://www.viral-hep.org)

### 2013 Taiwan Digestive Disease Week (TDDW)

**When:** October 4-6, 2013  
**Location:** National Taiwan University Hospital (NTUH) International Convention Center, Taipei, Taiwan  
**Organizer:** The Chinese Taiwan Gastroenterological Society  
**Email:** [service@tddw.org](mailto:service@tddw.org)  
**Website:** [www.tddw.org](http://www.tddw.org)

**Australian Gastroenterology Week 2013 Incorporating the Federation of Gastrointestinal Societies****When:** October 7-9, 2013**Address:** Melbourne Convention & Exhibition Centre**Location:** Melbourne, Australia**Organizer:** Gastroenterological Society of Australia (GESA)**E-mail:** [gesa@gesa.org.au](mailto:gesa@gesa.org.au)**Website:** [www.agw.org.au](http://www.agw.org.au)**ACG 2013 Annual Scientific Meeting and Postgraduate Course****When:** October 11-16, 2013**Location:** San Diego, California, USA**Address:** San Diego Convention Center, 111 West Harbor Drive, San Diego, California**Organizer:** American College of Gastroenterology (ACG)**E-mail:** [info@acg.gi.org](mailto:info@acg.gi.org)**Website:** <http://www.gi.org>**United European Gastroenterology Week****When:** October 12-16, 2013**Location:** Berlin, Germany**Address:** Messedamm 22 14055, Berlin**Organizer:** United European Gastroenterology (UEG)**E-mail:** [office@ueg.eu](mailto:office@ueg.eu)**Website:** <http://www.ueg.eu/week/>**Autumn Congress of the Czech Society of Gastroenterology****When:** October 31-November 2, 2013**Location:** Karlovy Vary, Czech Republic**Organizer:** Czech Society of Gastroenterology**Website:** [www.cgs-cls.cz](http://www.cgs-cls.cz)**Flemish Fall Symposium****When:** November 23, 2013**Location:** Bruges, Belgium**Organizer:** Flemish Society of Gastroenterology**Website:** [www.vvge.be](http://www.vvge.be)**New Zealand Annual Scientific Meeting****When:** November 20-22, 2013**Location:** Westpac Stadium, Wellington, New Zealand**Organizer:** New Zealand Society of Gastroenterology & New Zealand Nurses Organisation Gastroenterology Section**Email:** [Claire.Bark@tangerineevents.co.nz](mailto:Claire.Bark@tangerineevents.co.nz)**Website:** <http://gastro2013.co.nz/>**Hellenic Annual Congress****When:** December 5-7, 2013**Location:** Makedonia Palace, 2 Megalou Alexandrou Avenue, GR-54 640 Thessaloniki, Greece**Organizer:** Hellenic Society of Gastroenterology**Website:** [www.hsg.gr](http://www.hsg.gr)**XVIII Jornadas Bolivianas de Gastroenterología****When:** October 24-26, 2013**Location:** Buena Vista, Santa Cruz de la Sierra, Bolivia**Organizer:** Bolivian Society of Gastroenterology and Digestive Endoscopy:**Website:** [www.gastrobolivia.org](http://www.gastrobolivia.org)**Congress of Lithuanian Gastroenterology Society****When:** January 31, 2014**Location:** Kaunas, Lithuanian**Organizer:** Lithuanian Society of Gastroenterology**Website:** [www.gastroenterologija.lt](http://www.gastroenterologija.lt)**Canadian Digestive Diseases Week****When:** February 7-10, 2014**Location:** 100 Front St. W. Toronto, ON, Canada**Organizer:** Canadian Association of Gastroenterology**Email:** [CDDW@cag-acg.org](mailto:CDDW@cag-acg.org)**Website:** [www.cag-acg.org](http://www.cag-acg.org)**United European Gastroenterology Week****When:** October 18-22, 2014**Location:** Vienna, Austria**Organizer:** United European Gastroenterology Secretariat**Email:** [office@ueg.eu](mailto:office@ueg.eu)**Website:** [www.ueg.eu/week/past-future/future-ueg-week/](http://www.ueg.eu/week/past-future/future-ueg-week/)**The 32nd World Congress of Internal Medicine (WCIM 2014)****When:** October 26-30, 2014**Location:** COEX, World Trade Center Samseong-dong, Gangnam-gu, Seoul, Korea**Organizer:** The International Society of Internal Medicine (ISIM)**E-mail:** [wcim2014@intercom.co.kr](mailto:wcim2014@intercom.co.kr)**Website:** <http://www.wcim2014.org>

*Highlighted events represent WGO member events. For a full listing of events, please visit <http://www.worldgastroenterology.org/major-meetings.html>.*