INTERNATIONAL NEWS

News about the United European Gastroenterology Federation

The UEGF in an enlarging Europe

When the first ideas about the UEGF emerged in 1988, the Iron Curtain had only just been removed. Although there are outstanding active gastrointestinal research groups in eastern Europe, many wondered what the effects of levelling the Berlin wall and opening of the Iron Curtain on the scientific and professional developments in these countries would be. It is now clear that changes are occurring, perhaps not with lightning speed, but nevertheless they are noticeable and significant. Most remarkable in this respect is Germany. After a hesitant beginning, academics now play a leading part in dismantling the borders between East and West. For example, academic chairs in the eastern part are increasingly occupied by former West German trained professors and, as is true for many other professionals, doctors from the East have moved to the West. Similar changes are taking place in Poland, the Czech Republic, Slovakia, and Hungary where Warsaw, Prague, and Budapest, are slowly finding their place as European university towns. We are all gradually becoming better acquainted through EC sponsored exchange programmes. In addition, organisations such as the ESGE (European Society for Gastrointestinal Endoscopy), EASL (the European Association for the Study of the Liver) and others are organising courses and sponsoring meetings in eastern Europe. To reach as large a number of colleagues in eastern Europe as possible ESPGAN (European Society of Paediatric Gastroenterology and Nutrition) has taken a Travelling Summer School to tour different countries each year. The ASNEMGE (Association des Sociétés Nationales Européennes et Méditerranéennes de Gastroentérologie) also has longstanding ties with national organisations from the eastern part of Europe. Although for 40 years our paths have differed, the cultural heritage and the medical problems of East and West are very similar. History cannot change the facts: Semmelweis lived and worked in Budapest and Mendel in Brno; *Helicobacter pylori*, inflammatory bowel disease, and hepatitis C look very much the same whether in Poland or in Holland. It is not at all surprising that successful liver transplantation programmes have started in the Czech Republic, Slovakia, Hungary, and Poland.

What does this mean to the UEGF? We should realise that the so called seven sister societies (ASNEMGE, EAGE, ESGE, CIGD, EPC, EASL, and ESPGAN), which are unified in the UEGF, all have their roots in the west. That places our colleagues from the East in a somewhat disadvantaged position. Furthermore, a true East-West balance in European gastroenterology can only be achieved from bottom up. It does not help to have executives in leading positions when the students have no chance of an academic career, a situation too well known in the East. Thus the further development of East-West student exchange programmes, clinical train-

ing and research fellowships, travel grants for young investigators are all far more helpful than having someone fulfilling executive posts in any of the sister societies. However, every action in this regard does help to equalise the differences and efforts are required to ensure that exchange programmes and fellowships are adequately funded. In addition it is clear to the delegates of the UEGF council that sooner rather than later, a future UEGW should be organised in one of the great capitals of eastern Europe. Eastern European achievements have become increasingly visible in international medical conferences: for the 1995 UEGW in Berlin 2300 abstracts were submitted and 16.5 per cent came from east European countries; for this year's UEGW in Paris these figures are 2650 and 17.9 per cent. Among these, the majority come from Poland, the Czech Republic and Hungary. The number of submitted and of accepted abstracts from these countries is increasing particularly fast; this is a truly positive sign.

The UEGW and the electronic revolution

The UEGF is currently investigating the options offered by the Internet. It is clear that the annual migration of seven and in the future perhaps 10 thousand doctors may not be the most efficient means of disseminating medical knowledge. It is also bad for the environment. Teleconferencing is environmentally friendly, better for family life, less expensive, and less time consuming. It however lacks the additional cultural values that European conferences definitely have to offer. On the other hand the Internet makes many other facilities available to us, meaning big advantages for the medical profession, the first glimpses of which we are only beginning to see. Although in international football it is customary only to sell the rights to television stations after the stadiums have been sold out, the UEGF will offer the entire UEGW information via CD ROM at the end of the conference. In addition we are developing a Web Site that will enable you to get in touch with us, in the quickest possible way. More information will be available shortly.

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LETTERS TO THE EDITOR

Clinical ultrasound examination

EDITOR,—I read with interest the leading article by Dr Derrick Martin (*Gut* 1996; 38: 479–80). In Europe, clinical ultrasound, particularly of the abdomen as part of the initial patient examination, has been routine for many years. More especially, this has been performed by clinicians rather than by radiologists. The technique is easy to learn

and to apply and is particularly useful when integrated into the other data available to the physician from the history taking and physical examination. Ultrasound is also useful for monitoring progress of the patient's condition, for example, the gastroenterologist will confirm or refute his ultrasound findings of the pancreaticobiliary system by ERCP, and of the intestine by endoscopy or radiology. A suggestion from the European Union of Medical Specialties through the European Board of Gastroenterology, that to obtain a European Diploma in Gastroenterology a trainee will need to undertake 300 ultrasound examinations under guidance, is a good start. It will be clear to any doctor diagnosing and treating abdominal disease, that ultrasound is an indispensable diagnostic tool. As with all techniques of course, some doctors will learn rapidly and others more slowly and perhaps some will never become real experts at the procedure and this will probably be independent of the trainee's speciality be it radiology, internal medicine, etc.

Ultrasound machines at the cheaper end of the market do not necessarily give bad results; most or at least many ultrasound diagnoses (for example, gall stones, metastatic disease, kidney tumours, etc) are reliably found with such equipment. The old adage that in driving from A to B a Rolls Royce is more comfortable but a Volkswagen will do the job as well, can certainly apply to modern ultrasound equipment now on the market.

In central Europe especially Austria, Switzerland, and Germany, abdominal ultrasound (and in addition ultrasound of the thyroid, thorax, joints, peripheral vessels, etc) is the next step after history taking and physical examination in most hospitals and also in many outpatient care institutions. By following this approach, money can be saved and many unnecessary procedures such as luminal radiology, computed tomography, etc, avoided. The procedure is time saving by excluding or proving numerous disorders and by pointing the clinician in a logical direction for further investigations, for example, ERCP. Ultrasound is quick, repeatable, and avoids radiation dosage. In my opinion and experience, at least 80% of abdominal computed tomograms can be replaced by average quality ultrasonography without compromising patient care.

Clinical ultrasound of the abdomen is also indispensable as an immediate measure in the treatment of the acute abdomen. The clinician is again involved directly in the decision making process and to this end should have easy and immediate access to perform and, if necessary, repeat ultrasound examination on such patients. In addition, it should not be forgotten that under ultrasound guidance, therapeutic procedures such as percutaneous drainage of abscesses, can be performed by clinicians directly involved in the patient's initial care and follow up.

Ultrasound training is not expensive. In the United Kingdom, courses in ultrasound training will need to be set up and departments of gastroenterology will need to consider investment in ultrasound machines. In Germany, ultrasound training courses are readily available and are usually under the aegis of departments of gastroenterology. A course of four days (30 hours intensive training and theory) costs about £375. In Wuppertal such courses have been offered two to four times a year since 1979 (in English since 1996).

In conclusion, the value of clinical ultrasound is widely underestimated both by clinicians, family practitioners, and radiologists as well. Clinical ultrasound deserves a more widespread use than in departments of radiology alone because of its beneficial effects on patient care, the ease, speed, and safety of decision making and its capability for conserving scarce financial and manpower resources.

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Reply

EDITOR,—Professor Greiner is right to extol the virtues and simplicity of sonography as a first line imaging investigation in patients with gastrointestinal and abdominal disease and he is equally correct to point out that these values are not universally appreciated. In many countries, particularly the USA, sonography is less widely used, with the consequence that comparatively costly investigations such as endoscopy and magnetic resonance imaging or those involving ionising radiation, such as computed tomography are more liberally used in preference. In the UK however, gastroenterologists and surgeons appreciate the benefits of simple sonography and already understand most of the issues.

There are four questions of practical importance raised by Professor Greiner's letter. Who should do ultrasound? What are the costs? Is the Volkswagen as good as the Rolls Royce, and what training is necessary?

Many radiologists would disagree with me, but I do not feel that it matters who undertakes sonography, as long as they are properly trained and continue to learn by a process of audit and CME activity.

Costs are difficult to evaluate precisely, but the capital and revenue implications of a larger number of less frequently used ultrasound machines, are probably greater than those for a smaller number of centrally available, but heavily used machines. This is particularly so in view of the comparatively short life of an ultrasound machine, consequent upon rapidly advancing ultrasound technology. Most British hospitals tend to run a central endoscopy unit, used by physicians, surgeons, radiologists, and general practitioners, appreciating that a fragmented service is more costly. This is no less likely to be so for ultrasound than it is for endoscopy.

I cannot agree with Professor Greiner that the cheaper Volkswagen machine is as effective as the Rolls Royce machine. There are no hard data on this and a true comparison would have to take into account the cost of missed diagnoses and misdiagnoses that occur as a consequence of the equipment alone. Certainly radiologists appreciate that the sophisticated high specification machines give greater versatility and confidence to the examiner. Perhaps the real analogy between the Volkswagen and the Rolls Royce is not to ask which gets from A to B better, but to ask which you would rather have around you in difficult circumstances when there is the potential for danger or disaster.

Finally, Professor Greiner does not tackle the requirements for training at all. How do we define training for non-radiologists undertaking sonography? How do they know they are adequately trained and more importantly, how does the patient know that

they are adequately trained? Just as in endoscopy, the patient may well not be interested in whether the examiner is a physician, surgeon, nurse, sonographer, radiologist or general practitioner, as long as the examiner is properly trained and provides a safe, accurate service. Again, just as with endoscopy, I believe that it is the provision of acceptable training guidelines, which is the most crucial aspect of this debate and which will dictate the quality of ultrasound services.

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Diverticular disease

EDITOR,—The aetiology of non-infectious colitis may be difficult to ascertain as mucosal biopsy specimens do not consistently demonstrate diagnostic features.^{1,2} Shepherd provided a timely and comprehensive review of such inflammatory changes associated with diverticular disease (*Gut* 1996; 38: 801–2), highlighting the diversity of the inflammatory processes and providing an insight into the pathogenesis of ulcerative colitis. However in our experience diverticular disease presenting as a chronic continuous colitis is unusual.

We recently reviewed the case notes of all patients with a histological diagnosis of chronic non-specific proctocolitis made between 1985 and 1990 at our hospital. Of the 42 patients initially diagnosed 14 were subsequently shown to have ulcerative colitis. Twenty one patients had non-specific proctocolitis on repeat biopsies and the colitis in these patients, who were predominantly young women (18 women mean age 43), ran a prolonged (average five years) but mild course. Only continuous colitis was observed. Just two patients with colitis had concomitant diverticular disease and, in contrast with other studies,³ neither rectal sparing nor progression to ulcerative colitis was observed. The remaining patients had clinically distinct diagnoses such as radiation colitis.

We conclude that although diverticular disease associated colitis is a recognised entity, in our clinical practice its occurrence is rare constituting just two cases over a five year period. We accept that some diagnoses of ulcerative colitis or Crohn's colitis may be incorrect, none the less the association with diverticular disease appears unusual. Our finding that persistent non-specific proctocolitis predominated in women of reproductive age may suggest a distinct disease and warrants further investigation. However our report is limited to both sample size and duration of follow up; these deficiencies are currently being addressed.

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1 Nottegham B, Salomez JL, Gower-Rousseau C, Marti R, Lemahieu M, Nuttens MC, et al. What is the prognosis in unclassified colitis? Results of a cohort study of 104 patients in the Northern-Pas-de-Calais Region. *Gastroenterol Clin Biol* 1993; 17: 811–5.

2 Le Berre N, Heresbach D, Kerbaol M, Culet S, Bretagne JF, Chaperon J, et al. Histological discrimination of idiopathic inflammatory bowel disease from other types of colitis. *J Clin Pathol* 1995; 48: 749–53.

3 Makapugay LM, Dean PJ. Diverticular-disease associated chronic colitis. *Am J Surg Pathol* 1996; 20: 94–102.

Reply

EDITOR,—I entirely concur with the sentiments by Michell *et al* with regard to the difficulties of biopsy diagnosis in so called non-infectious colitis. I also accept that diffuse chronic inflammatory pathology associated with diverticular disease is a rare condition, as my leading article indicated. Focal luminal inflammation is more common in diverticular disease¹ but is still rare giving the overall prevalence of diverticular disease in the population. I was interested in their series that not only reports the comparative rarity of diffuse 'diverticular colitis' but also seems to identify an interesting subgroup of patients, particularly young women, with prolonged but mild 'inflammatory bowel disease'. As they indicate, this series of patients requires further investigation as to whether it represents a distinct disease entity.

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1 Gore S, Shepherd NA, Wilkinson SP. Endoscopic crescentic fold disease of the sigmoid colon: the clinical and histopathological spectrum of a distinctive endoscopic appearance. *Int J Colorect Dis* 1992; 7: 76–81.

Helicobacter pylori and duodenogastric reflux

EDITOR,—The paper by Ladas *et al* (*Gut* 1996; 38: 15–8) considers a very interesting theme, however it has some important methodological drawbacks, which in my opinion may affect the results. Firstly, a one hour assessment of duodenogastric reflux (DGR) seems inappropriate. A 24 hour monitoring is needed to quantify the exposure time of the mucosa to the refluxate. This is true because, although duodenogastric reflux physiologically occurs during 24 hours in normal subjects,^{1,2} 18 of 29 (62.1%) subjects included in this study and, more importantly, eight of 18 (44.4%) of those who were considered more prone to reflux (*H. pylori* positive subjects) were shown to be devoid of duodenogastric reflux. Secondly, the *H. pylori* positive and *H. pylori* negative series of subjects hardly seem comparable (44.4% DU, 44.4% NUD, 11.1% oesophagitis in the *H. pylori* positive and 18.2% DU, 81.8% NUD in the *H. pylori* negative group). These different illnesses are certainly capable of affecting duodenogastric reflux differently, independently from *H. pylori* status! Thirdly, post-treatment assessment of duodenogastric reflux (despite the inadequate method) in the three subjects, who had pre-treatment reflux and were not successfully cured of *H. pylori*, would have been interesting. Reflux persistence after eradication failure could have represented a good counterproof and would have strengthened the datum of eradication associated reflux disappearance, which was obtained in only six subjects! Unfortunately this was not done.

Therefore, the paper provides enough evidence for the conclusion that '*H. pylori* may survive the noxious effect of bile reflux in the