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 up would be. Semmewies 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 not as slow as often stated. 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 universities towns. We are all gradually becoming better acquainted through EC sponsored exchanges and 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 Gastroenterologie) and also by pointing our attention to the migration of the UEGF from Paris to Prague, to Budapest and to Prague, the Czech Republic and Hungary. The number of submitted and 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 in the future 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 environment 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 of great help in monitoring the progress of the patient's condition, for example, the gastroenterologist will confirm or refute his ultrasound findings of the pancreaticobiliary system by ERC; and of the intestine by endoscopy or radiology. A suggestion from the European Union of Medical Specialities through the European Board of Gastroenterology, to that aim 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 bladder stones, 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, at a much cheaper price, applies as well to ultrasound equipment now on the market.

In central Europe especially Austria, Switzerland, and Germany, abdominal ultrasound (and in addition ultrasound of the thyroid, joints, vascular territories, etc) has become 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 provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient. It 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 excluding or provoking numerous disorders and also by reducing time spent by the patient.

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 ultrasound guidance, therapeutic procedures such as percutaneous drainage of abscesses, can be performed by clinicians directly involved in the patient’s initial care.

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 be considered for 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).