

Functional Brain-Gut Research Group



Message from the President	1	Committee Reports	9
Editor's Column	2	Infrastructure Grants	12-13
Member Biosketch: Anthony Lembo	5	IFFGD Column	14
FBG Website Information	6	Election Biosketches	15
FBG News	6	Guest Article: Stephen M. Collins	16
New Members	8		



George F. Longstreth
President

Message from the President

FBG is becoming increasingly important through its members' research and education in the field of functional GI disorders and the care of patients having them. We have evolved from an era of under-representation of these disorders at professional society meetings in the 1980s (and earlier, when you could flip through months of GI journals and find only a few articles on functional disorders), to the present when relevant papers appear almost monthly in several journals. The maturation of FBG since its 1989

founding and the research increase have occurred in parallel, and we now expect to find FBG members among the authors of important papers and on professional meeting programs. However, much remains to be done, and FBG is evolving toward having an even greater role.

Organizational change has accelerated recently. I would like to highlight a few especially important developments:

Executive Director-It is impossible to overstate Deb Geno's tireless dedication to her Executive Director position. She traveled to Chapel Hill last year to begin the transition from the long heritage of Carlar Blackman and has worked countless hours more than we originally predicted. She has managed the office relocation from North Carolina to Minnesota and handled many issues outside of her fulltime employment. Now that she has completed much groundwork, the officers are committed to enabling her to devote less time to this job.

Official Journal-The presence of our logo on the cover of *Neurogastroenterology & Motility*, designed by Debbie Drossman, identifies it as our official journal, and the editors invite our manuscript submissions, including those covering topics that will broaden the journal's content. Beginning next year, members who have paid their dues by December 1, 2004 will have online access to the journal through our website (www.fbgweb.org) with a user name and secure password (enclosed with this Newsletter).

Dues Policy-It is now especially important to collect dues. Our arrangement with Blackwell, the journal publisher, to provide members online access requires us to pay \$27 annually for each non-member of the American Motility Society or the European Society of Neurogastroenterology & Motility (members of both societies receive the printed version). Therefore, dues payment must now be required to maintain membership and obtain online access. U.S. bank checks or charges to credit card accounts are accepted. We have increased the annual dues to \$50 and we will send

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1996-1998 -- Kenneth L. Koch, MD
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2002-2004 -- Kevin Olden, MD

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Founded 1989

continued on page 4

Medicine Has Become A Business: But What is the Cost?

Douglas A. Drossman, MD, *Editor*



In the care of patients with functional GI and motility disorders, the importance of the physician-patient relationship and the communication of these skills to trainees along with a careful clinical assessment of the disorders cannot be overstated. Yet the health care system is changing and these changes may compromise

the successful implementation of patient care and teaching. Below is an editorial comment that appeared in Gastroenterology this past April. Although the sociopolitical aspects of the article may be particularly relevant to health care in the USA, I believe there are components that have relevance world wide. If you would like to convey your thoughts to us, please feel free to send them to Ms. Deb Geno at our editorial office. We hope you will find this commentary worthy of some thought.

I have seen a great deal of changes in the practice of medicine. I grew up in the 50s and 60s, when Marcus Welby and James Kildare were role models for physicians. At that time, a physician would sit at the bedside, hold hands, take a pulse, and talk to families—and the patients expected it. Some would say this had healing value. Others would now argue that there really was not much more to do. There were no ultrasound or computed tomography studies, endoscopy was only beginning, and treatments were limited. During medical school in the 1960s, emphasis was placed on the medical history, the physical examination, and the clinical decision-making. The greatest respect went to the clinician/teachers. They could elicit on rounds that a patient with an obscure patchy pneumonia was a bird fancier, or identify that the new admission developed unexplained chest pain on the 1-year anniversary of the parent's death from a myocardial infarction. They could not only auscultate paradoxical splitting of S2, but also could draw the cardiac cycle and explain the physiology.

Later during residency and fellowship, rounds were rich with discussions on the pathophysiology of diarrhea with inpatients staying for d-xylose tests or 72-hour stool fat collections. We learned how to manage gastrointestinal bleeding, often to endoscope and identify the bleeding site before sending the patient to arteriography or surgery. The gastrointestinal fellows would see patients in clinic with attending supervision and would "follow" them over several years until they said goodbye when leaving for practice. For those staying in academic

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medicine, the goal was to emulate the highly respected "triple threats": effective clinicians and educators who could also secure National Institutes of Health grants (when the payline approached 50%) and even chair a gastrointestinal division or department of medicine.

So much has changed. The remarkable growth of medical knowledge and technology has relegated much of these time-honored "doctorisms," such as the physical examination, bedside teaching, or even continuity of care to the archives. Clinicians now must learn to interpret ultrasonography, or computed tomography, images and the physical examination cursorily screens for more definitive tests. In many ways, we believe we are smarter, more efficient, and more capable of saving lives.

But are we at risk of throwing out the baby with the bathwater? The well-executed history and physical examination not only permits the most valid acquisition of clinical information but also facilitates the physician-patient relationship and has therapeutic value. Bedside teaching enables a process of learning between teacher, student, and patient that brings to focus the patient and illness rather than the disease alone. Continuity of care provides a longitudinal dimension in which a physician can truly "know" the patient, and, in the process, provide ongoing knowledge, guidance, and hope. These are human values relating to the process of medicine that we as physicians must retain in our pursuit of new technical skills.

How is medicine now practiced compared with 30–40 years ago? The patient care seen on television has become an allegory; it has moved from the bedside to the emergency room where 3-camera fast takes and multiple sound bites show the speed and quick thinking of health care teams that move from one patient to another. With regard to the day-to-day activities in teaching centers, medical attendings are discouraged from teaching on work rounds because it interferes with team efficiency and autonomy. The training of complete physical examinations has been supplanted by regional examinations based on the patient's chief complaint, and technology is becoming the "gold standard" of diagnosis. One day on rounds, an intern presenting a patient with congestive cardiomyopathy noted the large neck veins and cardiac findings and reported a normal abdominal examination. The attending, eager to

continued on page 3

teach, showed the very large liver that was missed, only to hear the intern sheepishly ask the resident if he should get an ultrasound to confirm that it truly was enlarged.

Residents do “shift work” on their admission days, and the night floats, who cover until the early morning, are not around the next day when questions are asked about why a procedure was scheduled. On admission days, the ward team greets each new patient as a group, where 10–15 minutes are spent at the bedside while one person takes the history (“why are you here now?”) and 3 stethoscopes simultaneously auscult the chest. Then all retire to the computers to “cut and paste” the past medical and social history templates. Patients, confused about who is really their doctor, often link up with the medical student, the one who comes back after “lightning” rounds to see if there are any more questions.

What has led to such changes? A new factor is affecting health care in ways that would never have been anticipated: medicine has become a business. This has occurred because of hefty drug costs, decreasing reimbursements from insurance companies and Medicare/Medicaid, increasing regulatory burdens, the loss of cross-subsidization to cover the uninsured, and the need to treat a larger number and proportion of uninsured patients requiring more specialized and costly services. This fiscal aspect has so permeated medical practice and patient care that, to younger physicians, it goes unnoticed. In the real world of medicine, speed and efficiency using modern technology are the priorities, because the cost of health care and the very salaries of the health care personnel depend on it.

The effects are profound. Physicians are now “providers,” guided by case managers who decide on the length of “client” hospital stays, and professionals in business suits, not white coats, determine health care policy. Responsibility for patient care is now diffused among multiple providers with no single person willing or able to assume final responsibility for the patient. As a result, when decisions are made, the patient becomes confused and feels caught in the middle. It is no wonder that malpractice litigations and the use of alternative medicine have grown so dramatically.

Within gastroenterology, we are moving toward being an imaging specialty, in which patients may soon have direct access to procedures, thereby bypassing clinical decision making, as is occurring with community computed tomography studies. In fact, endoscopy, the investigative and therapeutic tool of the gastroenterologist, has become an annuity for the survival of academic programs and clinical practices, and the greatest respect goes to those who endoscope the most and the fastest.

However, the cost is greatest at the academic institutions where our physicians, teachers, and investigators of the future are being trained. Department chairs, who would like to be

valued for holding Chief of Service rounds to show clarity in thinking to the house staff, or for mentoring their faculty, are now also judged by their ability to balance the budget and to develop a top-notch market plan for approval by the Dean. Division chiefs who seek to promote and support the careers of their members reluctantly are compelled to request “bottom line” funding sources from faculty to account to the department for their time if or when their grants run out. Recruitment strategies have shifted from identifying young faculty with hopeful career paths to capturing those either already funded, or who are willing to work 4 days a week doing clinical service. For faculty, teaching is an uncompensated luxury that fits between writing grants and supporting oneself through clinical service. Furthermore, the time allotted for teaching is compressed with the loss of formal teaching rounds, reduced time for clinic visits, and increased numbers of consultations. In effect, the value of teaching, mentoring, and caring for patients has been supplanted by the need for each physician and their departments in academics or in practice to become fiscally independent.

It is understandable, desirable, and inevitable that health care must be efficient, and, in the least, financially neutral. However, I am concerned that we are losing our sense of professionalism if we substitute rather than integrate financial management for the time-honored values that distinguish us as physicians and educators: to develop an effective physician-patient relationship, to mentor trainees, to establish camaraderie in peer associations, and to feel gratified in the process. The deeply engrained physician ethic of doing what you do for the benefit of the patient and of teaching young physicians is becoming subsumed to the need to earn more money, often for third-party payers, and to get out on time. Technology, instead of being a resource that adds to our experience and wisdom, is believed to be sufficient for clinical decision-making. Yet, unguided technology coupled with the speed and volume of the workload actually increases costs and risk to patients. Conversely, our ability to obtain critical information directly from the patient with whom we develop a relationship reduces malpractice and improves patient satisfaction, adherence to treatment, and even the outcome. These timeless skills, if not transferred to our students, will be lost.

Are there solutions? There are a number of possibilities. I believe that we must reward scholarly clinicians and teachers by having the learning institutions, third-party payers who benefit from these clinicians, and Congress show their support financially. There needs to be a reallocation of institutional overhead expenses, a tax to third-party payers, and, possibly, a congressional mandate to provide direct educational funds. The continuation of good educational skills must be fostered. Accrediting agencies such as the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education could set standards for quality assurance in

continued on page 4

continued from page 1

dues announcements by e-mail in the fall. **IMPORTANT:** See subsequent article, "Logon to Our Website Now."

Initial Free Membership-Also, we have stopped offering an initial 12-month free membership because it would be too complicated to send dues announcements throughout the year, based on the expiration of each person's first 12-month period. And, Blackwell only initiates subscriptions (including online access) in January. Instead, we now provide free membership for the rest of any new member's first calendar year, regardless of when they join, which enables most of them to receive at least one Newsletter and the mailed Directory. Since everyone must be on the same annual cycle to obtain journal access, new members must pay their dues by December 1 to maintain membership and acquire online journal access.

E-mail Addresses-147 members have not provided their e-mail addresses, and many have not corrected changed addresses. Dues announcements will be sent by e-mail, simplifying the process and saving money, so the Executive Director must have every member's e-mail address. However, members will have the option of having their e-mail addresses listed in the Directory; the addresses of those who prefer not to do this will not be given to anyone. **IMPORTANT: See subsequent article, "Logon to Our Website Now."**

Membership Certificate-In response to members' requests, our Membership Committee Chair, Max Schmulson, has designed a certificate suitable for framing. We plan to mail a copy to each member next year.

Young Investigators Forum-Lin Chang and Rona Levy volunteered to plan the 2005 fellows forum and have started working on it. They will use a new professional organizer, which should make the meeting more economical even though they plan to increase the number of invited fellows.

Cross-Cultural Issues-Charles and Mary-Joan Gerson recognized a need for FBG to address cross-cultural aspects of functional GI disorders, and they are recruiting collaborators, possibly including a medical anthropologist. This is an excellent example of a member-initiated innovation that will broaden FBG activities.

The Executive Committee and other members have worked diligently on these and other matters to make the FBG administration more efficient and guarantee that the organization serves each member and advances our important mission. My main goal is to further increase the involvement of our members with FBG. New ideas and member efforts are needed to fulfill our professional role, which leads to improving patients' lives. I look forward to receiving your suggestions and increased participation in FBG activities.

George F. Longstreth

Editor's Column (from page 3)

teaching with more attention paid to basic clinical skills, evidence-based medicine, clinical reasoning, the use of the biopsychosocial interview, and the cost-effective use of diagnostic tests. Continuing medical education credits must be required in these areas. Certifying boards such as the American Board of Internal Medicine and the American Board of Medical Specialties should call for demonstration of these competencies for recertification. At the medical school level, deans could allocate specific funding for skilled teachers and reward their accomplishments with bonuses and promotions. Private foundations should support more fellowships and sabbaticals for clinician teachers. The Institute of Medicine and other nationally prestigious groups could influence the thinking of health care leaders by issuing appropriate directives. Ultimately, by fostering the development of educators and role models, we will reduce costs and improve quality of care. Is there time to work out the solutions? Our profession and society depend on it.

FBG Biographical Sketch

Anthony Lembo



We are pleased to offer this bio sketch of Dr. Tony Lembo, who has been an active participant in FBG and is well known and respected in the field of functional GI and motility disorders.

My parents came from a small town in northern Sicily in the early 1960s. Like many immigrants, they instilled in their children that work and education were the keys to the American Dream. My sister, an attorney, and I are living that dream.

I was fortunate to have an early decision acceptance to Amherst College, where my initial interest was in mathematics. When I discovered that a mathematician's career peaks in his early 20's, and I was nowhere near my first breakthrough, I moved on to the field of medicine.

I spent my first year after college in the laboratory of Dr. Louis Weinstein in the division of Infectious Disease at the Brigham and Women's Hospital. Dr. Weinstein was an old-time physician who taught me the importance of bedside manner. I followed in Dr. Weinstein's footsteps and entered Tufts Medical School in 1986.

In 1990, I lived out every Bostonian's fantasy of wintering in a sunny and warm climate by moving to Los Angeles for my residency at UCLA Medical Center. In my third year of residency, I worked in Emeran Mayer's laboratory. His creativity and energy inspired me to pursue a career in functional GI disorders. I was drawn to a field which was comparatively unstudied and one in which I could potentially help a great many people. Because of Emeran, I stayed in L.A. for my gastroenterology fellowship and continued on staff at UCLA for a year thereafter.

As luck would have it, the woman I met and married in Los Angeles had grown up in Boston, so it was inevitable that I we ended up back in Beantown. In 1997, I began work at the Beth Israel Deaconess Medical Center where I am now Director of the GI Motility Center. I've been fortunate to have a good mix of clinical responsibility and research opportunities. My current research focus is studying the role of acupuncture in IBS. I am collaborating with Ted Kaptchuk and others at Harvard Medical School's Osher Institute for Alternative Medicine on this project.

I love the marriage of human interaction and analytical thinking that academic medicine brings and I hope to practice it for a very long time.

Anthony Lembo

Third Annual FBG Functional GI Disorders Young Investigators' Forum

This meeting will be held on March 18-20, 2005 at L'Auberge Del Mar Resort and Spa. This beautiful resort is located by the beach in Del Mar which is on the California coast 20 minutes north of the San Diego International Airport. The meeting is a unique opportunity for fellows and other young investigators to present their research as well as interact with faculty members. There will be didactic teaching and interactive breakout sessions with the main emphasis on career development and mentoring. The meeting Chair is Rona Levy and the Co-Chair is Lin Chang. The faculty members are Michael Camilleri, William D. Chey, Lin Chang, Ray Clouse, Doug Drossman, Rona Levy and Arnold Wald. All young investigators are encouraged to submit an abstract and join us in sunny Southern California!



On July 16, 2004 Dr. Dan Dumitrascu organized a symposium in Baia Mare, Romania on Functional GI Disorders with the participation of the Bulgarian Professor of Anatomy and Histology, Nikolai Lazarov.

Dr. Dumitrascu speaking on the management of FGID in the Philharmonic Hall of Cluj, Romania, during the conference cycle Medicine and Art.

6th International Symposium on Functional Gastrointestinal Disorders

This symposium will be held April 7-10, 2005, at the Pfister Hotel, Milwaukee, Wisconsin and is jointly sponsored by the University of Wisconsin Medical School and the International Foundation for Functional Gastrointestinal Disorders, in cooperation with the Functional Brain-Gut Research Group. An international audience of clinicians and investigators will gather to exchange information on the latest advancements in the areas of functional gastrointestinal disorders. The symposium will offer a format of plenary sessions, interactive workshops and mini symposia on both adult and pediatric functional gastrointestinal disorders.

Contact: Terese Bailey, Office of Continuing Medical Education, 2701 International Lane, #208, Madison, WI 53704, call (608) 240-2141; fax (608) 240-2151; or Email: tmbailey@wisc.edu

Important! Login To Our Website Now

Due to the new billing system that FBG is implementing and the requirement of dues payment for online access to Neurogastroenterology & Motility, we must have a valid e-mail address for every member (see "President's Message"). A username and password for each member should have accompanied this newsletter. Please use this username and password to login to the "Members Area" (near bottom left) of <http://www.fbgweb.org> as soon as possible. Once you have logged in, you will have the ability to update your e-mail address, preferences and contact information. All members must enter a valid e-mail address, since everyone will receive an e-mail message that will allow them to "activate" their accounts. The e-mail address provided by members will be used for dues announcements and invoices. On the website, you will have the ability to choose whether to include your e-mail address in our printed Directory or limit it to the secure FBG database.

We have benefitted greatly from the assistance of David Maliachi of Adaptium, Inc., La Jolla, California in setting up this process. I highly recommend his services to any member needing programming, web design, database design, or other computer or software services (www.adaptium.net).

George F. Longstreth

Transition in Newsletter Management

My thanks go to Christina Lomax who has successfully taken over the task of FBG Newsletter managing editor. She has done a remarkable job in a very short period of time. I also want to thank John Herr who has helped the newsletter develop a new look. We hope you like it. Remember, this is your newsletter; please send along news items or any comment or suggestions.

Doug Drossman

Scandinavian Association of Gastrointestinal Motility (SAGIM) is arranging a seminar on GI motility studied by ultrasonography October 28-29 in Bergen, Norway. See their website (<http://www.haukeland.no/sagim/>) for contact information.

The Bergen Ultrasound Motility Day In cooperation with SAGIM (Scand. Assoc. GI Motility)

October 28 -- Quality Hotel Edvard Grieg; Bergen, Norway

October 28 -- Arrival - Dinner at the Hotel

October 29

0900	Opening (Svein Ødegaard)	1200	`Lunch
0905	Ultrasound of the Antrum – Gastric motility (Trygve Hausken)	1300	Motility of the small intestine visualized by Ultrasound (Hausken/Gilja)
0930	Ultrasound of the Proximal stomach 2D- and 3D methods (Odd Helge Gilja)	1330	Doppler of transpyloric flow (Trygve Hausken)
1000	Intragastric distribution - Ultrasonography and Barostat (Johan Lunding)	1400	The Ultrasound Meal Accommodation Test (UMAT) (Odd Helge Gilja)
1030	Coffee	1430	Coffee and practical demonstration
1100	Ultrasound and scintigraphy (Kristian Hveem)	1515	Endosonography of esophageal motility (Dag Arne Hoff/Jan Hatlebakk)
1130	Strain Rate Imaging of the Stomach (Aymen B. Bushra)	1535	Drink tests and intragastric volumes (Ina Hjelland)
		1600	Closing remarks

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CME Training Course: The Hypnosis Treatment for Functional GI Disorders

The UNC Center for Functional GI & Motility Disorders, University of North Carolina in Chapel Hill, will sponsor this course on November 11-14, 2004 at the William Charles Hamner Conference Center, North Carolina Biotechnology Center, Research Triangle Park, North Carolina. This course will teach health care practitioners how to use hypnosis in treatment of IBS and functional GI disorders.

November 11-12

“Part A: Basic Hypnosis Training Course”

November 13-14

“Part B: Hypnosis for Functional GI Disorders”

Fee for the entire course is \$545 (Part A+B, 27.25 credit hours). Fee for Part B only is \$285 (with proof of prior hypnosis training, 12 credit hours).

For more information, contact the Course Director, Olafur Palsson, PsyD, at: opalsson@med.unc.edu

IBD Mind-Body Presentation Available

An annotated Powerpoint presentation on mind-body interactions in inflammatory bowel disease is now available in English and German language versions at the website of the American Psychosomatic Society (www.psychosomatic.org/ed_res/index.htm). The 39 slides, covering pathophysiology, mind-body interactions, and disease impact, can be integrated individually into other presentations or used as the basis for a comprehensive lecture. It is possible to download the presentation or selected slides without charge, complete with notes and references, for offline screen viewing or projection, or to view the entire set online. Please feel free to check it out and use any and all slides as you wish.

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Disorders of Function Clinic Opens

The Disorders of Function Clinic (DFC), Institute for Preventative and Primary Health Care (IPPH) of Binghamton University and Valley HealthCare, began accepting new patients on March 1st of this year.

The DFC is committed to patient care, research and education in the field of Functional Disorders. The clinic will be open to all patients with Functional Disorders; that is, patients with symptoms that are not explained by physical or chemical findings following a work-up by a physician. Some of these patients are affected with more than one disorder, such as, Irritable Bowel Syndrome, Non-Cardiac Chest Pain, Irritable Bladder Syndrome, Fibromyalgia, Chronic Fatigue Syndrome and others. The main purposes of the DFC will be to conduct an epidemiological study of this subpopulation of patients in an attempt to determine whether we are dealing with one disorder with manifestations in many organ systems or many separate syndromes, whether some of these Functional Disorders have a common pathogenesis, and whether heredity plays a role. The data is entered into a software program designed for DFC by IPPH's Information Technology specialists.

Results of a pilot study have been submitted in abstract form for inclusion in the upcoming 69th Meeting of the American College of Gastroenterology in Orlando, Florida.

Marcelo A. Barreiro, MD, MSc
Director

New Members

Albert Svoboda, MD <i>Santa Barbara, CA</i>	Corti Rodolfo Bsas, <i>Argentina</i>	Brendan Drumm, <i>MD Dublin, Ireland</i>
Laura Sole, MD <i>Buenos Aires, Argentina</i>	Mirjam Bueno de Mesquita, MD <i>Vtrecht, Holland</i>	Jenny Molano, MD <i>Bogota, Colombia</i>
Banka Niranjani, MD <i>Mumbai, India</i>	Juan Marquez, MD <i>Medellin Ant, Colombia</i>	Alfonso Zetina, MD <i>Guatemala</i>
Kagalwalla Amir, MD <i>Naperville, IL USA</i>	Nuam Shroyer, PhD <i>Houston, TX USA</i>	Silvio Capparelli, MD <i>Uberlandia, MG Brazil</i>
Cuellar Rafael, MD <i>Visalia, CA USA</i>	Joong Goo Kwon <i>Daegn, South Korea</i>	Brian Mulhall, MD, MPH <i>Washington, DC USA</i>
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Arthur Vasquez, MD <i>Jackson, NJ USA</i>	Jou Morishita <i>Sendai, Japan</i>	B. Li, MD <i>Chicago, IL USA</i>
Susan Abeln, RPh <i>Mason, OH USA</i>	Chitkara Denesh, MD <i>Boston, MA USA</i>	Bill Aldrich <i>Napa, CA Venezuela</i>
Miguel Saps, MD <i>Pittsburgh, PA USA</i>	Alkalay Guliit Cfur <i>Suba, Israel</i>	R. Alberto Travagli, PhD <i>Baton Rouge, LA USA</i>
Mark Lemert, MD <i>San Diego, CA USA</i>	John Kuldau, MD <i>San Diego, CA USA</i>	Orlando Penaloga, MD, PhD <i>San Cristobal, Tachira, Venezuela</i>
Klaus Bielefeldt, MD <i>Pittsburgh, PA USA</i>	Gladys-Eugenia Pulgar-Granados, MD <i>Barran Quilla, Allantico, Colombia</i>	Borrelli Osuacdo, MD, PhD <i>Rome, Italy</i>
Caroline Danda, PhD <i>Kansas City, KS USA</i>	Luz Elena Vargas-Bolivar <i>Barran Quilla, Allantico, Colombia</i>	Laura Agoff, MD <i>Capital Federal, Argentina</i>
Gisela Chilimsky, MD <i>Cleveland, OH USA</i>	Aue Linden Porto <i>Alyre, RS Brazil</i>	Micheal Fried, PhD <i>Zurich, CH, Switzerland</i>
Manual Cachafoiro, MD <i>Panama City, Panama</i>	Jou Morishita <i>Sendai, Japan</i>	Nader Youssef, MD <i>MBA Morristown, NJ, USA</i>
Isaac Quintero, MD <i>Panama City, Panama</i>	Elyanne Ratcliffe, MD <i>New York, NY USA</i>	Nadina Frider, MD <i>Bsas, Argentina</i>
Sebastian Haag, MD <i>Essen, Germany</i>	Mahamane Mamadou Houson, <i>TX USA</i>	Steven Weil Oak <i>Park, IL, USA</i>
Aaron Bartoo, PhD <i>Pullman, WA USA</i>	Henry Nyhlin, Prof <i>Stockholm, Sweden</i>	Bishwa Tuladhar, PhD <i>Bradford, UK</i>

Program Committee*R. Giles Locke*

Each year the FBG has the opportunity to nominate ideas for symposia for consideration by the Nerve Gut Motility section of the AGA to consider for presentation at DDW. We had a strong response to our RFP and received 11 proposals-the most ever! The selection committee had the difficult task of identifying the specific proposals for FBG endorsement to the AGA. Thanks to Lionel Bueno, Paul Enck, Andrew Feld, Odd Gilja, Paul Hyman, Juan Malagelada, Richard McCallum, and Kevin Olden for their great ideas. Thanks to Fernando Azpiroz, John Kellow and Susan Lucak for serving on the committee. The details of the proposals selected for presentation at DDW will be included in the next newsletter.

The FBG is also involved in the abstract selection process for DDW. The abstract review panels have been selected for three abstract descriptors: Psychosocial and Psychotherapeutic, Symptoms and Epidemiology, and Pharmacotherapeutics. Thanks to all for agreeing to participate.

Public Policy Committee*George Longstreth*

New members of the Public Policy Committee are: A. Feld (Chair), L. Chang, W. Chey, F. Cremonini, and R. Levy and, replacing G. Longstreth (Chair), E. Corazziari, A. Feld, W. Whitehead, D. Drossman, and S. Lucak.

Awards Committee*Rona Levy*

The Functional Brain Gut Research Group (FBG) is pleased to announce a call for applications for its sixth annual awards in the following categories: Young investigator, Research Scientist, and International Travel. The deadline for receipt of applications is **April 1, 2005**. All FBG members will receive electronic notification of this award. Nomination forms will be available soon on the FBG website. 2004 Young Investigator Awards were received by Filippo Cremonini, MD and Anthony Hobson, MD. Nicholas Talley, MD received the research scientist award.

Membership Committee*Max Schmulson*

Our membership has increased steadily over the past years. Sixty-one new new members have joined our organization since DDW 2004. We are now 637 members from 48 different countries, an achievement that would not have been possible without all of your work. We need to keep expanding our membership. Therefore, we encourage you to identify professionals in your area of influence including gastroenterologists, physiologists, epidemiologists, surgeons, psychologists, neurologists, psychiatrists, and other health care professionals, interested in functional gastrointestinal disorders. Payment of dues by credit card is now possible. Enclosed is a membership drive letter and application form that can be filled out and sent by e-mail, fax or mail.

Nominating Committee

The four members currently running for the two positions on Council are Lesley A. Houghton, PhD, Brian Lacy, MD, PhD, Fermin Meamin, MD, and Max Schmulson, MD. They will be replacing Dr. Anthony Lembo and Dr. Emeran Mayer. See page 15 for biosketches.



Gerald Holtmann and trainees from Essen, Germany



Susan Lucak and Ray Clouse



Michael Jones, Mike Crowell, Bill Orr



FBG Executive Committee Meeting: Rick Locke, Deb Geno, George Longstreth, Bill Chey, Kevin Olden, Max Schmulson, Rona Levy, Nancy Norton, Howard Mertz



Rona Levy, Grant Thompson, Lin Chang



Nick Talley receives the 200 4FBG Clinical Investigator Award from Rona Levy



Rome III Chair, Co-Chair Planning Meeting at DDW, 2004: Nick Talley, Robin Spiller, Ray Clouse, Jack Wood Jose Behar, Fermin Mearin, Enrico Corraziari, Paul Hyman, George Longstreth, Robin Spiller, Adil Bharucha, Michel Delveaux



Rick Locke, Tony Lembo, Shin Fukudo



Rick Locke and Deb Geno



Fermin Mearin, George Longstreth, Robin Spiller



Mike Camilleri, Adil Bharucha, John Kellow



Doug Drossman receives the 2004 AGA Distinguished Educator Award from Emmett Keefe, President of the AGA



Paul Hyman and David Fleischer

UNC Receives Five-Year NIH Grant on Mind-Body Interactions and Health

September 2004 – Chapel Hill, NC. The UNC Center for Functional GI & Motility Disorders has been awarded a five-year grant from the National Institutes of Health (NIH) to foster interdisciplinary research on the interactions among the mind and body in health and disease. The Center will receive a total of \$4.3 million over a five-year period to establish a Gastrointestinal Biopsychosocial Research Program focused on the causes and treatment of functional gastrointestinal (GI) disorders.

The UNC Center for Functional GI & Motility Disorders is a center of excellence within the Division of Gastroenterology & Hepatology, School of Medicine, University of North Carolina at Chapel Hill. In a joint statement, the Center's co-directors William E. Whitehead (Professor of Medicine) and Douglas A. Drossman (Professor of Medicine and Psychiatry) said: "We are very pleased to be funded through the NIH initiative on Mind-Body Interactions and Health. This grant will enable us to carry out longer-term collaborations with other disciplines and with a variety of institutions nationally and internationally in mind-body and health studies. We are excited about the prospects for using this award to build on our longstanding record of NIH-funded research in this area and to develop new research partners and new areas of research."

Funding for mind/body centers is provided through the Office of Behavioral and Social Sciences Research (OBSSR) within the NIH Office of the Director, as a cooperative effort of about a dozen institutes within NIH. This broad-based initiative evolved from growing evidence that interdisciplinary research which integrates the study of social, behavioral, psychological and biological factors holds particular promise in understanding disease etiology and promoting health. The first five centers were funded in 1999. An additional five centers were selected for funding in 2004. The UNC grant was funded through the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

Research at the UNC Center has included studies on the pathophysiology and treatment of such prevalent functional GI disorders as irritable bowel syndrome (IBS), functional

dyspepsia, functional abdominal pain, fecal incontinence, and constipation. These disorders greatly impair quality of life and result in aggregate health care costs exceeding \$25 billion annually. Research themes at the Center have included the role of visceral pain perception and its modulation by cognitive and psychological processes, neuroimaging studies of central nervous system mechanisms modulating visceral pain, effects of reproductive hormones on IBS, the role of stress, abuse history and other psychosocial factors on clinical outcomes, intergenerational transmission of IBS through heredity and social learning, and excess comorbidity of IBS with other somatic disorders. Clinical trials research at the Center includes evaluation of cognitive behavior therapy (CBT), hypnosis, antidepressants, and patient education of IBS, and biofeedback for fecal incontinence and constipation.

The new Gastrointestinal Biopsychosocial Research Program funded through the NIH/NIDDK grant will be used to support core resources in a number of areas — a Research Network to facilitate large-scale, multi-center studies with other institutions; a Data Technology Core for internet-administered questionnaires, automated telephone systems for data acquisition, and internet software to track enrollment and manage multi-center studies; a Biometry Core providing biostatistical support and data management; a Seed Grant Core with funds for pilot projects by young investigators; and an Education Core to disseminate research findings to patients and other professionals. With the help of this grant, the UNC Center for Functional GI & Motility Disorders will become university wide and will include investigators from psychology, psychiatry, surgery (gynecology division), neuroradiology, dentistry, the school of public health, and other disciplines.

Contact:
Kirsten Nyrop at knyrop@med.unc.edu

See:
www.med.unc.edu/ibs

UCLA Receives Five-Year NIH Grant on Mind-Body Interactions and Health

The NIDDK-funded UCLA Center for Neurovisceral Sciences & Women's Health (CNS/WH) responded to RFA-03004 and successfully competed for a mind body center infrastructure grant to support a large number of investigators and collaborators on the UCLA campus and at other collaborating institutions. The award by the National Center for Complementary and Alternative Medicine (NCCAM) totals \$ 3.5M over 5 years and is entitled: **Mind/Brain/Body Interactions in Stress-Related Disorders**.

The funded proposal is an interdisciplinary, multidisciplinary proposal, involving all Schools on the UCLA campus (Medicine, Nursing, Dentistry and Public Health), as well as the UCLA Departments of Anthropology and Psychology. Within the School of Medicine, it will involve investigators from the Neuropsychiatric Institute and the Departments of Medicine, Psychiatry, Neurology, Neurobiology, Physiology, Pediatrics, Urology and OB/GYN. In addition, the proposal includes local investigators from the GLA VA Medical Center, UC Irvine, and the RAND corporation. The proposal also enlists outside collaborators from several institutions, including the Department of Psychiatry at the Max Planck Institute in Munich, Germany, the Department of Psychiatry at Emory University, Ohio State University, the University of Pittsburgh, and the School of Nursing at the University of Washington, Seattle.

The P.I. of the proposal is Dr. Emeran A. Mayer, MD, Professor of Medicine, Physiology, Psychiatry & Biobehavioral Sciences, and the co-P.I. is Dr. Yvette Tache, Professor of Medicine.

The long-range goal of this translational, interdisciplinary proposal is to integrate several disciplinary approaches to more effectively address complex, stress related clinical disorders with a focus on the neurobiology of stress-related disorders with the following sub themes:

- Pain
- Stress
- Sex-based differences in stress and pain biology
- Emotion and memory
- Addictive behaviors/food intake/obesity

The infrastructure support will match existing collaborative research efforts by the CNS & WH center and aim to expand these efforts into the following general disease areas:

- Chronic visceral and somatic pain disorders, including IBS, pelvic pain and fibromyalgia
- Anxiety and depression
- Obesity and eating disorders
- Substance abuse

Emeran A. Mayer



New Book Release

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International Foundation for Functional Gastrointestinal Disorders 2004 Update

The International Foundation for Functional Gastrointestinal Disorders (IFFGD) serves as the voice of people affected by functional gastrointestinal or motility disorders. Hundreds of thousands of people contact our organization for help in trying to understand and cope with chronic conditions that have the power to dominate their lives and marginalize them from society. Through these people, we have come to understand the desperate need for additional treatment options and increased public awareness. IFFGD voices these needs to those who can make a difference, and works to raise awareness of the serious nature of these disorders.

Raising awareness of functional disorders has always been a priority for IFFGD. Today, we are continuing this effort through an IBS media campaign, which publicizes the results of our recent IBS survey. Conducted in March 2004, the national survey measured the public's awareness of irritable bowel syndrome and identified quality of life issues for those affected by the disorder. The campaign has successfully reached out through radio, television, newspapers, and the internet, and offered the public a small glimpse of what people with IBS face as a regular part of their lives. For more information, visit www.aboutibs.org/Publications/ibsSurvey.htm.

As a representative of the patient community, IFFGD was invited to provide feedback on the FDA Critical Path Initiative. The Initiative was established in response to the FDA report, "Innovation/Stagnation: Challenge and Opportunity on the Critical Path to New Medical Products," which addresses the recent slowdown in innovative medical therapies submitted to the agency for approval. The goal of the Critical Path Initiative is to develop new tools and infrastructure to move products through the development process. IFFGD commented on pressing medical product development problems and offered suggestions for areas that provide the greatest opportunities for rapid improvement and public health benefits.

In recognition of the need for better understanding of functional disorders, IFFGD will sponsor the 6th International Symposium on Functional Gastrointestinal Disorders, April 7-10, 2005, Milwaukee, WI, at the Pfister Hotel. The meeting will once again address advances in the pathophysiology of functional gastrointestinal and motility disorders and facilitate the exchange of ideas among medical professionals and investigators in the field. For more information, contact Terese Bailey at the Office of Continuing Medical Education, University of Wisconsin Medical School, (608) 240-2141. I hope to see you there.

Lack of understanding about the true nature of functional GI and motility disorders affects not only the development of treatments, but also the way patients are perceived in our society. IFFGD is committed to increasing awareness and improving understanding of these disorders. We look forward to events like the upcoming GERD Awareness Week, during the week of Thanksgiving, and IBS Awareness Month, in April, which provide opportunities for our voice to reach an even broader audience.



Thank you for your support,
Nancy Norton
President, IFFGD

Election Biosketches

It is time for our annual election to identify two FBG Councilors to serve 2-year terms beginning May 2005. Dr. Emeran Mayer and Dr. Anthony Lembo will be rotating off the Council at that time.

Lesley A. Houghton, PhD

Dr. Lesley A. Houghton is a Senior Lecturer in Medicine and Physiological Sciences at the University of Manchester and Manager of Gastrointestinal (GI) Physiological Services for South Manchester University Hospitals National Health Services Trust, U.K.. Dr. Houghton's early career working with Professor NW Read (University of Sheffield, UK) and Professors J Dent and M Horowitz (University of Adelaide, Australia) focused on the coordinated motor function of the stomach, pylorus and duodenum in the control of gastric emptying in both health and disease (duodenal ulcer disease and functional dyspepsia). Her current main area of research is the pathophysiology of functional GI disorders, such as irritable bowel syndrome (IBS), functional dyspepsia (FD) and non cardiac chest pain (NCCP). In particular, she is interested in the relationship between the symptom of bloating and the physical distension of the abdomen in IBS together with related pathophysiology; the role of various neurotransmitters and hormones (eg 5-HT, CCK) and their receptors in the control and dysfunction of the GI tract; the role of gender and sex hormones in functional GI disorders; and the efficacy and physiological mechanisms of hypnotherapy in the treatment of functional GI disorders. She is principal investigator of a number of educational grants and commercial physiological studies with the pharmaceutical industry and co-investigator of a project grant assessing the efficacy of hypnotherapy in the treatment of NCCP. She is a member of the American Gastroenterological Association, committee member of the Neurogastroenterology and Motility Section of the British Society of Gastroenterology, Fellow of the Institute of Biology, and member of the Bowel Subcommittee of the Rome III Multinational Working Team. Dr. Houghton will be responsible for updating the section on Functional Bloating. Dr. Houghton also serves on advisory committees for a number of pharmaceutical companies who are developing drugs for the treatment of functional GI disorders.

Brian Lacy, MD, PhD

No Biography Provided

Fermín Mearin, MD

Dr. Fermín Mearin was born in Madrid, Spain in 1956. He completed his medical studies at the Autonomous University of Madrid, Spain and went on to specialize in gastroenterology at the Hospital de la Princesa (1979-1983). After this, Dr. Mearin undertook a GI research fellowship at the Mayo Clinic, Rochester, Minnesota, USA. After returning to Spain, he was appointed Staff Member at the Gastroenterology Department and Digestive System Research Unit of the Hospital Vall d'Hebron, Barcelona, Spain. Now, he is Director of the Gastroenterology Service, Institute of Functional and Motor Digestive Disorder, Centro Médico Teknon, Barcelona, Spain. Dr. Mearin is the Research Coordinator for Functional Digestive Disorders of the Spanish Gastroenterology Association. He is also a member of the American Gastroenterological Association and the International Foundation for Functional Gastrointestinal Disorders.

Dr Mearin has specific research interests in GI motility, visceral perception and functional bowel disorders, as well as in GERD.

Max Schmulson, MD

Dr. Schmulson was born in Colombia, South America, where he completed medical school and internal medicine residency. He then moved to Mexico, where he finished his GI residency at the Instituto Nacional de Ciencias Medicas y Nutricion Salvador Zubiran (INCMNSZ), a leading medical institution in Latin America. There, he started to work at the motility unit and began his research career in functional bowel disorders. Shortly afterward, he pursued a postdoctoral fellowship at UCLA working with Emeran Mayer, and started exploring the pathophysiological differences between constipation and diarrhea predominant IBS. After his fellowship, he returned to Mexico, establishing himself as a leader in functional gastrointestinal disorders. At the INCMNSZ, Dr. Schmulson works at the motility laboratory and runs an important FBD clinic. He works in Clinica Lomas Altas, a state of the art outpatient clinic, unique in its kind in Latin America, as well. His research is now focused on the epidemiological, clinical and pathophysiological characteristics of IBS in Mexico. He is an Associate Professor of Medicine in the Panamericana University School of Medicine, and Associate Professor of the Gastrointestinal Motility Postdoctoral Program of the National University of Mexico-UNAM. Currently, he serves as chair of the FBGRG Membership Committee, he is a member of the Latin American Consensus on IBS, as well as a member of the American College of Physicians, American Gastroenterological Association, and American College of Gastroenterology.



Inflammation in Functional Bowel Disorders

Stephen M Collins

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Functional bowel disorders are heterogeneous not only in their clinical presentation but also in their pathophysiology and pathogenesis. Putative pathogenetic mechanisms in IBS range from a primary behavioral model in which, for example, a history of psychological trauma precedes the development of IBS(1), to the situations where peripheral events, such as an acute bacterial gastroenteritis, precipitate the onset of chronic symptoms(2). This wide range of potential etiological factors has been invoked in the currently held bio-psychosocial model of functional bowel disorders(3).

There is increasing evidence that there is low-grade inflammation and immune activation in a subset of IBS patients. There are several lines of evidence supporting immune activation in IBS. Genetic studies have identified polymorphisms of cytokines that regulate the inflammatory process. The first such study identified a reduction in the frequency of alleles that encode for the high production of interleukin-10(IL-10)(4). Interleukin-10 is a counter-inflammatory cytokine that helps down-regulate inflammatory processes. A deficiency in IL-10 secretion following an inflammatory stimulus might lead to ongoing low-grade inflammation. A recent report examined the ratio of anti and pro inflammatory cytokine secretion from peripheral blood monocytes in IBS patients compared to controls. The preliminary report suggests that there is a reduced ratio of anti-to-pro inflammatory cytokine secretion in IBS(5), supporting the notion that some IBS patients may be inefficient in down-regulating inflammatory events. Another recent report showed that IBS patients have a significantly higher frequency of an allele that encodes for the intermediate production of TNF(6). Thus, IBS patients could be genetically at risk as a result of increased production of pro-inflammatory cytokines (such as TNF) and may inefficiently down-regulate their inflammatory responses through the limited production of IL-10 and other counter inflammatory cytokines such as TGF β . This profile is similar to that seen in IBD but is milder in nature. As both conditions are polygenetic, other factors must play a role in determining whether such individuals express IBS or IBD. Nevertheless, there is some epidemiological data to suggest that there is a higher incidence of IBD in patients with a

previous diagnosis of IBS(7). This increased incidence could not be accounted for on the basis of the increased surveillance and investigation to which IBS patients would be subjected compared to controls. Clinical evidence that corroborates the notion of ineffective downregulation of inflammatory responses is seen in patients who develop IBS following enteric infection. In these patients, the risk of developing IBS is higher in those patients with the more severe bacterial gastroenteritis(8;9). A study using Interleukin-1b mRNA expression as a marker of the inflammatory response to infection showed that patients who go on to develop IBS have higher initial expression of the cytokine during the infection and that this does not decrease significantly three months post infection compared to those patients who did not go on to develop IBS(10). Evidence for a smoldering of the inflammatory process is seen on biopsies taken from patients with PI-IBS and lymphocytes are prominent among these inflammatory cell types in the mucosa and lamina propria(11-13).

There is increasing interest in the role of mast cells as inflammatory mediators in IBS subsets. There is a long-standing observation taken from patients with "spastic colitis" a term used previously to identify patients with severe IBS and to distinguish them from those with IBD. The investigators examined surgically resected tissue from these patients, looking for mast cells throughout the gut wall. They found increased numbers of mast cells in all tissue layers in the spastic colitis patients compared to control. The increased numbers of mast cells were significantly greater than those in control but less than those found in inflammatory bowel disease patients(14). Since then, other studies have demonstrated increased mast cell numbers in the terminal ileum and colon of IBS patients(13;15-20). The findings tend to be more prominent in diarrhoea-predominant IBS but increased mast cell numbers are not restricted to that group. The finding of increased mast cell numbers does not appear to be explained on the basis of co-existing atopy.

A recent study provided the first functional correlate of increased mast cell presence in IBS patients (15). Barbara et al incubated mast cells from biopsies obtained from IBS

continued on page 17

patients or healthy controls. They identified increased release of both histamine and tryptase in the supernatants of biopsies from IBS patients compared to controls. The authors have proposed that tryptase, for example, might activate protease activated receptors (PAR), that have shown to be present on sensory nerves(21) and that this could provide a mechanism for the generation of abdominal pain. Several studies from across the globe have found a close juxta-positioning of mast cells and nerves in IBS samples compared to controls(13;15;19). Furthermore, the close clustering of nerves and mast cells appear to correlate with both the frequency and severity of abdominal pain. The finding of mast cells in close proximity to nerves also raises questions regarding the stimulus for a mast cell presence in IBS. Evidence for a role of atopy in IBS is unimpressive and the findings of Barbara and others raise the possibility that mast cells are being activated by neural stimulation, a phenomenon that is well described in animals. This could constitute the peripheral end of a neuro-immune axis in IBD. Long-standing studies by Hans Selye showed that stressors in rat could produce mast cells degranulation and subsequently increase mast cell numbers, and mast cell degranulation has been induced in the gut by Pavlovian conditioning(22)

Intestinal permeability is increased in some patients with IBS, particularly those with diarrhoea-predominant and following enteric infection(11). Studies by Dr. Perdue's group at McMaster University have shown that there is neural regulation of intestinal epithelial permeability and that permeability can be increased during stress through a mechanism that involves cholinergic nerves. Further work has shown that this stress-induced increase in permeability requires the presence of mucosal mast cells(23;24). Thus, behavioral factors might increase mast cell number and activation resulting in changes in intestinal permeability. This would allow luminal antigen to gain access to the intestinal milieu to further stimulate the mucosal immune system and drive intestinal pathophysiology on a long-term basis.

Enteric infection is now recognized as a risk factor for the development of IBS (2). There is evidence that bacterial gastroenteritis is the strongest risk factor identified to date for the development of irritable bowel syndrome in the West(25). There is one report of IBS following viral gastroenteritis in adults and this form of IBS was milder and shorter-lived than that associated with acute bacterial gastroenteritis(26). A recent study from China showed that Shigella infection was a risk factor for the development of IBS in that population (13). Chemical and histological features in the gut in the Chinese IBS patients were strikingly similar to those seen in previously reported studies from the West. These included increases in the numbers of CT3 positive lymphocytes and in mast cells. In addition, the Chinese investigators also found juxta positioning of nerves and mast cells in their biopsies. Thus, at least in large urban centers in the East, enteric infection

Advertisement from Solvay Pharmaceuticals

Cilansetron, a new 5HT₃ antagonist; results from phase III clinical trials

Cilansetron is a 5-HT₃ receptor antagonist for the treatment of IBS-D in both men and women. Solvay Pharmaceuticals is committed to supporting healthcare professionals and patients to ensure that the right people will benefit from cilansetron. The correct management of IBS has been shown to offer patients relief of symptoms and so improve their quality of life.

Results from Phase III studies have demonstrated that cilansetron is well tolerated and effective for multiple symptom relief of irritable bowel syndrome with diarrhoea predominance (IBS-D) in men and women in the long term. IBS-D can be severely debilitating. The combination of pain, urgent bowel movements and possible incontinence has a huge impact on patients' quality of life.

Phase III data presented at the Digestive Diseases Week congress (DDW), 2004, showed that, when treated with cilansetron 2 mg t.i.d. for 6 months, 59% of patients reported significant relief of multiple IBS symptoms, 61% relief of abdominal pain/discomfort and 64% normalisation of abnormal bowel habits including diarrhoea and urgency. Phase III study results also show a significant improvement in overall quality of life scores, including body image, health worries, social relationships and anxiety.

Registration dossiers are in development for many countries. In the UK, a dossier was filed with the Medicines and Healthcare products Regulatory Agency (MHRA) on 29 April 2004 and in the US a dossier was submitted on 30 June 2004.

is also a risk factor for the development of IBS, much in the same way as been shown in the West.

Epidemiological studies have shown that the prevalence and clinical manifestations of IBS are similar in development countries to data reported in the West(27-31). However, the role of chronic infection, that is sometimes endemic in these regions, in the development of IBS remains controversial. Studies identifying various species of amoeba in the colon of patients with chronic intestinal symptoms have generated conflicting results. For the most part, eradication of the parasite does not improve symptoms and this has been taken as evidence against the role for the parasite in the induction of IBS(32;33). However, studies in animal models have shown that the initial host immune response to the presence of the parasite is the determining factor in the development of long-standing gut dysfunction(34). Importantly, these studies showed that the continued presence of the parasite is no longer necessary for the persistence of gut dysfunction(34). If applicable to man, these studies would suggest that the

continued on page 18

persistence of symptoms following parasite eradication is insufficient evidence to exclude the infection as an initiating factor in the development of IBS in these regions. Further work is required in this area.

Pathogenic bacteria and parasites are not the only luminal stimuli that might result in the expression of IBS. It is now clear that patients with positive serology for celiac disease present functional symptoms that meet Rome criteria for the diagnosis of IBS(35;36). Symptoms improve following the removal of gluten from the diet. This demonstrates that dietary antigen can produce a clinical picture identical to IBS and raises the possibility that other, hitherto identified, dietary antigens may have a similar role in IBS. Since a role for atopy in IBS is very weak, dietary antigens must activate the immune system by mechanism other than type I hypersensitivity.

Much attention is currently being paid to the use of probiotics to treat IBS. However, results to date have not been impressive. The use of currently available probiotic preparations in IBS primarily reflects their availability rather than any scientifically proven basis for a beneficial effect in normalizing gut function. While there is evidence that commensal bacteria are important determinants of gut physiology(37-39), the potential benefit of specific bacteria contained in currently available probiotic preparations is not fully understood. Nevertheless, in an animal model of PI-IBS showed that oral administration of *Lactobacillus paracasei* normalized the increased cyclooxygenase II expression in muscle and restored normal muscle contractility(40). It is possible that subsets of IBS patients, clustered either geographically or on the basis of symptoms, may have some commonalities in the distribution of commensal bacteria. Once the technical difficulties of confidently characterizing floral populations can be overcome, it is necessary to characterize the flora of various IBS patient groups in different geographic locations and in different symptom groups. In addition, it is also necessary to better understand how commensal bacteria interact with the host to alter the function of tissues relevant to IBS, such as nerve and muscle.

Recent publications showing increased fermentation in the intestine of IBS patients raises the possibility that there are quantitative and/or qualitative changes in flora in IBS patients. In these studies, analysis of breath hydrogen and methane yielded abnormal results in some IBS patients compared to controls. In some patients, treatment with an oral antibiotic improved symptoms and normalized the breath fermentation results(41). These findings are extremely provocative and provide further indirect evidence that changes in resident bacteria in the gut could be a basis for the expression of IBS in some individuals. Whether this produces a low-grade inflammation or immune activation, or is simply a direct effective substances produced by the bacteria remain to be identified.

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Mark Your Calendars:

The next meeting of the Functional Brain-Gut Research Group will be held May 17, 2005 in Chicago, Illinois.

Reception 5:15 to 6:00 PM and Business Meeting 6:00 - 7:00 PM.



FBG Meetingn Spring 2004: Bill Whitehead, John Kellow, Grant Thompson, Robin Spiller, Fearmín Mearin, George Longstreth



FBG Meeting Spring 2004