

# Functional Brain-Gut Research Group



*The mission of the Functional Brain-Gut Research Group is to support, promote and advance multidisciplinary research and education in the basic science, clinical and behavioral aspects of brain-gut interactions.*



**George F. Longstreth**  
President

## Message from the President

My focus in this message is on recent FBG organizational accomplishments and those of individual members. We continue to benefit greatly from the efforts of our Executive Director, Deb Geno. She performs periodic tasks, such as tax form submission, membership recruitment at professional meetings and annual membership renewal, as well as daily activities, such as communication with members and corporate sponsors.

Our growing importance in the field of functional gastrointestinal disorders is shown by our active involvement in education and the professional awards that have recently honored our members. Rick Locke, Chair of the Program Development Committee, received nine clinical symposia proposals for DDW 2006, of which three were forwarded to the DDW planners. Members continue to be honored by organizations outside FBG. In 2004, Doug Drossman received the AGA Distinguished Educator Award and in 2005 he received the AGA/Miles & Shirley Fiterman Foundation Award for Distinguished Achievement in Clinical Research. Bill Chey received the AGA Distinguished Clinician Award in 2004 and I received it in 2005. Fernando Azpiroz received the 2005 IFFGD Senior Investigator-Clinical Science Award. At the 2005 Janssen Awards, Adil Bharucha and Andreas Smout received the Award for Basic or Clinical Research in Digestive Diseases, and David Thompson received the Award for Sustained Achievement in Digestive Diseases. Our members are spread all over the world, so I am probably not aware of all of their notable awards and I could have missed members who are not listed in our most recent

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Founded 1989



## Lessons from the Functional GI Disorders Clinic

**Douglas A. Drossman, MD, Editor**

One of the exciting challenges within our field relates to the proper diagnosis and care of patients with functional GI disorders (FGID's). They have symptoms that are complex and multi-faceted. The pathophysiological determinants of these conditions are only beginning to be understood: enteric dysfunction (abnormal motility and visceral hypersensitivity), mucosal immune alterations, and brain-gut dysregulation (altered CNS pain control and stress regulatory systems). These are relatively new concepts in the health care field and need to be properly communicated to clinicians and investigators.

Despite a growing scientific understanding of the pathophysiology of IBS, there is a lag in the dissemination of this new knowledge that adversely affects the opportunity to provide benefits to patients. There are also attitudes and beliefs imbedded in our health care system that impede the recognition and acceptance of this new knowledge. For example, physicians may set different standards for evaluation and treatment depending on whether they perceive the patient to have a "functional" or "organic" diagnosis (1). But, this distinction has become blurred and is not beneficial (2). Our functional GI clinic at the University of North Carolina receives a large number of "refractory" patients. In this clinic, we learn not only about the patients' illnesses, but also about physician knowledge, attitudes and behaviors toward these patients, and the effects of recent changes in our health care system that influence these provider behaviors. (3) Consider two patients who were referred to our clinic within the last few months:

### *Message from the President — from page 1*

Directory. Please let me know if you have received an award, so I can mention it in the next FBG newsletter.

Our financial status is becoming more secure, with annual membership dues collection increasing from about \$2,000 to \$11,000. Many members deserve praise for this marked improvement. However, dues cover only a minority of our expenses and we are indebted to generous corporate sponsorship for the rest of our operating budget. We are grateful to our new sponsors -- Alizyme, Salix, Sucampo and Takeda -- and for continued support from Novartis. Other companies are expressing interest in supporting us, as well. Our Secretary/Treasurer, Howard Mertz, has obtained legal consultation aimed at preserving our 501(c)3 tax status.

Tiffany Havlicek -- a new FBG member who is a second-year doctoral student in Chicago focusing on health psychology and cognitive behavioral therapy -- has volunteered to maintain our website. She is doing a wonderful job. It is now personalized with the officers' photographs! The website has received 43,848 "hits"

### **Case #1**

*A 22 year old woman was referred for left-sided abdominal pain, bloating and diarrhea which had become much worse in the past two years. Her illness began at age 17 after a caesarean. At age 18, because of these symptoms she underwent a pelvic laparoscopy and one endometrial implant was found. She was diagnosed to have endometriosis. Because of continued symptoms, she had another laparoscopy that was negative, and a third showed a few small implants which were treated but without resolution of pain. At age 19, after having a normal pelvic ultrasound, she underwent a hysterectomy for endometriosis, which she indicated was "to fix this problem once and for all". Yet, the symptoms continued after surgery. At age 21, a CT scan was done without contrast. The findings were thought to be consistent with Crohn's disease and she was started on prednisone. Six months later, after gaining 60 lbs., there was no change in the symptoms. She was then referred to a gastroenterologist for a second opinion. He did a colonoscopy and small bowel barium study, which were normal with no evidence for inflammatory bowel disease.*

*The patient was then referred to our functional GI clinic and additional information was elicited. The pain was cramp-like and frequently occurred after meals, leading to loose and frequent bowel movements. The pain was also relieved by defecation and worsened during menses and when she was under stress. She frequently had nausea and vomiting early in the day ("like morning sickness"). When the diarrhea was severe, she experienced fecal incontinence. There was no history of blood in the stool or a family history of IBD. The psychosocial history was notable for becoming pregnant at age 16, and her statement that "This was the first time*

since September 2004. The IFFGD has generously linked us to its website, which I am sure contributes to our website activity.

Each of our four Council members is involved in an FBG project. Brian Lacy is working with Bill Norton to organize a regular FBG column in the outstanding quarterly IFFGD publication, Digestive Health Matters. Fermin Mearin and the American Psychosomatic Society (APS) officers are discussing joint FBG/APS sponsorship of a session at DDW. Lin Chang continues to work with Bill Chey on the Young Investigators Conferences; all three of our annual meetings for fellows have been very successful. Adil Bharucha is supervising an effort to revise our Strategic Plan, which was developed by Rick Locke and other members about five years ago. Our journal, Neurogastroenterology & Motility, is broadening its content and increasing its appeal. We plan to pay for continued Internet access to this journal for members who support FBG with their dues.

Finally, all of the candidates for Vice-President, Secretary/Treasurer and Council are very capable and will devote considerable time to FBG, if elected. So, please support their commitment by voting.

*I wanted to have sex". She married her partner soon after the child's birth. Within a few months, the husband became physically and emotionally abusive to her and the symptoms became more severe. She divorced the husband and within several months remarried, and she is now reporting a good relationship. The patient notes that she feels depressed and has a poor quality of life. Because of the diarrhea and incontinence, she is fearful of going out to restaurants.*

*The physical examination was notable for moderate obesity with purple abdominal striae. The left lower quadrant overlying the sigmoid colon was tender without rebound and rectal exam revealed weak sphincter tone. Routine laboratory studies and endocrine evaluations were normal. She was tapered off prednisone, started on low dose cholestyramine and tricyclic antidepressant, and she began seeing our program psychologist. At 2-month follow up visit, she reported doing very well, having no diarrhea or incontinence and minimal abdominal pain. With her depression abated, she has experienced improved well being and quality of life, and has resumed her usual activities.*

What are the lessons from Case #1?

**i. When in doubt, "Don't just do something, stand there".** This patient's symptoms were incorrectly attributed first to endometriosis and then to Crohn's disease, and she underwent unneeded and harmful diagnostic and therapeutic procedures. Furthermore, the patient's psychosocial distress and symptom behaviors were inappropriately attributed to the physical symptoms, which led to more procedures, even when the role and relevance of the psychosocial issues could be easily obtained. The term "furor medicus" has been applied to physicians who are vulnerable to making faulty clinical decisions in the face of diagnostic uncertainty coupled with high patient distress and pain-related behaviors. In one study, it was shown that more diagnostic procedures, narcotics and exploratory laparotomies were ordered in the emergency room for patients with functional GI complaints than for patients with more acute structural diagnoses (4). The better choice would be to not react and to be conservative when making clinical decisions, after carefully appraising the information and applying it within a biopsychosocial context (5). A better outcome might have occurred if the information was understood from this more integrated perspective.

**ii. Application of Rome II Criteria and the exclusion of "red flags" can help reduce unneeded studies and treatments (6).** This patient fulfilled Rome II criteria and there were no "red flags". In this young woman, this is sufficient to stop further evaluation and begin treatment for IBS (7). Unfortunately, these data were either not obtained or were not recognized as relevant until several laparoscopies, a CT scan, a hysterectomy (8) and prolonged treatment with steroids, producing obesity and abdominal striae occurred. Furthermore, treatment for Crohn's disease based on an x-ray without endoscopic confirmation is inappropriate. And, a clinically relevant diagnosis of endometriosis was circumspect, given the laparoscopic findings and poor response to treatment, and since the pain was relieved by bowel movements. IBS is commonly mistaken for gynecological pain, particularly because of its common pelvic location and exacerbation with menses (9).

**iii. Obtaining relevant psychosocial data provides a more complete biopsychosocial understanding of the illness and leads a more focused and successful plan of care (10).** The psychosocial features are not only relevant but also inexorably linked to the patient's physical complaints and their pathophysiological determinants via the brain-gut axis. For the clinician, the issue is to recognize and appropriately respond to the compelling data at hand. A pregnancy in an unmarried woman at age 16 requires further understanding. The patient stated it was "the first time I wanted to have sex". This suggests a history of early sexual abuse (11), which can lead to poorer health outcomes (12). In this case, it may also have influenced her quick acceptance at age 19 to undergo hysterectomy, the attribution of her nausea as "morning sickness", and the early first marriage as an unsuccessful "way out" (13). The early traumatic experiences may have had a "kindling" effect when her partner later became abusive to her, worsening her GI symptoms at that time. The decision to begin an antidepressant and refer her for psychological counseling for pain control and psychological management was appropriate. In fact, on the first visit with the psychologist, the patient disclosed a history of childhood sexual abuse and this began a successful course of counseling visits.

#### Case #2

*A 29 year old woman was referred to the functional GI clinic with a 2 1/2-year history of lower abdominal pain and diarrhea. About two years earlier, she had seen a gastroenterologist and because of occasional blood streaking and mucus in the stool, he performed a sigmoidoscopy that showed "petechiae", which was interpreted as normal. The patient acknowledged feeling depressed and "stressed" by her symptoms. The physician diagnosed IBS and told her to reduce her stress. One year later, the symptoms had not improved and she returned to the physician urging him to perform more diagnostic studies. In part to accommodate her wishes, he did a repeat sigmoidoscopy and the results were the same. Six months later, she had lost 10 lbs. and reported more severe diarrhea and mild ankle swelling. He told her to go to the emergency room where the physical examination was reported as normal, the hemoglobin was 11.3, the WBC of 5000, and the urinalysis normal. She was placed on percocet for control of the pain and diarrhea, and was sent to the internal medicine clinic for further management. She was seen in the medicine clinic one month later, now two years after the onset of the symptoms, and by this time she had lost 15 pounds. The physician's note indicated that she had had an "extensive medical workup", was started on amitriptyline, and referred to the functional GI clinic. There, she was seen by the physician assistant who noted the following: the diarrhea was always present, bowel movements did not relieve the pain, and there was a cousin in the family with Crohn's disease. The patient acknowledged her marked depression, fatigue, sleep disturbance due to the pain and diarrhea, and loss of sexual drive. She very much wanted to have children, but she and her husband decided not to plan for this until her disease was "cured". She also noted that the illness was causing difficulties between her and her husband. He seemed intolerant of her illness, stating the problem was her "nerves"; she blamed herself for being unable to improve her symptoms and to please him.*

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The physical examination showed left and right lower quadrant tenderness overlying the bowel, perianal erythema, and a tender rectal exam that was positive for blood. Blood studies were drawn and showed na Hgb of 13, WBC 9600, platelet count of 535000, ESR of 58, and an albumen of 3.1. A colonoscopy was then obtained that showed friable nodular ulcerated mucosa extending from the mid sigmoid colon (40 cm. from the anus) to the cecum with areas of discontinuity, and she had a normal terminal ileum. There was also one perianal fistulous opening draining turbid fluid as well as tender nodular areas on her legs with early vesiculation consistent with early pyoderma gangrenosum. She was diagnosed with Crohn's colitis and started on 40 mg. prednisone/day, Mesalamine 4.8 gm/day, and Metronidazole 1 gm/day. Over the next several weeks, her clinical condition improved modestly with some improvement of the diarrhea, a 10 lb. weight gain, and improvement in the inflammatory blood studies. After two months, however, there was incomplete resolution of symptoms, and she was started on 6-MP which was gradually increased to 150 mg/day. Over the next 3 months, she had a notable improvement but with the development of a drug rash. Because of the rash and evidence for an incomplete histopathological response shown on a repeat colonoscopy, 6-MP was tapered down and she was started on infliximab. She continues in clinical remission with minimal disease on low dose 6-MP and infliximab. However, during the course of her treatment, she and her husband became aware of difficulties in their relationship. The illness had resulted in the patient's dependency on her husband. As she regained her strength and independence, conflicts arose with regard to their communication, their respective roles and responsibilities in the household, and plans for having children. Marital counseling was recommended and they agreed.

What are the lessons from Case #2?

**i. Exclusion of Rome II Criteria and the identification of "red flags" can help guide a more directed diagnostic plan.**

This patient did not fulfill Rome criteria for IBS and, more important, several "red flags" were noted -- blood in the stool, a family history of IBD and significant weight loss as well as inflammatory markers of high platelets and sedimentation rate and evidence for a protein losing enteropathy with low albumen. Furthermore, these data indicate that a colonoscopy be performed rather than a sigmoidoscopy as previously done, which had not lead to the proper diagnosis.

**ii. Don't attribute the presence of psychological stress as evidence for a functional GI disorder.**

The lack of a clear "organic" diagnosis and the patient's acknowledgment of emotional distress led quickly to the assumption that she had IBS. This diagnosis was made even without the supportive information as noted above. As a corollary to this:

**iii. Psychosocial difficulties can occur with all medical disorders and need to be addressed.**

The effects of the IBD were associated with emotional distress and depression. In addition, the disease led to difficulties in the marital relationship and the patient's clinical improvement seemed to "unroof" other issues that needed to be addressed -- issues of dependency and

respective roles and responsibilities in the family, and the decision as to whether or when to have children. Fortunately, both husband and wife saw these as important issues, and counseling has begun with expectations of benefit.

With these two cases, the physicians efforts were to categorize the patients as either "functional" or "organic" (14)(5) (see Spring, 2005 FBG newsletter Functional: What's in a Name) and then treat them as such. The physicians also tenaciously held to their diagnosis in the face of contrary data. In case #1, psychosocial factors were ignored or minimized when "organic" disease was presumed to be the cause of her complaints. Then, growing complaints of lack of improvement, coupled with uncertainty in the initial diagnosis led to more and more studies and treatments which did not benefit the patient until the true diagnosis of IBS and its psychosocial correlates were elicited. Conversely, in case #2, the symptom behaviors and repeated requests for help seemed to influence the physicians to set too high a diagnostic threshold, and thus not to appreciate the clues to IBD (blood in stool, high platelets and sedimentation rate, weight loss, low albumen), instead attributing her symptoms to stress.

Perhaps the main lesson from both cases is that the clinician needs to identify and address the mutual contribution of psychosocial and biological/medical factors on the patient and his/her illness -- a biopsychosocial understanding and plan of care. Neither the medical nor the psychosocial data are exclusive of each other and this is supported by growing research on the brain-gut axis. Unfortunately, our biomedical research and educational programs still promote dualistic thinking to the detriment of the patient by focusing on the disease rather than on the patient. Hopefully this will change.

Douglas A. Drossman, MD

Editor

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## The Placebo Effect and Health: Combining Science & Compassionate Care

W. Grant Thompson, MD

Approximately 50 years ago, double-blind randomized controlled trials (RCT) became the 'gold' standard method of evaluating the effect of medical treatments. Prior to this time, placebo was considered a morally useful treatment and most physicians used inert pills and therapies in their practices. With the advent of RCTs, the term placebo developed negative connotations and the conscious use of placebo (e.g., placebo pills) all but disappeared in clinical medicine. Yet today placebo remains alive and well in clinical medicine, although most physicians are unaware of its use in their practice.

In his book entitled "The Placebo Effect and Health: Combining Science and Compassionate Care", Dr. W. Grant Thompson skillfully argues for the importance of placebo in modern medicine. Rather than view placebo as the 'enemy', Dr. Thompson puts forth a compelling argument that placebo is an 'important clinical tool'. Although his book is not specific to Functional Gastrointestinal Disorders, it is particularly relevant to them given the pronounced placebo response seen in clinical trials involving IBS patients.

The book is divided into three parts. The first part defines placebo, reviews its history, outlines research in the field, and finally divides up the components of the placebo effect. In the second part, Dr. Thompson reviews the history of randomized clinical trials and evidence based medicine, explores the special challenges placebo presents in surgery, psychotherapy and CAM, and discusses the ethics associated with using placebo in medicine. In the book's final section, Dr. Thompson discusses the elements of a doctor/patient relationship that are necessary to develop a strong therapeutic bond as well as potential obstacles to the formation of these bonds.

Throughout the book, Dr. Thompson emphasizes the importance to medicine of the placebo effect that is "the effect of a treatment that goes beyond its intended pharmacological or physiological activity". Dr. Thompson compellingly argues that a close and compassionate doctor/patient relationship provides a placebo effect that should augment evidence based treatments in the provision of optimal health care.

Dr. Thompson's book is a must read for anyone interested in the art as well as the science of medicine.

## New Members

<b>Laurent Fischer, MD</b> <i>San Diego, CA</i>	<b>Laurie Keefer, PhD</b> <i>Chicago, IL</i>	<b>Enrique Rey, MD</b> <i>Madrid, Spain</i>	<b>Eric Muth, MD</b> <i>Clemson, SC</i>	<b>Mauricio Alario</b> <i>Sao Paulo, Brazil</i>	<b>Eric Waehner</b> <i>Lake Forest, IL</i>
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<b>Lars Kjellstrom, MD</b> <i>Stockholm, Sweden</i>	<b>Cristina Almansa, MD</b> <i>Madrid, Spain</i>	<b>Apostol Pappas</b> <i>Roodepoor, South Africa</i>	<b>Nezar Shobassy</b> <i>Port Arthur, TX</i>	<b>Dennis Kelleher</b> <i>Durham, NC</i>	<b>Christine Ladyga, MS PT</b> <i>Norwich, CT</i>
<b>Selahattin Unal, Prof.</b> <i>Ankara, Turkey</i>		<b>Felipe Finkelstein</b> <i>Vitacure, Santiago, Chile</i>	<b>Alvin Newman</b> <i>Toronto, Ontario, Canada</i>	<b>Eduardo Andre</b> <i>Sao Paulo, Brazil</i>	
				<b>Gauree Gupta</b> <i>Philadelphia, PA</i>	

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## Pharmacological Treatments of Functional Digestive Disorders

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The therapeutic approach to functional digestive disorders (FDDs) has been significantly modified over the last few decades. It has moved from empirical

treatments regarded as poorly effective to a multi-component therapeutic approach based on the concept of a multifactorial pathophysiology. This concept organizes etiological factors around the brain-gut axis, linking the gut and the central nervous system. Pharmaceutical treatments of FDDs may influence either peripheral or central control mechanisms to alter gut functions and relieve symptoms. Growing basic and clinical research in this field has resulted in the development of new pharmaceutical compounds, some of them licensed for treating these disorders. However, these newer treatments also have limited clinical efficacy and side effects.

New treatments for FDDs have been developed on the basis of pharmacological and physiological studies and targeted at specific gut functions or receptors. Drugs influencing the processing of sensations from the gut to the brain and thus modulating visceral hypersensitivity have been regarded as a particularly promising line for the development of new treatments. Why did so few of them succeed in getting approval from regulatory authorities?

Visceral afferents display a number of receptors for neurotransmitters that process sensation based on complex mechanisms. Serotonin, one of the main neurotransmitters in the myenteric plexus, was an obvious candidate, and drugs affecting 5-HT<sub>3</sub> and 5-HT<sub>4</sub> receptors are now available. However, the wide distribution of serotonin receptors on afferent and efferent nerve pathways also provides multiple pharmacodynamic effects, affecting visceral sensation but mainly gut motility. The effects on gut motility restrict their use to selected subgroups of patients with abnormal bowel patterns and, to some extent, explain their side effects. Moreover, motility effects most likely account for a large part of the clinical efficacy of these compounds, as shown in a recent study which evaluated the clinical effect of cilansetron, a 5-HT<sub>3</sub> antagonist, in a treatment-retreatment design. During the second treatment period, cilansetron continued to have a marked and significant effect on diarrhea over placebo, but its effect on abdominal pain was no longer different from placebo.

Studies demonstrating the clinical efficacy of serotonergic agents have generally used as the primary outcome measure "global relief" -- the improvement of all symptoms related to irritable bowel syndrome (IBS). So far, no study has measured the importance of abnormal bowel patterns in this "global relief" measure by the patient. One may assume that a patient with frequent urgency and diarrhea will feel more distress from these bowel patterns than from abdominal pain. On the other hand, serotonergic agents

have not been compared to laxatives or anti-diarrheal agents, which are known to improve bowel habits in most patients.

Central modulation of pain perception and treatment of conditions frequently associated with FDDs, such as anxiety and depression, are targeted by centrally active drugs like antidepressants. These are known to be effective not only in patients with high levels of anxiety or depression but also at lower doses to improve GI symptoms through either a peripheral or central pathway. This benefit has been recognized in controlled treatment trials and large meta-analyses of studies. Tricyclic antidepressants and serotonin reuptake inhibitors have been the most widely prescribed drugs for this indication. Prescription may vary from country to country, depending on the availability of other medications and the knowledge and experience of the physician. However, it remains worthwhile to recommend that a firm psychological diagnosis be obtained before prescribing a full dose treatment with antidepressants. Other psychological interventions, such as cognitive behavioral therapies and hypnosis, could be regarded as alternative options, when available.

The main issue in developing pharmacological treatments for FDDs is the relief of abdominal pain. Antispasmodics have been used, but their efficacy is limited and not established by well-designed clinical trials. Recent studies have shown that some of these compounds display effects on motility or sensation, and their pharmacological targets have been identified. Yet, knowing the pharmacodynamic properties of a compound does not predict its clinical efficacy. This observation is true for the newer compounds as well as the antispasmodics and musculotropic agents. Over the last decade, several compounds were shown to have marked effects on motility or sensation, but they have demonstrated only a mild effect over placebo and the magnitude has been considered insufficient by the regulatory authorities to obtain licensing. Effects on motility or sensation must, therefore, be regarded as a screening tool to discriminate classes of compounds that affect gut functions, but they may not predict their clinical efficacy.

Clinical trials are essential to select new medications for functional digestive disorders. In the absence of objective markers to measure the effect of a treatment, outcome is best evaluated by the evolution of the symptoms on treatment as compared to placebo. Intensity and quality of symptoms are subjective paradigms, influenced by the personal experience and perception of the patient. On the other hand, results from clinical trials are dramatically influenced by the important variability of symptom ratings by patients over time and their placebo response. This situation has led to an increase in the number of patients included in studies and the selection of homogenous subgroups of patients. As a consequence, clinical trials tend to diverge from the reality of daily practice in order to precisely figure out the actual clinical benefit of a compound. Thus, attention has been paid over the last two decades to improve the design of treatment trials. Despite this, many questions remain about the best study design, and current studies have shown a response rate no higher than 15 to 20 % over placebo.

Recent meta-analyses of the effect of antispasmodics in 12-week trials of IBS patients have concluded similar therapeutic benefit.

## International Symposium On Neurogastroenterology 22-25 September 2005, Brasov, Romania

The first International Symposium on Neurogastroenterology recently concluded in Brasov, Romania. Over 370 registered participants attended this meeting organized by Dan Dumitrascu and Laurentiu Nedelcu. The event was organized with the support of the Alexander von Humboldt Foundation in Germany, the medical schools from Cluj and Brasov, and BMJ/Romania. Pharmaceutical companies contributed to the funding, the primary sponsor being Solvay Pharmaceuticals.

Key speakers from the USA (Douglas Drossman) and Germany (Paul Enck, Heinz Krammer, Juergen Barnert) joined lecturers from Romania, Croatia, Bulgaria, Hungary, Serbia, and Moldavia. Important issues and new research in neurogastroenterology were presented, beginning with a background on anatomy and finishing with the diagnosis and therapy of functional gastrointestinal disorders. The highlight was a 2-hour workshop on medical communication (maximizing the interview) led by Douglas Drossman. Unlike a usual workshop with limited numbers of participants, this one was attended by over 100 physicians and psychologists, which made audience participation a bit difficult.



The high quality of the lectures and the social program -- which included a tour of the mountain city with many old buildings and Dracula's castle near Brasov -- contributed to the success of the meeting. The reunion of East and West European attendees was important to improving the reciprocal sharing of knowledge among specialists and for the dissemination of the Rome criteria. Through this opportunity, the Romanian Society of Neurogastroenterology was launched. It will be soon affiliated with the European Society of Neurogastroenterology.

*Submitted by D.L. Dumitrascu, MD, Cluj, Romania*

Which leads to the question -- do we need to continue to evaluate medications for FDDs in trials based on a continuous treatment? What should be the duration of these trials? The 3-months duration that has been used in most studies with the serotonergic agents has proven effective when the outcome was a global assessment of symptoms by the patient. But, a global assessment of symptoms might not be an accurate outcome measure to evaluate drugs that would be devoid of any effect on transit and bowel movements. From this perspective, new designs are needed for future treatment trials, including "pro re nata" or PRN trials to evaluate on demand therapy.

Medications for the treatment of FDDs are still far from fulfilling the expectations of patients and physicians. Active ones are available to treat symptoms like diarrhea and constipation or to improve specific gut functions like gastric emptying. However, their effect on pain seems to be indirect, and medications with a demonstrable effect on abdominal pain are still awaited. Targeting pharmacological receptors present on afferent nerves of visceral origin may address the issue of visceral hypersensitivity, but so far no compound has been shown effective in large clinical trials. Fedotozine, a kappa opioid agonist, was shown to significantly influence perception of colonic and rectal distension in patients with irritable bowel syndrome (IBS), but results from clinical trials have been disappointing. New candidates include tachykinin receptor antagonists, CRF antagonists, asimadoline, a new kappa agonist, and blocking agents at  $\alpha 2\delta$  subunit of voltage-gated

calcium channels. Their effect on visceral perception has been demonstrated in animal models and for some of them in humans, but evidence for clinical efficacy is still lacking.

Despite limited clinical results after two decades of intensive basic and clinical research in the field of functional digestive disorders, the advances have been considerable. A lot has been learned about the design of treatment trials: (i) the wide use of the Rome criteria has helped to include patients with more precisely defined conditions; (ii) comparative groups on placebo are now systematically included in these studies; (iii) the parallel groups design is widely used in treatment trials; and (iv) outcome measures other than symptoms intensity have been tested and validated in several studies. For the first time, new pharmaceuticals have been carefully tested in these clinical trials and some of them are now available for the patients in some countries. In addition, basic research has identified a number of pharmacological targets, which are currently under evaluation in ongoing clinical trials. Effective drugs could be expected in the future. However, this may be associated with increased intensity and severity of adverse effects and their limitation to well identified groups of patients. The Rome criteria provide clinicians with a valuable tool to diagnose specific disorders and with the upcoming Rome III version of these criteria to assess the severity of symptoms. Thereby, the clinician will get a better picture of the patient's status and a better evaluation of the benefit/risk ratio at the time of prescription. The road is still long, but certainly hopeful and well worth the effort!

## FBG Annual Meeting May 17, 2005 (DDW)



The FBG Annual Meeting was held Tuesday, May 17, 2005, at the Palmer House Hilton in Chicago, IL. The reception was from 5:30 to 6:30 p.m., followed by the annual meeting from 6:30 to 7:30pm. The meeting was called to order by FBG President George Longstreth. Minutes were approved from the 2004 FBG Annual Meeting (Hilton Riverside, New Orleans, LA.). The President's Report included updates on membership dues, FBG support for the journal *Neurogastroenterology & Motility*, FBG website, and Young Investigators' Conference. These remarks were followed by:

- » Kevin Olden -- FBG support for the journal *Neurogastroenterology & Motility*
- » Treasurer's Report -- Secretary-Treasurer Howard Mertz
- » Meetings Task Force -- Vice President & Chair Richard Locke
- » Rome III -- Douglas Drossman, Chair
- » FBG Newsletter -- Douglas Drossman, Editor
- » IFFGD -- Nancy Norton, President & Founder
- » FBG Awards Presentations – Rona Levy, Chair
  - » Research Scientist Award -- Emeran Mayer, MD
  - » Young Investigator Awards -- Nadia Pallotta, PhD and Christopher Fraser, MD
  - » International Travel Award – Nojkov Borko, MD
- » FBG Young Investigator Conference Awards – Rona Levy and Lin Chang
  - » Brecht Geeraerts, M. Biomed. Sc. -- "Influence of Experimentally Induced Anxiety on Gastric Sensorimotor Function in Man"
  - » Syed Thiwan, MD -- "Factors Predicting Symptom Reports of 'Side Effects' When Using Tricyclic Antidepressants"
- » Membership Committee – Max Schmulson, Chair
- » Program Committee – Richard Locke, Chair
- » Nominating Committee – Kevin Olden, Chair – Slate for Council 2006

### Award Winners

Four awards were presented during the FBG Annual Meeting in May 2005.



#### Young Investigator Award

Christopher Fraser, MD  
Middlesex, UK

Dr. Fraser is Consultant Gastroenterologist and Endoscopist at St. Mark's Hospital, Harrow, Middlesex, UK. He began his medical career as House Surgeon at Dunfermline and West Fife Hospital in Dunfermline, and as House Physician at Western General Hospital in Edinburgh, Scotland. This was

followed by Senior House Officer positions at the Cardiothoracic Centre, Liverpool; City Hospital, Birmingham; and Aberdeen Royal Infirmary, Scotland. From September 1997 to June 2003, Dr. Fraser was in the Specialist Registrar Programme at: Trafford General Hospital, Manchester; Hope Hospital, Salford; Royal Bolton Hospital, Bolton; and Manchester Royal Infirmary, Manchester. From April 1998 to August 2000, he was a Clinical Research Fellow in Gastroenterology and Honorary Registrar, Section of Gastrointestinal Science & Department of Stroke Medicine, Hope Hospital, Salford. He has been at St. Mark's Hospital since July 2003.

As a clinical research fellow for 2.5 years in the Department of GI Science, Hope Hospital, Salford, UK, Dr. Fraser explored the role of neuronal plasticity in the control of extrinsic GI function. This work included exploring the cortical and brainstem control of swallowing using a variety of techniques (transcranial magnetic stimulation, functional MRI, videofluoroscopy, sensory stimulation, anesthesia) and the role of electrical sensory stimulation as a potential clinical therapy for dysphagia after stroke. The findings from his studies have now expanded into a randomized controlled trial of oro-pharyngeal electrical stimulation versus regular swallowing therapy in acutely dysphagic stroke patients and led to the award of an MD from the Manchester University in 2004.



**Young Investigator Award**  
Nadia Pallotta, MD, PhD  
Rome, Italy

Dr. Pallotta was born in Rome, Italy. She graduated with studies in Medicine and specialized in Gastroenterology, and then received a PhD in Gastroenterology at the University La Sapienza. She is responsible for GI ultrasonography in the Gastroenterology A unit. In addition to her clinical duties at the University

Hospital Policlinico Umberto I in Rome, Dr. Pallotta does research in the area of GI motility using non-invasive techniques as well as various aspects of the physiopathology and epidemiology of functional gastrointestinal disorders. Furthermore, she has developed an ultrasonographic method to assess small bowel morphology.

Dr. Pallotta is a Founding Member of an Italian government group devoted to the study of gender roles in medicine. She has also worked with Italian anti-violence centers that offer shelter to victimized women, to assess the relationship between life stressor events and health status in patients with GI disorders and in non-patient women who have been victimized.



**International Travel Award**  
Nojkov Borko MD  
Skopje, Macedonia

I completed my Medical School and Internal Medicine training at the Medical Faculty in Skopje, Macedonia. I am currently proceeding with my training in gastroenterology at the Clinic for Gastroenteropathology in Skopje. During my residency training, I participated in

several studies that assessed the epidemiology of Inflammatory Bowel Disease (IBD) in Macedonia. More recently, I had the opportunity to work in the Gastrointestinal Physiology Laboratory at the University of Michigan Medical Center under the mentorship of Dr. William Chey. There, I was involved with the development and implementation of a study assessing predictors of treatment response to proton pump inhibitor (PPI) therapy in patients with erosive versus non-erosive gastroesophageal reflux disease (GERD). I also participated in a study evaluating esophageal sensation in healthy controls, patients who responded to PPIs, and patients who did not respond to PPIs.

I am pleased these projects have yielded results worthy of presentation at Digestive Diseases Week as well as other scientific meetings. I have learned a great deal from my experiences at the University of Michigan and appreciate the help of Dr. Chey and his associates. My plans for the future include the completion of my GI training as well as further clinical research in gastroenterology.

On this occasion, I would like to express my sincere gratitude to the FBG for this year's International Travel Award. Without it, I would not have been able to attend DDW in Chicago to present my research.



**Research Scientist Award**  
Emeran Mayer, MD  
Los Angeles, CA

Emeran Mayer, MD, is a Professor in the Departments of Medicine, Physiology, and Psychiatry & Biobehavioral Sciences at UCLA. He attended the Medical School at Ludwig Maximilians University in Munich, Germany, did his residency at the Vancouver General Hospital in Vancouver, BC, and his GI Fellowship at the UCLA/VA Wadsworth Integrated

Training Program in Los Angeles. As a faculty member at UCLA since 1985, Dr. Mayer has pursued his research interest in clinical and neurobiological aspects of brain-gut interactions in health and disease for the past 20 years. He has published over 135 original peer reviewed articles, 60 chapters and reviews, co-edited two books, and organized several interdisciplinary symposia in the area of visceral pain and mind-body interactions.

Dr. Mayer has made seminal contributions to the characterization of physiologic alterations in patients with functional disorders, particularly in the area of interoceptive mechanisms, and in stress-related modulation of pain perception. Specifically, his research efforts include the study of cellular and molecular mechanisms of chemo- and mechanotransduction of primary afferent nerves; animal studies on stress modulation of visceral pain and associated autonomic responses; human physiology studies on cerebral, autonomic, neuroendocrine, and perceptual responses to visceral stimulation; and health outcomes, quality of life, and epidemiological studies in populations suffering from chronic gastrointestinal disorders.

Dr. Mayer is Director of the NIH-funded Center for Neurovisceral Sciences & Women's Health and Co-Director of the CURE Digestive Diseases Research Center. He is PI on two NIH Center grants and has two active R01 grants -- one on basic mechanisms of NMDA receptors in visceral nociception, and the other on brain and perceptual responses to visceral stimuli. He has served on the editorial boards of the leading journals in digestive diseases, including Gastroenterology, Gut, American Journal of Gastroenterology, Digestion and the American Journal of Physiology, has served as reviewer for a wide range of medical and neuroscience journals, and as a reviewer for national and international funding agencies, including the NIH.

## FBG Annual Meeting

### Young Investigator Awards

The two award winners from the Third Functional GI Disorders Young Investigators' Forum (March 18-20, Del Mar, CA) were recognized during the FBG Annual Meeting in May 2005 – Brecht Geeraerts and Syed Thiwan (the runner-up was Lukas Van Oudenhove).



Brecht Geeraerts,  
M.Biomed.Sc.  
University of Leuven, Belgium

After completing my educational training at the University of Leuven in 2004, Professor Dr. Jan Tack gave me the opportunity to join a Ph.D. training program in his lab on visceral hypersensitivity in functional gastrointestinal disorders (FGIDs). It is generally accepted that psychosocial factors play an important role in FGIDs. However, the mechanisms through which they interact have not yet been elucidated. In my first major experimental study, I investigated the influence of experimentally-induced anxiety on gastric sensorimotor function. Considering the remarkable findings resulting from this study, we believe that further exploration of the interaction between psychosocial factors (such as anxiety, sadness, abuse) and sensorimotor function of the entire GI tract holds potential. This intriguing topic will be the focus of my research in the next few years.

As a rookie in the fascinating and sometimes overwhelming field of scientific research, I still have a lot to learn. Initiatives like the FBG Young Investigators' Forum provide a scientific and educational platform where young investigators have the opportunity to improve their research skills. I was surprised and honored to attend the meeting and I certainly learned a lot. It was an unforgettable experience, but it also made me realize that I have a long yet interesting way ahead of me.



Syed Thiwan, MD  
University of North Carolina,  
Chapel Hill, NC

I am currently a GI fellow at the University of North Carolina, Chapel Hill, NC. I did my medical training at Tirunelveli Medical College in India. After further postgraduate training in internal medicine, I came to the US. I did my Internship at St. Luke's-Roosevelt Hospital Center and completed my Internal Medicine residency at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson University Hospital in New Brunswick, NJ. I decided to come to UNC for further training after spending four years as an Internist for a non-profit organization at a rural clinic in North Carolina.

For the past two years, I have worked as a post-doctoral fellow at the UNC Center for Functional GI & Motility Disorders. Under the mentorship of Drs. Whitehead and Drossman, I have been primarily involved with two major projects. One is the "Heterogeneity of IBS" study with Dr. Whitehead's research team -- a cluster analysis where we are looking at different pathophysiologic mechanisms and are almost halfway through the data collection phase. Dr. Whitehead, Dr. Olafur Palsson and I have also developed two questionnaires on abdominal bloating -- one on severity and the other on the diagnosis of bloating. We validated the bloating severity questionnaire and presented it at this year's DDW. We are currently finishing up the study to validate the bloating diagnostic questionnaire.

I am working with Dr. Drossman at the functional GI clinic as well as on some of his research projects. One of the research projects was to look at symptom reporting with TCAs, using data obtained through the NIH-sponsored multi-center treatment trial of CBT and Desipramine for moderate to severe functional GI disorders. Based on this project, I presented "Predictors of symptom reporting when using tricyclic antidepressants in patients with functional GI disorders" at this year's DDW. My current interests are GI motility disorders and the pathophysiology of functional GI disorders. I am also interested in the extra-esophageal manifestations of GERD and endoscopic ultrasound.



## International Foundation for Functional Gastrointestinal Disorders

Fall 2005 Update

**Nancy Norton**

*President*

IFFGD had a busy Spring as we sponsored the 6th International Symposium on Functional Gastrointestinal Disorders in May. We are pleased to report it was a successful meeting, once again. We were honored that Dr. Allen Spiegel, Director of NIDDK, and Dr. Doug Drossman presented Research Awards to six well-deserving investigators.

Since we last reported on our efforts in Washington, we have seen the Senate approve its fiscal year 2006 appropriations bill for the Departments of Labor, Health and Human Services, and Education. The language includes two areas of particular interest to IFFGD:

“Incontinence -- Many otherwise healthy, active individuals suffer from incontinence. Fecal incontinence, also called bowel incontinence, affects people of all ages and is associated with a wide variety of causes. The Committee is pleased that NIDDK is contributing to the development of standardized approaches to measure incontinence and urges NIDDK to continue collaborating with NICHD on the incontinence state-of-the-science conference and on appropriate follow-up to this conference.”

“Irritable Bowel Syndrome -- The Committee is pleased that NIDDK is formulating an action plan for digestive diseases and that irritable bowel syndrome [IBS] will be a focus area of this overall plan. However, given the increasing frequency of IBS and the Committee’s long-standing interest in this condition, the Committee strongly urges the NIDDK to complete this digestive disease plan as quickly as possible.”

We are preparing for GERD Awareness Week November 20-26, 2005 with educational messaging to appear in print during the month of November.

Please remember IFFGD has a library of patient education materials that you can access for distribution to your patients. Call us at 1-888-964-2001 for more information on Professional and Patient Membership. Or visit our websites:

[www.IFFGD.org](http://www.IFFGD.org)  
[www.aboutIBS.org](http://www.aboutIBS.org)  
[www.aboutIncontinence.org](http://www.aboutIncontinence.org)  
[www.aboutGERD.org](http://www.aboutGERD.org)  
[www.aboutConstipation.org](http://www.aboutConstipation.org)  
[www.aboutKidsGI.org](http://www.aboutKidsGI.org)  
[www.GIresearch.org](http://www.GIresearch.org)

We thank you for your continued support of IFFGD.

Nancy Norton  
President, IFFGD

### 2005 IFFGD Research Award Winners

Senior Investigator – Clinical Science  
Fernando Azpiroz, MD, PhD  
Hospital General Vall d’Hebron, Barcelona, Spain

Senior Investigator – Basic Science  
Yvette Tache, PhD  
West LA-VA Medical Center, UCLA, Los Angeles, CA

Junior Investigator – Clinical Science  
Shaheen Hamdy, MRCP, PhD  
Hope Hospital, Salford, United Kingdom

Junior Investigator – Basic Science  
Michael Pezzone, MD, PhD  
University of Pittsburgh, Pittsburgh, PA

Pediatric Investigator – Clinical Science  
Rachel Rosen, MD, MPH  
Children’s Hospital Boston, Boston, MA

Pediatric Investigator – Basic Science  
Bridgett Southwell, PhD  
Murdoch Childrens Research Institute, Royal Children’s Hospital, Melbourne, Australia

## Neurogastroenterology and Motility 2006 Joint International Meeting

September 14-17, 2006

Seaport Hotel and World Trade Center, Boston, Massachusetts

Hosted by the American Motility Society

Jointly sponsored by:

American Motility Society

European Society of Neurogastroenterology and Motility

Functional Brain-Gut Research Group

International Motility Society

**Introduction.** This is the inaugural joint meeting of four prominent societies interested in the physiology and pathophysiology of the Brain-Gut axis. The program has been designed to be timely, exciting and informative. The program will showcase cutting-edge research covering a broad range of preclinical and clinical topics in this rapidly expanding field, from receptors to treatment and impact on health care delivery. The organizers have made every effort to integrate the major themes of the meeting into sessions that will be relevant and useful to a broad range of attendees. The meeting will be of interest to cell biologists, neurophysiologists, behavioral psychologists and psychiatrists, and clinicians.

The abstract deadline is March 17, 2006. The Call for Abstracts will be mailed in January 2006. Abstract and meeting registration will be submitted electronically on-line via the American Motility Society website at [www.motilitysociety.org](http://www.motilitysociety.org).

**Young Investigator Travel Awards.** A limited number of awards will be provided to selected young investigators to defray the cost of attending the meeting. Both basic science and clinical investigators will be eligible including undergraduate and graduate students, postdoctoral fellows, and junior faculty in the early stages of an independent career. Award criteria will be based on career status and the scientific quality of the applicant's abstracts and the applicant's financial need.

**Accreditation:** CME credit will be given for the hours actually spent in the educational activity.

For further information and updates throughout the year contact: American Motility Society, 45685 Harmony Lane, Belleville, MI 48111. Ph: 734-699-1130. Fax: 734-699-1136.

Website: [www.motilitysociety.org](http://www.motilitysociety.org)

Thursday, September 14	Friday, September 15	Saturday, September 16	Sunday, September 17
Registration and Welcome Reception	8:00 am – 12:00 pm Plenary Session	8:00 am – 12:00 pm Plenary Session	8:00 am – 12:00 pm Plenary Session
	New Concepts Involving the Brain-Gut Axis: Cells to Systems	The Role of Immune Modulation in the Brain-Gut Axis Drug Development and Innovative Therapeutic Interventions in GI Motility Disorders	Regulation of Appetite and Obesity
	12:00 pm – 1:30 pm Meeting the Investigator Lunch	12:00 pm – 1:30 pm Meeting the Investigator Lunch	12:00 pm Closing Ceremony
	12:00 pm – 3:00 pm Lunch and Poster Session	12:00 pm – 3:00 pm Lunch and Poster Session	
	3:00 pm – 5:00 pm Three Concurrent Sessions - Electrical Stimulation and Pacing - Novel Molecular Targets and their Role in GI Symptoms - GI Motility Disorders in Children and Young Adults	3:00 pm – 5:00 pm Three Concurrent Sessions - Novel Signaling Pathways in the ENS and GI Smooth Muscle - Innovative Approaches to Diagnosis - Health Services Research: Research in Digestive Disorders	
	Dinner and Social Program Harbor Cruise	Dinner and Social Program New England Aquarium	

**AGA / BSG Joint Symposium — Visceral Hypersensitivity**

7-8 September 2006

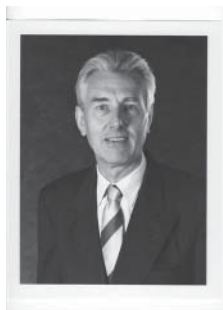
Robinson College

Cambridge/London UK

This will be the 3rd jointly sponsored annually AGA/BSG symposium. The focus will be on visceral hypersensitivity. For further information, contact Dr. Qasim Aziz (qaziz@home.man.ac.uk) or Dr. Douglas Drossman (drossman@med.unc.edu).

Thursday, September 7	Friday, September 8
<p><b>08.15hr</b> — Registration and coffee</p> <p><b>08.45hr</b> — Welcome - Qasim Aziz and Douglas Drossman</p> <p><b>09.00hr</b> — <b>Keynote Lecture</b> Hypersensitivity in Functional GI Disorders: Fact or Fiction <b>M Camilleri, Mayo Medical Center, Minnesota, USA</b></p> <p><b>Basic Science of Nociception</b></p> <p><b>09.30hr</b> — Nociceptive Pathways <b>WD Wills, Jr., Galveston, Texas, USA</b></p> <p><b>10.00hr</b> — Sensory Transduction <b>D Grundy, University of Sheffield, UK</b></p> <p><b>10.30hr</b> — Coffee</p> <p><b>11.00hr</b> — Hyperalgesia <b>J Gebhart, USA</b></p> <p><b>11.30hr</b> — Pharmacology of Pain <b>A Dickenson, University College London, UK</b></p> <p><b>12.00hr</b> — Lunch and Posters</p> <p><b>Neuroplasticity and Chronic Pain</b></p> <p><b>14.30hr</b> — Mechanisms of Enhanced Pain Processing and Developing Pathways <b>M Fitzgerald, University College London, UK</b></p> <p><b>15.00hr</b> — Animal Models of Stress Induced Visceral Pain and Hypersensitivity <b>E Al-Chaer, USA</b></p> <p><b>15.30hr</b> — Experimental Models of Inflammation/Injury Induced Visceral Hypersensitivity <b>Q Aziz, University of Manchester, Manchester, UK</b></p> <p><b>16.30hr</b> — Role of Conditioning/Learning in Chronic Pain <b>H Flor, University of Heidelberg, Germany</b></p> <p><b>17.00hr</b> — Can Pain Conditioning/Learning be Reversed by Psychological Techniques <b>E Guthrie, Manchester Royal Infirmary, Manchester, UK</b></p> <p><b>18.30hr</b> — Reception</p> <p><b>17.30hr</b> — Dinner</p>	<p><b>Inflammation</b></p> <p><b>08.30hr</b> — Role of Inflammation in Functional Gastrointestinal Disorders <b>R Spiller, University Hospital, Nottingham, UK</b></p> <p><b>09.00hr</b> — Does Stress Induce Gut Inflammation? <b>M Perdue, McMaster University, Canada</b></p> <p><b>09.30hr</b> — Altered Receptor Expression on Peripheral Nerves as a Cause of Hypersensitivity <b>J Wood, University College of London, UK</b></p> <p><b>10.00hr</b> — Molecular Targets for Inflammation Induced Central Sensitisation <b>C Woolf, Harvard, USA</b></p> <p><b>12.00hr</b> — Lunch and Posters</p> <p><b>Brain-Gut Axis</b></p> <p><b>14.30hr</b> — Does the HPA Axis Have a Role in Modulating Visceral Hypersensitivity <b>L Chang, UCLA, USA</b></p> <p><b>14.55hr</b> — New Insights on Endogenous Descending Modulation of Pain <b>E Mayer, UCLA, USA</b></p> <p><b>15.20hr</b> — Does Functional Brain Imaging Have a Role in Understanding Mechanisms of Visceral Hypersensitivity <b>A Hobson, University of Manchester, UK</b></p> <p><b>16.15hr</b> — <b>Keynote Lecture</b> How Realistic is it to Develop a Wonder Drug for Visceral Hypersensitivity? <b>C Bauntra, GSK, UK and B Coulie, Johnson &amp; Johnson, USA</b></p> <p><b>16.45hr</b> — <b>State of the Art Lecture</b> Heritability of Pain Antinociception <b>JS Mogil, McGill University, Canada</b></p> <p><b>17.15hr</b> — Conclusions – Douglas Drossman</p>

## In Memorium



**Martin Wienbeck**  
*Prof. Dr. Med.*  
 12/27/36 – 4/27/05

The very sad news of the sudden loss of one of the best members of FBG, Dr. Martin Wienbeck, has shocked the community of neurogastroenterologists, where he was very respected and beloved. It is the moment now to pay tribute to the man who avoided a comfortable retirement in his home in Germany, among family members, friends and many former scholars, in order to embark on brave projects in dangerous countries and to help people in need.

Born on Christmas Day 1936, he lost his father, a professor of pathology in Breslau, during World War II. Martin studied Medicine in Marburg and France and then joined Jerry Christensen in Iowa City for studies on gastrointestinal motility. Returning to Germany, he became a professor in Duesseldorf, where he organized an excellent research lab and created a successful team. In 1987, he moved to the new hospital in Augsburg. In 1990, he was President of the European Congress of Gastrointestinal Motility. In 2001, he stopped working in Augsburg and started a generous foundation to promote medical development in the Third World – the Wienbeck Foundation for Medical Development.

He worked in Africa and Haiti before settling in Kabul, Afghanistan, one of the most dangerous parts of the world in those days. He helped train young doctors in Afghanistan and promoted the donation of medical equipments. He was very beloved there for his commitment, generosity and modesty.

Unfortunately, he died in a tragic traffic accident in Kabul on 27 April 2005. Everybody who met him has only wonderful recollections of Martin Wienbeck. He was not only an excellent “pater familias” but also an outstanding expert in the field later to become known as neurogastroenterology, as well as a very active physician.

Remarkably, he was able to attract people who wanted to work with him throughout the world. They became not only dedicated disciples but also life long friends. His activities are documented on the website of the Foundation that he initiated (<http://www.wienbeck.net>) and will continue to carry his name and mission.

The German Society of Neurogastroenterology and Motility mourns the loss of its founder, and many of its younger members are aware that their careers very much depended on Martin’s support. The European Society of Neurogastroenterology, of which he was a

*On the occasion of the passing of Dr. Martin Wienbeck, we are re-running a piece contributed by Dr. Wienbeck published in the fall 2003 edition of the FBG newsletter.*

### **Functional Bowel Disorders are Frequent, Help is Rare in Afghanistan**

By Martin Wienbeck, MD, Professor

#### **Prologue**

Academic and hospital doctors in Germany have to retire at the age of 65. When I reached this age, I looked for a new opportunity to make use of my knowledge and pass it along to younger doctors in need of up-to-date training. Since in 2002 Afghanistan has been freed from the Taliban regime, I headed to Kabul/Afghanistan in the fall of that year to explore the situation with my own eyes and all my senses for a short visit. I was heartily welcomed at the Medical Faculty and the teaching hospitals of Kabul by very open-minded doctors who were eager to gain new knowledge and information after many years of exclusion from the rest of the world.

I, therefore, made preparations to come back to Kabul in spring 2003 for a long-term stay, and I was able to get some support from the German Academic Exchange Service (DAAD). This at least covered most of the cost of living in the Afghan capital, which is rather high because of the need to live in protected housing. A once-weekly flight from Frankfurt/Germany by Ariana, the Afghan airline, took me to Kabul in early April 2003, where I was met with open arms.

co-founder, celebrated his remembrance with an obituary at the Toulouse meeting in July 2005.

We are grateful for the opportunity to have witnessed his intellect and modesty, and we have been inspired by his dedication and willingness to serve his patients and humanity. The best way to think and act in the way Martin Wienbeck did is to consider offering tax-deductible donations to his foundation, whose projects still continue thanks to the commitment of his wife, Elisabeth. Donations should be addressed to:

Wienbeck Foundation for Medical Development  
 Augsburgener Aktienbank  
 Augsburg, Germany  
 Account No. 4 379 877 560  
 International Bank Code IBAN: DE38 7202 0700 4379 8775 60

The personality of Martin Wienbeck will continue to influence all who worked with him or had the chance to know him. It is our opinion that he could have become a second Albert Schweitzer if he had the chance to live longer!

Paul Enck, Tuebingen, Germany  
 Dan Dumitrascu, Cluj, Romania

## Projects

**Endoscopy course for female doctors:** Sensitized by my previous visit to the country, I knew that 23 years of war and varying regimes had changed the minds and bodies of many persons, in particular among the female population. Complaints about abdominal pain and altered bowel movements were frequent, but 8 out of 10 women would not allow a male doctor to examine their intestines and not a single woman practiced endoscopy in Afghanistan. The burka, still worn by most Afghan women, is an indicator of ongoing segregation in daily life. Against this background, I started a program to teach and train a group of four female Afghan doctors in gastrointestinal endoscopy. Two of them were expatriates who had fled to Pakistan during the Taliban regime and practiced medicine there, one had stayed in Afghanistan during that time, and one had studied medicine under the Taliban regime. The latter had never seen pictures during her medical education. She now has difficulties in her orientation when performing endoscopy. Teaching was done stepwise with presentations of tables and graphs in PowerPoint and pictures from a number of CD-ROMs which I had bought during DDWs 2002 and 2003 and got from friends. At the beginning, training was done on an old fiber gastroscope borrowed from an Afghan doctor, and later on a used video gastroscope and video colonoscopy which I was able to acquire as a set in a deal during DDW 2003. The frequent failures in electrical power were circumvented by a generator which I bought in Kabul. Of great help was a young and very committed Afghan gastroenterologist who assisted in translating English into Dari, the predominant language in Kabul, and in supervising the trainees. A final written and practical examination has already enabled two of the trainees to perform upper GI endoscopy on their own and the other two trainees will achieve that goal soon. Colonoscopy is to follow in the fall. It is intended that these trainees will pass along their knowledge and skills to other female doctors in and beyond Kabul. Since many sick patients come for an examination, some of them with advanced types of cancer, we also had to extend on therapeutic endoscopy and started bouginage, stenting and ligatures. These were the first therapeutic endoscopies ever done in Afghanistan – and they were successful.

**Postgraduate course in gastroenterology-hepatology:** As not a single trained gastroenterologist had been present in the hospital teaching gastroenterology at the Medical Faculty since the war started in Kabul, I announced a postgraduate course in gastroenterology-hepatology which was well-attended. Again, presentations via video projector were very helpful in clarifying and illustrating the orals. It was surprising for me to note that the large group of about 50 female and male doctors attending the course understood English presentations very well and got involved in a very lively open discussion afterwards. Current knowledge was thus transferred covering the most frequent diseases of the digestive organs.

**Postgraduate course in ultrasonography:** At the initiative of the Afghan-German Doctors Association, various postgraduate courses started in 2002. One of them was a course on ultrasonography which began in October 2002 and continued in three sessions of two weeks each up to April 2003. Eleven male and ten female doctors from different parts of the country participated. I joined this course in its last third as a teacher of abdominal ultrasonography and soon realized that, with the many pregnancies in the young population of the country, gynecological ultrasonography was at

least as important as that of digestive and urologic organs. Fortunately, two other teachers with great experience in obstetrics and gynecology assisted. This course was successfully terminated by a written and practical examination. This course brought systematic up-to-date training to a group of doctors practicing in different locations of Afghanistan, and it removed the necessity for them to learn the methods in the usual way of trial and error with a lack of control to detect the errors.

**Student teaching:** After repair of the most severe war damage at the Medical Faculty, teaching resumed soon after the overthrow of the Taliban regime. But, the electricity supply was still very unstable. Again, the generator was needed. It was a completely new experience for the medical students to see pictures during the lectures. Teaching so far had been done without audiovisual assistance; even the blackboard was rarely used. Photocopied manuscripts were usually used to prepare for the examination. The lack of spatial orientation or the illustration of diseases impeded the transition from theory to clinical practice in the students to a major extent. I was surprised by the enthusiasm of the students who sat in packed-full amphitheatres while they participated in modern visual presentations. More than one-third of the students were women.

In all four projects, it became evident that Afghan students and doctors are thirsty for new information. I had never before met persons so eager to learn and catch up to current knowledge as in Afghanistan. This was the best encouragement for me to rapidly overcome the many problems and uneasiness in daily life in Afghanistan.

## Gastroenterology and functional disorders in Afghanistan

Afghans now live in an environment following 23 years of war, destruction and suppression. Lack of hygienic water supply, cramped housing, and malnutrition are major problems all over the country. Average life expectancy is only 41.3 years. These facts contribute to the observation that diseases of the digestive tract and liver are the most prevalent medical problems. These include (in decreasing order): gastrointestinal infections, hepatitis, functional bowel disease, nutritional deficiencies, gastroesophageal reflux disease (GERD), and peptic ulcer disease. Facilities to classify most infections do not exist. Intestinal and peritoneal tuberculosis plays a definite role, whereas AIDS and alcoholic liver or pancreas disease are of minor importance in this Islamic country. Because of the low life expectancy, cancer is rarely seen. Most common are esophageal cancer attributed to ingestion of hot tea and/or GERD and/or tobacco chewing and hepatocellular carcinoma following hepatitis B and C.

Functional abdominal disorders are particularly prevalent in women. They suffered the most during war and the Taliban regime. Sexual abuse occurred frequently during Mudjahedin times and women were driven out of schools and jobs. The women were often the only ones left to care for their many children, on average 8.4. And, there is hardly a single family in Afghanistan who did not lose one or several family members in the years of war and suppression. Thus, it is not surprising that many if not the majority of

continued page 16

women complain about abdominal pain and/or stool irregularities, abdominal fullness and bloating, early satiety, heartburn, and nausea. They seek medical help if they can afford it, and rarely is a definite morphologic alteration found. The diagnosis usually made is “war trauma,” but this is often not accepted as conclusive by the women and their families. They ask for medicine, the more the better. Antispasmodics, antidiarrheic agents and laxatives, tranquilizers and gastric acid suppressing agents are the most commonly prescribed. In Kabul, more than 5000 pharmacies make their living from these and other prescriptions. A work-up of “war trauma” is very difficult. A western style approach of thorough psychotherapy is unknown in Afghanistan. Tools to deal with the psychosomatic problems are offered by only a few of the numerous aid organizations present in the country. Obstacles arise from a still very patriarchic structure, often medieval living conditions, and behavior in daily life brutalized in many persons by 23 years of war.

However, all of these statements about gastroenterology and functional bowel disease have to be looked at with caution, since no exact figures exist, not even in small samples. My statements are based on four months of personal observation in a gastroenterology and endoscopy clinic, on the experience of four staff members of the Kabul Medical Faculty with very busy gastroenterology, internal medicine and ultrasound clinics, and on information I obtained from four teaching hospitals in Kabul. I plan to visit and teach in hospitals and clinics outside Kabul when I return to Afghanistan this fall. The information I have so far is that observations similar to mine have been made by doctors and staff members in the major cities of Afghanistan, such as Mazar-e-Sharif, Djalalabad, Kandahar and Herat, and by NGOs (non-governmental organizations) in refugee camps and in the countryside. But, there are many areas in Afghanistan where no medical care is available at all or only basic care provided by health care workers.

Thus, exact data on the occurrence of functional bowel disorders and GI diseases are urgently needed in order to focus future efforts on what is the most needed. The present teaching and training program is a step in the right direction -- female doctors being trained in endoscopy, participants in the postgraduate courses in gastroenterology and ultrasonography, and teaching medical students how to document their observations and put them into a data base.

### **Situation of the medical profession in Afghanistan**

There are five major and several very small medical schools in Afghanistan. They continued to exist during the Taliban regime and turned out many doctors, although the standard of education was poor. Since the Taliban noticed they needed female doctors to run the women’s and also the children’s hospitals and clinics, they opened medical schools separate from the main medical schools specifically for women’s education. All medical schools during the Taliban regime had to get along without instructional materials, especially without any illustrations. The skeletons in the anatomy departments and similar items were destroyed. The rather large number of doctors who graduated tended to stay in the cities, if they did not have to participate in the war. There was and still is even nowadays no incentive for doctors to go into small towns and villages. The people living there have little or no money, and remuneration in eggs, chicken, lamb or other edibles is not what doctors want to head for.

Most of the well-established doctors of the pre-Taliban and even the pre-Mudjahedin times left the country in the 80s and early 90s

to start de novo abroad. The medical facilities were then forced to accredit non-academic doctors as staff members in order to fill the gaps left by the refugees. Thus, young doctors with inadequate education and little experience accumulated in the cities. The countryside became more and more depleted of medical care, because during the Russian occupation most NGOs had to leave the small hospitals and clinics established all over the country. The Russians deliberately bombed hospitals and clinics in the countryside in order to demoralize the opposing population. Despite incentives offered by the United Nations, only a few of the emigrant doctors have returned to Afghanistan, with the exception of those who fled to Pakistan and Iran where they often felt treated as underdogs.

Afghan doctors nowadays face a difficult economic situation: all state employees – be they entry-level, directors or even ministers – are supposed to receive the same low salary. This is the equivalent of approximately US\$35 per month, which is not even distributed every month. Since this salary is not enough to live on – in Kabul the monthly rent for family housing is US\$120 and much more – they have to get additional income from private practice. And, since the rates for medical care are fixed at a low level – the rate for a consultation is about US\$1, for an ultrasound examination close to US\$2, and for an endoscopy about US\$8 – they try to see as many patients as possible. The doctors leave the hospitals at noon and often work late into the night. This leaves little time, if any, for research projects and other academic work. NGOs who offer special courses, like those in ultrasonography, sometimes pay the participants remuneration for their loss of income in private practice in order to enable these doctors to participate. As everywhere in the world, there are also some black sheep among the doctors in Afghanistan; they attempt to increase their income by prescribing expensive medicine available only at a specific pharmacy and then get a share from the pharmacist. Similar tricks are used by others. A sufficient economic basis to live on is, thus, a prerequisite for a change in the doctors’ approach.

The situation is further impeded by the fact that all medical equipment and supplies have to be imported. Since the country at present does not export anything except dried fruit and opium, it is completely dependent on humanitarian help from abroad. As time goes by, global attention has turned more and more towards Iraq and the Near East, a fact that will and already has decreased support for Afghanistan. In addition, the country is far from being settled. The power of the government barely extends beyond the city limits of Kabul, and the warlords outside Kabul who had been supported from abroad in an attempt to get rid of the Taliban pursue their own business, which is not the medical care of the population in their areas. And, a new build-up of weapons is being seen among most warlords.

### **Conclusion**

Gastrointestinal diseases and particularly functional bowel disorders are very frequent in post-war Afghanistan, but exact figures are lacking. Tools to deal with “war trauma” (i.e., psychosomatic disorders) are difficult to establish, since methods of western psychotherapy cannot be transferred one-to-one into this Islamic country. Due to the structure of the present medical system in Afghanistan, the situation is not likely to change very much. However, long-term support – in particular the personal transfer of knowledge, skills and methods of critical evaluation in medical care – offers a realistic chance for major improvements.



### FBG Biographical Sketch

## Max Schmulson

Profesor Titular de Medicina

Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM)

Departamento de Medicina Experimental, Hospital General de México, México

I was born in Barranquilla, a city of 1.5 million inhabitants, on the Caribbean coast of Colombia, South America, where I graduated from high school receiving the medal for best student of the class of

1983. I come from a family where both of my grandparents, Benjamin and Liuba Schmulson, were physicians. My grandmother, probably the first woman doctor to practice in Colombia, founded the Faculty of Dietetics at the Universidad del Atlantico and had a big influence on my future medical career.

I studied Medicine at Pontificia Universidad Javeriana of Santa Fe de Bogota, in Colombia's capital city, where I graduated in 1989. In Medical School, I started to become interested in Gastroenterology and worked under the supervision of Dr. Jaime Alvarado from whom I started to learn about motility. At that time, motility testing was done using an old polygraph, a huge machine that printed large amounts of paper with recordings that needed further manual analysis. My interest in Gastroenterology continued during my training in Internal Medicine and, to this day, I consider Dr. Alvarado one of the most influential figures in my profession.

When I finished my training in 1994, I rotated in Gastroenterology at Georgia Baptist Medical Center in Atlanta. Afterwards, I decided to go to Mexico City for my GI residency at the Instituto Nacional de Ciencias Medicas y Nutricion Salvador Zubiran (INCMNSZ). I was fortunate, because my first rotation was in the Motility Lab and I must say that my background in the field helped me a lot. My interest in motility and FGIDs grew and soon after I started my residency I wrote my first reviewed paper -- "Non-cardiac chest pain" -- which was published in a Mexican journal. Later, I published my first chapter on the same subject in the most important Mexican textbook on Gastroenterology.

During this period, I did my first study on FGIDs using the Rome I criteria and this is probably one of the first epidemiological studies on FGIDs in Mexico. I then did a study on health care resources utilization by IBS patients that was published in the Mexican Journal of Gastroenterology. During the last year of my GI residency, the Chair of the Department and the Vice-Chair (Dr. David Kershenobich and Dr. Guillermo Robles) invited me to join their staff and to reinforce the area of FGIDs. I decided to accept the offer, but first I wanted to go to UCLA to work with Dr. Emeran Mayer and learn about visceral sensitivity.

But how could I get in touch with Dr. Mayer to try to work with him? I decided to go to Baltimore for a course at the inauguration of the new motility unit at Johns Hopkins, because I knew "all of the big ones" in motility and FGIDs where going to be there. It could be a great opportunity to run into Dr. Mayer and tell him about my interest in working with him. Emeran was very friendly and immediately agreed to receive me as a fellow.

I was already engaged to Monica, whom I had dated since my third month of GI residency. We got married in February 1997, after I finished my GI residency. After our honeymoon, we came back to Mexico for the Graduation Ceremony, where I was surprised to receive the award for the Best Residency Graduation Thesis of the Institute for my paper

titled "Gastroesophageal Reflux Associated with Different Alcoholic Beverages of Popular Consumption in Mexico". My finding (for those of you who might be interested) was that Tequila is the one that produced the least amount of reflux.

Monica and I moved to Los Angeles and I started to work in Emeran's group with Lin Chang and Bruce Naliboff. My work was focused on the differences in symptoms, motility and visceral sensitivity of IBS patients according to bowel habit predominance. I did database studies, ran colonic motility and barostat research projects, and worked in the clinic and the motility lab with Lin, as well. My work at UCLA has been one of the most important experiences in my life and one of the most decisive in my academic career. I consider Emeran my mentor in FGIDs and, to this day, I keep a great friendship with Emeran, Lin, Bruce, the entire group and their families. We continue to collaborate, as well.

It was time to come back to Mexico with mixed emotions for Monica and me -- the sadness of leaving LA (our second home) but also the challenge of a new future. I started a very important clinic in FGIDs in the INCMNSZ, and was appointed Associate Professor of Gastroenterology at Universidad Panamericana de Mexico and Associate Professor of Gastrointestinal Motility at Universidad Nacional Autonoma de Mexico-UNAM. I have presented my research work in national and international meetings and co-edited a book in 2001. I have also been an invited professor at the Mayo Clinic in Scottsdale and the Gastroenterological Program at the University of Arizona in Tucson. I have been a member of the National System of Researchers of Mexico since the year 2000 and a member of the Latin American Consensus on IBS. Since my return to Mexico, I also work in Clinica Lomas Altas, a state of the art outpatient clinic, where I work in the Gastroenterology and Endoscopy Departments. I also run the Motility Lab doing esophageal and anorectal manometries as well as pH monitorings with both catheter and wireless systems. In 2003, my friend Kevin Olden invited me to chair the Membership Committee of the FBG, work that I consider an honor and I hope to continue doing.

After almost 6 years of work at the INCMNSZ, at the beginning of this year I was appointed Professor of Medicine by the UNAM. Together with my good friends and colleagues David Kershenobich and Guillermo Robles, we are developing the Laboratory of Liver, Pancreas and Motility (HIPAM) in the Department of Experimental Medicine. I continue my work in epidemiology and QoL of FGIDs and the relationship of IBS with celiac disease in Mexico, visceral sensitivity studies, polymorphisms of various receptors involved in the pathophysiology of FGIDs, and a line in post-infectious IBS.

My medical career would have not been possible without the influence of my late grandmother Liuba, the support from the beginning of my parents Freddy and Susi, and together with my beloved partner and companion, my wife Monica, we have created my most important research project, our son Benjamin Aaron (Benji), a source of inspiration.

Max Schmulson, MD, is Profesor Titular de Medicina, Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM), Departamento de Medicina Experimental, Hospital General de México, Mexico City, Mexico.

## FBG Elections

### Officer Candidates



*For Vice President*  
**Emeran Mayer, MD**

Emeran Mayer, MD, is a Professor in the Departments of Medicine, Physiology and Psychiatry at UCLA. He went to Medical School at the Ludwig Maximilians University in Munich, Germany, did his residency at the Vancouver General Hospital in Vancouver, BC, and his GI Fellowship at the UCLA/VA Wadsworth Integrated Training Program in Los Angeles. As a faculty member at UCLA since 1985, Dr. Mayer has pursued his research interest in clinical and neurobiological aspects of brain gut interactions in health and disease for the past 20 years. He has published more than 135 original peer reviewed articles, 60 chapters and reviews, co-edited two books, and organized several interdisciplinary symposia in the area of visceral pain and mind body interactions. He has made seminal contributions to the characterization of physiologic alterations in patients with functional disorders, particularly in the area of interoceptive mechanisms, and in stress-related modulation of visceral pain perception. His research efforts include the study of cellular and molecular aspects of transduction mechanisms in afferent neurons; animal studies on stress modulation of visceral pain and associated autonomic responses; human physiology studies on cerebral, autonomic, neuroendocrine, and perceptual responses to visceral stimulation; and health outcomes, quality of life, and epidemiological studies in populations suffering from chronic gastrointestinal disorders.

Dr. Mayer is Director of the NIH-funded Center for Neurovisceral Sciences & Women's Health and Co-Director of the CURE Digestive Diseases Research Center. He is P.I. on two NIH Center grants and has two active R01 grants. He has served on the editorial boards of the leading journals in digestive diseases, and will become Associate Editor of Gastroenterology in 2006. He has served as reviewer for a wide range of medical and neuroscience journals, and as a reviewer for national and international funding agencies, including the NIH. He has been elected as Vice Chair of the AGA Section on Motility and Nerve Gut Interactions in 2005.

See Dr. Mayer's bio sketch on page 9



*For Secretary-Treasurer*  
**Lin Chang, MD**

Dr. Chang is an Associate Professor of Medicine in the Division of Digestive Diseases and Department of Medicine at the David Geffen School of Medicine at UCLA. She is the Co-Director and Head of the Clinical Program at the Center for Neurovisceral Sciences & Women's Health at UCLA. Dr. Chang's main area of research is the pathophysiology of irritable bowel syndrome (IBS), with particular interests in the overlap of IBS with fibromyalgia, as well as gender differences and neuroendocrine alterations. She is principal investigator on two NIH grants studying the central and peripheral mechanisms underlying IBS.

Dr. Chang is a member of the American College of Gastroenterology, the American Gastroenterological Association, and the Society for Neuroscience. She has been a Council member for the Functional Brain-Gut Research Group for the past 1-2 years and has served on the faculty for all three Young Investigators Conferences (YIC). She co-chaired the YIC meeting last year and is planning to chair the 2006 meeting.

Dr. Chang is Co-chair of the Rome III subcommittee on Gender, Age and Cultural Influences on Functional Bowel Disorders. She is currently serving on the FDA GI Advisory Committee. She has multiple publications in peer-reviewed journals and textbooks. She has given over 100 lectures at national and local meetings.



*For Secretary-Treasurer*  
**Adil Bharucha, MD**

Dr. Adil E. Bharucha is a Consultant in Gastroenterology and Hepatology, an Associate Professor in the Department of Medicine, and an Associate Director of the Clinical Enteric Neurosciences Translational and Epidemiological Research (C.E.N.T.E.R.) Program at the Mayo Clinic in Rochester, MN. Dr. Bharucha's federally funded research program is directed towards understanding the pathophysiology of, and developing novel approaches for managing female pelvic floor disorders, particularly fecal incontinence and obstructed defecation by applying multi-disciplinary integrated approaches. Dr. Bharucha is an active member of the FBG, having received the Fourth Annual Young Clinical Investigator Award in 1999, the First Annual Clinical Investigator Award in 2003, and served on the panel for Clinical Investigator Award. He is responsible for reviewing the FBG Strategic Plan. Dr. Bharucha is a member of the American Motility Society and serves on the Practice Parameters Committee of the American College of Gastroenterology as also the abstract review committee of the American Gastroenterological Association.

### Slate for the Council 2006



**Carlo Di Lorenzo, MD**

Dr. Di Lorenzo is Professor of Clinical Pediatrics at The Ohio State University and Chief of the Division of Pediatric Gastroenterology at the Columbus Children's Hospital. He went to Medical School in Italy at the Naples University of Medicine. He did research fellowships in Brussels, Belgium and at the University of Southern California, where his research interest led him to perform motility studies in pediatric and adult patients. Dr. Di Lorenzo completed his pediatric gastroenterology training at Harbor-UCLA, working with Dr. Paul Hyman. He then moved to Pittsburgh, where he became Professor of Pediatrics and Director of the Motility Center at Children's Hospital of Pittsburgh.

Dr. Di Lorenzo has conducted extensive research on the motility of the gastrointestinal tract in children and the pathophysiology and treatment of several childhood functional bowel disorders. He has been among the first clinical investigators to assess the diagnostic value of antroduodenal and colonic manometry and to use the electronic barostat to assess visceral sensitivity in children. He has co-authored the only book on pediatric gastrointestinal motility.

Dr. Di Lorenzo serves on the Editorial Boards of the Journal of Pediatric Gastroenterology, Hepatology and Nutrition and Neurogastroenterology and Motility. He has functioned as a grant reviewer for the NIH and as abstract reviewer for the AGA. Dr. Di Lorenzo has served on the Council of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, and has chaired the subcommittee of the American Academy of Pediatrics on the development of guidelines for evaluation and treatment of functional abdominal pain. He has also chaired the American Motility Society committee for the development of minimal standards for motility testing in children and currently serves

on the AMS Clinical Practice Committee. Dr. Di Lorenzo currently chairs the Adolescent Committee of the Rome III criteria, is member of the Pediatric Committee of the ACG, and a member of the Subboard of Pediatric Gastroenterology of the American Board of Pediatrics.



#### **Charles Gerson, MD**

Dr. Gerson is Clinical Professor of Medicine at Mt. Sinai School of Medicine, where he is former Chief of the Gastroenterology Clinic and member of the Mt. Sinai Executive Steering Committee that reorganized the clinical services of the hospital. Dr. Gerson has also served on the Constitution and By-laws Committee of the AGA. His interest in functional bowel disorders (FBD) was stimulated by spending three years of residency and

GI fellowship under Dr. Tom Almy at Cornell Medical Division, Bellevue Hospital.

After directing a research laboratory for the study of malabsorption at Mt. Sinai for a number of years, he shifted his focus to FBD through the development of a treatment and research program in collaboration with his clinical psychologist wife, Mary-Joan Gerson, PhD, who had been investigating IBD at Mt. Sinai. Their collaborative, interdisciplinary approach to FBD centers on the premise that functional disorders require attention to the complexity of how mind and body are integrated.

Dr. Gerson is highly interested in cross-cultural aspects of functional illness. This interest began during two years spent in Nigeria as a Peace Corps Physician followed by a stint in Peru as a Care-Medico visiting physician. He and his wife have conducted global research, trying to increase understanding of and sensitivity to cross-cultural differences that may affect FBD presentation and treatment. Recognizing the multi-national composition of the FBG, Drs. Gerson have formed a cross-cultural committee with membership from eight countries. The committee has begun an active discussion of cultural influence on FBD.



#### **Lesley Houghton, MD**

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. Her early career working with Professor Nick Read (University of Sheffield, UK) and Professors John Dent and Michael 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 functional and organic disease. Since moving to Manchester, she has widened her research interests to include the function of the oesophagus, small and large bowel in relation to the pathophysiology of irritable bowel syndrome (IBS), functional dyspepsia (FD), and non-cardiac chest pain (NCCP). Particular interests include the relationship between the symptom of bloating and the physical sign of abdominal distension in patients with IBS, together with related pathophysiology; the role of various neurotransmitters and hormones (5-HT, CCK, tachykinins) in the control and dysfunction of the GI tract; the role of gender and sex hormones in functional GI disorders; and the physiological mechanisms of action of hypnotherapy in amelioration of symptoms associated with functional disease.

She is principal investigator to a number of educational grants and commercial physiological studies with the pharmaceutical industry. She is a member of the international committee responsible for development of the Rome III criteria for diagnosis of Functional Bowel Disorders;

secretary to the Neurogastroenterology and Motility Section of the British Society of Gastroenterology; member of the Management Committee for the journal Neurogastroenterology and Motility, representing the Functional Brain Gut Research Group; and Fellow of the Institute of Biology. She also serves on advisory committees to the pharmaceutical industry developing drugs for the treatment of functional GI disorders.



#### **Ami Sperber, MD**

Dr. Sperber was born in New York City and moved to Israel in 1965. He completed his medical studies and training in Internal Medicine and Gastroenterology in the medical school of Ben-Gurion University and its affiliated Soroka Medical Center in Beer-Sheva, Israel. In 1992, he completed a Masters of Science in Public Health degree at the

University of North Carolina at Chapel Hill.

Since returning to Israel, Dr Sperber has worked as a senior gastroenterologist with a clinical and research emphasis on the FGIDs. His research has included the epidemiology of FGIDs in Israel (Jews, Arabs and Bedouins), cross-cultural aspects of GI disease (including the publication of a method to validate translation instruments for cross-cultural research), comorbidity between IBS and fibromyalgia, and sleep fragmentation in IBS. Dr. Sperber is currently leading a multi-center gene study into possible associations between personality-related genes, psychosocial disturbances and IBS. He is near completion of a bi-national prospective study, with Dr. Drossman as the co-PI, on the possible association between gynecological surgery and the development of IBS and other functional abdominal pain syndromes. Dr. Sperber has led efforts in Israel to develop educational programs on the FGIDs. He has helped organize patient education workshops throughout Israel and edits a Hebrew newsletter for IBS patients published twice each year for the past 5 years. He is near completion of a book in Hebrew on IBS for the general public. Dr. Sperber is an active member of the FBG. As a member of the membership committee, he has recruited new members from Israel, making Israel one of the more represented countries outside the US. He is also a member of the Awards Committee and Cross-Cultural Committee. Dr. Sperber is a member of the Rome III project, serving on the committee for "Gender, Age, Society, Culture and the Patient's Perspective in the Disorders of Gastrointestinal Function."

## Corporate Sponsors

The FBG greatly appreciates the generous contributions of corporate sponsors that supplement our annual membership dues and are critical to the success of our organization. The following corporations have recently been major financial sponsors:

- » Takeda
- » Sucampo
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- » Novartis Pharmaceuticals Corporation
- » Salix
- » Alizyme

## Upcoming Meetings

### American Motility Society Scientific Meeting

September 22-25, 2005  
Fairmont Miramar Hotel  
Santa Monica, California

### 14th Biennial Joint AMS/EGMS/FBG Meeting

September 14-17, 2006  
Seaport Hotel  
Boston, Massachusetts

### AGA / BSG Joint Symposium

7-8 September 2006  
Cambridge/London, UK

## Congratulations to FBG Members Awards in 2005

### 2005 Janssen Annual Awards in Gastroenterology

#### Award for Basic or Clinical Research in Digestive Sciences

Adil E. Bharucha, MD  
*Mayo Clinic College of Medicine, Rochester, MN*

Andreas J.P.M. Smout, MD  
*University Medical Center, Utrecht, The Netherlands*

#### Award for Sustained Achievement in Digestive Sciences

David G. Thompson, MD  
*University of Manchester Hope Hospital, Salford, UK*

### AGA 2005 Recognition & Research Awards

#### AGA Distinguished Clinician Award

George F. Longstreth, MD  
*Kaiser Permanente Medical Center, San Diego, CA*

#### AGA/Miles & Shirley Fiterman Foundation Award for Distinguished Achievement in Clinical Research

Douglas A. Drossman, MD  
*University of North Carolina, Chapel Hill, NC*

### 2005 IFFGD Award

#### IFFGD Senior Investigator — Clinical Science Award

Fernando Azpiroz, MD  
*Hospital General Vall d'Hebron, Barcelona, Spain*

## News and Announcements

### Miscellaneous

- » Plans are underway for the 2006, 4th annual Young Investigators' Conference. More details to follow.
- » Neurogastroenterology & Motility journal – free on-line for those who are up-to-date in their FBG dues
- » Summary of presentations available on-line at [www.med.unc.edu/ibs](http://www.med.unc.edu/ibs)  
-- Research Day 2005 – Gastrointestinal Biopsychosocial Research at UNC (Saturday, June 11, 2005, UNC at Chapel Hill)