The inflammatory bowel disease aspects of this Congress consisted of a number of symposia and several sessions of paper presentations.

The first symposium consisted of clinical vignettes of inflammatory bowel disease. The panel was asked to discuss the management and decision making process in a number of clinical situations. The audience could also make it's views known through a keypad. Audience responses to various questions were then graphed by computer and displayed on a screen. Although this method has some limitations, it was very interesting to see that the practice of gastroenterology is fairly standard worldwide. There was very little discrepancy between the audience response and that of the panel. There was little new to be learned in this particular session. It was pointed out that some of the decisions made in clinical practice are based more on intuition than on actual scientific data.

A second symposium dealt with time trends and the incidence and prevalence of inflammatory bowel disease. The question was raised as to whether apparent changes in incidence are actually due to a change in practice, in age of the population studied, or in study designs now being applied. The consensus seemed to be that ulcerative colitis is remaining fairly stable but Crohn's disease is increasing in incidence and prevalence. It was theorized that the rising incidence of Crohn's disease may indicate the removal of an environmental protective factor or the introduction of a harmful environmental factor, but that a transmissible agent remains a possibility.

The role of transmissible agents in inflammatory bowel disease was explored. With a touch of irony it was pointed out that it took many years to distinguish Crohn's disease from mycobacterial infection and that now many workers are attempting to put the two back together again. The role of mycobacteria as a possible causative agent for Crohn's disease was discussed in detail. The human condition was contrasted with that of Johne's disease. This is apparently a common cause of chronic diarrhea and ileitis in animals and has caused fairly widespread morbidity in the cattle population in the United States. Interestingly this disease spontaneously remits and relapses. It has been shown to be due to a cell wall-deficient mycobacterium. Johne's disease appears to be an animal model of a Crohn's-like illness due to mycobacteria; it probably deserves further study. The difficulties of isolating a mycobacterium from a human population with Crohn's disease were discussed, particularly the extremely long culture period required to detect the organisms. There is as yet no conclusive evidence for the involvement of mycobacteria in the causation of Crohn's disease.

Also on the microbiological aspect of the disease was a presentation on the role of intestinal flora and their products in the causation of inflammation. It was pointed out that the normal mucosa is an effective barrier to bacteria and their products, but that impairment of the mucosal barrier might lead to movement of bacterial products across the mucosa with resulting inflammation. It has been shown that in normal populations endotoxin concentrations in the peripheral blood are minimal; in patients with inflammatory bowel disease in relapse, however, huge amounts of bacterial products circulate. Normally the liver clears this from the circulation. This is certainly an interesting proposal in view of the finding that Crohn's disease patients and perhaps their relatives have abnormal intestinal permeability. It can be argued that the primary defect in inflammatory bowel disease is altered intestinal permeability; in this setting bacteria and their products are responsible for ongoing inflammation. Again, however, while an attractive hypothesis, it remains only that for the moment.

A number of papers were presented. Drs Crowe and Perdue from McMaster University in Ontario presented the physiological effects of mast cell stimulation on intestinal mucosa. They have shown that mast cell numbers are not reduced in tissues from patients with inflammatory bowel disease, but that responses to anti-IgE and histamine are reduced. A number of papers looked at the role of interleukins in serum and tissue from patients with inflammatory bowel disease. They suggested that the interleukins are important in the pathogenesis of inflammatory bowel disease. It is of course unclear whether this is a primary event or whether the interleukins simply represent a secondary phenomenon. The role of the neutrophil in inflammatory bowel disease was also
examine.

An abstract from the University of Copenhagen suggested that exudative polymorphs from patients with Crohn's disease show increased granular enzyme release. On the therapeutic side an abstract from Copenhagen, Denmark showed that selective 5-lipoxygenase inhibition was possible in patients with ulcerative colitis without significant adverse effects. It is likely that these drugs will be introduced for the treatment of inflammatory bowel disease in the 'not too distant' future. The roles of azathioprine and levamisole in Crohn's disease were discussed. According to the group from Lister Hospital and St Bartholomew's Hospital in the United Kingdom, levamisole is no more effective than placebo. Azathioprine, on the other hand, was found to enhance the short and long term efficacy of a course of steroid treatment in Crohn's disease.

Perhaps the most important paper presented at the open session was one on the natural course of Crohn's disease after ileocolonic resection. This was presented by the group from University Hospital in Lankoping, Sweden. They presented their data on the follow-up of 36 patients with Crohn's disease and ileocolonic resection. The ileal resection margin was macroscopically normal in all patients after surgery. Nineteen of 27 patients undergoing colonoscopy had ulceration three months after surgery, while only seven developed symptoms. In 21 patients examined after 12 months, 90% had endoscopic evidence of disease recurrence, and about 50% had clinical symptoms. Two years following surgery, 15 patients were examined: 93% had endoscopic evidence of inflammation and 80% had symptoms. The inflammatory lesions were pre-anastomotic and the authors found a time-related progression from aphthous ulcers to large ulcers and stricture. The authors suggested that the concept of recurrence after resection needs to be revised. This is especially important since there are at least some data to suggest that 5-aminosalicylic acid compounds may be useful in maintaining remission in Crohn's disease. If this is true, then clearly the question arises as to whether patients should be on 5-aminosalicylic acid prophylaxis almost immediately following ileocolonic resection.

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