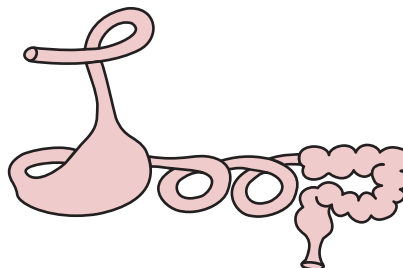




In the



LETTER FROM THE MEDICAL EDITOR

TIMING IS EVERYTHING

by David T. Rubin, MD

The old adage, "timing is everything" applies to the importance of being in the right place at the right time or choosing a path in life at a time, that although not obvious initially, in retrospect was completely appropriate.

For those few in the United States who converted their stock portfolio to cash prior to September or October 2008, this certainly is a prime example. But the expression "timing is everything" also applies to seeing a specialist, getting a second or third opinion, and now, it also applies to the importance of initiating the right therapy as early in the disease course as possible.

We are learning in numerous human diseases that earlier treatment results in better short-term and long-term outcomes. This has been particularly true in Crohn's disease and ulcerative colitis, where we have now learned that the approach of minimizing therapy or allowing a patient to "tolerate" active symptoms causes more harm than good. Numerous clinical trials in the field of inflammatory bowel disease

have demonstrated that patients with a shorter disease duration respond substantially better than those patients who have had longer disease duration and may have already had one or more surgeries and failed all other therapies. This certainly makes sense, as we intuitively understand that long-standing poorly treated disease results in structural damage, architectural changes, and more scar tissue. We also know that children with inflammatory bowel disease have better responses to the same therapies that we offer adults and often do better for longer periods of time after they have responded. We believe that this is due to the fact that children enrolled in clinical trials and provided with similar therapies that we use in adult medicine are often receiving these therapies after a shorter disease duration and earlier in their disease course.

I often describe to my patients that providing anti-inflammatory therapy to someone who has had long-standing untreated disease or ineffectively

...continued on page 12



"A Perfect Storm"

by Stephen B. Hanauer, MD

The economic tsunami has landed a direct hit on academic medicine and, I suspect, on medical practitioners as well. The financial underpinnings of academic medicine are based on income from clinical care, grant support (NIH and foundations), philanthropy and, until recently, industry support for research, training and continuing medical education.

I remain a perpetual optimist that we will withstand this crisis...more focused on strategic priorities unique to each institution, center and program.

I have previously noted the marked reduction in industry support related to avoidance of potential conflicts of interest. As only a small example of the effects of excluding pharmaceutical interactions at

our academic medical center, the burden of costs for meals at conferences (presently considered an entitlement for trainees) has shifted from industry sponsors to academic departments, and totals nearly US \$1 million. The current financial situation has led to marked reductions in this budget: food is no longer provided at noon conferences, which has resulted in drastic reductions in conference attendance as students, house staff, faculty simultaneously attempt to attend (compulsory?) educational programs while eating on the run.

Clinical revenue is also, by necessity, going to fall. Even if patients adhere to their planned medical visits, and certainly many will choose to delay elective

...continued on page 5



Support Groups for IBD Patients

by Marci Reiss

The IBD Support Foundation was established with a unique mission, to improve the lives of patients with Inflammatory Bowel Disease through psychosocial support and education. While there are many organizations dedicated to research for a cure, the IBD Support Foundation is focused on patients' lives right now.

As parents, psychologists, and physicians living with IBD, we have witnessed the incredible pain and suffering Crohn's Disease and ulcerative colitis cause among the patients and families we serve. Our efforts have gone to establishing multiple programs, including very successful psychoeducational support groups for preteens (ages 8-11), "tweens" (ages 12-14), teens (ages 15-19), parents of all age children with IBD and adult IBD patients in their mid-20's to mid-40's. Participants in the latter group come from various professional backgrounds, including physicians, teachers, psychologists, attorneys and film producers and are all living successfully while managing the difficulties of their disease.



Our monthly groups provide a forum for our participants to hear more about their disease and management by leading IBD physicians, and to navigate the often painful emotions associated with living with chronic illness. Through discussion, the participants share stories and advice, and they support and guide each other as they struggle with similar challenges in the fight against IBD. Each of the participants sees the support groups as a critical resource and refuge.

One of our participants recently wrote, "I had always thought I was the only one with Crohn's

Disease but the support groups have given me and my family a sense of belonging in a world where most people cannot relate to disease..."

Each month the attendance at our pediatric and parent groups in Los Angeles, ranges from 50-75 participants, making our support groups one of the most successful IBD support groups in the country! In February, 2008, we launched the IBD Support Foundation's first satellite chapter in Chicago, with the support of Dr. David Rubin at the University of Chicago. Since then, we have had monthly support groups in Chicago and are hopeful about commencing a pediatric program in Chicago as well.

In addition to our support groups, the IBD Support Foundation has a crisis management team and a transitional care program. The crisis management team provides an almost instant response of personal support to families in need who are dealing with a new diagnosis, hospitalization, or surgery. In collaboration with physicians, our crisis team goes directly into the hospitals with trained volunteers and helps patients and their families cope with the acute crisis. Teens with IBD that become independent and venture off to college or a vocation benefit from the resources of our transitional care program, where they learn to take responsibility for treatment and maintenance of their disease. The IBD Kid Konnection and IBD Campus Connection programs allow individuals with IBD to connect with peers worldwide. All of these programs are provided to the participants at no cost, but rather are funded from private donations and pharmaceutical sponsorships. A complete list of our

...continued on page 3

In this Issue of *In The Loop*

Letter From the Editor "Timing Is Everything"	1
by David T. Rubin, M.D.	
"A Perfect Storm"	1
by Stephen B. Hanauer, M.D.	
Support Groups for IBD Patients	2
by Marci Reiss	
News from the IBD Center	3
by Erica Matagrano	
Low Residue Diet	4
by Lori Rowell, MS, RD, LDN	
Coping with IBD	5
by Ann Bregman, PsyD	
One Patient's Story	6-7
by Robin Cruse Handbode	
Donating Life	8
by Andrew Aronsohn	
Who is the GIRF Associates Board and What Do They Do?	9
By Sabrina Bier	
The University of Chicago Celiac Disease Center	10
by Carol Shilson	
Recipes for Patients with Celiac Disease	11
Calendar of Events	12



News From the IBD Center

by Erica Matagrano

In June 2008 I was hired for my dream job, working in the newly created position: Administrative Director of the University of Chicago Inflammatory Bowel Disease Center. The creation of this position reflects the growth of our world-renown center and the plans to expand and improve our clinical services and foster interdisciplinary collaboration and high quality education. My responsibilities include: program development and implementation of both short term and long term programs including patient programs and physician CME courses; IBD fellowship coordination and development; assist the Co-Directors in the development of the IBD program for medical students, fellows, and visiting students; public relations that includes both marketing and working with not for profits; and research coordination.

With the advancements in new treatments and therapies for IBD a new void must be filled. Physicians, medical students, and patients are inundated with all sorts of information through the news, research studies, the internet, and even advertisements.

In order to help community physicians we are expanding our preceptorship program. At the IBD Center physicians come from all over the world to receive one on one training working along side the

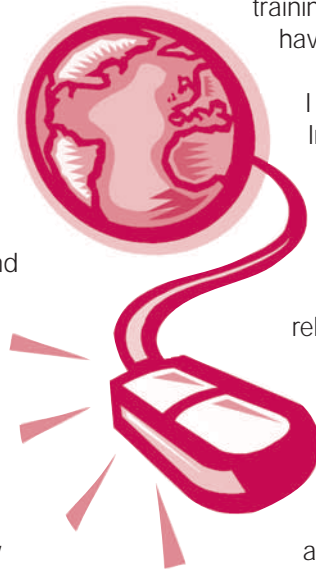
University of Chicago's top IBD Professionals. From past trainings we have created a template for these community physicians to maximize their time spent at UCMC and to ensure that they are learning new skill sets to apply to their own clinic in the treatment of IBD patients. In addition we also conduct a month long training for GI fellows who are at centers that do not have IBD specific curricula.

But I have to admit my favorite initiatives that I am working on right now are for the patients. In 2008 the IBD Center conducted three patient educational seminars with a combined attendance of over 225 people! Our topics have included updates in IBD therapies, life after diagnosis; developing a healthy outlook for living with Crohn's disease, genetics, and relationships, intimacy, and fertility in IBD.

In addition we have worked with the IBD Support Foundation (based in Los Angeles) to launch a Chicago chapter in order to provide psychosocial support to patients with Crohn's disease and ulcerative colitis. These meetings are conducted once a month and are open to anyone with Crohn's disease or ulcerative colitis. Included in this issue is an article by Marci Reiss, IBD Support Foundation's founder. If you suffer from Crohn's disease or ulcerative colitis, we invite you to join us for a meeting.

Lastly, we are creating an extensive website for IBD doctors and patients. Our vision for this site is to make it the most informative and extensive site of its

...continued on page 8



Support Groups for IBD Patients

(...continued from page 2)

programs and services can be found on our website at www.ibdsf.com.

Our Medical Advisory Board is comprised of many of the world's premier IBD physicians, who recognize the importance of psychosocial care in the quality of life, medication compliance and overall functioning of their IBD patients. Our Foundation has met with overwhelming support from the medical community. While a cure for IBD is being sought, there are approximately 1,000,000 Americans with IBD, of which more than 250,000 are children and

young adults who need psychological, social and educational support in order to assist them in leading full productive lives in spite of their disease.

I invite you to join us at our adult IBD support groups in Chicago over the coming months, as we continue to develop our community of support.

Monthly IBD Support Group meetings are listed in the calendar of events of page 12



Low Residue Diet

by Lori Rowell, MS, RD, LDN

Why low residue?

After some types of intestinal surgery, a low residue diet may be used as a transition to a regular diet. Many individuals with Crohn's disease or Ulcerative Colitis, which make up Inflammatory Bowel Disease (IBD) experience flares, which result in increased inflammation of the intestinal tract. The symptoms may include cramping, abdominal pain, nausea, frequent bowel movements, diarrhea, weight loss, dehydration, anemia and fever. During these times, many are unable to tolerate high fiber foods. It is important to be cognizant of the fiber intake, as it may actually exacerbate the flare. High fiber may trigger the gut to actually work harder, due to the bulking action, which is not optimal!

What would be considered low residue?

Consuming 10 grams of fiber or less per day would be classified as low residue. Avoid nuts, seeds, skins on vegetables and fruits, whole grain products, and popcorn is a start. Avoid intake of raw fruits and vegetables during a flare, but see below for some tips. I recommend meats that are easier to digest (think about how much work it takes to break down tough, fibrous meats compared to fish). Low residue diets should be considered temporary. Once the intestinal inflammation has subsided, slowly including fiber and returning to a well-balanced diet is the goal.

It is important to consume some fruits and vegetables, but in forms easier to digest...instead of apples, try applesauce. Instead of raw vegetables, steam or cook well prior to consuming. Mangoes, bananas, melons, pears and peaches (skins removed) are tolerated quite well in small portions. I see many people with IBD who report NO fruits or vegetables. This is not necessary; cooked or canned are in forms that the gut does not have to work to break down compared to raw. Potatoes, a source of soluble fiber, actually contain twice the amount of potassium of a banana; this mineral is important, especially for those experiencing frequent, loose stools. Remember to remove the skins!

The above recommendations contain soluble fiber (think oats in water and the texture formed), which absorb water and minimize cramping and gas. It is important to avoid insoluble fiber (think celery or rhubarb, which are not water soluble and bulky) for those with strictures, or narrowing of the intestines, as this fiber may possibly cause an obstruction, or



blockage, as well as increase gas and bloating. Soluble fiber, on the other hand, may boost the beneficial bacteria in the gut by fermenting, and providing the bacteria with a source of fuel.

IBD is often associated with poor digestion and absorption of dietary fat, protein, and carbohydrates, as well as a wide variety of vitamins and minerals. Although dietary habits do not cause IBD, they play a crucial role in managing it, and providing adequate intake. Consider seeing a Registered Dietitian to address your individual needs.

Curried Sweet Potatoes and Pineapple

This is a delicious savory and sweet combination! It's also high in Vitamin A, soluble fiber, Vitamin C, and potassium. Curry contains turmeric, a compound that has been found to be extremely anti-inflammatory as well as antibacterial; and has been used for centuries for its numerous beneficial health effects.

- 1 1/2 pounds sweet potatoes; peeled and cut into 1 inch pieces
- 1/4 cup of butter (or soy butter, margarine; your preference)
- 1/2 cup chopped red onion
- 1/2 cup packed brown sugar
- 2 tsp cornstarch
- 1/2 tsp ground cinnamon
- 1 tsp curry powder
- 2 cups canned pineapple chunks

1. Place sweet potatoes in large saucepan. Add enough water to cover 1-inch above sweet potatoes. Bring to boil.
2. Reduce heat; cover and cook for 15-20 min or until tender. Drain; set aside.
3. Melt butter (soy or your choice) in large skillet over medium heat.
4. Add onion, cook until soft to break down fiber content.
5. Add brown sugar, cornstarch, cinnamon and curry. Cook and stir for 2 minutes or until sugar dissolves.
6. Add pineapple and sweet potatoes. Stir and cook for up to 5 minutes.
7. ENJOY!

Contains 10 servings.

Per serving: 145 calories, 3.0 grams fat, 80 mg sodium, 30 g carbohydrate, 2.5 g fiber, 15 grams sugar, 2 grams protein, 190% Vitamin A, 22% Vitamin C, 4% iron, 8% potassium, 4% folate

To schedule an appointment with one of our registered dietitians call: 773-702-6140



Coping with IBD

by Ann Bregman, PsyD

Ann Bregman is a licensed clinical psychologist who has been living with Crohn's since 2006. She is committed to helping people who suffer from depression, especially those living with a chronic illness like Crohn's. Dr. Bregman spoke about the psychological challenges faced by newly diagnosed Crohn's patients at a recent Crohn's and Colitis Foundation of America symposium and writes a column called A Gut Feeling on the Crohn's & Me website.

In the upcoming issues we will be addressing many issues: relating to your well-friends, coping with physical pain, making the most of the time with your physician, having a fulfilling work life, cultivating confidence in your sexual self...in essence, how, as people with Crohn's disease, we can help take care of ourselves.

If you are reading this article and if you have Crohn's disease, then we have a common bond. Do you remember your life in the year B.C. – before Crohn's? For some of you it is a distant memory, someone with your same looks living in a different body. For others, life B.C. was only yesterday. We all have our own stories to tell about how we first got sick, when our suffering was given a name, and what our lowest points have been.

I am a licensed clinical psychologist practicing in downtown Chicago. I also have Crohn's disease. Like you, I have faced many obstacles since I was first diagnosed. I continue to fight to maintain my dignity

in the face of Crohn's, and I have had to rethink the illusion I once took for granted that life is predictable. The sum total of these experiences reminds me that as a patient my challenges deserve acknowledgment.

These challenges are a reality of any chronic medical condition. When our symptoms flare up, we seek help from our doctors. But physicians, with all their knowledge, are often learning about our disease right along with us. So how can we and our doctors manage and tolerate this lack of certainty? How can we maintain a modicum of humor when things that were once so private become so public?

Sharing more than a tissue: relating to your well friends

I sat wondering how clean the restaurant bathroom might be. How dirty was too dirty? Could I wait until I got home? "Do you have a tissue?" my friend asked, jolting me back to reality. "I think I do," I replied, relieved to rejoin the conversation. I reached into my purse and, with a dramatic flourish of the hand, produced — a hemorrhoid wipe! We laughed as I found the promised tissue for her. The conversation moved to the missed gossip and news of the last few weeks. Fatigue set in and I said goodnight, leaving just as it seemed the fun was about to begin.

...continued on page 7

A Perfect Storm

(...continued from page 1)

care, the economic layoffs will inevitably lead to a shift in reimbursement from private insurers (in the US, health insurance is an employee benefit) to less robust payments from national (Medicare) and state (Medicaid) resources. Most certainly, society as a whole will ultimately incur additional (both direct and indirect) downstream expenses when preventive care is delayed in favor of costly treatments for preventable or progressive diseases.

The NIH budget under the Bush administration was stagnant or de facto reduced. I hope that the Obama recovery plan will infuse additional funding to return vital research support at a time when scientific

advances are exponentially expanding in number in this era of genomic, translational and personal medicine. Meanwhile, the reduced 'pay-lines' (funding cutoff points) for grant support have already deterred potential investigators from competing for grants, and has limited the abilities of successful grant recipients to complete or expand their funded projects.

Similarly, despite several transformation grants (for improving effectiveness and efficiency in providing medical care) to medical centers announced in early 2008, foundations, universities and medical centers have seen drastic reductions in their endowments that

...continued on page 10



My children and me

One Patient's Story

by Robin Cruse Handibode

"Mom, can I get in the bathroom?!" How many times have I heard that over

the years as I was raising my 4 kids? I know it was countless times...especially since we had only one bathroom! Finally, after being on the toilet so often, at times one or two of my kids would have to get in the shower or brush their teeth.

"I've come a long way baby," since I was diagnosed with mild Ulcerative Colitis at Mayo Clinic at age 14. I can still remember some of those tests I had to take up at Mayo. One test I had to drink Castor oil, which came cherry-flavored but had to be shaken real well; otherwise, the cherry part just sat on top of the castor oil...I wanted to vomit but my mom kept telling me that I had to keep it down or I would have to drink another bottle! Everything SMELLED like castor oil! What a challenge that was to a 14-year old. Another test that I remember having to endure was getting around ten enemas in succession, "so I would come back clean!" What that meant was that my bowel would be cleaned out for the colonoscopy test I'd be getting the next a.m. I was a freshman in high school and the doctors told me to go on a "bland" diet which meant nothing spicy but did include eggs, mashed potatoes, chicken noodle soup the boring foods. Several years into this diet I then was told I could eat pretty much anything and if something didn't agree with me to eliminate it from my diet. I could eat pizza again!

One thing of which I am proud is that I did not let this disease rule me instead I ruled "IT!" I went on with my life and became the queen of the prom, met & dated my first love and met and dated many more because I thought I was all that AND a bag of chips! By my early 20's I was flying on corporate Lear jets on business trips. At times, I was the only woman at these business meetings because this was the mid 1970s and women were just coming into the business world. By my mid-20's I met up with my first love again, we married and had 4 babies in 3 years all single births. I had all natural childbirths and nursed each baby right away after their births. I can remember vaguely that I didn't sit down those first five years. My life was very busy throughout those years, with my 3 sons in various sports and my daughter playing softball or taking art lessons. I didn't *have the*

time to think about my disease!

My kids were 5, 6, 7, and 8 years old when I took on a sales position with Microsoft but due to the extensive travel I left after 2 1/2 years. With little children at home I thought that they'll be little kids for such a short time and I can find a job anytime! I worked part-time jobs after that and stayed involved with my kids driving them to and from everywhere. I was very involved in my community since I didn't think I had a right to complain unless I was helping to pitch in with different organizations. After my kids went off to college I got a job at my community newspaper selling advertising space and I became a Rotary Club member.

In January 2005, I started to have bad colitis attacks that became progressively worse. My gastroenterologist, tried various types of medicines, like prednisone, imuran and at one point I was on 21 pills per day. We even tried infusions of the miracle drug Remicade. Nothing was working. By then I had also finally quit smoking, for which I credit my doctor, who had told me a couple of years before, that he'd "rather have me have 'a bag' than to smoke!"

"A bag," I thought, "my God, how awful!!" But my colon had become like a slide. I wasn't making it home from work in time without having a bowel accident...the steroids were supposed to be giving me some energy, but I was collapsing and having to leave my job earlier & earlier each afternoon. Finally, Dr. Rubin asked me to write down how many times a day I was making bowel movements. I was shocked to see 18-20 a day!! I was also losing blood & tissue out my rectum, which is why I was getting dehydrated and collapsing. I was up through the night, sitting on the toilet for 30 - 45 minutes each time. I'd go back to bed and then I'd be back on the toilet 10 minutes later this would repeat all night long! I wasn't getting good sleep and was so fatigued! My livelihood, my quality of life was just awful especially for someone as active as I am.

Finally, after my second hospital stay within 3 months, I was told that my colon would have to be removed. I was introduced to Dr. Hurst, who would perform the surgery. In December of 2006, Dr. Hurst performed a temporary ileostomy, but due to my previous steroid use, he couldn't do a "J" pouch because my tissue would just tear. I also didn't have

...continued on page 7



One Patient's Story

(...continued from page 6)

enough elasticity and after the surgery, I needed to lose some weight and then I'd have the 2nd surgery & he'd try to do the "J" pouch again. As time went on and I healed from this surgery, I realized I didn't want the "J" pouch because there were more risks involved than if I had the permanent ileostomy. After talking to people who have had both types of surgery, I decided on the permanent ileostomy. In November 2007, Dr. Hurst performed this surgery.

For me, this was the best decision. I feel like I've been given a second chance in my life. For the first time in 38 years, I can honestly say, "I don't have colitis!" I also don't ever have to worry about colon cancer!! There's a freedom with this surgery! I don't have to *run* to the bathroom anymore. The only pill

I take today is a multi-vitamin with iron pill. Don't underestimate the challenges—these surgeries were very tough to recuperate from. But then again, I'm a tough woman. When my doctor told me a few years back he'd rather me have a bag than to smoke..."how awful" I'd thought at the time. I realize now, "how awful" if I hadn't experienced these surgeries. Besides, look how much money I'm saving on toilet paper and cigarettes!

Seriously, my children are healthy and none of them have any IBD. I am healthy! Thank you to the doctors, the nurses, the aides, and all the food services and maintenance people at the University of Chicago Hospitals for everything you all did for me! I am truly grateful!

Coping with IBD

(...continued from page 5)

Living a life divided

I would speculate that after your very first flare, when life got turned upside down, your re-entry into the well world was divided. Coming back to friendships as a person with Crohn's disease, one foot lives in the world of health and the other in the land of illness. The border between the two changes depending on how you're feeling. Although your friends may not always realize this at first, it's important to help them understand how you feel. Remember, they are your friends — they want to know and they want to help you.

Crohn's disease is often invisible or happening behind closed doors. No pink or yellow bracelets acknowledge our daily survival and triumph. While so much of what defines friendship is mutual experience, you now have to deal with many things that your friends don't. It can be very uncomfortable, even if a joke about bodily function is always good for a laugh. This new difference in your life is something your friends probably won't understand right away. Their well-intentioned misunderstanding is something we must try to allow for and gently correct. Just as you need to be kind towards yourself and allow yourself the emotional space you deserve, be kind towards your friends who want to help but may not always know how.

Take the space you need — you deserve it

Whether you are the friend of someone with Crohn's disease, or whether you yourself suffer from it, think for a moment about the kind of language that encircles your experience. Words like bravery, optimism, and positivity come to mind. Maintaining attitudes like these is undeniably a goal in the healing process, but this goal may sometimes make us put pressure on ourselves. We often don't allow ourselves to experience our fear, grief, and anger. We are all susceptible to admiring the sick person "you'd hardly know is sick." We think occasional tears or sad moments can be tolerated as passing moments of necessary release - but sadness is another story. To be clear, I am not recommending depression. But I am recommending that you allow yourself the emotional space you need for the healing process, and that you give your friendships that breathing room as well.

All of us are both the same people we were before we got sick, but now we are also people with Crohn's disease who are forever changed and forever changing. Although I can offer you no prescription or formula on how to re-engage in your friendships, I can offer the words of Wolfgang Amadeus Mozart. "All right. Life is sad. But if there is love, see how beautiful life can be."



Donating Life

by Andrew Aronsohn

For most people, gift giving is limited to birthdays, holidays and anniversaries.

Gifts given at these times are appreciated, but few are truly needed. For patients with end stage liver disease, a gift of transplantation can become the difference between life and death.

The liver carries out chemical reactions which are crucial to keeping our bodies healthy and detoxified. Liver disease affects one out of every ten Americans and has many causes including viral infections, autoimmune conditions, excessive alcohol use and genetic disorders. These diseases cause scarring of the liver, known as cirrhosis, and if this becomes severe enough, a liver transplantation is often the best option to restore health.

Although liver transplantation is a life saving procedure, we have been limited by a severe shortage of livers available for transplantation. In the United States last year, 6,493 people received a liver transplantation although currently over 16,000 patients in need remain on the waiting list. Historically livers used for transplantation have come from deceased donors. In 1989, University of Chicago physicians made a great stride in expanding the amount of donor livers available by performing the first successful living donor liver transplant from an adult to a child. In this procedure, a portion of the liver is surgically removed from the donor and transplanted into the recipient. Due to the liver's unique ability to regenerate, the liver grows back after transplantation to a fully functioning organ in both the donor and recipient. Living donor liver transplants are now being safely performed from adult donors to adult recipients and from adult donors to child recipients. Most donations are directed toward relatives and loved ones in need of a transplant who may be too sick to survive a long wait for a deceased donor liver. Last year, 266 living donor liver transplants

were performed in the United States, 10 of which took place at the University of Chicago.

Since liver donation is a major surgical procedure and is not without its risks, each potential donor at the University of Chicago receives extensive counseling to make certain that they fully understand the risks of the operation. In addition, each candidate undergoes a full medical evaluation to ensure they are healthy enough to donate. Living donors are asked to make an enormous commitment to the process of donation, which not only includes a major surgery, but also a potentially long hospitalization and time away from work and family.

Liver disease can have a devastating effect on patients and their families. Living donor liver donation combines breakthroughs in surgical and medical care with the kindness and selflessness of donors to create a treatment that gives many patients the gift of life.

"This article by Dr. Andrew Aronsohn highlights both the importance of organ donation generally as well as the emerging role of living donor organ donation, specifically. Many of the advances in living donor transplantation have occurred here at the University of Chicago. These could not have been possible, however, without bright and enthusiastic trainees such as Dr. Aronsohn, who assumed the highly-prized position of Transplant Hepatology Fellow in July 2009. The University of Chicago was one of only eight national liver programs to be designated as an accredited Transplant Hepatology Fellowship in 2006 when these fellowships were first announced. We are confident that Dr. Aronsohn will carry on our proud tradition."

News From the IBD Center

(...continued from page 3)

kind including information about diagnosis, treatment options, clinical trials, new research and even instructional videos. It will have specific components for our hospitalized patients too, since the New Hospital Pavilion (due in 2012) will have internet access in every room!

It is definitely an exciting time at the University of Chicago Medical Center as the IBD Center continues to grow and develop new programs. We look forward to sharing updates with you in the future.



What is the GIRF Associates Board and What Do They Do?

by Sabrina Bier, President, GIRF Associates Board

The Gastro-Intestinal Research Foundation of Chicago (GIRF) Associates Board is a not-for-profit made up of Chicagoland young professionals from all walks of life; many are patients, all are friends, united in a common effort to support research on the causes and cures of digestive diseases.

GIRF provides funds for equipment, laboratories and the support of investigators and young physicians in the University of Chicago Gastroenterology Section, a group of full-time dedicated doctors who seek solutions to all kinds of gastrointestinal illnesses, affecting the esophagus, the stomach, the small intestine, the large intestine, the liver, the gallbladder, and the pancreas.

Above all, GIRF is a unique blend of wonderful, kind and generous young professional men and women giving of themselves and their resources, whose greatest reward is that inner sense of satisfaction, that unique feeling of goodness that comes from helping the gastroenterologists in the clinic and in the laboratory at the University of Chicago Medical Center and, through them, helping sick people everywhere. We all share an interest in learning about and supporting leading edge knowledge to develop technology, therapies, treatments and cures for digestive diseases, such as Crohn's Disease, ulcerative colitis, cancer, liver ailments and much more. Motivation to participate on the GIRF Board is as varied as our members; an overall interest in supporting medical research, a special interest in digestive diseases, a friend or family member confronted with a GI medical problem, and/or a desire to volunteer.

The Associates Board continuously awards grants to a wide variety of research at the University

of Chicago. Our recent funding includes but is not limited to:

- Cancer Predicting Biomarkers
- Video Capsule Endoscopy
- Vitamin D Receptor Expression in Human IBD Tissue
- Characterization of microRNA in Colon Cancer and Inflammatory Bowel Disease
- Multibank Imaging Colonoscopy in Colitis Surveillance

These grants are made possible through our fundraising activities such as our annual fall event and silent auction. Friends, food, drink, and fun is our motto at this social event which continues to grow every year and accompanied by a silent auction which consists of items such as jewelry, sports memorabilia, gift certificates, and vacation getaways. We welcome anyone who wants to have a good time while helping to support our doctor's research to join us at this great party!

We invite you to join us to help raise funds for the University of Chicago for research to fight digestive diseases. We are continuously looking for new young professionals who have the passion, drive, and commitment. The various ways to become involved with the GIRF Associate Board are:

- Attend monthly meetings to help plan future fundraising events, review grant proposals, and participate in awarding the grants. This is open to all members and interested newcomers.
- Attend our education events.
- Be a part of our social/networking opportunities such as our annual fundraiser & silent auction.

— Save the Date —

2009 Annual Associates Board Benefit

October 17th, 2009 at 7:00pm

Lloyd's Chicago • 1 South Wacker, Chicago, IL

Open Bar • Heavy Appetizers • Silent Auction
Raffles • Live Music

REGISTER ONLINE: www.GIRF.org

For more information contact:

Jennifer Wright Jwright@girf.org

Gastro-Intestinal Research Foundation,

70 East Lake Street, Suite 1015, Chicago IL 60601

P: 312-332-1350



The University of Chicago Celiac Disease Center

by Carol Shilson

Celiac disease is a genetic inflammatory autoimmune disease of the small bowel, which is triggered by the presence of gluten in the diet. When a person who has celiac disease consumes gluten — a protein found in wheat, rye and barley — the individual's immune system responds by attacking the small intestine and inhibiting the absorption of nutrients into the body. Specifically, the villi, which are tiny fingerlike protrusions on the lining of the small intestine, disappear. Nutrients from food, which normally enter the bloodstream through these villi, can no longer be absorbed. Celiac disease can be associated with other autoimmune disorders and, undiagnosed and untreated, it can lead to other serious illnesses.

The University of Chicago Celiac Disease Center was founded in 2001 by Dr. Stefano Guandalini, a noted pediatric gastroenterologist, with the help of concerned parents whose daughter suffered from celiac disease. Since its inception, expertise has expanded from children to adults with the addition of Drs. Carol Semrad and Sonia Kupfer. The Center's mission is to raise awareness and diagnosis rates of celiac disease and to meet the needs of those with newly diagnosed disease nationwide through research, education and advocacy.

The Celiac Center is staffed with two registered dietitians who provide gluten-free diet education to people with celiac disease. Lara Field, MS, RD, works with the pediatric population and Beth Wall, MS, RD, educates adults with celiac disease. Keeping in line with the Celiac Center's core mission of education

the registered dietitians teach other health care professionals about the complexities of the gluten-free diet and necessary lifestyle modifications.

The University of Chicago Celiac Disease Center offers many services at little or no charge, including:

- An information line for anyone with questions about celiac disease. While the information line is not staffed by doctors and cannot dispense medical advice, it can help direct patients to the proper resources for their inquiries, and can answer general questions about the disease. Call 773-702-7593.
- A Gluten-Free Care Package Program, which provides newly diagnosed celiac patients all over the country with a basket of gluten-free food products educational materials to teach them about a gluten-free diet. At present, the gluten-free diet is the only treatment for celiac disease.
- An annual free blood screening for the disease and educational session with a panel of experts every fall. This year's free blood screening is scheduled for Saturday, October 10th. Advance registration is required and opens September 1.
- A Celiac Disease Preceptorship Program. This is an intensive, two-day course in celiac disease, geared toward doctors, nurse practitioners and dietitians. Selected candidates come to the University of Chicago Medical Center to learn from some of the world's most knowledgeable and experienced clinicians and researchers in celiac disease.

...continued on page 11

A Perfect Storm

(...continued from page 5)

translate into reduced payouts and available funds for research or capital expansion.

The effects of the economic downturn have already been felt in academic medicine with hiring freezes, staff and faculty layoffs, and budget reductions that will clearly impede research and education. One can easily anticipate future problems with recruitment of house staff, fellows and new faculty, who will be burdened by the highest educational loan debts in history.

Over the past decade, American researchers have been surfing a wave of good financial standing at most

academic centers as the overall economy expanded. Unfortunately, the current economic crisis created a tidal wave that is sweeping across the globe. I have explained to my section that we now need to 'cut fat to build muscle', and I remain a perpetual optimist that we will withstand this crisis...perhaps a bit leaner and certainly more focused on strategic priorities unique to each institution, center and program.

Stephen B. Hanauer, MD
GIRF Professor of Medicine and Clinical
Pharmacology
Chief, Section of Gastroenterology and Nutrition



The University of Chicago Celiac Disease Center

(...continued from page 10)

The University of Chicago Celiac Disease Center, completely funded by donations, also boasts one of the foremost research teams in celiac disease. In fact, the Center just launched a \$2 million dollar campaign to fund the creation of the world's first-ever mouse model of celiac disease—which will lead to untold

breakthroughs in the development of a vaccine and possibly a cure for the disease.

If you would like to learn more about The University of Chicago Celiac Disease Center or to make a donation, please visit www.CeliacDisease.net.

Recipes for Patients with Celiac Disease

Turkey Chili Molé

2 tablespoons vegetable oil
 2 pounds ground dark turkey (may substitute other ground meat: beef, buffalo, chicken, ostrich)
 1 large onion, chopped
 1 large red pepper, chopped
 1 28 ounce can crushed GF tomatoes in puree
 1 15 ounce can black beans, drained and rinsed
 2 teaspoons chili molé seasoning (see below)
 1/2 teaspoon salt
 1/2 teaspoon fresh ground pepper

In a large skillet, heat oil and sauté ground meat, onions and red pepper over medium-high heat until turkey is cooked through (no pink remains). Add tomato sauce and seasoning. Simmer for at least 15 minutes. Taste and adjust seasoning. Serve with white rice, guacamole or GFNF Nondairy sour cream or yogurt Serves 8

Sueson's Chili Molé Seasoning

Individual spices are available in bulk food section of natural or grocery stores making this seasoning blend easy and inexpensive.

1/4 teaspoon cayenne pepper
 1/4 teaspoon white pepper
 1/4 teaspoon allspice
 1/4 teaspoon nutmeg
 1 teaspoon thyme
 1-1/2 teaspoon marjoram
 1-1/2 teaspoon cinnamon
 3 teaspoon cocoa (unsweetened, not Dutch processed)
 2 tablespoon chili powder (single chili, like Ancho Chili Peppers, not chili powder blend)

IBD Center Patient Education Event a Big Success!

Congratulations to the IBD Center on the success of, "IBD Survival Education Event for Patients, Families, and Friends," on July 29th at the Chicago Symphony Center. Over 75 people attended to hear presentations from Russell Cohen, MD and David Rubin, MD, Co-Directors of the Inflammatory Bowel Disease Center and to participate in an active question and answer session. The conclusion of the program allowed for an excellent opportunity for the attendees to socialize and speak with others who have been affected by inflammatory bowel disease. Lastly, a special thank you to the GIRF Associates Board for assisting with this well received event!

For more information on future programs please contact Erica Matagrano: 773-702-6073 or visit the IBD Center's Website at www.ibdcenter.uchicago.edu

Dr. Russell Cohen speaking with patients at the July 29th event



Dr. David Rubin speaking with patients at the July 29th event



Letter From the Medical Editor:

(...continued from page 1)

treated disease is akin to "beating a dead horse," of course, referring to the attempt to treat scar tissue in the bowel with an anti-inflammatory therapy which does not work. Unfortunately, when we do this in attempts to avoid surgery and in attempts to control the disease process in other ways, we end up prolonging the suffering of our individual patients and exposing them to the risks of therapies without the benefits. Therefore, it has become apparent in our newest research and in our ongoing understanding of the complicated disease processes of inflammatory bowel disease that treatment with some of our best and most effective therapies early is often the best course of action. These therapies, which we may have once reserved for the most severe cases, are now considered as appropriate options for moderately active disease and in some cases for mild disease. We have learned that earlier use of our biologic therapies (like infliximab (Remicade), adalimumab (Humira) and certolizumab pegol (Cimzia)) result in the best outcomes. Accumulating evidence repeatedly shows that we can avoid surgeries, repeat surgeries, hospitalizations, disabilities, and other bad outcomes by embracing these options early.

The challenge of applying this newest information at a referral center like the University of Chicago Medical Center is that we often see patients who are referred to us after they have suffered for years or tried many other therapies. In these cases, we do not have the advantage of a newly diagnosed patient in our referral-based practice and therefore, do not often have the advantage of offering these therapies at the time when, ironically, it would be most effective and have the best likelihood of helping them. Therefore, I recommend that you seek effective therapy and embrace it early in your disease course and you have discussions about these benefits compared to the risks of active disease with your doctors. If you have been talking to a friend who suffers from these diseases who is thinking of getting another opinion, waiting until they have failed all their therapeutic options and are quite ill is not the right time. Encourage them to seek these opinions now. In life, and in disease, timing really can be everything.

Wishing you the best of health.

David T. Rubin, MD
Medical Editor

Calendar of Events

For further information or to register for an event please contact

Erica Matagrano, Administrative Director, Inflammatory Bowel Center
ematagrano@uchicago.edu • 773-702-6073

October 10th	Annual Celiac Free Blood Screening	December 3rd-4th	Celiac Disease Preceptorship Program
October 17th	2009 Annual Associates Board Benefit Lloyd's Chicago at 7:00 pm GIRF Associates Board	December 13th	IBDSF Support Group for Crohn's and Colitis at 7 pm Chicago Marriott, 540 N. Michigan Ave
October 18th	IBDSF Support Group for Crohn's and Colitis at 7 pm Chicago Marriott, 540 N. Michigan Ave	January 17th	IBDSF Support Group for Crohn's and Colitis at 7 pm Chicago Marriott, 540 N. Michigan Ave
November 15th	IBDSF Support Group for Crohn's and Colitis at 7 pm Chicago Marriott, 540 N. Michigan Ave	February 21st	IBDSF Support Group for Crohn's and Colitis at 7 pm Chicago Marriott, 540 N. Michigan Ave

For further information, or to make a donation for GI research:

Gastro-Intestinal Research Foundation

70 E. Lake Street, Suite 1015 • Chicago, IL 60601 • 312.332.1350 • Fax: 312.332.4757

Email: info@girf.org • Website: www.girf.org