

Young GI Angle: The young perspective of the UEG White Book 2 by the Friends of the UEG Young Talent Group

INTRODUCTION

The United European Gastroenterology (UEG) White Book 2 stands as a landmark piece of research, shedding light on the complex field of digestive diseases across Europe.¹ It offers a thorough analysis of the public health impacts of digestive diseases and cancers along with an evaluation of their economic effects. The White Book highlights considerable disparities in the burden of digestive diseases and access to prevention and treatment across European countries. Additionally, it probes into the current research gaps and identifies priorities within the realm of digestive health, all the while emphasizing the concerning surge in the prevalence of several digestive diseases since 2000.

As members of the UEG Young Talent Group (YTG) from eight different nations and Friends of YTG (FYTG) from a broader group of 43 nations, we appreciate that our unique viewpoint and collective responsibility offer a distinct opportunity to improve the understanding in the field and patient outcomes for those suffering from digestive diseases. Using the insights provided by the White Book as our guide and baseline, we believe we can make meaningful progress in this area. Our group's international nature grants us a wide-ranging perspective, encompassing diverse experiences, broad expertise and multidisciplinary insights. To harness this, we conducted an intensive workshop in Vienna attended by 51 young gastroenterologists (Figure 1). Here, we examined the differences that exist within individual nations, delving into potential causes and solutions for specific diseases. The insights gathered from these discussions form the basis of this article.

Our goal is to highlight these differences and suggest potential strategies to tackle them using a unique viewpoint of young gastroenterology (GI) professionals with the support of UEG. In doing so, we hope to support the wider efforts of the UEG community, its Public Affairs Group, and the Research Committee in their advocacy for improved patient outcomes, awareness and increased funding for digestive health research.

ALCOHOLIC LIVER DISEASE

Chronic liver-disease is the leading cause of years of life lost.²⁻⁶ Europe has the highest level of alcohol consumption world-wide,

being the most important risk factor for liver disease.⁷ There is a rise in alcoholic liver disease in some regions, with socioeconomic and geographic disparities evident amongst UEG member countries (Figure 2). Age-standardized incidence, prevalence, and mortality have declined in Western Europe, yet Central/Eastern Europe and parts of Western Asia have seen increases. Men experience higher rates across all age groups. Disparities relate to differences in alcohol policy, pricing, and marketing. Strategies to curb hazardous alcohol use must take a multisectoral approach, encompassing regulation, public health interventions, and treatment access. Evidence-based policies for prevention, regulating alcohol availability, taxation and marketing require implementation, incorporating the local context.⁸ Screening and brief interventions in healthcare settings provide opportunities for early risk identification and motivation for behavioral change. At-risk groups, including marginalized populations and those with substance use disorders, should be targeted by culturally tailored interventions addressing the complex interplay between individual and environmental factors influencing drinking behaviors. Importantly, broadly accessible non-invasive testing strategies to identify individuals at risk of liver-related events and referral pathways need to be implemented.⁹ Comprehensive treatment encompassing psychiatric and social support must be easily accessible. However, countries face different levels of access to resources required for implementation of these strategies. Multisectoral efforts bringing together policymakers, public health professionals, community organizations, and other stakeholders are vital to reduce the health, social, and economic harms of alcohol use and address these disparities.

LIVER CANCER

Liver cancer demonstrates clear geographic and gender disparities amongst UEG member countries (Figure 3).¹⁰ Incidence and mortality have substantially risen; however, recent stabilization provides hope. Men experience higher rates across all ages. Significant disparities exist regarding the implementation of screening/early detection strategies, which are vital given the typically asymptomatic onset of the disease. Groups at elevated risk, including those with chronic viral

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FIGURE 1 Picture from the Young Talent Group and Friends of Young Talent Group in Vienna UEG House of Gastroenterology in April 2023.

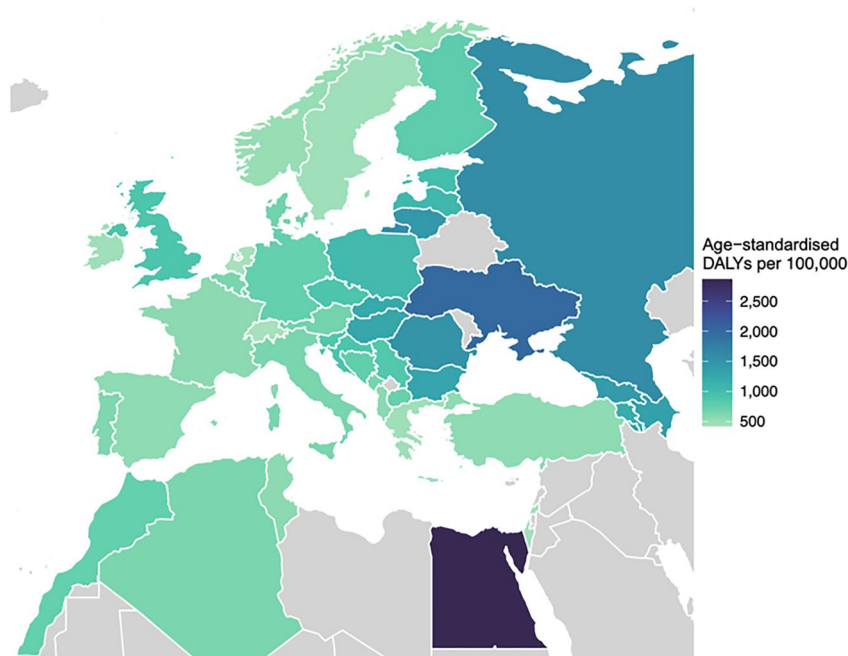
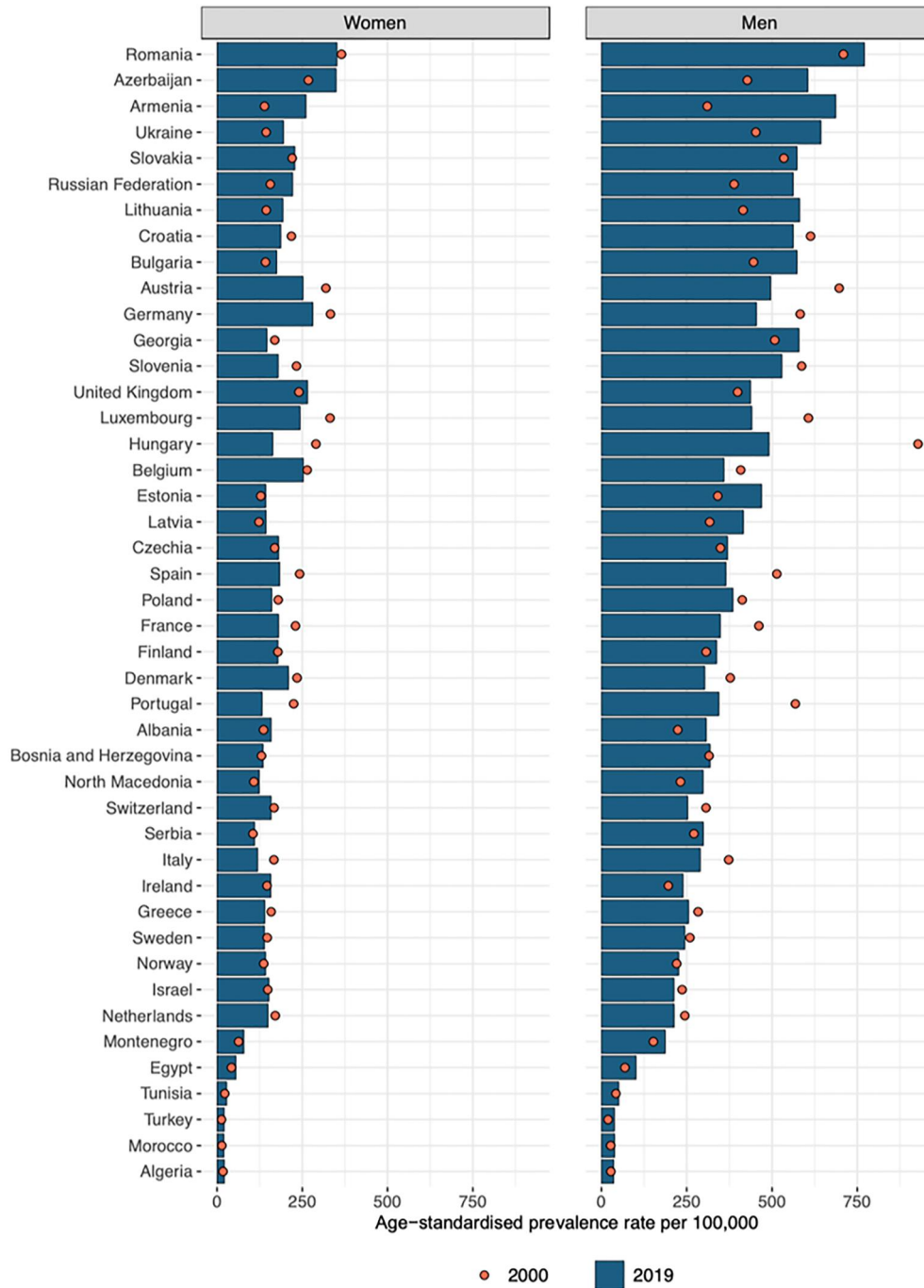


FIGURE 2 Age-standardized DALY rates for digestive disease in 2019 for 44 UEG Member Countries. Modified from UEG White Book 2.

hepatitis, require targeted screening with 6-month ultrasound +/- alpha-fetoprotein. Increasing screening coverage in high-risk groups should be prioritized, paired with expanded treatment access for hepatitis C. Also, there is a significant difference in the geographical distribution of liver cancer, a lower incidence of 2 per 100,000 people

annually in northern countries compared to southern nations with over 15 new cases per year, which is another challenge that should be addressed. The leading cause of the liver disease underlying most cancers in 2015 was viral hepatitis in a majority of the countries studied, followed by alcohol consumption as the next most common



Source: authors' compilation using GBD 2019 data.
Additional country-specific data can be accessed via the GRD Results Tool

FIGURE 3 Age-standardized prevalence rates per 100,000 for cirrhosis and other chronic liver diseases due to alcohol use in 2000 and 2019 by sex for 44 UEG member countries. Modified from UEG White Book 2.

factor. Further analysis of the data collected demonstrates these geographical and etiological patterns in liver cancer diagnoses. Lifestyle modifications, encompassing alcohol moderation, weight control, and smoking cessation are crucial for primary prevention, with multi-sectoral efforts needed to address environmental risk factors. The variation in the scale-up of hepatitis B vaccination as well as access and consumption of alcohol further contributes to disparities, requiring

policy attention. Liver cancer prevention and control necessitates a comprehensive approach: from primary prevention through vaccination, awareness, risk factor reduction and screening; to prompt diagnosis and management of screen-detected lesions; alongside universal access to optimal cancer treatment and palliative care. Realizing these strategies in an equitable and culturally appropriate manner is paramount.

IRRITABLE BOWEL SYNDROME

Irritable bowel syndrome (IBS) demonstrates high prevalence in Europe, reported up to 29%, with substantial disparities in diagnostic rates between populations (Figure 4).¹¹ The estimated prevalence varies widely depending on the diagnostic criteria applied as well as the methodology used. This creates challenges, as inconsistent definitions hinder comparative research and epidemiological monitoring. Consensus regarding standardized criteria and diagnosis is vital to elucidate the true variation in IBS prevalence and risk factors between populations. Multidisciplinary care integrating dietary, psychological and pharmacological approaches is beneficial; however, access barriers can exacerbate disparities.

Telemedicine may help overcome access issues in remote regions. Improving awareness in healthcare and society regarding IBS as a legitimate chronic disorder requiring comprehensive management is crucial to reduce stigma and empower those affected to seek appropriate care. IBS imposes substantial personal and economic burden, underscoring the need for increased research on therapeutic options providing sustained relief. Success requires cross-sector collaboration, encompassing efforts from researchers, clinicians, patient advocacy groups and policymakers to address current deficiencies in diagnosis, treatment, and awareness.

INFLAMMATORY BOWEL DISEASE

There are differences in inflammatory bowel disease (IBD) incidence and prevalence between specific countries and regions as well as evident county specific dividends (Figure 5). The proportion of deaths due to digestive cancers out of total cancer-related deaths by sex for 44 UEG member countries combined, 2019. While IBD epidemiology varies between nations, in 2019 member countries saw age-standardized IBD incidence from 2–35 and 2–38 per 100,000 for women and men, respectively, along with age-standardized prevalence ranging from 19–506 and 16–491 per 100,000. Mortality remained relatively low at 0.1–2.2 and 0.2–1.9 per 100,000 for women and men, reflecting differences in IBD burden between member states.¹² The prevalence peaks in middle age, resulting in high personal and economic costs during patients' peak productive years. Thus, equitable access to medication and surgery is paramount, yet disparities linked to socioeconomic status and location persist. Rural patients face particular barriers to specialist care. Telemedicine may help bridge this gap when in-person visits are impractical. Multidisciplinary models integrating GI, surgery, nursing, psychology, and dietetics optimize care quality. Delayed diagnosis worsens the prognosis, highlighting the need for improved awareness and rapid referrals when IBD is suspected. School-aged onset necessitates smooth transitions from pediatric to adult services. Addressing inequities requires evaluating barriers across patient journeys and throughout the life course. Success mandates collaboration between healthcare providers, researchers, patient organizations and policymakers. Though IBD control has improved, persistent disparities

emphasize the need for continued efforts to enable equitable access to high-quality, patient-centered care.

PANCREATIC CANCER AND CHRONIC PANCREATITIS

Pancreatic cancer incidence has increased in most UEG member countries in recent decades, particularly in Central/Eastern Europe (Figure 6). Pancreatic cancer has very low 5-year survival rates in Europe, from 0.5% to 9%, and is expected to become the second most common cause of cancer death by 2030.¹³ Moreover, its incidence of pancreatic cancer is projected to rise in coming years.^{14–16} As mortality closely mirrors incidence, the prognosis remains dismal, emphasizing the importance of detection and treatment of early stage disease to improve outcomes.¹⁷ At present, however, general population-based screening programs are not deemed feasible. While most pancreatic cancer patients have advanced disease at diagnosis, early detection and treatment provide the best chance for a cure, thus emerging approaches like blood tests and AI-assisted imaging interpretation could improve early diagnosis though balancing added costs and false-positive harms remains an obstacle to optimal screening.¹⁸ Although most pancreatic cancer cases are sporadic, the rising recognition of hereditary factors provides opportunities for expanded research into targeted pancreatic cancer surveillance for high-risk individuals.

Modifiable risk factors, including smoking and obesity, have been shown to contribute to the development of both pancreatic cancer and pancreatitis and need to be addressed through multifaceted interventions. Alcohol impacts chronic pancreatitis disproportionately across nations, suggesting inequities in harm minimization policies and access to addiction treatment. Multidisciplinary care integrating surgery, oncology, dietetics, psychology, and addiction medicine is ideal, yet concentrating expertise is challenging. Telemedicine and centralization of complex care may help bridge geographic barriers to specialist teams. However, optimal models of care require further elucidation. Ongoing research into screening, risk factors and therapy is vital to reduce the burden of these diseases.

COLORECTAL CANCER

Colorectal cancer (CRC) demonstrates clear socioeconomic gradients, with a higher incidence among disadvantaged populations within many nations. Mortality has declined overall, likely reflecting improved screening and treatment. However, inequities in early diagnosis persist as barriers to screening and delayed symptom appraisal delay help-seeking among underserved groups. Consequently, socioeconomically deprived patients tend to present at stage III and IV, requiring more radical treatment and facing a poorer prognosis. Universal health coverage for diagnostic investigations and treatment is imperative to minimize inequities. Beyond this, targeted efforts to increase screening uptake in marginalized communities are

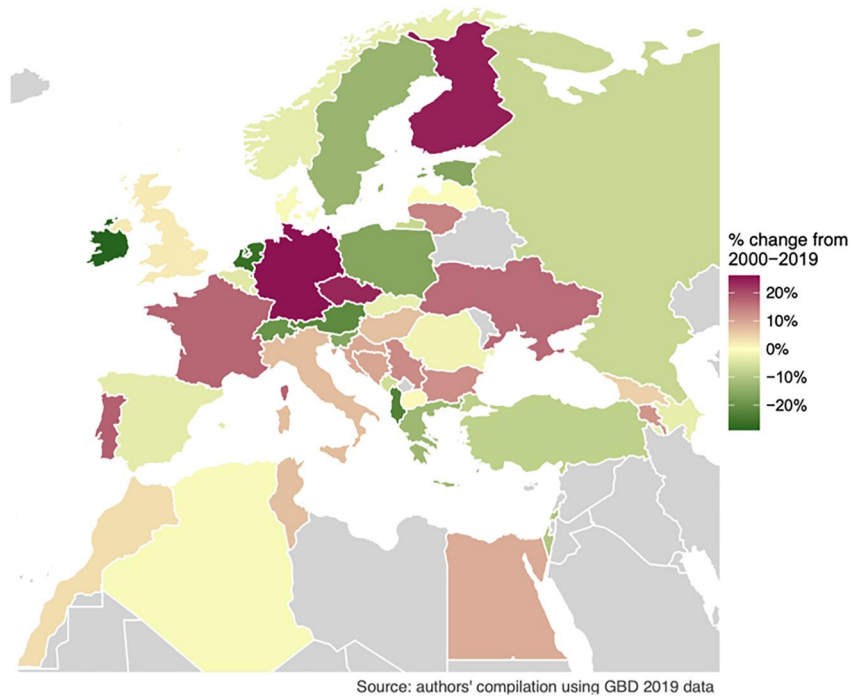


FIGURE 4 Percentage change in age-standardized DALY rates from 2000 to 2019, for 44 UEG member countries. Modified from UEG White Book 2.

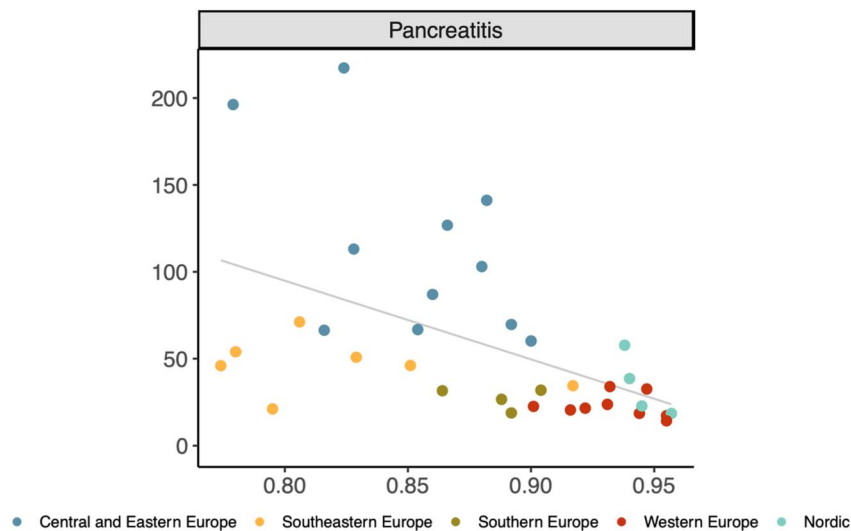


FIGURE 5 Relationship between age-standardized DALY rates for pancreatitis and human development, in 2019, for 35 European UEG member countries. Modified from UEG White Book 2.

needed, which may require outreach facilitating access and addressing knowledge gaps. CRC prevention necessitates multidimensional efforts: from awareness raising, improving screening participation, and enabling universal access to optimal treatment; to primary prevention via public health initiatives to promote healthy lifestyles and reduce risk factors including obesity, smoking and excessive alcohol intake. Tackling the upstream determinants of health inequalities is also vital to reduce CRC disparities.

UPPER GI CANCER

The epidemiology of esophageal cancer accounts for both squamous cell carcinoma and adenocarcinoma, two histological subtypes with known different risk factors.¹⁹ Overall, esophageal cancer's age-standardized incidence and mortality are stable or slightly decreasing amongst UEG member countries. However, several nations have experienced concerning increases, concentrated in

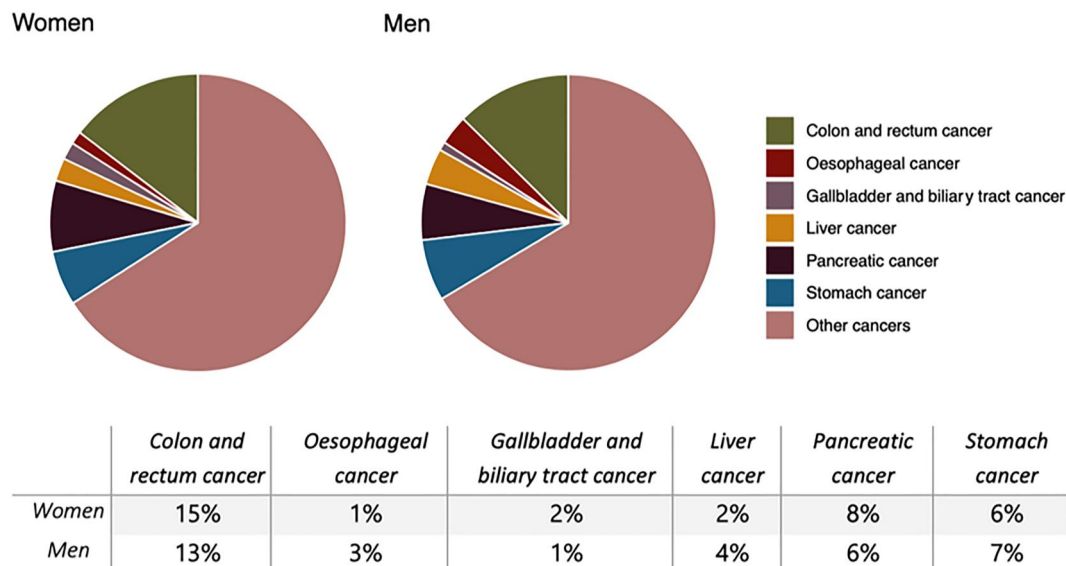


FIGURE 6 Proportion of deaths due to digestive cancers out of total cancer-related deaths by sex for 44 UEG member countries combined, 2019. Modified from UEG White Book 2.

Central/Eastern Europe. Age-specific rates are rising among older adults while falling among younger groups. Alcohol and tobacco account for a substantial proportion of the burden, though their contribution has declined in some countries. On the other hand, the proportion of burden attributable to high body mass index has increased in all member countries.

Stomach cancer has seen more consistent declines in incidence and mortality across nations. However, it remains one of the most common causes of cancer-related death, ranking third worldwide. As with esophageal cancer, smoking is an important risk factor, accounting for up to 28% of age-standardized disability-adjusted life year rates in some member countries. However, one of the most important risk factors for stomach cancer is *Helicobacter pylori*, which is also impacted by socioeconomic factors (namely level of education, income, hygiene and living conditions).²⁰

Targeted public health efforts are vital to curb these modifiable risks, which synergistically increase the risk of upper GI cancer. Smoking cessation, reducing hazardous alcohol intake, *H. pylori* screening/eradication and promoting healthy diets require ongoing attention.¹⁹ Alongside primary prevention, improving awareness and access to diagnosis and treatment are crucial to reducing disparities in outcomes. Multidisciplinary specialist care optimizes outcomes for these complex cancers. Centralization of services may help concentrate expertise; however, issues around access require consideration. Ongoing research exploring innovative early detection strategies is critical.²¹

CONCLUSION

In this article, we hope that our insights, drawn from the collective work of the YTG and FYTG, will stimulate further research, dialog, and action, particularly among our younger colleagues. Our aim was

to offer an introduction to the differences that exist within nations concerning specific diseases, providing a clear picture of these disparities, their potential causes, and possible solutions.

We express our deep appreciation for the significant work of the UEG, the Public Affairs Group, and the Research Committee. Their continuous efforts to raise awareness, inform policy, and promote research are a testament to UEG's mission and dedication to improving digestive health across Europe.²² As young professionals in the field of GI, we are privileged to contribute to this mission and are ready to support the implementation of ambitious prevention, screening, and treatment strategies at both the European and national levels.

In closing, this article is not just a summary of our findings but also a call to action. As emerging leaders in GI, we are committed to paving the way for more effective prevention strategies, improved patient outcomes, and increased funding for digestive health research.²³ We look forward to continued collaboration with UEG and its committees as we collectively strive toward a healthier future for all.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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