

23rd Congress of the European Committee for Treatment and Research in Multiple Sclerosis

11-14 October, 2007; Prague, Czech Republic.

More than 5000 neurologists from 75 countries around the world attended the 23rd Congress of the European Committee for Treatment and Research in Multiple Sclerosis (ECTRIMS) to hear the latest research in the field, ranging from the basic science of MS to highly sophisticated innovations with targeted new drugs and detailed scanning techniques. The meeting was held in the Czech capital of Prague, a city combining historical buildings and squares with modern transport and facilities to meet the challenges of a 21st European centre.

In the opening lecture of the congress, Christian Confavreux, Hopital Neurologique Pierre Wertheimer, Lyon, France, underlined the importance of neurologists from around Europe working together with collaborative databases and large cohorts of MS patients to make progress. He suggested that these efforts had resulted in major advances in understanding over the past decade, including the influence of pregnancy on the course of the disease and the risk of relapse following vaccination.

Professor Confavreux considered that there was now good evidence that relapses in MS are the clinical counterpart of acute focal inflammation of the central nervous system while progression is that of chronic diffuse neurodegeneration. He questioned whether MS should be considered as a primary autoimmune disease or as a primary degenerative condition. Late pathological studies have shown the presence of activated microglial-like inflammatory cells disseminated in the CNS. "In other words, diffuse neurodegeneration is likely to be related to inflammation, even if the latter is not autoimmune," he proposed. Assuming this pathogenetic picture was well founded, he told delegates, "Treating the acute focal inflammation is not enough. One must fight against the silent diffuse inflammation nested in the central nervous system beyond the blood-brain barrier. This is the new challenging frontier in MS treatment."

Study confirms Epstein-Barr virus associated with MS

Patients with MS have higher levels of Epstein-Barr virus (EBV) DNA than healthy controls and viral load fluctuates with disease activity, according to a study reported at the congress.

The study measured levels of EBV DNA in peripheral blood leukocytes from 112 patients with stable, relapsing remitting (RR) MS, 28 at the onset of a clinical relapse of RRMS, and 39 controls, using quantitative PCR for the BamHIW repeat and the LMP2a gene. Results showed a trend to higher viral loads in the MS patients. The median number of copies of BamHIW per million cells was 59 for controls, 91 for patients with stable RRMS and



102 for patients in relapse. The corresponding values for LMP2a were 0, 10.6, and 9.8. Although the range of values in the three groups overlapped, the differences approached statistical significance for the comparison of LMP2a in controls and patients with stable MS ($p=0.068$, rank sum test).

Fourteen of the patients had blood collected both during a relapse and while stable. Their levels of EBV DNA were increased during relapse in six of them, unchanged in six and decreased in two.

The researchers, led by J William Lindsey, Associate Professor in Neurology at the University of Texas, Houston, USA, said, "Our assay sensitivity was excellent and detected EBV DNA in the majority of subjects. There is a trend towards increased viral loads in MS patients and a suggestion that viral load may fluctuate with clinical disease activity."

A second, Norwegian Study showed that all 61 patients with RRMS tested were positive for a marker of previous EBV infection, anti-VCA IgG, while 98% were positive for a second marker, anti-EBNA IgG. However, there was no association between disease activity and EBV reactivation. A third study reported at the congress was consistent with EBV acting as a trigger of MS, with a higher level of activation of EBV-specific CD8+ T cells in patients with early MS.

Multiple Sclerosis 2007;13:P484, P483, P485

Study suggests FTY720 may repair MS damage by direct effect on brain

Encouraging findings were reported with several new agents, including a study showing that FTY720 (fingolimod), an oral sphingosine-1-phosphate receptor agonist, acts directly on the central nervous system (CNS) to reduce disease severity in addition to peripheral effects on the immune system.

The study in experimental autoimmune encephalomyelitis showed that administering FTY720 directly into the CNS significantly reduced disease severity. This occurred even though there was no reduction in lymphocytes in the bloodstream, indicating that the agent has a direct effect in the CNS that is

independent of its effects on peripheral lymphocytes. When FTY720 is given orally, it stops lymphocytes leaving peripheral lymph nodes and infiltrating the CNS, which is another important part of its action in MS.

Howard Weiner, Professor of Neurology at Harvard Medical School, Boston, USA, said: "MS is a disease affecting the central nervous system – but most of the drugs we currently have act peripherally. These results suggest that the mechanism of action of FTY720 may involve CNS-mediated effects, in addition to reducing T-cell infiltration into the CNS. This raises the possibility that it might also have protective effects in progressive stages of the disease."



A further study showed that FTY720 increased the number, growth and survival of oligodendrocytes – the cells that make myelin, which insulates nerve fibres and is damaged in MS - in cell culture. This effect could potentially limit destruction of myelin and promote its repair, which could contribute to the effectiveness of FTY720 in MS.

Results from a phase II study in 281 patients with relapsing MS (the commonest type) showed that once-daily, oral FTY720, reduced relapse rates by more than 50% after six months, compared to placebo. It also reduced magnetic resonance imaging (MRI) measures of inflammation, with around 80% of patients free of active brain lesions. In patients continuously treated with FTY720 for up to two years, up to 77% remained relapse-free and more than 80% were free of active brain lesions at two years.

Commenting on the findings, Gavin Giovannoni, Professor of Neurology at Barts and The London, Queen Mary's School of Medicine and Dentistry, London, said, "In the emerging therapies, FTY720 is interesting because of its mode of action – with results showing that it may act centrally to provide neuroprotection, as well as having effects on the immune system. The availability of an oral drug would change the face of MS treatment completely."

Positive results were also reported with rituximab, a monoclonal antibody that selectively depletes CD20+ B cells. A double-blind, controlled trial randomising 104 patients with RRMS to intravenous rituximab (1000mg) or placebo on days 1 and 15 showed a significant reduction in gadolinium (Gd) enhancing lesion counts at weeks 12, 16, 20 and 24 (mean 0.5 vs 5.5 with placebo, equating to a 91% reduction; $p < 0.0001$). There was also a reduction in new Gd-enhancing lesions and in relapses. Infusion-associated adverse events affected more than three-quarters (78.3%) of patients given rituximab.

A study in 45 patients with active RRMS who had failed beta-interferon treatment showed that alemtuzumab, a humanised monoclonal antibody targeting the CD52 antigen expressed predominantly on lymphocytes, achieved a 9.3 fold reduction in relapse

rate in the two years after treatment compared to the two years previously ($p < 0.0001$). Most patients (70%) also had stable or improved Multiple Sclerosis Functional Component scores at two years. Alemtuzumab was generally well tolerated, although four cases of autoimmune thyroid disorder and one case of transient thrombocytopenia occurred. Professor Giovannoni considered the efficacy results were 'remarkable.'

Multiple Sclerosis 2007; 13: P484, P554, P558

Summing up the new developments at the meeting, Gavin Giovannoni considered studies reported atECTRIMS with some of the newer agents had shown particularly promising results for the future. He suggested that the results seen with FTY720 were interesting, particularly because of the potential for activity in the central nervous system, and for neu-

roprotection. The phase 2 study results with rituximab also looked very interesting, in addition to the data reported with BG-12, laquinimod and cladribine.

Focusing on patients' needs, Professor Giovannoni thought that the development of oral therapies was the most pressing issue. "The introduction of effective oral treatment will change the face of treatment completely," he said. With moves to diagnose MS earlier, he predicted that earlier treatment would become standard. "It is beyond doubt that we should treat earlier, as the damage starts from an early phase of MS – so we need treatments that patients can use earlier easily, effectively and safely." He hoped that the next couple of years would see further positive data.

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Neurosocieties: The Rise and Impact of the New Brain Sciences

12-13 November, 2007; London, UK.

The launch meeting of the European Neuroscience and Society Network was held in the comfortable and attractive Darwin Building at Regent's College Conference Centre, within the beautiful setting of Regent's Park, London on 12th and 13th November 2007.

Professor Nikolas Rose, sociologist and Director of the BIOS Research Centre (for the study of Biosciences, Biomedicine, Biotechnology and Society) at the London School of Economics, welcomed a broad mix of specialists from the fields of neuroscience (neuroanatomy, clinical neuroscience, neuropharmacology etc) and the social sciences (sociologists, psychologists and anthropologists etc) to this bold venture in interdisciplinary discussion of the political, ethical and social implications of 'the new brain sciences'. Rose spoke of 'setting an agenda for Europe', in terms of discovering 'what's going on', noting major differences between countries, and also 'what's going on in different fields', getting the picture from, say, clinicians, imagers, psychiatrists and neuroscientists.

'Public health and the politics of the neurosciences' was the theme for the opening plenary. 'The challenges of regulating neuropharmacology' were outlined with lively and controversial examples by Simon Gregor (Director of Communications), stepping in for Professor Kent Woods (CEO) to speak about their work at the Medicines and Healthcare Products Regulatory Agency. The UK regulators' view was juxtaposed with the concerns of the clinician, Professor Matilde Leonardi, Consultant Neurologist (adult and paediatric), from the Neurological Institute Carlo Besta, Italy, speaking of 'Neurosciences and neuropolitics: two challenges for brain disorders'. "Maybe neurological patients do not get their voices heard: your GPs do not allow patients to get to neuro-

logists", but, " these disorders are at the top of the patients' agenda". Substantiating her arguments initially with figures from 28 European countries, Leonardi then challenged us to look afresh at statistics and their very conceptualisation towards a count of 'Years lived with disability', which added to length of life, produce the measure: 'Disability Adjusted Life Years' (DALY). On this basis, "neurological conditions count for 50% of all diseases in Europe... therefore, investment is not yet compatible with the impact of neurological disease". (see 'Measuring Health and Disease in Europe' at www.mhadie.it).

Rose, chairing this first plenary, raised three issues:

- that psychiatric and brain trauma had been brought together in Leonardi's figures;
- that the word 'burden' (used in reference to the amount of disease) is 'a term contested by survivors';
- the terms: 'disability' versus 'disease', how to reconcile this?

Here was an indication of the plunge pool of battles over words that the ENSN will encourage in its bringing together of embodied medical and social thought! Leonardi concisely and robustly defended her use of language before Rose proceeded to gather in questions of a diverse nature from the audience, which Gregor and Leonardi addressed. Ample time was arranged for these discussions within each plenary, and in the breaks for refreshments, delicious lunches and the splendid conference dinner, intensely interesting debates continued.

Each of the four plenaries was planned on a similar model, with two speakers from different disciplinary backgrounds presenting, a stimulus to lively question and answer sessions, for example:

'Sources of the Neurochemical Self: consciousness, personhood and difference' Professor Alexandre Maunon, University of Geneva 'The neurochemical self and social inequality: a new face of neuroethics' Dr Ilna Singh, BIOS Centre, LSE. 'Theories of personhood: self, brain and behaviour in boys with ADHD'.

The third session on 11th November was 'Neuroeconomies: markets, choice and the distribution of neurotechnologies', in which their global development and production was stunningly illustrated by the first speaker, Zack Lynch, Executive Director of the Neurotechnology Industry Organization. A discursive note on 'The birth of neuroeconomy' by Dr Philippe Pignarre, University of Paris, followed as counterpoint. The final plenary, to close the meeting on 12th, was 'Neuroscience and Society: Future Directions in Europe', after a morning spent in selected discussion workshops relating to the four plenary themes.

The interdisciplinary exchanges between life scientists and social scientists, from this and subsequent ENSN conferences and workshops (in Europe and North America), will be published in a series of annual volumes in international journals. Additionally, the network will provide exchange and travel grants to junior scholars in the field. The project is funded by the European Science Foundation to run from June 2007 to June 2012.

Further information:
www.esf.org/ensn
www.neurosocieties.eu

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Association of British Neurologists' Autumn Conference

14-16 November, 2007; London, UK.

What's New?

Historically, the ABN meeting comprised single sessions, from Wednesday lunchtime to Friday afternoon, including a mixture of basic science and clinical research presentations, and lectures from invited experts. However, with increasing numbers of attendees representing an ever-wider range of interests a number of innovations premiered this year including parallel sessions and dedicated teaching sessions. Although biased because one of the ABNT posters featured, I thought the expert led poster session was excellent, allowing lots of questions in an informal setting.

Teaching

In common with other meetings, the teaching role of ABN meetings is increasingly recognised, and the first session this year was a practical session on neuro-ophthalmology, led by Dr Gordon Plant and Prof Chris Kennard. This covered a wide range of practical aspects of ophthalmology as relevant to the neurologist.

Parallel Sessions

Two sessions were run at once on days one and two of the meeting, allowing for a greater spread of specialist interest. Although all presentations were of extremely high quality, several stood out as excellent.

- Confocal retinal microscopy for idiopathic small fibre sensory neuropathy. It appears sensitive, quick, and does not require a neurophysiologist (Pitceathly).
- The spectrum of neuro myelitis optica includes brain stem dysfunction at presentation. The aquaporin 4 antibody test offered at Oxford appears to be more sensitive than the original NMO IgG antibody. (Viegas). Why?
- Axonal loss in MS may be related to acid sensing ion channel 1. Craner showed results from genetic knock-out models, and small molecule inhibition with amiloride. Amiloride is a partial blocker that was effective even when given after onset of experimental autoimmune encephalomyelitis (EAE). Targeting the acid sensing channel 1 on immune cells had no effect.
- Biomarkers of neurodegeneration continue to be sought. The use of Diffusion Tensor Imaging (DTI) in PD was highlighted by Bajaj and Positron Emission Tomography (PET) using amyloid and microglial markers in AD by Okello.

Guest Lectures

As usual, the guest lectures (this time all on day 2) were of very high quality.

Raymond Tallis talked eloquently on the evolution of man, with relevance to the importance of the hand. An infinite array of movement was made possible by the move to bipedal locomotion in early humans. The hand, freed from locomotor tasks, became a "proto-tool", driving consciousness and ultimately to the evolution of a self-aware homo sapien. Tallis argued that 'man' is now free from the constraints of nature and biology that define the existence of all other life-forms on this planet. Whilst thought provoking, it is hard to cover this topic in 1 hour, with unavoidable gaps in the story. There is evidence of tool use from over 5 million years ago, followed by little evolutionary or societal change, but in the last 100,000 years language, technology and sociology have developed in an exponential fashion. Unanswered questions include:

1. Why did Homo sapiens come on to the scene so late and then become so successful?
2. Why did Neanderthals (and other hominids) fail to survive? Did they have subtly different hands, or were they just unlucky?

Richard Wise reviewed modern tractography and connections between Broca's area, Wernike's area, area 39, and the anterior temporal lobe. He presented evidence from fronto-temporal dementia subjects with seman-



tic and anomic deficits, as well as functional MRI and tractography from different animal models which although unable to produce language have excellent audiological cortexes. Parallels between these two models were discussed, and an over-riding theory of language dysfunction explored.

Industry sponsored sessions

The success of ABN meetings is in part thanks to the industry sponsors. Without their hard cash, the meetings (in their present form) would be uneconomical. One of the sponsored sessions was especially interesting.

Novel Therapeutic Agents: The challenges of Adoption in the UK

The decisions (and consequences thereof) made by NICE on both acetylcholinesterase inhibitors (for treatment of dementia) and Natalizumab (Tysabri, for the treatment of inflammatory disorders including Multiple Sclerosis) were reviewed. Data they presented showed that the UK is slower to use novel therapies than other countries, and that neurologists may be particularly slow to use them, compared with other medical specialties. Professor Isaacs reported data from questionnaire-based research (Programme Identifying and Observing Novel Therapy Adoption in Chronic Diseases: PIONEER), which compared neurologists to rheumatologists, in the treatment of Multiple Sclerosis (MS) compared with Rheumatoid

Arthritis (RA). Rheumatologists are more aggressive in their treatment choices, and far more of them support early treatment in RA compared with neurologists treating MS. Are neurologists more cautious? The rheumatologists said the 'tipping point' came when they accepted that RA was fatal, and that early joint damage was irreversible. The parallels to MS are striking. A Norwegian doctor asked whether we just don't have enough neurologists to treat and to act as advocates for our patients. If neurologists looked after patients with late complications of MS (such as urinary tract infection or aspiration pneumonia) then would we be more aware of the long term consequences of chronic neurological disorders? Would having enough neurologists to do all this change the nature of a UK neurologist?

ABNT forum

I would like to thank those trainees who got up early on Thursday morning to come to our forum. We would also like to thank all trainees that returned our questionnaires, which have allowed us to provide high quality data to support trainees' views on MMC and other issues.

The Tooke review was discussed, and its radical proposals (including an end to run-through training) were generally welcomed by trainees (Table 1). However, the transitional years of 2008-9 will be more competitive than 2007, due to under-provision of training posts, and mishandled transition mechanisms.

Table 1: Key points from the draft Tooke Report

<i>Principles of broad-based, flexible training and aspiration to excellence</i>
<i>Criticism of policy development and governance and current mechanisms for workforce planning</i>
<i>Streamlining of regulation – PMETB to become part of the GMC</i>
<i>Changes to structure of post-graduate training</i>
<ul style="list-style-type: none"> • <i>Foundation year 2 to be abolished</i> • <i>3 year basic specialist training programmes</i> • <i>Competitive entry to higher specialist training programmes</i>
<i>Possible distinction between post-CCT specialists and consultants with additional selection at this point</i>

Another future threat is a renewed interest in the sub-consultant grade. With a new potential “bulge” of trainees likely to complete training around 2012, our job is to ensure that consultant positions are available for them, and that they are not forced into non-consultant positions.

A Knowledge based assessment is very likely to be introduced for those of us in the new curriculum but increasing costs, and the potential for the exam to be branded and sold to non-specialist trainees has led to disquiet. There is not an easy solution to this problem – summative assessment of knowledge is required by PMETB, although the best format and style of this is unclear.

For the ABNT to be effective and representative, it is essential that trainees remain engaged and involved. Information is available on the

ABN website; and there is now a trainees forum that allows us to disseminate important information and encourages online discussion of contentious issues. The email addresses of all committee members and regional representatives are also available. It is important that the ABN office has a note of your most up-to-date email addresses to allow for rapid and cost-effective communication with you. Registrars will soon be emailed as part of the British Neurological Surveillance Unit (BNSU). Finally, please, encourage FY1& 2 and ST1 and 2 to become members of the ABN.

*Daniel Blackburn, Andrew Kelso and Biba Stanton
(On behalf of the ABNT)*

The True Cost of Brain Injury Headway, the Brain Injury Association’s 2007 Conference and Exhibition

October, 2007; Stratford-upon-Avon, UK.

Baroness Susan Greenfield was the big draw for this gathering of professionals concerned with the needs of the brain-injured. Her speech ‘The Future of Neuro-protection: the Benefits of Early Prevention’, highlighted on conference flyers, was the finale to a day filled with passionate discussion.

‘Passion’ was the word used by two personal injury solicitors from different firms in the exhibition. Asked what had drawn them into this specialist area, each cited the impact in their family lives of someone with brain injury.

Dr Andy Eynon’s opening discussion ‘Is Specialist Intensive Care Really Worth It?’ got people exercised about the relative lack of investment in acute specialist care, which would save vast sums of money in the long run. For example, survivors of ‘head and spinal trauma, stroke, intracranial infections’ whose ‘care is time-dependent’, may have reduced chances of appropriate rehabilitation and re-entry into the labour market, if they have not received specialist management in the critical early days. It is possible to focus on numbers of critical care beds available across the 27 specialist neuroscience centres in England and Wales (Feb. 2006, total adult beds 206). A Paediatric Neuroscience Nurse Consultant gave me a much smaller number available for children, and endorsed Eynon’s main argument, ‘It is the logistical reorganisation that is difficult’ within the NHS. This is despite recent governmental attention to neurological conditions (e.g. the National Service Framework for long term conditions, ‘Mending Hearts and Brains’, and the NICE guidelines for head injury management). NICE recommended ‘that all patients with severe head injury are managed at a specialist centre’. Eynon called for ‘rapid access to specialist units, aggressive treatment and early rehabilitation close to the patient’s home.’ It is not just a matter of more money, but careful and well-informed planning. (Eynon is Director of Neurosciences ICU at the Wessex Neurological Centre. Their evidence is in ‘Intensive Care Medicine’ 2007 33 Suppl 2 S 130).

Ron Payne provided a stark illustration of the individual and social costs incurred by the lack of targeted critical care and the uneven distribution of facilities for longer-term management. Heather, his wife, a brain injury survivor, sent apologies for not being well enough to speak that day. Slides of their lives before and after Heather’s brain injury enhanced Ron’s narrative. Both had worked in local government, enjoying healthy active lives and travelling. Seventy-two hours after a trip abroad Heather had an extensive DVT and intervention was difficult. She was deemed unlikely to survive. However, within a few days, Ron noticed some signs of response (flickering eyes, smiling), but not until Heather squeezed his hand, Ron said, was the care plan altered to support her accordingly. Several months later, Heather came home, and life became even more difficult through the lack of joined-up services. Few facilities were available in their area of Staffordshire, such as hydrotherapy, something Heather had benefited from in the early days. Ron described the strain of living with someone doubly incontinent, whose bedding he changed in the night, living in a downstairs room with insufficient space



Baroness Susan Greenfield at Headway conference 2007, by Richenda Power.

for two single beds and the necessary hoist. He felt unsupported and dealt with his stress by drinking. However, Heather’s sister discovered a specialist centre in Northumbria where ‘they have absolutely everything you could wish for: physio-, OT and neuropsychology for both of us’. They relocated. When asked about his own health, Ron replied, ‘My health has deteriorated to the same degree as Heather’s has improved, but the cost is worth it, to get my Heather back’.

Each personal story surrounding brain injury is unique. But the aims of helping, whether it be through rehabilitation of physiological function or the capacity to rejoin the labour market, as well as

the long term financial management, need to be considered in the round and across the whole of society. Alister Berry, Clinical Neuropsychologist, reported from Rehab UK on an evaluated project in South Tyneside; District Judge Gordon Ashton, Deputy Master, the Court of Protection, gave a compassionate and erudite outline of the implications of the Mental Capacity Act, including recent changes in the Court of Protection procedures and aims. His emphasis on consulting the protected person about the broadest aspects of their personal welfare, beyond basic financial management, was very welcome. Other speakers discussed ‘the Money Minefield’ of state benefits (Gillian Solly, of Davies and Partners) as well as the question of whether those should replace damages (Elizabeth-Anne Gumble QC and Henry Whitcomb QC).

This combination of speakers gave a kaleidoscopic view of the many and various costs of brain injury, to individuals, their families, work places, and society in general, over the decades that many survive.

After all this intensely concerned applied discussion it was a treat to be entertained and educated by Susan Greenfield, using a battery of engaging slides together with a very clear description of her research at the molecular level with possible neuroprotective agents (apoptosis inhibitors, anti excitotoxic agents; neurotrophic factors; ion channel moderators). She proposed to talk ‘controversially about the brain stem area’: ‘if there is damage in this vulnerable hub’, citing as examples, PD and Alzheimer’s, ‘although they arise from different areas embryologically they ‘retain the ability to grow again’ and what is necessary in early brain development may be damaging in later life. Sharing her question-raising approach to experimentation, she demonstrated her renowned skills as communicator of scientific ideas.

For further information on the 2008 Headway Conference and Exhibition, please contact Rachel Broughton on 0115240800 or email eventsandconferences@headway.org.uk. For further information on Headway, please visit www.headway.org.uk

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PREVIEW 18th Meeting of the European Neurological Society

7-11 June, 2008; Nice, France.

Neurology: Learning, knowledge, progress and the future

Teaching programme :

- 22 practical workshops
- Interactive case presentations
- Practical sessions in clinical neurophysiology
- 24 Teaching courses covering all important topics in Neurology

The eighteenth meeting of the European Neurological Society will be held at the Nice Acropolis Congress Centre on June 7-11, 2008. This year we will celebrate the 20th anniversary of the first meeting of the ENS, which was also held in Nice, in June 1988.

From the very beginning we have pursued the original goals of our society namely excellence in the teaching and scientific programmes, and support to young scientists. The number of participants of courses, symposia and free communications has dramatically increased since the beginning, but the spirit remains the same. The ENS bets on neurologists in training, with 300 of them invited to attend the meeting. Younger colleagues are especially interested in teaching courses. 37 courses will be available, including eight practical hands-on sessions and four teaching courses jointly organised with colleagues of the American Academy of Neurology. In addition, 22 workshops covering the different fields of clinical neurology will take place during the meeting.

The Presidential Symposium will be dedicated to current knowledge and practical management of Coma and locked-in syndrome. On the following day a symposium will cover behavioural disorders and dementia with talks on Physiopathological bases of behaviour, Synucleinopathies (Parkinson, Lewy body); Mild cerebral impairment and Alzheimer disease; and Tauopathies (Fronto-temporal, PSP, etc.). A symposium on autoimmune disorders of the nervous system will include talks on latest developments in Multiple Sclerosis; autoimmune diseases of the neuromuscular junction; Pathogenesis and treatment of the Guillain Barré syn-

drome and Immunopathogenesis of inflammatory myopathies.

On the last day of the meeting there will be a symposium on Multiple Sclerosis: 'When to start a treatment and which treatment' with the best experts in the field from Europe and the USA. Finally there will be symposia on Imaging and management of transient ischaemic attack (TIA) confronting the Diagnosis and risk assessment for TIA, Yield of brain and vascular imaging (MRI, ultrasound etc.); Feasibility and efficacy of ultra early evaluation and intervention after a TIA, and the concept of the TIA clinic.

In addition to the symposia, the Scientific Programme includes five Poster Sessions and approximately 16 Oral Sessions of free communications. We will once again have Poster Walks to display the posters in a lively and interesting format. Experts will lead a review of selected posters promoting discussion with their authors. The selection of scientific papers is based on the review by three experts in the field. On average 800-900 free scientific papers are selected for presentation at the meeting. We are very much looking forward to reviewing the abstracts of free communication in order to select the best for a very stimulating meeting.

Prof G Said, ENS Executive Committee.

Visit the ENS 2008 website www.ensinfo.com

- Continuously updated scientific programme
- Online registration as well as hotel & tour registration
- Option to compose your personal congress programme
- Details about the industrial exhibition and symposia arranged with the industry
- Information about Nice

Abstract submission deadline: 31 January 2008

Commissioning Rehabilitation Services – Reporting from the Community Rehabilitation Team Network Conference

21st September, 2007; Sheffield, UK.

Opening the annual conference of the CRT Network was Pam Enderby, Professor of Community Rehabilitation, Sheffield University. She welcomed everyone to the Edge, Sheffield's newest conference venue and invited them to enjoy a series of talks addressing key areas and concerns around commissioning of rehabilitation services.

The New Commissioning Agenda

The ever increasing split between commissioning and service provision has yet to be significantly seen to work effectively in relation to the commissioning of rehabilitation services. These are the thoughts of Daniel Mason, Strategy Manager at Sheffield PCT, who spoke at the conference. He felt that commissioners are beginning to assess patient needs properly, write service specifications and are looking at ways to 'develop the market'. However, things remain in their infancy. During his presentation Daniel explored the 'commissioning cycle' and how unbundling the tariff has created opportunities for commissioning services away from acute care. His main message to delegates was that it is not just about providing a good service; providers need to learn how to market themselves.

Drivers of Reform in Health Systems: possible lessons for therapists

The current obsession with structural reform in health systems worldwide can be exciting, challenging and at times overwhelming from the perspective of the clinician and the manager. Malcolm Whitfield, Director of Health Policy & Management at the University of Sheffield, said that decision makers are constantly prioritising competing demands, endeavouring to make rational, informed decisions and ensuring that they meet the performance demands placed upon them by both the payer in the health system and the users of the services.

It is therefore going to be essential for allied healthcare professionals to be prepared to defend their position because questions such as, "Why would you want a physiotherapist rather than a doctor or a nurse?", are going to be increasingly asked. Therapists are going to increasingly need to consider the value they add e.g. will an investment in therapy services today reduce costs elsewhere tomorrow? As clinicians we are brought up to believe that improving the quality of patient care or meeting patients needs are sufficient justification for investment in healthcare. They are not, according to Malcolm. As demand for healthcare grows against a limited level of resource we have to ask ourselves; does what we do work? And is it worth it?

Workforce considerations in health service commissioning

The organisation of the workforce has important implications for the outcomes and costs of services. From a commissioning perspective, services need to ensure their workforce configuration will optimise service productivity and efficiency. Yet despite this, there are enormous variations in staffing and service organisation across the range of community rehabilitation and intermediate care services which purport to have similar goals. Susan Nancarrow, Senior Lecturer in the Centre for Health and Social Care Research, Sheffield, gave an excellent presentation that described an ongoing study that is exploring how variations in staffing and service organisation can impact on patient and service outcomes (costs, length of stay, patient function) with particular implications for service commissioning. Specifically, she examined the way that the workforce configuration can impact on the productivity and efficiency of services. For instance, how can teams be reconfigured to shorten the duration of patient care? She described several different approaches to enhance staff efficiency, and looked at the reporting requirements for demonstrating these outcomes to commissioners. According to Susan this study is unusual in that it explores interdisciplinary workforce relationships, whereas most existing research examines unidisciplinary models of workforce change.

Her presentation also drew on research funded by the Service Delivery and Organisation (SDO) programme of the Department of Health, which explored the impact of workforce configuration on the costs and outcomes of older peoples' services.

Redesigning and Developing the Workforce

There is a major shift away from traditional workforce planning, which collects numbers of each professional group, to a skills-based approach. Fiona Shields, Development Specialist for the West Midlands Workforce Deanery, described how models are evolving that build on the methodology of population or patient-centred planning, which has been fundamental to community rehabilitation teams for many years. Tools have been developed by organisations such as National Workforce Projects and Skills for Health to facilitate these new approaches as well as Agenda for Change and the Knowledge and Skills Framework, which were always intended as enablers of workforce change and redesign. The levels of skills, i.e. the 'supply' need to match the needs of service users, the 'demand', so it is essential to understand what these needs are and what levels of skills and competencies are required to safely and effectively deliver services. The future

workforce, to be fit for purpose, requires accessible and appropriate education and training, with a move toward more multi-professional programmes that encourage better team working and more flexibility

Developing Innovative Service Solutions - Thinking Differently

Helen Baxter, on secondment to the NHS Institute for Improvement and Innovation ended an enjoyable day by explaining how the NHS traditional approaches are being changed by re-modelling existing practice. She presented an approach to service design which is innovative and challenges much of the current thinking in the NHS. The delegates went away with new ideas of tools and techniques to support improved outcomes for service transformation projects, which meant they could:

- recognise and understand the key components of Innovative Healthcare Service Design.
- understand the tools and techniques available for service design, (e.g. mindshift materials, observation and prototyping).
- understand and explore a range of approaches to develop a climate which supports creativity and innovation for patients and staff in your own organisation.

Helen described the innovation service design process which is a combination of processes, tools, experience and expertise that are used with a local project team's own experience and expertise to deliver radical and transformational solutions to the biggest challenges faced by local health communities. The process involves stretching and changing current mindsets about transforming care and then ensuring the best possible solutions are developed in the shortest possible timescales.

She felt it is paramount not to jump to solutions at the start of the programme and that ideas and potential solutions are developed and tested in a systematic way so that by the time of implementation, the solution is as good as it could be.

As a result of the significant interested stimulated from this meeting, follow up workshops to focus on key aspects of commissioning are planned for the early part of 2008. To find out more about this and other initiatives from the Community Rehabilitation Network, please go to www.rehabteams.org or email info@innervate.co.uk

Neil Bindemann - Secretariat Director.

For more information visit our newly relaunched website:
www.communitytherapy.org.uk

IANCON 2007

(XVth Annual Conference of the Indian Academy of Neurology in association with the Association of British Neurology)

4-7 October, 2007; Mumbai, India.

This joint venture between the Indian and British neurological associations was a great success, both as a learning experience and socially. The meeting tackled topics ranging from molecular biology to the problems of recognising and preventing arsenic toxicity in Bengal. The organisers managed a good balance between presentations from both associations.

There were a number of superb platform presentations, including overviews of dystonia by Kailash Bhatia and hereditary motor neuropathies by Mary Reilly which provided really useful practice points for general neurologists.

All breakfast sessions were packed, with a scramble for coffee and curry before well chosen topics, including stroke and rapidly progressive dementia.

RS Wadia, President of the Indian Association of Neurology, drew on his vast clinical experience to tell us of some of the many facets of his clinical research, while exhorting Indian neurologists to establish and run large-scale randomised controlled trials.

The scale of India, with more than one billion people and one neurologist per million people, is hard to comprehend. The contrasts between Mumbai, financial and Bollywood capital of India, and the immense treatment gap is huge.

We were given examples. 30-75% of people with epilepsy don't receive treatment. Folate deficiency, and associated neural tube defects, remains



common, with up to 60% of pregnant women in some regions of northern India being folate deficient. We also heard of triumphs, such as the reduction of cretinism by the simple but crucial iodination of salt.

The meeting was well organised, and speakers ran to time, particularly as their slides were on countdown, turning off when their time was up!

As a reward, all speakers received a gift presentation at the end of their lecture. Socially, there was a lot of interaction, especially at the Gala Night, when British

and Indians danced enthusiastically to the music of Bollywood superstar, Sonu Nigam. At the opening ceremony, there was a traditional dance presentation by the Indian Society for the Rehabilitation of the Handicapped.

I carry images of the Mumbai conference in my head, the lush shimmer of silk scarves at the markets, pigeons swarming before the Gateway of India, the enthusiasm and warmth of our hosts, people packed onto commuter trains in the burning heat, the heady smell of incense at a Jain temple, swarming traffic and the constant tooting of friendly horns, insights from many superb lectures and posters. Above all, I carry the image of enormous vitality and energy, reflected in the presentations and organisation of this large meeting in an exciting, complex and vast city.

*Heather Angus-Leppan,
Royal Free and Barnet Hospitals, UK.*

