Clinical features

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The clinical presentation depends on the pattern of disease. Occasionally , CD presents acutely with ileal inflammation and symptoms and signs resembling those of acute appendicitis or, much less commonly , free perforation of the small intestine resulting in a local or di ff use peritonitis. CD may present with acute severe colitis but this is considerably less common than in UC. Small bowel CD often presents with bouts of abdominal pain and mild diarrhoea. A tender mass may be palpable in the right iliac fossa. Intermittent fever, anaemia and weight loss are common. After months of repea ted attacks characterised by acute inflammation, the a ff ected area of intestine steno ses with fibrosis, causing chronic obstructive symptoms. Chil dren developing the illness before puberty may have retarded growth and sexual development. As CD progresses, transmural fissuring, intra-abdominal abscesses and fistulae may develop. Fistulation ma y occur into adjacent loops of bowel (entero - enteric or interloop fistulae). Occasionally , a mobile loop of sigmoid loop may become adherent to the a ff ected terminal ileum, resulting in ileosigmoid fistulation (Figure 75.11). The fistula tracks in such cases are usually small and the profuse diarrhoea that results from ileosigmoid fistulation is due vergrowth (attributable to colonisation primarily to bacterial o of the small bowel with colonic flora) rather than passage of small bowel content into the colon. Fistulation may also occur into the bladder (enterovesical), the female genital tract or, less commonly , the duodenum. Fistulation to the abdominal wall (enterocutaneous fistula) may also develop spontaneously or following appendicectomy in unrecognised CD, but more commonly presents as a complication of abdominal surgery .

Figure 75.11 Resected specimen of terminal ileum and sigmoid colon illustrating Crohn’s disease of the terminal ileum with multiple enterocolic /f_i stulae.

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