Endoscopy

Endoscopy

Colonoscopic examination may be normal or show patchy eal inflammation. Characteristically , there are areas of normal mucosa in between areas of inflammation that are irregular and ulcerated, with a mucopurulent exudate. The earliest findings are often aphthous ulcers surrounded by a rim of erythematous mucosa. These become larger and deeper with increasing severity of disease. There may be stricturing, and it is important to exclude malignancy at these sites by multiple and often repeated mucosal biopsies. An irregular Crohn’s stricture with polypoid mucosa may be almost macroscopically indistinguishable from malignancy . The terminal ileum may be ulcerated and strictured. In patients who have had previous ileocaecal resection and anastomosis, recurrent disease usually presents first with aphthous ulceration just proximal to the anastomosis. Interval colonoscopy is therefore important in the follow-up after surgery for CD. Upper gastrointestinal symptoms may require upper gas - trointestinal endoscopy , which may reveal deep longitudinal ulcers and cobblestoning of the mucosa in the duodenum, stomach or, rar ely , in the oesophagus or mouth. Enteroscopy may reveal jejunal ulceration and stricturing. Capsule endos - copy , which allows visualisation of the entire small intestinal mucosa by telemetry , has a useful role in those patients with - evidence of chronic gastrointestinal symptoms or blood loss and where no evidence of ulcera tion can be found with more conventional endoscopic assessment. Investigation of the small intestine by capsule endoscopy should not be undertaken when there is a suspicion of stricture because of the possibility of the capsule becoming impacted in the narrow segment. A biode gradable test capsule can be used if this is a source of concern. Imaging High-resolution ultrasound in expert hands can demonstrate inflamed and thickened bowel loops as well as fluid collections and abscesses – the string sign of Kantor (Figure 75.13 CT scans with oral contrast are widely used in the investi gation of abdominal symptoms and can demonstrate fistulae, intra-abdominal abscesses and bowel thickening or dilatation. Magnetic resonance imaging (MRI) is useful in assessing com plex perianal disease and has been shown to be an excellent method for in vestigating the small bowel. Magnetic resonance enterograph y (oral contrast) or enteroclysis (contrast adminis tered via nasoduodenal tube) is particularly e ff ective at demon strating small bowel stricturing, including the string sign of Kantor, and avoids the need for repeated exposure to large doses of ionising radiation in young patients (Figure 75.14 labelled white cell scan is occasionally of value to determine whether or not a segment of bowel is actively inflamed and to guide decisions on medical treatment. In patients with an enterocutaneous fistula, fistulography may help to demonstrate the anatomy and complexity of the fistula and allow adequate planning for future surgery .

Figure 75.13 Radiograph showing a small bowel enema illustrating a long, strictured segment of terminal ileum due to Crohn’s disease (string sign of Kantor).

Revision #1
Created 2025-12-31 15:27:35 UTC by Omar Ayman
Updated 2025-12-31 15:27:35 UTC by Omar Ayman