



FIGURE 37-5 Endoscopic image of Crohn's disease demonstrates linear ulcers in areas of otherwise normal mucosa.



FIGURE 37-6 Video capsule endoscopic image shows ulcerated stenosis in a patient with Crohn's disease (arrows).

repeated examination is necessary, or complications may develop that help identify the disease form.

Several types of radiologic studies can be used to diagnose IBD. In Crohn's disease, the most sensitive test to diagnose small bowel disease is video capsule endoscopy. Small erosions and ulcerations on the mucosa, as well as strictures, can be visualized best on video capsule endoscopy (Fig. 37-6). Patients with known or suspected strictures should be evaluated for risk of capsule retention before undergoing capsule endoscopy. On traditional small bowel radiography, segments of edematous bowel appear thickened next to uninvolved mucosa, a characteristic pattern referred to as *cobblestoning*. Tight, long strictures in the small bowel can be identified and are called a *string sign*. Cross-sectional imaging with computed tomographic (CT) enterography and magnetic resonance enterography has replaced traditional small bowel radiography. Cross-sectional imaging can identify bowel wall thickening with surrounding inflammation, as well as intra-abdominal abscesses and fistulas (Figs. 37-7 and 37-8). A characteristic finding on cross-sectional imaging in Crohn's disease is infiltration of the mesentery with fat, commonly known as *creeping fat*.

The differential diagnosis of IBD includes infectious colitis, ischemic colitis, radiation enteritis, enterocolitis induced by non-steroidal anti-inflammatory drugs, diverticulitis, appendicitis, gastrointestinal malignancies, and irritable bowel syndrome. In patients with acute onset of bloody diarrhea, infectious causes that must be excluded with stool testing include *Salmonella enteritidis*, *Shigella* species, *Campylobacter jejuni*, *Escherichia coli* O157, and *Clostridium difficile*. Among the infectious causes, *Yersinia enterocolitica* can mimic Crohn's disease because the pathogen causes ileitis, mesenteric adenitis, fever, diarrhea, and right lower quadrant abdominal pain. *Mycobacterium tuberculosis* infection, strongyloidiasis, and amebiasis must be excluded in high-risk populations, because these infections can mimic IBD, and



FIGURE 37-7 Computed tomographic enterography shows inflammatory stricture (arrow) and small bowel wall thickening in a patient with Crohn's disease.

treatment with corticosteroids can lead to disseminated infection and death.

TREATMENT

The goal of treatment is induction and maintenance of remission. As part of the initial management of IBD, the clinician must