



FIGURE 345-41 Eosinophilic esophagitis with multiple circular rings of the esophagus creating a corrugated appearance, and an impacted grape at the narrowed esophagogastric junction. The diagnosis requires biopsy with histologic finding of > 15–20 eosinophils per high-power field.

of small-bowel radiography, positive findings on capsule endoscopy are seen in 50–70% of patients with suspected small intestinal bleeding. The most common finding is mucosal vascular ectasias. CT or MR enterography accurately detects small-bowel masses and inflammation and is also useful for initial small-bowel evaluation. Deep enteroscopy may follow capsule endoscopy for biopsy of lesions or to provide specific therapy, such as argon plasma coagulation of vascular ectasias (Fig. 345-44).

COLORECTAL CANCER SCREENING

The majority of colon cancers develop from preexisting colonic adenomas, and colorectal cancer can be largely prevented by the detection and removal of adenomatous polyps (see Video 346e-17). The choice of screening strategy for an asymptomatic person depends on personal and family history. Individuals with inflammatory bowel disease, a history of colorectal polyps or cancer, family members with adenomatous polyps or cancer, or certain familial cancer syndromes (Fig. 345-45)

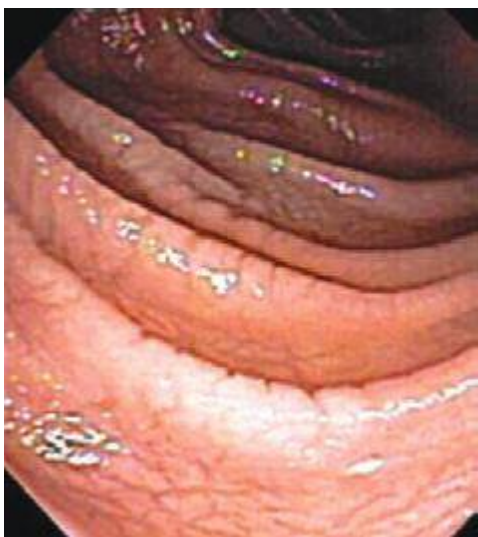


FIGURE 345-42 Scalloped duodenal folds in a patient with celiac sprue.

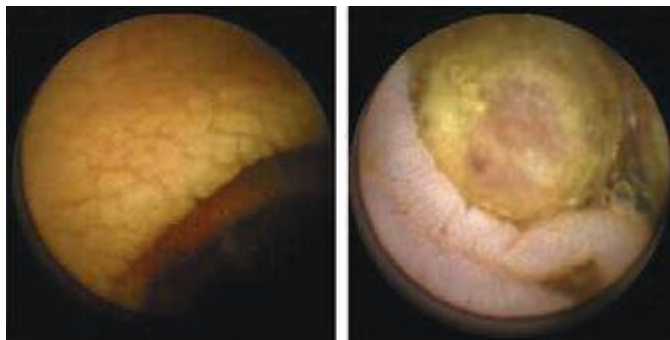


FIGURE 345-43 Capsule endoscopy images of a mildly scalloped jejunal fold (left) and an ileal tumor (right) in a patient with celiac sprue. (Images courtesy of Dr. Elizabeth Rajan; with permission.)



A



B

FIGURE 345-44 A. Mid-jejunal vascular ectasia identified by double-balloon endoscopy. B. Ablation of vascular ectasia with argon plasma coagulation.

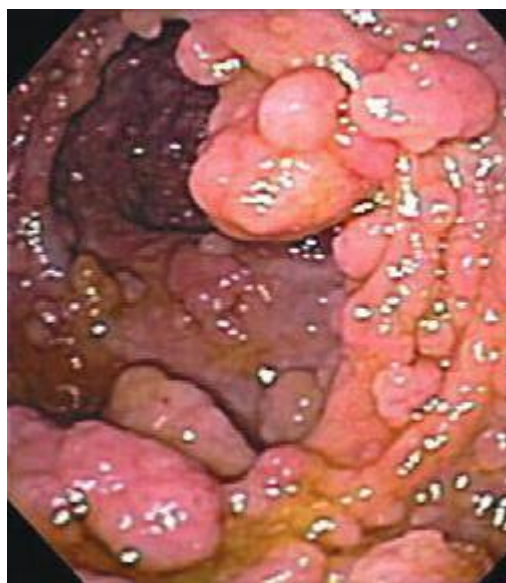


FIGURE 345-45 Innumerable colon polyps of various sizes in a patient with familial adenomatous polyposis syndrome.