Crohn’s disease and ulcerative colitis are lifelong diseases observed predominantly in the developed countries of the world. Both diseases are marked by frequent relapses and patients often undergo repeated investigations.

The advent of capsule and both single- and double-balloon-assisted enteroscopy is revolutionizing small-bowel imaging and has major implications for diagnosis, classification, therapeutic decision making, and outcomes in the management of IBD. Until a decade ago, mucosal visualization of the small bowel was limited to the reach of the push enteroscope (excluding invasive and expensive intraoperative enteroscopy). The advent of small-bowel capsule endoscopy (SBCE) allowed for the first time direct visualisation of the entire small bowel.

This Consensus aims to provide a worldwide perspective on the use of small-bowel endoscopy in the management of IBD. (Boureille A, …, Van Gossum A, Endoscopy, 2009, 4, 618-637)

**Suspected Crohn’s disease**

Ileocolonoscopy must be performed prior to SBCE for the diagnosis of Crohn’s disease.

Small-bowel cross-sectional imaging should generally precede SBCE. The choice of radiographic imaging depends on local availability and expertise.

SBCE is able to identify mucosal lesions compatible with Crohn’s disease in some patients in whom conventional endoscopic and small-bowel radiographic imaging modalities have been nondiagnostic.

As with other imaging modalities, a diagnosis of Crohn’s disease should not be based on the appearances at capsule endoscopy alone.

A normal capsule endoscopy has a high negative predictive value for active small-bowel Crohn’s disease.

SBCE may be better than small-bowel follow-through or enteroclysis at identifying small-gowel mucosal lesions consistent with Crohn’s disease.

SBCE may be superior to MR enterography for detection of mucosal lesions consistent with Crohn’s disease.

DAE (Device-assisted Enteroscopy) can be used to diagnose Crohn’s disease, because histological corroboration is available.

There are not enough data to recommend DAE, unless conventional studies including ileocolonoscopy and radiographic imaging have been inconclusive and histological diagnosis would alter disease management.
Established Crohn’s disease

The role of SBCE in patients with established Crohn’s disease should focus on patients with unexplained symptoms when other investigations are inconclusive, if this will alter management.

Radiographic imaging takes precedence over SBCE because it can potentially identify obstructive strictures, extraluminal disease, the transmural nature, or anatomical distribution of disease.

For patients with established Crohn’s disease, SBCE is better at identifying small-bowel mucosal lesions than barium and may be better than CT or MR enterography or enteroclysis, but the clinical significance of this potential difference remains to be defined.

For assessment of postoperative recurrence of Crohn’s disease, SBCE should only be considered if ileocolonoscopy is contraindicated or unsuccessful.

DAE is indicated when endoscopic visualization and biopsies are necessary from areas of the small bowel inaccessible to conventional endoscopy.

Ulcerative colitis (including ileal pouch-anal anastomosis (IPAA))

SBCE or DAE in a patient with a diagnosis of ulcerative colitis may be indicated if anaemia or abdominal symptoms are unexplained despite conventional imaging.

SBCE can detect mucosal lesions in ulcerative colitis patients with atypical or refractory symptoms, especially after IPAA, but the clinical significance is unclear. The presence of such lesions does not predict the outcome after IPAA for ulcerative colitis.

Paediatric practice

Gastroduodenoscopy with biopsies is necessary in all paediatric patients suspected of having IBD.

SBCE can be helpful in identifying mucosal lesions compatible with Crohn’s disease in paediatric patients.

SBCE should be performed in children or adolescents with a high suspicion of Crohn’s disease, when conventional endoscopy and small-bowel imaging are normal.

Although extensive data about the safety of SBCE in paediatric patients are lacking, it seems to be a safe procedure.

Complications and unresolved questions

In patients with suspected Crohn’s disease, the risk of small-bowel capsule retention is low and comparable to that when the indication for SBCE is bleeding.

In patients with an established diagnosis of Crohn’s disease, the risk of small-bowel capsule retention is increased, particularly in those with known intestinal stenosis.

In patients with established Crohn’s disease of the small bowel, it is essential to attempt to exclude small-bowel strictures by a thorough clinical history and radiographic imaging before SBCE. However, normal radiographic studies cannot entirely exclude the potential for small-bowel capsule retention.
A patency (biodegradable, “dummy”) capsule to reduce the risk of retention should be considered, or DAE, if strictures are identified.

References


