

Inflammatory Bowel Disease IBD (EGD 1.19)

The diagnosis of IBD is based on a combination of clinical presentation (abdominal pain, diarrhea, weight loss, fatigue) and endoscopic, radiologic, histologic, and pathologic findings. The initial evaluation of suspected IBD includes a thorough laboratory workup to assess inflammation, anemia, and malnutrition. This evaluation is complemented by stool tests to rule out infections and to further evaluate inflammation. These non-invasive tests should be performed prior to proceeding with invasive diagnostic procedure, such as endoscopy, to confirm the diagnosis.

Upper GI tract involvement involving involve the esophagus, stomach and duodenum, occurs in up to 16% of patients with CD, irrespective of upper GI symptoms. Dysphagia, odynophagia, pyrosis, nausea, epigastric pain, dyspepsia, anorexia, weight loss and vomiting are the more frequently reported UGI symptoms in individuals with IBD. Upper endoscopy is a valuable diagnostic tool in the initial evaluation of IBD, particularly when there are indications of upper GI tract involvement or when differentiating between various GI conditions. Upper endoscopy with biopsies should be performed in individuals with CD, to evaluate disease activity and response to therapy. EGD is indicated for individuals with symptomatic Indeterminate Colitis.

In individuals with UC, an EGD is indicated if there are abnormal radiologic findings that raise concern for CD. Upper endoscopy is indicated in individuals with UC, if there is a suspicion of a change in diagnosis to CD. EGD can be approved in a subset of individuals with UC who have undergone total proctocolectomy with IPAA, and are now suspected of having CD of the pouch. This enables the evaluation of the upper GI tract for Crohn's involvement, which can impact management and therapeutic decisions.