**IW186629**

Clinical History :Known Crohn's disease, Severe Vomiting, raised WCC and creatinine, to rule out megacolon/obstruction .

CT Abdomen/Pelvis with Contrast :Comparison: CT dated April 2020

Findings:

Active Crohn's disease is seen.

Interval appendicectomy and since last CT scan dated 2020.

Surgical alteration in anatomy in RIF region.

From distal to proximal, the small bowel show following changes-:

1. Transmural and stratified mural enhancement of the ileocaecal junction and short segment of terminal ileum. Saccular prominence of prominance bowel. The involved segment is narrowed and associated with mesenteric congestion- Narrowing without stricture with active inflammation.

2. Further proximally following a skip segment, long segment luminal narrowing, wall thickening, stratified mural enhancement, submucosal fatty atrophy and marked mesenteric stranding with associated upstream dilatation (3.8 cm)- Stricture with obstruction and active inflammation.

3. A tract like fluid attenuation extension inferiorly from this involved segment merging with distal ileum - indicate enteroenteric fistula.

4. The proximal ilial loops are dilated measuring up to 3.8 cm.

5. Small bowel mesentry in right side of abdomen shows an area of non-specific inflammation (inflammatory collection) measuring approximately 1.8 x 1 cm, shows only mild peripheral enhancement - not frankly abscess but inflammatory collection. No amenable to percutaneous access.

6. Further skip segments with another area of active inflammation but no luminal narrowing.

7. A long segment of luminal narrowing with inflammation but no stricture or upstream dilatation seen further proximally (proximal ileum/ distal jejunum). Inflammation in surrounding fat planes.

8. A star shaped fluid collection in adjacent mesentery is noted (5 X7 mm) - has few tracts running from it- atleast one appear to be forming enteroenteric fistula.

9. Another small sinus tract is noted in the same area.

10. In the pelvis, a collection is noted measuring 5.8 x 3.4 cm. This collection shows a track like extension superiorly and anteriorly on the right side and appears to be communicating with dilated ilial loop raising possibility of another sinus tract. This collection will be difficult to access percutaneously because of its close proximity with large bowel. No rim enhancement at present or air fluid level.

11. Large bowel is largely collapsed. There is short segment of mural hyperenhancement and pericolic fat stranding involving sigmoid and probably portions of descending colon indicating active inflammation. No narrowing or stricture.

12. Further there is an ill-defined hypoattenuating area in segment 4A/B of liver, involving subcapsular region measuring 2.8 x 1.5 cm. This area is merging with periparotid fat plane and appears to be associated with perihepatic fat stranding raising possibility of a small evolving abscess with element of perihepatitis. It does not appear consistant with focal fatty infiltration. If liver functions test are deranged then I would consider Crohn's related noninfectious inflammation of liver.

13. Gallbladder distended and shows a small calculus. No pericholecystic fat stranding. Normal intrahepatic biliary radicles and CBD. Normal pancreas and pancreatic duct.

Bilateral gynaecomastia. Diffuse fatty infiltration of liver.

Normal adrenals and kidneys as well as normal appearance of spleen.

SI joint and femoral heads grossly normal. Grossly normal perianal fat planes.

Conclusion:

Active inflammatory small bowel Crohn disease with luminal narrowing and skip segments.

Distal ileal stricture with active inflammation resulting in upstream small bowel dilatation.

Penetrating Crohn's disease with sinus tracts, mesenteric inflammatory collections and enteroenteric fistula as detailed above.

A pelvic collection with probable sinus tract.

Focal subcapsular and perihepatic inflammation in liver.

Recommended surgical and Multidisciplinary team review.

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