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Summary

Assessment of endoscopic recurrence and its clinical importance

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Endoscopy | IBD | Primary Care | Surgery

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The speaker reviewed endoscopic assessment of postoperative Crohn's disease recurrence using the modified Rutgeerts score, highlighting current management algorithms, conflicting evidence on the i2a versus i2b distinction, and challenges posed by modern surgical techniques.

KEY POINTS

- The speaker stated that colonoscopy at six months is recommended as the gold standard for postoperative assessment, with management based on Rutgeerts score: watchful waiting with or without immunomodulation for i0-i1, treatment optimization for i3-i4, and individualized decisions for i2
- The speaker reported conflicting literature on i2a versus i2b prognostic differences, citing a meta-analysis of 400 patients showing no distinction and a Netherlands study of over 600 patients suggesting i2b predicts worse clinical recurrence
- Modern surgical techniques create new anatomical landmarks (ileal blind loop, ileal inlet, colonic blind loop) not addressed in the original scoring system, and the speaker noted an updated score is being studied for interobserver agreement and outcome prediction
- The speaker stated that intestinal ultrasound with wall thickness above 5.5 millimeters has 84 percent sensitivity and 98 percent specificity for i3-i4 scores and may reduce need for colonoscopy in some patients
- In discussion, the speaker expressed the view that artificial intelligence may address low interobserver agreement and that anastomotic ulcerations from stapled techniques should potentially be disregarded, as they may not reflect true disease recurrence

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