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Summary

Ischaemia: The endoscopist's and the surgeon's perspective

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Ischaemic colitis requires integrated endoscopic, CT, and surgical assessment, with right-sided disease representing a critical red flag associated with substantially higher surgery rates and mortality compared to left-sided involvement.

KEY POINTS

- The speaker stated that right-sided ischaemic colitis carries five times the likelihood of surgery compared to left-sided disease (44% versus 11%) and double the mortality rate (20% versus 9%) based on systematic review data.
- High-risk endoscopic features include extensive or circumferential ulceration, dusky black mucosa, and gangrenous appearance, which should trigger urgent multidisciplinary escalation when combined with clinical markers such as rising lactate, shock, or peritoneal signs.
- CT is the preferred initial imaging modality, and in nonfulminant cases early colonoscopy within 48 hours is recommended to establish mucosal diagnosis and extent.
- Colonoscopy technique should prioritize CO2 use, gentle insertion, minimal insufflation, and advancing only as far as needed to define proximal extent; colonoscopy is contraindicated when peritoneal signs or suspected perforation are present.
- The speaker stated that in a presented case of an 87-year-old woman with severe circumferential ulceration, ischaemic colitis mostly resolved three months later with antibiotics and antithrombotic drugs without surgical intervention.
- Distribution is both diagnostic and prognostic, with left-sided disease often having a favourable course when uncomplicated, while isolated right colonic ischaemia demands lower threshold for surgical review and close monitoring.

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