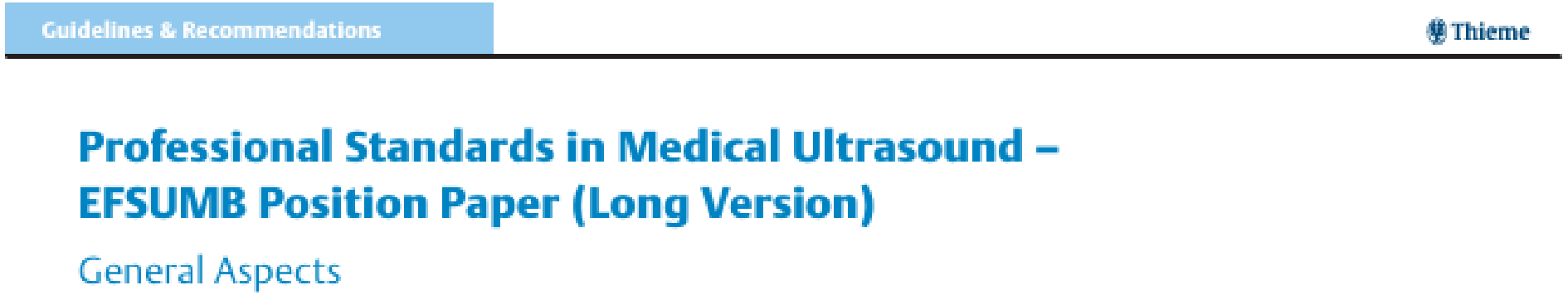
international bowel
ULTRASOUND GROUP

IBUS
HYBRID
module 1

7-8TH
NOVEMBER, 2025
MILAN, ITALY

How to document an IUS examination, IUS scoring

Dr. Frauke Petersen
Lüneburg, Germany



- Wüstner M et al. Professional Standards in… Ultraschall in Med 2022; 43: e36–e48 | © 2022

Journal of Crohn's and Colitis, 2022, 523–543
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ECCO Topical Review

ECCO Topical Review

ECCO-ESGAR Topical Review on Optimizing Reporting for Cross-Sectional Imaging in Inflammatory Bowel Disease

Torsten Kucharzik[a,*], Jeroen Tielbeek[b,*], Dan Carter[c], Stuart A. Taylor[d], Damian Tolan[e], Rune Wilkens[f], Robert V. Bryant[g], Christine Hoeffel[h], Isabelle De Kock[i], Christian Maaser[j], Giovanni Maconi[k], Kerri Novak[l], Søren R. Rafaelsen[m], Martina Scharitzer[n], Antonino Spinelli[o,†], Jordi Rimola[p,†]

Key Qualitiy Indicators for a good report

- **Pre-procedural and technical circumstances described**:
  - Indication, complaints
  - Medical history, former treatment
  - Known phenotype, missing segments due to surgery
  - (fasting period)
  - Known results of former imaging

  - Machine system and transducers used for the exam
  - Modalities and special techniques in use
  - (MI, TI and presets): are usually documented on the image as well
  - If neccessary: contrast , oral or iv

Key indicators for a good report

- Name of the examiner
- Precise time of the examination
- Which organs had been scanned
- General remarks about the conditions and limitations

  Limitations of the examination quality and confidence level should be indicated

- 3 Parts of the report:
  - Precise description (without judgement!)
  - Conclusion, summary (with activity score, signs of complication?)
  - Advice for the next step
- Storage, ways to retrieve the images

The exam

- US examinations should follow a predefined standardized scheme ,standard algorithm
- Every bowel segment should be depicted, documented at least in still images,
- Both long and cross-sectional aspects
- video loops preferred with all pathology
- Consider panoramic-view, if difficult to retrieve, or surgery planning
- Colour-doppler evaluation for activity
- Landmarks, body marker or text marking each segment

"Topographic pictograms are better and more rapidly understood than written transducer position labels, with the advantage of being independent of any language differences, mis-labelling avoided"

IUS: Assessment and reporting of inflammation

Current practice position 3

The number and anatomical location of intestinal segments with imaging findings of mural inflammation should be reported, including skip lesions. An estimate of the total affected length and length of all individual pathological areas of the small bowel is preferred. Segment(s) exhibiting the most severe mural inflammation should be reported in detail to guide therapeutic decision making

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Relevant findings for inflammation/complications that should be described

Table 2. Relevant findings for assessing inflammation and complications

Findings to be assessed on a segment basis	Extension/ localization of the disease	Overall interpretation
Abnormal bowel: - Thickness* - Ulceration(s) - Oedema† - Vascularization - Perienteric inflammatory changes Adjunctive techniques: - Motility ~~- Restricted diffusion~~ **Complications** - Stricture§ - Fistula and/or sinus¶ - Mesenteric mass/abscess** - Vascular complications†∞††	Terminal or neo-terminal ileum‡ Distal ileum‡ Proximal small bowel‡ Individual colonic segments	**Initial diagnosis** - No evidence of active disease - Evidence of active disease ± complications **Follow-up examination** Treatment response - Transmural remission - Significant transmural response - Stable disease - Progression of disease Status of complications

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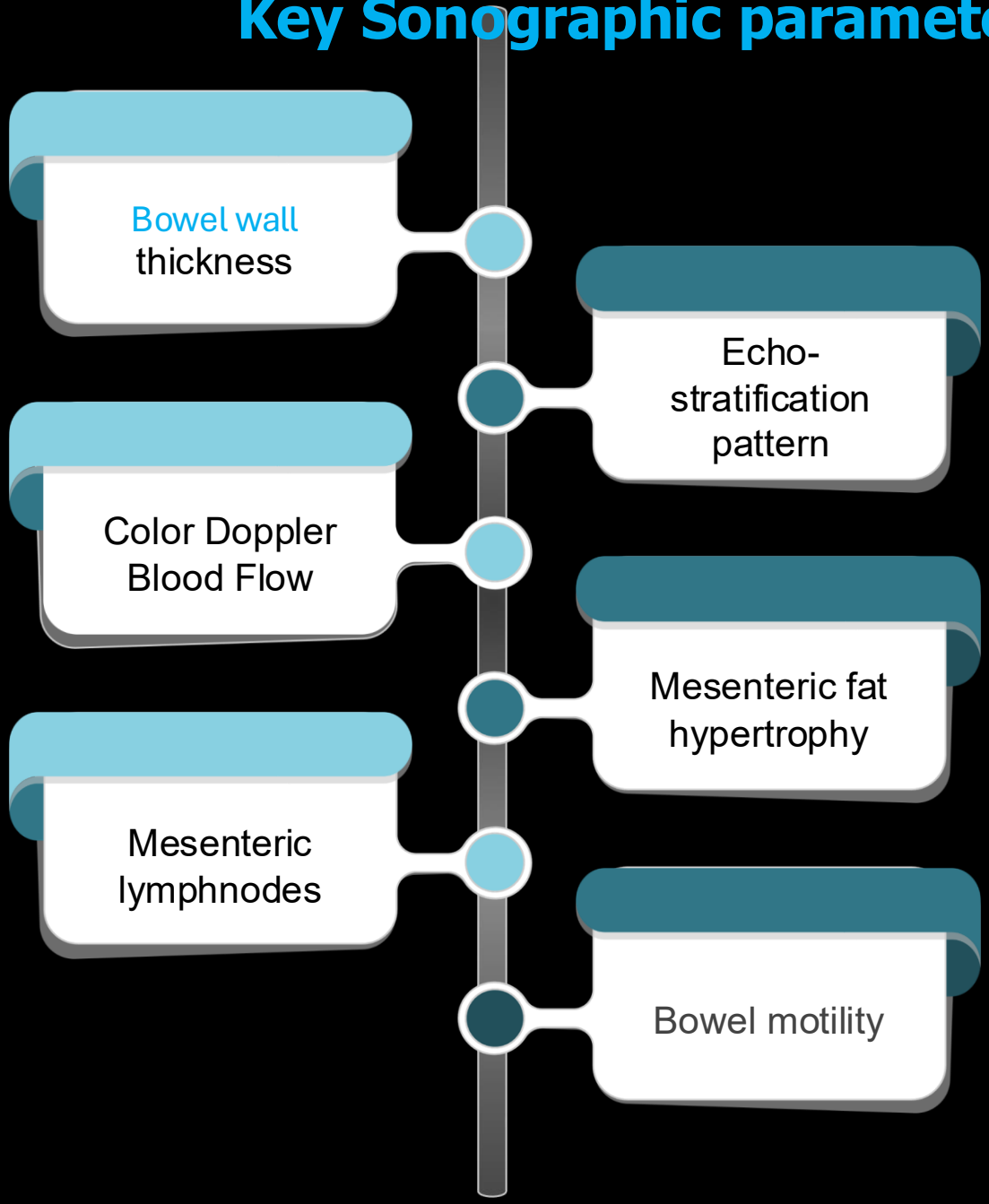
Key Sonographic parameters of active IBD



Key parameter in bowel pathology

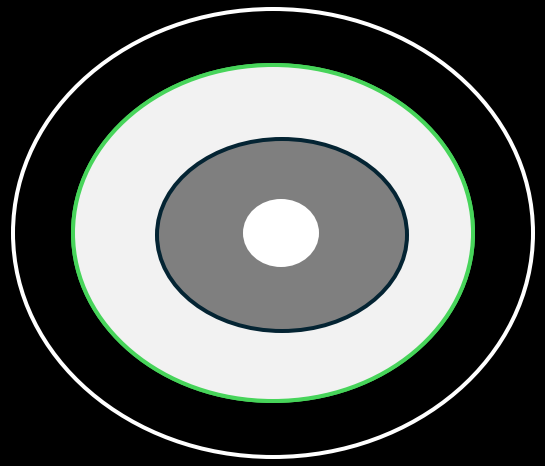
Bowel Wall Thickness

Serosal echo

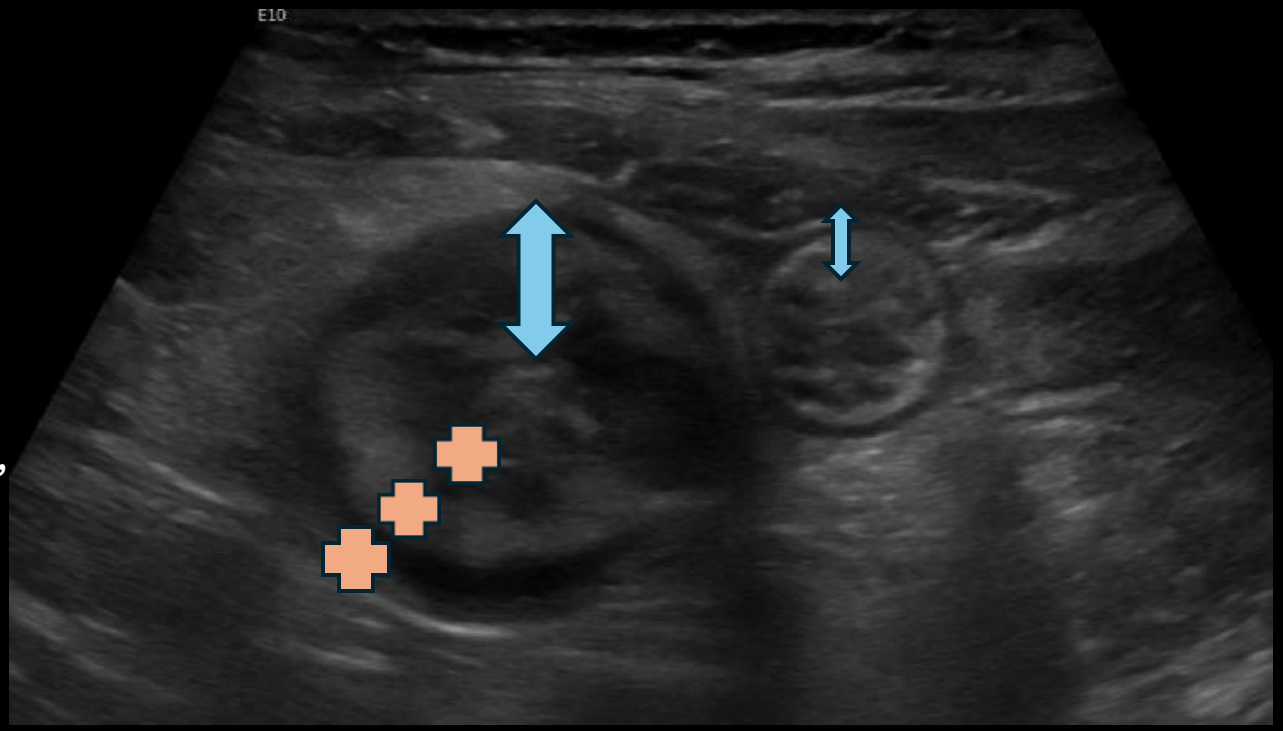
Muscularis propria

Submucosa

Mucosa



Luminal interface, gas reflexes



Bowel wall thickness

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WORKSHOP
7-8TH NOVEMBER, 2025
MILAN, ITALY

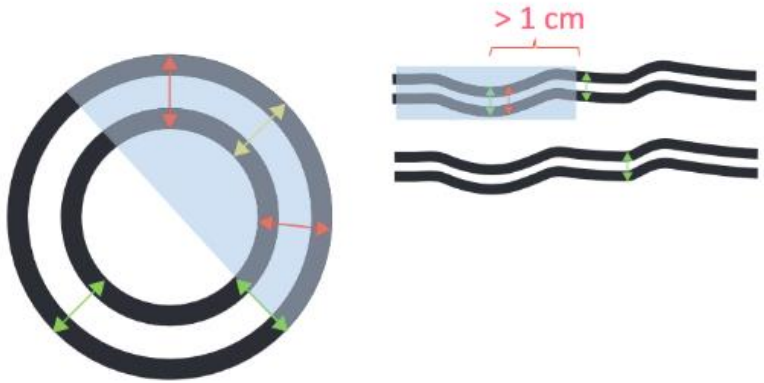
Current practice position 4

Thickness of the most involved small bowel and/or colonic segment, defined as bowel wall thickness (BWT), should be measured and reported. A threshold of 3 mm is the recommended cut-off for presence of mural inflammation for both small and large bowel

Measuring in theory

Expert Consensus on Optimal Acquisition and Development of the International Bowel Ultrasound Segmental Activity Score [IBUS-SAS]: A Reliability and Inter-rater Variability Study on Intestinal Ultrasonography in Crohn's Disease

Kerri L Novak,[a] Kim Nylund,[b,c] Christian Maaser,[d] Frauke Petersen,[e] Torsten Kucharzik,[e] Cathy Lu,[a] Mariangela Allocca,[f,g] Giovanni Maconi,[h] Floris de Voogd,[i,o] Britt Christensen,[j,o] Rose Vaughan,[j] Carolina Palmela,[k] Dan Carter,[l] Rune Wilkens[m,n,o], IBUS Group



Yellow arrow represents first measurement. Green arrows are allowed second measurement, red arrows are false second measurements

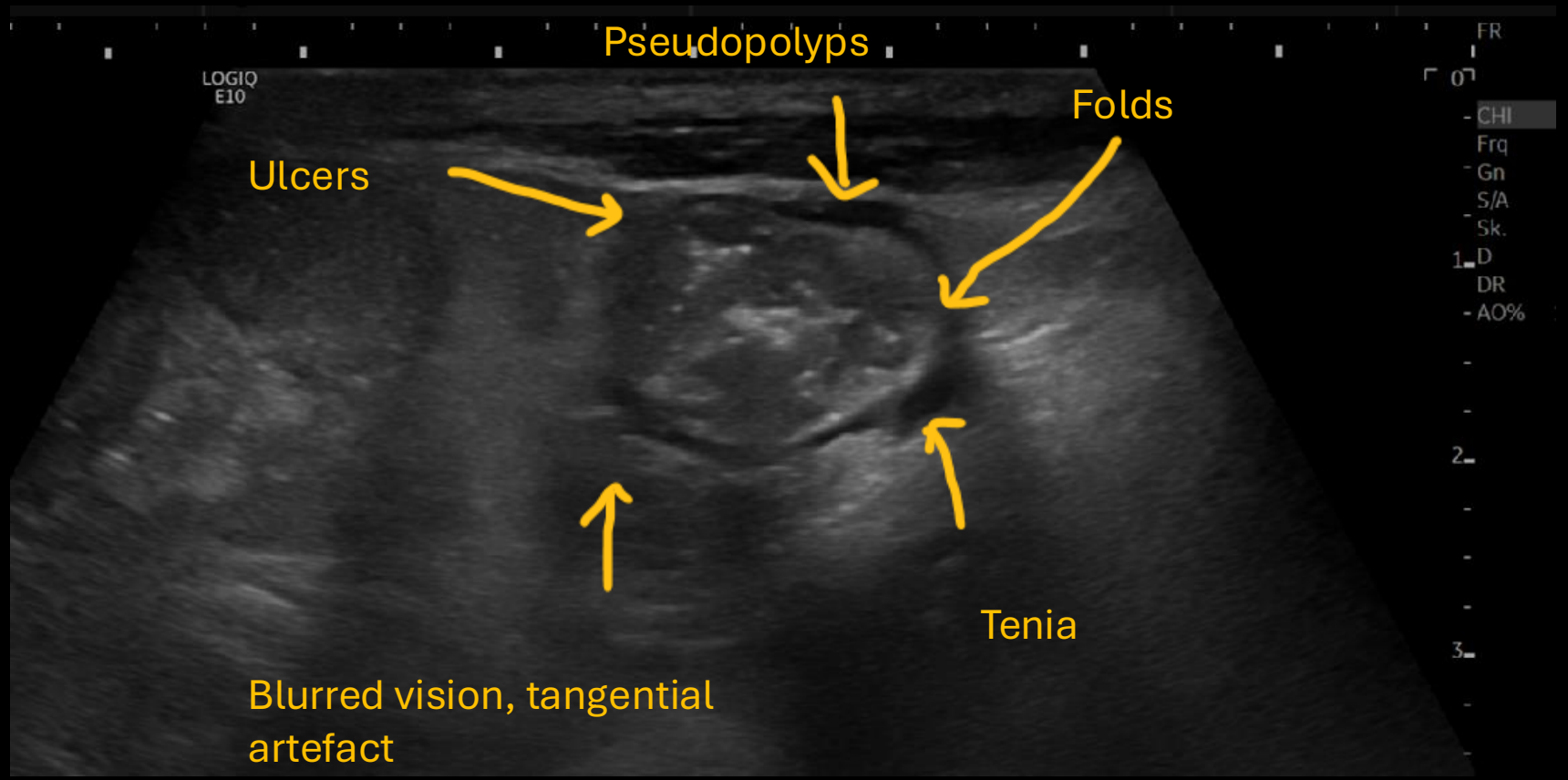
Interobserver variablity
k = 0.72-1

Fraquelli M et al. Dig Liver Dis 2008

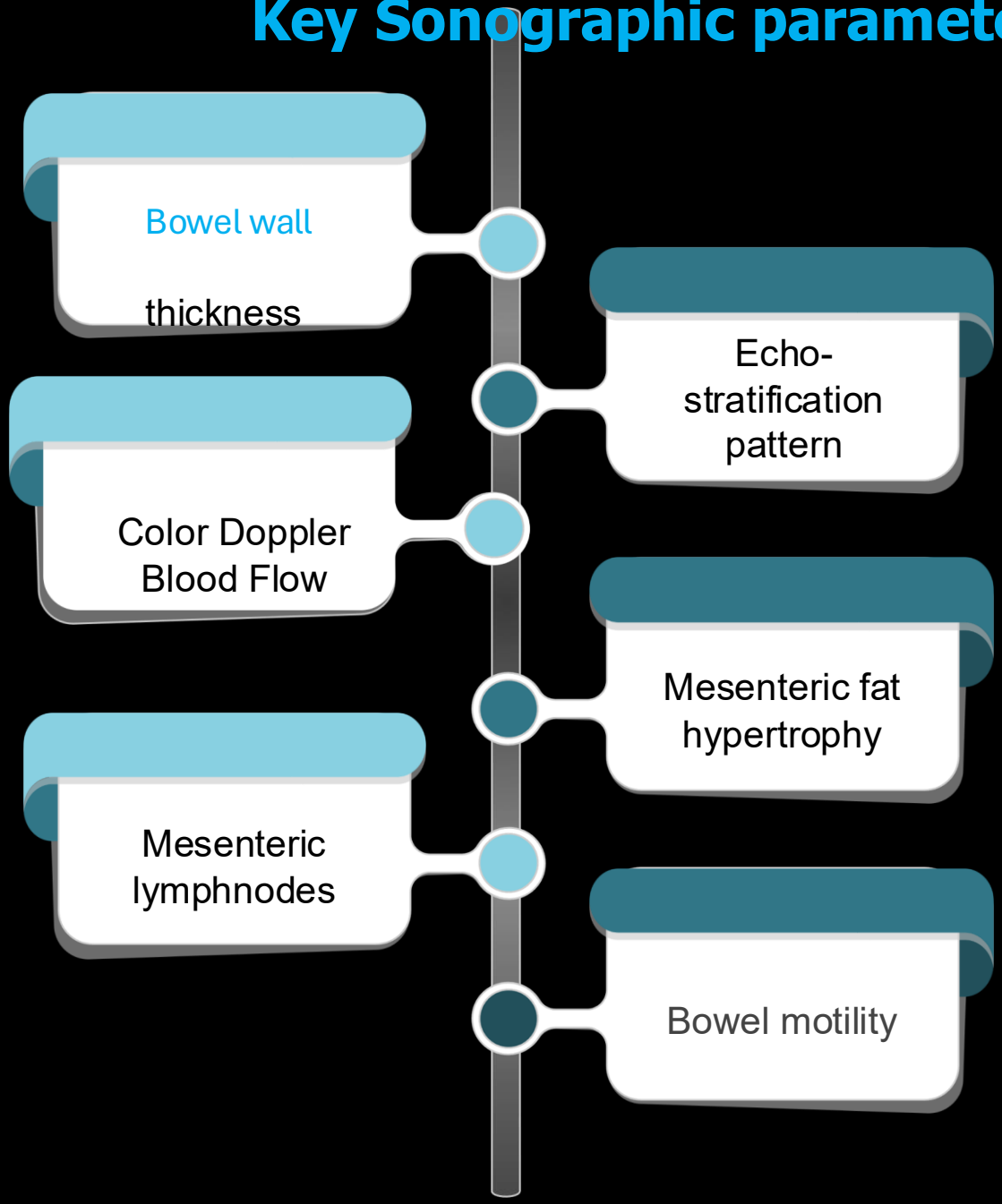
k = 0.96

Novak K et al. JCC 2021

Measuring problems



Key Sonographic parameters of active IBD



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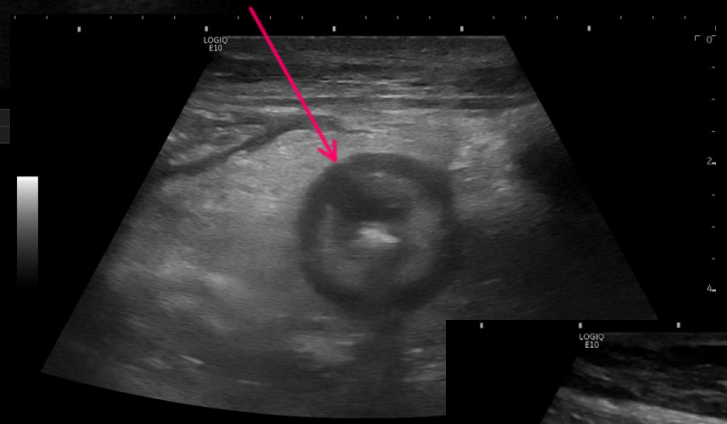
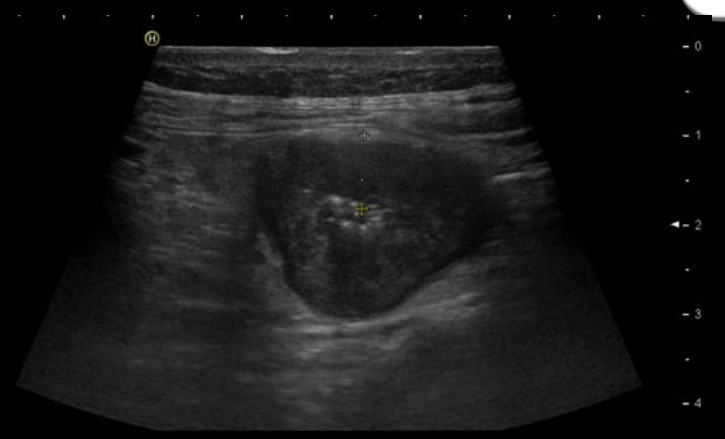
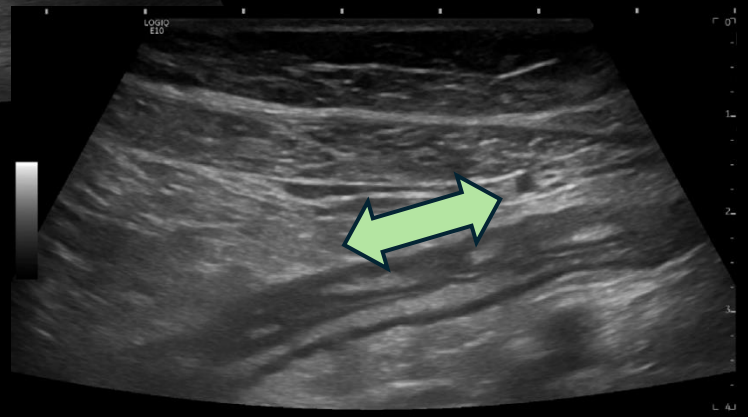
module 1

ECHOSTRATIFIC PATTERN



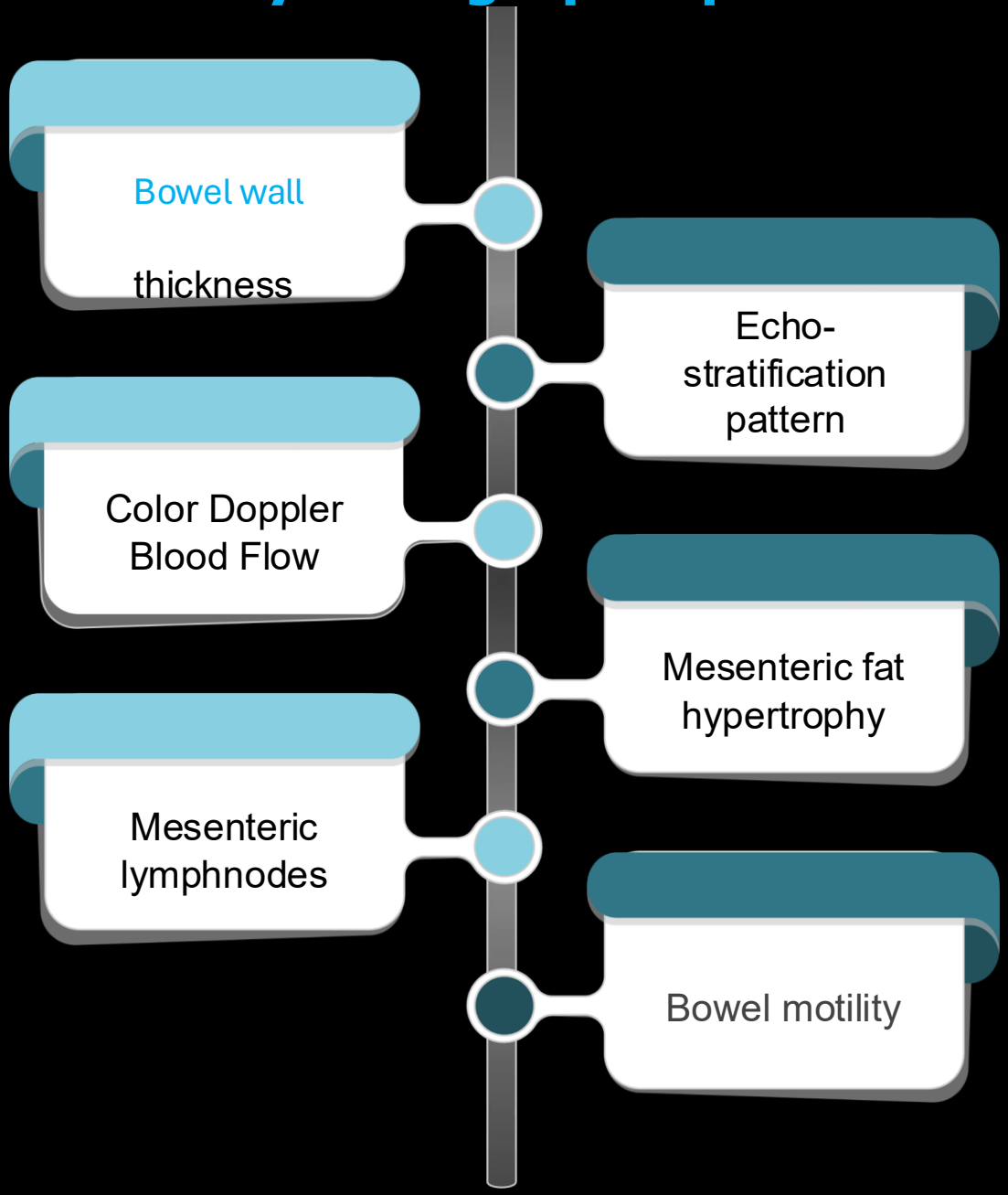




Categories

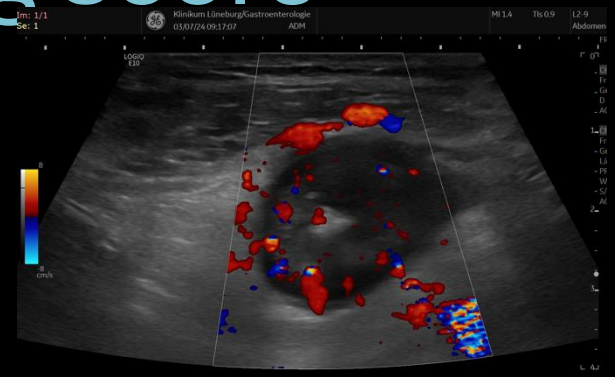
0: Normal/preserved echostratification
1: Uncertain
2: Focal discruption (< 3 cm)
3: Extensive disruption (> 3 cm)

Key Sonographic parameters of active IBD



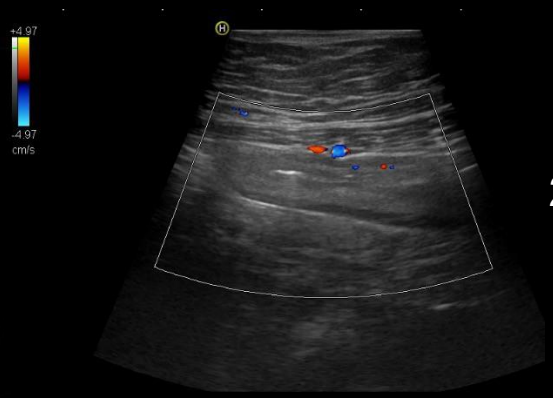
Vascularisation:
colour duplex

Modified Limberg score

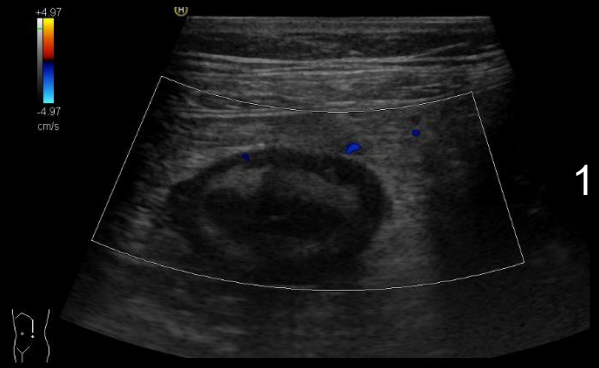


3 – signal is significant in the wall as well as the mesentery

2 – increased colour signal limited to the wall



1 – minimal pixels, scant



0 – No signal

set velocity range: 5-7 cm/s

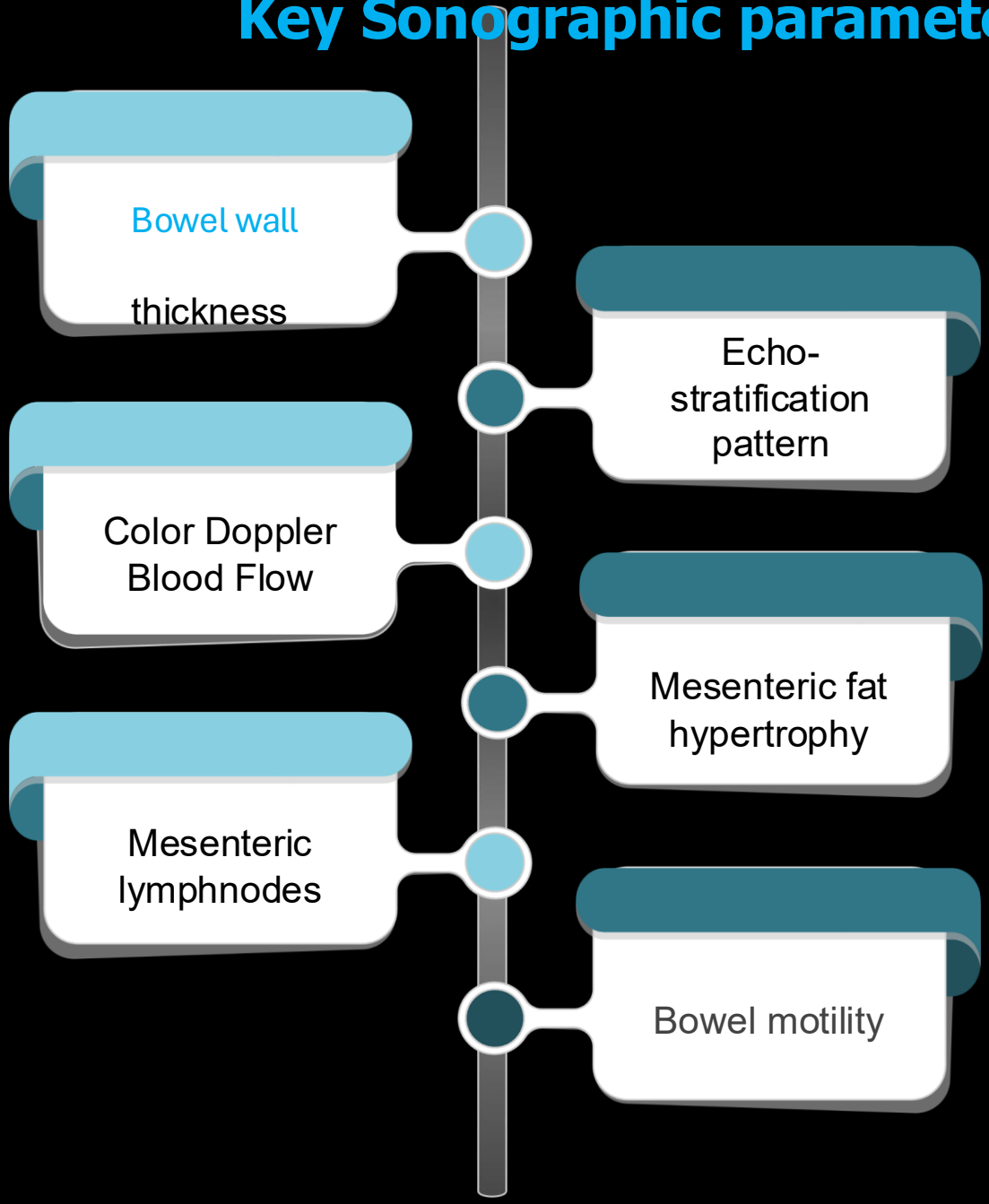
Vascularization - Doppler signal

Current practice position 6

Intestinal vascularization should be assessed by a semi-quantitative grading of intra- and extramural blood flow in abnormal bowel segments (colour Doppler on IUS). For MRE/CT, a qualitative impression of increased contrast hyperenhancement should be reported

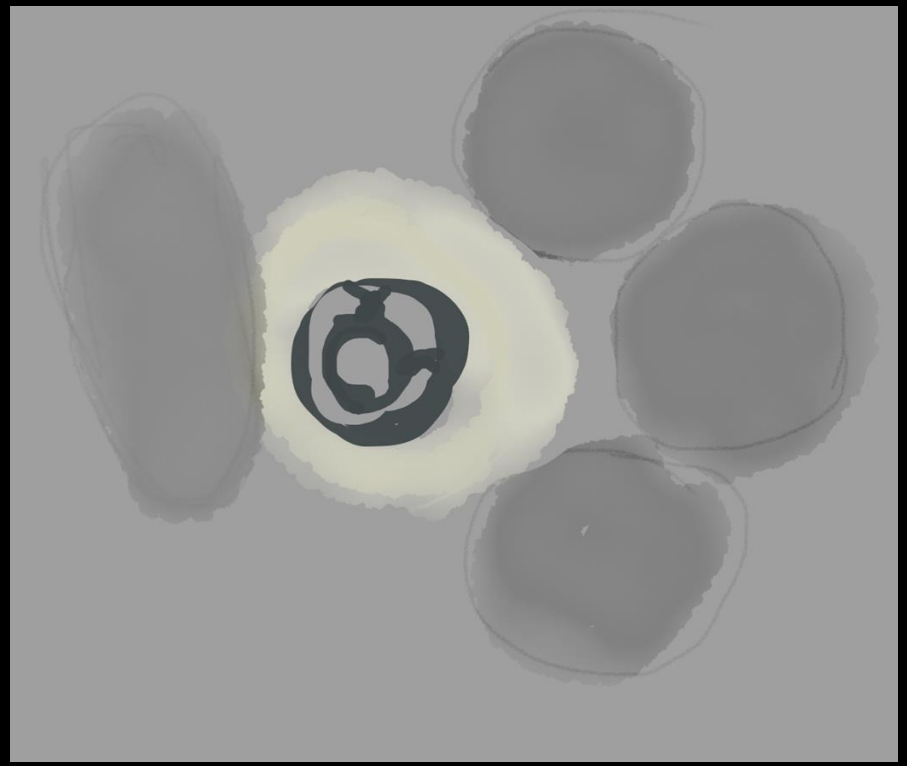
Kucharzik T et al JCC 2021

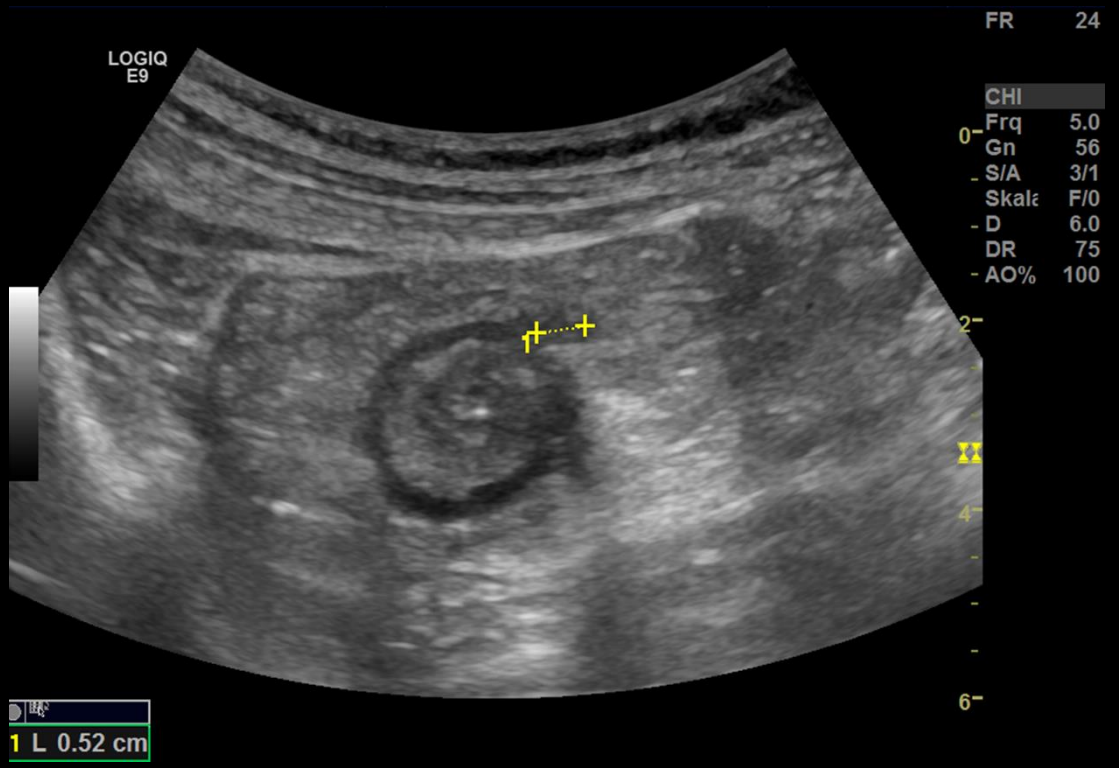
Key Sonographic parameters of active IBD



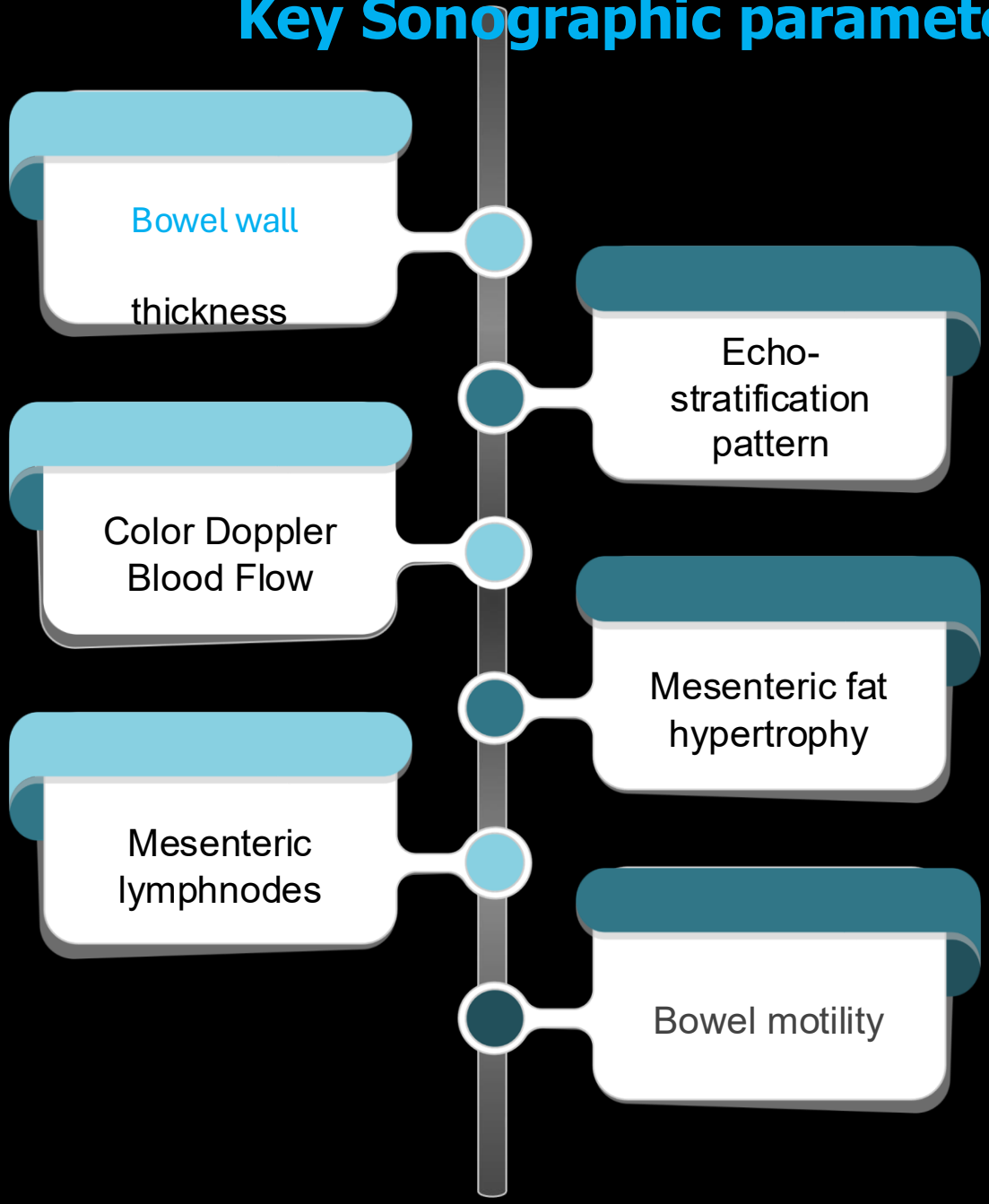
IBUS HYBRID

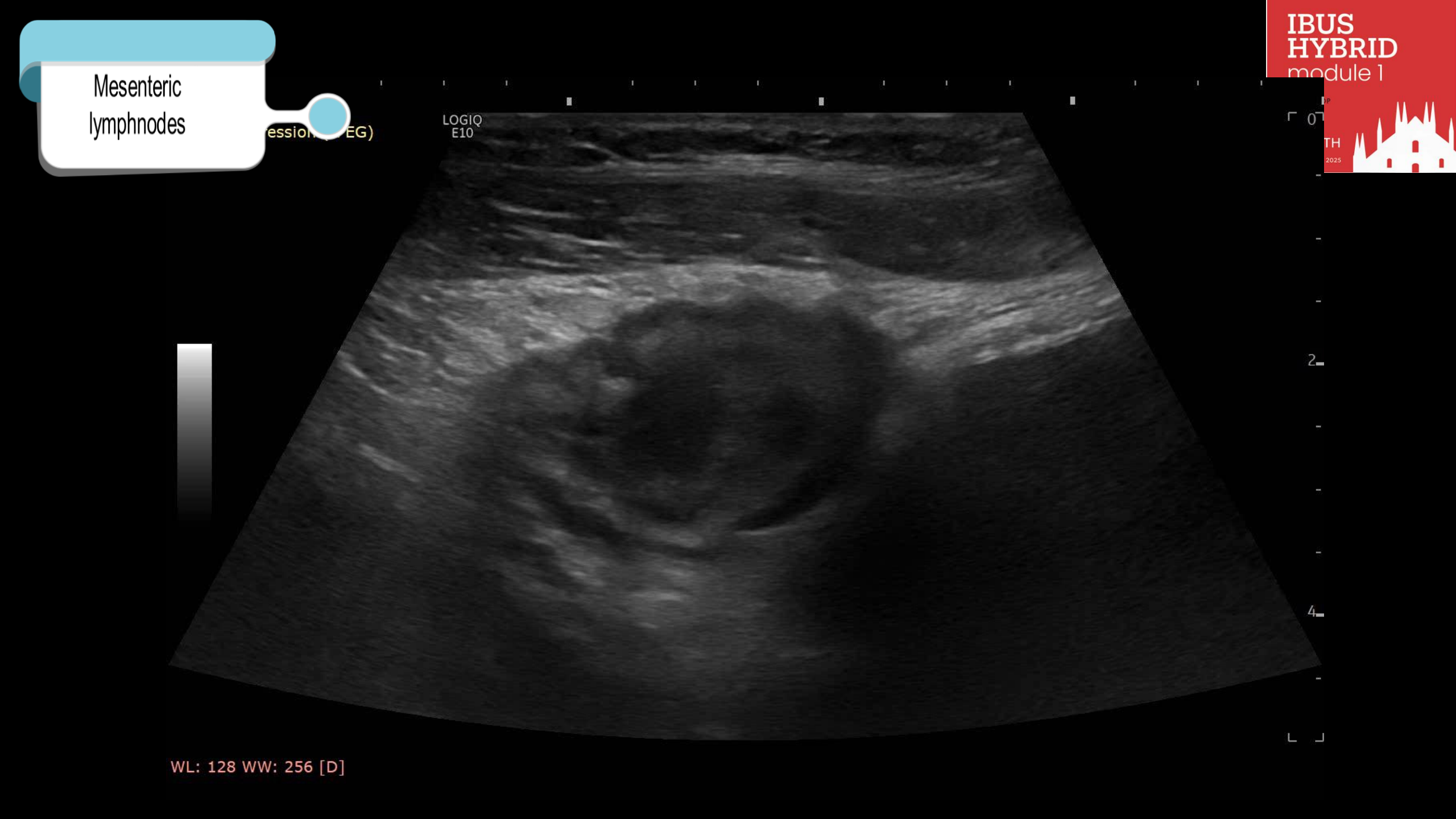
Mesenteric fat hypertrophy



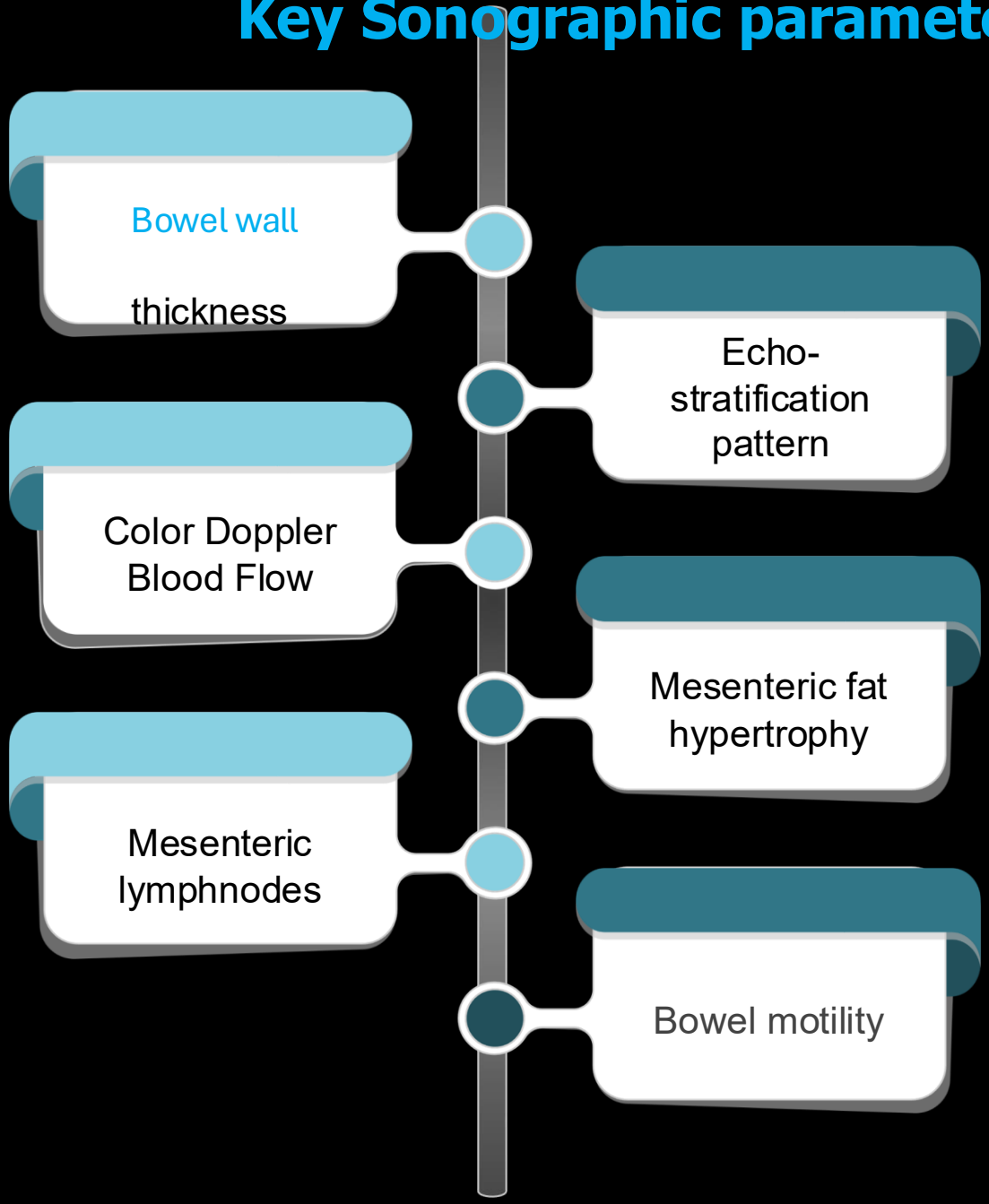


Key Sonographic parameters of active IBD



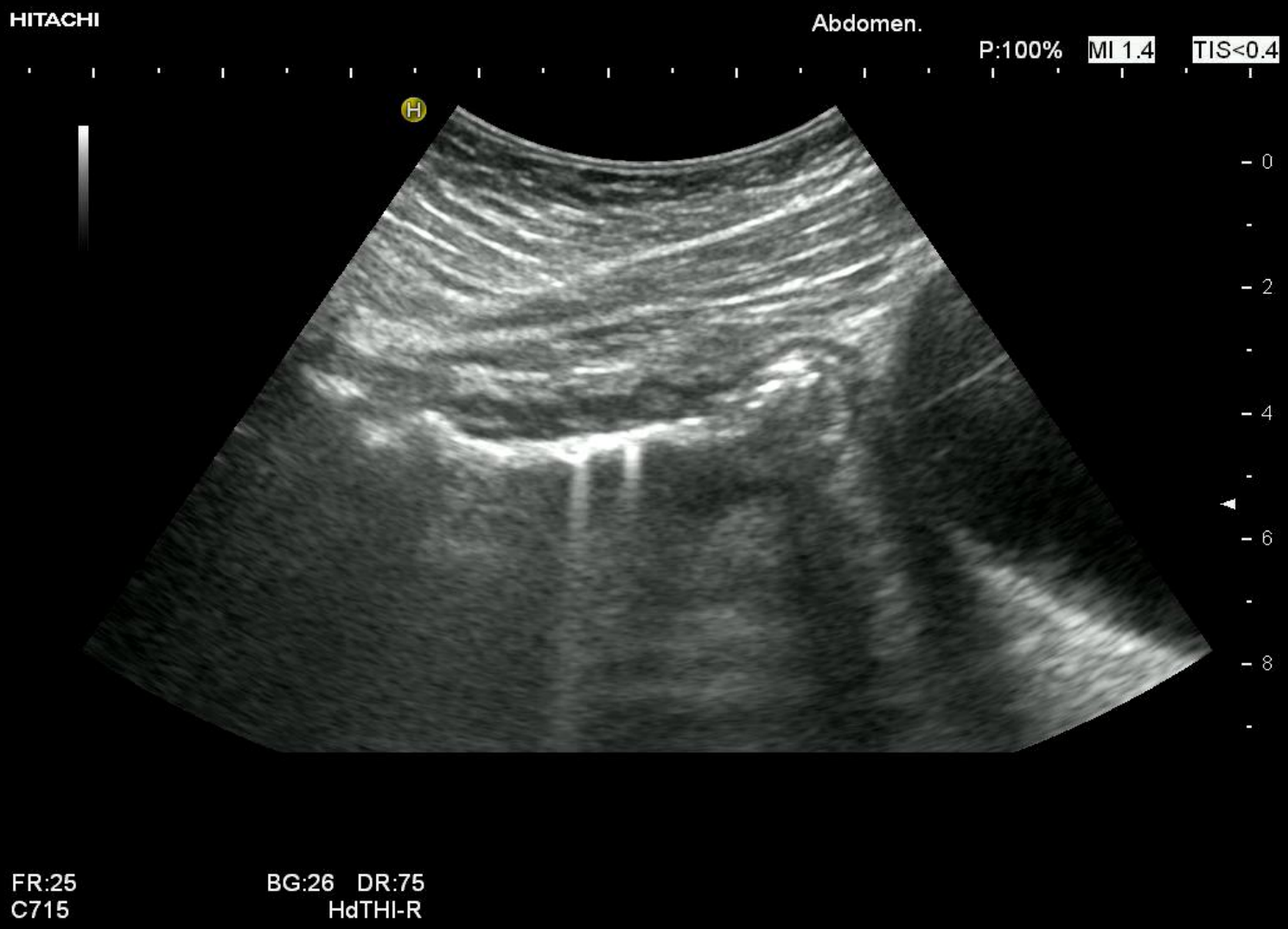

Mesenteric lymphnodes
LOGIQ E10
WL: 128 WW: 256 [D]
IBUS HYBRID module 1

Key Sonographic parameters of active IBD

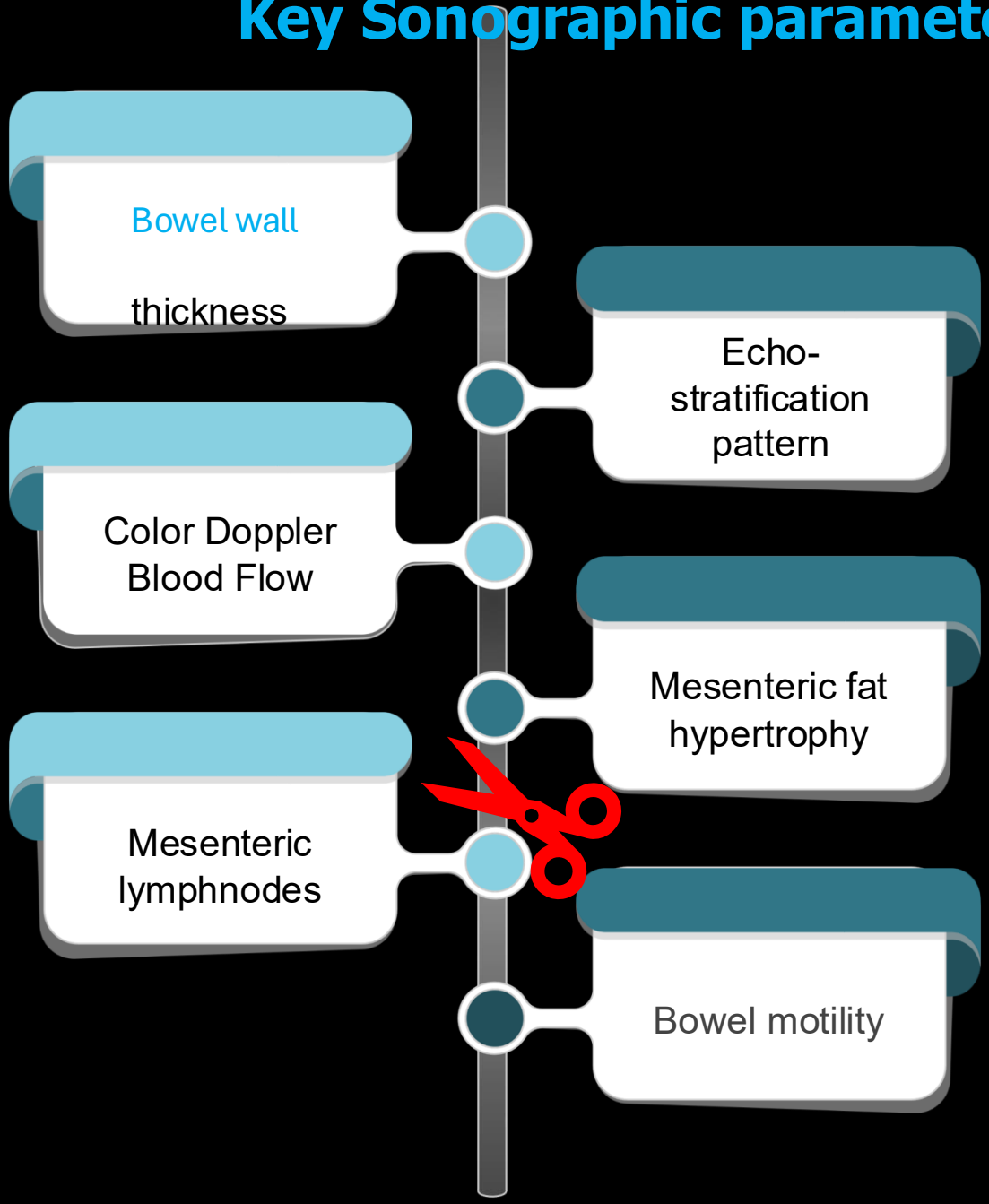


IBUS

Bowel motility



Key Sonographic parameters of active IBD



IUS Core Activity Parameters

Table 2. Core activity parameters, Delphi grading consensus

	Normal	Uncertain	Activity	
BWT	≤3 mm	NA	>3 mm	
i-fat	0 = Absent	1 = Uncertain	2 = Present	
CDS	0 = Absent [none]	1 = Short signals	2 = Long signals inside bowel	3 = Long signals inside & outside bowel
BWS	0 = Normal	1 = Uncertain	2 = Focal [≤ 3 cm]	3 = Extensive [>3 cm]

BWT, bowel wall thickness; i-fat, inflammatory fat; CDS, colour Doppler signal; BWS, bowel wall stratification; NA, not applicable.

Novak K et al. JCC 2021

JCC SYSTEMATIC REVIEW & META-ANALYSIS

Diagnostic accuracy of intestinal ultrasound and its advanced modalities in the detection of intra-abdominal complications in Crohn's disease

1498 studies screened

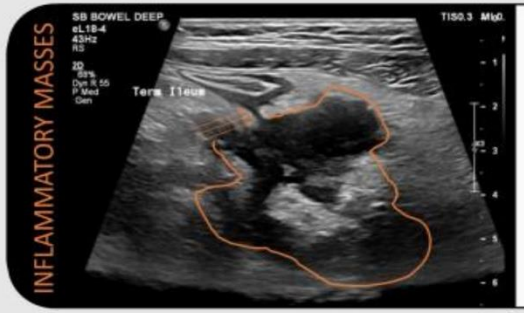
68 studies included in this review
23 studies in the meta-analysis

3863 patients

STRICTURES

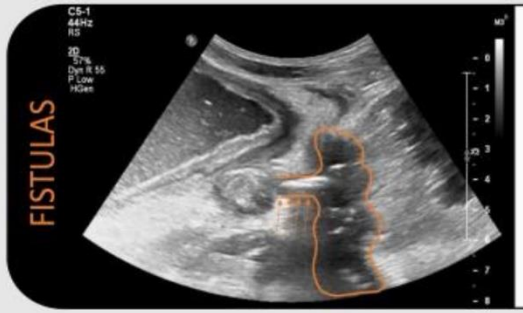
	B-mode	SICUS
Sensitivity	81%	94%
Specificity	90%	95%
Accuracy	86%	94%

INFLAMMATORY MASSES



	B-mode	SICUS
Sensitivity	87%	91%
Specificity	95%	97%
Accuracy	91%	94%

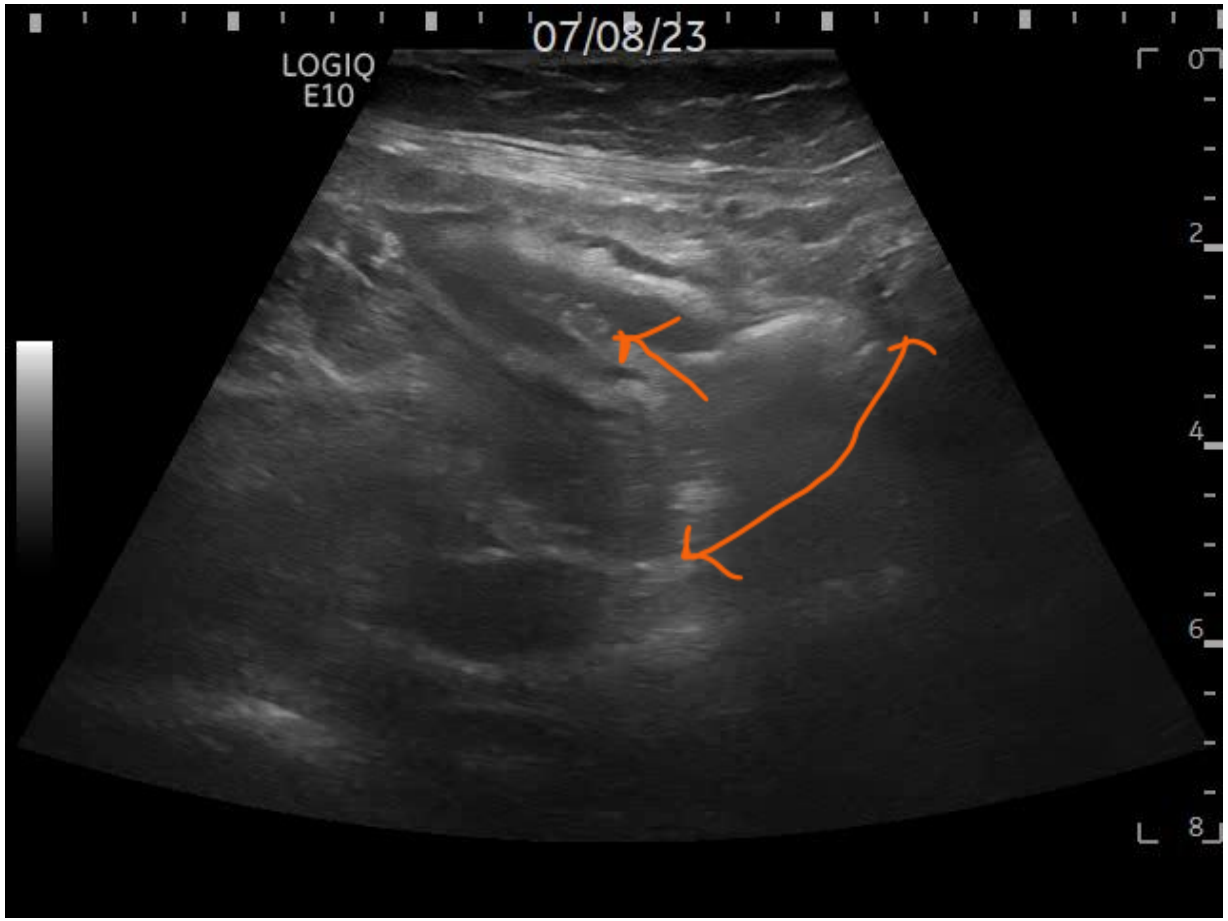
FISTULAS



	B-mode	SICUS
Sensitivity	67%	90%
Specificity	97%	94%
Accuracy	82%	92%

M. Pruijt et al. *journal of Crohn's and Colitis. Jan 2024*

Complications - stenosis



Stenosis - IUS criteria

- Increased bowel wall thickness
- Stiff bowel wall, loss of motility
- Narrowing ot the lumen
- Prestenotic dilatation (> 2.5 cm)
- Small bowel: Hyperperistalsis and gas collection in the upstream part

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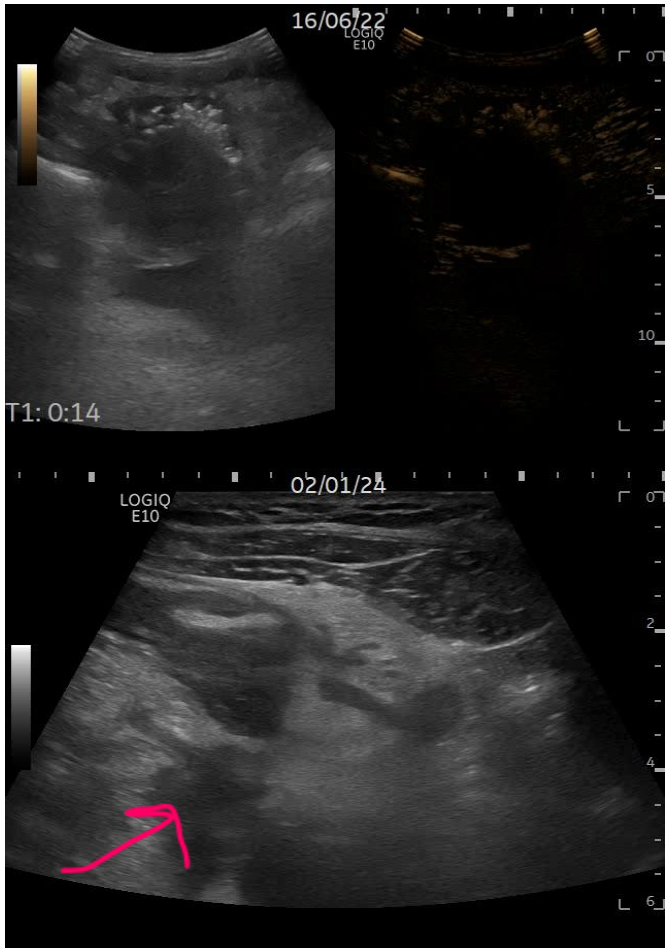
Describe your findings!
Complications – abscess/fistula



IUS criteria - abscess

- Hypo- or anechoic lesion with fluid and gaseous artefacts
- Posterior echo enhancement
- Irregular margins
- Frequently surrounded by mesenteric fat
- **CEUS:** absence of vascularization in the mass

IUS criteria - fistula

- Hypo- or anechoic extension from bowel wall sometimes with gaseous artefacts
- Irregular margins
- Frequently surrounded by mesenteric fat

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LOGIQ
E10
0
2
4

Relevant findings for inflammation/complications that should be described: Part2 Mapping

Table 2. Relevant findings for assessing inflammation and complications

Findings to be assessed on a segment basis	Extension/ localization of the disease	Overall interpretation
Abnormal bowel: - Thickness* - Ulceration(s) - Oedema† - Vascularization - Perienteric inflammatory changes Adjunctive techniques: - Motility - ~~Restricted diffusion~~ **Complications** - Stricture§ - Fistula and/or sinus¶ - Mesenteric mass/abscess** - Vascular complications†∞††	Terminal or neo-terminal ileum‡ Distal ileum‡ Proximal small bowel‡ Individual colonic segments	**Initial diagnosis** - No evidence of active disease - Evidence of active disease ± complications **Follow-up examination** Treatment response - Transmural remission - Significant transmural response - Stable disease - Progression of disease Status of complications

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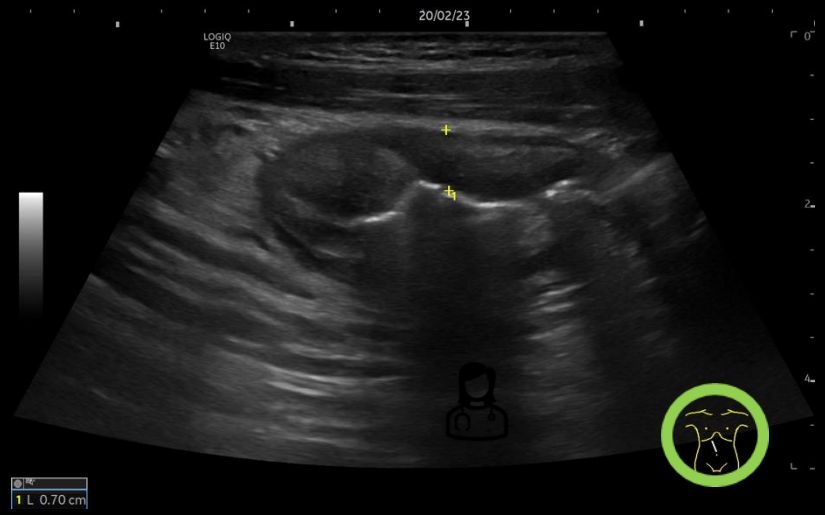
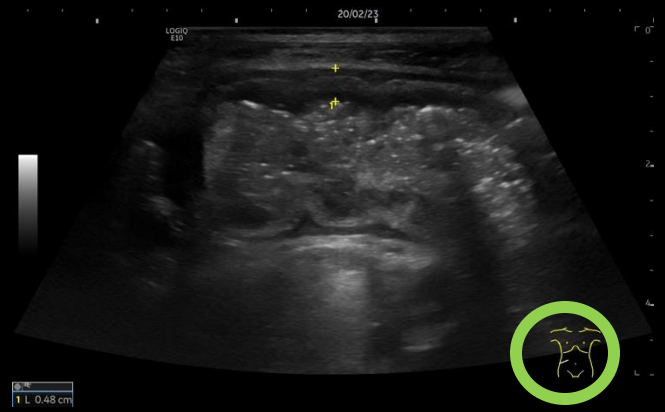
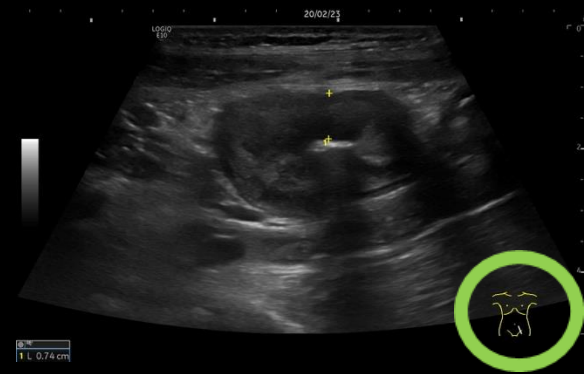
Extent mapping
Example Ulcerative Colitis



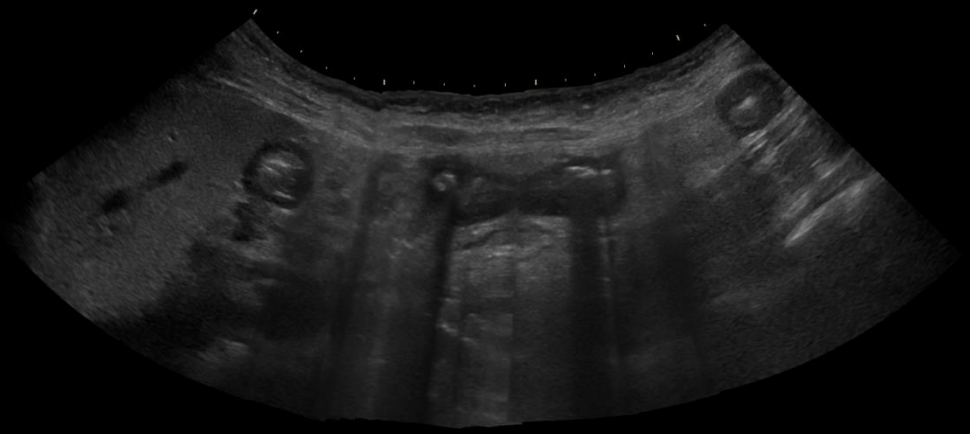


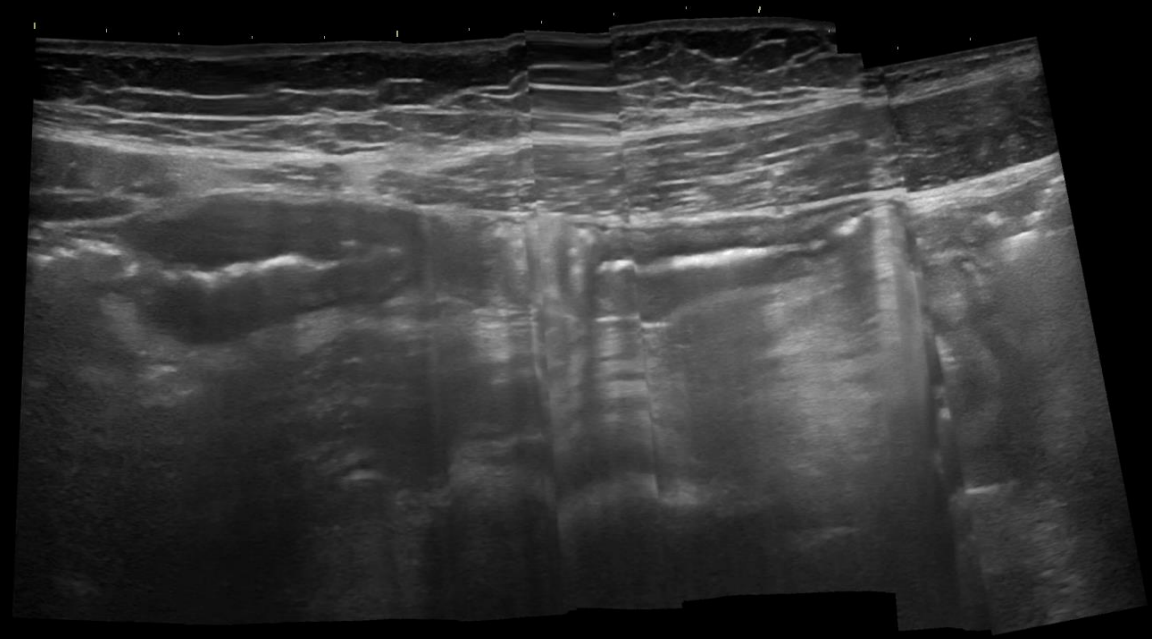


Videoloop with landmarks : Crohns’ colitis left flank position

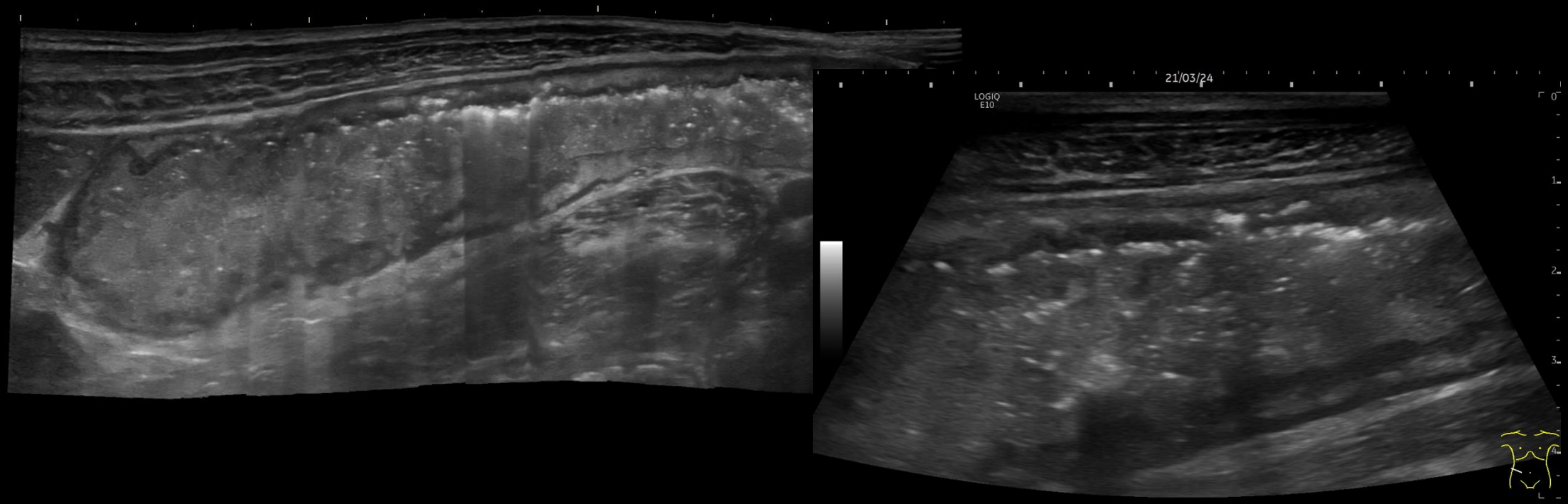
Video loop in case of multisegmental involvement of the jejunum: difficult assignment

Panoramic image of multisegmental jejunal involvement

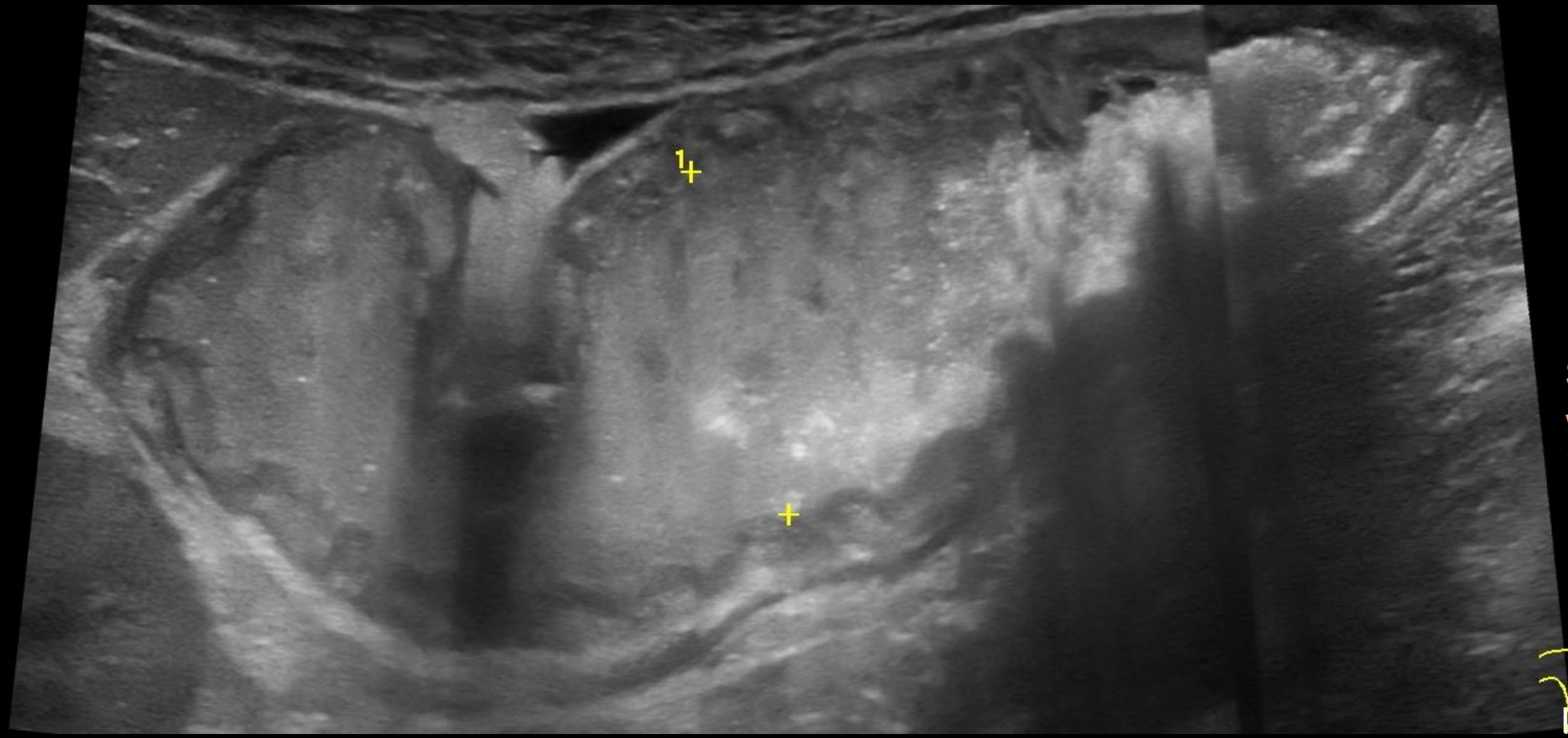




Panoramic aspect of the c ascendens, very deep ulcers, risk of colectomy high



The same patient, 2 days later



Surgeon convinced without further imaging

Relevant findings for inflammation/complications that should be described

Table 2. Relevant findings for assessing inflammation and complications

Findings to be assessed on a segment basis	Extension/ localization of the disease	Overall interpretation
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Monitoring disease activity

Current practice position 9

For follow-up examinations, reporting should focus on changes from the previous examination and should be categorized as transmural remission or significant transmural response, stable disease, or progression of inflammation. Changes in responsive features, including BWT, colour Doppler signal, BWS [IUS], ulcers, oedema [MRE], and perienteric inflammatory changes, should guide treatment response categorization.

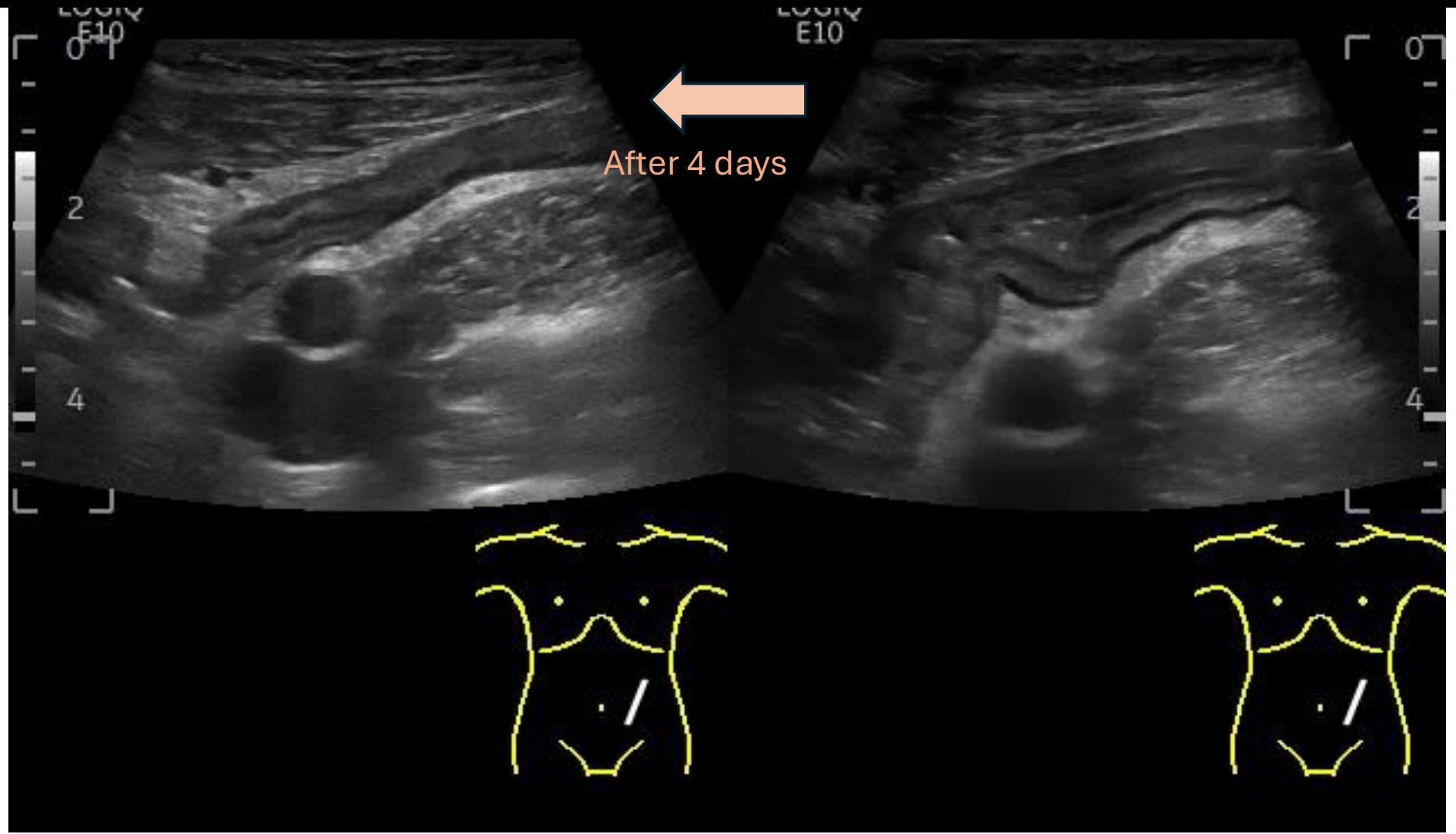
Categories

- Transmural remission (BWT ≤ 3 mm + CDS 0)
- Significant transmural response
- Stable disease
- Progression of inflammation

Kucharzik T et al JCC 2021

Ilvemark J et al *JCC* 2022

example :
Treatment Monitoring in ASUC



The written report

- Select and save **representative images** and **cine loops** that accurately depict IUS findings
- **Annotate** (label or body marker) the identified structures appropriately to facilitate interpretation and documentation
- Describe the steps involved in **storing ultrasound images and cine loops**, including data security and retrieval considerations
- Recall the standard terminology and abbreviations used in documenting intestinal ultrasound findings and construct a **well-structured IUS report**

IUS report example

Bowel ultrasound report

Name: _____

Date of birth: ___/___/_____ Patient number: _____

Crohn's disease ☐
Age at onset: _____; Extension: L1 ____ L2 ____ L3____ L4____
Behavior: B1____ B2 ____ B3____ p+____

Ulcerative colitis ☐
Extension: E1 ____ E2 ____ E3____

Current medication:
5-ASA ☐; AZA/6-MP ☐; MTX ☐; Infliximab ☐; Adalimumab ☐;
Ustekinumab ☐; Steroids ☐ Other _____

Prior surgeries: _____

Prior imaging: _____

Current disease activity: _____

Date ____/____/_____

Probes used: Convex ☐ Linear ☐

Exam quality: _____

		Small Bowel	Terminal ileum	Ascending colon	Transverse colon	Descending colon	Sigmoid colon
Bowel wall thickness (cross-section and longitudinal)	mm						
	mm						
Loss of stratification	Y/N						
Hyperemia (Limberg score)	0 – 4						
Length of involved segment	cm						
Mesenteric fat hypertrophy	Y/N						
Lymphadenopathies	Y/N						
Free fluid	Y/N						

Example from Dan Carter, Israel

Complications: Yes ☐ No ☐

☐ Stenosis: Location _____

☐ Fistulae: Location _____

☐ Abscess: Location _____

☐ Inflammatory mass: Location __

Conclusion/Impressions: _____

Confidence on findings

Failure to find a structure should be reported

Recommendations: _____

_____

Medication

Additional imaging, use of contrast

Provide contact information (optional)

IUS Core Activity Parameters

Scoring:
Different Scores use diffent parameters
and try to find a formula with responsiveness, cut-off-value and corellation:

Table 2. Core activity parameters, Delphi grading consensus

	Normal	Uncertain	Activity	
BWT	≤3 mm	NA	>3 mm	
i-fat	0 = Absent	1 = Uncertain	2 = Present	
CDS	0 = Absent [none]	1 = Short signals	2 = Long signals inside bowel	3 = Long signals inside & outside bowel
BWS	0 = Normal	1 = Uncertain	2 = Focal [≤ 3 cm]	3 = Extensive [>3 cm]

BWT, bowel wall thickness; i-fat, inflammatory fat; CDS, colour Doppler signal; BWS, bowel wall stratification; NA, not applicable.

Novak K et al. JCC 2021

Scores in IUS (selection)

Crohn‘s disease	Parameters	Validation	Responsive	Strength	Weakness
IBUS-SAS	BWT, CDS, iFat, Strat	+	+, predicive corr. +	Sens , spec, Interrater ⇧	Calculation!! semiquant. parameters
BUSS	BWT, CDS	+	+, corr+	Sens ⇧ spec ⇨	Less in severe
SUS-CD	BWT, CDS	+	+ corr histol	Sens ⇧ spec ⇨	Less in severe
UC	**Parameters**	**Validation**	**Responsive**		
IBUS-SAS	BWT,CDS,iFat, Strat	-*	+	Correl. MES, UCEIS	Calculation, Semiquant. parameters
MUC	BWT, CDflow	+	Pred of colectomy	Corr Colos	Not granular
UC-IUS	BWT,CDS, iFat, Strat	+ (not prospectiv.)	-		

Data at: Yanai, H et al J Crohns Colitis. 2025 Jul 3;19(7)

IUS Scoring CD BUSS Score

prospective observational study of 49 patients with active CD

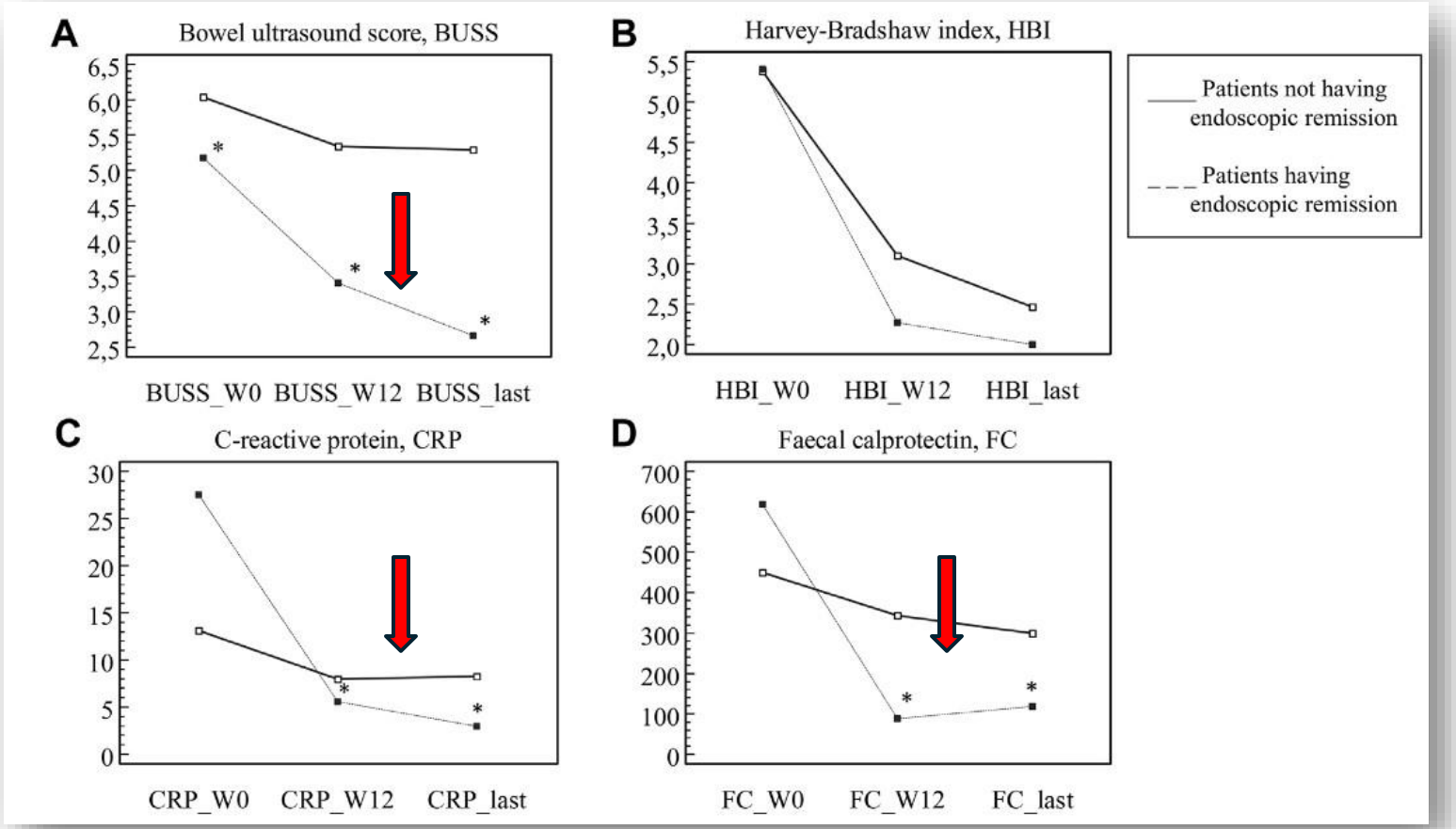
assess the sensitivity to change of BUSS in patients treated for active CD, using the SES-CD as reference

BUSS= 0,75xBWT(mm) +1,65CDS

BUSS >3.52 is an indicator of endoscopic activity (SES-CD>2

- Sensitivity: about 83–90%
- Specificity: about 74–85%
- ROC-AUC: 0.86

Allocca et al, Aliment Pharmacol Ther. 2022 Feb;55(4):446-454

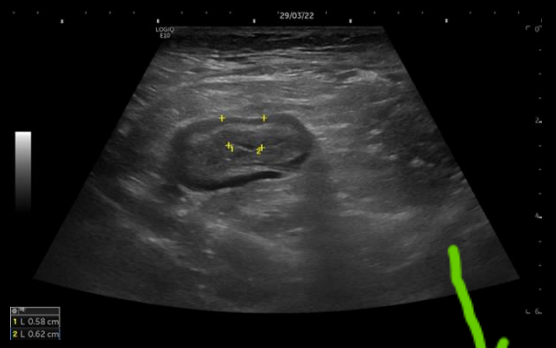


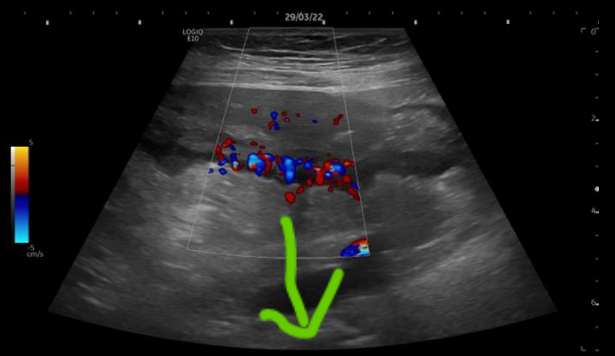
Change of clinical characteristics over time, according with the achievement of the endoscopic outcomes

Allocca M. et al, eClinical Medicine 2024;71: 102559

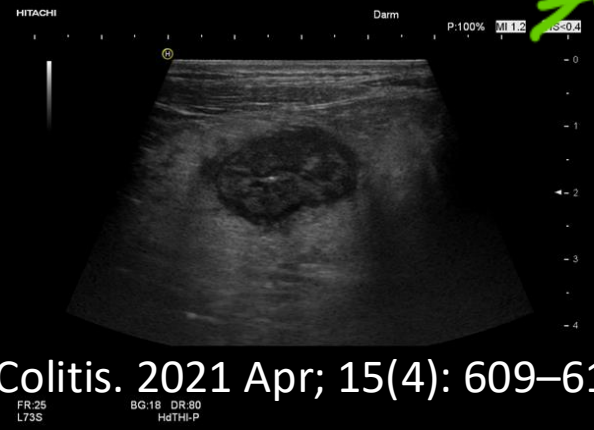
IBUS-SAS-Score

ICC 0.97, p < 0.001)





IBUS–SAS(0–100)=4·BWT + 15·i-fat + 7·CDS + 4·BWS



Novak ,K et al J Crohns Colitis. 2021 Apr; 15(4): 609–616.

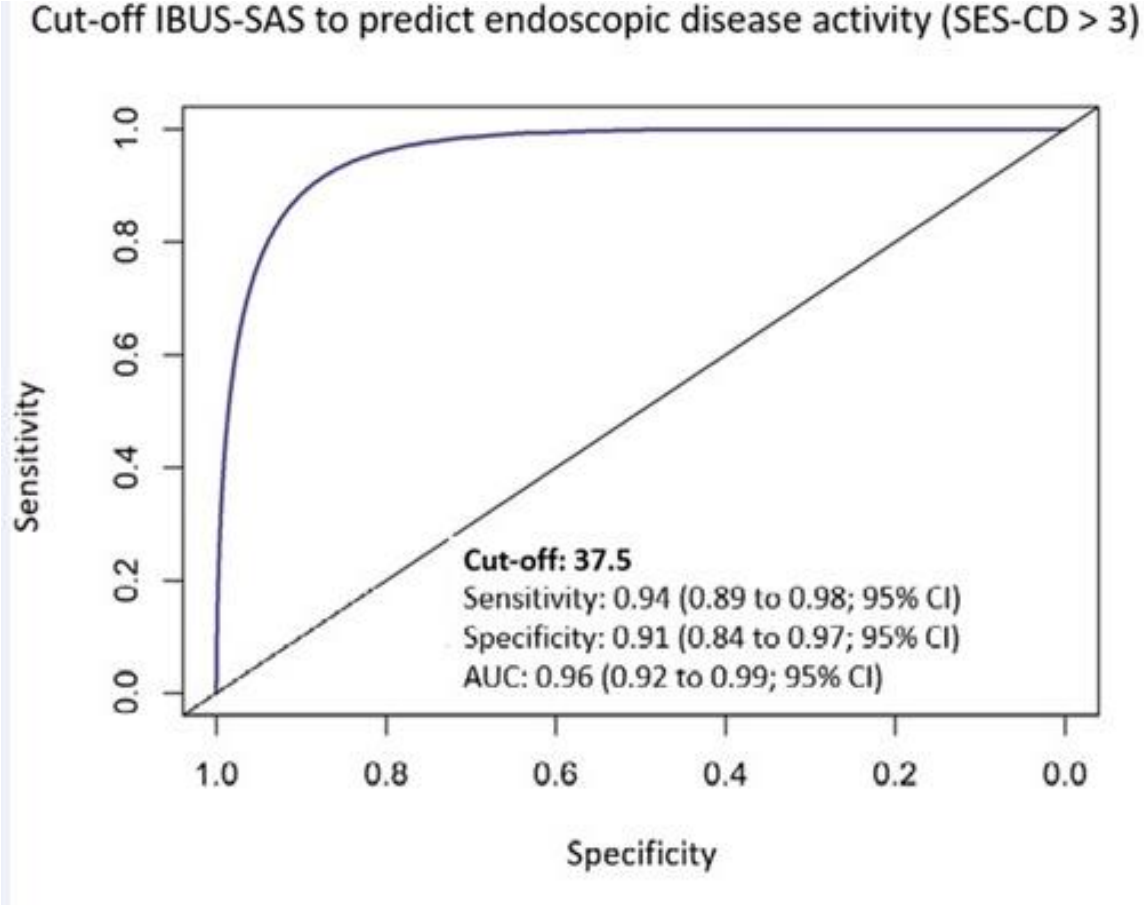
Cut-offs and sensitivities 1

- Cut- off for normal 23,5

- OC analysis of IBUS-SAS for CBR revealed an area under the curve of 0.92 (95% CI 0.86–0.97),
- with a sensitivity of 83.3% and a specificity of 91.3% for a cut-off value of **42.9**.

Dragoni et al *Journal of Crohn's and Colitis*, Volume 15, Issue Supplement_1, May 2021, Pages S226–S227, https://doi.org/10.1093/ecco-jcc/jjab076.268**IBUS-SAS for Crohn's disease ultrasound activity: initial validation and research of the optimal cut-off score**

Validations and cut-offs in CD one example



The IBUS-SAS score of > 37.5

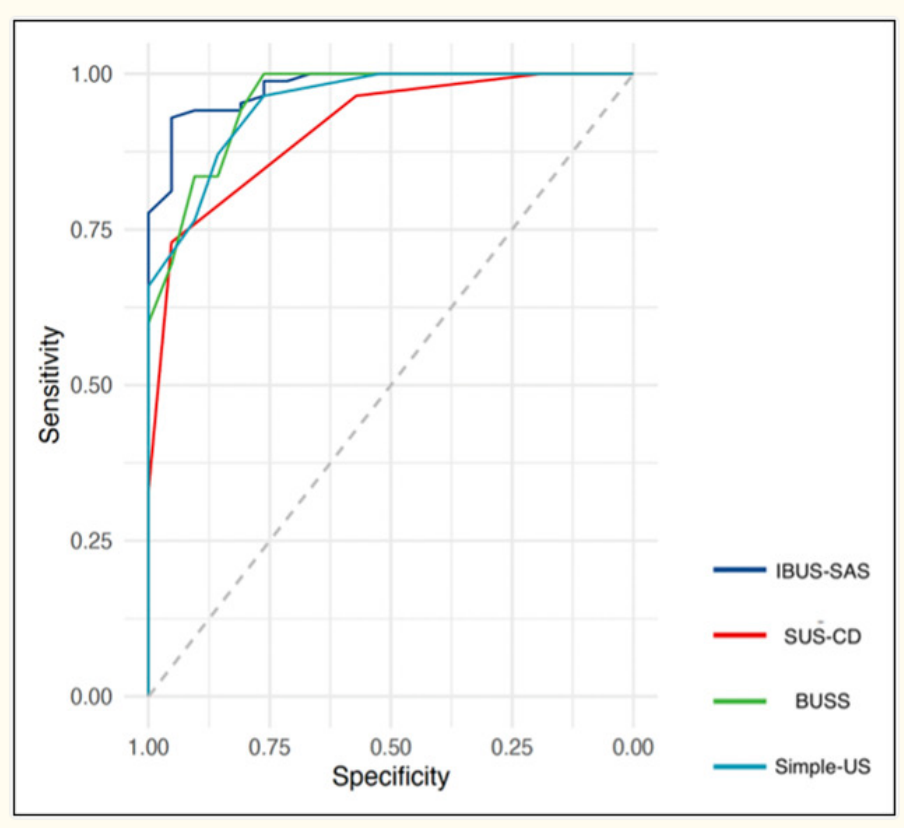
K V Nagarajan et al Journal of Crohn's and Colitis, Volume 18, Issue Supplement_1, January 2024, Pages i512–i513, https://doi.org/10.1093/ecco-jcc/jjad212.0329

Which score to use in CD?

Determining the Accuracy and Interobserver Agreement of 4 Ultrasound Scores in Crohn's Disease Assessment: Correlations With Endoscopy

A total of 106 patients with CD were enrolled for retrospective independent analysis of 4 scores

IBUS-SAS had only moderate agreement (Cohen κ = 0.427; P < 0.001).
BUSS had substantial interobserver agreement (Cohen κ = 0.947; P < 0.001),



Qin, J et al Clin Transl Gastroenterol. 2025 Jan 10;16(4):e00812.

Details in response between iliac and colonic disease

Table 2. BUS Parameters at Baseline and at 3, 6, and 12 Months

BUS parameters	V0 Baseline n = 188	V1 3 mo n = 188	V2 6 mo n = 171	V3 12 mo n = 156	*P* value V1 vs V0 n=188
BWT					
Median, range (*mm*)					
Ileal disease	6 (3.4–11.5)	5.5 (3–10)	5 (3–10)	5 (3–9)	<.0001
Colonic disease	6.35 (4.3–9)	5.5 (4–8)	4.9 (4–8)	4 (4–8)	.07
Lesion length					
Median, range (*cm*)					
Ileal disease	15 (4–60)	10 (0–60)	10 (0–60)	10 (0–50)	.009
Colonic disease	40 (20–100)	30 (0–100)	20 (0–100)	10 (0–100)	.98
Fibrofatty proliferation					
Ileal disease	94	64	57	44	.0002
Colonic disease	15	9	6	6	

Calabrese, (2021): Ultrasonography Tight Control and Monitoring in Crohn's Disease During Different Biological Therapies: A Multicenter Study. In: Clinical gastroenterology and hepatology : the official clinical practice journal of the American Gastroenterological Association. DOI: 10.1016/j.cgh.2021.03.030

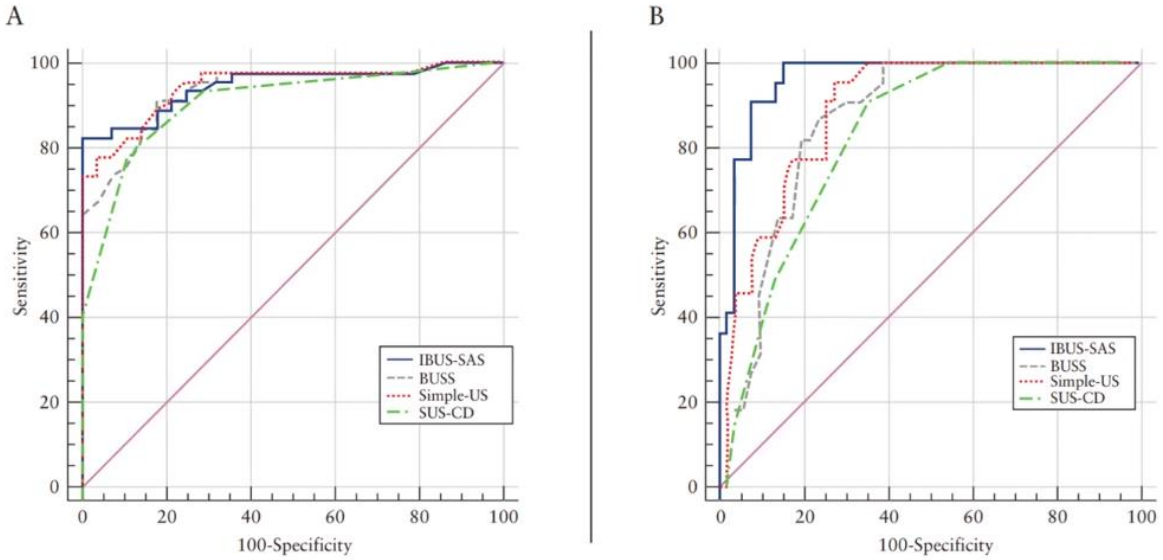
Superiority of IBUS-SAS in severe endoscopic activity

Any endoscopic activity
(segmental SES-CD ≥ 3
or Rutgeerts score ≥ i2b)

no significant difference

Severe endoscopic activity
(segmental SES-CD ≥ 9
or Rutgeerts score i4)

superiority of IBUS-SAS ($p<0.005$)



Dragoni G et al. JCC 2023.

Dragoni, G Journal of Crohn's and Colitis, 2023, 17, 1387–1394

IBUS HYBRID module 1

Ulcerative colitis : MUC Score

MUC=1,4xBWT+2,0xCWF

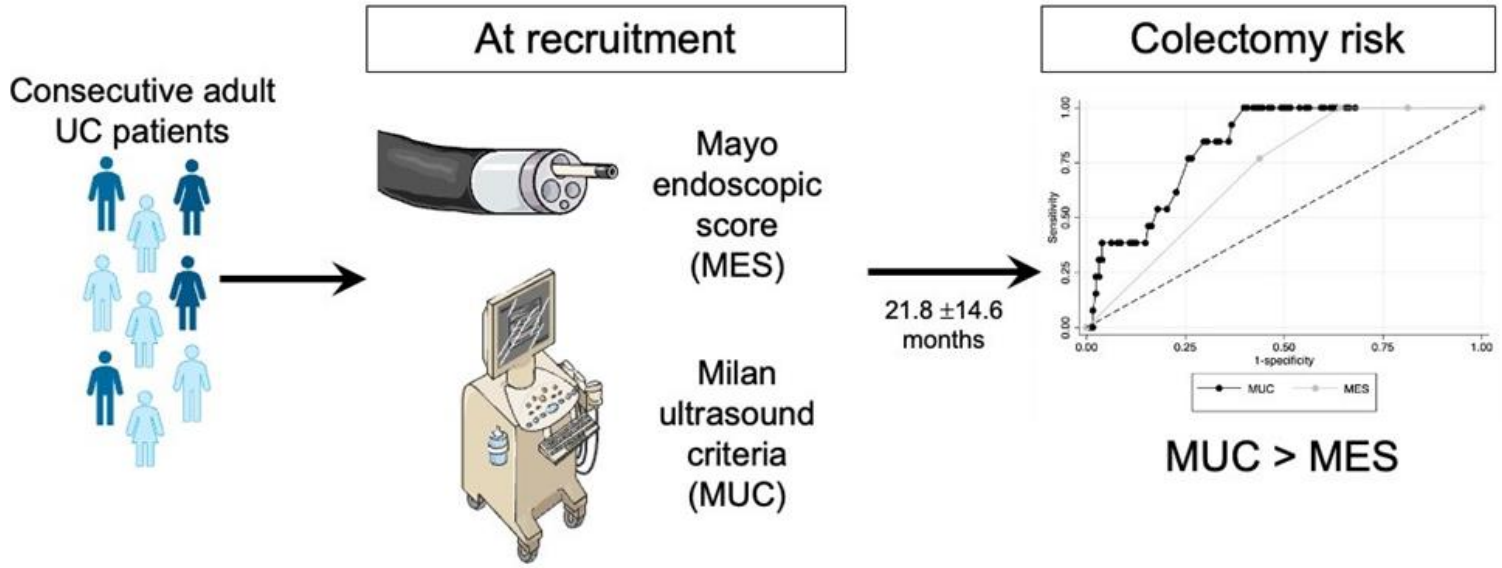
Threshold 6,2

Milan ultrasound criteria are accurate in assessing disease activity in UC: external validation

M. Allocca et al United European Gastroenterol Journal 2021 Feb 16;9(4) 438-442

parameters?

MUC ≤6.2 vs >6,2



Piazza O Sed, Journal of Crohn's and Colitis, Volume 18, Issue 2, February 2024, Pages 291–299,

New validation for IBUS-SAS for UC as well

- **Fischer, Sarah; Fischmann, David; Wilde, Judith; Vetter, Marcel; Wolf, Laurin; Geppert, Carol et al. (2025):**

IBUS-SAS Is a Highly Accurate Intestinal Ultrasound Score for Predicting Endoscopic Disease Activity in Ulcerative Colitis. In: United European gastroenterology journal DOI: 10.1002/ueg2.70053.

- **Innocenti, Tommaso; Rocco, Carmen; Balena, Eleonora; Petrucci, Giulia; Lynch, Erica Nicola; Bagnoli, Siro et al. (2025):**

- The use of International Bowel Ultrasound Segmental Activity Score (IBUS-SAS) in patients with ulcerative colitis: applicability and comparison with other ultrasound scores. In: Journal of Crohn's and Colitis DOI: 10.1093/ecco-jcc/jjaf050

"IBUS-SAS has an optimal performance in the assessment of UC endoscopic activity, despite having been initially developed for CD. Therefore, it might be adopted as a reference score both for CD and UC activity"

Unmet needs for the future

Quantification of ifat?

Standarisation of vascularisation ranking
Use of new vascularization tools?

Better identification of loss of stratification

Field of KI?

Any scoring for trials
n standarised triple-loop recording

Every segment cross

longitudinal

color doppler

IUS Report - 24y old man with ulcerative colitis

IUS REPORT

INDICATIONS and DISEASE CHARACTERISTICS

24y old man, ulcerative colitis since 2019, mesalamine-refractory, steroid-refractory, azathioprine-induced pancreatitis.

8-10 loose stools, blood, abdominal cramps, urgency

INTRA-PROCEDURE FEATURES

Point of care examination. No technical limitation. Normal body status

Fasting period: 6h

Examination quality: good

Diagnostic confidence: high confidence

Image storage location: cine loops and images stored in PACS

Examiner: Torsten Kucharzik

IUS machine: GE Logiq E10; Probe: 2-9 MHz

RESULTS

BWT: sigmoid colon 5.4 mm, descending colon 4.5 mm, transverse colon 4.5 mm, ascending colon 1.9 mm, TI 1.8 mm

Vascularisation (IBUS CDS Score): rectum: NA, sigmoid colon: 3, descending colon: 3, transverse colon: 3, ascending colon: 0; TI: 0, ileum: 0, jejunum: 0: duodenum: 0

Echostratification: Colon: normal; small bowel: normal

Mesenteric fat: sigmoid colon; descending colon: present (2); transverse colon, ascending colon, TI: absent (0)

Additional findings: Pseudopolyps, loss of haustration in left colon, free fluid, mesenteric lymph nodes

Activity Score: HUC Activity Score (1.4 x CWT (mm) + 2 x CWF): 1.4x5.4+2=**9.56**

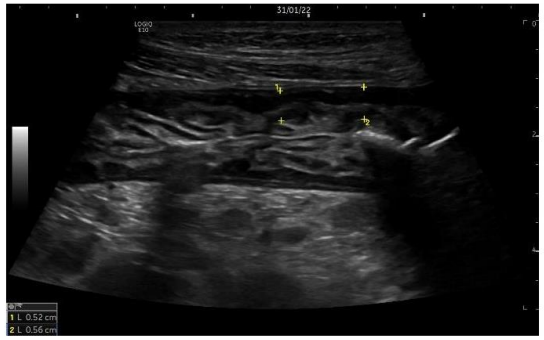
Complications of disease: None

DESCRIPTION: Markedly increased BWT in the left sided colon until right transverse colon with increased vascularisation, preserved echostratification, increased mesenteric fat, mesenteric lymphadenopathy, pseudopolyps, partial abrogated haustration in the left colon and free fluid

IUS DIAGOSIS: Highly active ulcerative colitis, E3

RECOMMENDATIONS: Suggested IUS follow up in 2 weeks

IMAGES:



Author of this slide: T.Kucharzik

IUS Report - 22y old man with Crohn‘s ileitis

IUS REPORT

INDICATIONS and DISEASE CHARACTERISTICS

22y old man, Crohn’s disease L1B1 since 2017, steroid-refractory, azathioprine-failure.

3-4 stools, abdominal cramps right lower quadrant, temp 37.9°C;

lab results: Hb 10.2 mg/dl, CRP 67 mg/dl, fCalpro: >800 mg/kg.

INTRA-PROCEDERE FEATURES

Point of care examination. No technical limitation. Normal body status

Fasting period: 4h

Examination quality: good

Diagnostic confidence: high confidence

Image storage location: cine loops and images stored in PACS

Examiner: Torsten Kucharzik

IUS machine: GE Logiq E10; Probe: 2-9 MHz

RESULTS

BWT: sigmoid colon 2.5 mm, descending colon 2.5 mm, transverse colon 2.2 mm, ascending colon 2.0 mm, TI 9.2 mm

Vascularisation (IBUS CDS Score) : rectum: NA, sigmoid colon: 1, descending colon: 1, transverse colon: 1, ascending colon: 1; TI: 3, ileum: 3, jejunum: 0: duodenum: 0

Echostratification: TI: completely abrogated; ileum: partially abrogated; colon: present

Mesenteric fat: TI and ileum: present (2); sigmoid colon; descending colon; transverse colon, ascending colon: absent (0)

Extension: TI/ileum: 18 cm length

Additional findings: free fluid, mesenteric lymph nodes; **CEUS:** (2.5 ml SonoVue) phlegmone, blind ending fistula, no absess

Complications: blind ending fistula TI, sinus tracks TI, no abscess, no stenosis

Activity Score: IBUS – SAS CD Score (0–100) = 4 · BWT + 15 · i-fat + 7 · CDS + 4 · BWS;

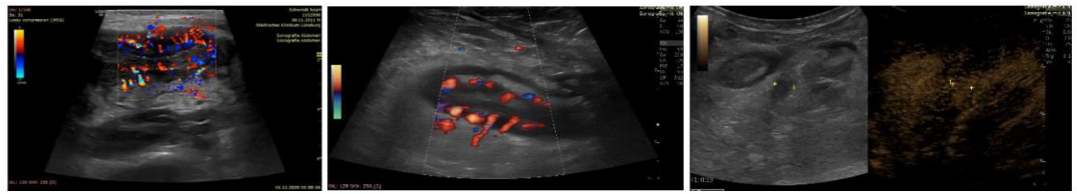
4x9.2+15x2 +7x3+4x3=**99,8**

DESCRIPTION: Markedly increased BWT in the terminal ileum, with markedly increased vascularisation, abrogated echostratification, increased mesenteric fat, abrogated motility, mesenteric lymphadenopathy, phlegmonre, sinus tracks, blind ending fistula and free fluid

IUS DIAGOSIS: Highly active penetrating Crohn’s disease L1B3 with blind ending fistula and sinus tracks in the TI

RECOMMENDATIONS: Suggested IUS follow up in 4 weeks

IMAGES



Author of this slide: T.Kucharzik

international bowel
ULTRASOUND GROUP

IBUS HYBRID module 1

7-8TH NOVEMBER, 2025
MILAN, ITALY

Thank you

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The Luneburg IBUS Team