

IUS in CD – State of Evidence in 2026

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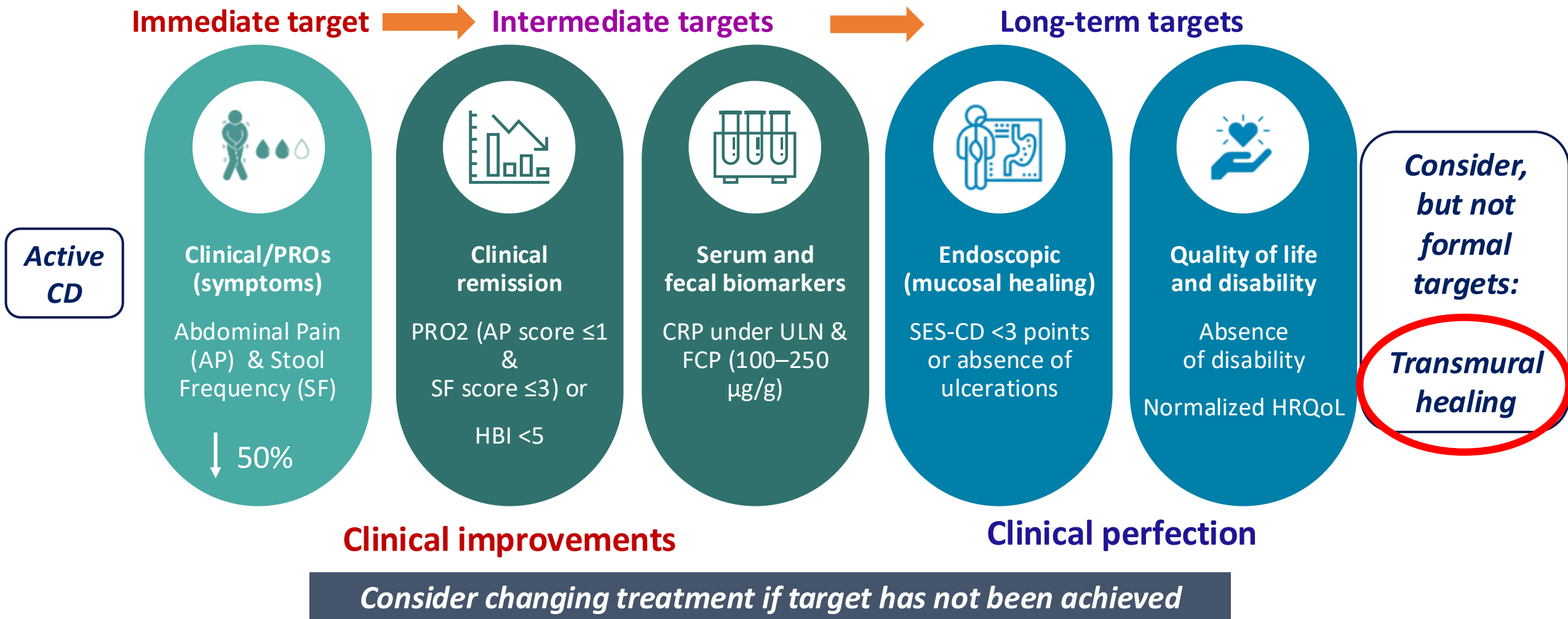
Disclosure

- I have no conflict of interest to disclose



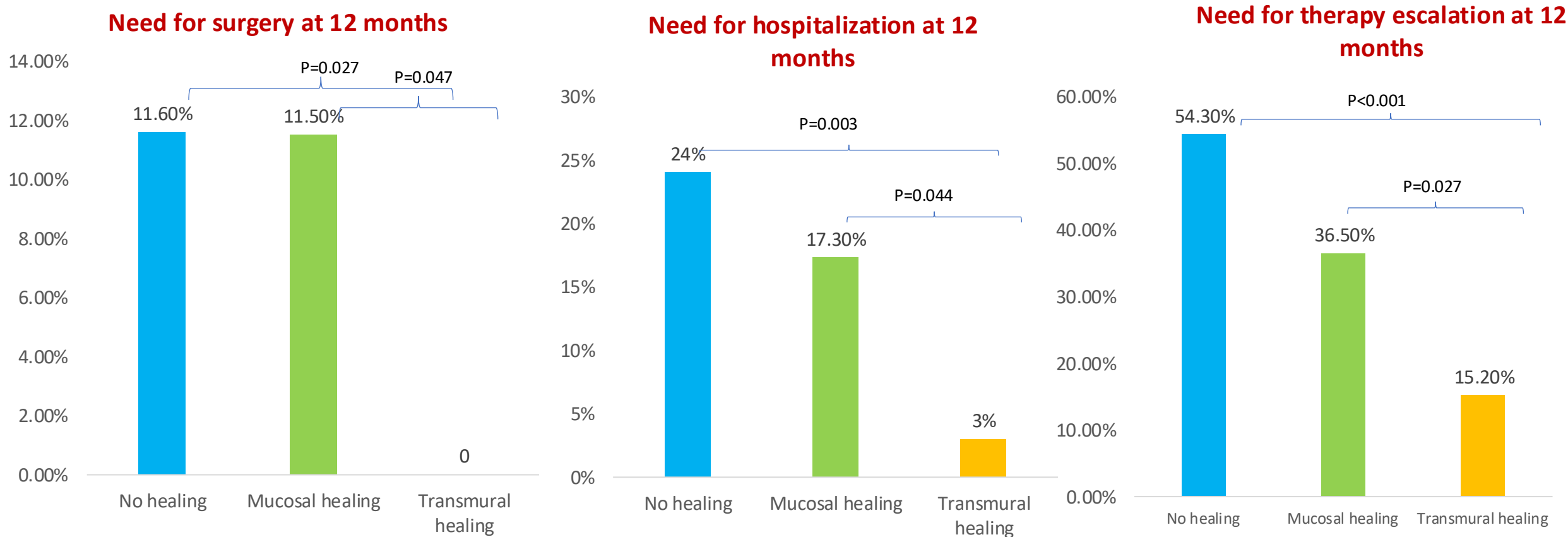
Why?

Treat-to-target: STRIDE-II consensus statement recognizes specific treatment targets for improved outcomes in Crohn's Disease¹



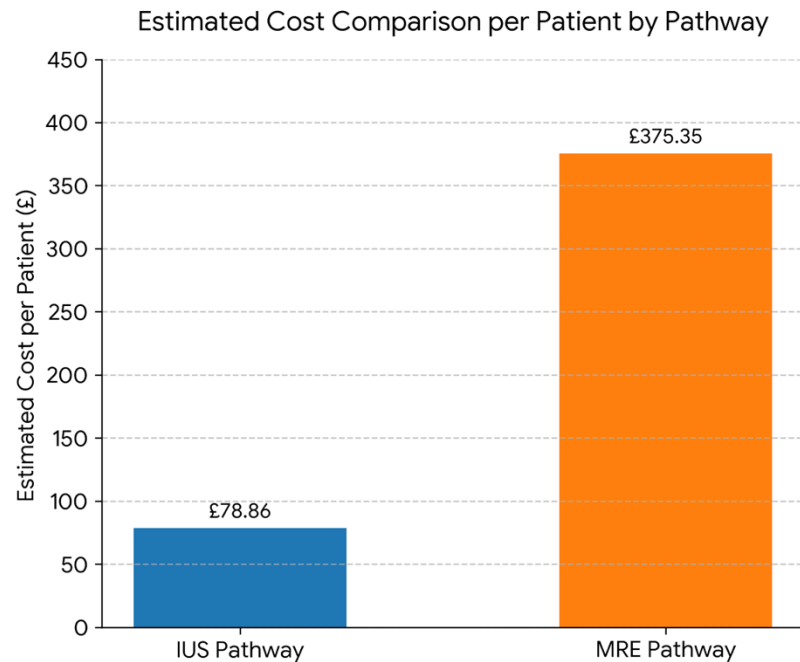
AP, Abdominal Pain; HBI, Harvey–Bradshaw Index; HRQoL, health-related quality of life; IOIBD, International Organization for the Study of Inflammatory Bowel Diseases; PRO, patient-reported outcome - 2 items; SF, Stool Frequency; STRIDE, Selecting Therapeutic Targets in Inflammatory Bowel Disease; ULN, upper limit of normal
1. Turner D et al. Gastroenterology 2021;160:1570–1583.

Transmural healing predicts CD remission

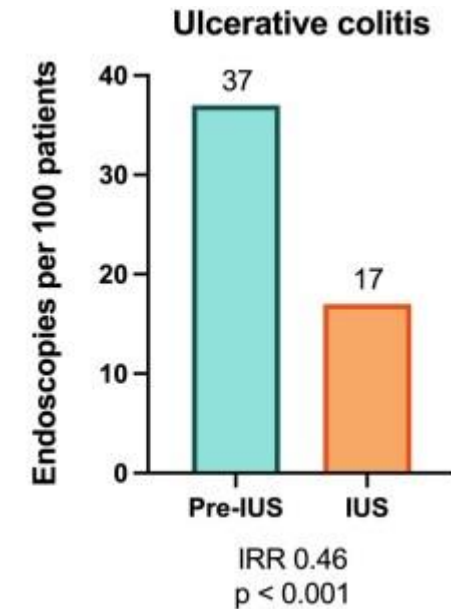
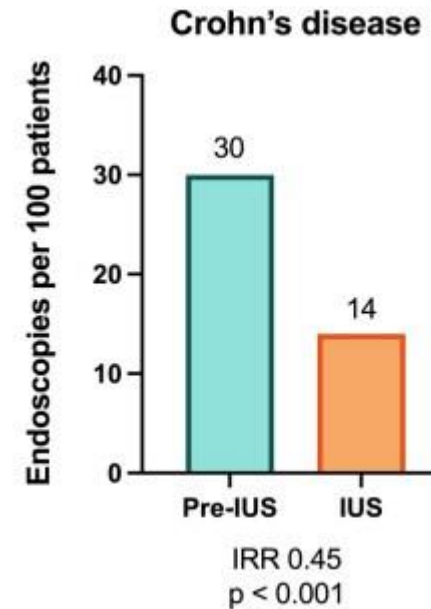
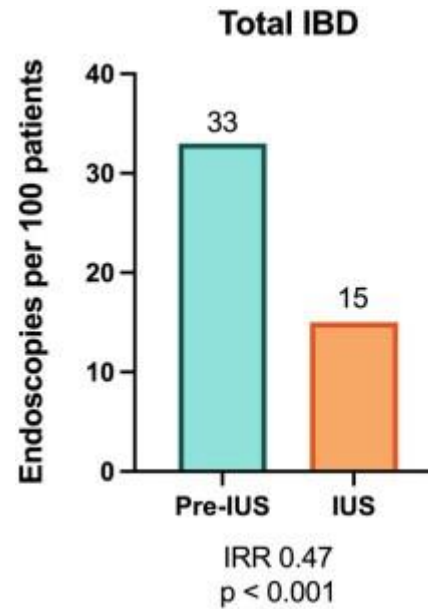


IUS is Cost Saving and Can Reduce the Number of Colonoscopies

The cost of IUS Pathway is only **1/5** of the MRE Pathway



Following the introduction of an IUS service, the number of endoscopies performed for evaluation of IBD activity was **halved**



International Guidelines have Incorporated IUS as part of the Diagnosis and Monitoring Strategy in IBD

Journal of Crohn's and Colitis, 2025, **19**(7), jjaf106
<https://doi.org/10.1093/ecco-jcc/jjaf106>
Advance access publication 31 July 2025
ECCO Guideline/Consensus Paper



OPEN

Intestinal Ultrasound for the Pediatric Gastroenterologist: A Guide for Inflammatory Bowel Disease Monitoring in Children

Expert Consensus on Behalf of the International Bowel Ultrasound Group (IBUS) Pediatric Committee

^{*}Amelia Kellar, MD, MSc, ^{*}Michael Dolinger, MD, MBA, [†]Kerri L. Novak, MD, MSc, [‡]Mallory Chavannes, MD, MHS, ^{*}Marla Dubinsky, MD, and [§]Hien Huynh, MD

ECCO-ESGAR-ESP-IBUS Guideline on Diagnostics and Monitoring of Patients with Inflammatory Bowel Disease: Part 1

Part 1: initial diagnosis, monitoring of known inflammatory bowel disease, detection of complications

Gastroenterology 2025;169:1166–1183

CLINICAL GUIDELINES 1225

CME

ACG Clinical Guideline: Management of Crohn's Disease in Adults

Gary R. Lichtenstein, MD, FACP¹, Edward V. Loftus, MD, FACP², Anita Afzali, MD, MPH, MHCM, FACP³, Millie D. Long, MD, MPH, FACP⁴, Edward L. Barnes, MD, MPH, FACP⁴, Kim L. Isaacs, MD, PhD, MACG⁴ and Christina Y. Ha, MD, FACP⁵

REVIEWS
AND
PERSPECTIVES

Role of Noninvasive Imaging in the Diagnosis and Management of Patients With Suspected and Established Inflammatory Bowel Disease

Torsten Kucharzik,^{1,2} Mariangela Allocca,³ Joana Torres,^{4,5,6} and Stuart A. Taylor⁷



Guidelines



OPEN ACCESS

British Society of Gastroenterology guidelines on inflammatory bowel disease in adults: 2025

Gordon W Moran,¹ Morris Gordon,² Vassiliki Sinopoulou,³ Shellie J Radford,⁴

IUS in Asia ... Gaining Popularity

Journal of
Gastroenterology and Hepatology



Solicited Review | [Free Access](#)

The failure of gastroenterologists to apply intestinal ultrasound in inflammatory bowel disease in the Asia-Pacific: A need for action

[Anil Kumar Asthana](#) ✉, [Antony B Friedman](#), [Giovanni Maconi](#), [Christian Maaser](#), [Torsten Kucharzik](#), [Mamoru Watanabe](#), [Peter R Gibson](#)

First published: 22 December 2014 | <https://doi.org/10.1111/jgh.12871> | [VIEW METRICS](#)

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Is IUS Accurate?



VS



Diagnosis of small bowel Crohn's Disease

- 234 patients with suspected small bowel CD
- IUS and MRE had **comparable accuracy**
- **MRE > IUS**: defining **SB extension** ($r=0.69$) and for detecting **fistulas** ($k=0.67$)
- **MRE = IUS**: detection of **strictures** ($k=0.82$) and **abscesses** ($k=0.88$)

	Sensitivity (95% Confidence Interval) (%)	Specificity (95% Confidence Interval) (%)	PPV (95% Confidence Interval) (%)	NPV (95% Confidence Interval) (%)
BS	94 (89–100)	97 (92–100)	97 (94–100)	94 (87–99)
MR enterography	96 (92–100)	94 (89–99)	94 (89–100)	96 (90–100)

IUS Scores for CD are highly accurate to the SES-CD

Score	Endoscopic remission [<i>n</i> = 28]	Endoscopic activity [<i>n</i> = 45]
IBUS-SAS	12.0 ± 5.4	45.4 ± 21
SUS-CD	0.4 ± 0.7	2.3 ± 1.1
BUSS	2.2 ± 0.9	4.6 ± 1.2
Simple-US	2.7 ± 0.9	5.8 ± 1.7

Table 4. ROC analyses of the four IUS scores with identification of the cut-off value for any endoscopic activity

	AUC	95% CI	Cut-off value	Sensitivity [%]	Specificity [%]	Accuracy [%]
IBUS-SAS	0.95	0.87–0.99	25.2	82.2	100	89.0
SUS-CD	0.91	0.81–0.96	>0	93.3	71.4	84.9
BUSS	0.93	0.85–0.98	2.9	91.1	82.1	87.6
Simple-US	0.95	0.87–0.98	4.5	77.8	96.4	84.9

Table 5. ROC analyses of the four IUS scores with identification of the cut-off value for severe endoscopic activity

	AUC	95% CI	Cut-off value	Sensitivity [%]	Specificity [%]	Accuracy [%]
IBUS-SAS	0.96	0.89–0.99	34.0	100	84.3	89.0
SUS-CD	0.82	0.72–0.90	>1	90.9	64.7	72.6
BUSS	0.86	0.76–0.93	4.2	86.4	76.5	80.2
Simple-US	0.89	0.79–0.95	4.6	95.5	72.5	79.4

Accuracy of IUS in small bowel Crohn's disease

METRIC Trial

Stuart T, et al. 2018

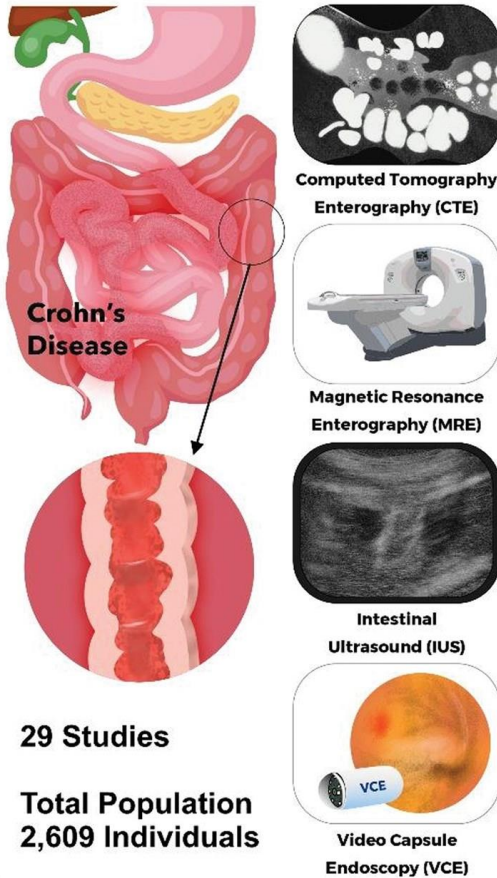
- Largest prospective multicenter comparison trial (n=284)
- Sensitivity for MRE (**97%**) and IUS (**91%**) for TI disease
- No clinically significant difference

IUS vs MRE + colonoscopy

Alloca M et al. 2018

- Consecutive, prospective study tertiary Italian IBD center (n=60)
- IUS detection of disease activity: Sn=92%; Sp=100%
- Stricture: IUS 75% vs. MRE + colonoscopy: 86%
- Penetrating complications: IUS 100%; MRE + colonoscopy >96%

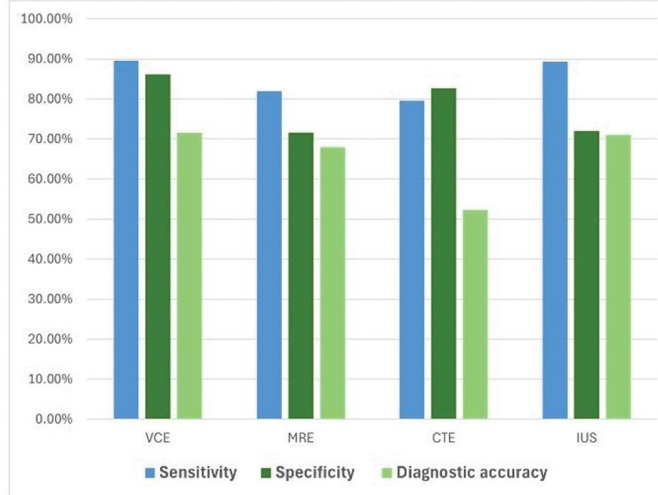
Comparable Performance Between VCE and IUS



Diagnostic Network Meta-analysis of Small Bowel Crohn's Disease

VCE has a superior diagnostic yield for proximal lesions.

IUS is a promising alternative, especially for distal lesions.

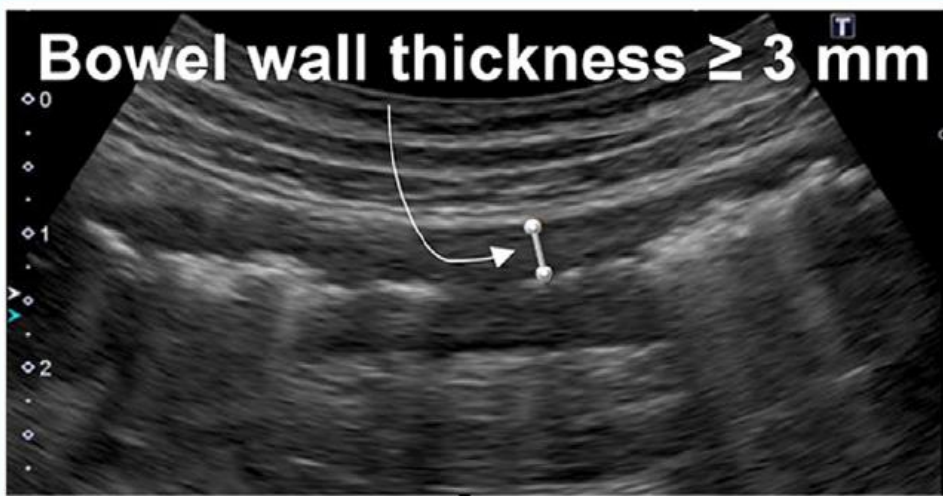


Ranking analysis positioned VCE (P -score .97) as the most effective diagnostic modality for SB-CD, followed by **IUS**, MRE, and CTE

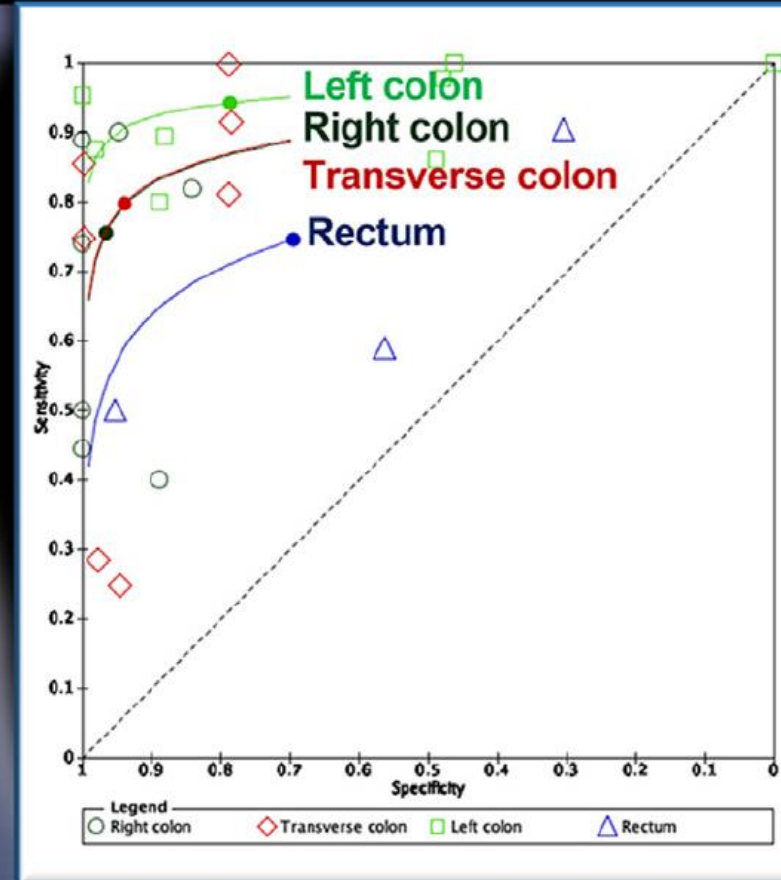
VCE was associated with capsule retention in 3.3% of the cases

MR is not accurate for colonic disease²

Systematic review and meta-analysis: Accuracy of ultrasound for the evaluation of colorectal segment in inflammatory bowel disease



Diagnostic accuracy detecting active disease in inflammatory bowel disease were high overall colon, but lower in the rectum.



IUS vs. CT/MRE vs. Endoscopy

Procedure	Preparation	Procedural risk	Cost	Limitation
Intestinal Ultrasound	None	None	\$	■ Limited visualization of the stomach, esophagus, and rectum ■ No ability for interventional procedure ■ Exam may be limited by body habitus and overlying bowel gas
MR-Enterography	■ Oral contrast ■ IV contrast ■ Fasting required	■ Contrast-related allergies ■ Claustrophobia-related discomfort	\$\$\$	■ Lower sensitivity for proximal small bowel disease compared with EGD and VCE ■ Lower sensitivity for colonic disease compared with ileocolonoscopy and IUS ■ No ability for interventional procedure ■ Weight limitations
CT-Enterography	■ Oral contrast ■ IV contrast ■ Fasting required	■ Contrast-related allergies ■ Radiation exposure	\$\$	■ No ability for interventional procedure
Video Capture Endoscopy (VCE)	■ Optional bowel prep ■ Fasting required	■ Capsule retention	\$\$	■ High sensitivity for smaller lesions may be non-specific ■ No ability for interventional procedure ■ Limited by ability of patient to swallow pillcam
Esophagogastroduodenoscopy (EGD) and Ileocolonoscopy	■ Full bowel preparation ■ Fasting required ■ Sedation/anesthesia	■ Bowel perforation ■ Hemorrhage ■ Infection ■ Sedation-related risks (hypotension, laryngospasm) ■ Increased risk in setting of cardiovascular comorbidities	\$\$\$\$	■ No small intestinal evaluation proximal to terminal ileum ■ Limited assessment in stenotic disease

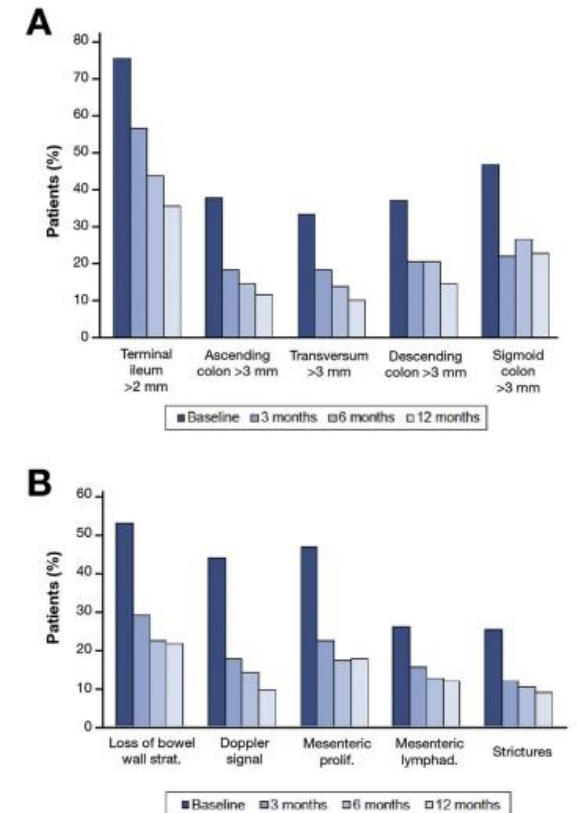
CT, Computed tomography; EGD, esophagogastroduodenoscopy; IV, intravenous; MR, magnetic resonance; IUS, intestinal ultrasound; VCE, video capture endoscopy

A close-up, endoscopic view of the interior of a large intestine. The mucosal lining is visible, showing characteristic haustra and deep folds. Several white, raised polyps of varying sizes are scattered across the mucosal surface, particularly in the lower half of the frame. The lighting is bright, highlighting the moist texture of the tissue.

Disease Activity Monitoring

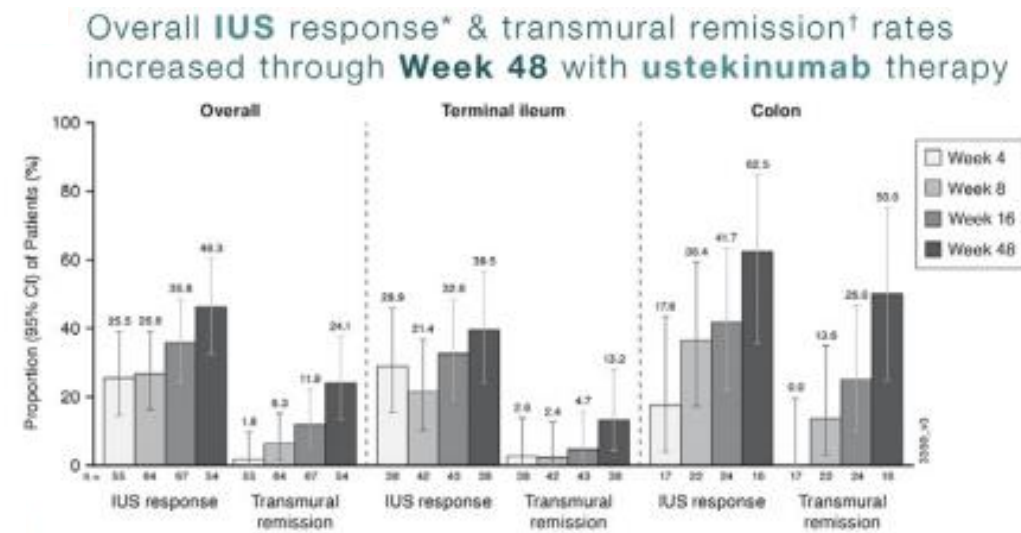
IUS Monitoring in Crohn's Disease

- **TRUST-CD trial:** a significant proportion of patients achieved transmural response and TR **as early as 3 months** after treatment induction using IUS
- Early transmural response in CD patients treated with UST, determined by central read IUS, could be detected **as early as 4 weeks** after treatment initiation.
- TR may take longer to achieve depending on the choice of treatment and appears to occur faster in the colon compared to TI

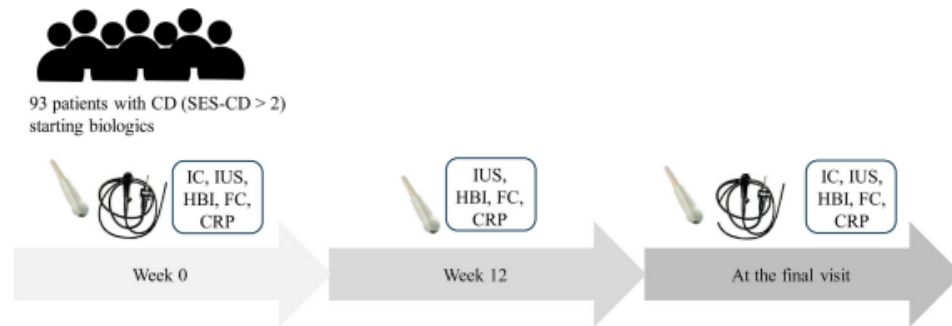


IUS Monitoring in Crohn's Disease

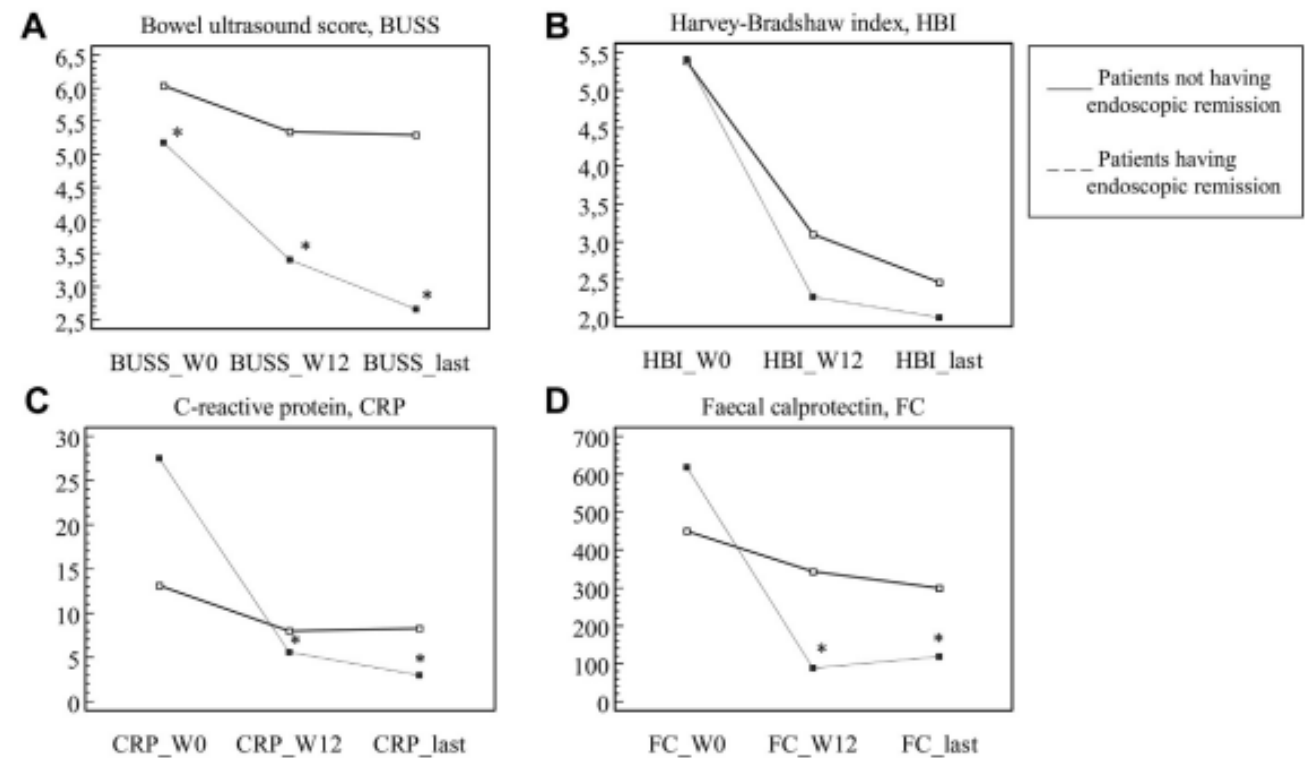
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- Early transmural response in CD patients treated with UST, determined by central read IUS, could be detected as early as 4 weeks after treatment initiation.
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Early IUS remission predicts long-term endoscopic remission in Crohn's disease

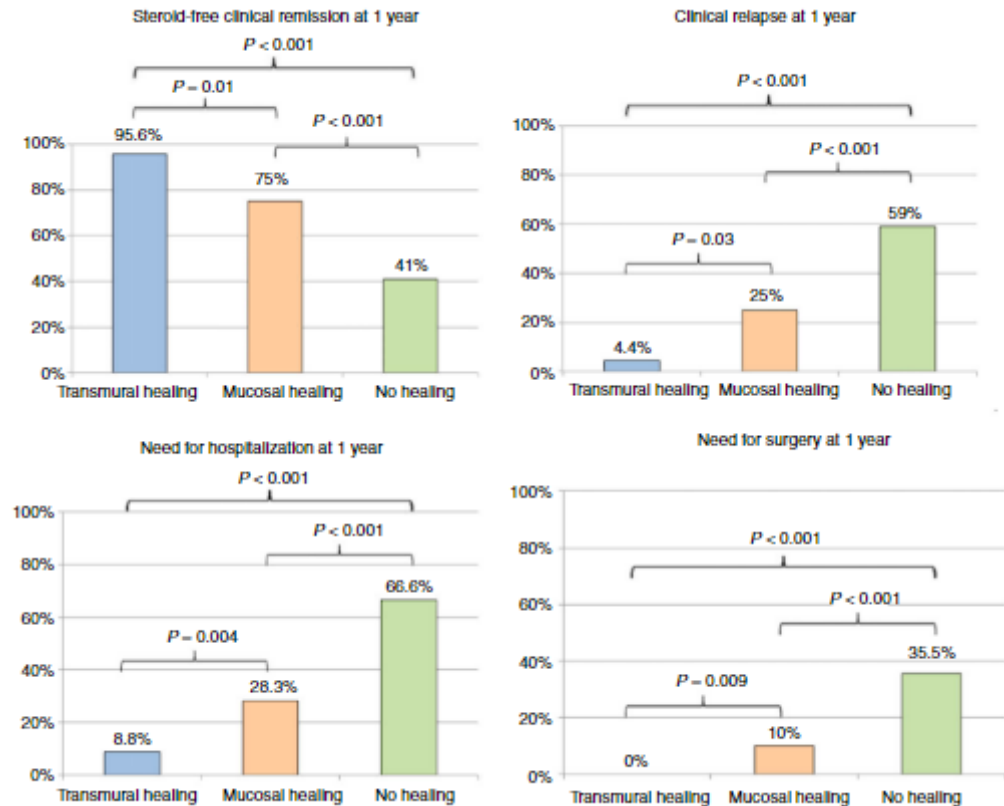


- Bowel Ultrasound Score (BUSS) greater than 3.52 by week 12 is associated with failure to achieve endoscopic remission (NPV 87%) at 12 months

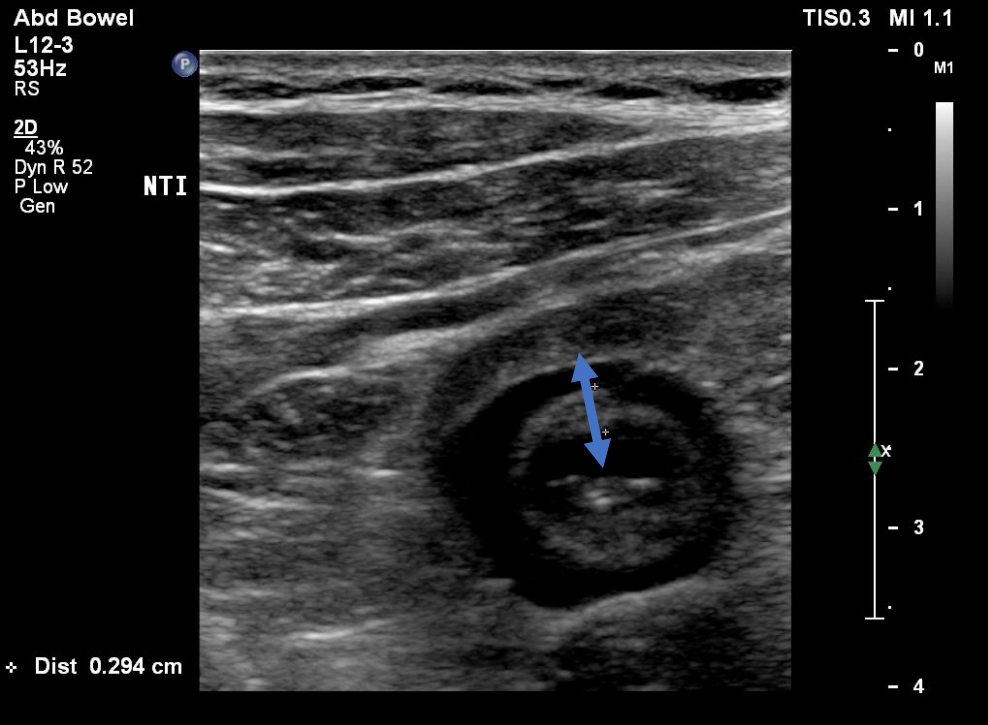


One-year clinical outcomes with biologics in CD: transmural healing compared with mucosal or no healing

- Prospective Cohort Study
- 218 CD patients
- 1-year outcome depending on transmural, mucosal or no healing
- **Transmural healing:** BWT ≤ 3 mm
- **Mucosal healing:** SES-CD ≤ 2

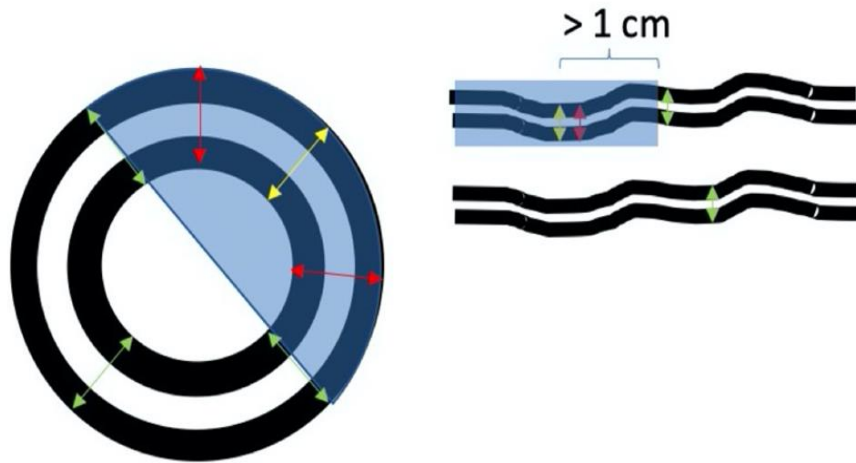






Bowel wall thickness

- Bowel wall thickness is the strongest predictor for disease activity^{1,2}.
- Thickness >3mm has a sensitivity of 88% & specificity of 93% for detecting active CD³



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

- It is also reliable: ICC almost perfect 0.81-0.96^{4,5}

1. Novak et al. IBDJ 2017
2. Bots et al. JCC 2018
3. Goodsall et al. 2020 JCC
4. Novak et al. JCC 2020
5. Saevik et al. JCC 2020



/FR31Hz /6.0cm

S

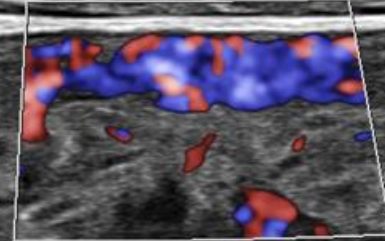
Sigmoid Colon



/LM2-18 /FR21Hz /6.0cm

S

Sigmoid Colon

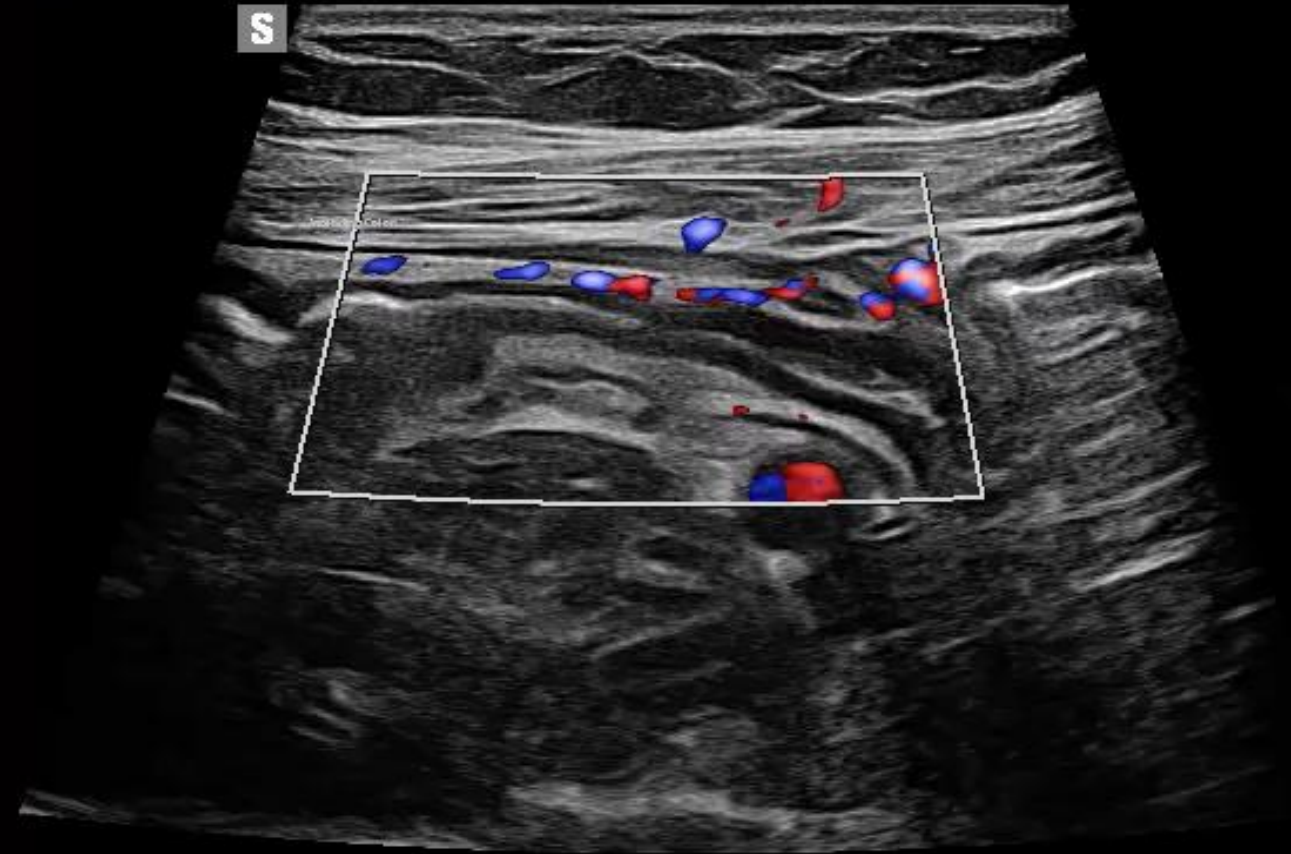


**Hyperemia =
Color Doppler signal**



Color Doppler Signal

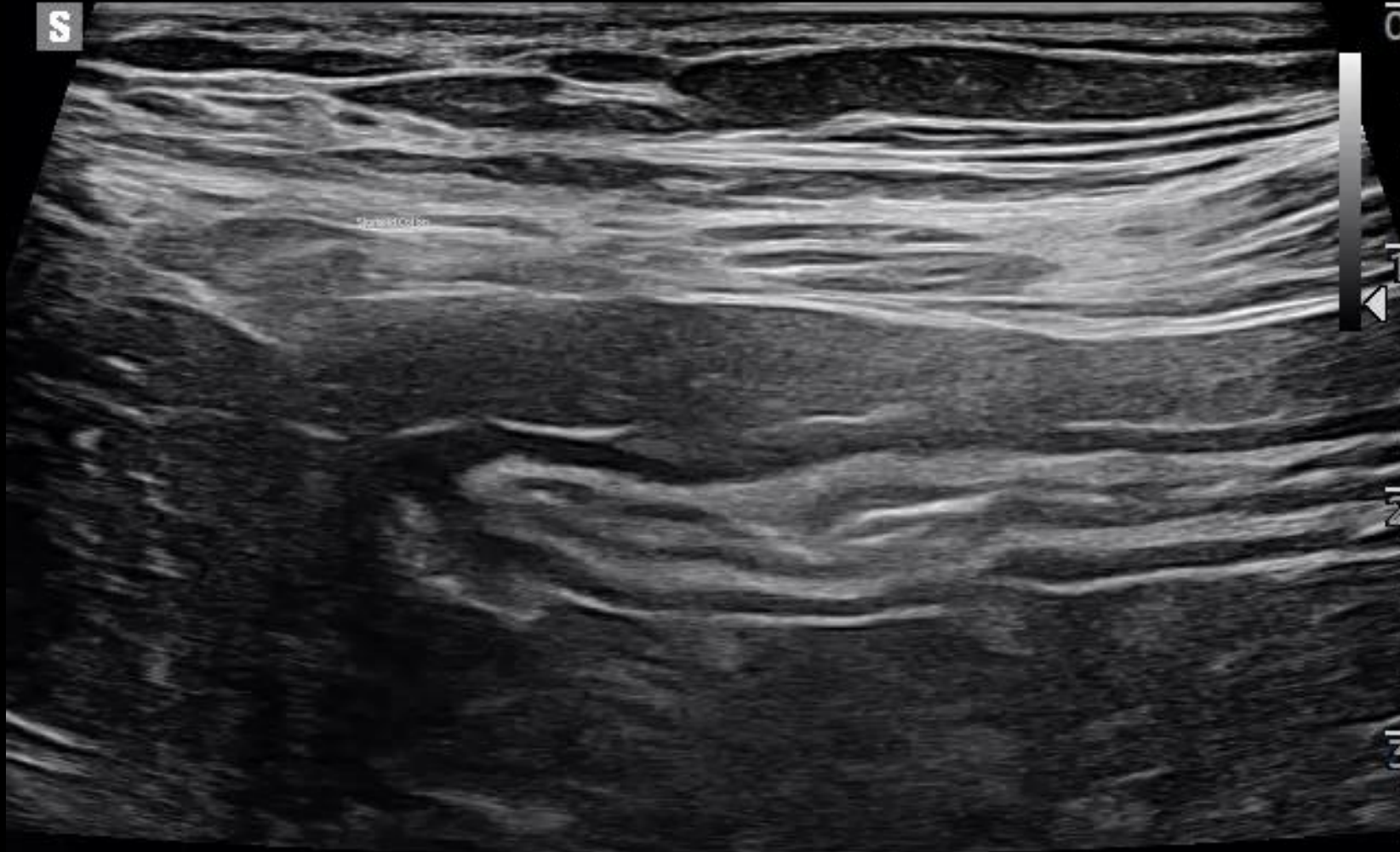
- Reliably measured: ICC ranges from 0.60 - 0.93^{1,2}
- Scoring semi-quantitative:
?preferences
- Strong correlation with histologic and endoscopic disease activity^{3,4,5}



1. Novak et al. JCC 2020
2. Saevik et al. JCC 2020
3. Moreno et al. JCC 2014
4. Sasaki et al. 2014
5. Ripolles et al. IBDj 2016



Echostratification: LAYERS



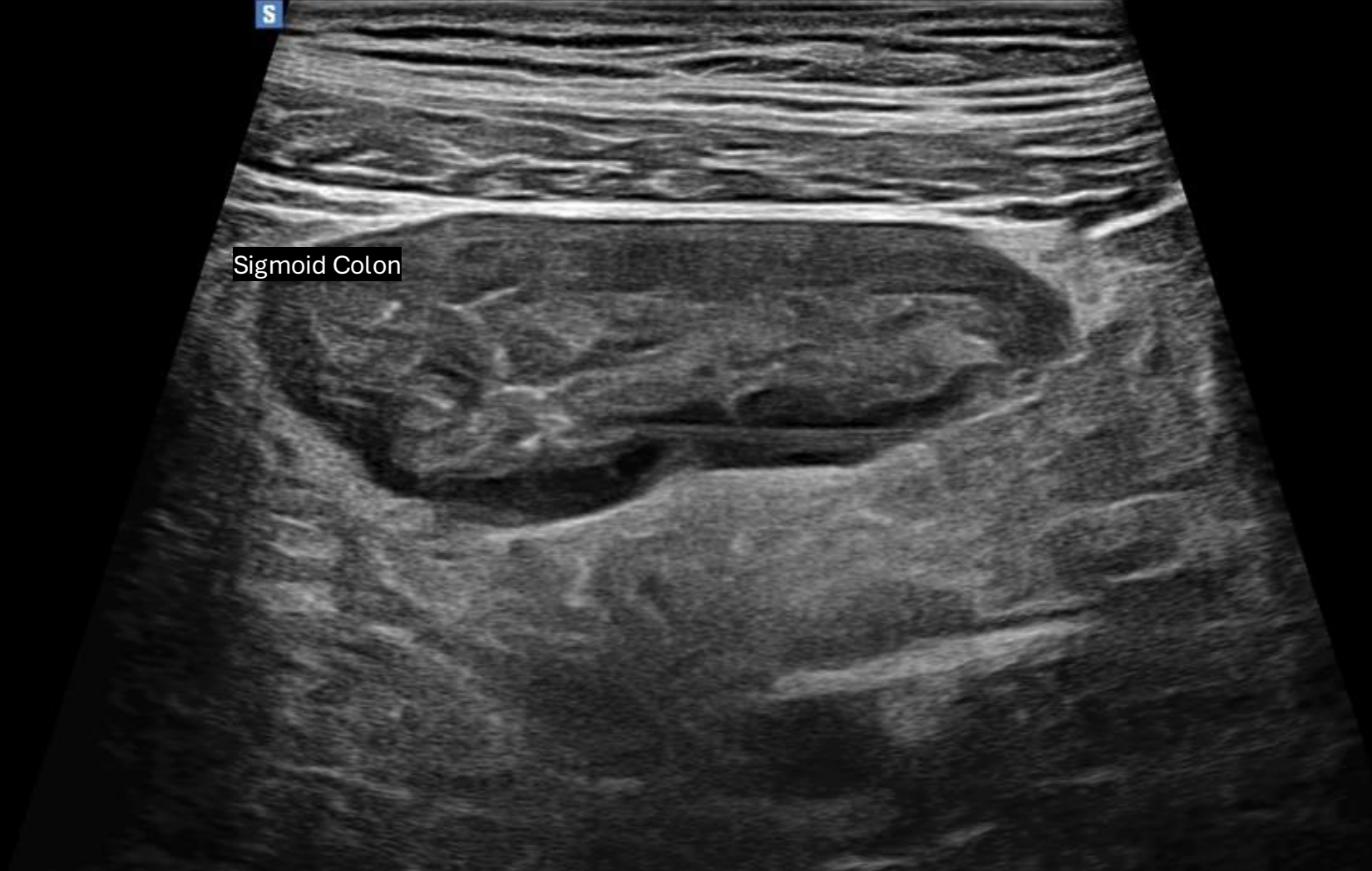


Inflammatory Fat

/LM2-18 /FR31Hz /6.0cm

S

Sigmoid Colon



Activity Scores

- Meta-analysis with 6381 identified studies, 23 reviewed with 23 US indices included
- Most common index parameters:
 - BWT
 - Blood flow seen through color Doppler
 - Bowel wall stratification
 - Inflammatory Fat
- Pooled Sensitivity: 68% - 100%
- Pooled Specificity: 57% - 100%
- Accuracy: 72% - 91%

Validated Ultrasound Activity Scores Can be Used to Quantify Disease Activity

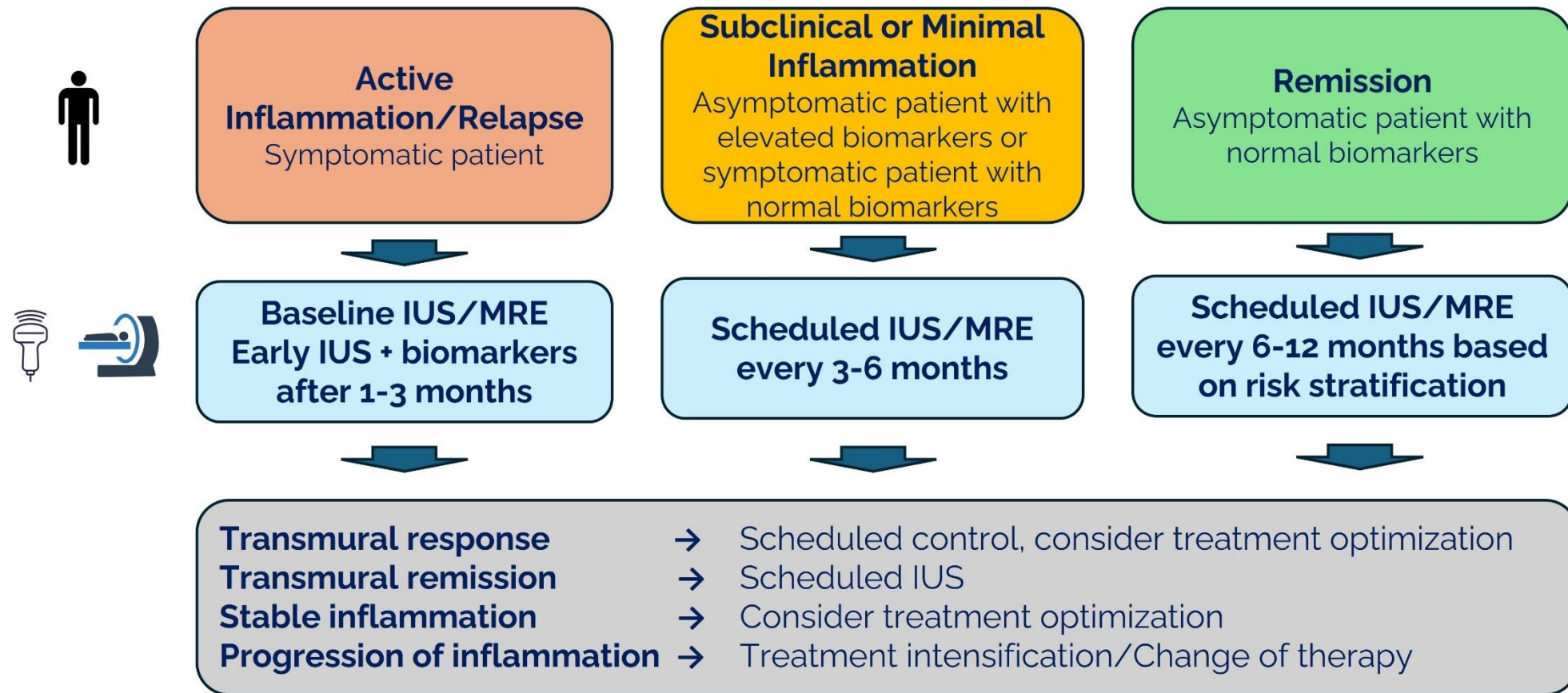
Study	Score name	Condition	Bowel wall thickness	Vascularization	Stratification	Inflammatory fat
Allocca 2018	MUC ^a	UC	 3 mm			
Allocca 2022	BUSS	CD	 3 mm			
Arienti 1996		UC	 unclear			
Bots 2021	UC-IUS index	UC	 2 mm			
Civitelli 2014	US Score	Ped UC	 3 mm			
Drews 2009	Modified Limberg score	CD	 3 mm	 L		
Futagami 1999	UICD	CD	 4 mm			
Kellar 2019	SPAUSS	Ped UC/CD	 4 mm			
Lenze 2012		CD	 4 mm	 L		
Liu 2020	UCS	CD	 3 mm	 L		
Livne 2021	MaRIA	CD	 3 mm			
Miyoshi 2022	KUC-UC	UC	 3 mm			
Neye 2004		CD	 5 mm			
Novak 2017	Simple Ultrasound Score	CD	 3 mm; 4 mm ^b	 L		
Novak 2021	IBUS-SAS	CD	 3 mm	 L		
Paredes 2010		CD	 3 mm			
Parente 2010	US Score	UC	 4 mm			
Pascu 2004	US Index	UC/CD	 3 mm			
Ripolles 2021	Simple US	CD	 3 mm	 L		
Rispo 2017	US-LI	CD	 3 mm			
Sævik 2020	SUS-CD	CD	 3 mm			
van Wassenæer 2023	PCD-US Score	Ped CD	 1.6 mm; 2 mm ^c			
Zhou 2023		CD	 2 mm	 L		

 Continuous variable in millimeters
 Categorical, ordered variable
 Binary variable (i.e., yes/no, present/absent, etc...)
 Limberg derivative, for vascularization

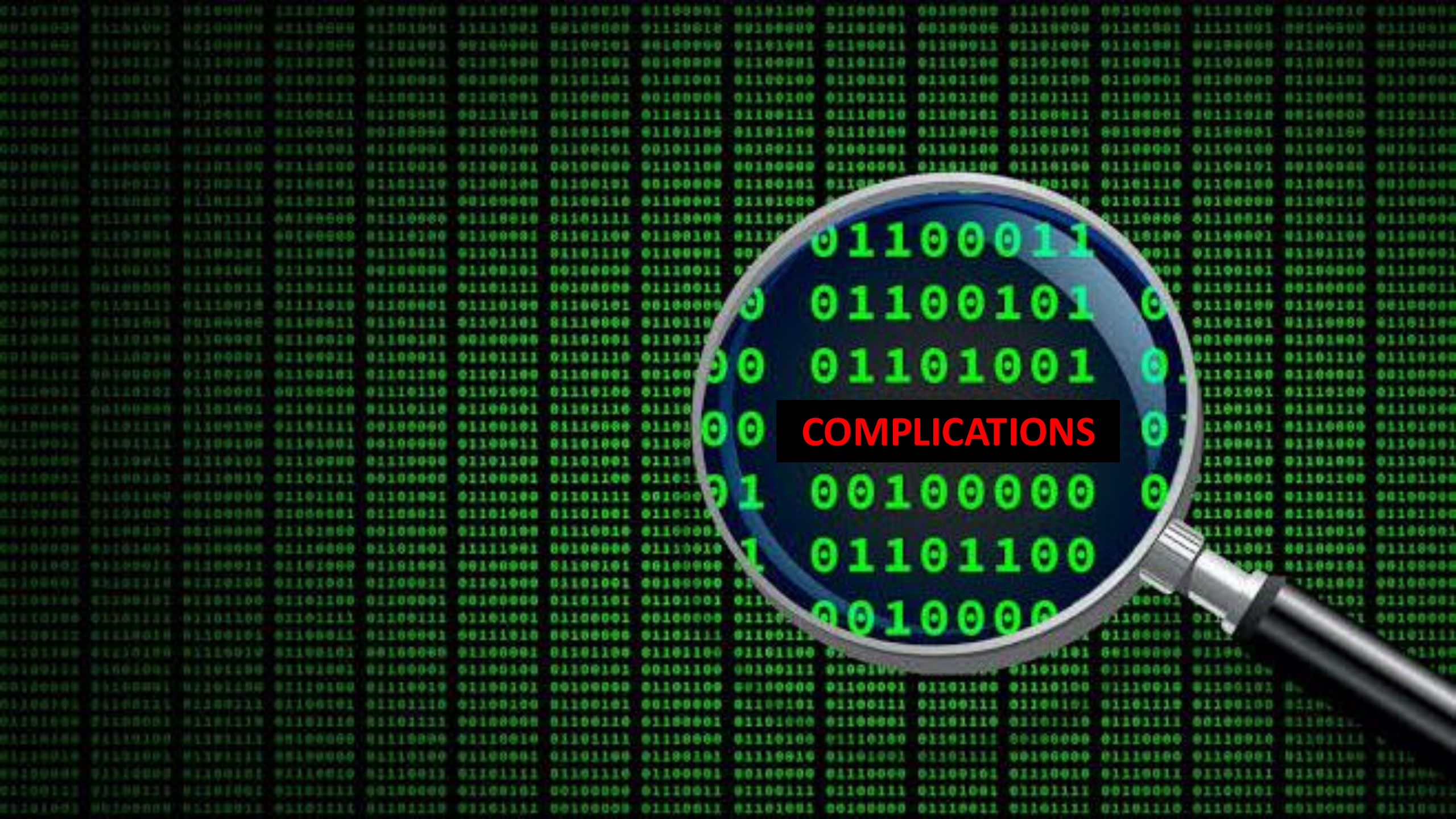
Take Away 1

Using a systematic approach, careful evaluation of sonographic parameters of inflammation in the small and large bowel, IUS has high accuracy for the detection of Crohn's disease and interval follow up is an **indispensable tool** for evaluating response to therapy.

Proposed Diagnostic Algorithm for the use of IUS in Crohn's Disease in Clinical Practice



MRE: magnetic resonance enterography
IUS: intestinal ultrasound
PoC: point of care



COMPLICATIONS

Detection of Complications

- Stricture has highest sensitivity 79-97.5% with evidence to suggest contrast may add to accuracy
- Specificity 75-100%
- TI strictures were identified more accurately than those in the proximal SB¹

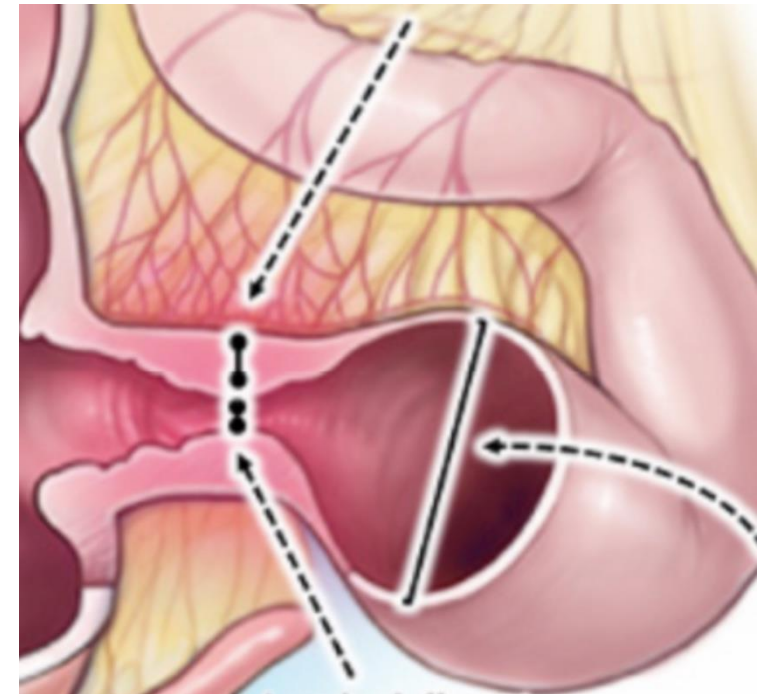
	Active disease	Strictures	Fistulas	Abscesses
Sensitivity	92% (73-99)	75% (53-90)	100%	100%
Specificity	100%	86% (70-95)	98% (90-99)	96% (88-99)

Definition of Stricture on IUS

- Luminal narrowing
 - <1 cm or
 - <50% relative to the normal adjacent bowel
- Bowel wall thickening
 - > 3mm at maximum BWT
- Pre-stenotic dilation
 - >2.5 cm or
 - >50% increase relative to adjacent bowel or
 - Unequivocal increase relative to the normal adjacent loop) ± Hyper-peristalsis

International expert guidance for defining and monitoring small bowel strictures in Crohn's disease on intestinal ultrasound: a consensus statement

Cathy Lu, Ryan Rosentreter, Claire E Parker, Julie Remillard, Stephanie R Wilson, Mark E Baker, Gaurang Bhatnagar, Jakob Begun, David H Bruining, Robert V Bryant, Britt Christensen, Brian G Feagan, Joel G Fletcher, Ilyssa Gordon, Gaylyn Henderson, Vipul Jairath, John Knudsen, Torsten Kucharzik, Kyle Lesack, Christian Maaser, Giovanni Maconi, Kerri Novak, Jordi Rimola, Stuart A Taylor, Rune Wilkens, Florian Rieder, on behalf of the Stenosis Therapy and Anti-Fibrotic Research (STAR) consortium



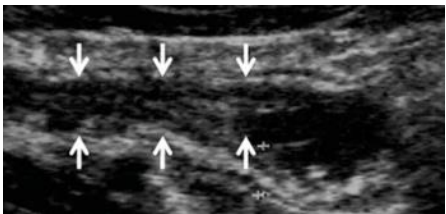
Intestinal Ultrasound Has Similar Accuracy to Cross-Sectional Imaging for Small Bowel CD & Small Intestinal Contrast Increases Accuracy for Strictures (CACTUS-CD)

- Prospective, paired, confirmatory study (CACTUS-CD) to test the accuracy of SICUS against reference test (cross-sectional imaging: CTE/MRE) in known small bowel CD.
- SICUS = IUS with 500 ml of PEG
- 96 CD patients recruited



Results

- Sensitivity and specificity for the detection of small bowel CD inflammation is high
- SICUS increases the sensitivity and accuracy of stricture detection and extent.
- In 81% of cases, it led to the same management as cross-sectional imaging
- False negatives by IUS associated with proximal SB disease



SICUS image of a small bowel stricture

- **IUS is a useful tool for monitoring small bowel CD;**
- **SICUS adds increased accuracy for the detection of strictures**

	Sensitivity	Specificity	Accuracy
Small bowel disease presence			
IUS	95.5%	100%	95.8%
SICUS	95.5%	100%	95.8%
Small bowel disease extent of involvement			
IUS	85.2%	87.5%	85.4%
SICUS	88.6%	87.5%	88.5%
Small Bowel Strictures			
IUS	53.8%	98.2%	80.2%
SICUS	74.3%	98.2%	88.5%
Small Bowel Stricture Extent of Involvement			
IUS	46.1%	98.2%	77.1%
SICUS	69.2%	98.2%	86.4%
Small Bowel Fistula			
IUS	60%	98.9%	96.9%
SICUS	80%	98.9%	97.9%

Characterizing strictures – Amsterdam Stricture Score

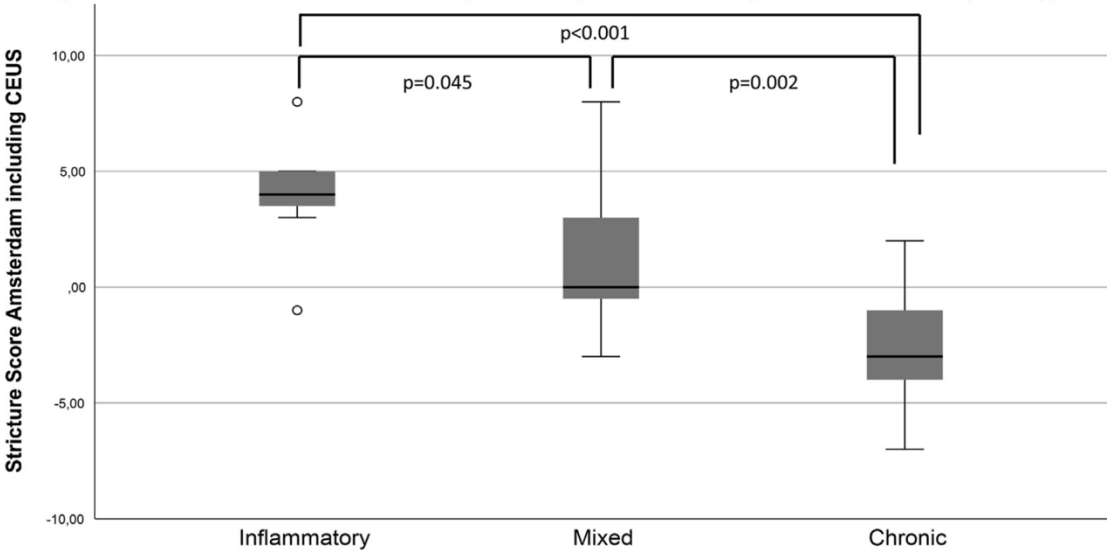
Clinical Gastroenterology and Hepatology 2026;24:474–483

Intestinal Ultrasound and Its Advanced Modalities in Characterizing Strictures in Crohn’s Disease

Floris de Voogd,^{1,6} Kim J. Beek,^{2,6} Maarten Pruijt,^{1,6} Kyra van Rijn,^{2,6} Jarmila van der Bilt,^{3,6} Christianne Buskens,^{3,6} Willem Bemelman,^{3,6} Andra Neefjes-Borst,^{4,6} Aart Mookhoek,⁵ Geert D’Haens,^{1,6} Jaap Stoker,^{2,6} and Krisztina B. Gecse^{1,6}

SSA		
BWT	<6.4 mm	−4
	≥6.4 mm	0
CDS	1 or 2	−3
	3	0
	4	+3
Wall layer stratification	Present	0
	Lost	+2
Contrast-enhanced ultrasound	WiAUC <38.20 dB	0
	WiAUC ≥38.20 dB	+3
Total score	Range, −7 to +8	

Boxplot for the Stricture Score Amsterdam (with CEUS) for inflammatory, mixed and chronic phenotypes



Score > 2: High accuracy for an **inflammatory phenotype**, making the patient a likely candidate for anti-inflammatory medical therapies.

Score < 0 (Negative): High accuracy for a **chronic/fibrotic phenotype**, which may require endoscopic dilatation or surgical resection

CD Complications – Abscess

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

CEUS to Differentiate Phlegmons from Abscesses in Crohn's Disease

Retrospective analysis:

71 inflammatory masses in 50 patients

- 21 phlegmons
- 36 abscesses

Specificity for detection of abscesses: **100%**

Kappa coefficient: 0.972 between CEUS and other techniques

Conclusion:

CEUS should be used to evaluate any inflammatory mass identified at US in Crohns disease

CD Complications – Fistula

IUS Criteria - Fistula

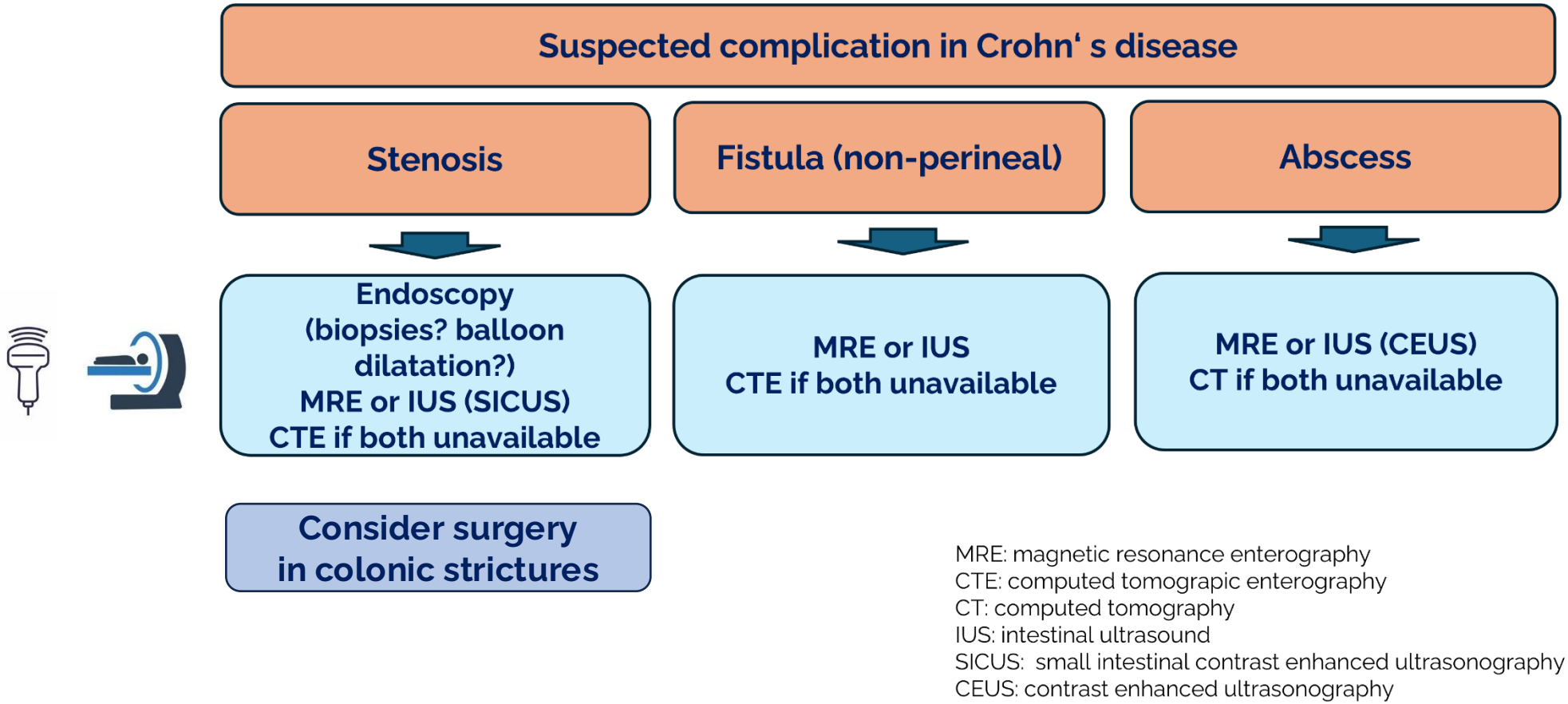
- Hypo- or anechoic extension from bowel wall filled with fluid and/or gaseous artefacts
- Irregular margins
- Frequently surrounded by mesenteric fat

Accuracy of IUS in CD-Related Complications

Systematic review and meta-analysis: 1970-2022, with 68 studies for the SR and 23 studies for the MA with 3863 patients

Complication	Exam type	Pooled sensitivity (95% CI)	I ² (%)	χ ²	Pooled specificity (95% CI)	I ² (%)	χ ²
Stricture	B-mode	0.84 (0.81-0.87)	75.3	68.74*	0.89 (0.87-0.90)	82.9	99.56*
	SICUS	0.94 (0.87-0.98)	0.0	2.42	0.95 (0.88-0.98)	55.2	6.7
Fistula	B-mode	0.67 (0.60-0.73)	65.6	34.91*	0.97 (0.96-0.99)	11.0	13.48
	SICUS	0.90 (0.78-0.97)	39.5	3.3	0.94 (0.87-0.98)	0.0	0.61
Inflammatory masses	B-mode	0.87 (0.78-0.93)	0.0	7.65	0.95 (0.92-0.97)	31.6	11.69
	SICUS	0.91 (0.72-0.99)	50.7	4.06	0.97 (0.92-0.99)	46.1	3.71

Assessment of Complications in CD

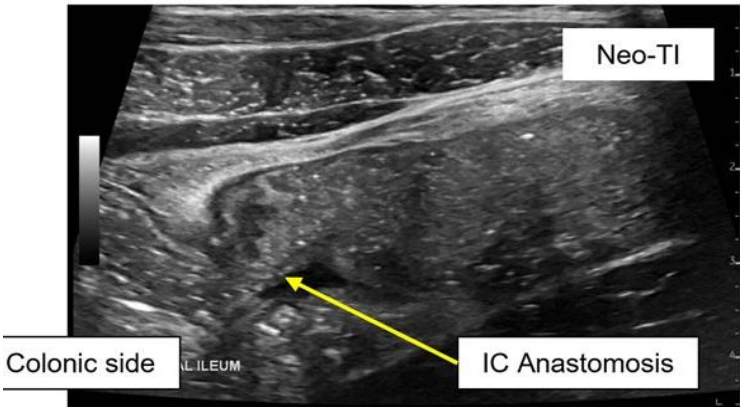
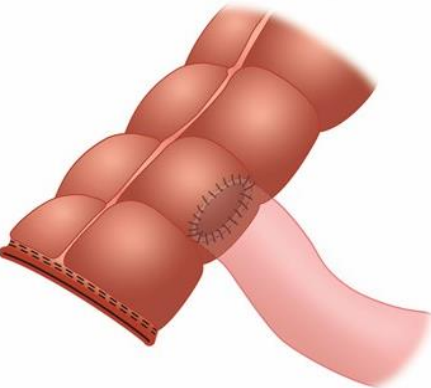


Take Away 2

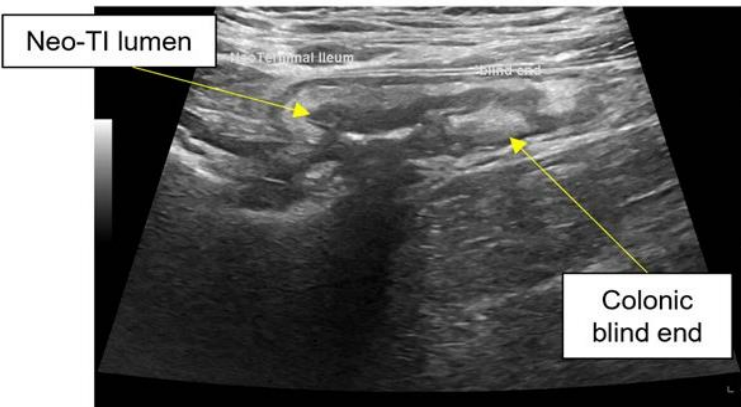
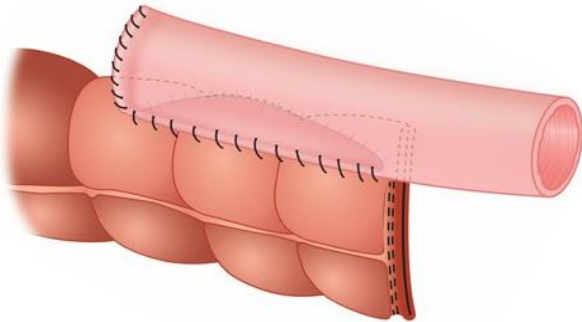
The detection of Crohn's disease complications, including
STRICTURES
INFLAMMATORY MASSES, ABSCESSSES
FISTULA

Can be challenging but is accurate.
Correlation with CT/ MR may be a consideration

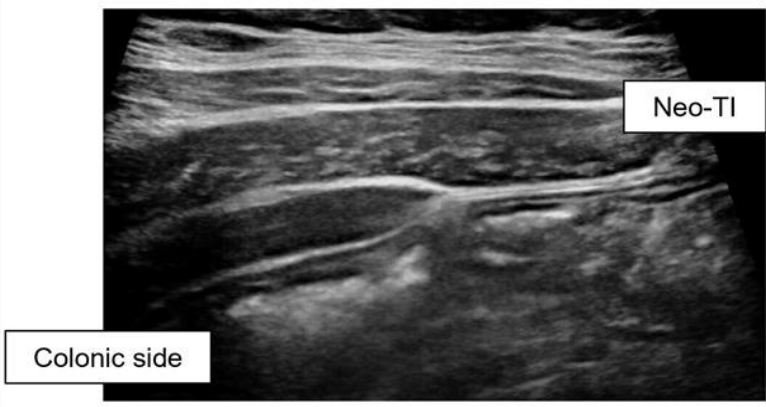
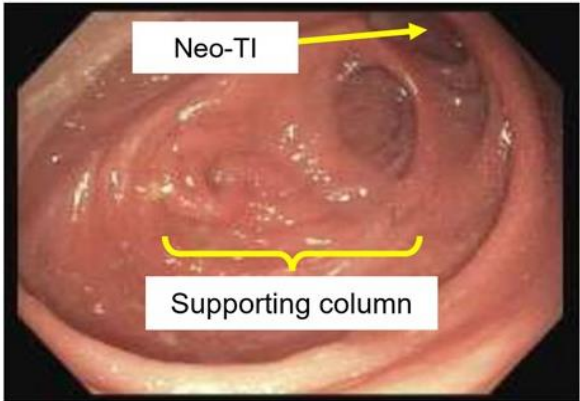
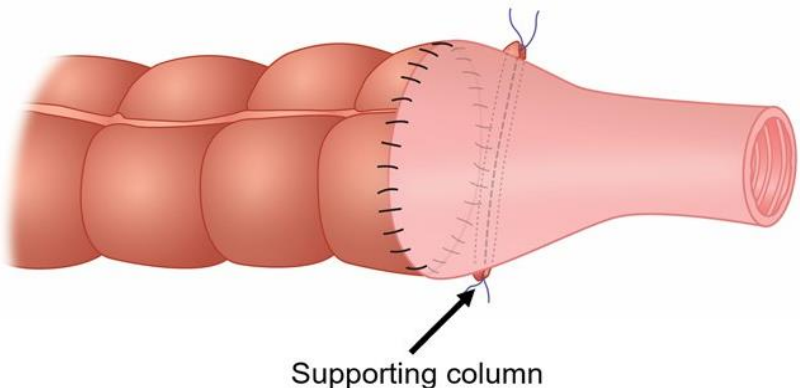
End-to-side anastomosis



Side-to-side anastomosis



Kono-S anastomosis



IUS for Postoperative Monitoring in CD

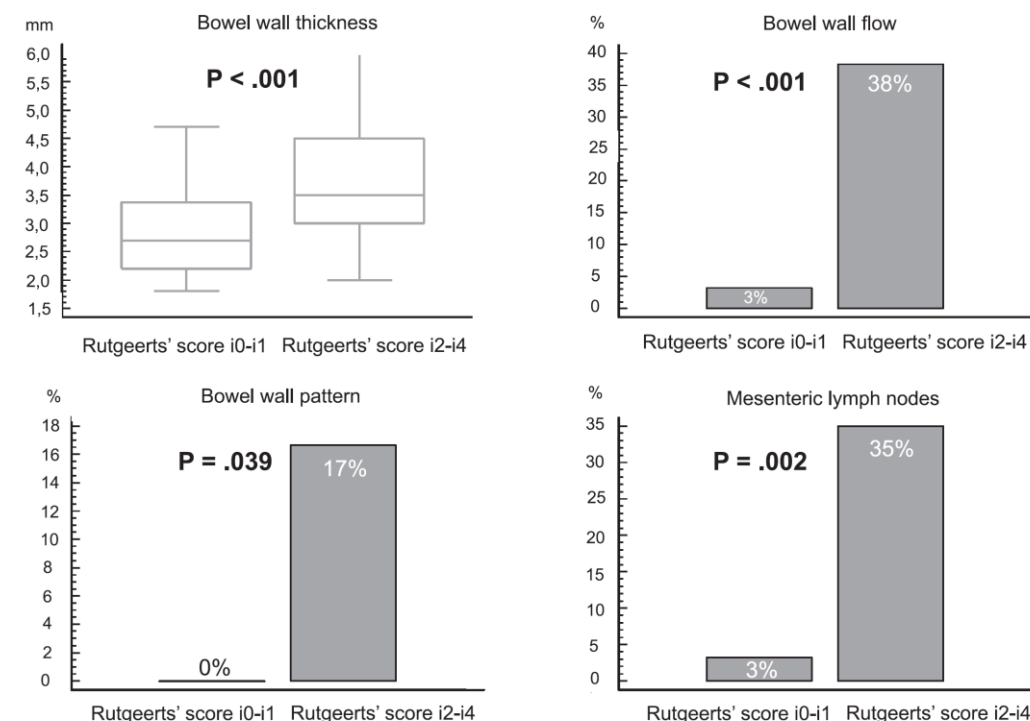
BWT > 3 mm plus FC > 50 µg/g
correctly classified **74%** of patients
with endoscopic recurrence

Independent predictors

BWT per 1 mm increase	OR 2.43
Lymph nodes	OR 15.6
FC	OR 8.58

Noninvasive Assessment of Postoperative Disease Recurrence in Crohn's Disease: A Multicenter, Prospective Cohort Study on Behalf of the Italian Group for Inflammatory Bowel Disease

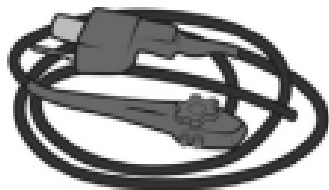
Federica Furfaro,¹ Ferdinando D'Amico,^{1,2} Alessandra Zilli,¹ Vincenzo Craviotto,³ Annalisa Aratari,⁴ Cristina Bezzio,⁵ Antonino Spinelli,³ Daniela Gilardi,⁶ Simona Radice,¹ Simone Saibeni,⁵ Claudio Papi,⁴ Laurent Peyrin-Biroulet,^{7,8} Silvio Danese,^{1,6} Gionata Fiorino,^{1,6} and Mariangela Allocca^{1,6}



Fecal calprotectin <50 µg/g and normal IUS have high sensitivity for excluding active CD recurrence

CHALLENGE: repeated colonoscopy for detecting Crohn's disease (CD) recurrence after surgery is expensive and invasive

AIM: evaluate the accuracy of non-invasive inflammatory biomarkers and imaging for detecting postoperative CD

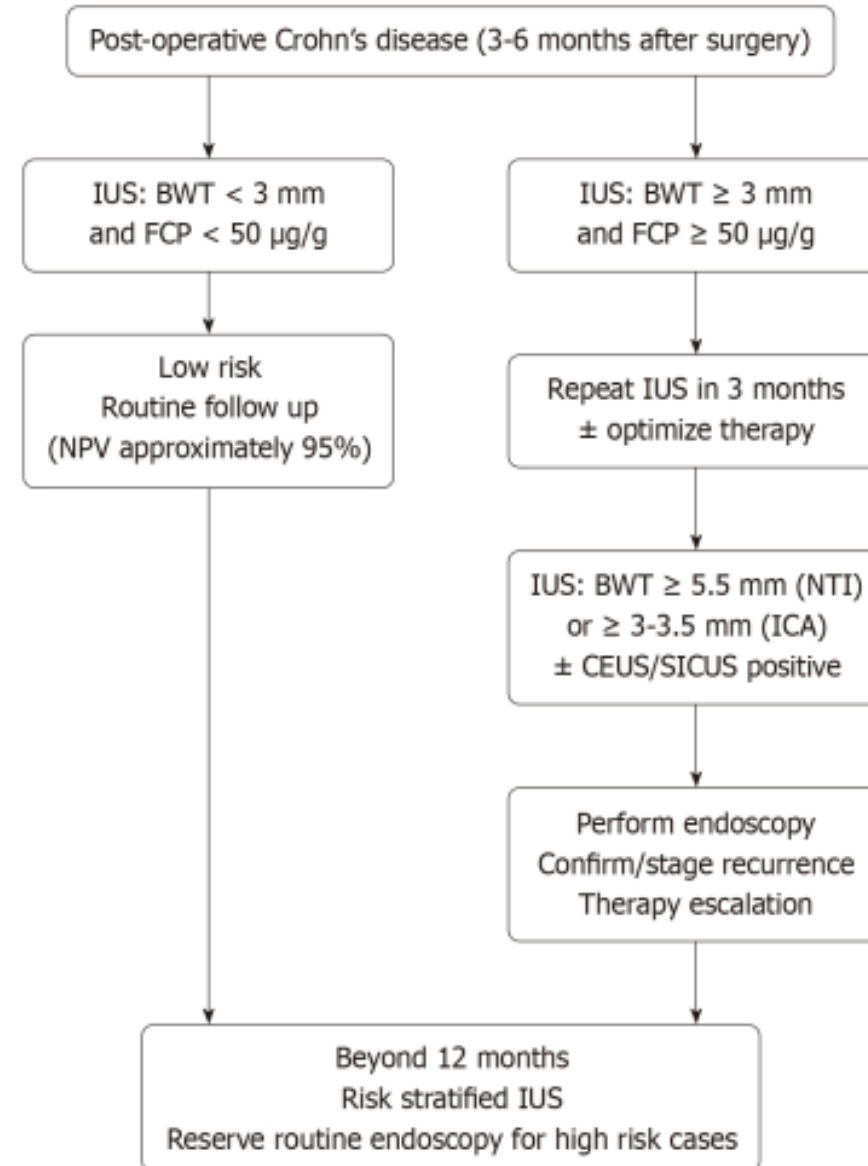


Systematic review
Meta-analysis
(34 studies)

Test	Pooled Sensitivity [95% CI]	Pooled Specificity [95% CI]
C-reactive protein	0.45 [0.33, 0.58]	0.83 [0.69, 0.92]
Fecal calprotectin	0.76 [0.7, 0.82]	0.66 [0.56, 0.75]
CTE or MRE	0.89 [0.73, 0.96]	0.65 [0.43, 0.82]
Intestinal ultrasound (IUS)	0.89 [0.75, 0.96]	0.76 [0.52, 0.90]
Optimized IUS definitions of recurrence	0.93 [0.80, 0.98]	0.85 [0.71, 0.93]

Conclusions: fecal calprotectin <50 µg/g and imaging, including IUS, have high sensitivity for excluding CD recurrence

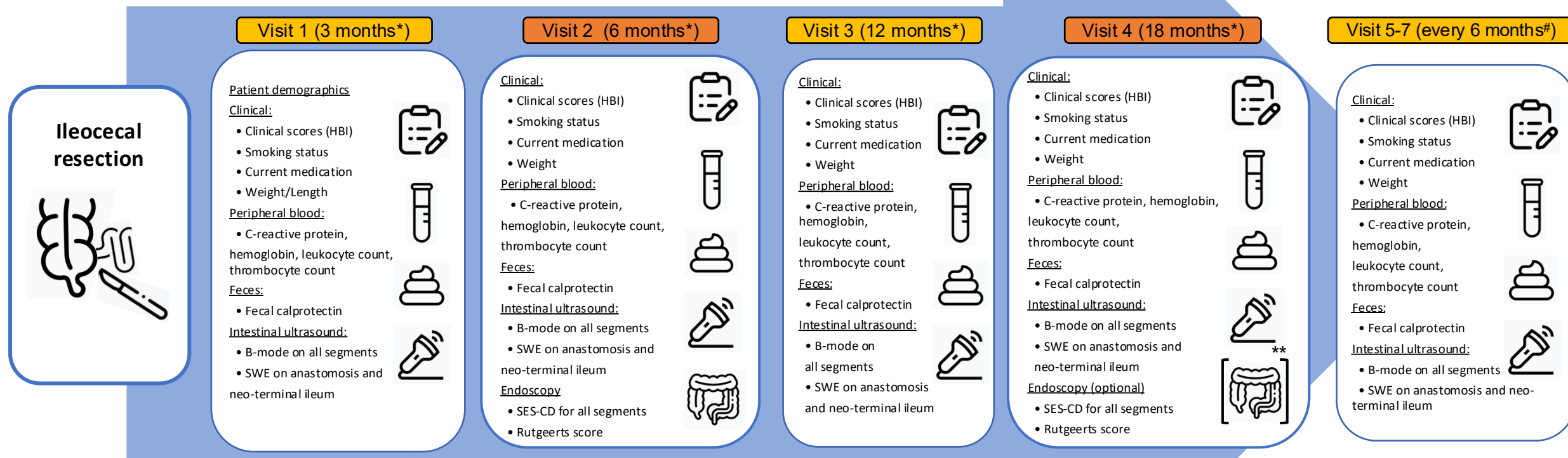
Proposed Algorithm for Postoperative Monitoring in CD



INSIGHT study – Postoperative Monitoring with IUS



Postoperative follow-up in standard care →



* Months approximately after surgery

** Optional, only if clinically indicated

every 6 months until 3 years after their surgery

Primary objective

-Investigate if IUS (B-mode, Doppler) in combination with fecal calprotectin at 3 months after ICR is an early surrogate marker of endoscopic recurrence (RS $\geq$ 2b) at 6 months

INSIGHT study – Postoperative Monitoring with IUS



**BWT Neoterminal Ileum ≥ 2.0 mm + FC ≥ 192 mg/kg:
OR of 11.8 (95% CI 2.4–56.8, $p=0.002$)
for endoscopic recurrence at 6 months (Ri2b)
Sens. 33%, Spec. 96%, PPV 86% and NPV 66%.**

Take Away 3

- **IUS accurately detects CD postoperative recurrence**
- **IUS suggests severity of endoscopic recurrence**
- **Early IUS predicts endoscopic outcome**
- **IUS should be integrated in early postoperative follow up**



international bowel
ULTRASOUND GROUP

Q&A