Editorial

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Ileal Ulcers: Are We Over enthusiastic about Crohn's Disease or Ignorant?

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Ileal ulcers are relatively common finding on ileal intubation during colonoscopy. But their etiological interpretation remains challenge in gastroenterology practice. Finding of ulcers in terminal ileum often triggers endoscopist to think about inflammatory bowel disease (IBD) specially Crohn's disease (CD), but is this inclination always justified? So, the debate; "Are we over-diagnosing or under-diagnosing CD" remains to be resolved.

Actually, a number of diseases may cause ileal ulcerations; like CD, intestinal tuberculosis, other infectious enteritis, NSAID, lymphoma, Behcet's disease, eosinophilic enteritis and a large number have non-specific causes.[1-3]

Though traditionally considered to be a disease of high-income countries, IBD today is a global condition with an accelerated incidence in Asia, Africa, and Latin America, which parallels industrialization and lifestyle change.[4] Considering this global disease, theme for World IBD Day 2025 (May 19) was "IBD Has No Borders: Breaking Taboos, Talking About It" and that of 2026 was "IBD Has No Borders: Access to Care".

After getting ileal ulcer at colonoscopy, it is important to take careful history pointing towards causes, evaluation of inflammatory markers like C reactive protein (CRP), Fecal calprotectin (FCal), other imaging modalities MR/CT enterography, histological findings are required to reach diagnosis. When combined with other biomarkers, CRP can significantly improve diagnostic performance of CD.[5] Fecal calprotectin also has sensitivity and specificity respectively 78% and 45% for cut-off value 100 µg/g.[6] In our context, exclusion of tuberculosis is a major concern also.

Problems of over-diagnosis: All of we know that CD is a costly disease in terms of drug cost as well as side effects related to treatment. Besides, labeling a patient with a chronic, incurable disease imposes profound psychological burden. So, we must resist our temptation to diagnose CD based on a few ileal ulcers no objective evidence of inflammation (normal calprotectin, CRP and imaging).

Problem of Under-Diagnosis: In early stages of disease, typical radiologic, endoscopic or histologic features may not be clearly evident. Absence of non-caseating granulomas doesn't exclude CD & it is found in fewer than 20% of biopsies.[7] Similarly, a normal CT/MR enterography does not rule out early CD, as mesenteric fat stranding and wall thickening appear late.

So, waiting for typical endoscopic, radiologic or histologic features, we may miss the window period for early immunomodulation, allowing subclinical inflammation progress to develop stricturing or penetrating disease within few years.

Young age, perianal symptoms, extra-intestinal manifestations, or a family history of CD, deep fissure like linear or serpiginous ulcers with nodular mucosa, narrowed & scarred ileo-caecal valve, coexisting colonic lesions point firmly toward the diagnosis of CD. In contrast, circumferential, shallow ulcers with patulous ileo-caecal valve indicate tuberculosis. For equivocal cases, follow up with history, CRP, fecal calprotectin & repeat ileo-colonoscopy after 6- 12 months is more rational than immediate treatment for CD.

So, all ileal ulcers are not CD & it is not easy to reach a definite diagnosis. Exclusion of tuberculosis is very important at our setting, other causes of ileal ulcers need to be considered positively but CD should not be underestimated.

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