

# **Заболевания кишечника**

## **Болезнь Крона**

## **Язвенный колит**

Лекция для студентов 3-го курса лечебного факультета

2018

# Колоноскопия

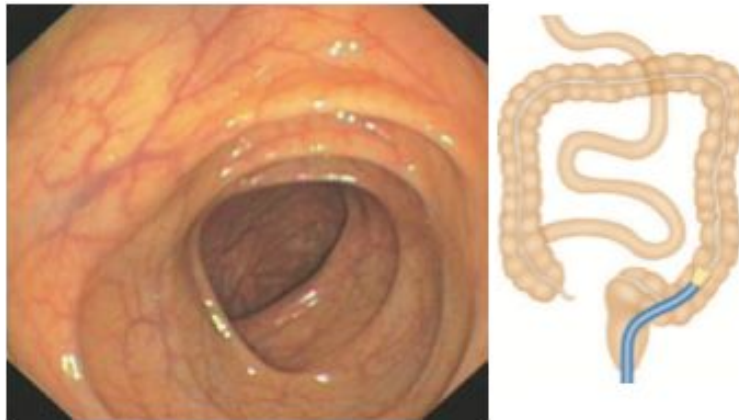


Fig. 5.11 View into the descending colon. Relatively straight path, oval lumen, and evenly spaced haustrations.



Fig. 5.12 Splenic flexure with luminal impression, shimmering of spleen.

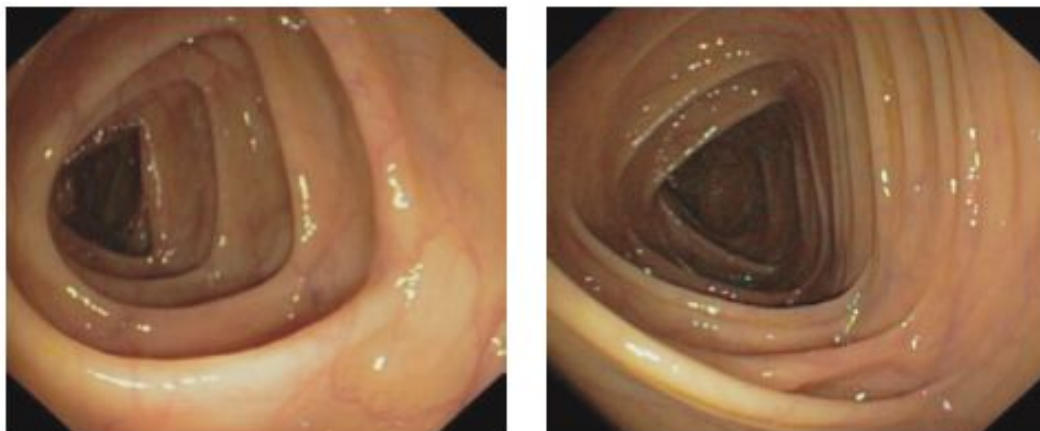


Fig. 5.14a, b View into the transverse colon after passing the splenic flexure: typical triangular configuration and pronounced, evenly spaced haustration.

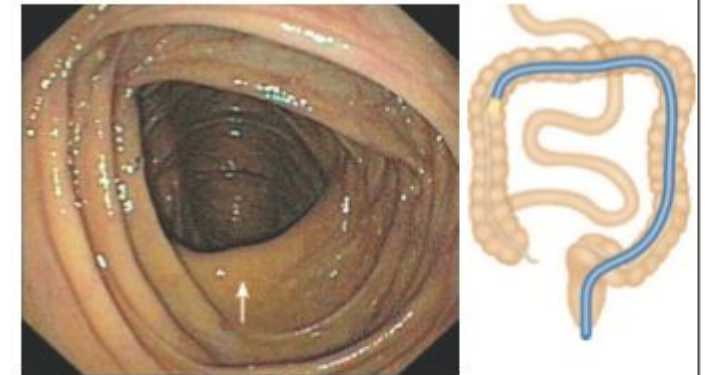


Fig. 5.17 View into the ascending colon after passing the hepatic flexure. The ileocecal valve, seen as a yellowish, thickened fold, is on the lower edge of the lumen (arrow) in the distance.

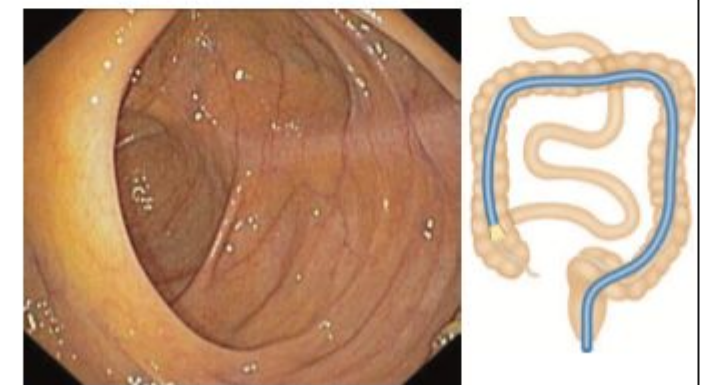
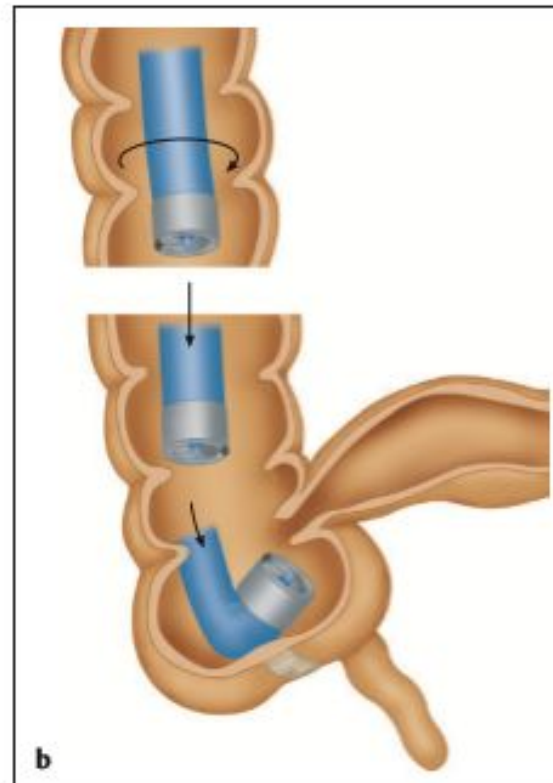
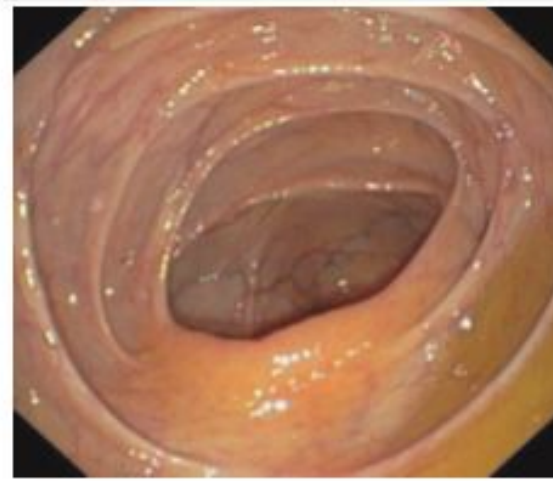


Fig. 5.19 View of the ileocecal valve (thickened, yellowish semi-circular fold on the left) and tilted cecum, obscured view into the cecum from this aspect.

# Илео- цекальный клапан



# Илеоскопия (осмотр терминального отдела подвздошной кишки)

- Отсутствие гаустраций
- “Вельветовая” слизистая







Hepatic flexure



Transverse colon



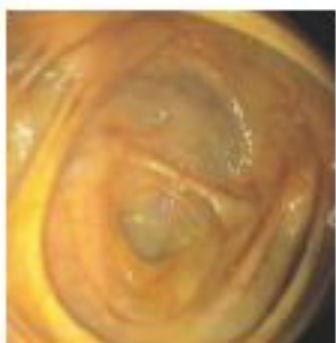
Splenic flexure



Ascending colon



Descending colon



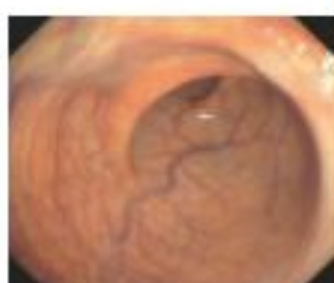
Cecum



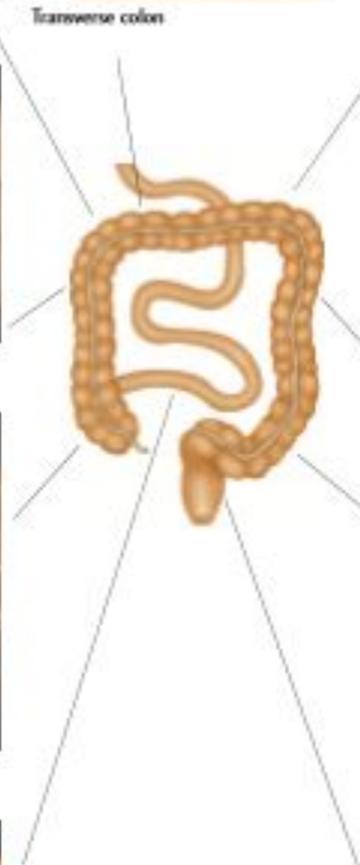
Sigmoid colon



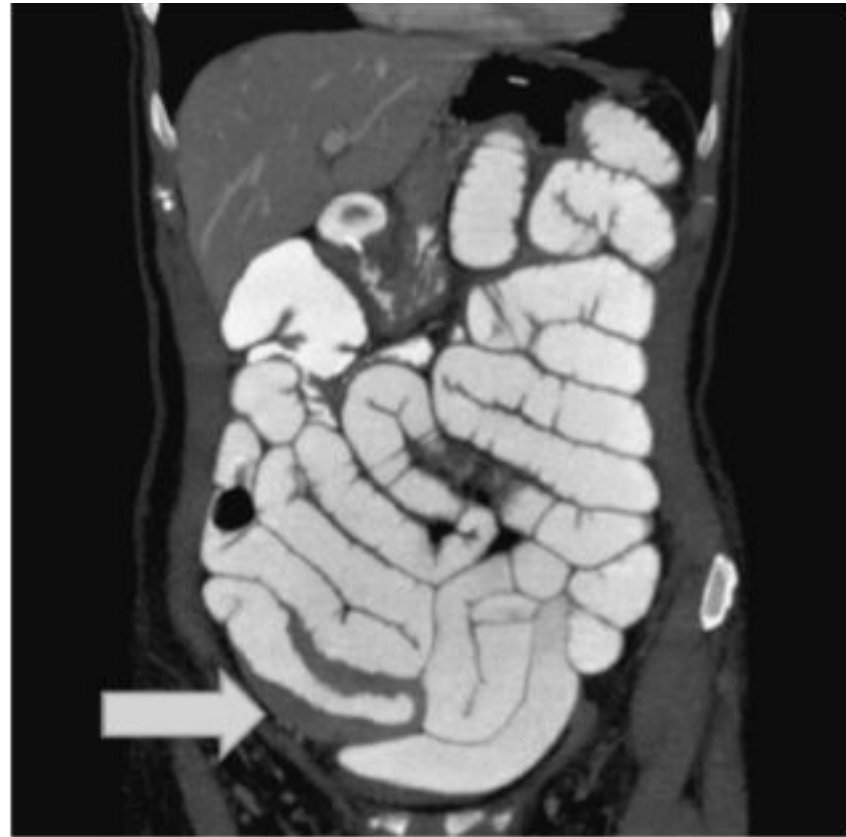
Ileum



Rectum



# Компьютерная томография кишечника



**Figure 37.33** Computed tomographic enterography showing thickened terminal ileum (arrow) in a patient with Crohn's disease.

# Ирригоскопия (бариевая клизма)



# Фекальный кальпротектин

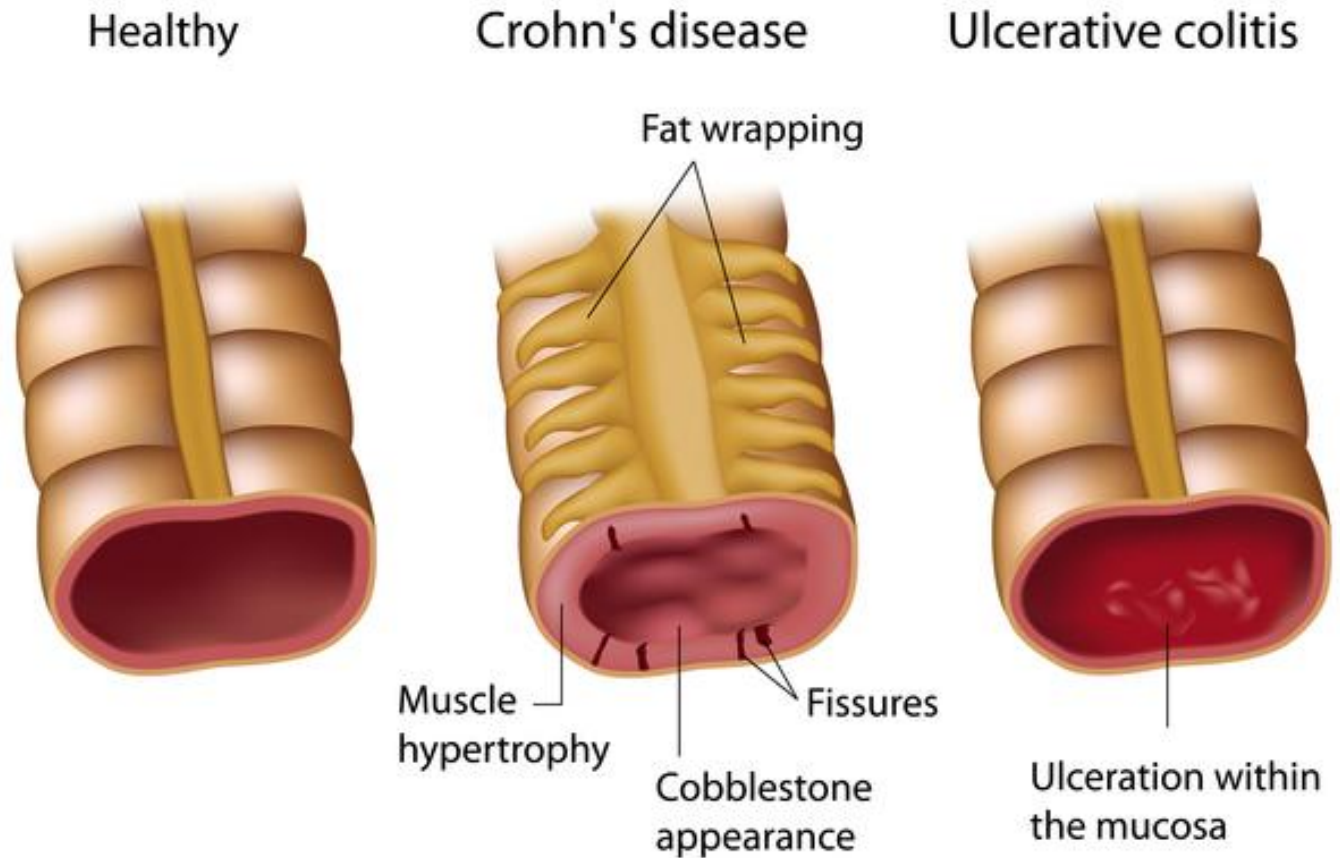
- Пациенты с гастроинтестинальными симптомами могут иметь или не иметь органическое заболевание кишечника
- Фекальный кальпротектин позволяет определить группу пациентов, которым необходимо проведение эндоскопического исследования
- Норма <50 мкг/г
- При ВЗК часто повышен до 1000 мкг/г и более
- Чувствительность и специфичность ФКП в диагностике ВЗК достигает 95-100%



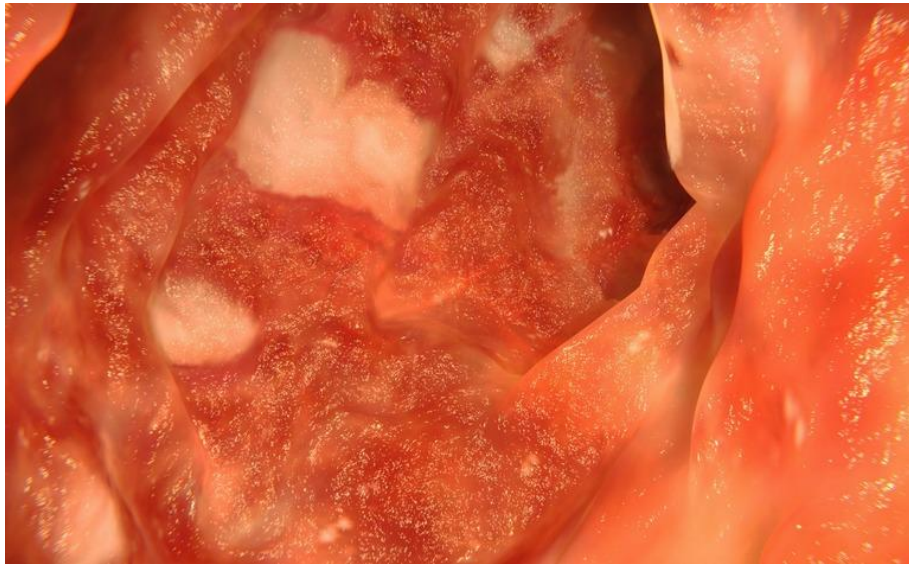
# Воспалительные заболевания кишечника

- Язвенный колит
- Болезнь Крона

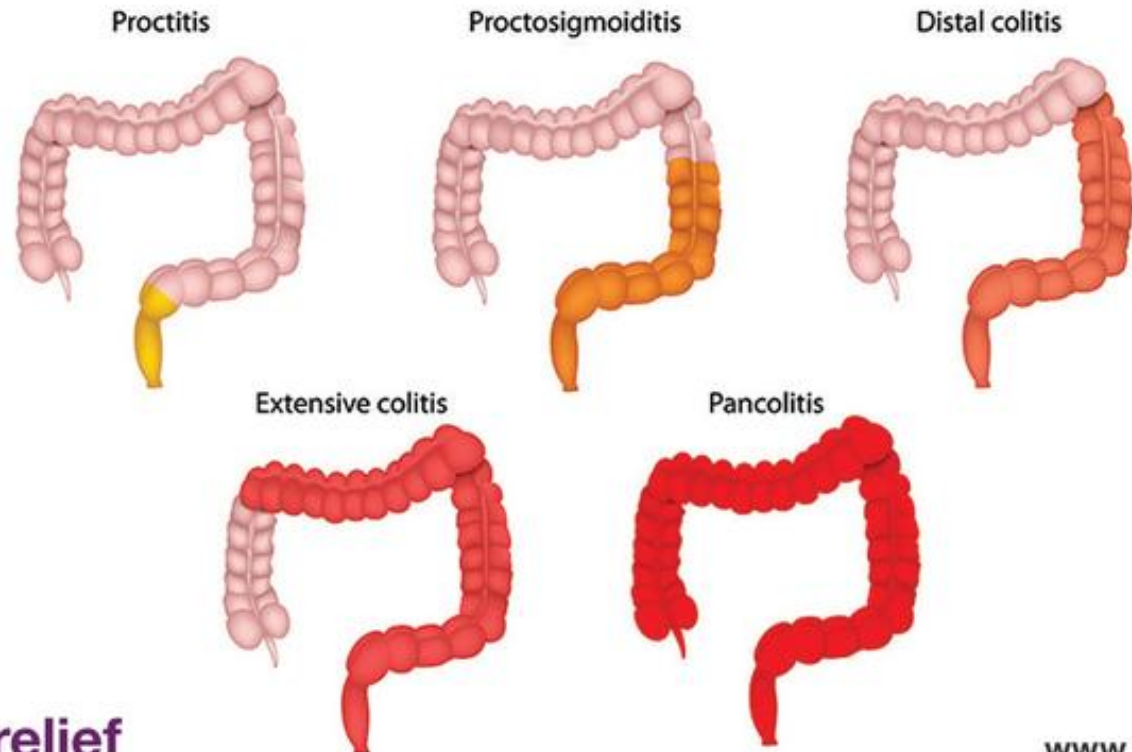
## Inflammatory Bowel Disease



# Поражение толстого кишечника при ЯК



## TYPES OF ULCERATIVE COLITIS



# Изменения слизистой прямой кишки при ЯК

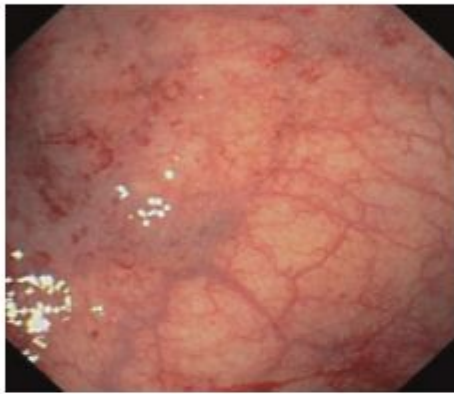


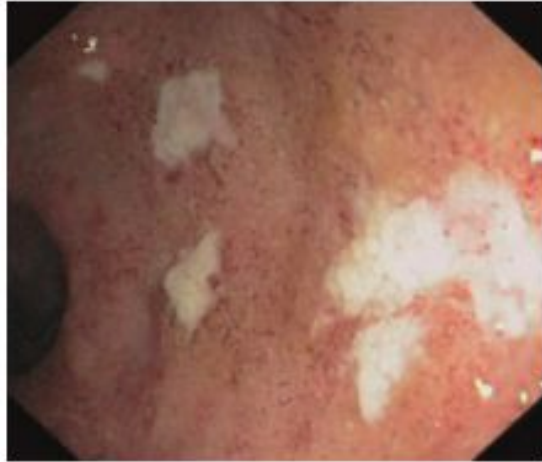
Fig. 12.1 **Ulcerative proctitis.** Sharp demarcation between inflamed mucosa (left) and normal mucosa in upper rectum.



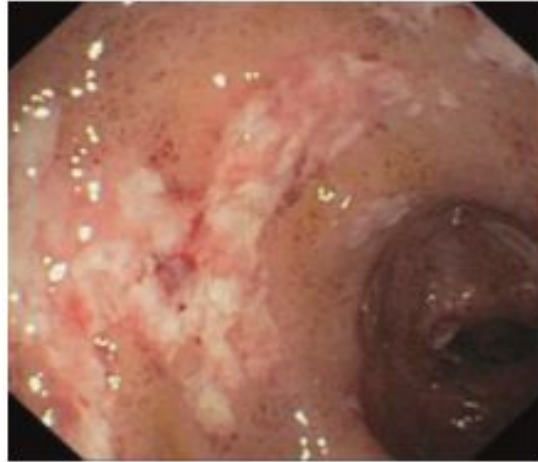
Fig. 12.2 **Ulcerative proctitis.** Florid attack in rectum with abrupt transition to normal sigmoid colon above.



■ 12.1 Ulcerative colitis: fibrinous exudates, edematous and granulated mucosa in an acute episode



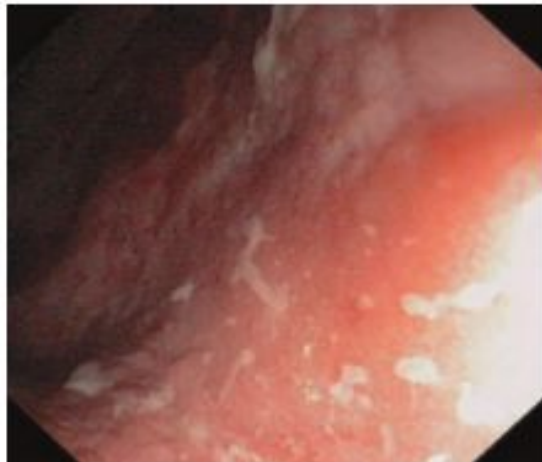
a Recent fibrinous exudates, appearing as a whitish covering on an already edematous mucosa (sigmoid colon).



b Fibrinous material on an edematous and granulated mucosa (rectum).



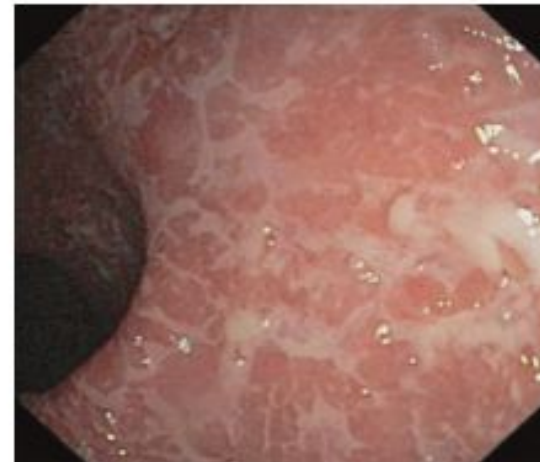
c Masses of fibrin and blood (sigmoid colon).



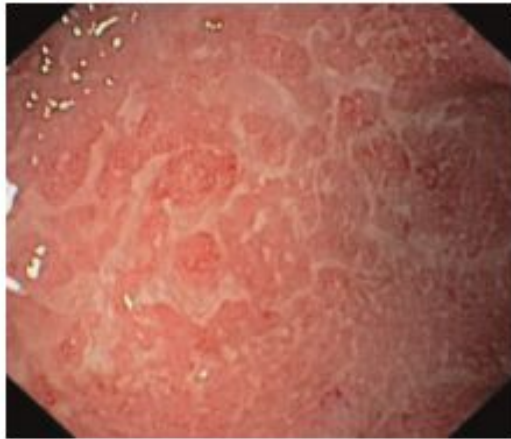
d Ulcerative proctitis: fibrinous exudates.



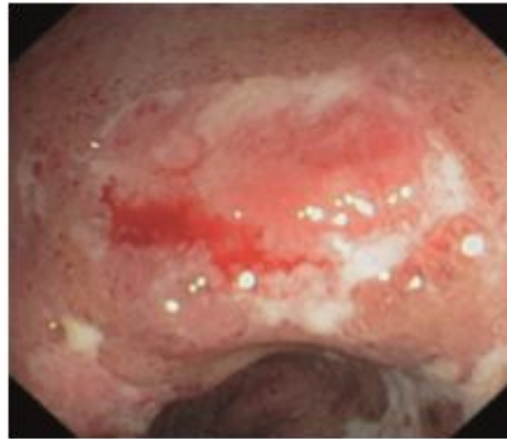
e Pancolitis, chronic ulcerations, also recent attack with fibrinous material in the ascending colon.



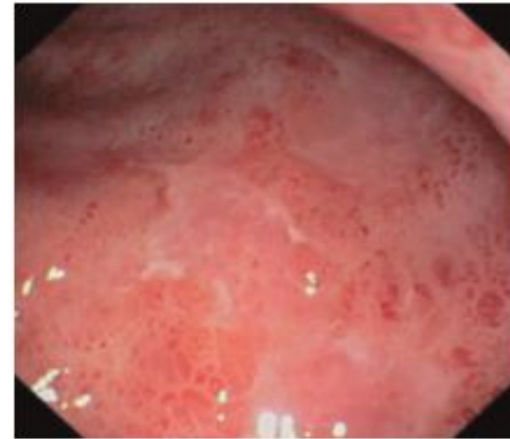
f Florid inflammation in the sigmoid colon with typical fresh fibrinous coverings, already weblike, precursor of ulceration.



a Weblike confluent ulcerations in an acute episode (rectum).



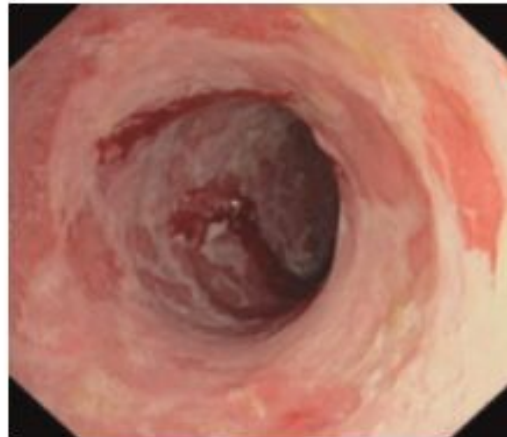
b Recent attack: flat, recent ulcer, fibrin in the background (sigmoid colon).



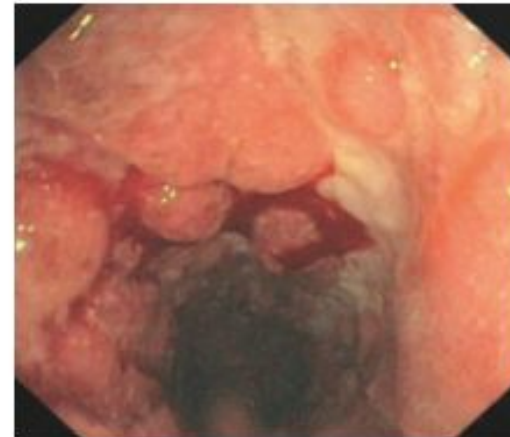
c Flat ulceration and mucosal petechiae in a treated attack (sigmoid colon).



d Confluent ulcers and fibrinous masses in an acute attack (lower sigmoid colon).



e Significant, almost circular mucosal necroses and flat ulcerations related to active chronic UC with persistent attack.



f Deep ulcerations can appear with a high degree of activity; vulnerability is overall greatly increased. Distinguishing UC from other forms of colitis is more difficult here; main criteria for UC are continuous inflammatory process and mucosal erythema.



# Псевдополипы при ЯК



**Fig. 12.7** Pronounced development of pseudopolyps with signs of florid inflammation on their surfaces; causing moderate stenosis.



**Fig. 12.8** Pale tiny pseudopolyp, smooth surface, thus appearing like remaining local mucosa or partially regenerated mucosa.

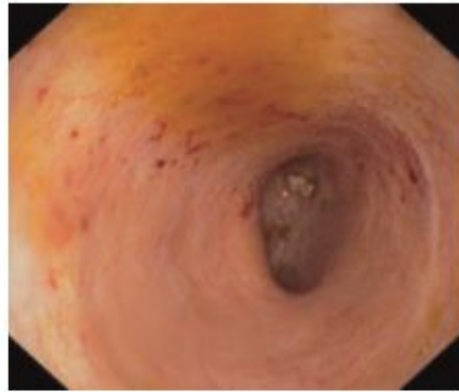


**Fig. 12.9** Pseudopolyps with typical whitish surface, similar to a sugar glaze, which usually does not cover the polyp completely.



# Изменения слизистой толстой кишки при хроническом течении ЯК

## 12.4 Clinical course of ulcerative colitis: chronic form

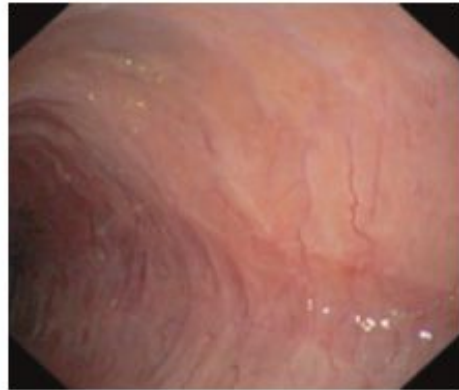


a



b

- a Pancolitis, longer duration, atrophied mucosa, and loss of haustra in ascending colon.
- b Longstanding ulcerative pancolitis, view into the ascending colon and cecum with apparently atrophied mucosa of the ascending colon, but florid changes in cecum (cectis).



c



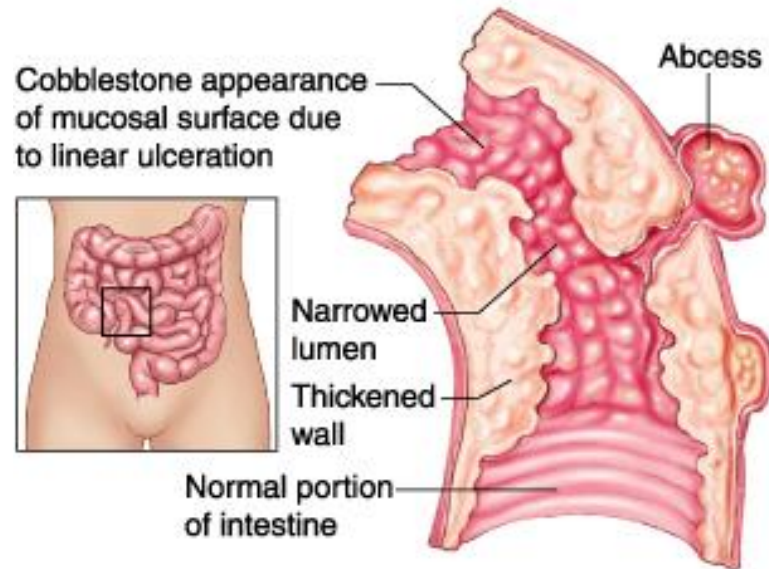
d



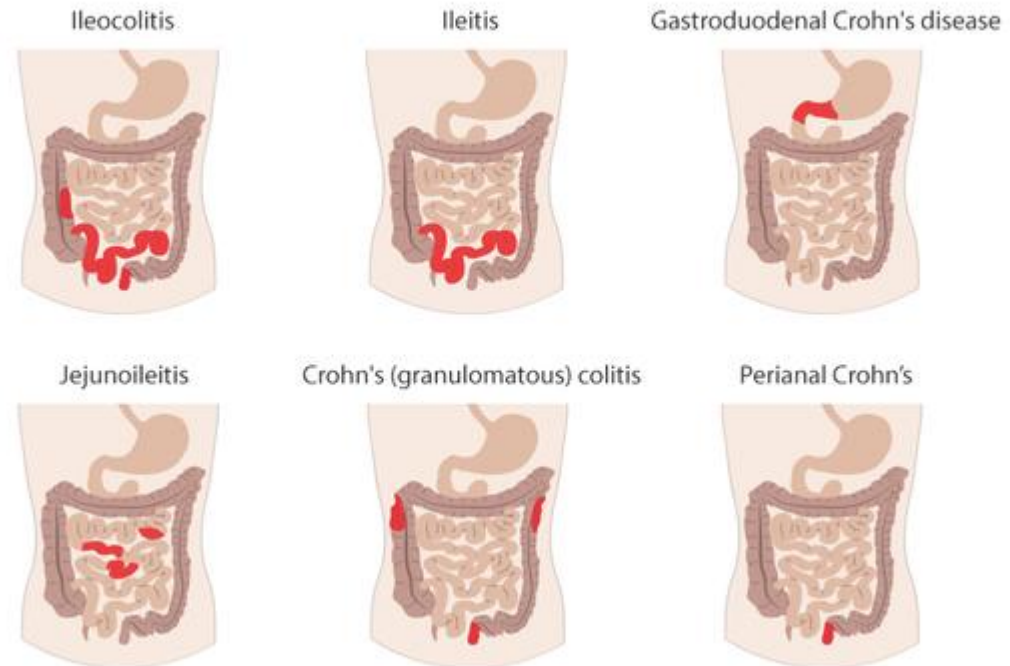
e

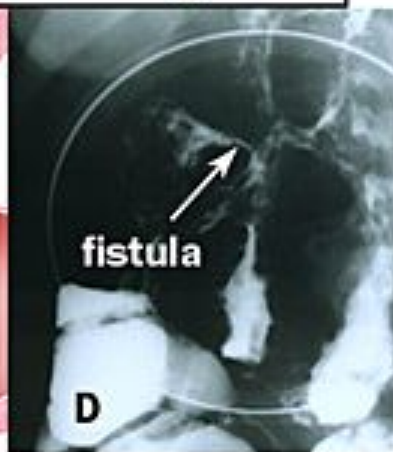
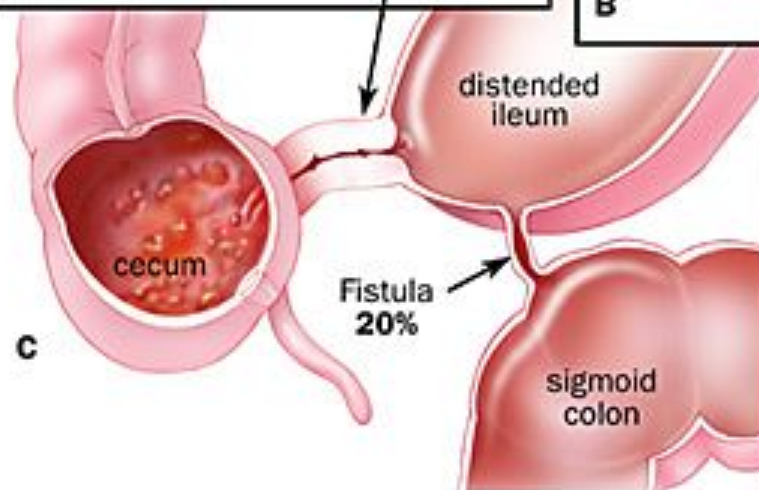
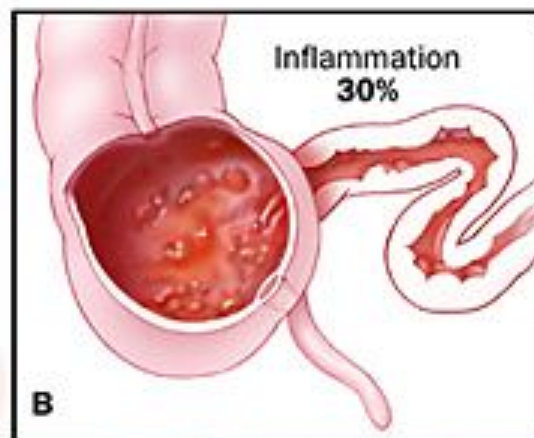
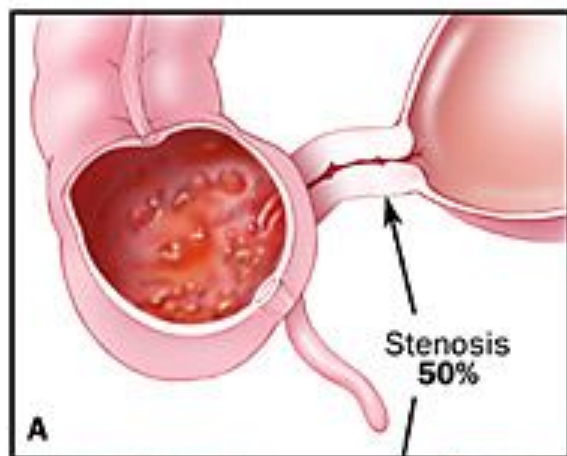
c–e Inactive stage. c Atrophied mucosa, whitish with solitary, regenerated vessel. Destroyed vessel pattern is always a sign of prior attack and after several episodes it will never return to its normal condition. d Another inactive area. The mucosa is flat and hardly rises during biopsy. A few elevated mucosal segments in between, so-called pseudopolyps. e Even in inactive intestinal segments, patchy inflammation foci can appear; in this case it is a circumscribed area which shows all typical characteristics of a recently inflamed area.

# Болезнь Крона



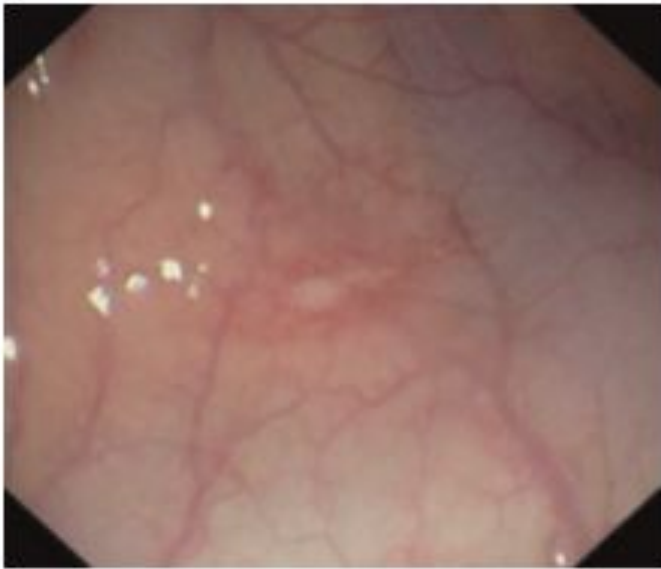
## TYPES OF CROHN'S DISEASE



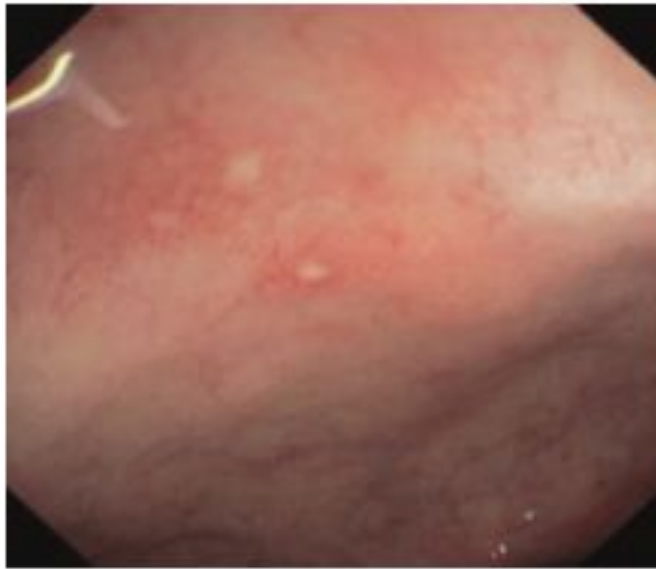


# Болезнь Крона

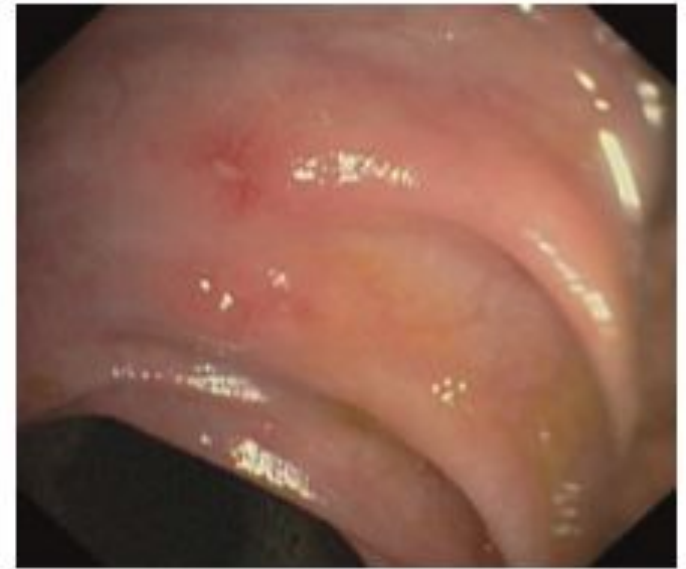
## 12.6 Aphthous erosions in early phase of Crohn disease



**a** Typical aphthous erosions in an otherwise normal surrounding (cecum).



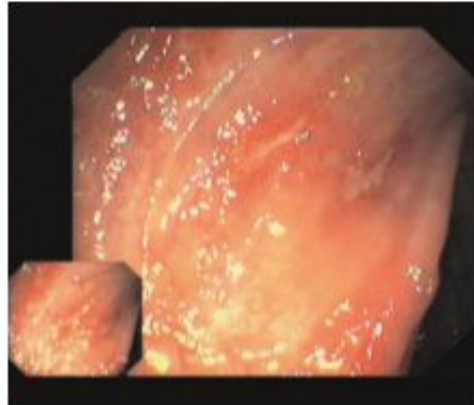
**b** Aphthous erosion in ascending colon.



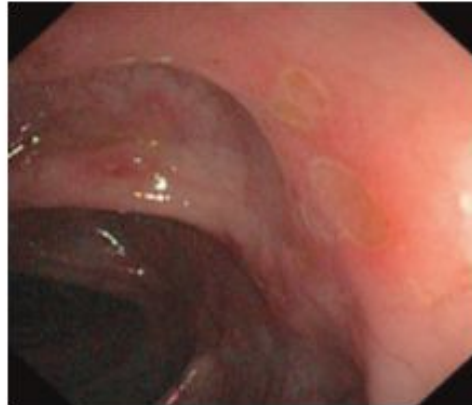
**c** Aphthae in the sigmoid colon. Other lesions were also nearby.



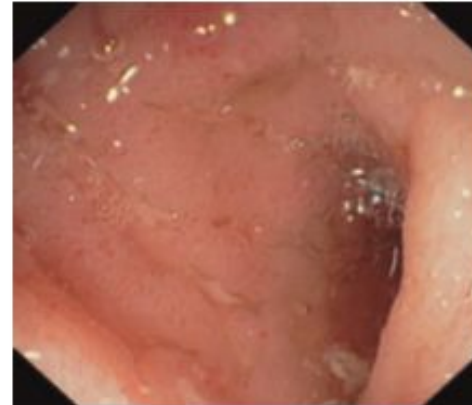
■ 12.6 cont.



**d** Larger erosions (ascending colon).

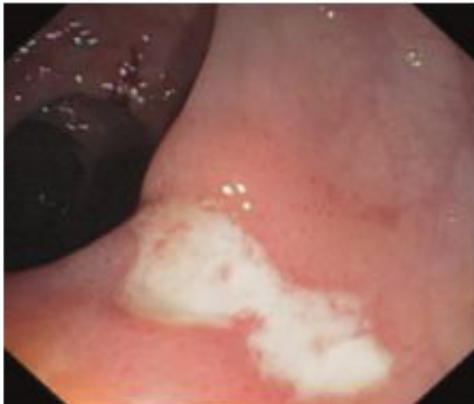


**e** Giant aphthae with punched-out appearance or mini-ulcers in right transverse colon.



**f** Attack in terminal ileum, more aphthous character.

■ 12.7 Ulcers in Crohn disease



**a** Elongated ulcer in otherwise normal area of sigmoid colon.

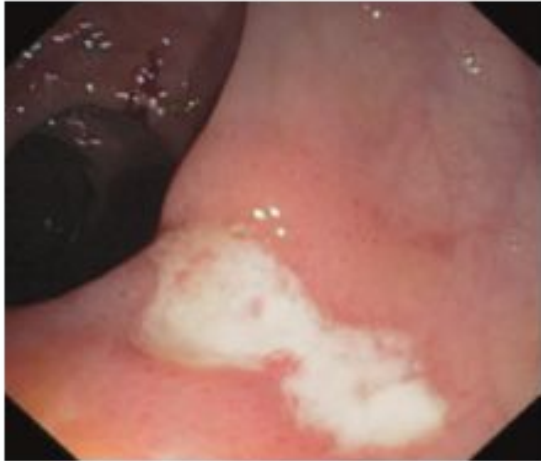


**b** Serpiginous ulcer, surrounding area quite normal (ascending colon).



**c** Oval ulcer at hepatic flexure.

## ■ 12.7 Ulcers in Crohn disease



**a** Elongated ulcer in otherwise normal area of sigmoid colon.



**b** Serpiginous ulcer, surrounding area quite normal (ascending colon).



**c** Oval ulcer at hepatic flexure.



**d** Appendix involvement: appendix edges are completely swollen, two small ulcers inside.



**e** Long, vaguely serpiginous, parallel ulcerations in descending colon; typical CD finding.



**f** Typical elongated ulcer in descending colon, extending toward upper sigmoid colon.





Fig. 12.19 CD in terminal ileum with a "skip lesion," i. e., an eccentric ulcer, a relatively wide ileal segment and low or moderate inflammation of the rest of the ileal wall.



Fig. 12.20 Scarring and discrete inflammatory change (vaguely aphthous), eccentric, i. e., "skip lesion" at the splenic flexure.

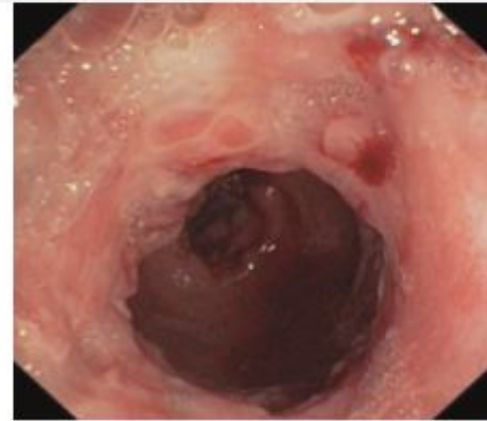


Fig. 12.21 Cobblestoning beginning to form in CD in the ascending colon.

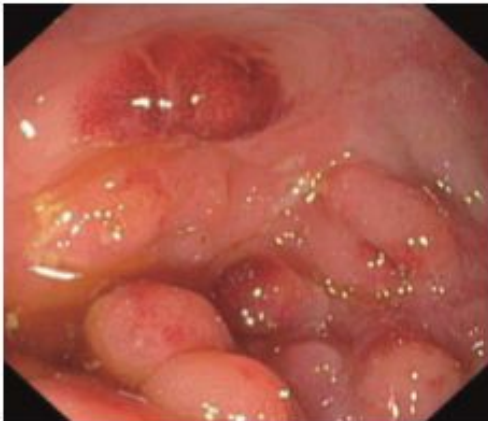


Fig. 12.22 Mixture of cobblestoning, pseudopolyp formation, and relative stenosis in the sigmoid colon related to CD. Several typical findings can appear simultaneously at varying locations in the intestine.

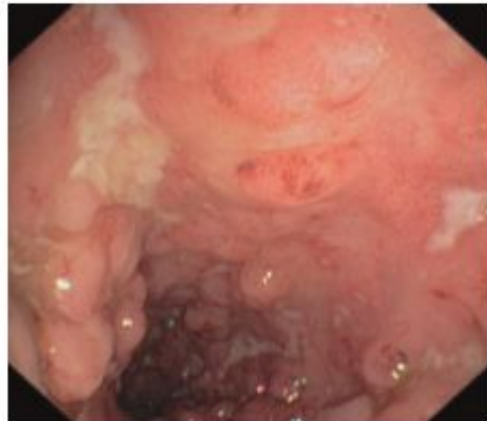
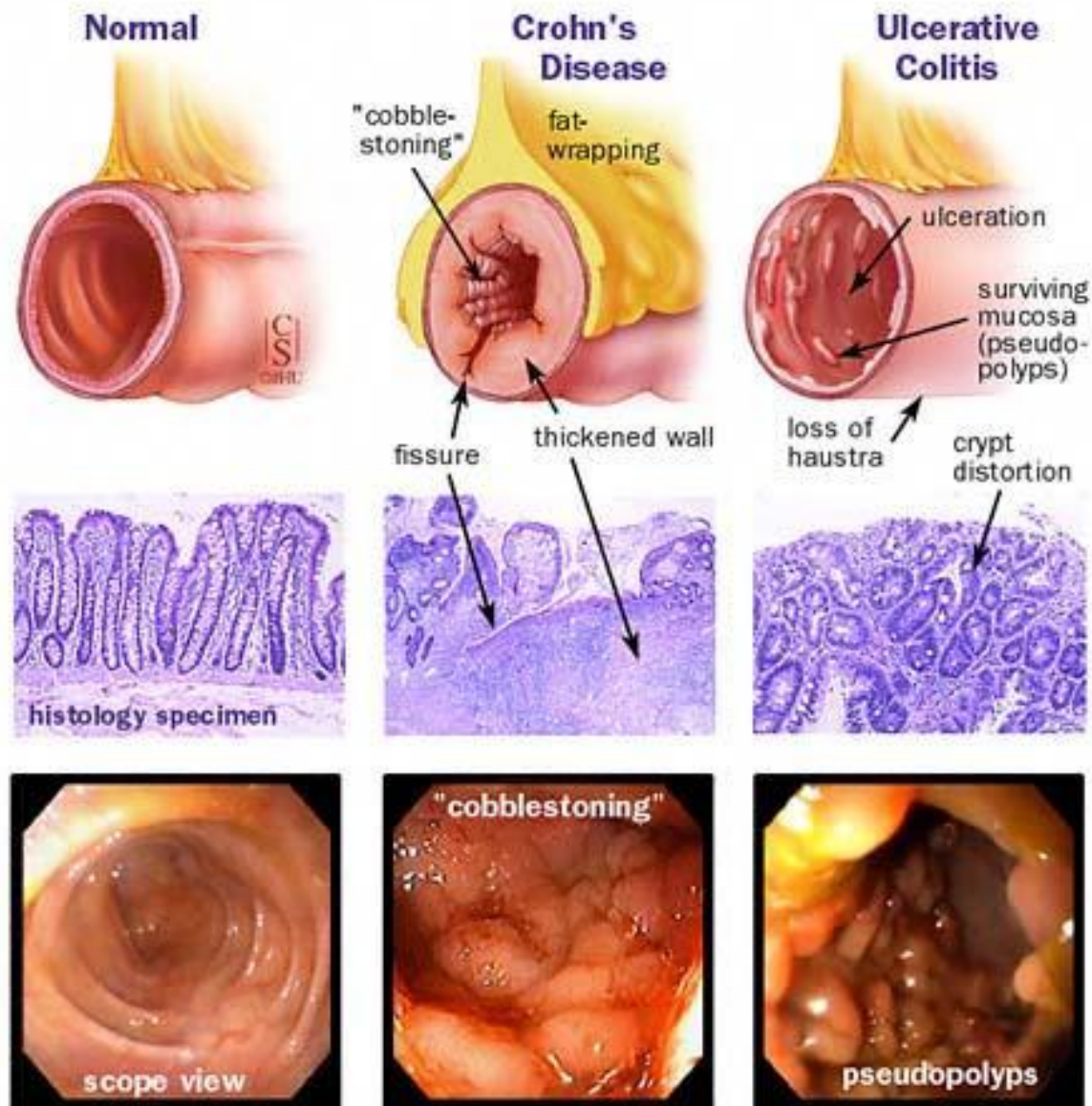


Fig. 12.23 Pancolitis Crohn with varied appearance: aphthous erythema, pseudopolyps, and small ulcers at the same time in ascending colon.



Fig. 12.24 Relative stenosis and pseudopolyp bouquet in sigmoid colon. There is also a fistulous tract ending here, originating in the neoterminal ileum (diagnosed at resection, not endoscopically identifiable).



**Figure 4.** Gross (**top**), histological (**center**), and endoscopic (**bottom**) appearance of normal colon, Crohn's disease, and ulcerative colitis.

# Отличия БК с поражением толстого кишечника и ЯК по данным ФКС

	ЯК	БК
Непрерывность поражения	Почти всегда	Редко
Пятнистое (неоднородное) поражение	Нет	Часто
Прямая кишка	Всегда поражена	Часто не изменена
Сосудистый рисунок	Уменьшен, отсутствует	Сохранен
Диффузная кровоточивость слизистой	Часто	Редко
Ранимость слизистой	Часто	Редко
Отек и гиперемия слизистой	Типично	Менее типично
“Булыжная” мостовая	Нет	Типично
Поверхностные изъязвления	При тяжелом течении	Типично
Афтозные язвы	Нет	Типично
Глубокие, щелевидные язвы	Редко	Часто
Стиктуры	Нет	Часто, типично

# Клинические проявления БК и ЯК

	ЯК	БК с поражением толстого кишечника	БК с поражением тонкого кишечника
Диарея с примесью крови, слизи	Главный симптом	Менее выражена, чем при ЯК	Нет
Тенезмы	Часто	Часто	Нет
Императивные позывы, ложные позывы	Характерны	Реже	
Перианальное поражение (трещины, перианальные свищи)	Не характерно	Характерно	Характерно
Свищи	Нет	Характерны	Характерны
Симптомы частичной кишечной непроходимости (боль, рвота, метеоризм)	Нет	Нет	Часто из-за стриктур кишечника
Язвы верхних отделов ЖКТ	Нет	Могут быть	Могут быть
Признаки мальабсорбции	Нет	Нет	При тяжелом течении
Снижение аппетита	Часто	Часто	Часто

# Иммунное воспаление при ВЗК

- Длительная лихорадка или субфебрилитет (при БК)
- Повышение температуры характерно для периодов обострения ВЗК
- Снижение веса (из-за иммунного воспаления и снижения аппетита)
- Повышение СОЭ, СРБ
- Высокий уровень фекального кальпротектина



# Внекишечные проявления ВЗК

## Поражение кожи

- Узловатая эритема
- Гангренозная пиодермия

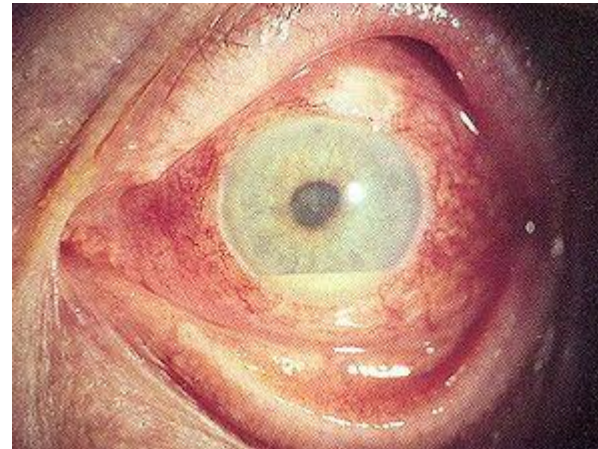


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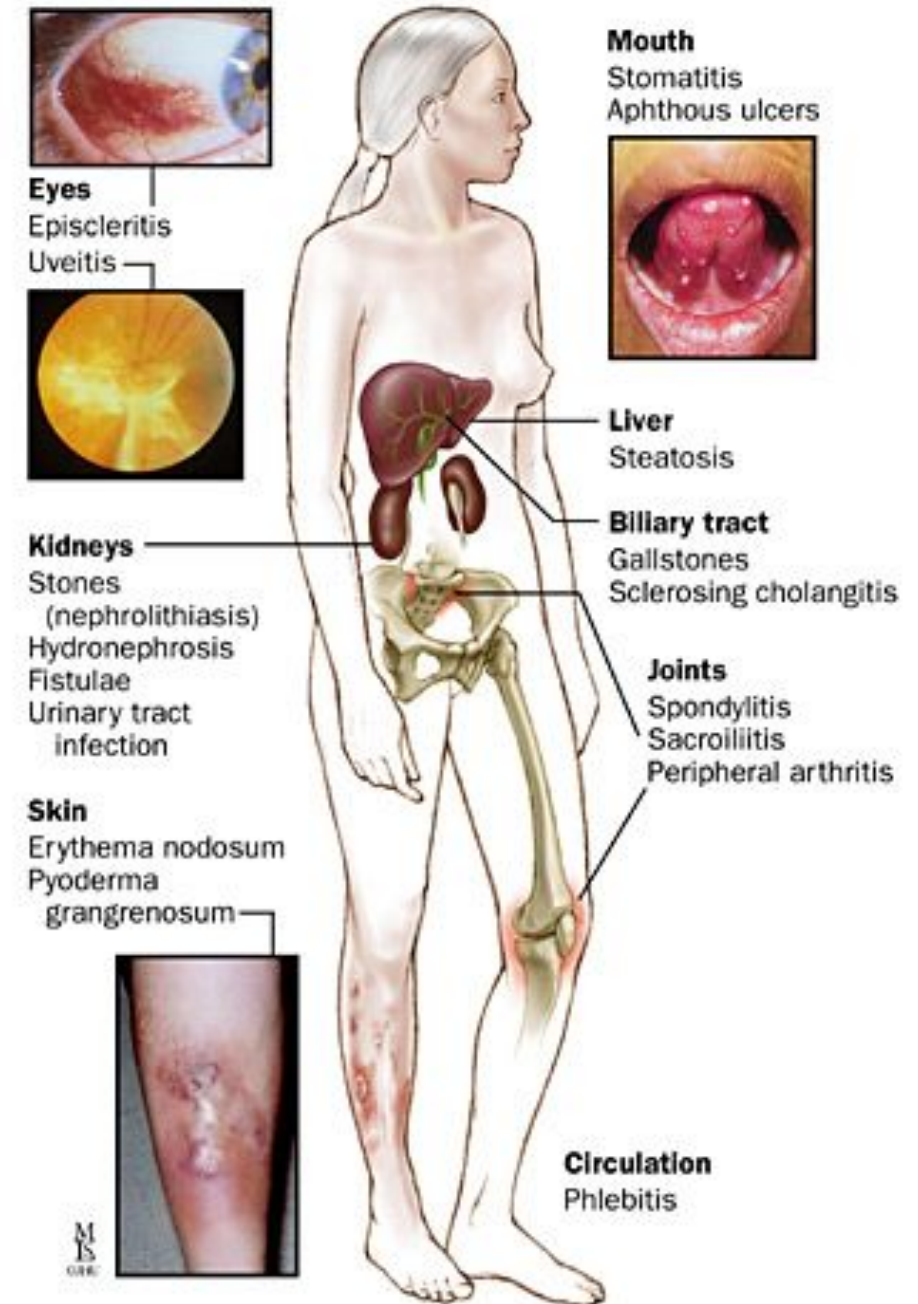
# Поражение глаз

- Эписклериты
- Увеиты и иридоциклиты
- Конъюнктивиты



# Поражение суставов

- Артриты крупных суставов
- Спондилоартриты
- Сакроилеит



# Псевдомембранозный КОЛИТ

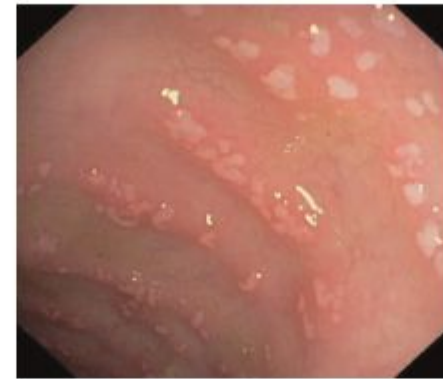
*Clostridium difficile*

Тяжелая диарея после  
приема антибиотиков

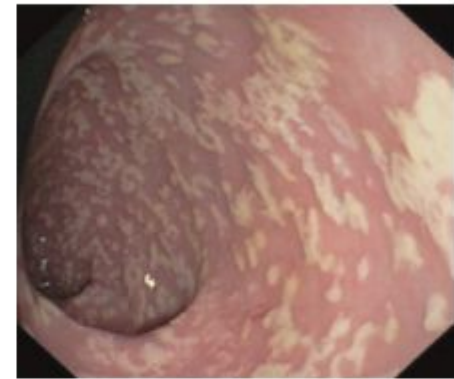
## 12.15 Pseudomembranous colitis



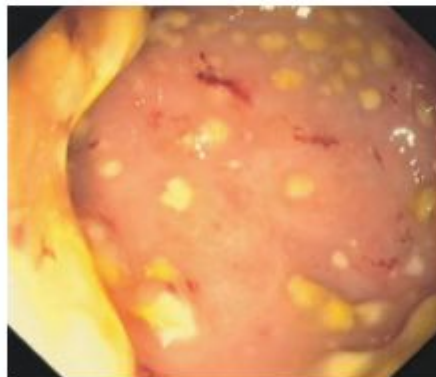
a Initial plaque formation, shown here with reddish "halo," evidence of underlying inflammation.



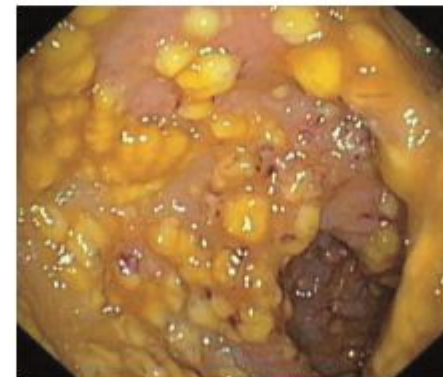
b Tiny plaques.



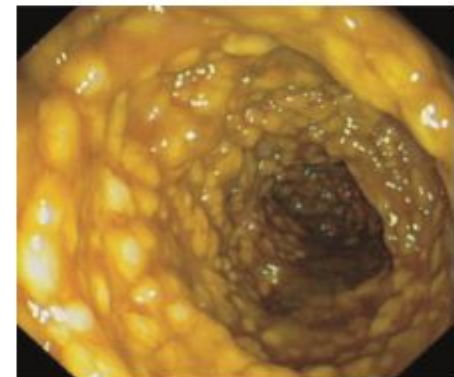
c Smaller plaques, but already confluent.



d Yellowish plaques, medium grade (sigmoid colon).



e Massive confluent plaque formation, chronic course.



f Massive confluent pseudomembranes that were so thick that stenosis was suspected in the sigmoid at radiological examination.