Finally, the document concludes with a discussion of alternative treatments that are so commonly used by patients.

The ECCO evidence-based consensus is an outstanding effort to assimilate a multinational European viewpoint regarding the diagnosis and treatment of Crohn's disease and for the most part the effort succeeded admirably. Although the application of evidence levels and recommendation grades is somewhat uneven, the evidence is provided in an unbiased manner to allow readers to establish their own basis for decision making. Furthermore, the large numbers of statements assigned evidence levels of 4–5 are ripe for future, hypothesis-generating clinical studies.

The diagnosis and treatment of Crohn's disease is on the verge of undergoing evolutionary changes with respect to advances in genetics, serology, understanding of the innate and adaptive immune responses and the resultant molecular targets for therapeutics. In addition, the disparate therapeutic approaches to ulcerative colitis and Crohn's disease are undergoing a convergence from similar advances

in aetiopathogenesis and treatment—for example, the expanding role of tumour necrosis factor treatment. The future treatments for these diseases will, eventually, be determined by genetic, serologic and proteomic standards that are yet to be determined. Ultimately, such techniques should define optimal inductive and maintenance strategies, possibly based on individualised profiles. In the mean time, assimilation of our current evidence and application of international standards, as complied by the ECCO evidence-based consensus document, highlights both the convergence of evidence and the areas in need of higher-quality data.

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EDITOR'S QUIZ: GI SNAPSHOT

Robin Spiller, editor

Acute abdomen after prolonged plane travel

Clinical presentation

A 69-year-old woman developed an acute abdomen immediately after a prolonged (>12-h) flight. At laparotomy, two abnormal segments of jejunum were found: one 16 cm long, immediately distal to the ligament of Treitz; the other 4 cm long, 20 cm distal to the first. Both were plum-coloured, swollen and sharply demarcated from the adjacent normal bowel. There was mild acute peritonitis. The jejunal arterial supply was intact. There was no volvulus or adhesion. Both segments were resected, anastomoses were performed, and the patient made an uneventful recovery.

The patient's history included aortic valve replacement, coronary artery bypass, cholecystectomy and 30 years of smoking. She had taken warfarin sodium since her valve replacement 9 years earlier, and had occasional episodes of epistaxis. At presentation, her international normalised ratio was 5.5 (preferred level, 2–3). Other drugs included carvedilol, valsartan and indapamide. There was no history of abdominal trauma.

Question

How can these pathological findings, which were present in both segments, be explained?

See page 242 for answer

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