Answers to questions:

1-

Crohn's disease and ulcerative colitis

...young age, female, chronic relapsing and remitting, diarrhea with blood and abdominal pain, family history of autoimmune disease, weight loss (may be also anemia), fever and systemic symptoms, aphthous ulcers, leg lesions (erythema nodosum, pyoderma gangrenosum), good hygiene

All these pointed to inflammatory bowel disease and are important when taking history.

...infection needs to be ruled out. However, the presentation is over 3 years and there is no history of travel or sick contacts. Stool analysis and culture are helpful

...irritable bowel syndrome is related to stress and without systemic symptoms, weight loss or bleeding perrectum

...diverticular disease is uncommon in such age

...colon cancer is uncommon in such age. However, if there is family history or hereditary cancer syndromes it cannot be ruled out

2-

-Stool analysis and culture...negative

-Leukocytosis

-Elevated ESR

-p-ANCA in a good percentage of ulcerative colitis cases

-Endoscopy

3-

In Crohn's any site from mouth to anus can be involved

Cecum and small bowel (terminal ileum and ileocecal valve) more affected by Crohn's

In UC the rectum is always involved with or without colon (in a continuous fashion) and may be also backwash ileitis

Rectal bleeding + diarrhea with mucus more in UC...but of course also in Crohn's

Abdominal pain more in Crohn's...sometimes acute in a picture similar to acute appendicitis

Anal fissure and perianal fistula more in Crohn's

Aphthous ulcers more in Crohn's

Strictures, adhesions, intestinal obstruction and fistulae between colon segments or colovesical (pneumaturia) or rectovaginal fistulae are all more in Crohn's

Perforation more in Crohn's

Cigarette smoking can trigger the attacks of Crohn's while it is protective from UC

Malabsorption due to small bowel involvement is more in Crohn's

Erythema nodosum in Crohn's and pyoderma gangrenosum in UC

4-

Both are characterized microscopically by activity (cryptitis/crypt abscesses) and chronicity (Distortion of crypt architecture, dropping of crypts and fibrosis) or chronicity alone (if quiescent)

Skip lesions in Crohn's

Continuous involvement in UC

Transmural inflammation and ulceration in Crohn's (and subsequently strictures, perforation and fistula formation)

Fissuring more in Crohn's

Granulomas in Crohn's

Cobblestone appearance in Crohn's

Pseudopolyps (non-ulcerated inflamed areas) more in UC

Broad-based superficial ulcers in UC (limited to the mucosa and submucosa) while deeper and transmural ulcers in Crohn's

5-

Perforation, fistula formation and strictures in Crohn's

Anemia and weight loss

Risk for colon cancer...much more in UC than Crohn's

Arthritis, uveitis, ankylosing spondylitis and primary sclerosing cholangitis (more in UC), clubbing...extraintestinal manifestations

6-

Mainly medical: aminosalicylates and immunosuppressants

Surgery for complication and cancer prevention