Atlas of Colonoscopy

Techniques - Diagnosis - Interventional Procedures

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Zu Inhaltsverzeichnis

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Normal Transverse Colon

The transverse colon runs across the upper abdomen, connecting the descending colon and the ascending colon; the splenic and hepatic flexures at either end of this colon segment demarcate the anatomical borders. The transverse colon is entirely intraperitoneal and is supplied by its own mesocolon. On the ventral side, the greater omentum is fixed to the transverse colon. Because both flexures are fixed to the posterior wall of the abdominal cavity, while the transverse colon lies in front of other organs, its course is not straight, but instead runs in a convex arc ventrally and, to varying degrees, caudally. This can range from a mild curvature to a deep loop extending down into the pelvis. The length of the transverse colon is thus highly variable, from 30 cm to more than 50 cm. Because it lies ventrally in the abdomen, the position of the endoscope may be seen (transillumination) through the abdominal wall.

The transverse colon is normally characterized by a triangular lumen with pronounced haustrations (Figs. 6.16–6.19). The shape of a typical transverse colon is rather similar to that of a Toblerone chocolate bar. The smooth and shiny mucosa and the clear vessel pattern in the transverse colon are similar to the rest of the colon.

Because the hepatic flexure is fixed retroperitoneally, it often has a funnel-shaped winding form; just before reaching the hepatic flexure the colon curves dorsally (Fig. 6.20), while in the region of the hepatic flexure itself the lumen is angled caudally toward the ascending colon. The liver is often visible near the hepatic flexure as a bluish coloration, shimmering through the colon wall (Figs. 6.21, 6.22). The area of surface contact between liver and flexure is significantly larger than that of the spleen near the splenic flexure.

Fig. 6.16 Transverse colon. Typical triangular shape.
Fig. 6.17 Transverse colon. Triangular lumen and strong haustrations.
Fig. 6.18 Midtransverse colon with triangular lumen.
Fig. 6.19 Transverse colon. Typical normal appearance, shown here with straight path.
Fig. 6.20 Transverse colon. Funnel-like transverse colon, angled dorsally just before the hepatic flexure. After passing this point, the instrument is angled caudally toward the ascending colon.
Fig. 6.21 Hepatic flexure with shimmering, bluish coloration of the liver. The colon angles at this point caudally (shown here at about the 7-o’clock position).
Normal Ascending Colon

The ascending colon runs near the right flank between the hepatic flexure and the ileocecal valve. Similar to the descending colon, the ascending colon is fixed to the dorsal abdominal wall and thus only slightly mobile, running relatively straight. The length of the ascending colon is variable, on average around 15–20 cm. However, it is occasionally very short, so that immediately after passing the hepatic flexure the ileocecal valve is reached. At the other extreme is a very long ascending colon, with the Bauhin valve located deep in the lower abdomen.

As a rule, the ascending colon has the widest lumen of any of the colon segments. The lumen is mostly triangular, similar to the transverse colon (Fig. 6.23), though the folds are mostly somewhat thicker and plumper than the more distal colon segments (Fig. 6.24). After passing the hepatic flexure, one often can already see the ileocecal valve in the distance as a yellowish arcuate fold, often with an indentation in the center (Fig. 6.25). Occasionally the valve is clearly prominent due to an accumulation of fat (Fig. 6.26). The mucosal appearance and vessel pattern in the ascending colon are the same as in the rest of the colon proximal to the rectum (Figs. 6.27, 6.28).

Tips for examining the ascending colon

- Due to the relatively thin colonic wall in the ascending colon and cecum, care must be taken to avoid perforation during therapeutic procedures such as argon plasma coagulation, laser therapy, and polyp removal. Precautionary measures for avoiding perforation, including liberally injecting flat polyps before removal with a snare, are strongly advised.