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Practices and perceptions of imaging assessment in inflammatory bowel disease: a nationwide survey of physicians in Korea by the KASID Guidelines Taskforce Team

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Background/Aims: Imaging-based assessment is essential for evaluating disease activity and structural damage in inflammatory bowel disease (IBD). This study aimed to evaluate real-world use and perceptions of imaging modalities among Korean IBD experts and to identify implications for future domestic guideline development. **Methods:** A nationwide, web-based survey was conducted among board-certified gastroenterologists affiliated with the Korean Association for the Study of Intestinal Diseases. The questionnaire assessed respondent characteristics, imaging modality use in Crohn's disease (CD) and ulcerative colitis (UC), and perceptions of clinical utility using a 5-point Likert scale. Results were summarized as frequencies and percentages. **Results:** Of 150 invited clinicians, 133 responded, with 74.4% practicing in tertiary referral centers. In CD, computed tomography enterography (CTE) and magnetic resonance enterography (MRE) were the most used modalities at diagnosis and follow-up. In contrast, IUS utilization was low (6.8% at diagnosis and 10.5% during follow-up), and 82.0% reported no intestinal ultrasound (IUS) use in the preceding year. In UC, CT-based strategies also predominated, and more than half reported no imaging during follow-up. Major barriers to IUS adoption included limited experience, time constraints, and institutional or equipment limitations. CT/CTE and MRE were perceived as useful for diagnosis and complication assessment, whereas IUS was viewed as suitable for repeated monitoring but highly operator dependent. **Conclusions:** IBD imaging practices in Korea rely predominantly on CT-based modalities, with limited real-world use of MRE and IUS despite their recognized clinical potential. Future Korean guidelines should acknowledge these real-world limitations while encouraging gradual integration of MRE and IUS. **(Intest Res 2026;24:270-280)**

Key Words: Inflammatory bowel diseases; Crohn disease; Ulcerative colitis; Surveys and questionnaires; Tomography, X-Ray computed

INTRODUCTION

Inflammatory bowel disease (IBD) is a chronic and relapsing condition that requires continuous assessment of disease activity and structural changes, as a symptom-based approach alone is insufficient to capture the full disease burden.[1] Crohn's disease is characterized by transmural inflammation and may be complicated by strictures, fistulas, and penetrat-

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ing lesions, making accurate evaluation of structural abnormalities essential for optimal disease management.[2,3] Accordingly, a wide range of imaging modalities—including abdominal computed tomography (CT), CT enterography (CTE), magnetic resonance enterography (MRE), intestinal ultrasound (IUS)—are utilized throughout the clinical course, each with distinct strengths and inherent limitations.[4-9]

In recent years, substantial progress has been made in Europe toward the standardization of imaging assessment in IBD. Updated joint guidelines from the European Crohn's and Colitis Organisation (ECCO), the European Society of Gastrointestinal and Abdominal Radiology (ESGAR), and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) have emphasized standardization, quantification, and reproducibility across imaging techniques.[10,11] MRE is primarily recommended for assessing transmural and extramural disease, given its strength in minimizing radiation exposure.[11,12] Notably, IUS has been highlighted as a key modality due to its feasibility for repeated, real-time monitoring without radiation exposure.[11,13-16] Despite these advances and recommendations, clinical practice in Korea remains strongly centered on CT-based diagnostic and monitoring strategies. This discrepancy likely reflects a combination of factors, including differences in resource availability, cost, time constraints, training infrastructure, and the distribution of responsibility for imaging acquisition and interpretation.[17,18] In this context, real-world imaging practice in routine clinical settings and the perceptions of Korean IBD specialists regarding diagnostic and monitoring strategies have not yet been systematically evaluated.

Therefore, this nationwide survey study aimed to evaluate the current use of imaging modalities in routine clinical practice, explore preferences and expectations regarding each imaging tool, and identify differences in perception as well as practical limitations. Based on these findings, we sought to propose key considerations to inform the development of future Korean Association for the Study of Intestinal Diseases (KASID) guidelines for diagnosis and monitoring using imaging-based assessment in IBD.

METHODS

1. Survey

This study was conducted as a nationwide, online survey targeting board-certified gastroenterologists who primarily manage patients with IBD and are members of the KASID. The survey was individually distributed via a mobile-based platform using Google Forms, and participation was entirely voluntary. Of the 150 experts invited to participate in the survey, 133 completed the questionnaire.

The survey instrument consisted of 4 major domains. First, baseline characteristics of the respondents were collected, including age, sex, type of medical institution, duration of IBD care experience, and the volume of IBD patients managed in routine practice. Second, respondents were asked to report on the imaging modalities used for disease activity assessment or follow-up in the management of patients with Crohn's disease and ulcerative colitis. Multiple selections were allowed among various imaging techniques, including CT/CTE, MRE, IUS, rectal MRI, and other relevant modalities. Third, to assess perceptions regarding the clinical utility and applicability of each imaging modality, respondents were asked to rate items related to initial diagnosis, evaluation of complications, periodic monitoring, operator dependency, and suitability as a standalone diagnostic tool using a 5-point Likert scale. Finally, open-ended questions were included to capture respondents' clinical experiences with imaging assessment, perceived strengths and limitations of each modality, and opinions on practical constraints and areas requiring improvement within the domestic clinical environment.

Quantitative data were summarized using frequencies and percentages, and the same approach was applied to numerical data presented in tables and figures. The survey was conducted anonymously with confidentiality fully ensured, and the purpose of the study was clearly stated at the beginning of the questionnaire. This survey study was approved by the Institutional Review Board of Samsung Medical Center (SMC IRB No. 2025-12-115-001).

2. Statistical Analysis

All statistical analyses were descriptive in nature. Categorical variables were summarized as frequencies and percentages. Responses to Likert-scale items were analyzed descriptively to evaluate overall trends in perception regarding the clinical utility and applicability of each imaging modality. All analyses were performed using IBM SPSS Statistics 21.0 for Windows (IBM Corp., Armonk, NY, USA).

RESULTS

1. Survey Participants

A total of 133 respondents participated in the survey. The sex distribution consisted of 84 male respondents (63.2%) and 49

female respondents (36.8%). Age was generally evenly distributed across groups, with the largest proportion of respondents aged between 35 and 54 years. Regarding experience in IBD care, 69 respondents (51.8%) reported more than 10 years of clinical experience, and a substantial proportion of these had over 20 years of long-term experience in managing IBD patients. With respect to the type of medical institution, most respondents were affiliated with tertiary referral centers (n=99, 74.4%), followed by secondary care hospitals (n=33, 24.8%). The annual volume of IBD patients managed by respondents varied widely, ranging from fewer than 100 to more than 500 patients per year. Specifically, 42 respondents (31.6%) reported managing fewer than 100 IBD patients annually, whereas 36 respondents (27.1%) reported managing more than 500 patients per year. Respondents were predominantly based in Seoul and the surrounding metropolitan area; however, participants from all major regions across the country—including Chungcheong, Honam (Gwangju, Jeolla), Yeongnam (Busan, Ulsan, Gyeongsangnam, Daegu, Gyeongsangbuk), Gangwon, and Jeju—were represented in the survey (Table 1).

Table 1. Baseline Characteristics of the Survey Respondents

Characteristic	No. of respondents (%)
Age (yr)	
<35	5 (3.8)
35–39	26 (19.5)
40–44	29 (21.8)
45–49	25 (18.8)
50–54	25 (18.8)
55–59	14 (10.5)
≥60	9 (6.8)
Sex	
Male	84 (63.2)
Female	49 (36.8)
Duration of IBD care experience (yr)	
<5	33 (24.8)
5–9	31 (23.3)
10–19	41 (30.8)
20–29	26 (19.5)
≥30	2 (1.5)
No. of CD outpatients over 1 yr	
<100	42 (31.6)
100–199	22 (16.5)
200–299	15 (11.3)
300–399	11 (8.3)
400–499	7 (5.3)
≥500	36 (27.1)
Type of medical institution	
Tertiary referral hospital	99 (74.4)
Secondary general hospital	33 (24.8)
Primary care clinic/hospital	0
Health screening center	1 (0.8)
Region	
Seoul	57 (49.2)
Gyeonggi Province, Incheon	24 (18.0)
Busan, Ulsan, Gyeongsangnam-do	22 (16.5)
Daegu, Gyeongsangbuk-do	9 (6.8)
Daejeon, Sejong, Chungcheong-do	9 (6.8)
Gwangju, Jeolla-do	8 (6.0)
Gangwon-do	3 (2.3)
Jeju	1 (0.8)

IBD, Inflammatory bowel disease; CD, Crohn's disease.

2. Actual Use of Imaging Modalities in Crohn's Disease

In the management of patients with Crohn's disease, the use of imaging modalities other than endoscopy was first evaluated at the time of initial diagnosis. CTE was the most used imaging modality, reported by 107 respondents (80.5%). Conventional abdominal CT was used by 70 respondents (52.6%), MRE by 79 (59.4%), and rectal MRI by 37 (27.8%). In contrast, IUS was used at initial diagnosis by only 9 respondents (6.8%). No respondent reported not using any imaging modality at this stage. During disease activity assessment or follow-up, MRE was used by 97 respondents (72.9%), followed by CTE by 92 (69.2%) and conventional abdominal CT by 36 (27.1%). Rectal MRI and IUS were used by 22 (16.5%) and 14 respondents (10.5%), respectively. Over the preceding 12 months, 109 respondents (82.0%) reported that they had not used IUS at all for either diagnosis or disease activity assessment in patients with Crohn's disease (Fig. 1). Overall, the utilization rate of IUS was low, with only 18% of respondents reporting any use. Reasons for not using IUS were diverse, with lack of operator proficiency (n=92, 84.4%) and insufficient consultation time (n=61, 56.0%) being the most frequently cited (Supplementary Fig. 1A). Even among respondents who reported using IUS, responsibility for performing the examination was not consistent. IUS was performed exclusively by gastroenterologists in 27.3% of cases and solely by radiologists in 36.4%, while the remainder reported institution-specific mixed approaches, indicating that IUS has not yet been established within a standardized clinical workflow.

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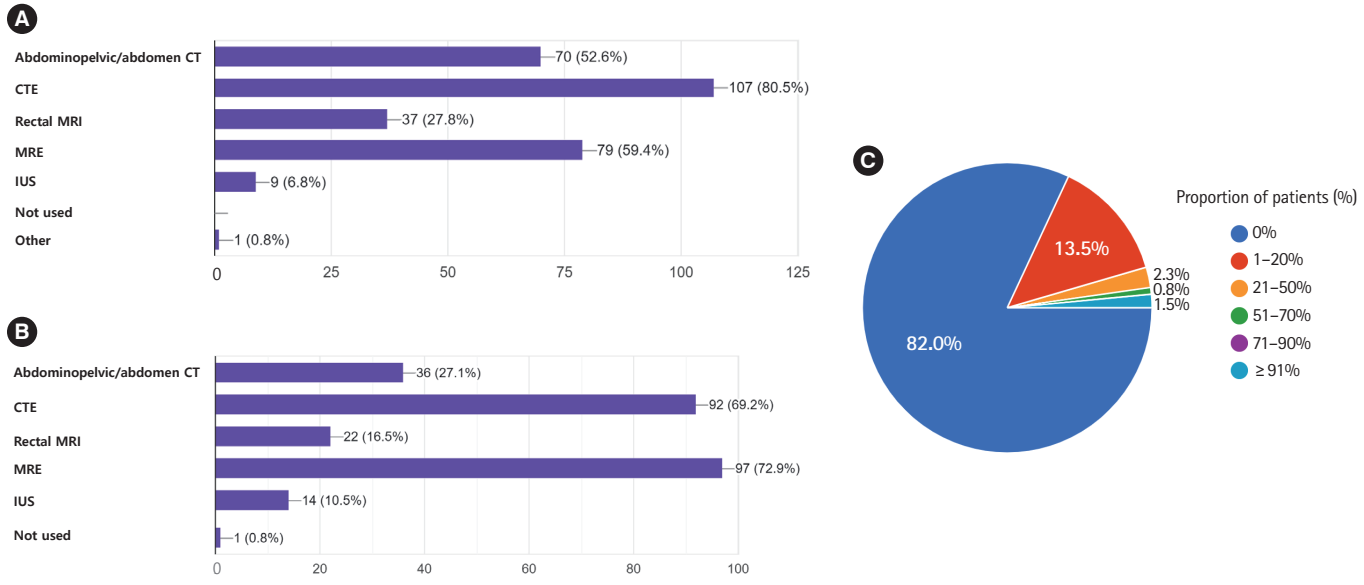


Fig. 1. (A) Imaging modalities used for initial diagnosis of Crohn's disease, excluding endoscopy. (B) Imaging modalities used for disease activity assessment and follow-up in Crohn's disease, excluding endoscopy. (C) Estimated proportion of Crohn's disease patients undergoing IUS for diagnosis or disease activity monitoring during the past 12 months. CT, computed tomography; CTE, computed tomography enterography; MRI, magnetic resonance imaging; MRE, magnetic resonance enterography; IUS, intestinal ultrasound.

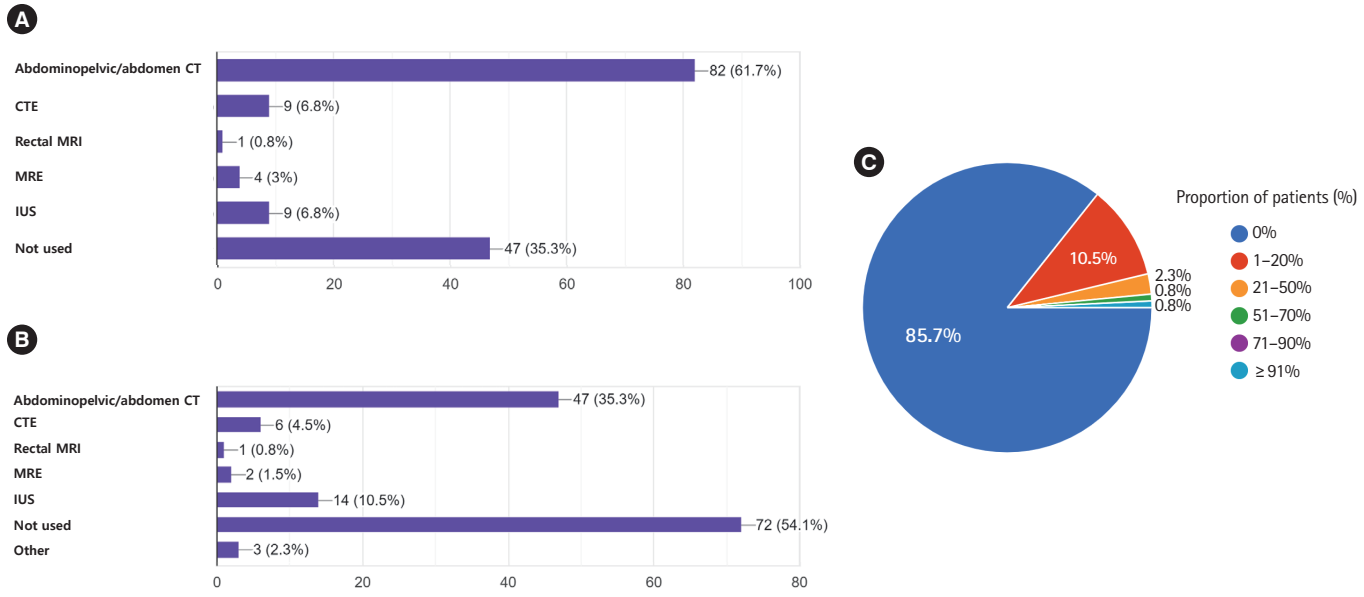


Fig. 2. (A) Imaging modalities used for the initial diagnosis of ulcerative colitis, excluding endoscopy. (B) Imaging modalities used for disease activity assessment and follow-up in ulcerative colitis, excluding endoscopy. (C) Estimated proportion of ulcerative colitis patients undergoing IUS for diagnosis or disease activity monitoring during the past 12 months. CT, computed tomography; CTE, computed tomography enterography; MRI, magnetic resonance imaging; MRE, magnetic resonance enterography; IUS, intestinal ultrasound.

3. Actual Use of Imaging Modalities in Ulcerative Colitis

In the management of patients with ulcerative colitis, imaging utilization patterns similarly demonstrated a strong reliance on CT-based assessment strategies. At the time of initial diagnosis, excluding endoscopy, conventional abdominal CT was the most frequently used imaging modality, reported by 82 respondents (61.7%), whereas CTE was used by 9 respondents (6.8%). MRE and rectal MRI were used infrequently, by 4

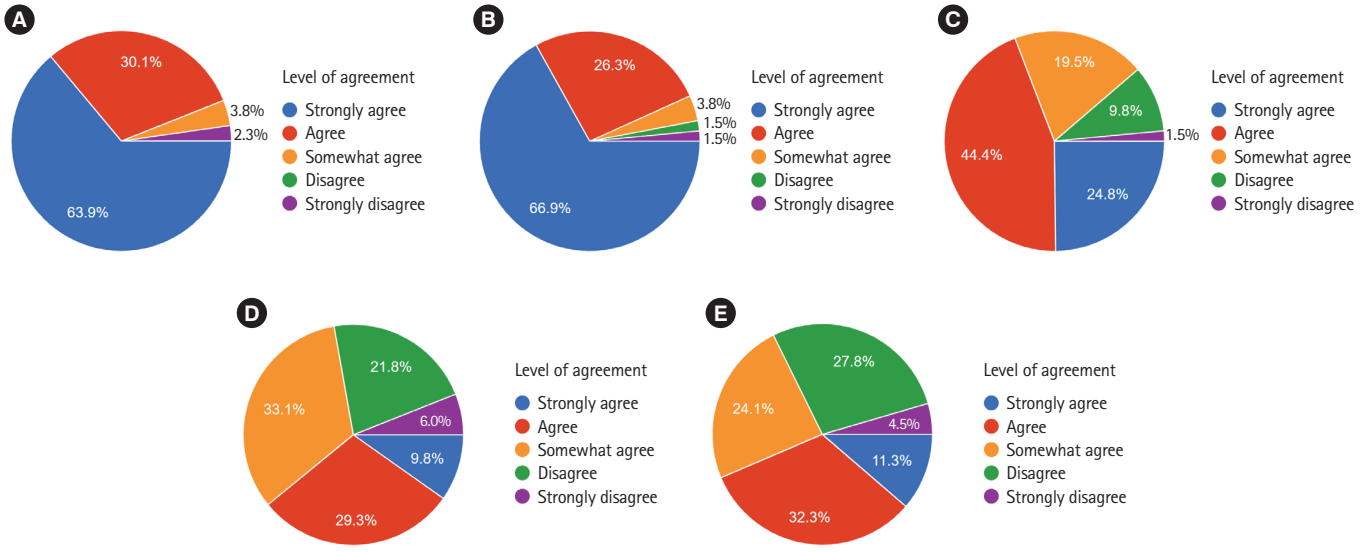


Fig. 3. Usefulness of abdominopelvic/abdominal CT and CTE in Crohn's disease. (A) Useful as initial diagnostic tool. (B) Useful for assessing disease-related complications. (C) Useful for periodic monitoring of disease course. (D) Useful as a stand-alone modality for overall disease assessment. (E) High operator/interpreter dependence. CT, computed tomography; CTE, computed tomography enterography.

(3.0%) and 1 respondent (0.8%), respectively. Notably, 47 respondents (35.3%) reported that no imaging modality was used at the initial diagnostic stage. IUS was used by 9 respondents (6.8%) at diagnosis. A similar pattern was observed during disease activity assessment or follow-up. Conventional abdominal CT was used by 47 respondents (35.3%), followed by CTE by 6 (4.5%), MRE by 2 (1.5%), and rectal MRI by 1 respondent (0.8%). More than half of respondents (n=72, 54.1%) reported that no imaging modality was used at this stage. IUS was used during follow-up by 14 respondents (10.5%). Over the preceding 12 months, 114 of 133 respondents (85.7%) reported that they had not used IUS at all for diagnosis or disease activity assessment in patients with ulcerative colitis, and only a small proportion reported any experience with IUS use (Fig. 2). The most commonly reported reasons for not using IUS in ulcerative colitis included lack of procedural and interpretative experience (n=91, 79.8%), insufficient consultation time (n=64, 56.1%), limited equipment availability (n=53, 46.5%), the perception that other imaging modalities were sufficient (n=34, 29.8%), and issues related to insurance coverage or cost (n=14, 12.3%) (Supplementary Fig. 1B).

4. Perceptions of Imaging Modalities in Crohn's Disease

In the assessment of perceptions regarding the role of abdominal CT and CTE, the majority of respondents considered CT-based imaging to be useful for the initial diagnosis of Crohn's disease. For this item, 63.9% (n=85) of respondents reported "strongly agree" and 30.1% (n=40) reported "agree," while only a small proportion selected "somewhat agree," and negative responses were rare (Fig. 3A). A similar distribution was observed for the evaluation of disease-related complications, with 66.9% (n=89) and 26.3% (n=35) reporting "strongly agree" and "agree," respectively, indicating a high level of consensus regarding the role of CT/CTE in initial diagnosis and complication assessment (Fig. 3B). Perceptions regarding the use of CT/CTE for periodic disease monitoring were more heterogeneous. In this domain, 24.8% (n=33) of respondents selected "strongly agree," 44.4% (n=59) "agree," and 19.5% (n=26) "somewhat agree," while a subset of respondents expressed negative views (Fig. 3C). The proportion of respondents who considered CT/CTE suitable as a stand-alone modality for overall disease assessment was relatively limited, with 9.8% (n=13) reporting "strongly agree" and 29.3% (n=39) reporting "agree" (Fig. 3D). Regarding dependency on the interpreter or operator, 32.3% (n=43) of respondents selected "agree" and 24.1% (n=32) "somewhat agree," with responses distributed relatively evenly across categories (Fig. 3E). Perceptions of MRE were generally similar to, or more favorable than, those of CT/CTE. As an initial diagnostic tool, 45.9% (n=61) of respondents reported "strongly agree," and 36.1% (n=48) reported "agree" (Supplementary Fig. 2A). For the evaluation of disease-related complications, "strongly agree" and "agree" responses accounted for 59.4% (n=79) and 32.3%

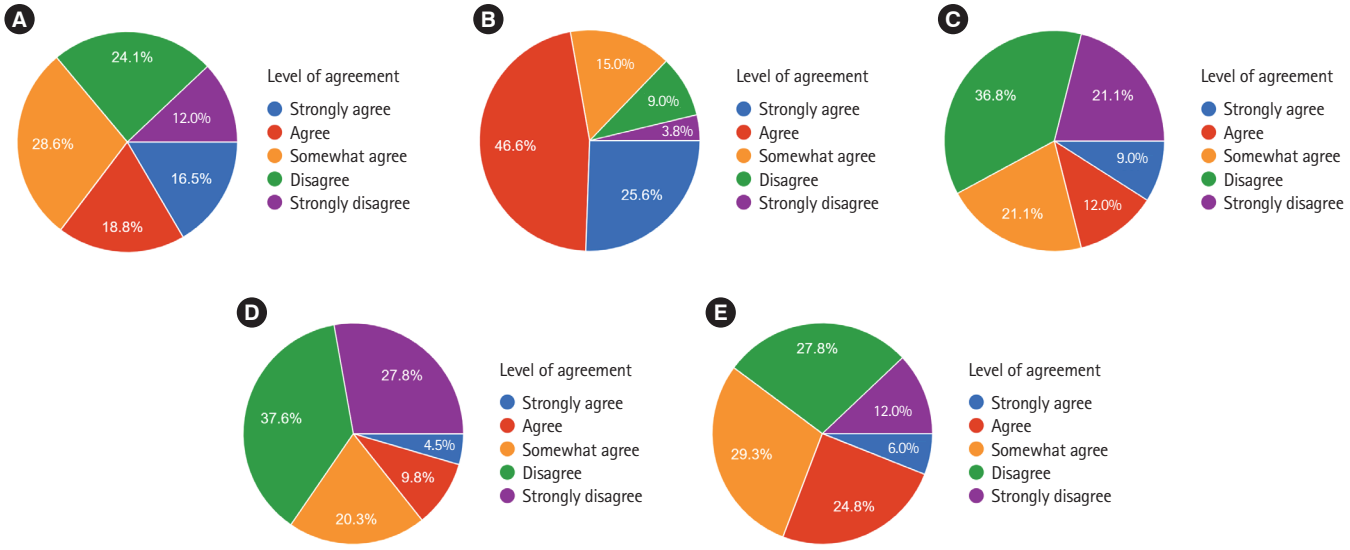


Fig. 4. Usefulness of abdominopelvic/abdominal CT and CTE in ulcerative colitis. (A) Useful as initial diagnostic tool. (B) Useful for assessing disease-related complications. (C) Useful for periodic monitoring of disease course. (D) Useful as a stand-alone modality for overall disease assessment. (E) High operator/interpreter dependence. CT, computed tomography; CTE, computed tomography enterography.

(n=43), respectively (Supplementary Fig. 2B). With respect to periodic disease monitoring, a relatively high level of agreement was observed, with 39.1% (n=52) reporting "strongly agree" and 42.1% (n=56) reporting "agree" (Supplementary Fig. 2C). A proportion of respondents also perceived MRE as potentially suitable as a stand-alone modality for comprehensive bowel assessment (Supplementary Fig. 2D). Regarding dependency on interpreter or operator expertise, 42.1% (n=56) selected "agree" and 24.1% (n=32) "strongly agree," while negative responses were relatively uncommon (Supplementary Fig. 2E).

Perceptions of IUS demonstrated a distinct pattern compared with other imaging modalities. Regarding its suitability as an initial diagnostic tool, 43 respondents (33.1%) somewhat agreed and 24 (18.8%) agreed, whereas 45 (34.6%) disagreed and 17 (12.8%) strongly disagreed (Supplementary Fig. 3A). Perceptions regarding the evaluation of disease-related complications were more variable, with 39.1% (n=52) reporting "somewhat agree" and 32.3% (n=43) reporting "agree" (Supplementary Fig. 3B), while a subset of respondents expressed negative views. In contrast, perceptions of IUS for periodic disease monitoring were relatively favorable, with 51.9% (n=69) selecting "agree" and 22.6% (n=30) selecting "strongly agree" (Supplementary Fig. 3C). However, negative responses predominated regarding the suitability of IUS as a stand-alone modality for comprehensive bowel assessment, with 36.8% (n=49) and 29.3% (n=39) reporting "disagree" and "strongly disagree," respectively (Supplementary Fig. 3D). For the item addressing dependency on interpreter or operator expertise, 76.7% (n=102) of respondents selected "strongly agree" and 18.0% (n=24) selected "agree" (Supplementary Fig. 3E), indicating near-universal acknowledgment of operator dependence.

5. Perceptions of Imaging Modalities in Ulcerative Colitis

In patients with ulcerative colitis, perceptions of the role of abdominal CT and CTE varied according to the clinical purpose. As an initial diagnostic tool, 16.5% of respondents reported "strongly agree" and 18.8% (n=25) "agree," while 28.6% (n=38) selected "somewhat agree." In contrast, negative responses were also substantial, with 24.1% (n=32) reporting "disagree" and 12.0% (n=16) "strongly disagree" (Fig. 4A). For the evaluation of disease-related complications, positive perceptions were more prominent, with "strongly agree" and "agree" reported by 25.6% (n=34) and 46.6% (n=62) of respondents, respectively, whereas negative responses were relatively limited (Fig. 4B). Conversely, perceptions regarding the use of CT/CTE for periodic disease monitoring were predominantly negative, with 36.8% (n=49) and 21.1% (n=28) selecting "disagree" and "strongly disagree," respectively (Fig. 4C). The proportion of respondents who considered CT/CTE suitable as a stand-alone modality for overall disease assessment was low, with only 4.5% (n=6) reporting "strongly agree" and 9.8% (n=13) reporting "agree." Responses regarding dependency

on interpreter or operator expertise were relatively evenly distributed across categories (Fig. 4D and E). Analysis of perceptions regarding MRE in ulcerative colitis revealed overall limited perceived utility. For initial diagnosis, only 3.8% (n=5) of respondents selected "strongly agree" and 12.8% (n=17) "agree," whereas 30.8% (n=41) and 32.3% (n=43) selected "disagree" and "strongly disagree," respectively (Supplementary Fig. 4A). Perceptions regarding the evaluation of disease-related complications showed a mixed distribution of positive and negative responses (Supplementary Fig. 4B), while perceptions of MRE for periodic monitoring were predominantly negative (Supplementary Fig. 4C). Similarly, negative responses predominated regarding the suitability of MRE as a stand-alone modality for comprehensive bowel assessment, with 39.8% (n=53) and 34.6% (n=46) reporting "disagree" and "strongly disagree," respectively (Supplementary Fig. 4D). For dependency on interpreter or operator expertise, 32.3% (n=43) and 15.8% (n=21) of respondents selected "agree" and "strongly agree," respectively (Supplementary Fig. 4E). Perceptions of IUS in ulcerative colitis also demonstrated a distinct pattern. For its usefulness as an initial diagnostic tool, responses were mixed, with both agreement and disagreement observed (Supplementary Fig. 5A). Perceptions regarding their role in evaluating disease-related complications were similarly heterogeneous (Supplementary Fig. 5B). In contrast, perceptions of IUS for periodic disease monitoring were relatively favorable, with 49.6% (n=66) of respondents selecting "agree" and 17.3% (n=23) selecting "strongly agree" (Supplementary Fig. 5C). Negative responses predominated regarding the suitability of IUS as a stand-alone modality for comprehensive bowel assessment, with 38.3% (n=51) and 29.3% (n=39) reporting "disagree" and "strongly disagree," respectively (Supplementary Fig. 5D). With respect to dependency on interpreter or operator expertise, many respondents expressed agreement, with 68.4% (n=91) reporting "strongly agree" and 24.8% (n=33) reporting "agree" (Supplementary Fig. 5E).

6. Analysis of Free-Text Responses

Analysis of free-text responses revealed several recurring themes. The most frequently expressed view was that a CT-centered imaging strategy is largely unavoidable in the current domestic clinical setting. Although respondents acknowledged MRE as the theoretically most accurate imaging modality, practical constraints such as long waiting times, cost, and limited accessibility often necessitated the preferential use of CT. Regarding IUS, a prevailing perception was that it has potential clinical value but faces substantial structural barriers. Commonly cited obstacles included limited training opportunities, increased examination time, lack of reimbursement, and unclear delineation of responsibilities between gastroenterology and radiology departments. In addition, many respondents emphasized the need for future guidelines to incorporate stepwise imaging algorithms and to provide pragmatic recommendations that account for inter-institutional differences in resource availability.

DISCUSSION

This study is the first comprehensive nationwide survey on real-world use and perceptions around imaging modalities of IBD among Korean specialists, providing clear insight into the structural characteristics and constraints that shape imaging strategies in the domestic clinical setting. Collectively, our results present a distinctly CT-centered imaging paradigm, which is consistently observed when considering several steps of care including diagnosis, emergency evaluation, and assessment of disease-related complications. The widespread reliance on CT/CTE appears to be driven by a combination of factors such as accessibility, rapid acquisition, spatial resolution, and immediate availability in acute clinical situations, which have collectively established CT as the default imaging modality within the Korean healthcare system.[8,19] While this approach offers advantages in terms of efficiency and prompt decision-making, it also raises long-term concerns related to cumulative radiation exposure and limitations in comprehensive structural assessment.[9,16,20]

Despite its well-recognized advantages for evaluating structural disease and defining disease extent, and avoiding radiation exposure, the real-world utilization of MRE was limited. The low adoption observed in this survey reflects not a lack of perceived value, but rather the influence of multiple practical barriers, including prolonged waiting times, financial burden, limited equipment availability, and longer examination duration. Compared with the European setting,[20,21] where MRE has been integrated as a core imaging modality, these findings underscore the structural constraints that characterize the domestic clinical environment and highlight the gap between ideal imaging paradigms and real-world practice. The difficulty of incorporating MRE into repeated assessment strategies was consistently emphasized in free-text responses, due to practical barriers such as long waiting times, cost, and limited accessibility, suggesting that the intrinsic strengths of MRE remain

insufficiently aligned with current clinical workflows in Korea.

In contrast to its established role as a cornerstone modality for repeated monitoring in Europe,[16,20,22] IUS was used only sparingly in Korean practice. Even among institutions where IUS had been introduced, responsibility for performing the examination varied widely, ranging from gastroenterology-led to radiology-led or mixed models, indicating the absence of a standardized implementation and training framework. While many respondents acknowledged the advantages of IUS as a noninvasive and repeatable imaging tool, they also identified substantial barriers to adoption, including operator dependency, variability in expertise, limited training opportunities, increased examination time, and the absence of reimbursement. These findings suggest that successful integration of IUS requires more than equipment availability, instead necessitating systemic changes such as the development of national training and certification pathways, restructuring of clinical workflows, and reform of reimbursement policies. In this context, the establishment of IUS training programs tailored to country-specific healthcare environments is essential. Alternatively, well-established international IUS training and certification programs could be adapted and supported at the national level to reflect local clinical workflows, workforce structures, and reimbursement systems. Such context-sensitive training strategies may facilitate more consistent implementation, reduce inter-operator variability, and ultimately promote wider and more sustainable adoption of IUS in routine clinical practice. In Korea, structured national training pathways for IUS are currently limited, and formal training opportunities remain largely dependent on participation in international educational initiatives such as programs organized by the International Bowel Ultrasound Group (IBUS). Consequently, only a small number of gastroenterologists have received dedicated training, often requiring overseas participation. To facilitate broader adoption of IUS, the development of domestic educational frameworks may be considered, including hands-on training courses, standardized competency-based curricula, and collaborative programs supported by national academic societies such as the KASID. In addition, adapting established international training models to the Korean healthcare environment may represent a pragmatic approach to improving operator proficiency and ensuring consistent quality of IUS implementation.

Overall, our results demonstrate a clear structural gap between an "ideal" imaging model emphasizing MRE and IUS for noninvasive and longitudinal assessment and the prevailing "pragmatic" CT-based model in current domestic practice. While European guidelines strongly advocate structured training, standardized scoring systems, and integrated imaging–clinical–pathologic assessment strategies,[11,19] direct implementation of these recommendations in Korea is challenged by constraints related to clinical workload, workforce composition, and inter-institutional variability in resources. These challenges were repeatedly reflected in the free-text responses, which highlighted disparities in imaging accessibility across regions and institutions, the need to balance rapid assessment with long-term safety considerations, and unresolved issues regarding the division of roles between gastroenterology and radiology.

Accordingly, future domestic guideline development should move beyond simply enumerating the roles of individual imaging modalities and instead provide stepwise, pragmatic recommendations tailored to the realities of Korean clinical practice. For example, while acknowledging the strengths of CT in initial diagnosis and emergency settings, strategies that incorporate MRE or IUS for structural evaluation and long-term monitoring may be encouraged when feasible. Establishing structured IUS training programs, defining minimum competency standards, standardizing image acquisition and interpretation, fostering collaborative frameworks between gastroenterology and radiology, and developing appropriate reimbursement models will be essential prerequisites for expanding the use of noninvasive imaging modalities. Moreover, imaging strategies should be individualized based on patient age, disease extent, disease stage, and risk profile, with increasing attention to cumulative radiation exposure over the long-term.

This study has several limitations that should be acknowledged. First, as this was a survey-based study conducted among IBD specialists, the findings reflect expert opinion rather than objective clinical practice data. In addition, because the survey was administered online, respondents may not have fully reflected prolonged or nuanced clinical decision-making, and response bias cannot be entirely excluded. Second, the data were self-reported, raising the possibility of recall bias and social desirability bias, particularly in questions related to preferred imaging strategies and clinical workflows. Third, despite careful survey design, certain questions may not have captured the full complexity of real-world clinical scenarios, and misunderstandings or heterogeneous interpretations of specific items may have occurred. Nevertheless, this study has several important strengths. To our knowledge, this

is the first nationwide survey to systematically assess imaging-based evaluation strategies for IBD in the context of contemporary Western guidelines. The survey captured the perspectives of a broad spectrum of Korean IBD specialists actively involved in clinical care, providing a representative overview of real-world practice patterns and perceptions within Korea. As such, our findings offer valuable insights into the current gap between guideline recommendations and clinical implementation and may serve as a foundation for the development of context-specific imaging strategies and future KASID guidelines for diagnosis and monitoring in IBD.

In conclusion, this study highlights that imaging assessment for IBD in Korea is at a critical crossroads. The CT-centered paradigm offers both strengths and inherent limitations, and the integration of alternative imaging strategies such as IUS and MRE represents not merely a technical challenge, but a broader issue requiring coordinated adjustments across the healthcare system. Our survey provides real-world evidence to inform context-specific imaging strategies and is expected to contribute to future revisions of the KASID guidelines for diagnosis and monitoring in IBD, particularly by supporting efforts to improve imaging accessibility, standardization, and training.

ADDITIONAL INFORMATION

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Conflict of Interest

Kim JE and Kim ES are editorial board members of the journal but were not involved in the peer reviewer selection, evaluation, or decision process of this article. No other potential conflicts of interest relevant to this article were reported.

Data Availability Statement

The data underlying this article cannot be shared publicly, given the privacy expectations of the individuals who participated in the study. The data will be shared upon reasonable request to the corresponding author.

Author Contributions

Conceptualization: Kim JE, Moon W. Data curation: Kim JE, Yang YJ, Moon W. Data interpretation: Kang SB, Kim ES, Kim SE, Kim SJ, Lee J, Na SY, Park SJ, Park SH, Jung SA. Formal analysis: Kim JE, Moon W. Methodology: Kim JE, Kim MH, Kang SB, Kim ES, Kim SE, Kim SJ, Lee J, Na SY, Park SJ, Park SH, Jung SA, Moon W. Writing–original draft: Kim JE, Moon W. Writing–review & editing: Bae JH, Shin SY, Kim DH, Hong SM, Song EM, Yoon J, Kang SB, Kim ES, Kim SE, Kim SJ, Lee J, Na SY, Park SJ, Park SH, Kim MH, Jung SA. Approval of final manuscript: all authors.

Additional Contributions

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Supplementary Material

Supplementary materials are available at the Intestinal Research website (https://www.irjournal.org).

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