SUPPORTING INFORMATION

Supplementary Table: RAND/UCLA responses with raw scoring and stratified by panelist specialty

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
Gastrointestinal ultrasound should be performed or supervised by an expert gastroenterologist or radiologist with specific training in gastrointestinal ultrasound.	0	0	0	1	0	0	0	2	14	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should be performed using both a low frequency and high frequency probe.	0	0	0	0	0	1	4	5	7	8	Appropriate	8	Appropriate	7	Appropriate
A low frequency probe should be used to detect anatomy and gross pathology before changing to a high frequency probe.	0	0	0	1	0	1	6	4	5	8	Appropriate	8	Appropriate	7	Appropriate
Gastrointestinal ultrasound should be performed with a relaxed and fully supine patient.	0	0	0	0	0	0	2	7	8	8	Appropriate	8.5	Appropriate	8	Appropriate
A systematic approach should be taken to examine the whole intestine when performing gastrointestinal ultrasound.	0	0	0	0	1	0	0	6	10	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The sigmoid colon	0	0	0	0	1	0	0	0	13	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The descending colon	0	0	0	0	1	0	0	0	13	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The transverse colon	0	0	0	0	1	0	0	0	12	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The ascending colon	0	0	0	0	1	0	0	0	13	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The caecum	0	0	0	0	1	0	0	0	12	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The terminal ileum	0	0	0	0	1	0	0	0	13	9	Appropriate	9	Appropriate	9	Appropriate
Gastrointestinal ultrasound should routinely evaluate: The proximal small bowel	0	0	0	0	2	0	0	0	9	9	Appropriate	9	Appropriate	9	Appropriate
The rectum should be evaluated in transabdominal ultrasound if possible, and the adequacy of rectal views should be documented.	0	0	2	0	0	0	4	6	5	8	Appropriate	8	Appropriate	8	Appropriate
Gastrointestinal ultrasound does not require fasting in most situations.	0	0	2	1	0	0	0	5	9	9	Appropriate	9	Appropriate	3	Inappropriate

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Gastrointestinal ultrasound does not require bowel preparation in most situations.	0	0	0	0	0	0	2	4	11	9	Appropriate	9	Appropriate	7	Appropriate
When performing small intestinal contrast ultrasound (SICUS), the patient should be instructed to ingest 300-500mL of polyethylene glycol 30-60 minutes before the procedure to increase the sensitivity and specificity of detection and characterisation of small intestinal lesions.	0	0	1	0	3	1	3	7	2	8	Appropriate	8	Appropriate	6	Uncertain
SICUS should be integrated into a Crohn's disease activity index.	3	8	4	1	1	0	0	0	0	2	Inappropriate	2	Inappropriate	2	Inappropriate
Contrast enhanced ultrasonography (CEUS) with intravenous contrast is a useful adjunctive technique for identifying inflammatory and penetrating complications of Crohn's disease.	0	1	0	0	1	1	4	5	5	8	Appropriate	8	Appropriate	7	Appropriate
Routine use of CEUS is not required in most situations because of limitations of the technique including time, expertise, and need for intravenous access.	1	0	0	0	0	0	0	8	8	8	Appropriate	8.5	Appropriate	8	Appropriate
The same general considerations apply when performing gastrointestinal ultrasound in adult and paediatric Crohn's disease patients.	0	0	0	0	0	0	4	7	6	8	Appropriate	8	Appropriate	8	Appropriate
A Visual Analogue Scale (e.g. 0-100mm) should be used to assess overall disease activity.	1	0	0	0	6	1	1	7	1	7	Appropriate	8	Appropriate	5	Uncertain
Bowel wall thickness is a useful marker of disease activity.	0	0	0	0	0	0	1	1	15	9	Appropriate	9	Appropriate	9	Appropriate
Bowel wall thickness can only be accurately measured using a high frequency probe.	0	1	2	1	0	3	3	4	3	7	Appropriate	7	Appropriate	8	Appropriate
Bowel wall thickness should be measured from the interface of the intestinal contents and hypoechoic mucosa to the luminal margin of the hyperechoic serosa.	0	0	0	0	0	0	1	5	11	9	Appropriate	9	Appropriate	8	Appropriate
The same bowel wall thickness cut-off should be used for both the large and small bowel.	0	1	0	2	1	0	6	3	4	7	Appropriate	7	Appropriate	7	Appropriate
A bowel wall thickness of 3.0mm should be used as a cut-off to distinguish normal from pathologic bowel in the colon.	0	0	0	1	1	1	6	3	5	7	Appropriate	7.5	Appropriate	7	Appropriate

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
A bowel wall thickness of 3.0mm should be used as a cut-off to distinguish normal from pathologic bowel in the small bowel.	0	0	1	1	0	0	6	4	5	8	Appropriate	8	Appropriate	7	Appropriate
Bowel wall thickness is the most reliable marker of Crohn's disease activity.	0	0	0	0	0	0	3	6	8	8	Appropriate	8.5	Appropriate	8	Appropriate
Longitudinal and transverse bowel wall thickness should be measured separately.	0	0	0	1	2	0	1	7	6	8	Appropriate	8	Appropriate	5	Uncertain
When measuring bowel wall thickness, the average thickness from two or more measurements should be used.	0	0	1	0	0	0	4	7	5	8	Appropriate	8	Appropriate	7	Appropriate
Bowel wall thickness should be scored continuously as a value in millimetres (to one decimal place, e.g., 3.0mm) in a GIUS index for assessing Crohn's disease.	0	0	0	0	0	1	1	7	8	8	Appropriate	8.5	Appropriate	7	Appropriate
Bowel wall thickness should be weighted more than other parameters in a GIUS index for assessing Crohn's disease.	0	0	1	0	2	0	3	6	5	8	Appropriate	8	Appropriate	7	Appropriate
The same method for scoring bowel wall thickness should be used in both adult and paediatric patients.	0	0	0	0	2	0	3	5	7	8	Appropriate	8	Appropriate	8	Appropriate
The presence of increased bowel wall vascularity as measured by colour Doppler imaging is a useful marker of Crohn's disease activity.	0	0	0	0	0	0	4	6	7	8	Appropriate	8	Appropriate	8	Appropriate
Colour Doppler imaging should be used to measure bowel wall vascularity using a low velocity setting, with sensitivity calibrated by reducing the gain until artefactual signal is no longer present.	0	0	0	0	0	1	4	6	6	8	Appropriate	8	Appropriate	8	Appropriate
Bowel wall vascularity should be scored as a binary outcome (i.e., absent or present).	2	2	6	1	2	2	0	2	0	3	Inappropriate	3	Inappropriate	4	Uncertain
Bowel wall vascularity should be scored semi-quantitatively as: None, Moderate (visible vessels within bowel wall), Severe (visible vessels within bowel wall and extending into mesentery)	0	1	0	4	3	1	5	2	1	6	Uncertain	6.5	Appropriate	5	Uncertain
Bowel wall vascularity should be scored as:0=No blood flow on colour Doppler imaging1=Small, circular intramural vascular signal on colour Doppler imaging2=Longer linear intramural vascular signal on colour Doppler imaging3=Longer stretches of vascular signal with	1	1	0	1	0	0	3	9	2	8	Appropriate	8	Appropriate	8	Appropriate

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
extension into mesentery on colour Doppler imaging															
Consistent GIUS equipment must be used for baseline and post-treatment assessment in clinical trials of Crohn's disease.	0	0	0	0	1	0	4	7	5	8	Appropriate	8	Appropriate	8	Appropriate
The same method for scoring colour Doppler imaging should be used in both adult and paediatric patients.	0	0	0	0	1	1	2	5	8	8	Appropriate	8.5	Appropriate	8	Appropriate
Loss of bowel wall stratification is a useful marker of disease activity.	0	0	1	0	0	3	2	8	3	8	Appropriate	8	Appropriate	8	Appropriate
Abnormal bowel wall stratification should be defined as loss of clearly demarcated mucosal, submucosal, and muscularis propria layers.	0	0	0	1	0	1	3	7	5	8	Appropriate	8	Appropriate	8	Appropriate
Abnormal bowel wall stratification should only be considered present if it is identified in two views, preferably longitudinal and cross-sectional images.	0	1	1	0	1	1	7	3	3	7	Appropriate	7	Appropriate	8	Appropriate
Bowel wall stratification should be scored as a binary outcome (i.e., present or absent).	1	1	3	1	3	2	5	1	0	5	Uncertain	5.5	Uncertain	4	Uncertain
Bowel wall stratification should be scored as present, focal loss (<3cm), or extensive (≥3cm).	1	0	2	1	1	0	6	5	1	7	Appropriate	7	Appropriate	8	Appropriate
Bowel wall stratification should be scored as present, unclear, or absent.	1	2	2	1	3	2	2	2	2	5	Uncertain	5.5	Uncertain	3	Inappropriate
Bowel wall stratification should include an assessment of submucosal prominence/thickening.	0	0	0	1	2	2	5	5	2	7	Appropriate	7	Appropriate	8	Appropriate
A Visual Analogue Scale (e.g., 0-100 mm) should be used to assess bowel wall stratification.	2	3	4	1	2	2	1	2	0	3	Inappropriate	3	Inappropriate	5	Uncertain
The same method for scoring bowel wall stratification should be used in both adult and paediatric patients.	0	0	0	0	1	0	3	7	6	8	Appropriate	8	Appropriate	8	Appropriate
Mesenteric inflammatory fat is a useful marker of disease activity.	0	0	0	0	0	2	5	4	6	8	Appropriate	8	Appropriate	8	Appropriate
Mesenteric inflammatory fat should be assessed based on changes in echogenicity of mesenteric fat surrounding a segment of thickened bowel wall and the presence of any fat wrapping around the associated segment of bowel.	0	1	0	0	0	1	5	4	6	8	Appropriate	8	Appropriate	8	Appropriate

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Mesenteric inflammatory fat should be scored as a binary outcome (i.e., absent or present).	0	1	1	2	1	2	4	6	0	7	Appropriate	7	Appropriate	5	Uncertain
Mesenteric inflammatory fat should be scored using three categorical variables (i.e., absent, equivocal, or present).	1	3	1	2	3	0	2	4	1	5	Uncertain	5	Uncertain	2	Inappropriate
Mesenteric inflammatory fat should be scored using the following categories: 0=Normal;1=Focal hyperechoic without fat wrap (i.e., focal defined area of mesenteric fat of increased echogenicity without overall increase in volume of peri-mural fat);2=Stratified heterogenous with fat expansion (i.e., overall increase in volume of peri-mural fat with maintained normal mesenteric stratification and no focal hyperechoic area);3=Focal hyperechoic with fat wrap (i.e., focal defined area of mesenteric fat of increased echogenicity with overall increase in volume of peri-mural fat).	0	2	3	3	3	2	0	3	1	5	Uncertain	4.5	Uncertain	8	Appropriate
The same method for scoring mesenteric inflammatory fat should be used in both adult and paediatric patients.	0	0	0	0	1	0	4	7	5	8	Appropriate	8	Appropriate	8	Appropriate
Bowel wall compressibility is a useful maker of disease activity.	0	4	3	3	2	2	2	1	0	4	Uncertain	3.5	Inappropriate	7	Appropriate
Bowel wall compressibility should be scored as a binary outcome (i.e. absent or present).	0	1	0	2	7	3	1	1	2	5	Uncertain	5	Uncertain	6	Uncertain
The same method for scoring bowel wall compressibility should be used in both adult and paediatric patients.	0	1	0	1	5	2	1	5	2	6	Uncertain	5.5	Uncertain	8	Appropriate
Mesenteric lymphadenopathy is a useful maker of disease activity.	0	3	2	1	2	2	4	2	1	6	Uncertain	6.5	Appropriate	3	Inappropriate
Mesenteric lymphadenopathy should be defined as lymph nodes greater than 4.0mm in short axis diameter that are located in the mesentery adjacent to an affected segment.	0	1	2	2	3	0	2	6	1	7	Appropriate	7.5	Appropriate	4	Uncertain
Mesenteric lymph nodes greater than 10.0mm in short axis diameter should be considered pathologic.	0	0	1	1	0	0	3	9	3	8	Appropriate	8	Appropriate	8	Appropriate
Mesenteric lymphadenopathy should be scored as a binary outcome (i.e., absent or present).	1	1	0	1	1	1	3	6	3	8	Appropriate	8	Appropriate	5	Uncertain

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
The same method for scoring mesenteric lymphadenopathy should be used in both adult and paediatric patients.	3	1	1	1	4	1	2	2	2	5	Uncertain	5	Uncertain	7	Appropriate
Loss of small bowel peristalsis in a segment with increased bowel wall thickness and/or increased Doppler vascularity is a useful marker of disease activity.	0	1	1	1	1	2	6	5	0	7	Appropriate	7	Appropriate	8	Appropriate
Small bowel peristalsis (within the context of inflammatory Crohn's disease) should be scored using categorical variables (i.e., absent, reduced, present, or increased).	0	0	1	2	0	1	5	5	3	7	Appropriate	8	Appropriate	7	Appropriate
Small bowel peristalsis (within the context of inflammatory Crohn's disease) should be scored as a binary outcome (i.e., absent or present).	2	2	1	3	0	3	4	2	0	6	Uncertain	5	Uncertain	7	Appropriate
Fasting status of the patient should be documented for evaluation of peristalsis.	0	0	0	0	6	1	5	4	1	7	Appropriate	6.5	Appropriate	8	Appropriate
The same method for scoring loss of small bowel peristalsis should be used in both adult and paediatric patients.	0	0	0	0	4	0	3	7	3	8	Appropriate	7.5	Appropriate	8	Appropriate
Absence of colonic haustra coli is a useful marker of disease activity.	0	1	3	0	4	0	7	2	0	7	Appropriate	7	Appropriate	5	Uncertain
Absence of colonic haustra coli should be scored as a binary outcome (i.e., absent or present).	0	1	0	1	3	0	8	3	1	7	Appropriate	7	Appropriate	5	Uncertain
The same method for scoring absence of colonic haustra coli should be used in both adult and paediatric patients.	0	0	0	0	2	0	6	5	4	8	Appropriate	8	Appropriate	7	Appropriate
Presence of complications such as abscess or fistula is a useful marker of disease activity.	0	0	1	1	2	0	3	4	6	8	Appropriate	8	Appropriate	8	Appropriate
Presence of complications such as abscess or fistula should be scored as a binary outcome (i.e., absent or present).	1	0	0	0	0	1	3	4	8	8	Appropriate	9	Appropriate	7	Appropriate
The same method for scoring presence of complications such as abscess or fistula should be used in both adult and paediatric patients.	0	0	0	0	0	0	3	6	8	8	Appropriate	8.5	Appropriate	8	Appropriate
The total length of a diseased segment should be reported using three categorical variables (i.e., discreet = <1.0cm; short = <5.0cm; long = >5.0cm).	1	1	1	2	3	2	4	1	2	6	Uncertain	6.5	Appropriate	4	Uncertain

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
The total length of a diseased segment should be scored continuously as a value in centimetres (to one decimal place, e.g., 3.0cm).	0	1	3	1	1	0	2	6	3	8	Appropriate	7.5	Appropriate	8	Appropriate
The Modified Limberg Score is an appropriate instrument for assessing Crohn's disease activity. (0 = Normal BWT [Bowel Wall Thickness] and normal CDI [Color Doppler Imaging], 1 = Increased BWT and no CDI, 2 = Increased BWT with short stretches of CDI, 3 = Increased BWT with longer stretches of CDI, 4 = Increased BWT and longer stretches of CDI extending into surrounding mesentery)	0	0	3	0	2	5	2	4	0	6	Uncertain	6	Uncertain	5.5	Uncertain
The Contrast Enhanced Ultrasound Score is an appropriate instrument for assessing Crohn's disease activity. (Peak contrast enhancement: <18.2dB = Inactive, 18.2-22.8dB = Mild to moderate, >2.8dB = Moderate to severe)	1	3	4	2	3	1	2	0	0	3.5	Inappropriate	4	Uncertain	2.5	Inappropriate
The Lenze Score is an appropriate instrument for assessing Crohn's disease activity. (Fibromatous = Hyperechogenic wall thickening and Limberg 1, Mixed = Mixed hypo- and hyper-echogenic wall thickening and Limberg 2, Inflammatory = Hypoechogenic wall thickening and Limberg 3 or 4)	0	2	4	0	6	2	2	0	0	5	Uncertain	5	Uncertain	4	Uncertain
The Neye Score is an appropriate instrument for assessing Crohn's disease activity. (1 (Inactive) = BWT <5.0mm and no vessels, 2 (Mild activity) = BWT <5.0mm and 1-2 vessels OR BWT ≥ 5.0mm and no vessels, 3 (Moderate activity) = BWT <5.0mm and >2 vessels OR BWT ≥ 5.0mm and 1-2 vessels, 4 (High activity) = BWT ≥ 5.0mm and >2 vessels)	0	1	3	1	5	3	3	0	0	5	Uncertain	5	Uncertain	4.5	Uncertain
The Paraedes Contrast-Enhanced Ultrasound Postoperative Recurrence Score is an appropriate instrument for assessing Crohn's disease activity. (0 = Normal BWT <3.0mm and CEUS enhancement <34.5%, 1 = BWT 3-5.0mm with CEUS enhancement <46% Recurrence, 2 = BWT >	1	2	5	1	5	1	1	0	0	3.5	Inappropriate	4.5	Uncertain	3	Inappropriate

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
5.0mm or CEUS enhancement >46%. Mod-severe recurrence, 3 = BWT >5.0mm or CEUS enhancement >70%, or presence of fistula)															
The Simple Ultrasonographic Score is an appropriate instrument for assessing Crohn's disease activity. (A continuous algorithm of BWT and CDI)	0	0	2	1	4	3	3	3	0	6	Uncertain	6	Uncertain	4.5	Uncertain
The Ultrasound Activity Index for Crohn's Disease is an appropriate instrument for assessing Crohn's disease activity. (A = Decreased compressibility and peristalsis with loss of haustrations but without bowel wall thickening (4.0mm cut-off), B = Pathologic wall thickening and presence of BWS, C = Pathologic wall thickening and loss of BWS)	1	1	2	1	4	5	2	0	0	5	Uncertain	5.5	Uncertain	3.5	Inappropriate
The Ultrasound Lemann Index is an appropriate instrument for assessing Crohn's disease activity. (A weighted score that differentiates structuring and penetrating disease. Small bowel – Stricturing, Grade 1 = BWT >3.0mm or segmental enhancement without pre-stenotic dilatation, Grade 2 = BWT >4.0mm or mural stratification without pre-stenotic dilatation, Grade 3 = BWT >4.0mm, narrowed lumen, and fluid distended or echogenic content-filled loops proximal to thickened tract. Small bowel – Penetrating, Grade 2 = Deep transmural ulceration, Grade 3 = Hypoechoeic duct-like structures with fluid or air content between intestine and skin, intestine or mesentery. Colon – Stricturing, Grade 1 = BWT >3.0mm or segmental enhancement without pre-stenotic dilatation, Grade 2 = BWT >4.0mm or mural stratification without pre-stenotic dilatation or <50% of lumen, Grade 3 = Stricture with pre-stenotic dilatation or >50% of the lumen. Colon – Penetrating, Grade 2 = Deep transmural ulceration, Grade 3 = Phlegmon or any type of fistula)	1	2	1	2	6	2	2	0	0	5	Uncertain	5	Uncertain	3	Inappropriate

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All images should be optimised with focal length set to the bowel segment of interest and depth set to demonstrate associated mesentery.	0	0	0	0	0	0	5	5	6	8	Appropriate	8	Appropriate	8	Appropriate
Two images with bowel wall measurements should be collected for each bowel segment: one cross sectional and one longitudinal.	0	0	0	1	0	0	4	4	7	8	Appropriate	8.5	Appropriate	5.5	Uncertain
For each segment, 3 short video loops should be collected in short axis, long axis, and with color Doppler imaging.	1	0	1	2	4	1	1	4	2	5.5	Uncertain	5.5	Uncertain	6	Uncertain
A 3-5 second video-loop demonstrating colour Doppler vascularity should be collected for each affected segment.	0	0	0	0	3	0	3	6	4	8	Appropriate	8	Appropriate	6.5	Appropriate
Images of lymph nodes with short axis measurements should be collected.	0	1	1	1	3	0	5	3	2	7	Appropriate	7	Appropriate	3.5	Inappropriate
A 10 second video-loop demonstrating distal ileal peristalsis should be collected.	0	1	0	0	3	4	5	1	2	6.5	Appropriate	6.5	Appropriate	6.5	Appropriate
A gastrointestinal ultrasound score should be calculated based on all visualised segments.	0	1	2	0	2	1	0	5	4	8	Appropriate	8	Appropriate	5.5	Uncertain
A gastrointestinal ultrasound score should be calculated based on the most severely affected segment.	1	0	1	0	2	2	2	6	1	7	Appropriate	8	Appropriate	4	Uncertain
The most affected segment(s) before and after treatment should be captured for central reading.	0	1	0	0	0	1	3	7	3	8	Appropriate	8	Appropriate	7	Appropriate
The same segments before and after treatment should be captured for central reading.	0	0	0	0	0	0	2	8	5	8	Appropriate	8	Appropriate	8	Appropriate
A gastrointestinal ultrasound score should be calculated by summing the total score of each segment examined.	0	1	2	1	2	1	2	5	1	7	Appropriate	7	Appropriate	4	Uncertain
A gastrointestinal ultrasound score should be calculated by dividing the sum of the individual segments by the number of segments explored.	0	4	3	0	4	1	2	0	1	5	Uncertain	5	Uncertain	4.5	Uncertain
Each examined segment should be scored and then an overall activity score should be calculated as both the most affected segment and overall activity are important for assessing activity and determining treatment response.	0	0	0	1	1	0	1	9	3	8	Appropriate	8	Appropriate	6	Uncertain
A GIUS index of Crohn’s disease activity should be designed to be easily calculated.	0	0	0	0	0	0	3	3	9	9	Appropriate	9	Appropriate	8	Appropriate

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A gastrointestinal ultrasound index should be calculated with a single numeric score to indicate disease activity.	0	0	0	0	0	1	5	4	5	8	Appropriate	8	Appropriate	8	Appropriate
Extraluminal complications such as fistula or abscess should not be part of a luminal activity score.	1	0	1	1	1	1	1	4	5	8	Appropriate	8	Appropriate	8	Appropriate
The same gastrointestinal ultrasound index can be used in both adult and paediatric patients.	0	0	0	0	1	2	2	4	6	8	Appropriate	8	Appropriate	8	Appropriate
Gastrointestinal ultrasound can be used as a screening tool to exclude patients from clinical trials if they have exclusionary criteria such as an abscess or fistula.	0	0	0	2	0	0	7	5	1	7	Appropriate	7	Appropriate	6	Uncertain
Gastrointestinal ultrasound can be used to qualify patients for clinical trials when diseased segments cannot be adequately assessed by ileocolonoscopy.	0	0	0	0	0	1	3	5	6	8	Appropriate	8	Appropriate	7	Appropriate
A gastrointestinal ultrasound activity index of Crohn’s disease can be used to define remission.	0	0	0	1	0	1	4	3	6	8	Appropriate	8	Appropriate	7	Appropriate
A gastrointestinal ultrasound activity index of Crohn’s disease can be used to define response.	0	0	0	0	1	0	3	7	4	8	Appropriate	8	Appropriate	7.5	Appropriate
When assessing response to induction therapy, gastrointestinal ultrasound should be done at: 4 weeks	0	3	1	1	2	2	2	2	2	6	Uncertain	6	Uncertain	3.5	Inappropriate
When assessing response to induction therapy, gastrointestinal ultrasound should be done at: 6 weeks	0	2	0	2	6	0	3	1	1	5	Uncertain	5	Uncertain	4	Uncertain
When assessing response to induction therapy, gastrointestinal ultrasound should be done at: 8 weeks	0	0	0	2	3	0	4	4	2	7	Appropriate	7	Appropriate	5.5	Uncertain
When assessing response to induction therapy, gastrointestinal ultrasound should be done at:12 weeks	0	1	0	0	1	0	1	5	7	8	Appropriate	8	Appropriate	8	Appropriate
When assessing response to induction therapy, gastrointestinal ultrasound should be done at: 16 weeks	0	0	1	1	3	1	3	3	3	7	Appropriate	7	Appropriate	7	Appropriate
When assessing response to maintenance therapy, gastrointestinal ultrasound should be done at: 26 weeks	0	0	0	0	0	1	2	5	7	8	Appropriate	9	Appropriate	7.5	Appropriate

Item	R 1	R 2	R 3	R 4	R 5	R 6	R 7	R 8	R 9	Median Rating (Overall)	Rating (Overall)	Median Rating (GIs)	Rating (GIs)	Median Rating (Radiologists)	Rating (Radiologists)
When assessing response to maintenance therapy, gastrointestinal ultrasound should be done at: 52 weeks	0	0	0	0	0	1	3	3	8	9	Appropriate	9	Appropriate	8	Appropriate
Remission should be defined as a combination of bowel wall thickness normalisation (<3.0mm) and no bowel wall vascularity on colour Doppler imaging.	0	1	0	1	1	4	3	4	1	7	Appropriate	7	Appropriate	5	Uncertain
Remission should be defined as a combination of bowel wall thickness normalisation (<3.0mm), no bowel wall vascularity on colour Doppler imaging, and no mesenteric inflammatory fat.	0	1	1	0	1	1	6	3	2	7	Appropriate	7	Appropriate	4.5	Uncertain
Remission should be defined as a combination of bowel wall thickness normalisation (even if >3.0mm), no bowel wall vascularity on colour Doppler imaging and no mesenteric inflammatory fat.	0	0	1	1	1	1	1	6	4	8	Appropriate	8	Appropriate	5.5	Uncertain
Remission should be defined as bowel wall thickness normalization (<3.0mm) alone.	1	2	2	2	1	3	2	2	0	5	Uncertain	6	Uncertain	3.5	Inappropriate
Sonographic remission should require complete resolution of mesenteric hyper echogenicity and lymphadenopathy.	0	2	2	2	3	2	2	1	1	5	Uncertain	5	Uncertain	4.5	Uncertain
The same remission criteria can be used in both adult and paediatric patients.	0	0	0	0	1	2	1	7	4	8	Appropriate	8	Appropriate	7	Appropriate
Response should be defined as a combination of the magnitude of the decrease in bowel wall thickness and colour Doppler activity.	0	0	1	0	1	0	4	6	3	8	Appropriate	8	Appropriate	4	Uncertain
The same response criteria can be used in both adult and paediatric patients.	0	0	0	0	1	1	3	5	5	8	Appropriate	8	Appropriate	7.5	Appropriate

Abbreviations: GI gastroenterologist