**LEGENDS FOR FIGURES IN TEXT**

FIG 1a: Sagittal post contrast CT showing an umbilical hernia with herniation of small bowel loops through a midline defect in the abdominal wall .

FIG 1b: Axial CT showing indirect inguinal hernia (blue arrow)

FIG 1c: Axial CT showing SBO with abrupt transition point (yellow arrow) with no associated mass in keeping with an adhesive band, confirmed at surgery.

FIG 1d: Axial CT in a known patient with Crohn’s disease showing mural hyper-enhancement (yellow arrow) and mural thickening(blue arrow)

FIG 2: Erect Abdominal radiograph: Small bowel dilatation with multiple air fluid levels at different heights with string of beads sign (arrow) in keeping with definite small bowel obstruction.

FIG 3a: Abdominal radiograph showing tubular air lucency (blue arrow) resembling bowel overlying the left inguinal region in keeping with an inguinal hernia.

FIG 3b: Plain radiograph of surgically confirmed ileosigmoid knot showing dilated sigmoid colon with the apex in the left upper quadrant and the point of convergence overlying the right iliac fossa(thick arrow) with dilated small bowel loops in the pelvis(thin arrow)

FIG 4: Coronal post oral contrast CT Abdomen showing markedly dilated jejunal loops measuring 3.8cm from outer wall to outer wall.

FIG 5: Coronal CT Abdomen showing an abrupt beak like transition point in the right iliac fossa with mural hyperenhancement (arrow) secondary to Crohn’s disease

FIG 6a: Axial CT in a known haemophiliac showing SBO secondary to a large hyperdense haematoma (arrow).

FIG 6b: Axial CT showing gross SBO with a target sign in the right iliac fossa secondary to active Crohn’s disease.

FIG 6c: Coronal CT showing gross small bowel dilatation (yellow arrow) with extensive mesenteric adenopathy (blue arrow) secondary to tuberculosis.

FIG 6d: Coronal CT showing marked small bowel obstruction secondary to a tumour in the right iliac fossa(arrow).

FIG 6e:. Axial post contrast CT abdomen showing markedly thickened small bowel loops (arrow) in a known patient with lymphoma.

Fig 6f: Axial post contrast CT showing a mass in the right iliac fossa (blue arrow) with alternating layers of low (mesenteric fat) and high attenuation(bowel wall) in keeping with ileocolic intussusception with SBO.

FIG 7: Axial CT appearance of the whirl sign (arrow) due to convergence of vessels around a fixed point of obstruction.

FIG 8a: Axial CT showing bulls-eye or target appearance in which there are alternating layers of high and low attenuation due to mural hyperenhancement and submucosal edema(arrow).

FIG 8b: SBO in a known patient with tuberculosis complicated by perforation. Extraluminal contrast filled collection (yellow arrow)

FIG 9a: Axial CT enterography using water showing gross SBO with an abrupt transition point (arrow) in the right iliac fossa secondary to a stricture from tuberculosis.

FIG 9b: 3D reconstruction of CT enterography showing marked SBO. Manipulation on the workstation allows accurate evaluation of the transition point

FIG 10: Reproduced with permission from :

 Amzallag-Bellenger E, Oudjit A, Ruiz A, et al. Effectiveness of MR enterography for the assessment of small-bowel disesases beyond Crohn Disease. *RadioGraphics* 2012;32:1423-1444.

Adhesive ileal obstruction in a 30-year-old woman with a history of ap­pendectomy and recurrent low-grade bowel obstruction. MR enterography was performed after the administration of 1 L of an oral con­trast agent. Coronal FISP image from MR enterography demonstrates ileal loop dilatation (curved arrow), a transition point (straight arrow), and normal distal caliber (arrowhead). No mass, bowel wall thickening, stricture, or other specific cause of obstruction was iden­tified. These findings were suggestive of an obstruction due to bowel adhesion, which was later confirmed at laparotomy

FIG 11: Small bowel follow through study showing gross small bowel dilatation with dilution of barium and poor mucosal detail and poor delineation of the transition point due to overlapping bowel loops.