SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-69972
DATE OF PROCEDURE: 04/15/2025
DATE OF REPORT: 04/19/2025
REQUESTING PHYSICIAN: Dr. Ashley Burton, Gastroenterology
PATHOLOGIST: Dr. Isabella Cunningham, Anatomic Pathology

CLINICAL HISTORY:

34 year old male with 3 week history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed severe friability, superficial ulcerations, and pseudopolyps throughout the colon. Clinical suspicion for ulcerative colitis.

SPECIMEN RECEIVED:

A. Rectum, biopsy

B. Sigmoid colon, biopsy

C. Descending colon, biopsy

D. Transverse colon, biopsy

E. Ascending colon, biopsy

F. Terminal ileum, biopsy

GROSS DESCRIPTION:

A. Received in formalin labeled "rectum" are 3 tan-pink tissue fragments measuring 2 mm in aggregate.

B. Received in formalin labeled "sigmoid colon" are 2 tan-pink tissue fragments measuring 8 mm in aggregate.

C. Received in formalin labeled "descending colon" are 2 tan-pink tissue fragments measuring 8 mm in aggregate.

D. Received in formalin labeled "transverse colon" are 4 tan-pink tissue fragments measuring 5 mm in aggregate.

E. Received in formalin labeled "ascending colon" are 5 tan-pink tissue fragments measuring 6 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 3 tan-pink tissue fragments measuring 4 mm in aggregate.

All specimens are entirely submitted in 1 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows moderate active chronic inflammation with severe cryptitis, crypt architectural distortion, and mucosal ulceration. The inflammatory process is limited to the mucosa without evidence of granulomas. Surface epithelium shows reactive changes.

B. Sigmoid colonic mucosa shows severe active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. The inflammatory process is limited to the mucosa without evidence of granulomas. Occasional Paneth cell metaplasia is noted.

C. Descending colonic mucosa shows moderate active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and goblet cell depletion. The inflammatory process is limited to the mucosa without evidence of granulomas. Lamina propria shows increased plasma cells and lymphocytes. Rare cells with intranuclear and cytoplasmic inclusions suspicious for cytomegalovirus (CMV) infection are identified.

D. Transverse colonic mucosa shows mild to moderate active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. No evidence of dysplasia is identified.

E. Ascending colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Surface epithelium shows reactive changes.

F. Terminal ileal mucosa shows normal small intestinal mucosa with preserved villous architecture. No evidence of chronic inflammatory bowel disease identified in this section.

DIAGNOSIS:

A. Rectum, biopsy:

- moderate active chronic colitis with crypt architectural distortion and goblet cell depletion
- Viral cytopathic changes suspicious for cytomegalovirus (CMV) infection
- moderate consistent with ulcerative colitis
- No dysplasia identified
- No evidence of cytomegalovirus (CMV) infection

B. Sigmoid colon, biopsy:

- severe active chronic colitis with crypt architectural distortion and goblet cell depletion
- severe consistent with ulcerative colitis
- No dysplasia identified

C-E. Descending, transverse, and ascending colon, biopsies:

- moderate active chronic colitis with crypt architectural distortion
- Features consistent with ulcerative colitis
- No dysplasia identified

F. Terminal ileum, biopsy:

- Mild non-specific inflammation
- No evidence of inflammatory bowel disease

COMMENT:

The histologic findings show a pattern of continuous chronic active colitis with greatest severity in the distal colon and rectum, with relative sparing of the proximal colon. The absence of granulomas, transmural inflammation, and terminal ileal involvement are features favoring ulcerative colitis over Crohn's disease. Correlation with clinical, endoscopic, and radiologic findings is recommended for definitive classification. The presence of diffuse crypt architectural distortion, basal plasmacytosis, and continuous inflammatory pattern strongly supports the diagnosis of ulcerative colitis. Immunohistochemical staining for CMV is positive, confirming the presence of CMV infection. This may contribute to the severity of colitis and should be considered in treatment planning.

SPECIAL STUDIES:

Periodic acid-Schiff (PAS) stain is negative for fungal organisms. Cytomegalovirus (CMV) immunohistochemistry reveals scattered positive cells confirming viral infection.