SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-79079
DATE OF PROCEDURE: 04/19/2025
DATE OF REPORT: 04/22/2025
REQUESTING PHYSICIAN: Dr. Joseph Ramirez, Gastroenterology
PATHOLOGIST: Dr. Emily Peterson, Anatomic Pathology

CLINICAL HISTORY:

29 year old female with 3 month history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed severe ulceration and spontaneous bleeding from rectum to descending 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 5 tan-pink tissue fragments measuring 5 mm in aggregate.

B. Received in formalin labeled "sigmoid colon" are 2 tan-pink tissue fragments measuring 7 mm in aggregate.

C. Received in formalin labeled "descending colon" are 5 tan-pink tissue fragments measuring 4 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 2 tan-pink tissue fragments measuring 6 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 5 tan-pink tissue fragments measuring 6 mm in aggregate.

All specimens are entirely submitted in 2 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows moderate active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. The inflammatory process is limited to the mucosa without evidence of granulomas. Lamina propria shows increased plasma cells and lymphocytes.

B. Sigmoid colonic mucosa shows moderate to severe active chronic inflammation with diffuse neutrophilic cryptitis, crypt abscesses, and epithelial injury. The inflammatory process is limited to the mucosa without evidence of granulomas. No evidence of dysplasia is identified. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia.

C. Descending colonic mucosa shows moderate active chronic inflammation with diffuse neutrophilic cryptitis, crypt abscesses, and epithelial injury. The inflammatory process is limited to the mucosa without evidence of granulomas. Surface epithelium shows reactive changes.

D. Transverse colonic mucosa shows mild to moderate active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and goblet cell depletion. Surface epithelium shows reactive changes.

E. Ascending colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Lamina propria shows increased plasma cells and lymphocytes.

F. Terminal ileal mucosa shows no significant pathologic abnormality. No evidence of chronic inflammatory bowel disease identified in this section. The inflammatory pattern shows overlapping features of both ulcerative colitis and Crohn's disease.

DIAGNOSIS:

A. Rectum, biopsy:

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

- No evidence of cytomegalovirus (CMV) infection

B. Sigmoid colon, biopsy:

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

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

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

F. Terminal ileum, biopsy:

- Mild non-specific inflammation
- Features of chronicity consistent with inflammatory bowel disease, with overlapping features of both UC and CD
- 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. Clinical correlation and follow-up biopsies are recommended to monitor disease activity and treatment response. The presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia. The histologic findings show overlapping features of both ulcerative colitis and Crohn's disease. This pattern may represent an 'indeterminate colitis' and correlation with clinical, endoscopic, and serologic markers is strongly recommended for further classification.

SPECIAL STUDIES:

CD3 and CD20 immunostains show a normal distribution of T and B lymphocytes without evidence of lymphoma. p53 immunohistochemical stain shows focal overexpression in areas of dysplasia.

This is a synthetic educational pathology report created for AI training purposes. It does not represent a real patient case.