

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-81214

DATE OF PROCEDURE: 04/22/2025

DATE OF REPORT: 04/26/2025

REQUESTING PHYSICIAN: Dr. Patrick White, Gastroenterology

PATHOLOGIST: Dr. Laurie Boyer, Anatomic Pathology

CLINICAL HISTORY:

47 year old male with 6 month history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed mild erythema and granularity limited to rectum and sigmoid 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 6 tan-pink tissue fragments measuring 4 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 6 tan-pink tissue fragments measuring 7 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 5 tan-pink tissue fragments measuring 3 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 2 tan-pink tissue fragments measuring 3 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 5 tan-pink tissue fragments measuring 5 mm in aggregate.

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

All specimens are entirely submitted in 6 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows fulminant active chronic inflammation with marked epithelial injury, neutrophilic cryptitis, and basal lymphoplasmacytosis. 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 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. Occasional apoptotic bodies are present in crypts.

C. Descending colonic mucosa shows moderate to severe active chronic inflammation with marked crypt architectural distortion, numerous crypt abscesses, and complete goblet cell depletion. The inflammatory process is limited to the mucosa without evidence of granulomas. Surface epithelium shows reactive changes.

D. Transverse colonic mucosa shows moderate active chronic inflammation with marked crypt architectural distortion, numerous crypt abscesses, and complete goblet cell depletion. Lamina propria shows increased plasma cells and lymphocytes.

E. Ascending colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Reactive epithelial changes are seen adjacent to areas of active inflammation.

F. Terminal ileal mucosa shows no significant pathologic abnormality. No evidence of chronic inflammatory bowel disease identified in this section. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia. Terminal ileal mucosa shows mild active inflammation with neutrophilic cryptitis, likely representing backwash ileitis.

DIAGNOSIS:

A. Rectum, biopsy:

- fulminant active chronic colitis with crypt architectural distortion and goblet cell depletion
- Mild active ileitis, consistent with backwash ileitis in the setting of ulcerative colitis

- fulminant 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 to severe active chronic colitis with crypt architectural distortion
- Features consistent with ulcerative colitis
- No dysplasia identified

F. Terminal ileum, biopsy:

- Mild non-specific inflammation
- Focal low-grade dysplasia identified
- 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 overall histologic features are characteristic of ulcerative colitis in the active phase. The presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia. The mild ileal inflammation in the context of pancolitis is consistent with backwash ileitis, which can be seen in ulcerative colitis and does not necessarily indicate Crohn's disease.

SPECIAL STUDIES:

No special stains were performed. 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.