

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-66240

DATE OF PROCEDURE: 04/23/2025

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REQUESTING PHYSICIAN: Dr. Elizabeth Christian, Gastroenterology

PATHOLOGIST: Dr. Timothy Johnson, Anatomic Pathology

CLINICAL HISTORY:

75 year old male with 2 month 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 6 tan-pink tissue fragments measuring 3 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 2 tan-pink tissue fragments measuring 6 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 5 tan-pink tissue fragments measuring 8 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 2 tan-pink tissue fragments measuring 5 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 3 tan-pink tissue fragments measuring 7 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 5 tan-pink tissue fragments measuring 2 mm in aggregate.

All specimens are entirely submitted in 4 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows fulminant active chronic inflammation with severe cryptitis, crypt architectural distortion, and Paneth cell metaplasia. The inflammatory process is limited to the mucosa without evidence of granulomas. No evidence of dysplasia is identified.

B. Sigmoid colonic mucosa shows moderate to severe active chronic inflammation with severe cryptitis, crypt architectural distortion, and Paneth cell metaplasia. The inflammatory process is limited to the mucosa without evidence of granulomas. Occasional Paneth cell metaplasia is noted. Terminal ileal mucosa shows mild active inflammation with neutrophilic cryptitis, likely representing backwash ileitis.

C. Descending colonic mucosa shows moderate to severe active chronic inflammation with severe cryptitis, crypt architectural distortion, and Paneth cell metaplasia. The inflammatory process is limited to the mucosa without evidence of granulomas. Marked decrease in goblet cell population.

D. Transverse colonic mucosa shows mild to moderate active chronic inflammation with crypt architectural distortion and crypt abscesses. Occasional apoptotic bodies are present in crypts.

E. Ascending colonic mucosa shows mild active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and goblet cell depletion. Occasional Paneth cell metaplasia is noted.

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:

- 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:

- 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 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
- 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 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.

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