

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-55304

DATE OF PROCEDURE: 04/23/2025

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REQUESTING PHYSICIAN: Dr. Charles Gibson, Gastroenterology

PATHOLOGIST: Dr. Adam Rodriguez, Anatomic Pathology

CLINICAL HISTORY:

34 year old female with 5 year 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 6 tan-pink tissue fragments measuring 6 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 4 tan-pink tissue fragments measuring 3 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 4 tan-pink tissue fragments measuring 6 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 2 tan-pink tissue fragments measuring 7 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 3 tan-pink tissue fragments measuring 3 mm in aggregate.

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

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

MICROSCOPIC DESCRIPTION:

A. Rectal 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. Reactive epithelial changes are seen adjacent to areas of active inflammation.

B. Sigmoid colonic mucosa shows mild to moderate 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. Mucosal edema and congestion are present.

C. Descending colonic mucosa shows moderate 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 crypt architectural distortion and crypt abscesses. Occasional apoptotic bodies are present in crypts. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia.

E. Ascending colonic mucosa shows mild to moderate active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and goblet cell depletion. Occasional apoptotic bodies are present in crypts.

F. Terminal ileal mucosa shows mild reactive changes. No evidence of chronic inflammatory bowel disease identified in this section.

DIAGNOSIS:

A. Rectum, biopsy:

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

- No evidence of cytomegalovirus (CMV) infection

B. Sigmoid colon, biopsy:

- mild to moderate active chronic colitis with crypt architectural distortion and goblet cell depletion
- mild to moderate 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
- 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 histologic findings show classic features of ulcerative colitis with diffuse crypt architectural distortion and diffuse mucosal inflammation. The presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia.

SPECIAL STUDIES:

Acid-fast bacilli (AFB) stain is negative for mycobacterial organisms. 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.