

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-18401

DATE OF PROCEDURE: 05/10/2025

DATE OF REPORT: 05/13/2025

REQUESTING PHYSICIAN: Dr. Andrew Fleming, Gastroenterology

PATHOLOGIST: Dr. Mr. Kyle Nicholson, Anatomic Pathology

CLINICAL HISTORY:

31 year old male with 6 month history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed diffuse erythema, loss of vascular pattern, and contact bleeding from rectum to hepatic flexure. 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 2 tan-pink tissue fragments measuring 6 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 4 tan-pink tissue fragments measuring 7 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 4 tan-pink tissue fragments measuring 2 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 5 tan-pink tissue fragments measuring 3 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 5 tan-pink tissue fragments measuring 7 mm in aggregate.

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

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

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows moderate 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 crypt architectural distortion, lamina propria plasma cells, and basal plasmacytosis. The inflammatory process is limited to the mucosa without evidence of granulomas. No evidence of dysplasia is identified.

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. Lamina propria shows increased plasma cells and lymphocytes.

D. Transverse colonic mucosa shows mild active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. Mucosal edema and congestion are present.

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 non-specific inflammation without architectural distortion. 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
- 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 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.

SPECIAL STUDIES:

No special stains were performed.