

# SURGICAL PATHOLOGY REPORT [SYNTHETIC]

**ACCESSION #:** UC-2025-79518

**DATE OF PROCEDURE:** 04/24/2025

**DATE OF REPORT:** 04/27/2025

**REQUESTING PHYSICIAN:** Dr. Daniel Cohen, Gastroenterology

**PATHOLOGIST:** Dr. Michael Henry, Anatomic Pathology

## CLINICAL HISTORY:

46 year old male with 3 week 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 2 tan-pink tissue fragments measuring 3 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 3 tan-pink tissue fragments measuring 6 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 6 tan-pink tissue fragments measuring 6 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 5 tan-pink tissue fragments measuring 4 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 6 tan-pink tissue fragments measuring 4 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 5 cassette(s).

## **MICROSCOPIC DESCRIPTION:**

A. Rectal mucosa shows fulminant 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.

B. Sigmoid colonic 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. Occasional apoptotic bodies are present in crypts.

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

D. Transverse colonic mucosa shows mild to moderate active chronic inflammation with marked crypt architectural distortion, numerous crypt abscesses, and complete goblet cell depletion. Reactive epithelial changes are seen adjacent to areas of active inflammation. 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. Mucosal edema and congestion are present.

F. Terminal ileal mucosa shows minimal increase in lamina propria lymphoplasmacytic infiltrates, likely reactive. 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
- fulminant consistent with ulcerative colitis

- No dysplasia identified
- No evidence of cytomegalovirus (CMV) infection

#### ***B. Sigmoid colon, biopsy:***

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

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

- moderate 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 presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia.

### **SPECIAL STUDIES:**

Immunohistochemical stain for p53 shows no evidence of dysplasia-associated molecular alterations. 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.\_