# SURGICAL PATHOLOGY REPORT [SYNTHETIC]

**ACCESSION #:** UC-2025-60016
**DATE OF PROCEDURE:** 04/18/2025
**DATE OF REPORT:** 04/22/2025
**REQUESTING PHYSICIAN:** Dr. Tammy Garza, Gastroenterology
**PATHOLOGIST:** Dr. Richard James, Anatomic Pathology

## CLINICAL HISTORY:

66 year old male with longstanding history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed continuous erythema and friability from rectum to splenic 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 3 tan-pink tissue fragments measuring 5 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 2 tan-pink tissue fragments measuring 6 mm in aggregate.

D. Received in formalin labeled "transverse colon" are 4 tan-pink tissue fragments measuring 5 mm in aggregate.

E. Received in formalin labeled "ascending colon" are 6 tan-pink tissue fragments measuring 2 mm in aggregate.

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

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

## MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows moderate to 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. Mucosal edema and congestion are present.

B. Sigmoid colonic mucosa shows mild to moderate 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. Terminal ileal mucosa shows mild active inflammation with neutrophilic cryptitis, likely representing backwash ileitis.

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. Occasional Paneth cell metaplasia is noted. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia.

D. Transverse colonic mucosa shows mild to moderate active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. Marked decrease in goblet cell population.

E. Ascending colonic mucosa shows mild 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 mild reactive changes. No evidence of chronic inflammatory bowel disease identified in this section.

## DIAGNOSIS:

### *A. Rectum, 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
- 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 active ileitis, consistent with backwash ileitis in the setting of ulcerative colitis
- Focal low-grade dysplasia identified
- 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
- 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 lack of granulomas, ileal involvement, and transmural inflammation favors ulcerative colitis over Crohn's disease. 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:

CD3 and CD20 immunostains show a normal distribution of T and B lymphocytes without evidence of lymphoma. p53 immunohistochemical stain shows focal overexpression in areas of dysplasia.