SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-84618
DATE OF PROCEDURE: 04/17/2025
DATE OF REPORT: 04/21/2025
REQUESTING PHYSICIAN: Dr. Daniel Gonzalez, Gastroenterology
PATHOLOGIST: Dr. Haley Phillips, Anatomic Pathology

CLINICAL HISTORY:

60 year old male with 1 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 5 tan-pink tissue fragments measuring 2 mm in aggregate.

B. Received in formalin labeled "sigmoid colon" are 5 tan-pink tissue fragments measuring 3 mm in aggregate.

C. Received in formalin labeled "descending colon" are 3 tan-pink tissue fragments measuring 2 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 4 tan-pink tissue fragments measuring 4 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 4 tan-pink tissue fragments measuring 4 mm in aggregate.

All specimens are entirely submitted in 1 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows fulminant active chronic inflammation with marked epithelial injury, neutrophilic cryptitis, and basal lymphoplasmacytosis. The inflammatory process is limited to the mucosa without evidence of granulomas. Lamina propria shows increased plasma cells and lymphocytes.

B. Sigmoid colonic mucosa shows moderate 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. Basal plasmacytosis is prominent. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia.

C. Descending 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.

D. Transverse colonic mucosa shows moderate active chronic inflammation with marked crypt architectural distortion, numerous crypt abscesses, and complete goblet cell depletion. Lamina propria shows increased plasma cells and lymphocytes. Terminal ileal mucosa shows mild active inflammation with neutrophilic cryptitis, likely representing backwash ileitis.

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 no significant pathologic abnormality. 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
- moderate consistent with ulcerative colitis
- No dysplasia identified

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

- mild to moderate active chronic colitis with crypt architectural distortion
- Mild active ileitis, consistent with backwash ileitis in the setting of ulcerative colitis
- 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. 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:

Periodic acid-Schiff (PAS) stain is negative for fungal organisms. p53 immunohistochemical stain shows focal overexpression in areas of dysplasia.