

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-88899

DATE OF PROCEDURE: 04/27/2025

DATE OF REPORT: 04/29/2025

REQUESTING PHYSICIAN: Dr. Breanna Castillo, Gastroenterology

PATHOLOGIST: Dr. Kathy Wang, Anatomic Pathology

CLINICAL HISTORY:

53 year old male with 10 year history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed circumferential ulceration and pseudopolyps from rectum to mid-transverse 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 3 tan-pink tissue fragments measuring 7 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 5 tan-pink tissue fragments measuring 8 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 5 tan-pink tissue fragments measuring 2 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 3 tan-pink tissue fragments measuring 7 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 6 tan-pink tissue fragments measuring 8 mm in aggregate.

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

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

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows 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 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. Surface epithelium shows reactive changes. Areas of crypt dropout and lamina propria fibrosis are present, suggesting chronicity and possible treatment effect.

C. Descending colonic mucosa shows 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. Basal plasmacytosis is prominent.

D. Transverse colonic mucosa shows mild active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. Occasional Paneth cell metaplasia is noted.

E. Ascending colonic mucosa shows mild active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and 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.

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:

- moderate active chronic colitis with crypt architectural distortion and goblet cell depletion
- Changes consistent with chronicity and treatment effect
- moderate consistent with ulcerative colitis
- No dysplasia identified

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

- moderate active chronic colitis with crypt architectural distortion
- Mild active ileitis, consistent with backwash ileitis in the setting of ulcerative colitis
- 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 presence of diffuse crypt architectural distortion, basal plasmacytosis, and continuous inflammatory pattern strongly supports the diagnosis of ulcerative colitis. 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. Histologic features suggesting chronicity and treatment effect are present. Correlation with treatment history is recommended.

SPECIAL STUDIES:

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

This is a synthetic educational pathology report created for AI training purposes. It does not represent a real patient case.