SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-50249
DATE OF PROCEDURE: 05/03/2025
DATE OF REPORT: 05/06/2025
REQUESTING PHYSICIAN: Dr. Mary Kennedy, Gastroenterology
PATHOLOGIST: Dr. Karen Pierce, Anatomic Pathology

CLINICAL HISTORY:

42 year old male with 2 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 3 tan-pink tissue fragments measuring 2 mm in aggregate.

B. Received in formalin labeled "sigmoid colon" are 5 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 6 tan-pink tissue fragments measuring 2 mm in aggregate.

E. Received in formalin labeled "ascending colon" are 3 tan-pink tissue fragments measuring 8 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 2 tan-pink tissue fragments measuring 8 mm in aggregate.

All specimens are entirely submitted in 2 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows fulminant 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. Mucosal edema and congestion are present.

B. Sigmoid 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. Mucosal edema and congestion are present.

C. Descending colonic mucosa shows moderate to severe 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 apoptotic bodies are present in crypts.

D. Transverse colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Lamina propria shows increased plasma cells and lymphocytes. Rare cells with intranuclear and cytoplasmic inclusions suspicious for cytomegalovirus (CMV) infection are identified.

E. Ascending colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Lamina propria shows increased plasma cells and lymphocytes.

F. Terminal ileal mucosa shows essentially normal ileal mucosa with intact villous architecture and no active inflammation. 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
- Viral cytopathic changes suspicious for cytomegalovirus (CMV) infection
- moderate 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. Immunohistochemical staining for CMV is positive, confirming the presence of CMV infection. This may contribute to the severity of colitis and should be considered in treatment planning.

SPECIAL STUDIES:

Periodic acid-Schiff (PAS) stain is negative for fungal organisms. Cytomegalovirus (CMV) immunohistochemistry reveals scattered positive cells confirming viral infection.

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