

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-68104

DATE OF PROCEDURE: 04/19/2025

DATE OF REPORT: 04/22/2025

REQUESTING PHYSICIAN: Dr. Theresa McIntosh, Gastroenterology

PATHOLOGIST: Dr. Joan Lee, Anatomic Pathology

CLINICAL HISTORY:

23 year old male with 5 year 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 3 tan-pink tissue fragments measuring 2 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 6 tan-pink tissue fragments measuring 2 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 5 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 5 tan-pink tissue fragments measuring 4 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 2 tan-pink tissue fragments measuring 7 mm in aggregate.

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

MICROSCOPIC DESCRIPTION:

A. Rectal 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.

B. Sigmoid colonic mucosa shows moderate to severe 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 crypt branching, crypt atrophy, and focal crypt abscesses. 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 active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. Lamina propria shows increased plasma cells and lymphocytes.

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

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:

- moderate active chronic colitis with crypt architectural distortion and goblet cell depletion
- moderate consistent with ulcerative colitis

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

B. Sigmoid colon, biopsy:

- moderate to severe active chronic colitis with crypt architectural distortion and goblet cell depletion
- Focal low-grade dysplasia identified
- moderate to severe 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 pattern of inflammation is consistent with ulcerative colitis as evidenced by the continuous mucosal involvement with greatest intensity distally. The presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia.

SPECIAL STUDIES:

No special stains were performed. 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.