

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-88679

DATE OF PROCEDURE: 05/05/2025

DATE OF REPORT: 05/07/2025

REQUESTING PHYSICIAN: Dr. Jasmine Christensen, Gastroenterology

PATHOLOGIST: Dr. Veronica Wilson, Anatomic Pathology

CLINICAL HISTORY:

71 year old male with 2 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 6 tan-pink tissue fragments measuring 7 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 5 tan-pink tissue fragments measuring 2 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 4 tan-pink tissue fragments measuring 8 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 5 tan-pink tissue fragments measuring 5 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 3 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 4 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows fulminant active chronic inflammation with severe cryptitis, crypt architectural distortion, and mucosal ulceration. The inflammatory process is limited to the mucosa without evidence of granulomas. Surface epithelium shows reactive changes.

B. Sigmoid colonic mucosa shows severe active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. The inflammatory process is limited to the mucosa without evidence of granulomas. No evidence of dysplasia is identified.

C. Descending colonic mucosa shows moderate to severe active chronic inflammation with diffuse crypt architectural distortion, crypt abscesses, and goblet cell depletion. The inflammatory process is limited to the mucosa without evidence of granulomas. Basal plasmacytosis is prominent. Areas of crypt dropout and lamina propria fibrosis are present, suggesting chronicity and possible treatment effect.

D. Transverse 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.

E. Ascending colonic mucosa shows mild to moderate active chronic inflammation with crypt architectural distortion and crypt abscesses. Surface epithelium shows reactive changes.

F. Terminal ileal mucosa shows minimal increase in lamina propria lymphoplasmacytic infiltrates, likely reactive. 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:

- severe active chronic colitis with crypt architectural distortion and goblet cell depletion
- severe 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
- Changes consistent with chronicity and treatment effect
- 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. Histologic features suggesting chronicity and treatment effect are present. Correlation with treatment history is recommended.

SPECIAL STUDIES:

Acid-fast bacilli (AFB) stain is negative for mycobacterial organisms.

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