

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-60026

DATE OF PROCEDURE: 05/09/2025

DATE OF REPORT: 05/12/2025

REQUESTING PHYSICIAN: Dr. Steven Sanchez, Gastroenterology

PATHOLOGIST: Dr. Eric Anderson, Anatomic Pathology

CLINICAL HISTORY:

44 year old male with recent onset history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed severe friability, superficial ulcerations, and pseudopolyps throughout the 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 5 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 3 tan-pink tissue fragments measuring 8 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 3 tan-pink tissue fragments measuring 7 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 2 tan-pink tissue fragments measuring 8 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 6 tan-pink tissue fragments measuring 6 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 2 tan-pink tissue fragments measuring 6 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. Basal plasmacytosis is prominent.

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. Lamina propria shows increased plasma cells and lymphocytes.

C. Descending colonic mucosa shows mild to 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 moderate active chronic inflammation with crypt branching, crypt atrophy, and focal crypt abscesses. Occasional apoptotic bodies are present in crypts.

E. Ascending colonic mucosa shows mild active chronic inflammation with crypt architectural distortion and crypt abscesses. Surface epithelium shows reactive changes. Focally, the colonic epithelium shows nuclear enlargement, hyperchromasia, and architectural complexity suspicious for low-grade dysplasia.

F. Terminal ileal mucosa shows mild non-specific inflammation without architectural distortion. No evidence of chronic inflammatory bowel disease identified in this section. Rare cells with intranuclear and cytoplasmic inclusions suspicious for cytomegalovirus (CMV) infection are identified.

DIAGNOSIS:

A. Rectum, biopsy:

- severe active chronic colitis with crypt architectural distortion and goblet cell depletion
- Viral cytopathic changes suspicious for cytomegalovirus (CMV) infection
- 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
- Focal low-grade dysplasia identified
- 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
- 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. The presence of low-grade dysplasia warrants close clinical follow-up and surveillance colonoscopy according to established guidelines for IBD-associated dysplasia.

SPECIAL STUDIES:

Acid-fast bacilli (AFB) stain is negative for mycobacterial organisms. Cytomegalovirus (CMV) immunohistochemistry reveals scattered positive cells confirming viral infection. 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.