

SURGICAL PATHOLOGY REPORT [SYNTHETIC]

ACCESSION #: UC-2025-97698

DATE OF PROCEDURE: 04/26/2025

DATE OF REPORT: 04/29/2025

REQUESTING PHYSICIAN: Dr. William Kelly, Gastroenterology

PATHOLOGIST: Dr. Steven Ramirez, Anatomic Pathology

CLINICAL HISTORY:

68 year old male with 1 month history of bloody diarrhea, abdominal pain, and urgency. Colonoscopy showed diffuse erythema, loss of vascular pattern, and contact bleeding from rectum to hepatic flexure. 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 2 tan-pink tissue fragments measuring 5 mm in aggregate.
- B. Received in formalin labeled "sigmoid colon" are 2 tan-pink tissue fragments measuring 3 mm in aggregate.
- C. Received in formalin labeled "descending colon" are 3 tan-pink tissue fragments measuring 4 mm in aggregate.
- D. Received in formalin labeled "transverse colon" are 6 tan-pink tissue fragments measuring 7 mm in aggregate.
- E. Received in formalin labeled "ascending colon" are 2 tan-pink tissue fragments measuring 4 mm in aggregate.

F. Received in formalin labeled "terminal ileum" are 5 tan-pink tissue fragments measuring 8 mm in aggregate.

All specimens are entirely submitted in 3 cassette(s).

MICROSCOPIC DESCRIPTION:

A. Rectal mucosa shows 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 Paneth cell metaplasia is noted.

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 severe cryptitis, crypt architectural distortion, and Paneth cell metaplasia. 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 moderate active chronic inflammation with crypt architectural distortion and crypt abscesses. Occasional apoptotic bodies are present in crypts.

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.

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:

- 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:

- 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
- 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.

SPECIAL STUDIES:

Grocott's methenamine silver (GMS) stain is negative for fungal organisms.