Isfahan University of Medical Sciences and Health Services
Department of Gastroenterology,
Department of Internal Medicine

Iranian Association Of Gastroenterology And Hepatology
Isfahan Branch

GI commission and grand round

October 16, 2023

List of cases on October 16 2023

	patient	Fellow	page
230701	A 49-year-old man	Dr. Izadi	
230702	A 32-year-old lady	"	
240701	A 37-year-old lady	Dr Namaki	

GI commission and grand round

A 49-year-old man

- About a month ago, he had an abdominal trauma caused by a chair handle hitting his abdomen, an injury to the RUQ region, and spread to the spine. In the beginning, it was continuous and gradually the intensity of the pain decreased and now it is positional, there has been no nausea and vomiting. Before the trauma, the patient had no history of abdominal pain, nor did he give a history of fever and chills.
- The patient works in a polyacryl company (contact with chemicals). He had a history of HLP and history of low platelets in the past (ITP?), takes atorvastatin.

- In the examination, the patient's abdomen is soft, deep palpation of the LUQ area is tender. No organomegaly was palpable.
- The patient went to the doctor for examination, who requested an ultrasound scan, noticed a liver cyst and then request laboratory data:

In sonography of abdomen and pelvis:

Liver has normal size and contour. ***Parenchymal echogenicity is mildly increased; suggesting fatty liver grade one. A cystic lesion (75x51.8mm) with irregular thin wall and internal septations in left hepatic lobe is seen.***

Spleen shows normal size, shape and echopattern without any evidence of space occupying lesion.

No dilatation in intra-hepatic biliary ducts is seen.

CBD has normal diameter with no obvious lesion.

Portal vein has normal diameter with hepatopetal flow.

IVC and hepatic veins have normal diameter with hepatofugal flow.

Gallbladder has normal size and wall thickness. No stone, sludge or space-occupying lesion is seen.

Pancreas and retroperitoneum as far as seen are normal. No paraaortic adenopathy is seen.

Both kidneys have normal size, contour, cortical echogenicity (including cortico-medullary differentiation) and parenchymal thickness.

No evidence of hydronephrosis, stone or space occupying lesion in both kidneys is seen.

Urinary bladder has normal wall thickness. No space- occupying lesion or stone is seen.

Prostate gland size is 43x34x30 mm and volume of 23 cc; which is in normal range.

No intra peritoneal fluid is seen.

IMPRESSION	***RECOMMENDATION***
Fatty liver grade 1 *Cystic lesion in liver*	*Triphasic CT-Scan*

Name: Mr. .
Age: 49 Y/O
Date: 02.07.1402
No: 365730

Triphasic MDCT study of liver:

- *Liver has normal size, shape and density.* ***There is a cyst measuring 66mm in right liver lobe without calcification and without obvious enhancing component. Correlation with lab data and follow-up with sonography is recommended.***
- *No opaque gallstone is seen.*
- *Intrahepatic bile ducts are normal.*
- *Spleen and pancreas show normal size, shape and density without any evidence of space occupying lesion.*

IMP:

- ***Hepatic cyst as described.***

Labs

- WBC=5700
- Hb=15.1
- Plt=103000
- ESR= 5
- CRP=Negative
- Ferritin=275
- Ca=9.6
- Na=146
- K=4.6
- Alt=25
- Alkp=193
- Hydatid cyst Ab(IgG)=0.21

درسونوگرافي انجام شده از کبد

شکل وابعاد واکوی پارانشیم کبد طبیعي است اکتازی مجاری صفراوی داخل کبدی دیده نشد .
تصویر یک ناحیه Round اکوژن به سایز ۸ میلیمتر در لوب راست کبد مشهود است که در درجه اول مطرح کننده همانژیوم بوده لیکن جهت بررسی بیشتر F/U و یا MDCT توصیه می شود.
قطر ورید پورت و CBD نرمال است .
کیسه صفرا داراي حجم وضخامت جدار نرمال است وسنگ صفراوي یا اسلاژ دیده نشد .

Question:

- **What diagnostic or therapeutic action is necessary according to the nature of the liver cyst in ultrasound?**

Dear Professor

With regards and much respect

Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:

The radiological picture in the ultrasound included septa, but in the CT scan, the septa are not visible, the wall is irregular and does not have the typical spherical appearance of simple cysts. On the other hand, in the previous ultrasound (of a few years ago), such a lesion is not evident, so this lesion is probably new and perhaps progressive. Considering the above, differential diagnoses include hydatid cyst, traumatic hepatic cyst and, to a lesser degree, cystadenoma and cystadenocarcinoma. On the other hand, the cyst has a subcapsular view and increases the possibility of complications.

In reviewing literatures, traumatic liver cysts have a prevalence of about 0.5%, and this diagnosis is possible due to the history of trauma a few weeks ago, but the radiological characteristics and time course are not typical.

In conclusion, it was recommended to first consult with the interventionist radiologist about the diagnosis of the lesion and, if possible and at their discretion, to perform aspiration or an interventional method (PAIR). It is recommended to start Albendazole first if intervention is needed. Also, consult a liver surgeon at the same time.

References:

www.ncbi.nlm.nih.gov/pmc/articles/PMC3691048
www.ncbi.nlm.nih.gov/pmc/articles/PMC3693346

A 32-year-old lady

- which mentions that gradual myalgia, weakness and fatigue. Also she remarks postprandial nausea and vomiting, but no articular pain, morning stiffness and no stomach pain.
- Weight loss, fever or chills was not recorded.
- During the tests, the patient noticed an increase in liver enzymes and performed various investigations…

مراجعه کننده: خانم
شماره پذیرش : ۲۵۲۸۱

تاریخ پذیرش ۱۴۰۰/۱۲/۱۸ پزشک معالج :جناب آقای
سن : ۳۰ سال
بیمه : آزاد

Hematology

Test	Risk	Result	Unit	Reference Interval
C.B.C		Attached Sheet		

Blood Biochemistry

Test	Risk	Result	Unit	Reference Interval
Fasting Blood Sugar		99	mg/dl	Normal :<100 Borderline :100-125 Diabetic >125
Urea		29	mg/dl	15-40
Creatinine		0.97	mg/dL	0.6-1.3
Calcium		9.7	mg/dl	8.6-10.3
Phosphorus		4.1	mg/dl	2.6-4.5
S.G.O.T (AST)	H	97*	U/l	up to 31
S.G.P.T (ALT)	H	164*	U/L	up to 31
Alkaline Phosphatase		1116*	IU/L	Child :180-1200 Male :80-306 Female :64-306

Serology

Test	Risk	Result	Unit	Reference Interval
R.F		Negative	IU/mL	Negative

Immunology

Test	Risk	Result	Unit	Reference Interval
ANA (IF)		<1/100	Titer	Negative <1/100 Positive >=1/100
Anti CCP		1.74	U/mL	Negative: <12 Doubtful: 12-18 Positive: >18
Anti DNA ds		<1/10	Titer	Negative : <1/10 Positive : >=1/10

Hormon Analysis

Test	Risk	Result	Unit	Reference Interva
T4		8.77	micg/dl	4.8 -11.6
TSH	H	5.65*	µIU/mL	0.3-5
P.T.H		11.0	pg/mL	11-67

* = Confirmed by Repeated Analysis

Normal values are based on specific age and gender.

Sysmex

Parameters		Value	Unit	Normal Values
WBC		4.4	x1000/mm3	(4-10)
Lymph%	-	12.5	%	(20-40)
Mixed%	-	3.6	%	(4-18)
Neut%	+	83.9	%	(40-80)
Lymph#	-	0.6	x1000/mm3	(1-12)
Mixed#		0.2	x1000/mm3	(0.2-1.6)
Neut#		3.6	x1000/mm3	(2-7)

Parameters		Value	Unit	Normal Values
RBC		5.58	million/mm3	(3.8-5.8)
Hgb		13.7	g/dl	(12-16)
Hct		42.6	%	(36-46)
MCV	-	76.3	fl	(83-101)
MCH	-	24.6	pg	(27-32)
MCHC		32.2	g/dl	(13.5-34.5)
RDW-CV	+	14.2	%	(11.6-14)
RDW-SD		42.0	fl	(39-46)

Parameters	Value	Unit	Normal Value
PLT	204	x1000/mm3	(150-450)
PDW	15.2	fl	(9.4-18.1)
MPV	10.5	fl	(8.5-12.4)
P-LCR	29.6	%	(14.3-44)

Bili total=0.61
Bili direct=0.23
HBs Ag=Negative
Hbs Ab: positive (38.01)
HCV Ab=Negative
HAV Ab=Negative
LKM1=Negative
CMV Ab(IGM)=Negative

کبد , کیسه صفرا و مجاری صفراوی

کبد دارای ابعاد وشکل طبیعی است .توده رویت نشد.

Liver span=135 mm

اکوژنیسیته پارانشیم کبد طبیعی است.

CBD و ورید پورت دارای قطر و دیامتر نرمال می باشند.

اتساع مجاری صفراوی داخل و خارج کبدی رویت نگردید.

عروق سوپراهپاتیک به صورت نرمال رویت می گردند.

کیسه صفرا دارای حجم نرمال میباشد .سنگ صفراوی دیده نشد .

افزایش ضخامت جدار کیسه صفرا رویت میگردد .(۸ م م) که مطرح کننده هپاتیت حاد میباشد .

مرکز تصویر برداری پزشکی تمام دیجیتال ،شفا

1401/01/23
NO. 333097

Dear Dr.H.R.SOLTANI

MRCP & Abdomen

The study was performed in multiplannar views obtaining multiple pulse sequences.

Intermittent foci of narrowing and dilatations are seen in intrahepatic biliary ducts as well as tight stricture in the confluence of right and left intrahepatic biliary ducts suggesting as sclerosing cholangitis needs clinical and lab correlation.

Common hepatic duct and choleduc appear normal with no biliary stone and no neoplasia.

Gallbladder measuring about 5cm in length shows marked wall thickening with no biliary stone needs clinical and lab correlation.

No portal vein thrombosis is seen.

Liver is enlarged measuring about 22cm in vertical diameter with no space occupying lesion.

Spleen is enlarged measuring about 15cm in vertical diameter.

Panaceas is normal with no space occupying lesion and no evidence of acute pancreatitis.

The kidneys are normal in size, shape and position with no hydronephrosis.

No paraaortic or paracaval adenopathy is present.

Conclusion:

1) Suggestive evidences of PSC
2) Gallbladder wall thickening as described above
3) Hepatosplenomegaly

مرکز تصویر برداری پزشکی تمام دیجیتال شفا

Dear Dr.M.DIANAT

1401/01/23
NO. 333097

Multislice CT Scan of the Abdomen and Pelvis
(with contrast)

The study was performed in axial views obtaining coronal reconstructed views administering oral and intravenous contrast as your request,
Liver is markedly enlarged with no space occupying lesion and no biliary dilatation.
Gallbladder is small and contracted shows marked wall thickening with no obvious opaque biliary stone.
Spleen is also enlarged with no space occupying lesion.
Small about 2cm accessory spleen is noted just anterior to spleen.
Pancreas is normal with no space occupying lesion with no evidence of acute pancreatitis.
The kidneys are opacified with no hydronephrosis and no S.O.L.
No paraaortic or paracaval adenopathy is present.
Small follicular cyst is seen in left ovary.
No obvious ascites is seen in pelvic cavity.
Urinary bladder's mucosa appear normal.

Conclusion:
1) Hepatosplenomegaly
2) Marked gallbladder wall thickening as explained
3) Otherwise normal study of the abdomen and pelvis

دکتر مسعود ربانی
متخصص رادیولوژی و سونوگرافی
CTscan, MRI

Cont’

- The patient has been treated with urso-deoxycholic acid. In June 1401, the patient experienced exacerbation of nausea, vomiting, hypertension, and abdominal pain. The pain was in the upper abdomen and was increasing-decreasing with spreading to the back.
- She was hospitalized and in the initial tests hypercalcemia was detected and treated, and then a liver biopsy was performed, which was diagnosed as granulomatous hepatitis and the level of ACE was high (73 iu/l).
- After discharge, the patient has been treated with prednisolone 25 mg, according to the patient expressions, the initial symptoms are partially resolved.

SURGICAL PATHOLOGY REPORT

Macroscopic Examination:

Received labeled with patient's name and **Liver biopsy,** composed of three tubular tissue each lengths 2 cm with max diameter of 0.1 cm, brownish gray color. Entirely submitted in one cassette.

Microscopic Examination:

Sections show hepatocytes arranged in cords, central veins and portal spaces.
Portal tract: Dense lymphocytic infiltrate in portal tracts with granulomatous inflammation composed of histiocytes and giant cells with destruction and loss of medium sized interlobular bile ducts within the liver is seen.Interlobular bile ducts (within small portal tracts) are destroyed by multiple poorly formed portal epithelioid **granulomas.**
There is no significant lobular inflammation present.
Interface hepatitis is not seen.
Mild macrovesicular steatosis is seen.
Periductal "onion skin" fibrosis is not seen.
In Masson's staining fibrosis was not identified.

Final Pathologic Diagnosis:

Liver Core Needle Biopsy:

- Chronic Granulomatous Hepatitis

Comment: Clinicopatologic correlation to rule in/out Primary Biliary Cholangitis is recommended

Cont’

- According to the diagnosis (liver sarcoidosis) , the patient has had frequent visits to other specialists and during this time he has taken the following drugs along with prednisolone:
- Cellcept 500 BID (Stopped 3 months ago)
- Hydroxy chloroquine 300 daily(stopped 3 months ago)
- leflunamid 20 mg qod
- After referring to the pulmonologist, only Hydroxy chloroquine and prednisolone (15 mg) continued.
- In May of 2023, he experienced an exacerbation of abdominal pain again, which was re-evaluated by a gastroenterologist, and the patient's abdominal CT and MRCP were repeated, and the patient was prescribed methotrexate 7.5 mg weekly, which he had been taking until 2 weeks ago.

- ALT=171
- AST=109
- Alkp=1307
- Bili=0.53 (0.33)

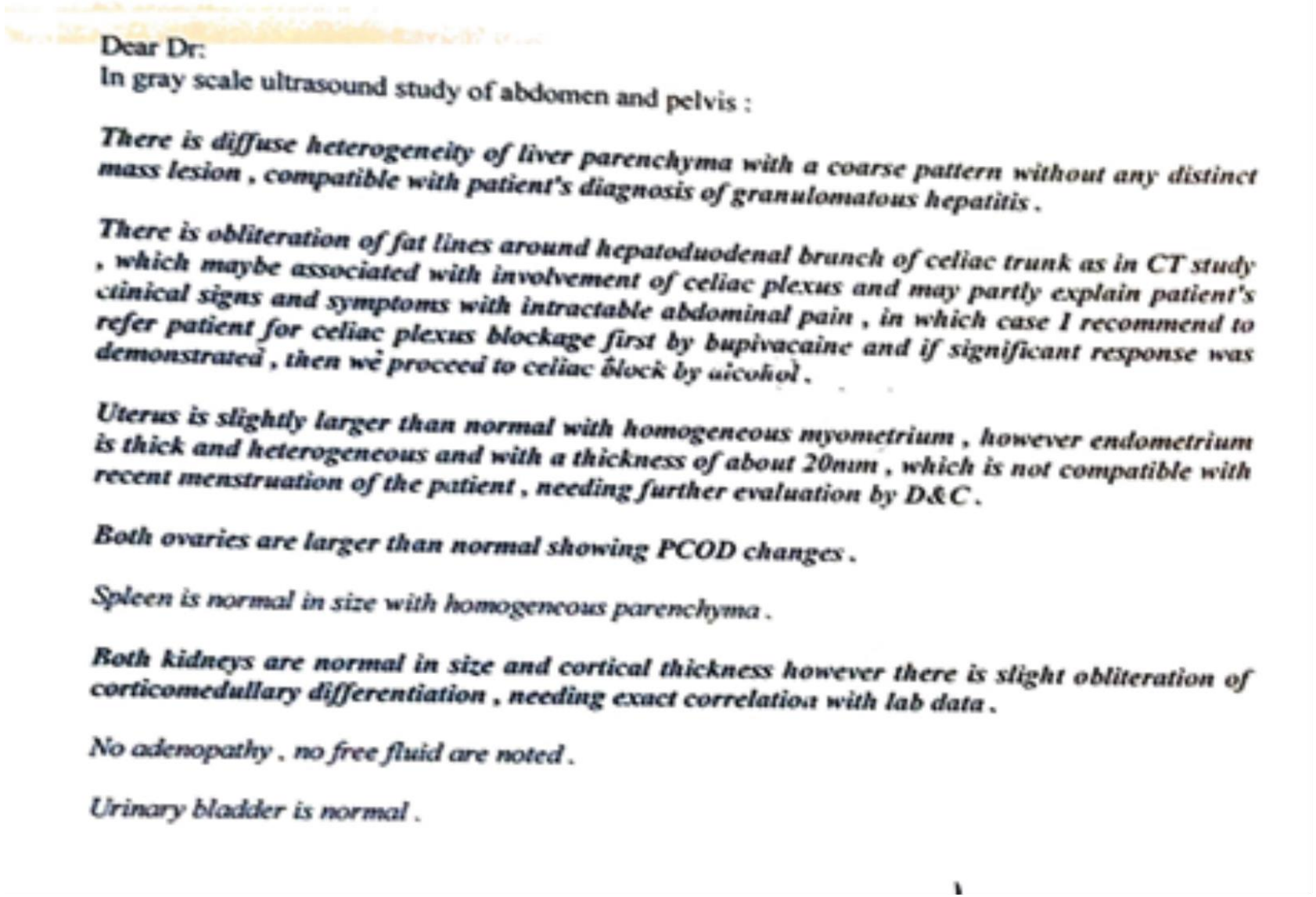
GGT= 478.6

Ca=12.1

WBC=7700

Hb=12.6

Plt=236



Dear Dr:
In gray scale ultrasound study of abdomen and pelvis :

There is diffuse heterogeneity of liver parenchyma with a coarse pattern without any distinct mass lesion , compatible with patient's diagnosis of granulomatous hepatitis .

There is obliteration of fat lines around hepatoduodenal branch of celiac trunk as in CT study , which maybe associated with involvement of celiac plexus and may partly explain patient's ctinical signs and symptoms with intractable abdominal pain , in which case I recommend to refer patient for celiac plexus blockage first by bupivacaine and if significant response was demonstrated , then we proceed to celiac block by alcohol .

Uterus is slightly larger than normal with homogeneous myometrium , however endometrium is thick and heterogeneous and with a thickness of about 20mm , which is not compatible with recent menstruation of the patient , needing further evaluation by D&C .

Both ovaries are larger than normal showing PCOD changes .

Spleen is normal in size with homogeneous parenchyma .

Both kidneys are normal in size and cortical thickness however there is slight obliteration of corticomedullary differentiation , needing exact correlation with lab data .

No adenopathy , no free fluid are noted .

Urinary bladder is normal .

Dear Dr:
In contrast enhanced CT study of abdomen and pelvis:

There is a thick irregular hypodense fibrous band , encasing hepatoduodenal branch of celiac trunk , having a thickness of about 7-10mm , completely obliterating fat lines at hepatic hilum , which is also the main cause of distortion of MRCP images .

This irregular hypodense band like structure , consists of fibrous tissue and also probably granulomatous tissue and well-correlates with patient recent liver core needle biopsy results, regarding granulomatous hepatitis.

Similar changes with a lesser degree are demonstrable around proximal portion of celiac trunk .

Mild hepatomegaly and mild splenomegaly are demonstrable without any distinct mass lesion in liver .

There is also very slight distortion of posterior cortex of left kidney, which may be attributed to this granulomatous disorder .

Main portal vein, splenic vein, SMV, IMV, aorta, IVC, hepatic veins , CBD, main pancreatic duct , both adrenal , iliopsoas muscles , urinary bladder , uterus and ovaries are normal.

No lytic or blastic lesion is detectable in scanned portions of bony skeleton.

No free fluid, nor peritoneal seeding is detectable.

Board certified radiologist
MRN : 42739

Dear Dr:
In MRCP of the patient :

This is a challenging case .

There appears to be significant deformity of soft tissue elements , fat pads and vascular structures at splenic hilum and there is an irregular high signal intensity fluid filled structure at hepatic hilum , at normal anatomic location of duodenal bulb , which overlaps central intrahepatic ducts , leading to complete distortion of MRCP images and despite giving patient MAGNEVIST solution , this irregular unusual structures do not show any signal drop in heavily T2 weighted sequences , completely distorting images .

CBD itself is clearly visible , which has smooth course , however common hepatic duct cannot be evaluated .

There appears to be slight edema of gallbladder wall , which has normal volume without any stone or sludge .

Unusual forms of aberrant bile ducts with Choledochal cyst formation maybe considered in this patient , however I need to perform an ultrasound study and also I need to perform IV oral contrast enhanced CT study of abdomen for more evaluation of above mentioned changes .

(continue to the next page)

Liver has a prominent Riedel's lobe , which is a common finding in women and there may only be slight hepatomegaly .

There is no gross evidence of cirrhosis .

No distinct mass lesion in liver parenchyma .

There is no evidence of PSC .

Spleen , pancreas , main pancreatic duct ,peripancreatic fat , both adrenals , both kidneys are normal .

No adenopathy is noted .

I highly recommend to refer patient for color Doppler ultrasound and evaluation of above mentioned abnormal anatomical structures and also contrast enhanced CT study of abdomen .

مرکز تصویربرداری پزشکی جم
دکتر امیرعلی یزدانی
متخصص رادیولوژی و سونوگرافی
ورادیولوژی مداخله ای از کانادا
نظام پزشکی

lab	00/12/18	01/03/17	01/12/07	02/02/03	02/03/13	02/06/06
Alkp	1116	1669	805	1307	582	444
ALT	164	55.5	199	171	345	124
AST	97	70	86	109	118	36
GGT		189	425	490	490	327
Ca	9.7			12.1	9.3	9

- The dose of prednisolone has now been reduced to 15 mg, and the abdominal pain and weakness have started again with tapering.

- Patient is presented to definitive diagnosis of sarcoidosis and the determination of appropriate treatment.

Dear Professor

With regards and much respect

Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:

- Considering the increased level of "ASE", hypercalcemia, liver biopsy findings (presence of noncaseating granuloma, absence of bile duct involvement and evidence of other liver parenchymal diseases) that confirmed by two pathologists, partial response to corticosteroids and counseling of rheumatologist, liver sarcoidosis are still concerned, although the lack of lung and other organ involvement requires careful evaluation and R/O of other differential diagnoses.
- The most common causes of liver granulomas are sarcoidosis and PBC. Considering that liver granulomas in other causes such as PBC, can also be the cause of hypercalcemia, and considering the increase of ACE less than two times and the age and gender of the patient, PBC must be considered seriously and check AMA is required.
- In reviewing the new MRCP of the patient, it seems that in addition to irregularities in the intrahepatic bile ducts, and also a relative enlargement of the pancreas and the reported intra-abdominal fibrotic bands, measurement of **IgG4 level** may also be helpful. Review MRCP was recommended.
- Amyloidosis should also be checked. (check of **serum and urine proteins electrophoresis**, …) Investigating other causes of abdominal pain, endoscopy and colonoscopy will help.
- Finally, the lesion reported in the hilum of the liver may be better diagnosed with **EUS**.
- References:

- Culver EL, Watkins J, Westbrook RH. Granulomas of the liver. Clin Liver Dis (Hoboken). 2016 Apr 27;7(4):92-96. doi: 10.1002/cld.544. PMID: 31041038; PMCID: PMC6490265
- www.sciencedirect.com/science/article/pii/S0929664612000034

A 37-year-old lady

- The patient has had abdominal pain and bloating since about six months ago, which is a generalized and continuous pain and worsens with eating. She has undergone repeated treatments.
- Since 2 months ago, following the curettage, he has been suffering from generalized abdominal pain with constipation and passing bright blood on the stool and after it.
- She mentions dysphagia to solids since 1998 following hemifacial spasm surgery, which is not progressive.
- No diarrhea or weight loss was recorded. She complains of abdominal bloating and dyspepsia. He does not have fever and night sweats, but she complains of progressive weakness and fatigue.
- She mentions spontaneous bruises that are currently present on both thighs and abdomen and are not related to trauma or history of trauma.
- No skin rash, no malar rash and no oral sores.

PMH:

- A history of suspicious convulsive movements.
- Facial hemifacial spasm since 1985, which was operated on in 1998.
- Thyroid nodule, which is recommended for annual follow-up.

DH:

- Esomeprazole 20 mg daily
- Paroxetine 20 mg BD
- Quetiapine 25 QHS
- Clonazepam 1 mg daily
- Clidinium- C TDS
- Atorvastatin 20 mg daily

- In the examination, the abdomen is soft and does not have distension. Ecchymosis is evident on the abdomen and thighs.
- Edema: 1+ lower limb
- knee swelling: 2+ without warmth, redness and tenderness.

- **TVS: 1402.02.27:**
- A subserosal myoma with a diameter of 12 mm behind the uterus.
- 15 mm thick endometrium with smooth margins.
- Polyp measuring 12x20 mm containing internal cystic changes.
- **Endometrial *curettage*: 1402.02.28**

Proliferative Endometrium with Endometrial Polyp

NO evidence of Malignancy

Abdominopelvic Sonography 1402.02.31

- Two hyperechoic images with a thickness of 7 and 8 mm in the right lobe of the liver indicate hemangioma.
- Gallbladder was not seen in anatomical location (Cholecystectomy)
- Flatulence is evident in intestinal loops.

- **Abdomen X-ray 1402.03.01**
- Normal

Lab Data 1402.03.22

WBC 6600	ESR 11	Urine :
Neu 56	CEA 0.56	Analysis NL
Lym 38	Human Epididymis PROTEIN4 60.2	
RBC 4.6	CA 19-9 6.8	
Hb 13.2	CA 125 25.8	
HCT 40	Risk Of Malignancy Algorithm 11.4	
MCV 89		
MCH 28		
MCHC 33		
PLT 265		

- She is hospitalized at **1402.03.24** due to severe abdominal bloating and generalized abdominal pain with hematochezia.
- Colonoscopy and biopsy were performed.
- She received antibiotics and steroids.

- Multi Slice CT scan of the ABDOMEN and PELVIC with and without contrast was normal.

Lab Data 1402.03.24

WBC 6400	FBS 80	AST 21	ANCA-P 2.1	Urine :	Stool :
Neu 50	BUN 36	ALT 15	Anti TTG IgG 2.9	Analysis NL	brown
Lym 45	Cr 0.8	Billi. T 0.7	Anti TTG IgA 2.6	Micro Alb: 47	formed
RBC 4.9	TG 142	Billi. D 0.09	ASCA 6.5		**RBC 8-10**
HB 13.4	Chol 254	PT 13	Anti Saccharomyces IgA 6.2		FIT Positive
HCT 41	HDL 58	INR 1			Calprotectin 349
MCV 84	LDL 135				Elastase 250
MCH 27	Ca 9.2				
MCHC 32	Phos 4.3				
PLT 283	Vit.D 24				

Internist
Gastroenterologist & Hepatologist
Member of A G A

متخصص داخلی
فوق تخصص گوارش، کبد و مجاری صفراوی
عضو انجمن گوارش آمریکا و استادیار دانشکده پزشکی

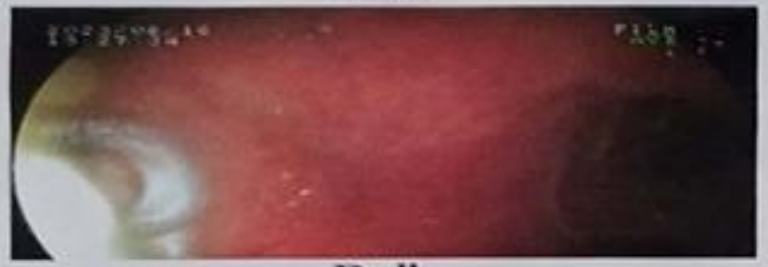
UGI Endoscopy Report

نام بیمار:	سن: ۳۷	شماره پرونده:	تاریخ: ۱۴۰۲/۰۳/۲۵

LES

Body

Antrum



Bulb

Duodenum,2nd

Reason for Endoscopy : DYSPEPSIA

Findings :

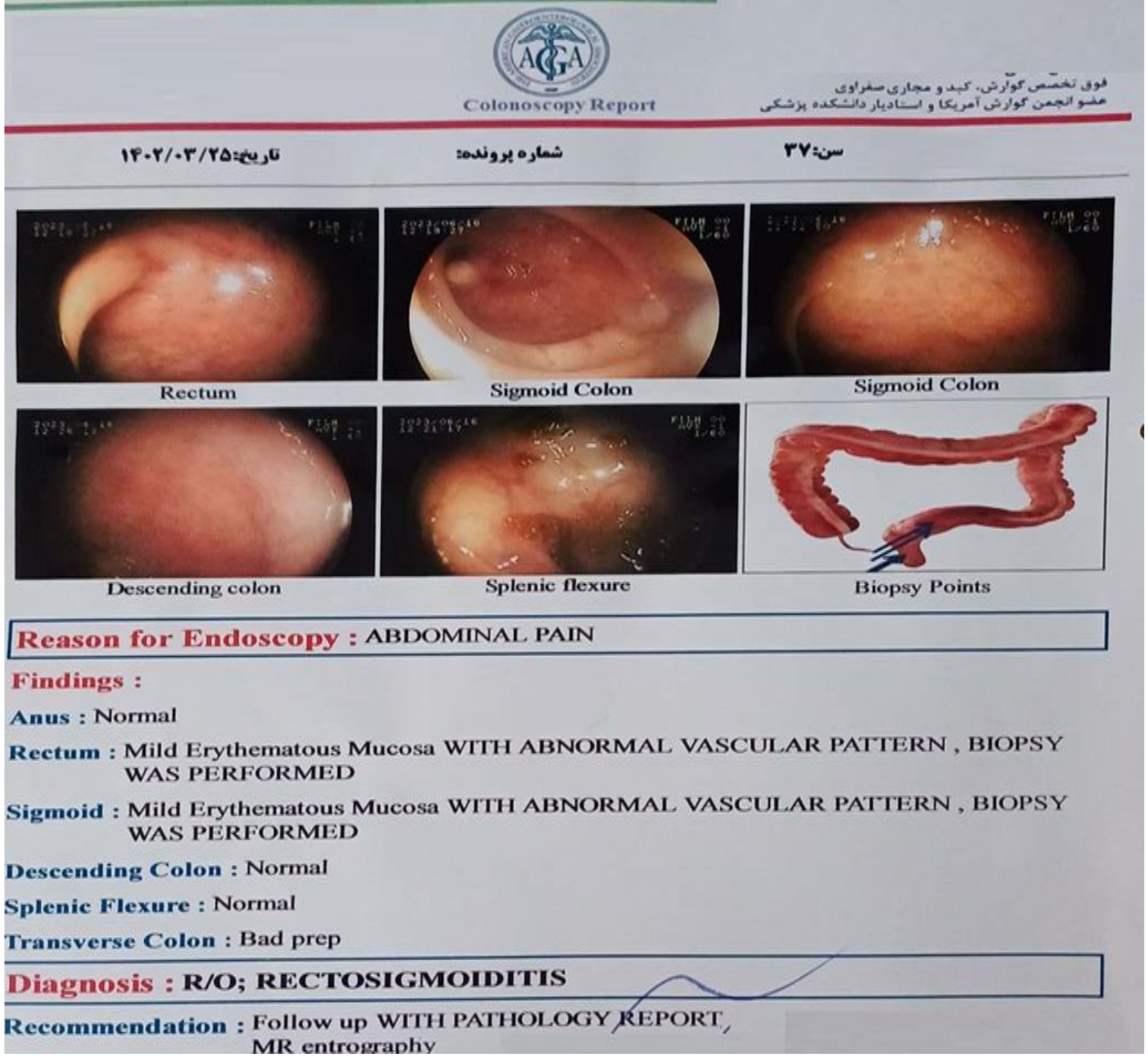
Esophagus : Normal

Stomach : Mild focal Erythematous Mucosa on the STOMACH

Duodenum : Normal

Diagnosis : Gastric erythema

Recommendation : FOLLOW UP
small bowel series



Colonoscopy Report

فوق تخصص گوارش، کبد و مجاری صفراوی
عضو انجمن گوارش آمریکا و استادیار دانشکده پزشکی

تاریخ:۱۴۰۲/۰۳/۲۵ شماره پرونده: سن:۳۷

Rectum

Sigmoid Colon

Sigmoid Colon

Descending colon

Splenic flexure

Biopsy Points

Reason for Endoscopy : ABDOMINAL PAIN

Findings :

Anus : Normal

Rectum : Mild Erythematous Mucosa WITH ABNORMAL VASCULAR PATTERN , BIOPSY WAS PERFORMED

Sigmoid : Mild Erythematous Mucosa WITH ABNORMAL VASCULAR PATTERN , BIOPSY WAS PERFORMED

Descending Colon : Normal

Splenic Flexure : Normal

Transverse Colon : Bad prep

Diagnosis : R/O; RECTOSIGMOIDITIS

Recommendation : Follow up WITH PATHOLOGY REPORT, MR entrography

- Biopsy:
- Colonic mucosa with preserved crypt architecture and unremarkable lamina propria infiltrate.
- Presence of some lymphoid follicles in lamina propria.
- : within normal limits

Dr.Shirneshan Pathobiology Laboratory
Tarahy Building, Shams Abadi St.Isfahan
Tell:03132365030

آزمایشگاه تشخیص طبی و پاتولوژی دکتر شیرنشان
اصفهان ، خیابان شمس آبادی ، روبروی بیمارستان سینا ، ساختمان فارابی،طبقه دوم
تلفن: ۰۳۱۳۲۳۶۵۰۳۰ (۲خط)

نام بیمار: خانم	تاریخ گزارش: 1402/03/31	نام پزشک
شماره پذیرش: 1	سن: مونث 36	تاریخ پذیرش: 1402/03/27

MACROSCOPIC DESCRIPTION:

The specimen consists of 5 pieces, the greatest measure 0.2cm, with a whitish color.

MICROSCOPIC DESCRIPTION:

Section show colonic glands, composed of a single layer of epithelial cells arranged in parallel rows of crypts covering a lamina propria containing a mixture of lymphocytes, plasmacells , macrophages and eosinophils .The crypts are straight tubular structures of equal lengh. There is no evidence of malignancy.
In masson's trichome staining, no excess collagen fibers is noted.
In IHC staining for CD117 it reveals 15 mast cells/hpf in lamina propria.

Dx: BIOPSY OF COLON: - WITHIN NORMAL LIMITS

دکتر کیوان شیرنشان
پزشک متخصص آناتومیکال و کلینیکال پاتولوژی
نظام پزشکی ۳۱۴۲۳ عضو آزمایشگاهی ۱۵۲۸

With The Best Regards: K.Shirneshan MD. A.P.C.P.

Lab Data 1402.03.26

WBC 7800	FBS 84	AST 18	Urine :
Neu 59	BUN 12	ALT 20	Analysis normal
Lym 34	Cr 1	ALP 142	
RBC 4.5	TG 129		
HB 12.7	CHOL 272		
MCV 85	HDL 63		
MCH 27	**LDL 160**		
MCHC 32	TSH 3		
RDW 14.6	T4 5.6		
PLT 290			
Ferritin 9.5			

Lab Data 1402.04.26

WBC 7900	ESR 20	Ca 9.2
Neu 62	CRP 0.12	Phos 4.1
Lym 30	SCL70 0.3	Alb 4.3
RBC 4.6	**ANA 1:80**	OBx1 Negative
Hb 13	Anti Sn-RNP 1.7	
Hct 40		
MCV 88		
MCH 28		
MCHC 31		
RDW 14.9		
PLT 307		

Lab Data : 1402.07.04

WBC 8300	FBS 110	**Fe 53**	ANCA MPO 1.7	Urine :	Stool :
Neu 69	BUN 8	**TIBC 329**	ANCA PR3 1.1	Analysis NL	Formed
Lym 23	Cr 0.9	Ferritin 10	Anti TTG IgG 5	**ACR 62.5**	Brown
RBC 4.67	TG 113	AST 14	Anti TTG IgA 1.8	Cr random 80	Undigested Few
Hb 13.5	CHOL 289	ALT 12	Calprotectin 2	Micro Alb 50	RBC 1-2
HCT 41	HDL 63	Bili. T 0.8			WBC 2-4
MCV 89	LDL 154	Bili. D 0.2			OBx1 Trace
MCH 29	Ca 9.8	PT 13			
MCHC 32	Ph 4.8	INR 1.1			
PLT 346	**Vit.D 24**				
Retic 1.4	TSH 1.5				

Dear Professor

With regards and much respect

Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:

- Episodic abdominal pains, pseudo-obstruction attacks and increased fecal calprotectin level can suggest IBD. Due to the possibility of IBD and not performing a complete colonoscopy, it is recommended to perform an **ileocolonoscopy** first. If this procedure did not lead to a diagnosis, the next appropriate step is MR enterography or CT enterography in an experienced center. Due to the possibility of small bowel obstruction, endoscopic videocapsule is not recommended now.
- Due to iron deficiency, it is recommended to continue the evaluation and treatment under the supervision of a gynecologist, and if gynecological causes are ruled out, Helicobacter and other causes should be checked.
- **Abdominal CT scan** with and without contrast is very helpful during pain attacks, and if it is not possible, at least a supine abdominal CT scan can be performed during pain attacks.