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

November 13 2023

List of cases-November 13 2023

	Patient	Fellow	page
230806		Dr. Izadi	
230805	A 25-year-old woman	"	
240803	A 46-year-old man	Dr. Namaki	
240804		"	
250803	A 43-year-old female	Dr. Jalili	
250804		"	

GI commission and grand round

A 25-year-old woman

- who suddenly developed a sever fever about 5 months ago (June 1402), and due to the severity of the fever, she went to the emergency room for treatment.
- At the same time, he complained of epigastric pain, which was not positional and did not radiate anywhere, and its quality was similar to the patient's previous pains (caused by dyspepsia) with greater intensity.
- She had nausea without vomiting. Along with fever, he did not have symptoms of coryza and urinary and diarrhea.

- In the following, weakness, lethargy, fatigue and anorexia have developed.
- Gradually, during the following days, he notices the darkening of the urine and the yellowing of the skin and sclera. Then, in the tests, they notice an increase in liver enzymes, and with further investigations, the patient is diagnosed with autoimmune hepatitis.
- The patient goes to his "own city" Isfahan for specialized tests and treatment.
- The patient does not mention morning stiffness and articular pains. She does not have mouth aphthous and light sensitivity.

- PMX:
- Hypothyroidism, dyspepsia, airway Hypersensitivity and autoimmune hepatitis.
- SHX:
- MSc student
- He is single and does not mention the history of alcohol and drug use.

Treatment:

- On the diagnosis of autoimmune hepatitis since about 4 months ago (July), prednisolone 50 mg for one week.
- Then the dose of 40 mg for two weeks (due to the lack of response of liver enzymes in the follow-up)
- The dosage was gradually reduced by 10 mg every week until it reached a dosage of 10 mg, and after a week, the dosage of 10 mg of prednisolone was stopped. (it has been used for about 45 days).
- Azram 50 mg tablet, which was started by another physician at the time of taking 10 mg prednisolone dose, which was continued at first once a day for two weeks, then twice a day for a week, and was stopped due to the lack of reduction in liver enzymes (Azram has been used for about three weeks).
- After that (from 14th of September), She started taking Usenide 3 mg daily and Cellcept 500 mg twice in the morning, and she has been taking 2 gr of Cellcept daily for about a month, now: Levothyroxine, Pantazol, Ucidrol every 8 hours, Symbicort.

10/04/1402

ALT	AST	AKP	Bili T	Bili D	HAV Ab	HBS Ab	HCV Ab	LDH
996	***848***	368	**6.91**	**5.14**	0.34	3.3	0.35	523

1402/04/13

ALT	AST	AKP	BILI T	BILI D	HBC Ab(IgM)	HAV Ab(IgM)	ANA
1298	**1113**	**355**	**6.9**	**2.1**	Non reactive	Non reactive	0.39

02/04/10

کبد ابعاد و اکوی طبیعی دارد.

کیسه صفرا حجم وضخامت جداری طبیعی داشته اکوی غیر طبیعی در لومن ان دیده نمیشود .

قطر مجاری صفراوی داخل وخارج کبدی طبیعی است .

قطرCBD و ورید پورت نرمال می باشد.

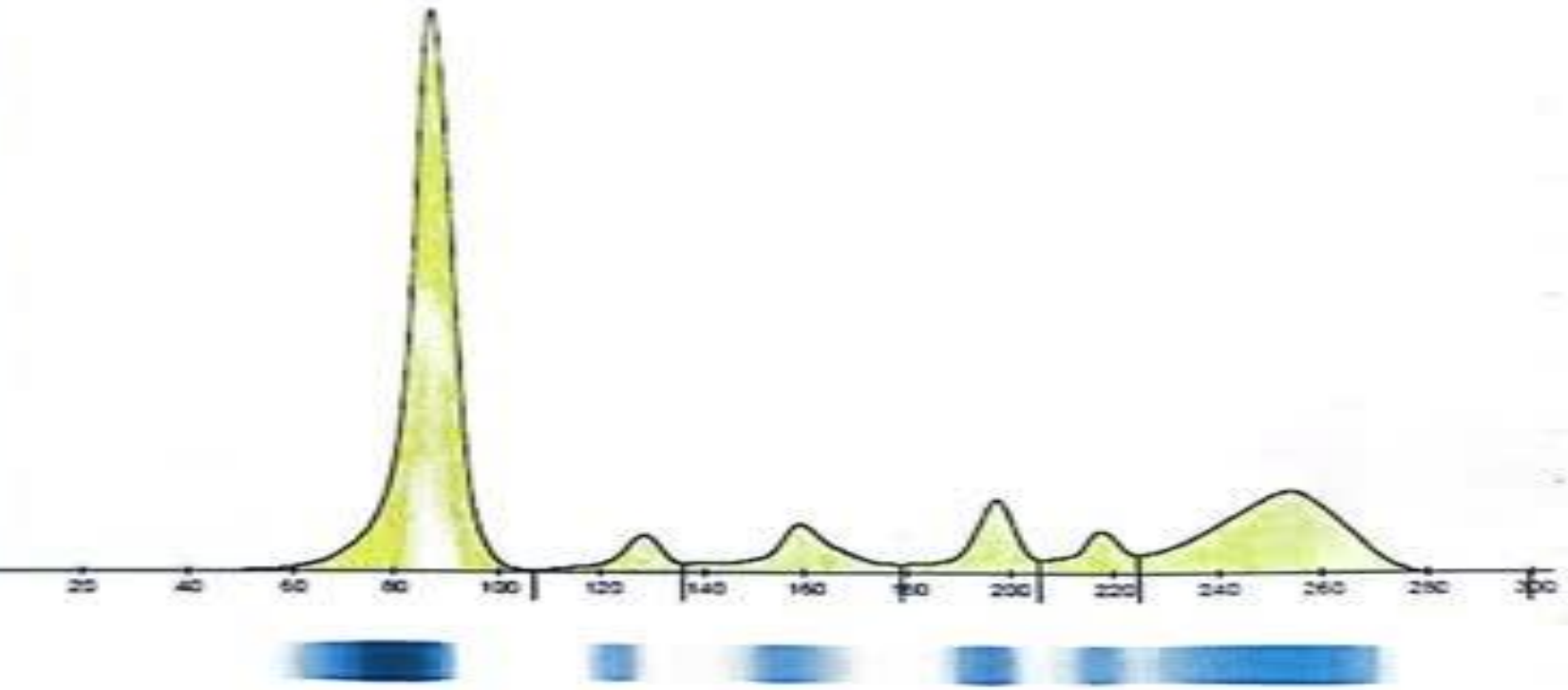
اندازه و اکوی پانکراس طبیعی می باشد.

1402/04/22

ALT	AST	ALK	BILI T	BILID	ANA	Ceruloplasmin	HAV Ab (IgM)	EBV Ab (IgM)	EBV Ab (IgG)	LKMA	gastrin	TTG Ab(IgA)
1014	-	352	**4.7**	**2.8**	17	25	0.09	0.1	14.6(up)	3.6	46.8	3.6

Capillary Serum Protein Electrophoresis

02/04/22



Fractions	%		Ref. %	g/dl	Ref. g/dl
Albumin	54.0	L	55.8 - 66.1	4.1	4.0 - 4.8
Alpha 1	3.9		2.9 - 4.9	0.3	0.2 - 0.4
Alpha 2	7.9		7.1 - 11.8	0.6	0.5 - 0.9
Beta 1	7.4	H	4.7 - 7.2	0.6	0.3 - 0.5
Beta 2	4.5		3.2 - 6.5	0.3	0.2 - 0.5
Gamma	22.3	H	11.1 - 18.8	1.7	0.8 - 1.4

Total Protein : 7.5 6.8 - 8.7

Albumin / Globulines: 1.17

02/04/22

سونوگرافی کالرداپلرعروق کبدی:

وریدپورت به دیامتر10/5mm مشاهده می شودکه دربررسی اسپکترال فلوموج وریدی نرمال داشته وجهت جریان خون بصورت هپاتوپتال می باشد.

وریدطحالی بادیامتر 7mm و فلوی نرمال مشاهده می شود.

سرعت وریدی متوسط وریدپورت برابر20cm/s می باشدوشواهدی ازترومبوزدران رویت نمی شود.

وریدهای سوپراهپاتیک دیامترنرمال داشته وموج وریدی طبیعی درانها دیده می شود.

شریان هپاتیک فلو و موج شریان نرمال داشته وRI ان برابر 72/. می باشد.

Clinical Data:
SGOT: 1113 **SGPT: 1014*** **ALK Ph: 352*** **Bili (T); 4.7** **GGT:**

HCV-Ab: Negative **HBS -Ag:** Negative **HAV-Ab(IgM):** 0.09 Negative

ANA: 17 Negative **ASMA:** **AMA :** **LKM; 3.6** Negative

Gamma Globulin: 22.3 **IgG;** **IgM;**

MRCP; **Fibroscan; F ;S**

Macroscopic Description:
Received specimen consist one tubular soft tan pieces total length 1.5 cm and 0.1cm in diameter.
A. Portal inflammation ;Moderate/marked, all portal areas 3

B.Interfaceheptatitis; Mild/moderate (focal, most portal areas) 2

C. Focal (spotty) lytic necrosis ;More than ten foci per 10 objective 4

D. Confluent necrosis ;Zone 3 necrosis in some areas 2

Fibrous Staging: No fibrosis 0

Plasma cell;:absent
Rosettes ;Present
Emperipolesis ; few: <2 foci
Bile duct injury;:Present
Bile duct loss; Not identified
Ductular reaction ;:Present
Cholestasis; absent
Prussian blue staining ;**Negative**
Diagnosis:
Liver Core Needle Biopsy:
Acute Hepatitis :

Note1;Modified simplified score and revised International Autoimmune Hepatitis Group Histologic criteria score 2
Note 2; Drug , toxin ,viral or acute presentation of AIH should be considered in differential diagnosis of this feature
Clinical and serologic correlation is recommended.

23/11/14

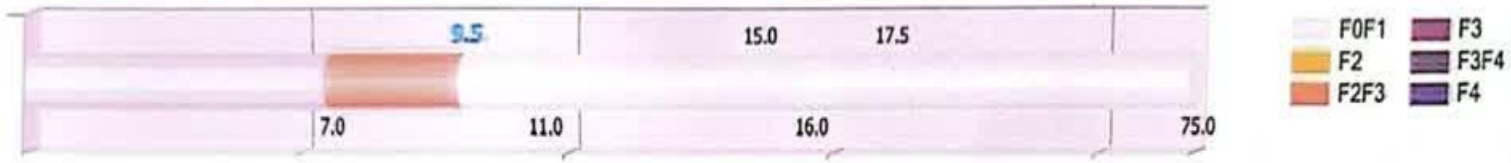
1402/5/1

برای بیمار در تاریخ ۰۱/
بیوپسی کبد انجام می شود

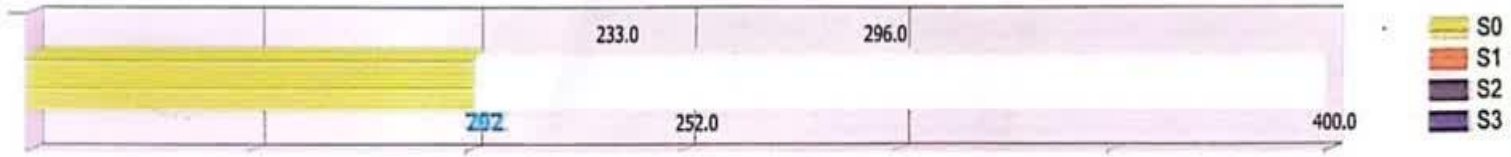
Lab data	ALT	AST	AKP	BILI T	BILI D
02/05/15	169	359	253	2.3	0.8
02/05/25	393	153	102	0.6	0.1
02/06/08	243	155	136	0.86	0.28
02/06/22	264	230	177	0.98	0.37
02/07/05	162	115	179	1	0.39
02/07/18	78	54	157	1.4	0.2
02/08/02	59	45	165	-	-

02/08/03

Diagnosis: Auto immune Hepatitis



Fibro Score = 9.5



CAP Score = 202

Fibroscan	CAP
Patient Score: 9.5 (kPa)	Patient Score: 202 (dB/m)
Metavir Score: F2	Steatosis Percent 0 - 10%
	Steatosis Stage: S0

Dear Colleague:

Thanks for referring this patient for fibroscan test.

I performed fibroscan in different parts of his liver. The median fibrosis score of his liver is 9.5 kPa, which is equal to F2 based on Metavir histological index.

Please be advised in acute hepatitis, PHT status and cardiopulmonary congestion, result of fibroscan may be higher than the actual fibrosis of the liver.

Data	WBC	HB	PLT	INR	ALB
02/04/10	8600	13.4	214000	1.0	--
02/05/15	15450	12.8	371000	1.0	4.2
02/05/25	10100	11.9	260000	--	--
02/06/08	8800	11.3	326000	--	--
02/06/22	5700	12.2	323000	--	--
02/07/18	5300	11.5	327000	--	4.46

Cellcept has been started with the diagnosis of non-response to Azram, but the liver enzymes have not normalized. Is additional treatment necessary?

Feedback

Dear colleague:

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:

- Clinical course, tests and liver biopsy support the diagnosis of autoimmune hepatitis. According to the appropriate clinical response to the treatment, it is recommended to continue cellcept and follow up the laboratory response.
- It is recommended to gradually taper and stop budesonide.

A 46-year-old man

- who has been suffering from generalized abdominal pain since 2015 after hemorrhoidectomy. Abdominal pain was not related to eating and was continuous. He was hospitalized for the pain and treated with antibiotics every six months.
- He have nausea and vomiting that contains eaten food during the pain periods and he has fecal and mucus secretions.
- He has lost 10 kilograms in the last two months.
- During the last few months, the pain has worsened, which wakes him up at night, and he complains of anorexia, bloating, fever, chills, and episodes of constipation and diarrhea.

- No medication now, No relevant family history.

Abdominopelvic CT scan + contrast
1395.02.20

Multiple hypodense lesion in both liver lobes are noted due to liver metastasis or lymphoma, …

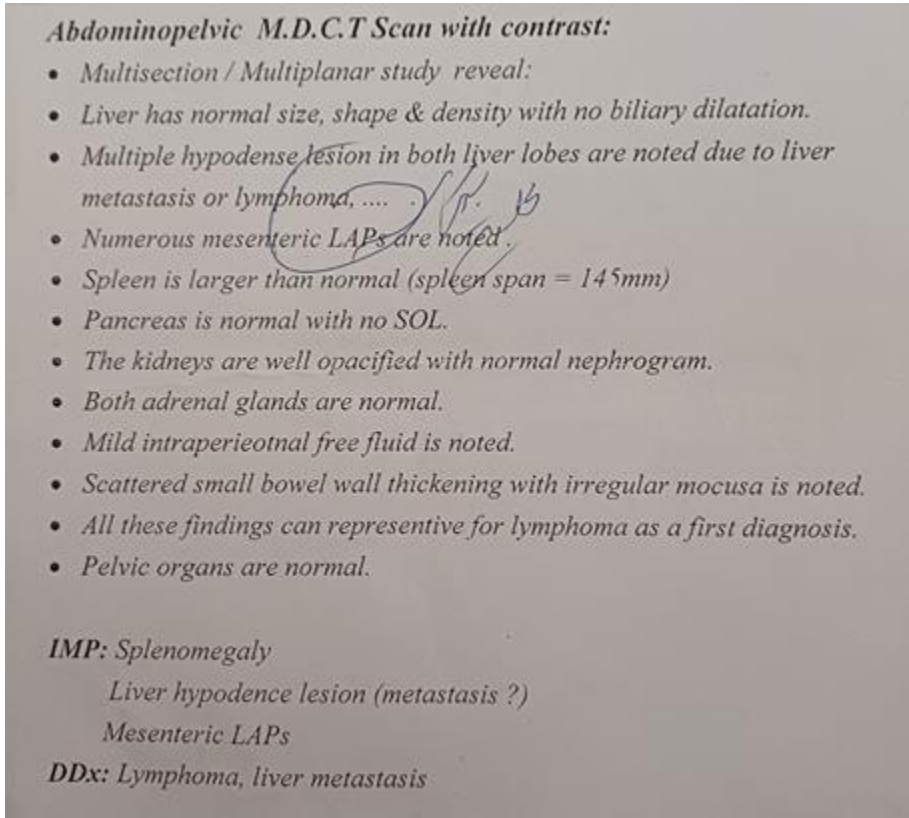
Numerous mesenteric LAPs are noted

Spleen is larger than normal (span:145mm)

Scattered small bowel wall thickening with

irregular mucosa is noted

IMP: Splenomegaly, Liver hypodense lesion, mesenteric LAPs



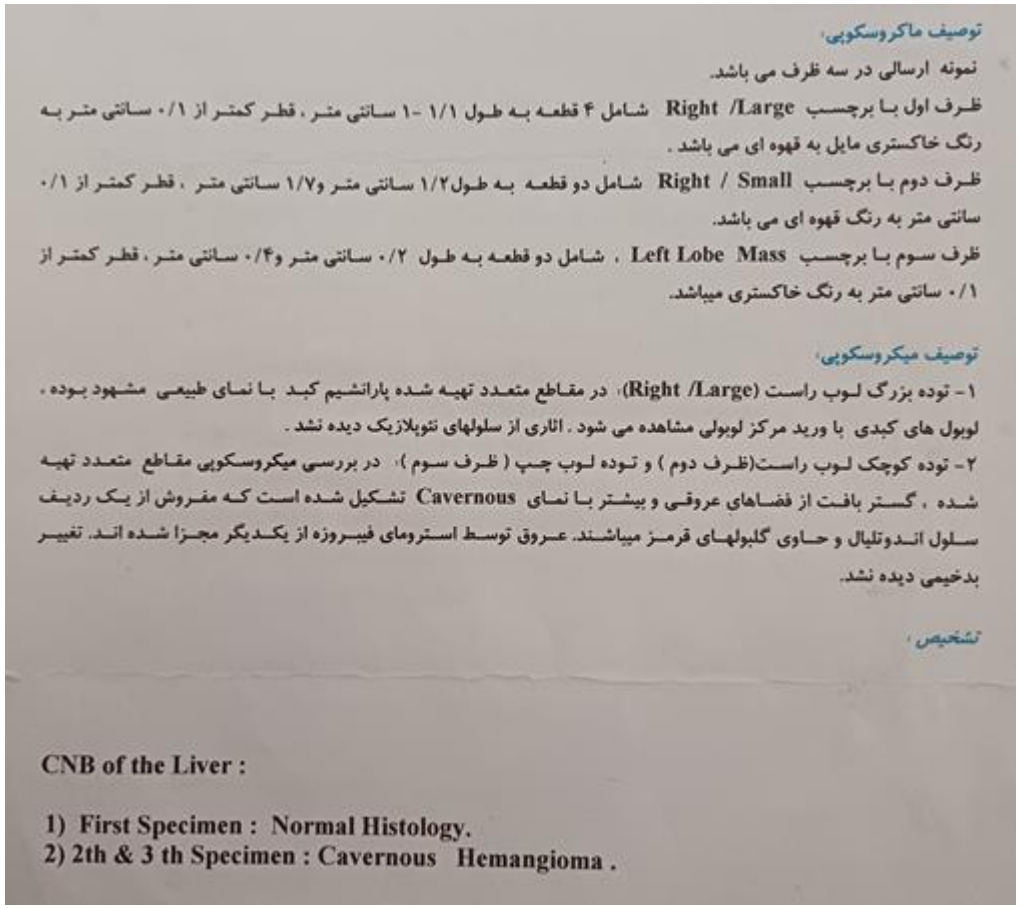
Abdominopelvic M.D.C.T Scan with contrast:

- *Multisection / Multiplanar study reveal:*
- *Liver has normal size, shape & density with no biliary dilatation.*
- *Multiple hypodense lesion in both liver lobes are noted due to liver metastasis or lymphoma, ...*
- *Numerous mesenteric LAPs are noted.*
- *Spleen is larger than normal (spleen span = 145mm)*
- *Pancreas is normal with no SOL.*
- *The kidneys are well opacified with normal nephrogram.*
- *Both adrenal glands are normal.*
- *Mild intraperieotnal free fluid is noted.*
- *Scattered small bowel wall thickening with irregular mocusa is noted.*
- *All these findings can representive for lymphoma as a first diagnosis.*
- *Pelvic organs are normal.*

IMP: *Splenomegaly*
Liver hypodence lesion (metastasis ?)
Mesenteric LAPs
DDx: *Lymphoma, liver metastasis*

Pathology (CNB of the liver)
1395.02.22

Left and Right lobes of liver samples: cavernous hemangioma



توصیف ماکروسکوپی:

نمونه ارسالی در سه ظرف می باشد.

ظرف اول با برچسب Right /Large شامل ۴ قطعه به طول ۱/۱ -۱ سانتی متر ، قطر کمتر از ۰/۱ سانتی متر به رنگ خاکستری مایل به قهوه ای می باشد .

ظرف دوم با برچسب Right / Small شامل دو قطعه به طول۱/۲ سانتی متر و۱/۷ سانتی متر ، قطر کمتر از ۰/۱ سانتی متر به رنگ قهوه ای می باشد.

ظرف سوم با برچسب Left Lobe Mass ، شامل دو قطعه به طول ۰/۲ سانتی متر و۰/۴ سانتی متر ، قطر کمتر از ۰/۱ سانتی متر به رنگ خاکستری میباشد.

توصیف میکروسکوپی:

۱- توده بزرگ لوب راست (Right /Large)، در مقاطع متعدد تهیه شده پارانشیم کبد با نمای طبیعی مشهود بوده ، لوبول های کبدی با ورید مرکز لوبولی مشاهده می شود . اثاری از سلولهای نئوپلازیک دیده نشد .

۲- توده کوچک لوب راست(ظرف دوم) و توده لوب چپ (ظرف سوم)، در بررسی میکروسکوپی مقاطع متعدد تهیه شده ، گستر بافت از فضاهای عروقی و بیشتر با نمای Cavernous تشکیل شده است که مفروش از یک ردیف سلول اندوتلیال و حاوی گلبولهای قرمز میباشند. عروق توسط استرومای فیبروزه از یکدیگر مجزا شده اند. تغییر بدخیمی دیده نشد.

تشخیص:

CNB of the Liver :

1) First Specimen : Normal Histology.
2) 2th & 3 th Specimen : Cavernous Hemangioma .

Endoscopy

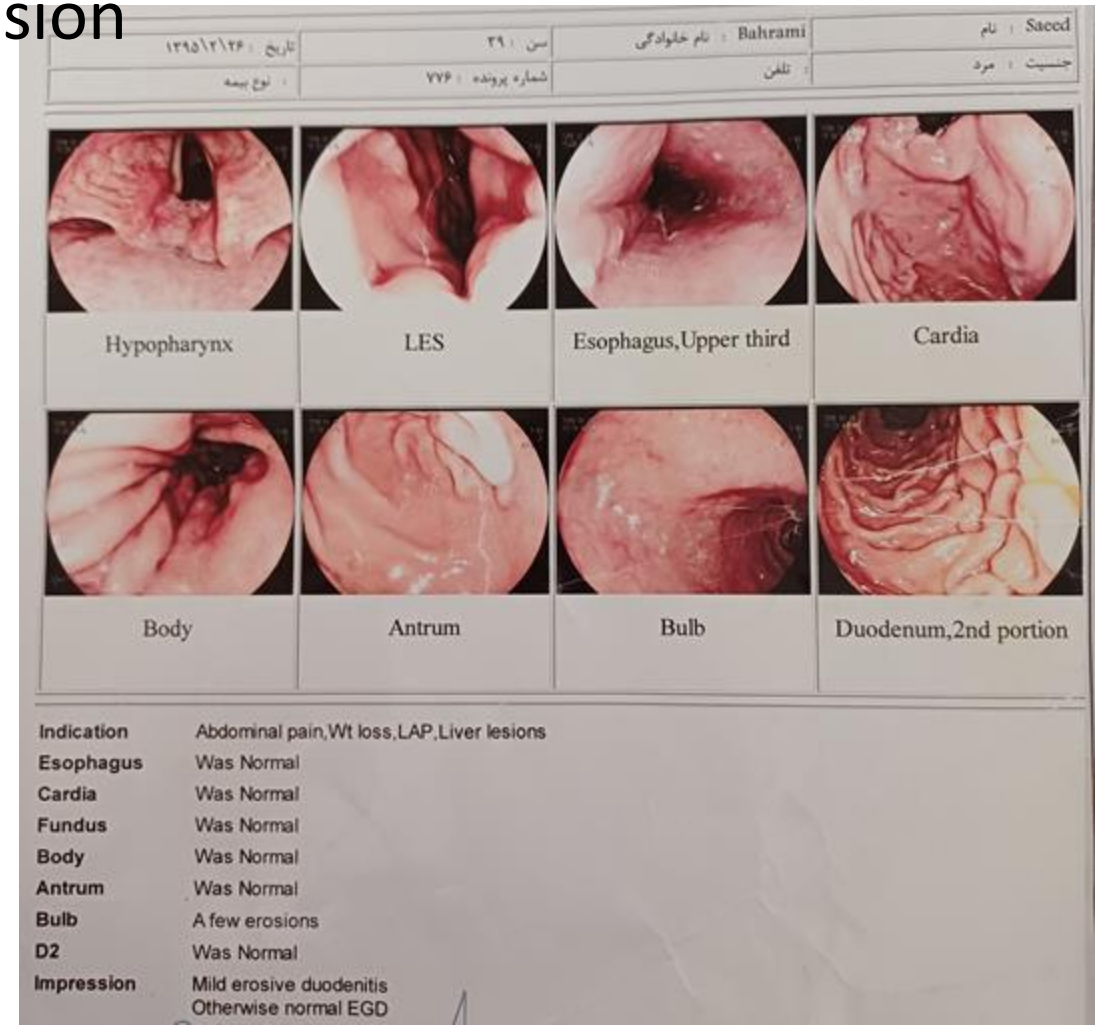
1395.02.26

Reason: abdominal pain, Wgt loss, liver lesion

Esophagus: NL

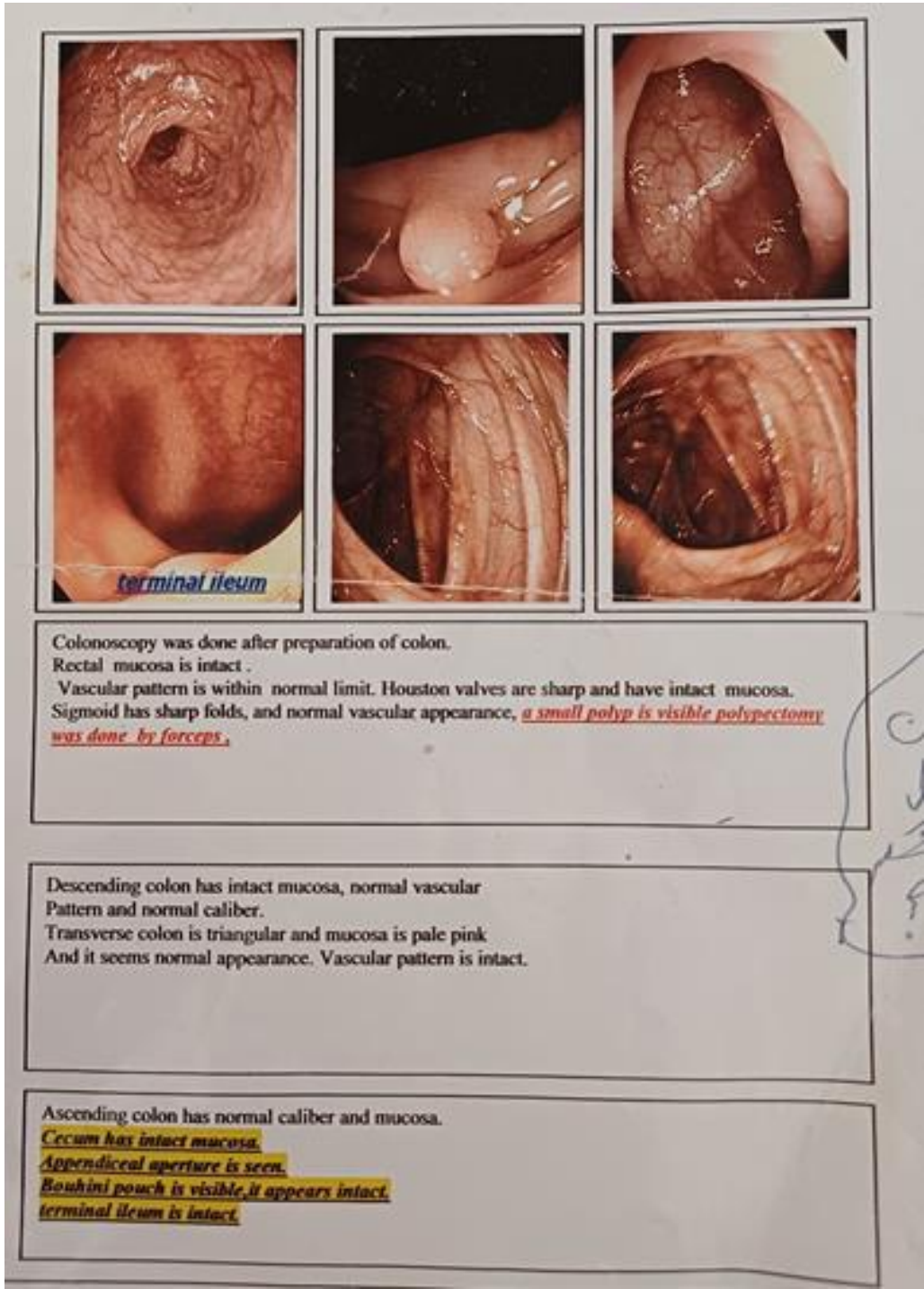
Stomach: NL

Duodenum: bulb a few erosions



Colonoscopy
1395.03.03

Rectum: small polyp is visible, polypectomy was done by forceps

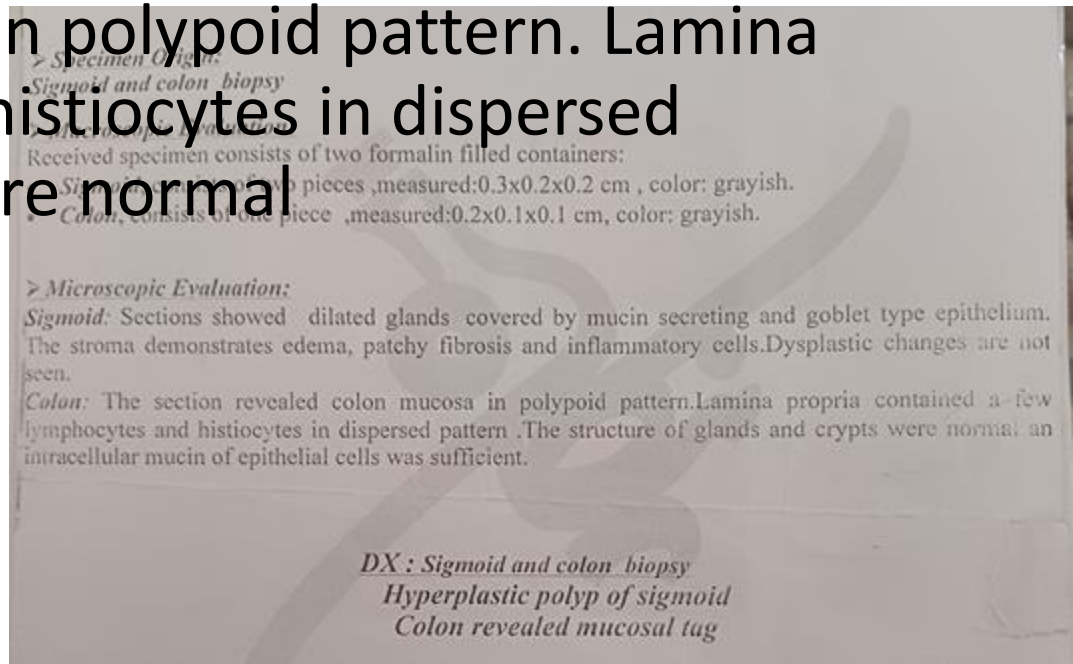


Pathology

1395.03.03

Sigmoid Sections showed dilated glands covered by mucin secreting and goblet type epithelium. The stroma demonstrates edema, patchy fibrosis and inflammatory cells. Dysplastic changes not seen.

Colon the section revealed colon mucosa in polypoid pattern. Lamina propria contained a few lymphocytes and histiocytes in dispersed pattern. The structure gland and crypts were normal


Sigmoid and colon biopsy

Received specimen consists of two formalin filled containers:

pieces ,measured:0.3x0.2x0.2 cm , color: grayish.

piece ,measured:0.2x0.1x0.1 cm, color: grayish.

Microscopic Evaluation:

Sigmoid: Sections showed dilated glands covered by mucin secreting and goblet type epithelium. The stroma demonstrates edema, patchy fibrosis and inflammatory cells.Dysplastic changes are not seen.

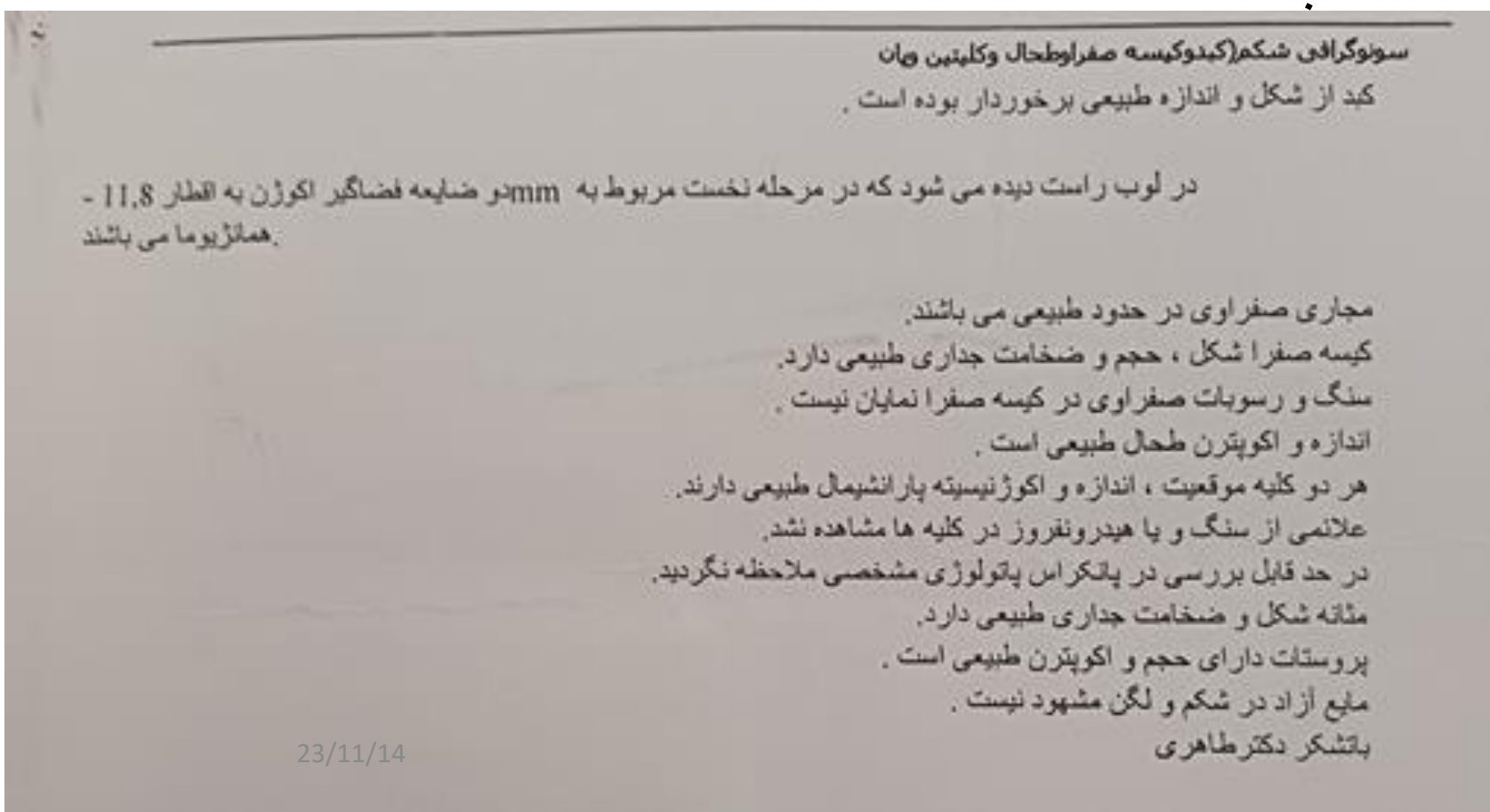
Colon: The section revealed colon mucosa in polypoid pattern.Lamina propria contained a few lymphocytes and histiocytes in dispersed pattern .The structure of glands and crypts were normal an intracellular mucin of epithelial cells was sufficient.

DX : Sigmoid and colon biopsy
Hyperplastic polyp of sigmoid
Colon revealed mucosal tag

Abdominal US

1395.03.05

در لوب راست کبد دو ضایعه فضاگیر اکوژن به اقطار ۱۱*۸م.م مربوط به همانژیوما می باشد



سونوگرافی شکم(کبدوکیسه صفراوطحال وکلیتین وبان

کبد از شکل و اندازه طبیعی برخوردار بوده است .

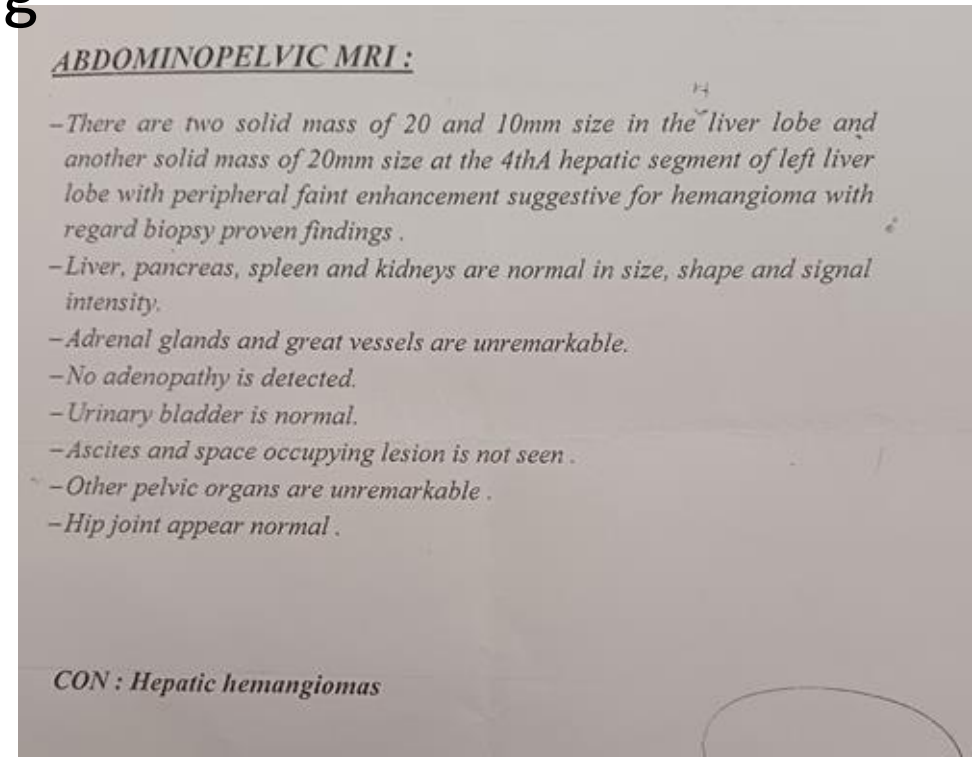
در لوب راست دیده می شود که در مرحله نخست مربوط به mmدو ضایعه فضاگیر اکوژن به اقطار 11.8 - همانژیوما می باشند.

مجاری صفراوی در حدود طبیعی می باشند.
کیسه صفرا شکل ، حجم و ضخامت جداری طبیعی دارد.
سنگ و رسوبات صفراوی در کیسه صفرا نمایان نیست .
اندازه و اکوپترن طحال طبیعی است .
هر دو کلیه موقعیت ، اندازه و اکوژنیسیته پارانشیمال طبیعی دارند.
علائمی از سنگ و یا هیدرونفروز در کلیه ها مشاهده نشد.
در حد قابل بررسی در پانکراس پاتولوژی مشخصی ملاحظه نگردید.
مثانه شکل و ضخامت جداری طبیعی دارد.
پروستات دارای حجم و اکوپترن طبیعی است .
مایع آزاد در شکم و لگن مشهود نیست .
باتشکر دکترطاهری

Abdominopelvic MRI
1395.03.06

There are two solid mas of 20 and 10 mm size in the liver lobe and another solid mass of 20 mm size at the 4thA hepatic segment of left liver lobe with peripheral faint enhancement suggestive for hemangioma with regard biopsy proven finding

IMP: Hpatic hemangiomas



ABDOMINOPELVIC MRI :

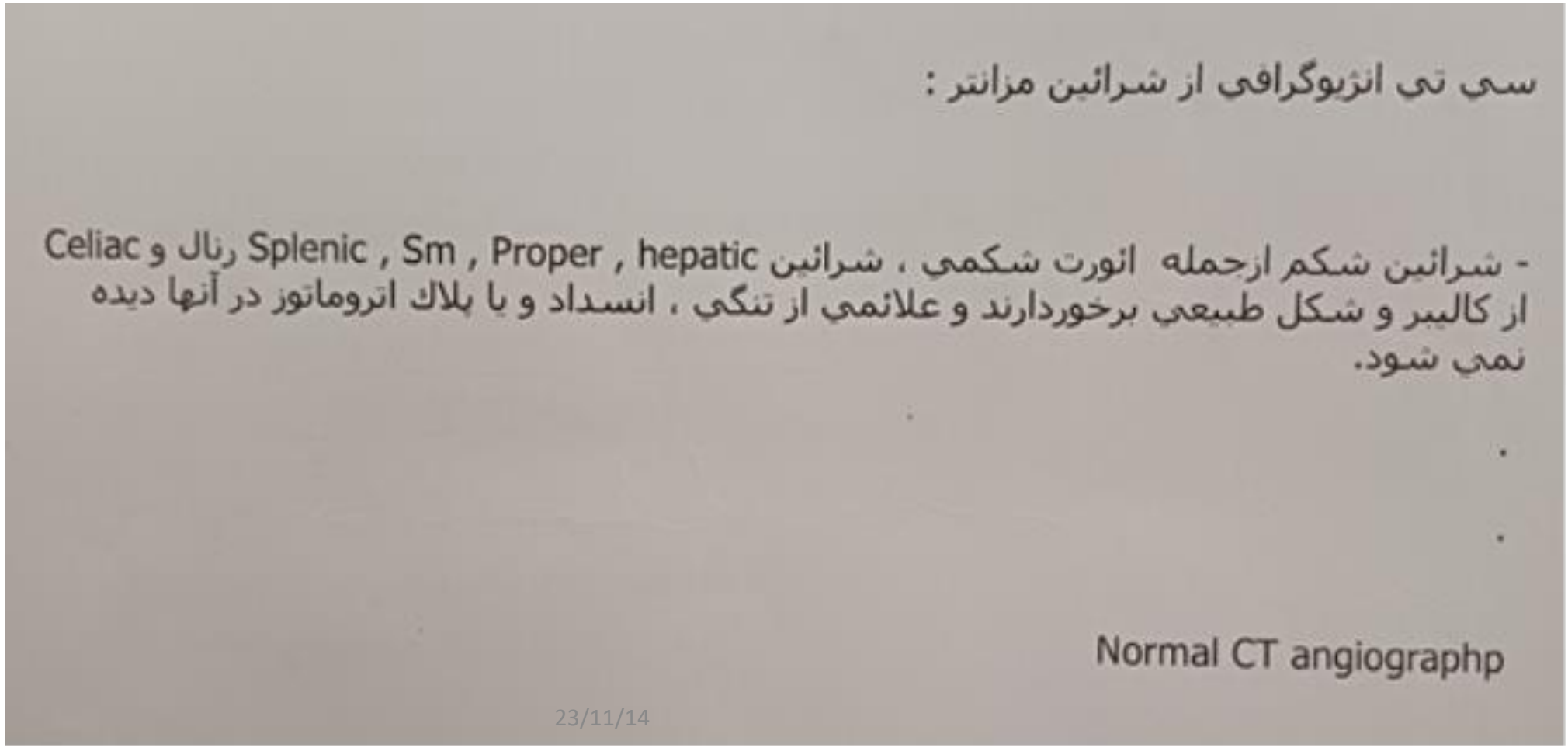
–There are two solid mass of 20 and 10mm size in the liver lobe and another solid mass of 20mm size at the 4thA hepatic segment of left liver lobe with peripheral faint enhancement suggestive for hemangioma with regard biopsy proven findings .
–Liver, pancreas, spleen and kidneys are normal in size, shape and signal intensity.
–Adrenal glands and great vessels are unremarkable.
–No adenopathy is detected.
–Urinary bladder is normal.
–Ascites and space occupying lesion is not seen .
–Other pelvic organs are unremarkable .
–Hip joint appear normal .

CON : Hepatic hemangiomas

Mesenteric arteries CT-angiography

1395.03.08

Normal



Abdominopelvic CT scan +/- contrast

1395.04.27

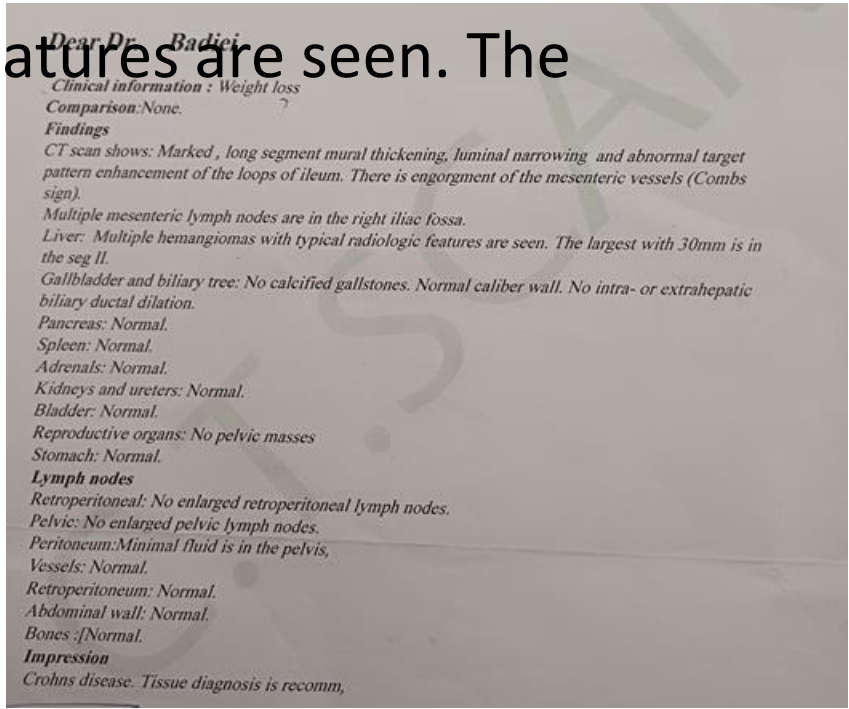
Long segment mural thickening, luminal narrowing and abnormal target pattern enhancement of the loops of ileum. There is engorgement of the mesenteric vessels

Multiple mesenteric lymph nodes are in the right iliac fossa

Liver: multiple hemangiomas with typical radiologic features are seen. The largest with 30mm is in the seg 2.

Minimal fluid is in the pelvis

Impression: Crohn's disease


Dear Dr. Badiei

Clinical information : Weight loss

Comparison: None.

Findings

CT scan shows: Marked , long segment mural thickening, luminal narrowing and abnormal target pattern enhancement of the loops of ileum. There is engorgment of the mesenteric vessels (Combs sign).

Multiple mesenteric lymph nodes are in the right iliac fossa.

Liver: Multiple hemangiomas with typical radiologic features are seen. The largest with 30mm is in the seg II.

Gallbladder and biliary tree: No calcified gallstones. Normal caliber wall. No intra- or extrahepatic biliary ductal dilation.

Pancreas: Normal.

Spleen: Normal.

Adrenals: Normal.

Kidneys and ureters: Normal.

Bladder: Normal.

Reproductive organs: No pelvic masses

Stomach: Normal.

Lymph nodes

Retroperitoneal: No enlarged retroperitoneal lymph nodes.

Pelvic: No enlarged pelvic lymph nodes.

Peritoneum:Minimal fluid is in the pelvis,

Vessels: Normal.

Retroperitoneum: Normal.

Abdominal wall: Normal.

Bones :[Normal.

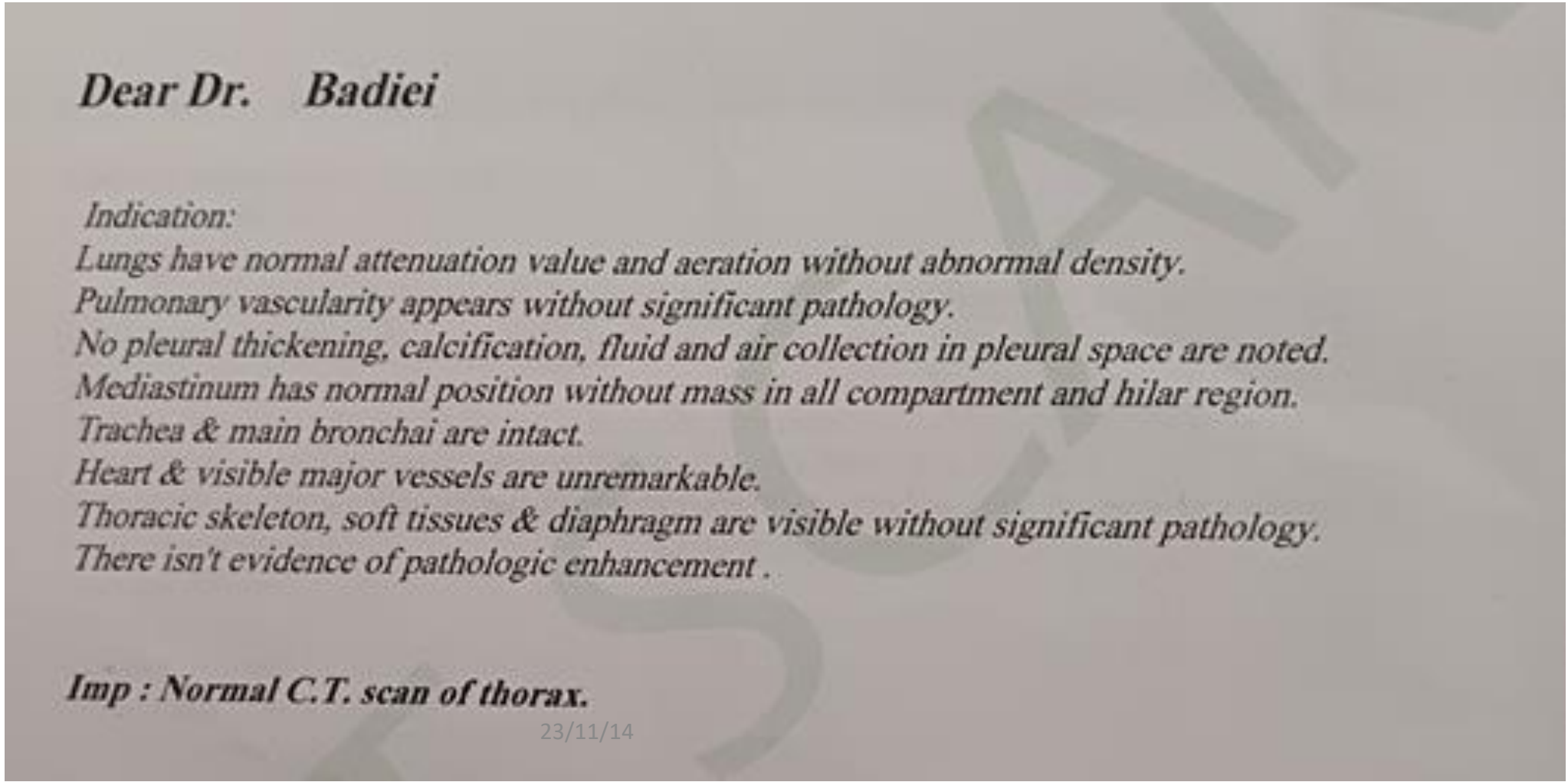
Impression

Crohns disease. Tissue diagnosis is recomm,

Chest CT scan + contrast

1395.04.27

Normal



Dear Dr. Badiei

Indication:
Lungs have normal attenuation value and aeration without abnormal density.
Pulmonary vascularity appears without significant pathology.
No pleural thickening, calcification, fluid and air collection in pleural space are noted.
Mediastinum has normal position without mass in all compartment and hilar region.
Trachea & main bronchai are intact.
Heart & visible major vessels are unremarkable.
Thoracic skeleton, soft tissues & diaphragm are visible without significant pathology.
There isn't evidence of pathologic enhancement .

Imp : Normal C.T. scan of thorax.

Pathology

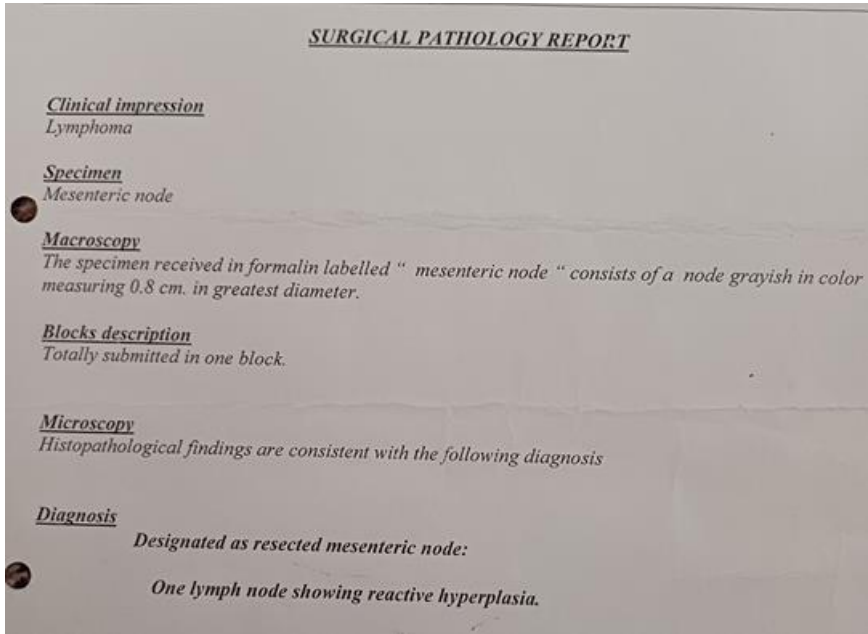
1395.04.28

Clinical impression: Lymphoma

Specimen: Mesenteric node

microscopy: histopathological findings are consistent with the following diagnosis

Diagnosis: **reactive hyperplasia**



SURGICAL PATHOLOGY REPORT

Clinical impression
Lymphoma

Specimen
Mesenteric node

Macroscopy
The specimen received in formalin labelled " mesenteric node " consists of a node grayish in color measuring 0.8 cm. in greatest diameter.

Blocks description
Totally submitted in one block.

Microscopy
Histopathological findings are consistent with the following diagnosis

Diagnosis
Designated as resected mesenteric node:

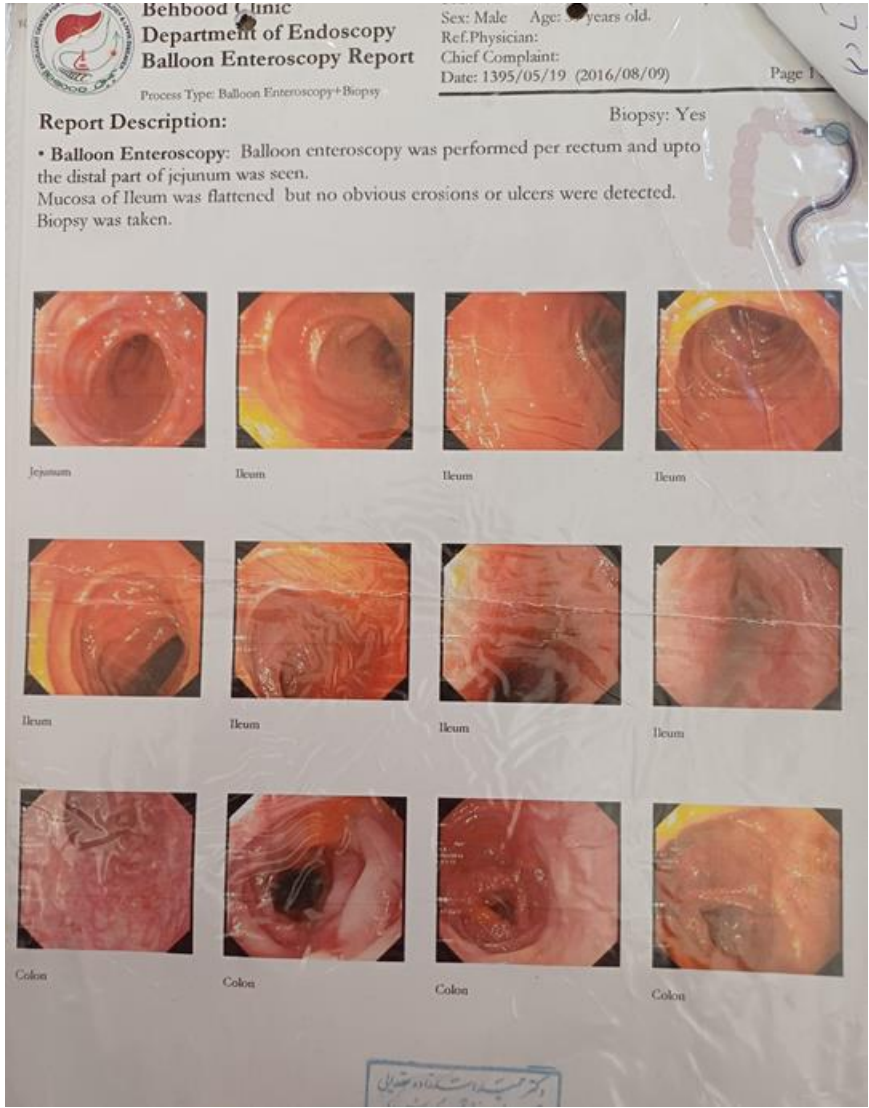
One lymph node showing reactive hyperplasia.

Balloon Enteroscopy

1395.05.19

Mucosa of ileum was flattend

but no obvious erosions or ulcers were detected.


Behbood Clinic
Department of Endoscopy
Balloon Enteroscopy Report
Process Type: Balloon Enteroscopy+Biopsy
Sex: Male Age: years old.
Ref.Physician:
Chief Complaint:
Date: 1395/05/19 (2016/08/09)
Page 1
Report Description:
Biopsy: Yes
• Balloon Enteroscopy: Balloon enteroscopy was performed per rectum and upto the distal part of jejunum was seen.
Mucosa of Ileum was flattened but no obvious erosions or ulcers were detected.
Biopsy was taken.
Jejunum
Ileum
Ileum
Ileum
Ileum
Ileum
Ileum
Ileum
Colon
Colon
Colon
Colon

Pathology (terminal ileum)
1395.05.19

Section show portions of small intestinal mucosa with intact surface

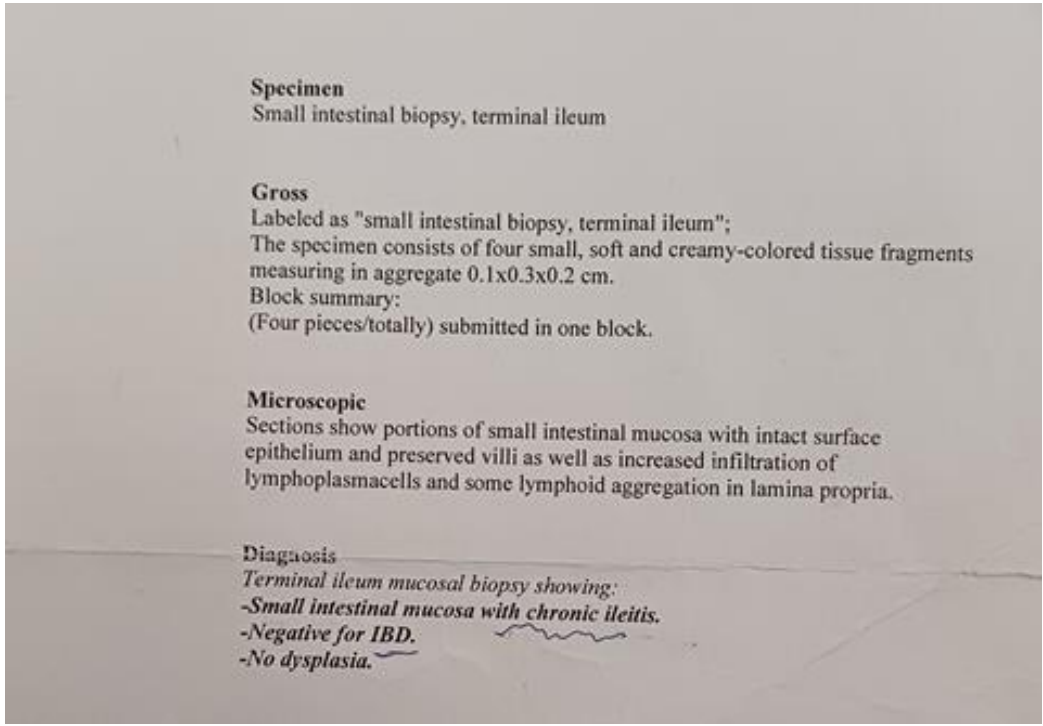
Epithelium and preserved villi as well as increased infiltration of lymphoplasma cells and some lymphoid aggregation in lamina propria

Diagnosis:

Small intestinal mucosa with chronic ileitis

Negative for IBD

No dysplasia



Specimen
Small intestinal biopsy, terminal ileum

Gross
Labeled as "small intestinal biopsy, terminal ileum";
The specimen consists of four small, soft and creamy-colored tissue fragments measuring in aggregate 0.1x0.3x0.2 cm.
Block summary:
(Four pieces/totally) submitted in one block.

Microscopic
Sections show portions of small intestinal mucosa with intact surface epithelium and preserved villi as well as increased infiltration of lymphoplasmacells and some lymphoid aggregation in lamina propria.

Diagnosis
Terminal ileum mucosal biopsy showing:
-Small intestinal mucosa with chronic ileitis.
-Negative for IBD.
-No dysplasia.

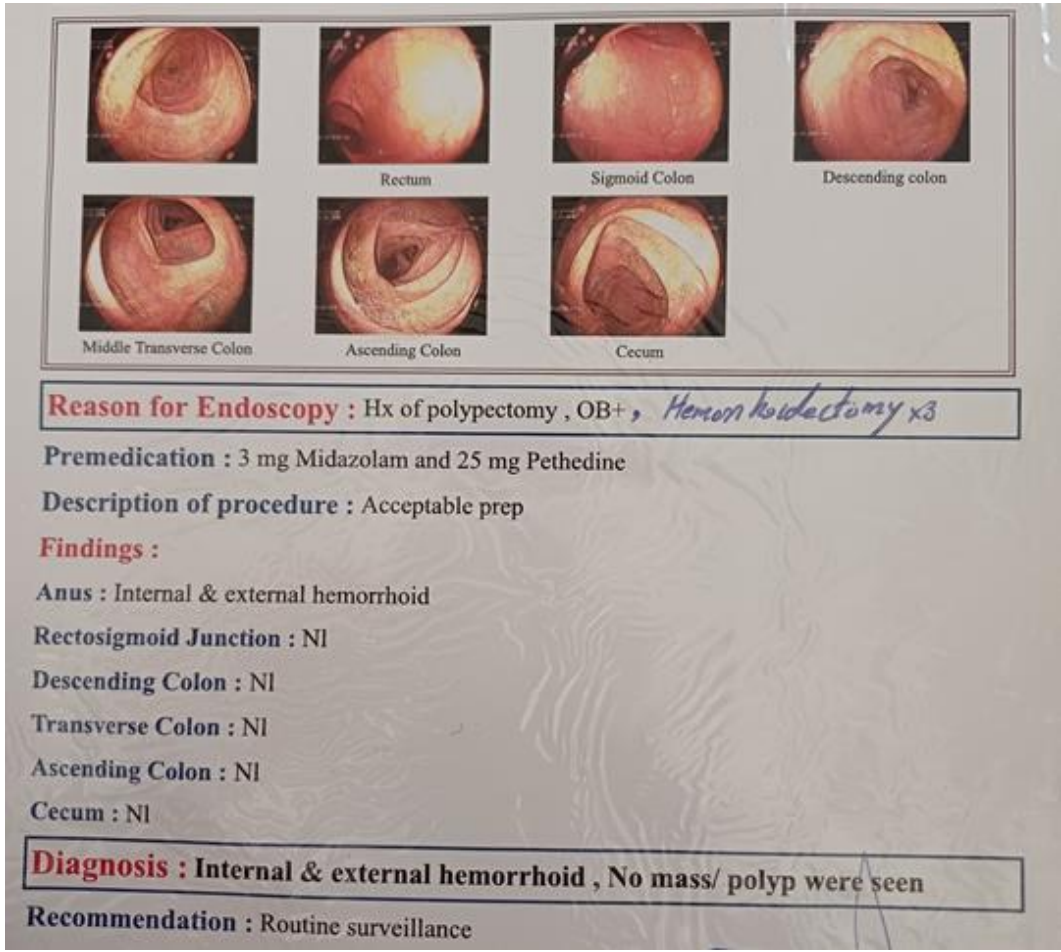
Endoscopy

1397.07.14

Reason: Hx of polypectomy , OB+ , hemorrhoidectomy x 3

Anus: **Internal & External Hemorrhoid**

The other: Normal



Endoscopy

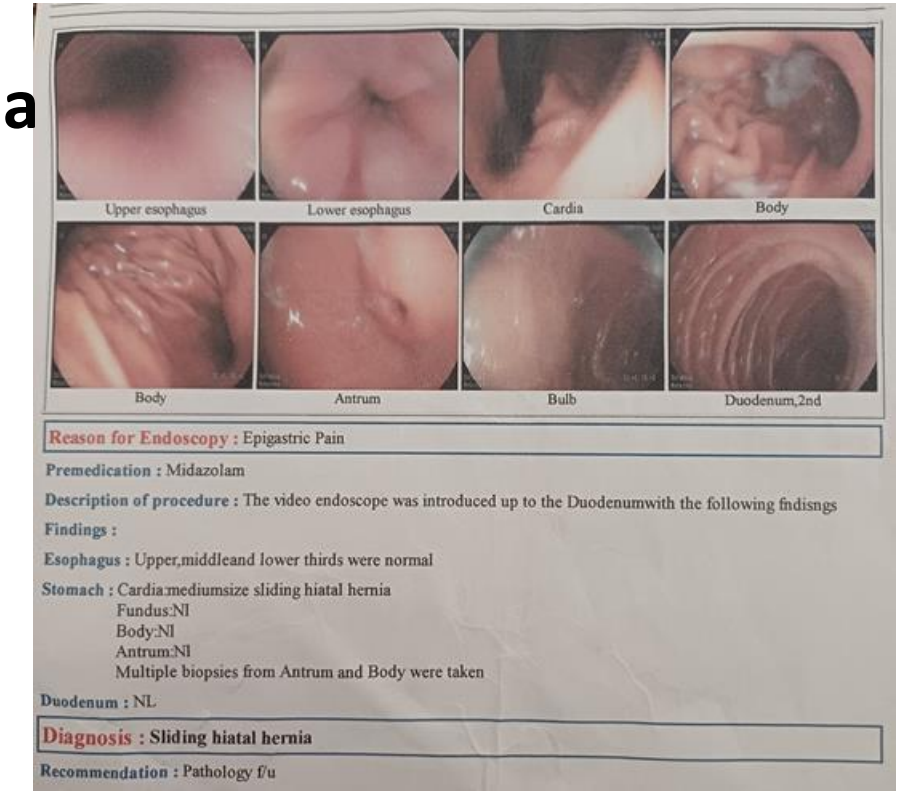
1399.11.28

Reason: epigastric pain

Esophagus: NL

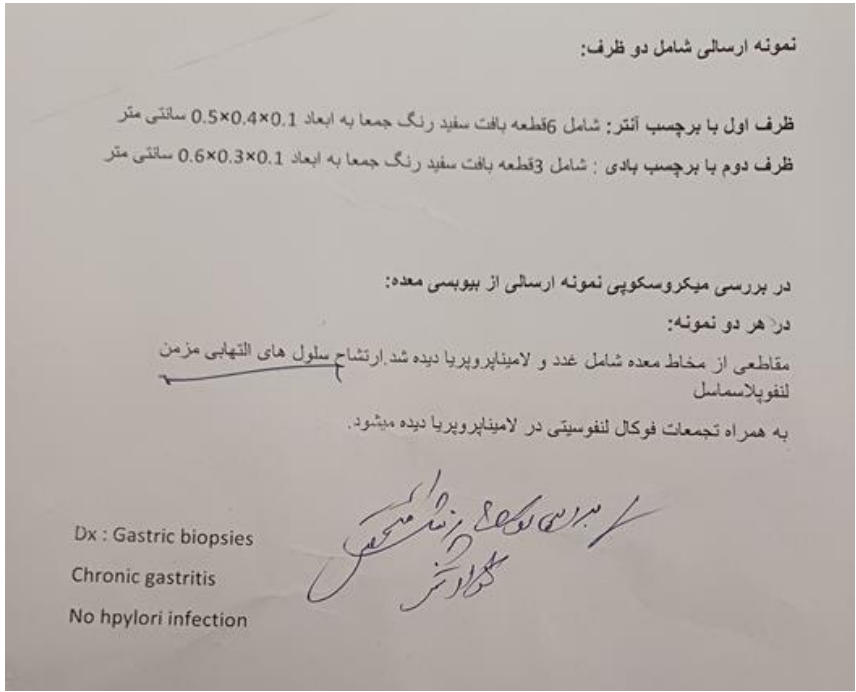
Stomach: cardia medium size **sliding hiatal hernia**

Duodenum: NL



Pathology (Gastric biopsy) 1399.12.12

- Sections of gastric mucosa including glands and lamina propria were seen.
- Infiltration of chronic lymphoplasmacytic inflammatory cells along with focal accumulations of lymphocytes in lamina propria which suggests chronic gastritis


نمونه ارسالی شامل دو ظرف:

ظرف اول با برچسب آنتر: شامل 6قطعه بافت سفید رنگ جمعا به ابعاد 0.1×0.4×0.5 سانتی متر

ظرف دوم با برچسب بادی : شامل 3قطعه بافت سفید رنگ جمعا به ابعاد 0.1×0.3×0.6 سانتی متر

در بررسی میکروسکوپی نمونه ارسالی از بیوپسی معده:

در هر دو نمونه:

مقاطعی از مخاط معده شامل غدد و لامیناپروپریا دیده شد.ارتشاح سلول های التهابی مزمن لنفوپلاسماسل

به همراه تجمعات فوکال لنفوسیتی در لامیناپروپریا دیده میشود.

Dx : Gastric biopsies

Chronic gastritis

No hpylori infection

Lab Data

1402.05.24

BUN 14	WBC 11.6	S/E NL
CR 0.9	Neu 81%	
ESR 9	Lym 10.8%	
CRP 100	RBC 6.8	
	HB 12.7	
	MCV 61	
	PLT 349	

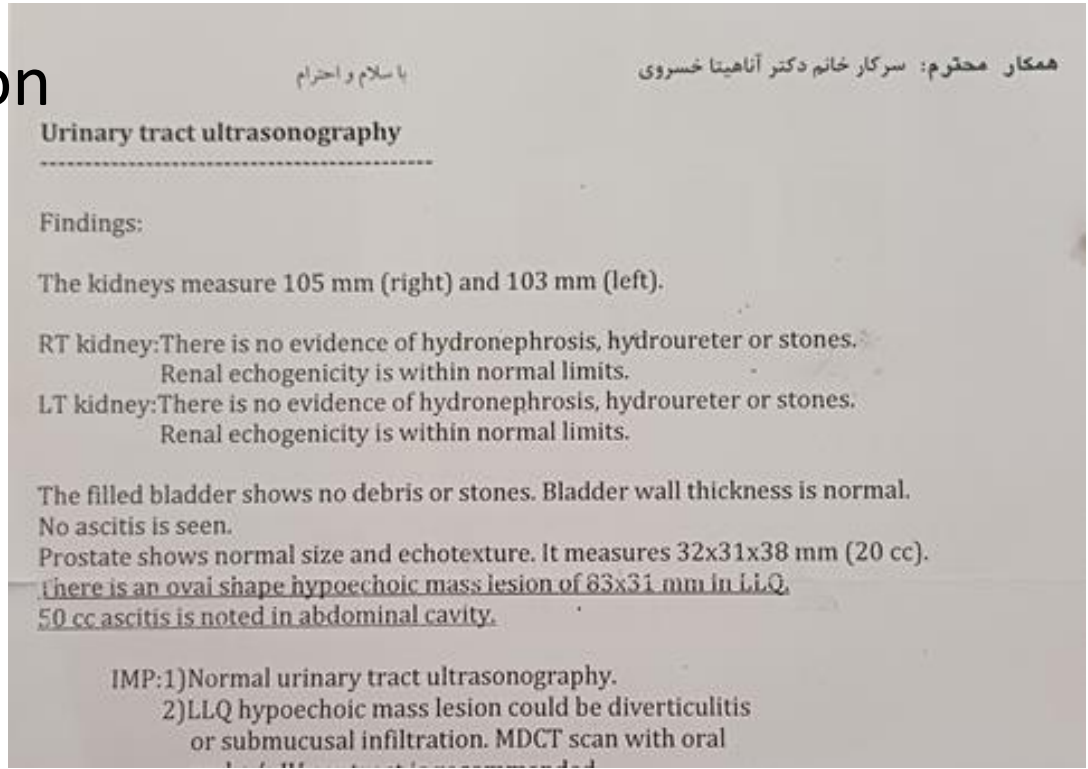
Urinary tract US

1402.05.24

There is an oval shape hypoechoic mass lesion of 83*31mm in LLQ

50cc ascites is noted in abdominal cavity

IMP: Diverticulitis or submucosal infiltration



همکار محترم: سرکار خانم دکتر آناهیتا خسروی

با سلام و احترام

Urinary tract ultrasonography

Findings:

The kidneys measure 105 mm (right) and 103 mm (left).

RT kidney: There is no evidence of hydronephrosis, hydroureter or stones.
Renal echogenicity is within normal limits.
LT kidney: There is no evidence of hydronephrosis, hydroureter or stones.
Renal echogenicity is within normal limits.

The filled bladder shows no debris or stones. Bladder wall thickness is normal.
No ascitis is seen.
Prostate shows normal size and echotexture. It measures 32x31x38 mm (20 cc).
There is an ovai shape hypoechoic mass lesion of 83x31 mm in L.L.Q.
50 cc ascitis is noted in abdominal cavity.

IMP: 1) Normal urinary tract ultrasonography.
2) LLQ hypoechoic mass lesion could be diverticulitis or submucusal infiltration. MDCT scan with oral

Abdominopelvic CT scan +/- contrast

۱۴۰۲/۰۵/۲۵

- There are intervening areas of edema and thickening of mucosal folds and wall of different parts of colon with significant edema of surrounding pericoloic fat with congestion of mesenteric vessels and prominent mesenteric adenopathies
- Skipped pattern of changes are highly in favor of Crohn’s colitis rather than ulcerative colitis also prominent mesenteric lymph nodes and edema of pericolic fat are more in favor of crohn's colitis rather than ulcerative colitis.
- Multiple hypodense solid venous based or subcapsular mass lesion 0f 20-50 mm are visible in different parts of right and left liver lobes with peripheral nodular enhancement during portal phase, compatible with benign hemangioma, which is not related to patient’s problems with colon.

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

There are intervening areas of edema and thickening of mucosal folds and wall of different parts of colon with significant edema of surrounding pericolic fat with congestion of mesenteric vessels and prominent mesenteric adenopathies .

Skipped pattern of changes are highly in favor of Crohn's colitis rather than ulcerative colitis also prominent mesenteric lymph nodes and edema of pericolic fat are more in favor of Crohn's colitis rather than ulcerative colitis .

Medical therapy and total colonoscopy with deep tissue sampling will be necessary , also MR enterogram after a period of medical therapy is recommended as complementary study .

Multiple hypodense solid venous based or subcapsular mass lesions of 20-50mm are visible in different parts of right and left liver lobes with peripheral nodular enhancement during portal phase , compatible with benign hemangioma , which is not related to patient's problems with colon .

Liver is otherwise normal .

Spleen , gallbladder, pancreas , both adrenals, both kidneys , aorta ,IVC , urinary bladder , prostate and seminal vesicles are normal .

مرکز تصویربرداری پزشکی جم
دکتر امیرعلی یزدانی
متخصص رادیولوژی و میانوگرافی

Abdominopelvic US

1402.06.07

- A number (about 10) of hyperechoic masses with sharp margins, the largest size of 51 x 47 mm, were seen in the both liver lobes without vascular flow. If the liver enzymes are normal, it can be a sign of hemangioma.
- A hyperechoic mass attached to the anterior wall of the 4.3 mm gallbladder was seen, which does not move when the patient's position is changed, and it suggests a gallbladder polyp.
- Mild free fluid is seen in the interloops and pelvis.
- An increase in the thickness of the segmental wall is seen in different parts of the colon (sigmoid, transverse colon, and descending colon). Proximal to these stricture areas, the expansion of the colon is seen, which suggests a stricture in the areas where the thickness of the wall increases.

Abdominal & Pelvic US :

کبد دارای ابعاد نرمال و اکوژنیسیته پارانشیمال هموژن و یکنواخت می باشد.

Mid axillary liver size = 120 mm

Border کبد Sharp بوده و قطر مجاری صفراوی داخل و خارج کبدی و سیستم وریدی اینتراهپاتیک و پورت نرمال است.

CBD= 3 mm P.Vien= 8 mm

تعدادی توده هایپراکو (حدود ده عدد) با حدود مشخص به ابعاد بزرگترین 51*47mm در کبد در هردو لوب راست و چپ بدون فلوی عروقی رویت شد در صورت نرمال بودن آنزیم های کبدی میتواند مطرح کننده همانژیوم باشد.

ضخامت جدار کیسه صفرا نرمال است. سنگ مشاهده نشد.

توده هایپراکو چسبیده به جدار قدامی 4.3mm کیسه صفرا رویت شد که با تغییر پوزیشن بیمار جا به جا نمی شود و مطرح کننده پولیپ کیسه صفرا می باشد.

در حد قابل رویت با سونوگرافی پاتولوژی در پانکراس، عروق بزرگ شکمی و زنجیره پاراآئورتیک و سلیاک مشاهده نشد.

طحال در ابعاد و اکوی پارانشیم نرمال دیده می‌شود. Spleen span = 109 mm

هر دو کلیه دارای ابعاد و افتراق کورتیکومدولاری نرمال می باشند. LK : 115 mm RK: 118 mm

اکوژنیسیته پارانشیم هر دو کلیه نرمال می باشد.

ضخامت پارانشیم کلیه راست 12 mm و کلیه چپ 10 mm اندازه گیری شد.

علائمی از هیدرونفروز و یا سنگ در سیستم پیلوکالیسیل کلیه‌ها مشهود نیست.

در قسمت های قابل مشاهده حالب با سونوگرافی، سنگ و ضایعه پاتولوژیک مشهود نیست.

ضخامت جدار مثانه طبیعی است. سنگ یا ضایعه اینترالومینال دیده نشد.

پروستات به ابعاد 32*31*37 mm و حجم تقریبی 20cc دارای ابعاد طبیعی می باشد.

اکوی پروستات طبیعی است.

سمینال وزیکل ها طبیعی می باشد.

مایع ازاد خفیف در اینترلوپ و لگن رویت می شود.

افزایش ضخامت جداری سگمنتال در قسمت های مختلف کولون (در سیگموئید و در کولون نزولی و کولون عرضی) رویت می شود. پروگزیمال به این نواحی تنگی اتساع کولون رویت می شود که این یافته مطرح کننده تنگی در قسمت های افزایش ضخامت جدار می باشد .

Colonoscopy

1402.06.11

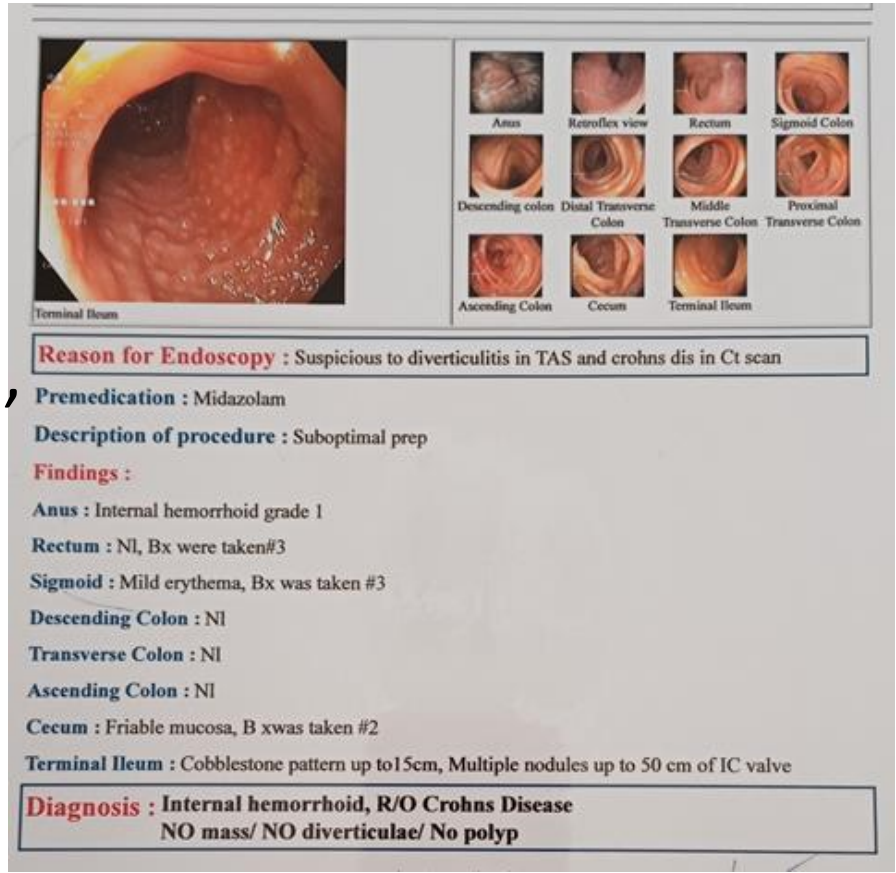
Reason: suspicious to diverticulitis in TAS and Crohn's disease in CT scan

Anus: internal hemorrhoid grade1

Sigmoid: mild erythema

Cecum: friable mucosa

Terminal ileum: cobblestone pattern up to 15cm, multiple nodule up to 50cm of IC valve

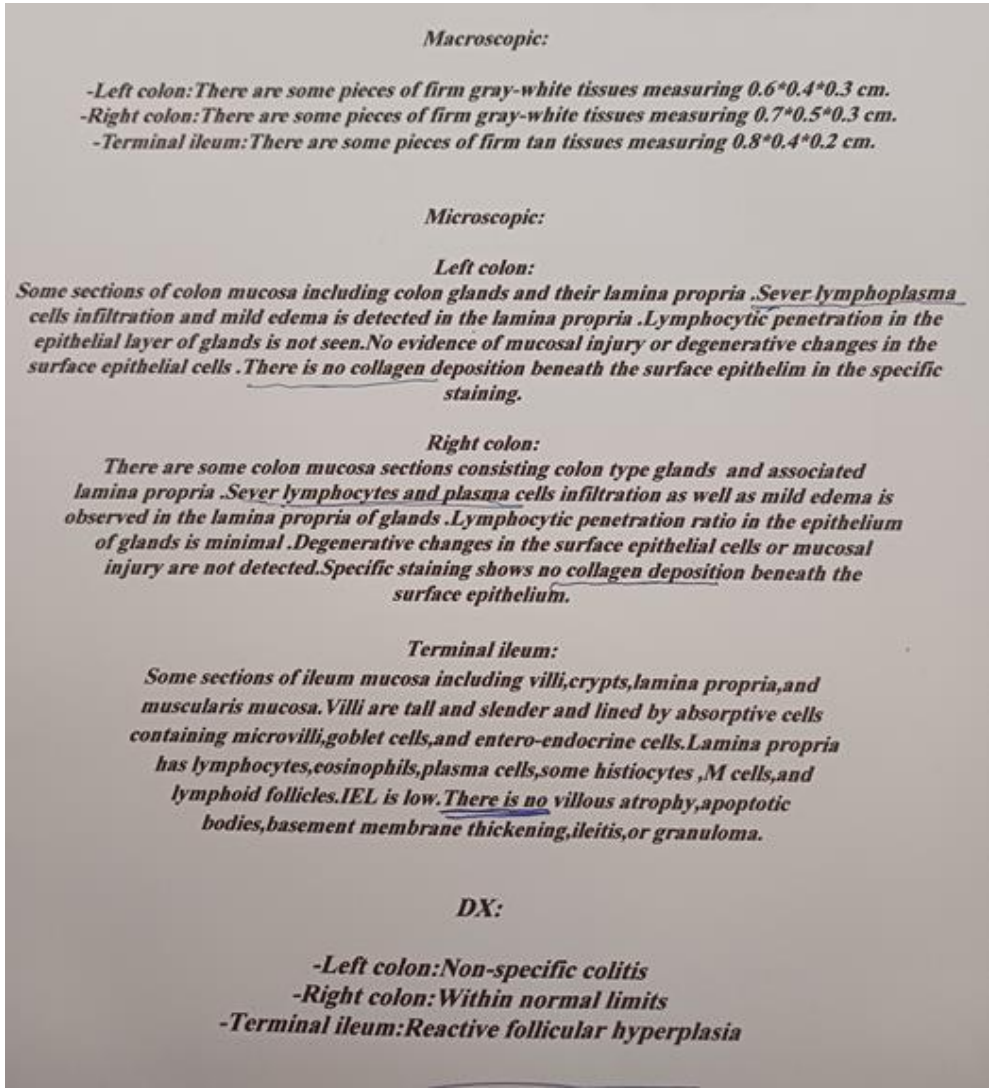


Pathology (colon)
1402.06.11

Left colon: Non-specific colitis

Right colon: within normal limits

Terminal ileum: reactive follicular hyperplasia



Macroscopic:

*-Left colon:There are some pieces of firm gray-white tissues measuring 0.6*0.4*0.3 cm.*
*-Right colon:There are some pieces of firm gray-white tissues measuring 0.7*0.5*0.3 cm.*
*-Terminal ileum:There are some pieces of firm tan tissues measuring 0.8*0.4*0.2 cm.*

Microscopic:

Left colon:
Some sections of colon mucosa including colon glands and their lamina propria .Sever lymphoplasma cells infiltration and mild edema is detected in the lamina propria .Lymphocytic penetration in the epithelial layer of glands is not seen.No evidence of mucosal injury or degenerative changes in the surface epithelial cells .There is no collagen deposition beneath the surface epithelim in the specific staining.

Right colon:
There are some colon mucosa sections consisting colon type glands and associated lamina propria .Sever lymphocytes and plasma cells infiltration as well as mild edema is observed in the lamina propria of glands .Lymphocytic penetration ratio in the epithelium of glands is minimal .Degenerative changes in the surface epithelial cells or mucosal injury are not detected.Specific staining shows no collagen deposition beneath the surface epithelium.

Terminal ileum:
Some sections of ileum mucosa including villi,crypts,lamina propria,and muscularis mucosa.Villi are tall and slender and lined by absorptive cells containing microvilli,goblet cells,and entero-endocrine cells.Lamina propria has lymphocytes,eosinophils,plasma cells,some histiocytes ,M cells,and lymphoid follicles.IEL is low.There is no villous atrophy,apoptotic bodies,basement membrane thickening,ileitis,or granuloma.

DX:

-Left colon:Non-specific colitis
-Right colon:Within normal limits
-Terminal ileum:Reactive follicular hyperplasia

Lab Data

1402.06.26

BUN 12	**Calprotectin 250**	Widal Neg	DNA Analysis Clostridium difficile Neg
CR 1	Selenium 85	Wright Agglutination Neg	*DNA Analysis Clostridium difficile(A&B) positive*
eGFR 100.9	Lead 6.18	Wright Agglutination (tube) Neg	Giardialambelia.Ag Neg
CRP +++		Coombs Wright Neg	
ESR 12			
WBC 8.3			
HB 12.8			
MCV 57			
MCH 18			
PLT 309			

Abdominopelvic US
1402.06.26

- A hyperechoic-heterogeneous area on the posterior surface of the left lobe of the liver, measuring 50x63x32mm, along with a hyperechoic nodule in the 7th segment of the right liver lobe, measuring 14x17mm and three hyperechoic nodules in the 6th segment, with a diameter of 13mm and 12 mm and 14 mm, and a hyperechoic nodule in segment 5 with dimensions of 20 x 24 mm was observed in the right lobe of the liver, primarily suggesting multiple hemangiomas.
- A polyp is seen in the anterior wall of the gallbladder with a diameter of 6.5 mm.
- An increase in the segmental thickness of the sigmoid colon is 40 mm length and the wall thickness is 10 mm, which is accompanied by inflammatory changes in the surrounding fat, and of course, in the Doppler examination, clear hyperemia is not seen in favor of the acute inflammatory process in the intestinal wall.

در سونوگرافي شكم و لگن انجام شده :

طحال و پانكراس داراي حجم و اكوژنيسيتي طبيعي هستند. ضايعه فضاگير ديده نشد.

*تصوير يک ناحيه هايپراکو-هترژن در سطح خلفي لوب چپ کبد به ابعاد 50x63x32 mm همراه با يک ندول هايپراکو در سگمان 7 لوب راست کبد به ابعاد 17x14 mm و سه ندول هايپراکو در سگمان 6 به قطر 13 mm و 12 mm و 14 mm و يک ندول هايپراکو در سگمان 5 به ابعاد 20x24 mm در لوب راست کبد در درجه اول مطرح کننده همانژيومهاي متعدد مشاهده گرديد.

Span طحال 105 mm مي باشد.
كيسه صفرا داراي حجم و جدار طبيعي عاري از سنگ است.

. *تصوير پوليپ در جدار قدامي كيسه صفرا به قطر 6.5 mm مشهود است.

اتساع مجاري صفراوي داخل و خارج كبدي ديده نشد.
كليه ها داراي حجم و اكوژنيسيتي طبيعي هستند.
كورتكس منظم است. CMj طبيعي است. سنگ و هيدرونفروز ديده نشد.
طول كليه ها Rt = 110 mm , Lt = 113 mm است.
ضخامت پارانشيم كليه چپ (13 mm) و كليه راست (13 mm) است.
مثانه داراي حجم و جدار طبيعي عاري از سنگ و توده است.

پروستات به حجم (22 cc) طبيعي مي باشد.

تصوير توده لنفاوي اطراف انورت ' توده يا مايع ازاد در فضاي شكم و لگن ديده نشد.

*افزايش ضخامت سگمنتال كولون سيگموئيد به طول 40 mm و ضخامت ديواره 10 mm با تغييرات التهابي در چربي اطراف آن ديده مي شود البته در بررسي با دايلر پرخوني واضحي به نفع پروسه التهابي حاد در ديواره روده ديده نمي شود.

Lab Data

1402.07.01

Stool Examination : Normal
Occult Bloodx3 Positive

1402.07.03

Creatinine (24hrs urine) 872
Urine volume (24hrs) 1900
Urine Lead 24hrs 2.01

Feedback

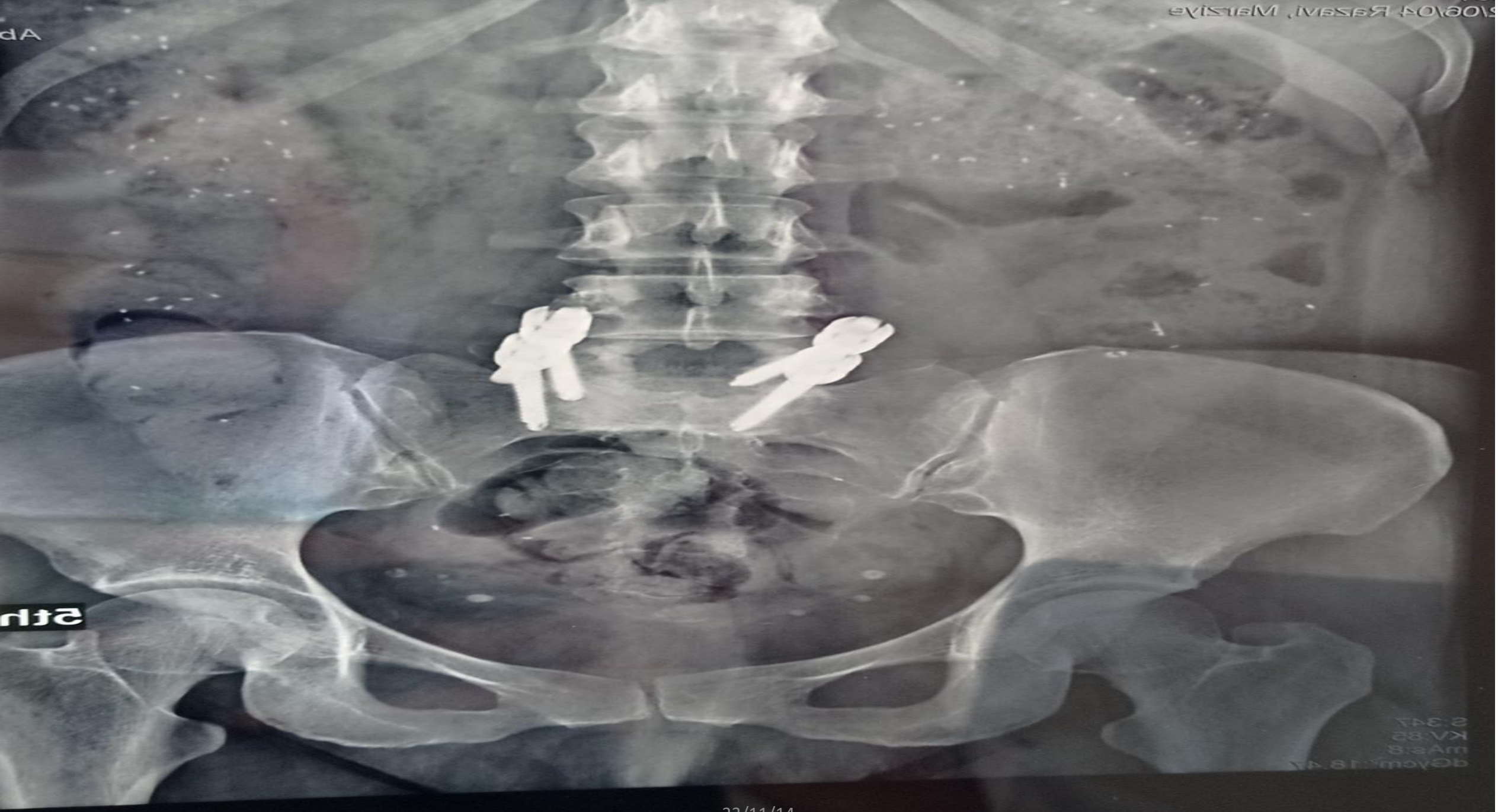
Dear colleague:

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:

- Currently, according to chronic pain and imaging findings, it is recommended for further investigation:
- Currently, IBD is not an issue for the patient.
- Rheumatology consultation to investigate FMF and even empirical treatment, although the patient's age and two-week periods of pain are detrimental to this diagnosis.
- To rule out CVID, the level of immunoglobulins should be checked.
- Check eosinophil count in CBC and peripheral blood smear.
- Finally, if no diagnosis is made in the above measures, full thickness laparoscopic biopsy of the intestine is recommended.

A 43-year-old female

- Patient with a history of controlled hypothyroidism and bipolar disorder since 20 years ago is being treated with daily lamotrigine, lithium bid, fluoxetine qd and bupropion qd, and clonazepam qd.
- He mentions the disease since childhood. Sometimes he defecates every 15 days. It also has nausea and vomiting and gas passing.
- Defecation can only be done with laxatives.
- In the examination, the abdomen is soft and has no tenderness.



Slow colon transit

Colon transit time :

2 capsules ,that each contains 60 markers were eaten by the patient , markers have 3mm diameter.

Abdominal x-ray were taken at 1st, 3th and 5th days.

In 5th day of graphy , 87 markers (73%) are remained in colon.

The score of constipation is about 3 .

IMP : Slow colon transit.

Date of birth:	01-09-1980	Hospital:	Alzahra
Patient number:	-	Investigator:	-
Height:	-	Referred by:	Dr Ahmadian
Weight:	-		

Investigation memo

CC :Constipation

PROCEDURE:

The patient was placed in a left lateral position. The manometric assembly consisted of a multilumen polyvinyl tube with 8 side holes 1 cm apart . At the tip a balloon was mounted for the Rectal Anal Inhibitory Reflex test (RAIR). The catheter was connected to a pneumohydraulic capillary infusion system .The distal sensor P8 was inside the rectum, P4was at the IAS (Internal Anal Sphincter) and P was located at the EAS (External Anal Sphincter).

Anal sphincter pressures :

1- Resting sphincter pressure 21 mmHg (Normal= 59-74)
2- Pressure increase 150 mmHg (Normal =65-78) in squeezing .
3- Max squeeze pressure 171 mmHg (Normal = 124-152)
4- Cough reflex : Normal
5- Push result: Average relaxation was 43 %

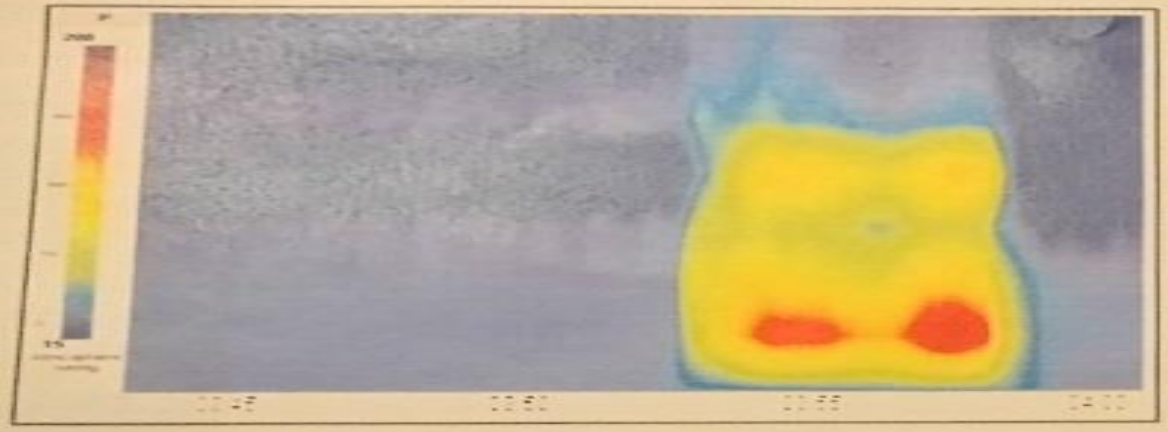
Rectoanal inhibitory reflex : Present

Rectal sensation :1-Threshold for first sensation 221 mL

BET was normal

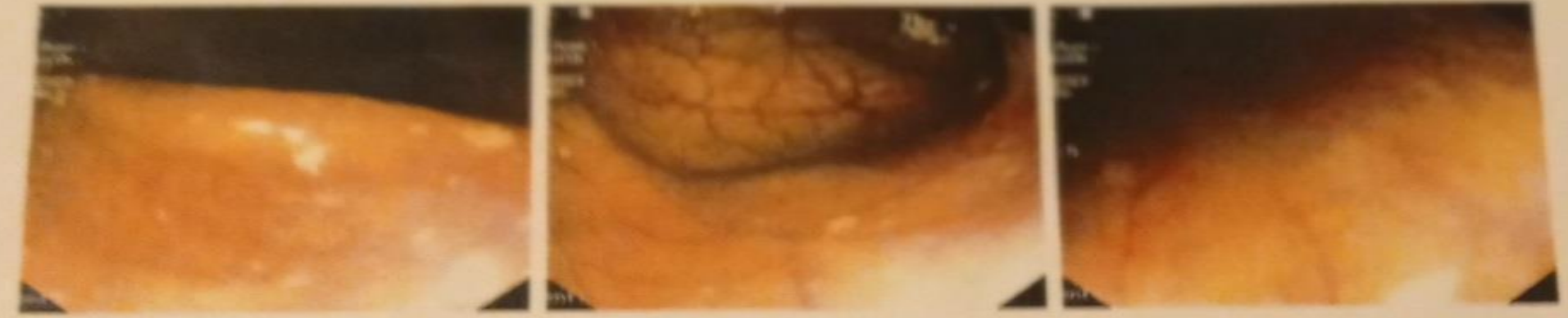
Diagnosis: Anal tone and contractility were normal.Rectoanal coordination was normal. Rectal sensation was decreased.

Squeeze #3



Scoring	
Result	Undefined
Resting box	
Resting (min)	-1.2 mmHg
Resting (mean)	0.2 mmHg
Resting (5th)	-0.9 mmHg
Resting (max)	3.7 mmHg
Anal canal	
Length	2.3 cm
Squeeze box	
Squeeze (mean)	109.3 mmHg
Squeeze (max)	171.4 mmHg
Squeeze Inc.(mean)	109.2 mmHg
Squeeze Inc.(max)	171.2 mmHg
Squeeze duration	6.5 s
Squeeze area under curve	710 mmHg.s
Fatigue slope from peak	-129 mmHg/s
Fatigue slope	2 mmHg/s

Cecum



Premedication

Midazolam = 5.0 mg, Hyoscine = 5 mg

Description of procedure

Quality of the procedure was Adequate

The video endoscope was introduced Down to the Colon with the following findings

Colon

Hemorrhids Without Active Bleeding was seen in Anus , Rectum was normal, Sigmoid was normal, Melanosis With Diffuse extent was seen in Descending Colon, Splenic Flexure, Transverse Colon, Hepatic Flexure, Ascending Colon and Cecum

- Considering refractory constipation is the patient a candidate for colectomy?

Feedback

Dear colleague:

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:

According to references and articles, constipation surgery is limited to cases with slow transit, normal anorectal manometry, normal balloon expansion test, and refractory to medical treatment, who have tried all available drugs, and abdominal pain should not be the main complaint of the patient, and CTT during treatment also confirms resistance.

Stomach scintigraphy to rule out proximal synchronous movement disorder should be down.

If new drugs such as linaclotide have not been tested, they must be tested and if there is a response and it is economically possible, to continue the long-term treatment.

In the mentioned patient, a psychiatric interview and confirmation of the reliability of the history is mandatory.

Finally, if the above procedures are done, the patient should be fully informed about the risks, benefits and consequences of the surgery.