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 23 2023

List of cases on October 23 2023

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230801	A 64-year-old man	Dr. Izadi	3
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GI commission and grand round

A 62-year-old male

- patient underwent a colonoscopy in 1400 due to a positive FIT and had multiple polyps in the colon. After colonoscopy and genetic testing, he has been referred now (1402) to evaluate the necessity of colectomy.

Family history:

- Sister: breast cancer at the age of 70 (improving after chemotherapy and surgery)
- Uncle: colon cancer at age 80 (died after 4 years)

Personal history:

diabetes, treated with melijent 5mg daily

Colonoscopy
1400/11/02

Anus normal

Rectum normal

Sigmoid *one 10mm sessile polyp*

Descending colon normal

Splenic flexure normal

Transverse colon *multiple small sessile polyps 3-5mm and one 7mm sessile polyp*

Ascending colon *multiple 12-14 small sessile polyps*

Cecum *multiple small sessile polyps*

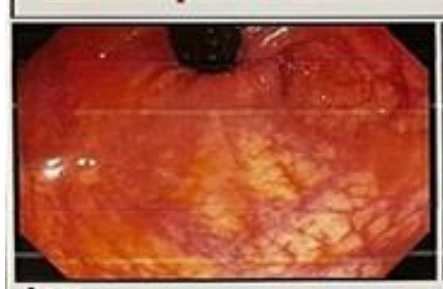
Diagnosis: right sided colonic polyposis (15-16). Large sessile polyp in the sigmoid

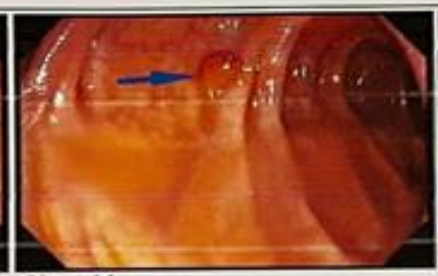
Colonoscopy Report

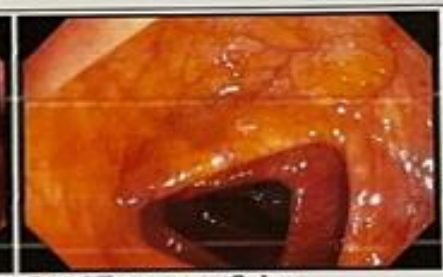
تاریخ : ۱۴۰۰/۱۱/۰۲

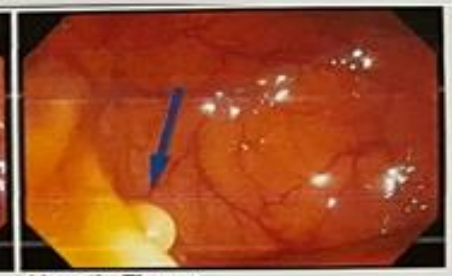
Endoscopist : Babak Tamizifar MD

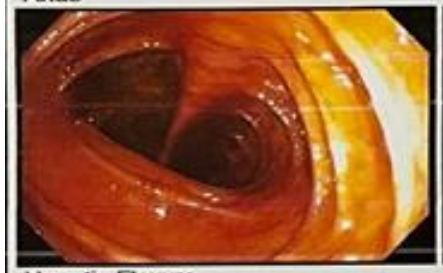
سن : ۶۰

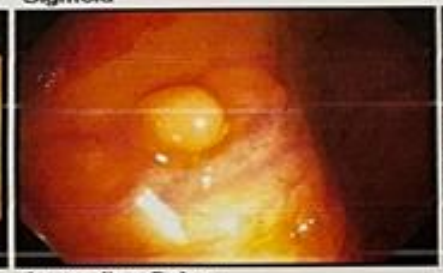

Anus

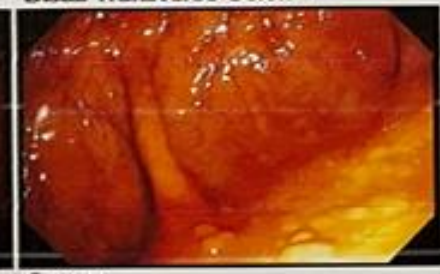

Sigmoid

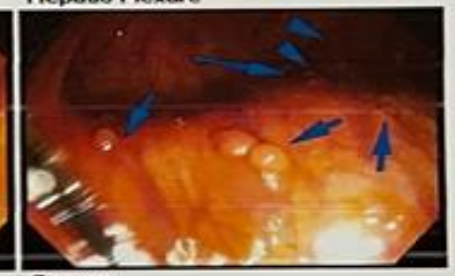

Distal Transverse Colon


Hepatic Flexure


Hepatic Flexure


Ascending Colon


Cecum


Cecum

Reason for endoscopy
Screening
Premedication
Midazolam = 5.0 mg, Pethidine = 25 mg
Description of procedure
Quality of the procedure was adequate , The video endoscope was introduced Upto the cecum of Colonsocopy . boston score 2,3,3,2
Anus
Anus was normal
Rectum
Rectum was normal
Sigmoid
one 10 mm sessile polyp was seen and resected by forcepse
Descending Colon
Descending Colon was normal
Splenic Flexure
Splenic Flexure was normal
Transverse Colon
multiple small sessile polyps ~3-5 mm and one 7 mm sessile polyp was seen , forcepse polypectomy was done
Ascending Colon
multiple ~ 12 -14 small sessile polyps were seen and the largest were resected by forcepse
Cecum
multiple small sessile polyps were seen and bx was taken from the largest

Final Diagnosis

right sided colonic polyposis (~15-16) , large sessile polyp in the sigmoid , largest were resecetd

Pathology

1400/11/02

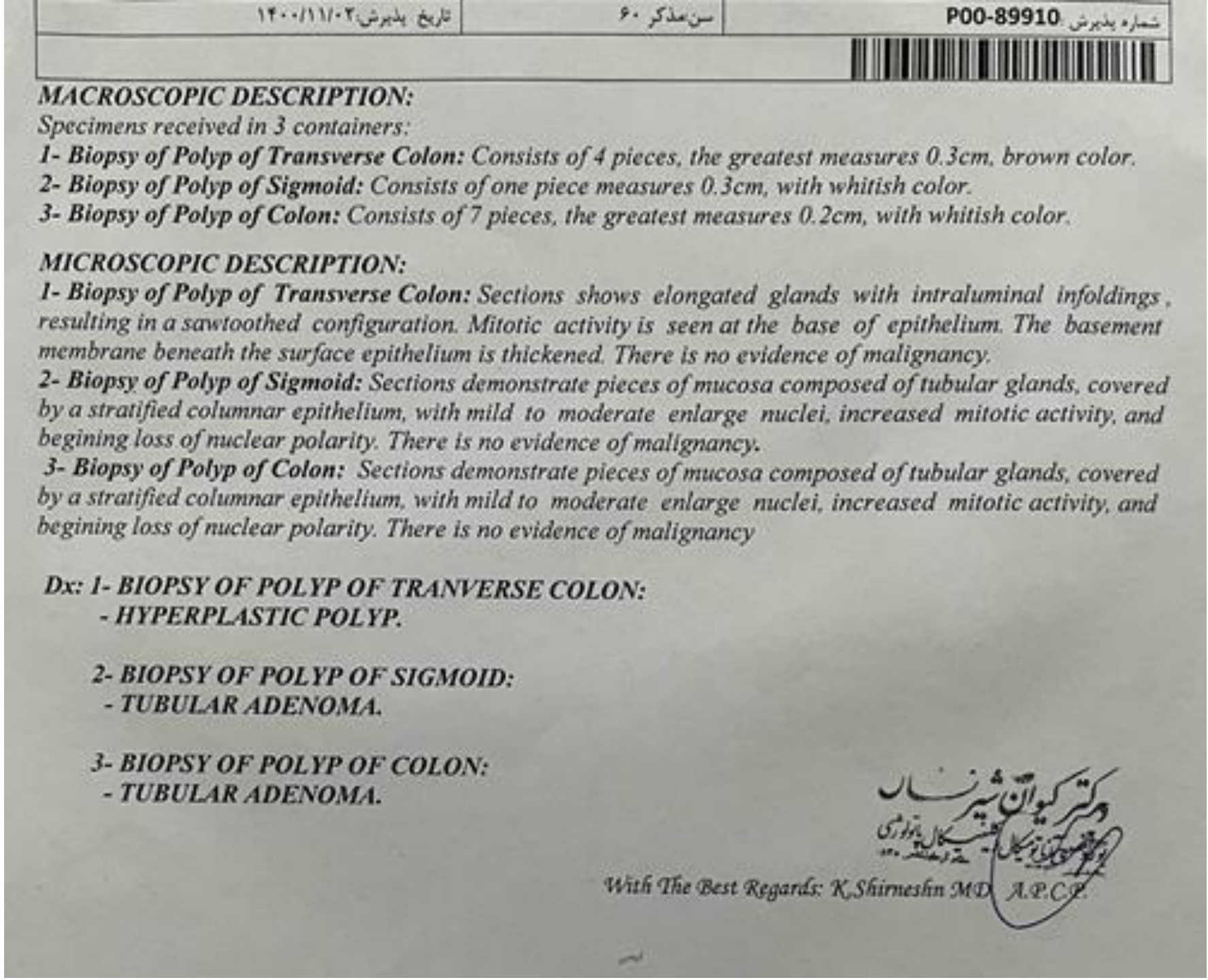
Transverse colon:
Hyperplastic polyp

Sigmoid:

tubular adenoma

Colon (other):

tubular adenoma



تاریخ پذیرش:۱۴۰۰/۱۱/۰۲ | سن مذکر ۶۰ | شماره پذیرش P00-89910

MACROSCOPIC DESCRIPTION:

Specimens received in 3 containers:

1- Biopsy of Polyp of Transverse Colon: *Consists of 4 pieces, the greatest measures 0.3cm, brown color.*

2- Biopsy of Polyp of Sigmoid: *Consists of one piece measures 0.3cm, with whitish color.*

3- Biopsy of Polyp of Colon: *Consists of 7 pieces, the greatest measures 0.2cm, with whitish color.*

MICROSCOPIC DESCRIPTION:

1- Biopsy of Polyp of Transverse Colon: *Sections shows elongated glands with intraluminal infoldings, resulting in a sawtoothed configuration. Mitotic activity is seen at the base of epithelium. The basement membrane beneath the surface epithelium is thickened. There is no evidence of malignancy.*

2- Biopsy of Polyp of Sigmoid: *Sections demonstrate pieces of mucosa composed of tubular glands, covered by a stratified columnar epithelium, with mild to moderate enlarge nuclei, increased mitotic activity, and begining loss of nuclear polarity. There is no evidence of malignancy.*

3- Biopsy of Polyp of Colon: *Sections demonstrate pieces of mucosa composed of tubular glands, covered by a stratified columnar epithelium, with mild to moderate enlarge nuclei, increased mitotic activity, and begining loss of nuclear polarity. There is no evidence of malignancy*

Dx: 1- BIOPSY OF POLYP OF TRANVERSE COLON:
- HYPERPLASTIC POLYP.

2- BIOPSY OF POLYP OF SIGMOID:
- TUBULAR ADENOMA.

3- BIOPSY OF POLYP OF COLON:
- TUBULAR ADENOMA.

دکتر کیوان شیرنشان

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

Colonoscopy

1402/02/22

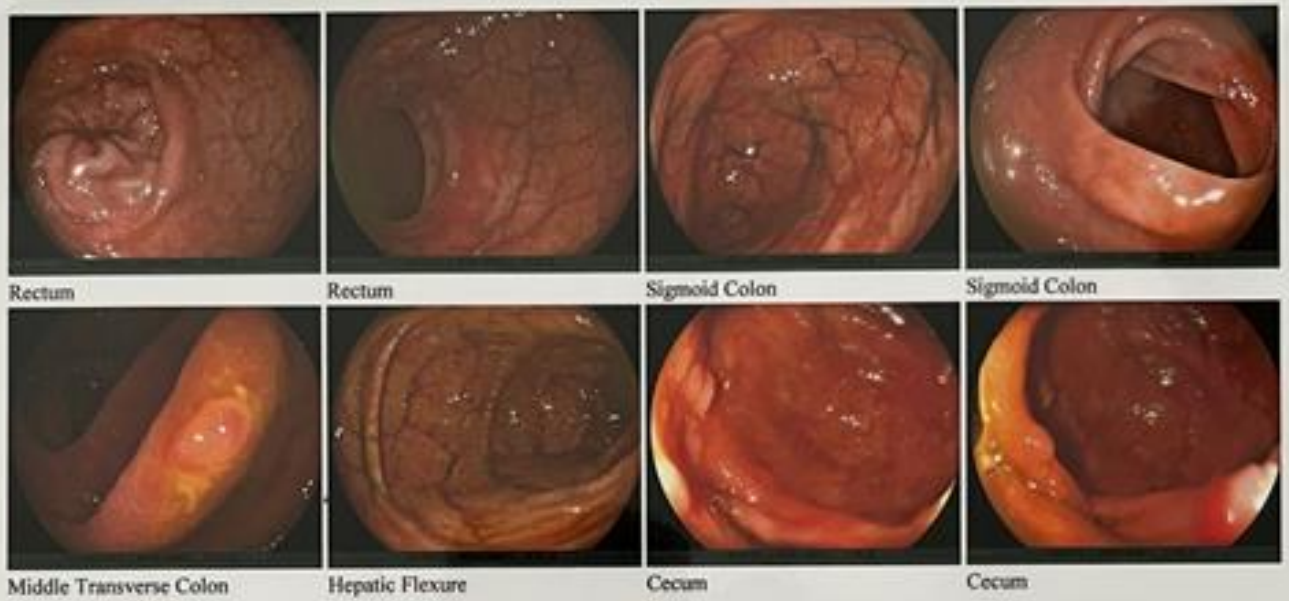
Anus normal
Rectum normal
Sigmoid normal
Descending colon normal
Transverse colon *two small (5&8mm) sessile polyps in proximal part*
Hepatic flexure normal
Ascending colon normal
Cecum *multiple about 20-30 small sessile polyps size between 5-8mm*

Diagnosis *multiple cecal polyps , R/O polyposis syndrome*

جنسیت : مرد
کد ملی:1288718195

سن : 62

تاریخ : 1402/02/23
شماره پرونده:103682



Reason for colonoscopy: **Abdominal distress/pain; hx of cecal polyp**
Premedication: **Midazolam = 2.5 mg; propofol = 2.5 cc**
Description of procedure: **Examination completed up to the Cecum , Boston prep score=3,2,2**
Anus: **Normal.**
Rectum: **Normal.**
Sigmoid: **Normal.**
Descending Colon: **Normal.**
Transverse Colon: **two small 5,8, mm sessile polyps were seen in proximal part and resected by frocepse**
Hepatic Flexure: **Normal.**
Ascending Colon: **Normal. poor bowel prep**
Cecum: **multiple about 20-30 small sessile polyps size between 5-8 mm were seen in cecum, forcepse polypectomy was done**

Final Diagnosis:
Colon: **multiple cecal polyps with selective resection, R/O polyposis syndrome**

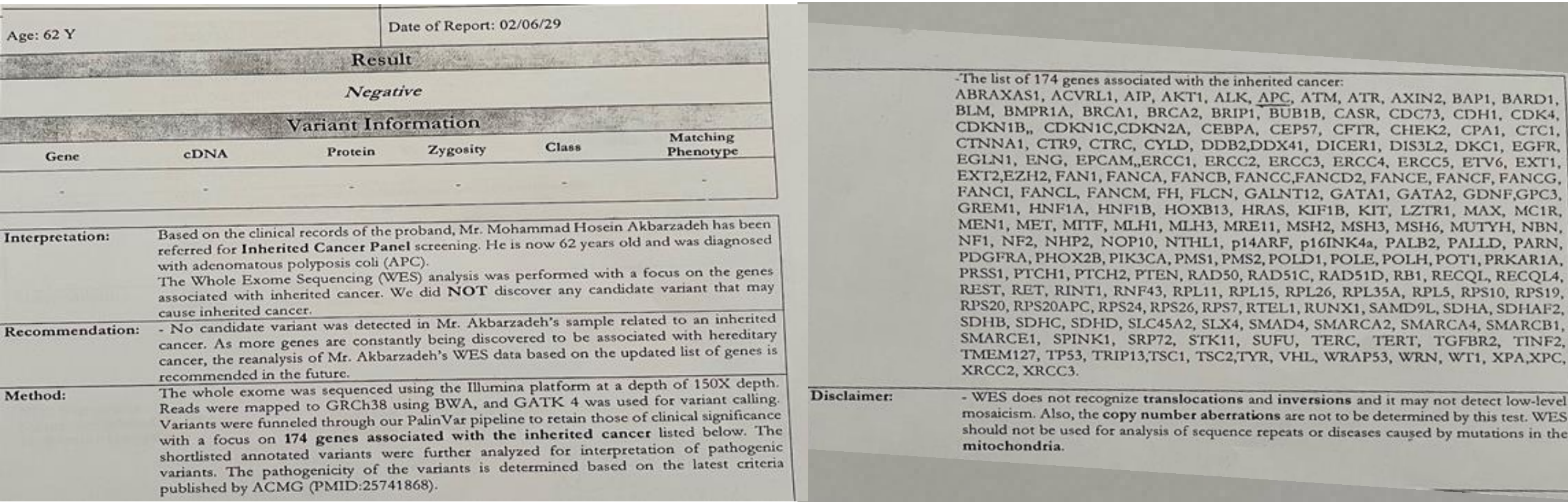
Whole Exome Sequencing

Inherited Cancer Analysis Report

1402/04/20

174 genes associated with the inherited cancer analyzed:

NO candidate variant was detected in patient's sample related to an inherited cancer



Age: 62 Y	Date of Report: 02/06/29

Result

Negative

Variant Information

Gene	cDNA	Protein	Zygosity	Class	Matching Phenotype
-	-	-	-	-	-

Interpretation:	Based on the clinical records of the proband, Mr. Mohammad Hosein Akbarzadeh has been referred for **Inherited Cancer Panel** screening. He is now 62 years old and was diagnosed with adenomatous polyposis coli (APC). The Whole Exome Sequencing (WES) analysis was performed with a focus on the genes associated with inherited cancer. We did **NOT** discover any candidate variant that may cause inherited cancer.
Recommendation:	- No candidate variant was detected in Mr. Akbarzadeh's sample related to an inherited cancer. As more genes are constantly being discovered to be associated with hereditary cancer, the reanalysis of Mr. Akbarzadeh's WES data based on the updated list of genes is recommended in the future.
Method:	The whole exome was sequenced using the Illumina platform at a depth of 150X depth. Reads were mapped to GRCh38 using BWA, and GATK 4 was used for variant calling. Variants were funneled through our PalinVar pipeline to retain those of clinical significance with a focus on **174 genes associated with the inherited cancer** listed below. The shortlisted annotated variants were further analyzed for interpretation of pathogenic variants. The pathogenicity of the variants is determined based on the latest criteria published by ACMG (PMID:25741868).

-The list of 174 genes associated with the inherited cancer:

ABRAXAS1, ACVRL1, AIP, AKT1, ALK, APC, ATM, ATR, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, BUB1B, CASR, CDC73, CDH1, CDK4, CDKN1B,, CDKN1C,CDKN2A, CEBPA, CEP57, CFTR, CHEK2, CPA1, CTC1, CTNNA1, CTR9, CTRC, CYLD, DDB2,DDX41, DICER1, DIS3L2, DKC1, EGFR, EGLN1, ENG, EPCAM,,ERCC1, ERCC2, ERCC3, ERCC4, ERCC5, ETV6, EXT1, EXT2,EZH2, FAN1, FANCA, FANCB, FANCC,FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FH, FLCN, GALNT12, GATA1, GATA2, GDNF,GPC3, GREM1, HNF1A, HNF1B, HOXB13, HRAS, KIF1B, KIT, LZTR1, MAX, MC1R, MEN1, MET, MITF, MLH1, MLH3, MRE11, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NHP2, NOP10, NTHL1, p14ARF, p16INK4a, PALB2, PALLD, PARN, PDGFRA, PHOX2B, PIK3CA, PMS1, PMS2, POLD1, POLE, POLH, POT1, PRKAR1A, PRSS1, PTCH1, PTCH2, PTEN, RAD50, RAD51C, RAD51D, RB1, RECQL, RECQL4, REST, RET, RINT1, RNF43, RPL11, RPL15, RPL26, RPL35A, RPL5, RPS10, RPS19, RPS20, RPS20APC, RPS24, RPS26, RPS7, RTEL1, RUNX1, SAMD9L, SDHA, SDHAF2, SDHB, SDHC, SDHD, SLC45A2, SLX4, SMAD4, SMARCA2, SMARCA4, SMARCB1, SMARCE1, SPINK1, SRP72, STK11, SUFU, TERC, TERT, TGFBR2, TINF2, TMEM127, TP53, TRIP13,TSC1, TSC2,TYR, VHL, WRAP53, WRN, WT1, XPA,XPC, XRCC2, XRCC3.

Disclaimer:	- WES does not recognize **translocations** and **inversions** and it may not detect low-level mosaicism. Also, the **copy number aberrations** are not to be determined by this test. WES should not be used for analysis of sequence repeats or diseases caused by mutations in the **mitochondria**.

Lab Data

1402.05.18

WBC 6.21	AST 23
HB 15.9	ALT 20
MCV 79.6	FBS 114
PLT 210	HBA1C 8.2
	CR 1.63

FEEDBACK

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 numerous polyps of different sizes, mainly on the right side of the colon, which could not be resected by polypectomy, the family history of possibly related malignancies, and considering the pathology reports that described the polyps as adenoma and sometimes hyperplastic, it was recommended that:

1. Upper gastrointestinal endoscopy and examination for stomach and duodenum polyps.

2. Colonoscopy of family and first degree relatives from the age of 40 and every five years.

3. The patient should be informed about the benefits, risks, and short-term/long-term complications of colectomy and changes in defecation and lifestyle, but ultimately, colectomy and ileorectal anastomosis are recommended. After colectomy surveillance should continue with rectoscopy.

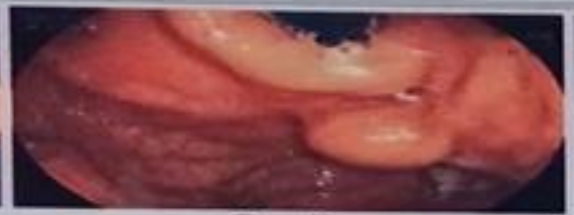
A 61-year-old lady

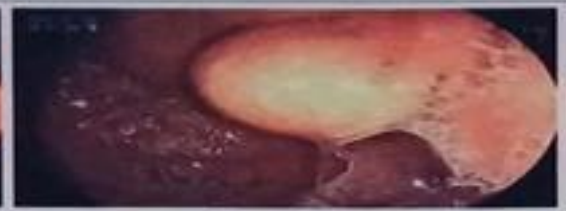
- Last year, the patient was diagnosed with subepithelial lesion, suspected to GIST was investigated and follow-up was recommended. It has been introduced to the commission again under endoscopic measures and for therapeutic measures.

UGI Endoscopy Report

نام بیمار:	سن: ۶۰	شماره پرونده:	تاریخ: ۱۴۰۱/۰۵/۰۸

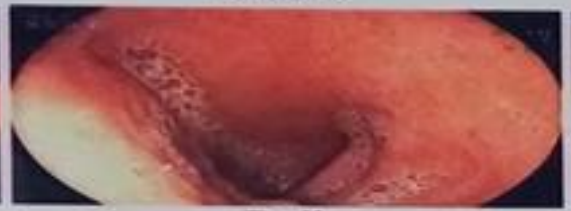

LES

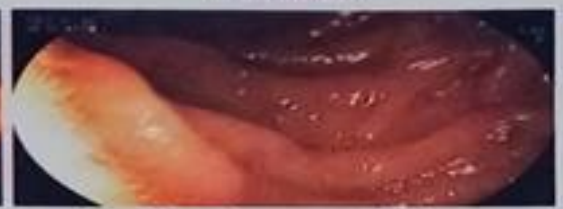

Cardia


Fundus


Body


Antrum


Bulb


Duodenum,2nd

Reason for Endoscopy : GERD

Premedication : Midazolam

Findings :

Esophagus : Were seen Small Size Sliding Hiatal Hernia and mucosal breaks < 5mm .

Stomach : Cardia : Normal
Fundus : Was seen a single SEL (22MM) with intact Mucosa .
Body : Normal
Antrum : Erythematous and Erosion , Biopsy was taken sent to pathology.

Duodenum : Normal

Diagnosis : SSH - Esophagitis - Gastric SEL - Gastropathy Erosive

Recommendation : Follow up the pathology - EUS

Pathology 1401.05.08

Microscopic

Some portions of gastric mucosa are seen with moderate infiltration of lymphoplasma cells in the lamina propria associated with regenerative changes like basally or centrally located nuclei that are enlarged, rounded and vesicular.

Giemsa staining

Few colony of H.Pylori on the surface of epithelium

There is not any metaplastic or dysplastic in this specimen

Dx : moderate chronic gastritis with regenerative changes + H.Pylori infection (grade:1/3)

Sina Clinical & Surgical Pathology Laboratory
دکتر دیبایی نیا
دارای بورد تخصصی کلینیکال و آناتومیکال پاتولوژی
آزمایشگاه سینا

تاریخ پذیرش : ۱۴۰۱/۰۵/۰۸ سن : ۶۰ سال تاریخ جوابدهی : ۱۴۰۱/۰۵/۲۰ شماره پذیرش
پزشک معالج : شماره پاتولوژی : S-1401-7793 نام مراجعه کننده :

Gross:

Received specimen are four tiny pieces of cream tissue with elastic consistency measuring totally 10mm*4mm*2mm.

Microscopic:

Some portions of gastric mucosa are seen with moderate infiltration of lymphoplasma cells in the lamina propria associated with regenerative changes like basally or centrally located nuclei that are enlarged, rounded & vesicular. In giemsa staining there is few colony of H.pylori on the surface of epithelium. there is not any metaplastic or dysplastic change in this specimen.

Dx:- Gastric biopsy(antrum):

- Moderate chronic gastritis with regenerative changes & H.pylori infection (grade=I/III).

EUS 1401.05.10

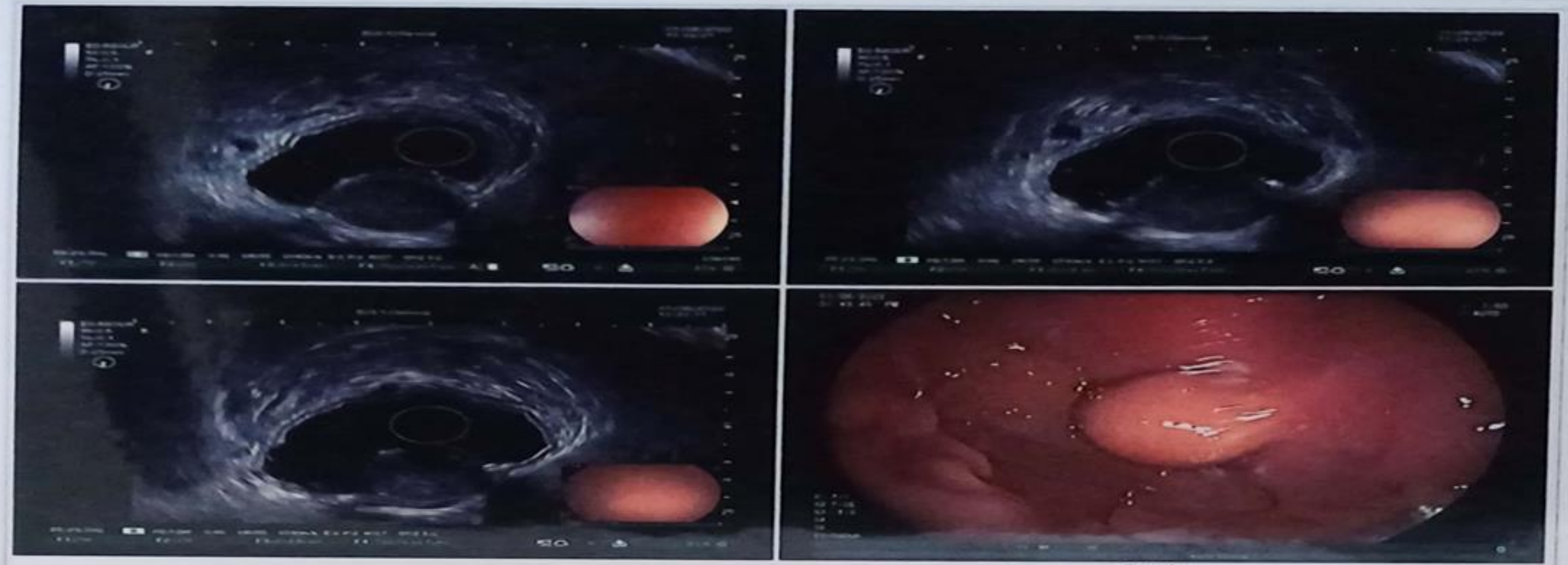
Stomach fundus there is subepithelial lesion, 16*15.5mm, hypoechoic and originated from fourth layer, no hyperechoic strand or cystic part, no regional lymph node

Pancreas NL

Gallbladder NL

Diagnosis: mostly GIST

نام بیمار | سن: ۶۰ | شماره پرونده | تاریخ: ۱۴۰۱/۰۵/۱۰



Fundus

Reason for EUS : Gastric subepithelial lesion
Referring MD : Dear Dr Saadatmand (with best regards).

Stomach : There is a subepithelial lesion in fundus. In EUS it was measured 16x15.5mm in size. It's hypoechoic and originated from the fourth layer (muscularis properia). No hyperechoic strand or cystic part was seen inside. No regional lymph node was seen.

Pancreas : Normal

Gallbladder : Normal

Diagnosis : - Fundal hypoechoic lesion from the fourth layer (mostly GIST).

Abdominopelvic Sonography 1401.08.29

سونوگرافي شكم ولگن:

كبد شكل و اندازه و اكوی پارانشيمال طبيعي دارد وفاقد توده فضاگير مي باشد. اتساع مجاري صفراوي داخل و خارج كبدي ديده نشد.

ورید پورت قطر طبیعی دارد.

كيسه صفرا طبيعي و حاوی اسلاژ میباشد.

كليه ها شكل ، ابعاد واكوي طبيعي دارندو فاقد سنگ و توده يا هيدرو نفروز مي باشند.

طول کلیه راست 108mmو دارای ضخامت پارانشیم 16mmمی باشد.

طول کلیه چپ 110mm و دارای ضخامت پارانشیم 16mm می باشد.

پانكراس (head& body)وطحال شكل و اكو و ابعاد طبيعي دارند وفاقد توده فضاگير مي باشند.

Span طحال 110mm است.

آئورت و ناحیه پاراآئورتیك دارای نمای سونوگرافیک نرمال می باشند.

مثانه پر و دارای ضخامت جداری طبیعی است. توده و سنگ دیده نشد.

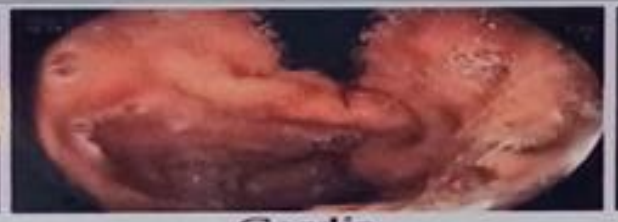
رحم و تخمدان ها در محل اناتومی خود رویت نشد(هیسترکتومی -اووفرکتومی قبلی)

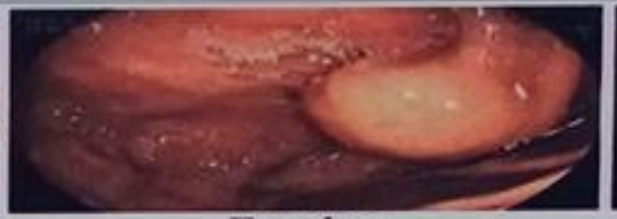
مايع آزاد در شكم ولگن ديده نشد.

UGI Endoscopy Report

نام بیمار	سن: ۶۰	شماره پرونده:	تاریخ: ۱۴۰۱/۱۲/۰۸


LES

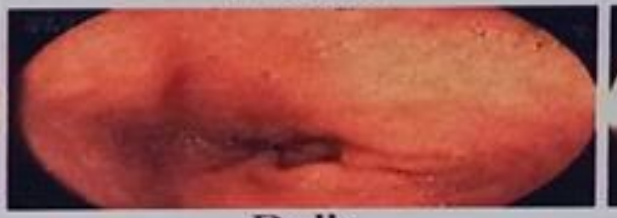

Cardia

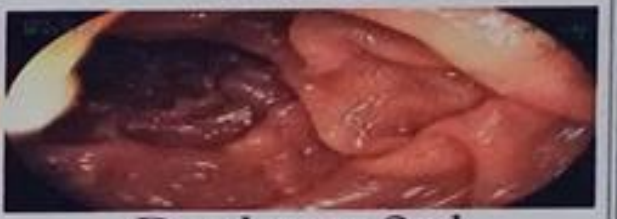

Fundus


Fundus


Body


Antrum


Bulb


Duodenum,2nd

Reason for Endoscopy : Follow up of SEL

Premedication : Midazolam

Findings :

Esophagus : Normal

Stomach : Cardia was Normal.
A Single Subepithelial lesion (18mm) was seen in Fundus.
Body was normal.
Multiple raised erosions and Erythema were seen in Antrum , Biopsy was taken sent to pathology.

Duodenum : Normal

Diagnosis : SEL - Gastropathy Erosive

Recommendation : Follow up EGD - EUS

Pathology 1401.12.08

Microscopic

Some portions of gastric mucosa are seen with mild infiltration of lymphoplasma cells in the superficial part of lamina propria associated with edema

Giemsa staining

Few colony of H.Pylori on the surface of epithelium

There is not any metaplastic or dysplastic in this specimen

Dx : superficial chronic gastritis + H.Pylori infection (grade:1/3)

Gross:

Received specimen are two tiny pieces of cream tissue with elastic consistency measuring totally 6mm*2mm*2mm.

Microscopic:

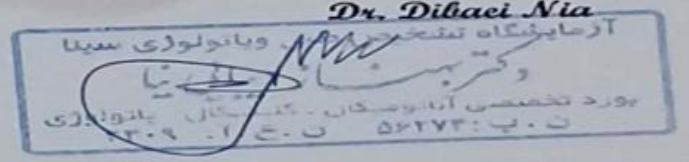
Some portions of gastric mucosa are seen with mild infiltration of lymphoplasma cells in the superficial part of lamina propria associated with edema. In giemsa staining there is few colony of H.pylori on the surface of epithelium. there is not any metaplastic or dysplastic change in this specimen.

Dx:- Gastric biopsy(antrum):

- Superficial chronic gastritis with H.pylori infection (grade=I/III).

With Best Regards

Dr. Dibaei Nia



Lab Data 1402.04.26

WBC 4800	FBS 111	AST 22	Urine :
Neu 33%	BUN 17.8	ALT 23	Analysis NL
Lym 52%	CR 0.9	ALP 198	
RBC 4.4	TG 96		
HB 12.9	Chol 227		
HCT 39	HDL 48		
MCV 88	LDL 150		
MCH 29	Ferritin 40		
MCHC 32	VitD3 52		
RDW 13	TSH 3.5		
PLT 150000			

EUS 1402.07.08

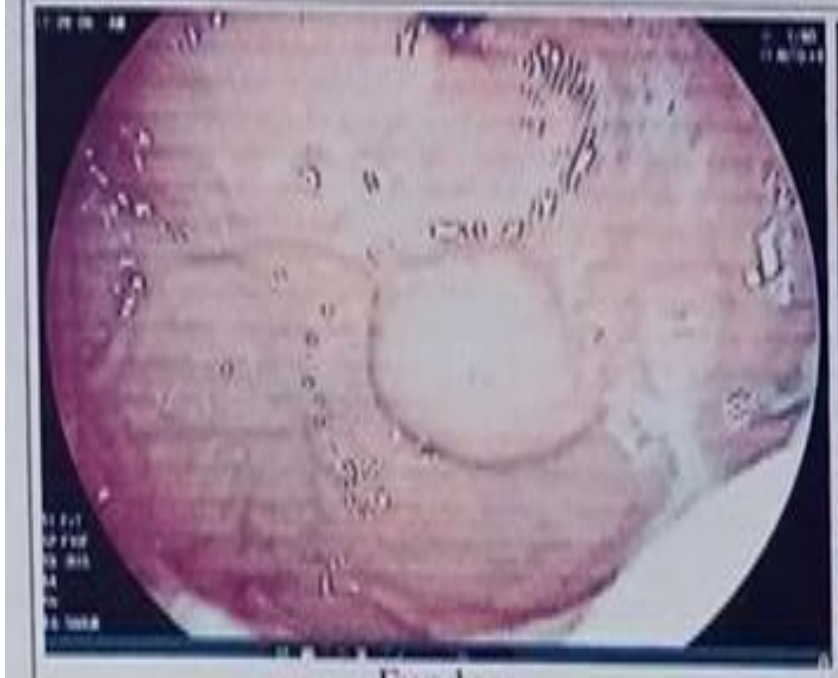
There is *subepithelial lesion in fundus* :

hypoechoic and originated from fourth layer(muscularis propria)

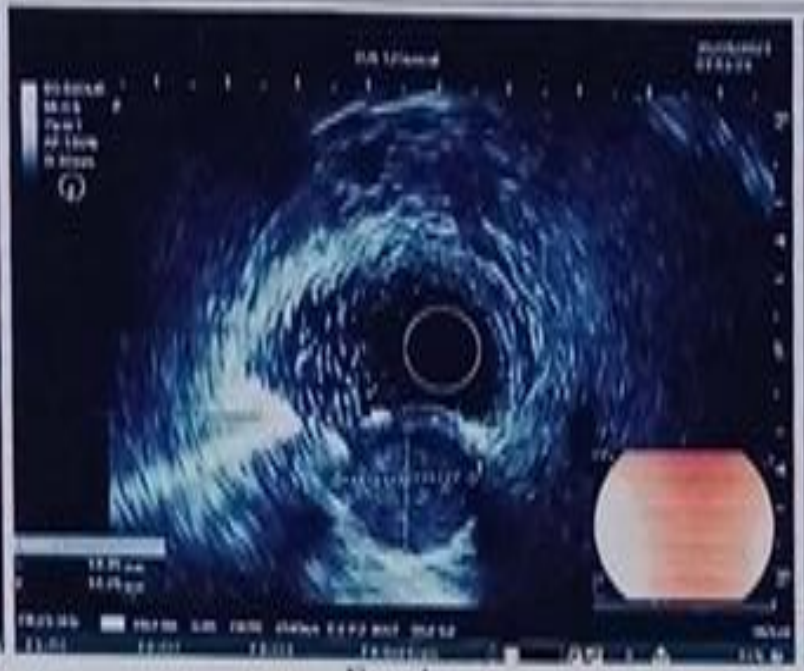
19.6x17 mm

No cystic area

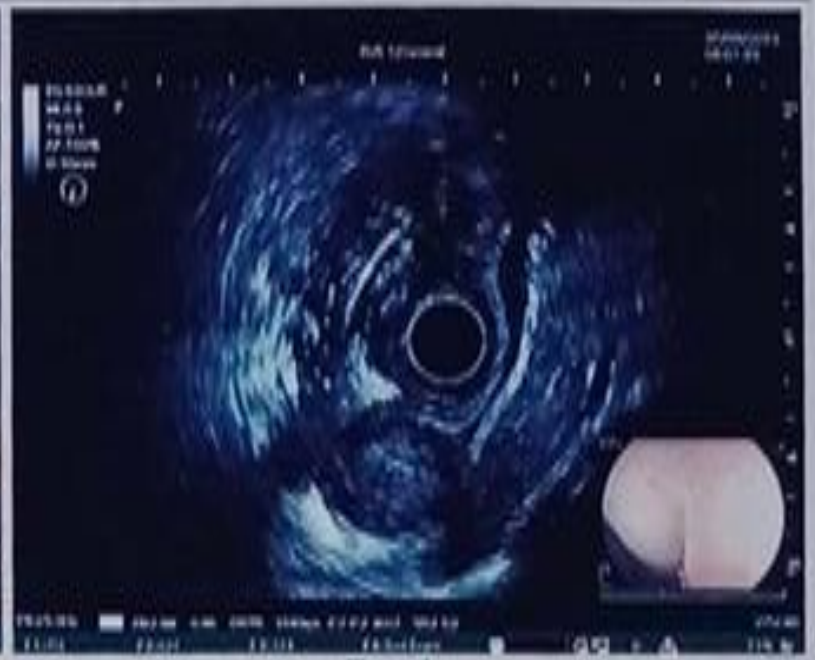
No regional lymph node



Fundus



Fundus



Fundus

Reason for EUS : Fundal subepithelial lesion , Referring MD : Dr Saadatmand (with best regards)

Stomach : There is a subepithelal lesion in fundus. In EUS this lesion is hypoechoic and originated from the fourth layer(muscularis propria).It was measured 19.6x17mm. No cystic area was seen inside. No regional lymph node was seen. , Indian INK injection was done in base of lesion

Lab Data 1402.08.29

WBC 5100	FBS 95	AST 26
Neu 42%	BUN 25	ALT 22
Lym 49%	Cr 0.8	ALP 172
RBC 4.5	TG 136	
HB 13.6	Chol 210	
MCV 89	HDL 59	
MCH 29	LDL 122	
MCHC 33	TSH 1.7	
HCT 40	Ferritin 70	
PLT 175		

Feedback

Dear colleague:

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:

According to the figure, contour and origin of the lesion, the most likely diagnosis for the lesion is GIST. Despite the small growth of the lesion in the recent EUS, due to the asymptomatic nature of the lesion and the absence of high-risk features, it is recommended to continue the annual follow-up of the lesion with EUS. There is no need for medical and surgical treatment now.

In case of growth of the lesion or changes in the features of the lesion, surgery will be required. In addition, despite the typicality of the lesion in endosonography, there is no need for sampling the lesion.

A 19-year-old girl

- A patient with a history of occasional epigastric pains, which worsened with stress, underwent endoscopy 6 years ago and had no special finding.
- A month ago, he had hypogastric pain, which was crampy. No nausea, vomiting or heartburn or other symptoms.
- A urine test and abdominal ultrasound are requested. After urine test, urinary infection was diagnosed and treated with antibiotics, and the patient's pain improved.

سن: ۱۹ سال

نام و نام خانوادگی:

همکار محتـــــره

در سونوگرافی انجام شده از شکم و لگن :

کبد ابعاد و اکوی پارانشیم طبیعی دارد و فاقد ضایعه ی فضاگیر می باشد .
قطر ورید پورت و CBD نرمال است.
کیسه صفرا دارای حجم و ضخامت جدار طبیعی و فاقد سنگ صفراوی و sludge می باشد.
تصویر یک توده ی هتروژن هایپراکو با حدود مشخص به ابعاد 65*62mm در سر و گردن پانکراس دیده شد. جهت بررسی بیشتر CT-Scan با تزریق کنتراست توصیه می شود.
آئورت و پاراآئورت در حد قابل بررسی با سونوگرافی دارای نمای نرمال می باشند.
طحال دارای ابعاد و اکوی نرمال و فاقد ضایعه ی فضاگیر می باشد. (spleen span: 104mm)
کلیه ها ابعاد و اکوی پارانشیمال طبیعی دارند.
طول کلیه راست 107mm و ضخامت پارانشیم 14mm می باشد.
طول کلیه چپ 110mm و ضخامت پارانشیم 15mm می باشد.
سنگ ، هیدرونفروز و توده فضاگیر درکلیه ها دیده نشد.
UVJ دو طرف نرمال است.
مثانه دارای حجم و ضخامت جدار نرمال و فاقد سنگ و توده می باشد.
رحم به ابعاد 77*30mm و فاقد ضایعه ی فضاگیر می باشد.
اکوی میومتر طبیعی است.
ضخامت اندومتر 10mm است.
تخمدانها ابعاد و اکوی طبیعی دارند و فاقد کیست یا توده می باشند.
ضایعه ی solid & cystic در ادنکس ها دیده نشد.
مایع آزاد مختصر در کلدوساک خلفی رویت شد.

متخصص رادیولوژی و سونوگرافی
دکتر عباسعلی سلامت

lipase	31
amylase	66
crp	-
esr	3
wbc	8200
HB	12/2
MCV	92/8
MCH	30
PLT	201000

Abdominopelvic M.D.C.T Scan with & without IV contrast:

The study is performed with & without IV and po contrast.so, as far as detected:

- Liver has normal size, shape & density without space occupying lesion or biliary dilation.
- Spleen is normal with no S.O.L.
- **There is a thin wall cystic lesion without solid or enhanceable component in head of pancreas is seen, can be suggested pseudocyst of pancreas**
- The kidneys has normal size and shape without space occupying lesion.
- Renal stone is not seen.
- No paraaortic adenopathy is present.
- Pelvic organs are normal.
- There is no abdominopelvic free fluid.

FEEDBACK

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:

- According to the history of the patient, the pains are chronic and non-specific and there is no history of trauma, so the pseudocyst lesion is considered accidental.
- In literatures and references, about 40 to 50 percent of pseudocysts are discovered incidentally and are asymptomatic. Regarding asymptomatic cysts in the head of the pancreas, references recommend **follow-up**, but due to its large size, the CT scan images of the current lesion should be reviewed by radiologist colleagues, and it is also helpful for further investigation of **endosonography and FNA**. The patient should be followed up based on the results of the above procedures.

A 50-year-old man

- About 2.5 months ago, the patient suddenly suffered from severe abdominal pain with nausea and vomiting
- Pneumoperitoneum was found, the patient underwent surgery and 50 cm of the jejunum was resected due to its necrosis.

MULTI SLICE CT SCAN OF THE ABDOMEN AND PELVIS WITHOUT CONTRAST

The study was performed in axial view obtaining sagittal and coronal reconstructed views.

- *Liver is normal in size, shape and density with no space occupying lesion or biliary dilatation.*
- ***A gallbladder stone is seen.***
- *Spleen and pancreas are also normal with no SOL.*
- *The kidneys are normal with no hydronephrosis, stone and space occupying lesion.*
- *No paraaortic or paracaval adenopathy is present.*
- *Both adrenal glands are normal.*
- ***Free air is seen in Abdominal cavity due to small bowel perforation (small bowel perforation is seen at hypogastric region.***
- *Pelvic organs are normal.*
- ***Mild free fluid is seen in abdominopelvic cavity.***
- ***Fat stranding is seen in peritoneal cavity.***

IMP:

- ***Mild free fluid is seen in abdominopelvic cavity.***
- ***Free air is seen in Abdominal cavity due to small bowel perforation (small bowel perforation is seen at hypogastric region.***
- ***Fat stranding is seen in peritoneal cavity.***

- After discharge from the hospital, the patient had non-bloody diarrhea for 2 months, but did not have abdominal pain or rectorrhagia. First (according to the pathology of the removed intestine), diagnosis of Crohn's disease is made and he is treated with mesalazine for a short time, but due to lack of response, it is discontinued and rifaximin are started for 2 weeks and the patient's diarrhea stops (he has had diarrhea for 2 months).
- During this period, he was fine until 10 days ago, when he suffered of hematochezia for 2-3 days, and after that, he had dark colored stools, but there was no melena, and the patient also has no abdominal pain or other symptoms.

شماره پاتولوژی :
PA-402-3047

کد ملی:
5419677857

Macroscopic examination of the sample:
The sample of small intestine adhesive tape includes a part of the stomach, 54 cm long, with a diameter of 2.5 cm at one end and 3 cm at the other end. At a distance of 10 cm from the larger margin of the perforation area, a notch was seen. The mucosa in this area is inflamed and ulcerative. Evidence of multiple diverticula was seen in the tissue. No evidence of tumoral lesion was seen.

Microscopic examination of the sample:
The mucous membrane was ulcerative and in the infiltrated wall, many neutrophil inflammatory cells were seen along with foamy macrophages. Sample margins are free. No evidence of malignancy was seen.

DX: Partial small intestinal resection:

- **Transmural acute inflammation and mucosal ulcer**
- **Multiple diverticula**
- **Surgical margin: Free**
- **No evidance of malignancy**

بیمارستان شهید اصفهان
M.Zarean M.D
دکتر مجتبی زارعیان
تخصص آسیب‌شناسی و آناتومیک پاتولوژی
نظام پزشکی ۹۰۶۲۰ ت ع ۳۱۵۹۰۲

	3419879857		

Macroscopic examination of the sample:

The sample labeled intraperitoneal secretions contains 15cc of red-brown liquid, from which 2 slides and 2 cell blocks were prepared.

Microscopic examination of the sample:

Abundant infiltration of neutrophilic inflammatory cells along with dietary fiber was observed.

Dx: Intraperitoneal washing cytology:

- **Acute inflammation**

Macroscopic Description:

Received specimen consists one paraffin block no 3047-6

Microscopic Description:

Small intestine tissue mucosa sub mucosa ans muscularis layer to serosa. Focal increase of chronic inflammatory cells, consist lymphoplasma cell and eosinophil was seen in lamina propria also focally in basal part of mucosa and surrounded crypt and crypt show acute inflammation (cryptitis) as well. inflammation and fibrosis extend to submucosa Granuloma was not seen.

Diagnosis:

Partial small bowel resection:

- Focal active chronic Ileitis. No granuloma

Note: Drug (NSAID) ,infection and crohn's disease are in differential diagnosis of this feature . No major histological criteria in favor of crohn's disease; however if other causes are ruled out and patient has clinical or imaging evidence in favor of crohn's disease it could be considered as possible cause.

With Best Regards Dr. Sanei .....

Abdominopelvic MRI (MR Enterography) (with & without c.m)

Distension of small bowel is satisfactory by ingested oral

Findings of recent midline laparotomy are noted.
There is an ill defined T2 hypointense mesenteric lesion measuring about 14*12mm in mid abdomen adherent to adjacent two proximal and distal ileal segments in mid lower abdomen without significant hyper enhancement associated with surrounding mesenteric fat haziness and some enlarged mesenteric lymph nodes. Low grade mural thickening is also noted in the described two ileal segments without significant hyper enhancement.
A mildly loculated interloop fluid (60*30*25mm) is evident in right side of operated bed in interloop space without significant mural enhancement or diffusion restriction.
The rest of jejunal and ileal loops are within normal limits in morphology and mural thickness with normal contrast enhancement pattern
No obvious abnormality is seen in fold pattern of small bowel loops
Ileum terminal and ileocecal valve are unremarkable in this exam
No luminal stricture or obstructive pattern is found.
There is no obvious intraluminal or intramural mass in small bowel
No ascites, collection or enteric fistula is found.
Colon is under distended in this exam without significant hyper enhancement or pericolic engorgement.

Impression:

- Suggestive signs of recent post op. changes in mid abdomen with an ill defined mesenteric T2 hypointense area (14*12mm) adherent to adjacent proximal and distal ileal segments which could be sequel of recently resolved collection/phlegmon with secondary adhesions. No definite evidence of active inflammatory process is seen in small bowel loops in this exam however an inactive (quiescent) CD could not be completely ruled out in this exam. Correlation with clinical findings and F/U MRE are advised.
- An interloop loculated fluid collection (60*30*25mm) without significant inflammatory changes which also needs clinical correlation. Percutaneous aspiration can be kept in mind.

ریپورٹ بغیر مہر و دستخط کالعدم ہے

Sincerely,
Radmard M.D.

MULTI SLICE CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST

The study was performed administering oral and intravenous contrast. Coronal and sagittal reconstructed views were also obtained.

- *Liver is normal in size, shape and density with no space occupying lesion or biliary dilatation.*
- ***Gallbladder contained biliary stone.***
- *Spleen and pancreas are also normal with no SOL.*
- *The kidneys are opacified with no hydronephrosis and space occupying lesion.*
- *No paraaortic or paracaval adenopathy is present.*
- *Both adrenal glands are normal.*
- *Bowel loops are normal.*
- *Pelvic organs are normal.*
- ***Intra-abdominal catheter is seen.***
- ***Mild free fluid is seen in abdominopelvic cavity.***
- ***Fat stranding is seen in peritoneal cavity.***

IMP:

- ***Post-op changes***

Best Regards

F. RABANI

MULTI SLICE CT ANGIOGRAPHY OF THE ABDOMEN

The study was performed administering oral and intravenous contrast. Coronal and sagittal reconstructed views were also obtained.

- *Abdominal aorta and branches: celiac, SMA, renal arteries and IMA are normal without significant stenosis.*
- *Both common iliac arteries and internal branches are normal*
- ***A gallbladder stone is seen.***
- ***Mild free fluid is seen in abdominopelvic cavity.***
- ***Fat stranding is noted in peritoneal cavity.***
- ***Mesenteric lymph nodes up to measuring 10mm is also seen.***
-

IMP:

- ***No evidence of thrombosis***

همکارگرامی دکتر : فتاحی - سیده فرنیار

در سونوگرافی انجام شده از شکم و لگن :

کبد دارای ابعاد نرمال است و اکوی پارانشیم آن افزایش یافته است که معادل Fatty Liver Grade I می باشد.

ضایعه فضاگیر در نسج کبد رویت نگردید.

کیسه صفرا دارای ضخامت جداری نرمال می باشد.

تصویر سنگ به دیامتر 9mm درون کیسه صفرا رویت شد.

مجاری صفراوی داخل و خارج کبدی دیامتر نرمال دارد.

کلیه ها ابعاد و اکوی نرمال دارند و فاقد سنگ و هیدرونفروز می باشند.

طحال دارای ابعاد و اکوی نرمال می باشد.

سر و تنه پانکراس اکوی نرمال دارد.

مثانه ضخامت جداری نرمال دارد.

مایع آزاد بسیار مختصر در شکم رویت شد.

تصویری به نفع کالکشن در شکم و لگن رویت نگردید.

Dear Dr. Irannejad

MDCT Scan of the abdomen and pelvis with and without ntrast:

- *Liver has normal size and parenchymal density. Subcapsular hypodense lesions measuring 25 mm, 10mm and 12mm are seen in RIGHT liver lobe.*
- *Gallbladder contains stone measuring 10.7mm.*
- *Intrahepatic bile ducts as far as seen are normal.*
- *Spleen and pancreas are normal in size and shape without any evidence of space occupying lesion.*
- *Adrenal glands are normal.*
- *Both kidneys show normal size, shape and cortical thickness without hydronephrosis, stone or space occupying lesion.*
- *Bladder is normal.*
- *Prostate is larger than normal.*
- *Rectum and para-rectal fat pads are normal.*
- *No ascites is noted.*
- *Mild bilateral pleural effusion is seen.*
- *Post-operative changes are evident with mesenteric fat stranding/edema.*

IMP:

- ***Liver hypodense lesions***
- ***Gallstone***
- ***Prostatic enlargement***
- ***Mild bilateral pleural effusion***
- ***Post-operative changes***

Findings :

Esophagus : Upper Third and Middle Third and Lower Third and Z-line were normal.

Stomach : Cardia and Fundus and Body and Incisura/Angulus and Antrum were normal.

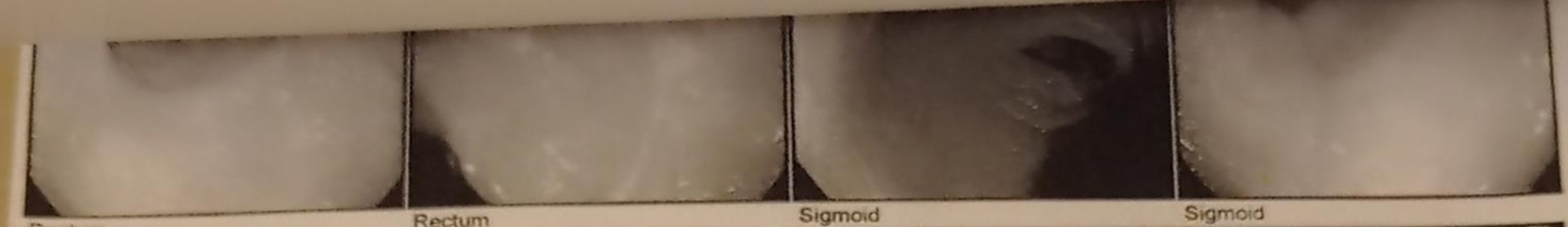
Duodenum : Duodenal Bulb and D2 were normal.

دکتر مجید مهسا

Diagnosis :

SMALL BOWEL RESECTION FOR SECOND OPINION :

- Perforated supparative transmural inflammation due to impacted fecalith in diverticulum.
- Negative for crohn's or vasculitis .
- Negative for thromboembolic event .



Reason for colonoscopy : Screening colonoscopy

Description of procedure : The video endoscope was introduced Upto the terminal ileum of Colonsocopy and Colonsocopy with the following findings

Colon : Anus, rectum, sigmoid, descending colon, splenic flexure, transverse colon, hepatic flexure, ascending colon, cecum and ileum were normal

Final Diagnosis

Normal Colon

Erfan Niayesh Hospital

Endoscopy Ward

بیمارستان عرفان نیایش

Erfane Niavesh Hospital

Colonoscopy Report

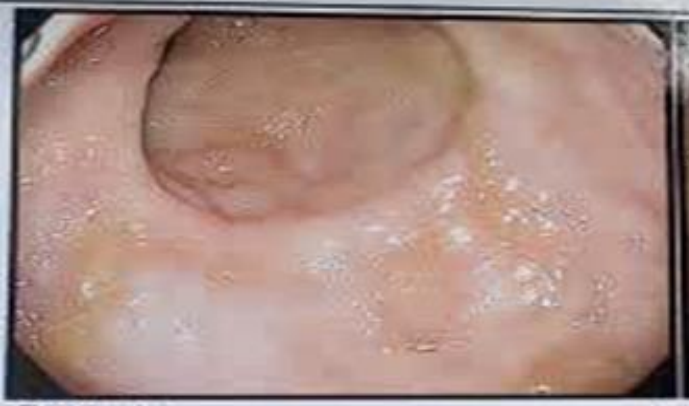
Endoscopist :

نام بیمار :

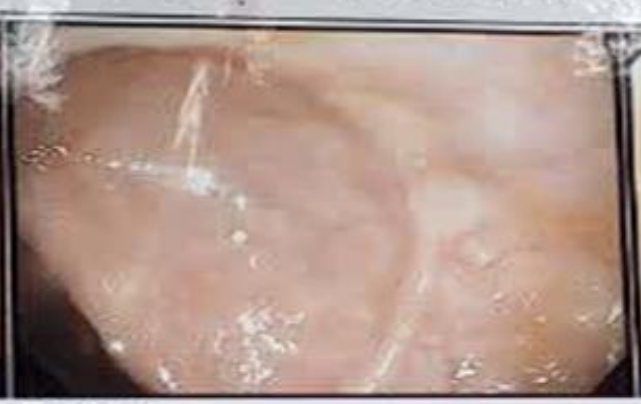
تاریخ : ۱۴۰۲/۰۵/۱۸

جنسیت : مرد

سن : ۴۹

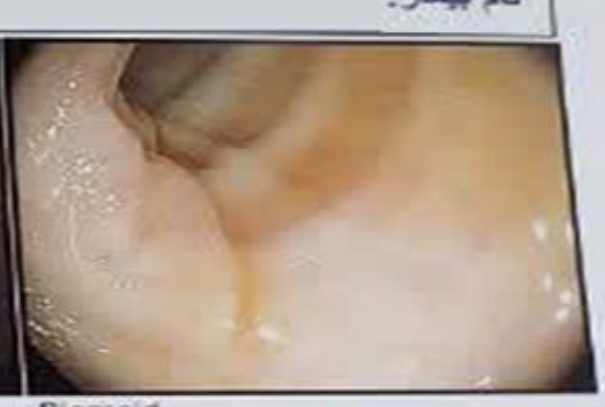


Rectum

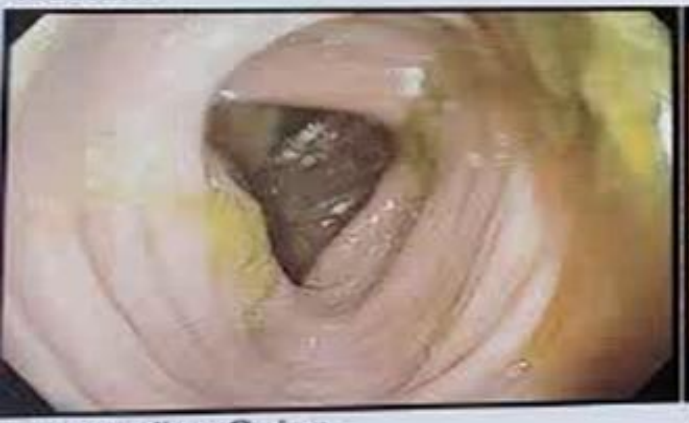


Rectum

Sigmoid

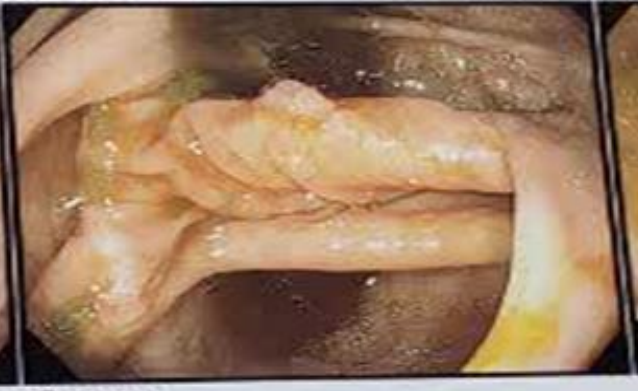


Sigmoid

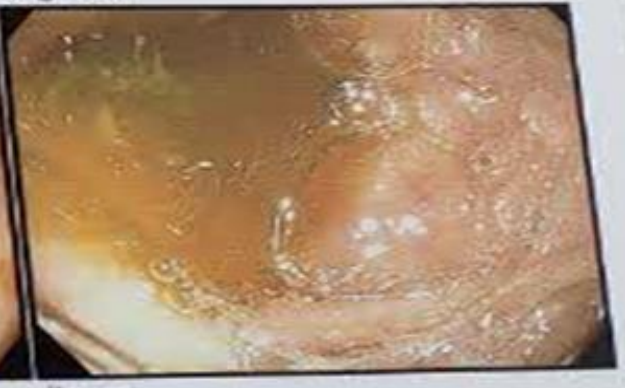


Descending Colon

Ascending Colon



Cecum



Ileum

Reason for colonoscopy : Screening colonoscopy

Description of procedure : The video endoscope was introduced Upto the terminal ileum of Colonsocopy and Colonsocopy with the following findings

Colon : Anus, rectum, sigmoid, descending colon, splenic flexure, transverse colon, hepatic flexure, ascending colon, cecum and ileum were normal

Final Diagnosis

August 2023			
WBC	9500	Calprotectin	325
PMN	71	Hbs Ag	-
Lymp	20	HCV ab	-
RBC	5.39*	CRP	12.7
HB	11.8	PPD	-
MCV	66	s/c	-
HCT	36	S/E	WBC: 2-3, RBC: 1-2
MCHC	32	FERRITIN	94
PLT	385	CR	0/8
Fe	100	LDH	237
TIBC	261		
AST	14		
ALT	15		
ALK	101		

October 2023	
CRP	3/8
FIT	**+**
CALPROTECTIN	-

FEEDBACK

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:

According to the history, the patient was asymptomatic before the surgery, IBD has not been confirmed in the recent pathology, the clinical course of the manifestations and laboratory findings is nit typical for small bowel Crohn's disease, so Crohn’s is not the possible diagnosis and therefore there is no need for treatment in this regard.

According to the type of recent rectal bleeding, normal colonoscopy and the course of the disease, probably the source of recent bleeding is distal rectal and anus, and it is not directly related to the surgery, so a detailed examination of the rectum and anus is recommended.

Considering the report of jejunum diverticulum in pathology, investigation for scleroderma and other causes of small bowel diverticulosis is recommended.

In order to approach the liver lesion, triphasic CT and appropriate follow-up were recommended.