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 07 2023

List of cases-November 07 2023

	Patient	Fellow	page
230803	56-year-old man	Dr. Izadi	3
		"	
240802	A 43-year-old lady	Dr. Namaki	21
		"	
250802	A 48-year-old female	Dr. Jalili	33
		"	

GI commission and grand round

56-year-old man

- has been examined by several gastroenterologists since about 16 years ago due to Unexplained iron deficiency anemia.
- The patient mentions weakness, loss of energy and fatigue, but it did not lead to activity intolerance.
- No abdominal pain. She has not anorexia, nausea and vomiting. She doesn't have diarrhea, but he has been temporarily constipated.
- Passing fresh red blood during defecation is transient, especially after constipation.
- There was no discharge of mucus and purulent secretions during defecation.
- She does not mention unwanted weight loss.
- During last years, she has undergone multiple endoscopy and colonoscopies, and last year (1401), according to the pathology results of the colonoscopy sample, he was treated with the diagnosis of Crohn's disease of small intestine.

- PMH: kidney stones, reflux, Crohn's?!
- DH: Ezonium 40 mg Qd, allopurinol, Urocitra (every 12 hours)
- Ferinject (prescribed by hematologist)(7/1401)
- Iron pills intermittently during years
- History of H.Pylori treatment in many years
- CinnoRA every 15 days since last year
- Methotrexate injection weekly since last year, which was stopped after a short period of time due to side effects (abdominal pains, nausea and vomiting).
- Azram 50 mg every 12 hours since 4 months ago (due to high calprotectin)

- FH: No family history of IBD
- SH: She is teacher and does not smoke or drink.

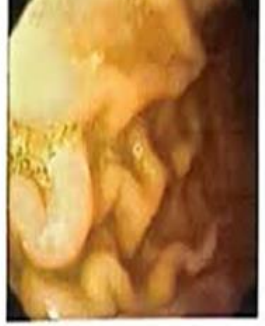
Considering the available finding, do you agree with the diagnosis of Crohn's disease and CinnoRA?

Lab data	Hgb	MCV	RDW	Fe	TIBC	Trans. sat	Ferritin	Calprotec.	OB
۹۱/۳/۲۷	12.2	76.5	13.2	40	345	12	5.57	-	-
۰۱/۱/۲۲	14/1	83.9	12.8	-			11		
۰۱/۵/۲۱	12	80.4	11.9				8		
۰۱/۶/۱	11/1	77.5	12.7	24	339	7.08	8.2		
۰۱/۷/۱۰	12.1	74.8	12.7					12.37	
۰۲/۲/۱۲	14.4	88.3	--						
۰۲/۳/۲۰	13.5	84.8	11.9	102	284	36	38		
۰۲/۴/۱۷	12.9	89.3	12.1					178	
۰۲/۷/۱۱	13.9	86	12.9						-

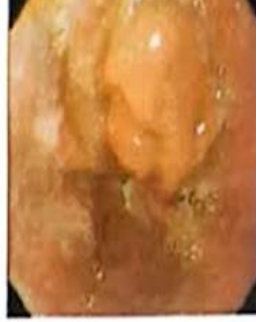
Data	Endoscopy results	Colonoscopy results	BX results
1386/10/3	Gastroduodenitis	Int hemorrhoids grade 1	Duodenum: Normal
1391/4/5	**Multiple longitudinal erythematous areas at fundus & body**	Int hemorrhoid grade 2	From D & G: **G: atrophic chronic active gastritis, HP +** D: normal
1396/8/14	Gastropathy with some erosion at the antrum		Mild chronic erosive gastritis at antrum Sever chronic gastritis at body Sever active chronic gastritis at fundus No atrophy in all of them. No HP infection
1397/3/20		hemorrhoids	**colon: Mild chronic colitis**
1401/6/21	Esophagitis LA class A	Int. hemorrhoids **Large pedunculated polyp at terminal ileum**	Mild chronic gastritis ,HP – **Focal active ileitis** **Polyp: ulcer & granulation tissue (inflammatory pseudo polyp)**

4- Bulb

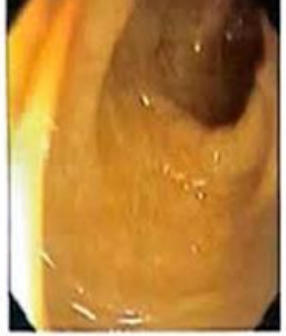
3- Antrum



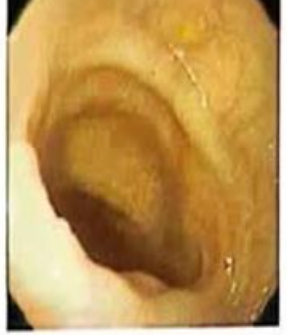
2- Body



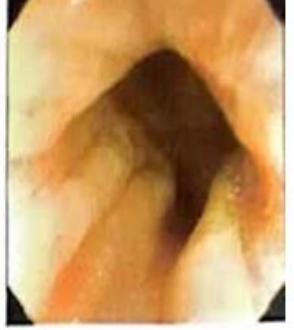
1- Esophagus



3-



2-



1-

86/10/3

Esophagus :	NL.
Stomach :	Antritis
Duodenum :	Bulbitis Bx from D2 for Celiac
Final Diagnosis :	Gastro duodenitis

خیابان شمس آبادی -روبروی بیمارستان سینا-ساختمان فارابی تلفن:۲۳۲۲۳۹۳

Esophagus :	Poor Prep. Grade 1 int.Hemorhoid Vascular Patern and mucosa of Rectum Sigmoid,descending and Transverse Colon was NL.
Stomach:	No Mucosal Lesion or Tumor
Duodenum :	
Final Diagnosis :	Grade 1 int. Hemorhoid

86/10/3

تاریخ پذیرش: ۸۶/۱۰/۰۳ شماره: p86-5308

MACROSCOPIC DESCRIPTION :

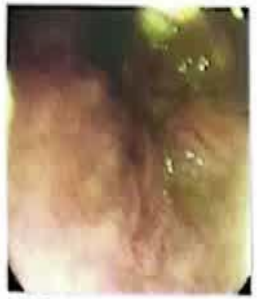
The specimen recived in formalin , consists of 4 pieces , the largest measuring 0.3 cm in diameter , with white color .

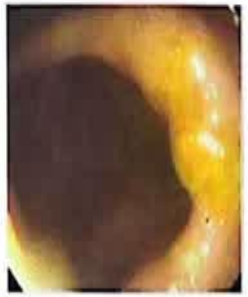
MICROSCOPIC DESCRIPTION :

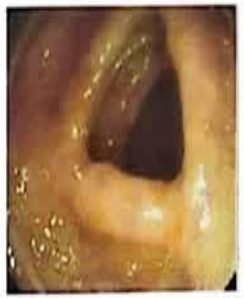
Sections show duodenal mucosa . The villi have normal shape and heigth and villous to crypt ratio is within normal limits .
There is no increase in intraepithelial lymphocytes , and no crypt hyperplasia.
(Evidences of Celiac disease are not seen .)

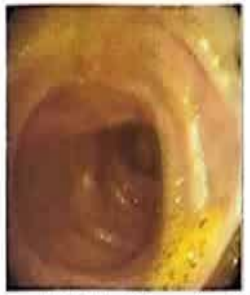
Dx : BIOPSY OF DUODENUM (D2) : WITHIN NORMAL LIMITS .

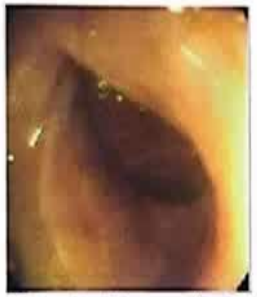
کد شناسایی: 000621 جنسیت: مرد سن: 45 تاریخ عمل: 1391/04/05

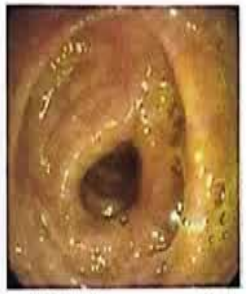

1) Rectum

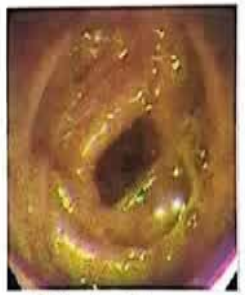

2) Cecum

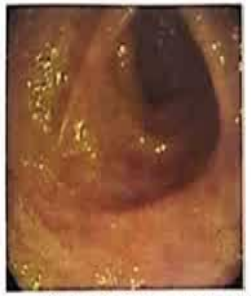

3) Middel Transverse Colon


4) Middle Discending Colon


5) Proximal Descending Colc


6) Distal Transverse Colon


7) Proximal Transverse Colo


8) Middel Transverse Colon

Reason for Colonoscopy: Anemia
Premedication: Propofol
Procedure Description: Bowel prep was poor.

Diagnostic Impression:

Anus:	**Normal**
Rectum:	**Grade 2 internal Hemorrhoids- Grade 2**
Sigmoid:	**Normal**
Descending Colon:	**Normal**
Transverse Colon:	**Normal**
Ascending Colon:	**Normal**
Cecum:	**Normal**
DX:	**Grade II internal Hemorrhoids**
Recommendation:	Medical F/U

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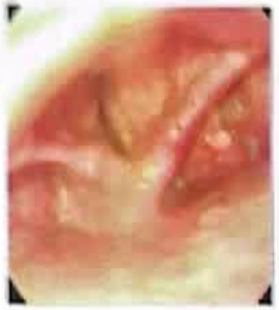
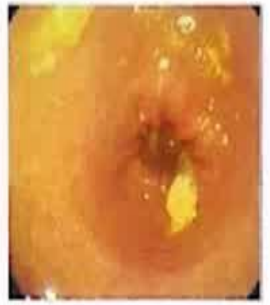
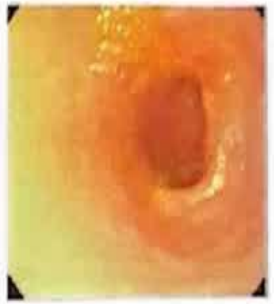
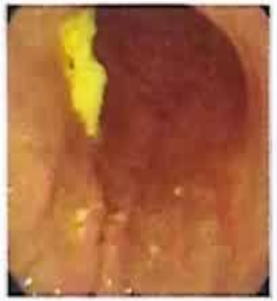
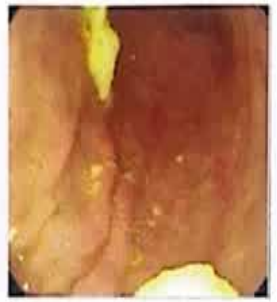

1) Larynx

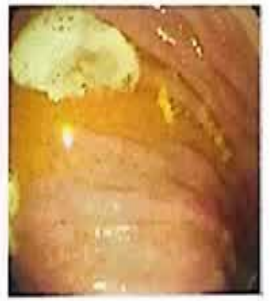

2) D2

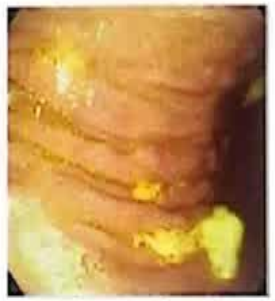

3) Antrum


4) Bulb


5) Body


6) Body


7) Fundus


8) Greater Curvature of Body

Reason for Endoscopy: Anemia
Premedication: Propofol
Procedure Description: Adequate

Diagnostic Impression:

Esophagus:	**Normal**
Cardia:	**Normal**
Fundus:	**Multiple Longitudinal Erythematous areas was seen throught fundus & body. Multiple Bx was taken for path. exam.**
Antrum:	**Normal**
Duodenum:	**Bulb & D2 were nl grossly. but multiple Bx was taken for path. exam from D2.**
DX:	**See above please**

1391/4/5

MACROSCOPIC DESCRIPTION :

Specimens received in two containers :

1- *Duodenal biopsy(D2)* : consists of 5 pieces, the largest measuring 0.3cm in diameter, with creamy-brown color.

2- *Fundus & Body biopsy* : consists of 4 pieces, the largest measuring 0.3 cm in diameter, with creamy color.

MICROSCOPIC DESCRIPTION :

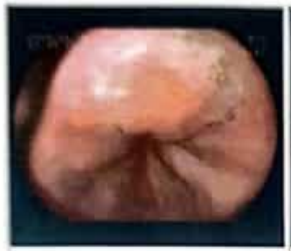
1- Sections show duodenal mucosa. The villi have normal shape and heigth and villous to crypt ratio is within normal limits . There is no increase in intraepithelial lymphocytes , and no crypt hyperplasia.
(Evidences of Celiac disease are not seen .)

2- Sections show moderate infiltration of lymphoplasmacells and neutrophils in the lamina propria , and infiltration of neutrophils in the epithelium of mucosal glands . Mucosal glands are moderately atrophic. H.Pylori is seen on the surface mucousa in Giemsa stain. *There is no evidence of malignancy* .

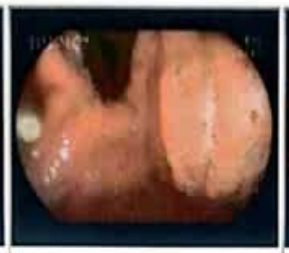
Dx : 1- BIOPSY OF DUODENUM (D2): - WITHIN NORMAL LIMITS .

91/4/5

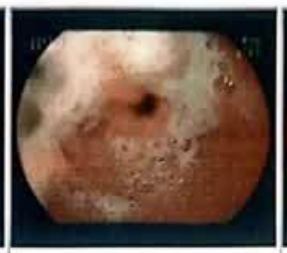
2- BIOPSY OF FUNDUS & BODY : - ATROPHIC CHRONIC ACTIVE GASTRITIS. POSITIVE FOR H.PYLORI (HP+).



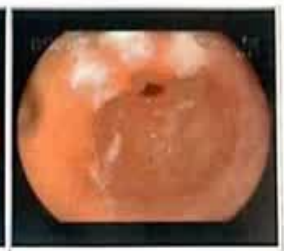
Esophagus,Lower third



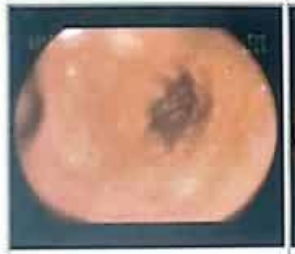
Cardia



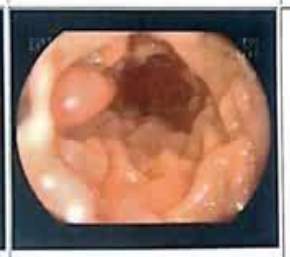
Antrum



Antrum



Bulb



Duodenum,2nd portion

96/8/14

Indication	Surveillance Colonoscopy Hx of Atrophic chronic gastritis in previous EGD & Bx
Esophagus	Was Normal
Cardia	Was Normal
Fundus	Was Normal-- Bx was taken for path exam.
Body	Was Normal-- Bx was taken for path exam.
Antrum	Mod. Antral predominant gastropathy with some erosions. Multiple Bx was taken & sent for path exam.
Pre-pyloric	Was Normal
Bulb	Was Normal
Duodenum,2nd portion	Was Normal
Final diagnosis	As a bove

Macroscopic:

*-Antrum:Received are some pieces of firm tan tissues measuring 0.7*0.5*0.3 cm.*
*-Body:There are some pieces of firm tan tissues measuring 0.6*0.4*0.3 cm.*
*-Fundus:Received are some pieces of firm tan tissues measuring 0.6*0.3*0.3 cm.*

Microscopic:

Antrum:

There are cutting sections of foveola and gastric mucosa including antral-type gastric glands and their lamina propria.Glandular to stroma ratio and vascularity is normal.Mild lymphocytes and plasma cells infiltration with mild edema and erosion is detected in the lamina propria. In the gimsa staining there is No H.pylori infection.

Body:

Cutting section of foveola and gastric mucosa including gastric glands and their lamina propria.Glandular to stroma ratio and vascularity is normal . There is sever lymphocytes and plasma cells infiltration with mild edema in the lamina propria of glands.Gimsa staining shows No H.pylori infection.

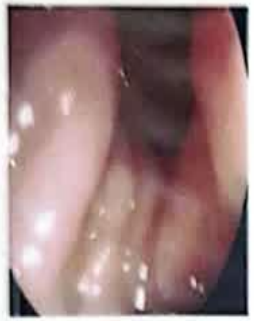
Fundus:

There are cutting sections of foveola and gastric mucosa including antral-type gastric glands and their lamina propria.Glandular to stromal ratio and vascularity is normal .Sever lymphoplasma cells and mild neutrophils infiltration as well as mild edema and lymphoid follicle is detected in the lamina propria of glands .some of neutrophils have penetrated the epithelial layers of glsnds .In the specific stainig there is No H.pylori infection .

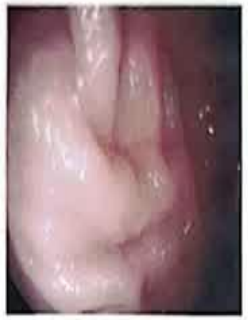
DX:

-Antrum:Mild chronic erosive gastritis
-Body:Sever chronic gastritis
-Fundus:Sever active chronic gastritis
-No evidence of atrophy in all of them

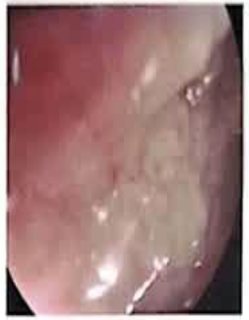
۹۶,۸,۲۳



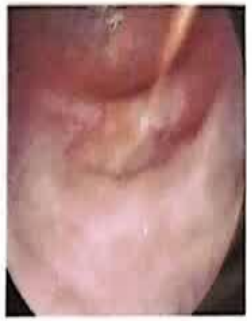
Rectum-Sigmoid



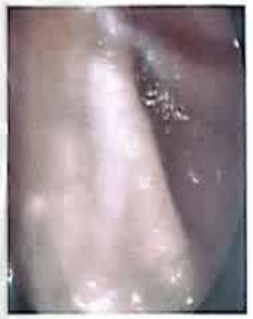
Sigmoid



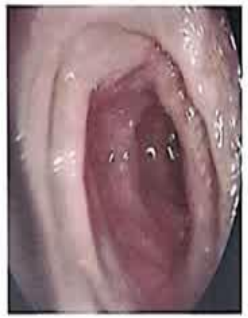
Left colon



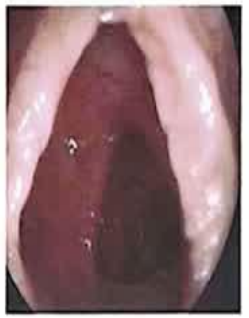
Left colon



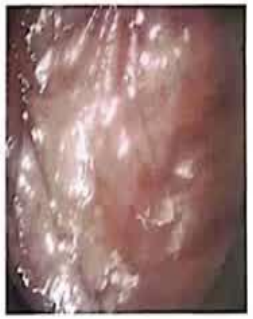
Distal part of Transverse Colon



Distal part of Transverse Colon



Right colon



Cecum

Description of procedure

Quality of the procedure was Adequate

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

Colon

Hemorrhids was seen in Anus , Rectum, Sigmoid, Descending Colon, Splenic Flexure, Transver
Colon, Hepatic Flexure and Ascending Colon were normal

Diagnostic and therapeutic operations

Biopsy was performed

Macroscopy:

نمونه ارسالی شامل یک قطعه به قطر 0.2 سانتیمتر

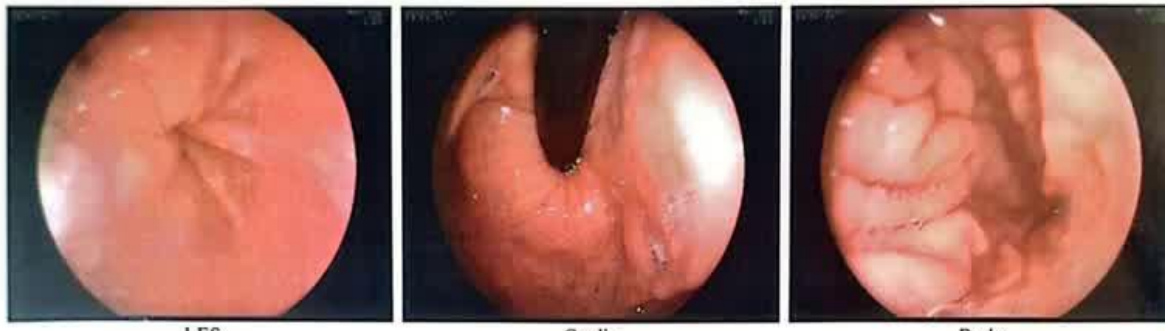
Microscopy:

در بررسی میکروسکوپی نمونه حاصل از کلون:ارتشاح خفیف سلولهای التهابی مزمن در استروما دیده شد.

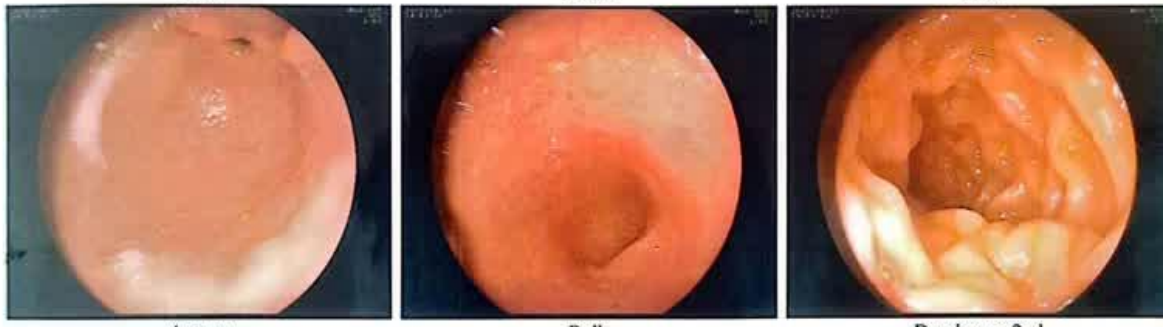
Diagnosis:

Colon biopsy:
mild chronic colitis

97/3/29



LES | Cardia | Body



Antrum | Bulb | Duodenum,2nd

Reason for Endoscopy : Surveillance EGD / Hx of chronic gastritis & mucosal atrophy in previos Bx - IDA

Premedication : Midazolam

Description of procedure : Optimum with HR & PO Monitoring

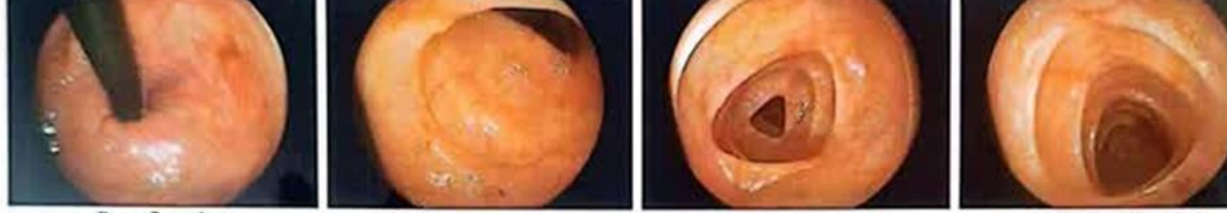
Findings :

Esophagus : Irregular z.line & evidence of esophagitis class A (LA)

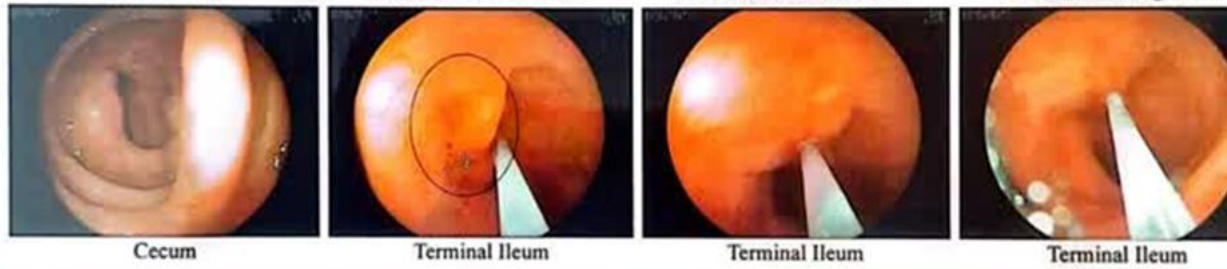
Stomach : Nl appearing mucosa in all parts. No evidence of H.H in retroversion Man. Bx were taken from ; 1- Antrum 2- Greater Cur. 3- Lesser cur. 4-Cardia according to Hx & sent for path exam.

Duodenum : Normal D1 & D2 in mucosa & vasculature

Diagnosis : As mentioned above



Retroflex view | Distal Transverse Colon | Middle Transverse Colon | Distal Ascending Colon



Cecum | Terminal Ileum | Terminal Ileum | Terminal Ileum

Reason for Endoscopy : Unexplained IDA
BBPS :3-3-3

04/6/21

Premedication : Pethedine + midazolam

Description of procedure : Optimum /Extent up to Terminal ileum

Findings :

Anus : Normal in DRE & Inspection

Rectum : Nl appearing mucosa & vasculature

Sigmoid : Nl appearing mucosa & vasculature

Descending Colon : Normal mucosa & vasculature

Transverse Colon : Normal mucosa & vasculature

Ascending Colon : Normal mucosa & vasculature -Bx was taken from RT colon.

Cecum : Normal

Terminal Ileum : Was intubated and seen up to 30 cm- There was pedunculated larg polyp in 10 cm from I-C valve so excised via single use snare after epinephrin injection.

Diagnosis : Int. Hemorrhoids
Ileal polyp so excised

-Final Pathologic Diagnosis:

Gastric Antrum , Greater curvature, Lesser curvature, Cardia, Ileum & Ileal lesion biopsy:

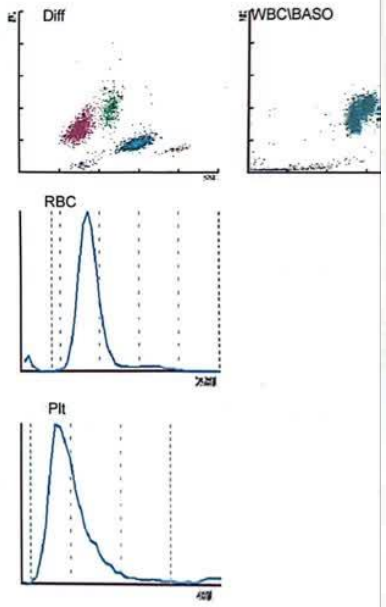
1. Gastric Antrum revealed Mild Chronic Gastritis
H.Pylori organism is not seen.
2. Gastric Greater curvature revealed Mild Chronic Gastritis
H.Pylori organism is not seen.
3. Gastric Lesser curvature revealed Mild Chronic Gastritis
H.Pylori organism is not seen.
4. Gastric Cardia revealed Mild Chronic Gastritis with Intestinal metaplasia, OLGIM=Score I
H.Pylori organism is not seen.
5.Ileum revealed Focal Active Ileitis
6. Ileal Lesion revealed Ulcer & Granulation Tissue (Inflammatory Pseudopolyp)

02/6/21

Hematology

CBC

	Result		Unit	Reference Value
WBC	4.33		10^3/µL	4 .00- 11.00
RBC	4.65		10^6/µL	4.20-6.10
Hb	13.9		g/dL	12 - 17.5
HCT	40.0		%	37.0 - 52.0
MCV	86.0		fL	80.0 - 97.0
MCH	29.9		pg	27.0 - 32.0
MCHC	34.8		gr/dl	32.0- 36.0
Platelet	219		10^3/µL	145 - 450
RDW-CV	12.9		%	11.0-15.0
MPV	10.2		fL	6.5 - 12
PDW	11.5			9.0-17.0
P-LCR	25.7		%	11.0 - 45.0
Microscopic diff %	**Result**		**Unit**	**Reference Value**
Neut %	43.9		%	40.0 - 74.0
Lymph %	41.6		%	19.0 - 48.0
Mono %	12.7*	H	%	3.0-12.0
Eosin %	1.6		%	0.0 - 5.0
Basophil	0.2		%	0.0 - 1.0
Absolute Count	**Result**		**Unit**	**Reference Value**
Neut #	1.90	L	10^3/µL	2.00 - 8.00
Lymph #	1.80		10^3/µL	0.90 - 5.20
Mono #	0.55		10^3/µL	0.16 - 1.00
Eosin #	0.07		10^3/µL	0.0 - 0.80
Basophil #	0.01		10^3/µL	0.0 - 0.1.0



Test	Result	Flag	Unit	Reference Interval
ESR 1st hr	15	H	mm	Female Up to 22 Male Up to 12

** = Confirmed by Repeated Analysis*

Biochemistry

Test	Result	Flag	Unit	Reference Interval
Fasting Blood Sugar	94		mg/dL	70-100
Blood Urea	24		mg/dL	17-43
Creatinine	0.91		mg/dL	Adult:0.6-1.2
Cholesterol total	181		mg/dL	Normal : Up to 200 200-240 :Equivocal Over than 240 :Abnormal
Triglyceride	202	H	mg/dL	20 - 200
HDL-Cholestrol	46		mg/dL	more than 35
LDL	95		mg/dL	<130 NormaL >160 Abnormal 130-160 Borderline
LDL / HDL Ratio	0.484		Ratio	low risk < 3 moderate risk : 3-6 High risk > 6
Chol/HDL	4		Ratio	Low Risk : 3.3-4.4 Average Risk : 4.4-7.1 Moderate Risk : 7.1-11 High Risk : >11
VLDL	40	H	mg/dL	Male:12-36
Calcium	9.4		mg/dL	8.6-10.3
Alkaline Phosphatase	189		IU/L	80-306
AST	22		IU/L	Men: 2 - 37
ALT	10		IU/L	Men : Up to 41
CRP	0.1		mg/L	0-6
E.G.F.R	94			Above 61

02/7/11

rinalysis

Urinalysis

Macroscopic		Microscopic	
Color	Yellow	WBC/hpf	1-2
Appearance	Clear	RBC/hpf	3-5
Specific Gravity	1021	Epithelial.Cells/hpf	2-3
PH	7	Bacteria/hpf	Not seen
Protein	Negative	Crystals/hpf	Not seen
Glucose	Negative	Casts/lpf	Not seen
Ketone	Negative	Mucus Threads/hpf	Few
Blood/Hb	Trace	Dismorphic RBC	70%
Bilirubin	Negative	Transitional cell	Not Seen
Urobilinogen	Negative	Leukocyte esterase	Negative
Nitrit	Negative		

licrobiology

Stool Culture&Sensitivity

Specimen	Stool
Culture	No Salmonella &Shigella isolated

arasitology

Stool Examination

	No.1
Consistency /Color	Soft /Brown
Fat	Not seen
Mucus	Not seen
Undigested Food	Not seen
Yeast	Not seen
Ova of Parasites	Not seen
Protozoa Cyst	Not seen
PH	7
WBC /hpf	Not seen
RBC /hpf	Not seen
Epethelial /hpf	Not seen

Occult Blood

	No.1
Occult Blood	Negative

Date:20.03.1402
No: 395144

MDCT of the abdomen with contrast with triphasic protocol:

- *Liver, spleen and pancreas are normal in size and shape without any evidence of space-occupying lesion.*
- *Gallbladder and intrahepatic bile ducts as far as seen are normal.*
- *No para-aortic adenopathy is seen.*
- *Adrenal glands are normal.*
- *Both kidneys show normal size, shape and cortical thickness with normal function without any hydronephrosis or space-occupying lesion.*
- ***A 4.5-mm cortically-embedded stone at mid-portion of right kidney is seen.***
- ***A 3-mm stone at lower pole of right kidney is seen.***
- *No ascites is seen.*

IMP:

- ***No obvious lesion in liver. Follow-up with ultrasound is recommended.***
- ***Right-sided renal stones***

FEEDBACK

Dear Professor

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 clinical course and paraclinical findings do not favor the diagnosis of IBD.

Iron deficiency can be caused by hemorrhoids or atrophy of the gastric mucosa, but in order to rule out other causes, further follow-up is recommended, preferably starting with CT enterography or MR enterography and continuing with other appropriate investigations. Currently, it is recommended to stop all treatments related to Crohn's disease and follow up the patient.

A 43-year-old lady

- Known-case of autoimmune hepatitis (since 2014 after increase liver enzymes and a rapid 20 kg weight loss, and vomiting).She has been treated with the diagnosis of autoimmune hepatitis, and is currently being treated with azathioprine. Due to recent thrombocytopenia and leukopenia, she has been referred to change the medication.
- PMH: hypothyroid
- FH: Brain tumor in the sister who died at the age of 51, Hypoventilation syndrome in the mother.

DH:

- One daily levothyroxine tablet
- Pantoprazole 40 mg daily
- Glucophage 500 mg daily
- Since 1994, he has been taking prednisolone 5 mg daily for 3 years, and then the drug was stopped, and after one year, he was again treated with prednisolone for 18 months and stopped again due to edema. Azathioprine is prescribed 75 mg daily, now.

Now he has abdominal pain in the epigastrium and RUQ, as well

she complains of significant weight loss in recent months and night sweats.

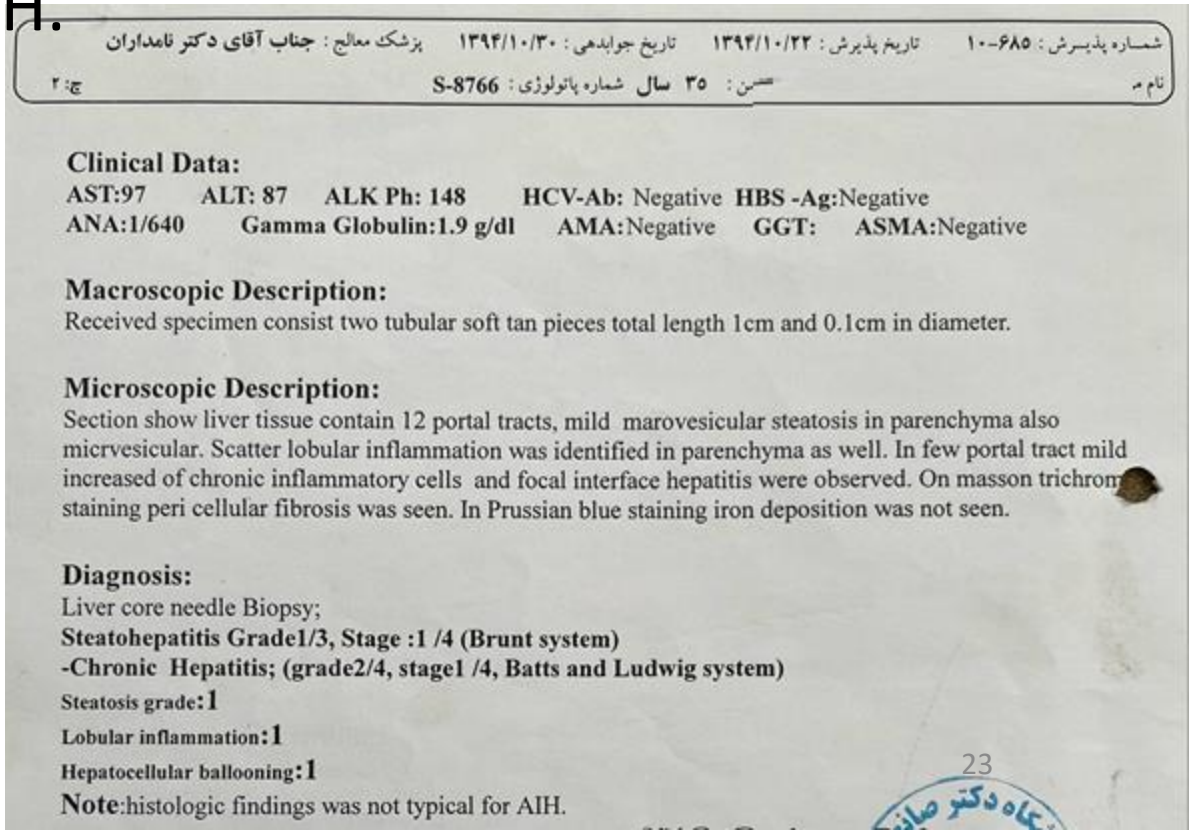
Pathology (liver core needle biopsy)

1394.10.22

Steatohepatitis grade1/3 , stage1/4 (Brunt system)

Chronic hepatitis , grade2/4 , stage1/4 , Batts and Ludwing system)

Histologic founding was not typical for AIH.



شماره پذیرش : ۶۸۵-۱۰ تاریخ پذیرش : ۱۳۹۴/۱۰/۲۲ تاریخ جوابدهی : ۱۳۹۴/۱۰/۳۰ پزشک معالج : جناب آقای دکتر نامداران

نام م ... سن : ۳۵ سال شماره پاتولوژی : S-8766 ج: ۲

Clinical Data:

AST:97 ALT: 87 ALK Ph: 148 HCV-Ab: Negative **HBS -Ag:**Negative
ANA:1/640 Gamma Globulin:1.9 g/dl AMA: Negative **GGT: ASMA:**Negative

Macroscopic Description:

Received specimen consist two tubular soft tan pieces total length 1cm and 0.1cm in diameter.

Microscopic Description:

Section show liver tissue contain 12 portal tracts, mild marovesicular steatosis in parenchyma also micrvesicular. Scatter lobular inflammation was identified in parenchyma as well. In few portal tract mild increased of chronic inflammatory cells and focal interface hepatitis were observed. On masson trichrom staining peri cellular fibrosis was seen. In Prussian blue staining iron deposition was not seen.

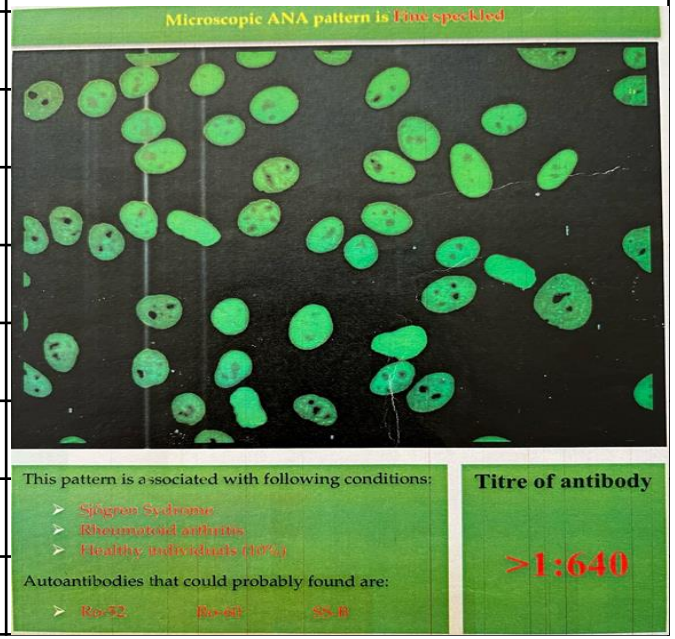
Diagnosis:

Liver core needle Biopsy;
Steatohepatitis Grade1/3, Stage :1 /4 (Brunt system)
-Chronic Hepatitis; (grade2/4, stage1 /4, Batts and Ludwig system)
Steatosis grade:1
Lobular inflammation:1
Hepatocellular ballooning:1
Note:histologic findings was not typical for AIH.

Abdominopelvic sonography 2015

- A slight increase in the echogenicity of the liver parenchyma caused by Fatty liver grade 1 is evident

Lab Data

LDH 673	**RF 18/Positive**	HBS Ag Neg	Salmonella typhi Neg
Amylase 70	C3 1.5	HAV IgM Low	Salmonella para typhi Neg
Albumin 4.1	C4 0.2	HAV IgG Neg	Stool calprotectin Neg
CRP 3	CH50 76	HCV Ab Neg	
ESR 43	**ANA 1/640**	H.Pylori IgG 31	
PT 13	ASMA Neg	HIV Ab Neg	
INR 1	AMA Neg		
Ceruloplasmin 37	LKM1Ab Neg		
	AntidsDNA Neg		
	Anti TTG IgA Neg		

Lab Data

Protein Electrophoresis	1394	1395	1397.4	1397.9	1400
Alpha1	4	4	4.1	4	3.7
Alpha2	9.4	10	10.2	10.4	9.5
Beta1	5.7	5.5	5.9	5.9	6.1
Beta2	4.6	5	4	4.3	4.4
Gamma	**23.6 H**	**19.3 H**	18.6	**25 H**	**23 H**
Albumin	**52 L**	56	56	**50 L**	**53 L**

Lab Data

	94.2	94.9	94.11	95.1	95.5	95.10	96.4	96.6	96.8	96.10	96.12	97.2	97.4	97.7	97.9	97.12	98.2	98.7	98.11	1400.9	00.12	01.5
AST	55	97	41	27	34	42	85	69	61	38	44	51	47	94	51	51	48	56	35	373	101	122
ALT	59	87	31	20	28	41	99	99	117	49	52	88	70	107	37	28	31	43	23	279	92	90
ALP		148	153	178	215	223	235	195	152	185	155	162	161		197	225	206	195	200	372	277	278
GGT		***92***	***39***	***21***	***43***	***36***	***93***	***74***	***56***	***42***	***31***	***39***	***46***	***68***	***35***	***51***	***29***	***31***	***32***	***15***	***157***	
Bil.T		0.9		1.2	1.4	1.2				1.4											1.45	
TG	174						189	167	169		163	158	182	151	231		212	142	204	124		158
chol	211						231	277	225		248	229	207	198	192		183	192	209	170		193
HDL	37						49		46		40	43	38	32	23		29	33	43	30		28
LDL	139						121		128		144	139	116	127	103		109	112	101	129		44
WBC	5	3.3	6.1	5	5	4.7	4	7.5		3.8	3.9	5.2	2.8	3.8	4	3.8	3.2	3.8	5.2	4.6	5.1	5.4
HB	13.2	13.2	15.2	13.9	14.4	13.9	12.9	13.8		13.9	13.6	13.6	13.3	13.6	12	12.8	12	13.4	13.4	14	12.5	13.3
PLT	167	191	261	206	215	206	218	226		244	196	222	171	162	158	203	166	190	180	148	146	162

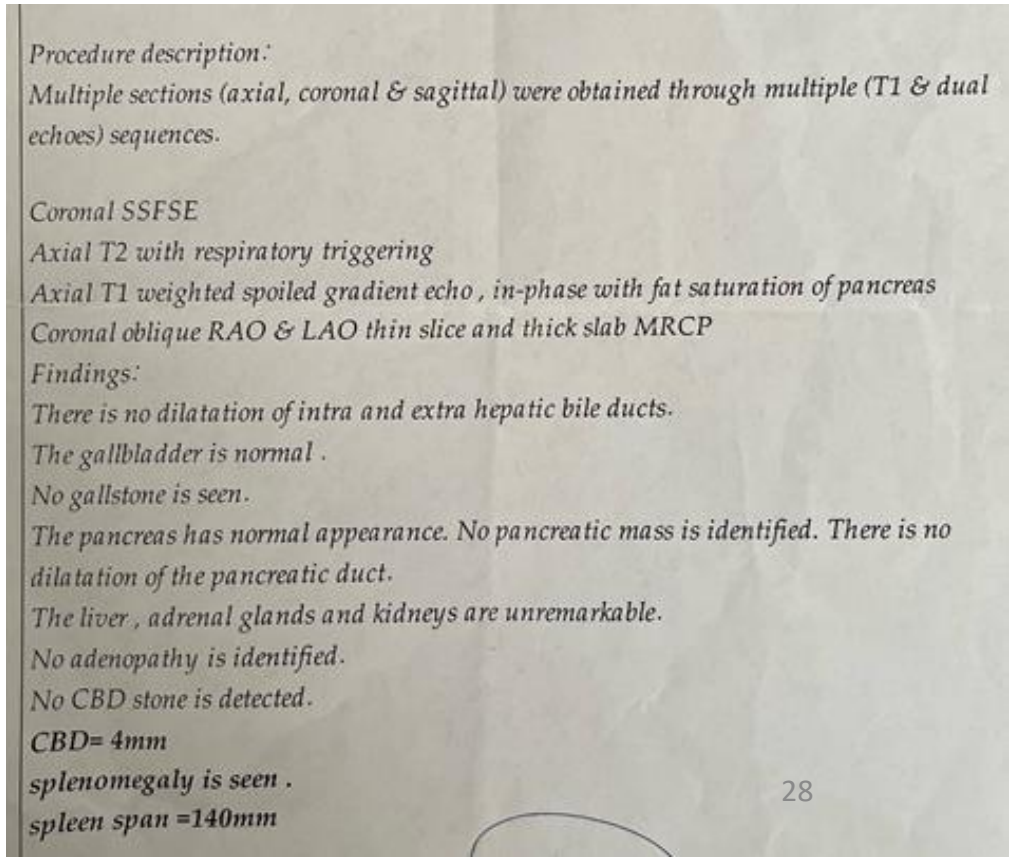
- Abdominopelvic sonography 1400
- A slight increase in the echogenicity of the liver parenchyma caused by Fatty liver grade 1.

MRCP: 1402

CBD 4mm

Splenomegaly is seen

Spleen span 140mm



Procedure description:
Multiple sections (axial, coronal & sagittal) were obtained through multiple (T1 & dual echoes) sequences.

Coronal SSFSE
Axial T2 with respiratory triggering
Axial T1 weighted spoiled gradient echo , in-phase with fat saturation of pancreas
Coronal oblique RAO & LAO thin slice and thick slab MRCP
Findings:
There is no dilatation of intra and extra hepatic bile ducts.
The gallbladder is normal .
No gallstone is seen.
The pancreas has normal appearance. No pancreatic mass is identified. There is no dilatation of the pancreatic duct.
The liver , adrenal glands and kidneys are unremarkable.
No adenopathy is identified.
No CBD stone is detected.
CBD= 4mm
splenomegaly is seen .
spleen span =140mm

Lab Data

	1402.3.28	1402.05.17	1402.06.05	1402.07.01
AST	91	80	71	91
ALT	51	35	41	66
ALP	311	193	215	222
GGT	191			
Billi.T	1.2	1.9	2.9	1.3
Billi.D	0.35	0.2	0.39	0.46
e.Glomerular Filtration Rate	63.9			
TG	193			
chol	161			
HDL	28			
LDL	95			
ferritin	44			72
PT		13	15.3	12
INR		1	1.3	1

Port doppler sonography: 1402.06.27

Echo parenchyma of the liver is coarse and slightly increased.

نوع خدمت: سونوگرافی داپلر کبد و پورت

اکوی پارانشیم کبد مختصر coarse و اندکی افزایش یافته می باشد.

کبد فاقد توده ضایعه فضاگیر می باشد. Liver span= 125mm

قطر مجاری صفراوی داخل و خارج کبدی نرمال می باشد.

ورید پورت به دیامتر 11mm مشاهده می شود که در بررسی اسپکترال فلو و موج وریدی نرمال داشته و جهت جریان خون بصورت هپاتوپتال می باشد.

حجم و اکوژنیسیته طحال نرمال *130x134x48mm* و حجم *445cc* با سایز حداکثر نرمال است.

ضایعه فضاگیر در طحال مشهود نیست.

ورید طحالی با دیامتر 6mm و فلوی نرمال مشاهده می شود.

ورید مزانتریک فوقانی دارای کالیبر نرمال بوده و فاقد ترومبوز می باشد.

سرعت متوسط ورید پورت برابر 13cm/s بوده و شواهدی از ترومبوز در آن رویت نمی شود.

شریان هپاتیک دارای فلو و موج شریانی نرمال بوده و RI برابر 0.77 می باشد.

وریدهای سوپراهپاتیک دیامتر نرمال داشته و تغییرات نرمال به سیکل تنفسی و قلبی در موج وریدی آن ها مشهود است.

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 the high titer of FANA, age, gender, and the course of the disease, the initial diagnosis of autoimmune hepatitis is very likely, but if other investigations as celiac serology, Wilson disease and other probable disease should be done.

According to the course of tests like AST more than ALT and the increase in the size of the spleen, it seems that the patient is progressing to cirrhosis, and therefore, considering the lack of adequate response to the treatment, it is recommended to replace the current drug with cellcept or tacrolimus. Paying attention to the literatures and opinions of colleagues, both choices are permissible, but in terms of the probability of response to Cellcept is preferable, but in terms of the probability of side effects, tacrolimus is more suitable.

Investigate other causes of abdominal pain and weight loss (endoscopy, colonoscopy, CT scan and appropriate laboratory tests).

A 48-year-old female

- Patient with a history of thalassemia major (transfusion since childhood), hypothyroidism, RA (treated with 2.5 mg prednisolone once every other day, hydroxychloroquine once every other day, portal vein thrombosis following OCP (with initial symptoms of abdominal pain, nausea and vomiting), which was treated by warfarin for 6 months and aspirin every other night.
- History of splenectomy and cholecystectomy.
- Currently, she has no symptoms and has decided to get pregnant.

- **Can a patient with chronic portal vein thrombosis get pregnant?**

Cr	0/8
WBC	7/12
HB	10
MCV	80
PLT	435
ESR	14
ALKP	274
AST	69
ALT	61
Feritin	975

نام بیمار			۱۴۰۲/۰۵/۱۷		دکتر مژگان عبدالهی
کد ملی		تاریخ و ساعت جواب	۱۴۰۲/۰۵/۱۷-۰۹:۰۰	بخش درخواست	
نام پدر		جنسیت	مونث	تشخیص	درد()
		تاریخ تولد	۱۳۵۲/۱۲/۲۰	پزشک رادیولوژیست	دکتر آنوسا ادیبی

سونوگرافی داپلر عروق شکمی

شکل وابعاد و اکوی پارانشیم کبد طبیعی است. توده فضاگیر دیده نشد.

قطر عروق پرتال و وریدهای کبدی نرمال است.

کیسه صفرا در محل اناتومیک خود رویت نشد(کله سیستکتومی قبلی)

قطر مجاری صفراوی داخل وخارج کبدی نرمال است.

طحال در محل آناتومیک خود رویت نشد (اسپلنکتومی قبلی)

ورید پورت با فلوی هپاتوپتال دارای **mean velocity** برابربا ۱۰ سانتیمتر برثانیه دارای **phasicity** وجهت جریان نرمال میباشد. که می تواند مطرح کننده هایپرتیشن پورت باشد .

شریان هپاتیک بافلوی هپاتوپتال دارای **EDV** برابربا ۰٫۷ سانتیمتر برثانیه میباشد .

وریدهای کبدی بافلوی هپاتوفوگال دارای قطر و جهت جریان نرمال میباشد.

تصویر یک ناحیه اکوژن درون ورید پورت مشهود است که می تواند مطرح کننده ترومبوز مزمن ورید پورت باشد .

سونوگرافی شکم ولگن

شکل وابعاد واکوی پارانشیمال کبد نرمال است.

کیسه صفرا در محل آناتومیک خود رویت نشد (کله سیستکتومی قبلی)

قطرپورت و CBD نرمال است.

ائورت و پاراائورت وپانکراس درحد قابل بررسی نرمال هستند.

طحال در محل آناتومیک خود رویت نشد (اسپلنکتومی قبلی)

هردوکلیه دارای شکل وابعاد و اکوی پارانشیم نرمال است.

(کلیه راست به طول ۹۲ میلیمتر و ضخامت پارانشیم ۱۲ میلیمتر و کلیه چپ به طول ۹۶ میلیمتر و ضخامت پارانشیم ۱۳ میلیمتر)

سنگ یا هیدرونفروز دیده نشد.

مثانه دارای حجم وضخامت جدار نرمال است.

رحم دارای ابعاد واکوی میومتر نرمال است.

ضخامت اندومتر طبیعی است.

تخمدانها دارای حجم و ابعاد نرمال است. توده فضاگیر دیده نشد.

فولیکول رویت نشد .

درحفره شکم ولگن مایع ازاد دیده نشد.

مرکز آموزشی درمانی الزهرا (س)
MRI واحد

Date
Admission Number
Name
Date of Birth 19740101
Height (cm) 0
Weight (kg) 50
Sex Female

Dear Dr.

Technique

ECG gated cardiac MR images were obtained for T2 calculation. Short axis images were prepared in different sequences.*
T2 and "Iron Load" values were calculated by "CMR Tools" software.*

Findings

Organ	T2* (ms)	Loading (mg/g/dw)
Heart	23.95	
Liver	15.15	2.029

Interpretation

Cardiac Iron Load: ***Normal***
Hepatic Iron Load: ***Mild***

with Best Regards

S Akhlaghpoor MD
Radiologist

دکتر شهرام اخلاقپور
متخصص رادیولوژی اینترونشنال
فلوشیپ MR قلب و عروق
نظام پزشکی ۳۵۹۳۳

A Shirkavand PhD
Physicist

دکتر افشان شیرکوند
دکتری تخصصی بیوفوتونیک
کارشناسی ارشد فیزیک پزشکی

Guidelines for Iron Assessment

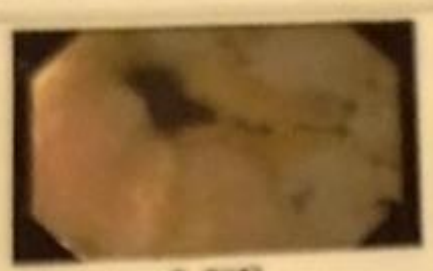
Myocardial Loading	Myocardial
Normal	>20
Mild	14-20
Moderate	10-14
*Severe**	<10

** In 89% of patients with heart failure, cardiac T2* is <10ms.*

Hepatic Loading	Hepatic T2* (ms)	Dry Weight mg/g
Absolute Normal	>30	<1.02
Considered Normal	>17	<1.8
Mild	>6.2	<5
Moderate	3.1-6.2	5-10
Sever	2.1-3.1	10-15
Very Severe	<2.1	>15

Garbowski et al. Journal of Cardiovascular Magnetic Resonance 2014,

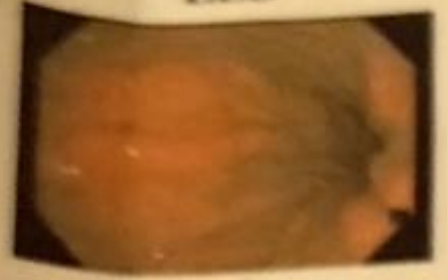

LES

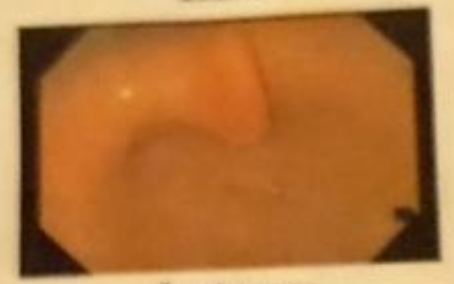

LES


Cardia


Fundus


Body


Body


Antrum


Duodenum,2nd

Reason for Endoscopy : Dyspepsia

Premedication : Midazolam 1.5 mg

Findings :

Esophagus : Normal

Stomach : Cardia and Fundus and Body were normal.
Erosion was seen , Biopsy was taken sent to pathology.

Duodenum : Normal

[Diagnosis]
Gastric (antral) biopsy :
-Mild chronic gastritis
-Positive for H.Pylori infection
-Eosinophilis: 0-1 HPF
-Atrophy: Negative
-Intestinal metaplasia: Negative

Diagnosis : Gastropathy Erosive

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 the review of articles and scientific references, there is no contraindication for the pregnancy of patients with portal thrombosis, the maternal and fetal consequences of pregnancy have been appropriate in studies. In this disease, if there is no liver fibrosis, no esophageal varices, the liver risks are not high.

In most studies, it is recommended to continue the treatment during pregnancy according to the hematologist's opinion. It is recommended to be monitored in case of pregnancy during this period, and the state of liver function and fibrosis should also be monitored.

According to the opinion of most of the present colleagues, regardless of the PVT, considering the age and current underlying disease, this pregnancy is high risk for the patient and is not recommended.