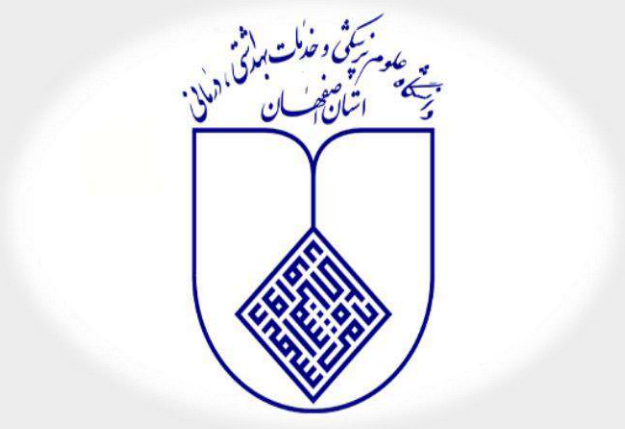


Isfahan University of Medical Sciences and Health Services
Department of Gastroenterology,
Department of Internal Medicine

Iranian Association Of Gastroenterology And Hepatology
Isfahan Branch

GI commission and grand round

July 17, 2023

List of cases on July 17, 2023

	patient	Fellow	page
111267	A 38-year-old man	Dr. Bagheri	3
111268	A 39-year-old man	"	23
111269	A 30-year-old female	"	30
222407	A 26-year-old female	Dr. Ahmadi Far	40
222408	A 42-year-old man	"	48

GI commission and grand round

A 38-year-old man

- The patient is a **38-year-old man** with a history of epigastric pain and anemia since childhood. After the COVID about 2 years ago, he suffered from weight loss, nausea and diarrhea, and had many visits by gastroenterologists and underwent endoscopy to treat H.Pylori, which he said did not improve.

-Specimen Received:
Gastric Biopsy

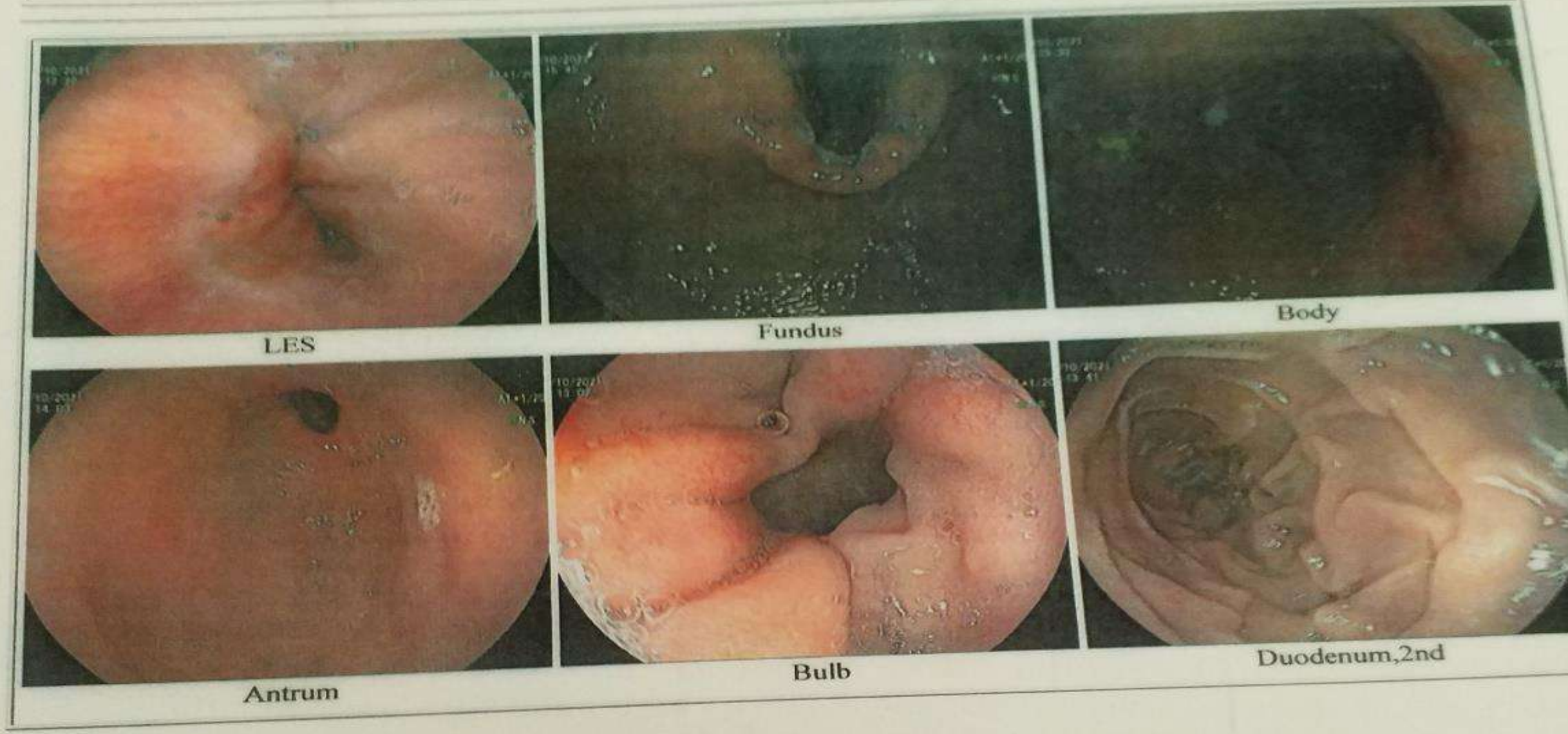
-Clinical Data: -

-Macroscopic Description:
Specimen received in formalin labeled with patient's name consist of three soft tan tissue fragments measuring in aggregate 0.7x0.4x0.2 cm. Entirely submitted in one cassette.

-Microscopic Description:
The sections revealed antral type gastric glands surrounded by lamina propria. Glandular to stroma ratio is normal. Some infiltrate of acute and chronic inflammatory cells composed lymphocytes, Histiocytes, plasmacell and PMNs in diffuse pattern was seen. A few penetration of PMNs within epithelium of glands was seen. On Giemsa staining H.Pylori organism was seen.

-Final Pathologic Diagnosis:

Gastric Biopsies Findings :
Moderate Chronic Gastritis with Mild Activity
H.Pylori organism is seen (Grade I/III)



Findings :

Esophagus : Normal

Stomach : Sever erythema in body and mild erythema in antrum were seen .biopsy was taken .fundus was normal

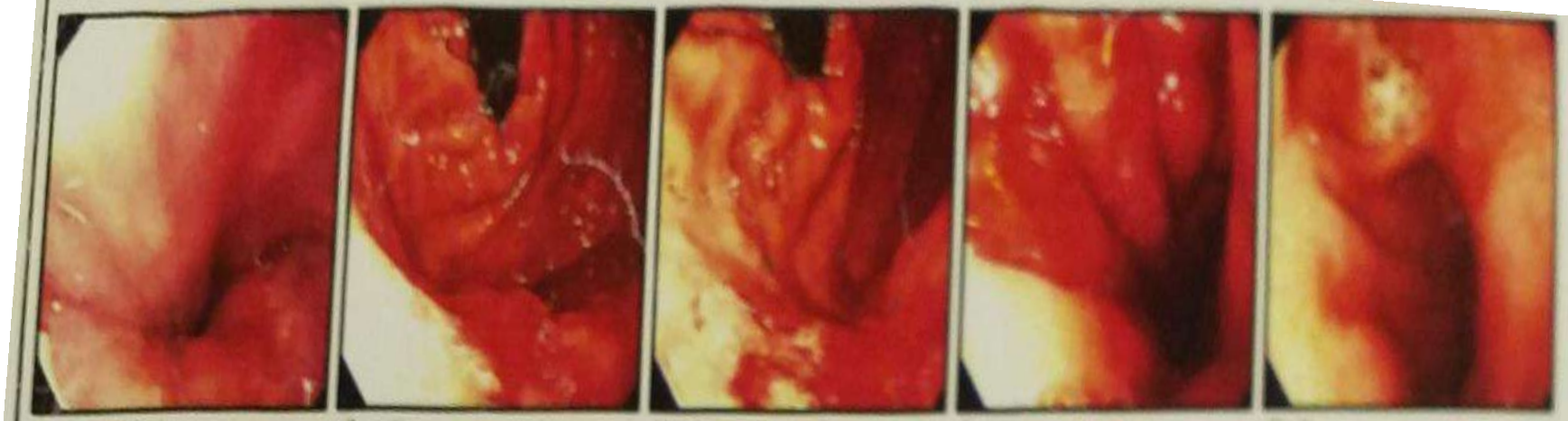
Duodenum : Bulb was erythematous.D2 was normal.

Hematology

Test	Result	Unit	Reference Interval	Differential
C.B.C				
W.B.C	8200	/µL	4000 - 11000	Neutrophils
R.B.C	5.52	x10*6/µL	4.5 - 5.9	MXD
Hemoglobin	**L 12.4**	g/dL	13.2 - 17.6	Lymphocyte
Hematocrite	40.7	%	39 - 50	Anisocytosis
M.C.V	**L 73.7**	fL	80 - 99	Hypochromia
M.C.H	**L 22.5**	pg	27 - 34	Microcytosis
M.C.H.C	**L 30.5**	g/dL	32 - 37	
R.D.W	**H 15.7**	%	11 - 14.8	
Platelets	210000	/µL	140000 - 650000	
PDW	12.0	fL		
MPV	9.6	fL		
P-LCR	24.1	%		

SYSMEX

کبد دارای حدود و ابعاد و حجم طبیعی است *(span = 120mm)* .
اکوژنیسیتی پارانشیم کبدی نرمال می باشد *(No fatty infiltration)* .
دیامتر وریدهای پورت و کبدی نرمال است .
تصویر ضایعه فضاگیر *cystic or solid* در داخل کبد مشاهده نشد .
کیسه صفرا حجم و ضخامت جداری نرمال دارد .
شواهدی از سنگ و اسلاژ درون کیسه صفرا مشاهده نگردید .
قطر مجاری صفراوی داخل و خارج کبدی نرمال است .
طحال دارای ابعاد و اکوی پارانشیمال نرمال است *(span = 90mm)* .
ضایعه فضاگیر درون پارانشیم طحال مشهود نمی باشد .
در ناحیه ی پاراآئورتیک (در حد قابل بررسی) آدنوپاتی مشاهده نشد .
پانکراس دارای ابعاد و اکوی پارانشیم نرمال می باشد .
کلیه راست به ابعاد *105x34mm* و کلیه چپ به ابعاد *95x45mm* می باشد.
ضخامت و اکوی کورتکس کلیه ها طبیعی است .
افتراق کورتیکومدولاری کلیه ها طبیعی است .
سنگ و هیدرونفروز در کلیه ها مشاهده نگردید .
حدود مثانه منظم و ضخامت جدار آن طبیعی است .
شواهدی از سنگ و یا توده جداری در مثانه رویت نگردید .
پروستات به ابعاد *40x27x31mm* و حجم تقریبی *18cc* دارای حجم و ابعاد نرمال و اکوی پارانشیمال طبیعی می‌باشد.
مایع آزاد در شکم و لگن وجود ندارد .



Esophagus

Mucosal breaks was seen in lower third were seen in lower third

Stomach

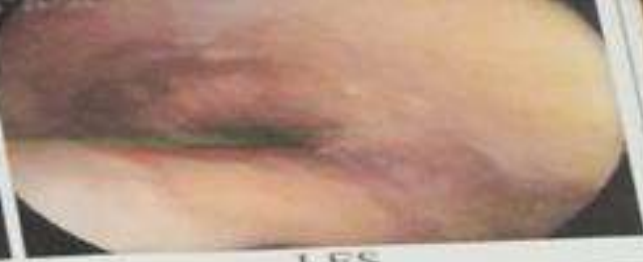
Small sliding hiatus hernia in cardia (retro-vision maneuver) , Mucosa of body was erythematous , snake skin appearence in body, ulcer was seen in body , Biopsy was taken and sent for pathology , Mucosa of antrum was hyperemic

Duodenum

Bulb deformity was seen

Middle esophagus

Lower esophagus



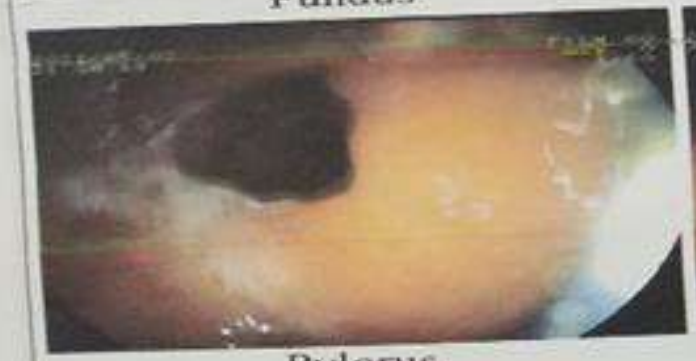
LES

Fundus

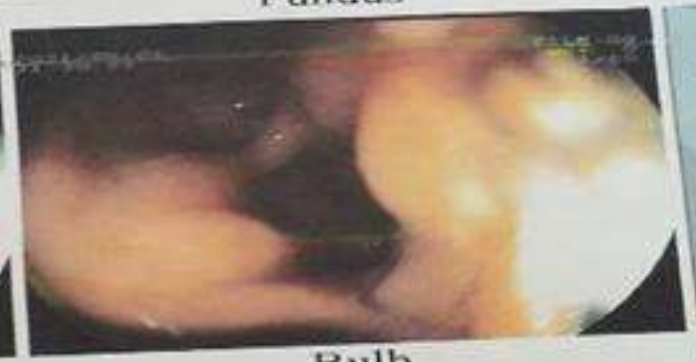
Fundus

Body

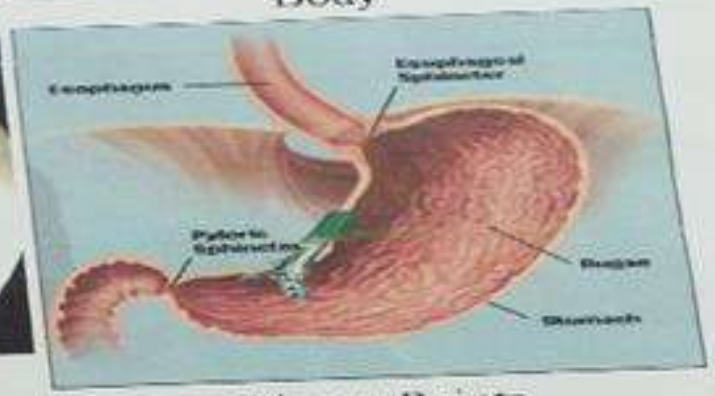
Lesser Curvature of Body



Pylorus



Bulb



Biopsy Points

Reason for Endoscopy : Abdominal distress pain , dyspepsia and heartburn

Premedication : 10 mg midozolam

Esophagus : Erythematous in z-line

Stomach : In cardia and fundus was normal Erythematous and erosion and ulcer in body and antrum

Duodenum : Erosion and ulcer in duodenal bulb

Diagnosis : Esophagitis with Gastroduodenal Ulcer

In the last April, the patient developed abdominal pain, epigastric pain and melena and was admitted to the hospital and subjected to various examinations.

Procedure: Upper GI endoscopy
Indication: Melena
Premedication: Spray lidocaine
Esophagus: Normal
Stomach: Small sliding hiatal hernia. Cardia, Fundus, Body and Antrum were normal. Antral biopsy was taken.
Duodenum: Pseudo diverticulum and healing linear ulcer were seen in bulb. D2 was normal.
Imp: Small sliding hiatal hernia
Duodenal Pseudo diverticulum
Duodenal Ulcer
Rec : Follow up the pathology
Colonoscopy

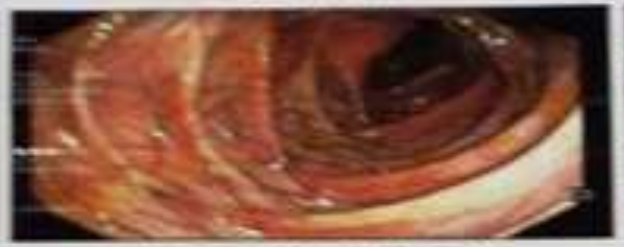
Retroflex view

Rectum

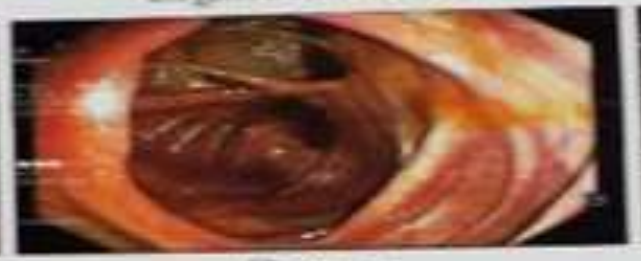
Sigmoid Colon

Descending colon

Middle Transverse Colon



Ascending Colon



Cecum

Terminal Ileum

Reason for Endoscopy : Melena

Description of procedure : Total colonoscopy was done up to cecum. BBPS in left , transverse and right were 2-2-2.

Findings :

Retroflex View : Internal hemorrhoids was seen.

Rectum : Normal mucosa and vascular pattern was seen.

Sigmoid : Normal mucosa and vascular pattern was seen.

Descending Colon : Normal mucosa and vascular pattern was seen.

Transverse Colon : Normal mucosa and vascular pattern was seen.

Ascending Colon : Normal mucosa and vascular pattern was seen.

Cecum : Normal mucosa and vascular pattern was seen.

Terminal Ileum : Was seen up to 20 cm from ileocecal valve that was normal.

Diagnosis : Internal Hemorrhoids

Diagnosis

Dx : Gastric (Antrum) biopsy

-Mild Activity

-Moderate Chronic Gastritis

-Negative for H.Pylori organism

-Eosinophils: 2-3 /HPF

-Negative for Atrophy

-Mild Complete Intestinal Metaplasia

OLGA Gastritis Staging: 0/4

OLGIM Gastritis Staging: 1/4

Immunology

Test	Result	Unit	Method	Reference Interval
HBS-Ag	Non-Reactive	S/CO RATIO		< 1 Negative >= 1 Positive

Method & Name of kit : ECL (Cobas E411) ' ELIZA (Pishtaz teb)

Anti HIV 1/2 4th — Non-Reactive

This kit detect HIV-1 P24 antigen & antibodies to HIV-1(Including group O) & HIV-2.

Method & Name of kit : ECL (Cobas E411) ' ELIZA (Pishtaz teb)

Tumor Marker

Test	Result	Unit	Method	Reference Interval
C.E.A	0.42	µg/L		Non Smokers : Up to 5 Smokers : Up to 10
CA 19-9	22.8	U/mL		<=40 Negative

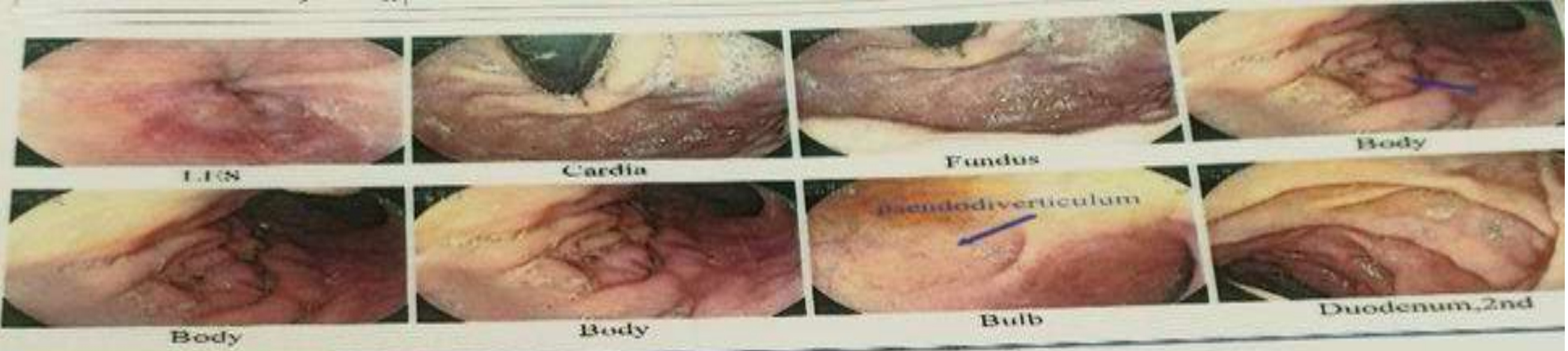
Parasitology

Test	1st Specimen
Stool Examination :	
Color	Brown
Consistancy	Formed
Ova of Parasites:	Not Seen
Protozoa Cyst:	Not Seen
W.B.C	Not Seen
R.B.C	Not Seen
Yeast	Not seen
Occult Blood :	Negative

Parasitology

Test	Result	Normal Rang
Calprotectin stool	5.7	Normal value ug/g mild IBD ug/g

- In the abdominal CT scan of the patient: left segment gastric wall thickening was reported. The patient was discharged with the recommendation to see a surgeon and oral pantoprazole. According to the patient, due to the lack of improvement in the symptoms of abdominal pain, epigastric pain and diarrhea, he will be referred to the gastroenterologist again and be examined.



Reason for Endoscopy : Iron deficiency anemia, Weight Loss
Increased thickness of greater curvature of the gastric body in C
scan

Findings :

Esophagus : Upper, middle and lower thirds : Normal
Z-line was normal.
No Sliding Hiatal Hernia

Stomach : Cardia and fundus : Normal
Body : Distensibility of stomach was normal in body of stomach.
some mucosal erosions & mild increased in thickness of gastric rugae were se
.(Deep biopsises were taken)
Antrum: Diffuse erythema and multiple raised erosions were seen

Duodenum : D1:bulb deformity and pseudodiverticulum formation was seen.
D2:Normal

Diagnosis : **Healed Duodenal ulcer + bulb deformity**
Corpous gastritis

Specimen:

Antral mucosa biopsy

Macroscopy:

Received Specimen in formalin consists of 3 creamy-gray tissue fragments totally measured: 0.6x0.5x0.4cm.

SOS: 3/1 E:100%

Microscopy:

Sections from Antral mucosa show severe infiltration of lymphoplasmacell and PMNs, performing several lymphoid follicles in lamina propria . Som PMNs permeated in glands.

On Giemsa staining show H.pylori infection (II/III).

١٤٠١ / ٤ / ٢١ B
١٤-١/٥/٢
١٤٠ ١٣/١٩

Diagnosis:

Antral mucosa, Endoscopic biopsy :

Follicular chronic active gastritis with H. pylori infection (II/III) ✓

- No metaplasia/ No dysplasia /Atrophy OLGA staging:0/IV

Note: Rebiopsy after treatment is recommended.

Macroscopic:

Received specimen in formalin consists of three soft tan pieces total measuring1x1 x0.3 cm.

Microscopic:

Sections show ileal mucosa consists of glands and lamina propria. Mild edema is seen in lamina propria. No architectural abnormality is identified. Lymphoid follicles are noted as well.

Diagnosis :

Small Bowel Biopsy:

-No Diagnostic Abnormality

اصلی بیمار و تشخیص اولیه

CC : درد شکم و کاهش وزن و اسهال

Chief complaint of the Patient & Primary Diagnosis

PI : بیمار آقای ۳۷ ساله که از حدود ۲ سال قبل دچار درد شکم شده که به صورت دوره‌ای بوده است و همراه با تب ... و شرح حال GIB می‌دهد و در اندوسکوپی افزایش ضخامت جدار معده را داشته است ... زمان گزارش شده و کولونوسکوپی ... و برای بیمار احتمال کرون مطرح بوده و بیمار جهت نمونه‌برداری به این مرکز ارجاع شده است.

تشخیص نهایی

Diagnosis

WBC = 8800 Neut ... Hb = 10.7 Plt = 164000 BUN = 6 Cr = 0.8

اقدامات درمانی و اعمال جراحی:

Medical & Surgical Procedures:

Na = 138 K = 4 PH = 7.40 HCO3 = 25.0 PCO2 = 38.9

شرح عمل ← تشخیص قبل از عمل ← chronic abd pain R/O IBD

تشخیص بعد از عمل ← The same

آزمایشات پاراکلینیکی

Results of Paraclinical Examination

لاپاراتومی میدلاین با برش اطراف ناف انجام شد لوپ‌های روده بخصوص در سمت دیستال افزایش ضخامت نداشت و شواهد مهاجرت چربی‌های مزانتریک به سمت روده داشت سطوح صفاقی یافته پاتولوژیک نداشت و لنف ادنوپاتی مزانتریک نداشت

سیر بیماری (در صورت فوت، علت مرگ)

Disease Progress (Cause Of Death)

از محل مشکوک به درگیری IBD انتروتومی انجام شد و بیوپسی تمام ضخامت به عمل آمد و به پاتولوژی ...

وضعیت بیمار هنگام ترخیص: محل انتروتومی ترمیم و فلاپ داخل شکم استنر تقویت شد.

Patients Condition on Discharge:

بیمار با حال عمومی خوب و علائم حیاتی پایدار و تفهیم علائم خطر توصیه به مراجعه چهارشنبه به درمانگاه دکتر طالب‌پناه و همراه با استراحت دادن مرخص است

توصیه‌های پس از ترخیص:

Recommendations After Discharge

Microbiology

Helico Bacter Pylori Culture

Specimen	Gastric tissue biopsy (Corpus)
Culture	Helicobacter pylori was not isolated after 4 weeks.
Note	It is recommended to use strict aseptic technique during the tissue samplin procedure & stop taking any antibiotic and antacids at least 2 weeks befo sampling for Helicobacter pylori culture.

Helico Bacter Pylori Culture

Specimen	Gastric tissue biopsy (Antrum)
Culture	Helicobacter pylori was isolated after 2 weeks.
Resistent	Levoflaxacin(1micg/ml),Rifabutin(4micg/ml), Metronidazole(8micg/ml),Clarithromycin(2micg/ml), Tetracycline(0.5micg/ml),Ciprofloxacin(1micg/ml), Ofloxacin(1micg/ml),Furazolidone(0.5micg/ml),
termediate	Amoxicillin(1micg/ml)
ote	According to the least Masstricht protocols,since2016,in order to pre development of multi-drug resistance,Helicobacter culture and Anti S Test have been strongly recommended in the first or second line of t

شیرنشان
پیشکال پاتولوژی
نظام پزشکی ۱۵۴۸

Hematology

Test	Result	Unit	Reference Interval
C.B.C	7400	cumm	3500 - 11000
W.B.C	H 6.26	Mil/Cumm	3.5 - 6
R.B.C	14.6	g/dL	12 - 18
Hemoglobin	44.5	GPL u/mL	36 - 55
Hematocrite	L 71.1	fl	75 - 100
M.C.V	L 23.3	pg	25 - 37
M.C.H	32.8	GPL u/mL	30 - 37
M.C.H.C	237000	cumm	150000 - 450000
Platelets	15.6	GPL u/mL	10 - 16
R.D.W	برگه کولتر به پیوست می باشد		
Comments			

H=High L=Low

Parasitology

Test	1st Specimen
H.pylori Ag (Stool)	Negative

With best regarder

Questions:

- Despite full thickness biopsy, we still don't have a diagnosis?
- What is the decision about the thickness of the stomach wall in CT scan?

A 39-year-old man

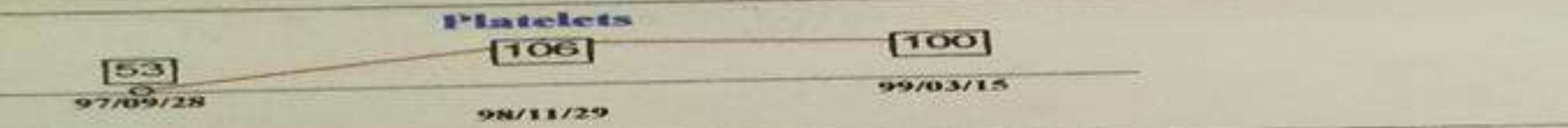
- The patient is a 39-year-old man with a history of Wilson's disease from about 20 years ago. Until about 2 years ago, the patient was treated with Penicillamine 3 times a day, which, according to the patient, was increased to 12 times a day following the worsening of neurological symptoms. He was treated with this amount of Penicillamine, and due to his drug intolerance, he changed his doctor, and Penicillamine was stopped (probably due to pancytopenia) and zinc was started, and he was referred to a gastroenterologist on the recommendation of a neurologist, and the patient was diagnosed with liver cirrhosis. The patient mentions that following the discontinuation of Penicillamine, the neurological symptoms have worsened and some degrees of inability to move have developed. Recently, the patient has been hospitalized three times with decreased level of consciousness. Recently, he has been started with Trientine by a gastroenterologist due to the prominence of his neurological symptoms (paraplegia and Bradykinesia).

Question(s):

- Is the patient a candidate for liver transplant? According to Meld score: 14
- Does liver transplantation improve the patient's neurological symptoms?
- Selective treatment?

ematological

Test	Result		Unit	Reference Range
omplete Blood Count				
CBC	Attached Sheet			
W.B.C	2.12	L	10^3/µl	4 - 10.8
R.B.C	5.11		10^6/µl	4.2 - 6.1
Hemoglobin	13.1		g/dL	12 - 18
Hematocrit	40.1		%	36 - 52
MCV	78.5	L	fl	79 - 99
MCH	25.6		pg	24 - 34
MCHC	32.7		g/dL	30 - 38
Platelets	100	L	10^3/µl	150 - 400



lood Biochemistry

Test	Result	Unit
S.G.O.T (AST)	19	U/L
S.G.P.T (ALT)	22	U/L

Test	Reuslt		NormalRang
Calcium	9 15	(Normal)	8 5_10
Inorganic Phosphorus	2 5	(Low)	2 6_4 5
AST(SGOT)1	45	(High)	10_40
ALT(SGPT)1	28	(Normal)	10_41
ALP	246	(Normal)	100_270
Serum Albumin	3 3	(Low)	3 9_4 9
Sodium	137	(Normal)	136_145
Potassium	4 1	(Normal)	3 5_5 1
Bilirubin Total	1 64	(High)	0 1_1 1
Bilirubin Direct	0 41	(High)	0 1_0 3
Blood Sugar	89	(Normal)	70_135
Magnesium	1 8	(Normal)	1 8_2 6

Serology

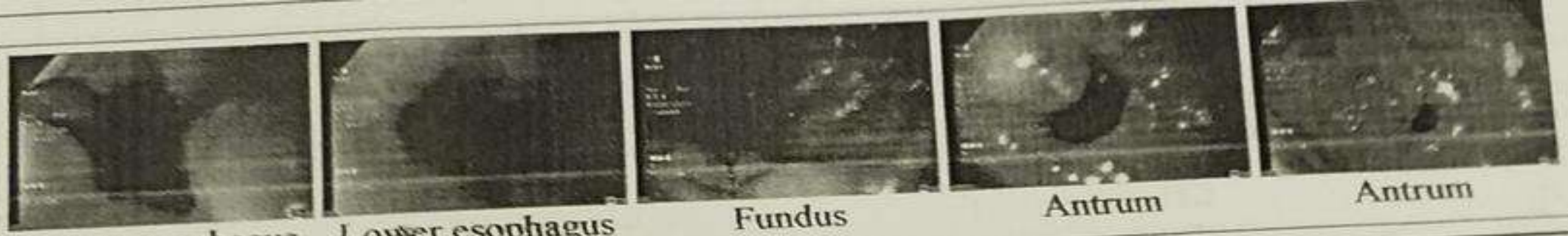
زمان درخواست ۱۴۰۲/۰۳/۱۰ ۱۲:۳۴:۱۴
زمان دریافت ۱۴۰۲/۰۳/۱۰ ۱۲:۴۲۳۰
زمان جواب ۱۴۰۲/۰۳/۱۰ ۱۴:۰۳:۱۸

Test	Reuslt		NormalRang
CRP کمی	9	(High)	0_6

VBG

زمان درخواست ۱۴۰۲/۰۳/۱۰ ۱۲:۳۴:۱۴
زمان دریافت ۱۴۰۲/۰۳/۱۰ ۱۲:۴۲۳۰
زمان جواب ۱۴۰۲/۰۳/۱۰ ۱۲:۴۳:۴۹

Test	Reuslt		NormalRang
BB	38 8		
PH	7 422	(Normal)	7 32_7 43
PCO2	27 7	(Low)	41_51
PO2	44 9	(High)	30_40
HCO3	17 /	(Low)	23_29
BEecf	-6 7		
BE	-8 0		
O2set	82 8		



Lower esophagus | Lower esophagus | Fundus | Antrum | Antrum

Reason for Endoscopy : WD, Cirrhosis, Hx of esophageal and EVL, No Hx of upper GIB, Refe
for evaluation of varices.

Description of procedure : Upper GI endoscopy was done up to second portion of Duodenu
by Olympus 190 apparatus.

Findings :

Esophagus : At least 3 rows of F1-F2 varices without red marking was seen in lower and mid
thirds.

Stomach : No fundal varices, Snake skin appearance was seen all through the stomach.

Duodenum : D1 and D2 were normal.

Diagnosis : Esophageal Varices (F1-F2)
Portal Hypertensive Gastropathy

زمان دریافت: ۱۴۰۲/۰۳/۱۰ ۱۶:۲۱:۴۳

زمان جواب: ۱۴۰۲/۰۳/۱۰ ۱۶:۲۱:۴۳

Test	Reuslt		NormalRang
M.C.H	26 52	(Normal)	26_32
M.C.H.C	32 47	(Normal)	32_36
M.C.V	81 69		
R.D.W	17 3	(High)	11_13
W.B.C	2.8	(Low)	4_10
R.B.C	4 26	(Normal)	3.9_5.9
Hemoglobin	11 3	(Low)	14_18
Hematocrit	34 8	(Low)	42_52
Platelet	33	(Low)	150_450
Lymphocytes	24.6		
Mix	16.0		
Neutrophils	59.4		

E.S.R

زمان درخواست: ۱۴۰۲/۰۳/۱۰ ۱۲:۲۴:۱۴

زمان دریافت: ۱۴۰۲/۰۳/۱۰ ۱۲:۴۲:۳۰

زمان جواب: ۱۴۰۲/۰۳/۱۰ ۱۵:۴۹:۳۸

Test	Reuslt		NormalRang
ESR 1st hr	38	(High)	0_12

Coagulation2

زمان درخواست: ۱۴۰۲/۰۳/۱۰ ۱۲:۲۴:۱۴

زمان دریافت: ۱۴۰۲/۰۳/۱۰ ۱۲:۴۲:۳۰

زمان جواب: ۱۴۰۲/۰۳/۱۰ ۱۳:۴۶:۱۲

Test	Reuslt		Normalrang
PTT	47	(High)	28_4
PT, Prothrombin Time	20.1	(High)	13_15
INR	1 67	(High)	1_1.2

کبد سایز نرمال دارد . (Liver span = 86 mm)

اکوی پارانشیم کبد coarse و حاشیه آن لوبوله می باشد ، در بررسی با پروب سطحی کپسول کبد ندولر می باشد ؛ زاویه لوب چپ کبد 52 و افزایش یافته می باشد ؛ یافته های فوق مطرح کننده درجاتی از سیروز کبدی می باشد .

عروق واریکونید ناشی از افزایش فشار ورید پورت در مجاور لبه لوب چپ کبد مشهود است .

قطر IVC و وریدهای داخل کبدی نرمال به نظر می رسد .

مجاری اینترا و اکسترا هپاتیک پترن نرمال دارند .

قطر قدامی خلفی پورت 14 mm و افزایش یافته می باشد ولی جریان خون در آن هپاتوپتال و ترومبوز در ورید پورت مشاهده نشد .

افزایش ضخامت جداری کیسه صفرا بدون اسلاژ یا سنگ صفراوی مشهود است که با توجه به بیماری زمینه ای کبد قابل توجیه است .

Head و Body پانکراس طبیعی مشاهده شد .

طحال سایز افزایش یافته دارد که با توجه به شرایط سیروز در کبد قابل توجیه است . (Spleen span = 183 mm)

لیه ها سایز و اکوپاترن نرمال دارند و Solid mass , هیدرونفروز یا stone با sharp shadow در آن ها دیده نشد .

یه راست : با طول 104 mm و با ضخامت پارانشیم 15 mm و کورتیکال و مدولاری نرمال مشاهده شد .

ه چپ : با طول 123 mm و با ضخامت پارانشیم 15 mm و کورتیکال و مدولاری نرمال مشاهده شد .

Ma یا آسیت یا لنفادنوپاتی پاراآنورتیک دیده نشد .

ه داراي ضخامت جداری نرمال بدون رویت Mass می باشد .

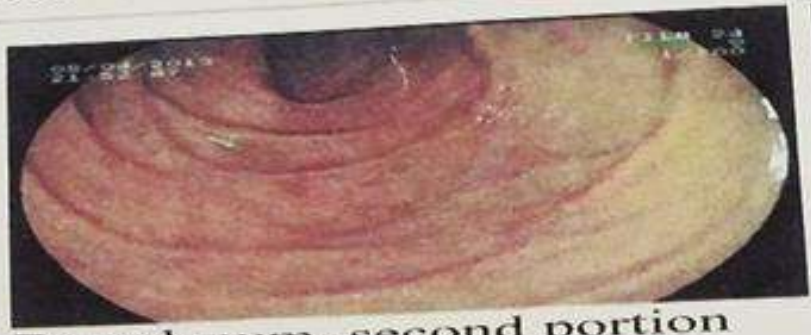
A 30-year-old female

- A 30-year-old female patient, who has had heartburn, vomiting and reflux symptoms since the age of 9, with a history of frequent reflux and vomiting, and Barrett's Esophagus (according to the patient herself), underwent fundoplication (no documents) in 2013. After the surgery, the patient suffered from swallowing disorder for some time, and after the recovery, reflux has relapsed again.

- Since 2016, she was treated by Prednisolone, Azaram, Hydroxychloroquine, Domperidone, Rabeprazole, according to the patient's tests and manifestations (myocarditis, increase in liver enzymes, and positive rheumatologic tests, including ANA and ACE)
- Now, the patient explains that since 2019 and after and episode of COVID, he feels every solid food gets stuck in his esophagus for about an hour, and this feeling is hardly relieved by drinking water, and also he vomits part of meals about an hour after eating.

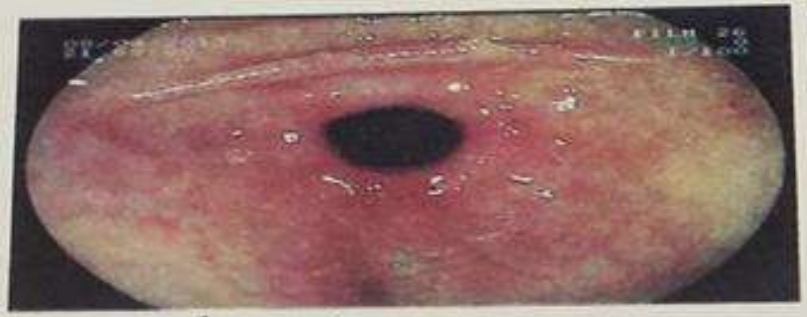
- Question: What are diagnostic and treatment options?

شماره پرونده: ۹۲۰۰۰۲۳

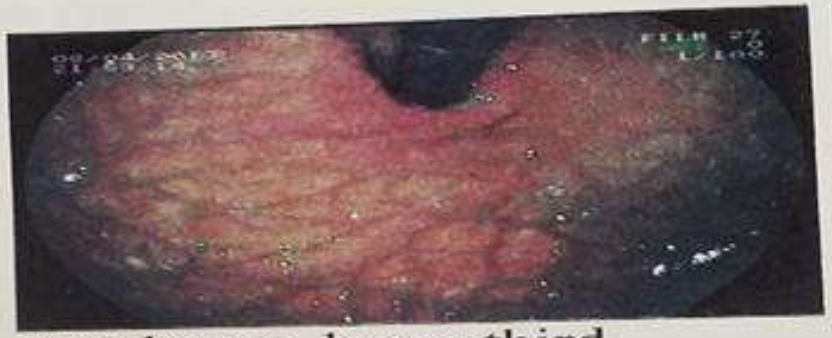


Deuodenum, second portion

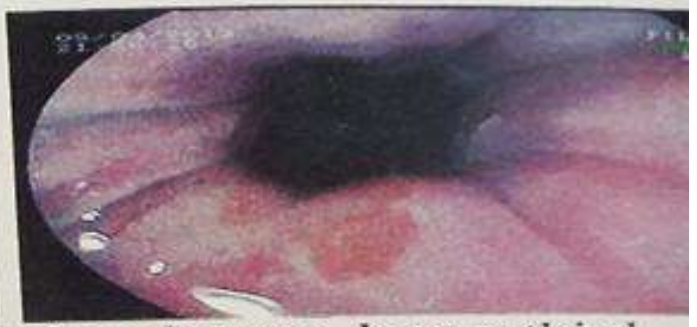
Deuodenum, bulb



Stomach, antrum



Esophagus, lower third



Esophagus, lower third

Sedation:
Esophagus: The salmon-colored tongue of mucosa was seen in the background of the th
pink squamous mucosa of distal esophagus ,biopsy was done
Stomach: Patchy erythema & with pale mucosa were seen on the gastric mucosa , so t
biopsy was obtained . Sliding hiatal hernia was seen .
Duodenum: Bulb and D2 were mild hyperemic & edematous, so that biopsy was ob
rom D2
Final Diagnosis: Erythematous mucosa of stomach R/O: Gastritis and Sliding hiatus he
Comment : See pathology report & follow up

2016 october 8

Dear Dr:ROGHA
Patient:KHATON ABADI.N.S
Date:95/7/17

Solid Phase Gastric Emptying Scintigraphy:

Imaging Procedure:

Following oral ingestion of 0.3mci of Tc-99m-phytate-solid meal, scanning was performed from the abdomen in LAO position, then quantitative data was performed at 1,2 and 4 hours.

Imaging Findings:
The study shows normal lag phase,normal moving of the food from the fundus to the anthrum and intestine.

The values were 10%, 60% and 95% at 1,2 and 4 hours, respectively.

Impression:Normal scan.

ESOPHAGOGRAM

Swallowing function was normal.

Esophagus has normal caliber with smooth mucosa, no abnormal narrowing or dilatation is present.

No G-E reflux or hiatal hernia is seen.

Impression: Normal esophagogram

Esophageal manometry re[illegible]t

[illegible]oon abadi, Neloufa

Gender:	Female	Investigation nr:	04
Date of birth:	01/01/1990	Private clinic:	Sepahan GI Center
Patient number:	164282 92/3/25	Investigator:	Dr. Rasouli
Investigation date:	03/02/2013	Referred by:	dr shavakhi

LES results

LES upper border	42.7 cm
LES lower border	44.4 cm
LES length	1.7 cm
PIP position	43.5 cm
Intraabdominal length	0.9 cm
Resting pressure	9* mmHg
Minimum resting pressure	7* mmHg

UES results

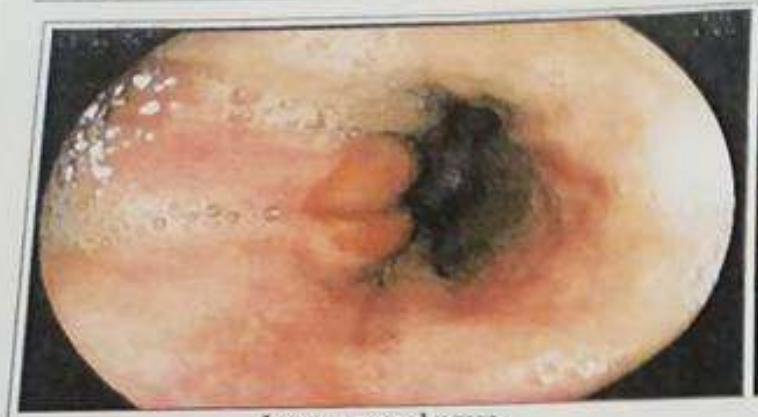
UES upper border	16.8 cm
UES lower border	19.4 cm
UES length	2.6 cm
Resting pressure	72 mmHg
Minimum resting pressure	13 mmHg

Average calculations for 9 (Wet swallow 5 ml) swallow(s)

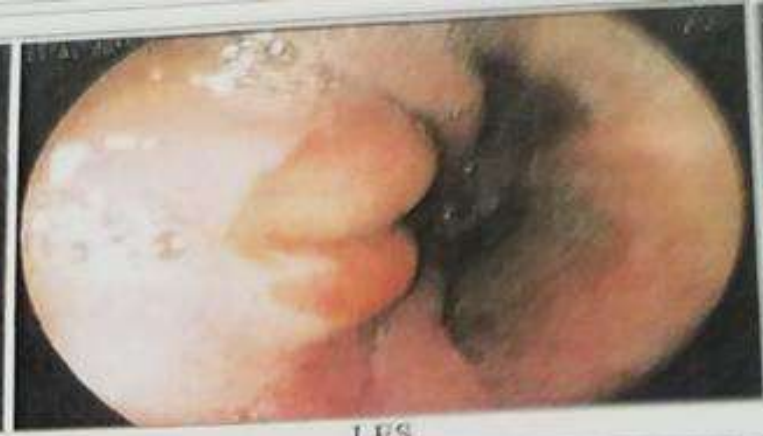
	Amplitude (mmHg) [30-160]	Duration (s) [2-6]	
P18	44	2.42	
P16	26	2.18	
P15	20	1.98	
P14	23	2.08	
P13	28	2.59	
[illegible]	49	3.54	
P8	57	5.36	
DCI	0		mmHg.s.cm
DCI Mean	0		mmHg

	LES Mean		UES Mean		
Resting	8	[6-25]	44	[46-81]	mmHg
Residual	8		10		mmHg
Percentage	2		78		%
Onset v.	-4.73				cm/s
Peak v.	-4.89				cm/

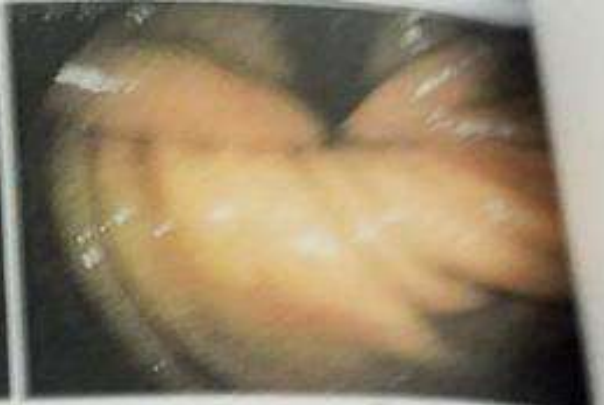
	#	%	
Non transmitted contractions	4	44.4	
Dropped contractions	5	55.6	



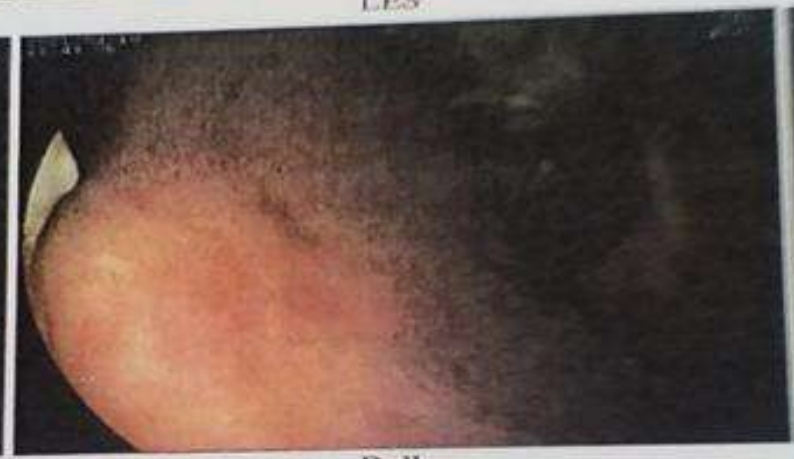
Lower esophagus



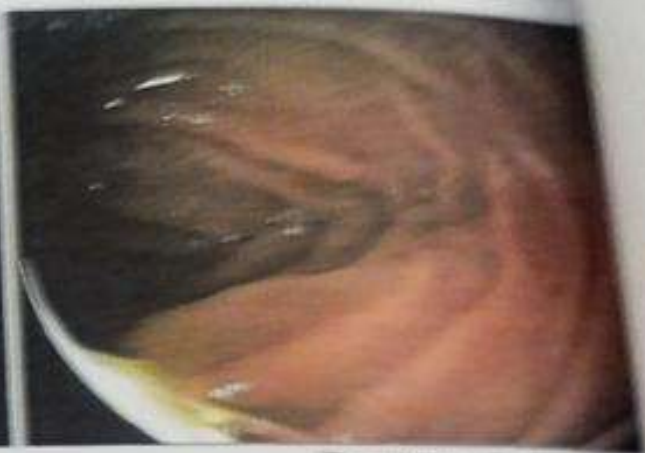
LES



Antrum



Bulb



Reason for Endoscopy : Longstanding GERD

Premedication : Midazolam

Description of procedure : Optimum

Findings :

Esophagus : Irregular z.line but no evidence of esophagitis or columnar lined epithelium.

Stomach : Evidence of previous Nissen Funduplication with Normal findings in all parts.

Duodenum : Normal D1 & D2

Diagnosis : As mentioned above

Investigation memo

CC :Dysphagia (Hx of antireflux surgery)
The equipment was calibrated prior to the study and catheter was placed via the nares.
While the patient was fasting :12 hours .
Local anesthesia that was used :Xylocaine Gel .
contra-indications to performing oesophageal studies :No
conditions that may hinder the performance or interpretation of the test (eg. large hiatal hernias, previous oesophageal surgery) :No
Any concurrent medication history :No

High resolution manometry results (average result of ten wet swallow):

1- UES(upper esophageal sphincter) result :Upper border was 17 cm , Resting pressure was 53 mmHg ,IRP(integrated relaxation pressure) in 2 second was 4 mmHg

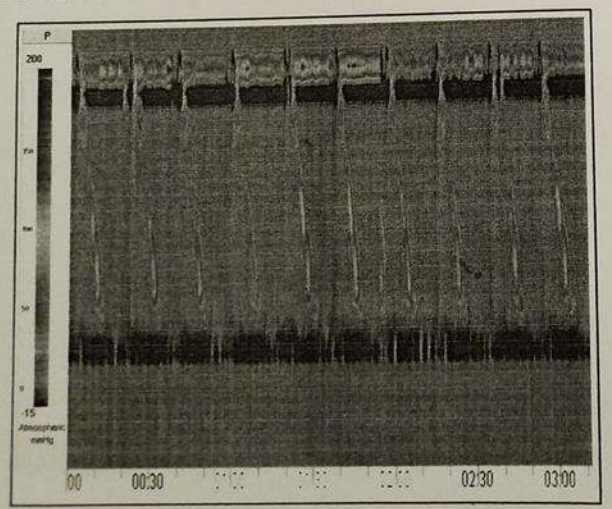
2-LES (lower esophageal sphincter) result :Upper border was 42.5 cm ,Resting pressure was 16 mmHg (normal=10-45), IRP was 0.42 mmHg(normal<15mmHg) ,without hiatal hernia .

3- Result of esophageal body contraction in wet swallow : Mean DL (distal latency) was 8.7 second(N0rmal>4.5 second) ,Mean DCI(distal contraction integral) was 875 mmHg.s.cm (normal <5000mmHg.s.cm) ,100 % of wet swallow contraction were peristaltic without large break and intrabolus pressure was with Normal pressurization.

MRS was normal.

Investigation conclusion : Normal manometry

Average of 10: Wet swallow 5 ml



Chicago classification[3] *

Normal

* The normal values and analysis are according to the Chicago Classification[3] as published in Neurogastroenterology & Motility, 2015, Vol. 27, Issue 2, p160-174. The classification is valid for adults and based on series of 10 swallows of 5 ml water each, swallowed in a supine posture. The Chicago Classification is only applicable for primary esophageal motility disorders. Th actual diagnosis remains under all circumstances the responsibility of the clinician/physician.

Esophagus

DCI	875 mmHg.s.cm
Peristaltic breaks	5.4 cm
Distal Latency	8.7 s

UES

Upper border	17.0 cm
IRP 0.2 s	-3.6 mmHg

LES

Upper border	42.5 cm
IRP 4 s	

Solid Phase Gastric Emptying Scintigraphy:

Imaging Procedure:

Following oral ingestion of 0.3mci of Tc-99m-phytate-solid meal,scanning was performed from the abdomen with dual head camera, then quantitative data was performed at in 2, 30, 90, 180 min and 4 hours.

Imaging Findings:
The study shows moderate to severe prolonged lag phase, moderate to severe delayed moving of the food from the fundus to the anthrum and intestine.

The emptying values were 9%, 30% and 58% in 30, 90, 180 min and 4 hours, respectively.

Impression: Moderate gastroparesis.

A 26-year-old female

- A 26-year-old female who was evaluated in 2005 due to epigastric abdominal pain, jaundice and N/V, was positive for HAV in the initial tests, and after about 2 weeks, jaundice and other symptoms disappeared. Six months later, following the appearance of similar symptoms, he was hospitalized, and this time the autoimmune hepatitis markers ANA, Anti Lkm1 were positive, and the patient underwent a liver core needle biopsy, which was reported to be autoimmune hepatitis. Although the documents are not available, it was recorded in the file and periodic visits by Dr. Saneyan and the patient was treated with prednisolone and azathioprine.

- **Ultrasound on 2016**
- Liver with span: 108 mm
- It has a coarse echo pattern and nodular surface.
- Intrahepatic and extrahepatic bile ducts are normal.
- The size of the spleen is 117 mm, free fluid was not seen.
- IMP: **cirrhosis & No definite sign of portal HTN**

- **Ultrasound of the liver and bile ducts on 2017**
- Cirrhotic liver (irregular outer border and coarse parenchymal echo) without space-occupying lesions
- The gallbladder has a normal volume and wall, and no stones or masses were observed in it.
- Dilation of intrahepatic and extrahepatic bile ducts was not seen.
- Spleen with a maximum span of 127 mm is normal

Endoscopy in 2017:

- Esophagus: Erythematous & Edematous mucosa were seen
- Stomach: Erythematous, edematous, granular, nodular, friable & hemorrhagic mucosa were seen, biopsy was taken
- Duodenum: Nl
- Jejunum: Nl
- **Biopsy:**
- Superficial erosive antritis. H.Pylori was negative.
- Mild incomplete intestinal metaplasia (OLGIM score 1/4)
- NO atrophy

- **Fibro scan on 8/8/1400:**
- Metavir score: F2F3
- Steatosis stage: S1
- **Fibro scan on 5/4/1402**
- Metavir score: F4
- Steatosis stage; S1
- **Abdominal and pelvic full ultrasound on 3/16/1402**
- The echo of the liver is heterogeneous and coarse, and its border is nodular, the findings are suggestive of cirrhosis.
- the gallbladder has a normal volume and wall thickness, and there is no space-occupying mass or stone.
- The diameter of the portal vein is normal, and the intrahepatic and extrahepatic bile ducts are normal
- The size and echoptteran of the spleen is normal.

FBS: 78	Cr: .77	Chol: 165
TG: 44	HDL: 66	LDL: 90
AST: 31	**ALT: 12**	ALKP: 115
Ferritin: 34	TSH: 4.2	VIT D: 22
HB: 14.3	**PLT: 130000**	Bili T: 1
INR: 1.53	**Alb: 3.6**	

- SPEP:
- Alb:64
- Alpha I: 2.6
- Alpha ll: 8.2
- Beta: 8.1
- Gamma: 16.8 (1.2gr/dl)

Q:

- A patient with a history of AIH who is being treated with budesonide and azaram has recently been reported F4 in the fibroscan. Is there a need to increase or change the medication in the osteoporotic patient?

A 42-year-old man

- A 42-year-old man who has been suffering from weight loss and abdominal pain in the epigastric area and diarrhea since 6 years ago, has undergone upper GI endoscopy and colonoscopy:
- **Colonoscopy:** Normal Total colonoscopy
- **Endoscopy:**
- Esophagus: Nl
- Stomach: Nl in all part
- D1: NL
- D2&D3: *Evidence of villous atrophy + scalloping Were seen.* Bx were taken
- Imp: Highly suspicious to celiac Disease

- **Pathology:** D2&D3 biopsies:
- Celiac disease
- In the following: DQ2 positive & DQ8 Negative
- The patient was treated with a gluten-free diet, and the patient's symptoms improved
- Endoscopy was performed again in 2019:

- Re-Endoscopy in 2019:
- Imp: Esophagitis LA classification grade A
- Stomach; Nl
- Bulb: Nl
- D2: Obvious villous atrophy & mucosal fissuring & scattered mucosal erythematous patches. Bx were taken
- Pathology: celiac disease (marsh type II)
- Since 2 years ago, the patient again had diarrhea + weight loss and abdominal pain despite following the GFD, and upper endoscopy was performed again:

- **upper endoscopy 4/22/1401:**
- Esophagus: Normal
- Stomach: Nl
- Duodenum: marked villous atrophy in bulb & D2 & mucosal fissuring & scalloping in D2 segment. Biopsy was taken.
- **Pathology:**
- D1 revealed mild & focal villi atrophy
- D2 revealed mild & focal villi atrophy

Comment: less than diagnostic criteria for celiac disease.

Please correlate with clinical history and challenge test for diagnosis March I of celiac.

- Due to the continuation of the symptoms, an enteroscopy was performed on 8/4/1401:
- Diagnosis: Crohn's disease associated with celiac disease
- Pathology:
- Duodenum revealed Duodenitis with partial villi atrophy and mild activity
- Jejunum revealed mild active enteritis
- Ileum revealed mild active ileitis
- Comments: finding suggested inflammatory bowel disease but cannot exclude the concurrent celiac disease

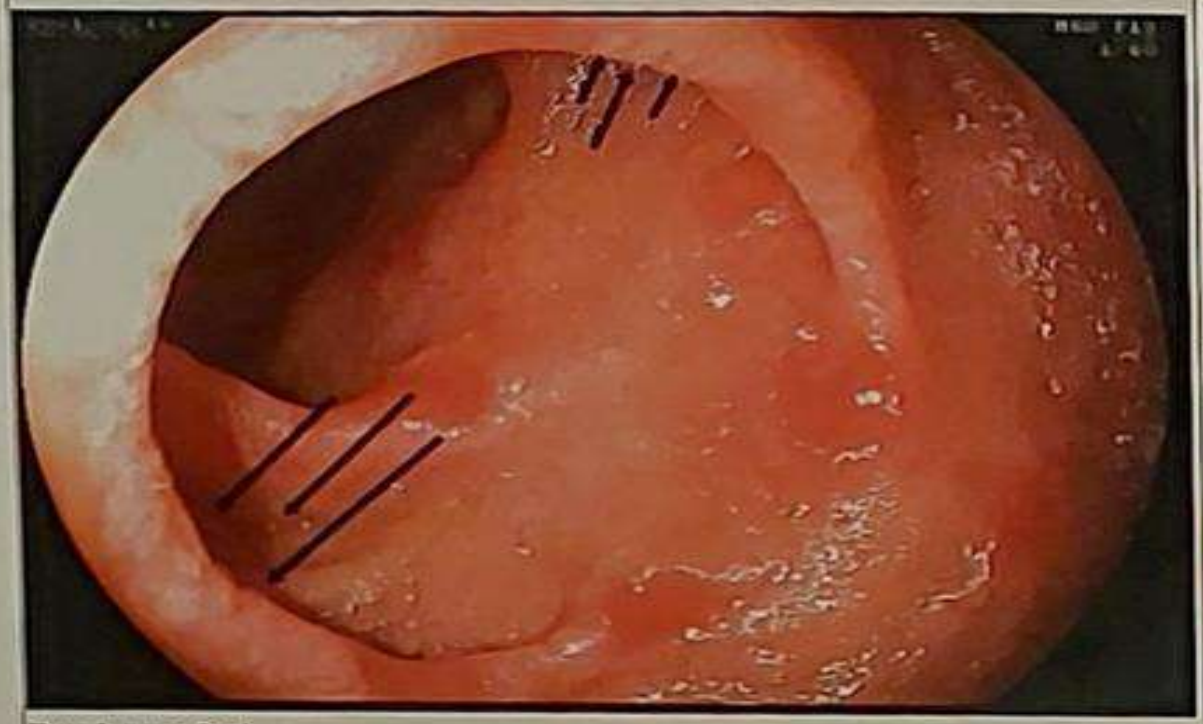
Hb: 12	MCV: 82	**MCH:28**
Plt: 293000	ESR: 10	**AST: 40**
Alt: 50	Total pro: 6.8	**Albumin: 2.7**
Mg: 1.9	CRP: ++	Anti TTG Ab (IgG): 53.6
Anti TTG Ab (IgA): >100	Anti-gliadin(IgG):16.5	Anti-gliadin (IgA): 19.3
Anti Endomesial Ab (IgA): positive	Anti Endomesial Ab (IgG): positive	

- **lab Data: 2/12/1402**

Hb: 12.4	MCV: 97	MCH: 31.2
Plt: 207000	Total Bili : .49	AST: 43
Alt: 47	Alp: 311	CRP: non-reactive
Stool calprotectin: 331/6	Anti TTG IgA: 2.6	IgA serum: 181/4
Alb: 3.2		

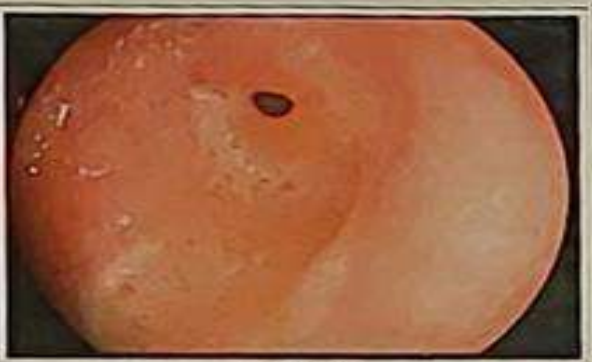
Q:

- According to the above history, Budesonide, Azaram, and CinnoRA were started for the treatment of IBD:
- The patient is a 42-year-old man with a history of treatment-resistant celiac disease, who has not gained weight despite following the GFD and has nausea and vomiting, as well as abdominal pains. He was treated with the possibility of Crohn's disease, but he did not respond well to the treatment.
- Q: Appropriate diagnostic and therapeutic measures?



Duodenum,2nd

LES



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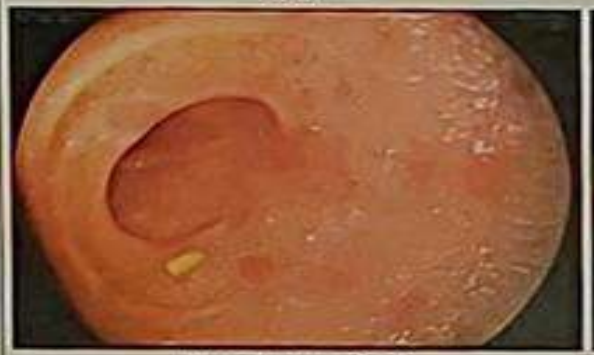
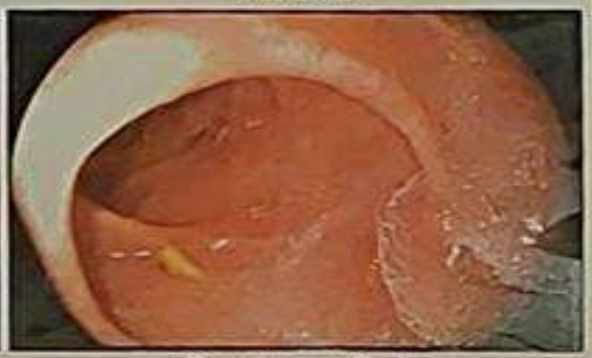


Duodenum,2nd



Duodenum,2nd

Reason for Endoscopy : Celiac Disease
Control EGD

Premedication : Midazolam

Description of procedure : Optimum

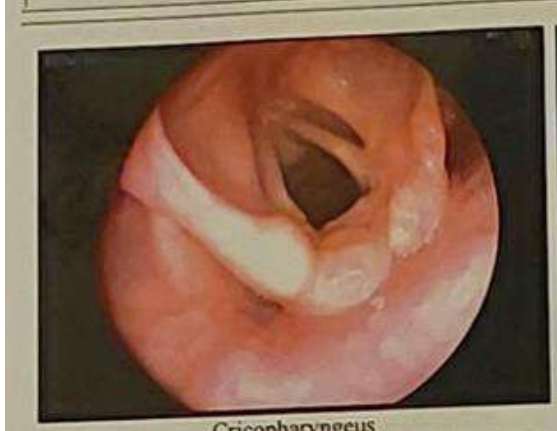
Findings :

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

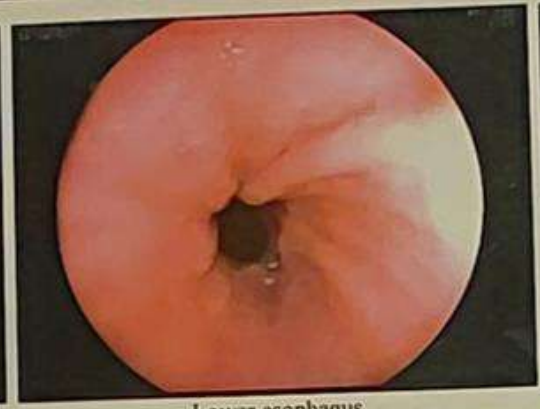
Stomach : Normal in all parts

Duodenum : Nl appearing mucosa in bulb
D2: Obvious villous atrophy & mucosal fissuring & scattered mucoal erythematous patches were seen so[illegible] Biopsies taken

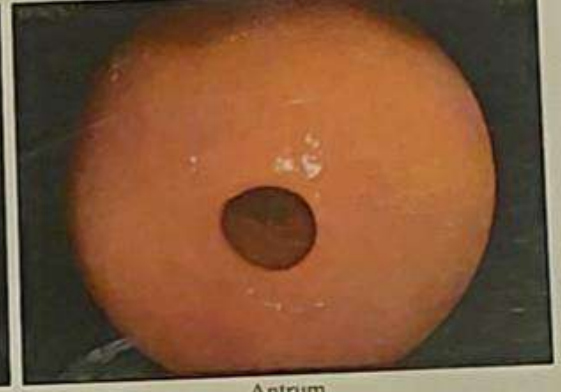
Diagnosis : As mentioned above



Cricopharyngeus



Lower esophagus



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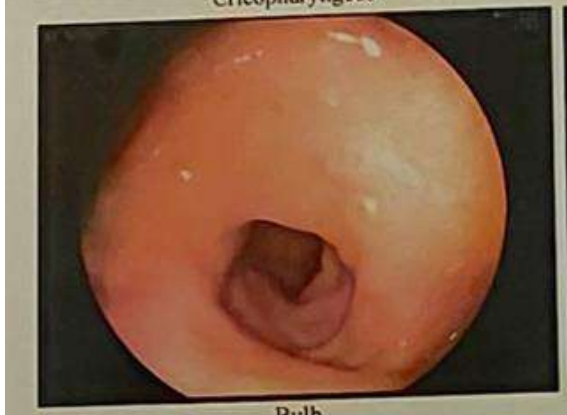
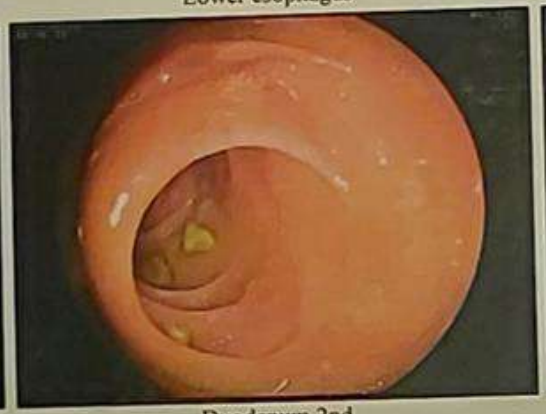
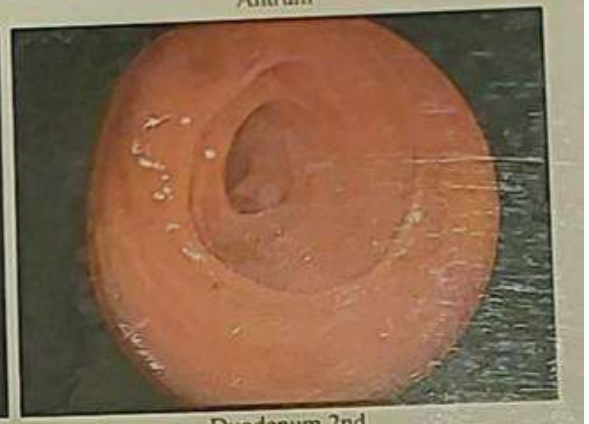


Bulb



Duodenum,2nd



Duodenum,2nd

Reason for Endoscopy : Refratory Celiac Disease

Premedication : Midazolam

Description of procedure : Optimum with HR & PO Monitoring

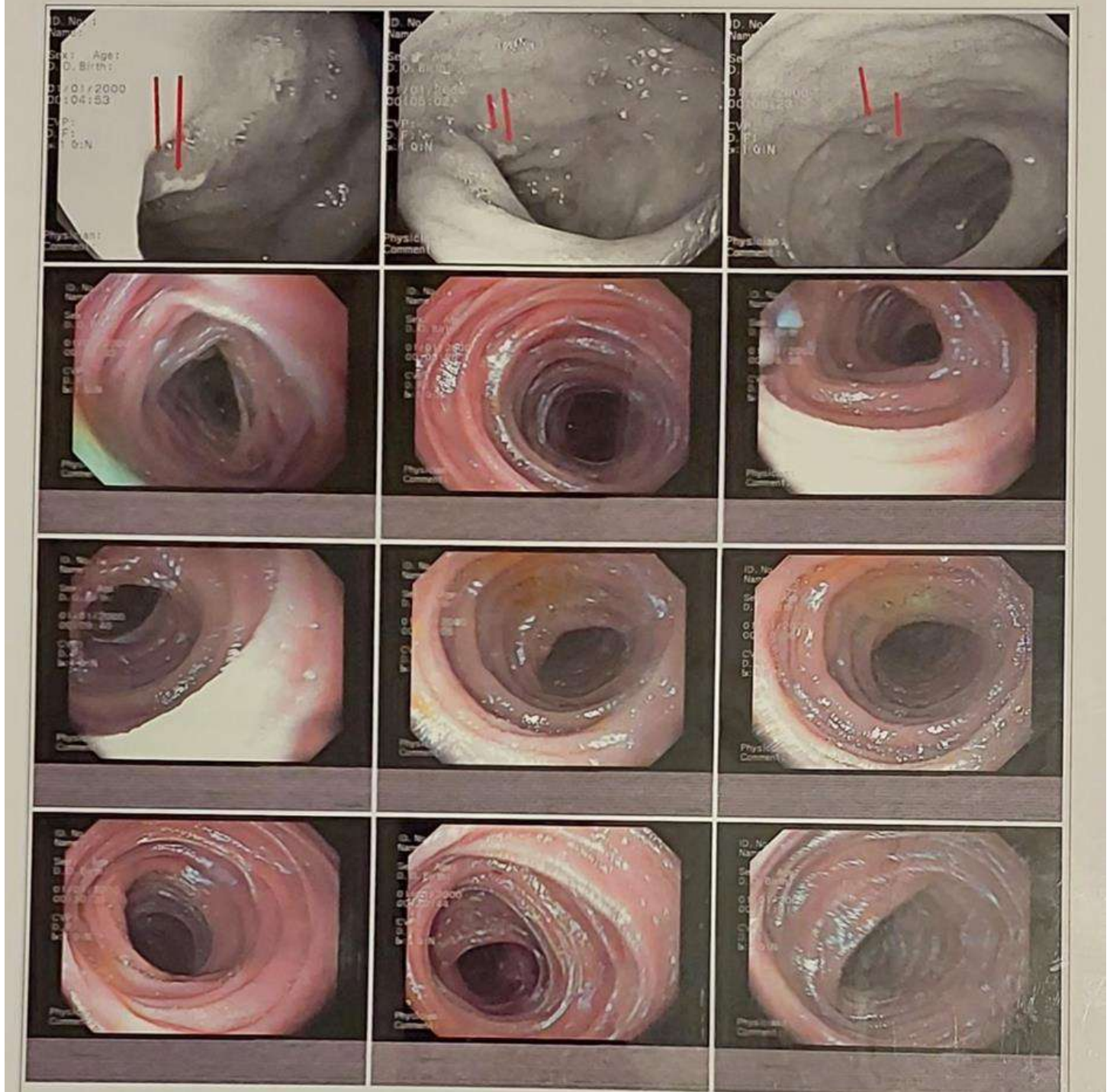
Findings :

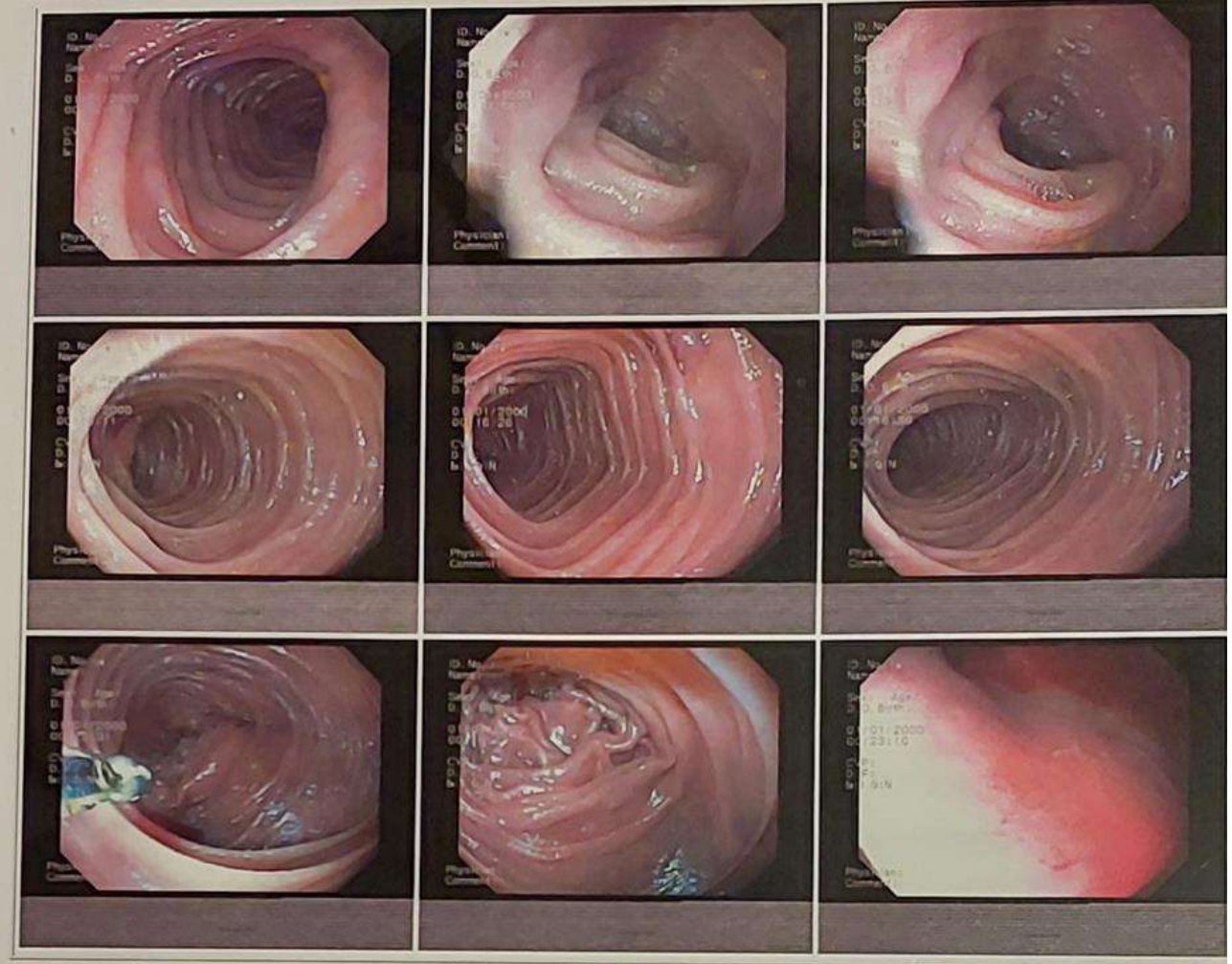
Esophagus : Normal color of mucosa in all parts -Intact Z-line

Stomach : Nl appearing mucosa in all parts.

Duodenum : Marked villous atrophy in bulb & D2 & mucosal fissuring & scallooping in D2 segment was evident so Bx were taken from 1-Bulb 2- D2 and sent for path exam.

Diagnosis : As mentioned above





Reason for Enteroscopy : KCO Celiac Sprue
CC: Recurrent vomiting & weight loss

Premedication : By Anesthesiologist

Description of the Procedure : Optimum with Monitoring of HR & PO by Anesthesiology service

Diagnosis : After Deep sedation + HM & PO Single balloon entroscopy was performed with good quality via Antrograde appraoch & scope was sent from mouth down to Terminal ileum .
Stomach: Normal mucosa & vasculature
D1-D2-D3 : Marked villous atrophy with widespread aphtous like lesions so multiple Bx were taken for path exam.
Jejenum down to terminal ileum were normal in mucosa & vasculature. Bx were taken from 1-D1-D2 2-Jejunum 3-terminal ileum & sent for path exam.
R/O : Crhon s disease associated celiac disease


GOOD
BYE!