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

December 3 2023

List of cases-December 27 2023

	Patient	Fellow	page
230901	**A 24-year-old female**	**Dr. Izadi**	**3**
230902	A 22-year-old female	"	**22**
240903	A 31-year-old female	**Dr. Namaki**	**31**
240904	A 64-year-old female	"	**64**
250901	**A 70-yerars-old man**	**Dr. Jalili**	**90**
250902	A 79-year-old woman	"	**100**

GI commission and grand round

A 24-year-old female

- A patient has been experiencing abdominal pain in the LUQ and pre-umbilical region for a year. The pains are constant, but its intensity is variable (score 2 out of 10) and has no association with eating. It has not been radiated. It is not positional
- During this period, he has been hospitalized repeatedly due to abdominal pain and bloody vomiting, melena or rectal bleeding. The intensity of abdominal pain increases during bleeding. The patient's vomit contains bright blood.
- There were no changes in bowel movements. She does not mention the discharge of mucus and pus. There is no menstrual disorder and GIB did not coincide with menstruation.

- She does not mention a similar family history.
- In the hospital where he had psychiatric consultation, she had one visit on 01/04/05 that MDD and R/O borderline personality disorder has been suggested.
- She has been treated with fluoxetine and gabapentin for a while, and one time in a recent hospitalization on 08/02, bipolar mood disorder was suggested and he was treated with Depakine 200.

- He was hospitalized on 01/01/01 with complaints of rectal bleeding and vomiting containing food and coffee grounds.
- The patient's hemoglobin was in the range of 10-11 during hospitalization and he was discharged with consent.

نوع آندوسكوبي

آندوسكپي

شرح

Procedure: Upper GI endoscopy
Indication: Dyspepsia
Premedication: Spray lidocaine + Propofol
Esophagus: Normal
Stomach: Cardia, Fundus and Antrum were normal and biopsies were taken from antrum. Multiple superficial small clean base ulcers and erosions were seen in proximal of body that biopsies were taken.
Duodenum: D1 D2 were normal.
Imp: Gastric ulcers
Rec: F/u pathology

Multiple superficial small clean bace ulcers and erosion in proximal of body

تشریحی بررسی ظاهری بافت وریزبینی(میکروسکوپی)شامل:معده ابوپسی

EXE.Time 1401/01/01 11:38 Result.Time 1401/01/08 10:49 Print.time

Macroscopic

Received specimen in formalin consist two soft tan pieces total measuring 0.2 x 0.2 x 0.1cm
Received specimen in formalin consist two soft tan pieces total measuring 0.2 x 0.2 x 0.2cm

Diagnosis

Stomach (antrum)Biopsy

-Moderate active Chronic Follicular Antral Gastritis

-Positive for H pylori organism

-Eosinophils: 0 /HPF

-No atrophy or metaplasia

Stomach (Ulcer)Biopsy:

-Mild active Chronic Gastritis

-Positive for H pylori organism

-Eosinophils: 0 /HPF

-No atrophy or metaplasia

نوع آندوسکوپی

کولونوسکپي

شرح

Procedure: Colonoscopy
Indication:Rectorrhagia
Premedication: Propofol
Preparation: B.B.P.S for left and transverse and right colon were 2-2-2
DRE : was normal
Anal canal: Iwas normal
Rectum: Was normal
Sigmoid: was normal
Descending colon: Was normal
Transverse colon: Was normal.
Ascending colon: Was normal.
Cecum: was normal
Terminal ileum: was normal
IMP: Normal colonoscopy

نسخه

On 01/04/05

- She was hospitalized with a complaint of 3 episodes of hematemesis, and she had a normal endoscopy.
- ENT and lung consultations have been done and there were no problem.
- Abdominal ultrasound was normal.
- Thoracic CT performed showed no PTE.

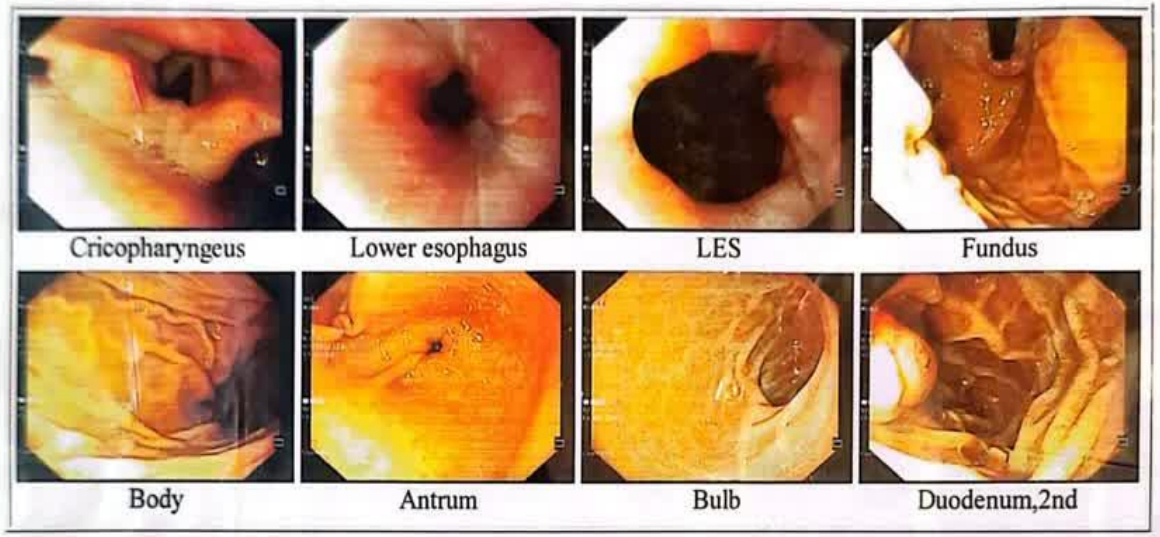
on 02/01/27

- She was admitted with abdominal pain, hematemesis and bloody vomiting.
- Hemoglobin at the time of discharge: 11.8
- Endoscopy: grade A erosive esophagitis
- Colonoscopy: external hemorrhoids and anal fissures
- Abdominal and pelvic CT was performed with contrast, which was normal.

on 02/06/11

- He was admitted with the complaint of rectorrhagea and 3 times of hematemesis.
- Hemoglobin on the day of hospitalization was 11.6 and he was discharged with hemoglobin of 13.
- Lung CT was performed and it was normal.

نام بیمار: طلا محمدی | سن: | شماره پرونده: | تاریخ: 1402/06/12



Reason for Endoscopy : Suspected hematemesis

Premedication : Provided By anesthesiologist

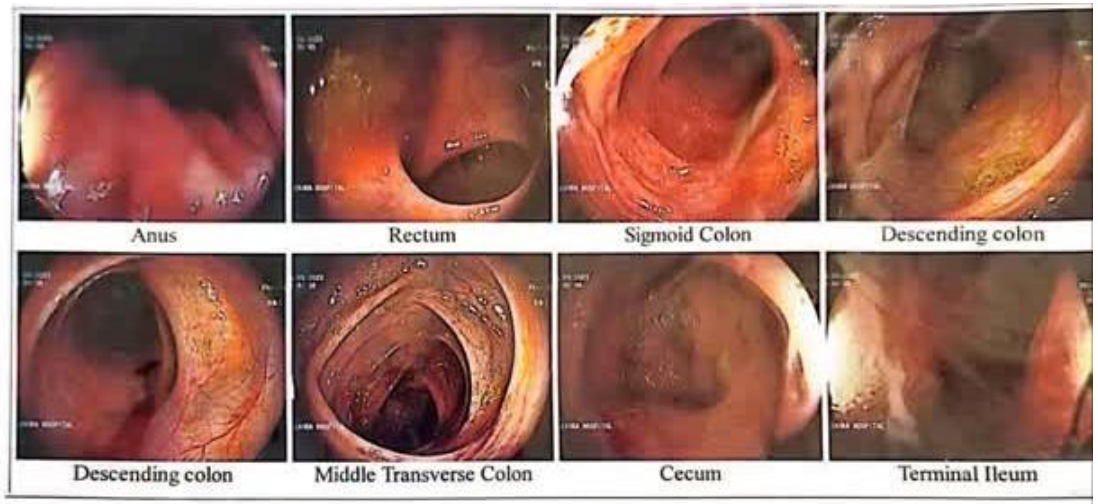
Findings :

Esophagus : Upper & middle thirds were normal. Two islet salmoon color were seen in lower third above GE junction.

Stomach : Cardia,fundus,body & antrum were normal.

Duodenum : Bulb & D2 were normal.

Diagnosis : Esophageal islet salmoon color



Reason for Endoscopy : Rectorrhgia

Premedication : By anesthesiologist

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

Findings :

Anus : Internal hemorrhoids were seen

Retroflex View : Internal hemorrhoids and hypertrophied anal papillae were seen.

Rectum : Normal mucosa and vascular pattern was seen.

Rectosigmoid Junction : 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 : Normal mucosa and vascular pattern was seen.

Diagnosis : Internal hemorrhoid

[redacted]

جوابدهی سی تی اسکن

نام و نام خانوادگی بیمار: طلا محمدی | کد پذیرش بیمار: ۲۷۹۳۷۲ | بیمه بیمار: (ثبت سایر اقلام) اتباع خارجی

پزشک برگه: مسجدی - مهسا | کد برگه: ۲۹۸۲۵ | تاریخ برگه: ۱۴۰۲/۰۳/۱۴ ۱۸:۱۱

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

- :Multisession / Multiplanar study reveal
- Liver has normal size, shape & density with no space occupying lesion or biliary dilatation.
- Spleen and pancreas are normal with no SOL.
- The kidneys are well opacified with normal nephrogram.
- Both adrenal glands are normal.
- No paraaortic adenopathy is present.
- The aortomesentric distance is mildly decreased (down to 6.5 mm) but the (aortomesentric angle is within the normal limit (48 degree
- No evidence of concomitant dilation of D3 segment is determined.
- The left renal vein in mildly compressed by SMA with it's minimal upstream dilation infavour of nutcracker syndrome; correlation with patient's clinical history.
- Pelvic organs are normal.
- There is no abdominopelvic free fluid.

IMP: Normal abdominopelvic CT angiography

R/O nutcracker syndrome

Decreased aortomesentric distance

Best regards
M. Masjedi. MD

Resident
Dr:Nourbakhsh

CT:

R/O Nutcracker
Decreased aortomesentric distance

On 02/06/26
RBC scan

Date: 1402.6.26

GI BLEEDING STUDY:

Following IV injection of 10 mci of Tc –99m-labeled RBC ,scanning was performed from the abdomen and pelvis in early and delayed phases.
The study shows abnormal mildly patchy increased activity at the proximal of the transverse colon with moving to the rest of the colon and rectum and normal distribution of the radiotracer the rest of the abdomen and pelvis.

IMPRESSION:
The study is abnormal GI bleeding from the proximal of the transverse colon

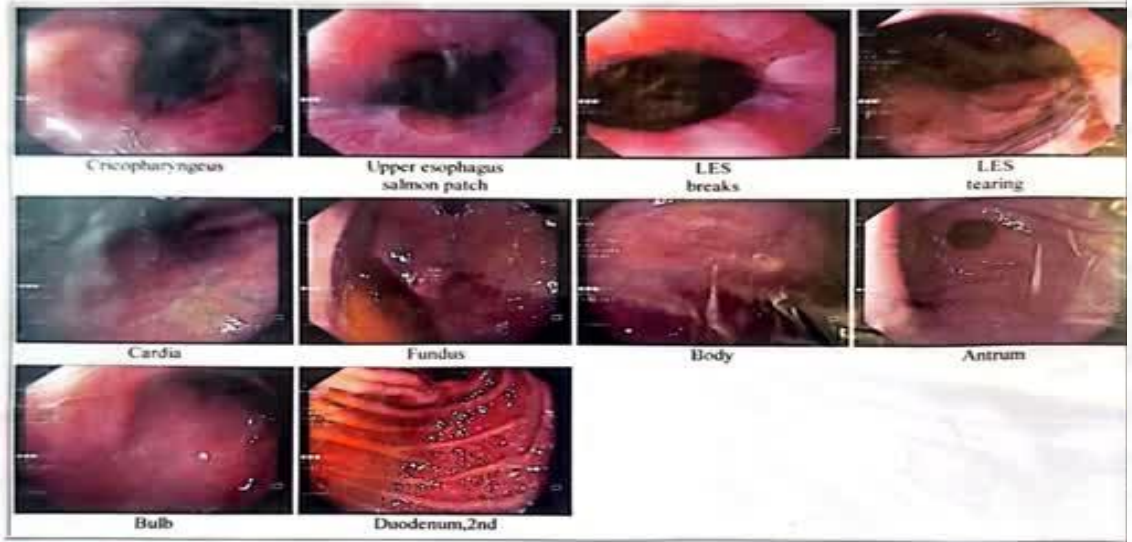
- She was admitted on 02/08/08 with bloody vomiting and rectorrhagea.
- In a recent hospitalization, he complained of repeated hematemesis daily.
- The course of the patient's hemoglobins: From 11.7, 10.8, 11.2, 10.6 and 10.2

مرکز آموزش درمانی الزهرا(س)

Gastrointestinal Endoscopy Ward

UGI Endoscopy Report

تاریخ 1402/08/09 | شماره پرونده | سن:



Reason for Endoscopy : Hematemesis

Premedication : The paitent was sedated by anesthesiologist

Findings :

Esophagus : Uni lateral swelling of cricopharyngeus was seen.Salmon patch was seen at the upper third.There were multiple mucosal break less than 5 mm in LES.Mucosal tearing was seen in LES.

Stomach : Small hiatal hernia was seen. Rugal folds were flattened and the submucosal vessels were visible at the body and antrum.Multiple biopcies(mapping protocol) were taken.

Duodenum : Bulb and D2 were normal.

Diagnosis :
Mallory Weiss Tearing
Esophagitis LA class A
R/O Atrophic gastritis
Sliding hiatal hernia
Swelling of Cricopharygeus

Recommendation : Follow up the pathology report
ENT consult becouse of swelling of cricopharygeus

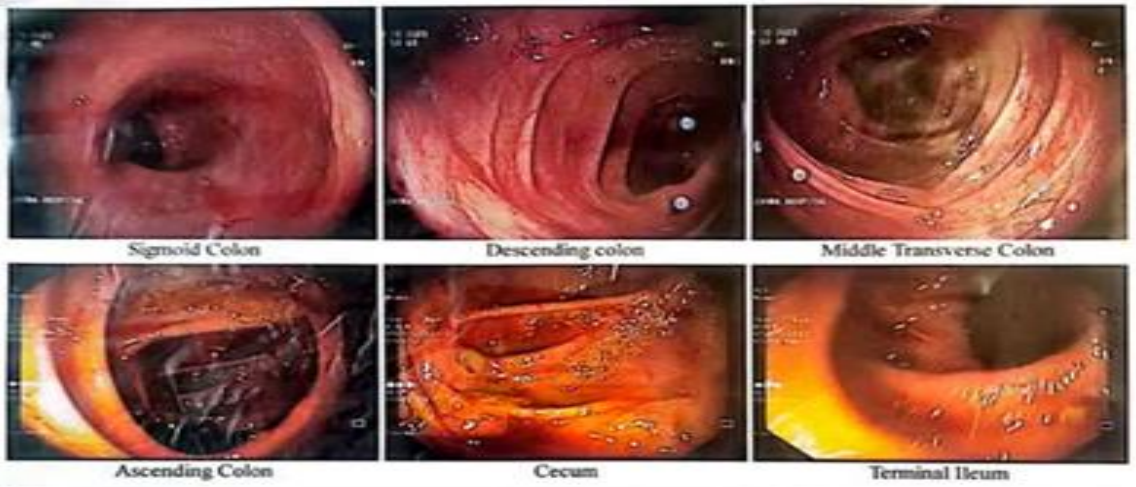
[redacted]

مرکز آموزش درمانی الزهرا(س)

Gastrointestinal Endoscopy Ward

Colonoscopy Report

[redacted] نام بیمار: | سن: | شماره پرونده | تاریخ: ۱۴۰۲/۰۸/۱۰



Reason for Endoscopy : Rectorrhgia

Premedication : By anesthesiologist

Findings :

Anus : Was normal.

Retroflex View : Was normal.

Rectum : Was normal.

Rectosigmoid Junction : Was normal.

Sigmoid : Was normal.

Descending Colon : Was normal.

Transverse Colon : Was normal.

Ascending Colon : Was normal.

Cecum : Was normal.

Terminal Ileum : Was normal.

Diagnosis : Normal colonoscopy

Macroscopic:

1-Received specimen in formalin labeled as body consists of one soft tan piece total measuring 0.3 x 0.2 x 0.2cm
2-Received specimen in formalin labeled as antrum consists of one soft tan piece total measuring 0.3 x 0.2 x 0.2cm

Microscopic:

1-Sections show gastric mucosa consists of glands and lamina propria with normal cytoarchitecture. Inflammation is not increase. H. Pylori is not seen on Giemsa staining.

Diagnosis :

1-Stomach (Body)biopsy:
-No diagnostic abnormality
-Negative for H. pylori

2-Stomach (Antrum) biopsy:
- Mild chronic gastritis
- Negative for H pylori organism
-Negative for atrophy
-Negative for intestinal metaplasia
-OLGA Gastritis Staging: 0 /4
-OLGIM Gastritis Staging: 0/4

- Due to the swelling of the cricopharyngeus, ENT consultation was requested, and they did an endovision examination, which was normal.
- According to the CT report of the previous hospitalization, vascular surgery consultation was also done: no need for emergency action.
- CT angiography of abdominal vessels: was normal

- The patient also complained of gross hematuria, and a urology consultation was performed: requested a Doppler ultrasound of the renal vessels and cystoscopy on an outpatient basis.
- In examining the patient's tests over the past two years in urine samples: most of them : blood 3 + RBC: many reported

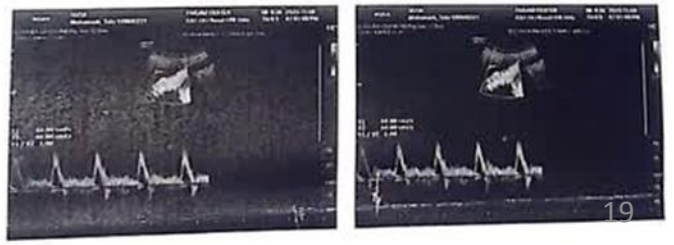
سونوگرافی دابلر شریان هر دو کلیه:

کلیه ها حجم و اندازه و اکوی کورتکس نرمال با ضخامت کورتکس طبیعی داشتند.
هیدرونفروز یا سنگ در داخل کلیه ها دیده نشد.

کلیه راست		کلیه چپ	
ابعاد	103 mm	طول	113 mm
شریان اینترا رنال		شریان اینترا رنال	
RI	0/67	RI	0/59
PI	1	PI	0/96
ابتدای شریان رنال		ابتدای شریان رنال	
PSV	88 cm/s	PSV	56 cm/s

PSV آئورت 64 cm/s میباشد.

موج parvus tardus در شریان های اینترا رنال دو کلیه دیده نمیشود. در مجموع یافته ای به نفع تنگی شریان رنال دو طرف رویت نگردید. موج وریدهای هر دو کلیه نرمال بوده و یافته ای به نفع ترمبوز و تنگی در وریدهای مذکور دیده نشد.



Data	00/12/29	01/02/17	01/11/10	02/05/02	02/03/14	02/05/08	02/06/19	02/06/24
Hb	**10.6**	12.4	11.7	13.5	13	11.4	14.6	12.2
MCV	80.8	83.4	84.7	85	82.8	84.1	83.9	83.9
RDW	12.2	12.1	13.1	13.7	13.5	12.7	12.8	83.9

Q: Considering the recurrence of bleeding and the lack of explanation, what method do you suggest?

A 22-year-old female

- Patient (immigrant) has chronic hepatitis B since about 8 years ago. In 2014, the patient was admitted to the hospital due to fever and nausea, and hepatitis B was diagnosed. One year later, she was treated with tenofovir 300 mg due to abnormal liver tests until now.
- She has no history of blood transfusions or tattoos. Her parents and siblings do not have hepatitis B (according to the patient, they were tested and it was negative).
- The patient got married at the age of 16 when knowing about his illness.
- An abortion in the 12th week of pregnancy in the past had been occurred.
- She has no family history of digestive disease.
- she does not complain of abdominal pain, nausea, vomiting, now.

Question?

According to the course of liver enzymes, ALT = 217, PCR DNA = 150,600

1) Determining the appropriate treatment for the patient?

2) Recommendations during next pregnancy, gynecologist's orders and post-partum measures)?

02/05/16

wbc	Hb	Plt	INR	Alb	Esr	Crp	Alt	Ast	Akp	Ferritin	HBe Ag	Hbe Ab	HDV Ab
7070	14	297	1	4.5	9	1	217	129	266	84	14.3	3.25	0.3

RT-PCR HBV DNA:

Lab data	95/04/23	96/04/14	97/09/18	99/06/24	00/03/29	01/04/18	02/04/06
PCR DNA (Q)	69010	8210	10×10^6	16×10^5	24100	25600	150600

istory:

Patient is known case of hepatitis B

acroscopic:

Received specimen consist three tubular soft tan pieces total length 2,1.8,0.6 cm and 0.1cm in diameter.

Microscopic:

A.Periportal or periseptal interface heptatitis (piecemeal necrosis)
□Mild (focal, few portal areas) 1

B. Confluent necrosis
□Focal confluent necrosis 1

C. Focal (spotty) lytic necrosis, apoptosis and focal inflammation
□One focus or less per 10 objective 1

D. Portal inflammation
□Moderate, some or all portal areas 2

□Fibrous expansion of most portal areas, with or without short fibrous septa 2

Plasma cell :Absent,
Rosettes ; Absent
Emperipolesis ; Absent
-Bile duct injury;Absent
-Bile duct loss;Absent
-Ductular reactive:Absent
-Cholestasis:Absent

Diagnosis :

Chronic Hepatitis
Modified HAI Grading: 5/18
Modified Staging: 2/6

02/07/10
Liver biopsy:
Chronic hepatitis

سونوگرافی کبد و مجاری صفراوی و کیسه صفرا:

کبد ابعاد نرمال داشته ; توده یا آبسه دیده نشد.

<u>افزایش اکوژنیسیته در پارانشیم کبد رویت شد که مطرح کننده fatty liver grade1 میباشد .</u>

کیسه صفرا ضخامت جداری نرمال داشته ; سنگ- توده یا علامتی از التهاب در حال حاضر دیده نشد.

وریدهای پورت - کبدی و ورید اجوف کبدی نمای طبیعی دارند.

A 31-year-old female

Patient who had symptoms of reflux and dysphagia to solids since 1395, which continued until 1400 and underwent fundoplication in 1400.

After the surgery, the patient's symptoms improved and she only complained of watery diarrhea with a small volume.

The patient has had progressive dysphagia to solids and liquids since two months ago.

There was no weight loss or abdominal pain. No fever, chills and night sweats.

Due to the increased thickness suspected of malignancy in the esophagus wall, it has been introduced to this commission to investigate the cause and also to reverse the fundoplication.

Family history: Lung ca in her uncle

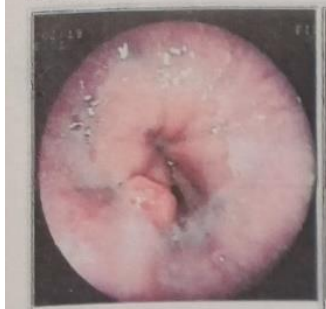
Drug history: Pantoprazole that have been stopped since four months ago

Endoscopy

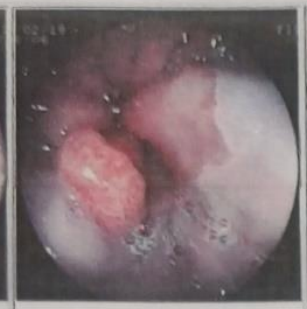
1395.11.29

Esophagus Normal
Cardia Normal
Fundus Normal
Body Normal
Antrum Normal
Pre-pyloric Normal
Bulb Normal
Duodenum, 2nd portion Was Normal

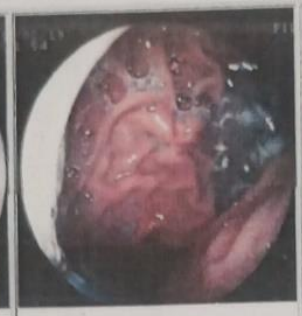
Final diagnosis: Oesophageal polyp



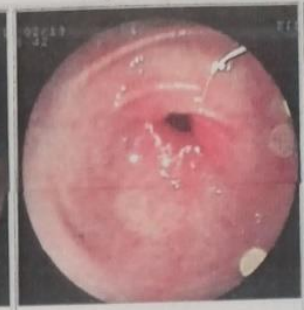
Esophagus,Lower third



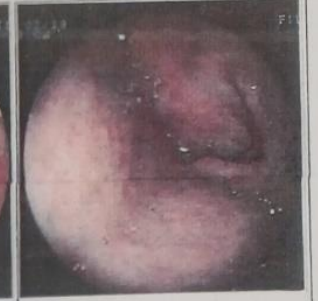
Esophagus,Lower third



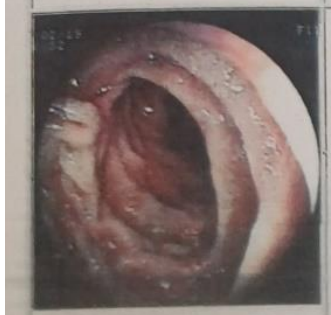
Body



Antrum



Bulb



Duodenum,2nd portion

Esophagus	Was Normal
Cardia	Was Normal
Fundus	Was Normal
Body	Was Normal
Antrum	Was Normal
Pre-pyloric	Was Normal
Bulb	Was Normal
Duodenum,2nd portion	Was Normal

Final diagnosis

Esophageal Polyp.

Endoscopy

1395.12.14

Esophagus Normal

Cardia Normal

Fundus Normal

Body Normal

Antrum Normal

Pre-pyloric Normal

Bulb Normal

Duodenum, 2nd portion Was Normal

Final diagnosis: lower oesophageal Polyp.

Pathology

1395.12.19

Specimen Received:

Gastric Antrum & Cardial polyp biopsy

Gross Description:

Antrum biopsy included one piece,Measured:0.6x0.4x0.2 cm, color: grayish. Cardial polyp biopsy included one piece, measured: 0.4x0.3x0.2 cm, color: grayish.

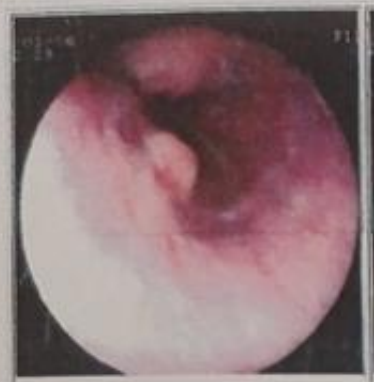
Microscopic Description:

Antrum biopsy: The sections revealed antral type gastric glands surrounded by lamina propria. The mucosa showed showed edema and congestion The lymphohistiocytes within lamina propria was scant. On Giemsa staining H.Pylori organism was not seen. There is no evidence of malihnancy in this specimen.

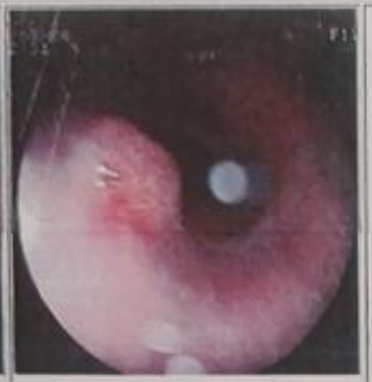
Cardial polyp biopsy: Sections show well-defined tissue composed of elongated, tortuous and dilated glands. The stroma demonstrates edema, patchy fibrosis and inflammatory cells and scattered smooth muscle bundles. A few lymphocytic infiltrate within stroma with focal goblet cells changes are seen.

-Final Pathologic Diagnosis:

Gastric Antrum & Cardial polyp Biopsy: 1. Antrum revealed Erosive Gastritis H.Pylori Organism Was Not Seen 2. Hyperplastic Polyp of Cardia



Esophagus,Lower third



Esophagus,Lower third

Esophagus	Was Normal
Cardia	Was Normal
Fundus	Was Normal
Body	Was Normal
Antrum	Was Normal
Pre-pyloric	Was Normal
Bulb	Was Normal
Duodenum,2nd portion	Was Normal
Final diagnosis	

lower esophageal polyp.

Surgical Pathology Report

-Specimen Received:
Gastric Antrum & Cardial polyp biopsy

-Gross Description:
Received specimen consisted of two formalin filled containers:
Antrum biopsy included one piece,Measured:0.6x0.4x0.2 cm, color : grayish.
Cardial polyp biopsy included one piece, measured: 0.4x0.3x0.2 cm , color : grayish.

-Microscopic Description:
Antrum biopsy: The sections revealed antral type gastric glands surrounded by lamina propria. The mucosa showed edema and congestion . The lymphohistiocytes within lamina propria was scant. On Giemsa staining H.Pylori organism was not seen. There is no evidence of malihnancy in this specimen.

Cardial polyp biopsy: Sections show well-defined tissue composed of elongated, tortuous and dilated glands. The stroma demonstrates edema, patchy fibrosis and inflammatory cells and scattered smooth muscle bundles. A few lymphocytic infiltrate within stroma with focal goblet cells changes are seen.

-Final Pathologic Diagnosis:

Gastric Antrum & Cardial polyp Biopsy:
1. Antrum revealed Erosive Gastritis
H.Pylori Organism Was Not Seen
2. Hyperplastic Polyp of Cardia

Endoscopy

1398.07.22

Reason for Endoscopy: Dyspepsia / Past hx of gastric polyp

Esophagus: Upper, and middle and lower thirds: Normal

Z-line was normal.

No Sliding Hiatal Hernia

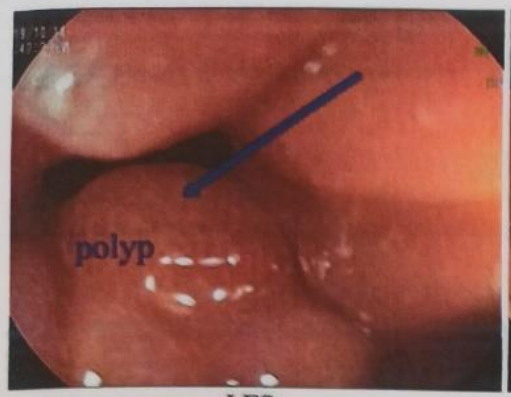
Stomach : Cardia: A small polyp (6-7mm) was seen just below z-line.

polypectomy was done.

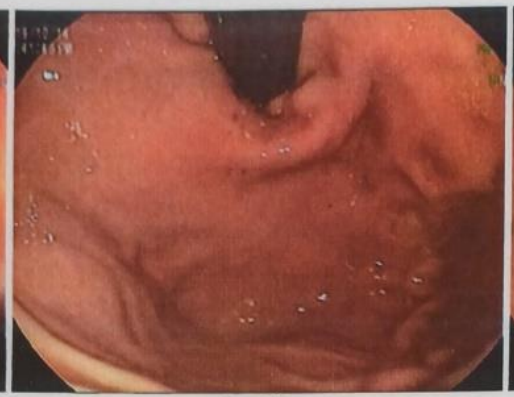
Fundus and body and antrum: Normal

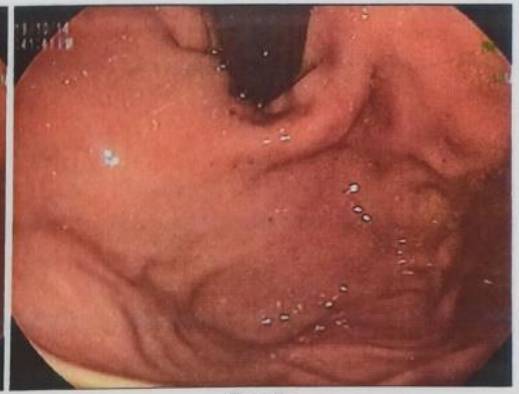
Duodenum: D1 and D2: Normal

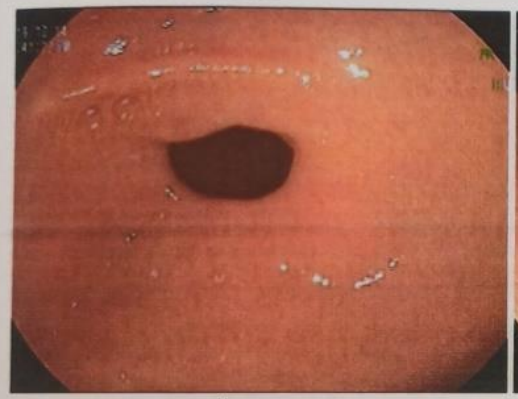
Diagnosis : Gastric polyp (just below z-line in cardia)

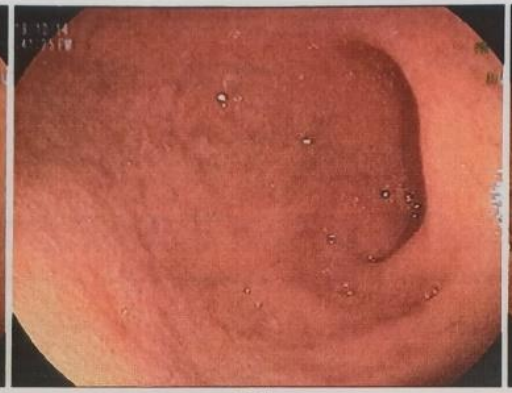


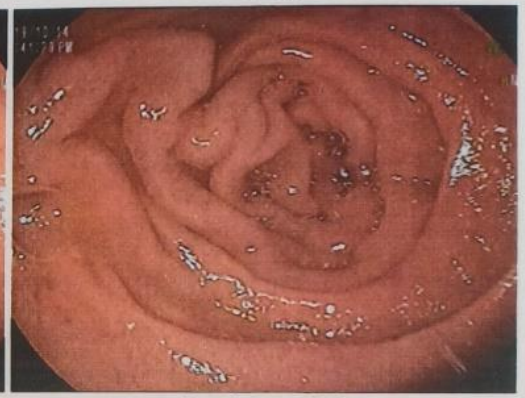
LES


Cardia


Cardia


Antrum


Bulb


Duodenum,2nd

Reason for Endoscopy : Dyspepsia
Past hx of gastric polyp

Findings :

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

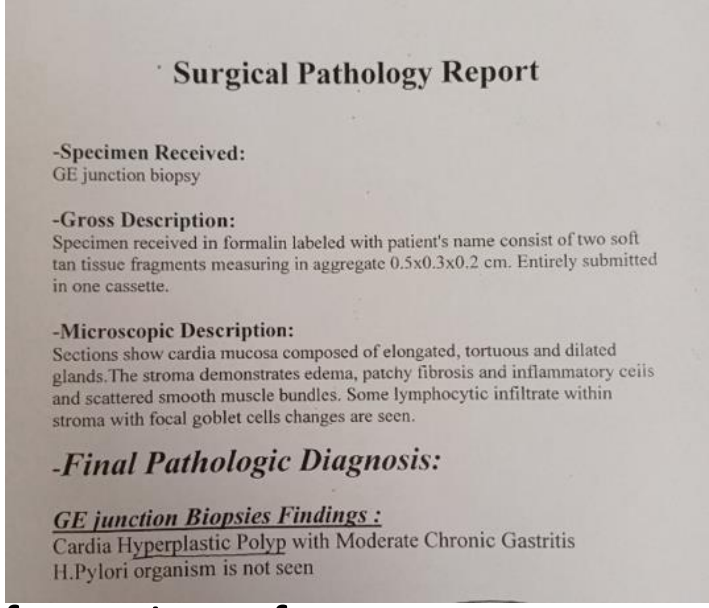
Stomach : Cardia: A small polyp (6-7mm) was seen just below z-line.polypectomy was done.
Fundus and body and antrum : Normal

Duodenum : D1 and D2 : Normal

Diagnosis : Gastric polyp (just below z-line in cardia)

Pathology

1398.07.22



Surgical Pathology Report

-Specimen Received:
GE junction biopsy

-Gross Description:
Specimen received in formalin labeled with patient's name consist of two soft tan tissue fragments measuring in aggregate 0.5x0.3x0.2 cm. Entirely submitted in one cassette.

-Microscopic Description:
Sections show cardia mucosa composed of elongated, tortuous and dilated glands.The stroma demonstrates edema, patchy fibrosis and inflammatory ceiis and scattered smooth muscle bundles. Some lymphocytic infiltrate within stroma with focal goblet cells changes are seen.

-Final Pathologic Diagnosis:

GE junction Biopsies Findings :
Cardia Hyperplastic Polyp with Moderate Chronic Gastritis
H.Pylori organism is not seen

Specimen Received: GE junction biopsy

-Gross Description:

Specimen received in formalin labelled with patient's name consist of two soft tan tissue fragments measuring in aggregate 0.5x0.3x0.2 cm. Entirely submitted in one cassette.

-Microscopic Description:

Sections show cardia mucosa composed of elongated, tortuous and dilated glands. The stroma demonstrates edema, patchy fibrosis and inflammatory ceils and scattered smooth muscle bundles. Some lymphocytic infiltrate within stroma with focal goblet cells changes are seen.

-Final Pathologic Diagnosis:

Cardia Hyperplastic Polyp with Moderate Chronic Gastritis H.Pylori organism is not seen

Endoscopy

1401.06.07

Reason for Endoscopy: Chronic diarrhea

Esophagus: Upper, middle and lower thirds: Normal

Z-line was normal.

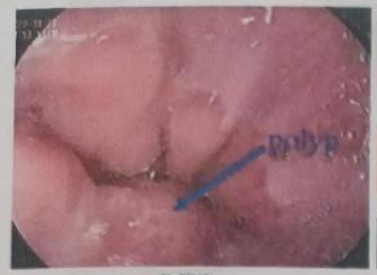
A small polyp (about 10mm) was seen just over the z-line(Bx was taken)

Stomach: Cardia and fundus and body and antrum : Normal

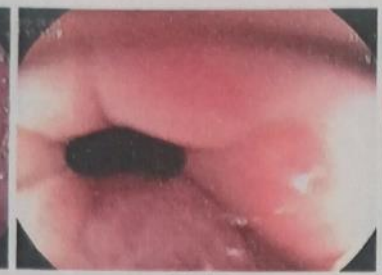
Duodenum: D1 and D2: Normal

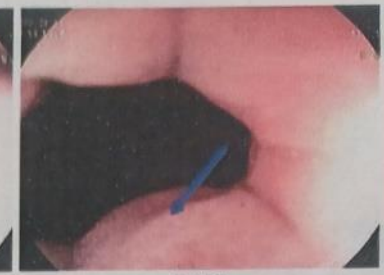
Biopsy for evaluation of celiac disease was taken

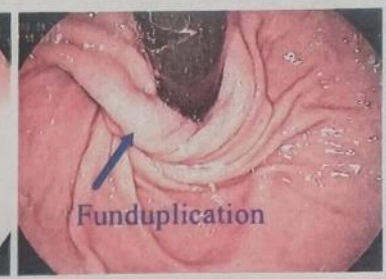
Diagnosis: GE junction polyp



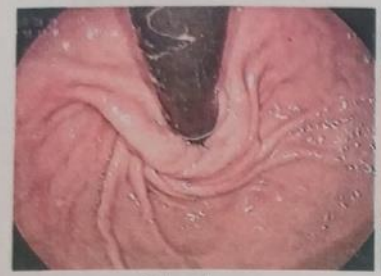
LES

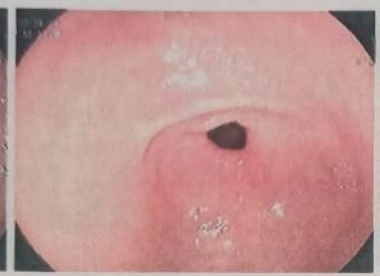

LES

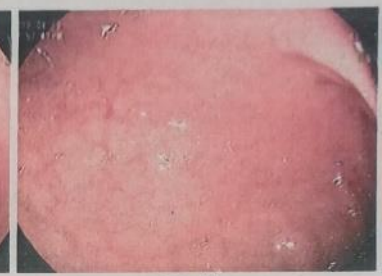

LES

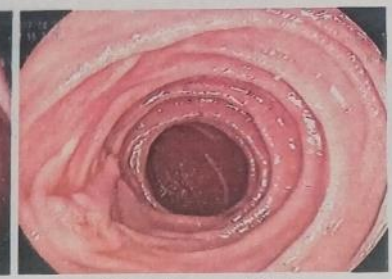


Cardia


Fundus


Antrum


Bulb


Duodenum,2nd

Reason for Endoscopy : Chronic diarrhea
Hx of funduplication

Findings :

Esophagus : Upper, middle and lower thirds : Normal
Z-line was normal.
A small polyp (about 10mm) was seen just over the z-line(Bx was taken)
No Sliding Hiatal Hernia

Stomach : Cardia and fundus and body and antrum : Normal

Duodenum : D1 and D2 : Normal
Biopsy for evaluation of celiac disease was taken

Diagnosis : GE junction polyp

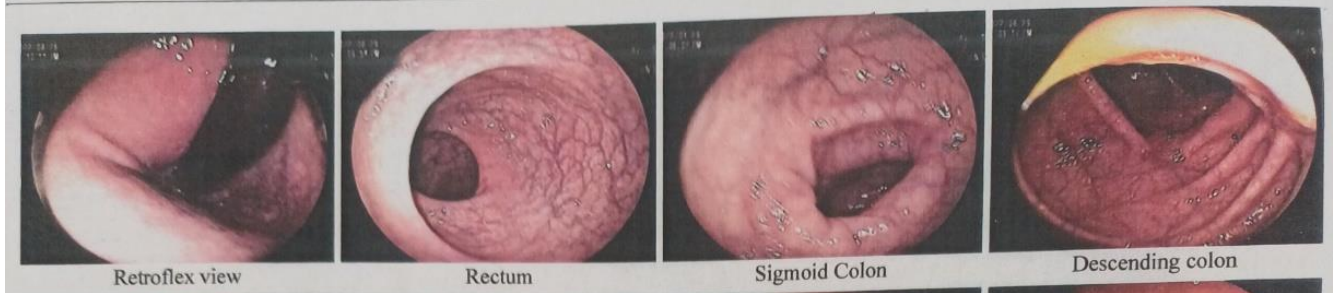
Colonoscopy

1401.06.07

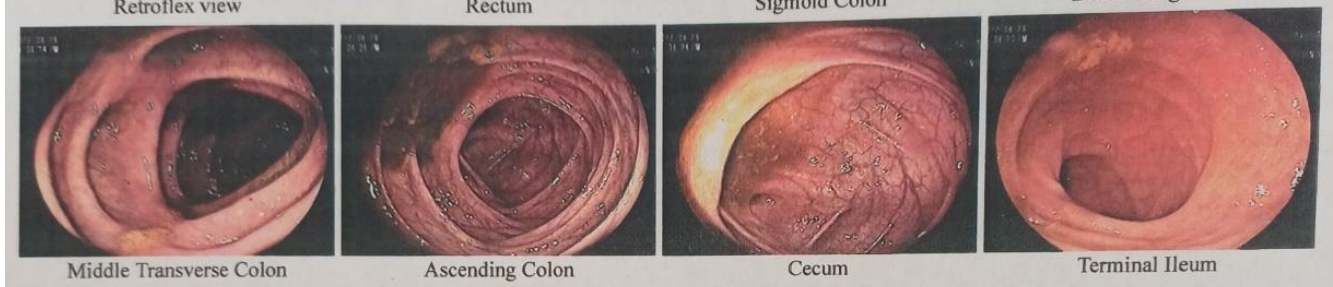
Reason for Endoscopy: Chronic Diarrhea WBC& RBC 2/hpf in stool exam

Retroflex View: Normal
Rectum : Normal
Sigmoid : Normal
Descending Colon: Normal
Transverse Colon: Normal
Ascending Colon: Normal
Cecum : Normal
(Biopsies from Right colon were taken for evaluation of microscopic colitis)
Terminal Ileum : Normal

Diagnosis: Normal ileo-colonoscopy



Retroflex view | Rectum | Sigmoid Colon | Descending colon



Middle Transverse Colon | Ascending Colon | Cecum | Terminal Ileum

Reason for Endoscopy : Chronic Diarrhea WBC& RBC 2/hpf in stool exam

Preparation : Good

DRE : Normal

Findings :

Retroflex View : Normal

Rectum : Normal

Sigmoid : Normal

Descending Colon : Normal

Transverse Colon : Normal

Ascending Colon : Normal
(Biopsies from Right colon were taken for evaluation of microscopic colitis)

Cecum : Normal

Terminal Ileum : Normal

Diagnosis : Normal ileo-colonoscopy

Pathology

1401.06.07

Specimen: Cardia polyp, Duodenal mucosa, Ascending colon mucosa biopsies

Diagnosis:

Cardia polyp: Hyperplastic polyp with foci of intestinal metaplasia

No dysplasia

Duodenal mucosa: Normal duodenal mucosa

Marsh classification (0)

Ascending colon mucosa: Focal active colitis

Specimen:

Cardia polyp, Duodenal mucosa, Ascending colon mucosa biopsies

Macroscopy:

Received Specimen in three bottles as below:

NO1: Labeled as **Cardia polyp** consists of 4 creamy gray tissue fragments totally measured:

0.6 x0.5x0.4cm

SOS: 4/1 E: 100%

NO2: Labeled as **Duodenal mucosa** consists of 3 creamy gray tissue fragments totally measured: 0.5x0.5x0.4cm

SOS: 3/1 E: 100%

No3: Labeled as **Ascending colon mucosa** consists of 3 creamy gray tissue fragments totally measured:0.4x0.4x0.3cm

SOS:3/1 E:100%

Microscopy:

No1: Section from gastric mucosa show polypoid structure included cystically dilated glands, distorted and irregular foveolar epithelium distributed in inflamed and edematous stroma. There are some glands with goblet cells. No dysplasia is seen in this specimen.

NO2: Sections from duodenal mucosa show villi length and villi/crypt ratio in normal limit. Mild infiltration of lymphoplasmacells in lamina propria with less than 30 lymphocytes per 100 enterocytes integrating to them were seen.

NO3: Section from colon mucosa show superficial erosion, normal crypt architecture with mild infiltration of lymphoplasmacells, PMNS in lamina propria and scant cryptitis. Granuloma was not seen.

Diagnosis:

Cardia polyp, Duodenal mucosa, Endoscopic biopsies and Ascending colon mucosa, Colonoscopic biopsy

NO1: Cardia polyp: Hyperplastic polyp with foci of intestinal metaplasia

No dysplasia

NO2: Duodenal mucosa: Normal duodenal mucosa

Marsh classification (0)

NO3: Ascending colon mucosa: Focal active colitis

Note:

Histology findings of colon mucosa are consistent with infection, early IBD, drugs, ect ….

Clinico _ colonoscopic correlation is recommended.

Endoscopy

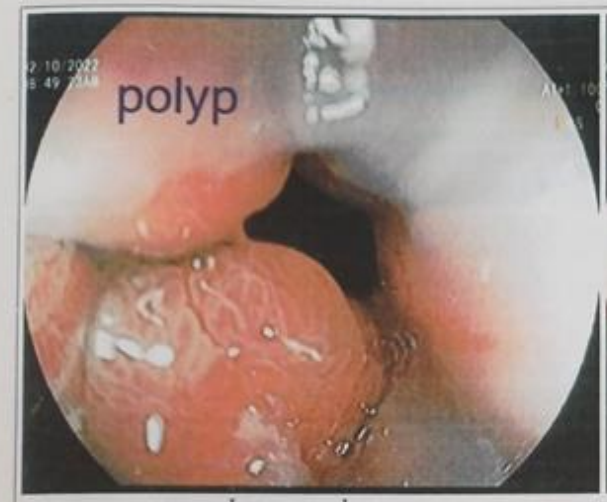
1401.07.10

Reason for Endoscopy: Polypectomy of OE JUNCTION POLYP

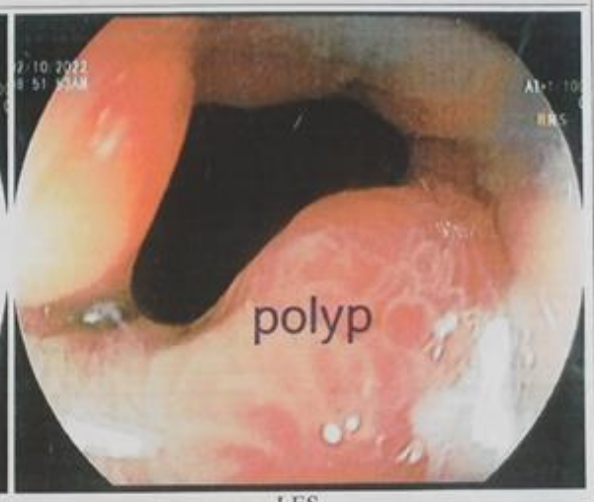
Pathology: hyperplastic polyp with foci of intestinal metaplasia

Esophagus: A polypoid lesion 10x15 mm was seen just below Z-line. After injection of diluted epinephrine and methylene blue then lesion was removed in peacemeal resection method. then APC was performed at the edge of lesion to ablate the remaining polypoid lesions. patient tolerated procedure without early complications.

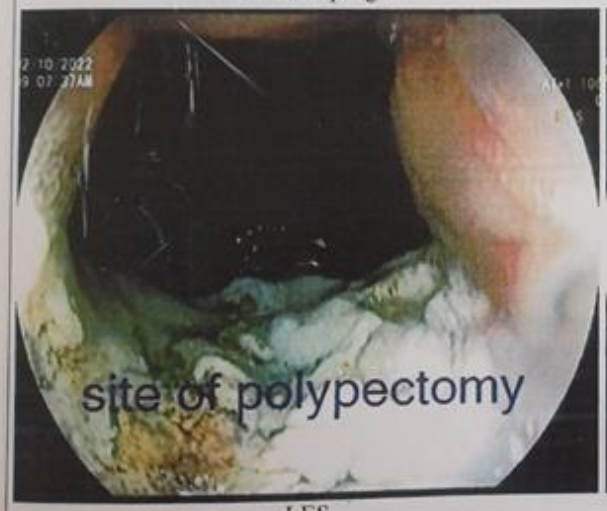
Diagnosis: Successful EMR of GE junction polyp



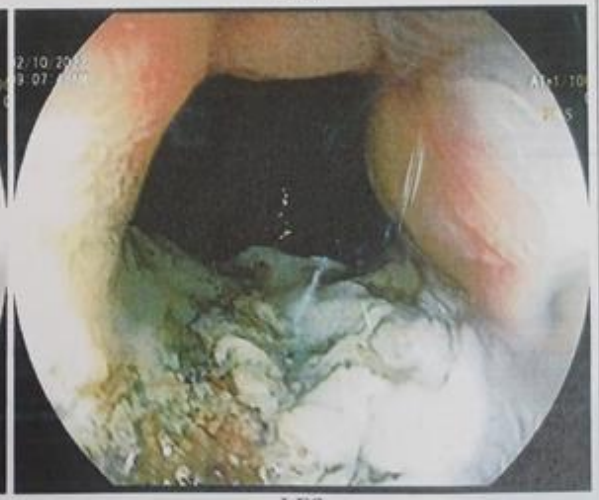
Lower esophagus



LES



LES



LES

Reason for Endoscopy : Polypectomy of GE JUNCTION POLYP
Pathology : hyperplstic polyp with foci of intestinal metaplasia

Findings :

Esophagus : A polypoid ledion 10x15 mm was seen just below Z-line. After injection of diluted epinephrin and methylen blue then lesion was removed in peacemeal resection method. then APC was performed at the edge of lesion to ablate the remaining polypoid lesions. patient tolerated procedure without early complications.

Diagnosis : Successful EMR of GE junction polyp

Barium swallow

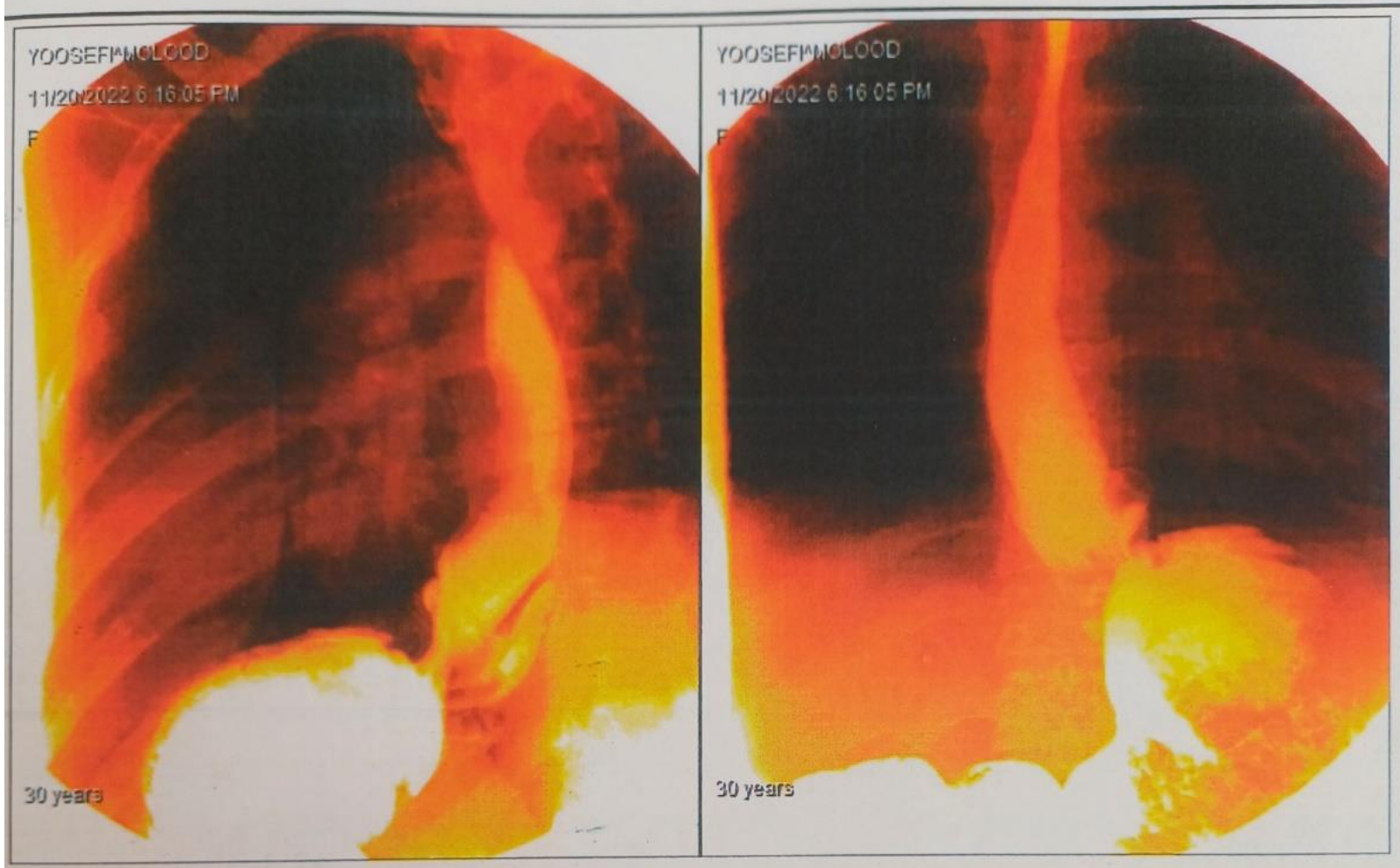
1401.08.29

In the scopy, the contrast material passed through the esophagus easily, and no pathological stricture or pressure effect was observed. Mucosa coating in esophagus is normal and filling defect is not seen.

The evidence of fundoplication can be seen in the fundus area. In this area, the compressive effect is evident.

A small hiatal hernia is seen in the distal esophagus.

There is no stenosis at the GE junction.



گرافي مري با بلع ماده حاجب :

دراسكوپي عبورماده حاجب از مري به راحتي صورت گرفت وتنگي پاتولوژيك واثر فشاري مشاهده نشد.

Coating مخاطي در مري طبيعي است و filling defect ديده نمي شود.

شواهد عمل funduplication در ناحيه فاندوس ديده مي شود در اين ناحيه مختصر اثر فشاري مشهود است.

هرني هيتال كوچك در ديستال مري ديده ميشود.

در محل GE junction تنگي مشهود نيست.

Endoscopy

1400.08.26

Reason for Endoscopy: Heartburn, Hx of distal oesophageal hyperplastic polyp

Esophagus: Upper, middle and lower thirds: Normal

A small polyp (7-8mm) was seen just over z line .(polypectomy was performed) Z-line was normal.

small Sliding Hiatal Hernia

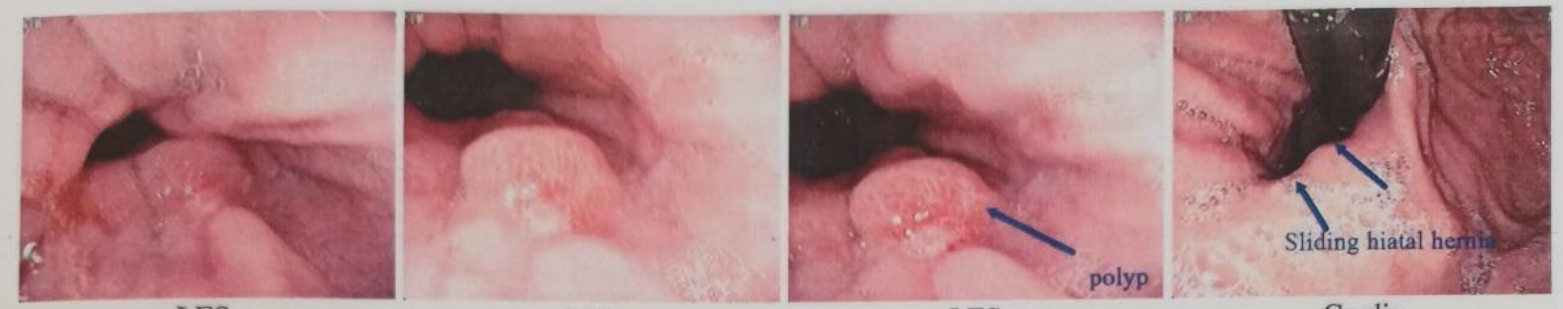
Stomach: Cardia and fundus and body and antrum : Normal

(Bx for evaluation of H.Pylori was taken)

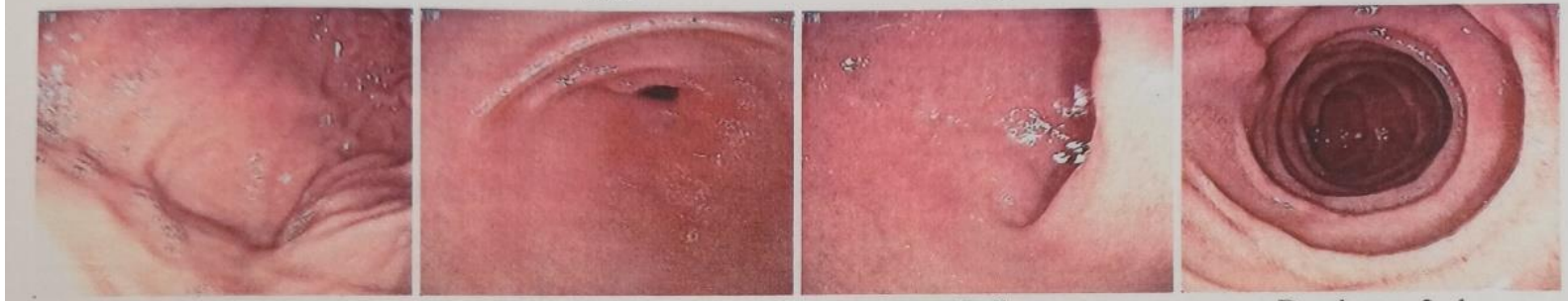
Duodenum: D1 and D2: Normal

Diagnosis: Distal esophageal Polypectomy

Small Sliding hiatal hernia



LES | LES | LES | Cardia



Fundus | Antrum | Bulb | Duodenum,2nd

Reason for Endoscopy : Heartburn , Hx of distal esophageal hyperplastic polyp

Findings :

Esophagus : Upper, middle and lower thirds : Normal
A small polyp (7-8mm) was seen just over z line .(polypectomy was performed)
Z-line was normal.
small Sliding Hiatal Hernia

Stomach : Cardia and fundus and body and antrum : Normal
(Bx for evaluation of H.pylori was taken)

Duodenum : D1 and D2 : Normal

Diagnosis : Distal esophageal Polypectomy
Small Sliding hiatal hernia

Pathology
1400.08.26

Microscopy:

No1: Sections from Gastroesophageal junction show polypoid structure included cystically dilated glands, distorted and irregular foveolar epithelium distributed in inflamed and edematous stroma. No dysplasia is seen in this specimen.

NO2: Sections from Antral mucosa show mild infiltration of lymphoplasmacells and PMNs in lamina propria. Some PMNs permeated in glands.

On Geimsa staining show no H.Pylori infection.

Diagnosis:

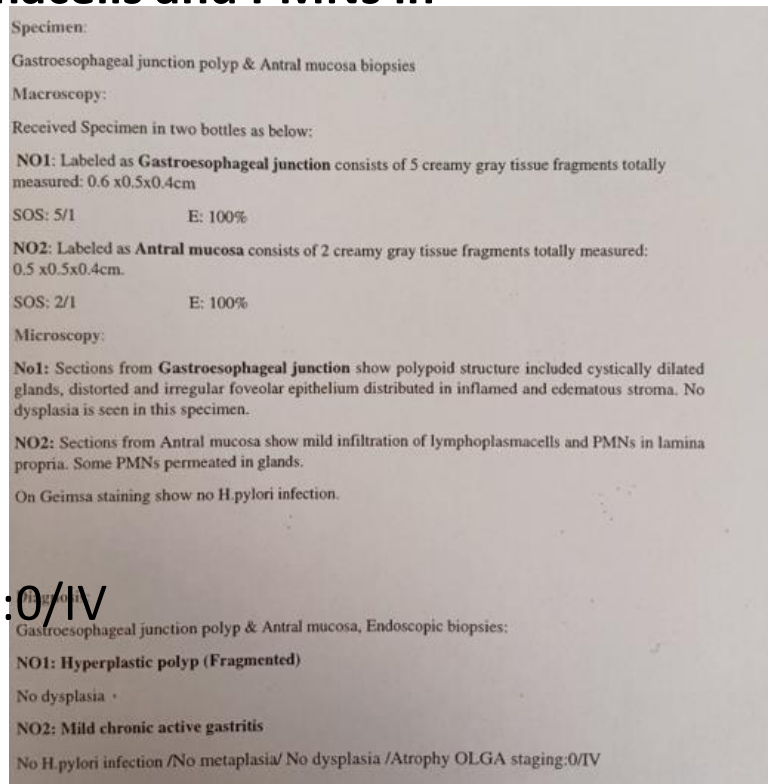
Gastroesophageal junction polyp & Antral mucosa, Endoscopic biopsies:

NO1: Hyperplastic polyp (Fragmented)

No dysplasia.

NO2: Mild chronic active gastritis

No H.pylori infection /No metaplasia/ No dysplasia /Atrophy OLGA staging:0/IV


Specimen:

Gastroesophageal junction polyp & Antral mucosa biopsies

Macroscopy:

Received Specimen in two bottles as below:

NO1: Labeled as **Gastroesophageal junction** consists of 5 creamy gray tissue fragments totally measured: 0.6 x0.5x0.4cm

SOS: 5/1 E: 100%

NO2: Labeled as **Antral mucosa** consists of 2 creamy gray tissue fragments totally measured: 0.5 x0.5x0.4cm.

SOS: 2/1 E: 100%

Microscopy:

No1: Sections from **Gastroesophageal junction** show polypoid structure included cystically dilated glands, distorted and irregular foveolar epithelium distributed in inflamed and edematous stroma. No dysplasia is seen in this specimen.

NO2: Sections from Antral mucosa show mild infiltration of lymphoplasmacells and PMNs in lamina propria. Some PMNs permeated in glands.

On Geimsa staining show no H.pylori infection.

Diagnosis:

Gastroesophageal junction polyp & Antral mucosa, Endoscopic biopsies:

NO1: Hyperplastic polyp (Fragmented)

No dysplasia

NO2: Mild chronic active gastritis

No H.pylori infection /No metaplasia/ No dysplasia /Atrophy OLGA staging:0/IV

Endoscopy

1402.07.04

Reason for Endoscopy: Dysphagia

Esophagus: Upper, and middle and upper third:Normal

A suspicious small polyp like lesion 5mm was seen at GE junction (Removed by forceps))

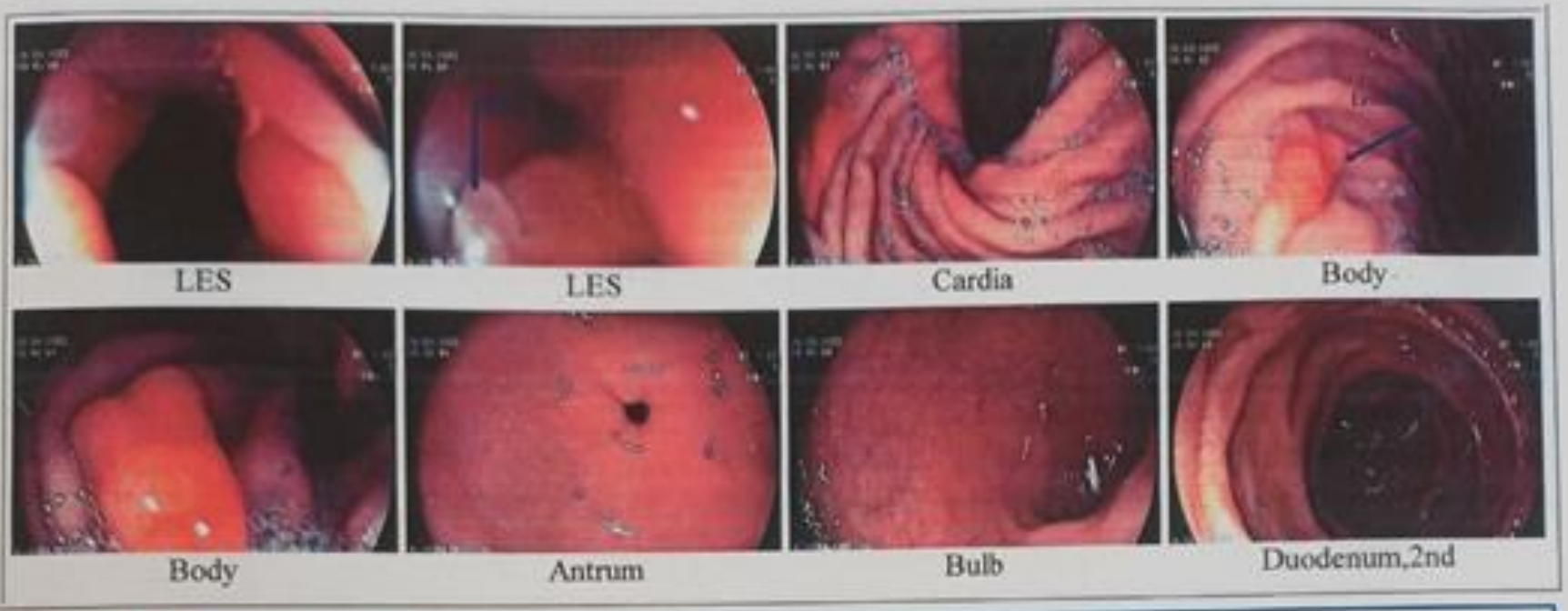
Stomach : Cardia : endoscopic evidence of funduplication was seen.

Fundus and antrum: Normal (Bx for evaluation of H.pylori was taken)

Body: An area of erythema and abnormal looking mucosa was seen in greater curvature of body (Bx was taken)

Duodenum: D1 and D2: Normal

Diagnosis: Corpous gastritis GE junction polyp?



Reason for Endoscopy : Dysphagia

Findings :

Esophagus : Upper , and middle and upper third:Normal
A suspicious small polyp like lesion 5mm was seen at GE junction (Removed by forceps))

Stomach : Cardia : endoscopic evidence of funduplication was seen.
Fundus and antrum : Normal (Bx for evaluation of H.pylori was taken)
Body : An area of erythema and abnormal looking mucosa was seen in greater curvature of body (Bx was taken)

Duodenum : D1 and D2: Normal

Diagnosis : Corpous gastritis
GE junction polyp?

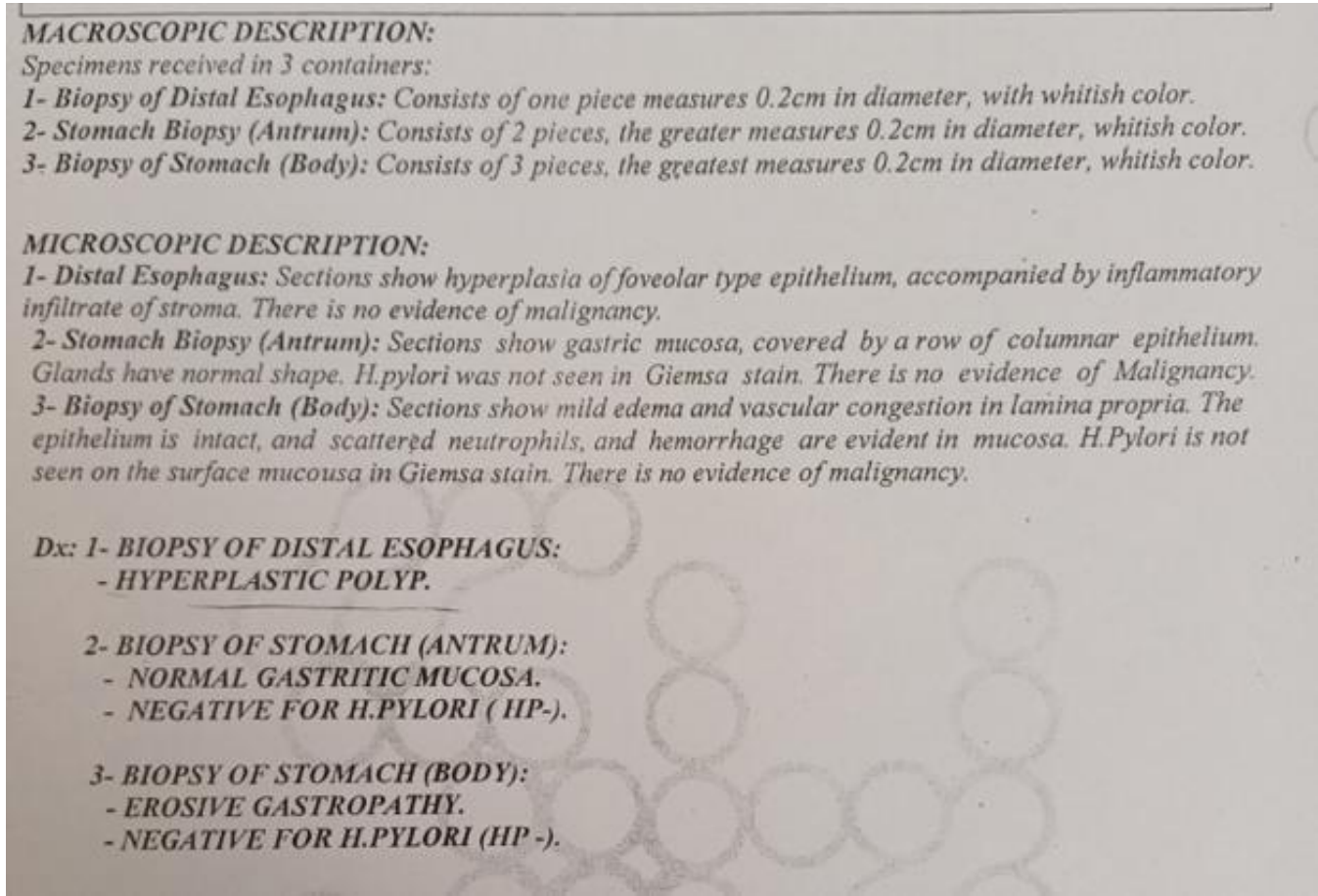
Pathology

1402.07.04

BIOPSY OF DISTAL ESOPHAGUS:
HYPERPLASTIC POLYP.

BIOPSY OF STOMACH (ANTRUM):
NORMAL GASTRITIC MUCOSA.
NEGATIVE FOR H.PYLORI (HP-).

BIOPSY OF STOMACH (BODY):
EROSIVE GASTROPATHY.
NEGATIVE FOR H.PYLORI (HP -).



MACROSCOPIC DESCRIPTION:
Specimens received in 3 containers:
1- Biopsy of Distal Esophagus: Consists of one piece measures 0.2cm in diameter, with whitish color.
2- Stomach Biopsy (Antrum): Consists of 2 pieces, the greater measures 0.2cm in diameter, whitish color.
3- Biopsy of Stomach (Body): Consists of 3 pieces, the greatest measures 0.2cm in diameter, whitish color.

MICROSCOPIC DESCRIPTION:
1- Distal Esophagus: Sections show hyperplasia of foveolar type epithelium, accompanied by inflammatory infiltrate of stroma. There is no evidence of malignancy.
2- Stomach Biopsy (Antrum): Sections show gastric mucosa, covered by a row of columnar epithelium. Glands have normal shape. H.pylori was not seen in Giemsa stain. There is no evidence of Malignancy.
3- Biopsy of Stomach (Body): Sections show mild edema and vascular congestion in lamina propria. The epithelium is intact, and scattered neutrophils, and hemorrhage are evident in mucosa. H.Pylori is not seen on the surface mucousa in Giemsa stain. There is no evidence of malignancy.

Dx: 1- BIOPSY OF DISTAL ESOPHAGUS:
- HYPERPLASTIC POLYP.

2- BIOPSY OF STOMACH (ANTRUM):
- NORMAL GASTRITIC MUCOSA.
- NEGATIVE FOR H.PYLORI (HP-).

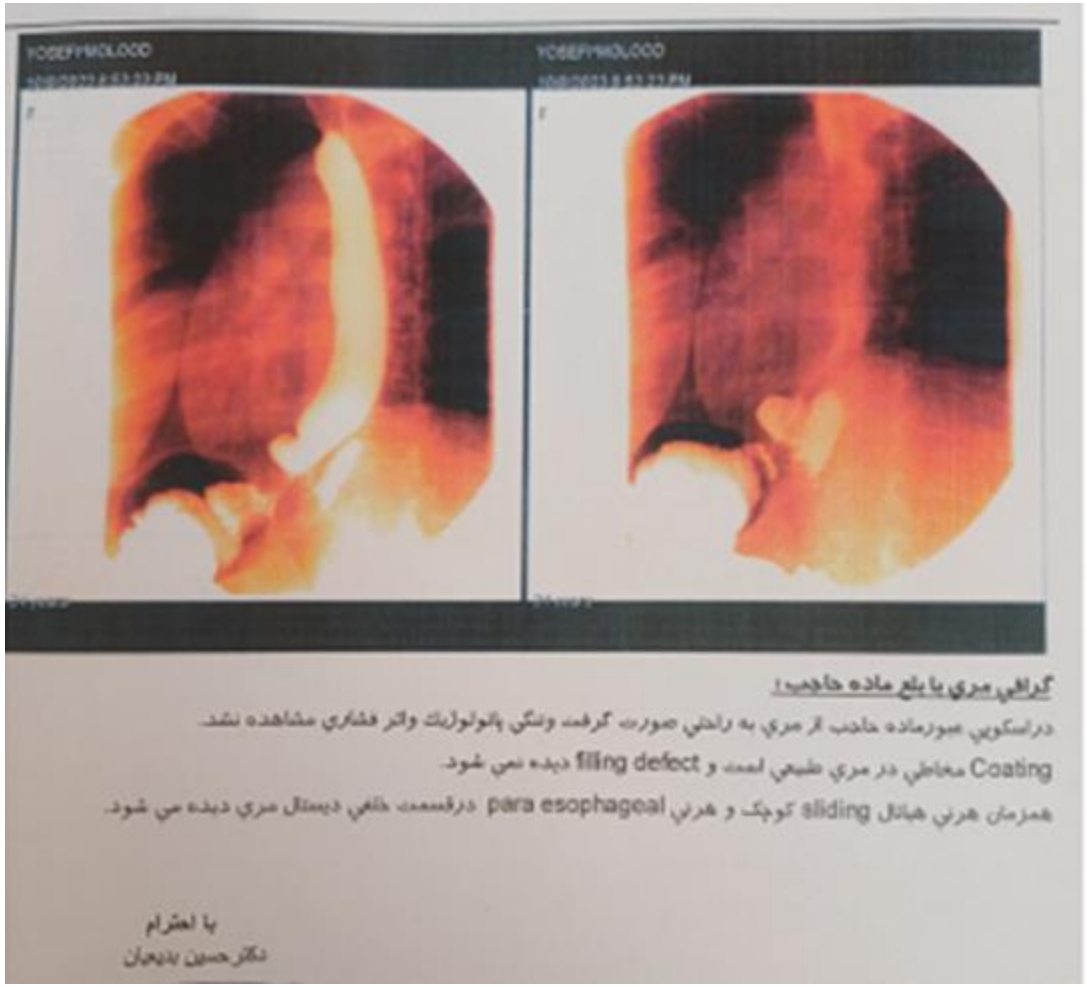
3- BIOPSY OF STOMACH (BODY):
- EROSIVE GASTROPATHY.
- NEGATIVE FOR H.PYLORI (HP -).

Barium swallow

1402.07.16

In the endoscopy, the contrast material passed through the esophagus easily, and no pathological stricture or pressure effect was observed. Mucosa coating in esophagus is normal and filling defect is not seen.

At the same time, a small sliding hiatal hernia and a paraesophageal hernia are seen in the posterior part of the distal esophagus.



CT SCAN OF ABDOMEN/PELVIS with contrast

1402.08.10

Distal esophagus is grossly distended shows air fluid level terminating an area of soft tissue density with questionable mucosal irregularity just in the region of gastric cardia causing partial obstruction, considering the previous history of fundoplication surgery should be more evaluated excluding possible neoplasia.

Liver is normal in size, shape and density with no space occupying lesion or biliary dilatation.

Spleen and pancreas are also normal with no S.O.L and no evidence of acute pancreatitis.

The kidneys are normal in size, shape and position, opacified with no hydronephrosis and no S.O.L.

No paraaortic or paracaval adenopathy is present. No pelvic mass or adenopathy is seen. Follicular cyst is seen in left ovary.

MULTISLICE CT SCAN OF ABDOMEN AND PELVIS

(with contrast)

The study was performed administering oral and intravenous contrast as your request obtaining coronal reconstructed views.

Distal esophagus is grossly distended shows air fluid level terminating an area of soft tissue density with questionable mucosal irregularity just in the region of gastric cardia causing partial obstruction, considering the previous history of fundoplication surgery should be more evaluated excluding possible neoplasia.

Liver is normal in size, shape and density with no space occupying lesion or biliary dilatation.

Spleen and pancreas are also normal with no S.O.L and no evidence of acute pancreatitis.

The kidneys are normal in size, shape and position, opacified with no hydronephrosis and no S.O.L.

No paraaortic or paracaval adenopathy is present.

No pelvic mass or adenopathy is seen.

Follicular cyst is seen in left ovary.

Conclusion:

As explained.

Esophageal manometry

1402.08.16

Normal manometry

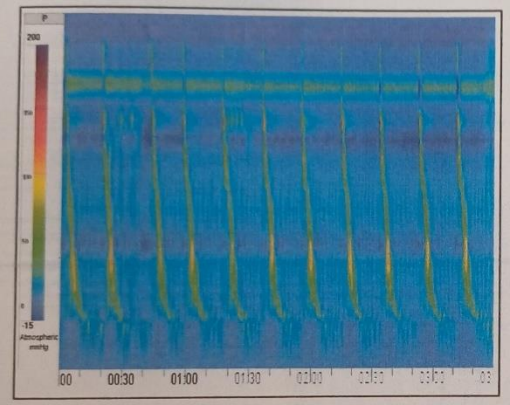
Esophageal manometry

Patient name:	Yusefi, Molud	Investigation date:	07-11-2023
Gender:	Female	Investigation nr:	02
Date of birth:	01-11-1992	Hospital:	Alzahra
Patient number:	-	Investigator:	-
Height:	-	Referred by:	Dr sebghatolahi
Weight:	-		

Investigation memo

Diagnosis: Normal manometry

Average of 11: 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. The actual diagnosis remains under all circumstances the responsibility of the clinician/physician.

Esophagus

DCI	1053 mmHg.s.cm
Peristaltic breaks	0.0 cm
Distal Latency	5.0 s

UES

Upper border	18.0 cm
IRP 0.2 s	9.1 mmHg
IRP 0.8 s	12.7 mmHg

LES

Upper border	44.6 cm
IRP 4 s	6.4 mmHg
Intraabdominal length	2.2 cm

Scoring parameter percentages[3]

Scoring		Intrabolus pressure pattern	
Normal	82 %	Normal	9 %
Ineffective	0 %	EGJ	0 %
Failed contraction	0 %	Compartmentalized	0 %
Premature	18 %	Panesophageal	0 %
Hyper	0 %	Unknown pressurization	91 %
Fragmented	0 %		

Average esophagus results

Wet swallow 5 ml	DCI mmHg.s.cm	Peristaltic breaks cm	Distal Latency s
1	1178	0.0	5.3
2	1351	0.1	4.3
3	1033	0.0	9.0
4	1207	0.0	4.5
5	610	0.0	4.7
6	878	0.1	5.1
7	995	0.0	4.3
8	997	0.0	4.8
9	1444	0.0	4.6
10	883	0.1	4.5
11	1010	0.1	4.5
Average	1053	0.0	5.0

Average UES results

Wet swallow 5 ml	Upper border cm	IRP 0.2 s mmHg	IRP 0.8 s mmHg
1	18.0	3.7	6.6
2	18.0	6.7	13.7
3	18.0	17.1	19.8
4	18.0	5.2	9.0
5	18.0	12.1	17.2
6	18.0	18.2	22.0
7	18.0	12.9	19.2
8	18.0	11.3	16.0
9	18.0	5.1	6.8
10	18.0	4.4	4.7
11	18.0	3.7	4.3
Average	18.0	9.1	12.7

Average LES results

Wet swallow 5 ml	Upper border cm	IRP 4 s mmHg	Intraabdominal length cm
1	44.1	8.3	2.0
2	44.1	5.5	2.0
3	44.1	0.0	2.0
4	44.1	7.3	2.0
5	44.1	8.3	2.0
6	45.8	6.1	2.7
7	44.8	8.3	2.3
8	44.8	6.6	2.3
9	44.8	6.4	2.3
10	44.8	6.2	2.3
11	44.8	7.5	2.3
Average	44.6	6.4	2.2

A 64-year-old female

Patient who has been suffering from massive and watery diarrhea with hematochezia that has been repeated several times since January of last year, was treated with the diagnosis of colon lymphoma and was hospitalized several times due to fever and neutropenia, the last time was in August this year.

After being discharged from the hospital, she had fecal discharge from the vagina and was treated for an enterovaginal fistula.

During this time, fecal discharge from the vagina has decreased, but it still continues in small amounts.

Ileoscal valve stenosis has been observed in recent colonoscopy.

To check if the patient has Crohn's disease or not / does he need anti-TNF treatment or not / does he need to check the small intestine or not? has been introduced to this commission.

Drug history

Apixaban 5 mg every 12 hours

Furosemide 40 mg daily

Bisoprolol 2.5 mg daily

Digoxin 0.25 mg daily

Mesalazine granules, 3 sachets daily

Colonoscopy

1401.11.27

Reason for colonoscopy: positive FIT

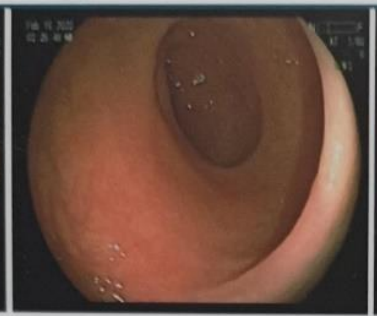
Rectum: Normal.
Sigmoid: Normal.
Descending Colon: Normal.
Splenic Flexure: Normal.
Transverse Colon: Normal.
Hepatic Flexure: Normal.
Ascending Colon: one large vegetative mass was seen,BX were taken. Final Diagnosis:

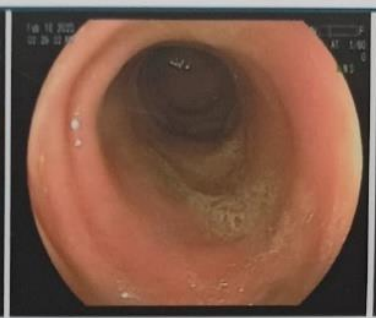
Colon: R/O right colon cancer.

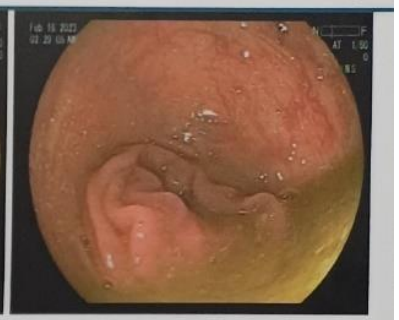
Recommendation: follow up pathology results-abdominopelvic

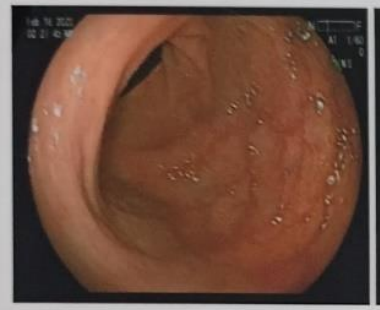
جنسیت : زن سن : 63 تاریخ : 1401/11/27

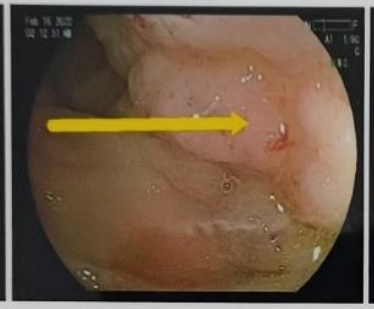

Retroflex view

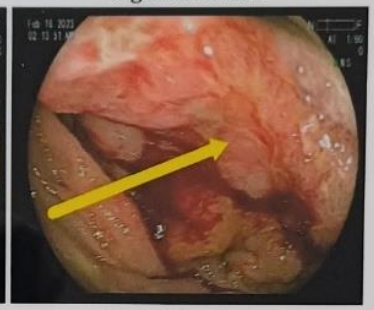

Rectum


Sigmoid Colon


Descending colon


Middle Transverse Colon


Ascending Colon


Ascending Colon

Reason for colonoscopy: positive FIT
Premedication: midazolam 2mg
Description of procedure: preparation was NOT adequate,BBPS:2-1-2
Anus: internal hemorrhoids were seen in retroflexion
Rectum: Normal.
Sigmoid: Normal.
Descending Colon: Normal.
Splenic Flexure: Normal.
Transverse Colon: Normal.
Hepatic Flexure: Normal.
Ascending Colon: one large vegetative mass was seen,BX were taken.

Final Diagnosis:
Colon: R/O right colon cancer.

Recommendation: follow up pathology results-abdominopelvic CT-CEA

PATHOLOGY

1401.11.27

Colon Mass Biopsy

DIAGNOSIS:

Highly suggestivbe for Lymphoma (most probably High Grade)

-IHC study for CD3, CD20, ki67 is recommended.

Colon Mass Biopsy

Macroscopic Description:

Received specimen in formalin consist Multiple soft tan pieces total measuring 0.6x0.5x0.3cm.E=T: SOS:M/1

Note: large vegetative mass : CEA within normal limit

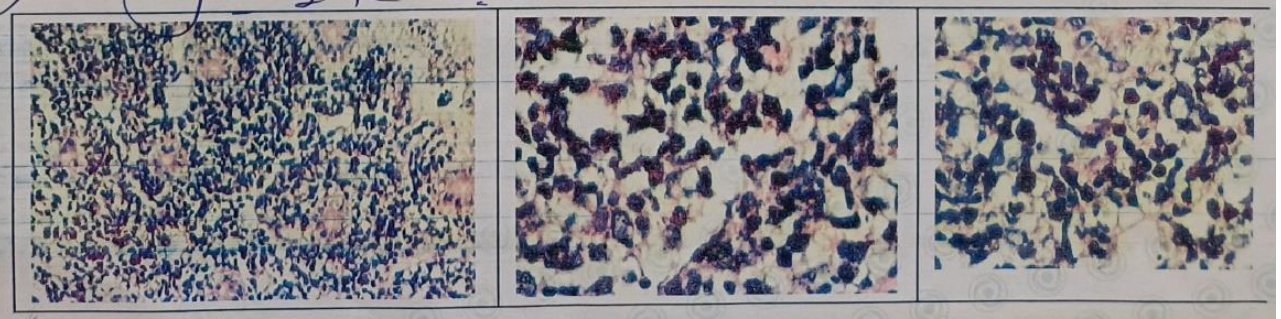
Microscopic Description:

Cross section of large bowel mucosa is seen
Infiltration of focally dense mono nuclear cells with variation in size and shape and plasma cells are seen within lamina prorpia and between crypts Mucosa replace partially by mixed lymphoid cell. Consist of lymphocyte, centrocyte like and plasma cell. In background transformation to centroblast was found in through the tumor and there was formed cluster and sheet in favor of transformation to high grade lymphoma. Lymphoepithelial lesion was observed focally as well. Invasion of cells with large round otr oval shape hyperchorme nucleus is seen
Dysplastic changes such as seen in conventional adeno Carcinoma cryostat re NOT seen.

DIAGNOSIS:

- Colon Mass Biopsy
- **Highly suggestivbe for Lymphoma** (most probably High Grade) -IHC study for CD3, CD20, ki67 is recommended.-

With Best reagdr Dr Rasti



CT SCAN OF ABDOMEN/PELVIS WITH CONTRAST

1401.12.08

Liver: Normal

Bile ducts: Normal

Gall bladder: No calcified gall stones

Spleen: Normal

Kidneys and ureters: Normal / **Bladder**: Normal

Reproductive organs: Hysterectomy

Bowel: Large tumoral infiltration in terminal ileum and cecum with peripheral infiltration and adenopathy (up to 17 mm) causing partial small bowel obstruction.

Abdominal lymph nodes: No enlarged abdominal lymph nodes

Pelvic lymph nodes: No enlarged pelvic lymph nodes

Peritoneum: Peritoneal infiltration at RLQ with mild ascites

Vessels: Normal

Retroperitoneum: Normal

Abdominal wall: Normal

Bones: Normal

Conclusion: Cecum and terminal ileum tumoral infiltration with regional adenopathy and probable peritoneal seeding

MULTISLICE CT SCAN OF ABDOMEN AND PELVIS WITH CONTRAST

The study was performed administering oral and intravenous contrast as your request obtaining coronal reconstructed views.

Findings:

-Liver: Normal

- Bile ducts: Normal
- Gall bladder: No calcified gall stones
- Spleen: Normal
- Pancreas: Normal- No mass, No inflammation.
- Adrenals: Normal
- Kidneys and ureters: Normal
- Bladder: Normal
- Reproductive organs: **Hysterectomy**
- Bowel: **Large tumoral infiltration in terminal ileum and cecum with peripheral infiltration and adenopathy (up to 17 mm) causing partial small bowel obstruction.**
- Abdominal lymph nodes: No enlarged abdominal lymph nodes
- Pelvic lymph nodes: No enlarged pelvic lymph nodes
- Peritoneum: **Peritoneal infiltration at RLQ with mild ascites**
- Vessels: Normal
- Retroperitoneum: Normal

-Abdominal wall: Normal

-Bones: Normal

Conclusion:

Cecum and terminal ileum tumoral infiltration with regional adenopathy and probable peritoneal seeding

دکتر علی نوروزی
برد تخصصی رادیولوژی

Best Regards

Immunohistochemical staining

1401.12.22

"Colon mass biopsy"

CD20: Positive
CK: Negative
Ki-67: Positive in 90% of tumoral cells
CD10: Positive
c-Myc: Negative
TdT: Negative
MUM1: Positive CyclinD1: Negative
BCL6: Positive

Diagnosis: Large B-cell lymphoma, germinal center type

Specimen: The sample submitted for IHC staining consists of a paraffin block and slide labeled as 22109 and the copy of the corresponding pathology report with the same pathology number from Sayed-Alshohada pathology laboratory which specified as "Colon mass biopsy".

IHC MARKERS:
Results of Immunohistochemical staining are as follow:

CD20: Positive
CK: Negative
Ki-67: Positive in 90% of tumoral cells
CD10: Positive
c-Myc: Negative
TdT: Negative
MUM1: Positive
CyclinD1: Negative
BCL6: Positive

Diagnosis: Large B-cell lymphoma, germinal center type

Pathologist: Dr.Mitra Heidarpour

Lab Data

1401.12.22

WBC 7.7	ESR 45	HBS-Ag Neg
Neu 74% Lym 19%	BUN 13	Anti HCV Neg
RBC 4.5	CR 1.2	
HB 10.9	Estimating GFR 46	
MCV 86	AST 26	
PLT 423	ALT 15	
	Billi.T 0.5	
	Billi.D 0.1	

CT scan of the thorax +/- contrast

1401.12.27

Clinical information: Ascending colon mass

Lung parenchyma: No pathologic mass or alveolar infiltration

Mediastinum: Multiple normal size middle mediastinal lymph nodes up to 8 mm

Lung hilum: No vascular lesion, no obvious lymphadenopathy

Heart: Mild pericardial effusion is noted.

Mediastinal great vessel: Unremarkable

Pleura: No pleural effusion or pleural thickening

Chest wall: Unremarkable

Others: Small sliding hiatal hernia is seen. / Minimal ascites is evident.

Thyroid has inhomogeneous enhancement with multiple calcified nodules probably due to multinodular goiter so if clinically indicated further evaluation with sonography is recommended.

IMP: Mild pericardial effusion / Minimal ascites / R/O Multinodular goiter

Multislice CT scan of the thorax
(with & without contrast)

The study was performed in axial views obtaining coronal reconstructed views focusing lung and mediastinal window settings administering intravenous contrast and vascular structures are well demarcated.

Clinical information: Ascending colon mass
Study for comparison: None

Lung parenchyma: No pathologic mass or alveolar infiltration
Mediastinum: *Multiple normal size middle mediastinal lymph nodes up to 8 mm*
Lung hilum: No vascular lesion, no obvious lymphadenopathy
Heart: *Mild pericardial effusion is noted.*
Mediastinal great vessel: Unremarkable
Pleura: No pleural effusion or pleural thickening
Chest wall: Unremarkable
Others:
-Small sliding hiatal hernia is seen.
-Minimal ascites is evident.
-Thyroid has inhomogeneous enhancement with multiple calcified nodules probably due to multinodular goiter so if clinically indicated further evaluation with sonography is recommended.

IMP:

- **Mild pericardial effusion**
- **Minimal ascites**
- **R/O Multinodular goiter**

CT scan of the thorax +/- contrast

1402.07.01

Clinical information: History of large bowel lymphoma

Lung parenchyma: No pathologic mass or alveolar infiltration

Mediastinum: Multiple prominent mediastinal lymph nodes are detected measuring up to 8 mm without significant changes in comparison with previous study

Lung hilum: No vascular lesion, no obvious lymphadenopathy

Heart: There is a thrombose in left ventricle apex measuring 14x10mm, myocardial thinning is also evident due to previous MI

Mediastinal great vessel: Unremarkable

Pleura: No pleural effusion or pleural thickening

Chest wall: Unremarkable

Others: -Small sliding hiatal hernia is noted.

Thyroid gland is enlarged and heterogenous indicating multinodular goiter

IMP: Evidence of previous MI / Left ventricle small thrombose as explained

Multislice CT scan of the thorax
(with & without contrast)

The study was performed in axial views obtaining coronal reconstructed views focusing lung and mediastinal window settings administering intravenous contrast and vascular structures are well demarcated.

Clinical information: History of large bowel lymphoma
Study for comparison: Previous CT scan dated 1401/12

Lung parenchyma: No pathologic mass or alveolar infiltration
Mediastinum: Multiple prominent mediastinal lymph nodes are detected measuring up to 8 mm without significant changes in comparison with previous study
Lung hilum: No vascular lesion, no obvious lymphadenopathy
Heart: There is a thrombose in left ventricle apex measuring 14x10 mm , myocardial thinning is also evident due to previous MI
Mediastinal great vessel: Unremarkable
Pleura: No pleural effusion or pleural thickening
Chest wall: Unremarkable
Others:
-Small sliding hiatal hernia is noted.
-Thyroid gland is enlarged and heterogenous indicating multinodular goiter

IMP:

- **Evidence of previous MI**
- **Left ventricle small thrombose as explained**

CT scan of the abdomen and pelvic +/- contrast

1402.07.01

- Clinical information: History of large bowel lymphoma -Study for comparison: Previous CT scan dated 1401/12

Liver: Normal volume with no obvious pathologic mass Biliary and portal system: Unremarkable

Gallbladder: Unremarkable

Kidneys: There is a tiny stone in right renal sinus, mild secondary / hydroureteronephrosis is also evident in right side.

Spleen: Normal volume without obvious pathologic S.O.L.

Pancreas: Unremarkable.

Retroperitoneum & peritoneal cavity: Unremarkable

Abdominopelvic lymphadenopathy: Unremarkable

GI tract: Mild wall thickening of terminal ileum is noted, significantly decreased in comparison with previous study. Dilation of terminal ileum loops are detected with adjacent soft tissue edema. There is a fluid collection in pelvic cavity between small bowel loops seems to be connected to abdominal wall, rectus muscle and seems to be connected to small bowel loop and sigmoid colon as well to superior bladder wall probably due to post radiation changes.

Pelvic organs: Uterus is not seen due to previous hysterectomy.

Bladder wall thickening is noted more prominent in upper portion with suspicious fistula tract to skin and pelvic fluid collection.

IMP:

Cecal and terminal ileum mild wall thickening (Significantly decreased in comparison with previous study)

Pelvic fluid collection between thick wall ileal loops seems to be connected to sigmoid colon, small bowel loops, rectus muscles and bladder

Multislice CT scan of the abdomen and pelvic
(with & without contrast)

- *Clinical information: History of large bowel lymphoma*
- *Study for comparison: Previous CT scan dated 1401/12*

Liver: Normal volume with no obvious pathologic mass
Biliary and portal system: Unremarkable
Gallbladder: Unremarkable
Kidneys: There is a tiny stone in right renal sinus, mild secondary hydroureteronephrosis is also evident in right side.
Spleen: Normal volume without obvious pathologic S.O.L.
Pancreas: Unremarkable
Adrenal glands: Normal volume without pathologic mass lesion
Retroperitoneum & peritoneal cavity: Unremarkable
Abdominopelvic lymphadenopathy: Unremarkable
GI tract: Mild wall thickening of terminal ileum is noted, significantly decreased in comparison with previous study. Dilation of terminal ileum loops are detected with adjacent soft tissue edema. There is a fluid collection in pelvic cavity between small bowel loops seems to be connected to abdominal wall, rectus muscle and seems to be connected to small bowel loop and sigmoid colon as well to superior bladder wall probably due to post radiation changes.
Pelvic organs: Uterus is not seen due to previous hysterectomy.
-Bladder wall thickening is noted more prominent in upper portion with suspicious fistula tract to skin and pelvic fluid collection.

IMP:

- **Cecal and terminal ileum mild wall thickening (Significantly decreased in comparison with previous study)**
- **Pelvic fluid collection between thick wall ileal loops seems to be connected to sigmoid colon, small bowel loops , rectus muscles and bladder**

Colonoscopy

1402.07.29

Reason for endoscopy: History of right colon lymphoma, Suspicious history of rectovaginal fistula., HF, Apex thrombus

Anus: Skin tags were seen. Normal DRE

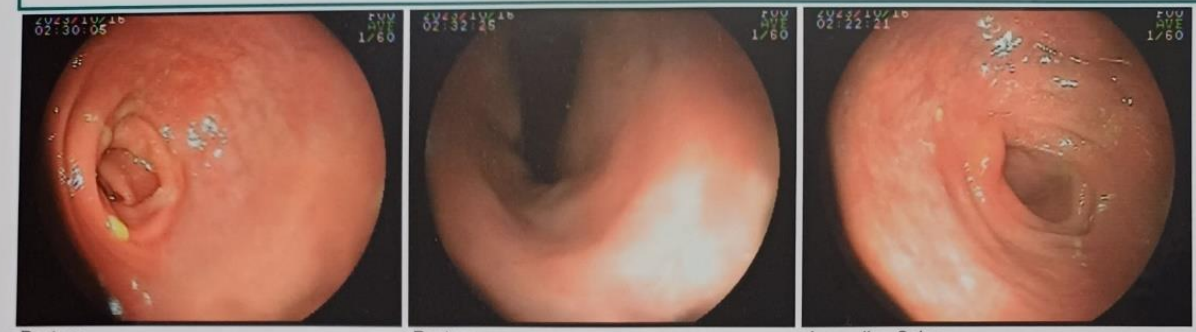
Rectum : Normal mucosa and vascular pattern was seen. No obvious orifice was seen.

Sigmoid Normal mucosa and vascular pattern was seen.

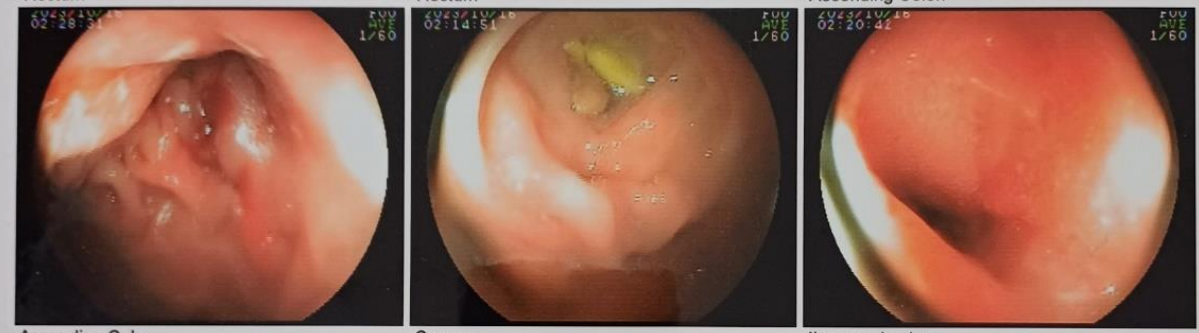
Ascending Colon: A suspicious plaque of mucosal friability was seen in distal of right colon, just before the hepatic flexure, Sampling was done to R/O relapse. No other mucosal abnormality was seen.

Cecum : Ileocecal valve was stenotic and scope could not pass to ileum, but sampling of distal ileum was done.

Final Diagnosis : Significant response of the right colon lymphoma / Ileocecal valve stenosis



Rectum | Rectum | Ascending Colon



Ascending Colon | Cecum | Ileo-cecal valve

Reason for endoscopy : History of right colon lymphoma, Suspicious history of rectovaginal fistula., HF, Apex thrombus

Premedication : Provided by anesthesiologist.

Description of procedure : The video endoscope was introduced up to the terminal ileum under deep sedation. Quality of procedure was adequate. Boston bowel reparation scale were 2, 2 and 2 in left, middle and right segments, respectively.

Anus : Skin tags were seen. Normal DRE

Rectum : Normal mucosa and vascular pattern was seen. No obvious orifice was seen.

Sigmoid : Normal mucosa and vascular pattern was seen.

Ascending Colon : A suspicious plaque of mucosal friability was seen in distal of right colon, just before the hepatic flexure, Sampling was done to R/O relapse. No other mucosal abnormality was seen.

Cecum : Ileocecal valve was stenotic and scope could not pass to ileum, but sampling of distal ileum was done.

Final Diagnosis

Significant response of the right colon lymphoma
Ileocecal valve stenosis

PATHOLOGY

1402.07.29

Final Pathologic Diagnosis:

Terminal Ileum Biopsy:

- Focal Severe Active Ileitis with Chronic changes
- No evidence of lymphoma

Comment: Patchy active inflammation and Chronicity changes (architectural distortion) in ileal mucosa consistent with chronic inflammatory process are present. After excluding Chemotherapy-induced ileitis, Infective etiology & NSAID use; possibility of Crohn's disease should be considered.

Ascending Colon Biopsy:

- No diagnostic abnormality
- No evidence of lymphoma

SURGICAL PATHOLOGY REPORT

Clinical Data: History of right colon lymphoma, suspicious history of rectovaginal fistula, HF, apex thrombus

Macroscopic Examination:

1: Received in formalin labeled with patient's name and **Terminal Ileum,** composed of three soft fragments measuring in aggregate 0.4x0.4x0.4 cm, whitish grey color. Entirely submitted in one cassette.
2: Received in formalin labeled with patient' name and **Ascending colon,** composed of five soft fragments measuring in aggregate 0.6x0.5x0.2 cm, whitish grey color. Entirely submitted in one cassette.

Microscopic Examination:

Terminal Ileum: Sections show edematous small intestine mucosa

- Villi/crypt ratio: mild villous blunting
- Infiltration of lymphocytes & plasma cells in lamina propria: Moderate
- Active inflammation (neutrophils in lamina properia with Cryptitis): Focal severe
- Chronicity changes : Present; crypt distortion & branching
- Eosinophils: 6/HPF
- Granuloma and fissure: Not identified.
- Lymphoid aggregates: Absent
- Dysplasia: Not identified

Ascending colon: Sections show large bowel glands lined by mucin producing columnar epithelium.

- Activity (Infiltration of Neutrophils in lamina propria , Cryptitis, crypt abscess): Absent
- Infiltration of lymphocytes & Plasma cells in lamina propria: Mild Eosinophils: 1-2/HPF
- Intraepithelial lymphocytes & Thickness of subepithelial collagen layer: within normal limit
- Chronicity change: Not identified, Preserved crypt architecture
- Dysplasia: Not identified

Final Pathologic Diagnosis:

 # Terminal Ileum; Biopsy:

- Focal Severe Active Ileitis with Chronic changes *

- No evidence of lymphoma

**** Comment: Patchy active inflammation and Chronicity changes (architectural distortion) in ileal mucosa consistent with chronic inflammatory process are present. After excluding Chemotherapy-induced ileitis, Infective etiology & NSAID use; possibility of Crohn's disease should be considered.***

 # Ascending Colon Biopsy:

- No diagnostic abnormality

- No evidence of lymphoma

PET-CT Scan

1402.08.20

No metabolically active FDG avid tumoral lesion in the imaged portion of body.

Bladder wall thickening with suspicious fistula to small bowel loops and rectus muscles. Correlation with Contrast enhanced CT is recommended.

Patient Name: Ms.Mosadegh...Parvin

Age: 64 Y/O

Referring Physician: Dr.Hajigholami

Height: 154 Cm

Weight: 55.3 Kg

Technique:

Blood Sugar at injection time: 108 **mg/dl**

Duration of fasting: **At least 6 hr**

Diabetes status: **Non-diabetic**

Injected Dose: 8.2 **mCi of F-18 FDG**

Interval between injection and acquisition: **60 min**

Field of View: **Vertex to Mid-Thigh** Time/Bed position: **3 min** Acquisition: **3D HD**

Low dose CT images (30 mAs and 120 KV) without contrast were obtained for attenuation correction and anatomical localization purposes. The PET and CT images were digitally fused for display. All images were acquired on a combined PET-CT scanner unit. The CT quality of low dose PET/CT study is not intended to replace the diagnostic CT quality used for clinical purposes. The patient received oral hydration.

SUVmax based on Time of Flight PET

Mediastinal Blood Pool SUVmax = 1.97

Hepatic Background SUVmax = 2.53

Status: Large B-Cell lymphoma (Colon mass biopsy)

Findings:

Brain, Head and Neck:

Physiologic FDG uptake is noted throughout the brain. Because of high physiologic FDG activity in the brain reliable judgment about abnormal FDG avid lesion in the brain could not be made. No remarkable lymph node or abnormal FDG uptake is visualized in the cervical regions. Physiological uptake is seen in salivary glands and tonsils. Both thyroid lobes show multinodular pattern with foci of calcification without evidence of abnormal increased FDG activity (MNG?).

Thorax:

Mediastinum, Lungs and Hila:

Multiple small sized mediastinal lymph nodes show no abnormal FDG uptake. No remarkable finding or abnormal FDG uptake is noted in the lung fields. No remarkable lymphadenopathy or FDG-avid lesion is noted in hila.

Chest Wall and Axillary Regions: No remarkable structural abnormality or abnormal FDG uptake is seen in the chest wall and breasts. No remarkable lymphadenopathy or abnormal FDG uptake is visualized in the axillary regions.

Abdomen:

Liver and Spleen: No remarkable structural finding or abnormal FDG uptake is seen in the liver and spleen.

Gastrointestinal/Peritoneal/Retroperitoneal: No remarkable lymphadenopathy or FDG-avid lesion is noted in the intraperitoneal and retroperitoneal regions.

FDG activity in the region of cecum is most likely physiologic/benign uptake; however needs attention in the future imaging.

Urinary System: There are renal stones in both kidneys with evidence of right side hydronephrosis. Physiologic uptake is noticed within the kidneys, ureters and bladder.

Other Abdominal Viscera: No abnormal uptake is noted in the adrenal glands and pancreas.

Pelvis:

There is evidence of previous hysterectomy.

Bladder wall thickening is noticed with suspicious fistula to small bowel loops and rectus muscles

Correlation with Contrast enhanced CT is recommended.

No other abnormal FDG uptake is seen in the pelvis.

Musculoskeletal System:

Except for mild FDG uptake in the degenerative joints no other abnormal uptake is noted in th musculoskeletal system.

Address: PET-CT scan Center, Farabi Hospital Complex, Arghavanieh Blvd 3rd Mushtagh St. Isfahan, Iran

Postal. Code: 8155113153, Tel: (+98 31) 37952594-95, Web site: Farabi@mui.ac.ir

FARABI Hospital
PET - CT Scan Center

Impression & Comment:

The current Study reveals:

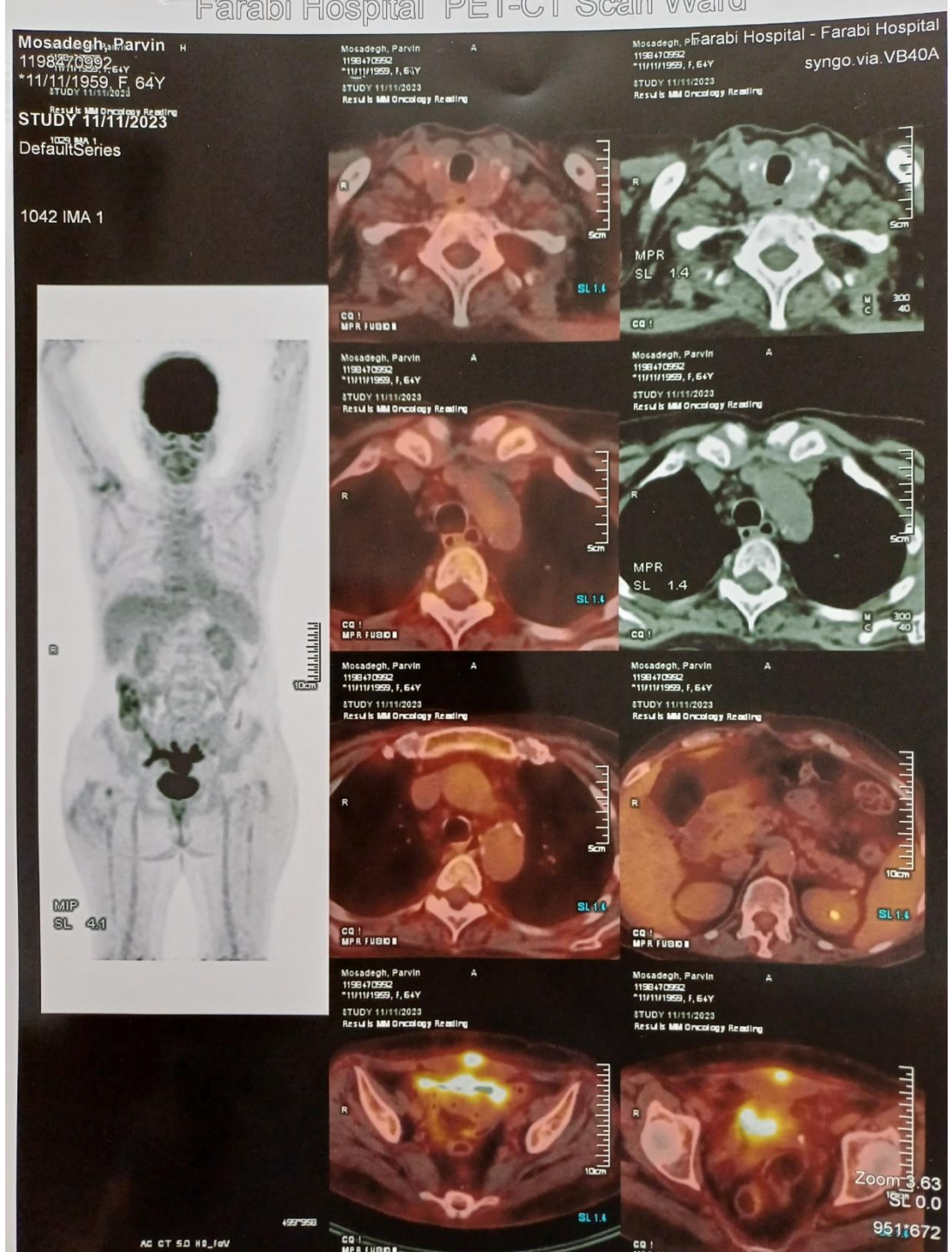
- No metabolically active FDG avid tumoral lesion in the imaged portion of body.
- Bladder wall thickening with suspicious fistula to small bowel loops and rectus muscles. Correlation with Contrast enhanced CT is recommended.

Yours Sincerely,
Nuclear Medicine Specialist

Emami Melika, MD

Moslehi Masoud, MD

Address: PET-CT scan Center, Farabi Hospital Complex, Arghavanieh Blvd 3rd Mushtagh St. Isfahan, Iran
Postal. Code: 8155113153, Tel: (+98 31) 37952594-95, Web site: Farabi@mui.ac.ir

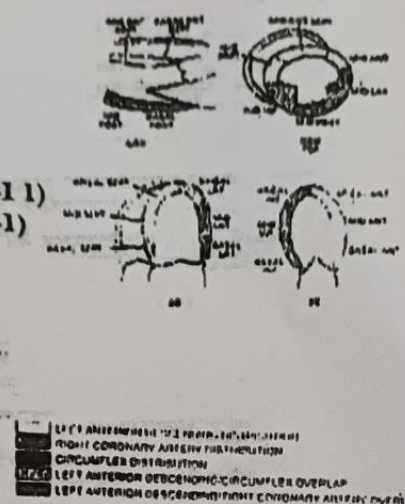


M- Mode, 2-D Echocardiography

Left Vantricle (LV) Studies:

End diastole: cm (3.5-5.4)
End systole: cm (2.3-3.4)
M-Mode EF % Globale EF
FS %
EPSS: cm (<0.8 cm)
IVS.d: cm (0 6-1 1)
PW.d: cm (0.6-1)

☐ Normal LV function
☐ LV dysfunction
☐ R.W.M. A
A.Akinetic.....
Hypokinetic.....
Dyskinetic .....
☐ Paradoxical
☐ Thrombus



Right Ventricle (RV):

End diastole: cm
End systole: cm
Fuction:
RA size: cm
☐ VSD
☐ RVH
Others:

Left Atrium (LA):

LA size:
☐ Thrombus
☐ Myxoma
☐ ASD
☐ PFO
Others:

Pericardiu: ☐ Normal ☐ Thickened ☐ Effusion ☐ Lat ☐ Ant ☐ Post Degree:

DOPPLER STUDIES (PWD & CWD & CFM)

Mitral flow: [Normal Value: (0.6-1.3 m/s)]
☐ Normal
☐ Mitral stenosis
MV area: cm2
☐ Mitral regurgitation

Tricuspid flow: [Normal Value: (0.4-0.6m/s)]
☐ Normal
☐ Tricuspid stenosis:
Peak velocity
☐ Ticuspid regurgitation: RV pr: mmhg

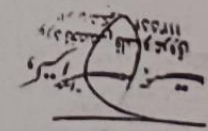
Aortic flow: [Normal value: (1.0-1.8m/s)]
☐ Normal
☐ Aortic stenosis
Peak velocity: m/s
Peak gradient: mmhg
☐ Aortic regurgitation:

Pulmonic flow: [Normal value: (0.6-0.9m/s)]
☐ Normal
☐ Pulmonic stenosis:
Peak velocity: m/s
Peak gradient: mmhg
☐ Pulmonary regurgitation:

Conclusion: - WEF. 20%

Signature:

- Global hypokinesia - EF
- large clot in apex was seen 2/1 d/s
- mild MR no MS
- no AF no AS
- nl RV size & function



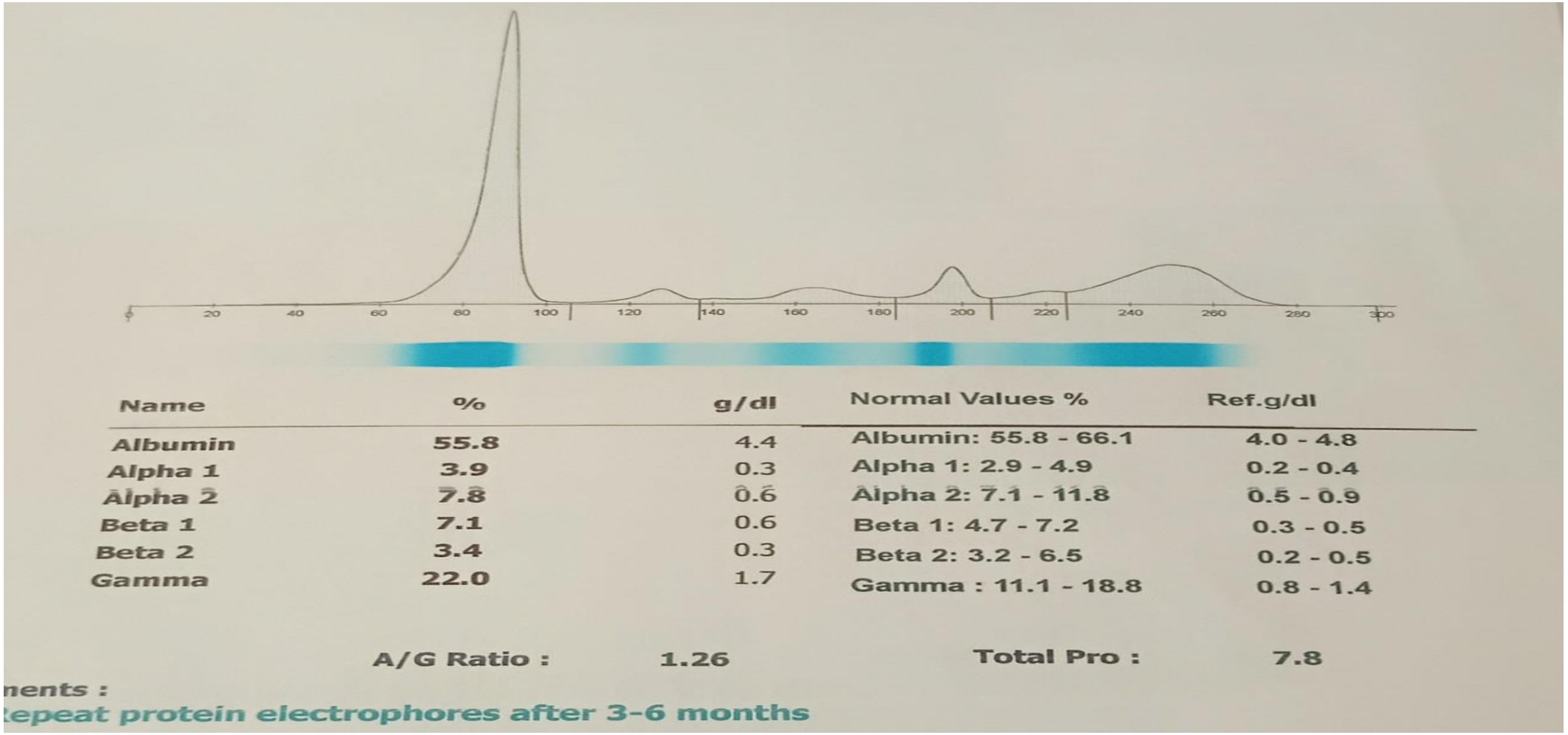
A 37-year-old

- The patient is woman who accidentally noticed high liver enzymes in 2019. The patient did not give a history of jaundice or abdominal pain, etc. At that time, and the liver enzymes gradually **decreased**.
- The patient **again** suffered from generalized jaundice a month ago. On examination, she has splenomegaly but no ascites. Asterixis was negative.
- DH: VITAMIN E, LIVERGOL, Mary thistle.

	1399/2/28	1399/3/17	13999/7/6	1399/12/25	۱۴۰۱/۲/۵	1402/4/31	1402/8/1	1402/8/4	1402/8/22
Billi T		2	1.6	0.9				18.56	10.6
Billi D		0.8	0.3	0.3				8.19	5.26
AST	178	87	65	47	65	55	239	230	219
ALT	122	72	52	34	32	53	170	156	143
ALKP		288	214	229	226	334		291	390
WBC	5.5				2.8	3.1		4.45	2.7
RBC	4.29				4	4.3		4.49	4.29
HB	11.4				11	12.3		13.4	13.3
MCV	83				82	88		88.5	91
PLT	105				68	74		97	70
PT		13	14			13			15.3
INR		1.1	1.1		1	1			1.19

ANA	-	ANTI HCV	-	
ANTILKM1	-	HBS Ag	-	
ASMA	-	Hbs Ab	-	
HAV ab	-	ceruloplasmin	-	
Hbe Ab	-	IgG	1313(800-1600)	
PANCA	-	AFP	9/3 +(99/3/8)	2/8 –(1401/2/5)
ANTITTG	-	Cr	1	
AMA	-			

2020



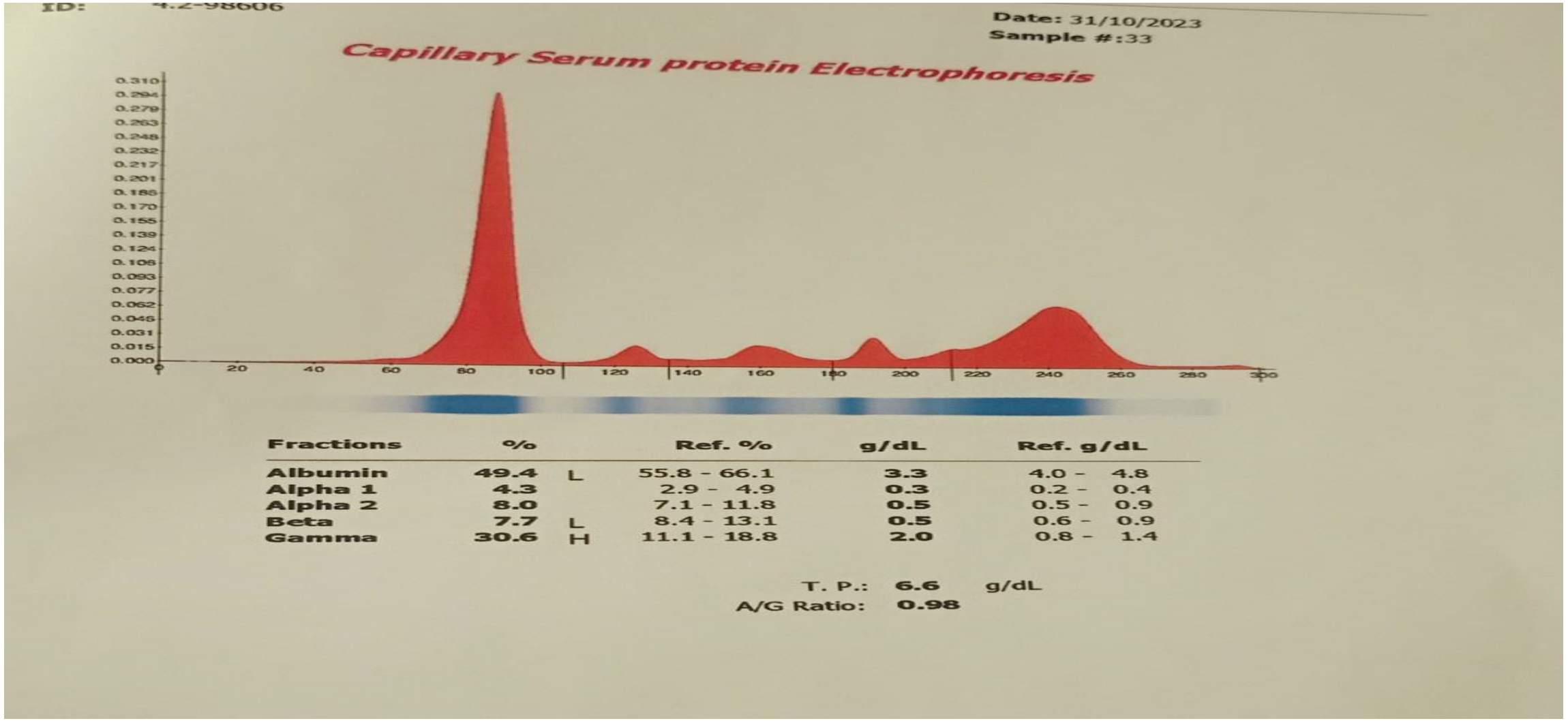
Name	%	g/dl	Normal Values %	Ref.g/dl
Albumin	55.8	4.4	Albumin: 55.8 - 66.1	4.0 - 4.8
Alpha 1	3.9	0.3	Alpha 1: 2.9 - 4.9	0.2 - 0.4
Alpha 2	7.8	0.6	Alpha 2: 7.1 - 11.8	0.5 - 0.9
Beta 1	7.1	0.6	Beta 1: 4.7 - 7.2	0.3 - 0.5
Beta 2	3.4	0.3	Beta 2: 3.2 - 6.5	0.2 - 0.5
Gamma	22.0	1.7	Gamma : 11.1 - 18.8	0.8 - 1.4

A/G Ratio : 1.26 Total Pro : 7.8

nents :

Repeat protein electrophores after 3-6 months

2023



Fractions	%		Ref. %	g/dL	Ref. g/dL
Albumin	49.4	L	55.8 - 66.1	3.3	4.0 - 4.8
Alpha 1	4.3		2.9 - 4.9	0.3	0.2 - 0.4
Alpha 2	8.0		7.1 - 11.8	0.5	0.5 - 0.9
Beta	7.7	L	8.4 - 13.1	0.5	0.6 - 0.9
Gamma	30.6	H	11.1 - 18.8	2.0	0.8 - 1.4

T. P.: 6.6 g/dL

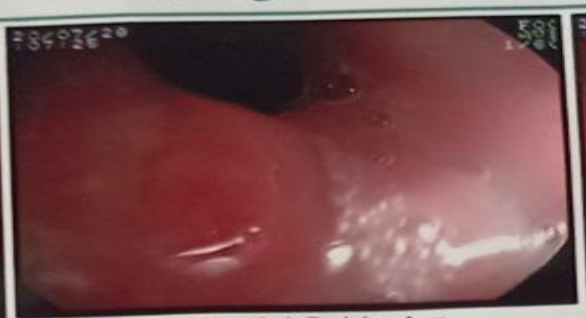
A/G Ratio: 0.98

1399/5/7

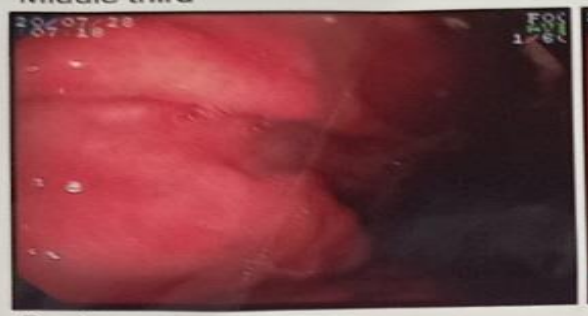
پزشک ارجاع دهنده :

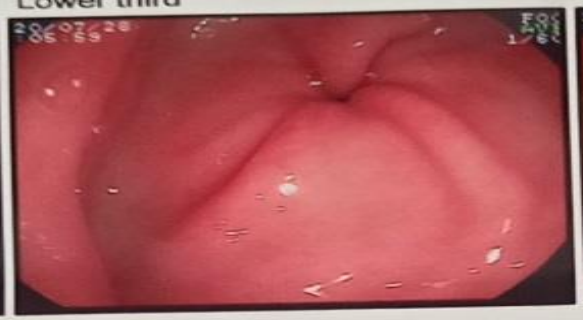

Middle third


Lower third


Lower Esophagial Sphincter


Cardia


Body


Antrum


Bulb


2nd portion

Indication : R/O Varix

Premedication : Midazolam

Description of procedure : The scope was passed through the mouth under direct vision and was advanced with ease to the 2nd duodenum.The scope was withdrawn and the mucosa was carefuly examined.The patient's toleration was good.Fasting was adequate.Findings were:

Esophagus : Normal

Stomach : Normal cardia,fundus,body and antrum

Duodenum : Normal D1 & D2

Final Diagnosis : Normal Esophagogastroduodenoscopy

1399/3/21

MRI of Abdomen with contrast

Findings:
Ascites: *There is no abdominal ascites.*
Liver: Rt. liver lobe volume loss & heterogeneous SI of liver suggestive for cirrhotic change with capsular irregularity & retraction.
Biliary ducts: *There is no intra or extrahepatic biliary dilatation.*
Gall Bladder: *Normal in size and configuration. There is no evidence of cholelithiasis and inflammation.*
Spleen: Splenomegaly about 181 mm is seen.
Pancreas and duct: *The pancreas is normal in signal. The pancreatic duct is normal in caliber.*
Adrenal Glands: *There are no adrenal nodules.*
Kidnies : *The kidnies enhance symmetrically without hydronephrosis or mass.*
Retroperitoneum: *There is no retroperitoneal adenopathy.*
Vessels: *The portal vein, superior mesenteric-vein, splenic vein and hepatic veins are patent. Superior mesenteric artery and hepatic artery are patent. Abdominal aorta is normal in course and caliber.*

Impression: Cirrhotic change of liver with splenomegaly

With best regards

1402/8/19

سونوگرافی کبد، وداپلر پورت :

اکوی پارانشیم کبد به صورت هتروژن و Course مشاهده شد که همراه با ندولاریته مارجینال به نفع سیبروز کبدی می باشد. Span کبد 85 mm کاهش یافته می باشد.

**وریدهای ناف طحال دیلاته با قطر 14 mm مشاهده شد .

**Span طحال 177 mm بزرگتر از حد نرمال است(Huge Splenomegaly)

**قطر ورید پورت 10 mm در محدوده نرمال دارای جریان هپاتوفوگال با سرعت ۱۰ سانتی متر بر ثانیه (مطرح کننده PTH) دارای فازیسیته تنفسی می باشد

کولترالهای ورید ی در ناحیه پری پورتال رویت شد با این وجود ورید امبلیکال ریکانالیزه نشده است .

ضایعه فضاگیر سالید یا کیستیک در پارانشیم کبد دیده نشد.

وریدهای هپاتیک دارای قطر نرمال هستند .

مجاری صفراوی داخل و خارج کبدی دارای نمای سونوگرافیک نرمال است.

کیسه صفرا ضخامت جداری نرمال دارد ; سنگ ، اسلاژ و یا توده درون کیسه صفرا دیده نشد.

Q:

A patient with liver cirrhosis of unknown cause who has a gamma peak in serum protein electrophoresis. Is there an indication for a liver biopsy?

Meld=15


6

A 79-year-old woman

- Patient with a history of diabetes has been suffering from pain and rectal discharge from 12/1398 and a perianal fistula that was drained in the office. After 3 months, she referred for surgery and was referred to a gastroenterologist for a colonoscopy:
- On 3/19/1999, a colonoscopy was performed, and numerous polyps and diverticula lesions were seen in the sigmoid, but the terminal ileum was not seen. Biopsy was reported to be non-specific colitis
- On 3/25/1999, he was treated with ciprofloxacin and metronidazole and linezolid, which caused abdominal pain (due to the medicines).
- On 4/1/99, he was treated with rifaximine and Asacol, and metronidazole was discontinued, but ciprofloxacin and linezolid were also continued.

- On 16/04/99, she was again treated with Pyloshat and Masalazine.
- On 20/05/99, she developed purulent discharge from the orifice above the fistula. She took ciprofloxacin and clindamycin for 10 days.
- On 16/06/99, he was treated with rifaximine and Asacol suppositories for 10 days, but he always had clear blood discharge from the fistula and was treated with Diltiazem ointment and Comflor capsules.
- On 8/1 due to migraine headache, he is treated with Depakine, Amitriptyline, Sulfasalazine, Mebeverine and Rifaximine.

- CT had revealed colonic diverticulum but no diverticulitis.
- Colonoscopy was done on 9/11 and Crohn's was diagnosed
- The patient is treated with infliximab, she develops a fever and is admitted to the hospital.
- And a drain was placed for 8 months.
- Colonoscopy was done again on 8/6, and Crohn's disease will be diagnosed, and treatment with Azaram, Prednisolone, Clindamycin, and Ciprofloxacin was started, which Azaram is not tolerable for the patient.

- On 8/1/1400, a CT scan of the abdomen and pelvis was done with contrast, but the abscess was not removed.
- The drain was removed on 8/8.
- 6 months ago, a substance was inserted into the fistula by a intervention radiologist, which improved and discharge was discontinued.
- A month ago, she suffered from perianal and abdominal abscess and is being treated with metronidazole.

1399

WBC	8.59	calprotectin	1892	
Hb	12/7	S/E:		
RBC	4/03	WBC	many	
MCV	88	RBC	18-20	
MCH	31			
Platelet	341			
ESR	65			
CRP	17			


Retroflex view


Rectum


Rectum


Sigmoid Colon


Sigmoid Colon


Descending colon


Middle Transverse Colon


Ascending Colon


Cecum

Reason for Endoscopy : Hx of chronic fistula and candidate for hemorrhoidectomy, Hx of take NSAID

Premedication : Midazolam 5 mg

Description of procedure : Sub optimal preparation

Findings :

1399/3/19

Anus : Orifice of suspected fistula was seen

Retroflex View : Internal hemorrhoid

Rectum : Patchy erythema was seen. multiple Bxs were taken

Sigmoid : Mucosal edema and erythema with deacrese vascular marking. multiple Bxs were taken. several polypoid lesion suspected to pseudo polyp were seen. multiple Bxs were taken

Descending Colon : Multiple diverticula were seen.Normal mucosa and vascular pattern

Transverse Colon : Normal mucosa and vascular pattern.

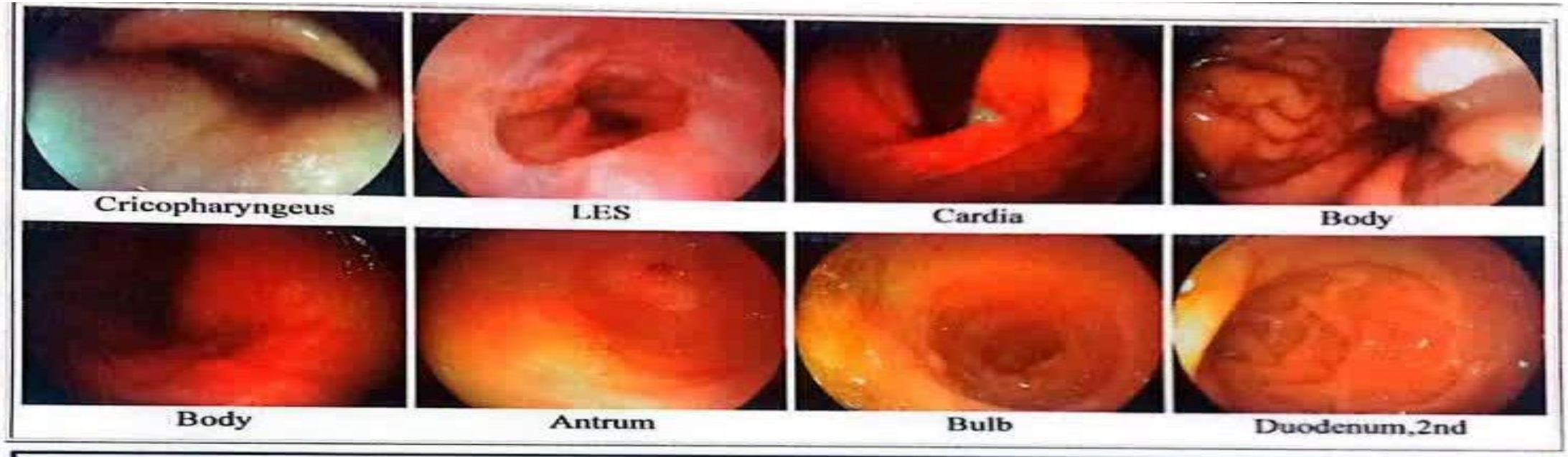
Ascending Colon : Normal mucosa and vascular pattern. small polyp was seen. polypectomy was done.

Cecum : Normal mucosa and vascular pattern

Terminal Ileum : Intubation of terminal ileum was impossible because of poor preparation in cecum

Diagnosis : See above

Recommendation : Pathology Follow up



Reason for Endoscopy : Epigastric pain and hx of use NSAID

1399/3/19

Premedication : Midazolam 3 mg

Findings :

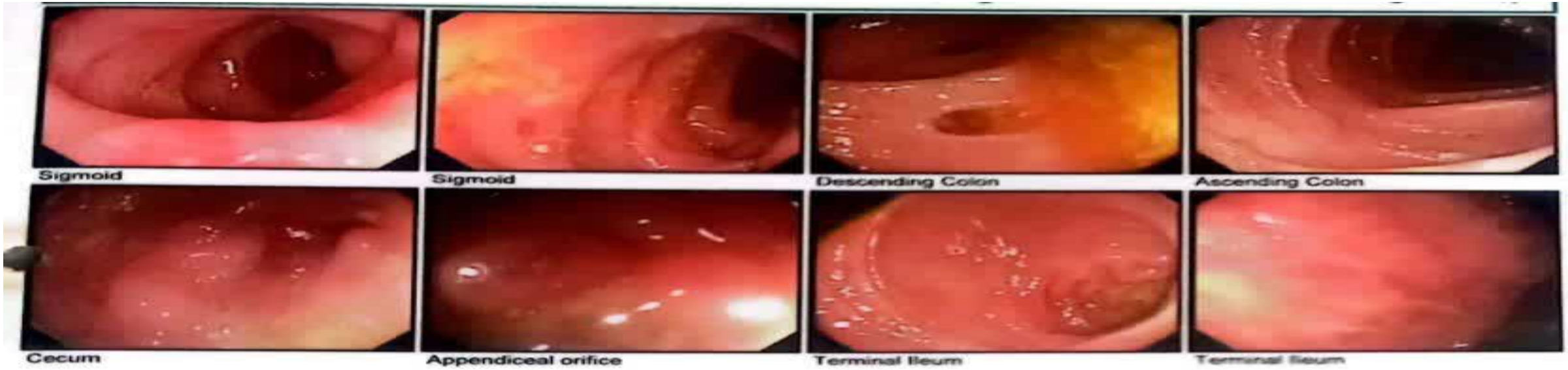
Esophagus : Upper third , Middle third and lower third were normal

Stomach : Small sliding hiatal hernia, Mucosal erythema in cardia and body. multiple Bxs were taken.
Multiple Diminutive polyp in body and polypectomy for pathology sampling was done.
Multiple erosion in antrum. Bxs were taken

Duodenum : D1 and D2 were normal

Diagnosis : Erosive gastropathy. Diminutive polyp

Recommendation : Pathology follow up



Indication : Fistula & Abdominal Abscess formation

Premedication : Deep sedation provided by anesthesiologist

1400/6/8

Anus : Normal

Rectum : Normal

Sigmoid : Patchy erythema & erosions & inflammatory polyps are seen in sigmoid colon from 20 cm up to 4o cm of anus. Bx R/O IBD (Crohn's disease).

Descending Colon : Normal but some diverticula are seen.

Transverse Colon : Normal

Ascending Colon : Normal

Cecum : Normal

Terminal Ileum : Normal Distal terminal ileum

Final Diagnosis

1- Patchy erythema & erosions & inflammatory polyps are seen in sigmoid colon from 20 cm up to 4o cm of anus. Bx R/O IBD (Crohn's disease).
2- Left sided diverticulosis.
3-Otherwise normal colonoscopy up to cecum.
2- Normal distal terminal ileum

Colonoscopy:

- 1400/8/6: Patchy erythema and erosion and inflammatory polyps are seen in sigmoid colon from 20 cm up to 40cm of anus .Bx R/O IBD(Crohn's disease)
- Left side diverticulosis.
- 1399/9/11;
- RECTUM: Edematous hundred ophthous lesion were seen.
- Sigmoid :patchy erythematous was seen.
- Suspect Crohn's colitis
- 1399/3/19;
- rectum: Patchy erythema was seen.
- Sigmoid; mucosal edema and erythema with decrease vascular marking. Several polypoid lesion suspected to pseudo polyp
- Descending: multiple diverticula

Biopsy1399/9/17

- FOCAL ACTIVE COLITIS

Macroscopic Description:
Received specimen in formalin consist three soft creamy pieces total measuring 0.8x0.5x0.4cm.

Microscopic Description:
Section show colon mucosa with normal cytoarchitecture . Mild to moderate increase of chronic inflammatory cells was seen in upper part of mucosa. Crypt show acute inflammation (cryptitis) as well.

Diagnosis:
Colon Biopsy:
-Focal Active Colitis
Note: Infectious ,preparation artifact and drug(NSAID) should be considered in differential diagnosis of this feature. , clinical, colonoscopic correlation is recommended.

Biopsy1399/3/25

- Endoscopy:
- Chronic gastritis
- Negative HPYLORI
- Fundic gland polyp
- Colonoscopy:
- Non specific inflammation

Macroscopic Description:
Received specimen consist seven containers labeled as:
Antral biopsy: Two soft creamy pieces total measuring was 0.6x0.5x0.2cm.
Body biopsy: Five soft creamy pieces total measuring was 1.5x0.5x0.2cm.
Body biopsy: Three soft creamy pieces total measuring was 0.6x0.5x0.2cm.
Colon biopsy:One soft creamy pieces total measuring was 0.3x0.3x0.2cm.
Ascending colon biopsy:Four soft creamy pieces total measuring was 1.6x0.5x0.2cm.
Sigmoid Colon Biopsy:Three soft creamy pieces total measuring was 1.0x0.5x0.2cm.
Rectum Biopsy: Two soft creamy pieces total measuring was 0.6x0.5x0.2cm.

Microscopic Description:
Antral biopsy: Section reveals gastric mucosa. There was just chronic inflammation of superficial portion of lamina propria. Regenerative change was seen in epithelium as well. H.pylori was not seen on Giemsa staining
Body biopsy: Section reveals gastric mucosa. There was just chronic inflammation of superficial portion of lamina propria. Regenerative change was seen in epithelium as well. H.pylori was not seen on Giemsa stainin
Body biopsy: Section shows polypoid mass. Core of polyp consist from oxyntic epithelium. Foveolar part of epithelium has decrease. Also some dilated change was seen in gland. H.pylori was not seen on Giemsa staining.
Ascending colon biopsy: Section reveals colon mucosa and muscularis mucosa. Architecture was normal an chronic inflammatory cell was seen in lamina propria.
Sigmoid Colon Biopsy: Section show colon mucosa with normal cytoarchitecture .Mild to moderate increas chronic inflammatory cells was seen in upper part of mucosa. No acute inflammation or evidence of IBD wa found in this specimen.
Sigmoid Colon Biopsy: Section reveals colon mucosa and muscularis mucosa. Architecture was normal an chronic inflammatory cell was seen in lamina propria.
Rectum Biopsy: Section show colon mucosa with normal cytoarchitecture .Mild to moderate increase of chronic inflammatory cells was seen in upper part of mucosa. No acute inflammation or evidence of IBD w found in this specimen.

Diagnosis:
Antral biopsy:
-Chronic Superficial Antral Gastritis
-Negative for H.pylori (Giemsa staining)
Body biopsy:
-Chronic Superficial Corpus Gastritis
-Negative for H.pylori (Giemsa staining)
OLGA Gastritis Staging: 0/4
OLGIM Gastritis Staging: 0/4
Body biopsy:
-Consist With Fundic Gland Polyp.
-Negative for H.pylori (Giemsa staining)

1399/3/25

Liver and GI Pathology From Mount Sinai of New York

Ascending colon biopsy:

- Mucosal Tag

Sigmoid Colon Biopsy:

-Non-Specific inflammation

Sigmoid Colon Biopsy;

- Mucosal Tag

Rectum Biopsy:

-Non-Specific inflammation

CT 1399/8/15

- No evidence of abscess formation in abdominal cavity.
- Colon diverticulosis with out evidence of diverticulitis.

abdomino pelvic MDCT with IV contrast

R/O of abdomeno pelvic abscess formation and diverticulitis

-NO free fluid in abdomenopelvic cavity is seen

colon diverticulosis is seen

minimal fat staranding surrounding sigmoid colon is present

تاریخ:	نام پزشک مشاور و امضاء:
	Consultation Physiciaon Name & Sign:

NO evidense of bowel thicking and no evida

of increase wall attenuation, no evidence of

of entrenusatia of gas are seen

No evidence of abscess formation in abdominopelvic
cavity is present

left ovarian cyst is present with size of 40 mm
is seen

Imp
- No evidence of abscess formation in abdominopelvic cavity
- colon diverticulosis without evidence of diverticulitis

Pathology1400/6/14;

- Patchy moderate active colitis with focal chronicity change
- IBD (CROHN)

SURGICAL PATHOLOGY REPORT

Clinical Data: *Fistula & Abdominal Abscess Formation*

Macroscopic Examination:

Received in formalin labeled with patient's name and **Sigmoid,** composed of five soft fragments measuring in aggregate 0.6x0.5x0.2 cm, whitish grey color. Entirely submitted in one cassette.

Microscopic Examination:

Sections show large bowel glands lined by mucin producing columnar epithelium. The lamina propria focally infiltrated by moderate amount of inflammatory cells including lymphocytes, Plasma cells, eosinophils and neutrophils. Moderate cryptitis is encountered. Crypt abscess and granuloma or fissure is not seen. Focal chronicity changes including glandular structure abnormality with crypt distortion and branching is seen. There is no evidence of dysplasia or malignancy.

Final Pathologic Diagnosis

Sigmoid Colon; Biopsy:

- Patchy Moderate Active Colitis with Focal chronicity changes

* *COMMENT:*
Patchy active inflammation and Chronicity changes (architectural distortion) in colonic mucosa consistent with chronic inflammatory process are present.
The findings are compatible with Inflammatory Bowel Disease more consist with: "Crohn's disease".
(An infective etiology should be considered, as it cannot be excluded on pathologic grounds).

CT

- A tract is seen between anterior abdominal wall and sigmoid colon which have suggestive of colon-cutaneous fistula
- Acute diverticulitis in sigmoid colon (LLQ)

1402/4/19

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 biliary dilatation.*
- ***Two hypodense lesion measured 27mm and 21mm are seen in segment 7th and 4th of liver respectively.***
- *Spleen and pancreas are also normal with no SOL.*
- *The kidneys are opacified with no hydronephrosis and space occupying lesion.*
- ***A tract is seen between anterior abdominal wall and sigmoid colon which have suggestive of colon-cutaneous fistula.***
- ***Short segment circumferential wall thickening is seen in sigmoid colon at LLQ and also some diverticula are seen in sigmoid colon and descending colon and also fat stranding are seen around sigmoid colon at LLQ which have suggestive of diverticulitis.***
- *No paraaortic or paracaval adenopathy is present.*
- *Both adrenal glands are normal.*
- ***A cyst measured 41mm is seen in left ovary.***
- *Other pelvic organs are normal.*

IMP:

- ***A tract is seen between anterior abdominal wall and sigmoid colon which have suggestive of colon-cutaneous fistula.***
- ***Acute diverticulitis in sigmoid colon (in LLQ)as mentioned above***

MRI 1402

- There is a long complex fistulous tract with its orifice in left side of inner aspect of buttock with approximate length of about 8 cm which extends medial to ischio-anal for anteriorly and superiorly traversing between internal and external sphincters, ending at 4 o’clock of anal canal. about 15mm proximal to anal verge and there is a branch separating from mid portion of abovementioned fistula. traversing right side to the main fistula, then traversing between internal and external sphincter ,ending at 7 o’clock of anal canal about 15 mm proximal to anal verge
- The main fistulous tract has a posterior limb ,traverses in mid line, toward tip of coccyx.

- Fistulous tract of about 55mm length in left side of anterior abdominal wall in left flank, is connected to jejunal loop and not to left colon.
- There is a conglomerated mass like stricture in left flank ,which is consist of multiple jejunal loops adherent to each other with complete obliteration of surrounding mesenteric fat.
- The pattern of changes are highly in favor of crohn’s disease with fistula formation, traversing through mesenteric fat, perforating transvers abdominis, internal and external oblique muscle and finally having an orifice on skin surface.

- As I mentioned ,this fistulous tract is not related to colon.
- Conglomerated jejunal loop do not show any significant enhancement after injection of contrast and are not associated with significant thickening ,so it may be regarded as chronic phase of crohn’s disease with a predominantly fibrotic nature.
- There is another fistulous tract of about 70mm between these conglomerated jejunal loops with mesenteric border of sigmoid colon.
- Rest of ileojejunal loops are clear and if you want to perform surgery, it may be necessary to resect not only this area of conglomerated jejunal loop but also the fistulous tract between these abnormal loops with sigmoid colon.

1402/6/1

Dear Dr:

In non-contrast and dynamic contrast enhanced MRI study of perianal region:

There is a long complex fistulous tract with its orifice in left side of inner aspect of buttock with approximate length of about 8cm , which extends medial to ischioanal fat anteriorly and superiorly , traversing between internal and external sphincters , ending at 4 O'clock of anal canal , about 15mm proximal to anal verge and there is a branch separating from mid portion of abovementioned fistula , traversing right side to the main fistula, then traversing between internal and external sphincter , ending at 7 O'clock of anal canal, about 15mm proximal to anal verge .

The main fistulous tract has a posterior limb , traverses in mid line , toward tip of coccyx .

Ischiorectal and mesorectal fat are clear and intact.

There is no perforation of external sphincter .

There is no extension beyond levator ani muscle.

Dear Dr:

In non-contrast and dynamic contrast enhanced MRI study of pelvis:

There is approximate dimensions of uterus are about 78*42*50mm with a few intramural myoma, the largest of 22mm in anterior wall of uterine body and a few others of 10-12mm in other parts without any submucosal extension.

Endometrium is a single smooth line with a maximum thickness of 5.5mm.

Junctional zone is nearly smooth and intact.

There is an unusual multilobulated cystic lesion of 40mm in right cornu of uterus, which appears to be encased by fallopian tube , having no solid enhancing internal septa or any enhancing mural nodule , overall is considered as ORADs-II .

A simple cyst of 10mm is noted in right ovary .

Uterine cervix, vaginal canal , urinary bladder are normal for age of the paient.

Dear Dr:

In non-contrast and dynamic contrast enhanced MRI study of abdomen and also contrast enhanced MR enterogram of small bowel ioops:

Fistulous tract of about 55mm length in left side of anterior abdominal wall in left flank, is connected to jejunal loops and not to left colon .

There is a conglomerated mass like structure in left flank , which is consists of multiple jejunal loops adherent to each other with complete obliteration of surrounding mesenteric fat .

The pattern of changes are highly in favor of Crohn's disease with fistula formation , traversing through mesenteric fat , perforating transverse abdominis, internal and external oblique muscles and finally having an orifice on skin surface.

As I mentioned, this fistulous tract is not related to colon .

Conglomerated jejunal loops do not show any significant enhancement after injection of contrast and are not associated with significant thickening , so it may be regarded as chronic phase of Crohn's disease with a predominantly fibrotic nature.

There is another fistulous tract of about 70mm between these conglomerated jejunal loops with mesenteric border of sigmoid colon .

(continues next page)

Rest of ileojejunal loops are clear and if you want to perform surgery , it may be necessary to resect not only this area of conglomerated jejunal loops but also the fistulous tract between these abnormal loops with mid sigmoid colon .

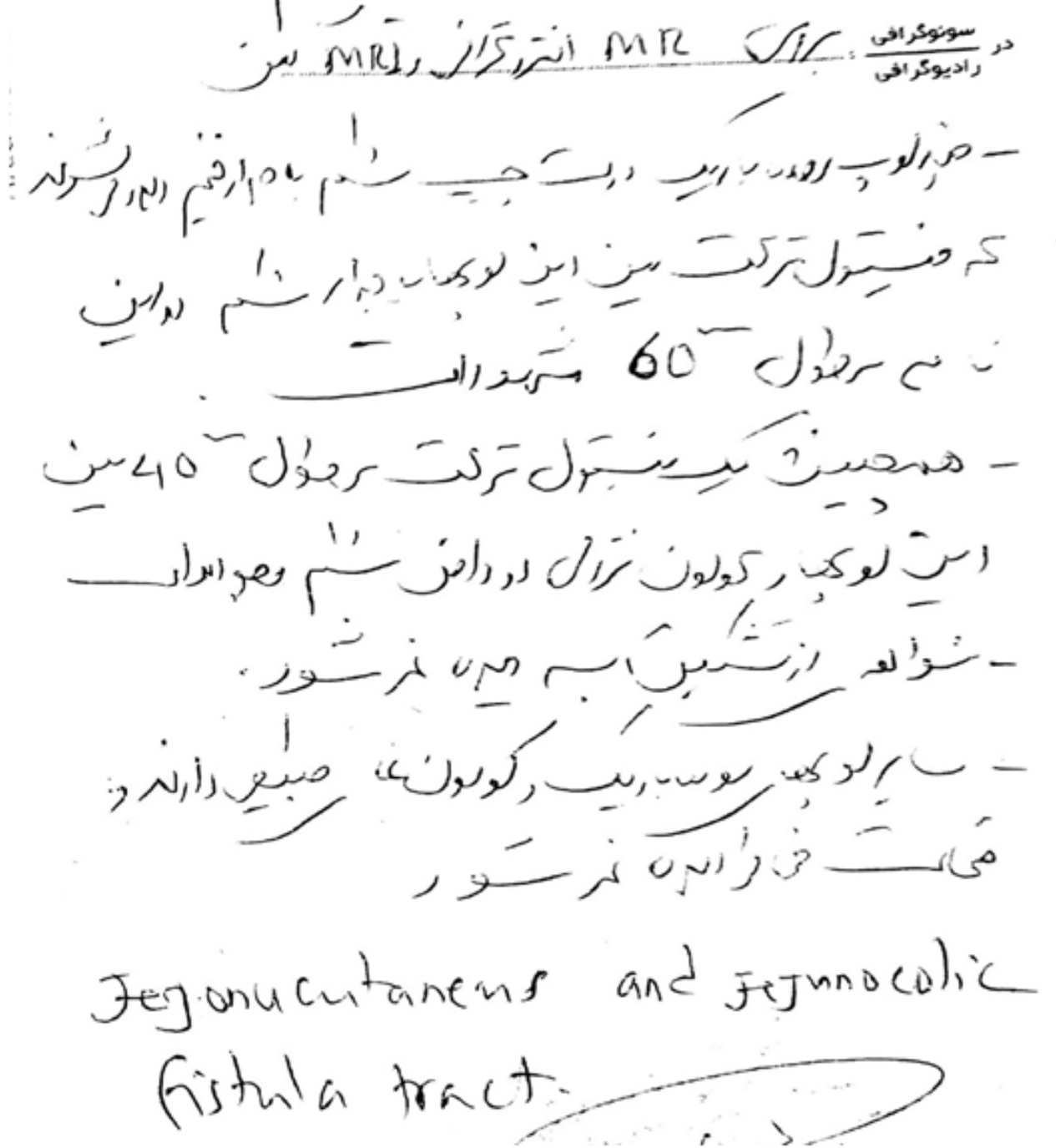
So patient has two fistulous tracts, one between jejunal loops with anterior abdominal wall and the other between the same jejunal loops with mesenteric border of sigmoid colon.

- A few loops of the small intestine can be seen on the left side of the abdomen with a thick wall. A tract fistula between these loops or the abdominal wall is visible in this area with a length of 60 mm.
- There is also a 40 mm tract fistula between these loops of the descending colon inside the abdomen
- No evidence of abscess was seen.
- Jejuno-cutaneous and jejunocolic fistula tract

در سونوگرافی / رادیوگرافی

- Intersphinctric fistula tract in left primary region (65 mm in length) is noted branching in midpart and opening at 5 and 7 o'clock position to rectum with no abcess formation
- and also a blind branch ending in posterior aspect
- A simple cyst (40 mm) in left ovary and multiple fibromas in uterus is noted

در سونوگرافی / رادیوگرافی



Fegonucutaneus and Fegnocolic
fistula tract.

- Is the fistula due to Crohn's disease or due to chronic diverticulitis?