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 4 2023

# List of cases-December 04 2023

| | Patient | Fellow | page |
|---|---|---|---|
| 230901 | **A 24-year-old female** | Dr. Izadi | |
| | | | |
| 240903 | A 31-year-old female | Dr. Namaki | |
| 230901 | A 17-year-old male | Dr. Izadi | |

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 آندوسکوپی

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

CS Scanned with CamScanner

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

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

*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



نتیجه

# 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.

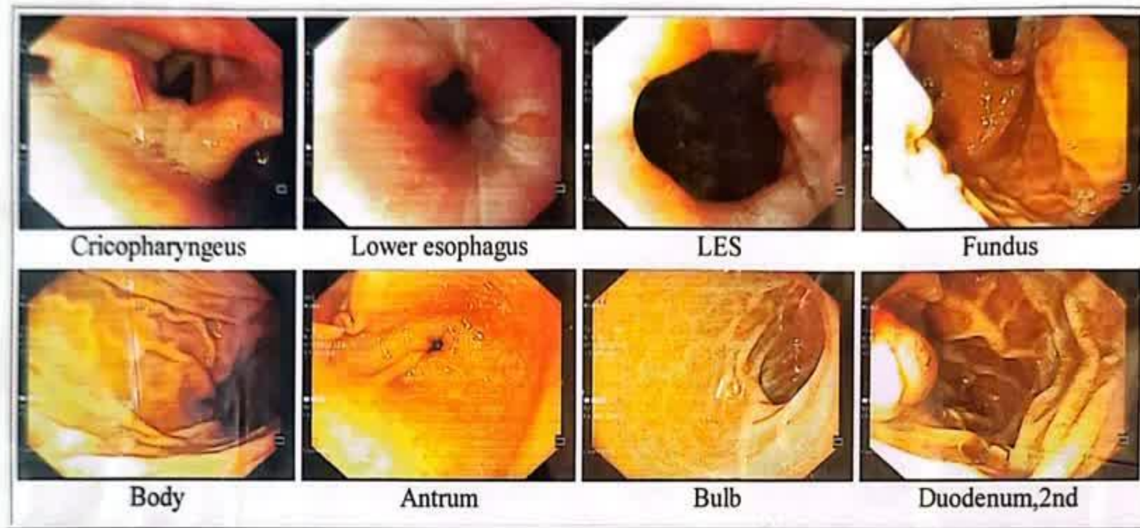
# on 02/01/27

- 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

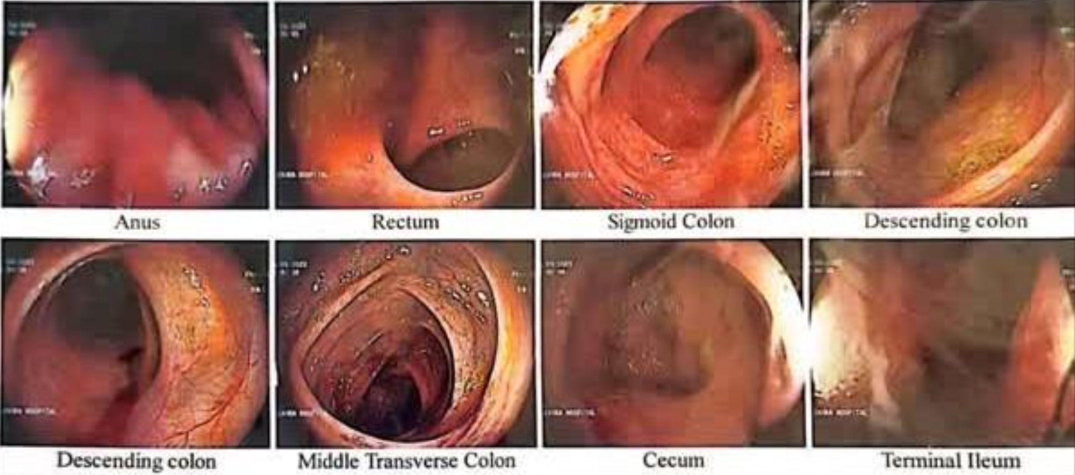
**Findings :**

**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

## جوابدهی سی تی اسکن

| | | | | | |
|---|---|---|---|---|---|
| نام و نام خانوادگی بیمار | طلا محمدی | کدپذیرش بیمار | [illegible] | بیمه بیمار | [illegible] |
| پزشک برگه | مسجدی - مهسا | کد برگه | [illegible] | تاریخ برگه | [illegible] |

***: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*** — ***Resident***

***M. Masjedi. MD*** — ***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.*

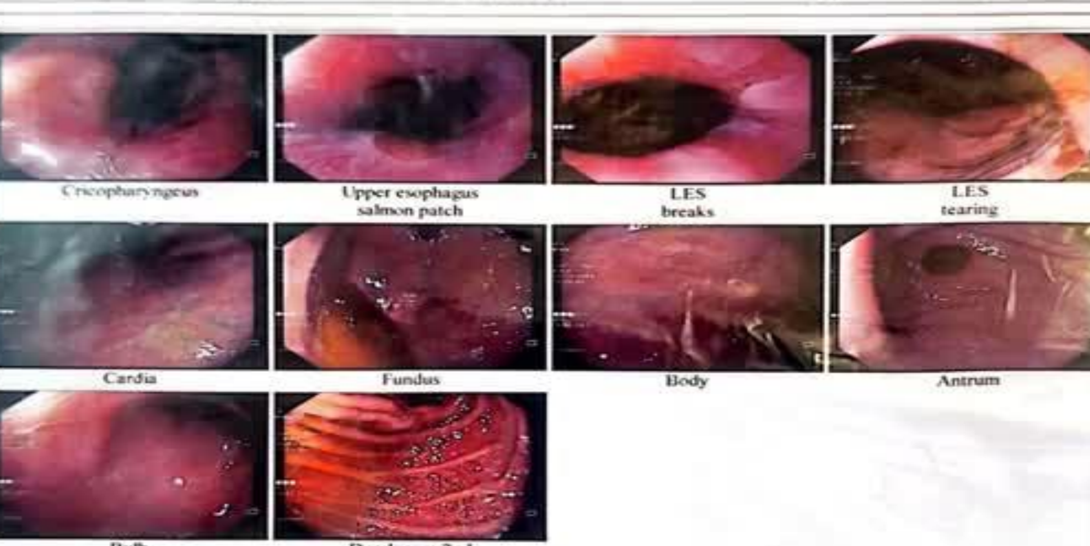
*IMPRESSION:*
*The study is abnormal GI bleeding from the proximal of the transverse colon*

- 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

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

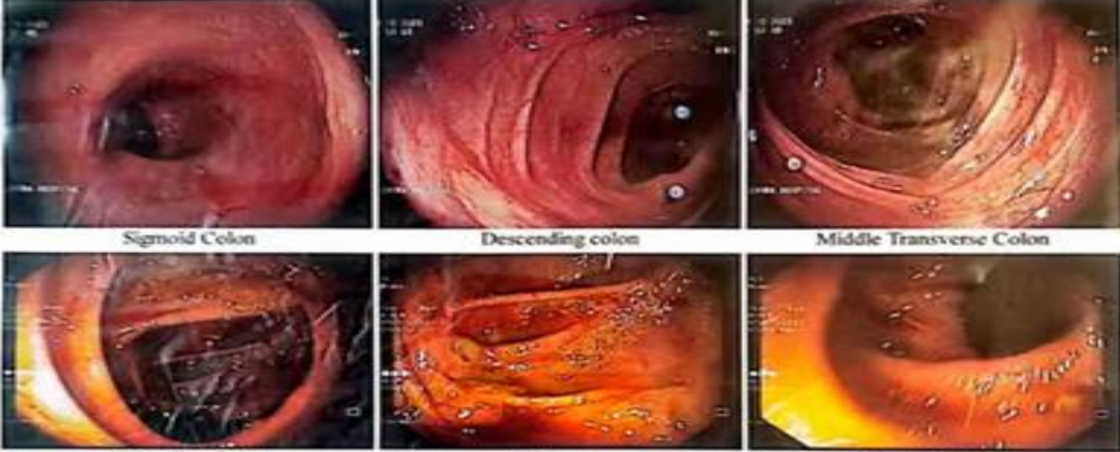
**Recommendation :** Follow up the pathology report
ENT consult becouse of swelling of cricopharygeus

مرکز آموزش درمانی الزهرا(س)

Gastrointestinal Endoscopy Ward

Colonoscopy Report

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

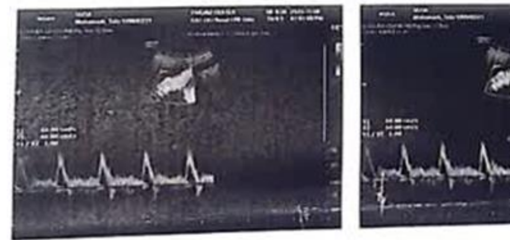
سونوگرافی داپلر شریان هر دو کلیه:

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?

# Feedback

*Dear Professor:*

*Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:*

The history of bipolar disorder or borderline personality causes lack of trust in the history of hematomas and regurgitation, so it was recommended to evaluate and stabilize the psychological condition first under the supervision of a psychiatrist, and then if the condition of frequent gastrointestinal bleeding is confirmed, the following measures are helpful:

- Examination of coagulation status with a hematologist.
- Examination of hematuria under the supervision of a urologist.
- In case of re-hospitalization, push enteroscopy to examine the proximal small intestine.
- Finally, if the results are not achieved with the above, video capsule is helpful.
- It should be noted that the findings of the RBC scan do not require further follow-up due to the subsequent colonoscopy and clinical course.

# 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.

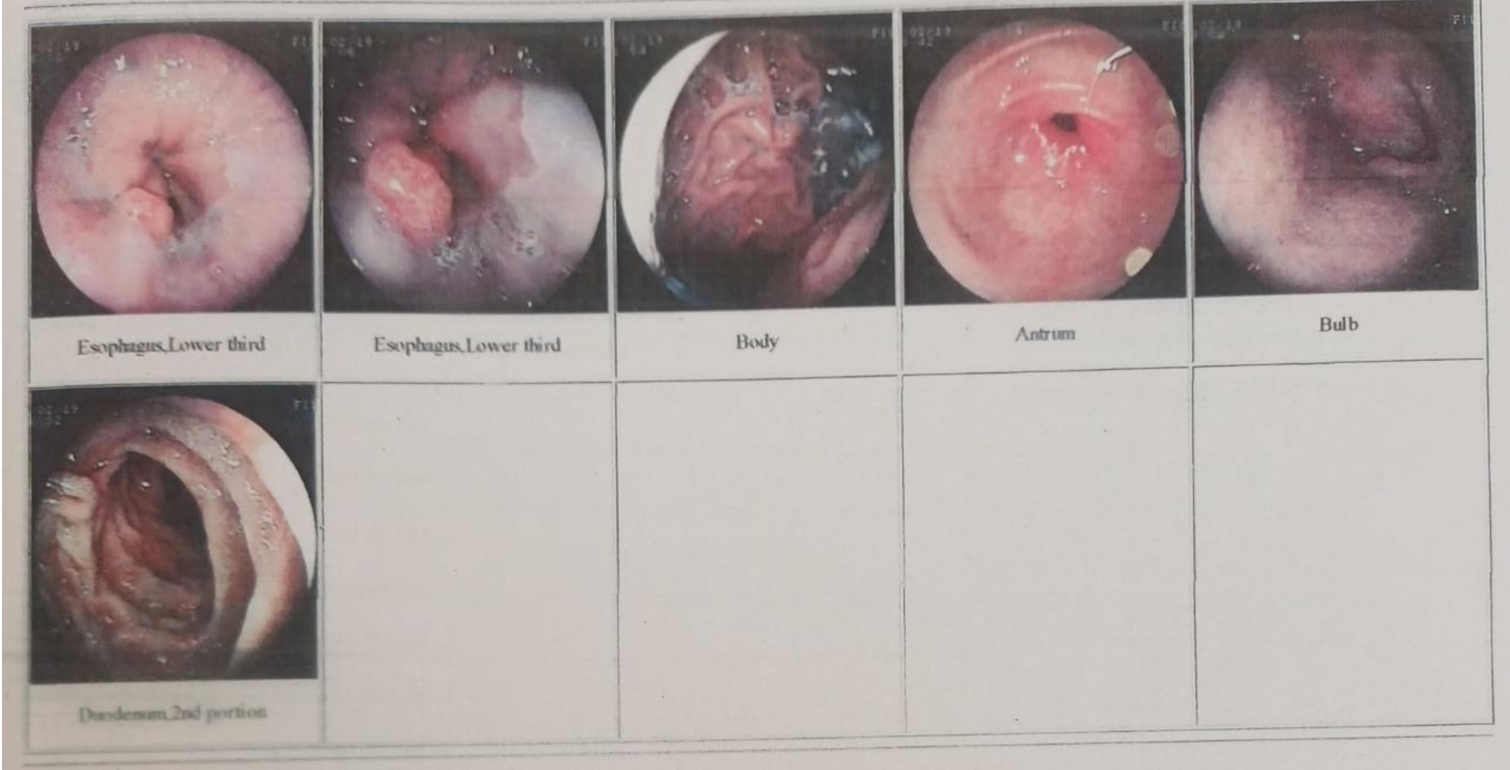
Family history: Lung ca in her uncle

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** | 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.

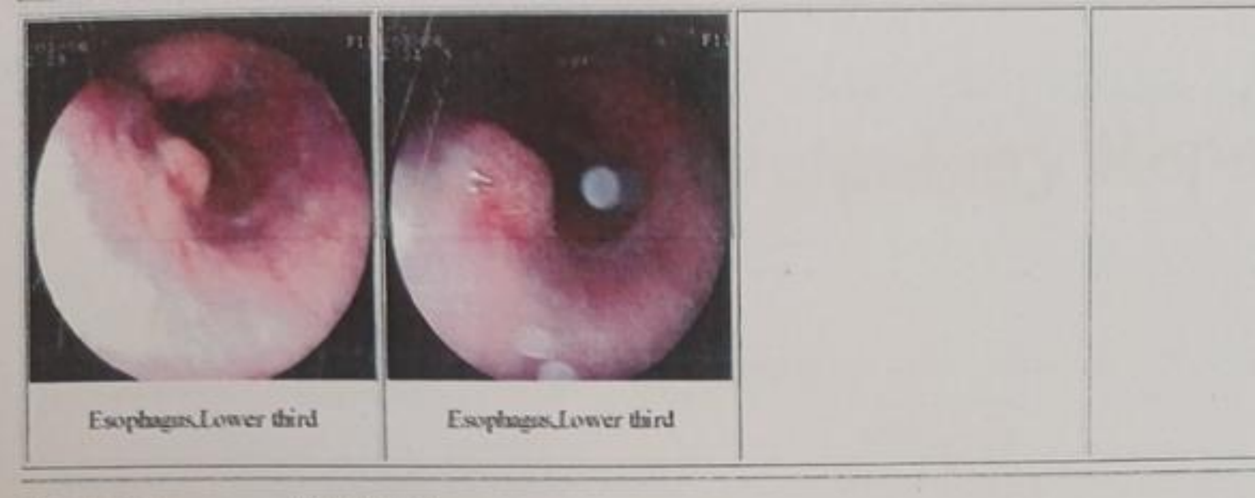
**Microscopic Description:**

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:***

***<u>Gastric Antrum & Cardial polyp Biopsy:</u>***
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

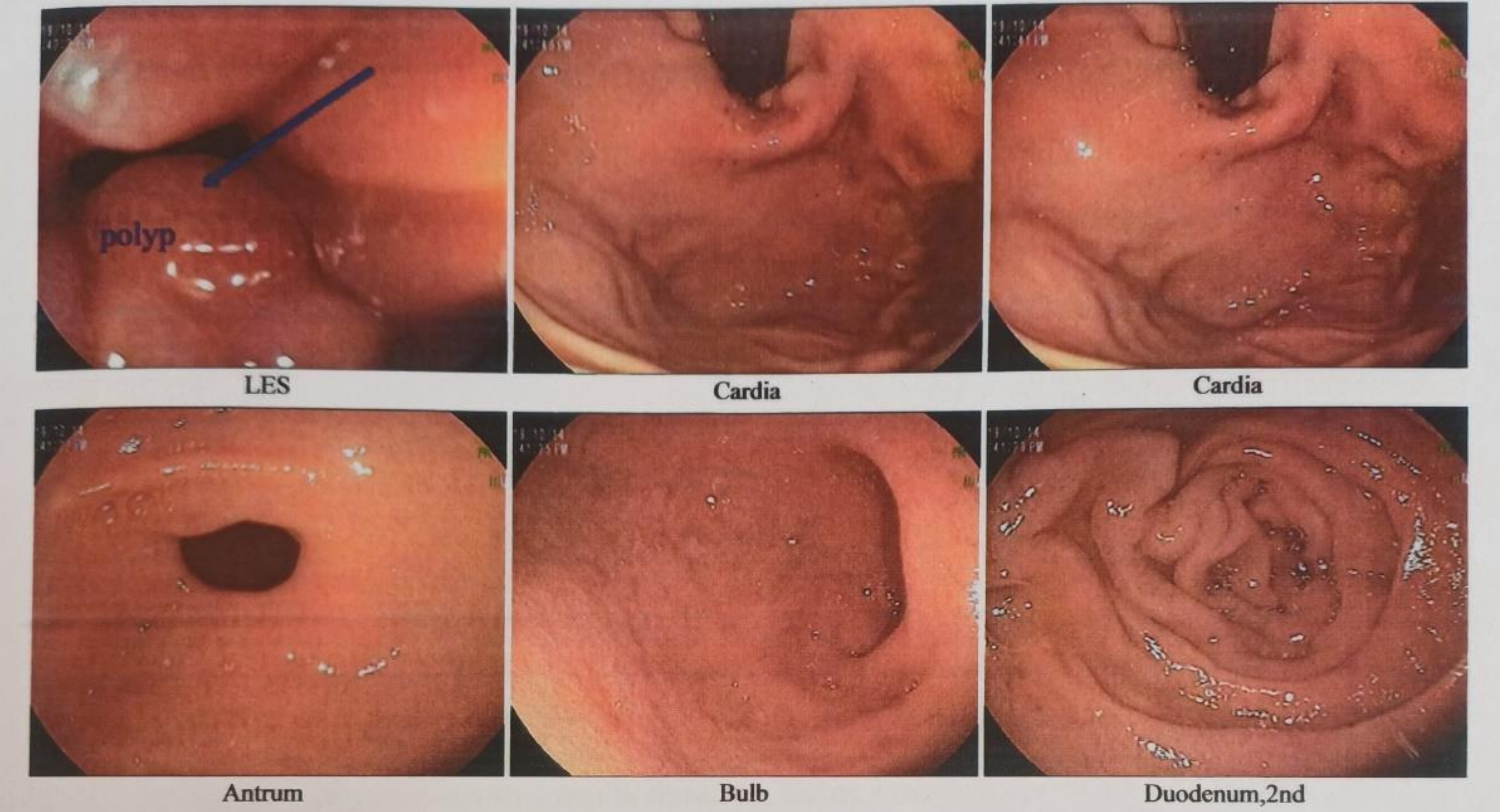
**Stomach** : Cardia: A small polyp (6-7mm) was seen just below z-line.

polypectomy was done.

Fundus and body and antrum: Normal

**Duodenum:** D1 and D2: Normal

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




**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

**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

**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 ceils 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

# Endoscopy

1401.06.07

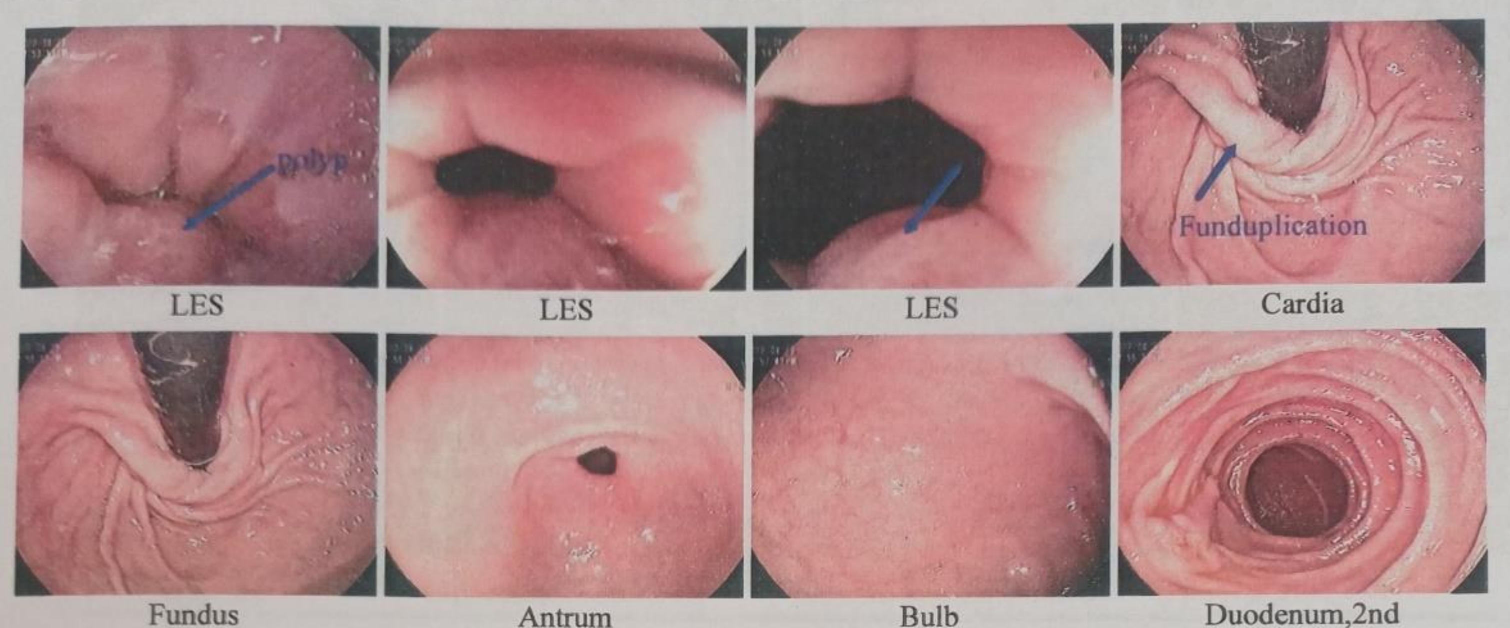
Reason for Endoscopy: Chronic diarrhea

**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

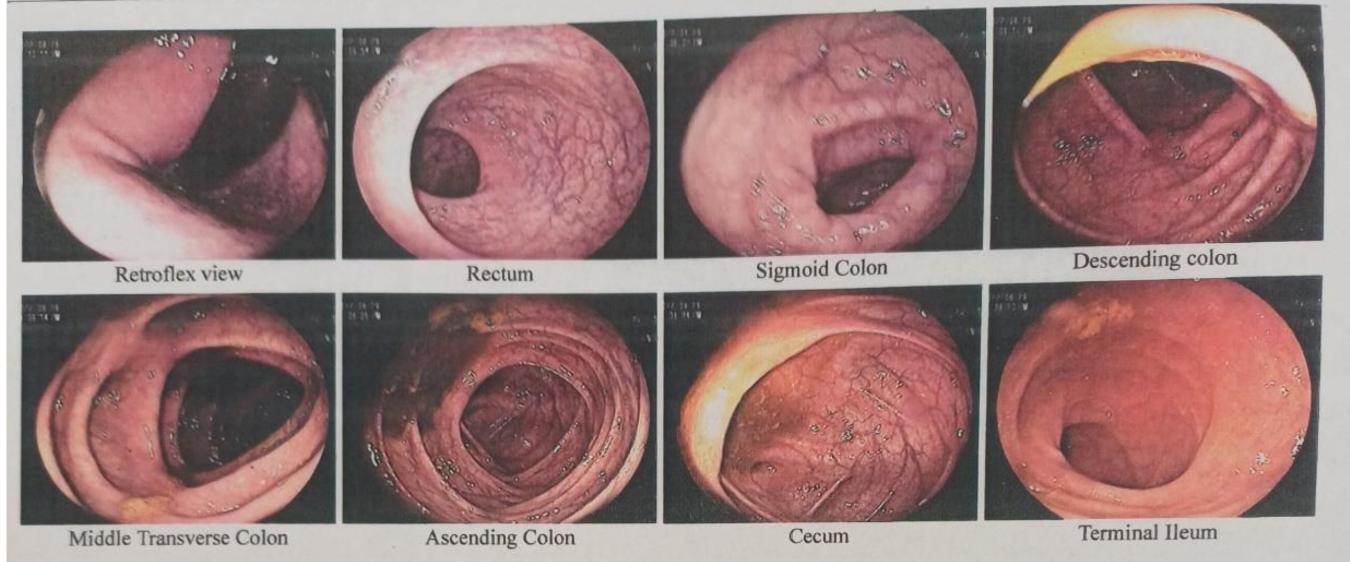
**Ascending Colon**: Normal

**Cecum** : Normal

(Biopsies from Right colon were taken for evaluation of microscopic colitis)

**Terminal Ileum** : Normal

**Diagnosis**: Normal ileo-colonoscopy




**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

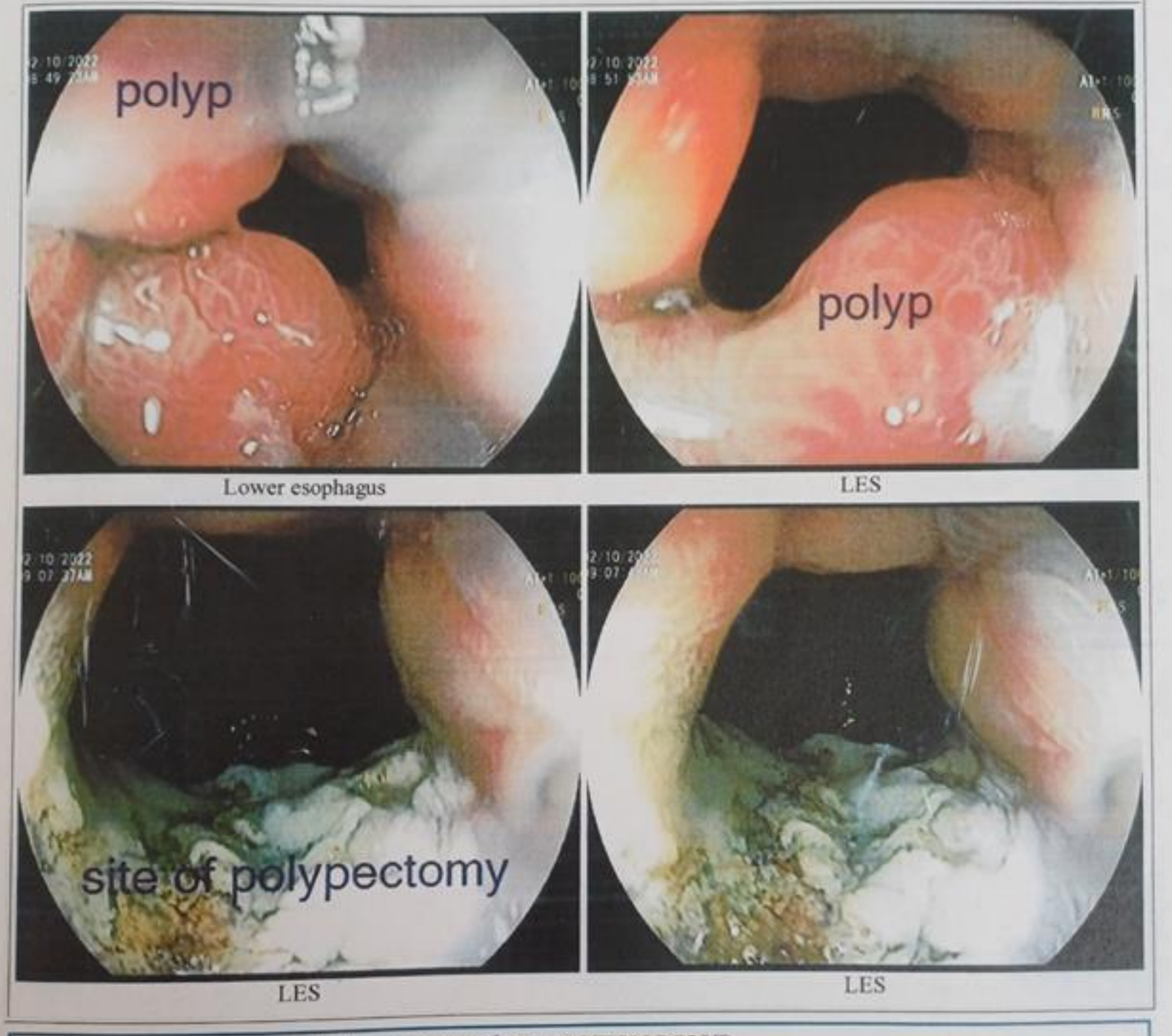
1401.07.10

**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




**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

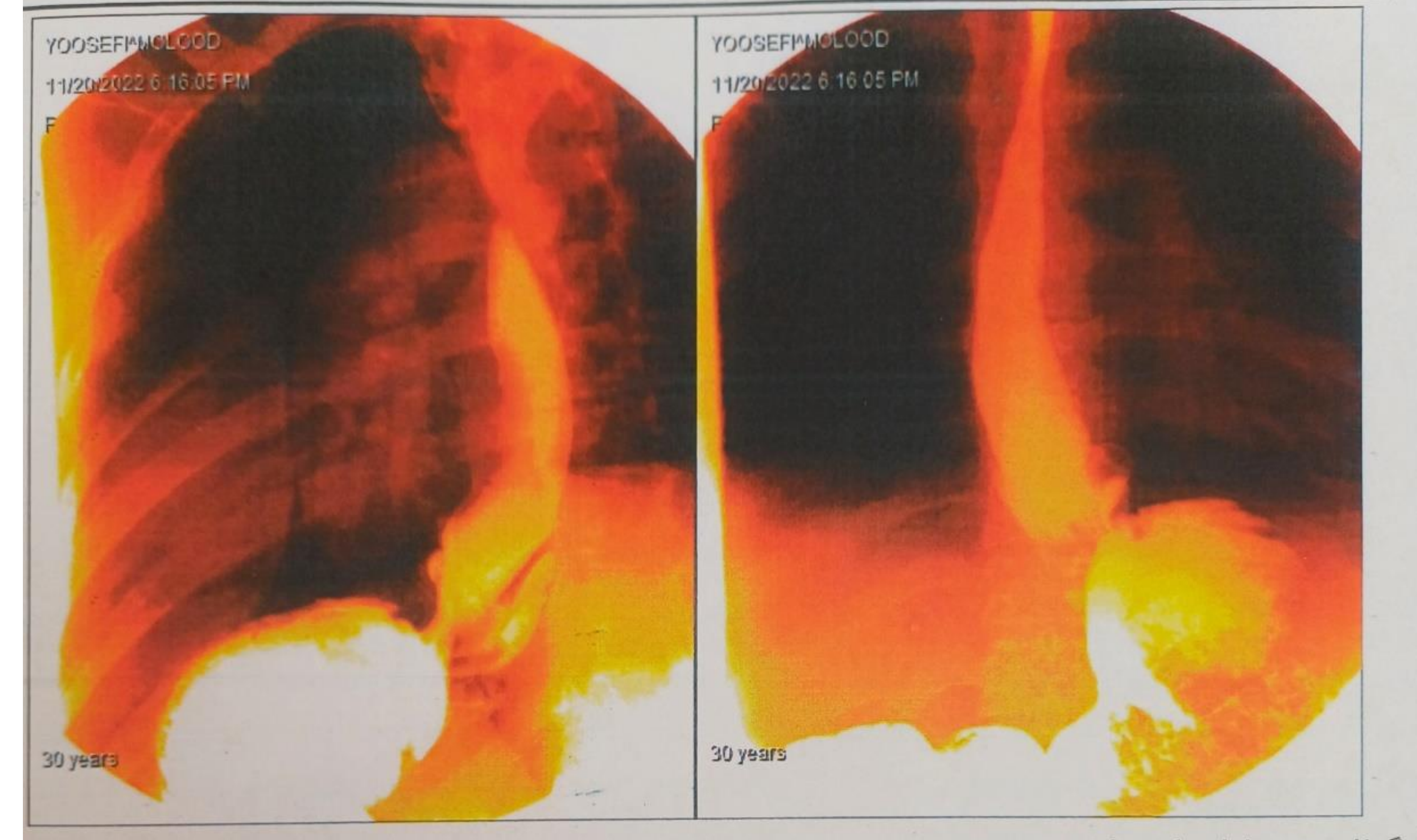
1401.08.29

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.




**<u>گرافي مري با بلع ماده حاجب :</u>**

دراسکوپي 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 کوچک در ديستال مري ديده ميشود.

در محل GE junction تنگي مشهود نيست.

# Endoscopy
## 1400.08.26

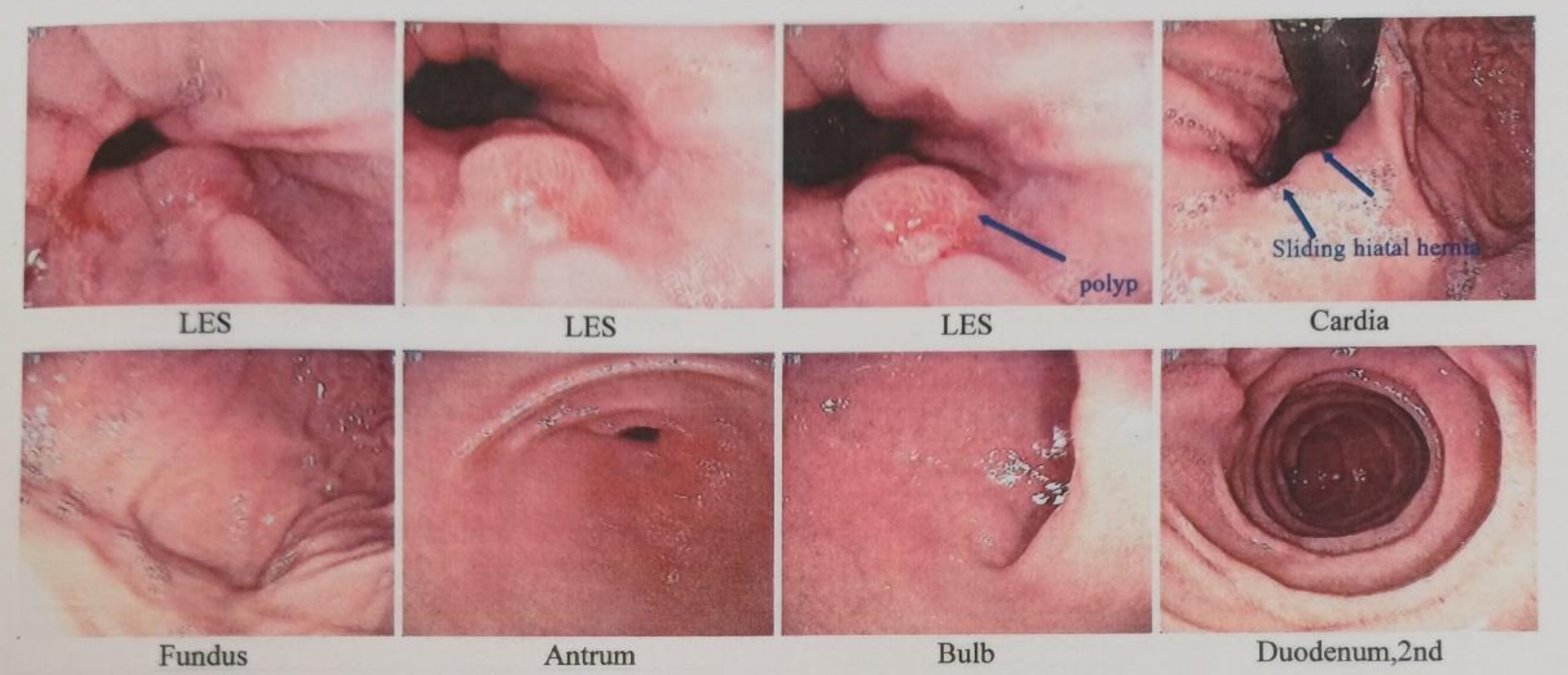
**Reason for Endoscopy**: Heartburn, Hx of distal oesophageal hyperplastic polyp

**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




**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.

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

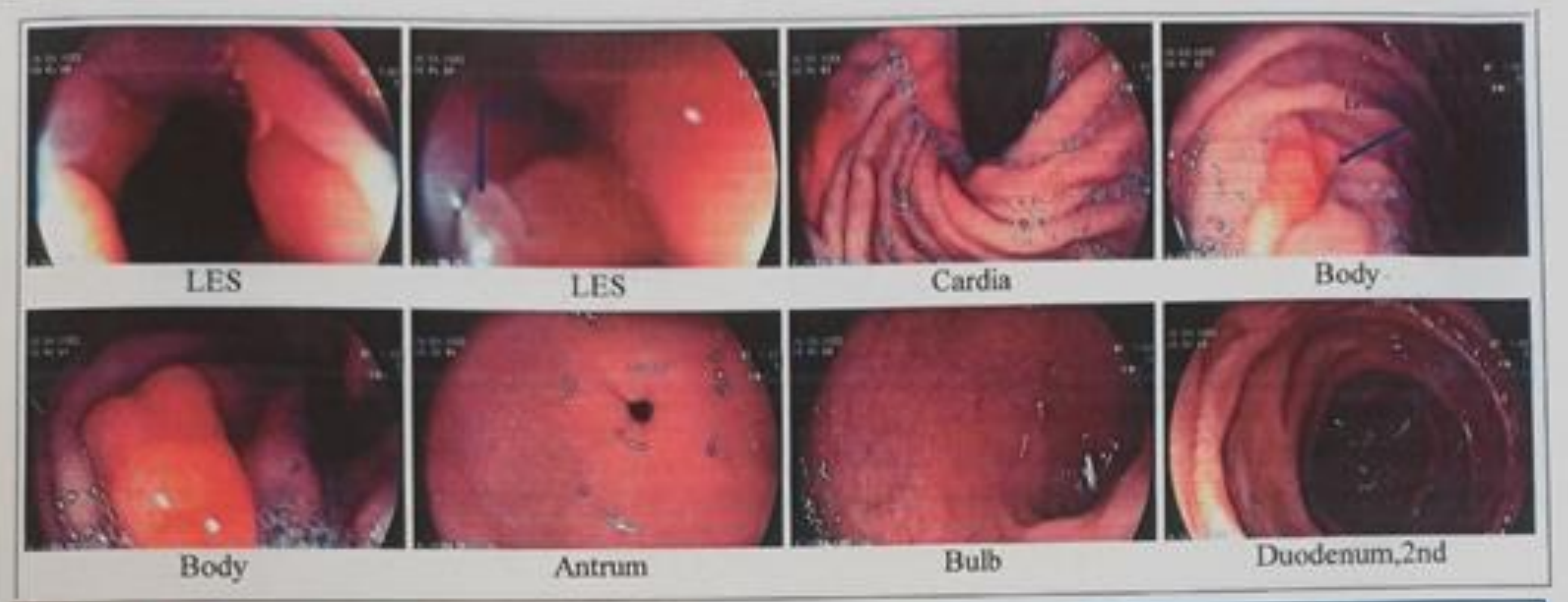
**Reason for Endoscopy**: Dysphagia

**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-).*

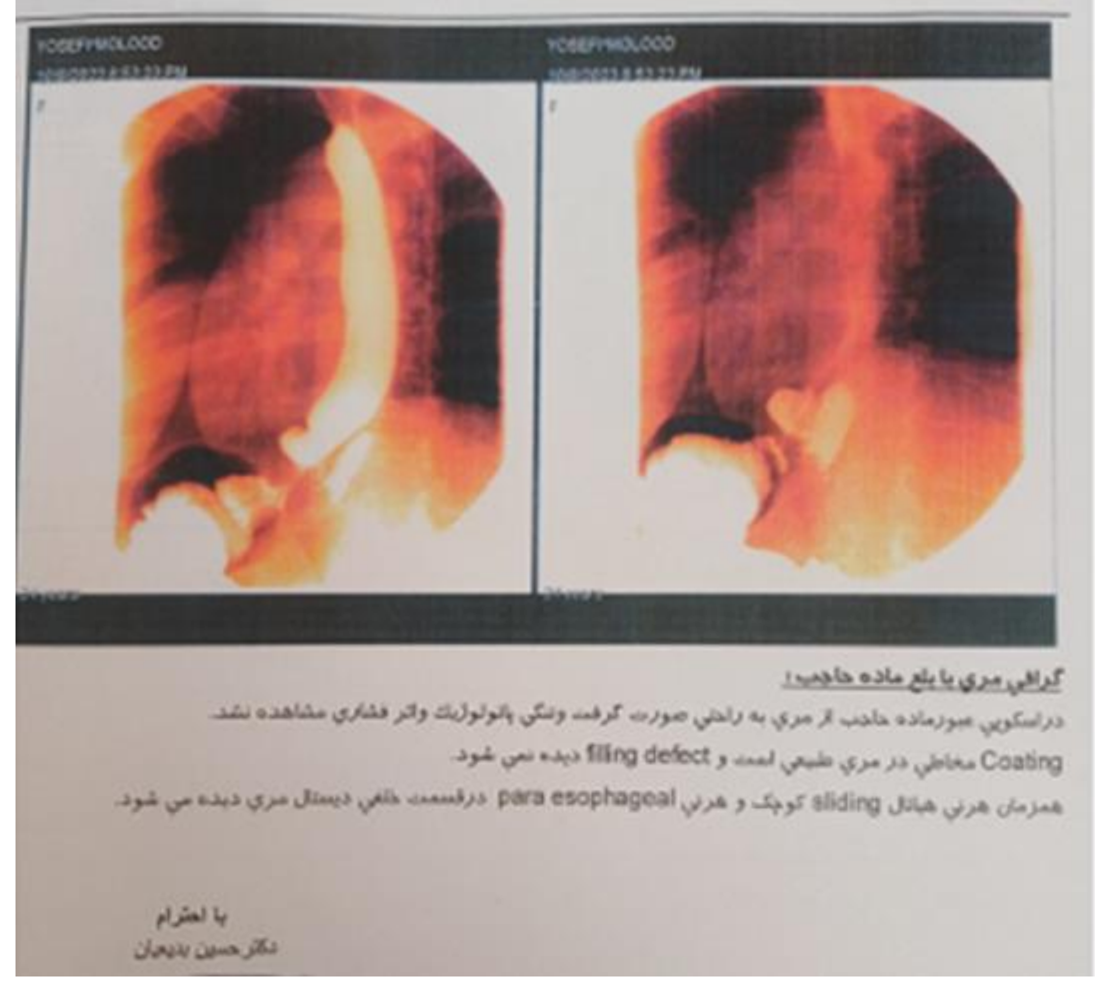
*3- BIOPSY OF STOMACH (BODY):*
*- EROSIVE GASTROPATHY.*
*- NEGATIVE FOR H.PYLORI (HP -).*

# 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.



گرافی مری با بلع ماده حاجب:

درانسکوپی عبورماده حاجب از مری به راحتی صورت گرفته وتنگی پاتولوژیک واثر فشاری مشاهده نشد.

Coating مخاطی در مری طبیعی است و filling defect دیده نمی شود.

همزمان هرنی هیاتال sliding کوچک و هرنی para esophageal درقسمت خلفی دیستال مری دیده می شود.

با احترام

دکتر حسین بدیعیان

# 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

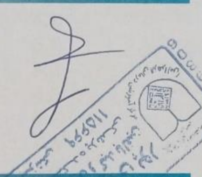
Normal manometry

**Esophageal manometry**

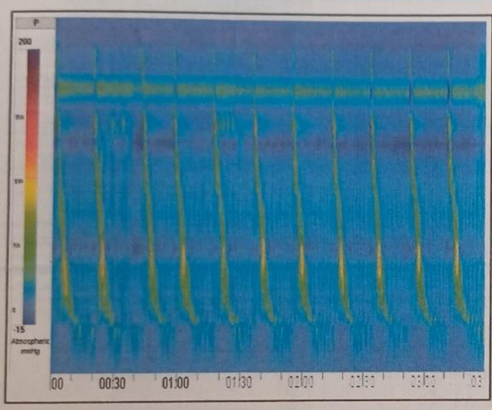
| | | | |
|---|---|---|---|
| Patient name: | Yusefi, Molud | Investigation date: | 07-11-2023 |
| Gender: | Female | Investigation nr: | 02 |
| Date of birth: | 01-11-1992 | Hospital: | Alzahra |
| Patient number: | - | Investigator: | - |
| Height: | - | Referred by: | Dr sebghatolahi |
| Weight: |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

**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 % | | |

...ber:

**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 |

# Feedback

*Dear Professor:*

*Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:*

*The patient's main complaint is dysphagia for liquids and solids with mild intensity, and with this assumption, it seems that fundoplication surgery had not been lead to significant complications.*

*The type and severity of the symptoms are not worrying, but if it has led to a disruption in the patient's quality of life, the following may help:*

*A. Esophageal biopsy to rule out eosinophilic esophagitis*

*B. Prescribing neuromodulators to relieve symptoms*

*C. Modifying the eating style in the form of complete chewing, slow swallowing and full concentration on eating*

*D. All present colleagues recommended conservative measures and did not agree with re-surgery and reversal of fundoplication.*

# A 17-year-old  male

- The patient is a boy who has been suffering from suddenly abdominal pain, fever, nausea and vomiting after eating since about 6 years ago (2016) during a trip. After going to the hospital and doing tests, he noticed an increase in liver enzymes. It has done many work ups during the past years,

| Lab data | Alt | Ast | Akp | Bili T | Bili D | GGT |
|---|---|---|---|---|---|---|
| 96/06/05 | 1410 | 648 | 1043 | 0.65 | 0.20 | - |
| 96/08/26 | 780 | 348 | 1140 | 0.67 | 0.26 | 80.9 |
| 96/08/29 | 794 | 318 | 1023 | 0.5 | 0.2 | 94 |

## Immunology

| Test | Result | Unit | Method | Reference Interval |
|---|---|---|---|---|
| LKMAb | 1.4 | U/mL | | Negative:<12<br>Equivocal:12-18<br>Positive:>18 |
| HBS-Ab | 17 | mlu/mL | CLIA | <9 Negative<br>9-11 Equivocal<br>>11 Positive |
| Anti EBV (vca)(IgM) | 0.2 | Index | | Negative : <0.8<br>Doubtful : 0.8-1.2<br>Positive : >1.2 |
| C.M.V Ab (IgM) | 0.3 | Ratio | CLIA | Negative : < 0.9<br>Equivocal :0.9-1.1<br>Positive : > 1.1 |
| Anti Mitochondrial Ab | 1.6 | AU/mL | | Negative:<12<br>Doubtfull:12-18<br>Positive:>18 |
| Anti smooth muscle Ab | Negative | Titer | | Up to 1/100 : Negative |
| Anti.Hbc (total) | 2.02 | Index | | >1 Not reactive<br><=1 reactive |

1396/08/29

## Hormone Analysis

| Test | Result | Unit | Method | Reference Interval |
|---|---|---|---|---|
| Ferritin | 201 | ng/mL | CLIA | 6mo-14yr : 7-140<br>Male:18-340 |

## Urine Biochemistry

| Test | Result | Unit | Reference Interval |
|---|---|---|---|
| Urine Volume (24 hr) | 520 | ml/24hr | Male : 600-1800<br>Female : 600-1800<br>Newborn 3-10 days :100-300<br>Children 3-10 years :500-600 |
| Urine Creatinin (24 hr) | 374 | mg/24hr | Male :800 - 2000<br>Female: 600-1800 |
| Urine Cupper (24 hr) | 23 | micg/24H | Up to 70 |

## Blood Biochemistry

| Test | Result | Unit | Reference Interval |
|---|---|---|---|
| Sodium | 137 | mEq/L | 135 - 150 |
| Potassium | 3.6 | mEq/L | 3.5 - 5.5 |
| Iron | 57 | µg/dL | Children : 22-135<br>Male : 40-160 |
| TIBC | 375 | ug/mL | Newborn : 140-240<br>Children : 280-380<br>Adult : 250-410 |
| **SGOT (AST)** | **H 318*** | U/L | Up to 38 |
| **SGPT (ALT)** | **H 794*** | U/L | Up to 41 |
| Alkaline Phosphatase | 1023 | IU/L | 60-300<br>Children : 180-1200 |
| CPK | 80 | U/L | 24 - 195 |
| Bilirubin Total | 0.5 | mg/dL | 0.1 - 1.2 |
| Bilirubin Direct | 0.2 | mg/dL | Less than 0.4 |
| Aldolase Serum | 6.5 | u/l | Adult Male :up to 16<br>Famale :up to 11<br>Children(3-14 Years ) :up to 16 |
| **Gamma GT** | **H 94** | U/L | 0 - 49 |

* = Confirmed by Repeated Analysis H=High

1396/08/29

## Specific Biochemistry

| Test | Result | Unit | Method | Reference Interval |
|---|---|---|---|---|
| Copper Serum | 85 | mg/dL | | 70 - 150 |
| Ceruloplasmin | 35 | mg/dL | | 15 - 60 |

## Serology

کبد به (span= 115 mm) همراه با در حال حاضر اکوژنیستی کبد طبیعی است

اکتازي مجاري صفراوي داخل وخارج کبدي ديده نميشود

وريدهاي کبدي، ورید پورت دارای دیامتر طبیعی است (دیامتر ورید پورت 6mm )

کيسه صفرا داراي حجم و ضخامت جداري نرمال و فاقد سنگ و اسلاژ می باشد

طحال با Span= 109 mm دارای ابعاد و شکل و اکوی پارانشیمال طبیعی است

تصویر فوکوس کلسیفیه با طول 9mm در طحال دیده می شود که میتواند ثانویه به گرانولوم کلسیفیه باشد

در بررسي کالر داپلر کبد :

**hepatic artery :**

PSV: 73 RI:23 EDV:23
35 mean velosity : 21 TAMV: 22 TAPV:
arear: 0.10 cm2
blood flow: 134 cc/min

**portal vein:**

pick velosity :17.8
mean velosity :15.4
TAMV:7.7
blood flow: 178 cc/min
area:0.38 cm2

DPI:0.42

وریدهای کبدی با پترن تری فازیک و با حداکثر PSV برابر با 19 مشاهده می شود

سایر قسمت های شکم نکته پاتولوژیک رویت نشد .( قابل ذکر است rise آنزیم های کبدی در تطبیق با fatty liver مشهود نمی شود ؟)

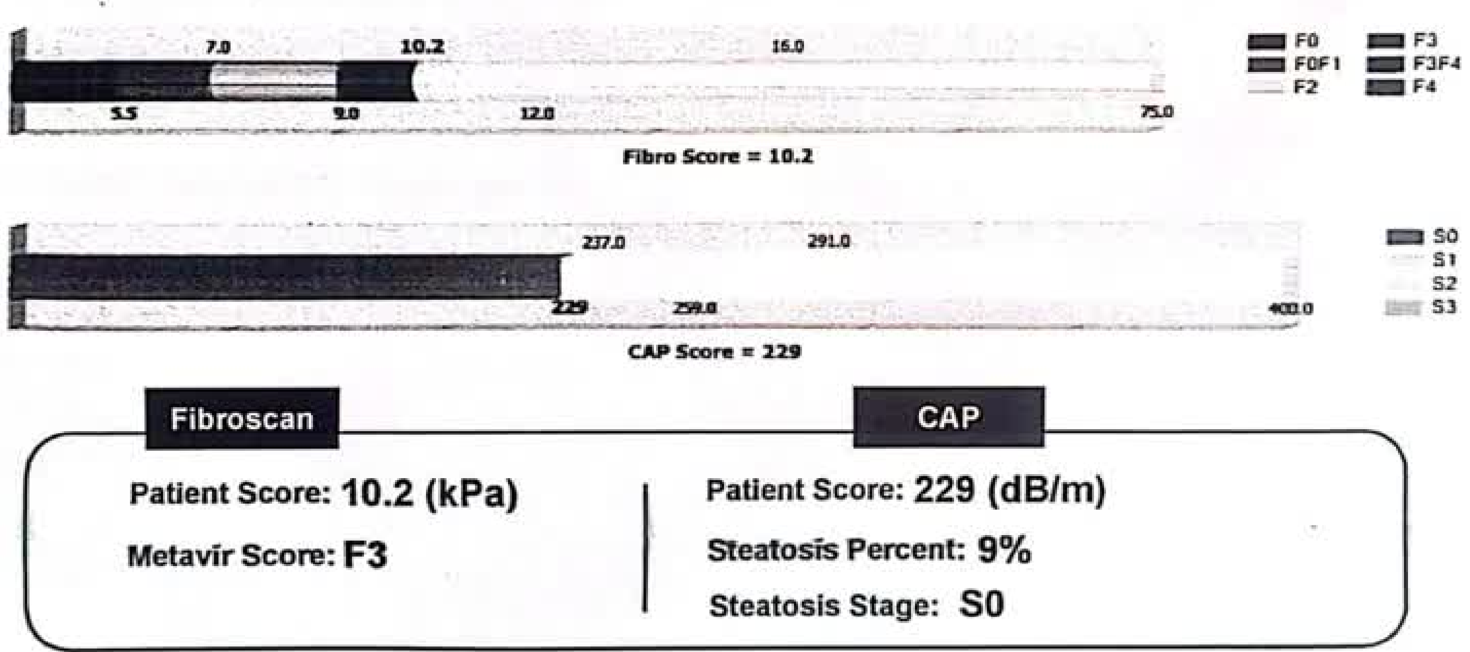
1396/08/30

MEDICAL GROUP

# Fibroscan - CAP Report

نام و نام خانوادگی: سید رضا بنی هاشمی
شماره پرونده: ۲۵۵۹
پزشک ارجاع دهنده:
تاریخ: ۱۳۹۶/۰۸/۳۰

**Diagnosis: None Alcohol Fatty Liver Disease**




Dear Colleague:
Thanks for referring this patient for fibroscan test.
I performed fibroscan in different parts of his liver. The median fibrosis score of his liver is 10.2 kPa, which is equal to F3 based on Metavir histological index.
Please be advised in acute hepatitis, PHT status and cardiopulmonary congestion, result of fibroscan may be higher than the actual fibrosis of the liver.

Regards

1396/08/30

Clinical impression:
R/O:
-AIH
-Wilson
-NASH
-Alpha1-ATD

*Gross:*
Received specimen consists of two pieces of cylindric tissue measuring 1,2cm x0.1cm in cream color.

*Microscopic description:*
Sections show hepatocytes and portal tracts in adequate number.(10)

Lobules show:

-Inflammation: Mild Inflammation (1-2 foci/LPF).A few dead hepatocytes are seen also.
-Giant cell:Absent
-Feathery degeneration: Present(Mild)
-Ballooning:Present
-Steatosis:Less than 3% of specimen: Occasional macrovesicle fat
-Cholestasis:Absent
-Rosette formation:Occasional

-Portal tracts show:

-Inflammation:Present(Mild to moderate in most portal tracts):Lymphocytic type
-Interface hepatitis: Mild focally in some portal tracts
-Bile ducts: Intact
-Fibrosis(Masson staining):Fibrous expansion of most portal tracts with occasional portal-portal bridging(3/6)
-PAS/PAS-D staining:Negative

*Diagnosis:*
Sono guided liver core needle biopsy:
-Chronic hepatitis(grade 4/18,stage 3/6)

*Comment:*
1)Histologic findings are compatible with autoimmune hepatitis.
Clinical and serologic correlation are recommended.
2)In wilson disease variety pattern of liver pathology can be seen. In case of unresponse to AIH treatment, evaluation for wilson disease is recommended.

1396/09/04

Liver biopsy:

Chronic hepatitis
(grade 4/18 stage 3/6)

1)Compatible with AIH

2)Wilson disease variety pattern of liver BX thus unrespanse to AIH TX evaluation for Wilson disease

**Hormones**

| Test | Result | Unit | Normal Value |
|---|---|---|---|
| ANA Elisa Screen | 3 | | <10 Negative<br>>=10 Positive |

پانل کامل آنسفالیت های ویرال و مننژیت های باکتریال بصورت روزانه انجام می شود

در این مرکز آزمایش Cell Free DNA و Quantiferon انجام می شود

آزمایش PLA2 انجام می شود

**Biochemistry**

| Test | Result | Unit | Normal Value |
|---|---|---|---|
| Biochemistry | | | |
| Billirubin Total | 0.6 | mg/dl | 0.5-1.2 |
| Billirubin Direct | 0.1 | mg/dl | < 0.4 |
| Billirubin Indirect | 0.5 | mg/dl | 0.1-0.8 |
| Alkaline Phosphatase | * 1055 | IU/L | Female: 64-306<br>Children: (Up to 15 years) :180-1200<br>Male:80-306 |
| CPK | 142 | IU/L | Female:24-170<br>Male:24-195<br>Baby:6-12 Months: 24-229<br>Baby:<6 Months: 41-330<br>Baby:<5 Days: 195-700 |
| SGOT | * 806 H | IU/L | Female:2-31<br>Male:2-37 |
| SGPT | * 1040 H | IU/L | 2-38 |
| Gamma Glutamyltranfrase | * 84 H | IU/L | Female:0-32<br>Male:0-49 |
| Blood Copper | 153 H | Ug/dl | Male: Adult : 71-140<br>Female: Adult: 80-155<br>Baby:1-6 Months: 20-70<br>Children: 1-12 years: 80-160 |
| Blood Ceruloplasmin | 40.8 H | mg/dl | 20-40 |

TPMT(Thiopurine 5-Methyltranse mutation PCR)انجام می شود

آزمایش سرب به صورت روزانه انجام میشود.

**Comment : H : High * : Rechecked**

**Immunology & Serology**

| Test | Result | Unit | Method | Normal Value |
|---|---|---|---|---|
| Immunology & Immunopathology | | | | |
| .LKM-1 Chorus | <3 | AU/ML | | <12 Negative |

1396/09/11

| | | | |
|---|---|---|---|
| | | | >18 Positive |
| AMA-M2 Chorus | <3 | AU/ML | <12 Negative<br>>18 Positive<br>12-18 Doubtful |

Auto Immune Disease

| | | | |
|---|---|---|---|
| P-ANCA(Myeloproxidase | 1 | U/ml | <3.1:Negative<br>3.1-4:Intermediate<br>>4: Positive |
| ASMA | Negative | Titer | >=1/10 Positive<br>Negative |

Positive ASMA may occur in patients with active hepatitis caused by toxin (eg,Ethanol) and are not absolutely specific for chronic autoimmune hepatitis (CAH),also low positive titer of ASMA was seen in primary biliary cirrhosis and infection with EBV, or CMV

| | | | |
|---|---|---|---|
| Anti Ds DNA(Elisa) | 30 | IU/ml | <100 Negative<br>>100 Positive |

Candida Albicans و IgD در این مرکز انجام می شود

پانل آنسفالیت های اتوایمیون مشتمل بر Anti NMO-Anti GAD-Anti MAG-Anti Gangloiside

1396/09/11

Urine 24h Biochemistry

| Test | Result | Unit | Normal Value |
|---|---|---|---|
| Creatinine Urine in 24 hr | 770 | mg/24hr | 15-80 years: Adult:700-2500<br>Infant:8-20 mg/Kg/24 hr<br>Child:8-22 mg/Kg/24hr |
| Total Volume (24 hr) | 1350 | ml/day | |
| Copper Of Urine in 24 hr | 655 H | Ug/24hr | Up To 70 |

Comment : H : High

**CLINICAL DATA:**

**History of Elevated Liver Enzymes Since Three Years Ago /**
**Treated Since Then With Diagnosis of Fatty Liver /**
**Poor Response To Treatment /**
**Severe Elevation of Enzymes A Month Ago /**
**Possible Auto- Immune Hepatitis /**
**Liver Needle Biopsy Performed And Paraffin Block Sent to Our Lab For Second Opinion.**

*****************************************************************

**MACROSCOPY:**

One paraffin block No: 9091 from Imam Hossein Hospital Path Lab with diagnosis of:
Sono guided liver core needle biopsy:
Chronic hepatitis (grade 4 / 18, stage 3 / 6)
received for consultation.

**MICROSCOPY:**

Sections show liver tissue with fibrous expansion of portal areas (thin pieces of liver tissue left in paraffin block), forming short septae (bridges are not well seen in our slides) and portal - portal bridges (3 - 4).
There is mild to moderate infiltration of lymphomononuclear cells in portal areas (1-2), resulting in mild interface hepatitis (1).
Few foci of intra - lobular inflammatory cells infiltration seen (1).
No confluent necrosis seen (0).
Few hepatocytes show macro - vesicular fatty change (<5%).
Bile ductuli are unremarkable.

**DIAGNOSIS:**
**Liver Needle Biopsy:**
**Chronic Hepatitis.** **Stage 3-4**
**Grade: 3-4 / 18**

**NB: Dear Colleague:**
**Liver Copper Content Was Assessed By Atomic Absorption Spectroscopy (AA-96-334) And Copper Content Was 151.2 Microg/gr.**

1396/09/26

Liver BX for evaluation of Wilson disease:

Chronic hepatitis

Copper content:
151.2 microg/gr

- In 2016, a pediatric gastroenterologist diagnosed autoimmune hepatitis and was treated with prednisolone and Azram 50 mg (half a tablet).
- According to him, Wilson's disease is rejected.
- In 2018, due to lack of response to treatment (no decrease in liver enzymes), he underwent re-examinations and liver biopsy.

| Lab data | Alt | Ast | Akp | Bili T | Bili D | GGT |
|---|---|---|---|---|---|---|
| 96/12/23 | 453 | 170 | 608 | 0.80 | 0.23 | 52.2 |
| 96/12/26 | 571 | 187 | 646 | 0.8 | 0.2 | 62 |

Lab Receipt: 0-168

| | |
|---|---|
| Clinical data | Requested for Alpha1-Antitrypsin Z and S Mutations. |
| Specimen | Whole Blood in EDTA tube |
| Method | DNA was extracted using QIAGEN DNA blood mini kit and PCR has been done with two pairs of standard primers for S and Z mutations in SERPINA1 gene. Pyrosequencing analysis has been done on both fragments. The Z mutation resulting in the substitution of Lysine for Glutamate at position 342 (Glu342Lys). The S variant, resulting in substitution of Valine for Glutamate at position 264 (Glu264Val). |
| Test Result | Wild-type for Z (C/C)<br>Wild-type for S (T/T) } MM: Normal- has 100% of the normal plasma concentration for A1AT enzyme. |
| Comment | Homozygotes (M/M) have normal plasma concentration for A1AT enzyme. |
| Cautions | Test results should be interpreted in context of clinical findings, sampling, and other laboratory data. If results obtained do not match other clinical or laboratory findings, please contact the laboratory for possible interpretation. Misinterpretation of results may occur if the information provided is inaccurate or incomplete. Every molecular test has a 0.5-1 % error rate. This is due to rare molecular events and factors related to the preparation and analysis of samples.<br><br>The specimen was not collected in Partolab, improper labeling handling and storage or delayed delivery may cause inaccurate or false results. No responsibility of patient's identity accepted. |

97/01/16

Requested for alpha 1antitrypsin:

MM: normal

MRCP:

Thick slab heavily T2 images were obtained from biliary system, followed by multiplanar images in different pulse sequences from the upper abdomen.
The study shows the followings:

1- CBD is well visualized which has normal diameter with 2 mm and smooth contour, however, two bile duct are seen in the course of CBD, looks to be independent duct of left collecting systems which is joined at the junction of middle and lower third of the main CBD (congenital anomaly of bile ducts).
2- Main intrahepatic bile ducts are well visualized with normal diameter, but, there are short segment defect in projection of distal end of right hepatic duct, as well as, proximal left hepatic duct. These could be vascular imprint, less like to be inflammatory stricture.
3- The liver is of normal size shows no evidence of SOL, but, diffuse signal void in fat suppression technique is seen. Please correlate with LFTs to rule out liver parenchymal disease.
4- Gall bladder has thin wall with no detectable stone. Portal branches and hepatic veins, as well as, IVC are unremarkable.
5- Thin rim of signal void defect is demonstrated in projection of spleen, is there history of trauma to the spleen ? If not, it is considered to be lobulation of spleen, as a normal variant.
6- A few centimeters from pancreatic duct is well seen with normal diameter, pancreas also shows normal anatomy with normal signal intensity, no detectable pancreatic mass, no signs of pancreatitis.
7- Kidneys are normal, no paraaortic or paracaval lymphadenopathy.

97/03/21

تاریخ درخواست: ۱۳:۱۳ ۲۹/۵/۹۷ تاریخ گزارش: ۱۰:۳۷ ۱۷/۶/۹۷

سن: ۱۲ ساله شماره پرونده: 1736223

سطح ۵

97/05/27

**Path.No:** 7141-18

**Clinical Diagnosis:**

Known case of autoimmune hepatitis, on treatment

**MACROSCOPIC:**

Received specimen in formalin consist of 1 fragment of creamy soft tissue M;1.5x0.1x0.1cm labeled as liver biopsy.

s.o.s 1/1
Em: T
Dr.Nekooei

**MICROSCOPIC:**

Sections from liver needle biopsy show adequate tissue with relatively distroted lobular and vascular architecture. Individual hepatocytes show moderate ballooning degeneration, with mild macrovesicular steatosis (about 20-25%) and foci of spotty necrosis. Portal tracts show mild lymphocytic infiltration with bile duct proliferation. Masson-Trichrome stain shows severe fibrosis with nodule formation. PAS with diastase stian shows intraportal ceroid laden macrophages. Iron and orcein are negative.

**DIAGNOSIS:**

LIVER NEEDLE BIOPSY:

----------------------------

-CHRONIC HEPATITIS WITH MILD ACTIVITY AND SEVERE FIBROSIS (GRADE 5/18, STAGE V/VI).

مبناي تشخيص *Unknown*

ICD-10 Classification: *Non Neoplasm*

Scanned with CamScanner

Path.No: C-9708-18

MACROSCOPIC:

Received slides for consult labeled as 9091

MICROSCOPIC:

Sections from liver needle biopsy show adequate tissue with distorted lobular and vascular architecture. Individual hepatocytes show cytoplasmic clearing and focal macrovesicualr steatosis as well as a few mallory bodies. Portal tracts show a few lymphocytes with focal interface activity.Masson-Trichrome shows bridging fibrosis.

DIAGNOSIS:

LIVER NEEDLE BIOPSY:

-CHRONIC HEPATITIS WITH MILD ACTIVITY AND MARKED FIBROSIS (GRADE 6/18, STAGE 4/6)

-MACROVESICULAR STEATOSIS, MILD (5-10%)

مبناي تشخيص Unknown

ICD-10 Classification: *Non Neoplasm*

Note:

Wilson's disease should be considered as the possible underlying cause.

Reported By:

B.Geramizadeh MD

97/09/14

97/09/10

Readout of tissue samples in Namazi hospital:

Chronic hepatitis with mild activity and mark fibrosis

(Grade 6/18 stage 4/6)

Macrovesicular steatosis

Wilson should be considered

- The patient is visited at the Shiraz Namazi center, and was diagnosed with autoimmune hepatitis and suspected of Wilson's disease, who also took penicillamine for a one-year period, but it had no effect, and it was discontinued in 1998.
- The doctor treating the patient in Isfahan was against Wilson's diagnosis.

Dr. Majid Kheirollahi

Gene Azma Laboratory

Medical Genetics Center

No.208, west shariati St

8173958353Isfahan, Iran

Sample type: Blood

Sample collection date: 1397/10/05

Report date: 1397/11/14

Lab Code: M97-568

Referred by Dr. M. Imanieh

DOB: 1385/03/20

2019

ATP7B gene was performed:

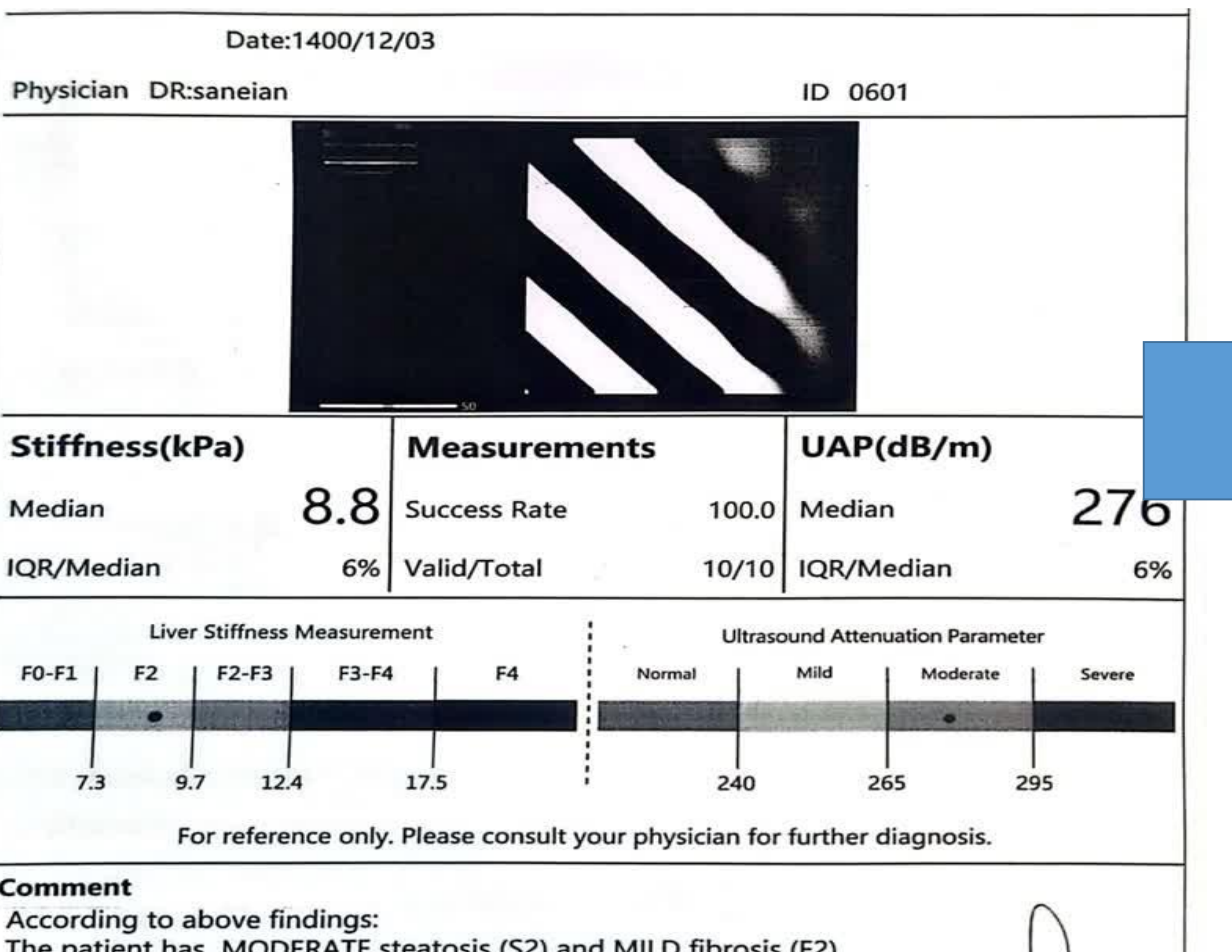
No pathologic mutation was found

**Result:** Sequencing of thirteen exons (2-6, 8, 14, 15, 17-21) of *ATP7B* gene was performed in a Wilson suspected patient. Exons 14, 15 and 8 contain common mutations of Wilson disease. No pathogenic mutation was found in these exons.

CS Scanned with CamScanner

- In 2018, the patient referred to his doctor in Isfahan, who was referred to a pediatric gastroenterologist in Tehran, who gradually stopped prednisolone and Azram drugs and started cyclosporine (from February) 100 mg every 12 hours for 6 months. According to the patient's companion, it causes a significant decrease in liver enzymes in the range of 50 to 60.
- After 6 months, cyclosporine is stopped and the patient is again treated with Azram (75 mg) and prednisolone (2019).

- In February 2019, due to a severe drop in hemoglobin, he was treated with three units of Packedcells.
- An endoscopy is performed for the patient, which was normal, and according to the hematologist's opinion, Azram is discontinued due to its side effects.
- And since 2021, with the opinion of the medical commission in Imam Hossein Hospital, Isfahan, he started cellcept, which is still going on now, and he has been taking 3 pills a day since about two months ago.



Date:1400/12/03

Physician DR:saneian

ID 0601

| Stiffness(kPa) | | Measurements | | UAP(dB/m) | |
|---|---|---|---|---|---|
| Median | 8.8 | Success Rate | 100.0 | Median | 276 |
| IQR/Median | 6% | Valid/Total | 10/10 | IQR/Median | 6% |



For reference only. Please consult your physician for further diagnosis.

**Comment**

According to above findings:
The patient has MODERATE steatosis (S2) and MILD fibrosis (F2).

00/12/03

- In March 2022, following a drop of platelets, he underwent a liver biopsy again.

| lab | Wbc | Hb | Plt |
|---|---|---|---|
| 01/12/03 | 6580 | 12.1 | 85000 |

Macroscopic:

Received specimen in formalin consist seven soft tan pieces total measuring 1.2 x 0.5 x 0.3cm

Microscopic:

A.Periportal or periseptal interface heptatitis (piecemeal necrosis)
□Absent 0
B. Confluent necrosis
□Absent 0
C. Focal (spotty) lytic necrosis, apoptosis and focal inflammation
□Absent 0
D. Portal inflammation
□Mild, some or all portal areas 1

□Fibrous expansion of most portal areas with occasional portal to portal (P-P) bridging 3

Plasma cell : Absent
Rosettes : Absent
Emperiopolesis : Absent

Mild steatosis (About 10%)
Rosettes : Absent
Emperipolesis : Absent
Modified Staging : 3/6

500

Diagnosis :

Liver biopsy;
-Mild steatosis (About 10%)
-Mild portal inflammation

Comment :

Dry copper tissue measurment is recommended.

01/12/08

## ABDOMINAL SONOGRAPHY:

- ***Liver is normal in size, with slightly coarse increased and mild increased parenchymal echogenicity, without surface irregularity, due to parenchymal damage, correlation with LFT is suggested.***
- *CBD is normal in diameter and appearance, with no sign of intra or extra hepatic biliary dilatation.*
- *Intrahepatic vascular channels and main portal vein have normal caliber and range with no evidence of thrombosis.*
- *Gall bladder is well distended, with no sign of stone, sludge, polyp or wall thickening. (No sign of gall bladder wall edematous or other sign of cholecystitis is seen).*
- ***Spleen is normal in size (130mm) , correlation with lab data is recommended.***
- *Pancreas is normal in size, shape and echopattern, without S.O.L.*
- *Both kidneys size are* ***(RT: 116mm & LT: 115mm)****, with normal cortical parenchymal echotexture and sufficient cortical thickness, without sign of stone, stasis or perinephric collection.*
- *Ureters are not dilated.*
- *Urinary bladder has normal volume, well distended with normal wall thickness and mucosal lining, without sign of stone or abnormal mass lesion.*

CS Scanned with CamScanner

01/11/27

| lab | Wbc | Hb | Plt | Alt | Ast | Akp | Bili T | Bili D | GGT |
|---|---|---|---|---|---|---|---|---|---|
| 98/04/20 | 5940 | 12.6 | 140,000 | 287 | 134 | - | 1.15 | 0.87 | - |
| 02/02/30 | 5640 | 13 | 60,000 | 110 | 52 | 414 | 1.3 | 0.2 | 38 |
| 02/03/24 | 6670 | 13.6 | 83,000 | 98 | 55 | - | - | - | - |
| 02/06/18 | 6450 | 13.6 | 90,000 | 115 | 59 | 481 | 1 | 0.2 | - |
| 02/08/14 | 6100 | 13.7 | 67,000 | 171 | 71 | 459 | 1.3 | 0.3 | 50 |

- The patient is currently 17 years old, he is obese (85 kg and 158 cm tall), he has no complaints of weakness, lethargy and fatigue, his appetite is good, he has no abdominal pain, nausea, vomiting, and no changes in bowel movements.
- There is no history of similar disease in other family members.

هوالشافی

استاد گرامی جناب آقای دکتر [illegible] - [illegible]

با سلام و احترام

حال تحت [illegible] Overlap Synd [illegible] ۱۸

علاوه بر آن سمپتوم بودن بیماری، همکاری بیمار و خانواده بسیار پائین بوده [illegible]

و نتیجه [illegible] Refractory و ارجاع شده بود. علاوه بر این بیمار بسیار چاق

و احتمالا NASH [illegible] هم دارد. (شاید با [illegible] personality

Drink هم باشد). [illegible] منجر به [illegible] سوابق [illegible]

۱) [illegible] OLT [illegible] ۲) همکاران [illegible] بیمار ترکیبات

[illegible] و استاتین ها را شروع [illegible] sleeve [illegible]

خواهشمند است [illegible] در درمان [illegible]

Refer to adult gastroenterologist

# Feedback

*Dear Professor:*

*Thank you for introducing the patient. The patient was presented at the joint meeting of the commission and the grand round. The patient's documents were seen. After discussion and debates with our gastroenterologist colleagues and review of references and literatures, the following advisory decisions were made, which are announced to you for your information, help and, if you consider it appropriate, to apply:*

Clinical and paraclinical evidence is consistent with the diagnosis of autoimmune hepatitis, but according to complete examination, Wilson's is not an explanation for the patient's disease, however, checking the serum level of IgG, serum protein immunoelectrophoresis and anti-Soluble antibody and other markers are helpful.

Considering the recent weight gain, it is possible that a portion of the increase in transaminases is caused by fatty liver, which strongly recommended lifestyle modification, exercise and weight loss through diet or with the help of medicine. It is recommended to completely stop drinking alcohol, if any.

Currently, it is recommended to continue MMF and monitor the therapeutic response, and in case of insufficient therapeutic response, tacrolimus can be added or replaced.