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

Iranian Association Of Gastroenterology And Hepatology
Isfahan Branch

GI commission and grand round

November 27 2023

List of cases-November 27 2023

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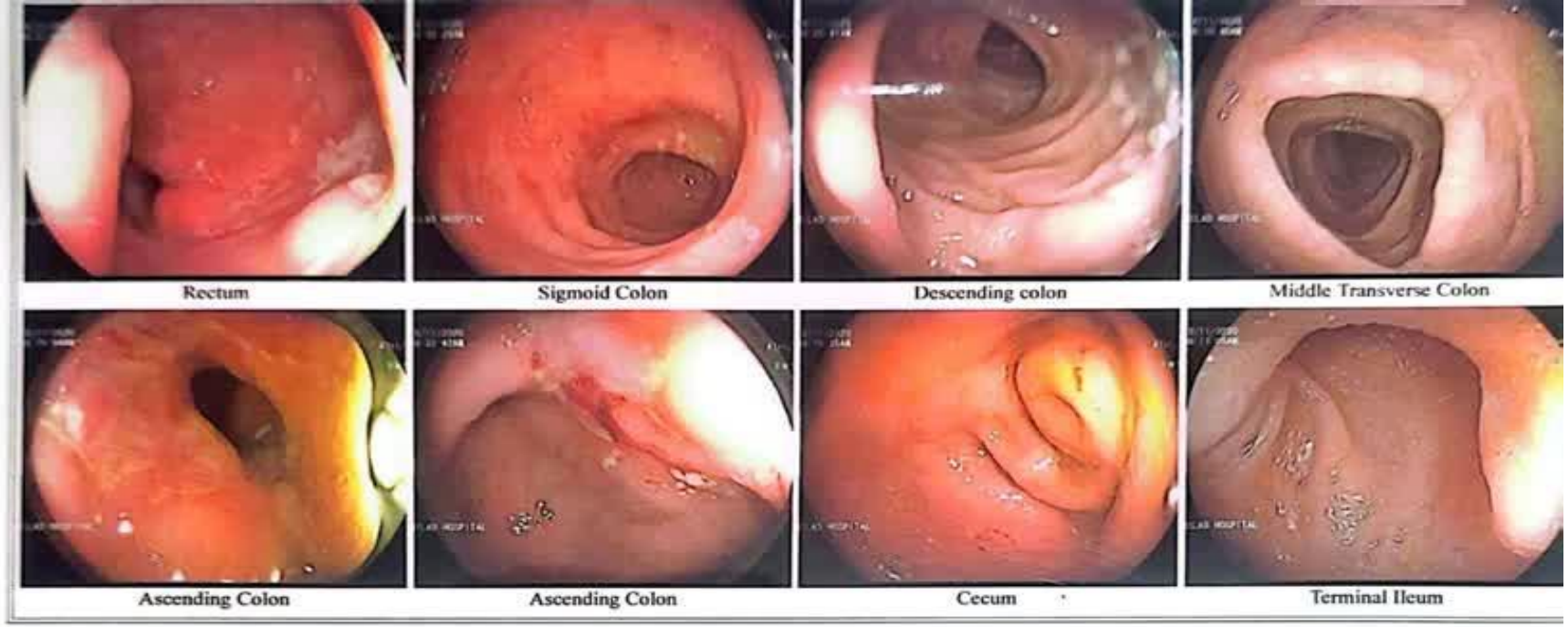
GI commission and grand round

A 57-year-old woman

- The patient who has had frequent constipation, painful stools with bright blood since 10 years ago, and underwent hemorrhoidectomy. (We do not have a surgery report and the she did not have a colonoscopy before the surgery).
- One year after the surgery, the patient had colicky abdominal pain in the peri-umbilical region, with large amounts of bright bloody stools, and mucus and purulent secretions. Colitis (probably UC) was diagnosed by colonoscopy and is being treated by Asacol or Mesalazine (no document).

- Abdominal pains have improved, but the patient did not take regular medication and regular follow-up, and took most of the medications only when he had abdominal pain.
- However, since 2009, he has been following up on a regular basis, due to abdominal pains and clear blood discharge, he had another colonoscopy in 2009, and with the diagnosis of UC, he is being treated with Asacol.



Reason for Endoscopy : Ulcerative Colitis

Premedication : Midazolam - pethedine

Description of procedure : Preparation : Good

Findings :

Rectum : Were seen loss of Vascular pattern and Erythematous and Multiple ulcer and erosions , Bx .

Sigmoid : Were seen loss of Vascular pattern and Erythematous and Multiple ulcer and erosions , Bx .

Descending Colon : Normal

Transverse Colon : Normal

Ascending Colon : Were seen loss of Vascular pattern and Erythematous and Multiple ulcer and erosions , Bx .

Cecum : Normal

Terminal Ileum : Normal , Bx

Diagnosis : Ulcerative Colitis

Recommendation : F/U of Bx

شرح ماکروسکوپی :

نمونه ارسالی شامل سه ظرف:

ظرف اول ایلئوم شامل چند قطعه مجموعا به ابعاد ۰/۱*۰/۳*۰/۶ سانتیمتر می باشد .

ظرف دوم کولون صعودی به ابعاد ۰/۱*۰/۱*۰/۱ ساتیمتر می باشد .

ظرف سوم رکتوسیگموئید شامل پند قطعه به ابعاد ۰/۱*۰/۱* ۱ سانتیمتر می باشد .

شرح میکروسکوپی :

در بررسی میکروسکوپی بیوپسی ایلئوم و رکتوسیگموئید و کولون صعودی :

ایلئوم : مقطعی از بافت ناحیه همراه با ارتشاح متوسط سلولهای لنفوسیت و پلاسماسل و نوتروفیل و به طور پراکنده ائوزینوفیل در لامیناپروپریا دیده می شود . گسترش سلولهای التهابی نوتروفیل به اپیتلیوم پوشاننده برخی از غدد و کاهش موسین داخل سلولی برخی از غدد دیده می شود .

در ناحیه رکتوسیگموئید ارتشاح نسبتا شدید سلولهای التهابی لنفوسیت ،پلاسماسل و نوتروفیل در لامیناپروپریا و تخریب برخی از غدد و گسترش سلولهای التهابی نوتروفیل به اپیتلیوم پوشاننده برخی از اپیتلیوم پوشاننده برخی از اپیتلیوم پوشاننده کریپتها ایجاد Cryptitis دیده می شود و به هم ریختگی غدد و کاهش موسین داخل سلولی و کاهش گابلت سل ها دیده می شود .

در ناحیه کولون صعودی تغییرات التهابی شدید تر و تخریب مخاط سطحی همراه با تجمع سلولهای التهابی نوتروفیل و دبریهای سلولی در این ناحیه با نمای aphtous دیده می شود . به هم ریختگی غدد و گسترش سلولهای التهابی به اپیتلیوم پوشاننده غدد و داخل لومن کریپتها و تشکیل criptitis و cryptabscess دیده می شود . کاهش موسین داخل سلولی و کاهش گابلت سل ها دیده می شود .

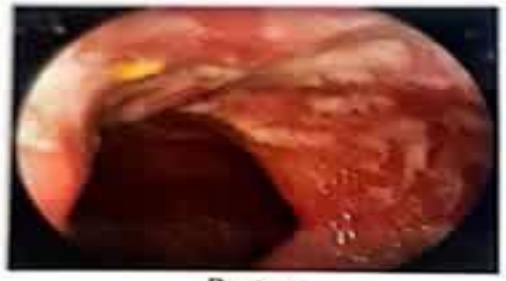
تغییرات رژنراتیو هسته ای در سلولهای اپی تلیال پوشاننده غدد وجود دارد .

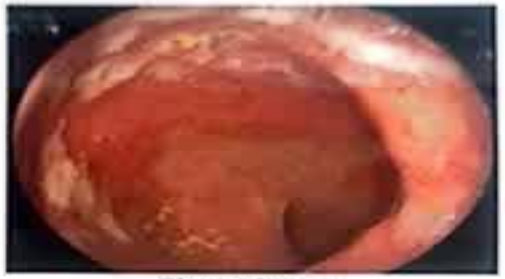
با توجه به یافته های فوق و کلینیک بیمار کولیت اولسراتیو حاد مطرح می شود .

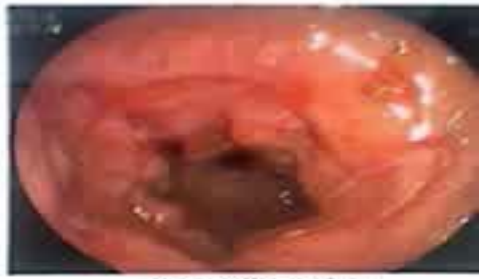
تغییرات دال بر بدخیمی در این نمونه دیده نشد .

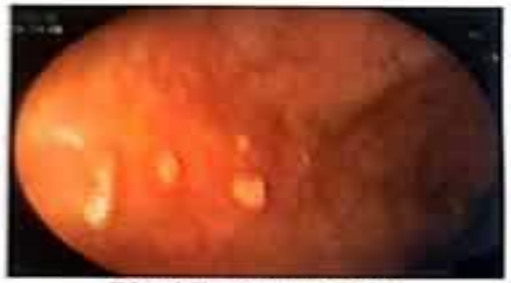
Diagnosis :Ileum &dscending colon & rectosigmoid biopsy specimens :
Findings are consistent of ulcerative colitis

- Again in 1400 due to lack of proper response to the treatment (abdominal pains and blood discharge) they undergo colonoscopy again:
- Remicade was started along with Azram (50 mg every 8 hours) and Asacol (daily enema and 6 tablets of 400 mg daily):

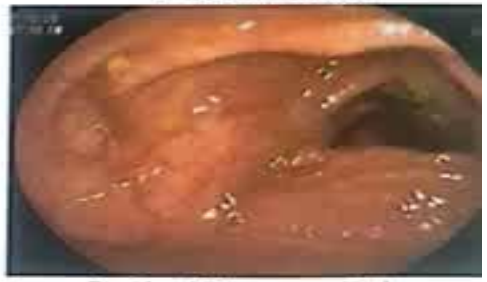

Rectum

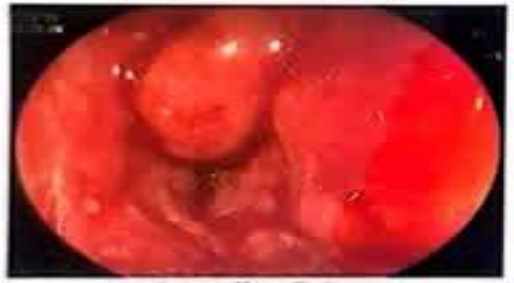

Sigmoid Colon

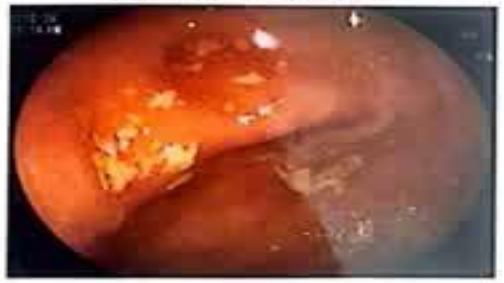

Descending colon


Distal Transverse Colon


Middle Transverse Colon


Proximal Transverse Colon


Ascending Colon


Cecum


Appendix orifice

Reason for Endoscopy : History of IBD , She is referred for colonoscopy because of incomplete responce

Findings :

Anus : Anal fissure

Rectum : Large deep ulcers were seen in rectum. Biopsies were taken.

Sigmoid : Large deep ulcers were seen

Descending Colon : Multiple small ulcers and aphtous lesions were seen.

Transverse Colon : Multiple small ulcers and aphtous lesions were seen.

Ascending Colon : Circumferential ulcer with contact bleeding just above the cecum was seen. Biopsies were taken.

Cecum : Periappendix is normal.

Large deep ulcers in rectum and sigmoid
Multiple small ulcers and aphthous lesions in sigmoid and transverse colon
Circumferential ulcer with contact bleeding just above the cecum

Specimen: A: Rectal biopsy **B:** Ascending colon biopsy

Macroscopic: Received in two containers of formalin were the following:
A: Labeled as " rectal biopsy " consisted of 4 cream colored tissue fragments measuring 3 mm in greatest dimension.
B: Labeled as "ascending colon biopsy " and consisted of 2 fragments of cream colored tissue measuring 3 mm in greatest dimension.

Microscopic:
A,B: Sections show colon mucosa with architectural distortion and increased in inflammatory cells of lamina propria, composed of neutrophils and lymphoplasma cells with penetration of neutrophils to glandular epithelium (cryptitis) and areas of crypt abscess. In multiple sections examined No granuloma is found. Basal plasmacytosis is also seen. There **is no evidence of dysplasia or malignancy** in these specimens.

Diagnosis:
A: Rectal biopsy:
Active chronic colitis, Compatible with active phase of IBD

B: Ascending colon biopsy :
Polypoid granulation tissue (inflammatory polyp)

Comment: NO evidence of dysplasia or malignancy

- In 2022, due to the disease activity (calprotectin level: 650 and ESR: 105) and the high level of infliximab antibody, Remicade will be stopped and will start for the Cinnora patient (from September):

Inflixmab	Anti infliximab
0.16	23.7

- In February 2023, she was admitted to the hospital due to generalized abdominal pain:

نام خدمت	سونوگرافی کامل شکم و لگن

شکل و ابعاد و اکوی پارانشیمال کبد و طحال نرمال می باشد .Spleen span =۱۲۵ mm

اکتازی مجاری صفراوی داخل و خارج کبدی رویت نشد.

قطر ورید پورت و CBD نرمال است .

کیسه صفرا دارای حجم و ضخامت جداری طبیعی است .سنگ و اسلاژ مشاهده نشد .

پانکراس و اثورت و پاراائورت درحدقابل بررسی نرمال هستند.

هر دو کلیه دارای شکل و ابعاد و ضخامت پارانشیمال طبیعی است

طول کلیه چپ ۱۱٦میلیمتر و ضخامت پارانشیمال۱٤ میلیمتر و طول کلیه راست ۱۱٤ میلیمتر و ضخامت پارانشیمال ۱۵ میلیمتر

سنگ و هیدرونفروز رویت نشد .

تصویر یک کیست کورتیکال به قطر ۸ میلیمتر در کلیه چپ رویت شد .

مثانه دارای حجم وضخامت جداری نرمال است .

تصویر یک long segment از ایلئوم با ضخامت جدار افزایش یافته همراه با اکوژنیسیت Fat مزانتر اطراف ان رویت شد که

میتواند مطرح کننده ایلئیت باشد (تطبیق با یافته های بالینی و سی تی اسکن توصیه میشود)

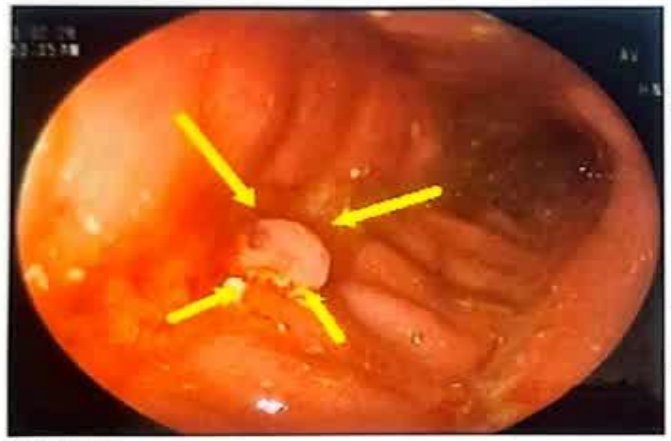
در شکم ولگن مایع ازاد رویت نشد .

: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 -
.There is no abdominopelvic free fluid -
Soft tissue attenuated short segment wall thickening of ascending colon is -
seen with peripheral congestion and regional lymph nodes compatible with colon
.cancer
Another segmental wall thickening is seen in sigmoid colon, for more -
.evaluation colonoscopy is recommended
Gray attenuated wall thickening of rectum with peripheral fat stranding is -
.noted suggestive of proctitis
.Atherosclerotic changes is seen in abdominal aorta -
.Some vertebral body hemangioma is seen -
Also there are some hypodense areas in lumbar spine suggestive of bone -
.metastasis
: In limited view of thorax -
.Mosaic perfusion is seen in both lungs -
.Bilateral pulmonary thin wall cysts is noted -

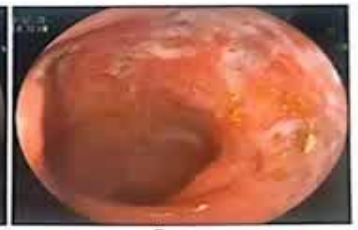
IMP: Ascending colon cancer
Sigmoid wall thickening
Proctitis
R/O bone metastasis
REC : Colonoscopy
Bone scan

After 4 days of hospitalization, she is discharged and she is referred for colonoscopy as an outpatient.

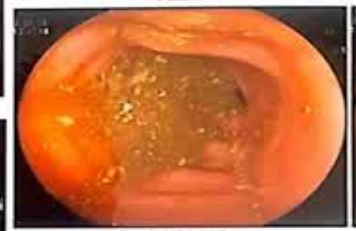


Sigmoid Colon

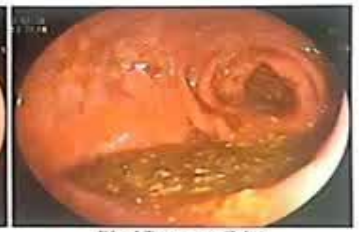
Anus
Fistula



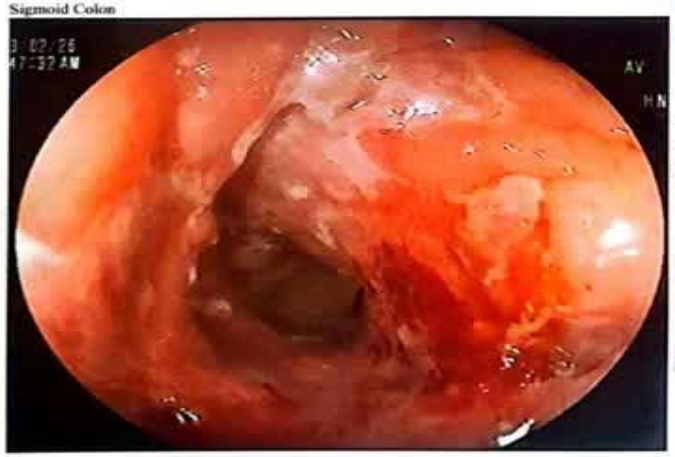
Rectum



Descending colon

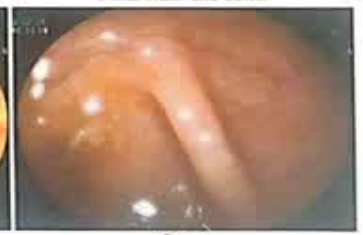


Distal Transverse Colon



Ascending Colon

Proximal Transverse Colon



Cecum

Reason for Endoscopy : IBD (most likly crohn's) with abdominal pain

Findings :

Anus : Fistula orifice was seen in left side of perianal region.
External hemorrhoid + Anal fissure

Rectum : Diffuse edema with deep ulcers were seen in rectum.

Sigmoid : Multiple ulcers with a 6mm polyps were seen. Polyp was resected.

Transverse Colon : Normal . Poor preparation

Ascending Colon : There was an ulcerative and edematous part in ascending colon in a 6cm lenght. Scope was passed with pressure. Biopsies were taken (R/O : Malignancy).

Cecum : Normal

1401/12/06

Fistula orifice in left side of perianal region + anal fissure + ext. hemorrhoid
Diffuse edema with deep ulcers in the rectum
Multiple ulcers with a 6mm polyps in sigmoid
Ulcerative and edematous part with 6 cm length in the ascending colon that scope was passed with pressure

01/12/06

Specimen Origin:

Colon and sigmoid biopsy

Macroscopic Evaluation:

Received specimen consisted of two formalin filled containers:

Colon consisted of three pieces , Measured:0.3x0.2x0.2 cm,

color: grayish.

Sigmoid , consisted of one piece , Diameter:0.2 cm, color: grayish.

Microscopic Evaluation:

Colon:Sections showed dense infiltrate of PMNs admixed with fibrin material.Epithelial lining was not seen.

Sigmoid:The mucosa was ulcerated and replaced by granulation tissue contained a dense infiltrate of PMNs , some lymphocytes and plasma cells .Adjacent mucosa showed a dense infiltrate of acute and chronic inflammatory cells including PMNs,lymphocytes and plasma cells within lamina propria and intraepithelium.

DX: Colon and sigmoid biopsy: Colon: PMNs rich fibrin exudate/no viable mucosa/in favor of ulcer Sigmoid: Inflammatory pseudopolyp with severe chronic active colitis (In favor of inflammatory bowel disease) No Dysplasia Findings are in favor of inflammatory bowel disease.

- In April 2023, the patient was hospitalized and examined due to anal pain, abdominal pain, rectal bleeding and fever.
- Cinnora is discontinued, treated with antibiotics (ciprofloxacin and metronidazole), Start with methylprednisolone and continue with prednisolone fort.

نام خدمت	سونوگرافی کامل شکم و لگن

شکل و ابعاد و اکوی پارانشیمال کبد و طحال نرمال می باشد .Spleen span =۱۲۵ mm

اکتازی مجاری صفراوی داخل کبدی رویت نشد.

قطر ورید پورت و CBD نرمال است .

کیسه صفرا دارای حجم و ضخامت جداری طبیعی است .سنگ و اسلاژ مشاهده نشد .

پانکراس و ائورت و پاراائورت درحدقابل بررسی نرمال هستند.

هر دو کلیه دارای شکل و ابعاد و ضخامت و اکوی پارانشیمال طبیعی است .

طول کلیه چپ ۱۰۸ میلیمتر و ضخامت پارانشیمال ۱۶ میلیمتر و طول کلیه راست ۱۰۶ میلیمتر و ضخامت پارانشیمال ۱۵ میلیمتر

سنگ و هیدرونفروز رویت نشد .

مثانه دارای حجم وضخامت جداری نرمال است .

رحم با نمای آتروفیک مشاهده شد .

ضایعه فضاگیر در آدنکسها رویت نشد .

تصویر چند لوپ روده با جدار ادماتو و ضخامت جداری افزایش یافته (۷.۵ میلیمتر) همراه با Fat stranding اطراف آنها رویت شد که

میتواند مطرح کننده پروسه های التهابی باشد .

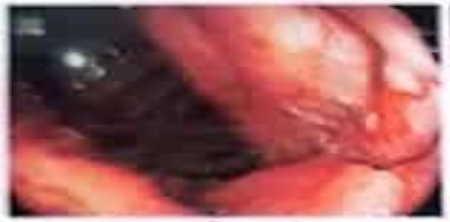
در شکم ولگن مایع ازاد رویت نشد .

MRI (به عنوان مثال proton) لگن با و بدون ماده حاجب

MRI (به عنوان مثال proton) شکم با و بدون مواد حاجب

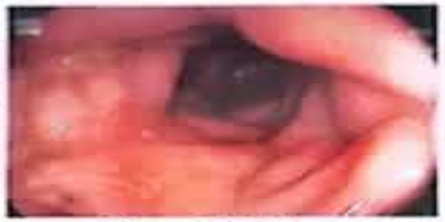
MR entrography :
Long segment wall thickening of sigmiod is noted .
Also wall thickening of cecum and gastric fundus are seen .
Two anal fistula are seen with below characteriatics :
A : - intersphincteric
- lateral wall
- in 10 o'clock
-40 mm above the anal verge

B : - Mid line inter sphincteric
-Anterior wall
- in 12 o'clock
- 20 mm above the anal verge



Retroflex view

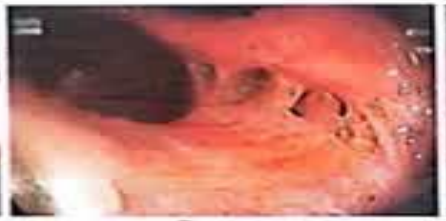
Rectum



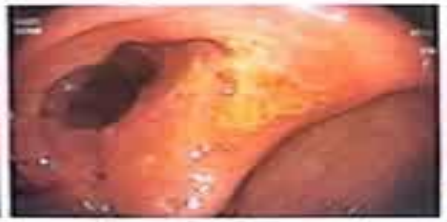
Sigmoid Colon

Descending colon

Middle Transverse Colon



Cecum



Terminal Ileum
Ileocecal valve

Terminal Ileum

Reason for Endoscopy : R/O CORHON

Premedication : By anesthesiologist

Findings :

Rectum : Mucosal ulceration & Decreased vascularity were seen.

Sigmoid : Mucosal ulceration & Decreased vascularity were seen.

Descending Colon : Normal mucosa & vascular pattern.

Transverse Colon : Normal mucosa & vascular pattern.

Ascending Colon : Normal mucosa & vascular pattern.

Cecum : Mucosal Erythema & Edematous and ulceration were seen .Multiple biopcis were taken.

Terminal Ileum : Ileocecal valve was patulous with edematous & Erythematous mucosa. Multiple biopcis were taken.
Terminal ileum was normal up to 10 cm from ileocecal valve

Diagnosis : **Rectosigmoiditis**
Cecal+ ileocecal valve inflammation
R/O crohn disease

Recommendation : Follow up pathology report

History:

R/o Crohn disease

Macroscopic:

1-Received specimen in formalin consists several soft creamy pieces total measuring 0.7x0.5x0.2cm.
2-Received specimen in formalin consists three soft creamy pieces total measuring 0.5x0.3x0.2cm.
3-Received specimen in formalin consists four soft creamy pieces total measuring 0.4x0.3x0.2cm.

Microscopic:

1- Sections show colon mucosa with architectural distortion and severe increase of chronic and acute inflammatory cells which lead to gland destruction and lamina propria expansion. Crypts show acute inflammation (cryptitis) as well. Muscularis mucosa is infiltated by lymphoid cells. One fragment lack inflammation with normal glands.
2- Sections show colon mucosa with architectural distortion. Mild to moderate increase of chronic inflammatory cells was seen in upper part of mucosa. Crypt show acute inflammation (cryptitis) as well. Granuloma formation was noted in the lamina propria.
3- Sections 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 :

1-Cecum Biopsy:
-Severe Focal Active chronic Colitis, mild chronicity

2-Sigmoid Colon Biopsy:
-Focal Active chronic Colitis, mild activity; mild chronicity

1-Rectal mucosa Biopsy:
-Diffuse Active Colitis, no chronicity

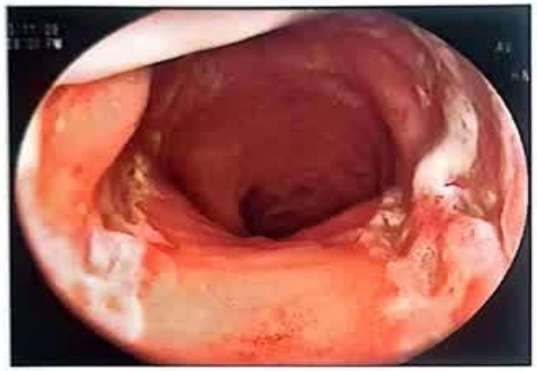
Comment :

Histologic findings are infavor of crohn's disease, clinicopathologic correlation is recommended.

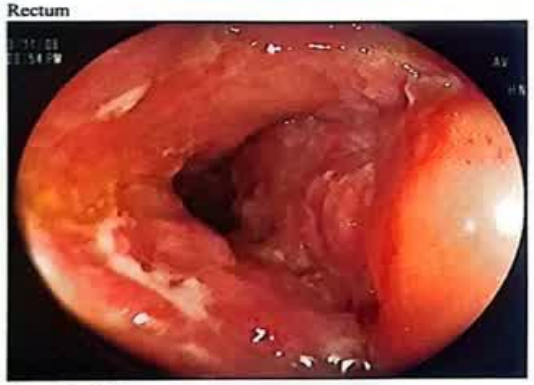
- The patient is discharged from the hospital with consent.
- For the patient, Azram, Asacol and prednisolone 50 mg is prescribed, which is gradually tapered and is currently continued with a dose of 2.5 mg, which is to be discontinued.
- Currently, the patient does not complain of abdominal pains, hematochezia is very small and transient, and he defies once a day. The patient does not complain of joint and bone pains, and he does not mention blurred vision.
- In the examination, there is no skin lesion in the limbs, the abdomen is soft, there is no tenderness, there is no active fistula or abscess in the anal area.

Q:

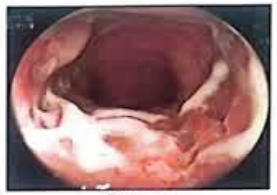
- 1) What should be done for stenosis in the ascending colon?
- 2) What is the appropriate treatment for distal rectal involvement?



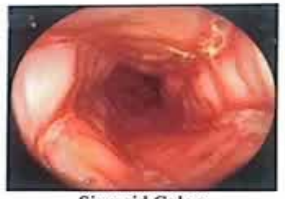
Rectum



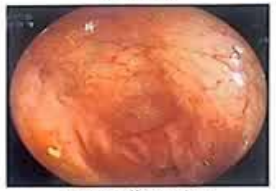
Ascending Colon



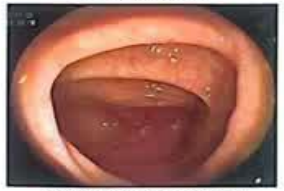
Rectum



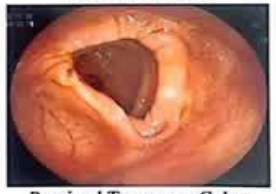
Sigmoid Colon



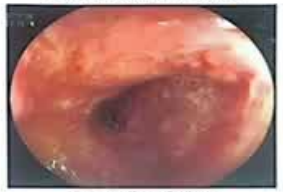
Descending colon



Distal Transverse Colon



Proximal Transverse Colon



Ascending Colon

Reason for Endoscopy : IBD + severe inflammation in ascending colon

Findings :

Anus : Anal fissure

Rectum : Mucosa in distal part of rectum is ulcerative and edematous with multiple holes

Sigmoid : Longitudinal linear ulcers were seen.

Descending Colon : Normal

Transverse Colon : Normal

Ascending Colon : There was a circumferential ulcerative part in ascending colon. Passage of scope through it was impossible.
Biopsies were taken (R/O : Adenocarcinoma)

Distal part of rectal Mucosa is ulcerative and edematous with multiple holes

Longitudinal linear ulcers in sigmoid

Circumferential ulcerative part in ascending colon was seen that passage of scope through it was impossible

Specimen: Transverse colon biopsy

Macroscopic: The specimen received in formalin consisted of 6 cream colored tissue fragments, the largest measuring 4 mm.

Microscopic: Sections show colon mucosa with architectural distortion and severe increased in inflammatory cells of lamina propria, composed of neutrophils and lymphoplasma cells with penetration of neutrophils to glandular epithelium (cryptitis) and crypt abscess. In multiple sections examined No granuloma is found. Granulation tissue formation is seen. There **is no evidence of CMV, dysplasia or malignancy** in these specimens.

Diagnosis: Severe diffuse active chronic colitis with mucosal ulceration and granulation tissue formation, Compatible with active phase of Ulcerative colitis

Comment: There is NO evidence of malignancy in this specimen, but if malignancy is highly suspicious, further biopsy is recommended.

Whole Body Bone Scan
SPECT-CT
(Three Phasic)

Procedure:

Immediately after IV injection of 740 MBq Tc- 99m MDP, the study was performed in angio and blood pool phases from lumbar spine. Also three hrs later whole body bone scan (delayed images) was performed in anterior and posterior aspects. Multiple spot images were also obtained.

Description:

The scan shows rather homogenous radiotracer uptake throughout the skeletal system in the flow, blood pool and delay images. No abnormal finding is noted in the skeletal system.

Interpretation:

- ***No evidence of metabolically active bony lesion in the skeletal system. Further evaluation is recommended, if clinically indicated.***
- ***Follow up scan is recommended.***

Yours Sincerely
Nuclear physician

مرکز پزشکی هسته ای شهید چمران
دکتر حسین براتی
متخصص پزشکی هسته ای
نظام پزشکی ۵۷۰۴۵

Because of the report of hypodense area in the lumbar spine on CT, a whole body bone scan is requested and the result was normal.

In the name of God

Mahdieh Diagnostic bone densitometry center

Patient's name:fateme,mokhtari	Height: 161 cm
scan date :1402/4/11	Weight: 62 kg
Date of birth:1967	Age/Gender:56

Dear Dr.

Technique/ machine identification: *The patient underwent PA lumbar spine and proximal femur DXA bone density studies on a hologic model Discovery Wi (S/N 86189).*

Diagnostic category: Osteoporosis *based on the* T-score *of -3.8 at lumbar spine applying World Health Organization Criteria for postmenopausal women*

10 –year fracture risk (FRAX Adjusted for TBS) Hip :1.9 % Other major FX:9.9 %

TBS L1 – L4 : 1.141 (degraded)

BMI: 23.9

Region	BMD gr/cm^2	T-score	Diagnosis	Z-score
Lumbar spine	0.631	-3.8	Osteoporosis	-2.6
Femoral neck	0.557	-2.6	Osteoporosis	-1.5

Conclusion:

1-The patient is in High risk because prior hip or vertebral fractureT score <=-3.8 at lumbar spine 10 year hip fracture risk probability 1.9% 10 year all major osteoporosis related fracture probability of 9.9% .

Treatment:

1-Basic bone health for all individual include regular active weight-bearing exercise, calcium (diet and supplements) 1200 mg daily, vitamin D 800–2000 IU (20–50 µg) daily(if needed), cessation of tobacco smoking and fall-prevention strategies.

2-Anti-resorptivetreatment (bisphosphonates, estrogens, selective estrogen receptor modulators (SERMs), calcitonin and monoclonal antibodies such as denosumab.)

BMD/TBS monitoring:

1- 24-36 month's follow-up depending on fracture risk factors and treatment

Definitions: **A) WHO criteria** for postmenopausal women: **1- Normal:** T-score >-1.0

2-Osteopenia: T-score< -1 and > -2.5 **3-Osteoporosis:** T-score < -2.5

B) Some Secondary causes of bone loss are hypogonadism, hypercortisolism, hyperparathyroidism, hyperthyroidism, hypercalciuria, hyperprolactinemia, diabetes type one ,acromegaly ,malabsorbtion anorexia nervosa, vit D deficiency,chronic liver disease, myeloma, R.A, renal tubular acidosis , alcoholism, and use of medications such as corticosteroids, lithium, excessive thyroid hormone, anticonvulsants,and GnRH agonists.

Treatment of osteoporosis was started with calcium, alendronate and vitamin D

Test	Result	Unit	Method	Norm
FBS	95	mg/dl		Norma
S.G.O.T (AST)	11	U/L		<31.0
S.G.P.T (ALT)	9	U/L	Colorometric	<31

---------- Note: SGOT

under 2 year not estabilished and condition dependent

Alkaline Phosphatase	200	U/L	photometric	110 - 3

Hematology -

Test		Result	Unit	Normal Ra
CBC		-		-
W.B.C		9.98	x10*3/µL	3.5 - 11.0
R.B.C		5.06	x10*6/µL	4.0 - 5.2
Hemoglobin	↓	11.6	g/dL	12.0 - 16.32
Hematocrite		37.8	%	35.0 - 48.0
M.C.V	↓	74.7	fL	80.0 - 100.0
M.C.H	↓	22.9	pg	26.0 - 34.0
M.C.H.C	↓	30.7	g/dL	31.0 - 37.0
RDW-CV	↑	17.7	%	11.5 - 14.0
Platelets		410	x10*3/µL	130 - 450
PDW		10.2	%	8.0-17.0
MPV		9.0	fL	8.0 - 13.0
Neutrophils		70.3	%	40 - 70
Lymphocyte		16.7	%	20 - 45
Monocyte		9.4	%	0 - 8
Eosinophil		3.5	%	0 - 6
Basophil		0.1	%	0-1
Neutrophils#		7.01	x10*3/µL	1.8 - 7.7
Lymphocyte#		1.67	x10*3/µL	1.2 - 5.2
Monocytes#		0.94	x10*3/µL	0.2 - 0.8
Eosinophils#		0.35	x10*3/µL	0- 0.5
Basophils#		0.01	x10*3/µL	0 - 0.1

E.S.R 1 hrs	↑	44	mm/hr	Newborn: 0 - 2 Female>50Yea

02/06/27

Metabolic Intermediates Department

Test	Result	Unit	Method	Normal Range
25 hydroxy Vitamin D	21.42	ng/mL		< 10: Severe deficiency 10-30: Defici Optimal level 81-150: Overdose >151

Infectious Serology-

Test	Result	Unit	Method	Normal Range
Calprotectin (stool)x1	↑ 151.0	micgr/gr	Elisa	Normal Value: <50.0 Positive Valu

Immunology Department-Autoantibodies Screening

Test	Result	Unit	Reference Interval
C.ANCA (IF)	1:20 (Borderline)	titer	Negative: <1/20 Positive: >1/20
	recommended to repeat the analysis after two weeks.		
P.ANCA (IF)	<1:20 (Negative)	titer	Negative: <1:20 Positive: >1:20

Immnology Department

Test	Result	Unit	Reference Interval
ASCA (IgG)	H 40.9	U/mL	Negative: <20.0 Positive: >20.0
ASCA (IgA)	H 155.1	U/mL	Negative: <20.0 Positive: >20.0

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:
- Currently, according to the active ulcers in the rectum and the stricture created in the ascending colon, the following are recommended:
- Increasing dose of CinnoRA
- Consultation with a colorectal surgeon
- PET SCAN and rheumatology consultation to check the bone lesions reported in the patient's previous CT scan

A 55-year-old male

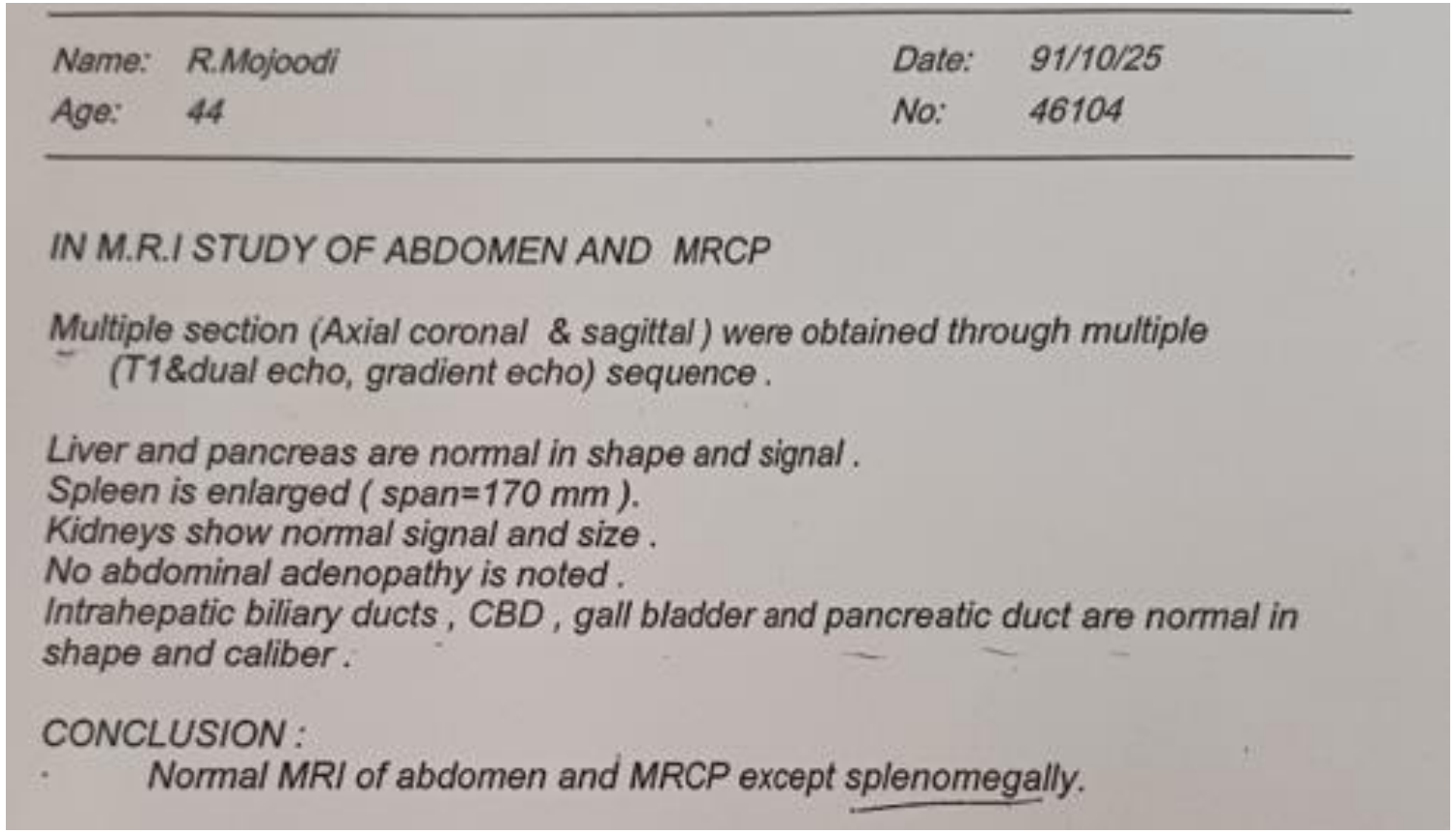
- ... with a history of liver cirrhosis and PBC since about 10 years ago was referred due to Retroperitoneal fibrosis and bone lesion for consult of further measures.
- Currently, he only complains of anorexia and weight loss.
- Drug history:
- Hydroxyurea one daily
- Ursodeoxycholic acid, every eight hours

- family history:
- Lung cancer in a brother at the age of 67

Abdominal MRI and MRCP

1391.10.25

Normal MRI of abdominal and MRCP except **splenomegaly**



Name: R.Mojoodi Date: 91/10/25
Age: 44 No: 46104

IN M.R.I STUDY OF ABDOMEN AND MRCP

Multiple section (Axial coronal & sagittal) were obtained through multiple (T1&dual echo, gradient echo) sequence .

Liver and pancreas are normal in shape and signal .
Spleen is enlarged (span=170 mm).
Kidneys show normal signal and size .
No abdominal adenopathy is noted .
Intrahepatic biliary ducts , CBD , gall bladder and pancreatic duct are normal in shape and caliber .

CONCLUSION :
Normal MRI of abdomen and MRCP except splenomegally.

Lab Data

1391

PT 13	HBS Ag Neg	Ferritin 155	IgA 2.1
INR 1	HIV(1,2,P24)-Ab Neg	Iron 86	AntiTTG-IgA Neg
PTT 39	HCV-Ab Neg	TIBC 352	ANA 8
Alb 4.8		Retic 2.2	ASMA Neg
AST 20		ESR 37	LKM-Ab 0.2
ALT 42		TSH 1.7	Anti ENDOMESIAL IgA 0.7
ALP 893			Anti ENDOMESIAL IgG 0.8
Billi.T 0.8			
Billi.D 0.1			

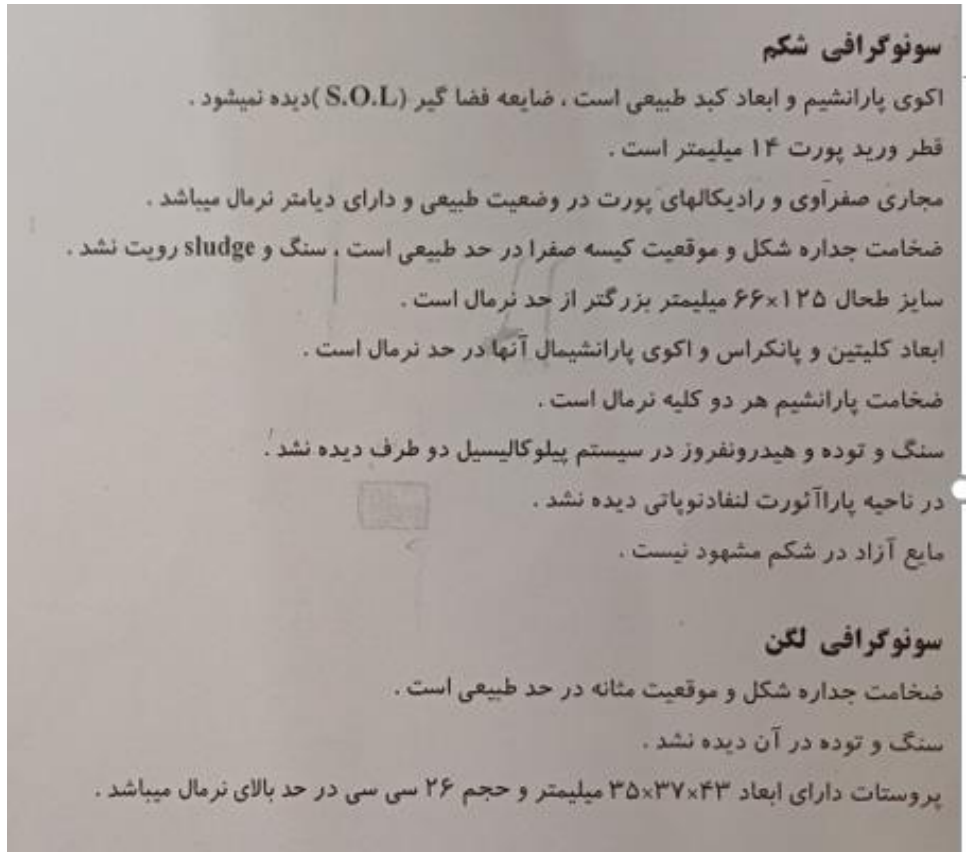
Peripheral blood smear: anisocytosis-pikilocytosis-microspherocyte (possibility of hemolytic anemia-spherocytic anemia-myelofibrosis)

Abdominopelvic Sonography

1391.11.14

Spleen size: 66x125 mm and larger than normal

Prostate size: 35x37x43 mm and volume 26 cc is above the normal.



سونوگرافی شکم

اکوی پارانشیم و ابعاد کبد طبیعی است ، ضایعه فضا گیر (S.O.L)دیده نمیشود .

قطر ورید پورت ۱۴ میلیمتر است .

مجاری صفراوی و رادیکالهای پورت در وضعیت طبیعی و دارای دیامتر نرمال میباشد .

ضخامت جداره شکل و موقعیت کیسه صفرا در حد طبیعی است ، سنگ و sludge رویت نشد .

سایز طحال ۱۲۵×۶۶ میلیمتر بزرگتر از حد نرمال است .

ابعاد کلیتین و پانکراس و اکوی پارانشیمال آنها در حد نرمال است .

ضخامت پارانشیم هر دو کلیه نرمال است .

سنگ و توده و هیدرونفروز در سیستم پیلوکالیسیل دو طرف دیده نشد .

در ناحیه پاراآئورت لنفادنوپاتی دیده نشد .

مایع آزاد در شکم مشهود نیست .

سونوگرافی لگن

ضخامت جداره شکل و موقعیت مثانه در حد طبیعی است .

سنگ و توده در آن دیده نشد .

پروستات دارای ابعاد ۴۳×۳۷×۳۵ میلیمتر و حجم ۲۶ سی سی در حد بالای نرمال میباشد .

Lab Data

1392

BUN 12.5	Ca 9.2	Billi.T 0.9	ANA 0.2	WBC 5.2
CR 0.9	Phos 3.5	Billi.D 0.1	Anti.ds.DNA Neg	RBC 4.2
ESR 24		AST 12		HB 12.4
CRP Neg		ALT 9		HCT 37
		ALK 489		MCV 88
		GGT 83		MCH 29
				PLT 168

Pathology of liver mass CNB

1392.02.18

Clinical Data:

Elevated liver enzymes: (ALP:913 and GGT: 115) / Normal level of SGOT and SGPT

Normal sonography of liver and gall bladder

Macroscopic Description:

Specimen received in formalin labelled with patient's name is one core of soft brown tissue 1.5 cm in length. Entirely submitted in one cassette.

Microscopic Description:

Sections show liver tissue consist of lobules and portal spaces.

There is mild mononuclear inflammatory cells infiltration around portal spaces with scattered neutrophils and eosinophils in portal spaces and around the bile ducts. Mild periportal fibrosis is seen in masson staining.

Final Pathologic Diagnosis: cholangitis

Comment: Drug reactions could be among the differential diagnosis. Clinicopathologic correlation is recommended.

Name:	R.Mojodi	Date:	92/05/09
Age:	45	No:	54157

CT SCAN STUDY OF THE ABDOMEN AND PELVIS WITH CONTRAST

• History:
-

• Technique:
- Multiple axial images of the abdomen and pelvis from the lung bases to the ischial tuberosities are acquired in coordination with intravenous and oral contrast agent using 64 slice scaner. 5-mm contiguous axial images are reconstructed.

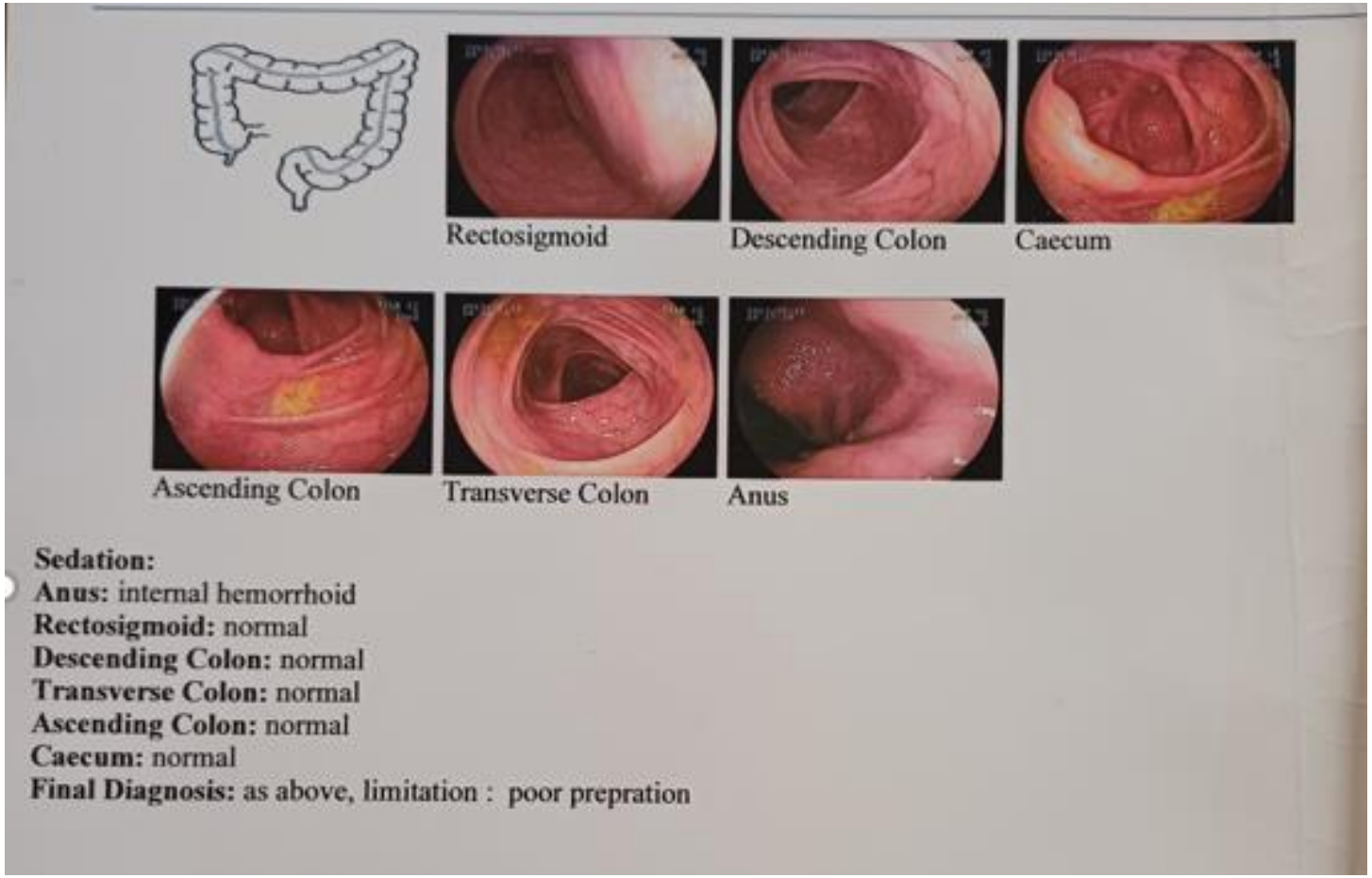
• Findings:
- Lung bases are clear.
- Abdomen: Liver has normal contour and density with no SOL. Liver and spleen are enlarged (liver span=210 mm and spleen span=190mm). Pancreas, adrenal glands and gallbladder are unremarkable. Kidneys enhance symmetrically. No lymph nodes in the abdomen are abnormally enlarged.
- Pelvis: Opacified loops of large and small bowel are unremarkable.There is no free fluid in the pelvis. No lymph nodes are abnormally enlarged. The urinary bladder has a normal configuration.
- Density of bones is increased diffusely with no bone expansion..

• Impression:
- Diffuse osteosclerosis (myelofibrosis , is the first DDX due to presence of hepatosplenomegally however renal osteodystrophy, hyperthyroidism, hypoparathyroidism, osteopetrosis, lymphoma and blastic metastasis, paget disease ,fluorosis and mastocytosis are in DDX)
- Hepatosplenomegally (due to extramedulary hematopoisis?)

Colonoscopy

1392.03.02

Normal



Abdominopelvic CT scan with contrast

1392.05.09

- Liver and spleen are enlarged (liver span=210mm and spleen span=190mm)
- Density of bone is increased diffusely with no bone expansion

IMP :

Diffuse osteosclerosis (myelofibrosis, is the first DDX due to presence of hepatosplenomegally however renal osteodystrophy, hyperthyroidism, hypoparathyroidism, osteopetrosis, lymphoma and blastic metastasis, paget disease, fluorosis and mastocytosis are in DDX)

Hepatosplenomegally (due to extramedulary hematopoisis?)

Name:	R.Mojodi	Date:	92/05/09
Age:	45	No:	54157

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• History:
-

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- Hepatosplenomegally (due to extramedulary hematopoisis?)

Abdominopelvic C.T Scan with & without contrast
(pancreas protocol)
1393.02.06

Liver size is increased (=182mm) with no space occupying lesion.

Mild dilatation of intrahepatic biliary ducts is seen.

Diameter of main portal vein is increased up to 17mm (portal hypertension?)

Spleen size in marked increased (=180mm in span) with no SOL

Also marked pancreatic head LAPS with 30*20mm measurement is noted. but no evidence of Sol in pancreas is present.

Para-aortic LAPS with 11mm in maximum short axis is noted.

Also multiple mesenteric LAPS with up to 8mm short axis in mesentery of jejuna loops are seen.

Also generalized increased bone density with permeative pattern is noted (DDX: myelofibrosis, metastatic infiltration, fluorosis, ...).

IMP: Hepatosplenomegaly associated with multiple mesenteric and retroperitoneal LAPS and also increased generalized bony density

DDX: Myeloproliferative as myelofibrosis and leukemia and lymphoproliferative as lymphoma should be considered.

Abdominopelvic M.D.C.T Scan with & without contrast(pancreas protocol):

- *Multisection / Multiplanar study reveal:*
- *Liver size is increased (=182mm) with no space occupying lesion .*
- *Mild dilatation of intrahepatic biliary ducts is seen.*
- *Diameter of main portal vein is increased up to 17mm (portal hypertension?)*
- *Spleen size in marked increased (=180mm in span) with no SOL*
- *Also marked pancreatic head LAPs with 30*20mm measurement is noted. but no evidence of Sol in pancreas is present.*
- *The kidneys are well opacified with normal nephrogram.*
- *Both adrenal glands are normal.*
- *Para-aortic LAPs with 11mm in maximum short axis is noted.*
- *Also multiple mesenteric LAPs with up to 8mm short axis in mesentery of jejuna loops are seen.*
- *There is no abdominopelvic free fluid .*
- *Pelvic organs are normal.*
- *Also generalized increased bone density with permeative pattern is noted (DDX: myelofibrosis, metastatic infiltration , fluorosis,...).*

IMP: *Hepatosplenomegally associated with multiple mesenteric and retroperitoneal LAPs and also increased generalized bony density*

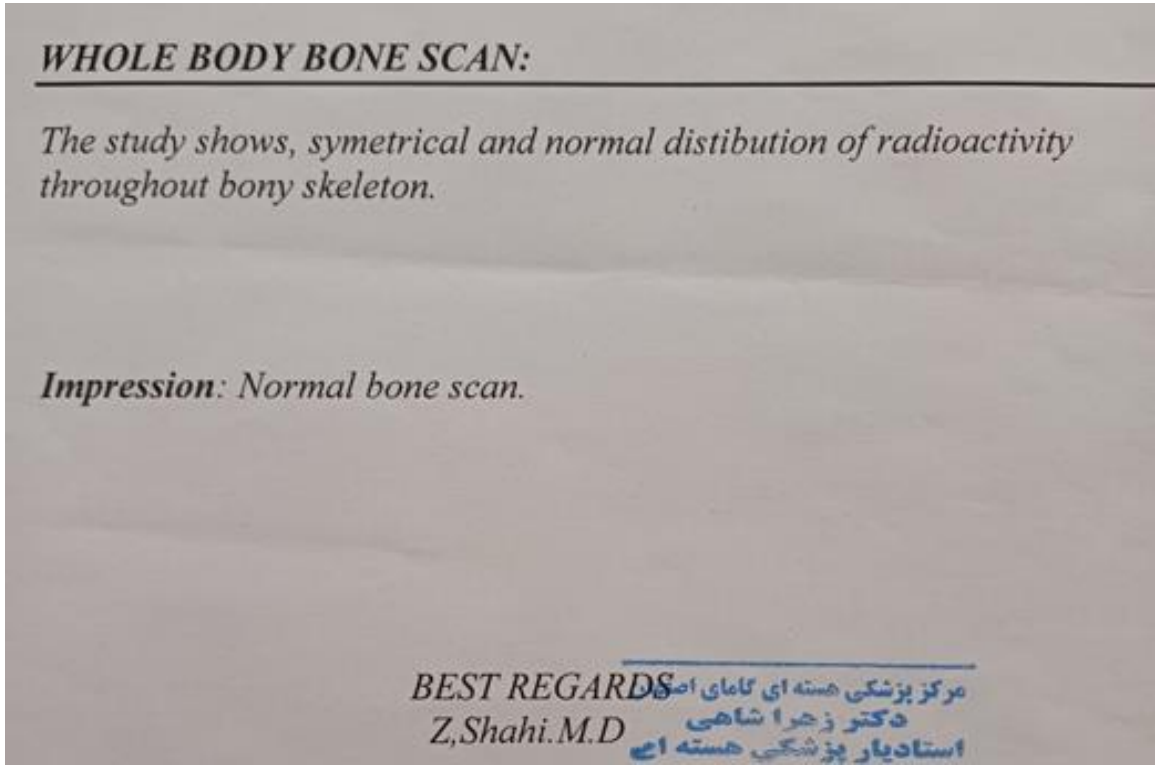
DDX: *Myeloproliferative as myelofibrosis and leukemia and lymphoproliferative as lymphoma should be considered.*

WHOLE BODY BONE SCAN

1393.02.20

symmetrical and normal distribution of radioactivity throughout bony skeleton.

Impression: Normal bone scan



WHOLE BODY BONE SCAN:

The study shows, symetrical and normal distibution of radioactivity throughout bony skeleton.

***Impression**: Normal bone scan.*

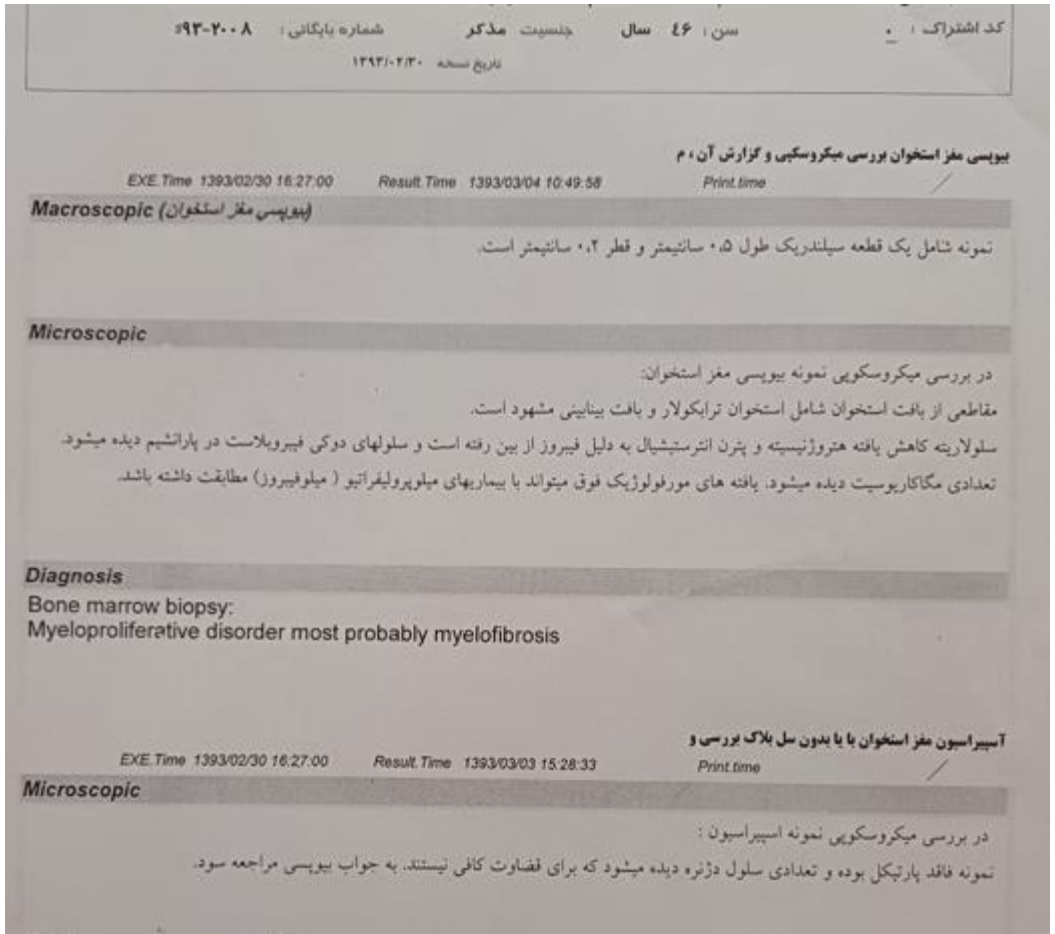
BEST REGARDS
Z,Shahi.M.D

مرکز پزشکی هسته ای کامای اصف
دکتر زهرا شاهی
استادیار پزشکی هسته ای

Pathology of BMB

1393.02.30

Myeloproliferative disorder most probably myelofibrosis



کد اشتراک : . سن : ۴۶ سال جنسیت مذکر شماره بایگانی : ۹۳-۲۰۰۸
تاریخ نسخه ۱۳۹۳/۰۲/۳۰

بیوپسی مغز استخوان بررسی میکروسکپی و گزارش آن ، م

EXE.Time 1393/02/30 16:27:00 Result.Time 1393/03/04 10:49:58 Print.time

Macroscopic (بیوپسی مغز استخوان)

نمونه شامل یک قطعه سیلندریک طول ۰،۵ سانتیمتر و قطر ۰،۲ سانتیمتر است.

Microscopic

در بررسی میکروسکوپی نمونه بیوپسی مغز استخوان:
مقاطعی از بافت استخوان شامل استخوان ترابکولار و بافت بینابینی مشهود است.
سلولاریته کاهش یافته هتروژنیسیته و پترن انترستیشال به دلیل فیبروز از بین رفته است و سلولهای دوکی فیبروبلاست در پارانشیم دیده میشود.
تعدادی مگاکاریوسیت دیده میشود. یافته های مورفولوژیک فوق میتواند با بیماریهای میلوپرولیفراتیو (میلوفیبروز) مطابقت داشته باشد.

Diagnosis

Bone marrow biopsy:
Myeloproliferative disorder most probably myelofibrosis

آسپیراسیون مغز استخوان با یا بدون سل بلاک بررسی و

EXE.Time 1393/02/30 16:27:00 Result.Time 1393/03/03 15:28:33 Print.time

Microscopic

در بررسی میکروسکوپی نمونه اسپیراسیون :
نمونه فاقد پارتیکل بوده و تعدادی سلول دژنره دیده میشود که برای قضاوت کافی نیستند. به جواب بیوپسی مراجعه شود.

Lab Data

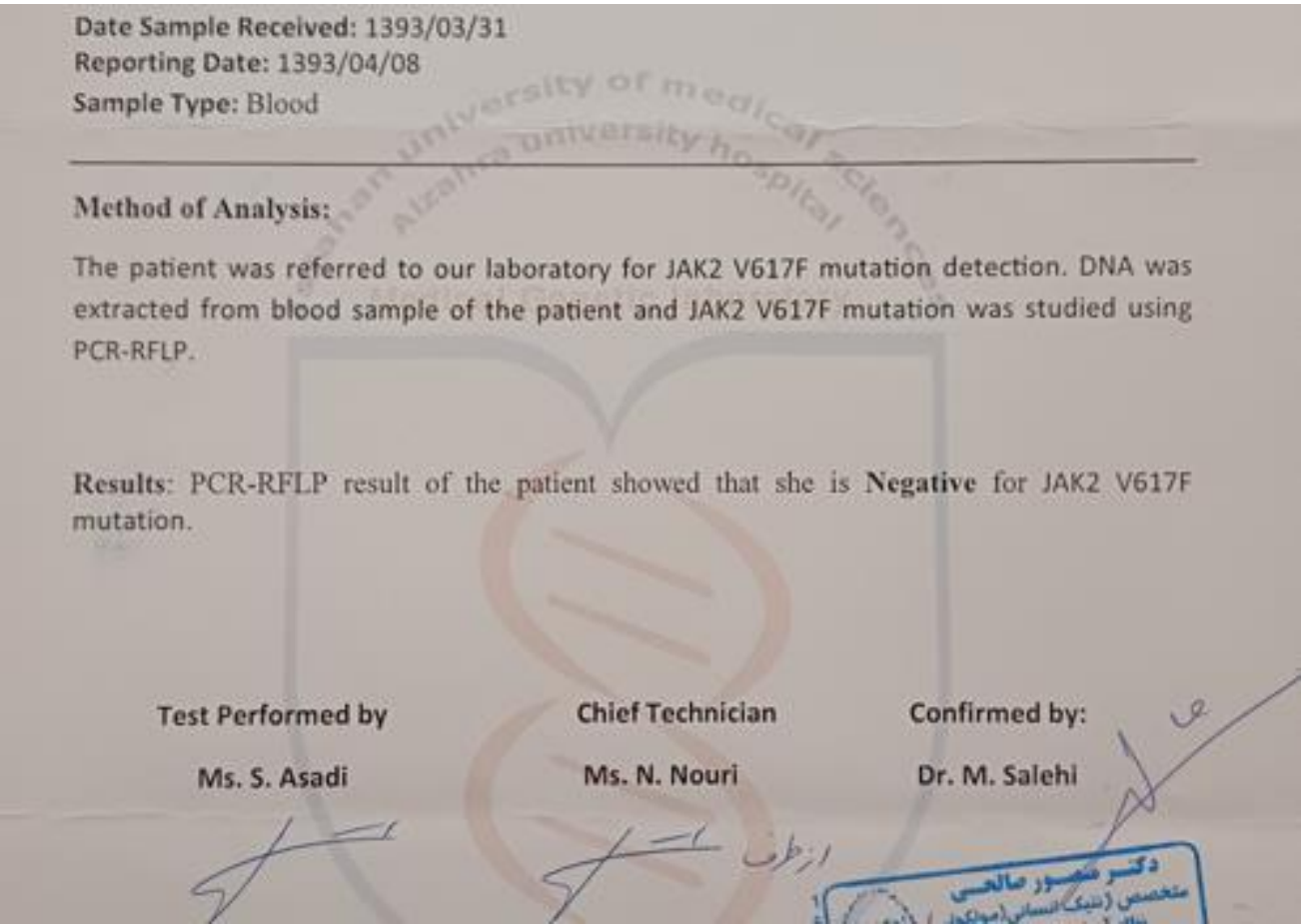
1393.03.19

Ca 9	Billi.T 0.9	BUN 25
Phos 3.5	Billi.D 0.2	CR 1
VitD 7.6	AST 11	
PTH Intact 41	ALT 22	
LDH 165	**ALK 700**	

Molecular analysis report for Philadelphia chromosome (mbcr-abl)

1393.04.08

Negative



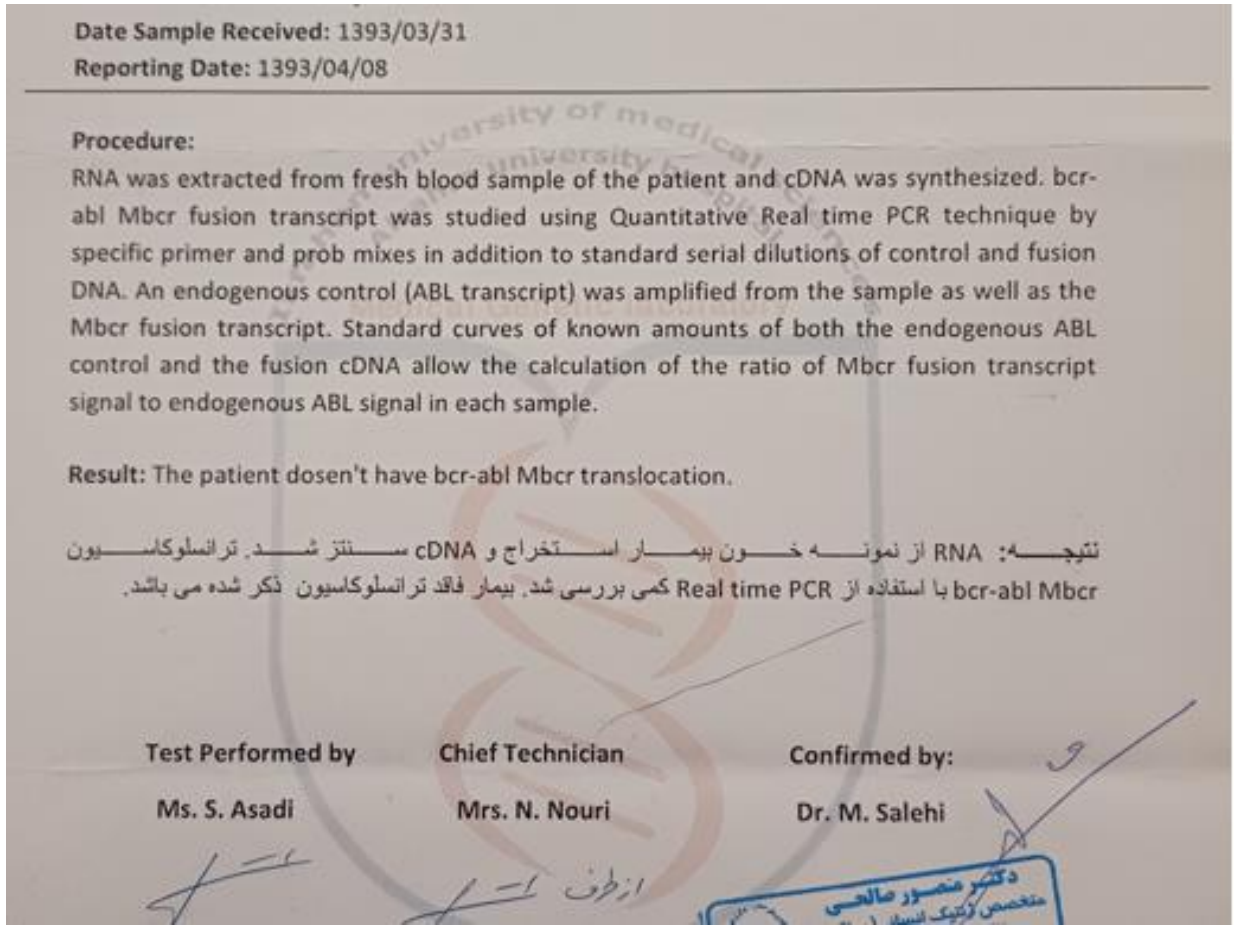
Date Sample Received: 1393/03/31
Reporting Date: 1393/04/08
Sample Type: Blood

Method of Analysis:

The patient was referred to our laboratory for JAK2 V617F mutation detection. DNA was extracted from blood sample of the patient and JAK2 V617F mutation was studied using PCR-RFLP.

Results: PCR-RFLP result of the patient showed that she is **Negative** for JAK2 V617F mutation.

Test Performed by	Chief Technician	Confirmed by:
Ms. S. Asadi	Ms. N. Nouri	Dr. M. Salehi



Date Sample Received: 1393/03/31
Reporting Date: 1393/04/08

Procedure:
RNA was extracted from fresh blood sample of the patient and cDNA was synthesized. bcr-abl Mbcr fusion transcript was studied using Quantitative Real time PCR technique by specific primer and prob mixes in addition to standard serial dilutions of control and fusion DNA. An endogenous control (ABL transcript) was amplified from the sample as well as the Mbcr fusion transcript. Standard curves of known amounts of both the endogenous ABL control and the fusion cDNA allow the calculation of the ratio of Mbcr fusion transcript signal to endogenous ABL signal in each sample.

Result: The patient dosen't have bcr-abl Mbcr translocation.

نتیجه: RNA از نمونه خون بیمار استخراج و cDNA سنتز شد. ترانسلوکاسیون bcr-abl Mbcr با استفاده از Real time PCR کمی بررسی شد. بیمار فاقد ترانسلوکاسیون ذکر شده می باشد.

Test Performed by	Chief Technician	Confirmed by:
Ms. S. Asadi	Mrs. N. Nouri	Dr. M. Salehi

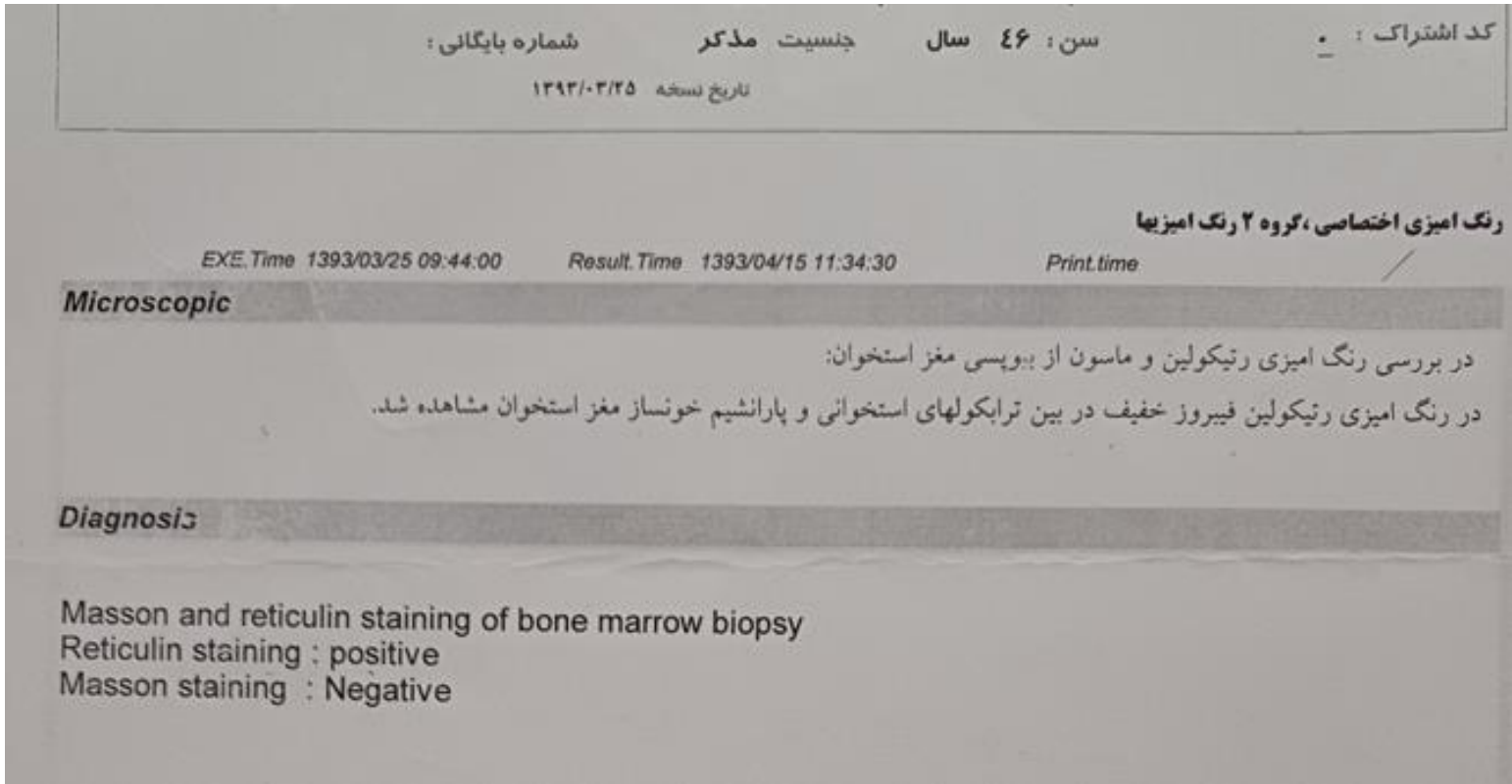
Masson and reticulin staining of bone marrow biopsy

1393.04.15

Reticulin staining showed mild fibrosis between bone trabeculae and bone marrow hematopoietic parenchyma.

Reticulin staining: **positive**

Masson staining : **Negative**



کد اشتراک : . سن : ۴۶ سال جنسیت مذکر شماره بایگانی :

تاریخ نسخه ۱۳۹۳/۰۳/۲۵

رنگ امیزی اختصاصی ،گروه ۲ رنگ امیزیها

EXE.Time 1393/03/25 09:44:00 Result.Time 1393/04/15 11:34:30 Print.time

Microscopic

در بررسی رنگ امیزی رتیکولین و ماسون از بیوپسی مغز استخوان:

در رنگ امیزی رتیکولین فیبروز خفیف در بین ترابکولهای استخوانی و پارانشیم خونساز مغز استخوان مشاهده شد.

Diagnosis

Masson and reticulin staining of bone marrow biopsy
Reticulin staining : positive
Masson staining : Negative

Endoscopy

1393.05.26

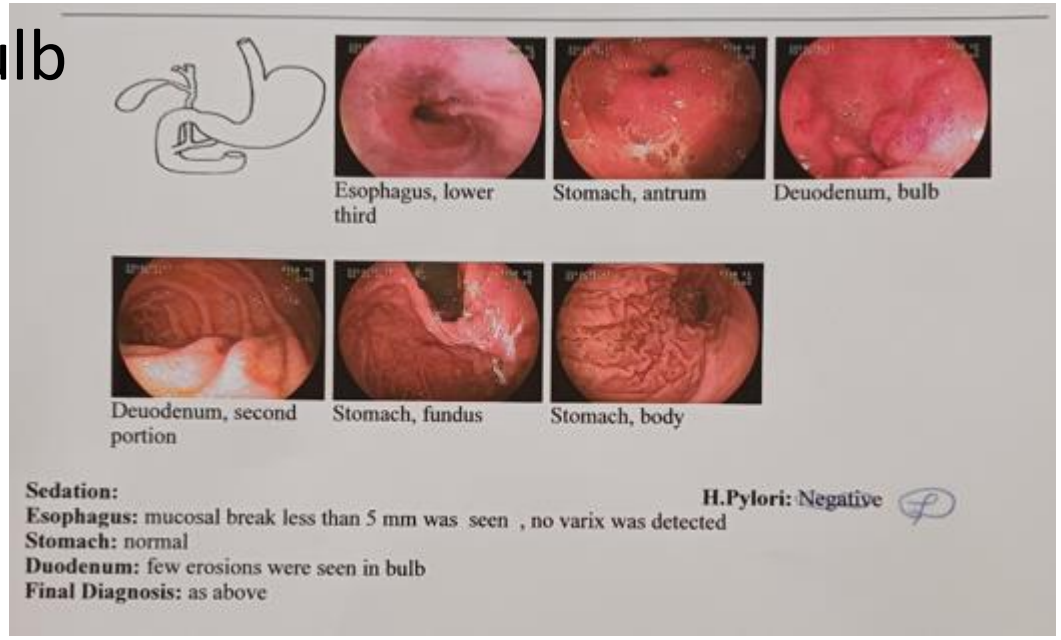
H.Pylori: Negative

Esophagus: mucosal break less than 5 mm was seen, no varix was detected

Stomach: normal

Duodenum: few erosions were seen in bulb

Final Diagnosis: as above

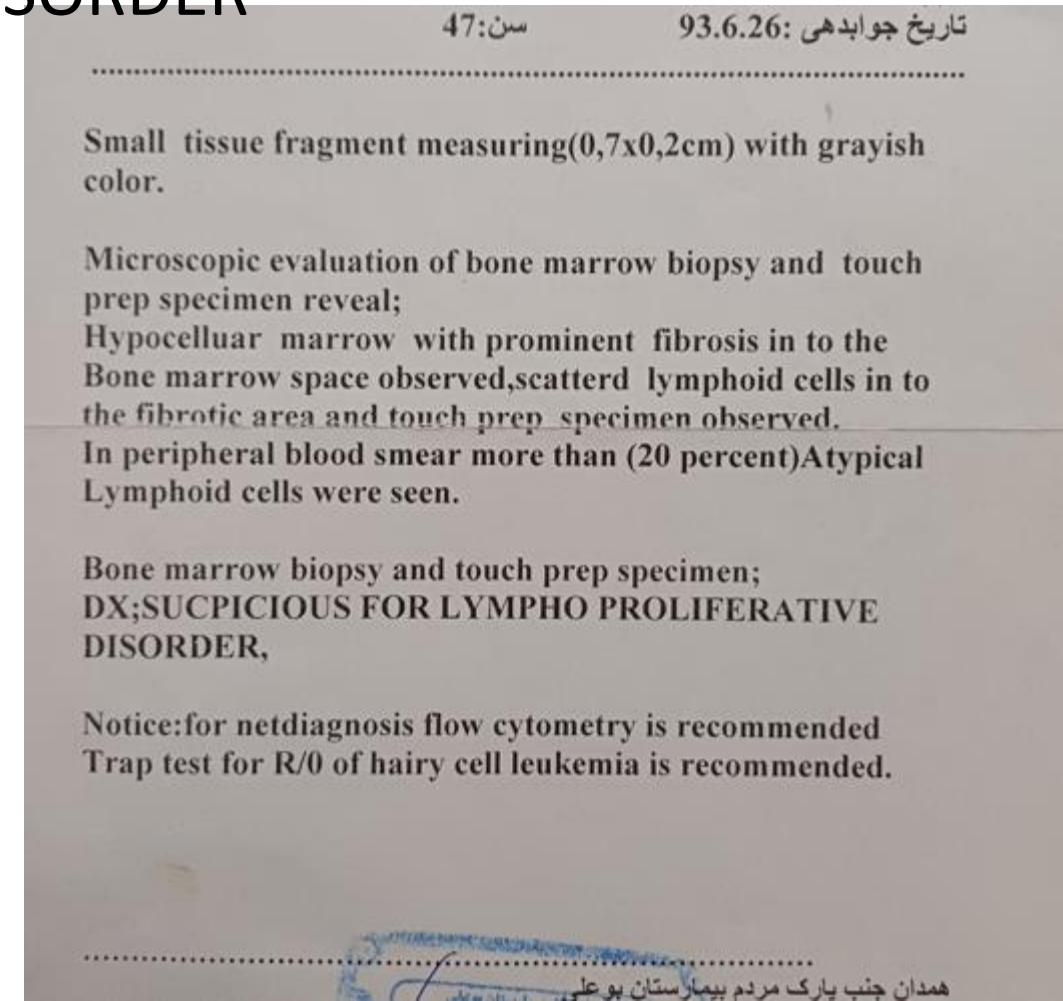


Pathology of BMB

1393.06.26

SUCPICIOUS FOR LYMPHOPROLYFRATIVE DISORDER

For netdiagnosis flow cytometry is recommended



تاریخ جوابدهی :93.6.26 سن:47

Small tissue fragment measuring(0,7x0,2cm) with grayish color.

Microscopic evaluation of bone marrow biopsy and touch prep specimen reveal;
Hypocelluar marrow with prominent fibrosis in to the Bone marrow space observed,scatterd lymphoid cells in to the fibrotic area and touch prep specimen observed.
In peripheral blood smear more than (20 percent)Atypical Lymphoid cells were seen.

Bone marrow biopsy and touch prep specimen;
DX;SUCPICIOUS FOR LYMPHO PROLIFERATIVE DISORDER,

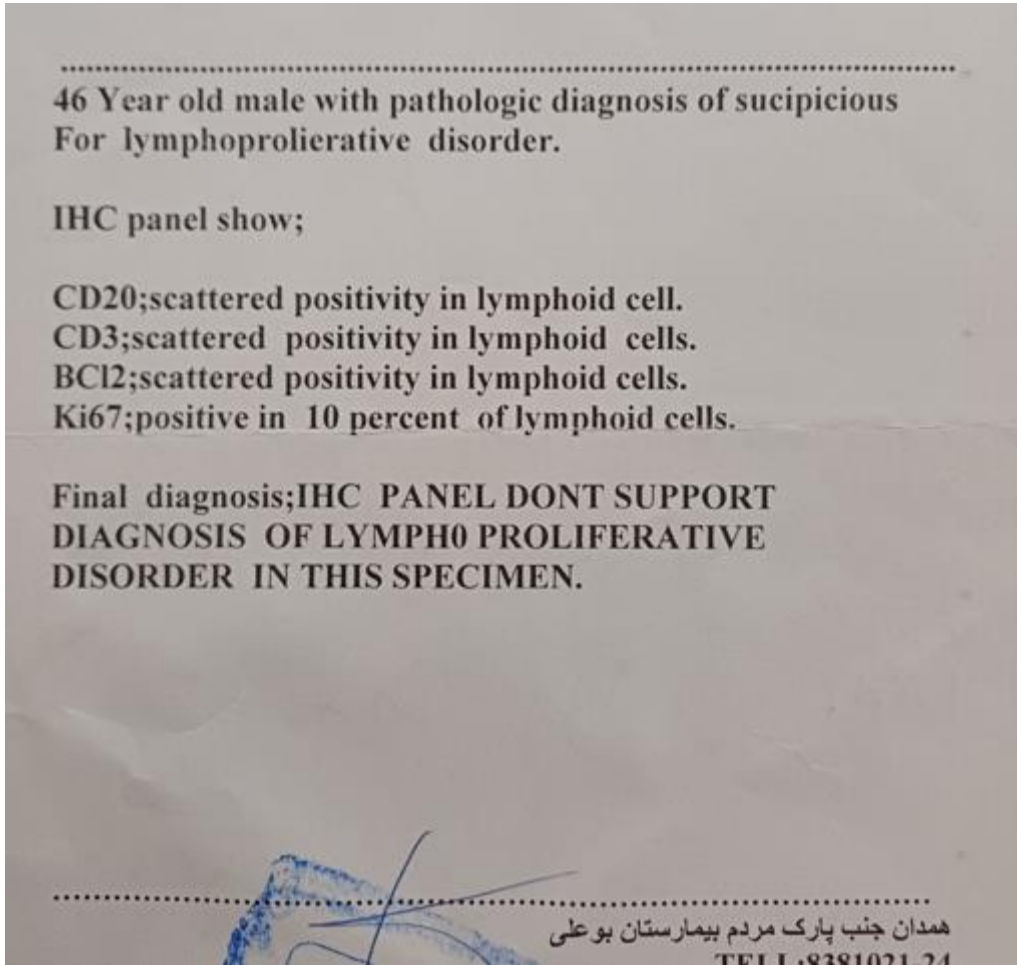
Notice:for netdiagnosis flow cytometry is recommended
Trap test for R/0 of hairy cell leukemia is recommended.

همدان جنب پارک مردم بیمارستان بوعلی

flow cytometry

1393.06.26

IHC panel <u>don't support diagnosis of LYMPHOPROLIFERATIVE disorder</u>



46 Year old male with pathologic diagnosis of sucipicious
For lymphoprolierative disorder.

IHC panel show;

CD20;scattered positivity in lymphoid cell.
CD3;scattered positivity in lymphoid cells.
BCl2;scattered positivity in lymphoid cells.
Ki67;positive in 10 percent of lymphoid cells.

Final diagnosis;IHC PANEL DONT SUPPORT
DIAGNOSIS OF LYMPH0 PROLIFERATIVE
DISORDER IN THIS SPECIMEN.

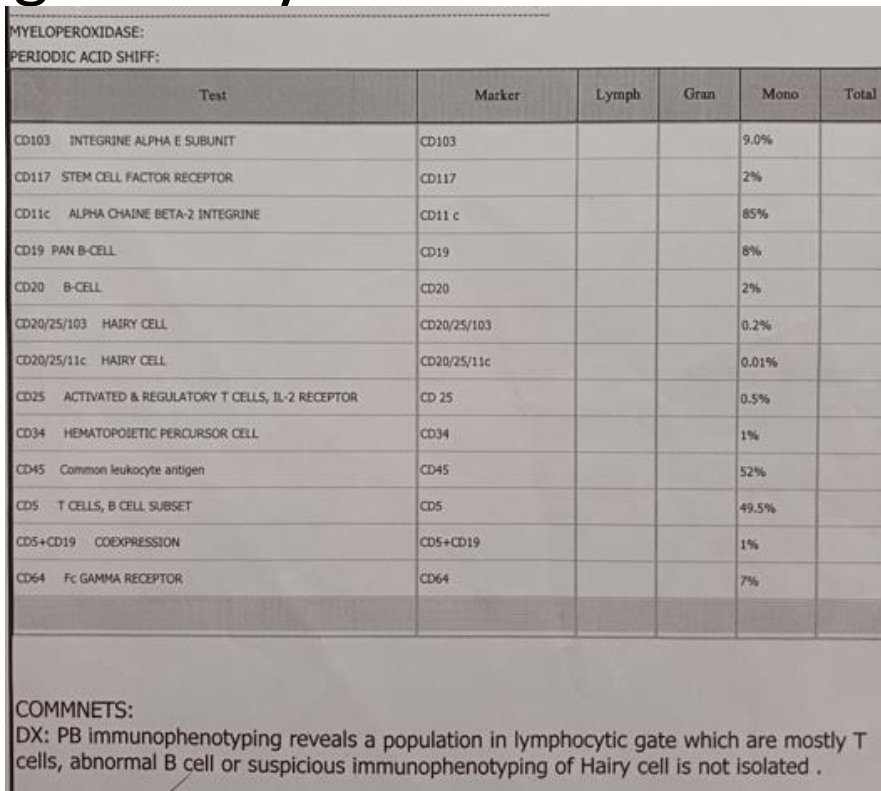
همدان جنب پارک مردم بیمارستان بوعلی

FIOWCYTOMETRTY

1393.07.22

PB immunophenotyping reveals a population in lymphocytic gate which are mostly T cells,

abnormal B cell or suspicious immunophenotyping of Hairy cell is not isolated.



MYELOPEROXIDASE:
PERIODIC ACID SHIFF:

Test	Marker	Lymph	Gran	Mono	Total
CD103 INTEGRINE ALPHA E SUBUNIT	CD103			9.0%	
CD117 STEM CELL FACTOR RECEPTOR	CD117			2%	
CD11c ALPHA CHAINE BETA-2 INTEGRINE	CD11 c			85%	
CD19 PAN B-CELL	CD19			8%	
CD20 B-CELL	CD20			2%	
CD20/25/103 HAIRY CELL	CD20/25/103			0.2%	
CD20/25/11c HAIRY CELL	CD20/25/11c			0.01%	
CD25 ACTIVATED & REGULATORY T CELLS, IL-2 RECEPTOR	CD 25			0.5%	
CD34 HEMATOPOIETIC PERCURSOR CELL	CD34			1%	
CD45 Common leukocyte antigen	CD45			52%	
CD5 T CELLS, B CELL SUBSET	CD5			49.5%	
CD5+CD19 COEXPRESSION	CD5+CD19			1%	
CD64 Fc GAMMA RECEPTOR	CD64			7%	

COMMNETS:
DX: PB immunophenotyping reveals a population in lymphocytic gate which are mostly T cells, abnormal B cell or suspicious immunophenotyping of Hairy cell is not isolated .

Abdominopelvic Sonography

1394.03.16

- The liver is observed with an increase in size and echogenicity (Grade II) and with a brief coarsening of the parenchyma.
- Portal vein with a diameter of 15 mm was observed.
- The hepatic and suprahepatic vascular system is normal.
- The gallbladder and intrahepatic and extrahepatic bile ducts are normal.
- The pancreas has a normal size and echogenicity, **but a space-occupying hypoechoic lesion with a size of 21x10 mm was observed between the head and the body of the pancreas.**
- The size of the spleen was observed with a length of 171 mm.
- There was no sign of space-occupying lesion and adenopathy in the para-aortic area
- Kidneys have normal size and echogenicity.
- There was no sign of space-occupying lesion, urinary stasis, or acoustic shadow caused by stones.
- There was no trace of ascites in the abdomen.
- The bladder was found to have a normal volume and wall thickness and no space-occupying mass.
- Prostate with a size of 40*30*41 mm with a volume of 37, normal shape and echo ptteran, no calcification was observed in it.

کبد با افزایش اندازه و اکوژنیسیته (Grade II) و با مختصر Coarse شدن پارانشیم مشاهده میشود .

ورید پورت باقطر 15 mm مشاهده گردید .

سیستم عروق کبد و فوق کبدی طبیعی است .

کیسه صفرا و مجاری صفراوی داخل وخارج کبدی طبیعی است .

پانکراس دارای اندازه و اکوژنیسته طبیعی می باشد ولی درحدفاصل سر وبادی پانکراس ضایعه فضاگیرهیپواکوئی بااندازه 21*10 mm مشاهده شد .

بزرگی طحال با طول 171 mm مشاهده شد .

اثری از ضایعه فضاگیر و ادنوپاتی در ناحیه پاراآئورتیک مشاهده نشد .

کلیه ها دارای اندازه، شکل و اکوژنیستی طبیعی می باشند .

اثری از ضایعه فضاگیر ، استاز ادراری و یا سایه صوتی ناشی از سنگ در آنها مشاهده نشد .

اثری از آسیت در شکم مشاهده نشد .

مثانه دارای حجم و ضخامت جدارطبیعی و بدون توده فضاگیرمشاهده شد .

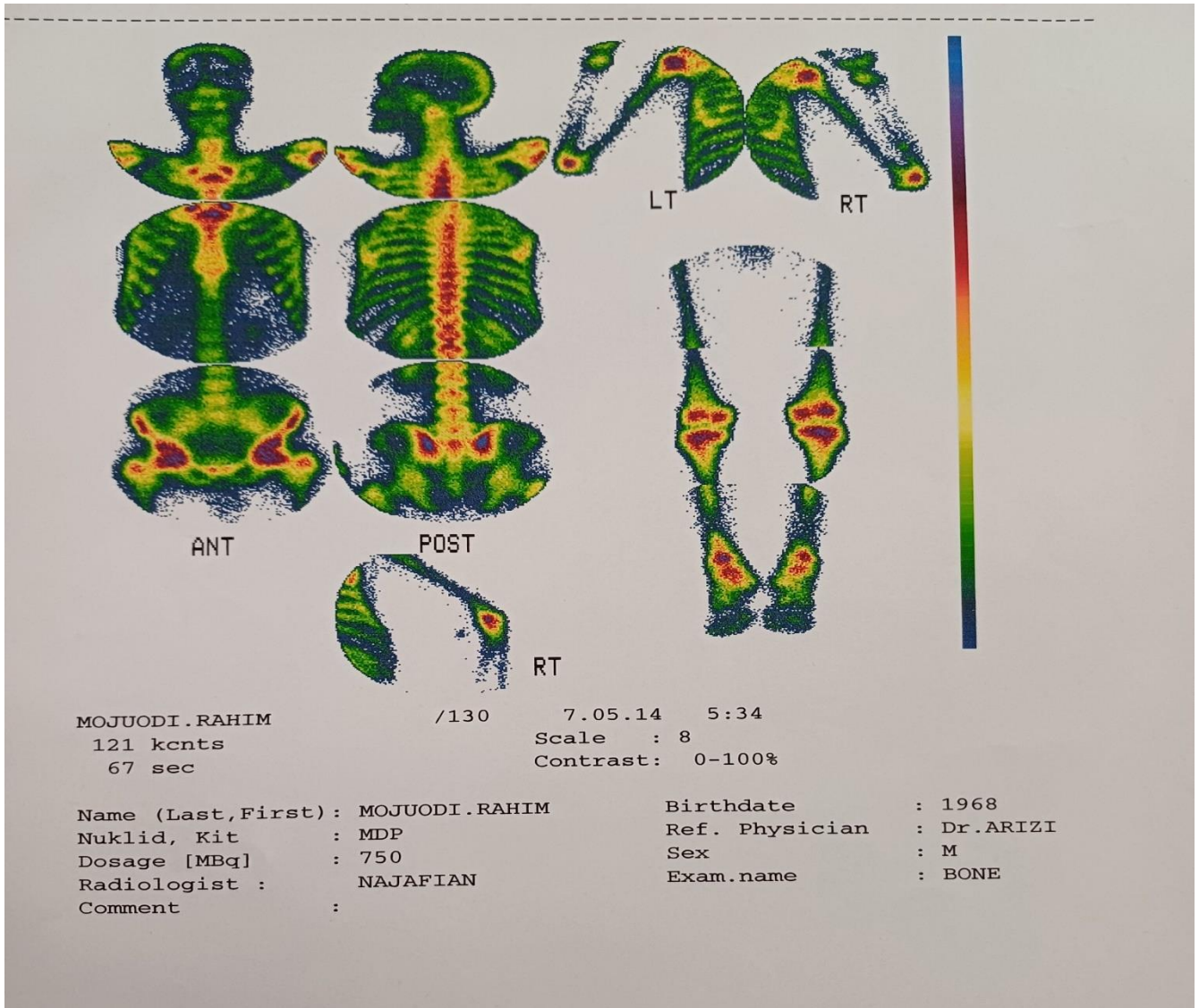
پروستات با اندازه 40*30*41 mm با حجم 37 cc ، شکل و اکوپترن طبیعی ، کلسیفیکاسیون در آن مشاهده نشد .

Lab Data

1395.05.16

WBC 4.9	PT 13	ANA 2.5	FBS 98
NEU 51% LYM 40%	**PTT 50**	AMA 0.7	BUN 29
RBC 4.3	INR 1	AFP 2.3	CR 1
HB 12.3	AST 10	IgG 8.5	Estimating G.F.R 89
HCT 38	ALT 16	**GGT 122**	TG 167
MCV 90	**ALK 741**	ESR 22	CHOL 172
MCH 28	Billi.T 0.9		HDL 26
PLT 168	Billi.D 0.2		LDL 85
			LDL/HDL 3

1397.05.14


LT
RT
ANT
POST
RT
MOJUODI.RAHIM
121 kcnts
67 sec
/130
7.05.14 5:34
Scale : 8
Contrast: 0-100%
Name (Last,First): MOJUODI.RAHIM
Nuklid, Kit : MDP
Dosage [MBq] : 750
Radiologist : NAJAFIAN
Comment :
Birthdate : 1968
Ref. Physician : Dr.ARIZI
Sex : M
Exam.name : BONE

Abdominopelvic M.D.C.T Scan with contrast

1398.03.09

Liver span is about: 207 mm / Spleen span is adont : 202 mm.

Hypodense hepatic mass measuring 13 mm is seen in right hepatic lobe further evaluation with triphasic CT scan is recommended.

A isodense lesion to pancreas measuring 16*16 mm the same as previous study..

Some paraaortic and mesenteric LAPS with short axis diameter up to 10 mm is noticed.

Increased bone density is noted. Representing bone marrow infiltration compatible with the diagnosis of myelofibrosis.

IMP: Hepatic lesion (further evaluation is recommended)

Hepatosplenomegaly

Paraaortic and mesenteric LAPS

Increased bone density

ALZAHRA MEDICAL CENTER
C.T. Scaning 64 slice Department
مرکز آموزشی درمانی الزهرا (س)
سی تی اسکن مولتی ۶۴ اسلایس

Name: Rahim Mojodi

Date: 98/3/9

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

- *Multisection / Multiplanar study reveal:*
- *Hpatosplenomegaly is noticed.*
- *Liver span is about : 207 mm*
- *Spleen span is adont : 202 mm .*
- *There is no abdominopelvic free fluid .*
- *Hypodense hepatic mass measuring 13 mm is seen in right hepatic lobe .further evaluation with triphasic CT scan is recommended.*
- *A isodense lesion to pancreas measuring 16*16 mm the same as previous study. .*
- *The kidneys are well opacified with normal nephrogram.*
- *Both adrenal glands are normal.*
- *Pelvic organs are normal.*
- *Some paraaortic and mesenteric LAPs with short axis diameter up to 10 mm is noticed.*
- *Increased bone density is noted. Representing bone marrow infiltration compatible with the diagnosis of myelofibrosis .*

IMP : *Hepatic lesion (further evaluation is recommended)*

Hepatosplenomegaly

Paraaortic and mesenteric LAPs

Increased bone density

Best regards
A. Adibi.MD

دکتر توسا ادیبی
متخصص رادیولوژی
استاد دانشکده پزشکی
نظام پزشکی: ۱۵۵۱

Resident
Dr. Kardanpour

Abdominopelvic Sonography

1402.02.17

In the center of the right lobe, a hyperecho-solid spot with a diameter of 18 mm can be seen, which, although hemangioma is the most likely, it is recommended to follow it up with a CT scan or MRI.

The liver is hyperechoic (grade 1 fatty liver).

There is a stone with a diameter of 3 mm in both sides of the middle calyx, which does not explain the patient's pain

Spleen slightly larger than normal (splenomegaly: 70x140mm)

Heterogeneous prostate with larger than normal volume and dimensions.

Abdominopelvic M.D.C.T scan with contrast

1402.02.30

- Hepatosplenomegaly (liver span=207 and spleen span=202)
- Hypodense lesion with peripheral nodule enhancement in size of 20*13mm in 6^{th} segment of liver
- Some mesenteric LAPs with short axis diameter up to 12mm
- Diffuse bone marrow infiltration
- Prostate is enlarged

IMP: Liver Hemangioma , Hepatosplenomegaly , mesenteric LAPs , bone marrow infiltration

MRCP

1402.04.17

- Hepatosplenomegaly
- Slight diffuse low signal intensity of splenic parenchyma
- There is some pressure effect on common hepatic duct and proximal CBD , due to a low signal intensity fibrous in portohepatic around pancreatic head and around celiac trunk
- This fibrous tissue is also visible alongside periportal space , also alongside main lobar fissure
- Small hemangioma of 15mm at intersegment 7 and 8
- Fibrous tissue in retroperitoneal space and extends to precaval region

Hepatosplenomegaly is demonstrable .

There is slight diffuse low signal intensity of splenic parenchyma , which needs correlation with patient's history and lab data , regarding any kind of bloody dyscrasia , as conditions like Myelofibrosis .

Central and peripheral intrahepatic ducts are in normal in diameter with smooth course without any evidence of PSC or PBC .

CBD has a maximum diameter of about 7mm with normal distal tapering without any stone or sludge .

There is some pressure effect on common hepatic duct and proximal CBD , due to a low signal intensity fibrous tissue in portahepatis around pancreatic head and around celiac trunk .

This fibrous tissue is also visible alongside periportal space , also alongside main lobar fissure .

I highly recommend to refer patient to me for CT study of abdomen and pelvis , because this abnormal fibrous tissue maybe suggestive for retroperitoneal fibrosis , however I need to review IV oral contrast enhanced CT study of the patient .

(continue to the next page)

Small hemangioma of 15mm at intersegment 7 and 8 , has no clinical significance .

Typical changes related to cirrhosis are absent .

As I mentioned there is no evidence of PBC or PSC .

Pancreas , main pancreatic duct are normal ***however as I mentioned there is significant fibrous tissue in retroperitoneal space , which I need to correlate with CT study and if indicated performing CT guided core needle biopsy .***

This fibrous tissue extends to precaval region .

Lab Data

1402.07.09

WBC 5.4	FBS 105	Ca 9.8	AST 18	TSH 1.7
RBC 4.6	BUN 26	Phos 3.3	ALT 21	PSA 0.6
HB 14.5	CR 0.9	Na 137	**ALP 599**	CEA 0.6
MCV 92	CHOL 172	K 4.8	Alb 4.8	CA19-9 5.8
MCH 31	TG 188		**GGT 143**	AMA 0.3
MCHC 34	HDL 37		E.G.F.R 93	Occult blood Neg
PLT 230	LDL 97			
NEU:57% LYM:35%	**VLDL 38**			

Molecular analysis report for JAK2 MUTATION: Negative

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:
- According to the presence of the lymph node, a biopsy is recommended to determine the source of the fibrosis.
- Ig G4 level should be checked to R/O related diseases.
- Colonoscopy was recommended to rule out IBD.

A 66-year-old female

- patient who has had abdominal bloating and symptoms of nausea and vomiting with anorexia since 2 years ago.
- So that in the time frame of 2-3 months, he lost about 30 kg of weight. After that, he was diagnosed with GOO and treated.
- Currently, due to a suspicious abdominal mass, it has been introduced to this commission for a diagnostic-therapeutic approach:

DH:

- Losartan 25 mg qhs
- Gabapentin 100 mg qhs
- ursodeoxycholic acid qhs
- Ropixone 20 mg qhs
- Osvix 75 mg in the morning
- Ferrofort daily
- Chlordiazepoxide qhs
- Nolpaza 40 mg morning and night
- Domperidone before each meal

- PMH: heart problems

Abdominopelvic sonography

1401.01.31

- Liver parenchyma echo is increased, fat infiltration grade (1). No spacer lesion was seen.
- Intrahepatic and extrahepatic bile ducts have a normal diameter. The gallbladder is well dilated, the wall thickness is normal, no stones or sludge were seen.
- The stomach is distended and contains gas and food.
- Intestinal loops were observed between the liver and the diaphragm (interposition of the colon).
- A 1 cm fascial defect was seen along with omentum fat herniation and intestinal loops in the epigastric area.
- The spleen has normal dimensions and parenchymal echogenicity,(34 x 88 mm), no space-occupying mass was seen
- Pancreas of normal dimensions and echogenicity. No space-occupying lesion was seen.
- The dimensions of the kidneys are in lower limits of normal, the right kidney is 89 mm and the left kidney is 91 mm. Echogenicity of the parenchyma is normal, corticomedullary differentiation is preserved. The thickness of the cortex of the kidneys is normal. Several parapelvic cysts with a maximum diameter of 10 mm were seen in the left kidney.
- Mild diffuse hydronephrosis of the right kidney was seen.
- Calcification of abdominal aorta wall and common iliac artery was seen on both sides.
- The atrophied uterus measures 21-42 mm and the myometrium has homogeneous echogenicity.
- The endometrium is regular and 3 mm. No lesions were seen in the adnexa.

- ☑ اکوی پارانشیم کبد افزایش یافته میباشد. (اینفیلتراسیون چربی گرید ۱)
- ☑ ضایعه فضاگیر دیده نشد .
- ☑ مجاری صفراوی داخل و خارج کبدی قطر طبیعی دارند.
- ☑ کیسه صفرا به خوبی متسع بوده، ضخامت جداری نرمال دارد. سنگ و *sludge* دیده نشد.
- ☑ معده متسع و حاوی گاز و مواد غذایی میباشد .
- ☑ لوپ های روده ی بین کبد و دیافراگم مشاهده (اینترپوزیشن کولون)
- ☑ یک نقص فاسیای ۱ سانتی متری همراه با هرنیاسیون چربی اومنتوم و لوپ های روده ی در ناحیه اپی گاستر دیده شد.
- ☑ طحال ابعاد و اکوژنیسیته پارانشیمی نرمال دارد.(۳۴× ۸۸میلیمتر)توده فضاگیر دیده نشد.
- ☑ پانکراس ابعاد و اکوژنیسیته طبیعی دارد. ضایعه فضاگیر دیده نشد.
- ☑ ابعاد کلیه ها حداقل نرمال است (کلیه راست:۸۹میلیمتروکلیه چپ: ۹۱میلیمتر)،اکوژنیسیته پارانشیم نرمال است.افتراق کورتیکومدولاری حفظ شده است. ضخامت کورتکس کلیه ها نرمال می باشد .
- ☑ چند سیست پاراپلویک با حداکثر دیامتر ۱۰ میلیمتر در کلیه چپ دیده شد .
- ☑ هیدرونفروز خفیف منتشر کلیه راست دیده شد .
- ☑ لنفادنوپاتی پاراآئورت دیده نشد. مایع آسیت یا *collection* دیده نشد.
- ☑ کلسیفیکاسیون جدار آئورت شکمی و شرایین ایلیاک مشترک دو طرف دیده شد .
- ☑ مثانه ضخامت جداری نرمال دارد. سنگ و ضایعه فضاگیر دیده نشد.
- ☑ رحم آنتروفیه به ابعاد۲۱×۴۲میلیمتر بوده و میومتر دارای اکوژنیسیته هموژن میباشد.
- ☑ اندومتر منظم و ۳میلیمتر است.
- ☑ در آدنکس ها ضایعه ای دیده نشد .

Colonoscopy

1401.02.10

Reason for Endoscopy: Abdominal Distress Pain

Description of procedure:

Preparation : Poor

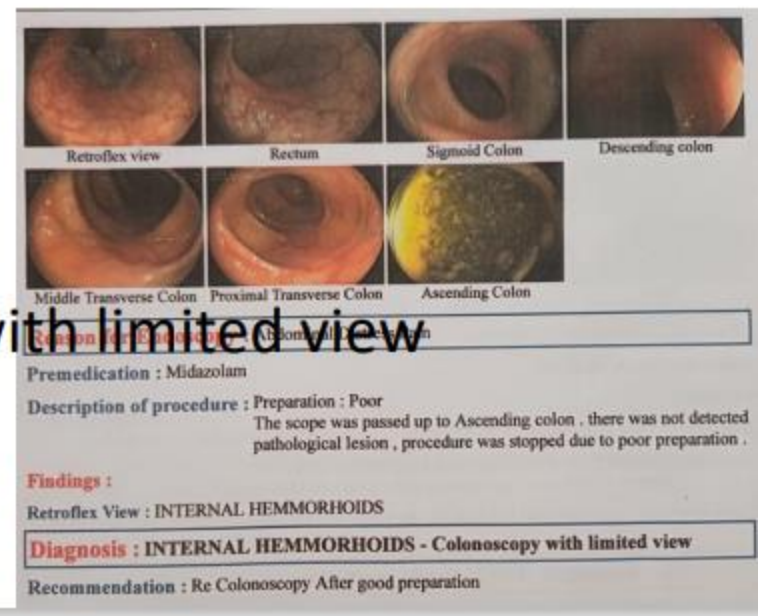
The scope was passed up to Ascending colon. there was not detected pathological lesion, procedure was stopped due to poor preparation.

Findings:

Retroflex View: INTERNAL HEMMORHOIDS

Diagnosis : INTERNAL HEMMORHOIDS - Colonoscopy with limited view

Recommendation : Re Colonoscopy After good preparation



Endoscopy

1401.02.10

Reason for Endoscopy: Vomiting

Esophagus: Were seen Multiple Linear Superficial Ulcer in Middle third and Lower third

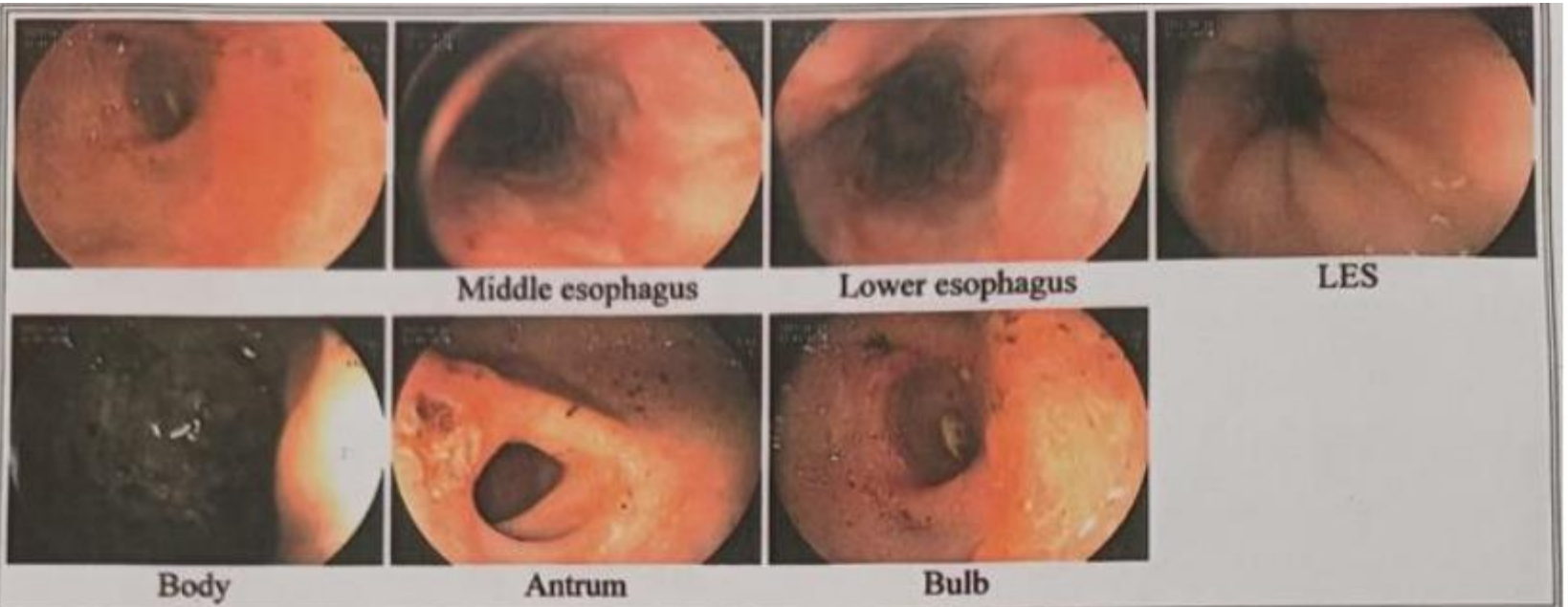
Stomach: Was seen a lot of food remnant in body and Fundus.

Antrum : Were seen Erythematous and a ulcer (10) in Prepyloric, Bx

Duodenum : D1: Erythematous and Erosion, the scope was not passed to D2 due to Severe sticture

Diagnosis: Esophagitis - GOO - Duodenopathy Erosive

Recommendation: Follow up the pathology - PPI - RE Endoscopy After One month



Reason for Endoscopy : Vomiting

Premedication : Midazolam

Findings :

Esophagus : Were seen Multiple Linear Superficial Ulcer in Middle third and Lower third

Stomach : Was seen a lot of food remnant in body and Fundus .
Antrum : Were seen Erythematous and a ulcer (10) in Prepyloric , Bx

Duodenum : D1 : Erythematous and Erosion , the scope was not passed to D2 due to Severe sticture

Diagnosis : Esophagitis - GOO - Duodenopathy Erosive

Recommendation : Follow up the pathology - PPI - RE Endoscopy After One month

Pathology

1401.02.10

Gastric biopsy:

Active chronic gastritis with regenerative hyperplasia & H.pylori infection (grade I/III).

Gross:

Received specimen is a tiny piece of cream tissue with elastic consistency measuring 3mm in diameter.

Microscopic:

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

Dx:- Gastric biopsy:

- Active chronic gastritis with regenerative hyperplasia & H.pylori infection (grade I/III).

CT SCAN STUDY OF ABDOMEN AND PELVIS WITH AND WITHOUT CONTRAST

1401/02/11

Liver: Normal / Bile ducts: Normal / Gall bladder: No calcified gallstones.

Pancreas: Normal. / Spleen: Normal. / Adrenals: Normal.

Kidneys and ureters: Normal. A stone in upper calyx of right kiney (8 mm) / Bladder:Normal.

Reproductive organs: Unremarkable..

Bowel: Normal caliber. Interposition of hepatic flexture of colon between liver and diaphragm.

Abdominal lymph nodes: No enlarged abdominal lymph nodes. / Pelvic lymph nodes: No enlarged pelvic lymph nodes.

Peritoneum : No ascites or free air .No fluid collection.

Vessels: Normal.

Retroperitoneum : Normal.

Abdominal wall: A defect in mildine in hypogastric region (18 mm) with herniation of omentum to abdominal wall

Bones: Bilateral spondylolysis with Spondylolisthesis of L5 over S1 (grade II).

Impression:

Right renal stone, abdominal wall henria in hypogastric region, Chiladiti syndrome

Bilateral spondylolysis with Spondylolisthesis of L5 over S1 grade II).

CT SCAN STUDY OF ABDOMEN AND PELVIS WITH AND WITHOUT CONTRAST

• Technique:
- Multiple axial images of the abdomen and pelvis from the lung bases to the ischial tuberosities are acquired before and after intravenous and oral contrast agent using 64 slice scaner. 5-mm contiguous axial images are reconstructed.

• Findings:
Liver : Normal
Bile ducts : Normal
Gall bladder: No calcified gallstones.
Pancreas: Normal.
Spleen: Normal.
Adrenals: Normal.
Kidneys and ureters : Normal. A stone in upper calyx of right kiney (8 mm).
Bladder:Normal.
Reproductive organs : Unremarkable..
Bowel: Normal caliber. Interposition of hepatic flexture of colon between liver and diaphragm.
Abdominal lymph nodes : No enlarged abdominal lymph nodes.
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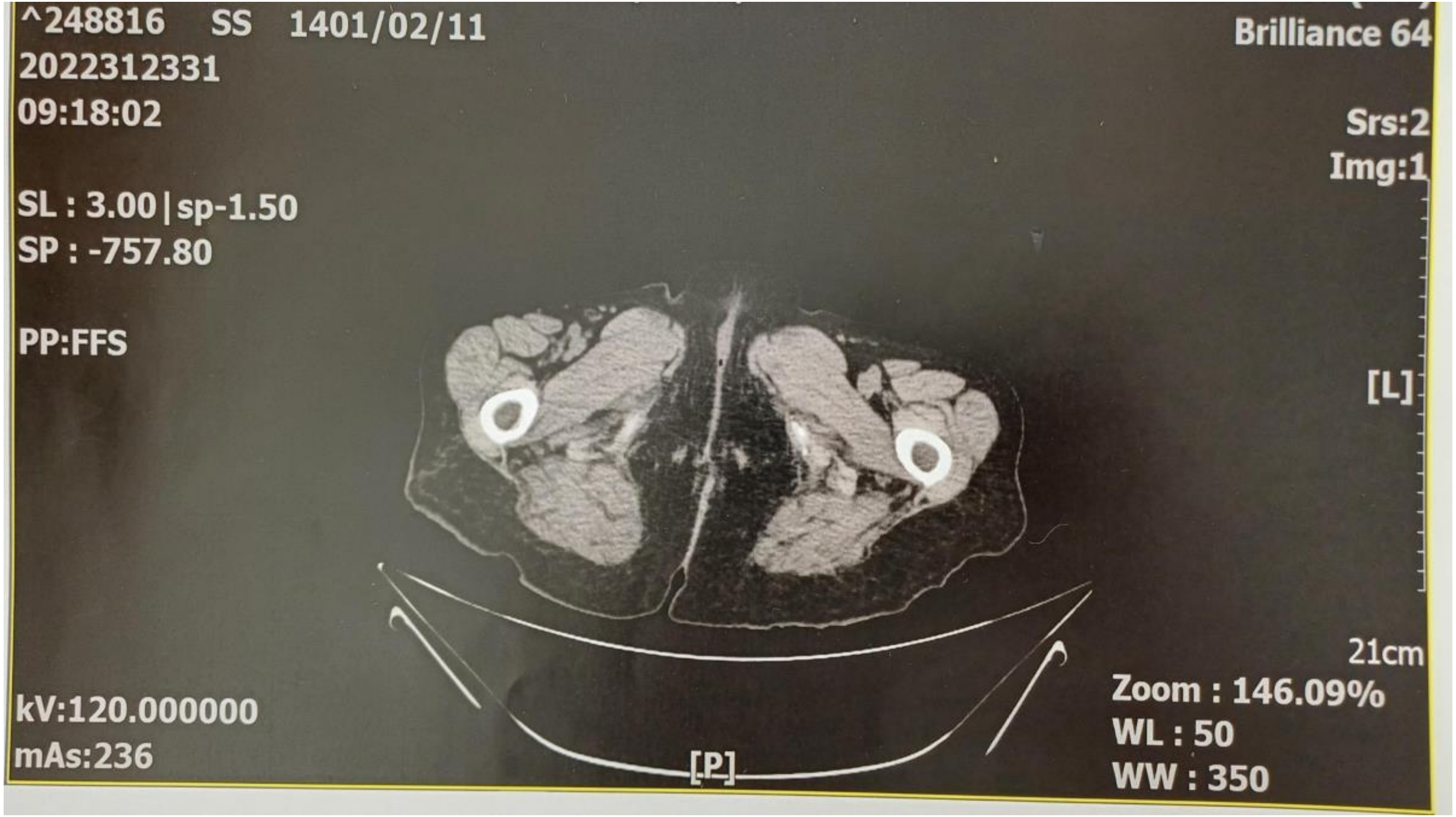
• Impression:
- Right renal stone, abdominal wall henria in hypogastric region, Chiladiti syndrome.
- Bilateral spondylolysis with Spondylolisthesis of L5 over S1 grade II).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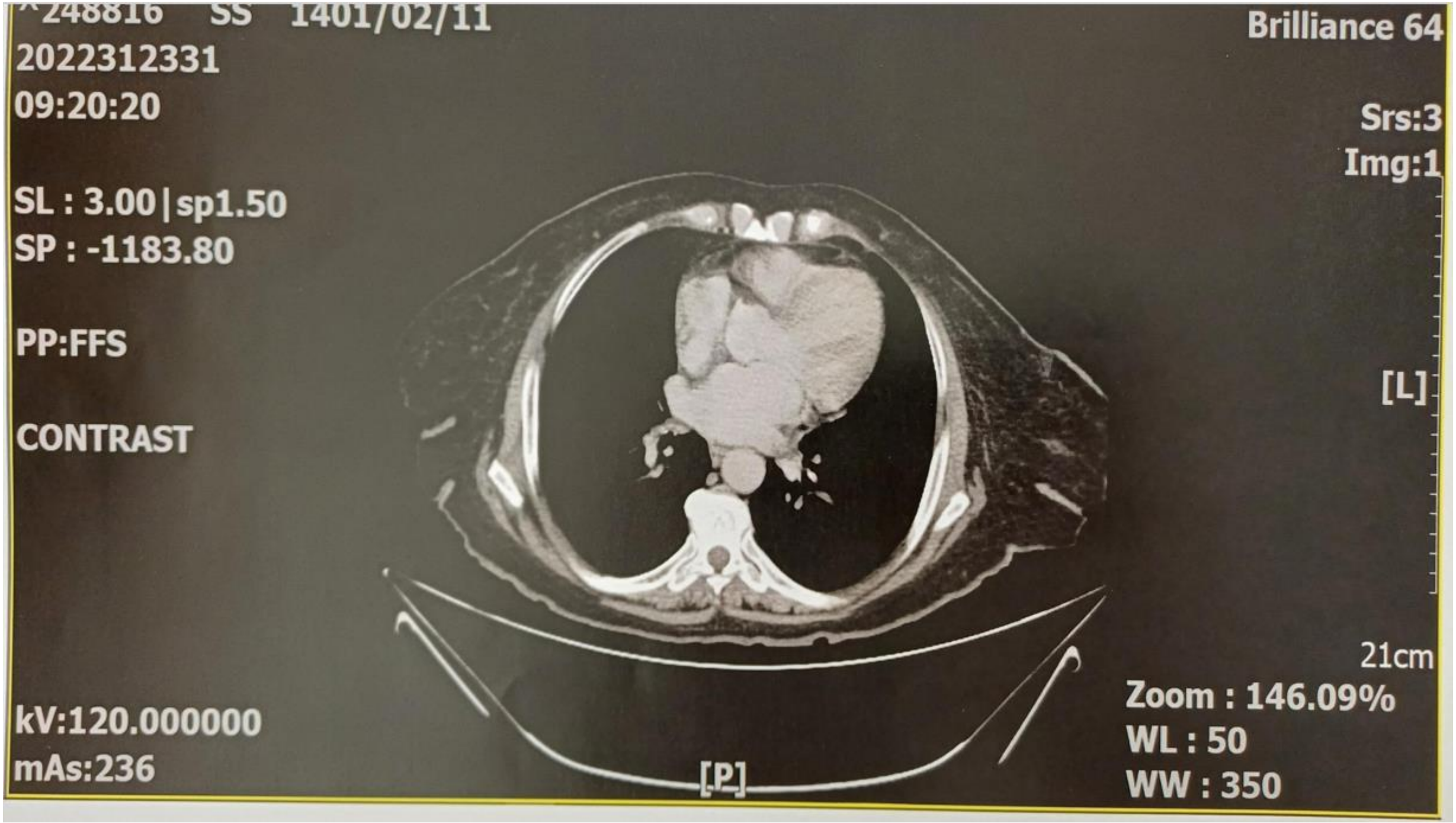
WW : 350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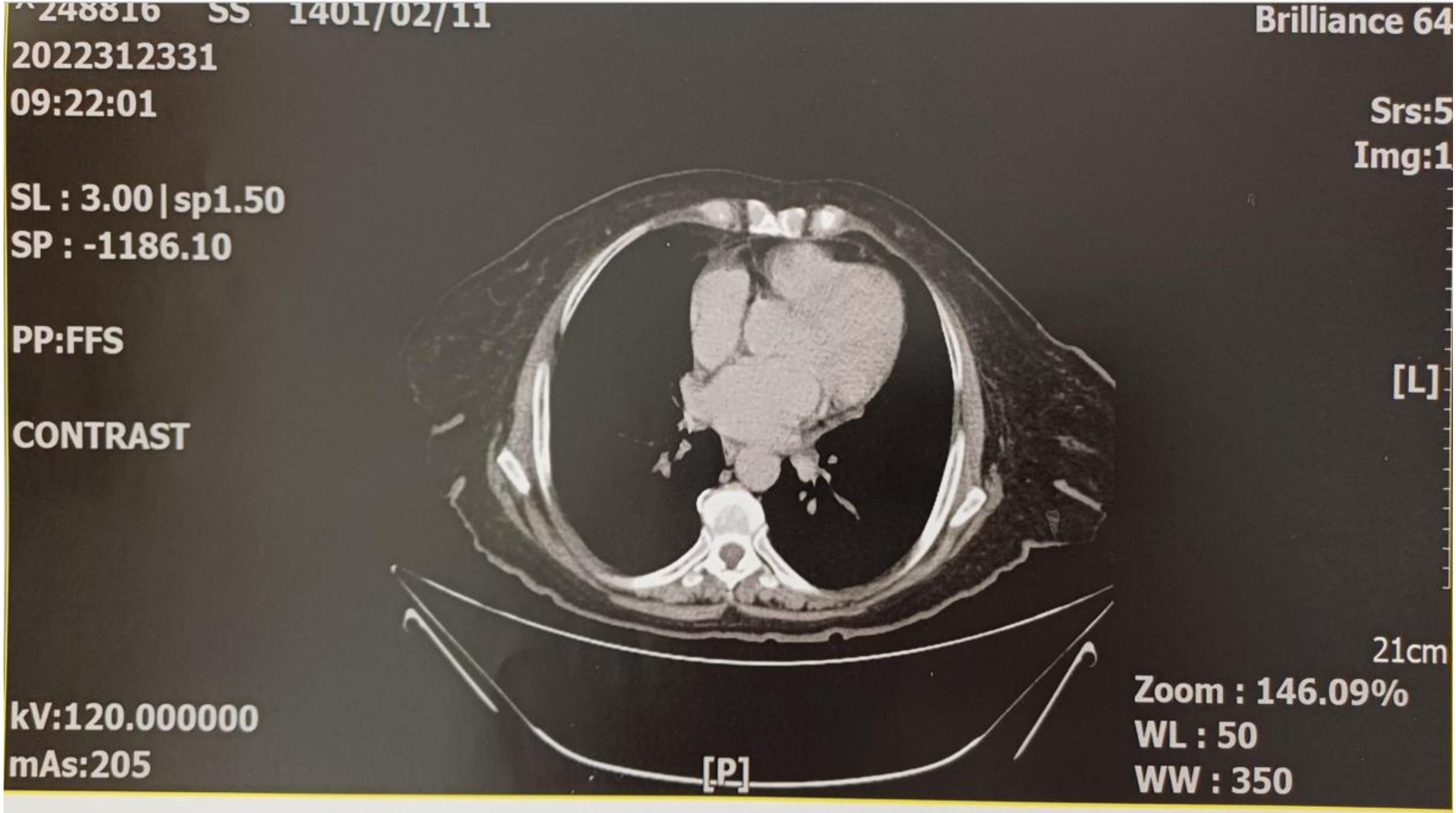
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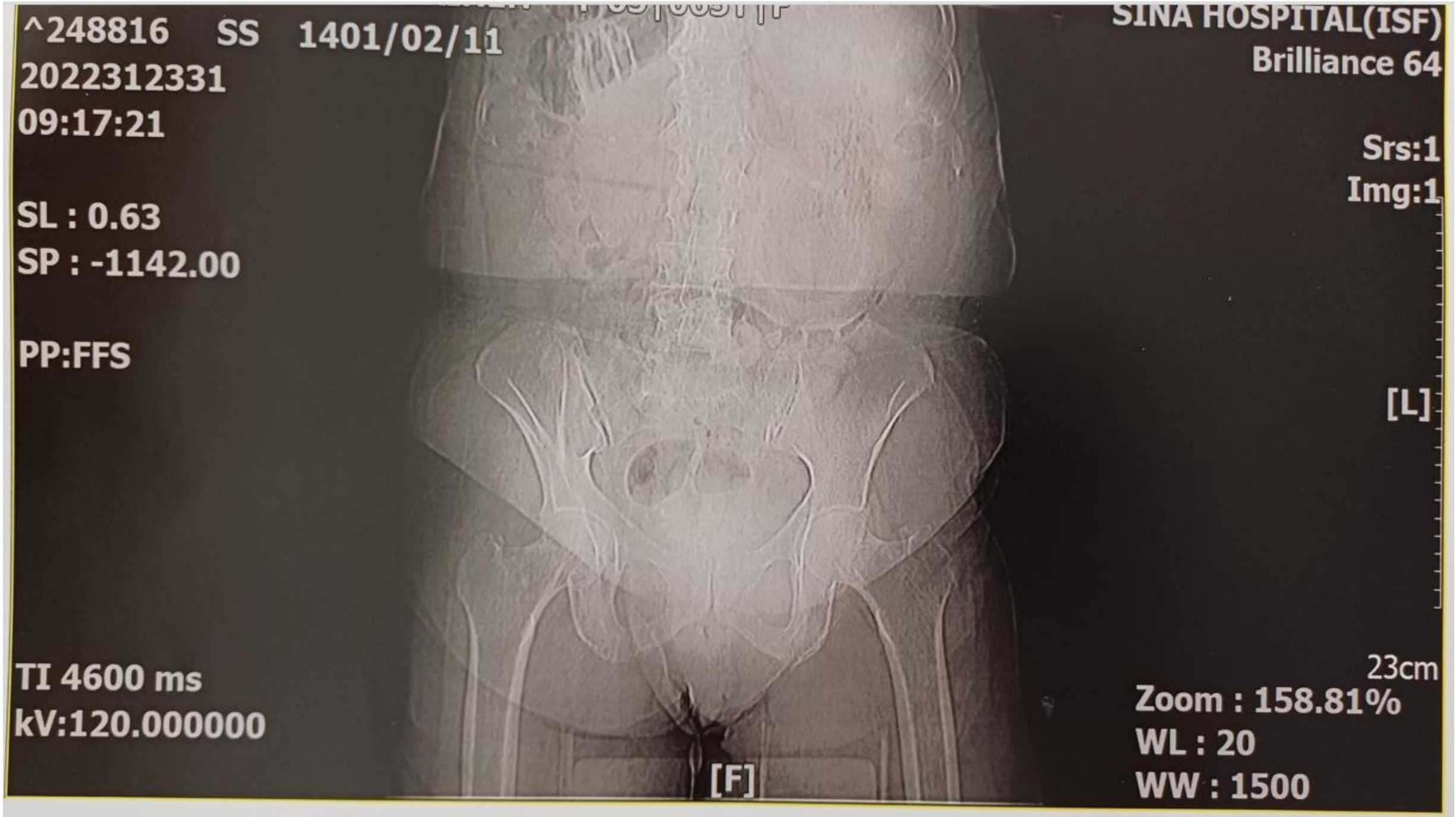
WL : 50
WW : 350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SINA HOSPITAL(ISF)
Brilliance 64
Srs:1
Img:1
[L]
23cm
Zoom : 158.81%
WL : 20
WW : 1500
[F]

Abdominopelvic sonography

۱۴۰۲/۰۳/۰۸

Liver parenchyma echo and dimensions are normal / space occupying lesion was not seen.

Intrahepatic and extrahepatic bile ducts have normal diameter. / The gallbladder is well dilated and has a normal wall thickness.

A hyperechoic focus of 4 x 8.5 mm was seen in the fundus of the gallbladder, which is more suggestive of sludge-stone complex.

The spleen has normal dimensions and parenchymal echogenicity (96 39 mm).

An 8 mm hypoechoic mass was seen in the splenic hilum, which suggests the secondary spleen.

Pancreas of normal dimensions and echogenicity. No space-occupying lesion was seen.

Abdominal aortic wall calcification was seen.

Kidneys have minimum normal dimensions (right kidney: 90 mm and left kidney: 90 mm), parenchyma echogenicity is normal. The corticomedullary differentiation is preserved, the thickness of the kidney cortex is normal, mild diffuse hydronephrosis of the right kidney and mild urinary fullness of the left kidney were seen.

The atrophied uterus measures 21 x 50 mm and the myometrium has homogenous echogenicity. / The endometrium is regular and 3.5 mm.

No lesions were seen in the adnexa. No free fluid was seen in the pelvis.

An 11 mm fascial defect was seen in the epigastric region along with any omental fat herniation and a brief fluid accumulation of approximately 1 cc.

Endoscopy

1402.06.21

Reason for endoscopy: IDA and dyspepsia

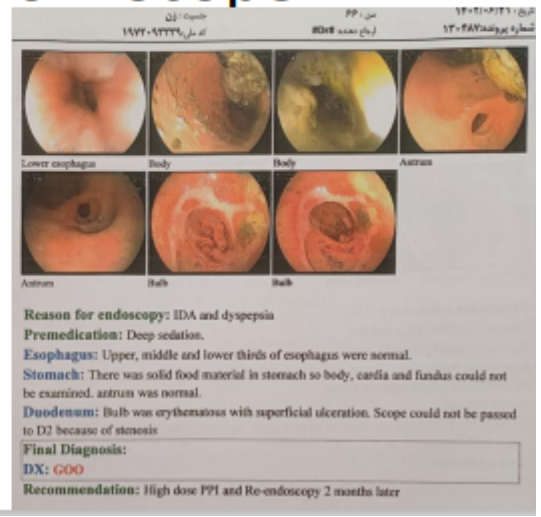
Esophagus: Upper, middle and lower thirds of esophagus were normal.

Stomach: There was solid food material in stomach so body, cardia and fundus could not be examined. antrum was normal.

Duodenum: Bulb was erythematous with superficial ulceration. Scope could not be passed to D2 because of stenosis

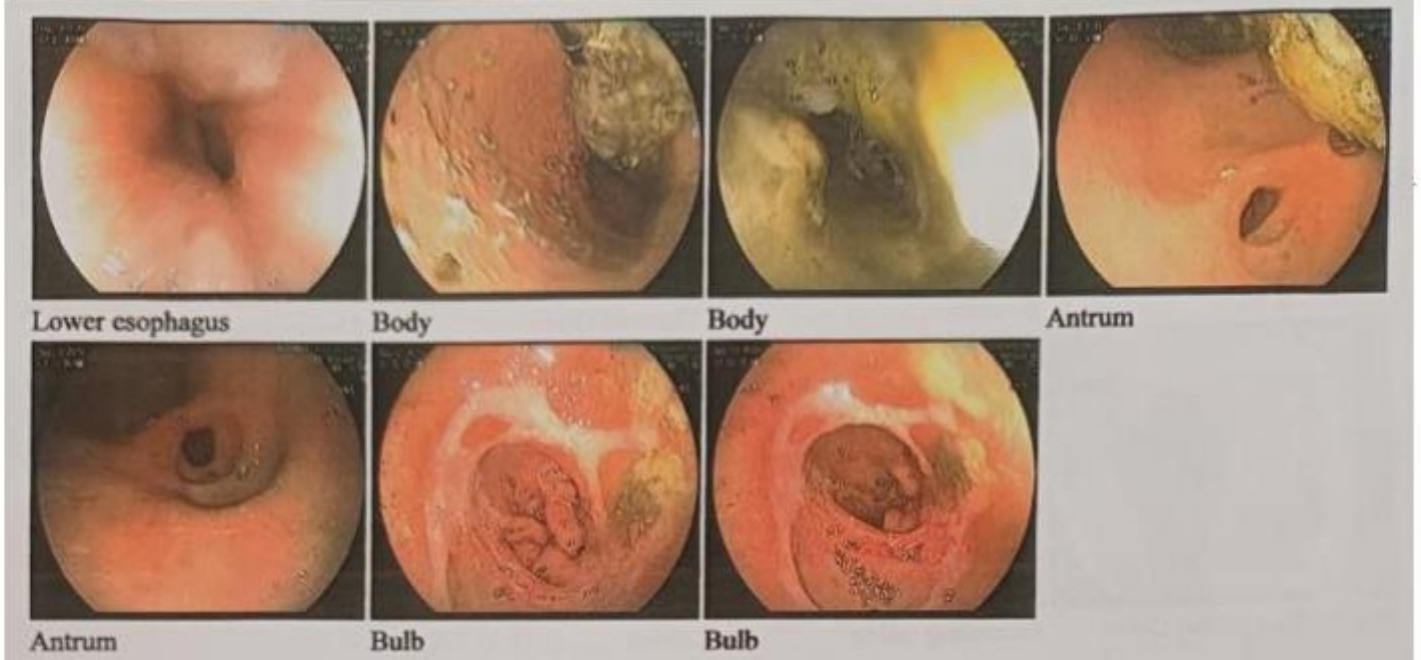
DX: GOO

Recommendation: High dose PPI and Re-endoscopy 2 months later



تاریخ : ۱۴۰۲/۰۶/۲۱ سن : ۶۶ جنسیت : زن

شماره پرونده:۱۳۰۴۸۷ ارجاع دهنده: #Dr# کد ملی:۱۹۷۲۰۹۳۳۳۹



Reason for endoscopy: IDA and dyspepsia

Premedication: Deep sedation.

Esophagus: Upper, middle and lower thirds of esophagus were normal.

Stomach: There was solid food material in stomach so body, cardia and fundus could not be examined. antrum was normal.

Duodenum: Bulb was erythematous with superficial ulceration. Scope could not be passed to D2 because of stenosis

Final Diagnosis:

DX: GOO

Recommendation: High dose PPI and Re-endoscopy 2 months later

Colonoscopy

1402.06.21

Reason for colonoscopy: IDA

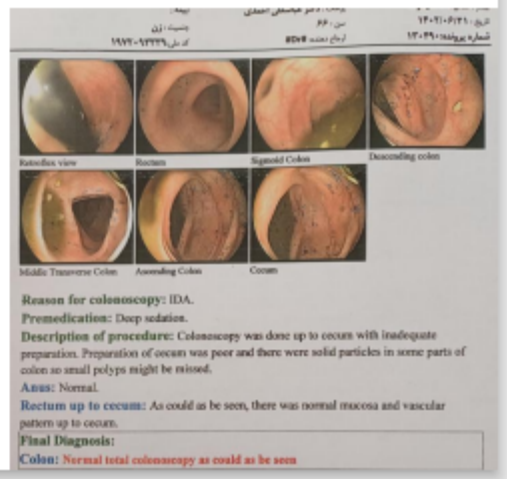
Description of procedure: Colonoscopy was done up to cecum with inadequate preparation. Preparation of cecum was poor and there were solid particles in some parts of colon so small polyps might be missed.

Anus: Normal.

Rectum up to cecum: As could as be seen, there was normal mucosa and vascular pattern up to cecum.

Final Diagnosis:

Colon: Normal total colonoscopy as could as be seen


Retroflex view
Rectum
Sigmoid Colon
Descending colon
Middle Transverse Colon
Ascending Colon
Cecum
Reason for colonoscopy: IDA.
Premedication: Deep sedation.
Description of procedure: Colonoscopy was done up to cecum with inadequate preparation. Preparation of cecum was poor and there were solid particles in some parts of colon so small polyps might be missed.
Anus: Normal.
Rectum up to cecum: As could as be seen, there was normal mucosa and vascular pattern up to cecum.
Final Diagnosis:
Colon: Normal total colonoscopy as could as be seen

lab Data

1401.06.22

WBC 3900	Na 137
Lym 20% - Neu 70%	K 4.3
RBC 3.7	
HB 9.8	
MCV 87	
MCH 26	
RDW 18	
PLT 483	

CT SCAN STUDY OF ABDOMEN AND PELVIS WITH AND WITHOUT CONTRAST

1402.07.18

Liver: Normal / Bile ducts: Normal / Gall bladder: No calcified gallstones.

Pancreas: Normal. No obvious mass, no inflammation. / Spleen: Normal. / Adrenals: Normal.

Kidneys and ureters: A stone in upper calyx of right kidney (5.5 mm) but no stone in left

kidney and both ureters. / Bladder:Normal.

Reproductive organs: Unremarkable..

Bowel: Normal caliber.

Abdominal lymph nodes: No enlarged abdominal lymph nodes. / Pelvic lymph nodes: No enlarged pelvic lymph nodes.

Peritoneum : No ascites or free air .No fluid collection.

Vessels: Normal / Retroperitoneum : Normal / Abdominal wall: Normal

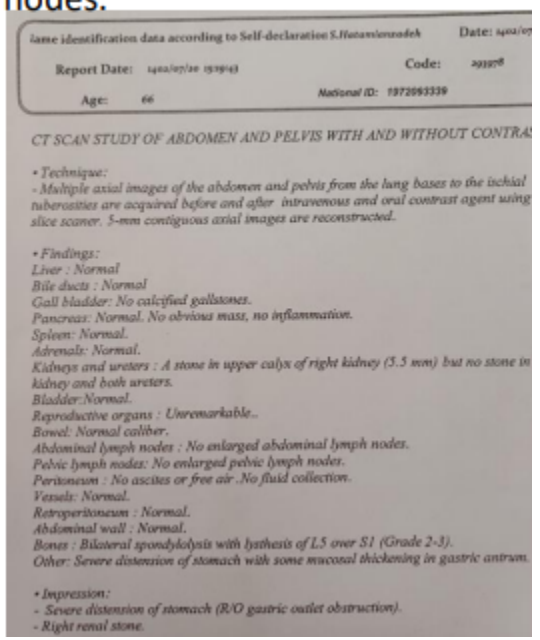
Bones: Bilateral spondylolysis with lysthesis of L5 over S1 (Grade 2-3).

Other: Severe distension of stomach with some mucosal thickening in gastric antrum.

Impression:

Severe distension of stomach (R/O gastric outlet obstruction).

Right renal stone.



Report Date: 1402/07/18 15:39:43 Code:

Age: 66 National ID: 1972093339

CT SCAN STUDY OF ABDOMEN AND PELVIS WITH AND WITHOUT CONTRA

• Technique:
- Multiple axial images of the abdomen and pelvis from the lung bases to the ischial tuberosities are acquired before and after intravenous and oral contrast agent using slice scaner. 5-mm contiguous axial images are reconstructed.

• Findings:
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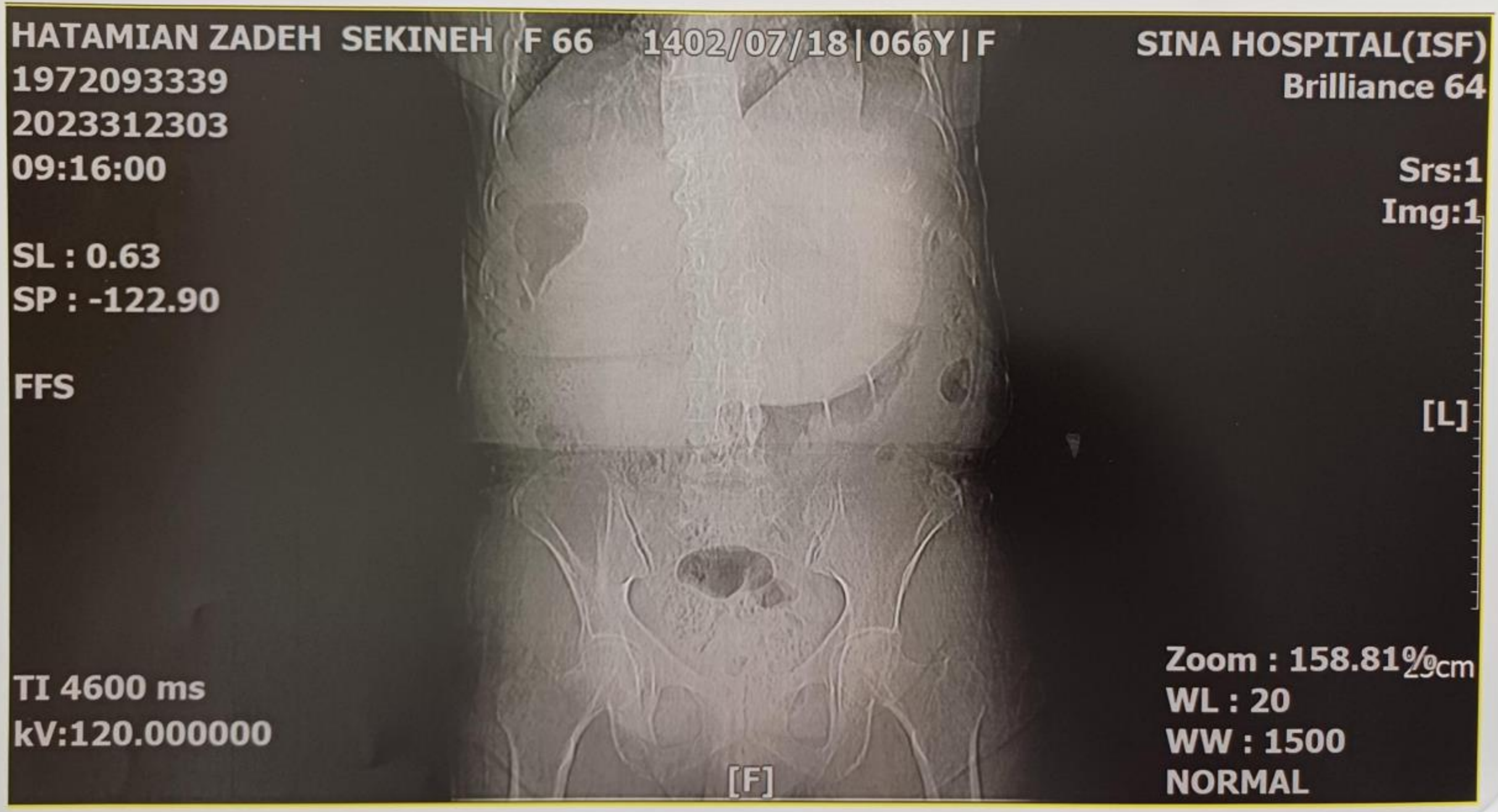
- Right renal stone.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Zoom : 158.81%
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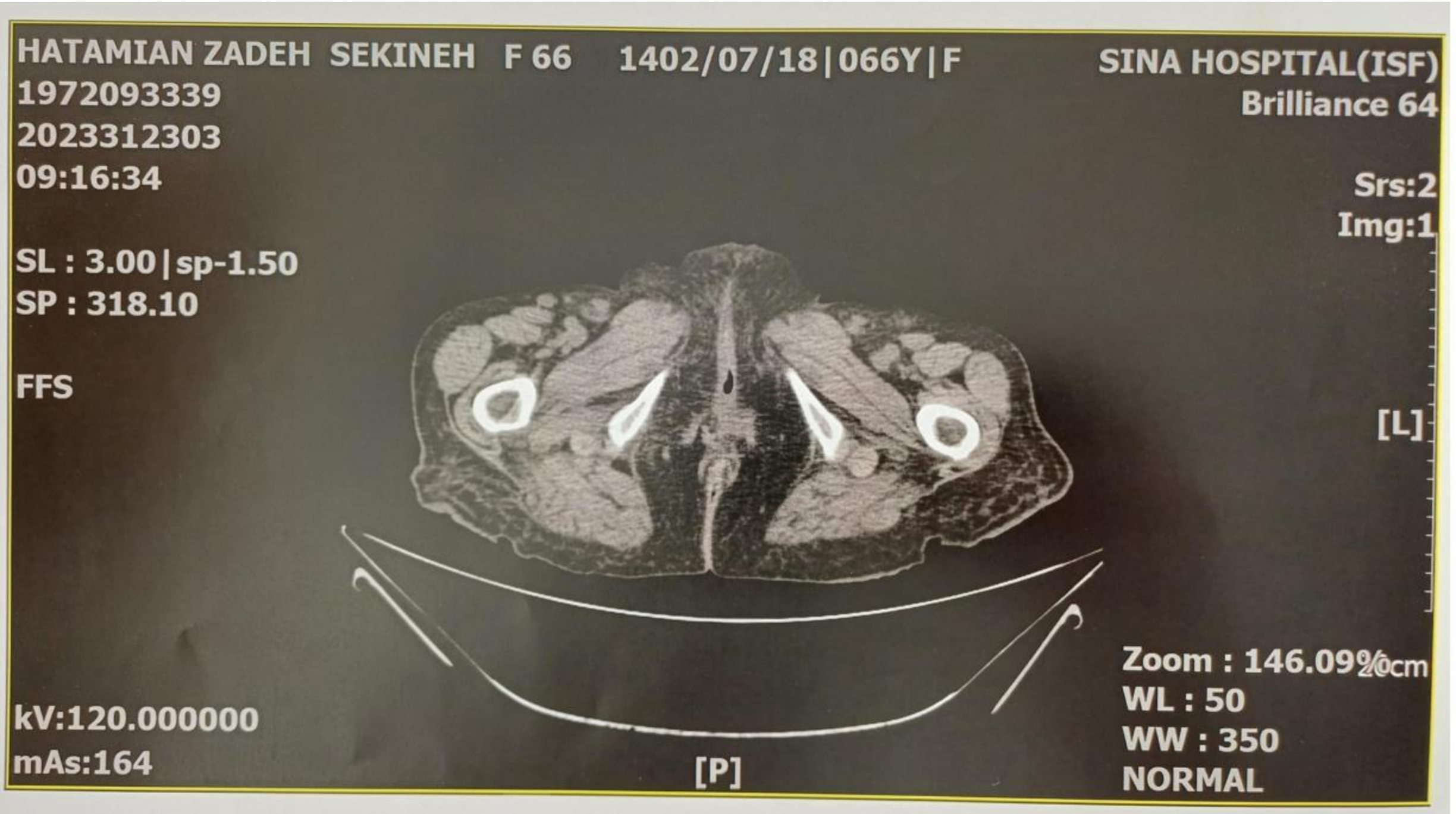
WL : 20
WW : 1500
NORMAL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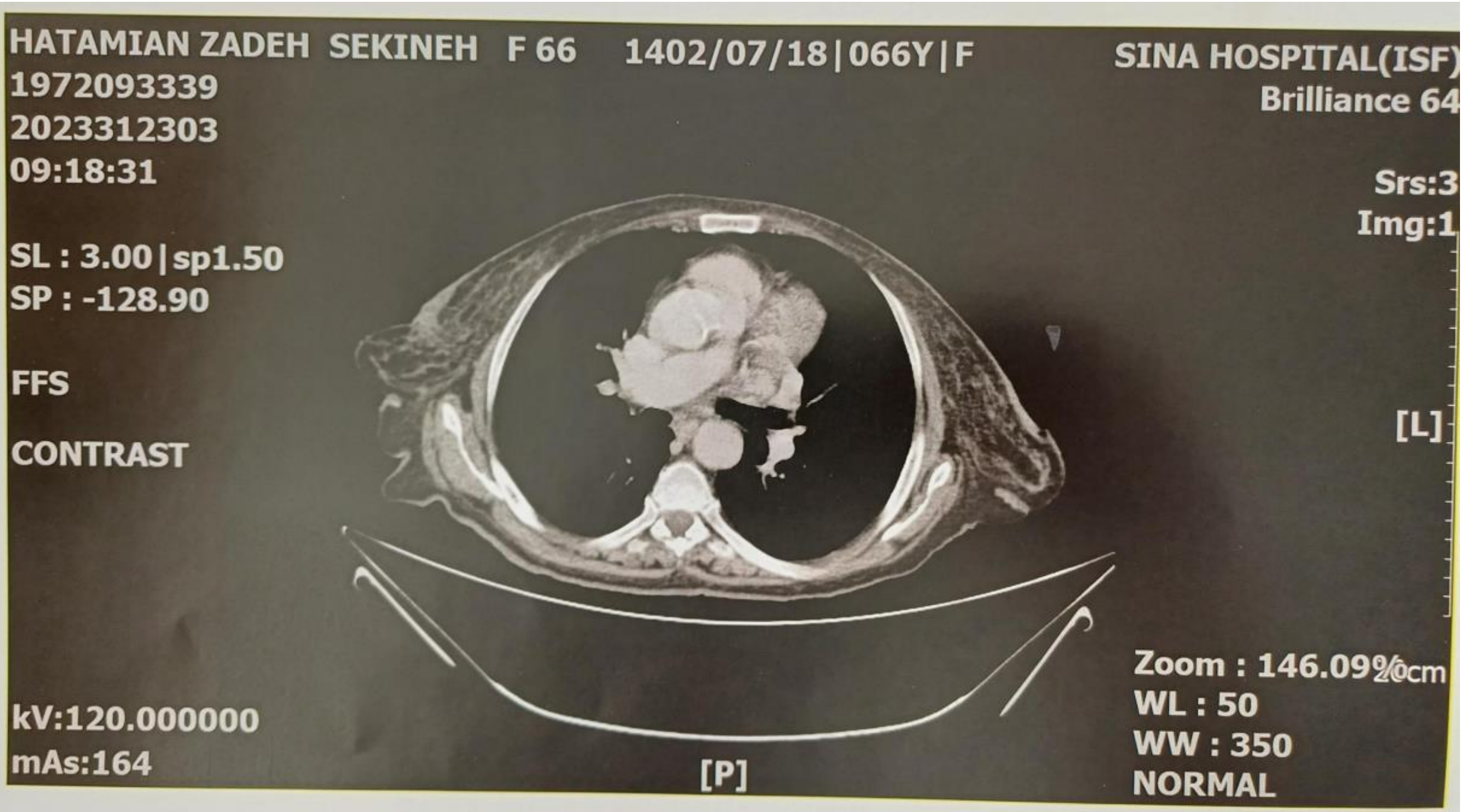
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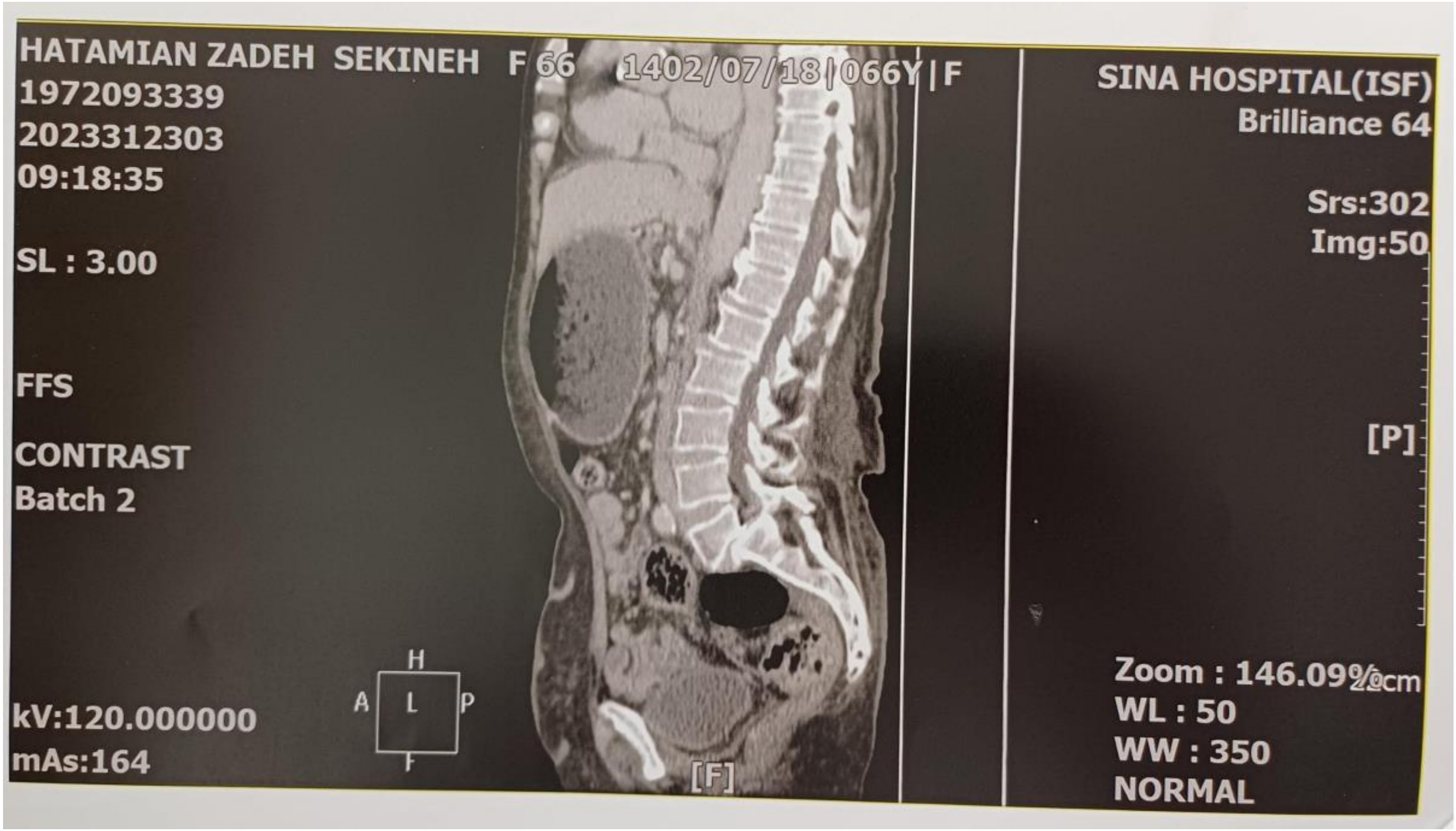
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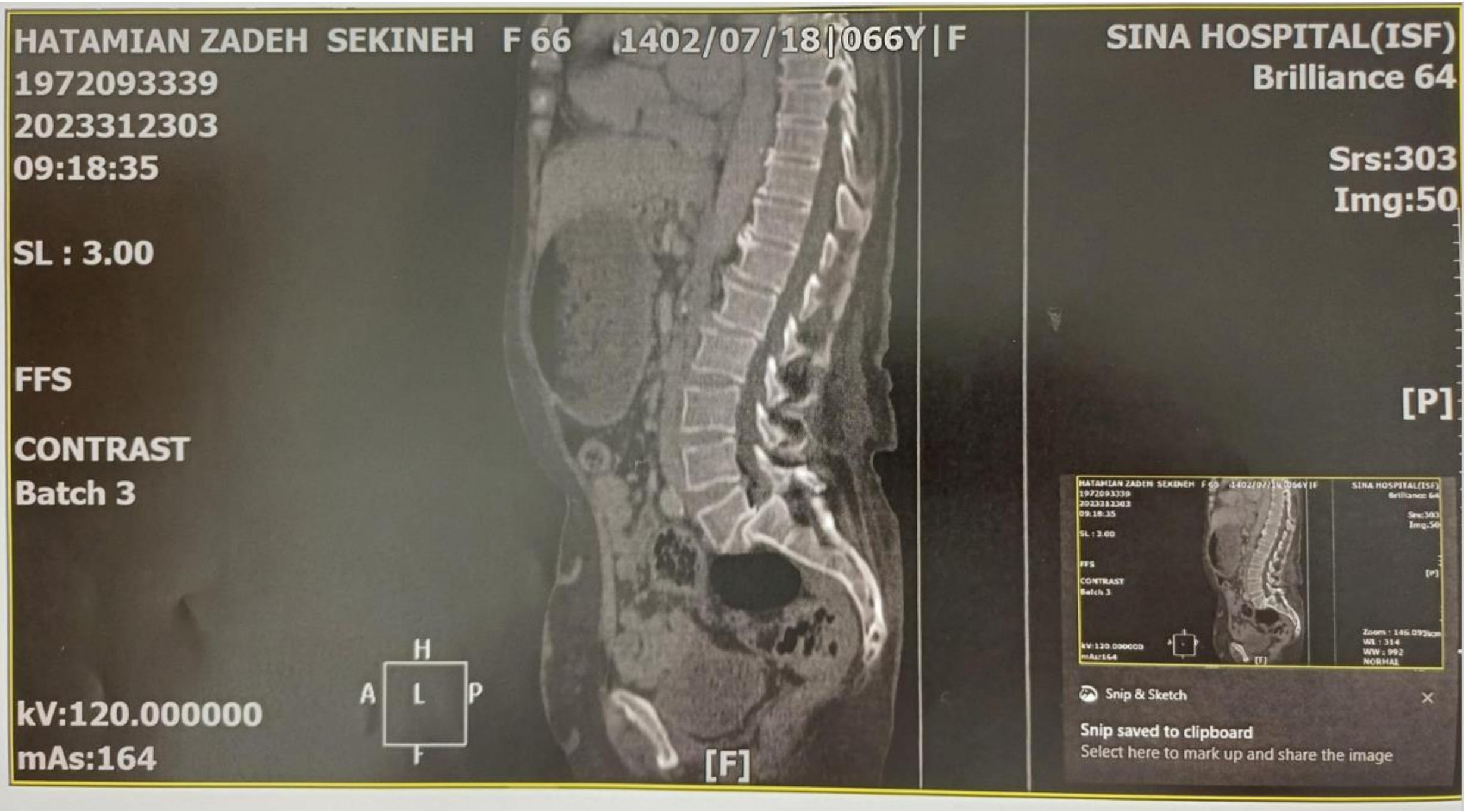
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lab Data

1402.07.19

WBC 5.3	Na 140	AST 17
Lym 11% - Neu 75%	K 3.8	ALT 10
RBC 3.1	ESR 26	ALK 174
HB 8.7	Uric acid 3.8	Alb 3.8
MCV 95	Iron 55	
MCH 27	TIBC 389	
RDW 22	Transfern saturation 14	
HCT 30	Folic acid 7.4	
PLT 443	Vitamin b12 982	

پزشک معالج:	تاریخ:	تشخیص اولیه:	سن بیمار:	نام و نام خانوادگی:

Left Vantricle (LV) Studies:
End diastole: cm(3.5 -5.4)
End systole: cm(2.3 -3.4)
M-Mode EF: %Globale EF 55%
FS %
EPSS: cm(<0.8 cm)
IVS.d: cm(06-11)
PW.d: cm(0.6-1)
LV function ....
R.W.N.A.
Akinetic ....
Hypokinetic ... Apical ...
Dyskinetic ....
☐ Paradoxical
☐ Thorombus

Right Ventricle (RV):
End diastole: cm
Endsystole: cm
Function:
RA size: cm
☐ VSD ☐ RVH
Others:

Left Atrium (LA):
LA size:
☐ Thrombus
☐ Myxoma
☐ ASD
☐ PFO
Others:

Mitral Vlave:
☐ Normal — [illegible]
☐ Stenosis
-M.V.A by Planimetry : cm_2
-EchoScore:
☐ Prolapse
☐ Thickened — MAC
☐ Flail
☐ Vegetation
Others:

Aortic Valve:
Number of cups:
Ao V opening: cm(1.5-2.6)
Ao root: cm(2-3.7)
☐ Normal
☐ Stenosis
☐ Thickened
☐ Vegetation
Others:

Pulmonic Valve:
☐ Normal
☐ Stenosis PDA
PA size: cm
Others:

Trcuspid Valve:
☐ Normal
☐ Stenosis
☐ TVP
Others:

pericardium: — Normal ☐ Thickened ☐ Effusion ☐ Lat ☐ Ant ☐ Post

DOPPLER STUDIES (PWD& CWD&CFM)

Mitral flow: [Normal Value:(0.6-1,3m/S)]
☐ Normal
☐ Mitral stenosis
MV area: cm_2
— Mitral regurgitation ++

Tricuspid flow:[Normal Value: (04-0.6m/S)]
☐ Normal
☐ Tricuspid stenosis :
peak velocity m/s
☐ Ticuspid regurgitation : RV pr: mmhg

Aortic flow: [Normal value:(1.0-1.8M/s)]
☐ Normal
— Aortic stenosis
peak velocity: 2 m/s
peak gradient: mmhg
— Aortic regurgitation: + Poor View

pulmonic flow: [Normal Valve: (0.6-0.9m/s)]
☐ Normal
☐ Pulmonic stenosis:
peak velocity: m/s
peak gradient : mmhg
☐ pulmonary regurgitation :

Conclusion: LVEF= 55% Apical HK
G I Diastolic Dysfunction
MR++/mod AS+/AI+

[illegible signature/stamp]

همکار محترم جناب آقای دکتر طالب زاده
با سلام و احترام
خانم ۵۵ ساله [illegible] تحت درمان
قلبی از نظر stable است
EF 55% MR++ AS+/AI+
CAD. Mod CAN
انجام جراحی از نظر قلبی با high risk [illegible] است
۱) کنترل قند و BP
۲) پروفیلاکسی DVT (با نظر [illegible])
۳) [illegible] LOXI [illegible]
۴) [illegible]
۵) ECG و Trop [illegible]

دکتر [illegible]
متخصص قلب

Risk Factors	Hypertension -
Angiography Data	Angiography Type: Native Coronary Angiography
	Clinical Status: Elective Approach: Rt Radial
	Contrast Volume(cc): 60 Contrast Type: Nonionic FluoroDose(mGy): 100

Clinical Presentation: Stable Angina

Segment	Stenosis	Length	Lesion Charecteristics	Stent	Run Off	TIMI
LM						
			Normal			
LAD Territory						
Mid.LAD	50-69%	Discrete			Ante(Good)	3
LCX Territory						
			Normal			
RCA Territory						
			Normal			

Dominancy: Left Complication: no

RESULT: **Minimal CAD**

all vessels have severe tortuosity
RCA: diminutive
multiple Aortic calcification seen

RECOMMENDATIONS: **Medical treatment**

کاربر مهمان Resident	امضا:	دکتر رضا خاتجاتي (Cardiologist)
کاربر مهمان Resident		

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:
- It is recommended to check the level of fasting serum gastrin.
- For two weeks, a high dose of PPI and at the same time a H2RA should be taken , and then TTS balloon dilation should be performed twice
- If there is no improvement, talk to the patient about Anterectomy and vagotomy.