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

Iranian Association Of Gastroenterology And Hepatology
Isfahan Branch

FEEDBACK

GI commission and grand round

December 13 2023

List of cases-December 13 2023

	Patient	Fellow	page
230902	A 22-year-old female	Dr Izadi	3
250901	**A 37-year-old woman**	Dr. Jalili	97
250902	A 79-year-old woman	"	100

GI commission and grand round

A 22-year-old female

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

Question?

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

1) Determining the appropriate treatment for the patient?

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

02/05/16

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

RT-PCR HBV DNA:

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

istory:

Patient is known case of hepatitis B

acroscopic:

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

Microscopic:

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

B. Confluent necrosis
□Focal confluent necrosis 1

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

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

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

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

Diagnosis :

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

02/07/10
Liver biopsy:
Chronic hepatitis

سونوگرافی کبد و مجاری صفراوی و کیسه صفرا:

کبد ابعاد نرمال داشته ; توده یا آبسه دیده نشد.

افزایش اکوژنیسیته در پارانشیم کبد رویت شد که مطرح کننده fatty liver grade1 میباشد .

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

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

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:

1) First of all, the patient's medicine compliance is necessary to confirmed due to the possibility of ١ fluctuations in HBV PCR DNA in noncompliant patient and very low risk of drug resistance .

2) In case of drug compliance approval, it is necessary:

A) Tenofovir resistance is rare but should be checked. Mutation check should be done and in this context. Coordination with Dr. Keyvan's laboratory can be done.

b) Tenofovir resistance in the patient is important in terms of epidemiology and in other family members

C) All Family members need to be screened and vaccinated

3) In order to increase the dose of tenofovir, you can consult infectious disease specialists or Entecavir added to tenofovir.

4) It is better not to get pregnant until undetectable HBV DNA occurs.

5) Complications of pregnancy in HBV positive person (including gestational diabetes, pregnancy cholestasis, preterm labor, neonatal asphyxia, …) should be explained to the gynecologist and the patient.


6

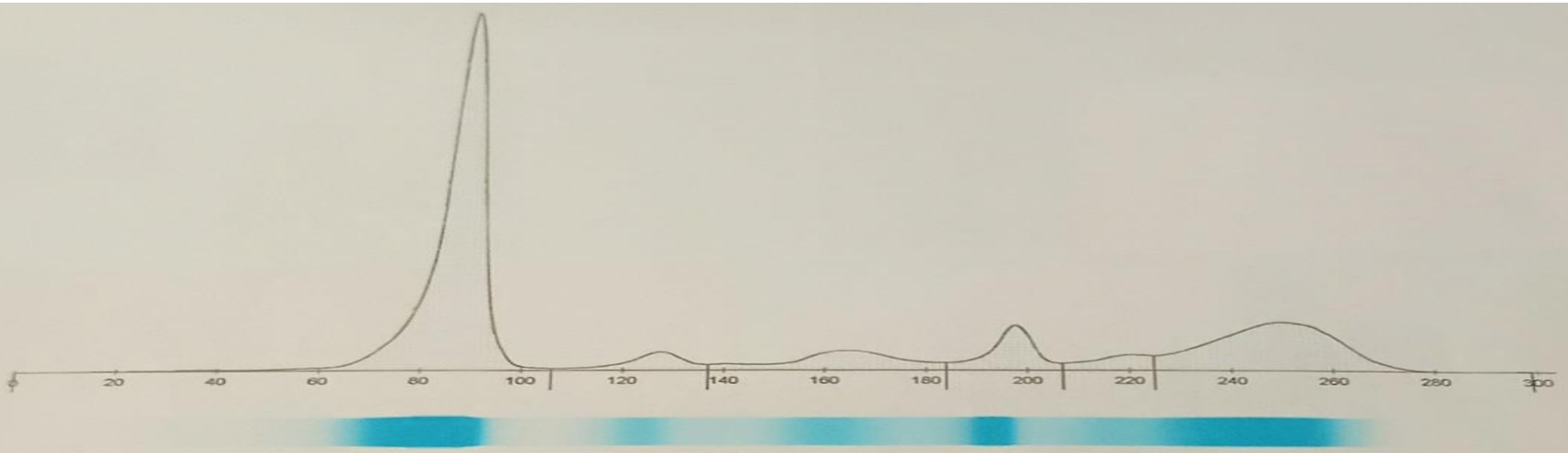
A 37-year-old woman

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

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

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

2020



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

A/G Ratio : 1.26 Total Pro : 7.8

nents :

Repeat protein electrophores after 3-6 months

2023

ID: 4.2-98606

Date: 31/10/2023
Sample #:33

Capillary Serum protein Electrophoresis

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

T. P.: 6.6 g/dL
A/G Ratio: 0.98

1399/5/7

پزشک ارجاع دهنده :


Middle third


Lower third


Lower Esophagial Sphincter


Cardia


Body


Antrum


Bulb


2nd portion

Indication : R/O Varix

Premedication : Midazolam

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

Esophagus : Normal

Stomach : Normal cardia,fundus,body and antrum

Duodenum : Normal D1 & D2

Final Diagnosis : Normal Esophagogastroduodenoscopy

1399/3/21

MRI of Abdomen with contrast

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

Impression: Cirrhotic change of liver with splenomegaly

With best regards

1402/8/19

سونوگرافی کبد، وداپلر پورت :

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

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

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

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

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

ضایعه فضاگیر سالید یا کیستیک در پارانشیم کبد دیده نشد.

وریدهای هپاتیک دارای قطر نرمال هستند .

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

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

Q:

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

Meld=15

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:
- One of the indications of liver biopsy is the chronic increase of transaminases with the aim of investigating the cause and prognosis as well as the suspicion of inflammation or reversible fibrosis, but liver biopsy is risky in this patient and maybe transjugular biopsy is safer if possible.
- In the current situation, the low-risk alternative is a trial of corticosteroids and monitoring the response. If a therapeutic response is observed, long-term treatment is recommended, for the proper selection of both methods, the advantages and disadvantages of each should be explained to the patient, and the patient should be visited and followed up at short intervals.
- In any case, the following are recommended:
- Follow up MRCP
- Measurement of serum Ig G level and other autoimmune markers
- Avoid herbal medicines and supplements.
- If MELD remains above 12, consult for pre-transplant investigations.

A 79-year-old woman

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

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

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

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

1399

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


Retroflex view


Rectum


Rectum


Sigmoid Colon


Sigmoid Colon


Descending colon


Middle Transverse Colon


Ascending Colon


Cecum

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

Premedication : Midazolam 5 mg

Description of procedure : Sub optimal preparation

Findings :

1399/3/19

Anus : Orifice of suspected fistula was seen

Retroflex View : Internal hemorrhoid

Rectum : Patchy erythema was seen. multiple Bxs were taken

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

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

Transverse Colon : Normal mucosa and vascular pattern.

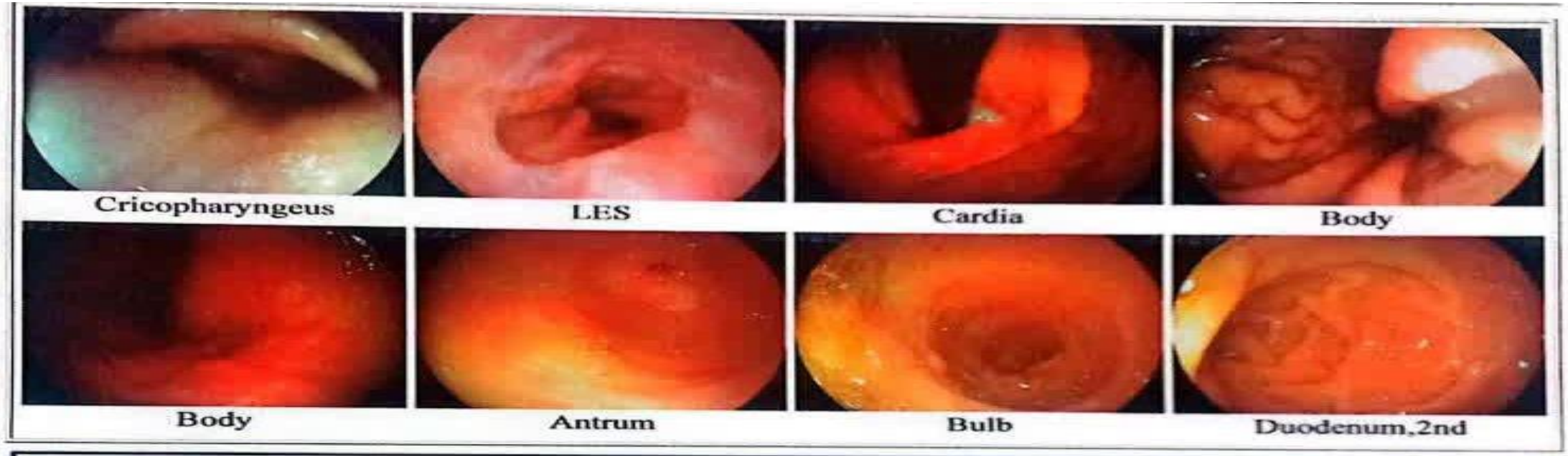
Ascending Colon : Normal mucosa and vascular pattern. small polyp was seen. polypectomy was done.

Cecum : Normal mucosa and vascular pattern

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

Diagnosis : See above

Recommendation : Pathology Follow up



Reason for Endoscopy : Epigastric pain and hx of use NSAID

1399/3/19

Premedication : Midazolam 3 mg

Findings :

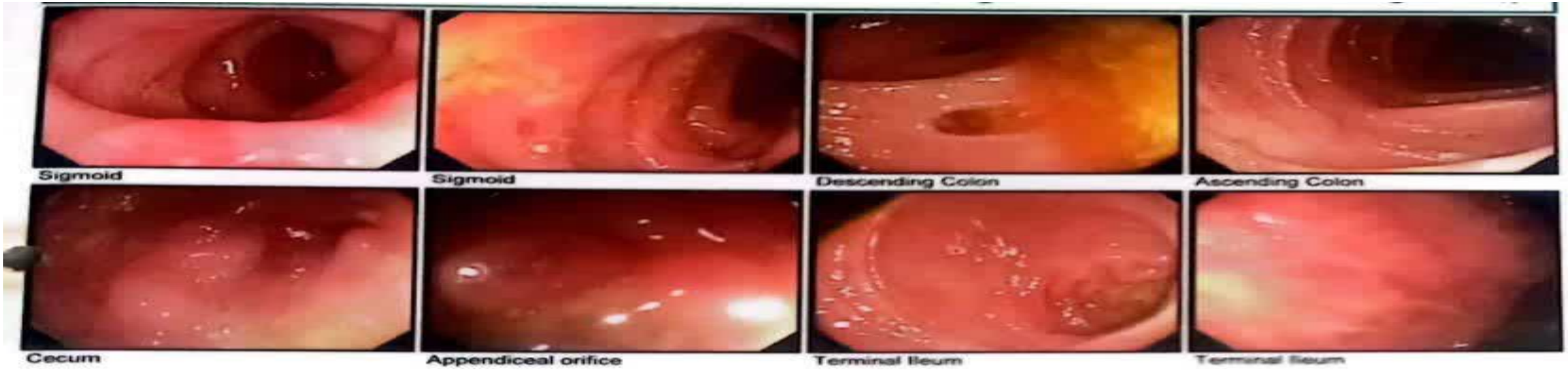
Esophagus : Upper third , Middle third and lower third were normal

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

Duodenum : D1 and D2 were normal

Diagnosis : Erosive gastropathy. Diminutive polyp

Recommendation : Pathology follow up



Indication : Fistula & Abdominal Abscess formation

Premedication : Deep sedation provided by anesthesiologist

1400/6/8

Anus : Normal

Rectum : Normal

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

Descending Colon : Normal but some diverticula are seen.

Transverse Colon : Normal

Ascending Colon : Normal

Cecum : Normal

Terminal Ileum : Normal Distal terminal ileum

Final Diagnosis

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

Colonoscopy:

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

Biopsy1399/9/17

- FOCAL ACTIVE COLITIS

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

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

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

Biopsy1399/3/25

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

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

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

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

1399/3/25

Liver and GI Pathology From Mount Sinai of New York

Ascending colon biopsy:

- Mucosal Tag

Sigmoid Colon Biopsy:

-Non-Specific inflammation

Sigmoid Colon Biopsy;

- Mucosal Tag

Rectum Biopsy:

-Non-Specific inflammation

CT 1399/8/15

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

abdominopelvic MDCT with IV contrast

R/O of abdomenopelvic abscess formation and diverticulitis

-NO free fluid in abdomenopelvic cavity is seen

colon diverticulosis is seen

minimal fat staranding surrounding sigmoid colon is present

تاریخ:	Consultation Physiciaon Name & Sign: نام پزشک مشاور و امضاء:
	NO evidense of bowel thicking and no evida

of increase wall attenuation, no evidence of

of entrenusatia of gas are seen

No evidence of abscess formation in abdomenipelvic cavity is present

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

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

Pathology1400/6/14;

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

SURGICAL PATHOLOGY REPORT

Clinical Data: *Fistula & Abdominal Abscess Formation*

Macroscopic Examination:

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

Microscopic Examination:

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

Final Pathologic Diagnosis

Sigmoid Colon; Biopsy:

- Patchy Moderate Active Colitis with Focal chronicity changes

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

CT

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

1402/4/19

MULTI SLICE CT SCAN OF THE ABDOMEN AND PELVIS WITH CONTRAST

The study was performed administering oral and intravenous contrast. Coronal and sagittal reconstructed views were also obtained.

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

IMP:

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

MRI 1402

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

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

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

1402/6/1

Dear Dr:

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

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

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

Ischiorectal and mesorectal fat are clear and intact.

There is no perforation of external sphincter .

There is no extension beyond levator ani muscle.

Dear Dr:

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

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

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

Junctional zone is nearly smooth and intact.

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

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

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

Dear Dr:

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

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

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

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

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

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

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

(continues next page)

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

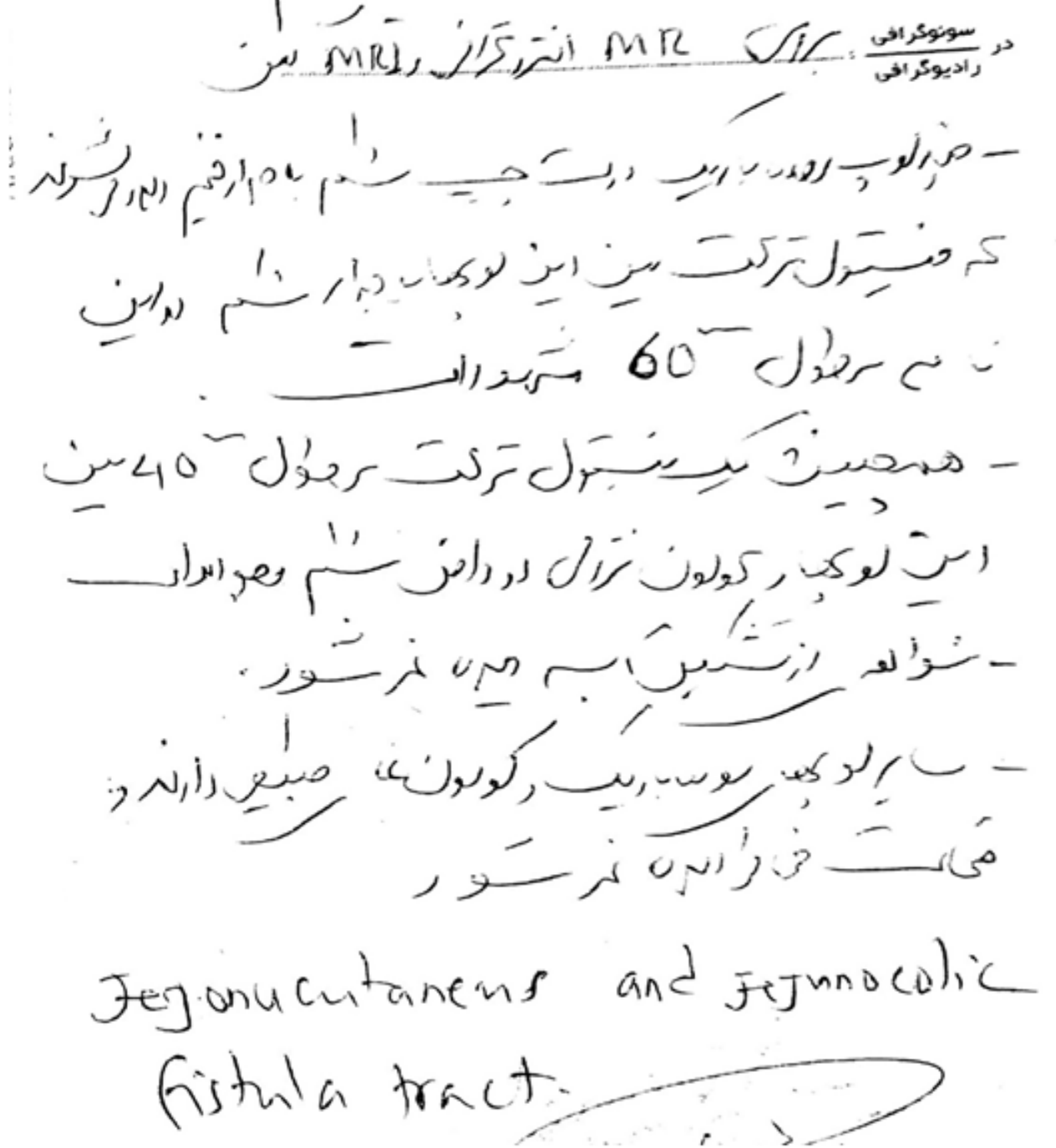
So patient has two fistulous tracts, one between jejunal loops with anterior abdominal wall and the other between the same jejunal loops with mesenteric border of sigmoid colon.

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

در سونوگرافی / رادیوگرافی MRI

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

در سونوگرافی / رادیوگرافی



Fegonucutaneus and Fegunocolic
fistula tract.

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

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:
- Multiple fistulas in this patient raised the possibility of Crohn's disease, but generally Crohn's disease is rarer in the elderly, and the absence of rectal involvement in such a disease makes the perianal involvement of Crohn's disease less. On the other hand, lack of adequate response to antibiotics and low output fistulas in an elderly person is more supportive for conservative treatment. Previous history of complications, age and underlying diabetes are also detrimental to biological treatment, which can even be life-threatening.
- More conservative treatments such as long time antibiotics with or without methotrexate, stem cells injection and even surgery make more sense for now.
- Small bowel re-evaluation with the combination of WCE and double balloon enteroscopy may be very helpful.