

Beaumont Health

## Beaumont Health Scholarly Works and Archives

---

Conference Presentation Abstracts

Pathology and Laboratory Medicine

---

9-2022

### Association of Isolated Colitis With Nonsteroidal Anti-Inflammatory Drug Usage

Ashbita Pokharel

Wei Li

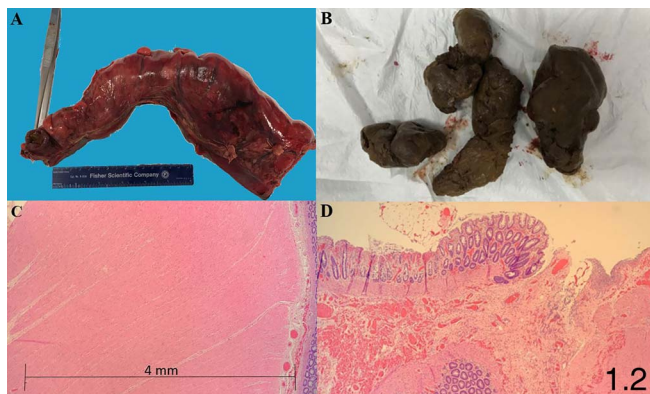
Follow this and additional works at: [https://scholarlyworks.beaumont.org/pathology\\_laboratory\\_medicine\\_confabstract](https://scholarlyworks.beaumont.org/pathology_laboratory_medicine_confabstract)



Part of the Pathology Commons

---

packed and hardened fecal matter) (Figure 1.2, B). Histologic sections showed markedly thickened muscularis propria (Figure 1.2, C) and acute fibrinopurulent serositis, with the colonic mucosa around the perforation site showing ischemic changes (Figure 1.2, D). Given the clinical history of chronic constipation and luminal impacted fecal material, the findings were compatible with stercoral colitis, complicated with perforation and peritonitis. The clinical history of heroin and opioid abuse was a likely contributing factor to the patient's constipation and fecal impaction.



### How Diagnostic Is “Undiagnostic”: A Review of Benign and Nondiagnostic Fine-Needle Aspirates of Pancreatic Lesions

(Poster No. 3)

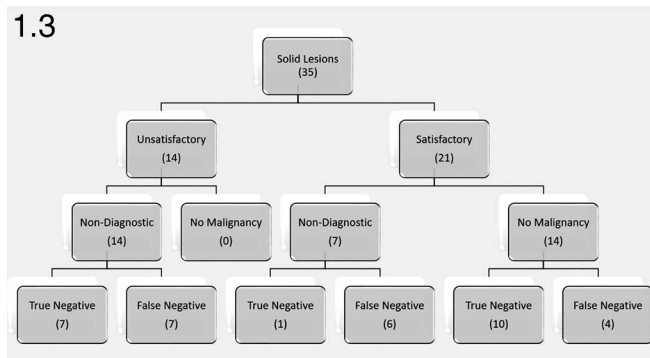
**Danielle R. Petty, DO<sup>1</sup>** (dani.r.petty@gmail.com); **Omer A. Hassan, MD<sup>2</sup>**; **Wencheng Li, MD<sup>2</sup>** <sup>1</sup>Department of Pathology, University of Florida, Gainesville; <sup>2</sup>Department of Pathology, Wake Forest Baptist Medical Center, Winston Salem, North Carolina.

**Context:** Fine-needle aspiration (FNA) is used to diagnose pancreatic lesions. If initial results are “no malignancy” or “nondiagnostic” and clinical suspicion remains high, rebiopsy is performed. The purpose of this study was to evaluate the negative predictive value (NPV) of the diagnoses “no malignancy” and/or “nondiagnostic” for solid pancreatic lesions to provide data to aid in decision-making.

**Design:** One hundred ten pancreatic FNAs from 2015 to 2017 with diagnoses of “nondiagnostic” or “no malignancy” were identified. Patients without follow-up or those who died of unknown or unrelated causes were excluded, leaving 98 cases. Thirty-five had radiographically solid lesions.

**Results:** Fourteen FNA adequacy statements were “suboptimal” or “unsatisfactory,” and consequently all were categorized as “nondiagnostic.” Of these, 7 were eventually diagnosed with cancer, 86% (6) of which were neuroendocrine tumors. Twenty-one cases were “satisfactory,” although 7 were categorized as “nondiagnostic.” Six of the nondiagnostic cases were eventually diagnosed with cancer, 5 of which were ductal adenocarcinomas and 1 of which was neuroendocrine. Fourteen cases were diagnosed as “no malignancy”—71% representing true negatives. Four patients (29%) with this diagnosis were eventually diagnosed with cancer (3 ductal adenocarcinomas and 1 mucinous cystic neoplasm) (Figure 1.3).

**Conclusions:** “Satisfactory” cases with a diagnosis of “no malignancy” had an NPV of 71%. Between 57.1% (unsatisfactory samples) and 86% (satisfactory samples) of “nondiagnostic” biopsies were



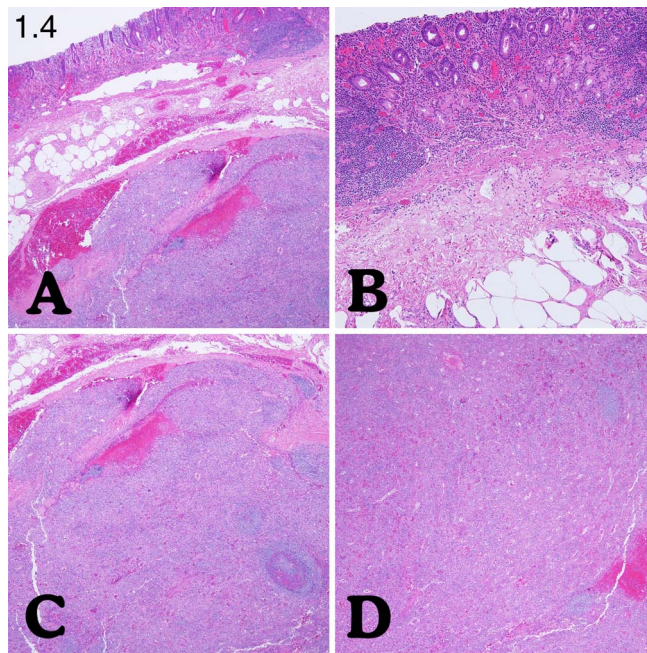
proven to be malignant. “Unsatisfactory” samples were disproportionately neuroendocrine tumors (86%), which suggests that neuroendocrine lesions may be more difficult to sample.

### Accessory Spleen Presenting as Gastric Fundic Lesion

(Poster No. 4)

**Fnu Raja, MD** (fraja@metrohealth.org); **Rania Rayes Danan, MD**; **Amer Khyami, MD**. Department of Pathology, MetroHealth Medical Center, Cleveland, Ohio.

An accessory spleen (AS) is a small nodule of splenic tissue located separately from the main body of the spleen and is found in approximately 15% of the population. The physiologic function is similar to that of the normal spleen, and it is usually located in the splenic hilum and tail of the pancreas. We describe a rare case of AS that presented as a gastric fundic mass in a middle-aged woman with a history of breast cancer and hysterectomy for a benign condition. She presented with fatigue and was found to have iron-deficiency anemia. On further workup, endoscopy revealed a submucosal gastric fundic lesion with nonneoplastic overlying mucosa. Follow-up radial endoscopic ultrasonography for the lesion revealed a uniform, oval-like lesion measuring 2.0 × 1.5 cm. Full-thickness resection was performed, and tissue was sent for histology. Microscopically, a polypoid gastric mucosa was remarkable for active gastritis, ulceration, pit abscesses, and chronic lymphoplasmacytic inflammation (Figure 1.4, A and B). No dysplasia or intestinal metaplasia was seen. Submucosa was significant for AS tissue extending to the deep tissue (Figure 1.4, C and D). *Helicobacter pylori* immunohistochemistry was negative. Patients with gastric AS are usually asymptomatic; complications include rupture, hemorrhage, and torsion. ASs are usually discovered incidentally and can be mistaken for neoplastic growth. In a clinical case necessitating a therapeutic splenectomy, it is necessary to remove AS tissue as well to resolve symptoms. We must be aware of possible ASs in the stomach. Histology and immunohistochemistry stains can guide our diagnosis.



### Association of Isolated Colitis With Nonsteroidal Anti-Inflammatory Drug Usage

(Poster No. 5)

**Ashbita Pokharel, MBBS** (ashbita.pokharel@beaumont.org); **Wei Li, MD, PhD**. Department of Anatomic Pathology, William Beaumont Hospital, Royal Oak, Michigan.

**Context:** Nonsteroidal anti-inflammatory drugs (NSAIDs) have been known to produce various clinical gastrointestinal side effects and histopathologic changes. It has been reported that NSAID usage is

associated with isolated colitis in the periappendiceal orifice region. This study aimed to further evaluate the clinicopathologic features of 16 patients with isolated colitis limited to the cecum or periappendiceal orifice region.

**Design:** A retrospective review was performed on biopsy specimens from 16 patients with histologically proven colitis (focal active colitis with no chronicity) limited to the cecum or periappendiceal orifice. No significant pathologic changes in the terminal ileum or other parts of the colon were identified in cases studied. Patients with a history of colorectal tumor or inflammatory bowel diseases were excluded from the study. Relevant clinical history, follow-up studies, and endoscopic findings were evaluated.

**Results:** Erosion, ulceration, and erythema were the main endoscopic findings in the cases studied. Among 16 cases, 9 (56%) had a history of routine NSAID usage. Among these 8 patients, 7 demonstrated resolution of pathologic abnormality after cessation of the drugs following repeated colonoscopy. Seven patients (44%) had nonroutine NSAID usage. After follow-up examination, none of the patients had infectious disease of the gastrointestinal tract or inflammatory bowel disease.

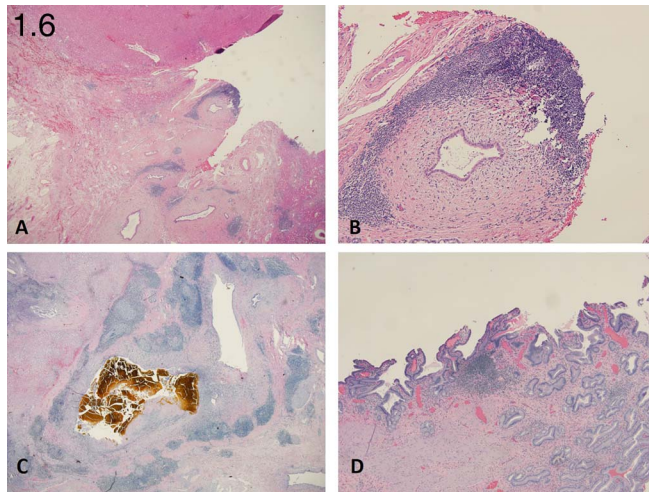
**Conclusions:** Our results confirm previously reported findings of a strong association of isolated colitis in the cecum or periappendiceal orifice region with NSAIDs. Our data support the conclusion that pathologic changes of isolated colitis are reversible after the cessation of NSAIDs.

### Segmental Cholangiectasia: A Diagnostic Pitfall for Radiologists

(Poster No. 6)

**Recep Nigdelioglu, MD** (rcpnig@gmail.com); Zong-Ming Eric Chen, MD, PhD. Department of Laboratory Medicine and Pathology, Mayo Clinic, Rochester, Minnesota.

Segmental cholangiectasia is a rare disease that appears to result from recurrent attacks of obstructive cholangitis and shares similar histologic features with recurrent pyogenic cholangitis, which is more common in Asian populations. The etiology is unclear. However, the role of *Escherichia coli* in promoting bile precipitation through its bacterial  $\beta$ -glucuronidase activity is widely accepted. Radiologically, segmental cholangiectasia can present as a mass or a biliary stricture, suggesting a cholangiocarcinoma or a cystic biliary neoplasm, which can be a big pitfall. We present a case of a 43-year-old man with abdominal pain and intermittent fevers during the past 2 years. MRI showed a gallbladder mass with accompanying left hepatic atrophy



suggesting a cholangiocarcinoma. A liver resection and cholecystectomy were performed. The gross pathologic examination of the gallbladder showed hemorrhagic sludgy material with no mass lesion in the liver or gallbladder. Sections of the liver showed hilar parenchymal atrophy, bile duct dilation (Figure 1.6, A), prominent periductal fibrosis (Figure 1.6, B), active and chronic inflammation with plasma cells, and focal intraductal cholelithiasis (Figure 1.6, C). The gallbladder showed chronic inflammation and prominent reactive lymphoid follicles, consistent with follicular cholecystitis (Figure 1.6, D). There was no epithelial dysplasia or malignancy. The IgG4/IgG index in plasma cells was less than 5%. Overall, the presence of intraductal cholelithiasis, ductal ectasia, and parenchymal atrophy was most consistent with segmental cholangiectasia (recurrent pyogenic cholangitis) of the liver. In conclusion, segmental cholangiectasia can be a clinical pitfall and should be considered by pathologists in the appropriate clinical context.

### Clinicopathologic Features of Benign Vascular Lesions of the Gastrointestinal Tract: A Single-Institution Experience

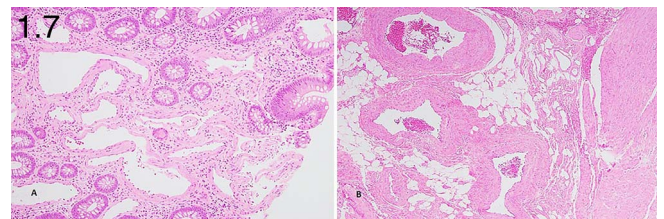
(Poster No. 7)

**Cansu Karakas, MD** (Cansu\_Karakas@urmc.rochester.edu); Aaron R. Huber, DO; Diana Agostini-Vulaj, DO. Department of Pathology and Laboratory Medicine, University of Rochester Medical Center, Rochester, New York.

**Context:** Various types of benign vascular lesions (BVLs) occur in the gastrointestinal (GI) tract. We sought to further evaluate and clinicopathologically characterize these entities.

**Design:** We searched our pathology archives from 2009 to 2021 for patients with BVLs. Clinicopathologic data were collected.

**Results:** There were 28 patients (46% women, 54% men) with a median age of 65 years (range, 35–81 years). Sites included the colon (n = 26), with the ascending colon being most common (n = 13); small bowel (n = 1); and stomach (n = 1). Patients presented for screening colonoscopy (n = 15), GI bleeding (n = 9), or nonspecific GI symptoms (n = 5). Endoscopically, polyps were most common (15 of 28, 54%), with size range 0.2–3.0 cm (median, 0.4 cm). Histologically, 18 (64%) were hemangiomas (Figure 1.7, A); 5 (18%) arteriovenous malformations (Figure 1.7, B); 2 (7%) portal colopathies; and 1 (3.5%) each hemangiolymphangioma, lymphangioma, and florid vascular proliferation. Fifteen (53%) involved mucosa, 5 (18%) submucosa, 6 (21%) both, and 2 (7%) were transmural. Erosion/ulceration was observed in 2 (7%). Concurrent lesions included 12 (43%) adenomas, 5 (18%) hyperplastic polyps, and 1 (3.5%) each leiomyoma, lipoma, and colon adenocarcinoma. Furthermore, 23 (82%) had additional comorbidities, with cardiovascular disease being most common (7, 25%). Only 2 had subsequent/recurrent BVLs (1 year and 6 months after initial diagnosis).



**Conclusions:** BVLs occur in elderly patients and are most commonly identified as small polyps on screening colonoscopy; however, a significant number may have GI bleeding. These entities can be further refined into a specific diagnosis with histologic examination, although this can be difficult with small biopsies. In our cohort, BVLs were most commonly reclassified as hemangiomas.

### Lymphoglandular Complexes Are Likely Diagnostic Pitfalls for Risk-Stratifying Colonic Adenomatous Polyps

(Poster No. 8)

**Cherry Pun, MD<sup>1</sup>** (cherry.pun@mail.utoronto.ca); Hala Faragalla, MD, MSc<sup>2</sup>; Jeffrey Mosko, MD, MSc<sup>3</sup>; Catherine Streutker, MD, MSc.<sup>2</sup>  
<sup>1</sup>Department of Laboratory Medicine and Pathobiology, University of Toronto, Ontario, Canada; <sup>2</sup>Department of Laboratory Medicine and <sup>3</sup>Division of Gastroenterology, Unity Health, Toronto, Ontario, Canada.

**Context:** Lymphoglandular complexes (LGCs) are present in the gastrointestinal tract where lymphoid aggregates reside beneath the overlying epithelium. They are known to cause defects in the muscularis mucosae and can traverse into the submucosa (SM). This can pose a diagnostic