Purpose: We report a successful ampullectomy of a partially prolapsing intraductal ampullary adenoma, using an improvised endoscopic technique by attaching an adjunctive tube to allow simultaneous passage of a balloon catheter and snare.

A 78-year-old woman with history of hypothyroidism was involved in a motor vehicle collision and underwent CT scan that incidentally revealed a 17x20-mm ampullary mass. On ERCP, the ampulla bulged with a soft polypoid tissue mass. FNA showed benign glandular cells. Respecting the patient’s wish to avoid Whipple procedure, we offered an endoscopic approach. ERCP was performed in the operating room with the patient supine. Intraductal tumor extension in the periampullary area was endoscopically seen. The ampulla was cannulated and sphincterotomy performed, taking the cut as high as possible. Segmental resection around ampulla edges using the hot snare removed the intraduodenal part of the mass.

A sterile hollow accessory tube was then attached to the endoscope. A snare was passed through the endoscope and a balloon catheter through the accessory tube. The snare was looped around the balloon. The balloon catheter tip was manipulated with the snare to cannulate the bile duct, passed over a wire to above the lesion, and then retracted, completely prolapsing the tumor. The looped snare was advanced over the balloon catheter and the entire prolapsed ampullary adenoma, completely resecting it. The resection site was impressive for deep tissue exposure to the level of the muscle fibers with ductal mucosa widely separated from the duodenal mucosa. Pancreatic and bile duct stents were placed. Duodencholedochal clipping was done around the stents, mimicking anastomosis. With no post-procedural complications, she was discharged home after a 24-hour observation period. A three-month follow-up ERCP showed patent ducts and resolution of the previously observed filling defect from the adenoma intraductal extension. EGD at six months revealed no residual adenomatous growth.

The only definitive therapy for intraductal ampullary adenoma is complete excision, but they are suboptimal candidates for standard ampullectomy. A custom-added accessory channel allowed successful utilization of two devices to completely excise an intraductal ampullar adenoma without surgical intervention.

Methods: N/A
Results: N/A
Conclusion: N/A
Somashekar Krishna: Nice technique. A pediatric snare can be passed in the same channel with a balloon as an alternative.

Julia LeBlanc: [No Comments]

Girish Mishra: [No Comments]

Rayburn Rego: [No Comments]
Purpose: Although uncommon, hemangiomas of the gastrointestinal (GI) tract have been reported in a variety of presentations, and can be a significant source of morbidity and even mortality. Blue rubber bleb nevus syndrome (BRBNS) is a rare diagnosis consisting of venous malformations of the skin, soft tissues and GI tract. We present a 41-year-old man found to have BRBNS on endoscopy, and discuss the literature regarding gastrointestinal hemangiomas and BRBNS management.

Case Report: A 41-year-old man with no significant past medical history presenting with chronic fatigue was noted to have iron deficiency anemia and occult positive stools. Colonoscopy revealed multiple blue-colored and vascular appearing lesions in the ascending, transverse and sigmoid colon. Upper endoscopy showed similar lesions in the esophagus, gastric body and duodenum. Histology of the resected lesions revealed submucosal cavernous hemangiomas with focal calcifications. A repeat colonoscopy performed three months later again showed blue-colored and vascular appearing lesions, but this time of the cecum and of the recto-sigmoid colon. These lesions were resected and retrieved. The patient was recommended to undergo surveillance colonoscopy in one year.

Discussion: We report a case of BRBNS presenting as symptomatic anemia. Treatment options are limited for this rare GI hemangioma syndrome, and usually consist of supportive and conservative management. Iron supplementation and transfusions for symptomatic anemia are the mainstay of therapy, but if recurrent bleeding occurs, endoscopic and surgical treatment may be warranted, as medical options have shown little, if any, proven benefit.

Methods: N/A

Results: N/A

Conclusion: N/A

A lesion seen in the terminal ileum.
A lesion with no bleeding was noted in the 1st portion of the duodenum.

**IMAGE CAPTION:** A lesion seen in the terminal ileum. A lesion with no bleeding was noted in the 1st portion of the duodenum.

(no table selected)

**AVERAGE SCORE:** 3.5

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
TITLE: Gastro-jejunal Obstruction Caused by Clotting After Gastric Bypass Surgery: A Case Series

PRESENTER: Jarred Marshak

PRESENTER (INSTITUTION ONLY): Winthrop University Hospital

PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: One of the most frequent surgical modalities for the treatment of obesity is the Roux-en-Y gastric bypass (RYGB). Previously described complications of RYGB include stomal stenosis, gastric staple line dehiscence, leaks, jejunal and gastric wall necrosis, and loculated fluid collections. Another reported complication is post-operative intraluminal bleeding, which is usually self-limiting. However, it is uncommon to encounter early gastric outlet obstruction secondary to intraluminal blood clots. Intraluminal blood clot formation causing obstruction post RYGB has been reported in only a few case reports, where management predominantly included laparotomy and surgical revision. We report a case series of 3 patients who developed intraluminal blood clots at the gastro-jejunal anastomosis following robotically-assisted RYGB occurring within 72 hours of surgery.

Our first case involves a 63-year-old woman with morbid obesity (BMI = 42) who presented with persistent nausea and vomiting for 3 days after an elective, robotically-assisted RYGB and laparoscopic lysis of adhesions. After the procedure, the patient underwent a routine upper GI series without evidence of leakage from the visualized pouch; however, there was no evidence of emptying into the alimentary limb. Physical exam revealed a distended abdomen which was appropriately tender to palpation at the surgical site. EGD was performed and a large blood clot was visualized at the anastomotic site, causing a gastric outlet obstruction. After unsuccessful attempts at irrigation of the clot, biopsy forceps were utilized to fragment the clot. Thereafter, an 8 mm balloon was advanced twice through the clot and inflated to successfully create a lumen. Case 2 and Case 3 include a 53-year old woman (BMI = 46) and a 29-year old woman (BMI = 43), respectively, who were both admitted for elective RYGB. Both patients experienced persistent nausea for 3 days after surgery. Upper GI series revealed retention of contrast in the gastric pouch, concerning for a gastro-jejunal anastomotic stricture. A subsequent EGD revealed friable, ulcerated, and granulated clot tissue at the gastro-jejunal anastomosis. Thus, a 10-mm gastroscope was passed across the surgical anastomosis to break the clot and relieve the obstruction allowing for passage into the alimentary limb.

Endoscopic dilation has become the elected treatment for gastrojejunal anastomotic stricture after RYGB, due to the low morbidity of this procedure. We highlight 3 cases of obstructing blood clots at the gastro-jejunal anastomosis managed endoscopically. Endoscopic evaluation and evacuation of clot and fibrinous material should be pursued prior to proceeding straight to laparotomy.

Methods: N/A

Results: N/A

Conclusion: N/A

AUTH DESIG: ACG Membership Status <font color="red">*</font>:

Kumkum Patel : ACG Member
Jarred Marshak : ACG Non-Member
Anik Patel : ACG Non-Member  
James Grendell : ACG Non-Member  
Collin Brathwaite : ACG Non-Member  
(No Image Selected)  
(no table selected)  
**AVERAGE SCORE:** 3.5  
**REVIEWER FLAGS:** (none)  
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None  
**REVIEWER COMMENTS:**  
Somashekar Krishna: [No Comments]  
Julia LeBlanc: [No Comments]  
Girish Mishra: [No Comments]  
Rayburn Rego: [No Comments]  
[No Comments]
Purpose: Studies have shown that poor nutrition during pregnancy can adversely affect maternal and fetal outcomes. We successfully managed 3 pregnant women with declining nutrition by inserting feeding tubes endoscopically. Patient 1 was a 37 year old G8P4A4L4 woman at 27 weeks of gestation who was admitted for a pontine hemorrhage. The patient was started on NG tube feeds. No neurologic improvement was seen in 2 weeks and a PEG tube was inserted endoscopically. Fetal condition was stable on initial serial evaluations. However, at 31 weeks of gestation, a cesarean-section was performed for a non-reassuring fetal heart rate and a pre-term infant was delivered with improving Apgar scores [Table 1]. Patient 2 was a 25 year old G2P0A0L1 woman at 18 weeks of gestation who presented with vomiting secondary to hyperemesis gravidarum refractory to anti-emetic therapy. Given her weight loss of 20 lbs and persistent symptoms, a PEG-J tube was inserted at 19 weeks gestation [Table 1]. She tolerated the tube feeds well and her symptoms improved with anti-emetic therapy. At 25 weeks of gestation the patient redeveloped persistent vomiting. EGD revealed a displaced PEG-J tube in the stomach which was repositioned into jejunum without any complications. A cesarean section was performed at 37 weeks of gestation due to preeclampsia. The patient delivered a 1,990 gram healthy infant. Patient 3 was a 30 year old G1P0A0L0 woman at 27 weeks of gestation who also presented with refractory hyperemesis gravidarum for the last 24 weeks. She had lost 10 lbs from her pre-pregnancy weight [Table 1]. A PEG-J tube was inserted at 28 weeks of gestation. She had a vaginal delivery at 37 weeks with a term infant weighing 2.400 grams. The feeding tube was removed in the latter two patients within 2 days after delivery with good tolerance of oral diet. This is the first series of 3 cases of endoscopically placed feeding tubes to maintain nutrition in pregnant women with poor oral nutrition. Ultrasound guidance was used to insert the tubes as the gravid uterus causes changes in the anatomy of the stomach. Continuous fetal monitoring was done to ensure fetal well being during the procedure. Endoscopically placed gastrostomy and jejunostomy tubes in such cases have been reported as 1-2 patient case reports previously in the literature (n=12), with good maternal and fetal outcomes and a low feeding tube related complication rate. Total parentral nutrition may not be a suitable option in these cases due to high risk of complications with TPN in pregnancy. Endoscopically inserted feeding tubes at an experienced facility may be a better alternative to TPN in pregnant women with poor oral nutrition for improved maternal and fetal outcomes.

Methods: NA

Results: NA

Conclusion: NA
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<th>Serial number</th>
<th>Comorbidities</th>
<th>Diagnosis</th>
<th>Age at presentation (in years)</th>
<th>Gestational age at tube insertion (in weeks)</th>
<th>Type of feeding tube</th>
<th>Weight loss before insertion of feeding tube (in lbs)</th>
<th>Weigh gain after insertion of feeding tube (in lbs)</th>
<th>Serum Albumin at the time of tube insertion (in g/dl)</th>
<th>Serum Albumin at the time of tube removal (in g/dl)</th>
<th>Pregnancy outcome</th>
<th>Weight of the newborn (in grams)</th>
<th>Apgar score of the newborn (at 0, 5, and 10 minutes)</th>
<th>Tube removal after delivery</th>
<th>Tube related complications</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hypertension, Gestational Diabetes, asthma, anemia, hepatitis C, polysubstance abuse</td>
<td>Pontine hemorrhage</td>
<td>37</td>
<td>28</td>
<td>PEG</td>
<td>None</td>
<td>None</td>
<td>NA</td>
<td>NA</td>
<td>Cesarean section at 31 weeks</td>
<td>1,660</td>
<td>2,5,7</td>
<td>Not done due to dysphagia</td>
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<td>2.</td>
<td>Type 1 diabetes, diabetic gastroparesis</td>
<td>Hysterectomy gravidarum</td>
<td>25</td>
<td>19</td>
<td>PEG-J</td>
<td>20</td>
<td>15.4</td>
<td>4.5</td>
<td>4.0</td>
<td>Cesarean section at 37 weeks</td>
<td>1,990</td>
<td>9,9,9</td>
<td>1 day</td>
<td>Dislodged once at 25 weeks of gestation replaced with EGD</td>
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<td>3.</td>
<td>Urolithiasis, Hypertension, Diabetes mellitus, Morbid obesity, GERD, polycystic ovarian syndrome, endometriosis, DVT</td>
<td>Hysterectomy gravidarum</td>
<td>30</td>
<td>28</td>
<td>PEG-J</td>
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<td>4.4</td>
<td>2.5</td>
<td>3.2</td>
<td>Vaginal delivery at 37 weeks</td>
<td>2,400</td>
<td>9,9,9</td>
<td>2 days</td>
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**TABLE TITLE:** Indications for percutaneous feeding tube insertion with related pre-pregnancy variables and post-pregnancy outcomes.

**AVERAGE SCORE:** 2.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
Splenic Injury After Colonoscopy: A Rare But Life-Threatening Occurrence

Mohammad Ali
Winthrop University Hospital
United States

Purpose: Colonoscopy is a safe procedure that is performed routinely worldwide. There is, however, a small but significant risk of splenic injury, as this case report highlights.

A 73-year-old female with a history of small bowel obstruction status post small bowel resection underwent colonoscopy for work-up of anemia. Colonoscopy revealed severe diverticulosis in the sigmoid, descending and transverse colon. Small sessile polyps were found in the sigmoid, ascending and descending colon, and were removed via cold and hot snare technique. Post-procedure, the patient developed abdominal pain, became hypotensive and had a drop in her hemoglobin. CT revealed a 13.9 cm x 9.5 cm x 12.9 cm clot in left upper quadrant suspicious for splenic injury. Surgical consultation was obtained, and the patient was taken to the OR.

The patient was found to have a large area of denuded spleen where the capsule was torn off over the anterolateral portion of the organ (60% of the surface area). 2.5 L of clot and blood were suctioned off and a splenectomy performed. The patient's post-operative recovery was complicated by splenic fossa abscess, treated with antibiotics. Since discharge, patient is doing well and has obtained the appropriate vaccinations.

Splenic rupture post-colonoscopy is a rare complication, with only 100 cases being reported in the literature to date. More common adverse outcomes are perforation and hemorrhage. The three hypothesized mechanisms of splenic injury are: 1.) Traction on the splenocolic ligament 2.) Adhesion formation between the spleen and colon after abdominal surgery 3.) Direct trauma to the spleen during difficult intubation of the colon. In our patient, it was likely due to a combination of adhesions from prior abdominal surgery, direct trauma to the spleen and existing splenic hemangiomas.

Methods: N/A
Results: N/A
Conclusion: N/A

Current Category: G. Clinical Vignettes/Case Reports
Current Sub-Category: K. Endoscopy
Presentation Type: Oral or Poster
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

Auth Desig: ACG Membership Status <font color="red">*</font>:
Mohammad Ali : ACG Non-Member
Elizabeth Williams : ACG Non-Member
Vineet Korrapati : ACG Member
Aleksandr Morim : ACG Non-Member
Bhawna Halwan : ACG Non-Member

Cross section CT scan of the abdomen before and after colonoscopy; Image on the right shows hemoperitoneum and a ruptured spleen.
CT Scan showing the post-splenectomy splenic bed.

**IMAGE CAPTION:** Cross section CT scan of the abdomen before and after colonoscopy; Image on the right shows hemoperitoneum and a ruptured spleen.

CT Scan showing the post-splenectomy splenic bed.

<table>
<thead>
<tr>
<th>Procedure</th>
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<tr>
<td>ERCP</td>
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<td>Liver Surgery</td>
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<td>Gastroscopy</td>
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<td>Displaced CAPD Catheter</td>
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### TABLE TITLE: Cases of splenic rupture following a medical procedure

**AVERAGE SCORE:** 3.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
- Somashekar Krishna: [No Comments]
- Julia LeBlanc: [No Comments]
- Girish Mishra: [No Comments]
- Rayburn Rego: [No Comments]

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<td>Laparoscopy</td>
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<td>Hysterectomy</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>98</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>
Gastric Inflammatory Fibroid Polyp Presenting with Occult Bleeding and Anemia

Sara Ancello

University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine

Purpose: Inflammatory fibroid polyps (IFPs) are rare, benign, submucosal, sessile or pedunculated polyps which can occur anywhere along the gastrointestinal (GI) tract. Roughly 80% are found in the gastric antrum. Incidence is low, accounting for less than 3% of all GI polyps. IFPs can be asymptomatic or present with bleeding, abdominal pain and/or dyspeptic symptoms. Immunohistochemical staining is diagnostic. Treatment typically requires surgical resection to alleviate symptoms, and/or to stop bleeding. We report the case of a 61-year-old male who presented with occult bleeding and anemia, and was found on endoscopy to have a 5-6-cm submucosal gastric mass prolapsing into the duodenum. Immunohistochemical staining was consistent with the diagnosis of IFP. The patient was subsequently taken to the operating room for surgical resection. Following excision, the anemia resolved and he maintained a stable blood count at discharge. While uncommon, IFPs are benign lesions that should be considered in the differential diagnosis of patients with occult bleeding and anemia. Resection with clean margins leads to resolution of symptoms and typically does not show reoccurrence.

Methods: N/A

Results: N/A

Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports

CURRENT SUB-CATEGORY: K. Endoscopy

PRESENTATION TYPE: Poster Only

Supported by Industry Grant: No

Commercial Products or Services: No

Initiated Research: Investigator

Financial Relationships: No

FDA Approval: No

Designed Study: Investigator

Abstract Author: Investigator

AUTH DESIG: ACG Membership Status

Sara Ancello : ACG Non-Member
Ricardo Prieto Roig : ACG Non-Member
Jon Finan : ACG Non-Member
Patrick Brady : ACG Member

IFP prolapsing through the pylorus

Polyp in the duodenum
H&E stain shows spindle shaped cells and a background of inflammatory cells with increased eosinophils

**IMAGE CAPTION:** IFP prolapsing through the pylorus Polyp in the duodenum H&E stain shows spindle shaped cells and a background of inflammatory cells with increased eosinophils

(no table selected)

**AVERAGE SCORE:** 4.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
Herald Bleeding: A Hidden Catastrophe

Parag Brahmbhatt
East Tennessee State University, United States

Purpose: The word “Herald” means to indicate or sign that something is about to happen. Herald bleeding is defined as an episode of hemorrhage, often accompanied by abdominal pain, which may precede, by hours to weeks, a catastrophic hemorrhage.

Case Report: A 57-year old male with past medical history of abdominal aortic aneurysm repair around 15 years ago and peptic ulcer disease diagnosed 10 years ago, presented to the hospital with maroon-colored stool of 2 weeks’ duration, along with a few days' onset of melena, coffee ground emesis and sharp epigastric pain. Medications included plavix, protonix, tramadol and occasional NSAIDs. Physical examination revealed normal vital signs, and epigastric tenderness without any peritoneal signs.

Laboratory analysis showed hemoglobin of 7.1 mg/dL, platelets of 355,000/μL and INR of 1.2. A CT scan of abdomen and pelvis with IV contrast showed 1.6 x 1.6 x 1.8 cm saccular aneurysm originating from the termination of the distal abdominal aorta without adjacent acute findings, and 3.1 cm aneurysm infrarenal abdominal aorta with circumferential thrombus. Upper gastrointestinal endoscopy showed L.A. grade B esophagitis and hiatal hernia. Colonoscopy showed a scant amount of blood in colon without any obvious bleeding source. Tagged RBC scan was negative. Second look endoscopy was performed with pediatric colonoscope, revealing 3 to 4 mm clean based ulcer over 4th portion of duodenum, and 2 vascular clips were placed. Vascular surgery was consulted and, based on the location of the ulcer on the lateral wall of the abdominal aorta, along with CT finding of induration and inflammation of the aortic graft right at the renal arteries, suspicion was made for Aortoenteric fistula (AEF). The patient underwent emergent laparotomy and was found to have AEF. The patient then underwent repair of AEF with a successful outcome.

Discussion: AEF is a direct connection between abdominal aorta and gut, most commonly duodenum. It occurs in 0.3-4% of patients who underwent open AAA repair. The most common clinical manifestations are upper or lower gastrointestinal bleeding (Herald bleeding) (64%), abdominal pain (32%) and a pulsatile abdominal mass (25%). The proposed theories for the formation of primary ADF are direct wear and inflammatory destruction triggered by infection, foreign bodies or erosions. The characteristic site of formation is the 3rd or 4th part of the duodenum. AEF should be considered in all patients with GI bleeding and a history of AAA or previous aortic revascularization with prosthetic graft. A high index of suspicion is the key. The mortality rate of untreated AEF is 100%. Surgical intervention is mandatory for survival and successful outcome.
Parag Brahmbhatt : ACG Member
Jennifer Phemister : ACG Non-Member
Antwan Atia : ACG Member
Jason McKinney : ACG Member
Lawrence Schmidt : ACG Non-Member
Mark Young : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 4.75
**REVIEWER FLAGS:** (none)
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Purpose: A 36-year-old man presented with a 2 day history of epigastric abdominal pain and vomiting. His medical history was significant for a sleeve gastrectomy in 2010 complicated by post-operative gastroesophageal junction (GEJ) leak with 4 prior attempts at endoscopic stent therapy. A plain film of the chest identified 3 proximally placed self-expandable metal stents and 1 stent was noted to have migrated distally to the ileum.

Esophagogastroduodenoscopy (EGD) was carried out and the 3 proximal esophageal stents were removed. Antegrade double balloon enteroscopy under fluoroscopic guidance was then performed and the scope was advanced to the level of the mid ileum. The distally migrated esophageal stent was identified and found to be impacted in an area of matted bowel adjacent to a percutaneous drain previously placed for a fluid collection. Due to poor positioning of the stent, the proximal edge could not be visualized. Multiple attempts at trying to reposition the stent proved unsuccessful. The enteroscope was then passed through the lumen of the stent and the overtube balloon was inflated at the distal end of the stent to allow for traction. The endoscope balloon was inflated at the proximal edge of the stent for protection of bowel mucosa. With both balloons remaining inflated, the scope was slowly withdrawn, dragging the stent proximally (Fig. 1). Once in the more proximal jejunum, the balloons were deflated and the stent was successfully retrieved using 2 biopsy forceps. The patient tolerated the procedure well with no complications.

We present the first reported case of this novel technique for retrieval of an impacted esophageal stent from the ileum with the use of antegrade double balloon enteroscopy. There have been reports of esophageal stent migration to the small bowel which subsequently required laparoscopic removal after failed trials of rectal passage. This case helps add to the expanding literature on therapeutic techniques and implications for double balloon enteroscopy. Endoscopists may utilize this technique to help patients avoid more invasive surgical procedures.

Methods: N/A
Results: N/A
Conclusion: N/A
REVIEWER COMMENTS:
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
Purpose: A 79-year-old woman with multiple medical problems presented to the hospital with metabolic encephalopathy secondary to severe hyponatremia from excessive fluid intake. Hyponatremia had successfully resolved with fluid restriction.

During the hospital stay, her hemoglobin dropped from 11.8 to 7.7 gm/dL, and guaiac stool test was positive. Physical examination was benign, and no evidence of upper gastrointestinal bleed was noted. After one unit of blood transfusion, hemoglobin stabilized. Colonoscopy showed multiple diverticula in the sigmoid colon without any evidence of bleeding. Multiple polyps ranging from 8-12 mm in size were also observed in the cecum, ascending colon, transverse colon, sigmoid colon and rectum. Most of these polyps showed evidence of bleeding from the surface. Multiple polypectomies were performed to remove these polyps, and multiple endoclips were placed.

Twelve hours after the procedure, the patient complained of severe diffuse abdominal pain. Physical examination revealed diffuse abdominal tenderness even with light palpation, but no guarding. White blood cell count was normal and hemoglobin was stable. Abdominal radiograph did not show free air. Computed tomography of the abdomen revealed no free air, but wall thickening of the cecum and proximal ascending colon was noted. Based on imaging and laboratory testing, usual complications of colonoscopy were excluded. Due to persistent abdominal pain, post-polypectomy syndrome was suspected. Patient was treated with ciprofloxacin and metronidazole for five days. The patient improved clinically.

The most common complications of colonoscopic polypectomies are bleeding and colonic perforation. Post-polypectomy syndrome is also a complication present in about 0.5% to 2% patients. The thermal energy that is used during polypectomy sometimes extends beyond the mucosa deep into the serosa, leading to localized peritoneal inflammation and, consequently, local peritonitis. The patients usually present between 12 hours and five days after polypectomy with localized abdominal tenderness, guarding, fever and leukocytosis.

Post-polypectomy syndrome clinically presents similarly to perforation, but management and prognosis are different. Perforation presents with free air on abdominal radiograph and computed tomography (CT). Post-polypectomy syndrome lacks presence of free air, but can present with focal colonic wall thickening on abdominal CT. Treatment includes broad-spectrum antibiotics, intravenous hydration, and bowel rest. Diagnosis of post-polypectomy syndrome should not be missed, because although an uncommon complication of colonoscopic polypectomy, it can cause significant distress to the patient.

Methods: N/A
Results: N/A
Conclusion: N/A
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Kirti Basil : ACG Non-Member
Rangan Murali : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 5

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
ABSTRACT BODY:

Purpose:
Background:
Extranodal non-Hodgkin's lymphoma (NHL) commonly is found in the GI tract; however, small bowel follicular lymphoma remains a rare diagnosis. The incidence of primary gastrointestinal NHL has been reported to be 2.39 per 100,000 people, and the subset of follicular lymphoma only represents 8% of these cases. Gastrointestinal lymphoma is commonly diagnosed via endoscopic biopsy, and previous studies have demonstrated the use of double balloon enteroscopy (DBE) to diagnose follicular lymphoma. We present what we believe is the first case of follicular lymphoma diagnosed by spiral enteroscopy (SE).

Case:
Patient is a 70 year old male with history of NHL first diagnosed in his descending duodenum 13 years ago. His lymphoma at this time was low grade and never treated. Surveillance imaging and endoscopies, in the interim, remained negative for recurrence. Recently, he presented for evaluation of nausea and abdominal pain x 24 hours and was diagnosed with small bowel obstruction (SBO). His CT abdomen demonstrated obstruction with transition point in the mid-jejunum with mild bowel wall thickening, but without discrete mass at this site. He was managed conservatively with NPO and NG tube decompression, with return of bowel function by hospital day 2. Previously, he had two similar presentations necessitating admission for SBO, one 1 month prior, another 2 years ago, with multiple imaging studies negative for abdominal mass. EGD done on the prior admission was similarly unremarkable with normal duodenal biopsies. Subsequently, he underwent outpatient SE. On endoscopy, localized areas of white, granular mucosa were noted throughout the jejunum, with a similar appearing area of stenosis in the mid-jejunum. Cold forceps biopsies were taken which revealed low-grade follicular lymphoma, suggested by dense lymphoid aggregate of CD20+, bcl2+ cells with molecular studies positive for bcl2-IgH fusion transcript.

Conclusion:
The diagnosis of follicular lymphoma is often made by incidental finding on endoscopy, with lesions most often presenting in the duodenum. The diagnosis in small bowel, beyond the duodenum, remains challenging, especially because tissue sampling is needed to confirm the diagnosis even if it is suspected on imaging or video capsule. Previous reports have demonstrated that DBE is helpful to diagnose malignant lymphoma of the small intestine at earlier stages as well as to diagnose recurrence after lymphoma was in remission. We believe this case represents the first report in the literature of follicular lymphoma diagnosed by SE, proving that SE a highly effective as well as safe modality for diagnosis and staging of small bowel lymphoma.

Methods: N/A
Results: N/A
Conclusion: N/A
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>

- David Anjelly: ACG Non-Member
- James Watson: ACG Member
- Paul Akerman: ACG Member

(No Image Selected)
(no table selected)

AVERAGE SCORE: 5

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
- Somashekar Krishna: [No Comments]
- Julia LeBlanc: [No Comments]
- Girish Mishra: [No Comments]
- Rayburn Rego: [No Comments]
CONTROL ID: 1728457
TITLE: Water Exchange Colonoscopy without Air Insufflation May Facilitate Terminal Ileum Intubation
PRESENTER: Aung Kaung
PRESENTER (INSTITUTION ONLY): Veneren Affairs West Los Angeles Medical Center
PRESENTER (COUNTRY ONLY): United States
ABSTRACT BODY:
Purpose: We report that colonoscopy without air insufflation may facilitate terminal ileum intubation and examination in a difficult case.

Case:
A 78-year-old male was admitted with melena with hypotension. Hemoglobin level was 11.4 g/dl dropped to 7.5 g/dl with fluid resuscitation, a decrease from baseline of 14 g/dl. EGD did not reveal a bleeding source. He developed hematochezia with blood clots. Angiogram and technetium labeled RBC scan did not identify the bleeding site. Push enteroscopy using Pentax 3490 pediatric endoscope did not reveal evidence of bleeding to mid-jejunum. Colonoscopy with air insufflation using pediatric and adult colonoscopes (Table 1) revealed red clots in the distal ileum, which could be intubated only to ~5 cm proximal to the IC valve. If the endoscope was advanced further, paradoxical movement would repel it back into the cecum. After supportive care for 5 days, his hematochezia resolved. Repeat water exchange colonoscopy by a standard enteroscope (Table 1) without air insufflation allowed examination of ~100 cm of the distal ileum. No bleeding source was identified. He was discharged 2 days later.

Discussion:
First colonoscopy was performed following push enteroscopy with diagnostic and therapeutic intent to treat bleeding. Substantial air could have been introduced into the small bowel during push enteroscopy. Hence, it would require more time and thorough examination of the colon compared to the colonoscopy done after bleeding cessation. Ileal intubation with the enteroscope, with greater length and different handling characteristics to adult/pediatric colonoscopes, was not attempted with the air insufflation method.
In both methods, water was used extensively. However, in the second session of colonoscopy, air insufflation was not used and infused water was suctioned during insertion to minimize colonic distension. This allowed less sedation, less looping and examination of terminal ileum to a much greater extent. (Table 1)

Conclusion:
Our findings suggest that water exchange colonoscopy may facilitate terminal ileum intubation in a difficult case and deserves further evaluation.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Aung Kaung : ACG Non-Member
Eric Chak : ACG Non-Member
Table 1: Comparison of the two methods of colonoscopy used in the same patient

<table>
<thead>
<tr>
<th>Method(s)</th>
<th>Standard</th>
<th>Water Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Insufflation during insertion</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Indication</td>
<td>Hematochezia, Following Push Enteroscopy</td>
<td>Post hemorrhage</td>
</tr>
<tr>
<td>Sedation</td>
<td>IV versed 6mg, fentanyl 125 mcg</td>
<td>IV versed 4mg, fentanyl 100 mcg</td>
</tr>
<tr>
<td>Endoscope(s)</td>
<td>Colonoscopes: Pentax EC-3490Li and Pentax EC-3890Li (both 160 cm)</td>
<td>Enteroscope: Pentax VSB-3430K (230 cm)</td>
</tr>
<tr>
<td>Water infused during insertion to the cecum</td>
<td>Volume not recorded</td>
<td>2700 ml</td>
</tr>
<tr>
<td>Water suctioned during insertion to the cecum</td>
<td>Volume not recorded</td>
<td>2600 ml</td>
</tr>
<tr>
<td>Finding at cecum</td>
<td>Clot in cecum, red blood with clots coming from IC valve</td>
<td>No blood in cecum or coming from IC valve</td>
</tr>
<tr>
<td>Length of colonoscope in patient upon arrival at the cecum</td>
<td>Not recorded</td>
<td>80 cm</td>
</tr>
<tr>
<td>TI intubation</td>
<td>Inability to intubate &gt; 5 cm due to paradoxical movement despite use of 2 different colonoscopes</td>
<td>Intubated ~100 cm proximal to IC valve with enteroscope (230 cm)</td>
</tr>
</tbody>
</table>
## Special interventions

Paradoxical movement:
- Repellence of colonoscope to cecum when both colonoscopes advanced further in cecum

- Enteroscope pulled back 20 cm (loop reduction) whenever paradoxical movement occurred and pushed forward with application of abdominal pressure
- The process repeated ten times to reduce looping

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>5 cm proximal to IC valve</th>
<th>~100 cm proximal to IC valve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>120 min</td>
<td>80 min</td>
</tr>
<tr>
<td>Patient position</td>
<td>Left lateral -&gt; Supine</td>
<td>Left lateral -&gt; Supine -&gt; Left lateral -&gt; Supine</td>
</tr>
<tr>
<td>Use of abdominal compression</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Abbreviations:** EGD, esophagogastroduodenoscopy; IC, ileocecal; IV, intravenous; TI, terminal ileum

**TABLE TITLE:** Table 1: Comparison of the two methods of colonoscopy used in the same patient

**AVERAGE SCORE:** 5.25

**REviewer flags:** (none)

**Reviewer recommendation code description:** None

**Reviewer comments:**
- Somashekar Krishna: [No Comments]
- Julia LeBlanc: [No Comments]
- Girish Mishra: [No Comments]
- Rayburn Rego: [No Comments]
Purpose: A 65 year old man with gastric adenocarcinoma with extension into the distal esophagus underwent partial esophagogastrectomy with gastric pull-up and stapled anastomosis. Postoperatively, the patient developed an anastomotic leak. Primary closure of the leak was performed with a pleural patch, but failed. The patient was a poor candidate for further surgical intervention, thus endoscopic closure was pursued.

A 12cm by 2.2cm partially covered self-expanding metal stent (PCSEMS; Wallflex, Boston Scientific, Natick, MA) was placed across the 1cm defect. A PCSEMS was chosen in order to decrease risk of stent migration. Post-placement contrast study showed no extravasation; the patient was able to tolerate a soft diet.

Six weeks after PCSEMS placement, EGD showed the stent embedded across the anastomosis with hyperplastic tissue at the ends of the stent. A stent-in-stent technique was then used to remove the PCSEMS. A 12cm by 2.2cm fully covered self-expanding metal stent (FCSEMS; Wallflex, Boston Scientific, Natick, MA) was deployed within the PCSEMS [Figure 1]. After four weeks of dual stenting, both stents were removed without significant resistance by grasping the stent drawstrings [Figure 1]. Contrast study confirmed leak closure. The patient continues to tolerate a solid diet.

In benign esophageal conditions such as leaks and fistulas, PCSEMS have the advantage of mucosal anchoring, with a more secure placement and likely improved seal of defects. This benefit is also their main drawback, leading to difficult removal with higher risk of complications such as severe bleeding or perforation.

The stent-in-stent technique results in pressure necrosis by the inner FCSEMS onto the hyperplastic mucosa. This causes the tissue to recede, allowing for removal of the PCSEMS.

Esophageal leaks and fistulas are associated with high surgical morbidity and mortality. Endoscopic closure with the stent-in-stent technique could be a safe, effective and less invasive alternative.
James Sattler: ACG Non-Member
Viktor Eysselein: ACG Member

Partially-covered metal stent in the distal esophagus (A). Six weeks after placement (B). Fully-covered metal stent placed within the partially-covered metal stent (C). Endoscopic appearance after stents removed. Residual surgical suture, arrow (D).

**IMAGE CAPTION:** Partially-covered metal stent in the distal esophagus (A). Six weeks after placement (B). Fully-covered metal stent placed within the partially-covered metal stent (C). Endoscopic appearance after stents removed. Residual surgical suture, arrow (D).

**AVERAGE SCORE:** 4
**REVIEWER FLAGS:** (none)
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None
**REVIEWER COMMENTS:**
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
Purpose: Hepatic portal venous gas (HPVG), a rare condition in which gas accumulates in the portal venous circulation, is often associated with significant underlying pathology such as intestinal ischemia, inflammatory bowel disease, sepsis and trauma. HPVG after endoscopic procedures is an unusual complication.

A healthy 34-year-old male with a past medical history significant for eosinophilic esophagitis presented to his physician with dysphagia to both liquids and solids. Subsequently, he underwent upper endoscopy for further evaluation. Upper endoscopy revealed esophageal mucosal changes suggestive of eosinophilic esophagitis including loss of vascular pattern and whitish exudates along the middle third of the esophagus. A benign appearing stricture was also noted at the gastroesophageal junction. This stricture was dilated with a balloon size of 18mm. Biopsies were taken to confirm the diagnosis of eosinophilic esophagitis. The procedure was then terminated with no noted complications. However, post procedurally the patient experienced significant nausea and epigastric pain. Physical exam demonstrated diffuse epigastric tenderness to palpation with no guarding or rigidity. Laboratory workup revealed a normal complete blood count as well as normal liver and pancreatic enzymes. Computerized tomography demonstrated diffuse portal venous gas throughout the right hepatic lobe extending to the periphery of the liver (Figure 1). The patient was admitted for observation and treated conservatively with IV fluids and pain control. He was discharged the following day with resolution of his symptoms. Follow up CT scan revealed no residual portal vein air and he continues to do well at 6 months.

This case highlights an unusual complication of HPVG after upper endoscopy and dilation and the role of conservative management. As endoscopy continues to serve as a therapeutic role in management of many GI disorders, potential for an increase in complications is likely. Recognition of HPVG as a transient complication is critical to guiding appropriate therapeutic management.

Methods: NA
Results: NA
Conclusion: NA

AUTH DESIGN: ACG Membership Status:
Kristina Seeger : ACG Non-Member
Sami Achem : ACG Non-Member

Diffuse portal venous gas is seen throughout the right hepatic lobe extending to the periphery of the liver.

IMAGE CAPTION: Diffuse portal venous gas is seen throughout the right hepatic lobe extending to the periphery of the liver.
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
CONTROL ID: 1734090
TITLE: To Biopsy or Not to - That is the Question!
PRESENTER: Sweta Kochhar
PRESENTER (INSTITUTION ONLY): UAMS
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: Case: A 64-year-old previously healthy male was referred for endoscopic ultrasound (EUS) evaluation of a cystic lesion in the left upper quadrant of the abdomen. Computed tomography (CT) revealed a 15 x 13 cm predominantly fluid-filled cystic mass with a peripheral nodular/irregular thick density wall. A differential of pseudocyst or gastric duplication cyst was considered. This exophytic mass abutted the lateral wall and greater curvature of the stomach. Esophagogastroduodenoscopy revealed a sub-mucosal bulge on lesser curvature of the stomach, but no mucosal defect. EUS measured this mass at 12 x 10 cm. It was a large unilocular cyst with a thick irregular wall, which abutted the wall of the stomach (Image A). The pancreas was normal and separate from the cyst. The cyst was punctured with a 19 G needle, and brownish liquid was obtained that was sent for carcino-embryonic antigen (CEA) and amylase levels. The wall of the cyst was thick (Image B), and hence the decision was made to biopsy for cytology. The results of CEA (0.5 ng/mL) and amylase (25 U/L) were normal. The biopsy from the wall of this cyst demonstrated epithelioid gastrointestinal stromal tumor (GIST), which was positive for c-KIT/CD-117 (strong/diffuse/cytoplasmic) and CD-10 (weak/focal/cytoplasmic), but negative for PAX, RCC, CD34, CK (AE1/3) markers. A correct diagnosis of GIST was made. The patient is being evaluated by oncology and surgery for appropriate management.

Discussion: This presentation is unique because most GISTs present as solid small masses. This was a histological surprise, as we expected the cytology to be otherwise. Our case illustrates the importance of obtaining biopsy from the wall of the cyst, without which a correct pathological diagnosis would not have been made. We recommend FNA-biopsy of all cysts with thick walls seen by EUS, except possibly pseudocysts.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only

AUTH DESIG: ACG Membership Status: Sweta Kochhar : ACG Member
Mohit Girotra : ACG Member
Rayburn Rego : ACG Member
Pneumatosis Cystoides Intestinalis: The Importance of Endoscopic Recognition

Eduardo Rodrigues-Pinto

Centro Hospitalar São João
Portugal

Purpose: Introduction: Pneumatosis cystoides intestinalis is a rare clinical entity in which there are gaseous cystic collections in the wall of the gastrointestinal tract. It is usually associated with obstructive pulmonary disease, being there other possible causes, however, in 15% of the cases, the etiology is unknown.

Case presentation: A male patient, 58-years old, was submitted to screening colonoscopy due to family history of colon neoplasmia. He had no complaints other than intestinal meteorism. In the first colonoscopy, performed at an outpatient clinic, there were described multiple sessile polyps in the sigmoid colon. Colonoscopy was repeated afterwards, and previously reported polyps were in fact multiple sessile, ball-shaped subepithelial nodules that were clustered in streaks, scattered mainly in the left colon, suggestive of pneumatosis cystoides intestinalis. Some of the nodules were covered with a reddish mucosa, but most of them had normal mucosa. Biopsies were made with the intention to reveal the air cysts, and some of them were deflated after puncturing with a needle, with resolution of the cystic cavities. Abdomino-pelvic computed tomography (CT) confirmed the cysts, with visualization of air bubbles in the intestinal wall. No other abnormalities were identified. No underlying disease was found, and the patient remained asymptomatic until now.

Discussion: Colonoscopy can confirm pneumatosis colonic forms. Biopsies of the submucosal lesions can reveal the air cysts underneath the mucosa, and these can be posterior deflated if punctured.

Conclusion: The importance of endoscopic diagnosis lies in the differential diagnosis with colonic polyps, once the risk of perforation is increased, if polypectomy is performed.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">^</font>:
Eduardo Rodrigues-Pinto : ACG Non-Member
Pedro Pereira : ACG Non-Member
Guilherme Macedo : ACG Member
AVERAGE SCORE: 2.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Somashekar Krishna: [No Comments]
Julia LeBlanc: [No Comments]
Girish Mishra: [No Comments]
Rayburn Rego: [No Comments]
Purpose: To demonstrate the feasibility of stenting from gastroesophageal junction (GEJ) to duodenal bulb in the treatment of a large 5.0 cm gastric dehiscence/perforation related to a gastric sleeve gastrectomy complication.

Methods: A 43 year old morbidly obese male underwent a laparoscopic vertical sleeve gastrectomy complicated 3 days latter by complete dehiscence of the gastric sleeve resulting in a 5 cm long gastric perforation with resultant peritonitis. This was confirmed by laparoscopy and attempted emergent surgical closure which failed. The patient progressed to sepsis, respiratory and renal failure. Stenting of the GI tract from the GEJ to the duodenal bulb was achieved using a 12 cm partially covered stent proximally and a 15 cm fully covered stent distally. The proximal rim of the distal stent was secured to the distal end of the proximal stent using Resolution clips to prevent distal stent migration. Immediate gastrografin study revealed a small leak. The patient was kept NPO for 2 weeks with a follow up study confirming closure of the leak.

Results: The stents were removed 5 weeks latter. A repeat gastrografin study at that time revealed no leak. The patient was able to resume oral intake. EGD 3 months after initial stenting confirmed complete healing of the prior dehiscence with the patient tolerating a regular diet.

Conclusion: Endoscopic stenting of a gastric perforation/dehiscence as large as 5.0 cm with complete healing and closure is achievable with esophageal wall stents that are fully covered and secured with Resolution clips.

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: Yes
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: Yes
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Mark Johnston : ACG Member
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Devi Rampertab: Spelling errors, but this is novel topic.
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
ABSTRACT BODY:

**Purpose**: BACKGROUND: Retrorectal cyst hamartomas or tail gut cysts (TGC) are rare developmental cysts that arise in the retrorectal region. They are most commonly seen in middle-aged women. Traditionally, pathologic diagnosis of TGC was provided on surgical resection. However, recently, endoscopic ultrasound (EUS) with fine needle aspiration (FNA) has been used to establish diagnosis. So far, only one case of tail gut cyst diagnosed by EUS guided FNA has been reported. We report another rare case of tail gut cyst diagnosed by EUS guided FNA.

**CASE REPORT**: A 46-year-old female with lower abdominal pain was referred to our institution for evaluation of perirectal mass noted upon digital rectal examination. She had an unremarkable colonoscopy. CT abdomen revealed a multiloculated cystic mass anterior to the lower sacrum to the right of midline and posterolateral to the rectum. EUS showed a well-delineated hypoechoic mass with a few cystic spaces measuring 3.7 x 3.4 cm in the retrorectal space anterior to the sacrum at 15 cm from the anal verge. The lesion involved the serosa and had both solid and cystic components. FNA of the lesion was performed and was consistent with anucleate squamous cells with mild atypia, keratin debris with scattered multinucleated histiocytes consistent with TGC. Post procedure, patient developed perirectal abscess due to inadequate antibiotic prophylaxis which was drained. Patient improved clinically and is scheduled to follow up with surgery for further management.

**Methods**: NA

**Results**: NA

**Conclusion**: TGC affecting the anorectum can be asymptomatic or cause mass-related symptoms such as pain or constipation. Malignant components have only been rarely reported in these anomalies. Differential includes epidermoid cyst, dermoid cyst and rectal duplication cyst. These are usually unilocular versus TGCs which are multilocular. EUS guided FNA may provide an accurate and reliable diagnosis of TGC. This less invasive technique has the potential to be used as an alternative to surgery for establishing diagnosis. This may allow observation and avoid surgery in asymptomatic patients. Further studies are needed to help establish the safety and efficacy of this promising method.

**CURRENT CATEGORY**: G. Clinical Vignettes/Case Reports

**CURRENT SUB-CATEGORY**: K. Endoscopy

**PRESENTATION TYPE**: Poster Only

**ACG Research Grant Support**: No

**Supported by Industry Grant**: No

**Commercial Products or Services**: No

**Initiated Research**: Investigator

**Financial Relationships**: No

**FDA Approval**: No

**Designed Study**: Investigator

**Abstract Author**: Investigator

**AUTH DESIG: ACG Membership Status**: Harini Rathinamanickam : ACG Member

Swati Pawa : ACG Member

Vicki Williams : ACG Non-Member

**EUS IMAGE OF TGC

**IMAGE CAPTION**: EUS IMAGE OF TGC

(no table selected)

**AVERAGE SCORE**: 4.5

**REVIEWER FLAGS**: (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION**: None
REVIEWER COMMENTS:
Devi Rampertab: well written but ? value
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
INTRODUCTION: Submucosal lesions in the colon represent a wide differential of conditions, from benign lesions to aggressive malignancies. We present a case of a submucosal lesion of unusual etiology.

CASE PRESENTATION: A 24 year-old man presented with painless rectal bleeding. His past medical history included an abdominal gunshot wound 3 years prior, for which he underwent exploratory laparotomy. Review of systems was otherwise negative. Physical exam was unremarkable. Laboratory evaluation showed a hemoglobin of 14.3 g/dL and a normal white blood cell count and differential.

A colonoscopy was performed showing a submucosal lesion at the rectosigmoid junction and internal hemorrhoids. An endoscopic ultrasound was performed, which showed a 15mm by 9.8mm hypoechoic lesion with surrounding submucosal wall thickening and a ring-shaped, hyperechoic focus with shadowing in the center of the lesion. An endoscopic mucosal resection was performed using a Duette kit. During the resection, pus was seen extravasating from the center of the lesion and a piece of metal was seen in the center of the lesion. It was retrieved with a rat tooth forceps and two endoclips were placed over the site to prevent bleeding. External inspection proved the metal to be a fragment of a bullet. The patient was discharged home on antibiotics.

CONCLUSION: Gastrointestinal injury secondary to gunshot wounds is described in the literature as intestinal perforations requiring surgical intervention. This is a unique case in that the bullet became embedded within the submucosa of the colon without causing perforation. Instead, formation of a walled-off abscess surrounding the bullet was formed over several years and was only discovered incidentally on colonoscopy done for rectal bleeding (likely of hemorrhoidal origin).
AVERAGE SCORE: 2.5
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Devi Rampertab: Excellent!!
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
Obliteration of Schatzki rings in patients with refractory dysphagia utilizing multiple standard endoscopic biopsies

PRESENTER: Aaron Bellows
PRESENTER (INSTITUTION ONLY): University of Miami
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: The Schatzki ring, a benign lower esophageal structural anomaly, is one of the most common causes of dysphagia and intermittent food impaction. Therapy for Schatzki rings has traditionally utilized esophageal dilation with either bougienage or balloon dilators. No clear advantage has been demonstrated between these dilator types and both are associated with recurrent dysphagia. Alternatively, endoscopic electrosurgical incision of the fibrous, elastic core of Schatzki rings has been shown to be an efficacious treatment modality ever since it was first described almost thirty years ago in two patients who did not respond to conventional bougienage. However, the needle knife is not commonly employed during upper endoscopy, and its use in the treatment of benign esophageal strictures is likely to be technically difficult among most gastroenterologists with a risk of serious complications. In a fashion similar to that of electrosurgical incision, direct disruption of Schatzki rings may be more feasibly achieved with standard endoscopic biopsy forceps. To our knowledge, no study or case series has described ring obliteration by endoscopic biopsy forceps in patients who have refractory dysphagia after Savary dilation or through-the-scope balloon dilation. In our case series, we describe three individuals who underwent Schatzki ring obliteration utilizing multiple biopsies with standard forceps after undergoing conventional esophageal dilation that did not relieve their dysphagia. In the presence of acid suppression, obliteration was performed by obtaining four to five circumferential biopsies from various points of the Schatzki ring; no complications were encountered and dilation was immediately confirmed by the passage of a 13.5 or 15 millimeter through-the-scope balloon without resistance. Two of the patients reported no symptoms of dysphagia at follow-up six to eight months later. The third patient had recurrent dysphagia that was later discovered to have an oropharyngeal etiology. Based on these outcomes, we suggest that multiple standard biopsies performed at equidistant sites around the Schatzki ring "break" the ring and relieve refractory dysphagia in a manner that is comparatively safer, more cost-effective, and more widely accepted in routine practice than electrosurgical incision.

Methods: N/A

Results: N/A

Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Aaron Bellows : ACG Member
Jamie Barkin : ACG Member
(No Image Selected)
(no table selected)
AVERAGE SCORE: 3.25
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Devi Rampertab: not much case description but that is okay. Novel concept and very well written.
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
ABSTRACT BODY:

**Purpose:** Upper gastrointestinal bleeding (UGIB) is a serious condition requiring definitive and early treatment. In patients with chronic pancreatitis, pseudoaneurysm formation in the vessels near the pancreas is a very rare complication. Treatment of bleeding pseudoaneurysms is difficult, and rarely endoscopic. We present a case of a patient with chronic pancreatitis and pseudoaneurysm eroding through the wall of duodenal bulb that underwent endoscopic therapy for initial stabilization.

**Case:** A 54-year-old male with history of chronic pancreatitis from alcohol and hypertension who was admitted to hospital for acute on chronic pancreatitis. On hospital day nine, the patient experienced ~300 cc of hematemesis. Vitals were normal except for tachycardia of 122 bpm. Physical exam revealed epigastric tenderness to palpation, but was otherwise normal. Laboratory evaluation demonstrated hemoglobin of 7.3 g/dL (baseline 9.9 g/dL). Gastroenterology was consulted, and the patient underwent EGD, showing a bulging 1.5-cm red lesion in the duodenal bulb, with sharp borders, that was actively bleeding. Epinephrine (1:10000) was injected in 4-quadrant fashion around the lesion x 10 cc, and five resolution endoclips were placed in sequential fashion to close the lesion. Hemostasis was achieved with endoscopic therapy, and patient's hemoglobin improved and stabilized at ~10 g/dL after 3 units pRBCs transfused. Later that day, CT of abdomen was performed and showed a probable 1.2-cm aneurysm formation adjacent to an inflammatory pancreatic mass and immediately adjacent to the duodenum. Three days later, he underwent CT angiogram showing endoclips on medial aspect of duodenal wall and contrast pooling in pancreatic head region near the superior pancreaticoduodenal artery with focus within the duodenal wall, consistent with pseudoaneurysm with extravasation. His hemoglobin ranged from 9-10 g/dL. Later that day, he underwent angiography, demonstrating a bleeding bilobulated pseudoaneurysm arising from the gastroduodenal artery, which was successfully coiled, resulting in hemostasis. After 19 days in the hospital, complicated by UGIB, necrotizing pancreatitis and abscess formation, the patient was discharged with stable hemoglobin.

**Conclusion:** Pseudoaneurysm is a rare complication of chronic pancreatitis, with endoscopic therapy of such lesions being rarely performed. In this unique case, endoscopic therapy of the pseudoaneurysm was performed for initial stabilization with subsequent coiling of the vessel.

**Methods:** N/A

**Results:** N/A

**Conclusion:** N/A
Hazem Hammad : ACG Member
Jonathan Godfrey : ACG Member
Michelle Matteson : ACG Member
Matthew Bechtold : ACG Member
(No Image Selected)
(no table selected)
AVERAGE SCORE: 3.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Devi Rampertab: What do they mean by lesion - a tear?

Why wait 3 days for CT angiogam?|Selvi Thirumurthi: [No Comments]|Renu Umashanker: [No Comments]|James Vecchio: [No Comments]
Gastrointestinal Stromal Tumor Causing Massive Upper GI bleeding: A Case Report

Dina Ahmad

University of Missouri - Columbia, United States

Purpose: Gastrointestinal stromal tumors (GISTs) are rare mesenchymal tumors of the GI tract, which are usually sporadic and mainly located in the stomach or small intestine. Gastric GISTs usually present with vague abdominal discomfort, early satiety, vomiting and dyspepsia. Massive upper gastrointestinal bleeding (UGIB) is considered a rare complication of GISTs. We present an interesting and rare case of massive UGIB as a complication from a gastric GIST.

Case: A 55-year-old female presented to our hospital complaining from massive hematochezia and dizziness for a few days’ duration, with two syncopal episodes at home. Her symptoms were associated with generalized abdominal pain, diarrhea and nausea. She denied fever, chills, hematemesis or vomiting. Abnormal vital signs included tachycardia 106 bpm and blood pressure of 109/53. On examination, she was pale and had mild tenderness in the upper abdomen. Abnormal labs included hemoglobin of 6.3 g/dL, hematocrit 18.3%, platelets 97,000/mm3. She had normal liver function tests. She was transfused with two units of packed red blood cells and was resuscitated with IV fluids. Just prior to her EGD, she developed hematemesis, respiratory distress and tachycardia requiring intubation and ICU transfer. Subsequently, she underwent EGD that showed a gastric cardia, anterior wall submucosal mass measuring 3 cm with a deep central clean-based ulceration measuring 1 cm with a visible vessel. Epinephrine (1:10000) was injected near visible vessel and a resolution endoclip was placed with no signs of further bleeding. Abdominal computed tomography (CT) scan was performed immediately following EGD results, and it revealed an intraluminal low-attenuation homogenous gastric mass measuring 5.4 x 4.6 x 2.4 cm with minimal peripheral enhancement. Due to concern for malignancy and the high likelihood of rebleeding, general surgery was consulted for resection of the mass. Pathological examination showed gastrointestinal stromal tumor with maximum dimension of six cm. On immunohistochemical examination, CD117 and CD 34 were positive. Patient was discharged home on the fifth postoperative day with Oncology outpatient follow-up.

Conclusion: Massive UGIB from GISTs is quite rare. This unique case demonstrates an unusual presentation of GIST. It highlights the importance of early surgical intervention to prevent rebleeds, and the need of close follow-up after resection to monitor for any signs of local recurrence or metastasis.

Methods: N/A
Results: N/A
Conclusion: N/A

Gastrointestinal Stromal Tumor Causing Massive Upper GI bleeding: A Case Report

Dina Ahmad : ACG Non-Member
Alisha Hinds : ACG Non-Member
Kristi Lopez : ACG Member
Zachary Berg : ACG Non-Member
Joseph Muenster : ACG Non-Member
Jason Scott Holly : ACG Non-Member
Michelle Matteson : ACG Member
Matthew Bechtold : ACG Member

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(no table selected)

**AVERAGE SCORE:** 4.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**

Devi Rampertab: Nothing new at all. In fact I have personally seen 3 cases of GIST in last 2 years presenting just like this.

Selvi Thirumurthi: [No Comments]

Renu Umashanker: [No Comments]

James Vecchio: [No Comments]
Purpose: Abdominal aortic aneurysm (AAA) rupture is a serious although rare complication leading to 100% mortality if immediate medical attention is not received. Aorto-enteric fistulas usually occur as a result of inflammation after surgical AAA repair via graft placement – rarely in patients with native aneurysms.

A 73-year-old female was emergently brought to our emergency department after having several episodes of hematemesis and hematochezia while on a cruise ship, eventually leading to syncope. Evaluation by the cruise ship medic revealed hemoglobin of 6.8 that responded appropriately to two units of packed red blood cells. She subsequently had two large volume hematemesis and several small 1-2 cups worth of hematochezia prior to arrival. She had no history of cirrhosis or NSAID use. The patient did have a known AAA that measured 3.5 cm on surveillance ultrasound performed one-month prior, but no history of surgical repair.

An emergent EGD did not reveal any old or active bleeding within the stomach and/or duodenum. There was no evidence of esophageal or gastric varices as well as no evidence of peptic ulcer disease. Given the clinical presentation of a significant upper GI bleed with an initial non-diagnostic examination, the endoscope was once again advanced to the duodenum for another thorough evaluation to identify a bleeding source. Luckily, a small pulsatile opening was noted at the junction of the bulb and the 2nd portion of the duodenum. It was not actively bleeding, but appeared consistent with an aorto-duodenal fistula.

CT angiogram revealed an area concerning for aortic rupture with the 2nd portion of the duodenum lying anteriorly; however, there was no active extravasation of contrast into the lumen. Vascular surgery emergently took the patient to the OR. She underwent repair of the aorto-enteric fistula and paravisceral aneurysm with a tube graft and primary repair of the duodenal perforation with an omental pedicle flap. She had no further episodes of bleeding and was discharged to a rehab facility within a week.

Primary aorto-duodenal fistula (ADF) formation occurs as a result of inflammatory damage from atherosclerotic disease and the incidence is significantly less common than secondary ADF, which occurs after surgical aneurysmal repair. This case is unique as the primary ADF was diagnosed via endoscopy after persistent evaluation to identify the etiology of this patient’s upper GI bleed, resulting in prompt surgical intervention.

Methods: N/A
Results: N/A
Conclusion: N/A
Amit Gajera : ACG Member
Yasser Saloum : ACG Member
(No Image Selected)
(no table selected)
AVERAGE SCORE: 3
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Gastric and duodenal pseudomelanosis - A rare entity: Report of five cases.

PRESENTER: Sami Samiullah
PRESENTER (INSTITUTION ONLY): UMDNJ- New Jersey Medical School
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: Introduction:
Pseudomelanosis of the upper GI tract is an extremely uncommon entity characterized by endoscopic visualization of speckled dark pigmentation of the mucosa. It remains a rare finding in the duodenum and exceedingly rare in the stomach, with only 4 reported cases in literature.

Cases:
5 cases of upper GI pseudomelanosis were encountered during 2012 at our endoscopy center. The demographics, clinical features and lab values are summarized in table 1 and the histopathology in table 2. Endoscopic images and histopathology are shown in image 1. The mean patient age was 70. Four were female and one was male. All had endoscopic finding of pseudomelanosis in the duodenum with one with pseudomelanosis in duodenum and gastric antrum. All patients had iron deficiency anemia, hypertension and chronic kidney disease. 2 patients had diabetes, 4 had dyslipidemia, 2 reported dysphagia, 3 had COPD and 1 had CHF. All patients were taking hydralazine and oral iron sulfate. 3 patients were on Lasix and 3 were taking inhaled bronchodilators and steroids for COPD. Biopsies were taken in 4 cases, and all showed pseudomelanosis.

Discussion:
Histochemical and electron probe analysis have revealed this pigment to be composed mainly of iron sulfide, with various other elements. It exhibits unpredictable staining patterns, postulated to be secondary to varying amounts of sulfur being incorporated and the oxidation of the iron. It is visualized as dark deposits in macrophages at the tips of the duodenal villi. When reviewing all the reported cases, it is noted that the most common indications for EGD are in order, GI bleeding, GERD, dyspepsia and dysphagia. Upper GI pseudomelanosis remains a rare finding weakly associated with chronic kidney disease, diabetes, hypertension, and certain medications including iron supplements and anti hypertensives. Yet none of these associated features appear to be essential in its development. The pathogenesis remains unclear and no clinical or prognostic significance has thus been determined. No long term follow up has been reported in literature. It is considered to be a benign condition and no follow up or surveillance is currently recommended.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Oral or Poster
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No

Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>
Sami Samiullah : ACG Member
Hadi Bhurgri : ACG Non-Member
Fatima Samad : ACG Non-Member
Gregory Conti : ACG Non-Member
Zamir Brelvi : ACG Member
Histological and Endoscopic Gastric & Duodenal Images showing pseudomelanosis.

**IMAGE CAPTION:** Histological and Endoscopic Gastric & Duodenal Images showing pseudomelanosis.

<table>
<thead>
<tr>
<th>Table 1: Demographics, clinical features and lab values of patients with pseudomelanosis:</th>
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<td><strong>Case Number</strong></td>
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<th>Table 2: Histopathological features</th>
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**TABLE TITLE:** Table 1: Demographics, clinical features and lab values of patients with pseudomelanosis:  
Table 2: Histopathological features  

**AVERAGE SCORE:** 3.25  
**REVIEWER FLAGS:** (none)  
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None  
**REVIEWER COMMENTS:**  
Devi Rampertab: Not a very clinically relevant topic, however it is very well written.|Selvi Thirumurthi: [No Comments]|Renu Umashanker: [No Comments]|James Vecchio: [No Comments]
Purpose: Breast cancer metastasis to the gastrointestinal (GI) tract is rare. Due to very non-specific symptoms which may be attributed to chemotherapy itself, the metastasis can be easily missed if clinical suspicion is not high. We present 3 cases of breast cancer with non-specific GI complaints.

Case 1. 59 year old Caucasian female with history of lobular breast cancer presented to GI lab in view of epigastric discomfort, abdominal pain and worsening anemia. Patient subsequently had upper GI endoscopy and colonoscopy which has shown benign findings like erosions and biopsy samples taken confirmed metastasis to the stomach, duodenum, and colon.

Case 2. 71 year old female diagnosed with invasive lobular carcinoma 7 years prior to the presentation was referred to GI lab with complaints of worsening anemia and nausea. Patient subsequently had upper GI endoscopy which has shown mild erosions of antrum and biopsy samples suggestive of metastasis to the antrum and duodenum.

Case 3. 65 year old Asian female with remote history of breast cancer diagnosed 30 years prior to the presentation was evaluated in view of nausea and vomiting for 2 months. Upper GI endoscopy subsequently has shown mild constriction of duodenal area and biopsy confirmed the sub mucosal infiltration of the duodenal mucosa with breast cancer.

Conclusion. It is critical to maintain a high index of suspicion when faced with subtle GI symptoms in breast cancer patients. Endoscopy findings may be benign with no obvious lesions in mucosa. The breast cancer metastasis to the GI tract warrants systemic chemotherapy. Surgery has a limited role and is only for palliative purposes. Tumor markers like CEA play an important role in follow up of lobular breast cancer patients.
Endoscopy with normal mucosa.

**IMAGE CAPTION:** Colonoscopy with normal mucosa

Endoscopy with normal mucosa.

(no table selected)

**AVERAGE SCORE:** 2.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**

Devi Rampertab: not enough detail in the case histories, however it is a very clinically relevant topic.

Selvi Thirumurthi: Patient identifier can be seen on 2nd endoscopy image.

Renu Umashanker: [No Comments]

James Vecchio: [No Comments]
ABSTRACT BODY:

**Purpose:** Symptomatic gastric/duodenal polyp and large polyps (>1 cm) are indicated for treatment. Endoscopic resection of polyps > 3 cm are technically difficult and usually associated with a higher risk of perforation and bleeding. For patients who are deemed poor surgical candidates or those on anticoagulation, some centers propose endoscopic biopsy only for large polyps. This may lead to unsatisfactory symptom relief, inadequate control of bleeding or insufficient biopsy. Therefore, a novel endoscopic technique for the safe removal of large polyps is highly desirable in such a patient population. This abstract is to report two cases performed in our institution of successful endoscopic treatment for large duodenal/gastric polyps with a double endo-loop ligation technique.

**Methods:** Case #1: A 74 year-old woman with multiple comorbidities including CAD and atrial fibrillation on warfarin was referred for acute gastrointestinal bleeding. Initial EGD revealed a 4 cm duodenal mass crossing four folds. The patient opted for endoscopic management. The 4 cm duodenal mass was identified and ligated at its base with two endo-loops under endoscopy. Hot snare polypectomy above the endo-loops was then successfully performed.

Case #2: A 65 year-old man with a history of COPD and diabetes mellitus II was initially referred for iron deficiency anemia. Initial EGD identified a 2.5cm elongated polyp in the fundus, with superficial ulcerations and active oozing. Two endo-loops were successfully placed with adequate hemostasis. A cold snare biopsy of this polyp was obtained.

**Results:** Case #1: A repeat EGD three months later confirmed complete removal of large duodenal mass with no new growth or bleeding. Pathological examination revealed a tubular adenoma with Brunner’s gland hyperplasia.

Case #2: A repeat EGD three months later found a smaller fundal polyp with no signs of active bleeding. Pathological examination revealed hyperplastic polyp with focal superficial ulceration.

**Conclusion:** Double loop ligation has a few advantages over traditional single loop ligation including the following: 1) the base loop ensures mucosa closure, minimizing the chances of perforation; 2) the top loop double secure closure to prevent any potential bleeding, especially for patient on anticoagulation; 3) increase chance of complete polypectomy for large polyp. Our experience suggests that for patients who are not good surgical candidates due to multiple comorbidities or on anti-coagulation, endoscopic polypectomy with double endo-loop ligation can be considered a viable alternative to surgical resection.
AVERAGE SCORE: 3.25
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Successful Treatment of Duodenal Perforation with Over the Scope Clip After Failed Surgical Repair

Purpose: Over the Scope Clips (OTSC) have been reported to be useful in primary repair of iatrogenic endoscopic perforations. We report the successful use of the OTSC in an elderly patient who failed surgical repair for an iatrogenic duodenal perforation.

Methods: A 94 year old man presented with a history of chronic duodenal strictures due to a duodenal ulcer. He was limited to a liquid diet and had undergone two prior balloon dilations without fluoroscopy. The third dilation, with fluoroscopic guidance, identified the stricture at the apex of the duodenal bulb. As the balloon was dilated to 12mm, a small amount of blood was seen coming from the stricture. The patient felt well and was discharged. The following day the patient presented with dyspnea and an episode of coffee-ground emesis. On exam the patient was tachypneic with a grossly distended, hypertympanic, tender abdomen. Abdominal and pelvic CT revealed a peri-duodenal fluid collection in the anterior perirenal space consistent with a duodenal perforation. The patient was taken to the OR for exploration, where a fist-sized abscess containing coffee ground material as well as a 1.5cm posterior perforation of the duodenum was found. The duodenum was closed with an omental patch; a gastrojejunostomy was formed and a feeding jejunostomy created. He recovered well until post-operative day six when he experienced bilious emesis and a leukocytosis of 21.1 x10^9/L. A CT of the abdomen with oral contrast showed a persistent duodenal perforation. The patient was made NPO and kept on IV antibiotics. Two weeks after the initial repair, endoscopy was performed which identified an abnormal area which had a white non-mucosal base and sutures, representing the area of the failed repair. An OTSC was deployed and the opening could no longer be visualized.

Results: The following day an UGI study revealed no evidence of an extraluminal leak. Five days after clip placement, abdominal CT showed persistent right pararenal fluid collections without evidence of fluid extravasation. The collections were drained by radiology. The patient was discharged on a pureed diet to a skilled nursing facility a week later without further complications.

Conclusion: Over the Scope Clips may be an intervention to avoid surgery or re-surgery for iatrogenic endoscopic perforations. Given this patient’s advanced age, OTSC was attempted and was successful. To our knowledge, this is the first case report of its use after failure of surgical repair. Our unusual case suggests that OTSC should be considered an option in repair of iatrogenic perforation even after failed surgical repair.

AVERAGE SCORE: 2.75
Dysplasia associated lesion or mass (DALM) refers to a heterogeneous population of lesions with flat epithelial dysplasia in the surrounding mucosa that are distinct from sporadic adenomas, which can be safely removed with standard polypectomy. Generally, DALM is an indication for total colectomy as these non-delineated lesions are considered inappropriate for endoscopic therapy and associated with synchronous/metachronic neoplasia. However, complete endoscopic resection of DALMs with current techniques may be possible, and synchronous neoplasia may be excluded by rigorous endoscopic examination. Here we detail the first reported case, to our knowledge, of endoscopic submucosal dissection (ESD) to remove a DALM in a patient with Ulcerative Colitis (UC).

A 73-year-old male with long-standing pan-UC maintained in remission on Azathioprine and Remicade underwent a surveillance colonoscopy that revealed a 20mm area of depressed mucosa with irregular pit pattern 40 cm from the anal verge. This area was injected with saline but unable to be lifted. Biopsies revealed focal low-grade dysplasia in the background of active UC. Given that he was not an optimal surgical candidate, definitive endoscopic management was pursued. Examination revealed a flat, non-bleeding, type IIC (Paris Classification) lesion. A combination of hyromellose, indigo carmine, and saline was injected. Then, a circumferential incision into the submucosa was performed with a flexible tipped knife. Pathology from the en bloc specimen revealed a flat low-grade dysplastic lesion arising in a background of active UC. There were no intra or post procedural complications. Six months later a repeat colonoscopy was performed. Biopsies taken at the resection site and randomly every 10cm revealed only chronic active UC without evidence of dysplasia.

ESD appears to be a safe and effective treatment for early dysplastic lesions of the GI tract, particularly for lesions over 20 mm, which often would require a piecemeal approach by endoscopic mucosal resection (EMR). Compared to EMR, ESD is associated with lower tumor recurrence rates. While colonic ESD is difficult given thin walls, difficulty of technique, and length of procedure, we propose that ESD is an acceptable technique to remove DALMs in patients with UC who would otherwise be subjected to a total proctocolectomy. ESD affords more accurate histopathologic diagnoses, higher en bloc resection rates, and ease of removal of lesions embedded in superficial mucosal fibrosis associated with long-standing colitis. ESD may be an effective alternative therapy for patients who are not surgical candidates.
Gabriel Lang: ACG Non-Member
Uzma Siddiqui: ACG Member
Vani Konda: ACG Member
Irving Waxman: ACG Member
(No Image Selected)
(no table selected)
**AVERAGE SCORE:** 2.75
**REVIEWER FLAGS:** (none)
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None
**REVIEWER COMMENTS:**
Devi Rampertab: [No Comments]
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
Purpose: To demonstrate a novel approach to the management of a challenging esophageal pill impaction.
Case: We report a case of a 26 yo male who presented with symptoms of acute esophageal obstruction immediately after swallowing an 800mg ibuprofen table. The patient could not tolerate oral secretions and complained of focal anterior neck pain. An urgent upper endoscopy found a circular hard pill tightly impacted into a mid esophageal stricture at 25 cm from incisors. The esophagus was narrow caliber and the diagnostic endoscope could only be advanced to just proximal to the pill. Multiple attempts to extract the pill with a variety of traditional endoscopic retrieval devices (rat-tooth forceps, snare, Roth net, Talon grasper, etc) were not successful. After consideration of management options for refractory esophageal impaction including surgical referral, we chose to attempt to disrupt the pill with a 7f Soehendra stent retriever. The stent retriever was centered in the lumen and placed gently against the pill. Rotation of the threaded tip was initiated and a central defect was easily created within the pill substrate. Subsequently, a rat tooth forceps was able to rapidly crush the remaining pill working off the central defect. Upon pulverization of the impacted pill, a 2 cm in length by 8mm in diameter mid esophageal strictures was appreciated via inspection with a pediatric upper endoscope. The exam was completed and the patient recovered uneventfully.
Conclusion: When encountering a difficult to manage esophageal pill impaction refractory to extraction with standard endoscopic retrieval devices the utilization of a Soehendra stent retriever should be considered. Further studies would be required to determine efficacy and safety of the Soehendra stent retriever in removal of a variety impacted foreign bodies within the gastrointestinal tract.

Methods: n/a
Results: n/a
Conclusion: n/a

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIGN: ACG Membership Status <font color="red">*</font>:
Sean Caufield : ACG Member
Eric Lavery : ACG Member
Brett Partridge : ACG Member
Left image: Gentle rotation of stent retriever
Right image: Central defect after disruption with stent retriever

**IMAGE CAPTION:** Left image: Gentle rotation of stent retriever
Right image: Central defect after disruption with stent retriever

(no table selected)

**AVERAGE SCORE:** 3.25

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Devi Rampertab: [No Comments]
Selvi Thirumurthi: [No Comments]
Renu Umashanker: [No Comments]
James Vecchio: [No Comments]
Purpose: Endoscopic Ultrasound-guided Fine Needle Aspiration (EUS-FNA) has been widely utilized to diagnose and stage primary gastrointestinal solid lymphomas. Utilizing flow immunocytometry (FCM) on ascitic fluid aspirated during EUS-guided paracentesis to diagnose disseminated disease has not been reported. We report a case of primary gastric large B-cell lymphoma where FCM was utilized on ascitic fluid after EUS-guided paracentesis.

A 62-year-old woman presented with a 2-month history of dyspepsia, early satiety, increasing nausea with emesis and night sweats. The patient was afebrile, and her physical examination revealed skin pallor and epigastric tenderness without evidence of rebound or hepatosplenomegaly. Laboratory data revealed a hemoglobin of 7.7 g/dL, and an albumin of 2.4g/dL.

Contrast-enhanced CT scan of the abdomen and pelvis revealed a large mass along the gastric fundus, with extension to the celiac axis and splenic artery. Two hypodense lesions measuring 2 cm and 1.5 cm respectively, were seen in the right lobe of the liver, suggesting a metastatic process.

Endoscopic ultrasound was then performed and revealed a 55 mm by 25 mm infiltrative mass in the gastric fundus extending into the lesser curvature. Many malignant-appearing lymph nodes were seen in the gastrohepatic ligament and celiac axis. A small amount of ascites was visualized in the perihepatic peritoneal space. The right lobe liver lesions were not accessible with EUS-FNA.

EUS-FNA was performed on the gastric mass as well as a celiac lymph node. Cytology from these aspirations revealed large transformed lymphoid cells suspicious for large cell lymphoma.

EUS-guided paracentesis was also performed yielding 5 cc of straw-colored fluid. Ascitic fluid cytology revealed large transformed lymphoid cells that subsequently stained positive for CD20, CD79a and CD5 by immunohistochemistry (IHC). FCM was performed and demonstrated the presence of kappa-restricted monoclonal large B-cells. With these results, a diagnosis of disseminated large B-cell lymphoma was confirmed.

Obtaining tissue samples utilizing EUS-FNA has become a common approach in patients with suspected lymphoproliferative disorders. Flow immunocytometry (FCM) has become the standard method of phenotyping lymphoproliferative disorders, as small populations of malignant cells can be missed on routine cytologic evaluation, and subclass categorization can be difficult based on cell morphology alone. Combined FCM and conventional cytopathology can increase the diagnostic sensitivity to 100% with a specificity of 94%. We recommend EUS-guided paracentesis with flow immunocytometry (FCM) in patients with suspected lymphoma and concomitant ascites.

Methods: N/A
Results: N/A
Conclusion: N/A
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status *<font color="red">*</font>:
Motaz Ashkar: ACG Non-Member
Douglas Schneider: ACG Non-Member
Bhavesh Shah: ACG Member

(No Image Selected)
(no table selected)

AVERAGE SCORE: 2.33

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: We present a unique case of a granular cell tumor following radiofrequency ablation (RFA) of Barrett's esophagus with high-grade dysplasia (BE-HGD). This is the first reported case of a potentially unrecognized long term consequence of esophageal RFA.

Case: A 52 year old male with a history of four RFA sessions for BE-HGD in 2009 presented for a routine surveillance endoscopy. The past ablation had been successful with no acute complications and normal squamous mucosa on surveillance endoscopies done in 2010 and 2012. During the 2013 surveillance endoscopy a normal appearing esophagus was observed with no evidence of recurrent Barrett’s and multiple surveillance biopsies were obtained. Incidentally, esophageal biopsies at 40cm from the incisors (the neo-G-E junction) yielded a fragment of tissue with abundant granular cytoplasm and uniform round to ovoid nuclei. There was strong immunoreactivity to antibodies of S-100, consistent with granular cell tumor (Figure 1).

Discussion: BE is a relatively common entity encountered by gastroenterologists around the world. It affects approximately 1.6% of the general population and 5-8% of those with daily reflux symptoms. In patients with BE-HGD, RFA has proven safety and efficacy for treating HGD. However, the durability of RFA has been challenged by reports of up to 5% of patients who develop post-ablation subsquamous dysplasia and carcinoma. Up to 14% of treated patients develop strictures needing dilatation therapy. Granular cell tumors are extremely rare and have no reported association with BE. Since this tumor occurred in the RFA field we can only assume it is related. RFA delivers significant heat energy to the esophagus and this may have long-term deleterious effects to surrounding tissue. An analogy with reports of mediastinal granulomas from the Stretta procedure in the past can be made. This case highlights the need for continued post-ablation surveillance following successful RFA treatment of BE-HGD. The novelty of this procedure may lend itself to unrecognized long term complications in the future as is reported in this case.

Methods: N/A
Results: N/A
Conclusion: N/A

ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIGN: ACG Membership Status <font color="red">*</font>

Thomas Corredine : ACG Member
Houman Rezaizadeh : ACG Member
Shounak Majumder : ACG Member
John Birk : ACG Member
Poornima Hegde : ACG Non-Member
IMAGE CAPTION: (no table selected)

AVERAGE SCORE: 2.33

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
A 66-year-old white male with Child class A, HCV cirrhosis and Barrett’s esophagus (BE) was found on surveillance EGD to have new findings of grade 2 esophageal varices (EV) and an esophageal nodule at 38 cm. Biopsies of the BE and nodule revealed intestinal metaplasia with high grade dysplasia (HGD). Exam was significant for spider angioma and trace lower extremity edema. Significant labs were: platelets 84, INR 1.57, TB 1, creatinine 0.67, and albumin 3.9, with a MELD score of 11. An US showed splenomegaly but no ascites. An EUS confirmed 3 columns of grade 2 EV from 20-36 cm and BE from 36-30 cm with two nodules at 36 cm; biopsies confirmed HGD. There were no lymph nodes or neoplastic involvement of the submucosal layer. Band ligation for management of EV was not performed given concerns for scarring and interference with subsequent resection; thus, a TIPS was planned for decompression of EV prior to treatment of HGD. A successful TIPS was placed with two 10mm diameter Viatorr stents, totaling 55 cm covered length, dilated to 10mm for reduction of HVPG from 16 mm Hg pre-TIPS to 6 mm Hg post-TIPS. Six days after TIPS placement, an EGD with EMR was performed with no distal varices noted. Oozing from the margins of his EMR required APC therapy, with total estimated blood loss of 30 mL. Pathology confirmed HGD with negative margins. A repeat EGD at 2 months showed resolution of EV, scattered BE from 35-41 cm without nodules and extensive re-epithelialization of the area of prior EMR. The residual BE was then treated with RFA.

Discussion:

Patients with BE and cirrhosis who develop HGD or adenocarcinoma in the setting of concomitant EV present a unique, dual therapeutic dilemma. There is limited literature regarding optimal management of portal hypertension (portal HTN) in cirrhotics prior to EMR. This is the first case of TIPS placement for reduction of portal pressure to facilitate EMR for BE with HGD. Only one previous case report described TIPS prior to EMR of an early gastric cancer in a cirrhotic with severe hypertensive gastropathy. One other case report described TIPS prior to palliative laser therapy for adenocarcinoma overlying EV. In our case, TIPS was successful in reducing the portal HTN and decompressing the EV prior to EMR of Barrett's with HGD that had been overlying a grade 2 EV. On repeat EGD, EV were subsequently absent, and the BE was safely and completely ablated. This case demonstrates TIPS as an effective method of decompressing EV to allow for EMR and avoidance of surgery. TIPS can be considered for reducing portal pressure prior to EMR in patients with cirrhosis and portal HTN with EV.
Meghan NeSmith : ACG Non-Member
Janice Jou : ACG Member
M. Brian Fennerty : ACG Member
Kenneth Kolbeck : ACG Non-Member
Brent Lee : ACG Member
Joseph Ahn : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 2
**REVIEWER FLAGS:** (none)
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: A 60-year-old lady was admitted for hypertensive urgency with nausea and non-bloody vomiting for 2 days. Her past history was significant for gastric ulcer bleeding, iron deficiency anemia, coronary artery disease, diabetes, hypertension, and chronic kidney disease. Her medications included insulin, simvastatin, furosemide, carvedilol, hydralazine, clopidogrel and iron sulfate. On day 2 of admission, she had one episode of coffee-ground emesis but had stable vital signs with no orthostasis. Her hemoglobin was 11 gm/dL, unchanged from her baseline. Subsequently, upper endoscopy showed patchy erythema in antrum with thick mucosal folds and diffuse peppered black pattern in the stomach, duodenum and proximal jejunum. No old or fresh blood was seen. Histopathology of gastric and small bowel biopsies showed subepithelial pigment deposition in an otherwise normal mucosa. Aggregates of macrophages with coarse black-brown cytoplasmic pigment were seen within the lamina propria, consistent with pseudomelanosis. This pigment was positive with iron staining. Patient had no further episodes of vomiting with uneventful follow-up.

Unlike melanosis coli, pseudomelanosis is a rare finding on upper GI endoscopy. There is only one reported case involving the stomach, duodenum, and jejenum, and almost a decade later we report the second. The classical appearance is black or brown peppered pigmentation. This pigment accumulates inside macrophagic lysosomes within the lamina propria but can also be found in extracellular material or rarely in epithelial cells. The black, brown or grey pigment in melanosis was originally thought to be melanin but later other pigments such as ferrous sulfide, ferrum sulfate, lipomenin, hemosiderin and lipofuskin were isolated. The exact pathology for this aberrant pigment deposition is still unclear. Electron probe x-ray analysis has shown that iron and sulfur are transported together in this condition resulting in hindrance of iron absorption and hence ferrous sulfide deposition. Mucosal biopsy is necessary for diagnosis as other conditions such as metastatic melanoma, post hemorrhagic deposition of hemosiderin and substance ingestion like barium sulfate or charcoal can mimic this condition.

Most patients are over 60 years of age but few pediatric cases have also been described. Pseudomelanosis of the upper GI tract has been associated with hypertension, chronic kidney disease, anemia, diabetes and gastric hemorrhage, all of which were present in our patient. Medications including hydralazine, methyldopa, furosemide and iron sulfate have also been linked to this entity. There are no long term complications associated with this condition and no specific management is recommended.

Methods: N/A
Results: N/A
Conclusion: N/A
AVERAGE SCORE: 3
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
A Rare Care of Metastatic Melanoma Involving the Stomach

A 79 year old man with a distant history of choroidal melanoma treated with brachytherapy, was admitted to the hospital by his cardiologist with complaints of worsening fatigue and nausea. Prior to his presentation to the hospital, he had also noted mild right sided abdominal pain, and a CT scan (done without IV contrast because of renal insufficiency) was unrevealing. In addition to a cardiac work up and telemetry monitoring while in the hospital, an ultrasound of the abdomen was obtained. Ultrasound revealed a mass measuring 9.4 x 7.8 x 10.3 cm in the right lobe of the liver with other smaller, hypoechoic masses throughout the liver that were suspicious for metastases. The patient had a normal colonoscopy within the last 3 years. Subsequent esophagastroduodenoscopy revealed multiple flat, black, punctate mucosal lesions throughout the stomach with intervening areas of normal mucosa in the fundus, body and antrum. Gastric biopsies of these black lesions confirmed metastatic melanoma.

Ocular and head and neck melanomas have a predilection to metastasize to the liver. However, malignant melanoma metastasizing to gastrointestinal tract is rare. Gastric metastases have a poor prognosis with 50% of patients surviving for less than 12 months. Endoscopically, metastatic melanoma can appear as a single lesion similar to gastric adenocarcinoma, as multiple ulcerated polypoid lesions or less commonly as a small mucosal lesion. Our case represents a rare endoscopic presentation of multiple, small, flat, punctate lesions throughout the stomach. The diagnosis of melanoma should be considered when such lesions are encountered on upper endoscopy.

Methods: N/A
Results: N/A
Conclusion: M/A

AUTH DESIGN: ACG Membership Status <font color="red">*</font>
Lakshmi Lattimer : ACG Member
Aamir Ali : ACG Member
Marie Borum : ACG Member

Multiple, flat, punctate melanoma lesions in the gastric body

IMAGE CAPTION: Multiple, flat, punctate melanoma lesions in the gastric body

AVERAGE SCORE: 4
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: A 71 year old male underwent an EGD for melena and iron-deficiency anemia. He was found to have active bleeding from the Ampulla of Vater (A). An emergent CT was done to evaluate for hemosuccus pancreaticus as well as hemobilia secondary to a hepatocellular carcinoma. The CT did not show any structural anomalies. A subsequent angiogram was unremarkable for pancreatico-biliary pathology including splenic artery aneurysm. An ERCP demonstrated that the inferior aspect of the ampulla had a rim of erythematous mucosa around a ductal orifice with scant amount of fresh blood oozing out of the center (B). Moderate amount of oozing was seen from the angioectasia on contact with a forceps. A 5Fr by 6cm external pig-tail stent was advanced into the PD and coagulation with argon plasma (45 watts) was performed (C). A follow up ERCP 1 month later showed persistence of the angioectasia with active oozing. The PD stent was exchanged and the CBD was stented with a 7 Fr center-bend stent. Four mL of 1:10,000 solution of epinephrine were injected with good blanching after which APC (30 watts) was carried out for residual oozing. Three ligature clips were placed with good hemostasis. Follow-up ERCP 2 months later showed complete resolution of angioectasia (D). The patient is asymptomatic on follow-up with stable hemoglobin.

We report an ampullary angioectasia as a rare cause of upper gastrointestinal bleeding in a unique location. This was successfully treated with local thermal coagulation, epinephrine injection and placement of ligature clips.

Methods: N/A

Results: N/A

Conclusion: N/A

AUTH DESIGN: ACG Membership Status: Divyanshoo Kohli : ACG Non-Member
Raj Majithia : ACG Member
Zone-En Lee : ACG Member
Mitesh Patel : ACG Member

Figure A: EGD showing bleeding from the papilla
PD stent and mucosal changes after thermal coagulation
IMAGE CAPTION: Figure A: EGD showing bleeding from the papilla PD stent and mucosal changes after thermal coagulation

AVERAGE SCORE: 3.33

REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: Introduction: Involvement of the GI tract in leishmania is atypical, and develops predominantly in immunocompromised patients. We report a case of duodenal leishmania presenting as a whitish, nodular mucosa on Esophagogastroduodenoscopy (EGD).

Case: A 47 year old Nicaraguan man with a history of AIDS and visceral leishmaniasis was seen for dyspepsia. Leishmania Donovani was diagnosed from biopsy of a skin lesion. An EGD was done that showed nodular gastritis and severe nodularity and whitesh discoloration of the duodenal mucosa extending from the duodenal bulb to the second portion of the duodenum (See Image). Duodenal biopsies showed flattened villi in duodenum, and mucosa riddled with dotlike structures consistent with leishmania (See Image). Gastric biopsies also showed evidence of leishmania.

Discussion: Digestive involvement of visceral leishmaniasis is seen in 5-10% of cases and duodenum is most frequently involved. Diagnosis is made by histological visualization of duodenal villi infiltrated by macrophages filled with leishmania bodies. Varying endoscopic findings have been described in cases of duodenal leishmaniasis including normal mucosa, non specific duodenitis, atrrophic mucosa, inflamed mucosa, whitesh-nodular appearance and pave-like mucosa. In case reports by Jawher NM and E Valenzuela et al, they describe a whitish discoloration of mucosa with nodularity similar in appearance to our case. Marked infiltration of mucosa with protozoan laden macrophages results in poor visualization of submucosal blood vessels leading to loss of normal pink color of the mucosa. The severity of loss of normal endoscopic pattern may also parallel the disease severity in the mucosa. The major differential diagnosis of nodular white duodenal mucosa is Whipple's disease. The histology in both diseases is infiltration of mucosa by organism-containing macrophages, hence similar appearance of mucosa is seen on endoscopy. The appearance of a whitesh, nodular mucosa on endoscopy should raise suspicion of duodenal leishmaniasis versus whipple's disease in the appropriate clinical settings.

Methods: N/A
Results: N/A
Conclusion: N/A

Histological and endoscopic appearance of duodenum in leishmania.
IMAGE CAPTION: Histological and endoscopic appearance of duodenum in leishmania.

(no table selected)

AVERAGE SCORE: 3

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments]
Charlene Le Pane: [No Comments]
Renee Young: [No Comments]
Rowen Zetterman: [No Comments]
Purpose: Case: An 87 year old male with a history of HTN, and a prior subtotal colectomy with an ileo-sigmoid anastomosis for diverticular bleeding presented with complaints of loose stools, vomiting, and abdominal distension for several days. He had been admitted multiple times in the past for apparent partial obstructions at the anastomotic site. On exam, his abdomen was noted to be distended, with hyperactive bowel sounds, and mild tenderness to palpation. Labs displayed a mild leukocytosis, an elevated amylase of 960 U/L, and an elevated lipase of 674 U/L. A CT abdomen and pelvis displayed a normal appearing pancreas with no signs of acute pancreatitis, and dilated small bowel loops with air-fluid levels. The patient was treated conservatively with NPO, and IV fluids, however, he failed to make significant improvement. A flexible sigmoidoscopy was performed to evaluate the area, which displayed 2 mucosal bands at the site of the anastomosis causing luminal narrowing and obstruction as well as dilated small bowel loops proximal to this site. Given the failure of conservative management, thermal ablation of one of the bands was performed utilizing multiple passes of the hot-biopsy forceps set to cut-coag, with immediate decompression achieved. Discussion: Post-op intestinal obstructions are common, most-frequently due to adhesions or hernias. While ileus is a common finding in acute pancreatitis of almost any etiology, it is known that high levels of pancreatic enzymes are not uncommon secondary to small bowel obstruction, tending to normalize with resolution of obstruction. In our case, workup failed to confirm pancreatitis. Unique to this case is both the etiology of the small bowel obstruction resulting from deviant post-op intraluminal anastomotic healing causing luminal obstruction, mimicking ileus associated with acute pancreatitis, and also the novel use of the hot-biopsy forceps as a therapeutic tool to ablate these bands and relieve the obstruction. Conclusion: We reported a unique case of anastomotic site small bowel obstruction caused by transluminal mucosal bands, treated successfully by novel through scope thermal ablation.
Anastomotic bands

**IMAGE CAPTION:** Anastomotic bands

(no table selected)

**AVERAGE SCORE:** 4.67

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
- David Hass: [No Comments]
- Charlene Le Pane: [No Comments]
- Renee Young: [No Comments]
- Rowen Zetterman: [No Comments]
Purpose: Endoscopic tattooing is performed to facilitate identification of gastrointestinal lesions at follow-up endoscopy or surgery. We present a rare complication of endoscopic tattooing presenting as inflammatory pseudotumor.

Case: A 62-year-old male presented with painless hematochezia and acute blood loss anemia. The patient had undergone colonoscopy with polypectomy two days prior to admission. During polypectomy, piecemeal resection of a large 2-cm sessile serrated adenoma was performed in the ascending colon. Proximal and distal ends of the polypectomy site were tattooed by injecting a sterile suspension of highly purified carbon particles (SPOT ink). A repeat colonoscopy was performed after admission for likely post-polypectomy bleed. A large amount of fresh blood was seen throughout the colon. Recent polypectomy site was identified in the ascending colon with ulceration and an adherent clot. The clot was dislodged and a visible vessel with active bleeding was seen. Hemostasis was achieved by injecting 1:10,000 diluted epinephrine and placing three endoclips on the bleeding lesion. Incidentally, a second large ulcer (1.5-cm x 1.0-cm in size) with heaped-up margins and surrounding induration was noted just proximal to the polypectomy site. This was the area of recent endoscopic tattooing with blue-black discoloration of the colonic mucosa and the ulcer crater.

Methods: N/A

Results: N/A

Conclusion: Endoscopic tattooing is an effective technique to mark gastrointestinal lesions by submucosal dye injection. It is a safe procedure; however rare complications (focal peritonitis, abscess formation, infected hematomas, perforation) have been reported. Tattooing agents may elicit inflammation, thrombosis and fibroblast proliferation resulting in fat necrosis and ulceration at the injection site. It is important for endoscopists to be aware of the potential localized tissue injury induced by endoscopic tattooing because it can mimic malignancy.

AVERAGE SCORE: 5
Purpose: Squamous cell neoplasms of the head and neck commonly metastasize to the lungs, mediastinal lymph nodes, liver and bone- gastrointestinal metastases (especially small bowel) are extremely rare. We report a case of hypopharyngeal squamous cell carcinoma with metastasis to the duodenum presenting with anemia.

A 53-year-old male with a known history of Stage IV-hypopharyngeal squamous cell cancer status post chemoradiation therapy, presented with a 3-day history of dark stools and fatigue. The patient was afebrile, and his physical examination revealed scleral pallor. Laboratory data revealed a WBC of 4.4 k/cm2, a hemoglobin of 7.1 g/dL, platelets of 207 k/cm2, an albumin of 2.4g/dL and normal electrolytes. Carcinoembryonic Antigen (CEA) was 41.1ng/ml, and CA 19-9 Antigen was 2932 U/mL. Contrast-enhanced CT scan of the chest, abdomen and pelvis revealed a 4 cm mediastinal mass with extensive hilar adenopathy, numerous hypodense liver lesions and extensive duodenal wall thickening. Our patient underwent upper endoscopy (EGD), which revealed a large fungating ulcerated mass with stigmata of recent bleeding in the second portion of the duodenum- this was biopsied with cold forceps and revealed a poorly differentiated squamous cell carcinoma. Immunohistochemical staining (IHC) was performed and was positive for p63 and CK5/6- supporting the diagnosis of recurrent disease. Subsequently, radial Endoscopic Ultrasound (EUS) demonstrated a 50 mm by 28 mm poorly defined mediastinal mass, numerous malignant appearing subcarinal lymph nodes, and an irregular hypoechoic 33 mm by 65 mm left lobe liver lesion. Examination of the duodenum revealed a 12 mm by 35 mm heterogeneous mass with poorly defined borders in the second portion, a 16mm by 11mm peripancreatic lymph node and a large amount of abdominal ascites. EUS-FNA was performed on the mediastinal, hepatic and duodenal masses. Immediate Cytologic Evaluation (ICE) revealed malignant cells and cell block subsequently demonstrated metastatic squamous cell carcinoma with extensive necrosis from all 3 sites. Squamous cell carcinomas of the head and neck develop distant metastases in 11% to 23% of patients. There are several reports of metastasis to the small bowel (most frequently the ileum) and patients usually present with abdominal pain and/or obstructive symptoms. We report a rare presentation of a 53 year-old male with recurrent squamous cell carcinoma with metastasis to the duodenum presenting with anemia. This case demonstrates how patients with squamous cell carcinoma can present atypically when distant metastases develop.

Methods: N/A
Results: N/A
Conclusion: N/A
Bhavesh Shah : ACG Member
(No Image Selected)
(no table selected)
**AVERAGE SCORE:** 4.67
**REVIEWER FLAGS:** (none)
**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None
**REVIEWER COMMENTS:**
David Hass: [No Comments]|Charlene Le Pane: [No Comments]|Renee Young: [No Comments]|Rowen Zetterman: [No Comments]
TITLE: Obstructed Common Bile Duct Stent Leading to a Spontaneous Choledocho-duodenal Fistula – A Rare Complication.

PRESENTER: Motaz Ashkar

PRESENTER (INSTITUTION ONLY): Department of Medicine, St. Elizabeth's Medical Center, Tufts University School of Medicine

PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: An 80-year-old woman with history of choledocholithiasis presented with a 2-day history of right upper quadrant abdominal pain, nausea and emesis. She admitted to previous ERCP and stent placement approximately 5 years prior. She denied fevers, chills, or mental status changes. The patient was afebrile and normotensive, and physical examination revealed right upper quadrant tenderness without rebound. Laboratory data revealed a WBC of 17.0 k/cm², total bilirubin of 1.4mg/dL, alkaline phosphatase of 135U/L, aspartate aminotransferase of 64U/L, and an alanine aminotransferase of 60U/L. Serum electrolytes were within normal limits. Transabdominal US revealed a large stone in the gallbladder neck. Contrast-enhanced CT scan of the abdomen and pelvis revealed common and intrahepatic bile duct dilatation, and a plastic biliary stent within the common bile duct with extensive pneumobilia filling nearly the entire gallbladder. Endoscopic retrograde cholangiopancreatography (ERCP) was then performed. The major ampulla was located partially within a peri-ampullary diverticulum. A large stone, bile duct casts and debris that was seen within the diverticulum was cleared using a rat-toothed forceps. An occluded 10 Fr stent was removed from the bile duct orifice with an endoscopic snare. The bile duct was then cannulated through the major papilla and a 0.035 inch guidewire was advanced into the biliary tree. Contrast injection demonstrated a diffusely dilated bile duct, with pus and contrast seen extravasating into the peri-ampullary diverticulum. This was consistent with a choledocho-duodenal fistula. The fistula orifice was located within the diverticulum and was then cannulated- a 0.035 inch guidewire was then advanced into the biliary tree from the fistula to confirm communication with the bile duct. One 10 Fr by 7cm biliary stent was then placed into the native orifice of the common bile duct- with bile and pus flowing through the stent. Complications of obstructed plastic biliary stents include recurrent jaundice, pruritus and cholangitis. Spontaneous biliary-enteric fistulas are rare, and risks for formation include long-standing biliary stones and recurrent biliary tract infections. The most common type of fistula formed is cholecysto-duodenal (68%), followed by cholecysto-colonic (13.6%) and choledocho-duodenal (8.6%). Most fistulas heal spontaneously, although surgery and closure with endoscopic staples has also been reported. We report the 1st known case of spontaneous choledocho-duodenal fistula secondary to an obstructed common bile duct stent. Our patient's symptoms improved after ERCP and will return for a repeat ERCP for assessment of her fistula and biliary stent removal.

Methods: N/A

Results: N/A

Conclusion: N/A

AUTH DESIG: ACG Membership Status <font color="red">* </font>:
Motaz Ashkar : ACG Non-Member
Diana Winston : ACG Non-Member
Jeffrey Sorokin : ACG Non-Member
Prakhar Agarwal: ACG Non-Member
Bhavesh Shah: ACG Member

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(no table selected)

AVERAGE SCORE: 4

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments]
Charlene Le Pane: [No Comments]
Renee Young: [No Comments]
Rowen Zetterman: [No Comments]
Purpose: The efficacy and safety of endoscopic submucosal tunnel technique dissection (ESTTD) on patients with circular superficial esophageal neoplasia (CSEN) was examined in the present study.

Methods: We reviewed and analyzed data of the four patients diagnosed as CSEN and underwent ESTTD from May 2009 to December 2010 at our Digestive Endoscopic Center. Steps of ESTTD are as follows: Step 1: Chromoendoscopy with iodine staining was used to determine the size the CSEN. Step 2: The proximal and distal edge was marked using a Dual knife. Step 3: After submucosal injection of saline with 0.3% indigo carmine, a circumferential incision was made along the marking dots parallel to both the proximal and distal edge of the CSEN. Step 4: Beginning from the proximal entry incision, a submucosal tunnel was established using the IT knife between the mucosal and the muscularis propria layer, which extended from beneath the proximal end to the distal end of the CSEN. Step 5: The remaining mucosa was dissected little by little from within the tunnel.

Results: En bloc resection of the CSEN was successfully achieved in all the four patients. Esophageal stricture was confirmed by endoscopy in all the four patients within 1 month after ESTTD but treated by placement of full covered retrievable metal stent in combination with balloon dilation or only by the latter and completely resolved after follow up of 14 to 33 months. Intra-operative minor bleeding less than 10 ml in total occurred in two patients. Subcutaneous emphysema and pneumothorax were observed in one patient. Metachronous lesion was detected in one patient 13 months after ESTTD.

Conclusion: ESTTD made en bloc resection of CSEN more convenient and was safe, but post-ESTTD esophageal stricture should be well aware of beforehand although placement of full covered retrievable metal stents could reduce sessions of balloon dilation needed to achieve a complete resolution of esophageal stricture.

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Oral or Poster
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status: Enqiang Linghu: ACG Non-Member
Huikai Li: ACG Non-Member
(No Image Selected)
(No table selected)
AVERAGE SCORE: 3.33
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: Upper endoscopic ultrasound (EUS) is mainly used to examine mediastinal and upper intraabdominal structures. Part of the thyroid is usually visualized at 18-20 cm from incisors during EUS examination. There is a paucity in literature regarding EUS examination of the thyroid gland. We report here the first case of papillary thyroid carcinoma diagnosed using EUS with fine needle aspiration.

A 66 year old man with history of treated esophageal adenocarcinoma underwent endoscopic ultrasound to evaluate mediastinal adenopathy. His CT/PET scan suggested presence of mediastinal lymphadenopathy with normal uptake. Endoscopic examination revealed a normal esophagus with no evidence of cancer. EUS showed few benign appearing medistinal lymph nodes. Fine needle aspiration of the lymph nodes was performed and yielded benign findings.

Upon withdrawing the radial EUS scope, a 1.7 cm hypoechoic well defined lesion was noted in the right thyroid lobe close to the common carotid artery (Figure). Under echo-endosonographic guidance, a fine needle aspiration using 22g Boston needle was performed successfully. Results of the FNA were consistent with papillary thyroid carcinoma (Figure 2). The patient was referred back to his oncologist to determine the next appropriate step in managing the patient. The patient was contacted after three days and he reported no clinical complaints.

This case illustrates the importance of examining the thyroid during EUS and considering performing FNA of suspicious thyroid lesion.

Methods: N/A

Results: N/A

Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports

CURRENT SUB-CATEGORY: K. Endoscopy

PRESENTATION TYPE: Poster Only

ACG Research Grant Support: No

Supported by Industry Grant: No

Commercial Products or Services: No

Initiated Research: Investigator

Financial Relationships: No

FDA Approval: No

Designed Study: Investigator

Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>:

Abdulah Mahayni : ACG Non-Member

Fateh Elkhatib : ACG Non-Member

Amer Alkhatib : ACG Non-Member
AVERAGE SCORE: 3
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: Angiosarcoma is a rare malignant tumor with the incidence of 1%–2% of all sarcomas. It is one of the most common tumors caused by therapeutic radiation, after treatment of breast cancer of Hodgkin lymphoma, with a median time of development of 8 to 10 years. Its occurrence in the gastrointestinal tract is extremely rare. We report a case of disseminated angiosarcoma presenting as melena and anemia.

Methods: CASE REPORT: An 88 y.o. woman was admitted to the hospital with melena for 2 days and anemia. She had history of breast cancer s/p L mastectomy with radiation (1995), H. pylori gastritis s/p eradication therapy, and lymphocytic colitis. She was on budesonide for her microscopic colitis. She might have used Advil for her back pain. Her labs were hemoglobin 11.1g/dL, MCV 80.1 and ferritin 186. After appropriate resuscitation and PPI therapy, she underwent an EGD.

The EGD revealed a normal esophagus and GEJ and moderate erosive gastropathy with a few diminutive aphthous ulcers of the antrum. There were no lesions requiring intervention. Her H. pylori stool antigen was negative and her fasting gastrin level was 48 pg/ml. Her hospital course was without complications. Her hemoglobin remained stable and she stopped having melena. She was discharged home with scheduled follow up in the GI clinic. During the clinic visit, she mentioned that she was seeing “black stool”. Her hemoglobin had dropped to 9.8 g/dL. She was on a PPI. She was offered an EGD/colonoscopy but she declined because she felt she was too old for these invasive tests. She agreed though to have a CTE (bleeding protocol) and a CE. The CTE was negative but the CE identified multiple large maroon ulcers throughout the small intestine. The patient refused further invasive tests again. 9 weeks after her initial hospitalization she was admitted again with melena and anemia.

Results: After a long discussion, she agreed to have EGD/colonoscopy. Multiple large maroon ulcers were identified throughout the stomach, duodenum and colon. Biopsies were obtained. Based on the morphology we were considering a metastatic carcinoma. Given the epithelioid morphology, we considered angiosarcoma in our differential. We performed a battery of angiosarcoma markers including FLI-1, CD34, CD31 and ERG and the tissue was strongly positive. HHV8 stain was negative (not Kaposi’s). In summary, the morphologic and immunophenotypic features supported the diagnosis of angiosarcoma. The patient decided to have comfort care only and passed away 3 weeks later.

Conclusion: Angiosarcoma in the gastrointestinal tract is extremely rare. If gastrointestinal bleeding is detected in patients who have undergone radiation therapy in the past, the possibility of angiosarcoma should be considered.
AVERAGE SCORE: 4.33
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Purpose: Boerhaave syndrome (BS) is a spontaneous perforation of the esophagus that can arise due to increased intraesophageal pressure combined with a negative intrathoracic pressure when vomiting against a closed glottis. Evidence of free perforation is serious and requires either surgery or endoscopic therapy with self-expandable metal stents (SEMS) or self-expandable plastic stents (SEPS). Esophageal perforation can be fatal in the absence of therapy. We present here a case of BS treated with a SEPS complicated by complete closure of the cervical esophagus necessitating percutaneous endoscopic intervention.

A 41 year-old male with history of proximal and distal esophageal perforation 10 months prior to presentation following severe emesis was referred to cardiothoracic surgery for further management. He was treated with diversion of the cervical esophagus through the neck (cervical fistula) as well as stenting of the distal perforation with a SEPS at an outside facility. A G-tube was then placed for alimentation. Initial evaluation with x-ray found the stent was dislodged in the stomach. Barium esophagogram showed no leakage in the distal esophagus with a well-healed distal tear with leakage from the cervical fistula (CF). Narrowing of the lumen just distal to the CF measuring 4mm was also observed. Gastroenterology was consulted to retrieve the displaced stent prior to the surgical repair of the cervical esophagus. Given the concern for perforation, an upper endoscopy was performed through the CF in the neck. With the help of the cardiothoracic surgeons the CF opening was dilated and the scope was introduced until it reached the esophageal lumen. The dislodged stent was seen in the stomach. It was retrieved using rat tooth forceps, and after some manipulation the stent was extracted in one piece through the dilated neck fistula. Because the esophageal mucosa appeared irritated following these maneuvers the CF was taken down and the esophagus was successfully reconstructed one month later.

Methods: N/A

Results: N/A

Conclusion: To the best of our knowledge, this is the first case report of Boerhaave syndrome repair in which a cervical fistula created therapeutically was also utilized for both endoscopy and stent removal. This case illustrates that endoscopy can be used in an unconventional manner successfully when medically appropriate, although such a technique is not without its own risks.
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
David Hass: [No Comments]|Charlene Le Pane: [No Comments]|Renee Young: [No Comments]|Rowen Zetterman: [No Comments]
Purpose: A 69-year-old African-American woman with osteoarthritis on ibuprofen was admitted with symptomatic, microcytic anemia. On hospital day two she underwent upper endoscopy to evaluate for gastrointestinal bleeding as the potential etiology of her anemia. She was pretreated with benzocaine spray and given a total of fentanyl 125 mg and midazolam 7 mg for sedation. Eight minutes into the procedure, she became hypoxemic with cough and abrupt onset facial, oral mucosal, periorbital, and neck edema but no urticaria, pruritis, or hypotension. The endoscope was withdrawn. She was ventilated with a bag valve mask and given naloxone 0.2 mg and flumazenil 0.2 mg with improvement of her oxygen saturation. She was also given diphenhydramine 50 mg and methylprednisolone 125 mg and underwent endotracheal intubation for impending airway compromise with airway and arytenoid edema. After transfer to the medical intensive care unit, she was given ranitidine 50 mg daily and received no further doses of benzocaine, fentanyl, or midazolam. C3 and C4 levels were 129 and 37 mg/dL, respectively, antinuclear antibody titer < 1:80, anti-cyclic citrullinated peptide antibody < 13 units, rheumatoid factor negative, tryptase level 2 ng/mL, and C1 inhibitor level 28 mg/dL. Family noted that her brother died suddenly one year prior after severe, sudden onset head and neck swelling. She was extubated two days after endoscopy and transferred to the general medicine service. After an uneventful recovery she was discharged home and has been seen by her primary care physician without further complications.

Angioedema is transient, often recurrent, localized swelling of the skin or submucosa of the upper respiratory or gastrointestinal tract with acquired and hereditary causes. Angioedema during upper endoscopy has been reported only twice previously in the English language literature with benzocaine and midazolam as reported causes. The diagnosis is made clinically. Initial evaluation for an underlying cause should include family history, screening C4 levels, allergy testing, a localized cold stimulation test, and workup for suspected associated connective tissue disease. Our patient had idiopathic angioedema due to benzocaine or type III hereditary angioedema. Reaction to midazolam or fentanyl was less likely given her exposure to both midazolam and meperidine during prior colonoscopy. The causative agent, if known, should be withheld. If laryngeal edema or anaphylaxis occurs, epinephrine, fluid replacement, antihistamine therapy, and early intubation at the first sign of airway compromise should be implemented. Clinicians should be aware of angioedema as a rare but potential complication of upper endoscopy.
AVERAGE SCORE: 3
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments] Charlene Le Pane: [No Comments] Renee Young: [No Comments] Rowen Zetterman: [No Comments]
Therapeutic Endoscopic Intervention For Management Of Gastric Outlet Obstruction Resulting From Stenosed Gastro-Jejunal Anastomosis After Whipple Procedure.

PRESENTER: Ganesh Aswath
PRESENTER (INSTITUTION ONLY): SUNY Upstate Medical University
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: Stenosis of the Gastrojejunostomy after Whipple procedure is a known complication, which usually occurs as an intermediate or late event. This could lead to gastric outlet obstruction (GOO), which may need surgery for correction. This has been described mostly in patients with cancer and having ingrowth of the tumor. However, we describe a case where it occurred as an early complication and was successfully managed by a relatively uncommon endoscopic technique.

Our patient is a 53 year old male, who has a history of Chronic Pancreatitis (CP) with suspicious lesions on his pancreas on EUS. FNAC/biopsies showed features of chronic pancreatitis and atypical cytology. He has a history of alcohol abuse for about ten years and quit about 18 months ago, when he started having symptoms of pancreatitis. He has a 18 pack year history of smoking.

An elective pancreaticoduodenectomy was done as he had persistent pain and due to the suspicion of malignancy because of the atypical cytology. Surgical biopsies showed no evidence of malignancy. He tolerated the surgery well, but in the early post-operative period, he developed nausea, vomiting, diffuse abdominal pain and abdominal distension. NG tube suctioning yielded food and gastric contents. The patient was taken up for endoscopy and was found to have GOO, with severe stenosis of the G-J anastomosis, which was not even visualized.

A repeat endoscopy was performed under fluoroscopic guidance and dye was injected into the stomach. Extensive probing was carried out to identify the GJ junction, with the help of fluoroscopy and endoscopy. We were able to identify and insert a guide wire through the G-J anastomosis, which was occluded, secondary to stenosis and edema. We used a 18 mm x 12 cm Evolution fully covered controlled-release stent with a 23 mm flange under fluoroscopic guidance to open up the stenosed G-J junction. Soon after this, flow was established from the stomach into the jejunal limb and we were able to pass the endoscope through this.

In the subsequent days, the patient was able to tolerate PO intake and had resolution of his symptoms of GOO.

About a week later, he returned with similar symptoms and was found to have GOO again. Endoscopy showed migration of the duodenal stent into the stomach. We were able to retrieve the stent and deploy a new one, and this time, we used clips to secure their position. This again resulted in resolution of his symptoms, and 2 weeks after the procedure, the patient is still asymptomatic.

We emphasize the importance of endoscopy and also want to share the experience with this relatively uncommon intervention for GOO resulting from stenosis due to edema of the G-J junction.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Ganesh Aswath : ACG Non-Member
Nasser Hajar : ACG Member
Praveen Sampath : ACG Member

(No Image Selected)
(no table selected)

AVERAGE SCORE: 3.67
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
David Hass: [No Comments]|Charlene Le Pane: [No Comments]|Renee Young: [No Comments]|Rowen Zetterman: [No Comments]
Purpose: Introduction:
Metastatic prostate cancer generally has survival rates ranging from 1 to 3 years. Prostate cancer commonly metastasizes to the bones and lymph nodes and rarely to the lungs or liver. We report a rare pattern of metastatic spread for hormone refractory prostate cancer with involvement of the stomach and rectum without bony disease.

Case:
A 64-year-old male presented with fatigue and chronic intermittent upper abdominal pain for several months and black stools. His medical history included of coronary artery disease, hypertension and hormonal insensitive prostate cancer. Physical examination revealed pallor and epigastric tenderness without mass. Labs were significant for a hematocrit of 11% with normal liver chemistries and coagulation profile. Upper endoscopy showed multiple giant folds with nodularity in the fundus and body (Fig.1a). Histological exam showed metastatic poorly differentiated adenocarcinoma consistent with prostate primary (Fig.1b). Cells were positive for AE1/AE3, prostate specific antigen (PSA) and P504S (Fig.1c). Colonoscopy showed the rectal mucosa with circumferential nodularity and poor distensibility of the rectal lumen (Fig.2a). Histological exam showed malignant cells positive for prostate specific antigen and human prostatic acid phosphatase, consistent with a poor differentiation (Figs. 2b and 2c). Bone marrow biopsy did not show any infiltration. A bone scan as well as imaging studies did not reveal any bony involvement. Palliative therapy with radiation and chemotherapy was recommended.

Discussion:
We report a rare pattern of metastatic spread for prostate cancer with involvement of the stomach and rectum without bony disease. The mechanism of metastasis to the GI tract from the prostate cancer is unclear. Lymphatic spread may be the mechanism bypassing usual routes of direct invasion and hematogenous spread.

Methods: N/A
Results: N/A
Conclusion: N/A
Mahesh Krishnaiah : ACG Non-Member

Fig.1: a. Upper Endoscopy showing giant folds in body of stomach, b. Metastatic Adenocarcinoma in the Stomach (200x), c. Immunohistochemical staining for Prostate Specific Antigen (PSA) highlights the malignant cells.

Fig.2: a. Colonoscopy showing circumferential nodular mucosa and poor distensibility of the rectum, b. High-grade prostatic carcinoma in rectal biopsy (200x), c. A PSA stain also show few positive malignant cells.

**IMAGE CAPTION:** Fig.1: a. Upper Endoscopy showing giant folds in body of stomach, b. Metastatic Adenocarcinoma in the Stomach (200x), c. Immunohistochemical staining for Prostate Specific Antigen (PSA) highlights the malignant cells. Fig.2: a. Colonoscopy showing circumferential nodular mucosa and poor distensibility of the rectum, b. High-grade prostatic carcinoma in rectal biopsy (200x), c. A PSA stain also show few positive malignant cells.

(no table selected)

**AVERAGE SCORE:** 4.67

**REVIEWER FLAGS:** Haritha Avula - Conflict of Interest: 1

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Novel use of endoscopic ultrasound and injection of sclerosant for the treatment of Bleeding Stomal Varices

An 82 yo male presented to the ED with large volume red blood from his ileostomy. His PMH was significant for a total proctocolectomy with end-ileostomy 8 years prior due to diverticulitis. He had similar presentations multiple times over the past few years with numerous ileoscopies and EGDs. No definite source had been identified. At presentation, hemoglobin was 5gm/dl with symptoms of weakness and fatigue. Chemistry and coagulation panel were unremarkable. Physical exam was remarkable for red blood in the ostomy bag. There had been no report of preceding melenic stools, change in ostomy output, history of NSAID use or upper GI complaints.

EGD was normal. Ileoscopy revealed no intraluminal bleeding source, but a small oozing area at the inferior margin of the ostomy was seen. Surgical evaluation was obtained and the area was treated with Silver Nitrate with successful hemostasis. 48 hrs later, the patient had a repeat episode of clinically significant stomal bleeding. Peristomal Doppler ultrasound revealed prominent vessels in the abdominal wall adjacent to the ostomy opening. With concomitant Stage IV chronic kidney disease, the patient was unable to undergo a contrast enhanced CT or MR. As a result of this and continued, clinically significant bleeding, the patient underwent curvilinear EUS through the stoma. 5cm proximal to the stomal opening, a prominent, dilated vessel was seen. Doppler confirmed venous flow and using a 19G needle the varix was successfully injected with 5% ethanolamine. Repeat doppler post injection confirmed absence of flow. The patient was discharged 48 hours later and has experienced no further bleeding over the last 9 months.

Stomal varices are a rare, but clinically important cause of stomal bleeding. Unlike other ectopic varices throughout the GI tract, stomal varices have traditionally not been amenable to endoscopic treatment due to location exterior to the bowel wall. Historically, treatment included external compression, and percutaneous, blind injection of sclerosant. Percutaneous therapy is limited due to high risk for stomal breakdown/stenosis, ulceration and possible blind injection of a high pressure varix. Currently, the mainstay of therapy for recurrent bleeding includes decompressive procedures such as TIPS or other shunting procedures. These invasive procedures have systemic consequences and risk of their own. We describe a novel approach utilizing therapeutic EUS to treat bleeding stomal varices which appears both safe and efficacious in this challenging clinical situation. Further study is warranted before this modality can be recommended for wide spread clinical use.
Successful Endoscopic Management Of Retained Suture Related Complication In A Gastric Bypass Patient

Ganesh Aswath

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United States

Purpose: Gastric Bypass (GBP) Surgery is becoming an increasingly popular surgery in the management of obesity. Marginal Ulcers (MU) are a common immediate/intermediate complication, with reported incidences up to 3-23%. Suture remnants have been seen in ulcer beds in up to 32% of the cases in one study. Mucosal ischemia, foreign body reaction, traction and bezoar like effect of food have been proposed as the mechanisms causing the ulcers.

We present the case of a 57 year old male s/p GBP surgery for obesity 8 months ago, with a 100 pound weight loss coming to the hospital with severe 10/10 epigastric pain with non-bilious, non-bloody vomiting, abdominal distension and hypoactive bowel sounds. Basic metabolic work up and blood counts were normal. Abdominal films and CT scan showed multiple air fluid levels. He was kept NPO and was started on IV hydration.

EGD was then performed, which showed evidence of a Roux-en-Y Gastrojejunostomy. The G-J anastomosis was characterized by congestion, edema, erythema and an impacted suture. This was traversed. The pouch to jejunum limb was characterized by congestion, edema, erythema and ulceration. The duodenum-to-jejunum limb was not reached. The impacted sutures were then cut with a hot biopsy forceps. There were multiple ulcerations in the efferent limb over the jejunal folds in a linear pattern consistent with traction injury from the suture. The patient was started on pantoprazole 40mg twice a day resulting in complete symptom resolution and ulcer healing.

Endoscopy is evolving as a novel technique for the management of GBP related complications. Redundant suture is typically regarded as a normal part of the postoperative anatomy. However, they should be considered a potential etiology of chronic pain in symptomatic patients, and removal is shown to be beneficial and helps prevention and healing of the ulcers. Suture cutting can be accomplished with simple hot biopsy forceps or with regular/flexible endoscopic scissors.

Methods: N/A

Results: N/A

Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status: Ganesh Aswath : ACG Non-Member
Divey Manocha : ACG Member
Sekhou Rawlins : ACG Member

AVERAGE SCORE: 4.25
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Purpose: To report a hot biopsy forceps method to treat transparent cap slip during peroral endoscopic myotomy (POEM).

Methods: A 35-year-old man presented with dysphagia for over one year. He was diagnosed with esophageal achalasia 1 year ago and underwent endoscopic balloon dilation, but his dysphagia reoccurred 1 month later. In December 2012, he underwent peroral endoscopic myotomy (POEM) in our Digestive Endoscopic Center. The procedure of POEM included the following steps as reported: Entry incision, establishment of submucosal tunnel, myotomy and closure of the entry incision. In this case we encountered unintentional slip of the transparent cap attachment off the distal end of the endoscope while withdrawing the endoscope from inside the submucosal tunnel right after accomplishment of myotomy of the inner circular muscle [Fig. 1-3]. Then we used a hot biopsy forceps to catch the cap [Fig. 4] and successfully retracted it slowly and slightly to avoid doing any more damage to the tunnel. 

Results: Finally the entry incision was well closed by endoscopic clips and the post-POEM X-ray did not expose complications like pneumothorax or pneumomediastinum. One week after POEM, dysphagia was relieved and the patient was discharged after a routine endoscopy assuring the complete closeness of the entry of the submucosal tunnel.

Conclusion: Transparent cap slip during POEM could be treated by use of hot biopsy forceps.
AVERAGE SCORE: 4.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
Purpose: Inferior vena cava filter (IVC) perforations into the duodenum are exceedingly infrequent. IVC filters are primarily used to prevent pulmonary embolisms from lower extremity deep vein thrombosis (DVT). While surgery is required for symptomatic duodenal perforations, there is a paucity of literature on the treatment of asymptomatic penetrations. Case Presentation: A 46-year old male with a history of paraplegia due to a motor vehicle accident, bilateral lower extremity DVT’s, and placement of an IVC filter 6 years prior presented with an exacerbation of his lower abdominal pain of several years when urinating. A CT scan was remarkable for IVC-filter strut (FS) penetrations into the right psoas muscle, L3 vertebral body, and possibly the duodenum. The patient denied symptoms of gastrointestinal (GI) bleeding. An EGD confirmed a single IVC-FS penetration into the 2nd part of the duodenal wall. The intraluminal strut measured 1.5 cm in length and was hooked, thus providing a soft end (figure). There was no ulceration or bleeding at the site of penetration. An erosion was found on the contralateral wall. The patient’s abdominal pain improved after starting terazosin for symptomatic benign prostatic hypertrophy. Vascular surgery opined that the potential complications from IVC filter removal would outweigh the benefits in an otherwise asymptomatic patient. The patient is on close follow-up. Discussion: The overall incidence of filter perforation through the IVC wall is approximately 0.2% but the incidence of IVC-FS duodenal penetrations is unknown. Persuasive indications to remove IVC filters after strut penetrations include GI bleeding and significant abdominal pain. Currently, though, there are no guidelines in the management of patients with asymptomatic IVC-FS penetrations into the duodenum. While patients are at risk for sepsis, bleeding complications and fistulous tracts, IVC filter removal after strut penetrations can lead to surgical or endovascular complications. In this case, given the presence of an otherwise quiescent duodenal wall, a non-surgical approach was adapted for the management of IVC-FS penetration through the duodenal wall.

Methods: n/a

Results: n/a

Conclusion: n/a

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*<font>:
Jean Park : ACG Non-Member
Somashekar Krishna : ACG Member
AVERAGE SCORE: 5
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Control ID: 1745483
Title: Delayed Diagnosis of Massive Gastrointestinal Hemorrhage: Dieulafoy Mistaken for Aortoenteric Aneurysm
Presenter: David Johnson
Presenter (Institution Only): Mayo Clinic Rochester
Presenter (Country Only): United States
Abstract Body:
Purpose: We report the case of a 73 year old woman with recurrent obscure overt gastrointestinal bleeding (GIB), presenting with large volume hematochezia. Investigations included colonoscopy and esophagogastroduodenoscopy (EGD), and capsule enterography which showed blood in the bowel without source. CT angiogram was nondiagnostic. Because of a remote history of abdominal aortic aneurysm (AAA) graft repair, she was taken for surgical exploration. After negative findings a loop ileostomy was created for the purposes of endoscopic access. Large volume episodic bleeding continued from the ileostomy and she was transferred to our referral center.

She then underwent numerous invasive investigations over a five day period including three angiograms, with selective and subselective exams of the superior mesenteric artery and jejunal branches, antegrade single balloon enteroscopy, retrograde ileoscopy, and provocative angiography, all without identified source. A tagged red blood cell scan showed a large amount of intraluminal blood in the left upper quadrant. Aortogram was performed and showed a briskly bleeding connection to bowel at the level of the aortic bifurcation (Figure). Bleeding persisted despite placement of bilateral covered stents spanning the lesion, stent balloon dilation, additional proximal stents, and aortic cuff insertion. Her condition deteriorated precluding more aggressive intervention and she ultimately expired.

At autopsy, the aortic graft was intact without evidence for leak. However, an aberrant artery arose from the aorta immediately proximal to the bifurcation. On histopathology of the jejunum, a submucosal persistent caliber artery was seen, consistent with a Dieulafoy lesion.

Dieulafoy lesions at any location present challenging cases of gastrointestinal hemorrhage. The episodic nature of the bleeding makes diagnosis or successful intervention difficult. The rare, aberrant aortic origin of a large artery was interpreted by several expert clinicians as aortoenteric fistula, resulting in fatal diagnostic delay. The correct diagnosis was only possible post-mortem, underscoring the importance of obtaining autopsy.

Methods: NA
Results: NA
Conclusion: NA
Current Category: G. Clinical Vignettes/Case Reports
Current Sub-Category: K. Endoscopy
Presentation Type: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
Auth Design: ACG Membership Status
David Johnson : ACG Non-Member
William Edwards : ACG Non-Member
Michael Keeney : ACG Non-Member
Jared Verdoorn : ACG Non-Member
John Kisiel : ACG Member
Image Caption: (no table selected)
Average Score: 3.75
Reviewer Flags: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
Purpose: Insulinoma is uncommon cause of persistent hypoglycemia. NET producing only proinsulin or proinsulin- predominant is a rarity and we describe pt w/ persistent hypoglycemia was found to have proinsulinoma diagnosed via EUS & underwent EUS-fiducial markers placement to assist in the surgical approach/localization. 47 WF present w/ sx hypoglycemia x1yr. The 72h fast was stopped due to sx hypoglycemia in 40s and was started on continuous D10. She had a low insulin level, low-normal C-peptide, high proinsulin suggesting proinsulin-secreting NET. CT was negative. On EUS, a mass in the midbody pancreas was seen and confirmed to be NET. Insulinoma is most common functioning pancreatic NET and present w/ sx of hypoglycemia and most are benign. EUS was used in diagnosis and localization in this case & revealed the tumor despite neg CT. Using EUS for preop staging of pancreatic tumors w/ fiducial markers for localization eliminate the unwanted risk of ink absorption into surrounding tissues.

Methods: na
Results: na
Conclusion: na

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Oral or Poster
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>: Jeffrey Juneau : ACG Non-Member
Ioana Smith : ACG Non-Member
Brandi Blackburn : ACG Non-Member
Shabnam Sarker : ACG Non-Member
Ali Khan : ACG Member
Jessica Tracht : ACG Non-Member
Jessica Trevino : ACG Member

A) Histopathologic examination reveals a solitary, encapsulated, well- differentiated neuroendocrine neoplasm. NI pancreatic parenchyma is present, adjacent to the tumor. B) Tumor consists of trabeculae architecture w/ uniform neuroendocrine cells showing low-grade nuclear features and cytoplasmic neurosecretory granules. Amyloid deposits are seen to the tumor nests. C) Immunohistochemistry for Ki-67 is reactive in <2% of cells, consistent with a grade 1 neuroendocrine tumor.
A) Cytopathologic examination w/ diffquick stain reveals a loosely cohesive, monotonous population of cells with round nuclei and scant poorly defined cytoplasm containing neurosecretory granules. Immunohistochemistry performed on cell block preparation is reactive for both chromogranin (B) and synaptophysin (C).

Intraop u/s revealing the proinsulinoma and fiducial markers

**IMAGE CAPTION:** A) Histopathologic examination reveals a solitary, encapsulated, well-differentiated neuroendocrineneoplasm. NI pancreatic parenchyma is present, adjacent to the tumor.  B) Tumor consists of trabeculae architecture w/ uniform neuroendocrine cells showing low-grade nuclear features and cytoplasmic neurosecretory granules. Amyloid deposits are seen t/o the tumor nests. C) Immunohistochemistry for Ki-67 is reactive in <2% of cells, consistent with a grade 1 neuroendocrine tumor. A) Cytopathologic examination w/ diffquick stain reveals a loosely cohesive, monotonous population of cells with round nuclei and scant poorly defined cytoplasm containing neurosecretory granules. Immunohistochemistry performed on cell block preparation is reactive for both chromogranin (B) and synaptophysin (C). Intraop u/s revealing the proinsulinoma and fiducial markers

(no table selected)

**AVERAGE SCORE:** 4

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Purpose: Transesophageal echocardiography (TEE) is a safe, minimally invasive procedure widely used to evaluate cardiac conditions. Complications are rare. An 81-year-old hospitalized female was referred for TEE to exclude infective endocarditis after isolation of methicillin-resistant Staphylococcus aureus despite intravenous vancomycin administered for a septic joint. The patient was stable post-procedure, without nausea and vomiting. Three days after, she developed profound hematemesis without antecedent vomiting. Gastric aspiration via NG tube revealed 150cc of bright red blood. The patient became hypotensive, with a blood pressure of 66/48 mmHg with a drop in hematocrit to 25.4%. Emergency EGD revealed active bleeding and a 10-cm-long clot extending proximal from the GE junction to the distal esophagus. Interventional angiography with coil embolization of left and right gastric arteries failed to arrest the bleed. Emergency EGD performed for continued bleeding revealed two vertical linear Mallory-Weiss tears at the GE junction with no active bleeding but with stigmata of recent hemorrhage consisting of a blood clot in the lower third of the esophagus. The lesion was treated with heater probe therapy of 6 pulses of 20 joules each with successful cessation of bleeding. The patient died from bowel necrosis secondary to hypovolemic shock from the bleeding.

Mallory-Weiss tears after TEE are rare and occur mostly in patients who are anticoagulated postoperatively after TEE performed during cardiac surgery. The mechanism involves trauma by the echoprobe and/or ultrasonic thermal injury. Only a few complications have been reported from diagnostic TEE in nonsurgical patients. Min et al. (JAmSocEchocardiogr 2005) reported a .03% rate of esophagogastric trauma among 10,000 procedures, further validating the safety of TEE. The present case describes an otherwise healthy elderly female, who experienced fatal upper gastrointestinal bleeding from Mallory-Weiss tear from TEE despite no known gastrointestinal abnormalities and despite not being anticoagulated. This case extends the clinical spectrum of Mallory-Weiss tears from TEE.

Methods: n/a
Results: n/a
Conclusion: n/a
Case Report: Hemoperitoneum After Colonoscopy In Absence Of Splenic Injury

Purpose: A 53 year old woman with a past medical history of hypertension presented with syncope and cramping abdominal pain one day following an uncomplicated screening colonoscopy, which showed small ascending colon diverticuli and a rectal polyp, removed by cold forceps biopsy. On exam, the patient was afebrile and hemodynamically stable. Abdominal exam showed mild distention and non-localizing lower abdominal tenderness, without any rebound or guarding. Labs were significant for a Hemoglobin of 10g/dl, from baseline of ~12. No intraperitoneal air was seen on upright CXR. CT of the abdomen demonstrated a large, heterogenous, hyperdense, partially circumferential lesion consistent with an intramural/submucosal hematoma, with moderate resultant hemoperitoneum. The patient was admitted for observation and had serial blood draws to monitor for further bleeding. She began improving clinically with no further interventions. By hospital day 2, the abdominal pain had resolved. Hgb remained stable throughout hospitalization and the patient did not require any transfusions.

Colonoscopy is considered a routine screening test for colorectal cancer in adults over the age of 50. The purpose of this report is to present a case of a rare complication of colonoscopy, spontaneous hemoperitoneum. A comprehensive review of literature was performed: there have only been a few cases reported on post-colonoscopy hemoperitoneum in the absence of splenic injury; which were attributed to torn mesenteric vessel, ruptured epiploic appendage [1], and ovarian tumor [2]. Although intraluminal bleeding and bowel perforation are possible complications of colonoscopy, hemoperitoneum should be on the differential in patients presenting with abdominal pain post-colonoscopy.

References:

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: G. Clinical Vignettes/Case Reports
CURRENT SUB-CATEGORY: K. Endoscopy
PRESENTATION TYPE: Poster Only
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: Not Applicable
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>
Omar Kallas : ACG Non-Member
Nikhil Kumta : ACG Member
Michelle Cohen : ACG Member
David Wan : ACG Member

IMAGE CAPTION:
AVERAGE SCORE: 4
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
ABSTRACT BODY:

Purpose: Pyogenic granuloma, also called lobular capillary hemangioma, is a benign vascular tumor presenting on skin surfaces but rarely in the GI tract. These benign neoplasms are seldom found in areas that can be visualized by EGD and colonoscopy making the diagnosis more problematic. We describe a case series of four patients, with different clinical presentations, all found to have pyogenic granulomas in different segments of the GI tract.

Patient “A” is a 34-year-old healthy male who presented with two weeks of gradual fatigue and found to have iron deficiency anemia, with hemoglobin of 9.0. EGD showed a friable ampullary orifice with active oozing of blood. Patient subsequently had an endoscopic ampullectomy and surgical pathology demonstrated an ulcer with granuloma pyogenicum of the ampulla of Vater.

Patient “B” is a 59-year-old male with history of alcoholic cirrhosis presenting with symptomatic anemia and melena for 2 days with hemoglobin of 7.1. EGD showed a polyp in the second portion of the duodenum which was resected and surgical pathology demonstrated prominent vascular proliferation compatible with pyogenic granuloma.

Patient “C” is a 63-year-old female with history of heavy aspirin use, presenting with symptomatic iron deficiency anemia and heme positive stools. EGD was normal but colonoscopy showed blood throughout the colon coming from the terminal ileum. Video capsule endoscopy showed a bleeding polypoid lesion in the mid-small bowel. Anterograde double balloon enteroscopy showed a 1.5cm polyp in the distal jejunum which was resected. Surgical pathology showed a pyogenic granuloma with ulceration at its surface.

Patient “D” is a 78-year-old female with history of alcoholic cirrhosis, with recurrent transfusion dependent melena and anemia now presenting with dyspnea and lightheadedness. The patient had prior endoscopies and colonoscopies showing no active sight of bleeding. Capsule endoscopy showed a bleeding source in the ileum and subsequent retrograde double balloon enteroscopy showed a bleeding polyp in the proximal to mid ileum with endoscopic polypectomy performed to control the bleed. Surgical pathology was consistent with a pyogenic granuloma.

Although pyogenic granulomas typically do not present in the GI tract, our case series demonstrate that these rare vascular tumors should be considered in the differential diagnosis of GI bleed and that they are easily treatable by endoscopic resection which is safe and very effective. Pyogenic granulomas can occur mucosally from the oral cavity to the rectum, but are very rare to present in the small bowel and thus our case series highlights these obscure locations of occurrence in various parts of the small intestine.
Harshit Khara : ACG Member
Mark Metwally : ACG Member
Maged Bakr : ACG Member
Dennis Meighan : ACG Member
William Hale : ACG Member
Rakhee Mangla : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 3

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:

Use of an Esophageal Fully Covered Self Expanding Metal Stent (FCSEMS) with Interventional Radiology Pigtail Catheter Placement to treat an Esophageal-Respiratory Fistula with Abscess Formation

Purpose: A 57 year-old male with unresectable esophageal cancer presented to the hospital with fevers to 102 degrees and uncontrollable cough over one week. Four months ago he was diagnosed with esophageal cancer invading into the trachea. He underwent a surgical PEG, was kept NPO, and had been doing well on chemotherapy and radiation. Physical examination on the current admission was remarkable for halitosis, tachypnea, rhonchi in the right upper lung (RUL), and a WBC count of 20K. He was started on antibiotics, and underwent a CT chest. This revealed a large fistulous tract in the upper third of the esophagus and extending into the RUL with abscess formation; the trachea was intact. After discussing options, decision was made to stent the fistulous tract. A 23 mm x 12 cm Esophageal Wallflex FCSEMS was deployed with the proximal portion of the stent 4 cm below the UES and 4 hemoclips were placed. Patient was extubated after the procedure, with no evidence of respiratory compromise. Interventional Radiology then placed a 14 Fr pigtail catheter into the abscess. Within one week the patient's WBC normalized, and repeat imaging showed the stent and catheter in good position with the abscess improved. Two weeks later, barium swallow revealed no evidence of leak and the patient began oral intake. Both his nutritional status and quality of life improved after this combined GI-IR approach used to treat his tracheo-esophageal fistula, and he was eventually discharged tolerating a soft diet and no longer needing PEG feeds.

Methods: N/A

Results: N/A

Conclusion: Esophageal fistula formation is a known complication of chemo and radiation therapy. There are several studies that document effectiveness of using FCSEMS in treating these fistulas. We present a rare case with impressive clinical and endoscopic findings in which a combined GI-IR approach helped treat an esophageal fistula causing significant pulmonary symptoms, and then also eventually improved the patient's quality of life by allowing him to once again tolerate PO.
Barium Swallow Image showing Esophageal FCSEMS Covering Fistula Tract and IR Pigtail Catheter Placed into Abscess

**IMAGE CAPTION:** Barium Swallow Image showing Esophageal FCSEMS Covering Fistula Tract and IR Pigtail Catheter Placed into Abscess

*no table selected*

**AVERAGE SCORE:** 4.25

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
Purpose: Case 1: A 58 year old male presented with complaints of persistent diarrhea, anorexia, and weight loss over the past several months. Colonoscopy revealed an inflammatory appearing circumferential mass in the rectum. After a difficult retroflexion was attempted, a small defect consistent with a perforation was noted. An 11mm over-the-scope clip (OTSC) was then placed over the defect with successful closure of the colonic mucosa. Post-procedure x-ray was negative and clinically the patient did well. Case 2: A 53 year old female underwent a rectal endoscopic ultrasound (EUS) after she was noted to have a 5cm perirectal mass on CT scan. The area of the rectosigmoid colon was significantly tortuous due to extrinsic compression and during passage of the EUS scope beyond this area a mucosal defect was noted. An 11mm OTSC was used to successfully close the defect. Post-procedure imaging did show free air, however the patient did well with no evidence of infection or significant pain. Case 3: A 60 year old male with a history of achalasia presented with worsening dysphagia. Endoscopy showed a dilated esophagus with narrowing at the GE junction. A 30mm pneumatic balloon dilation was performed under fluoroscopy, after which a 1cm transmural tear was noted. An 11mm OTSC was used to close the tear with success. Post-procedure gastrograffin esophagram did not demonstrate a perforation. The patient was placed on a course of antibiotics and did well with no further complications. This small case series highlights our institution’s highly effective experience with OTSC in closing mucosal defects. Perforations related to colonoscopy procedures, overall remains infrequent at around 0.1%, however still remains one of the most feared procedural complications for any endoscopist. Complications related to perforations continue to remain a concern as advanced therapeutic endoscopic techniques, such as endoscopic mucosal resection, become more widespread and available. Therapeutic interventions that may be warranted for iatrogenic perforations have traditionally required surgery with little other options. The OTSC now offers a potential safe and effective alternative to surgical intervention, as exemplified by this case series as well as several other studies. With use of the OTSC there is now an option for a minimally invasive, purely endoscopic approach in closing perforations and deep mucosal tears in selected cases. The use of the OTSC may also have a potential role in the management strategy for iatrogenic perforations, both as a bridge to eventual surgical correction, reducing potential interval complications or as a viable option in those patients that would otherwise be poor surgical candidates.

Methods: N/A
Results: N/A
Conclusion: N/A
AVERAGE SCORE: 3.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
Purpose: Barotrauma or injury to the colon from intraluminal air pressure induced by air insufflation during colonoscopy is rare. Most instances are mild and asymptomatic and resolve without complication or intervention. We present a case of barotrauma-induced colonic perforation in a healthy 56 year old female undergoing screening colonoscopy.

A 56 yo woman underwent screening colonoscopy for a family history of colon cancer. The sigmoid was tortuous and filled with diverticuli. Eventually a pediatric colonoscope was passed beyond the sigmoid after 7-10 minutes. In the proximal ascending colon linear hemorrhagic mucosa termed “cat scratch” colon, suggestive of barotrauma, was noted. No therapeutic manipulation or polyp removal was performed, the cecum was intubated but no attempt at ileal intubation was made given the barotrauma. Air was suctioned away and the scope gently withdrawn. The patient was told of the findings and instructed to be vigilant for any abdominal cramping or fever. Immediately post procedure she felt fine with minor gas discomfort. She reported to the hospital the next day with increased abdominal pain; a CT abdomen/pelvis revealed only a distended right colon without free air. She was admitted for observation, placed on IV antibiotics and discharged the next day feeling well. Two days later she had acute severe pain and returned to the hospital; she was hemodynamically stable, but with diffuse guarding; plain films revealed free air under both diaphragms. She was taken to the OR. A laparoscopic right hemicolectomy with direct anastomosis was performed. A large serosal tear the length of the ascending colon was found on examination of the resected colon. The patient recovered and was discharged on post-op day 6.

Endoscopists must be aware of the rare occurrence of colonoscopy-associated barotrauma. Barotrauma is marked by parallel hemorrhagic corkscrew lesions or “cat scratches” and must be distinguished from AV malformations or focal inflammation which tend to be less numerous and radiate from a central point.

Delayed rupture can occur. Colonoscopic light sources generate sufficient pressure to rupture the colon. Barotrauma occurs from colonic overdistention when intraluminal pressure is significantly increased. This increase occurs if the insufflation rate exceeds the air passage rate, especially with a competent ileocecal valve. Delayed or failed cecal intubation increases risk. We postulate that this patient’s deformed sigmoid colon requiring prolonged intubation time contributed to barotrauma and subsequent rupture.
Abstract Author: Investigator

AUTH DESIG: ACG Membership Status <font color="red">*</font>: Giorgio Napoli : ACG Non-Member
Samir Shah : ACG Member
Edward Feller : ACG Member
Neil Greenspan : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 4
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Haritha Avula: [No Comments]
James Buxbaum: [No Comments]
Raquel Davila: [No Comments]
Brian Weston: [No Comments]
Recurrent urothelial cancer masquerading as a large colonic mass and massive gastrointestinal hemorrhage

TYPE: Clinical Vignettes/Case Reports
SUB-TYPE: Gastrointestinal Endoscopy
PRESENTER: Asra Batool
PRESENTER (INSTITUTION ONLY): SUNY Downstate medical center
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

CASE:

A 62-year-old man from Honduras presented with painless rectal bleeding for 2 days. He reported no weight loss or family history of malignancy. He had transurethral resection of the bladder tumor (TURBT) with subsequent intravesical Bacillus Calmette-Guerin (BCG) vaccine a year ago. One month prior, he presented with diarrhea and had a colonoscopy that showed a large submucosal polypoid mass at the appendiceal orifice and in the sigmoid colon. Biopsies showed chronic colitis with marked eosinophilia, consistent with parasitic colitis and stool studies were positive for Strongyloides stercoralis. He was treated with ivermectin for a week and repeat stool studies were negative. Labs were significant for normocytic anemia with Hb of 10 gm. CT scan showed a large exophytic mass in the sigmoid colon with rectal wall thickening, para aortic lymph nodes, and normal urinary bladder wall. Colonoscopy at this time showed a large, nearly obstructing, friable mass, with oozing blood in the sigmoid colon. Complete hemostasis was not achieved despite epinephrine injection and cautery/extensive argon plasma coagulation on two subsequent days. He underwent partial embolization of the inferior mesenteric veins and its branches by interventional radiology and still continued to have rectal bleeding requiring multiple units of blood transfusion. He finally underwent surgical resection of the mass which showed high-grade urothelial carcinoma with extensive lymphovascular invasion on pathology.

DISCUSSION:

Primary treatment of early bladder cancer with TURBT and intravesical BCG vaccine has high survival rate but failure of therapy can result in recurrence or progression in a minority of cases. Recurrence usually occurs in the bladder wall or extravesical organs including the upper urinary tract or prostate. It is very rare to recur in the GI tract. Review of the literature shows few reported cases of hematemesis due to upper GI tract metastasis and some cases presenting with bowel obstruction secondary to annular compression of the rectum. Our case is unique as it presented as a large bleeding colonic mass with normal urinary bladder wall on imaging.

CONCLUSION:

In patients presenting with GI hemorrhage and prior history of bladder cancer, recurrence should be strongly considered as a differential diagnosis even in presence of normal urothelial structures.

METHODS: N/A
RESULTS: N/A
CONCLUSION: N/A

AUTH DESIGN: ACG Membership Status: Investigator
Asra Batool: ACG Member
Rajesh Ramachandran: ACG Member
Veronika Dubrovskaya: ACG Non-Member
David Lee: ACG Member

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(no table selected)

**AVERAGE SCORE:** 5

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Sita Chokhavatia: [No Comments]
Waqar Qureshi: [No Comments]
Bo Shen: [No Comments]
Marc Zuckerman: [No Comments]
Purpose: A 19 year old male presented with nausea, vomiting and epigastric pain. He had a recent history of NSAID-related perforated prepyloric ulcer with omental patch repair. EGD revealed a pin-hole sized pylorus, likely related to scarring from peptic ulcer disease and recent surgery. The narrow pylorus could not be traversed. Balloon dilation was performed to 10 mm. Biopsies were negative for H. pylori. High dose PPI therapy was continued. Two more endoscopies over five weeks showed persistent pyloric stenosis and dilation was performed to 15 mm. A fourth endoscopy was performed 3 months from initial presentation, again demonstrating a stenosed pylorus with inability to pass the endoscope into the duodenum. Balloon dilation was again performed to 15 mm. This time, 4 ml of 10 mg/ml solution of triamcinolone acetonide was injected in a four quadrant fashion into the stricture. Follow-up EGD three months later showed marked improvement in the appearance of the pylorus, which was now patent. The endoscope easily traversed the pylorus. The patient is asymptomatic on a general diet at 10 month follow up.

Endoscopic balloon dilation is the first-line therapy for patients with benign acquired pyloric stenosis. Patients who require more than two dilations are at high risk of endoscopic failure and need for surgical intervention. Endoscopic balloon dilation combined with intralesional steroid injection may be an effective alternative to surgery in such patients. Intralesional steroid inhibits stricture formation by interfering with collagen synthesis, fibrosis and chronic scarring processes. Triamcinolone inhibits the transcription of matrix protein genes, including fibronectin and pro-collagen. It also reduces the synthesis of α2-macroglobulin, an inhibitor of collagenase activity. It prevents the cross-linking of collagen which results in scar contracture, so that if the scar is stretched and corticosteroid is injected into it, contracture will presumably not occur. Corticosteroids also decrease the fibrotic healing that appears to occur after dilation. To our knowledge, this is only the sixth reported case of treatment of benign refractory pyloric stenosis with intralesional steroid injection.

Methods: N/A
Results: N/A
Conclusion: N/A
REVIEWER COMMENTS:
Purpose: Approximately 1.27 million colonoscopies are performed yearly. At least two large studies have analyzed the rates of complications, reporting rates between 1.98 and 2.8 per 1000 examinations. Among the rarer complications, spontaneous hemoperitoneum, on most recent review, was found to coincide most frequently with splenic injury. Only a handful of cases of spontaneous hemoperitoneum have been reported in the absence of splenic involvement.

We present a 48 year old cirrhotic male who developed worsening peritoneal signs the morning after an attempted diagnostic colonoscopy for iron deficiency anemia. The procedure was aborted due to a sudden onset of wheezing and distention upon entering the ascending colon while applying external pressure. Immediate imaging post colonoscopy was negative for a perforation. A follow up CT scan confirmed the presence of possible blood in the hepatorenal fossa without extravasation of contrast. Due to the presence of a fluid wave pulse on examination, a paracentesis was performed and demonstrated grossly bloody ascitic fluid.

No surgical intervention was required and the patient was managed conservatively. Lab testing confirmed transudative ascitic fluid with the presence of blood. The patient remained stable during the remainder of his admission. Due to the lack of alternate sources of bleeding, the etiology of the patient's hemoperitoneum was thought to be secondary to a ruptured porta-caval collateral. This was further substantiated after the initiation of octreotide and stabilization of the patient's hemoglobin.

The development of hemoperitoneum without any evidence of organ damage, ruptured tumors, or adhesions is rare and has been only documented twice. Typically, the mechanism of injury occurs with splenic damage by traction from manipulation or adhesions causing increase mobility of the splenocolic ligament. The use of external pressures applied to assist in colonoscope advancement is a common practice. We propose, in the setting of cirrhosis and increased intra-abdominal pressures, the application of an external force may have lead to barotrauma related bleeding in our patient.
AVERAGE SCORE: 5
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Sita Chokhavatia: [No Comments] | Waqar Qureshi: [No Comments] | Bo Shen: This case will raise the precaution for doing colonoscopy in cirrhotic patients | Marc Zuckerman: [No Comments]
Purpose: Juvenile polyposis is an uncommon condition of multiple hamartomatus polyps primarily in the colon, that usually presents at an early age. We report a case of juvenile polyposis, predominantly involving the stomach and duodenum, and presenting later in life.

64 year old man with diabetes, hypertension, and CAD who presented with chest pain. Examination revealed anemia and occult blood in stool. Both upper and lower GI endoscopy were performed revealing extensive gastric and duodenal polyposis, and multiple variable-sized polyps scattered throughout the colon. Initially, the resected polyps appeared as hyperplastic on pathologic examination, yet given the extensive involvement, multiple biopsies were re-examined and the diagnosis of juvenile polyposis was made.

Juvenile polyps are hamartomatous polyps found primarily in infants and children, and in association with juvenile polyposis as in juvenile polyposis syndrome (JP) or Cowden syndrome (CS). Although solitary juvenile polyps are benign lesions, in JP patients, these polyps also carry risk of malignant change. Germline mutations in MADH4 and BMPR1A predispose to JP, and both genes are involved in TGF-β superfamily signaling pathways. In CS, juvenile polyps are a less consistent feature, and such patients are at risk for breast and thyroid cancers. Despite different underlying genetic mechanisms, these and other syndromes share the same phenotypic feature of juvenile polyps. Pathologically this type of polyps can be confused with hyperplastic polyps unless multiple biopsies are reviewed. This case is unique as the polyposis presented at such a late age, and while the initial pathologic examination indicated hyperplastic polyps, the extent and subsequent re-biopsy confirmed the juvenile polyposis.

We report a case of juvenile polyposis in an adult patient. Our case demonstrates the importance of vigilance in the setting of extensive polyposis and to question benign pathologic examination of resected polyps since, in contrast to hyperplastic polyps, juvenile polyposis carries some risk of malignant change, and dictates implementation of appropriate genetic testing and surveillance.

Methods: N/A

Results: N/A

Conclusion: N/A
REVIEWER COMMENTS:
Sita Chokhavatia: [No Comments]
Waqar Qureshi: [No Comments]
Bo Shen: [No Comments]
Marc Zuckerman: [No Comments]
Purpose: A healthy 63-year-old man underwent an uneventful screening colonoscopy without propofol sedation and was asymptomatic when discharged. Three hours later, he became light-headed and diaphoretic with standing. He had a syncopal episode and hit his head against a wall. He lay down for several hours, but when he sat up, lightheadedness and diaphoresis returned and he lost consciousness again. His wife witnessed and confirmed the episode. He was brought to the Emergency Department and denied having post-ictal confusion or bowel/bladder incontinence. He described mild, poorly localized abdominal discomfort following the second syncopal episode. Pulse and blood pressure were normal without postural changes; exam was unremarkable except for mild tenderness to palpation over the left trapezius, diminished bowel sounds, and mild tenderness to palpation in the LLQ without signs of peritoneal irritation. He had a third syncopal event in the ED two hours after arrival. Systolic blood pressure decreased to the 60s; Hemoglobin dropped from 12.3 g/dL to 8.7 g/dL. Abdominal CT scan revealed a 13x10x13 cm splenic hematoma with splenic rupture. Head and neck CT was normal. After emergency splenectomy, his hemodynamic status stabilized with no recurrence of syncope.

Splenic injury due to colonoscopy is rare and believed to be due to tension on the splenocolic ligament with subsequent capsule avulsion or from direct instrument-induced splenic injury. Risk factors include a pathologic spleen or splenomegaly, anticoagulation, inflammatory bowel disease, therapeutic or difficult colonoscopy, intra-abdominal adhesions secondary to prior surgery or trauma, propofol sedation, inadequate bowel preparation limiting visualization, and rapid procedure completion time. Signs of splenic rupture are often subtle and non-specific, thus contributing to delayed diagnosis. Diagnosis requires a high index of suspicion since symptom-free intervals can last up to seven days and because abdominal complaints may be absent, mild or non-specific. Symptoms are often reported several hours to several days after procedures and are not necessarily suggestive of splenic rupture. The majority of reported patients experience symptoms only after discharge.

Methods: N/A
Results: N/A
Conclusion: N/A

AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Daniel Jamorabo : ACG Non-Member
Edward Feller : ACG Member
Samir Shah : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 4
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Sita Chokhavatia: [No Comments]
Waqr Qureshi: [No Comments]
Bo Shen: [No Comments]
Marc Zuckerman: [No Comments]
Purpose: Systemic lupus erythematosus (SLE) is a chronic inflammatory disease encompassing a variety of presentations, one of which commonly being gastrointestinal symptoms. Eosinophilic gastroenteritis is a rare manifestation of SLE, and highly unlikely to present as one of the initial signs. Laboratory finding typically show peripheral eosinophil counts ranging from 5-35 percent, and diagnosis is confirmed with endoscopy with biopsy showing eosinophilic infiltration on histology. Clinical features are related to the layers and extent of bowel involved. We describe a 34-year-old female who developed recurrent episodes of epigastric pain, nausea and vomiting, with a concomitant maculopapular rash, which was treated with a 5-day course of oral steroids. On follow up visit, patient was noted to have leukocytosis, with an elevated eosinophil differential of 64.2%. CT scan of the abdomen and pelvis demonstrated mild thickening of the gastric, duodenal and proximal jejunal walls. EGD displayed a linear ulcer in the distal third of the esophagus and gastritis in the antrum and body of the stomach. Duodenal biopsies showed severe chronic inflammatory infiltration composed predominantly of eosinophils. She was subsequently placed on a course of Prednisone, with moderate decreases in peripheral eosinophils, and symptoms. Within the next three months, the patient developed proximal muscle weakness, changes in bowel habits, heavy menstruation, joint pain and Raynaud phenomenon with laboratory studies showing positive ANA and SSA titers. She was diagnosed with SLE (meeting the diagnostic criteria), and placed on Prednisone and Hydroxychloroquine. Repeat EGD was performed, as the patient had an episode of hematemesis. Duodenal biopsies demonstrated mild eosinophilic infiltration, drastically improved from the previous study. There have been reports of rheumatic disease associated eosinophilic gastroenteritis, but seldom with SLE, making the diagnosis of lupus from eosinophilic gastroenteritis as a presenting manifestation difficult.
REVIEWER COMMENTS:
Sita Chokhavatia: [No Comments]
Waqar Qureshi: [No Comments]
Bo Shen: [No Comments]
Marc Zuckerman: [No Comments]
We present a case of a patient who had simultaneous occurrence of both an esophageal and aortic rupture as a result of violent vomiting.

A 62 year old male with a past medical history of diabetes mellitus, hypertension, hyperlipidemia, and stroke, presented to an outside hospital with two days of nausea, vomiting, dizziness, as well as melena. One month prior to admission, the patient had magnetic resonance imaging for epigastric pain, where an atherosclerotic plaque and beginning of a pseudoaneurysm appeared to be forming in the descending aorta. This finding, however, was not included in the radiological report. On admission, he developed tachycardia and hypotension. His initial labs revealed a hemoglobin of 6 g/dL. CT scan of the chest demonstrated a thoracic aortic pseudo-aneurysm as well as IV contrast in the esophagus. He subsequently underwent endovascular repair of the aorta. An emergent esophagogastroduodenoscopy (EGD) was then performed, which showed a long tear in the distal esophagus, as well as a pulsating bleeding vessel in the duodenum, controlled by emergent coiling by interventional radiology. After transfer to our hospital, the patient underwent a repeat EGD which demonstrated a large Boerhaave’s tear that was approximately 10 cm in length, which was in communication with the pleural space. He was managed conservatively, and was discharged home on a liquid diet after about a month-long stay.

Esophageal rupture is a rare complication of vomiting. Boerhaave’s syndrome constitutes about 15% of all ruptures, and occurs when there is a full thickness tear of the esophagus. Most commonly, these tears arise secondary to increased intra-esophageal pressure from severe retching and vomiting. This highly fatal condition has an estimated mortality rate of 20% to 40%. Similarly, aortic rupture is a rare and highly fatal syndrome. Ruptures usually occur at a weak spot in the aorta such as a pseudoaneurysm, post-surgical site, or infected endovascular graft, and can lead to aorto-enteric fistulas (AEFs). Our patient’s violent vomiting and retching was secondary to his bleeding duodenal ulcer. The retching then proceeded to cause both an esophageal and aortic rupture. There are a few cases in the literature of atherosclerotic ulcers penetrating into the esophagus, but no cases reported of a simultaneous esophageal and aortic rupture developing as a result of severe retching. Upon discovery of an AEF, primary management is almost universally surgical. AEF is a rare and often fatal condition, and survival is highly dependent on early recognition. Our case demonstrates an unusual presentation with a very fortunate outcome.
James Watson : ACG Member
Paul Akerman : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 4.25

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Sita Chokhavatia: [No Comments]
Waqar Qureshi: [No Comments]
Bo Shen: [No Comments]
Marc Zuckerman: [No Comments]