Purpose: We report the case of an adolescent with a rectal MALT lymphoma manifesting with hematochezia who was treated successfully with radiotherapy. Pediatric gastrointestinal (GI) malignancies are very rare. Of these, lymphomas are the most common. In adults, primary GI, non-Hodgkin lymphomas (NHL) account for 4-20% of all NHL. WHO classifies NHL as Burkitt's, diffuse large B cell, mantle cell, follicular cell and extranodal marginal zone mucosa-associated lymphoid tissue lymphoma (MALT). Colorectal lymphomas are very rare (10-20% of GI NHL and 0.2-0.6% of all colonic malignancies), and only 10-25% localize in the sigmoid and rectum. MALT lymphomas represent 5% of NHL and the majority occur in the stomach. MALT rectal lymphomas are extremely rare and have been treated with surgery, chemotherapy, antibiotics or radiation therapy. A 16-year-old male presented with a history of painless hematochezia and constipation for 2 months. Past medical and family history were unremarkable. Rectal exam revealed redundancy of the posterior rectal mucosa and gross blood on the glove. The physical exam was otherwise normal. Colonoscopy was normal except for mild nodularity of the rectosigmoid, with cobblestoning of the first 5 cm of the rectum and the presence of two hypertrophic anal papillae. Biopsies of the first 5 cm of rectum, including the anorectal junction, showed an infiltrate of large atypical B cells CD20+, Pax 5+, CD 79a+, CD43+, MUM1+, BCL2+, BCL6+, CD5-, CD10-, BCL1-. Plasma cells were CD20- showing cytoplasmic IgA kappa restriction. CD79a was strongly expressed in plasmacytic cells and poorly in B cells. Ki67 proliferation index was low to moderate. EBER-ISH was negative. The findings were consistent with marginal zone lymphoma with plasmacytic differentiation. PET scan showed a hypermetabolic uptake in the anal region (SUV 11.4). CT of the chest, abdomen and pelvis was negative. The patient received 24 GCE involved field proton beam radiotherapy in 12 fractions to the anorectal lesion. Pelvic and inguinal nodes were not irradiated. Repeat PET scan 5 months after radiotherapy showed decreased anal hypermetabolic uptake (SUV 4.4). Colonoscopy after 6 months showed mild nodularity of rectosigmoid. The anorectal margin had mild erythema and nodularity. Rectal biopsies showed benign lymphoid aggregates and the anorectal junction mucosa was normal. He reported occasionally minor anorectal bleeding when constipated. To our knowledge this is the first pediatric case of a rectal MALT lymphoma that was induced into remission by low dose proton beam radiotherapy. Although very rare, anorectal malignancies should be considered in the differential diagnosis of hematochezia in children and adolescents.

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

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AVERAGE SCORE: 4.25
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
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Purpose: Omental infarction (OI) is an uncommon but increasingly recognized cause of acute abdominal pain in children, with the great majority of cases presenting as significant right sided abdominal pain. To our knowledge there are only two cases presenting with a left sided OI reported in the pediatric literature. We report the case of a previously healthy obese 13-year-old male who presented to the emergency room with a 6-day history of intermittent colicky abdominal pain located in the left upper quadrant (LUQ). There was no history of trauma, anorexia, nausea, vomiting, or diarrhea.

Physical examination revealed tenderness to palpation in the LUQ without rebound, guarding, rigidity, or masses. CBC, CMP, and coagulation profile were normal, with a mildly elevated ESR at 17 seconds. Stool for occult blood and calprotectin were normal. Computed tomography (CT) scan revealed a hypodense, homogeneous mass with fat stranding in the left upper quadrant. Based on the radiological findings, a diagnosis of OI was made. The patient underwent conservative management with overnight hospitalization for pain control and was discharged the following day with improvement of symptoms. To our knowledge he has remained asymptomatic.

Conclusion: Healthcare providers should be aware of the possibility of a left sided OI when presented with a child with complaints of acute left sided abdominal pain. The clinical symptoms when combined with CT findings allow for prompt diagnosis and conservative treatment; potentially avoiding unnecessary tests and surgical procedures.

Methods: NA

Results: NA

Conclusion: NA

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Abdominal CT scan: A hypodense, homogeneous mass with fat stranding in the left upper quadrant consistent with idiopathic segmental omental infarction

**IMAGE CAPTION:** Abdominal CT scan: A hypodense, homogeneous mass with fat stranding in the left upper quadrant consistent with idiopathic segmental omental infarction

(no table selected)

**AVERAGE SCORE:** 4.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Purpose: Solitary rectal ulcer syndrome (SRUS) is a rare condition, especially in the pediatric population, characterized by hematochezia, constipation, and sometimes perineal pain. SRUS is caused by increased abdominal pressure due to intense straining, which forces the rectal mucosa into the contracting puborectalis muscle, leading to ulceration, chronic ischemia, and even mechanical trauma. Diagnosis is made by endoscopy, and confirmed by histology, showing characteristic obliteration of the lamina propria, crypt distortion, and disorientation of muscle fibers. All cases heal with medical or surgical intervention. To our knowledge there are no case reports of cellular metaplasia during the healing process of SRUS.

We report a 6-year-old patient with functional constipation who presented with hematochezia and found to have a solitary rectal ulcer on proctoscopy. She had a prolonged course of treatment with topical sucralfate and mesalamine enemas. Her clinical symptoms resolved and follow-up proctoscopy showed improvement in the ulcer. Four years later she presented with hematochezia again, being non-compliant with stool softeners. Proctoscopy revealed islands of velvety appearing mucosa at the previous ulcer site. Biopsy of these areas revealed squamous mucosa with no inflammation. Subsequent surveillance proctoscopy 6 months later showed resolution of the metaplasia. Clinicians must be made aware that cellular metaplasia can occur during the healing process of SRUS. Squamous metaplasia of the colorectum is not well characterized and is rarely described in both adults and children. If persistent, this metaplasia can theoretically put the patient at risk for dysplasia. Hence, close follow-up is imperative for all pediatric patients that have been diagnosed with SRUS.

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

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AVERAGE SCORE: 4.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Purpose: Introduction: Over 100,000 cases of foreign body ingestions are reported each year in the U.S. 80% occur in children between the ages of 6 months and 3 years and 98% of foreign body ingestions in children are accidental. Serial intentional foreign body ingestions are more prevalent in adults due to underlying psychiatric disorders, mental retardation, alcohol ingestion, or in prisoners seeking secondary gain (i.e., transfer to medical facility). We present a case of a 16-year-old female who started serial intentional foreign body ingestions at the age of 10. We describe the nature of progressive escalation and innovation of foreign bodies ingested.

Case: The patient is a 16-year-old female with a history of depression, bipolar disorder and post-traumatic stress disorder who presented with recurrent self mutilation behaviors and foreign body ingestions since 10 years of age. Despite being in a highly monitored inpatient psychiatric facility, she has continued to ingest foreign bodies intentionally for secondary gain. The patient self reports her ingestions so she can be transferred to a “safer” hospital. She initially started swallowing smaller, blunt objects such as coins, EKG leads, and AA batteries. Some of these objects were allowed to pass spontaneously and required no intervention. In order to meet urgent endoscopic criteria for foreign body removal, she quickly learned to start swallowing a variety of innovative long, sharp, and large foreign bodies such as sharpened coloring pencils (10 cm), pencils (6-10 cm), sharp razor blades (3 cm), broken CD pieces, sharp metal nails taken off walls, plastic spoons (6 cm), and broken toothbrush to create sharp edges (6 cm).

Recently, she has learned to break and ingest sharp and long pieces of wood from a bookshelf. She has undergone 15 endoscopies in the past 4 months for foreign body retrieval. Thus far, patient has not required surgical intervention and survived with minimal morbidity. (Images to be included in presentation.)

Discussion: Despite having complete supervision in an inpatient psychiatric facility, our 16-year-old enterprising pediatric patient started escalating foreign body ingestion patterns starting at 10 years of age and identified new techniques for ingesting longer, larger, and sharper foreign bodies, which are associated with higher complications rates. Although ingestions are usually accidental in the pediatric population, we describe a child who started ingesting foreign bodies intentionally, similar to adult patients. Pediatric and adult gastroenterologists caring for pediatric patients need to be aware of this behavior, as well as the endoscopic techniques for removal of intentionally ingested sharp foreign bodies.

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

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**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: always entertaining although any unique / interesting methods of removal would been nice
Title: An Unusual Cause of Abdominal Pain

Purpose: 12-year-old boy with no past medical history that presented to the hospital with a 3-week history of constipation and intermittent epigastric pain. The pain was described as sharp and burning in character, at times a 10/10 in intensity, worsened by food and not relieved after having a bowel movement. Seen in the E.R. at another institution and was prescribed medications for suspicion of GERD and constipation as the cause of his symptoms, but there was no improvement.

A CT abdomen/pelvis revealed a 1.9 cm multiloculated cystic structure abutting the greater curvature of the stomach and the pancreatic body/tail. An MRCP/MRI of the abdomen revealed a stable fluid signal mass adjacent to the upper stomach and distal body of the pancreas. Given these findings, an endoscopic ultrasound was performed which revealed a well-defined triangular cyst, found superior to the pancreatic body, medial to the left adrenal and kidney. The cyst was extrinsic to the wall of the stomach. These findings were concerning for a gastric duplication cyst.

Due to the persistence of symptoms, decision was made for patient to undergo exploratory laparoscopy with cyst excision. There were no complications after the procedure. After excision, abdominal pain improved and patient was discharged post-op day 3 tolerating a regular diet. Pathology came back as a benign cyst with histomorphology consistent with a bronchogenic cyst.

Discussion: Bronchogenic cysts are a rare clinical entity that come from the result of anomalous development of the ventral foregut that forms the respiratory system. These cysts are usually located close to the trachea or main stem bronchi. Bronchogenic cysts are mostly asymptomatic. Symptomatic patients usually present with symptoms related to cyst infection or compression of adjacent structures (i.e., chest pain, difficulty breathing and dysphagia). Some cases have been reported in remote locations such as the neck, abdomen, and retroperitoneum.

Conclusion: It is extremely difficult to make a definitive diagnosis preoperatively just based on imaging findings, since at first it was thought to be a gastric duplication cyst. This rare clinical entity of a bronchogenic cyst of the stomach was identified by pathological examination only after surgical resection.

Methods: N/A

Results: N/A

Conclusion: N/A
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

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