Gastric bypass surgery is an effective method of treating obesity becoming more commonly performed. Although relatively safe, there are several known complications, including diarrhea. Causes of diarrhea post-gastric bypass surgery include bacterial infections, malabsorption and dumping syndrome. Cytomegalovirus can cause diarrhea in immuno-incompetent patients by causing colitis. We present a case of cytomegalovirus in a patient who underwent gastric bypass surgery with no evidence of immuno-incompetency. A 43 year-old obese male 6 weeks status post gastric bypass surgery presented with complaints of crampy lower abdominal pain, non-bloody diarrhea (4–5 episodes/day), intermittent nausea, vomiting and low grade fever. His past medical history was significant for type II diabetes and hypertension. He had no history of smoking drinking or illicit drug use. Prior to surgery, his HIV status was negative. On admission, he was an obese man with no apparent distress. His abdominal exam was significant for diffuse tenderness on light palpation, especially in the right lower quadrant, hyperactive bowel sounds. There was also a surgical scar with for diffuse tenderness on light palpation, especially in the right lower quadrant, hyperactive bowel sounds. There was also a surgical scar with lab evaluations for this anomaly, particularly when examining the left upper quadrant.

Wegener’s Granulomatosis is a rare disease characterized by a triad of necrotizing granulomas of the upper respiratory and lower respiratory tract and glomerulonephritis. The pathology is defined by the triad of small vessel vasculitis, granulomatous inflammation and necrosis. Associated symptoms can be scleritis, arthritis, purpura and neuropathy. We present a patient with Wegener’s granulomatosis who presented with massive lower gastrointestinal bleeding secondary to colonic ulceration. A 35 year-old woman with a 10 year history of Wegener’s Granulomatosis presented with hemoptysis and shortness of breath for one month. There were also complaints of nausea and vomiting for one day and painful oral ulcerations for three days. Past medical history also included asthma and anemia. On admission, physical exam was significant for ulcerative lesions on the tongue, buccal mucosa and midline lips. Lungs had bilateral ronchi in upper lung fields. Abdominal exam was normal and stool guaiac was negative. Laboratory analysis was significant for leukocytes 15,200, hematocrit 24.4. Treatment with intravenous steroids and cyclophosphamide was begun. On the seventh day of admission, the patient began to have massive lower gastrointestinal bleeding, passing blood and clots from the rectum. Upper endoscopy revealed only gastritis. Colonoscopy was performed which revealed fresh blood and clots. There were multiple 1–2 cm ulcerations in the cecum and ascending colon. Hemostasis was achieved with heater probe and injection of epinephrine. This case represents the first report of colonic ulceration from Wegener’s granulomatosis leading to massive lower gastrointestinal bleeding. An ischemic process complicating the typical vascularis seen in Wegener’s disease is suspected as causing the colonic ulcers. Despite standard medical treatment of Wegener’s granulomatosis, the colonic ulcers do not appear to respond. Endoscopic therapy is required and appears effective.

A 42 year-old female who was otherwise healthy presented with several weeks of intermittent dysphagia for solids. One evening, she developed a food bolus while eating meat and subsequently underwent an esophago-gastroduodenoscopy (EGD) for a suspected food bolus impaction of the distal esophagus. On endoscopy, the distal esophagus appeared narrowed at the level of the GE junction. No distinct stricture was identified. In the stomach, there was a 1 to 1.5 cm submucosal mass along the greater curve of the stomach. A referral was made to our facility for an endoscopic ultrasound (EUS) to evaluate the submucosal mass in the stomach. The EUS was performed using an Olympus radial echoendoscope. The submucosal lesion was identified in the fundus, along the greater curve of the stomach. On endoscopic ultrasound, the lesion appeared homogeneous, round, and well circumscribed. It measured 9.9 mm by 23.2 mm. The impression of the endosonographer was that it was a benign lesion, most likely a leiomyoma. A CT scan was recommended in 4-6 weeks. Two months later, a CT scan was obtained. The CT scan showed a 7 cm gastric mass in the area of the gastric fundus. The pancreas was not well seen. With the apparent increase in size of this tumor over such a short period, there was concern for a possible malignancy. The patient was taken to the operating room for an exploratory laparotomy and excision of the gastric submucosal tumor. During the operation, there appeared to be a densely adherent gastric mass. She underwent a wedge resection of the proximal fundus. Under microscopic examination, the mass was identified as a nodule of accessory spleen. The accessory spleen is a common congenital abnormality present in about 10% or more of the population. In our experience of over 500 EUS cases over the last three years this is the first case of an accessory spleen being identified. If our experience is representative of other institutions, experienced endosonographers are likely not seeing or not recognizing this common splenic abnormality. Reasons for this apparent underreporting could be the lack of well-defined EUS criteria for diagnosing this entity as well as its usually small size and benign appearance. We contend that the endosonographer should have a heightened awareness for this anomaly, particularly when examining the left upper quadrant.

Tattooing of the gastrointestinal tract with India Ink is often employed to facilitate identification of a polypectomy site or a mass lesion for possible subsequent surgery or a second look by the endoscopist. It is generally believed to be a safe procedure, with a reported complication rate of only 0.2%. Recently, a new tattooing agent containing carbon particles in suspension has been introduced commercially for general use (“SPOT”, GI Supply, Camp Hill, Pa). The SPOT preparation is more convenient to use since unlike India Ink it does not require sterilization or filtration. We report two complications within a six-month period following the use of the new compound.