were IPAS. Accessory spleens can be acquired entities (splenosis) which is the auto-transplantation of splenic tissue in abnormal locations as a result of trauma or post-splenectomy. This is the first case that incorporates real-time endomicroscopy and onsite pathology to diagnose IPAS. Patients with IPAS may undergo distal pancreatectomy because they mimic a hypervascular NET on CT and MRI scans. Onsite pathology and endomicroscopy review increases the diagnostic accuracy for differentiating between IPAS and pancreatic NET. In patients with a hypervascular mass in the tail of pancreas addition of real-time nCLE to traditional FNA can increase the diagnosis yield of EUS and potentially prevent unnecessary surgery.

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Diffuse Involvement of Mixed-Type IPMN
Kevin B. Patel, MD, Peter J. Sargos, MD, Jennafer Ottenheimer, MPH, PA-C, Smita Patel, MD, A. Aziz Aadam, MD. Rush University Medical Center, Chicago, IL.

Introduction: The malignant potential of intraductal papillary mucinous neoplasm (IPMN) of the pancreas is associated with involvement of the main pancreatic duct. We present a case of a multi-cystic IPMN involving the main pancreatic duct and its side branches.

Case: A 72-year-old male with a medical history of stroke and tobacco use presented with a 3-week history of abdominal pain, along with unintentional weight loss of 40 lbs over the last year. A CT scan
showed a grossly abnormal pancreas with a multi-macrocytic mass centered at the head of the pancreas, measuring approximately 5.7 cm x 7.0 cm. The extrapancreatic and intrapancreatic bile ducts demonstrated marked dilatation. Laboratory evaluation was significant for total bilirubin 3.8 mg/dL, alkaline phosphatase 758 U/L, AST 79 U/L and ALT 107 U/L. The patient underwent EUS showing multi-cystic replacement of the majority of the pancreas parenchyma. The pancreatic duct was dilated to 12 mm in the head of the pancreas. The common bile duct was dilated to 17 mm and abruptly terminated in the head of the pancreas due to the obstructing cyst. Cyst aspirate was performed and sent for analysis. Cytology of the cystic fluid showed acute inflammatory cells and proteinaceous debris, suggestive of a pseudocyst. The fluid amylase and CEA were elevated to 10,203 U/L and >1500 ng/mL, respectively. Serum CA 19-9 was elevated to 230 U/mL. These findings are consistent with a mixed-type IPMN, which has a similar risk for malignancy as a main-duct IPMN. According to the Fukuoka guidelines, this patient had high-risk stigmata of malignancy including obstructive jaundice and main pancreatic duct > 10 mm. Therefore, he underwent a total pancreatectomy with pathology revealing invasive mucinous carcinoma arising in the background of extensive IPMN. The surgical margins were free of involvement, and he is being treated with adjuvant chemotherapy.

Discussion: Multi-cystic lesions of the pancreas can often appear as pseudocysts, but may in fact represent mixed-type IPMN. Most IPMNs are solitary, but 5-10% involve the entire gland. Further evaluation of these lesions is essential, as mixed-type IPMN carries a similar risk of malignancy as main-duct IPMN.

A Unique Cause of Painless Jaundice
Caroline R. Joukourian, MD, Moises Guerard, MD. Tufts Medical Center, Boston, MA.

Background: Kaposi sarcoma (KS) is a virally transmitted vascular tumor associated with the human herpes virus 8 (HHV-8). Although having four epidemiologic forms, KS is often associated with AIDS. Due to the advent of antiretroviral therapy, the incidence of AIDS related KS has declined to 10%. Despite this decline, KS remains the most common HIV associated gastrointestinal (GI) malignancy with our knowledge limited to case reports. AIDS related KS often presents with cutaneous lesions but in 25% of patients manifests in the visceral organs. GI involvement typically presents with asymptomatic or bleeding mucosal lesions predominantly in the stomach and duodenum. Biliary tract involvement has been seldomly reported and usually occurs with pancreatic and hepatic infiltration. We present a unique case of AIDS related KS presenting with painless jaundice due to ampullary involvement and discuss the management of the patient.

Case: A 28 year old cachectic male with AIDS, not on therapy, presented with complaints of fatigue and painless jaundice. Blood work revealed a transaminitis in the 300 IU/L range, an alkaline phosphatase of 384 IU/L, and a total bilirubin of 5.2 mg/dL. Concern for AIDS cholangiopathy prompted an endoscopic retrograde cholangiopancreatography (ERCP) which revealed a normal cholangiogram, however an abnormal appearing ampulla was noted and thus biopsied (picture 1). A plastic biliary stent was subsequently placed. Pathology revealed a Kaposi sarcoma (picture 2). He was started on HAART therapy and alpha interferon with subsequent regression of the tumor (picture 3) and amelioration of his liver function test.

Conclusion: KS is an AIDS defining disease. With our increased understanding of HIV and advancement in treatment, the incidence of KS has dramatically declined. GI manifestations of KS are even rarer with seldom, if little, biliary involvement. Our case highlights a unique presentation of painless jaundice in an HIV patient that stresses the need for consideration on a differential. Additionally, we describe non-surgical management of the lesion.

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Pancreatic pseudocysts can present in atypical locations. This case highlights the diagnostic and therapeutic challenges associated with mediastinal pseudocysts.

A 50-year-old male presented with a 3-day history of dyspnea and chest pain. He had a history of congestive heart failure, recurrent pleural effusions, a print episode of pulmonary embolism and chronic alcoholic pancreatitis. On arrival, he was hypoxic and hypotensive. Chest radiograph showed a large left pleural effusion. Thoracostesis removed 2000cc of cloudy fluid with stabilization of respiratory status. Pleural fluid analysis showed an amylase level of >7500 U/L and a lipase level of 22149 U/L. CT showed a large lobulated cystic mass measuring 10.2 X 8.5 X 17.8 cm from the pancreatic head, extending superiorly into the mediastinum with a thin communicating tract extending superiorly from the pancreatic duct. ERCP with pancreatic sphincterotomy was performed; a 7Fr X 15cm transpapillary stent was placed into the pseudocyst. Patient symptomatically improved. Repeat CT 5 days later showed marked decrease in pseudocyst size. Repeat CT at 10 weeks showed complete resolution of the pseudocyst and pleural effusion. Transpapillary stent was then removed without complications.

Atypical pancreatic pseudocysts can present a diagnostic and therapeutic challenge. Atypical locations can include liver, spleen, kidneys and mediastinum. The most common cause of pancreatic pseudocysts is acute or chronic alcohol induced pancreatitis. Mediastinal pseudocysts present most commonly with abdominal pain, followed by dyspnea from direct space occupation or recurrent pleural effusions, and compressive symptoms i.e. dysphagia. It has been reported that between 54% and 90% of mediastinal pseudocysts have an associated pleural effusion. Therapeutic modality depends on the presence and identification of fistula, ductal anatomy and experienced interventionist. Endoscopically, EUS-guided drainage and ERCP have shown to be > 90% effective in the treatment of mediastinal pseudocysts.

This case report demonstrated a successful treatment of a mediastinal pseudocyst using a transpapillary stent.