A Rare Case of Isolated Superior Mesenteric Vein Thrombosis in an Elderly Woman With Late-Onset Anti-Phospholipid Syndrome

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Introduction: Mesenteric vein thrombosis (MVT) is an uncommon cause of acute mesenteric ischemia. MVT presents with nonspecific symptoms including diffuse, colicky abdominal pain, abdominal distension, and ascites. At times, it may be asymptomatic and the cause for the thrombosis may be due to malignancy, prothrombotic state and abdominal surgeries. We describe the first case of isolated superior mesenteric vein (SMV) thrombosis in the elderly as the initial manifestation of anti-phospholipid syndrome (APS).

Case summary: A 69 years old female presented with diffuse, colicky abdominal pain for one week preceded by nausea, vomiting, poor appetite and early satiety. Pertinent negatives include fever, chills, gallstones, alcoholism, hematocritia or melena. Otherwise, a comprehensive review of systems was negative. She had multiple first-degree relatives with thrombotic diseases, but no personal history of malignancy, prothrombotic state or abdominal surgeries. History of contraceptive use included combined oral contraception. Abdominal exam revealed distension, hypoactive bowel sounds, and diffuse tenderness. Exam of all other systems were unremarkable. Basic laboratory findings were within normal limits. Computed tomography (CT) of the abdomen with contrast showed SMV opacification indicating SMV thrombosis (Figure 1). Management included anticoagulation with enoxaparin and warfarin. Further workup revealed positive ANA, anti-cardiolipin-IgM and hexagonal phase antibody that were still positive after 12 weeks.

Discussion: The relationship between APS and MVT is well established but it has been rarely described among elderly people. APS is a disorder commonly seen in young patients and typically presents before the fifth decade. This is the first case of isolated SMV thrombosis in the elderly (> 65 years old) as the initial manifestation of APS. Two other cases of MVT due to APS were reported in a 27 years old woman and 51 years old man. Also, there are seven reported cases of APS in the elderly (mean age of diagnosis: 77 +/- 6 years) who presented with deep venous thrombosis in the upper & lower limbs, brachiocephalic vein and ischemic stroke. These seven latter cases did not cause MVT.

Conclusion: Early diagnosis of MVT and APS in the elderly requires high index of suspicion. A thorough history and physical examination is needed.

Meckel’s Diverticulum Harboring a Rare Gastrointestinal Stromal Tumor

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A 48-year-old Caucasian woman presented with severe abdominal pain and nausea for the previous 24 hours, with off and on mild abdominal pain the last 6 months. She initially presented with some small bowel obstructive symptoms and later had an abdominal ultrasound and abdominal CT suggesting an adnexal mass (Figures 1,2,3). The patient was scheduled for robotic hysterectomy and in the operating room was found to have a pelvic mass adhered to the right pelvic side wall, attached to the small bowel and some omentum. Laparoscopic small bowel resection with primary anastomosis was performed.
Pathology and subsequent immunohistochemical analysis confirmed a gastrointestinal stromal tumor of intermediate risk, measuring 8.5 cm in greatest dimension. The patient was discharged after 5 days in the hospital and told to follow-up. She started imatinib, but had a severe allergic reaction to the drug and was switched to cetirizine and prednisone. However, due to prolonged use of this regimen, she developed adverse side effects and is now on only supplements and following up every 3 months with a pelvic and chest CT and routine blood work, as she remains symptom-free and is seeking further opinions.

Meckel's diverticulum results from incomplete closure of the vitellointestinal duct and affects 2% of the population, representing the most common congenital anomaly of the small intestine. Most cases are asymptomatic, but when symptomatic, adults can present with bleeding, obstruction, diverticulitis, or perforation, with the majority incidentally diagnosed during laparotomy or laparoscopy. Tumors within Meckel's diverticulum are a rare but recognized complication observed in only 0.5-3.2% of symptomatic cases. The majority include benign tumors such as leiomyomas, lipomas, and angiomas. Though less common, malignant neoplasms typically include carcinoid tumor (31.5%), sarcoma (25.5%), and adenosarcoma (14.4%). The majority of gastrointestinal stromal tumors (GISTs) (60-70%) have been reported to arise in the stomach, whereas 20-30% originate in the small intestine, and < 10% in the esophagus, colon, and rectum. Uncommon extraintestinal site of GISTs is omentum, mesentery, and retroperitoneum. However, GISTs arising from Meckel's diverticulum is extremely uncommon, with only eleven known cases reported to date.

A Case of Persistent JP Drain Output and Ileus After Cholecystectomy
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Introduction: Portal vein thrombosis (PVT) can cause complications such as ascites, diarrhea, ileus, transient moderate elevation in serum aminotransferases and even intestinal ischemia from clot extension into mesenteric veins. Here, we describe a case of persistent ileus resulting from PVT after cholecystectomy.

Case presentation: 72 year-old male with DM-2 was diagnosed with choledocholithiasis and biliary pancreatitis two weeks prior for which he underwent endoscopic retrograde cholangiopancreatography (ERCP) with stone extraction. Subsequently, he was taken for laparoscopic cholecystectomy which was converted into open cholecystectomy due to portal vein damage which was immediately repaired. He then developed small bowel ileus, persistent nasogastric tube drainage and non-bloody diarrhea. The JP drain had persistent output as high as 1 liter/day. A HIDA scan ruled out bile leak and an ultrasound with doppler ruled out thrombosis. He was subsequently transferred to our medical center. On examination, abdomen was soft, moderately distended, diffusely tender and an indwelling JP drain in RUQ was draining serous fluid. The fluid analysis was not suggestive of bile leak (fluid total bilirubin = 0.4 mg/dL, serum bilirubin = 1 mg/dL) and SAAG ratio was 2.2 (fluid albumin = 0.7 g/dL, serum albumin = 2.9 g/dL), consistent with portal hypertension. An ultrasound with doppler study showed patent portal veins with slow flow. A CT scan with contrast showed a non-occlusive thrombus involving the extrahepatic main portal vein, obstructing >75% lumen, superior and inferior mesenteric venous thrombosis, and ascites. Over course of next few days after patient was started on anticoagulation, the ileus resolved and JP drain output decreased gradually. Patient was able to advance his diet and was discharged home.

Discussion: The major risk factors for PVT include cancer of any abdominal organ, focal inflammatory lesions (e.g. pancreatitis, cholecystitis, duodenal ulcer), portal vein injury and cirrhosis. Several factors particular to laparoscopic procedures such as venous stasis, alteration in coagulation parameters as a result of pneumoperitoneum and damage of splanchnic endothelium by surgical manipulation also play a role. The portal vein is much less vulnerable to injury in cholecystectomy than the right hepatic artery.