had appearance of white esophagus due to exudates of necrotic debris. Although the clinical appearance and presentation of AEN is variable, the etiology can be attributed to hemodynamic compromise of the relatively hypovascular distal esophagus.

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When Esophagogastroduodenoscopy (EGD) Is Not the Right Thing to Do
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A 63 years old female presented to the emergency room with symptoms of hematemesis of bright colored blood, generalized fatigue, non-specific chest pain and low grade fever. A month prior to presentation she had pulmonary vein isolation for refractory atrial fibrillation. Initial vitals: Blood pressure: 139/64, HR: 156, Temp: 38°C. Physical Exam was remarkable for sick-appearing pale and lethargic patient. Pulse was irregularly irregular. Cardiac auscultation showed normal S1, S2, no murmurs. Abdominal exam was within normal limits.

Laboratory findings includes: White count of 9400 cells/microliters with neutrophilic shift 8.8, lymphopenia 0.3, Hemoglobin of 10.9 (two weeks prior to presentation Hemoglobin was 13.9). Creatinine of 0.57, BUN: 15, Na: 139, K: 4.5.

EKG upon admission showed ST elevation in inferior leads concerning for STEMI, these ST elevation resolved spontaneously within 5 minutes (Figure 1). Patient was admitted to the cardiac intensive care unit for monitoring. Shortly after admission, she had a seizure, CT scan of the brain showed two focal areas of edema in the right occipital and left temporal lobes.

EGD showed a fistula between the esophagus and the left atrium with pulsatile mass, and clot the site of the fistula (Figure 2). Immediately following EGD, the patient had a recurrence of ST elevation on telemetry, became hypotensive and bradycardia. The working diagnosis was air emboli to the coronary and cerebral arteries secondary to the fistula. Patient was placed on Trendelenburg position, and supportive therapy was started to maintain the hemodynamics.

She underwent emergent cardiothoracic surgical repair. However, she had severe coagulopathy following the surgery requiring massive blood transfusion. She rapidly progressed into septic shock and multi-organ failure. The patient passed away on the same day of operation.

Discussion: Atrioesophageal fistula, a rare but life-threatening complication of pulmonary vein ablation therapy, has been reported in the literature with time of manifestation ranging from few days following the procedure to few weeks later. The clinical presentations includes pleuritic chest pain, signs of air emboli which depending of the vasculature involved could result in ischemic strokes and myocardial infarction, signs of upper gastrointestinal bleeding which may result in hemorrhagic shock and mediastinitis that starts as chemical and later evolves into septic mediastinitis, severe sepsis or septic shock. Establishing the diagnosis requires a very high index of suspicion. CT scan of the chest is the best method to make the diagnosis. EGD could provide therapeutic modalities such as esophageal stents however it carries a risk of massive air embolism and should not be used to establish a diagnosis. Emergent cardiothoracic surgery to isolate the fistula is the standard of care.

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Primary Esophageal Adenocarcinoma With Colon Metastases After Esophagectomy
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Esophageal carcinoma is an aggressive cancer with predominance to squamous cell variation worldwide, but in the United States, adenocarcinoma is more common. Risk factors for esophageal adenocarcinoma (AC) include gastric acid reflux and tobacco use leading to an increase in oxidative stress resulting in inflammation and increase cellular turnover with metaplasia. Esophageal AC presents with manifestations of dysphagia, weight loss, malnutrition and advanced disease with dyspnea, cough or hoarseness. Esophageal AC can metastasize to the lung, liver, bone, celiac lymph nodes with rare spread to the colon. We present a case of primary esophageal AC status post chemoradiation and esophagectomy with metastatic disease found as asymptomatic colon polyps.

Our patient is a 70 year-old male smoker presenting with dysphagia and weight loss of twenty pounds over 4 weeks. Esophagogastroduodenoscopy and endoscopic ultrasound revealed a nearly occlusive, friable mass invading the muscularis propria with celiac lymphadenopathy and biopsies confirming invasive, poorly differentiated AC without distant metastasis. Concomitant chemoradiation was initiated prior