stomach with 3.1 cm perforation. The overlying clot was removed using a snare and Hemospray was deployed achieving hemostasis of the entire ulcer (Figure 3). Post EGD, no immediate complications were seen. CT abdomen was performed which revealed a decreased amount of intraperitoneal free air without evidence of new perforation and no active bleeding. At this point, the patient was cleared to start chemotherapy. On follow-up EGD 2 months later, the contained perforation was seen nearly resolved (Figure 3).

DISCUSSION: Tumor-related gastrointestinal bleeding is a challenging problem as it is difficult to control with conventional endoscopic hemostatic techniques. Hemospray is a newly FDA approved modality that can be helpful in controlling upper, lower and tumor-related GIB. Hemospray is an inorganic compound that when in contact with blood, absorbs water and adhesively forms a barrier over the bleeding site. Hemospray, unlike traditional therapies is a nonthermal, nontraumatic, and noncontact modality that doesn’t require precise targeting of other endoscopic devices. Hemospray is not absorbed by the body and usually passes through the lower GI tract within 72 hours. Overall the spray is 95% effective to achieve hemostasis in cases with upper and lower GIB.

Jejunal Varices: A Diagnostic and Therapeutic Nightmare
Dayyan M. Adoor, MD1, Charlie Buffle, MD2
1University Hospitals Case Medical Center, Case Western Reserve University, Cleveland, OH; 2New York-Presbyterian / Weill Cornell Medical Center, New York, NY.

INTRODUCTION: Gastrointestinal hemorrhage is a common complication among cirrhotic patients with portal hypertension, due to the development of bleeding varices. While esophagus and stomach are the most common location for development of varices, it can also rarely occur in ectopic locations, such as the jejunum, ileum, rectum and duodenum. Here, we report a case of a patient with severe gastrointestinal hemorrhage due to a bleeding jejunal varix.

CASE DESCRIPTION/METHODS: A 55-year-old male with a history of hypertension, splenectomy, and alcoholic cirrhosis had presented initially to an outside ED with complaints of bright red blood per rectum. At admission, he required multiple infusions of pRBCs, and several upper endoscopies due to refractory bleeding with unclear source. Initial endoscopies showed non-bleeding esophageal varices, for which he underwent ligature banding. However, he continued to deteriorate, developing recurrent melena, hypotension, and syncope. On admission to our hospital, he had a repeat upper endoscopy, lower endoscopy, CT angiography and tagged red blood cell study; but we were unable to localize the source of the bleeding. He continued to deteriorate, and also developed a PEA arrest in the setting of a profuse bright red blood per rectum, requiring massive transfusion protocol. After successful resuscitation, he underwent a small bowel enteroscopy, which finally revealed a bleeding jejunal varix. However, the varix was not amenable to any endoscopic intervention. Subsequently, he underwent a successful balloon-occluded retrograde transvenous obliteration (BRTO) of varix. Patient’s condition stabilized and after adequate recovery, he was extubated.

DISCUSSION: Early diagnosis of ectopic varices is difficult to achieve due to low likelihood of presentation and low sensitivity to various diagnostic tests. Due to its low prevalence, there are no protocols for its management. As in our patient, endoscopic intervention such as sclerotherapy and band ligation can be difficult due to the narrow lumen of the small bowel. Alternatively, BRTO and TIPS are also considered effective therapeutic options. However, due to his poor liver function, BRTO was a better alternative. In conclusion, through this case report, we want to emphasize the importance of early recognition and appropriate management of ectopic varices due to its potential for massive, even fatal hemorrhage.

Metastatic Merkel Cell Carcinoma Presenting With Upper GI Bleeding and Obstructive Jaundice
Ahmed A. Elkhafrawy, MD1, Laith Numan, MD1, Yousaf Safar, MD1, Mohammed A. Elshenawy, MD1, Mekki Elbahy, MD1, Cynthia Lou, Fadi Hamad, MD1
1University of Missouri Kansas City School of Medicine, Kansas City, MO; 2University of Missouri, Kansas City, MO; 3Cook County Health and Hospital Systems, Chicago, IL; 4Saint Luke’s Hospital, Kansas City, MO.

INTRODUCTION: Merkel Cell Carcinoma (MCC) is a rare and aggressive skin cancer that was first described in 1972. Lymph node metastases are common in MCC and distant metastases occur in 84% of cases. We present a case of MCC, complicated by melena and obstructive jaundice from GI metastases. To the best of our knowledge, less than 20 cases were reported with a similar presentation.
CASE DESCRIPTION/METHODS: The patient is a 67-year-old male with a history of CAD, COPD and metastatic MCC, who was admitted with melena and severe blood loss anemia. He was diagnosed with MCC of the right eyebrow 2 years ago and had a recurrence in the parotid gland that was treated with resection, radiotherapy (RT) and chemotherapy. PET CT scan 3 months prior to admission showed no evidence of distant metastases. After resuscitation and initiation of appropriate medical therapy, the patient underwent an EGD that showed multiple (1 cm) lesions scattered in the stomach and a large (4 cm) ulcerated mass in the lesser curvature with stigmata of recent hemorrhage. Hemospray was applied successfully for hemostasis. Biopsies of the gastric lesions confirmed metastatic MCC. The patient was discharged home and started on palliative immunotherapy (Atezolizumab) and RT. Repeated PET CT scan showed the progression of the disease with widespread lymphatic, pancreatic, right perinephric, diffuse gastric and bony metastases. Four weeks later he was admitted with jaundice. Bilirubin was 2.5 g/dl, ALP 458, ALT 457 and AST 441. Abdominal ultrasound showed dilated intra and extrahepatic ducts. An ERCP was performed and showed a distal CBD stricture. An uncovered metal stent was successfully placed. The patient continued to have recurrent melena and a repeated EGD showed a new friable 4 cm ulcerated periampullary duodenal mass that was not amenable to endoscopic intervention. Mesenteric arteriogram was performed and showed active bleeding from the duodenal mass with tumor blush in the third part of duodenum was seen. Coil embolization of the GDA and PDA was successfully performed with the cessation of the bleeding. The patient was discharged home to resume treatment.

DISCUSSION: Merkel cell carcinoma is rare and aggressive skin cancer. GI metastases are very uncommon. Close surveillance with PET CT scan is important and high suspicion of GI metastases should be exercised when clinically appropriate.

Thoracic Aortic Erosion Into the Esophagus With Aortoesophageal Fistula
Edward C. Gillford IV, MD1, Ipsa Arora, MD2, Alexander Lestine, MD2, Parth J. Parekh, MD2, 1University of Virginia, Charlottesville, VA; 2Eastern Virginia Medical School, Norfolk, VA.

INTRODUCTION: Aortoesophageal fistula is a rare but well described life-threatening cause of upper gastrointestinal bleeding. Primary aortoesophageal fistula is predominately caused by descending thoracic aortic aneurysms (52.4%), followed by foreign body ingestion and esophageal carcinoma.1 Secondary aortoesophageal fistula is an increasingly recognized complication of thoracic endovascular aortic repair (TEVAR), occurring in 1.7-1.9% of cases.2,3 CASE DESCRIPTION/METHODS: A 76-year-old female with a past medical history of known 6cm thoracic aortic aneurysm was transferred to our facility for one day of hematemesis and melena. On arrival the patient had an emergent esophagogastroduodenoscopy which revealed a visible thoracic aorta through a large transmural defect adjacent to an aortoesophageal fistula in the middle esophagus (Figure 1). After the procedure, the patient underwent emergent CTA of the aorta, which revealed corresponding images to the endoscopic findings with an aortoesophageal fistula directly superior to an area of thoracic aorta protruding into the esophagus (Figure 2). The patient then had an emergent endovascular repair of the aortoesophageal fistula and thoracic aortic aneurysm with fluoroscopic images demonstrating successful graft deployment and fistula closure (Figure 3).

DISCUSSION: Aortoesophageal fistula is a life-threatening condition that must be on a gastroenterologist’s differential for upper GI bleeding, in particular in patients with a known aortic aneurysm. Proper and rapid identification of the diagnosis is essential to allow for emergent vascular intervention and hemostatic control. Additionally, literature review highlights a paucity of evidence on the options for endoscopic intervention with esophageal stents. In this particular case, there was unfortunately no active gastrointestinal bleeding at time of endoscopy and the patient had successful endovascular grafting; however, there are a number of case reports suggesting that esophageal stenting may be another therapeutic option if there is active esophageal hemorrhage, albeit more of a temporizing measure and one associated with a number of complications.4,5

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