rhabdomyolysis.

INTRODUCTION: Legionella pneumonia commonly presents with myalgia, fatigue, and dyspnea and accounts to about 10-15% of all pneumonia cases. With less than 100 unusual cases of Legionella reported, this is a unique presentation with fulminant hepatic failure, acute kidney failure, and rhabdomyolysis and accounts to about 10-15% of all pneumonia cases. With less than 100 unusual cases of Legionella reported, this is a unique presentation with fulminant hepatic failure, acute kidney failure, and rhabdomyolysis and accounts to about 10-15% of all pneumonia cases. With less than 100 unusual cases of Legionella reported, this is a unique presentation with fulminant hepatic failure, acute kidney failure, and rhabdomyolysis and accounts to about 10-15% of all pneumonia cases. With less than 100 unusual cases of Legionella reported, this is a unique presentation with fulminant hepatic failure, acute kidney failure, and rhabdomyolysis and accounts to about 10-15% of all pneumonia cases. With less than 100 unusual cases of Legionella reported, this is a unique presentation with fulminant hepatic failure, acute kidney failure, and rhabdomyolysis.

CASE DESCRIPTION/METHODS: 52-year-old African-American male with no medical history presented to the emergency room with nausea, diarrhea, and fatigue. He was febrile and tachycardic on presentation. On further evaluation, he reported exposure to a new air-conditioner at work. Chest x-ray (CXR) revealed a right lower lobe pneumonia. Blood work was remarkable for elevated liver enzymes, hyponatremia, acute kidney injury, and elevated creatinine phosphokinase (CPK). His urine drug screen and alcohol level was normal. Liver ultrasound (US) showed fatty infiltration, but no cirrhosis, confirming his social history of being non-alcoholic. Hepatitis (A, B and C), Cytomegalovirus (CMV) IgM and HIV serologies were all negative. Patient was started on fluid resuscitation and antibiotics. Despite a lobar consolidation, Legionella urine antigen returned positive. This confirmed Legionella induced fulminant liver failure and rhabdomyolysis. Patient later developed respiratory symptoms and his repeat Chest x-ray revealed patchy infiltrates in multiple regions, consistent with Legionella. His liver enzymes and CPK trended down, and he was discharged home. He was followed as outpatient with resolution of the fatty infiltration on the Liver US.

DISCUSSION: Legionella is transmitted through inhalation of aerosols derived from water or soil. It mimics alcoholic hepatitis and is distinguished from other types of hepatitis by having no evidence of cirrhosis. Presentation with gastrointestinal symptoms, consolidation on imaging, rhabdomyolysis, and acute kidney injury makes Legionella hepatitis most likely etiology. Exact mechanism is still unclear; however, release of endotoxins and bacterial invasion have been reported in many studies. Diagnosis is made with rapid PCR or urine antigen. Levofloxacin or Azithromycin are the preferred antibiotics as these agents are bactericidal, achieve high intracellular concentrations, penetrate lung tissue, and are active against all sub-type species. Treatment usually is for 7-10 days but for immunocompromised patients is 14 days due to risk of re-infection and relapse. Legionella should be high in the differential with the other hepatitis causing diseases like HIV, Hepatitis A, B or C and CMV.

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Incidental Diagnosis of Merkel Cell Carcinoma in a Liver Transplant Patient Admitted for Diverticulitis
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INTRODUCTION: Merkel cell carcinoma (MCC) is a rare and highly aggressive neuroendocrine skin cancer. Most patients (90%) who develop MCC have been infected with a Merkel cell polyomavirus. Sun exposure, fair skin, and age are risk factors; however, it occurs most commonly in immunosuppressed patients, specifically organ transplant and HIV-infected patients. Though the exact mechanism is still unknown, it is thought that immunosuppression contributes to viral integration, mutation, and carcinogenesis of the virus.

CASE DESCRIPTION/METHODS: 75-year-old white male with a history of liver transplantation for NASH cirrhosis, maintained on mycophenolate and tacrolimus, was admitted to the hospital for diverticulitis. Lab results showed pancytopenia. CT abdomen showed acute diverticulitis, and a nonspecific soft tissue density near the porta hepatis causing encasement of the common and proper hepatic arteries (Figure 1). A focused physical exam showed a large axillary mass (Figures 2 and 3). His diverticulitis improved with a course of broad-spectrum antibiotics. The mass was biopsied and positive for MCC, suggesting the lesion near the porta hepatitis represented metastasis. The axillary mass was excised and he received local radiation therapy. He was unable to undergo chemotherapy due to poor performance status. Within 10 months of the diagnosis, the patient died.

DISCUSSION: While MCC is most commonly associated with the long-term immunosuppression following solid-organ transplantation, its occurrence is also rising in older adults whose immune function naturally declines with time. The median onset of MCC is greater than 60 years of age, and occurs most often in white patients. The most common site of origin is the head and neck region, but it can arise anywhere in the body. The diagnosis of MCC can be challenging due to the innocuous appearance of the primary tumor. This case demonstrates the importance of understanding the potential sequelae of immunosuppressive medications in organ transplant patients and performing regular and thorough physical exams in order to quickly detect and treat diseases like MCC.