revealed poorly differentiated, high grade adenocarcinoma with areas of squamous differentiation, arising from a vilious adenoma and extending into the muscularis propria (pT2).

DISCUSSION: ASC can involve any organ including lungs, pancreas, liver, gallbladder and the gastrointestinal (GI) tract. ASC of ileum is an extremely rare diagnosis. Published case reports show that metastases of small intestinal ASC is common at the time of diagnosis. Our patient was fortunate enough to have been diagnosed with ASC in an early stage without evidence of metastasis, due to TI intubation during a routine colonoscopy. Surgical resection was likely curative for this patient. To our knowledge, no study has been published to evaluate the prevalence of TI malignant tumors during routine colonoscopy. In addition, intubation of the TI is currently not required during routine colonoscopy. This raises the question if there is utility in measuring TI intubation rates as a potential quality indicator for colonoscopists in the future.

2560

Small Bowel Carcinoid Causing Chronic Anemia

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INTRODUCTION: Carcinoids are a relatively rare tumor that are often discovered incidentally. If symptoms are present, they may include abdominal pain, carcinoid syndrome, and occasionally bleeding.

CASE DESCRIPTION/METHODS: A 59-year-old woman was admitted for bloody bowel movement. Past medical history includes hypertension and morbid obesity. She had chronic microcytic iron deficiency anemia and was evaluated in 2015 with EGD, colonoscopy, and capsule endoscopy. EGD was normal with no bleeding source, colonoscopy showed blood throughout colon without diverticulosis or AVMs, and capsule endoscopy revealed a jejunal ulcer. At presentation, vital signs were stable. Laboratory profile revealed iron deficiency anemia with hemoglobin 7.3 g/dL. Colonoscopy revealed a medium-sized mass in terminal ileum with oozing present and appearance concerning for carcinoid tumor. The mass was tattooed and a clip was placed. CT showed 2.1 cm mass in ileum as well as 1.9 cm enhancing lymph node concerning for metastasis. She underwent laparoscopic ileocolic resection with removal of said mass and was noted to have multiple lesions along small bowel concerning for metastasis and grossly enlarged mesenteric lymph nodes, which were also removed. Pathology showed well-differentiated grade 1 neuroendocrine tumor with a lymph node positive for metastasis. Patient is scheduled to follow-up with oncology to determine treatment plan.

DISCUSSION: Carcinoids are relatively rare with an incidence of 4.7 per 100,000 with rising incidence due to increased detection on endoscopy and imaging as well as increased provider awareness. They can arise in the gastrointestinal tract, lung, and gonadotropin tract and are relatively slow growing and less aggressive than other cancers. Within the gastrointestinal tract, most carcinoids are found in the small intestine, rectum, and stomach, while small bowel carcinoids are commonly located in the ileum. Small intestine carcinoid tumors have been characterized as more aggressive in nature and commonly metastasize to lymph nodes or the liver. They require multidisciplinary evaluation with gastroenterologists, oncologists, and surgeons. In our case, the patient had chronic anemia many years prior and had undergone work-up prior to presenting with hematochezia. Previous evaluation showed a jejunal ulcer thought to be due to NSAID use. However, she continued to have iron deficiency anemia. This case illustrates the importance of repeat endoscopic evaluation in cases of persistent iron deficiency anemia.

2561

Not All That Ulcerates Is Crohn’s: A Malignant Mimic of Small Bowel Crohn’s Disease

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INTRODUCTION: Capsule endoscopy (CE) is indicated in the evaluation of suspected Crohn’s disease (CD) when ileoscopy and radiographic studies are negative or inconclusive. However, it should be recognized that mucosal breaks or ulcers alone are not always diagnostic of CD.

CASE DESCRIPTION/METHODS: A 55 year-old man from India who immigrated to the US as a child was admitted to our institution with ongoing abdominal pain and unintentional weight loss but no diverticulosis or AVMs, and capsule endoscopy revealed a jejunal ulcer. At presentation, vital signs were stable. Laboratory results were: Hgb 8.3 g/dL, iron studies consistent with iron-deficiency, albumin 24 g/dL, C-reactive protein 130 mg/L, and erythrocyte sedimentation rate 40 mm/hr. CT angiography showed wall thickening of the mid-jejunum with mesocolic enhancement and mesenteric root adenopathy. Retrograde double balloon enteroscopy 90 cm into the ileum revealed a 15 mm thickened ulcer 80 cm proximal to the ileocecal valve and a similar ulcer 15 cm proximal to the ileocecal valve. Biopsies showed ulcerated mucosa with infiltrating atypical cells that stained positive for ERG, a highly specific endothelial marker, and negative for other immunostains, leading to a diagnosis of primary intestinal angiosarcoma.

DISCUSSION: Primary intestinal angiosarcoma is a rare soft tissue sarcoma that may present with abdominal pain, GI bleeding, obstruction, or weight loss. Tumors, detected on 2-4% of CE, are in the differential diagnosis for small bowel CD along with infection, ischemia, vasculitis, lymphoma, Behcet disease, radiation enteritis, and drug-induced enteritis. In suspected CD, there is no reference standard or uniform criteria for diagnosis by CE. And, many of the lesions that lead to a diagnosis of CD are non-specific with the specificity of CE for CD as low as 33% and the positive predictive value <60% in some studies. Thus, findings of CE should be interpreted with an adequate degree of skepticism and a broad-differential diagnosis considered to minimize mimics being mistaken for CD.
CASE DESCRIPTION/METHODS:
A 42-year-old man presented to the ED for intolerance chronic diarrhea, lower extremity swelling, paresthesia, migratory monoarticular arthralgia, and weakness. Over 2 years he lost 60-pounds and had early satiety, intermittent dysphagia, and decreased concentration. Physical exam was remarkable for a scaphoid abdomen with mild diaphragmatic bellies. Labs abnormalities: hemoglobin 6.5 g/dL, albumin 1.9, 25-OH vitamin D 5 ng/mL (nl > 30 ng/mL), CRP 25.4 mg/L. Bilateral lower extremity ultrasound showed a blood clot in the right deep femoral vein and bilateral Baker's cysts. Colonoscopy and EGD examinations were unrevealing. Histologic exam of duodenum biopsies showed dilated fat vacuoles and a positive periodic acid-Schiff (PAS) stain confirming Whipple's Disease. Ceruloplasmin fluid was negative and cognitive changes improved with electrolyte replacement. He was treated with a 14-day course of intravenous ceftriaxone followed by Bactrim doubled-strength twice a day. After intravenous antibiotics, the diarrhea resolved and he regained weight.

DISCUSSION:
WD most commonly affects men (86%), farmers (35%), and those with occupational exposure to soil or animals (66%). Transmission is thought to be fecal-oral since sewage workers are more prevalent carriers. Common symptoms are weight loss, arthralgia, diarrhea, and abdominal pain. Arthralgia is the sentinel symptom preceding others by ~6 years. Less common include skin hyperpigmentation, endocarditis, and CNS symptoms (severe disease). Three diagnostic tests exist: PAS-staining, PCR of the 16S ribosomal RNA of T. whipplei, and immunohistochemistry (IHC) via rabbit anti-T. whipplei antibodies. Diagnostic criteria include: 1) small intestine biopsies positive on PAS stain for bacillus material in the lamina or 2 positive tests from other origins. Initial testing is done with EGD and duodenal biopsies submitted for PAS staining and PCR testing or IHC. If extraintestinal symptoms, PAS staining and PCR testing or IHC on tissue or fluid samples. CSF should be tested by PCR in all cases. After diagnosis, treatment starts with a 2-week course of IV of antibiotics (4 weeks if CNS infection or endocarditis) followed by one year of Bactrim. Relapse occurs in 17-33%, years later.