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 and bilateral lower extremity strength 4/5. Labs abnormalities: hemoglobin 6.5 g/dL, albumin 1.9, 25-OH vitamin D 5 ng/mL (nml > 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 cyst. Colonoscopy and EGD exams were unremarkable. Histologic exam of duodenal biopsies showed dilated fat vacuoles and positive periodic acid-Schiff (PAS) stain confirming Whipple’s Disease. Cerebrospinal 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 ± IHC. If extraintestinal symptoms, PAS staining and PCR testing ± 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 17-35%, years later.

RARE MALIGNANT PERITONEAL MESOTHELIOMA MASQUEERING WITH RESPIRATORY MANIFESTATION

INTRODUCTION: Mesothelioma is a rare and aggressive cancer that affects the linings of the pleura, peritoneum and pericardium. Pleural involvement is however most common. Malignant Peritoneal mesothelioma (MPM) is a cancer developing in the lining of the peritoneum, which is extremely rare. Most MPM cases are caused by asbestos exposure. Common symptoms of MPM include abdominal distension, abdominal pain, swelling or tenderness and constipation or diarrhea, with most common being abdominal swelling. MPM is difficult to diagnose due to its vague, non-specific symptoms.
Enteritis Refractory to Multiple Fecal Microbiota Transplantations

CLOSTRIDIUM DIFFICILE ENTERITIS

Enteritis is a common condition caused by Clostridium difficile, a Gram-positive bacillus that can colonize the gut and cause inflammation. The enteritis is typically treated with antibiotics, but some cases can be refractory to treatment, leading to persistent symptoms. In this case, the patient had recurrent episodes of C. difficile enteritis despite multiple courses of antibiotics and fecal microbiota transplantations (FMT).

CASE DESCRIPTION/METHODS: A 77-year-old female with a history of fulminant CDI colitis requiring subtotal colectomy with end ileostomy presented with abdominal pain and increase in ileostomy output two months after surgery. Her ileostomy drainage test positive for C. difficile and she was started on oral vancomycin for CDI enteritis with resolution of her symptoms. Over the next year, she had multiple recurrences of her CDI that failed vancomycin, fidaxomicin and IV immunoglobulin (IVIG). She eventually had fecal microbiota transplantation (FMT) with daxomicin and IVIG and two FMT with recurrence of the symptoms after the fourth one. Prophylactic oral vancomycin was started on the patient’s request and she noticed improvement in her symptoms. Prophylactic vancomycin has been effective in preventing recurrence of CDI in patients with a history of CDI being treated with oral antibiotics. Our case is unusual given the ongoing symptoms in a PCR negative CDI state. Further research is needed in patients with refractory CDI enteritis with analysis of their bowel flora to better understand this disease and how to treat it.

Essential Thrombocytopenia and AVM-Related Gastrointestinal Bleeding: A Rare Paradigmatic Phenomenon

INTRODUCTION: Essential thrombocytopenia (ET) is a myeloproliferative neoplasm characterized by excessive platelet production. It usually presents with thrombotic events. However, rarely, essential thrombocytopenia may present with gastrointestinal (GI) bleeding. This phenomenon is seen paradoxically at very high platelet counts. We present a case of GI bleeding secondary to atherosclerotic malformation (AVM) in a patient with platelet counts >1 million/mcL.

CASE DESCRIPTION/METHODS: A 74 year old male with history of hypertension, myelo-proliferative disease, on hydroxyurea therapy, complicated by deep vein thrombosis requiring inferior vena cava filter placement, ischemic stroke, was admitted to inpatient rehabilitation after suffering from acute ischemic stroke 2 weeks ago. The patient was started on clopidogrel for acute stroke. He was found to have melena and gradual drop in hemoglobin (11.5 g/dL down to 6.5 g/dL). Complete blood count showed progressive rise in his platelet count (from 957 k/cL to 2.4 million/mcL). Upper endoscopy revealed one small AVM in the fourth portion of the duodenum, treated successfully with hemostatic spray. Clopidogrel was switched to aspirin and hydroxyurea dose was increased for cyto reductive therapy as suggested by hematologist. Subsequent colonoscopy revealed two non BLEEDING AVMs in the cecum, treated with argon plasma coagulation (APC).

DISCUSSION: ET is known to increase the risk of thrombotic events, including cardiovascular events, deep vein thrombosis, pulmonary embolism, retinal artery occlusion, dissection ischemia and hepatic or portal vein thrombosis. However, ET also increases the risk for bleeding paradoxically with incidence rates ranging from 5-50 percent at the time of diagnosis. In GI tract, the bleeding is mostly from AVMs in ET. This phenomenon has been associated with qualitative defects and alteration in the platelets aggregation due to depletion of high molecular weight von Willebrand factor multimers and development of an acquired von Willebrand disease. Interestingly, incidence of bleeding in ET correlation with the severity of thrombocytopenia, mostly seen with extracorpuscular thrombocytopenia (pet counts >1 million/mcL). [2-3]. Previous bleeding episode and use of antiplatelet drugs may further increases the risk of bleeding. Hydroxyurea is used for cyto reduction with platelet apheresis reserved for extreme cases where platelets exceed 1.5 Million/mcL.