Abstracts

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A Unique Cause of Ischemic Colitis: Docetaxel Chemotherapy
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INTRODUCTION: Ischemic Colitis (IC) is the most common form of intestinal ischemic diseases.
This disease process typically affects older adults and is the result of non-occlusive hypoperfusion, which can be precipitated by a multitude of risk factors. Patients usually present with lower abdominal pain and hematoma. A colonoscopy with biopsies is the gold standard for diagnosis. Increasingly, medications have been associated with contributing to this disease process. Here, we report the unique case of IC attributed to Docetaxel, a taxane class chemotherapeutic agent.

CASE DESCRIPTION/METHODS: A 76-year-old Caucasian female with a history of multi-focal intraductal carcinoma (Stage IIA), hypertension, and diverticulosis presented to the emergency room (ER) with complaints of lower back and abdominal pain. She had begun therapy with Docetaxel and Cyclophosphamide 8 days prior to presentation. In the ER, she was afibrile, neutropenic (ANC 400), and hypotensive requiring supportive care including antibiotics, fluids and a very brief course of norepinephrine. She was subsequently admitted to the intensive care unit where her neutropenia was noted to have resolved and antibiotics were discontinued in setting of negative cultures. On hospital day 3, she complained of continued abdominal pain and hematoma with CT imaging that demonstrated bowel wall thickening and mild inflammatory changes in the sigmoid/descending colon. Subsequently, a colonoscopy was performed and showed circumferential, violaceous mucosa consistent with IC. Antibiotics were reinitiated and the patient was treated supportive with complete resolution of symptoms. Following hospital discharge, she was evaluated by her oncologist who discontinued her Docetaxel and initiated therapy with Paclitaxel. No recurrence of her symptoms have been noted and repeat cross sectional imaging demonstrated resolution of colonic thickening in the previously noted watershed distribution.

DISCUSSION: IC is a rare but serious complication that has been described in patients receiving Docetaxel. Among the 6 reported cases, symptoms occur within 10 days of Docetaxel administration. Patients present with abdominal pain and hematoma in the setting of neutropenia with or without fever. This type of IC is often severe, with spontaneous perforation, bowel necrosis, and a reported mortality rate of 40-50%. Although underreported, Docetaxel use is a risk factor for developing IC, one deserving of more clinical awareness.

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Eosinophilic Gastroenteritis and Eosinophilic Proctocolitis With A Large Rectal Sessile Serrated Adenoma: A Rare Association
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INTRODUCTION: Eosinophilic Gastrointestinal Disorders (EGID) are a group of rare disorders characterized by eosinophilic infiltration of the gastrointestinal tract. Eosinophilic gastroenteritis (EGE), eosinophilic colitis (EC) and eosinophilic proctitis (EP) are different types of EGID. We report a case of a rare association of EGE and a large sessile serrated adenoma in a middle-aged Hispanic female.

CASE DESCRIPTION/METHODS: A 49-year-old Hispanic female presented with epigastric discomfort, nausea and hematemesis. The symptoms were insidious in onset and evolved over the span of 3 years. Upper GI Endoscopy showed mild diffuse erythematous mucosa in the antrum and body of the stomach. Colonoscopy showed a few superficial ulcers in the terminal ileum, two polyps in the transverse colon and a large laterally spreading polypoid lesion in the rectum with adjacent multiple small polypoid lesions (Figures 1 and 2). Histological assessment of the gastric biopsy specimen revealed chronic active gastritis, numerous H. pylori, in addition to very high number of eosinophils in the lamina propria. Biopsies of ileum, colon and the rectum also revealed very high number of eosinophils in the lamina propria. Stool for ova and parasite examinations were negative and no peripheral eosinophilia was noted. Patient did not have any food or environmental allergies. Other disorders that could contribute to eosinophil infiltration of the GI tract were ruled out. Hematemesis was likely due to eosinophilic proctitis and rectal polypoid lesion. Although exact eosinophilic count in the biopsy specimen of the stomach, small bowel and the colon was not reported, the clinical presentation and histology was likely consistent with EGE. Patient was treated for H. pylori infection. Endoscopic submucosal dissection of the rectal polypoid lesion was performed (Figure 3). Pathology revealed sessile serrated adenoma.

DISCUSSION: Eosinophilic gastrointestinal disorders are a group of rare gastrointestinal diseases with non-specific symptoms and clinical presentation. Diagnosis of EGE, EC and EP involves evaluating for presence of gastrointestinal symptoms, histopathology finding of eosinophilic infiltration of the GI tract and ruling out secondary causes of eosinophilia. Endoscopic examination may reveal patchy erythema, loss of vascularity and lymphoid nodular hyperplasia mostly localized to the rectum. The authors report this rare case of possible association of IEGD and sessile serrated adenoma.

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In Colon Cancer: Superficial Thrombophlebitis Is a Road to PE
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INTRODUCTION: In general, all cancers associated with developing vascular thromboembolism (VTE). Colorectal cancer (CRC) can also cause VTE, but overall incidences of VTE related to CRC is underestimated. Superficial thrombophlebitis (STP) involves phlebitis and thrombosis of superficial vein of upper or lower extremity. It is broadly known as self-limiting condition and requires conservative management. Nonetheless, few case reports suggest that superficial thrombophlebitis can progress into Pulmonary Embolism (PE), especially, with concomitant hypercoagulable state such as cancer, chemotherapy.

CASE DESCRIPTION/METHODS: 56-year-old Caucasian-female with pertinent history of adenocarcinoma of colon x resection, on adjuvant chemotherapy presented to ED with right side chest pain and dyspnea. CT chest showed right upper and lower lobe PE’s. Around 2 months prior to this, after her chemotherapy cycle, patient had developed right leg redness and pain along the ankle and lower inner leg. She had developed STP in right Great Saphenous Vein without any DVT’s noted on prior imaging. Repeat CT chest and abdomen revealed new improvement in PE’s. Sudden onset of new PE’s prompted the return of the patient to ED for further inpatient evaluation.

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Histopathology revealed fragments of mixed tubular adenoma and hyperplastic polyp with many eosinophils (>15%HPF) in the lamina propria.

DISCUSSION: Cancer and chemotherapy are major risk factors for developing VTE, and it causes imbalance between coagulation and fibrinolytic system. Study shows that chances of getting CRC related VTE is more during first 6 months after diagnosis and then it falls subsequently. Our patient, developed PE in 4 months after diagnosis. No robust study has been done that shows prospects of developing VTE if CRC patient develops STP. Many factors can play role in such situation, like; age, sex, location (below or above-knee STP), health condition, chemotherapy, and coagulation profile. Few studies have reported that STP should be managed more rigorously when it is associated with cancer and starting anticoagulants (AC) prophylactically can help patient from getting PE. Therefore, from our and other case reports, we suggest that CRC patient on chemotherapy should be considered for prophylactic AC if they develop STP to minimize risk of developing VTE.

Initial Presentation of Advanced Colorectal Cancer in the Cecum Presenting With Mild Tenesmus
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INTRODUCTION: Colorectal cancer (CRC) is a lethal disease. 140,250 new cases of large bowel cancer are diagnosed annually in the USA including 97,220 colon and 43,030 rectal cancers. 50,630 Americans are expected to die of large bowel cancer each year. CRC is the third most common cause of cancer death in the USA in women, and the second leading cause of death in men. Common symptomology include change in bowel habits (74%), rectal bleeding with change in bowel habits (71%), non-deficiency anemia (21%). Appendicitis as the initial symptom of CRC is less than 1% for individuals over 40.

CASE DESCRIPTION/METHODS: Patient is a 52 year old man who presents to our facility for general abdominal pain and tenesmus for three months. The patient has no family history of CRC nor colonoscopy. In the ED routine labs negative imaging revealed acute appendicitis. Laparoscopic appendectomy was performed and the patient was discharged the following day. Patient returned two months later with complaints of tenesmus and abdominal pain. In the ED acute macroscopic anemia was discovered. CT Abdomen and pelvis demonstrated diverticulosis without diverticulitis and FORT positive. Colonoscopy performed and findings consisted of large 6 cm cecal mass, biopsies taken, 8 mm polyp in transverse colon removed with cold snare, two 5-7 mm polyps in the ascending colon removed by cold snare, and 4 cm polyp removed via the hot snare in the descending colon. The patient then underwent colonic resection of the mass by general surgery.

DISCUSSION: What is learned from this case is the importance of CRC screening and rare initial symptom of CRC of appendicitis in a male over the age of 40. The patient is 52 years old with without having CRC screening and acute appendicitis. Had the patient had his diagnostic colonoscopy at the age of 50 the cecal mass would have been discovered sooner and treatment could have been initiated. Another aspect of this case that makes it unusual was the patient did not have any of the more common symptoms of CRC. Our patient presented with general abdominal pain and tenesmus and the latter accounts for less than 1% of all symptomatology along with acute appendicitis. The patient did not have any of the “alarm” symptoms and if not for the appendicitis diagnosed in the hospital the patient "had no intention" of doing CRC screening. The patient explains he had no family history of gastric or colon cancer. “So why bother?” The acute appendicitis from the cecal mass proved to be critical in the initiation of treatment.

Post Colonoscopy Diverticulitis in a 50-Year-Old Woman Undergoing Surveillance Colonoscopy
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INTRODUCTION: Diverticulitis is used as a diagnostic and therapeutic tool to treat a wide range of gastrointestinal disorders. Acute diverticulitis after colonoscopy is a rare but potentially serious complication. The incidence of acute diverticulitis after colonoscopy is reported to be 0.084%. Since this is a rare entity, there is limited data regarding the risk, prevention and management of acute diverticulitis after colonoscopy.

CASE DESCRIPTION/METHODS: A 50 year old woman with a history of adenomatous polyp with villous component detected 4 years prior presented for surveillance colonoscopy. She did not have any abdominal pain. Her labs from a year prior showed WBC 6.86 k/uL. Colonoscopy was notable for pan-colonic diverticulitis (Figure 1), most prominent in sigmoid colon. There was a 2 mm sessile polyp in recto-sigmoid colon that was removed with cold biopsy forceps. The procedure was otherwise uncomplicated. She presented to the emergency department (ED) 3 days later with left lower quadrant pain (LLQ) and fever up to 101 Fahrenheit. The pain started 2 days after the underwent colonoscopy. She did not have nausea, vomiting or rectal bleeding. In the ED, she was afibrile with moderate LLQ tenderness without rebound or guarding. Labs showed WBC 15.41 k/mL (72.5% segmented neutrophils), BUN 11 mg/dL, Cr 1.0 mg/dL. CT of the abdomen and pelvis had findings concerning for acute sigmoid colon diverticulitis without absces (Figure 2). The patient was discharged from the ED on moxifloxacin and metronidazole.

DISCUSSION: The American Society for Gastrointestinal Endoscopy (ASGE) lists diverticulitis as a miscellaneous complication, however, there is limited data regarding the risk of developing diverticulitis after colonoscopy. In a retrospective cohort of 236, 377 patients who underwent colonoscopy, 68 patients (0.029%) developed post-colonoscopy diverticulitis. The mean time to develop diverticulitis after colonoscopy was 12 ± 8 days. 34 patients (50%) had a history of diverticulitis prior to colonoscopy and 30 patients (46%) required hospitalization. Prospective studies are now needed to evaluate the risk, mechanism and prevention of diverticulitis induced diverticulitis. If significant diverticula are noted on colonoscopy, post-colonoscopy diverticulitis should be discussed as a potential complication, and it should be considered in a patient who presents with fever and abdominal pain after undergoing colonoscopy.

Inverted Appendix Caused by Inversion-Ligation Appendectomy: An Unusual Case of Cecal Mass
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INTRODUCTION: Polypoid lesions involving the cecum and more specifically the appendiceal orifice (AO) can be a diagnostic dilemma. The thin walled cecum poses risk of perforation, therefore resection should be avoided for benign lesions. Invasive adenocarcinoma or adenocarcinoma in situ arising from the appendiceal lumen on AO are rare with less than 230 reports. Other lesions include appendiceal endometriosis, juvenile polyps, adenomatous polyps, and appendiceal inversion.

CASE DESCRIPTION/METHODS: A 68-year-old female with a past medical history of fibroids, s/p hysterectomy and prophylactic appendectomy over 30 years ago presents for first time screening.