CASE DESCRIPTION/METHODS: The patient is a 55-year-old woman with a history of well differentiated neuroendocrine tumor of the liver treated with transcatheter arterial chemoembolization, complicated by development of a liver abscess and then a biliary cutaneous fistula, s/p segment 4 liver resection, who presented to an outside facility for a 3 week history of RUQ abdominal pain, shortness of breath and bilipyts. She underwent a HIDA scan for evaluation of her RUQ pain and was found to have a BBF. An unsuccessful ERCP attempt was made and the patient was transferred to our center for surgical evaluation. Our team was consulted, and she underwent successful ERCP with a clear demonstration of a fistulous communication between the distal left hepatic system and the bronchial tree on cholangiogram. A 10Fr x 80mm covered metal stent was deployed with complete resolution of the patient’s symptoms. She was seen weeks later in clinic and remained symptom free.

DISCUSSION: The pathogenesis of BBF formation has not been completely understood, increased pressure within the biliary tree with local inflammation appears to be two major factors that contribute to its development. Diagnosis can be made with CT imaging or HIDA scan, as well as with interventional techniques, such as ERCP, percutaneous transhepatic cholangiography, bronchoscopy or fistulography. In our case, multiple causes are suspected to have provoked the formation of the fistula in this patient, including liver tumor, chemoembolization, abscess and hepatectomy. Due to its low incidence, there is no clear consensus on the treatment of this uncommon complication. According to published literature, best clinical outcomes were seen with surgical management. Our patient was successfully treated endoscopically with deployment of a biliary stent, thus providing a least invasive alternative to surgery when performed by a skilled gastroenterologist.

S1406

Right Hepatic Artery Pseudoaneurysm Causing Hemobilia: A Rare Complication of Laparoscopic Cholecystectomy

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INTRODUCTION: Laparoscopic cholecystectomy is considered the gold standard for cholecystitis and symptomatic cholelithiasis. However, it poses a risk of bile duct injury and injury to the right (R) hepatic artery when compared to the open operation. While injuries including bile leakage of aberrant ducts, cystic stump injury, or main bile duct injury have been documented, hemobilia secondary to hepatic artery pseudoaneurysm is a rare complication of laparoscopic cholecystectomy. This case represents delayed gastrointestinal bleeding sustained from laparoscopic cholecystectomy with injury to the common bile duct (CRD).

CASE DESCRIPTION/METHODS: An 82 year-old male presented to the hospital with mid-epigastric abdominal pain and melena beginning two months after a cholecystectomy that was converted to an open procedure secondary to complications from a gangrenous gallbladder. During that procedure, a leak within the Duct of Luschka noted and closed with placement of a T-tube (draining tube). This would stay in until two weeks prior to admission. On initial presentation, the patient had an elevated temperature of 100.3 F. Initial hemoglobin (Hgb) was 13 g/dL, which dropped to 9 g/dL after 24 hours. Liver enzymes were elevated (total bilirubin 5.4, AST 194, ALT 149, and alkaline phosphatase 188). Computed tomography revealed dilatation of both the intra and extrahepatic bile ducts and hyperdense material within an 18 mm dilated common bile duct. Magnetic resonance cholangiopancreatography confirmed the findings above. Endoscopic retrograde cholangiopancreatography revealed blood emanating from the ampullary orifice. A small sphincterotomy was performed and a 10 french × 3 cm plastic biliary stent was placed. Interventional radiology was consulted and angiography revealed a large pseudoaneurysm of a branch of the R
Polyangiitis (Churg-Strauss Syndrome)

A Rare Case of Pancreaticobiliary IgG4-Related Disease and Eosinophilic Granulomatosis With Polyangiitis (Churg-Strauss Syndrome)

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INTRODUCTION: IgG4-Related Disease (IgG4-RD) is a rare but increasingly recognized condition. It can manifest as pancreatitis and sclerosing cholangitis. Eosinophilic granulomatosis with polyangiitis (EGPA) may increase IgG4 levels but is not associated with IgG4-RD.

CASE DESCRIPTION/METHODS: A 42 year old white male with longstanding EGPA on chronic steroids for EGPA. Bile duct, pancreatic, and liver biopsies all lacked features of EGPA. Pancreatitis and cholangitis are not associated with EGPA. Thus, it is likely the patient had two distinct and rare processes. His chronic steroid treatment for EGPA may have masked longstanding IgG4-RD. Rituximab was shown to be an effective second-line treatment modality for both conditions.

DISCUSSION: This case demonstrates IgG4-RD with pancreaticobiliary disease in a patient on chronic steroids for EGPA. Bile duct, pancreatic, and liver biopsies all lacked features of EGPA. Pancreatitis and cholangitis are not associated with EGPA. This, however, is the likely the patient had two distinct and rare processes. His chronic steroid treatment for EGPA may have masked longstanding IgG4-RD. Rituximab was shown to be an effective second-line treatment modality for both conditions.

A Choledochoduodenal Fistula Masquerading as an Upper GI Bleed

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INTRODUCTION: We present a case of a choledochoduodenal fistula (CDF), a rare complication of duodenal peptic ulcer disease (PUD) that was successfully treated using a full-covered metal biliary stent.

CASE DESCRIPTION/METHODS: A 62-year-old woman presented with syncope, cough, ground emesis, and chronic abdominal pain. Her hemoglobin was found to be 5.4 g/dL. Subsequently, the patient was admitted for an upper GI bleed and symptomatic anemia. Upper endoscopy demonstrated a 4cm duodenal bulb ulcer. The ulcer was noted to have a "linear transverse slit at the base" and pigmented spots. An abdominal CT showed thickening of the duodenum, consistent with an ulcer that had a contained perforation. The CT scan also noted air within the biliary system and a possible fistula to the common bile duct.

DISCUSSION: This case demonstrates IgG4-RD with pancreaticobiliary disease in a patient on chronic steroids for EGPA. Bile duct, pancreatic, and liver biopsies all lacked features of EGPA. Pancreatitis and cholangitis are not associated with EGPA. Thus, it is likely the patient had two distinct and rare processes. His chronic steroid treatment for EGPA may have masked longstanding IgG4-RD. Rituximab was shown to be an effective second-line treatment modality for both conditions.