during follow up clinic visit a few weeks after her surgery. The gallbladder tissue was sent for pathological evaluation, which showed mild chronic cholecystitis (Image 2).

**DISCUSSION:** To our knowledge, multiseptate gallbladder has been rarely reported in the literature and chronic cholecystitis is not a common etiology. Symptoms usually occur due to transient impaired emptying of bile from the gallbladder. Some patients have had co-existing pancreatic and biliary duct abnormalities as well as gallbladder or bile duct cancer. Most of the cases were symptomatic and required therapy. Treatment options include conservative measures such as intake of a modified diet or treatment with ursodeoxycholic acid which have limited benefit and patients usually ultimately require cholecystectomy as definitive treatment.

## S1410

**Mycotic Abdominal Aneurysm Associated With Chronic Pancreatitis**

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**INTRODUCTION:** Vascular complications are a rare but serious manifestation of pancreatitis. The mechanism is thought to be due to inflammation and necrosis from local spread of proteolytic enzymes, compressive forces, or local infection. Splanchnic and gastroduodenal vessels are the most common given their proximity, but in rare cases, the aorta is affected.

**CASE DESCRIPTION/METHODS:** A 53-year-old white male with long-standing chronic alcohol induced pancreatitis complicated by pancreatic ascites and pseudocysts presented with one day history of epigastric pain, nausea and emesis. Other history included gastroesophageal reflux, peptic ulcer disease complicated by a gastric bleed 4 months prior, and hypertension. He reported 37 pack years of tobacco use and marijuana use. He had a history of alcohol abuse but had been abstinent for the past 10 months. He denied intravenous drug use. His exam was notable for moderate distress due to pain, thin appearing (BMI 18), poor dentition, and epigastric tenderness to palpation without rebound or guarding. Labs were notable for a mild leukocytosis (WBC 16.7 g/L) and anemia (HGB 12.3 g/dL). His lipase was within normal limits (17 U/L). A CT scan revealed a bilobed aortic aneurysm (4.4 x 4.5 cm) with wall thickening and surrounding fluid and tissue suggestive of a mycotic aneurysm (Figures 1 and 2). Infectious workup including blood, fungal, and urine cultures, and bartonella and Q fever serologies was unrevealing. Comparison to a CT scan done 4 months prior showed periaortic inflammation and caliber of 2.4 cm (Figure 3). The patient was started on empiric antibiotics and surgery was consulted. Given the rapid expansion and complexity, he was deemed high-risk and completed outpatient antibiotics prior to surgery. He returned two months later for a planned open repair of the aneurysm with a rifampin-soaked graft. Intraoperative cultures and pathology were unrevealing for infections etiology. On outpatient follow up, his symptoms improved and had no signs of ongoing infection. He was placed on suppressive doxycycline and continues to do well 17 months later.

**DISCUSSION:** Aortic pseudoaneurysms are a rare complication of pancreatitis with both infected and non-infected cases being reported in literature. Surgery is the definitive management, often done promptly upon diagnosis. Here we present a case of mycotic aortic aneurysm associated with chronic pancreatitis in which the surgical management was successfully postponed for infection control and stabilization of the patient.

## S1411

**Acute Esophageal Necrosis in a 29-Year-Old Patient With ESRD**

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INTRODUCTION: Acute esophageal necrosis (AEN), or Giarvits Syndrome, is a rare disorder with an incidence of about 0.001-0.2% with males having a 4:1 predilection. It is diagnosed clinically with endoscopic visualization of sharply demarcated circumferential black necrotic tissue occurring in the distal 1/3rd of the esophagus; whilst sparing the GEJ. Patients with AEN often have other comorbidities, such as vascular compromise, ESRD, DKA, malignancy, and duodenal ulcers. In 90% of cases, initial presentation includes melena, coffee ground emesis or frank hematemesis. We present a case of AEN seen in a 28-year-old male with ESRD, amongst other comorbidities.

CASE DESCRIPTION/METHODS: Our patient is a 29-year-old African American male with a history of ESRD on HD, HTN, and poorly-controlled T2DM who presented for sepsis secondary to non-healing diabetic foot ulcer. Vitals were significant for T 100.9, P 100, BP 168/78. Labs were significant for WBC 31.49, Na 130, K 3.1, BUN 41, Cr 9.80, CRP 21. Patient was treated for presumed osteomyelitis. During hospitalization, patient underwent HD three times per weekly schedule. On day 6, 8, and 10, he became hypotensive during his HD sessions. On day 13, he was found unresponsive and hypotensive with large melena stool. Upon stabilization, EGD showed black necrotic esophagus spanning the entire length until GEJ. Colonscopy was unremarkable. Conservative management with NPO, IVF, pRBC and IV PPI was done. Repeat EGD two weeks later showed patchy areas of necrosis interpersed with edematous throughout the esophagus improved from prior EGD. He recovered remarkably well including tolerating an oral diet.

DISCUSSION: Although the exact pathophysiology is unknown, a two hit hypothesis postulates the proposed mechanism for AEN formation. An initial event precipitates a lack of blood flow causing necrosis and vulnerability to insults that precipitate bleeding at the affected site. There is eventual reversal of necrosis with normalization of the tissue. Prognosis is poor and carries a high mortality rate from 15 to 35% and is dependent upon underlying disease. Some complications include esophageal perforation, stenosis and stricture, and mediastinitis. Management of AEN involves treating underlying disease along with supportive care. Although our patient was young, he had multiple comorbidities including ESRD, vascular compromise, DM and septic shock. This led to the development of ischemia and eventually necrosis especially in vulnerable areas of distal third of the esophagus.

S1412

Pancreatic Tuberculosis: A Challenging Diagnosis

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INTRODUCTION: Pancreatic tuberculosis is an exceedingly rare condition, even in areas of the world where the disease is highly prevalent. Its presenting features are usually vague and non-specific, while the radiological features mimic pancreatic malignancy in many cases and pancreatitis in others.

CASE DESCRIPTION/METHODS: A 26 years old active military male, originally from Virginia with no past medical history presented to the emergency department with a two-week history of abdominal pain, vomiting, dark urine, and pale stool. His physical examination was remarkable for scleral icterus as well as generalized abdominal tenderness. His laboratory results were remarkable for an alkaline phosphatase of 583 U/L, total bilirubin of 4.7 mg/dL, and direct bilirubin of 3.9. A CT scan and subsequent MRI of the abdomen showed a pancreatic mass at the body obstructing the common bile duct and causing intrahepatic bile dilation. ERCP/EUS was performed showing a biliary structure in the middle of the common bile duct for which a stent was placed, and fine-needle aspiration of the pancreatic mass was performed which was consistent with necrotizing granulomatous lymphadenitis. A stain of the pancreatic fluid was negative for TB. The infectious disease team was consulted and conducted a full infectious workup including HIV, Hepatitis panel, CMV DNA quantitative PCR, QuantiFeron-TB gold. Ova and parasite, Histoplasma antigen, Blastomycosis serology, RPR which all came back negative. All noninfectious causes of granulomatous disease were ruled out. A CT thorax was ordered and showed hilar and mediastinal lymphadenopathy as well as a nodule in the right upper lobe centrally. The patient subsequently underwent a Bronchoscopy with Broncho-alveolar lavage and bronchial brushing which came back negative for Pneumocystis jiroveci, Legionella pneumonia, Mycoplasma Pneumonia, fungal infections, and AFP stain. A Mycobacterium PCR of the pancreatic fluid culture was analyzed and showed Mycobacterium tuberculosis DNA complex.

DISCUSSION: Increased awareness of pancreatic TB existence in clinical conditions associated with immunocompetence is needed. Increased awareness among clinicians might dampen the health care-cost associated with unnecessary diagnostic tests. We also encourage that EUS-guided biopsy be a crucial step in the diagnostic algorithm in pancreatic lesions in order to spare patients from risky surgical procedures.

S1413

Caroli’s Syndrome: A Common Presentation of a Not-So-Common Disease

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INTRODUCTION: Caroli’s syndrome is a congenital disorder associated with autosomal recessive polycystic kidney disease characterized by intrahepatic bile duct dilatation and congenital hepatic fibrosis. While uncommon, it should be considered in the differential diagnosis of those with right upper quadrant pain and jaundice as it can lead to recurrent cholangitis and cholangiocarcinoma.

CASE DESCRIPTION/METHODS: A 25 year old male with end stage renal disease secondary to autosomal recessive polycystic kidney disease presented with right sided abdominal pain and fevers of two months duration. Labs were remarkable for liver injury, coagulopathy, elevated inflammatory markers, and hyperamteria. Extensive autoimmune, rheumatologic, and infectious workup were negative. Imaging was remarkable for cystic dilation of infrahepatic bile ducts, common bile duct dilatation, and hepatomegaly with sequel of portal hypertension. Liver biopsy revealed congenital hepatic fibrosis. Patient was diagnosed with Caroli’s syndrome with sclerosing/hydrate cholangitis. He completed a seven day course of antibiotics and was discharged with Gastroenterology follow up to determine if he would be continued on chronic antibiotics or undergo endoscopic evaluation.