A 76-year-old woman with a remote history of breast cancer in remission and chronic back pain with spinal stimulator presented to the emergency department with aphasia, confusion, 3 weeks of recurrent rectal bleeding, and unintentional weight loss. Upon further review, patient was admitted to hospital four months prior with infectious colitis. CT Abdomen/Pelvis at that time concerning for rectal mass. Hgb 14, Platelets 202. On current admission vitals were stable, labs showed WBC 8.2, Platelets 124, Sodium 135, Potassium 1.7, ALT 1583, ALP 1583, AST 19, LDH 4917, PT 16.5, INR 1.4. Hematology was consulted and disagreed chronic DIC presumably from rectal cancer. Declining mental status was concerning for sepsis. Labs showed: WBC 4.5, Hgb 8.2, Platelets 21, Sodium 124, Potassium 3.3, Total Bilirubin 1.7, albumin 3.4. Hemolytic workup revealed: LDH 4917, PT 16.5, INR 1.4. Fibrinogen elevation and likely microthrombotic processes on brain, however CT head only showed chronic ischemic changes, MRI not obtained due to spinal stimulator. Flexible sigmoidoscopy with biopsy of fungating, bleeding rectal mass revealed poorly differentiated rectal adenocarcinoma with necrosis. Family opted for hospice and died one day after discharge.

DISCUSSION: Chronic DIC, sporadic exposure and clearing of small amounts of tissue factors by the liver precludes severe complications. Clotting times and thrombocytopenia may be normal or mild, however, fibrinogen can be elevated and consequently thrombosis is the predominant feature. This case has two key learning features, one, the differential of chronic DIC should be added to any patient with hemolytic anemia and known or presumed malignancy, and two, chronic DIC is a distinct entity from acute DIC with fibrinogen elevation and likely microthrombotic processes on presentation. DIC should be ruled out in patients presenting with neurologic symptoms with known or presumed malignancy as treatment modalities are distinct from other etiologies.

S1730

Postpartum Hematochezia in 28-Year-Old Due to Primary Signet Ring Adenocarcinoma of Colon

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INTRODUCTION: Colorectal cancer (CRC) is the 3rd leading cause of deaths in the United States. Out of all primary colorectal cancers, adenocarcinoma accounts for the majority of cases. Mucinous and signet ring types are less frequent. Primary signet ring cell carcinoma of the colon is < 1% of all CRC. >90% signet ring carcinoma from stomach and rest from other part of GI tract, urinary bladder and breast.

CASE DESCRIPTION/METHODS: 29 YO F with no known past medical history presents to the emergency department with abdominal pain for 5 years but never medical advice until recently. Used NSAID for almost a year. No Flu of colon or gastric cancers. Never had colonoscopy or EGD. She is non-smoker and drinks occasionally. CT abd pelvis showed sigmoid wall thickening with para aortic and iliac lymphadenopathy. Her labs were significant with Hb of 9.1 and CEA 384. (AFP- 3.4, CA125 -128, CA19-9 -22.4, CA27-29 -37 , CA 15-3 -14.7). Flexible sigmoidoscopy showed ulcerated partially obstructing mass in distal sigmoid colon with 3-4 mm lumen. Biopsy showed adenocarcinoma with signet ring features. Immunohistochemistry tumor cells with CK20+, CK7+, synaptophysin- and chromogranin - EGD was unremarkable. Pt was diagnosed with M1 disease given para aortic lymphadenopathy RAS, BRAF, MSI testing is pending. Pt was started on neoadjuvant therapy with FOLFOX regimen given high risk partial obstruction with no clinical signs of obstruction and the plan was follow it with colostomy or stent placement.

DISCUSSION: Signet ring carcinoma of colon (SRC) occurs mostly in young female < 40 YO. SRC cells show high BRAF mutation rate and more prevalent MSI compared to adenocarcinoma. Loss of E-cadherin expression is associated with high grade and invasive nature of SRC. Tumor staging is the best predictor of overall prognosis. 5 yr survival rate is 0-12% and disease recurrence is higher compared to adenocarcinoma. Patients with SRC can benefit from intensified adjuvant chemotherapy given high risk of recurrence and distant metastasis. According to a retrospective study on 22 patients with primary signet ring carcinoma,11 patients were cured with surgical resection. It was found that age, gender,FHx, the size of the tumor, presence of liver metastasis, depth of invasion, and addition of adjuvant as well as neoadjuvant therapies, had no statistically significant effect on the survival period (P > 0.05).

S1731

A Rare Case of Tapeworm Infestation in United States Presented With Appendicitis

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INTRODUCTION: Taenia is a rare infection in the developed world and its association with appendicitis is even rarer. Taenia solium is mostly found in pork while saginata is primarily found in beef however determining can be difficult and requires microscopy for certain anatomic characteristics. Taenia is a growing concern in developed countries due to immigration from endemic areas and its potential to cause disseminated disease. Here we are presenting a case of Taenia infestation presented as an Appendicitis.

CASE DESCRIPTION/METHODS: A 19 y/o male with no known past medical history presents to the Emergency Department with complaints of Right lower quadrant (RLQ) pain. Patient (Pt) stated the pain began in his RLQ that radiates all over his abdomen with 10/10 in intensity. Pt admits to dizziness and loss of appetite but denies nausea or vomiting. Pt appeared in acute distress with heart rate of 95 bpm but afebrile. Abdomen was non-distended, soft, and had tenderness to palpation it the RLQ with slight rebound tenderness. CT abdomen showed appendicitis and surgery was consulted for appendicectomy. Pathology report showed a mildly dilated and inflamed appendix as well as presence of strobilla in the appendix. Pt was discharged home on anti-helminthics post-surgery with resolution of symptoms upon discharge.

DISCUSSION: Taenia occurs in human hosts after ingestion of either undercooked pork or beef that contains the larvae of the tapeworm. The worm works its way to the intestine, where the scolex can attach itself to the intestinal wall and produce strobilla. The eggs of the tapeworm can...
obstruct the lumen of the appendix which will lead to inflammation and infection. Furthermore, the worm can migrate to the end of the digestive tract where it can be excreted with fecal material leaving proglottids in the soil and contaminating water. This leads to risk for ingestion of larvae and proglottids leading to further dissemination of the parasite to another host. Taenia infection is highly preventable by ensuring adequate cooking temperatures and timing of meat as well proper sanitary precautions. It is also important to take into consideration of examination of family members and others for possible infection from the same meals. Praeziquantel and albendazole has shown to be effective in treating this infection. As immigration from endemic areas continues to grow due to Globalisation further understanding of the relationship between parasitic infection and appendicitis may be beneficial.

S1732

Solitary Rectal Ulcer Syndrome: Neither Solitary, nor Ulcerated, a Misnomer Indeed

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INTRODUCTION: Solitary rectal syndrome is an enigmatic medical condition first described by 1829 when Cruveiher reported four cases of unusual rectal ulcers. The exact prevalence of this condition is not known due to its rarity, but has been estimated to be around 1 in 100,000. Patients characteristically present with rectal bleeding, passage of mucous, perineal or rectal pain, tenesmus, incomplete evacuation, straining on defecation and rectal prolapse. The condition presents with polypoid lesions in 44%, ulcerations in 29% and edematous, non-ulcerated hyperemic mucosa in 27%. As such, Solitary Rectal Ulcer is a misnomer because the lesion is neither solitary nor ulcerated in the majority of cases.

CASE DESCRIPTION/METHODS: We highlight two elusive cases with solitary rectal ulcer syndrome. The first patient is a 54-year-old HIV positive male who presented with tenesmus and rectal bleeding. On further evaluation he was found to have proctitis, rectal mucosal hyperemia with a whitish exudate on endoscopy which lead to an initial diagnosis of Lymphogranuloma Venerum. Failure of prolonged antibiotic treatment prompted further investigation which showed a histopathological picture of Solitary rectal ulcer syndrome. Patient continued to have symptoms despite multiple medical treatment modalities. Partial control of the patient’s symptoms was achieved post low anterior resection and ileostomy with later reversal. The second patient is a 63-year-old male who presented with weight loss and microscopic hematuria who on digital rectal examination had rectal induration. A CT scan done for further evaluation revealed pre-sacral and peri-rectal soft tissue thickening. A subsequent colonoscopy showed a 1.5 cm triangular rectal ulcer, with edematous and erythematous edges, at approximately 8 cm from the anal verge. Pathology results were consistent with solitary rectal ulcer syndrome. The patient’s course was complicated by the development of recurrent peri-rectal abscesses requiring surgical intervention and prolonged antibiotic therapy. Patient then went on to develop superimposed Clostridium difficile colitis.

DISCUSSION: Solitary rectal ulcer syndrome is a rare and benign syndrome with an extremely varied presentation that can prompt an easy misdiagnosis of malignancy, infection or inflammatory bowel disease. Treatment is not well defined and most cases eventually require surgical intervention. A high degree of suspicion is needed to avoid an easy misdiagnosis with resultant prolonged morbidity.

S1733

Schwannoma of the Sigmoid Colon Discovered on Screening Colonoscopy

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INTRODUCTION: Schwannomas may present anywhere in the body along the peripheral nervous system, but one of colonic origin is very rare. Here we present a case of a colon Schwannoma diagnosed on routine screening colonoscopy.