A Case of Descending Colon Volvulus Following Sigmoid Volvulus Status Post Sigmoidectomy
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INTRODUCTION: Colonic Volvulus is the 3rd leading cause of colonic obstruction worldwide behind carcinoma and diverticulitis. The sigmoid colon and cecum are the most common locations. This case describes a patient with prior sigmoid volvulus (SV) and sigmoidectomy (SDY) presenting with descending colon volvulus (DCV). There have only been a few reports of DCV and to our knowledge no case in someone with a prior SV s/p SDY.

CASE DESCRIPTION/METHODS: A 75-yr male with past medical history (hx) of SV s/p SDY with colo-colonic anastomosis after failed detorsion, chronic constipation, and hypothyroidism presented with a 4-day hx of abdominal pain and obstipation. No hx of epigastric pain. K+ 3.9 and TSH 1.021. Abdominal x-ray showed dilated loops of large bowel with concern for distal obstruction. On CT Abdomen and Pelvis (CT A/P) with IV contrast, there was diffuse large bowel dilatation up to the sigmoid colon with no mass or wall thickening visualized. Colonoscopy showed a patent anastomosis with colo-colonic anastomosis after failed detorsion, chronic constipation, and hypothyroidism.

DISCUSSION: Volvulus is the torsion of a colonic segment over its mesenteric axis. DCV is a rare entity. The descending colon is a retroperitoneal structure usually without a mesentery. However, the primitive dorsal mesocolon may fail to fuse with the parietal peritoneum in the 4th-5th month of gestation, resulting in persistent descending mesocolon. Abdominal x-ray can show a grossly dilated loop of bowel without air or gas in the rectum. CT A/P can show “coffee bean” sign with a large twisted loop of bowel, “whirl” sign with twisting of the mesentery and its vessels, “X marks the spot” sign with crossing loops of bowel at the site of transition, and “split wall” sign with mesenteric fat indenting. Typical CT imaging features may be absent in 1/4th of all patients. On colonoscopy, there is usually a spiral, siphon-like area of mucosa and visibility of mucosa can be assessed. Gentle pressure and insufflation are carried out for reduction. Recurrence rate after detorsion is around 85%. The incidence of recurrent volvulus after previous resection and anastomosis is around 6–36%. As this patient is at high risk for recurrence after detorsion, subtotal colectomy will be completed.

Aeromonas Spp. Enteritis in the Course of Recurrent Immune Checkpoint Inhibitor Colitis
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INTRODUCTION: The role of Aeromonas spp. as a gastrointestinal pathogen is debated. Here we present an Aeromonas infection in a patient with recurrent immune checkpoint inhibitor (ICI) colitis.

CASE DESCRIPTION/METHODS: A 61-year-old Caucasian female with Stage IV Melanoma and history of recurrent ICI colitis presented with 8 days of watery diarrhea, nausea, and vomiting. The patient had recently completed 2nd induction of Ilimumab, an anti-CTLA-4 immunotherapy agent, while being on vedolizumab concurrently with oral budesonide for previous episodes of nausea and vomiting. She endorsed intermittent abdominal cramping and decreased PO tolerance but denied fevers, bloody diarrhea, hematemesis. On exam, abdomen was benign and non-tender. Serology labs were unremarkable. Stool studies were significant for positive lacto-ferrin and elevated calprotectin to 432 μg/g. Patient was started on solumedrol 40 mg IV BID empirically. GI multiplex PCR panel was negative including C. difficile. Stool culture was positive for pan-susceptible Aeromonas spp. Patient was started on a 7-day course of Ciprofloxacin 500 mg BID and prednisone taper resulting in improved PO tolerance, resolution of diarrhea and decreased nausea and vomiting on discharge.

DISCUSSION: Aeromonas spp. infections, although rare, most typically present with gastrointestinal symptoms. It has been implicated as an opportunistic pathogen in inflammatory bowel disease, however, its role in patients with ICI colitis remains unclear. Our patient had presented with similar symptoms and negative stool cultures several months prior and was treated for ICI colitis. This diagnosis was confirmed by colonoscopy showing active cryptitis and apoptotic bodies. In the current presentation, it is unclear what the primary cause of her symptoms was. Concurrent administration of both antibiotics and steroids improved her symptoms possibly suggesting a combination of Aeromonas spp. infection and ICI colitis which has never been reported previously in literature. Further studies with larger cohorts of patients with ICI colitis are warranted to investigate the pathogenicity and role of Aeromonas infection.

REFERENCES

Gardner’s Syndrome and Familial Adenomatous Polyposis: Unusual Presentation With Eye Pain
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