DISCUSSION: Splenic laceration is a rare complication of colonoscopy (incidence 0.00005 – 0.17%) associated with significant mortality (5%), and as such requires a low threshold of suspicion for early diagnosis and management in the post-colonoscopy period. Anticoagulation, a requisite for management of cardiovascular comorbidities, is a notable risk factor and may predispose to splenic capsular rupture with minimal colonoscopic manipulation.

S1843
Gastrointestinal Malignancy and Timing of Dermatologic Manifestations
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INTRODUCTION: Dermatologic manifestations of gastrointestinal malignancies are a relatively rare presentation. However, these skin findings can be a prompt to survey for and result in early detection of gastrointestinal malignancy resulting in improved patient morbidity and mortality.

CASE DESCRIPTION/METHODS: A 77-year-old man with a history of pan-diverticulosis and iron deficiency anemia presented with 24-hours of melena and skin lesions on his back that developed over 3–4 days. On Physical examination, his vital signs were normal, had melena on rectal exam, and back showed diffuse, dark-brown, waxy, raised plaques consistent with Leser-Trelat sign (Figure 1). Labs were significant for anemia (hemoglobin 10 g/dL) and elevated blood urea nitrogen (38 mg/dL). An abdominal computed tomography without contrast revealed a 3.4 cm ascending colon mass described as an “apple core” lesion. The patient underwent esophagogastroduodenoscopy without significant findings. His colonoscopy was significant for blood throughout the colon and a large, 2–2.5 cm rectal mass. Biopsy of the rectal mass revealed tubulovillous adenoma with high-grade dysplasia. A follow up outpatient colonoscopy with endoscopic ultrasound was performed, and the rectal mass removed via endoscopic mucosal resection.

DISCUSSION: There are few dermatologic manifestations associated with gastrointestinal malignancies in the adult population. These conditions can be divided into three broad categories: genetic conditions, inflammatory conditions, and para-neoplastic syndromes.¹ The genetic conditions include Howel-Evans syndrome, Peutz-Jeghers syndrome, Muir-Torre syndrome, Gardner syndrome, and Cowden syndrome. The inflammatory conditions include dermatomyositis and multicentric reticulohistiocytosis. The para-neoplastic syndromes include sign of Leser-Trelat, acanthosis nigricans, tripe palm, acrokeratosis paraneoplastic, necrolytic migratory erythema, and hypertrichosis lanuginosa.² Identification of these skin findings in most of the conditions results in an earlier detection of the respective gastrointestinal malignancy, hence, improving patient morbidity and mortality. References: C. R. Schadt, “The cutaneous manifestations of gastrointestinal malignancy,” Seminars in Oncology, vol. 43, no. 3, pp. 341–346, 2016.

S1844
Early Onset Colorectal Cancer (EOCRC) in a 43-Year-Old Woman: Current Guidelines Miss Patients at Risk for EOCRC
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INTRODUCTION: The incidence of colorectal cancer (CRC) among individuals less than 50 years old is increasing and is estimated to double by 2030. Risk factors for early onset CRC (EOCRC), outside of hereditary CRC syndromes or personal history of IBD, are not well understood. We present a case of EOCRC in a 43-year-old woman.

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MUTYH-Associated Polyposis With Colorectal Cancer and Metachronous Extraintestinal Cancers

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INTRODUCTION: MUTYH-associated polyposis (MAP) is a hereditary cause of colorectal cancer (CRC). Without surveillance, patients with MAP have an 80-90% lifetime risk of CRC. We present a case of a patient with CRC and 2 metachronous primary extraintestinal (EI) cancers (CAs) with germline mutations in the MUTYH gene.

CASE DESCRIPTION/METHODS: Our patient was diagnosed with endometrial CA at age 33 and underwent a hysterectomy. She was diagnosed with CRC fourteen years later and underwent a left hemicolectomy with chemotherapy. It is unclear if she had a full colonoscopy at that time. Two years later, a surveillance colonoscopy revealed many tubulovillous adenomas, and a repeat procedure six months later noted innumerable polyps. She then underwent genetic testing which was negative for Lynch syndrome, but revealed biallelic MUTYH gene mutations, Y179C and G396D. A total colectomy was recommended, but she was lost to follow-up. Eight years later, she was diagnosed with breast CA, a third primary CA. She achieved remission with mastectomy, chemotherapy, and radiation. That year, an EGD was normal, and a colonoscopy revealed multiple rectal hyperplastic polyps. A year later, two cecal masses were found and the biopsy showed villous adenoma with high-grade dysplasia. Subsequently, she underwent a subtotal colectomy with deoarectal anastomosis.

DISCUSSION: There is limited evidence regarding the colorectal phenotype of MAP and its EI spectrum, which poses a challenge when creating surveillance guidelines. Current guidelines only outline targeted surveillance for CRC, gastric polyps, and duodenal polyps. A trend towards an increased risk of breast and gynecological CAs has been identified, but these findings were only reported by small series and case reports. One small study estimated the incidence of all EI malignancies was nearly doubled in MAP patients and the lifetime risk was 38% compared to the general population. This case serves as a prudent reminder about the importance of genetic testing in patients with CA diagnosed at a young age and the importance of age-appropriate screening for other CAs. Further, all CRC patients should have a full colonoscopy at the time of diagnosis to assess for synchronous lesions or possible polyposis syndrome.

REFERENCES