typically mild, but serious complications can occur, including incarceration, strangulation, and bowel obstruction. We present a rare case of incarcerated right inguinal hernia causing cecal ischemia and hemorrhagic shock.

CASE DESCRIPTION/METHODS: A 74 year-old male with history of ESRD, pulmonary HTN, and aortic stenosis s/p TAVR two weeks ago presented with three days of hematochezia and sharp, colicky abdominal pain for several months. He was discharged post-TAVR with a hemoglobin 10.8 and INR 1.1. He was taking aspirin but no anticoagulants or NSAIDs. On admission, he was hypotensive with a hemoglobin of 7.7 concerning for hemorrhagic shock. He briefly required vasopressors, but responded to transfusions appropriately. CT angiogram was negative for aortoenteric fistula or other source of active bleed. It did reveal a right inguinal hernia containing appendix, cecum, and terminal ileum (Figure 1) which was not seen on prior CT several months earlier. Colonoscopy was performed, revealing bright red blood to the level of the cecum and a large blood clot filling the entire cecum partially removed via Roth net and snare (Figure 2). There was large ulceration involving a quarter of the cecum with adherent clot, associated mucosal denudation and pale mucosa in the surrounding area, consistent with moderate ischemic colitis. A 2 cm linear ulcerated segment with mucosal oozing was treated with three hemoclips (Figure 3). The patient had no peritoneal signs or evidence of transmural necrosis and was thus consistent with moderate colonic ischemia. Given this, the hernia was able to be manually reduced by general surgery. The patient did not require further surgical intervention and continued to do well at thirty day follow-up.

DISCUSSION: Few cases have reported isolated cecal ischemia related to an incarcerated inguinal hernia and none leading to hemorrhagic shock requiring vasopressor support. The cecum is in a "watershed territory" similar to the splenic flexure and rectosigmoid colon, making it susceptible to ischemia. Strangulation occurs when there is total vascular compromise. However, ischemic changes are seen if compromise is incomplete, as in our case. Thus, this case illustrates a unique cause of gastrointestinal bleeding and the importance of maintaining a high index of clinical suspicion in order to avoid critical complications.

S2107

Successful Management of Refractory Esophageal Variceal Bleeding Secondary to Chronic Portal Vein Thrombosis by Transsplenic Portal Vein Recanalization and Transjugular Intrahepatic Portosystemic Shunt

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INTRODUCTION: Transjugular intrahepatic portosystemic shunt (TIPS) becomes challenging in the presence of portal vein thrombosis (PVT). We describe a case of successful management of...
refractory esophageal variceal bleeding secondary to chronic PVT and splenic vein thrombosis (SVT) by portal vein recanalization – TIPS through transsplenic and transhepatic approach.

**CASE DESCRIPTION/METHODS:** A 29-year-old male with a history of homozygous methyl-
entetrahydrofolate reductase mutation with normal homocysteine levels on warfarin presented with acute hematemesis. He underwent emergent endoscopic band ligation of esophageal and GOV1 gastric varices. He had a history of chronic PVT with prior mechanical thrombectomy and thrombolyis two years ago, and received band ligation for bleeding esophageal varices in the last year, but did not follow up for surveillance. MBI of abdomen and pelvis revealed chronic PVT with cavernous transformation (Fig A) and chronic SVT. No further bleeding was reported after endoscopy. Liver biopsy one year ago showed benign liver tissue with focal mild congestion and sinusoidal dilation. There was a normal hepatic venous pressure gradient. Given concerns about his compliance and risk of re-bleeding, multidisciplinary team discussion led to consideration of a high-risk TIPS with splenic vein recanalization and stenting. Under ultrasound and fluoroscopic guidance, TIPS was placed using two snares targets. One snare was placed in the occluded portal vein via splenic vein access, and another was placed in the middle hepatic vein via internal jugular vein access. Using the gun-sight technique, a 21-gauge Chiba needle was advanced transhepatically through both the loop snares and then a guidewire was advanced until it could be captured by both the above snares (Fig B). With this newly obtained access, TIPS and splenic stents were successfully deployed (Fig C). Pressure gradient across TIPS was lowered to 6 mm Hg from 16 mm Hg. As varices did not fill on post TIPS portogram, embolization was not performed. He was started on aspirin in addition to his warfarin. Acute hematemesis was prevented by aspirin and warfarin use. Repeat CTA at 3 months demonstrated patent TIPS and splenic stent, and no further episodes of hematemesis were reported.

**DISCUSSION:** In our patient, the gunsight TIPS approach helped decompress portal hypertension and prevent recurrent variceal bleeding when other alternatives including Sugihara surgery carried high morbidity and were not amenable. Post TIPS re-stenosis is a known complication, and may be prevented by aspirin and warfarin use.

**S2108**

**Metastatic Gastric Carcinoma Masquerading as a Pedunculated Bleeding Gastric Polyp**

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**INTRODUCTION:** The majority of gastric polyps are found incidentally and are benign hyperplastic or fundic gland polyps with low malignant potential. Up to 10% can be adenomas which harbor underlying malignancy or cause complications, e.g. bleeding. We present a case of an elderly patient with acute upper GI bleeding from a metastatic gastric adenocarcinoma masquerading as a typical fundic gland polyp.

**CASE DESCRIPTION/METHODS:** A 77-year-old woman presented with 2 days of loose foul-smelling black stools and fatigue, was hemodynamically stable with a benign abdominal exam, and had a hemoglobin of 7.1 g/dL. EGD revealed a 3.5 × 2 × 1.8 cm pedunculated polyp on the lesser curvature of the gastric body with an adherent clot with normal appearing surrounding gastric mucosa. Staging scans revealed peritoneal implants consistent with disseminated stage IV disease. Due to age, a palliative treatment approach was taken with radiotherapy.

**DISCUSSION:** Gastric polyps can be seen in incidentally on 6% of endoscopies with gastric adenomas representing only 6-10%. While all classes of gastric polyps are usually incidental findings on EGD, gastric adenomas are more likely than all other classes to cause complications. The neoplastic potential of two other commonly encountered polyps - hyperplastic and fundic gland polyps - are generally quite low at 1% and virtually nonexistent outside of familial polyposis syndromes, respectively. On the contrary, gastric adenomatous polyps are associated with concurrent gastric carcinoma in 8-59% of cases. Isolated polyps that are pedunculated with normal surrounding mucosal tissue, as seen here, conventionally have a low suspicion for malignancy. Furthermore, is it uncommon to encounter a purely pedunculated gastric adenoma, as the majority of these lesions are sessile. Often, signs of upper GI bleeds can be the initial presentation of gastric carcinomas. As older populations are more prone to gastric polyps, many may also have comorbidities such as chronic anemia or on medications preventing hemostasis, which has potential to be detrimental. In conclusion, here we highlight a unique presentation of metastatic gastric carcinoma and stress vigilant assessment of all gastric polyps and discuss potential complications as even benign appearing lesions could harbor malignancy.