CASE DESCRIPTION/METHODS: A 23-year-old healthy male presented with new iron deficiency anemia. We describe a case of metastatic testicular cancer presenting as GI bleeding.

INTRODUCTION: The most common solid malignancy affecting young males is testicular germ cell tumors (GCT). Most GCTs present with painless testicular swelling, however 10% of patients can present with symptoms related metastatic disease. Rarely, 5% of the time, GCT can metastasize to the gastrointestinal tract, most commonly to the jejunum and ileum likely from direct extension from the retroperitoneal cavity. Direct contact between peritoneal and gastrointestinal (GI) tract with invasion of local structures, allowing a correct identification of duodenocaval fistula in approximately 50% of patients. It allows evaluation of collateral vascular outflow and provides information for treatment options.

REFERENCE:

S2188

Metastatic Testicular Cancer Presenting as Gastrointestinal Bleeding
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INTRODUCTION: The most common solid malignancy affecting young males are testicular germ cell tumors (GCT). Most GCTs present with painless testicular swelling, however 10% of patients can present with symptoms related metastatic disease. Rarely, <5% of the time, GCT can metastasize to the gastrointestinal tract, most commonly to the jejunum and ileum likely from direct extension from the retroperitoneal lymph nodes that drain the testes. GCT metastasis to the GI tract can present with obstruction and occult or overt bleeding leading to hemodynamic instability. Unfortunately, GCT metastasis to the GI tract at diagnosis indicates poor prognosis given the typically concomitant widespread disease. We describe a case of metastatic testicular cancer presenting as GI bleeding.

CASE DESCRIPTION/METHODS: A 23-year-old healthy male presented with new iron deficiency anemia and intermittent melena. He initially presented to an outside urgent care with fatigue and dark stools in the setting of NSAID use for new headaches and was found to be anemic requiring transfusion. He underwent unrevealing EGD/colonoscopy but video capsule endoscopy demonstrated two ulcerated lesions in the jejunum so was referred to us to be evaluated for balloon-assisted enteroscopy. He was pale and tachycardic during clinic visit so was subsequently admitted. Chart review revealed a prior outpatient testicular ultrasound from 2016 done for scrotal swelling that demonstrated varicocele and bilateral testicular microlithiasis. Ultrasound and MRI brain done for new headaches revealed findings consistent with metastatic testicular cancer. He was transferred to a higher-level facility due to brain edema which took precedence. He was started on Bleomycin, Etoposide and Cisplatin therapy and underwent orchiectomy. Follow-up imaging and visits show a significant reduction in metastatic disease and complete resolution of further GI bleeding.

DISCUSSION: Though this patient’s disease was widely metastatic to GI tract, lungs, brain, bones, and skin, the key presenting symptom that prompted evaluation was GI bleed from metastasis to his small bowel. GI manifestations of GCTs are exceedingly rare and literature review found less than 30 patients with similar presentations. Any new anemia with associated GI bleed in an otherwise healthy young man should be approached with high clinical suspicion for malignancy and though other cancers are more common than GCT, this diagnosis should be considered when an ulcerating small lesion is identified in a young male.

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Appendicular Ulcer- A Rare Cause of Lower GI Bleed
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INTRODUCTION: Although lower gastrointestinal bleeding (LGB) is not uncommon, appendicular ulcer as cause is extremely rare. Here, we present a case of young male who presented with LGB due to appendicular ulcer.

CASE DESCRIPTION/METHODS: A 30-year-old healthy Asian male presented with loss of consciousness following 3 episodes of painless massive LGB. On arrival, he was hemodynamically unstable which improved following immediate resuscitation with a bolus of fluids and 2 units of packed red blood cells. On examination, he was very pale, tachycardic and obtunded while abdominal examination was benign. Rectal examination showed bright red blood with no evidence of external hemorrhoids. Initial labs showed hemoglobin of 10 mg/dL. He underwent an urgent upper endoscopy and colonoscopy which showed gastric erosions and diffuse bleed in the entire colon with poor visualization of the source of bleed, respectively. He underwent Meckel’s scan as well as CT abdomen with negative results. Repeat colonoscopy was done on the following day which showed 7 mm ulcer at appendicular orifice that was thought to be the source of LGB due to increased vascularity around the orifice. He was discharged the very next day with recommendation to follow up with outpatient surgery. Due to the concern for malignancy, patient underwent partial Colectomy and the biopsy of the surgical specimen showed an early appendicular abscess with no evidence of granulomatous findings or malignancy.

DISCUSSION: Diverticulosis, angiodysplasia, inflammatory disease are the most common causes for LGB. LGB due to appendicular ulcer is an extremely rare cause with only few cases reported so far. Urgent colonoscopy needs to be considered in the hemodynamically unstable patient as it will offer a therapeutic intervention as well. Although it is very efficient and a safe tool for evaluation of LGB, the chances of finding an appendicular origin bleeding is rare. Treatment needs to be individualized. Although colonoscopy hemostasis can be considered, surgical treatment plays an important role in the management of appendicular bleeding. Open or laparoscopic appendectomy can be considered for local appendicular bleeding but cecrectomy , ileo-cecetomy and right hemicolecetomy also needs to be considered based on the operative findings. With this case, we would like to educate about the possibility of appendicular ulcer bleedings to be considered as part of differential diagnosis of LGB, especially in young male patients.

S2190

A Rare Presentation of Blue Rubber Bleb Nevis Syndrome in the Elderly
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INTRODUCTION: Blue Rubber Bleb Nevis Syndrome (BRBNS) is a rare congenital condition consisting of venous malformations manifesting as blue blanchable rubber blood filled sacks. BRBNS is often diagnosed in childhood to early adulthood, and can occasionally present with significant blood loss anemia requiring hospitalization and blood product transfusions. In the case below, we discuss a patient with no prior history of anemia who presented with suspected BRBNS associated GI bleeding manifesting in late adulthood.