abnormal liver function tests with unclear etiology. In these cases, early liver biopsy should be pursued. The overall prognosis of primary hepatic lymphomas remains poor and early recognition of this disease may improve the prognosis.

Parotid Epithelial-Myoepithelial Carcinoma Recurring as a Metastatic Cystic Lesion of the Liver
Amir Riaz, MD1, Adalberto Gonzalez, MD2, Fernando I. Castro, MD2, Fayssa Salomon, MD3.
1Cleveland Clinic Florida, Weston, FL; 2Cleveland Clinic Florida, Plantation, FL; 3Cleveland Clinic Foundation, Weston, FL.

INTRODUCTION: Liver metastases is a rare cause of cystic liver lesions and most frequently originate from the colon, pancreas, ovary, kidney, neuroendocrine tumors, and prostate cancer. Metastasis of a salivary gland cancer to the liver is infrequent. We present the rare case of a parotid epithelial-myoepithelial carcinoma (EMC) recurring with a liver cyst metastasis.

CASE DESCRIPTION/METHODS: A 63-year-old female presented with right upper quadrant abdominal pain of 1-month duration. The pain was described as non-radiating, dull, and progressively worsening. Accompanying symptoms included reduced appetite, nausea, and unintentional weight loss. Her past medical history was pertinent for a stage III right parotid EMC diagnosed three years prior treated with parotidectomy and radiation. There was no family history of malignancy. Laboratory studies showed a normal complete blood count, total bilirubin 1.4, alkaline phosphatase 637, ALT 110, and AST 89. A CT abdomen with IV contrast showed a 21 cm cystic hepatic mass with thick internal septations suspicious for a biliary cystadenocarcinoma. However, given her prior history of malignancy, a subsequent liver biopsy was performed and revealed metastatic EMC. Further work up revealed right lung nodules up to 0.7 cm on CT. She underwent total right hemihepatectomy and peri-portal lymphadenectomy and has done well. There are plans for further chemo-immunotherapy and radiotherapy.

DISCUSSION: Cystic liver lesions are heterogeneous in their etiology, manifestations, management, and prognosis. Making the correct diagnosis is important. Initially, we suspected our patient to have a biliary cystadenocarcinoma given the radiologic findings. However, given her prior history of malignancy, we performed a liver biopsy, which revealed an EMC, thought to be metastasis from the parotid EMC resected 3 years earlier. EMC represents less than 1% of salivary gland tumors. It is considered a low-grade malignant tumor since it is slow growing and metastasizes in 15% of cases, mainly to the lung, liver, and kidney. It may also recur in 25-50% of cases after resection. It is important to recognize metastasis as a possible cause of cystic liver lesions. When in doubt, liver biopsy or resection is reasonable. Early diagnosis and treatment may increase the likelihood of a successful recovery.

MY OCP Is Out of Control!—A Case of Acute Portal and Mesenteric Vein Thrombosis After One Week of OCP Use
Deeksha Misra, MD1, Jaychidambaram Ambalavanan, MD2, Shiva S. Vangimalla, MD3, Amanda Magee, MD1.
1MedStar Washington Hospital Center, Washington, DC.

INTRODUCTION: Oral contraceptive pills (OCPs) are the most common non-invasive method of contraception adopted by women per a recent CDC report. OCPs are a known risk factor for thromboembolism (VTE), especially when combined with other risk factors such as smoking, obesity, or thrombophilia. Though VTE in such users commonly manifests as DVT or PE, there have been a few case reports suggesting OCPs as a cause of portal or mesenteric vein thrombosis, but usually after prolonged use of months to years. Here, we describe an exciting case of a woman with no above-mentioned risk factors presenting with abdominal pain within a week of OCP use.
Primary Hepatic Lymphoma: A Rare Entity

Mishri Subramaniam, MD1, Prakash Vissanathan, MD2.
1Boston Medical Center, Boston, MA; 2Central Maine Medical Center, Lewiston, ME.

INTRODUCTION: Primary Hepatic Lymphoma (PHL), also known as primary Non-Hodgkin lymphoma of the liver is a rare disease. It represents 0.016% of all Non-Hodgkin lymphomas (NHL) and 0.4% of extranodal lymphomas. It is often misdiagnosed due to non-specific clinical symptoms and radiographic imaging, with a lack of diagnostic criteria. We present a case of PHL diagnosed via endoscopic ultrasound (EUS) with fine-needle biopsy (FNB).

CASE DESCRIPTION/METHODS: An 83-year-old man with no relevant past medical history presented to the emergency room with a one-month history of abdominal pain and a 40 lb weight loss. He was tachycardic and had abdominal distension with epigastric tenderness to palpation, but no palpable adenopathy. Labs were notable for anemia, thrombocytopenia, elevated INR, and elevated alkaline phosphatase. He had negative infectious hepatitis and autoimmune panels. Computed Tomography (CT) with contrast showed a cirrhotic liver with hypodense focal lesions in the left and right hepatic lobe. Malignancy workup showed normal AFP and CEA levels. EUS with FNB was performed, with positive immunohistochemical tissue stains consistent with Diffuse large B cell lymphoma (DLBCL).

DISCUSSION: PHL is a rare disease and limited evidence is available to provide adequate diagnostic criteria. It is often defined as lymphoma that is confined to the liver or has predominant liver involvement. PHL has a higher incidence in patients with cirrhosis, hepatitis, autoimmune conditions, and transplantation with immunosuppression. Laboratory data can be difficult to interpret and is often unrevealing, as seen in this case. Results of radiographic imaging can be categorized into three groups: one solitary liver lesion, multiple hepatic lesions, or diffuse infiltration. The gold standard for diagnosis is liver biopsy, usually obtained by percutaneous or transangular approach by interventional radiology (IR). Studies have shown that EUS guided biopsy may be comparable to IR with regards to sufficiency of tissue sample but with an improved safety profile. Treatment options include surgical resection, chemotherapy, and radiation. The median survival of the disease varies from 3 months to a few years. In conclusion, PHL should be included in the differential for a patient with hypodense liver lesions, elevated alkaline phosphatase, and negative CEA/AFP. Biopsy and histochemical testing are the gold standards for diagnosis and EUS guided biopsy may be an adequate yet safer approach.

A New Great Mimicker: A Rare Case of IgG4-Disease With Isolated Sclerosing Cholangitis

Alessia Al-Fouly, MD1, Nasam Alfraji, MD2, Mujtaba Mohamed, MD2, Mihir Odak, MD2, Ans Alameri, MD1, Abbas Alhami, MD1, Khuloud Agarwal, MD2, Reza Akhtar, MD2.
1Jersey Shore University Medical Center, Ocean Township, NJ; 2Jersey Shore University Medical Center, Neptune, NJ.

INTRODUCTION: Immunoglobulin G4-related disease (IgG4-RD) is a rare newly discovered systemic immune-mediated fibroinflammatory disease of unknown etiology that can involve multiple organs. IgG4-RD has a broad spectrum of entities. IgG4-related sclerosing cholangitis is the bilary manifestation of IgG4-RD, typically occurring together with type 1 AIP, but isolated IgG4-SC accounts for only 8% of IgG4-RD cases. Although the mainstay of IgG4-SC treatment is steroid (with and/or without immunosuppressants), but clinical studies are still scarce about this disease.

CASE DESCRIPTION/METHODS: We present a rare and challenging case of a 66-year-old male who presented with steatorrhea and elevated liver enzymes without clinical signs of obstructive jaundice. Imaging revealed mild intrahepatic biliary ductal dilatation and mild wall thickening with no evidence of pancreatitis or mass. Esophagogastroduodenoscopy (EGD) and small bowel biopsy were unremarkable for malignancy or other inflammatory changes. ERCP and EUS-FNA was inconclusive but excluded malignancy. However, a high index of suspicion for IgG4 has driven to check serology and immunoglobulin G4 (IgG4) staining, which showed a significant elevation of IgG4. Liver biopsy confirmed the diagnosis of IgG4-RD. The patient was started on steroids and improvement in clinical symptoms and biochemical markers was observed.

DISCUSSION: IgG4-RD is a newly recognized disease in the early 2000s, with unknown exact prevalence. The disease is difficult to diagnose and still does not have its own unique International Statistical Classification of Diseases and Related Health Problems (ICD)-10 code: IgG4-RD can mimic other autoimmune rheumatic diseases such as Sjogren’s syndrome (SS), systemic lupus erythematosus (SLE), and granulomatosis with polyangiitis, as well as a number of other conditions. An isolated IgG4-SC may also mimic other conditions such as primary sclerosing cholangitis (PSC) and cholangiocarcinoma (CCA). Therefore, physicians must carry a high index of suspicion for this under-recognized disease as IgG4-SC can respond to steroids in comparison to malignancy which is treated with surgical intervention. Early diagnosis and treatment are required to prevent irreversible fibrosis, biliary sepsis, and hepatic failure.