following a bone marrow biopsy. At the time of abstract submission, the patient remained hospitalized receiving HLH treatment with etoposide and high-dose steroids.

**DISCUSSION:** This case report highlights a concurrent case of SJS/TEN and vanishing bile duct syndrome following an episode of acute influenza B. While there have been previously reported cases of VBDS with concurrent SJS/TEN, this appears to be the first reported case of SJS/TEN, VBDS, and subsequent HLH in the same patient. While this is a single case, it raises the possibility of a shared immuno-allergic pathogenesis between these three conditions.

**S2T08**

A Case of Infiltrative Hepatocellular Carcinoma With Vascular Extension Into the Heart

Chinomia Anugwom, MD1, Johnstone Kayandabila, MBBS1, Siobhan Flanagan, MD1, Jose Debo, MD1, University of Minnesota, Minneapolis, MN, 1Arusha Lutheran Medical Center, Arusha, Arusha, Tanzania

**INTRODUCTION:** Hepatocellular carcinoma (HCC) is a represents one of most common causes of morbidity and mortality in Africa with a preponderance of late diagnoses and advanced disease. We present a case of a patient, previously diagnosed with Hepatitis B (HBV) infection, who presented with infiltrative HCC complicated by vascular invasion to the heart.

**CASE DESCRIPTION/METHODS:** A 59-year-old male who was previously diagnosed with untreated Hepatitis B (HBV) infection, with no follow up and no diagnosis of cirrhosis, presented to the Emergency room in Arusha, Tanzania, with a one-week history of abdominal pain. He was lethargic and weak, but denied fever, nausea or vomiting. An abdominal computed tomography (CT) scan with intravenous contrast revealed a heterogeneous infiltrating mass occupying most of the liver, with tumor invasion of the inferior vena cava into right atrium of the heart. This was consistent with locally and distally advanced hepatocellular carcinoma. The patient was further referred to Oncology in an outside institution but was lost follow up.

**DISCUSSION:** To our knowledge this is the first case reported of direct cardiac extension of HCC. This unique case of advanced hepatocellular carcinoma (HCC) presenting with vascular invasion and tumor extension into the right atrium, underscores the immense healthcare burden of HCC in Africa. Such a late diagnosis of HCC dramatically limits treatment options to palliative therapy and end-of-life comfort cares. Extensively invasive HCC diagnosed at age 59 suggests an early onset of disease. This, though perturbing, is not uncommon in the region. Recent studies from our group in Sub-Saharan Africa show development of HCC in patients less than 40 years of age in almost 40% of reported cases. Later diagnosis of HCC such as was seen in our patient, is relatively common in Africa and largely responsible for the high morbidity and mortality of the disease. Provision of adequate resources, immunization programs and adequate screening of at-risk individuals will be pivotal in reducing the burden of HCC in Africa.

**S2T09**

Delayed Hemobilia Following Liver Biopsy: A Rare Presentation

Rebecca Sullivan, MD1, Hamsa Abdulla, MD2, Michelle Bulus, DO2, Aria Bagherpour, DO1, Sewram Paripudi, MD1.

1University of Alabama, Birmingham, AL, 2University of Texas Medical Branch, Galveston, TX.

**INTRODUCTION:** Percutaneous liver biopsy remains the gold standard in assessing several hepatic diseases. Major bleeding following liver biopsy is uncommon but well recognized risk of the procedure, estimated to be around 0.16%.1–3 Severe bleeding is usually immediate and clinically evident within 24 hours but delayed presentation can occur. We describe a patient who presented with significant hemobilia one week following liver biopsy.

**CASE DESCRIPTION/METHODS:** A 63-year-old female with a history of pruritus was seen at an outside facility for chronically elevated liver chemistries. She underwent a left lobe liver biopsy using 18-gauge biopsy needle. A single 3 cm core was obtained on the first attempt. The procedure was tolerated well with no immediate complications. Eight days later, she presented to our institution with hematemesis and bright red blood per rectum reporting intermittent epigastric pain since her biopsy. She was started on IV Protonix and IV Octreotide planning for esophagastroduodenoscopy the next morning. Overnight, her hemoglobin decreased from 11.1 to 7.7 g/dL with hypotension requiring a blood transfusion. An urgent CT angiogram showed a hyperdensity throughout the proximal hepatic ducts and common bile duct concerning for active bleed and an arterial-biliary fistula resulting in hemobilia. A conventional angiography located a hyper-vascular blush in the caudal aspect of the right hepatic lobe. Successful embolization of the right hepatic artery with 1-and 2-mmillimeter coils followed by Gelfoam. Given the known biopsy in the left hepatic lobe and arterio-biliary fistula, a segment of the left hepatic artery was prophylactically embolized with Gelfoam. The patient recovered and was discharged three days later. One month later, she had no further bleeding and was continued on Urosol 30mg twice daily with improvements of her liver function tests.

**DISCUSSION:** This is the first reported case of significant hemobilia one week following liver biopsy. The rare possibility of delayed hemobilia following liver biopsy may not be appreciated due to decrease in frequency of diagnostic liver biopsies and the overall low rate of clinically significant complications. The rare possibility of delayed bleeding should been recognized in patient undergoing liver biopsy.

**S2T10**

A Case of Hypermucoviscous Klebsiella Pneumoniae Pyogenic Liver Abscess

Jeremy Yan, DO1, Justin Mitchell, DO, MS1, 1Rush University Medical Center, Chicago, IL.

**INTRODUCTION:** Hypermucoviscous (HMY) Klebsiella pneumoniae (KP) is a hypervirulent strain of KP containing regulator of mucoid phenotype A1/A2 and mucoviscosity-associated gene. This increases capsule production and confers a HMY state. With this genotype and phenotype, there is a high risk of disseminated infection. This case describes a patient (pt) with HMY KP bacteremia complicated by pyogenic liver abscess (PLA).

**CASE DESCRIPTION/METHODS:** A 42-year-old Hispanic male with past medical history (PMHx) of type II diabetes mellitus (DMII) presented w/ 3 weeks of generalized abdominal pain. No PMHx of liver/biliary disease. AST 34, ALT 29, Alk Phos 120, Hgb A1c 14. CT Abdomen and Pelvis (CTAP) w/ IV contrast (IVC) showed a 4.9 x 6.7 cm multiloculated cystic lesion in the posterior right hepatic lobe, re-demonstrated on MRI. Blood cultures (cx) were positive (+) for pan sensitive (PS) KP w/ + string test. Purulent fluid was aspirated from the lesion and aerobic cx grew PS KP w/ + ST. Acid fast bacilli cx, anaerobic cx, and fungal cx were negative. Cysticercosis IgG and stool Ova and Parasites were negative as well. He was treated w/ IV Bicillin for 4 weeks.

**DISCUSSION:** HMY KP PLA tend to be found in Asian pts w/ an increasing number of cases in North America. DMII is believed to be a risk factor because of impaired neutrophil phagocytosis of K1/K2 hypercapsular serotypes in HMY KP. Data is limited on how HMY KP is acquired but it develops in those without biliary disease, a common risk factor for other PLA’s. It also tends to seed the liver hematogenously from an intestinal route of entry. A unique feature, uncommon in other enteric Gram-negative bacilli, is the ability to metastatically spread, causing endophthalmitis for example. The “string” test, using an inoculation loop on a cx and generating a viscous string >5mm,