pediatrician due to abdominal pain and constipation. CT scan of the abdomen showed hepatomegaly with heterogeneous attenuation and calcified, low-attenuation mass components. Beta-chorionic gonadotropin was slightly elevated and alpha fetoprotein was significantly elevated at 115,000 ng/mL. Liver biopsy results were positive for epithelial hepatoblastoma with fetal and embryonal patterns. After chemotherapy failed to shrink the tumor, the patient received a successful liver transplant.

**DISCUSSION:** To our knowledge this is the third case reported in literature of a patient with GS and hepatoblastoma. Commonly, patients with hepatoblastoma presents with no symptoms. However, the two previously reported cases and our case presented with severe constipation and abdominal pain. This may suggest a predisposition to this atypical presentation in patients with GS. The mechanism for this hypothesis is unknown and more studies would need to be conducted to confirm the association. Findings from this case can further support the argument that a relation exists between these two entities. Additionally, there are no current recommendations regarding appropriate surveillance for liver neoplasms in patients with diagnosis of GS. We believe that new guidelines and diagnostic studies will become more widely available as the associations between hepatoblastoma and Goldenhar syndrome are established.

Vitamin K Deficiency in the Setting of Long-Term Blended Tube Feeds in a Teenager

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**INTRODUCTION:** Severe, symptomatic presentation of nutritional deficiencies are uncommon in the current era. Vitamin K deficiency is classically seen in newborns and can present as early as 24 hours after birth and as late as 6 months. However, in pediatric patients with chronic comorbidities, vitamin K deficiency can also occur later in life with factors such as enteral feeding and recent antibiotic use. We describe a case of acquired vitamin K deficiency in a teenager on long-term enteral nutrition.

**CASE DESCRIPTION/METHODS:** A 17-year-old male with spinal muscular atrophy type 1, ventilator, and gastrostomy tube dependence, was admitted for coagulopathy noted during routine follow up due to a diaphoretic illness. He was treated with a short course of metronidazole for suspected small intestinal bacterial overgrowth as stool pathogens were negative. Physical examination revealed ooze from an anal fissure, tracheostomy, and gastrostomy sites. Laboratory studies revealed a prothrombin time (PT) of 114 s (normal: 9.4-12.5 s), partial thromboplastin time (PTT) 99.2 s (normal: 25.1–36.5 s) and international normalized ratio (INR) of 9.5 (normal: 1.1 or below). Fibrinogen and D-dimer were normal, ruling out disseminated intravascular coagulation. Factor V were normal at 94%, VIII more than 150%, VII low at 3%, and IX low at 11%. Mixing studies revealed deficiencies of the intrinsic and extrinsic pathways and this, coupled with low factors VII and IX confirmed vitamin K deficiency. He received parenteral vitamin K which resolved his coagulopathy – PT 13.2 seconds, PTT 37.2 seconds, and INR of 1.2. His blended tube feeding regimen consisted of a base of Vironex Pediatric mixed with baby foods and juice. This formulation did not meet the Dietary Reference Intake for vitamin K (44.2mcg/dL, recommended is 60-75mcg/dL), protein, phosphorus, calcium, zinc, folate, and essential fatty acids. He was discharged home on supplemental vitamin K, a multivitamin, protein supplement and, safflower oil.

**DISCUSSION:** Our case highlights an important, yet frequently unrecognized differential of coagulopathy: vitamin K deficiency. This could be asymptomatic until the patient develops a bleeding diathesis. This case occurred for a pediatric patient on long-term blended tube feeds, it is essential to monitor micros and macronutrients on a regular basis.

**Pooping Clear Liquid: Diarrhea or Something Else?**

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**INTRODUCTION:** Diarrhea is commonly seen in renal transplant (RT) patients. Common causes are immunosuppressive medications as well as by infectious (bacterial, viral, parasite) etiologies. Diarrhea is associated with increased morbidity and mortality in transplant patients.1 There have been no reported cases of diarrhea caused by uretero-jejunal (UJ) fistula in RT patients in literature so far. We present an interesting case of an 8 year old RT patient who presented with diarrhea caused by uretero-jejunal (UJ) fistula and the diagnostic dilemmas associated with it.

**CASE DESCRIPTION/METHODS:** An 8 years old female with End-stage renal disease (ESRD) secondary to focal segmental glomerulosclerosis (FSGS) underwent right native kidney nephrectomy and en bloc RT which was complicated by acute rejection. She was on methylprednisolone and azathioprine for immunosuppression. The patient started developing non-bloody, watery diarrhea associated with intermittent periumbilical abdominal pain and distention.

**DISCUSSION:** Our case highlights an important, yet frequently unrecognized differential of coagulopathy: vitamin K deficiency. This could be asymptomatic until the patient develops a bleeding diathesis. This case occurred for a pediatric patient on long-term blended tube feeds, it is essential to monitor micros and macronutrients on a regular basis.

**Gastrointestinal and Hepatic Manifestations of COVID-19 in a Pediatric Patient**

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**INTRODUCTION:** A pediatric case of COVID-19 presented initially with gastrointestinal symptoms and then developed MIS-C with cholestatic hepatitis and synthetic dysfunction.

**CASE DESCRIPTION/METHODS:** An 11yo Caucasian male with no significant past medical history presented with fever, headache, and right-sided abdominal pain after multiple family members tested positive for SARS-Cov-2. Initial work-up was positive for Group A strep and SARS-Cov-2. He was sent home with amoxicillin and directions to return daily for clinical follow-up and serial labs. Day 5 of illness he had marked elevation of D-dimer, new onset transaminists and hyperbilirubinemia. He began Lovenox prophylaxis with transfer to tertiary care. The patient remained febrile with decline in respiratory status by Hospital Day (HD) 2. Labs revealed increasing cholestatic hepatitis. All liver tests came back negative except US which showed an echogenic, mildly enlarged liver with fatty infiltrate and no biliary dilatation, cholelithiasis, or cholecystitis. Patient deteriorated on HD 4 with non-bloody diarrhea, hypotension, pulmonary edema, lactic acidosis, and oliguric acute kidney injury, prompting transfer to PICU. On HD 5, he began Rendovivse therapy. PICU course was complicated by immune-mediated thrombotic microangiopathy including maculopapular rash. Supportive management stabilized him without the use of vasoactive medications, mechanical ventilators, or dialysis. He received 5 days of IV steroids and IVIG. On HD 12 he was discharged home with normal liver enzymes.

**DISCUSSION:** Gastrointestinal symptoms and abdominal pain are more prominent in pediatric COVID-19 patients at initial presentation and may possibly allude to development of more severe disease including MIS-C with cholestatic liver injury. Elevated liver enzymes and coagulation dysfunction are seen in severe cases of COVID-19, although cholestasis has not been reported previously. A correlation between abnormal liver function tests and severity of COVID-19 is emerging, manifesting as transient elevation of serum LFTs, likely due to systemic inflammation than direct hepatocyte injury by the virus, given rapid and complete resolution.

**REFERENCES**
