CASE DESCRIPTION/METHODS: A 54 year old female with lupus, antiphospholipid syndrome, cerebrovascular accident, heart failure, and left ventricular thrombus on warfarin, presented with melena, non bloody non bilious vomiting and a hemoglobin of 6. EGD revealed a duodenal 4 mm nodule consistent with well differentiated NET on histopathology and multiple 2 mm clean base ulcers. The patient was transfused blood and treated with PPI therapy. Serotonin and gastrin levels were < 20 and 40 respectively. Chromogranin A level was elevated at 1486. She was scheduled for EUS guided endoscopic resection of her NET. She later developed acute abdominal pain and coffee ground emesis. CT Angiography was negative for mesenteric ischemia but revealed pneumoperitoneum and hemorrhagic ascites. She underwent emergency exploratory laparotomy with repair of perforation of duodenal wall but decompensated and expired.

DISCUSSION: The WHO classifies NETs based on mitotic activity, G1 to G3. D-NET can also be classified as gastrinomas (30–60%), somatostatinomas (15%), nonfunctional tumors (19–27%), para-gangliomas (< 2%) and poorly differentiated carcinomas (< 3%). Diagnosis is usually incidental during EGD evaluation and is based on histological analysis for chromogranin and synaptophysin. Our patient was on antiangualation and presented with prptic ulcer disease and NET in the duodenum. Gastrin level was only 60, ruling out a functional gastrinoma and Zollinger Ellison Syndrome. 80% of NETs tend to have elevated serum chromogranin. Only 3% of patients develop carcinoid syndrome, a complication of metastasis to the liver. For our patient, CT did not reveal any metastasis and serotonin levels were normal. Local nonfunctional < 1 cm NET can be endoscopically resected. Our patient was planned for EUS guided resection, but she did not make it to her procedure. EGD showed clean based ulcers, which have the lowest risk for ulcer complications. It is reasonable to speculate that her NET may have contributed to mucosal fragmentation and ulcer perforation. Unusual presentations of rare diseases such as D-NETs should be reported and is an area that requires further research.

Ileocolonic Intussusception Associated Large B-Cell Lymphoma
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INTRODUCTION: Intussusception is characterized by the telescoping of a more proximal portion of the gastrointestinal tract into a more distal portion. This is rare in the adult population, representing 5% of all cases of intussusception. Unlike in children, a pathological lead point is detected in 70–90% of cases, with up to 65% being malignant. Common malignancies leading to intussusception in the small intestine are often hypoalbuminemic and have elevated fecal alpha-1-antitrypsin level. CP is thought to cause protein-losing enteropathy in which the classic workup is unrevealing. Post-operative course was uncomplicated and the patient was discharged home with Hematology/Oncology follow up.

DISCUSSION: Intussusception is uncommon in adults, with the ileocolic or ileocolic variety comprising the most rare category. In a review of 14 papers in which 396 intussusception cases were investigated, 12% were malignant. The most common malignant lead points were colorectal polyps (45%) followed by adenocarcinoma (31%), lymphoma (9%), and melanoma (4%). In a case series of 31 patients with intussusception, 10% were malignant neoplasms. The differential diagnosis of adult intussusception includes malignancy, lymphocytic adenitis, and idiopathic intussusception. This case highlights the uncommon diagnosis of adult intussusception caused by large B-cell lymphoma.
colorectal surgery showed a large pulsatile blue mass extrinsically compressing the colon in multiple locations, subsequently aborted at the splenic flexure due to this extrinsic compression. The patient then underwent open repair which found an aortoduodenal fistula in the 4th duodenal segment. The duodenum was resected with primary anastomosis, the aortic stent was explanted, aortic aneurysm resected, and reconstruction performed. After surgery, the patient improved clinically and had no further bleeding.

**DISCUSSION:** Primary AEFs are a devastating condition which are difficult to identify. The likely cause, an abdominal aortic aneurysm, can be clinically silent and typically lack any history of prior aortic surgical interventions. When symptoms do occur, it is typically GI bleeding ranging from mild to an exsanguinating hemorrhage, with other nonspecific symptoms including malaise, weight loss, and abdominal pain. CT angiography is a quick initial diagnostic tool but if there was no prior suspicion of primary AEF, an EGD would reveal a clot or fresh blood in the duodenum. With such findings on endoscopy, it is important to quickly involve vascular surgery for emergent repair via open or endovascular techniques to avoid adverse outcomes.

**S2824**

A Case of Myelodysplastic Syndrome-Associated Intestinal Behcet’s Successfully Treated With Infliximab

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**INTRODUCTION:** Myelodysplastic syndrome (MDS) is a hematologic disorder characterized by ineffective hematopoiesis and immunological abnormalities. A few case series and reports have previously described the trisomy 8-variant MDS (T8MDS) and its association with an intestinal Behcet’s-like syndrome (BLS). We present a patient with torrential small bowel bleed found to have BLS associated with T8MDS.

**CASE DESCRIPTION/METHODS:** A 58-year-old white male with a past medical history of T8MDS on no treatment given stable disease, seronegative inflammatory arthritis, cryoglobulinemia, and aphthous stomatitis presented with a three-day history of massive hematochezia. Ileocolonoscopy revealed multiple excavated colonic and ileal ulcers (Figure 1). Biopsies showed an increased number of neutrophil granulocytes in the lamina propria and evidence of chronic inflammation in the submucosa; no granulomas were identified. He was started on high pulse-dose steroids for suspected BLS, but he continued to bleed, receiving a total of 37 units of packed red blood cells over 20 days. A retrograde double-balloon enteroscopy revealed large, cratered ulcers with adherent blood clots throughout the entire examined ileum (Figures 2 and 3). Due to lack of response to high dose systemic steroids, he was trialed on infliximab 10 mg/kg IV leading to resolution of GI bleed within 24 hours. A follow-up video capsule endoscopy 12 days after initiation of infliximab showed healing ileal ulcers. He was discharged 2 weeks after infliximab infusion and continued outpatient infliximab maintenance therapy and tapering doses of prednisone. Ten months later, with continued treatment on infliximab 10 mg/kg every 8 weeks, the patient is doing well without any further episodes of GI bleed or requirement of blood transfusion.

**DISCUSSION:** To our knowledge, this is the first case describing successful treatment of BLS associated with T8MDS using high dose infliximab. Treatment is ideally aimed at the underlying MDS with considerations for stem-cell transplant or chemotherapy; however individuals with acute bleeding disorders are poor candidates for such therapies. Our patient achieved luminal healing with infliximab and was promptly referred to hematology with plans to start chemotherapy for his MDS. Differential diagnosis of bleeding, excavated ulcers in the small bowel and colon in a patient with underlying MDS should include BLS. While the mainstream therapy is high dose systemic steroid, in refractory patients, as seen in our case, infliximab may be helpful.