part of the duodenum with base of long thin stalk in the duodenal bulb [Figure 1]. Cold forceps biopsy was nondiagnostic and showed small intestine mucosa. Patient continued to have persistent symptoms and underwent EGD and Endoscopic ultrasound (EUS) two months later. EUS showed smooth, slightly hyperemic, pedunculated mass, confined to the mucosal layer of the polyp without extension into the submucosal layer [Figure 2]. Endoscopic mucosal resection (EMR) was performed without any complications. Biopsy showed benign duodenal mucosa with lipoma [Figure 3]. Patient reported resolution of her symptoms at one month follow up.

**DISCUSSION:** GI lipomas are usually asymptomatic and are encountered incidentally. Most symptomatic GI lipomas are larger than 4 cm and presentations include epigastric fullness, abdominal pain, obstructive symptoms, ulceration and hemorrhage. Uncommon complications include intussusception and pancreatitis. Cross sectional imaging can be diagnostic if associated with typical features. EGD features include soft, compressible, yellowish, oval, polypoid lesion. EUS typically shows a homogenous, hyperechoic mass in submucosal layer. Malignant transformation of lipomas has never been reported, therefore small, asymptomatic lipomas can be safely observed. Large and symptomatic lipomas need resection. Choice of intervention depends on the size, position of the lesion, presence of stalk and the associated complications. Endoscopic techniques include snare polypectomy, EMR, endoloop, unroofing and submucosal dissection. Surgical resection is generally reserved for large and sessile lipomas.

**CASE DESCRIPTION/METHODS:** A 30-year-old female was admitted to the hospital with three months of vomiting, abdominal pain and diarrhea. She was having up to ten bowel movements per day and had lost approximately thirty pounds. Initial CT scan of her abdomen was completed and showed diffuse small bowel wall thickening, mesenteric fat edema and lymphadenopathy. An EGD showed edema, erythema and a large pseudopolyp-like lesion in the entire duodenum. A colonoscopy showed moderate erythema in the antrum and terminal ileum. She also had pancycopenia with blasts seen on peripheral smear. Flow cytometry was ultimately suggestive of acute myeloid leukemia with 35% blasts. Concomitantly, results from endoscopic biopsies returned showing myeloid sarcoma involving small intestine and colon. She began standard induction chemotherapy for AML with daunorubicin and cytarabine. Despite therapy, she continued to clinically decompensate and ultimately succumbed to complications of her aggressive disease.

**DISCUSSION:** This case report demonstrates a rare case of myeloid sarcoma involving the small intestine and colon being diagnosed concomitantly with AML. Myeloid sarcomas are usually found in patients with active AML. 2 patients previously treated for AML, 3 in patients with MDS. 4 de novo in healthy subjects. If isolated myeloid sarcoma is not treated, it will usually evolve into AML within a few months. There has been scarce literature investigating the survival and prognosis of patients with myeloid sarcoma. First line treatment continues to be systemic induction therapy. The prognosis largely depends on timing of diagnosis and onset of therapy. Gastrointestinal myeloid sarcoma is difficult to diagnose due to its rarity and the wide spectrum presentation of non-specific symptoms.

A Case of Gastrointestinal Myeloid Sarcoma
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**INTRODUCTION:** Myeloid sarcoma is a rare disease that presents as an extramedullary tumor of immature myeloid cells. It has been reported in 2-8% of patients with acute myeloid leukemia (AML) and most commonly is diagnosed concurrently with this disease. Common sites include the bone and skin. Rare sites include the gynecologic and gastrointestinal tract. Due to the rarity of this disorder, causes of idiopathic granulomatous appendicitis (GA) and appendiceal Crohn’s disease (CD) are less than 5% of specimens, and typed into idiopathic granulomatous appendicitis (GA) and appendiceal Crohn’s disease (CD). Less than 10% of GA cases develop CD.

**CASE DESCRIPTION/METHODS:** A healthy 26-year-old male was advised to seek care for computed tomography (CT) suggesting acute appendicitis, ordered to assess dysuria and right testicular and abdominal pain of 1-month duration. CT measured a dilated appendix extending to the seminal vesicle, with fecolith and fat stranding. Vitals were stable, abdomen benign, and labs normal. During appendectomy, an inflamed appendix was seen adherent to the bladder. An uneventful post-op period was followed by discharge home. Despite interval recovery, readmission for pain, vomiting, and diarrhea occurred on POD 10. Tachycardia was noted without fever. Abdomen was distended and generally tender. There was leukocytosis. CT found thickened jejunum with proximal dilation and air-fluid levels. Ileitis and obstruction resolved with conservative care, but evidence of GA (granuloma with giant cell, negative AFB and GMS stains) on recent pathology prompted testing for a broadened differential. There was denial of travel, ill contacts, personal and family history of CD, but admittance to colonscopy a decade prior with evidence in different settings: 1) in patients with active AML 2) in patients previously treated for AML 3) in patients with MDS 4) de novo in healthy subjects. If isolated myeloid sarcoma is not treated, it will usually evolve into AML within a few months. There has been scarce literature investigating the survival and prognosis of patients with myeloid sarcoma. First line treatment continues to be systemic induction therapy. The prognosis largely depends on timing of diagnosis and onset of therapy. Gastrointestinal myeloid sarcoma is difficult to diagnose due to its rarity and the wide spectrum presentation of non-specific symptoms.

**DISCUSSION:** This case report demonstrates a rare case of myeloid sarcoma involving the small intestine and colon being diagnosed concomitantly with AML. Myeloid sarcomas are usually found in patients with active AML. 2 patients previously treated for AML, 3 in patients with MDS. 4 de novo in healthy subjects. If isolated myeloid sarcoma is not treated, it will usually evolve into AML within a few months. There has been scarce literature investigating the survival and prognosis of patients with myeloid sarcoma. First line treatment continues to be systemic induction therapy. The prognosis largely depends on timing of diagnosis and onset of therapy. Gastrointestinal myeloid sarcoma is difficult to diagnose due to its rarity and the wide spectrum presentation of non-specific symptoms.

**INTERVENTION:** Isolated granulomatous inflammation of the appendix is a rare entity, identified histologically in < 2% of specimens, and typed into idiopathic granulomatous appendicitis (GA) and appendiceal Crohn’s disease (CD). Less than 10% of GA cases develop CD.

**CASE DESCRIPTION/METHODS:** A healthy 26-year-old male was advised to seek care for computed tomography (CT) suggesting acute appendicitis, ordered to assess dysuria and right testicular and abdominal pain of 1-month duration. CT measured a dilated appendix extending to the seminal vesicle, with fecolith and fat stranding. Vitals were stable, abdomen benign, and labs normal. During appendectomy, an inflamed appendix was seen adherent to the bladder. An uneventful post-op period was followed by discharge home. Despite interval recovery, readmission for pain, vomiting, and diarrhea occurred on POD 10. Tachycardia was noted without fever. Abdomen was distended and generally tender. There was leukocytosis. CT found thickened jejunum with proximal dilation and air-fluid levels. Ileitis and obstruction resolved with conservative care, but evidence of GA (granuloma with giant cell, negative AFB and GMS stains) on recent pathology prompted testing for a broadened differential. There was denial of travel, ill contacts, personal and family history of CD, but admittance to colonscopy a decade prior with evidence in different settings: 1) in patients with active AML 2) in patients previously treated for AML 3) in patients with MDS 4) de novo in healthy subjects. If isolated myeloid sarcoma is not treated, it will usually evolve into AML within a few months. There has been scarce literature investigating the survival and prognosis of patients with myeloid sarcoma. First line treatment continues to be systemic induction therapy. The prognosis largely depends on timing of diagnosis and onset of therapy. Gastrointestinal myeloid sarcoma is difficult to diagnose due to its rarity and the wide spectrum presentation of non-specific symptoms.
Symptomatic Gastrointestinal Amyloidosis in a Patient With Systemic AL Amyloidosis

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INTRODUCTION: Gastrointestinal (GI) amyloidosis is a rare protein deposition disorder that can be limited to the GI tract but is most often a manifestation of systemic amyloidosis. While it can be asymptomatic, typical presentations include dysmotility, malabsorption, bleeding and protein-losing gastrenteropathy. GI amyloidosis is most commonly in the esophagus, duodenum, stomach and rectum. The diagnostic gold standard is tissue biopsy with positive Congo red staining, usually from the rectum (sensitivity, 75-85%) or duodenum.

CASE DESCRIPTION/METHODS: A 57-year-old woman with systemic amyloid light-chain (AL) amyloidosis complicated by restrictive cardiomyopathy, heart failure and junctional bradycardia requiring a pacemaker, and treated with bortezomib and dexamethasone with good response, presented to the hospital with recurrent constipation, nausea, vomiting and abdominal discomfort. Abdominal radiographs and CT scan demonstrated dilation of the cecum to 7.9 cm, concerning for ileus, but no obstruction (Figure 1). She was diagnosed with likely colonic pseudoobstruction, treated with neostigmine, and discharged on a regimen of antiemetics and prokinetics. Soon after, she was re-admitted with rectal bleeding; colonoscopy showed normal-appearing mucosa and polyps (Figure 2), with a large hemorrhoid as the likely source. Subsequently, she was re-admitted for a heart failure exacerbation; she was considered for heart transplant as her disease was believed to be in remission but had persistent poor oral intake, nausea and constipation. Endoscopy was notable for a gastric phytobezoar and duodenal ulcers; gastric, duodenal and rectal biopsies with Congo red stain confirmed the diagnosis of GI amyloidosis. She was started on ixazomib and dexamethasone, with improved GI symptoms and only mild dysmotility seen on a gastric emptying study, and is pursuing heart transplantation.

DISCUSSION: GI amyloidosis is rare but has important clinical and prognostic implications. Our patient presented with a range of vague GI symptoms and non-specific radiographic and gross endoscopic findings. Maintaining a high index of suspicion and obtaining mucosal biopsies with Congo red staining early in the course avoids delay in diagnosis and symptom progression. Upon diagnosis of GI amyloidosis, this patient was treated with chemotherapy, which targeted the underlying cause of her GI symptoms, resulting in sufficient improvement. In this case, the patient’s diagnosis of GI amyloidosis was key to her consideration for cardiac transplant.

A Unique Manifestation of Cutaneous Sprue Enteropathy Due to Losartan

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INTRODUCTION: Angiotensin receptor antagonist associated enteropathy is becoming increasingly prevalent within the literature. The first series of reports were from Mayo clinic in a case series of olmesartan induced sprue-like enteropathy. Clinical manifestations of these patients include abdominal pain, severe weight loss and chronic diarrhea with severe electrolyte derangements. Serological workup for celiac disease is commonly negative. Histology is notable for duodenal villous atrophy with inflammation in the lamina propria. Symptoms resolve within 3-12 months of medication discontinuation. Currently sprue-like enteropathy has yet to be classified as class effect among ARBs; however, the increased incidence within the literature advocates in favor of this idea.

CASE DESCRIPTION/METHODS: We report a case of sprue-like enteropathy associated with losartan with a unique cutaneous manifestation. A 59-year-old female presented with chronic...