and conventional endoscopic evaluation. In such cases, video capsule endoscopy may prove invaluable - although not without risk.

CASE DESCRIPTION/METHODS: A 56-year-old man developed recurrent, symptomatic transfusion-dependent iron deficiency anemia and fecal occult positive stool despite no overt gastrointestinal bleeding. He had undergone subtotal colectomy with ileorectal anastomosis three years earlier for colorectal cancer and was on hemodialysis for end-stage renal failure. Recent negative evaluation included esophagogastroduodenoscopy, ileo-colonoscopy, computed tomogram enteroclysis, and push enteroscopy to the distal duodenum. Informed consent was obtained for video capsule endoscopy (VCE), including risk counseling for capsule retention.

VCE showed fresh blood and recurring views of an ulcerated nodular lesion on multiple frames obtained for video capsule endoscopy (VCE), including risk counseling for capsule retention.

DISCUSSION: This case illustrates a presentation of obscure occult gastrointestinal bleeding secondary to small bowel adenocarcinoma diagnosed by retained video capsule endoscopy. While the risk of capsule retention is low, informed consent regarding this risk is paramount. Once the capsule is retained, definitive curative resection of the affected small bowel section is almost mandatory irrespective of pathology. Retrieval of retained capsules in patients without clinical small bowel obstruction may be feasible endoscopically. Simultaneous endoscopic examination of the partially obstructed site can further facilitate diagnosis and location marking prior to surgery. Simple, cheap and readily available investigations such as serial abdominal x-rays can have an adjunct role in putting the pieces together to solve a seemingly complex diagnostic puzzle.

S2916

When the Well Runs You Dry: A Case of Entamoeba histolytica Enteritis

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INTRODUCTION: Amoebiasis is the second leading cause of death from parasitic disease worldwide with approximately 40,000-100,000 yearly deaths. Entamoeba histolytica is a health risk when there is an insufficient barrier between human feces and water source. Most individuals are infected by ingestion of E. histolytica cysts in contaminated food or drinking water. In the United States, most cases arise in immigrants from endemic areas or those with lower socioeconomic status. We present a case of amoebic enteritis in a patient without history of travel but exposure to well water.

CASE DESCRIPTION/METHODS: 44-year-old male with history of chronic pancreatitis attributed to familial hypertriglyceridemia, pancreatic pseudocyst status post CT-guided drainage and failure to thrive status post PEG-J placement presented with progressive intolerance of J-tube feeds. CT Scan of the abdomen and pelvis revealed no structural reason for the patient to be intolerant of his feedings but did reveal new mild thickening of the mid small bowel indicative of enteritis. A GI pathogen panel with PCR was sent to rule out infectious causes. His J-tube was exchanged, and though he had ongoing pain, he was tolerating tube feeds and was subsequently discharged. The patient was readmitted 2 weeks later with worsening left lower quadrant abdominal pain and up to 10 episodes of watery bowel movements a day. GI Pathogen panel was noted to be positive for E. Histolytica. On detailed history, patient admitted to bathing, drinking, and flushing his GI tube with well water. He was treated with Metronidazole 500mg every 8 hours for 10 days followed by paromomycin dosed 25-30mg/kg divided into 3 doses daily for 7 days. His diarrhea and left lower quadrant pain resolved.

It was recommended that the patient have his well water tested for other infectious agents or parasites.

DISCUSSION: Most Entamoeba infections are asymptomatic. Risk factors for severe disease and increased morbidity include young age, pregnancy, immunosuppression, malignancy, and malnutrition. Our patient was at increased risk due to malnutrition and flushing of the J arm which allowed the parasitic trophozoites to bypass the gastric acid unharmed. Misdiagnosis for ulcerative colitis and subsequent treatment with steroids has been shown to precipitate severe and fulminating forms of amebic colitis. Careful history taking and testing of stool with PCR when feasible should be conducted before initiating immunosuppression for inflammatory bowel disease.

S2916 Figure 1.