material was noted upon lavage and a protonix drip was initiated. An EGD was performed which revealed: extensive ulceration, exudates, dullness, and ischemic/necrotic appearance in the gastric fundus comprising approximately 20% of the gastric mucosa. mucosal friability and mild oozing of blood were noted at multiple areas of the ulcerations concerning for ischemic disease, the antrum had regions of patchy erythema consistent with gastritis which were biopsied. The patients symptoms were monitored and clinically improved after an antibiotics course. Pathology revealed suspected reactive/chemical gastritis with necroinflammatory debris with Kayexalate crystals present. Patient was told to follow up outpatient for a repeat EGD.

**Discussion:** Kayexalate has been seen in rare incidents to cause fatal injury. To our knowledge, this is one of the few case reports reporting a kayexalate induced gastric pneumatosis in a relatively healthy 52-year-old male. This case emphasizes a unique presentation of gastric pneumatosis caused by Kayexalate. Clinicians should be aware that upper gastrointestinal damage associated with kayexalate is relatively benign and should be monitored closely.

S2989

**A Case of Collagenous Gastritis Presenting as Persistent Diarrhea, Abdominal Pain, and Vomiting**

Justin Lewis, MD1, Mandy VanSandt, DO1, Sarah Diamond, MD1, 1Oregon Health & Science University, Portland, OR.

**Introduction:** Collagenous gastritis (CG) is a rare disease characterized by subepithelial collagen deposition and mucosal inflammation. We present a patient who exhibited both typical and atypical features of CG, discuss the characteristics of CG, and highlight the need for definitive treatment guidance.

**Case Description/METHODS:** A 19-year-old female with PMH of CG presents to GI clinic for evaluation of chronic emesis, abdominal pain, and diarrhea. She reports years of symptoms that started spontaneously. Emesis is multiple times per day, non-bloody, non-bilious and unrelated to meals. Abdominal pain is episodic and dull, variable but at least daily; she reports 3-7 stools per day, loose and brown. An EGD one year prior showed CG pathology confirmed, after which she was started on three months of prednisone that moderately improved her emesis. Vital signs are stable. Physical exam is notable for mild epigastric tenderness. Laboratory work up is benign: normal CBC with diff, CMP, TSH, negative STI screen, hepatitis panel, celiac, GI pathogen panel, H pylori and C diff. We started her on Ondansetron as needed, and she underwent endoscopy. EGD showed diffuse nodular mucosa in the gastric body (Figure 1), with pathology consistent with CG (Figure 2). Colonoscopy was unremarkable. She has been started on oral crushed budesonide daily with mild improvement in symptoms, and is due for follow-up endoscopy.

**Discussion:** CG is a rare disease characterized by subepithelial collagen deposition thicker than 10μm and inflammatory infiltrates in the lamina propria [1]. There are only 60 reported cases that are characterized as: 58% female, 9 months – 80 years in age, abdominal pain 43%, anemia 40%, diarrhea 30%, and nausea/vomiting 12% [1]. While our patient shows classic features, her severe emesis is unique, as is her diarrheah given her age (of existing CG patients with diarrhea, 83% were over 20 years old). Thus although rare, CG should be considered in young patients with persistent vomiting and/or diarrhea of unclear origin. Gastric corpus nodularity is the classic endoscopic finding in CG, as seen in our case. Due to the small number of cases and no definitive etiology, there is no established therapy. PPIs, steroids, immunomodulators, iron, and dietary therapy have been trialed with minimal success [1]. If our patient has a robust response to crushed budesonide, then this treatment modality should be given more consideration.

**Reference:**


S2990

**Myeloid Sarcoma (Chloroma) of the Gastrointestinal Tract in a 6 Year-Old Child: An Exceedingly Rare Manifestation of AML**

Ashley Mahajan1, Elizheh Hikol, MD2, Lori Mahajan, MD2, 1Cleveland Clinic Foundation, Strongsville, OH; 2Cleveland Clinic Foundation, Cleveland, OH.

**Introduction:** Myeloid sarcoma, also known as a chloroma, is a malignant neoplasm of myeloid origin that localizes outside the bone marrow. The most common sites of involvement are the skin, orbit, bone, soft tissue and lymph nodes. Involvement of the GI tract is relatively rare. It usually manifests in the late stages of AML [1]. It is characterized by the accumulation of myeloid precursor cells. The most common sites of involvement are the skin, orbit, bone, soft tissue and lymph nodes. Involvement of the GI tract is relatively rare. It usually manifests in the late stages of AML. Myeloid sarcoma occurs as a result of the overproduction of myeloid cells within the bone marrow. Myeloid sarcoma may herald a relapse in a patient with previously treated disease. In others, it may be the first indication of acute leukemia.

**Case Description/Methods:** A 48-year-old male presented with nausea, vomiting and epigastric pain. Physical exam showed tachycardia, and epigastric tenderness. Nine months earlier he was diagnosed with acute myelomonocytic leukemia; cytogenetics showed 47,XY, t(11q)(p21.3;q23.3). At that time, he was treated with standard induction therapy with the 7 + 3 regimen with Cytarabine and Daunorubicin followed by 3 cycles of High-Dose Cytarabine (HiDAC). Lab results showed pancytopenia including leukemia with 18% blasts. Peripheral blood flow cytometry showed 18% monoblasts. CT chest and abdomen revealed diffuse klobular thickening of the gastric wall, segmental thickening of the small bowel loops, and pancreatic, paraspinal, and infrarenal right ventricular wall masses. Upper GI endoscopy showed thickened gastric folds with a nodular mucosa. Gastric mucosal resection was performed, and biopsy showed abnormal blasts infiltrating through the mucosal glands, consistent with myeloid sarcoma. A bone marrow biopsy was consistent with relapsed AML. Urgent therapy was instituted however the patient suffered a cardiac arrest and resuscitation was unsuccessful.

**Discussion:** Myeloid sarcoma (aka granulocytic sarcoma, myeloblastoma, or chloroma) may present simultaneously with, or precede bone marrow disease and may be seen in relapse or as progression of a prior myeloproliferative neoplasm. The most common sites of isolated myeloid sarcoma are the skin, followed by mucosa membranes, orbits, central nervous system, and other

S2991

**Gastric Myeloid Sarcoma as a Presentation of Relapsed Acute Myelomonocytic Leukemia - A Case Report**

Mina Makary, MD, FHM1, Joseph Vadicava, MD1, Suhaila Tahir, MD2, Rachit N. Shah, DO2, Duane M. Evrett, DO, FACG2, Srihatha House, MD3, Fatima Abbas, MD, MPH2, Priyanka Pathak, MD, MPH1, 1Geisinger Health System, Danville, PA; 2Geisinger Commonwealth School of Medicine, Danville, PA; 3Geisinger Health System, Wilkes-Barre, PA.

**Introduction:** Myeloid sarcoma is an extramedullary proliferation of myeloid blasts that may be associated with a concurrent myeloid neoplasm involving the bone marrow, but such an association is not required. In some cases, myeloid sarcoma may herald a relapse in a patient with previously treated disease. In others, it may be the first indication of acute leukemia.

**Case Description/Methods:** A 48-year-old male presented with nausea, vomiting and epigastric pain. Physical exam showed tachycardia, and epigastric tenderness. Nine months earlier he was diagnosed with acute myelomonocytic leukemia; cytogenetics showed 47,XY, t(11q)(p21.3;q23.3). At that time, he was treated with standard induction therapy with the 7 + 3 regimen with Cytarabine and Daunorubicin followed by 3 cycles of High-Dose Cytarabine (HiDAC). Lab results showed pancytopenia including leukemia with 18% blasts. Peripheral blood flow cytometry showed 18% monoblasts. CT chest and abdomen revealed diffuse klobular thickening of the gastric wall, segmental thickening of the small bowel loops, and pancreatic, paraspinal, and infrarenal right ventricular wall masses. Upper GI endoscopy showed thickened gastric folds with a nodular mucosa. Gastric mucosal resection was performed, and biopsy showed abnormal blasts infiltrating through the mucosal glands, consistent with myeloid sarcoma. A bone marrow biopsy was consistent with relapsed AML. Urgent therapy was instituted however the patient suffered a cardiac arrest and resuscitation was unsuccessful.

**Discussion:** Myeloid sarcoma (aka granulocytic sarcoma, myeloblastoma, or chloroma) may present simultaneously with, or precede bone marrow disease and may be seen in relapse or as progression of a prior myeloproliferative neoplasm. The most common sites of isolated myeloid sarcoma are the skin, followed by mucosa membranes, orbits, central nervous system, and other..
internal organs. Myeloid sarcoma is more common in pediatric AML, although the true incidence in adults is unknown. In adults, roughly one third of myeloid sarcomas present with concurrent myeloid disease, and one third have a history of a prior myeloid neoplasm. The presence of a myeloid sarcoma is diagnostic of AML, regardless of the bone marrow status, or blast count. The diagnosis of myeloid sarcoma should be restricted to tumors that form space-occupying lesions. The approach to treatment of patients with myeloid sarcoma without evidence of AML on bone marrow biopsy is similar to that for patients with overt AML.

INTRODUCTION:
Gastric volvulus (GV) is a rare condition due to the abnormal torsion of the stomach along its horizontal or vertical axis. It can be classified into two types based upon the axis of rotation into Organoaxial (long axis) and mesenteroaxial (short axis) volvulus. Here we present a case of a 50 year old male with organoaxial volvulus.

CASE DESCRIPTION/METHODS:
The patient is a 50 year old male with a medical history of morbid obesity, hypertension, anemia, hiatal hernia, gastroesophageal reflux disease (GERD) who presented to the hospital with complaining of the sudden onset of severe epigastric abdominal pain of one day duration associated with nausea and non-bloody vomiting. He had been having intermittent mild abdominal pain, heart burn for several years prior to this episode. On arrival to the ED notable workup included a computed tomography (CT) scan of the abdomen and pelvis which showed a massive intrathoracic hiatal hernia containing fluid with organoaxial volvulus. The patient was then admitted to the medical ward for further workup. On admission the general surgery service was consulted. After evaluating the patient, the surgical service performed a laparoscopic hiatal hernia repair and a Nissen fundoplication. The patient’s post-operative course was unremarkable and she was discharged home days later.

DISCUSSION:
Gastric volvulus is a very uncommon condition usually presenting in the 5th decade. Presentation could be acute or chronic depending upon the degree of rotation and rapidity of onset. Patients with hiatal hernia are prone to develop gastric volvulus. Presentation could either be acute or chronic. In acute gastric volvulus patients usually have sudden onset of abdominal pain, nausea, vomiting and often need urgent management based on the severity of obstruction. Conversely,