transverse, descending, and sigmoid colon. A non-obstructing, circumferential, friable, ulcerated, nodular mass was seen from the dentate line to 14 cm. Biopsy histology revealed ulcerated tissue and proliferation of bland spindle cells with HHV-8 positive endothelial cells. Specimen was negative for granulomata or carcinoma.

DISCUSSION: KS develops after HHV-8 infection and is associated with immunodeficiency states. Although uncommon, KS can present on visceral surfaces, such as the GI tract, in the absence of cutaneous lesions. Gastric KS is the most common primary GI site. When KS is discovered in the lower GI tract, isolated anorectal KS in the absence of skin involvement is rarely seen. Endoscopic evaluation is warranted in symptomatic patients as it can be mistaken for adenocarcinoma. Diagnosis requires histologic evidence of spindle cell proliferation combined with HHV-8 latent nuclear antigen expression. Treatment inhibits cell growth, invasion, and angiogenesis with ART and liposomal doxorubicin. We describe a 41 year old man with new-onset HIV/AIDS who presented with rectal bleeding found to have rectal KS with no prior skin lesion nor evidence of cutaneous disease on exam. Despite endoscopic appearance which mimics adenocarcinoma, rectal KS should remain in the differential for rectal mass in the immunosuppressed patient, even without typical cutaneous lesions.

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Expect the Unexpected in a Young Male: A Case of Leiomyosarcoma in the Ascending Colon
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INTRODUCTION: Leiomyosarcomas (LMS) are soft tissue tumors that can develop in various organs. However, primary LMS of the GI tract are considered rare tumors, especially after differentiating LMS from gastrointestinal stromal tumors (GIST) by histopathologic testing. We report a case of a young male found to have primary LMS of the colon.

CASE DESCRIPTION/METHODS: A healthy 24-year-old male presented with acute onset sharp RLQ abdominal pain for 1-day after eating breakfast, it was severe, constant, associated with nausea, non-bloody non-bilious emesis. He denied fever, diarrhea, dark or bloody stool, weight loss, family history of GI disease or malignancies. Physical exam was relevant for a tachycardic male in mild distress, with soft non-distended abdomen, tender to palpation in RLQ, active guarding but without rebound or rigidity, negative Rovsing’s sign, normoactive bowel sounds, and normal rectal exam. Diagnostics were significant for leukocytosis with bandemia, slight anemia and mildly increased creatinine. CT abdomen/pelvis with IV contrast showed an 8.2cm segment of the proximal ascending colon with wall thickening, colonic stranding, possible perforation, and a normal appendix. Gas-trografin enema demonstrated a large apple core lesion in the ascending colon. Exploratory laparotomy revealed a bulky malignant appearing tumor in a proximal ascending colon with two prominent lymph nodes. A right hemicolectomy and lymph node dissection was performed. Pathology revealed a 7.7cm spindle cell neoplasm with necrosis, invasion into the pericolonic adipose tissue, negative surgical margins, and spindle cell neoplasm in 1/40 lymph nodes. Immunostains strongly positive for desmin consistent with LMS (pT2bN1, FNCLCC grade 2). Chemotherapy with Ifosfamide and Doxorubicin was initiated. One year follow up imaging with no signs of recurrence. DISCUSSION: Primary LMS needs to be differentiated from other smooth muscle tumors of the GI tract. The more common GISTs can be identified by immunohistochemical staining positive for CD117, CD10, DOG-1 and KIT. LMS are positive for desmin, alpha-SMA, vimentin and negative for GIST markers. Surgery is the mainstay of treatment for LMS. The efficacy of chemotherapy and radiation on survival remains unclear due to small sample size. Our patient received chemotherapy and remains in remission 18 months after initial presentation. Further investigations of LMS will provide more information for the prognosis and outcomes of treatment for this disease.

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A Rare Intestinal Complication of a Common Side Effect of Opioids
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