A 72-years-old male with a history of pancreatic WON who is debated. We report a patient who developed delayed massive gastrointestinal bleed after the placement of LAMS using a lumen-apposing metal stent (LAMS) placement is relatively simple but the practice of whether to place 1 to 2 double-pigtail plastic stents (DPs) through the LAMS to prevent complete collapse of the fluid cavity is debated. We report a patient who developed delayed massive gastrointestinal bleed after the placement of a LAMS without double pigtail stents 8 weeks later.

**CASE DESCRIPTION/METHODS:** A 72-years-old male with a history of pancreatic WON who received a LAMS at an outside hospital 8 weeks ago presented with hematemesis. The initial EGD showed oozing around the LAMS with a large blood clot within the stent. A CT angiography (CTA) showed no active bleeding in the area. The LAMS was removed with a second EGD which showed tracings in bile duct concerning for obstruction. He did not have tenderness or fever. MRCP without obvious lesions. EUS showed focal in distal CBD suggestive of small stone/slime. Sludging during EUS, major papilla was stenotic. Standard papillotomy performed using ERBE. Using balloon, stones removed from bile duct and plastic stent placed. Next day, Hgb fell and there was melena requiring transfusion. EGD revealed post papillotomy bleed controlled with epinephrine, clips and hemoxy. Patient did well for two days and again Hgb dropped with melena. Hepatitis surgery and IR were consulted. Patient underwent embolization of branches of GDA and hemostasis secured. Repeat endoscopy revealed no further bleed, stent removed, patient discharged home.

**DISCUSSION:** Post-ERCP bleeding is clinically significant or insignificant. Patient risk factors are coagulopathy, high bilirubin, cirrhosis, or papillary stenosis. Technique factors are rapid cutting, papillotomy length, or papillotomy. Operator factors are inexperienced endoscopist. Bleeding often stops spontaneously, rarely life threatening and managed with endoscopic therapy. Our patient had papillary stenosis and bilirubin >10. He underwent standard papillotomy with an experienced endoscopist. He had a clinically significant and refractory bleed uncontrolled by endoscopic therapy requiring GDA embolization. Endoscopists should be vigilant about recurrent bleeding despite endoscopic intervention and be open to angiogram and if required hepatobiliary surgery consultation.

**REFERENCES:**

Praneeth Bandaru, MD1, Andrew Ofosu, MD2, Ali Aamar, MD1, Mohamed Barakat, MD2, Fathima K. Suhail, MD, BS1, Abdul Qadir Bhutta, MD2, Pujitha Kudaravalli, MBBS3, 1Creighton University School of Medicine, Phoenix, AZ; 2St. Joseph’s Hospital, Brooklyn, NY.

**INTRODUCTION:** Endoscopic retrograde cholangiopancreatography (ERCP) has become the standard of care for initial management of choledocholithiasis. Conventional technique of sphincterotomy combined with balloon catheter or baskets is usually sufficient for the extraction of most stones. We present a case of a very large CBD stone that was removed intact endoscopically after ERCP to prevent Bouvier’s syndrome. After a thorough literature search, this is the largest reported intact bile stone that has been removed endoscopically out of the patient after ERCP.

**CASE DESCRIPTION/METHODS:** 86-year-old man with advanced dementia was sent from nursing home for evaluation of painless jaundice of one-week duration. On examination scleral icterus was noted, and no abdominal tenderness or murphy sign could be elicited. Labs were significant for elevated LFT’s with obstructive jaundice pattern. Ultrasonography of abdomen showed dilation of CBD up to 1.9 cm and gall stones. CT scan revealed a dilated CBD up to 1.9 cm in diameter with mildly hyperdense material (arrow) seen in the 4 cm long segment of the CBD proximal to the ampulla, which may represent sludge, noncalcified gallstones or possible neoplasm.

**DISCUSSION:** The practice of placing DPs in LAMS varies among endoscopists. In theory, a DPs through LAMS can prevent the relatively sharp LAMS from embedding into the collapsed cavity, decreasing the risk of a pseudoaneurysm. A retrospective study by Puga et al. showed the LAMS alone group had a significantly higher rate of adverse events than the LAMS plus DPs group (42.9% vs 10.0%; P = 0.04) with bleeding being the most common. Based on this case presentation, we advocate routine use of DPs with LAMS. Additionally, we recommend close monitoring of the cavity through cross-sectional imaging and prompt removal of LAMS once the cavity has resolved.

Massive hematemesis occurred another 72 hours later. A second exploratory laparotomy confirmed perforation. The patient was discharged but returned 72 hours later again with massive hematemesis. The patient was referred for EUS with ERCP to rule out cholangiocarcinoma. EUS showed a 9 mm × 7 mm lesion in the left intrahepatic duct, not amenable to EUS. ERCP was then performed, with SpyGlass-guided direct visualization of the bile tree. Multiple impacted stones were found in the left intrahepatic ducts, measuring up to 20mm (see Figures 1, 2 and 3). EHL was implemented with successful clearance of multiple large stone fragments. Two plastic stents were placed; one in the left hepatic duct to maintain patency, and the other in the ventral pancreatic duct to decrease risk of post ERCP pancreatitis.

**DISCUSSION:** Conventional percutaneous procedures for treating patients with recurrent hepatobiliary disease often involve multiple dilation sessions before stone extraction. EHL is superior to conventional management with a high efficacy in clearing hepatolithiasis, and a post-procedure clearance rate up to 91%. The complication rate of EHL is 7-9% with most common complications of pancreatitis, cholangitis, sepsis, and hemobilia. Fortunately, our patient did not experience any complications, and she is scheduled for follow-up ERCP with stent removal in 2-3 months. This case demonstrates EHL via peroral endoscopic cholangioscopy as a highly successful and safe technique for treating hepatolithiasis.
diameter with 4 cm long mildly hyperdense material seen in CBD proximal to the ampulla [Figure 1]. Endoscopic ultrasonography (EUS) and ERCP were performed with EUS showing large CBD stone with dilated CBD up to 15-16mm [Figure 2]. Subsequent ERCP was performed, with biliary sphincterotomy and balloon sweeping. One large, intact, cylindrical stone measuring 5 × 1.5 cm is extracted from bile duct. The stone was seen endoscopically and it was noted to almost completely obstruct the duodenal lumen. Due to potential for Bouvér’s syndrome, mechanical lithotripsy with a Roth net and a hexagonal snare was performed to extract the stone safely out of patient [Figure 3]. Post extraction there were no complications and the LFTs trended down to normal.

**DISCUSSION:**
Large CBD stones are defined as stones ≥15 mm in diameter and pose a challenge for conventional stone extraction. Larger stones especially those with diameter ≥2 cm need fragmentation before removal to reduce risk of stone impaction and complications. Mechanical lithotripsy, balloon dilation of papillae, newer sophisticated techniques such as cholangioscopy guided lithotripsy have been used endoscopically for the extraction of large, difficult, impacted, or intrahepatic stones. Bouvér’s syndrome is a variant of gall stone ileus where a large gall stone becomes impacted in pyloric channel or duodenum causing gastric outlet obstruction, so endoscopist should be aware of its potential occurrence when a large stone is extracted out of CBD.

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**S3492**

**Solid and Cystic Pancreatic Mass on Endoscopic Ultrasound**

Supipara Tintara, MD,1 Mohammad Rizki, MD,2 Yaho Ono, MD,3 Tyler M. Berzin, MD3.

1Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA.

**INTRODUCTION:**
A 74-year-old woman was found to have an incidental pancreatic mass on CT scan of the abdomen and pelvis performed for vaginal bleeding.

**CASE DESCRIPTION/METHODS:**
The CT scan showed a possible mass within the abdomen abutting the duodenum, portal vein and superior mesenteric vein (SMV), which was not present on a prior CT scan 5 years ago. An MRI scan revealed a 3.4 × 3.4 × 3.3 cm cystic and solid mass adjacent to the pancreatic head (A). There was no evidence of calcifications within the mass and no pancreatic ductal dilation was seen. The patient was referred for an endoscopic ultrasound which showed a 3.2 cm peri-pancreatic mass adjacent to the SMV with a cystic and solid component (B). Fine needle biopsy was performed and histological examination showed spindle cells arranged in palisades. Immunohistochemical staining was positive for S100 consistent with a Schwannoma.

**DISCUSSION:**
The patient was evaluated by surgery and the plan is for annual surveillance MRI scans or resection if patient develops symptoms. Initial imaging also revealed calcifications in the uterus suggestive of a degenerating leiomyoma. Schwannomas can also be seen with Carney complex which includes uterine leiomyomas. The patient is scheduled to follow up with gynecology.

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**S3493**

**Suspected Pneumoperitoneum After an ERCP**

Leandro R. Ramirez, MD, MHA1, Dong Joo Seo, MD1, Alexander J. Harmatz, MD1.

1Roger Williams Medical Center, Providence, RI.

**INTRODUCTION:**
Endoscopic retrograde cholangiopancreatography (ERCP) continues to evolve as a diagnostic and therapeutic intervention for numerous pancreatobiliary disorders. The incidence rate of duodenal perforation (DP) is rare (0.5 to 1%) but with high mortality (9-18%). DP is often recognized radiographically with the presence of extrabiliary free air, but it is important to differentiate from pneumobilia, the free air of no clinical significance following an ERCP.

**CASE DESCRIPTION/METHODS:**
A 73-year-old female with past medical history of hypertension, hyperlipidemia, and diabetes presented to the emergency department due to fever, weakness, and confusion for which broad spectrum intravenous antibiotics were initiated. Labs demonstrated an ALT predominated transaminisits and hyperbilirubinemia. Computed tomography (CT) scan showed a pneumoperitoneum suspicious for pneumobilia. The patient was managed conservatively with serial imaging and resolved without sequelae.

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