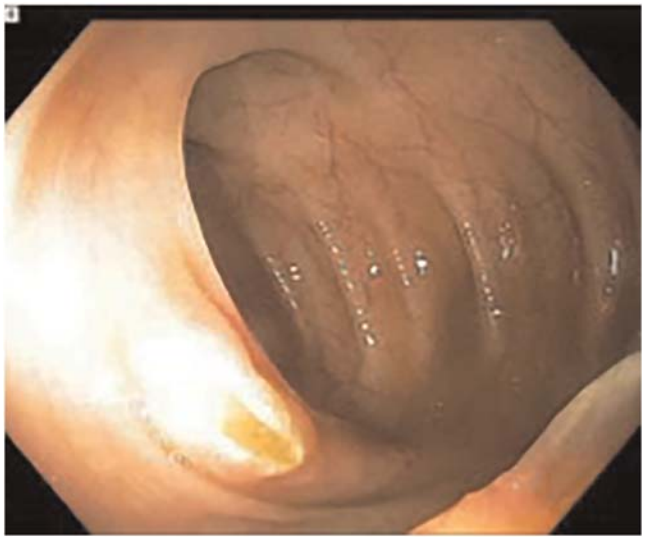
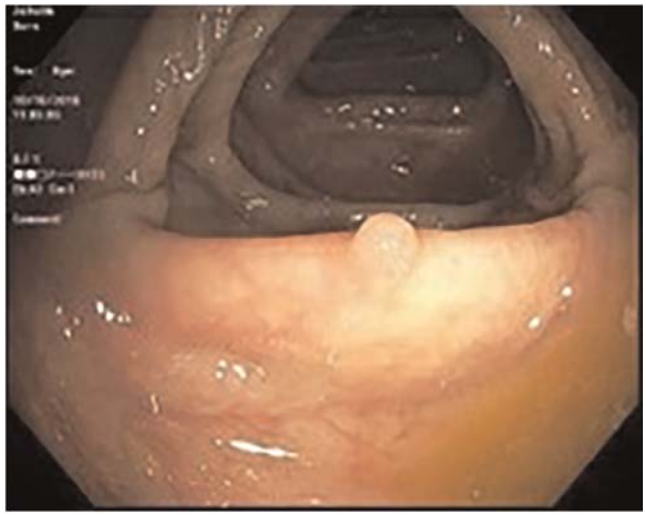
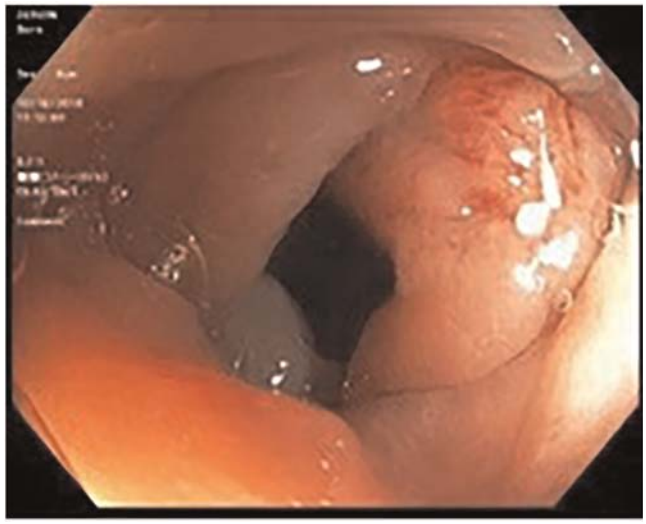


[1578] **Figure 3.** Post-polypectomy.



[1579] **Figure 1.** Pre polypectomy (ascending colon).

INTRODUCTION: We present a case of primary endometrioid adenocarcinoma with invasion of the rectosigmoid colon, highlighting the importance of colonoscopy, biopsy, cross-sectional imaging, and a multidisciplinary approach to the management of extraluminal lesions.
CASE DESCRIPTION/METHODS: A 47-year-old female with a history of lymphangioleiomyomatosis (LAM) was admitted for abdominal pain, hematochezia, tenesmus, and proctalgia following 7 months of abnormal bowel habits and 20 pounds of unintentional weight loss. Review of symptoms was negative for abnormal uterine bleeding. Examination revealed tenderness on palpation of the lower abdominal quadrants, and grossly bloody stool with digital rectal exam. Computed tomography (CT) of the abdomen and pelvis with contrast demonstrated circumferential rectal wall thickening with enhancement. Colonoscopy revealed an ulcerated extraluminal rectosigmoid mass, and biopsies were obtained. Magnetic resonance imaging (MRI) demonstrated a large heterogeneous mass involving the uterus and rectum with no discernable fascial plane. Initial pathology reported invasive adenocarcinoma without a primary origin delineated. A multidisciplinary conference prompted additional immunostaining of the sample, confirming endometrioid adenocarcinoma. The patient was diagnosed with International Federation of Gynecology and Obstetrics (FIGO) stage IVa endometrioid adenocarcinoma and underwent surgical management with adjuvant chemoradiation. Genetic testing demonstrated heterozygosity with a pathologic variant in the MutL homolog 1 (MLH1) gene consistent with Lynch Syndrome. Surveillance positron emission tomography scanning 6 months later revealed no evidence of disease recurrence.
DISCUSSION: Extraluminal lesions are notoriously difficult to diagnose with endoscopy alone. In this case, cross-sectional imaging with CT and MRI was unable to differentiate the origin of the lesion, and pathologic examination without the clinical context of the extraluminal nature of the tissue obtained on colonoscopy delayed the definitive diagnosis. This case highlights the importance of a multidisciplinary approach to cases of suspected extracolonic malignancies with colonic invasion in order to expedite definitive diagnosis and treatment. There are no reports of concomitant Lynch Syndrome and LAM in the literature and the clinical significance is unclear. Further study may be helpful in elucidating potential links between these two uncommon conditions.



[1579] **Figure 2.** Post polypectomy (ascending colon).

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Sequential Fecal Microbiota Transplantation for Severe Acute Refractory *Clostridium difficile* Colitis: A Life-Saving Treatment Approach

Sindhu Kilakkathi, MD, Rushikesh Shah, MD, Francis Edward LeVert II, MD.
Emory University School of Medicine, Atlanta, GA.

INTRODUCTION: Fecal microbiota transplantation (FMT) is now a commonly used mode of treatment for recurrent Clostridium difficile infection (rCDI) refractory to antibiotics. We report a unique case where two sessions of sequential FMT were used to treat acute rCDI refractory to antibiotics with endoscopically documented marked improvement in disease process.
CASE DESCRIPTION/METHODS: A 69 year-old female presented with 4 days of fever, large volume non-bloody diarrhea and poor appetite. She denied abdominal pain, nausea or vomiting. She reported two months before this admission, she was treated for hospital-acquired CDI, but could not recall what she was treated with. Physical examination revealed a non-tender abdomen without guarding or rigidity. Laboratory tests revealed hemoglobin 11.3 g/dL and white blood cell (WBC) count 18,700/mcL. Stool testing was positive for C. difficile toxin assay. Computed tomography of the abdomen showed diffuse pancolitis, compatible with CDI, no evidence of bowel perforation or obstruction. Despite treatment with oral vancomycin (500 mg every 6 hours), intravenous metronidazole and probiotics for 5 days, her leukocytosis increased to 32,000/mcL, hemoglobin dropped to 6 g/dL and her symptoms persisted. The decision was made to try FMT and antibiotics were stopped for 48 hours as per FMT protocol. Colonoscopy showed severe pancolitis (Figure 1) and pseudomembranes consistent with severe C. difficile colitis with distal ascending colonic mucosa concerning for ischemia. 250 mL of donor stool was delivered at the proximal transverse colon. After the first FMT, mild improvement was noted in her symptoms and leukocytosis but she persisted to have severe diarrhea. A second FMT was performed 4 days later. Repeat colonoscopy (Figure 2) showed marked improvement in the appearance of pancolonic erythema, inflammation and pseudomembranes compared to prior. 250 mL of donor stool was infused through the colonoscope into the cecum. The following day after the second FMT, the patient began having formed stool and improved leukocytosis. She was discharged from the hospital 3 days after the second FMT with normal stool consistency and normal WBC count.
DISCUSSION: There have been no clear data regarding directing severe rCDI treatment with regards to the length of time in between FMTs. Clinicians should be aware that patients may need multiple FMTs to treat rCDI. A shorter duration in between FMTs may rapidly improve severe rCDI, reduce the duration of hospitalization, and improve outcomes.

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A Case of Complicated Diverticulitis Masquerading as Crohn's Disease: A Diagnostic Dilemma

Gaurav Bhardwaj, MD[1], Waqas Nawaz, MD[1], Hilary Hertan, MD[2].
[1]Montefiore Medical Center, Bronx, NY; [2]Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, NY.

INTRODUCTION: Diverticular disease can have a complicated course in patients younger than 40 years of age and may mimic Crohn's disease (CD), thus presenting a diagnostic challenge. We report a case of a young adult presenting with complicated diverticulitis which was initially mistaken as CD.