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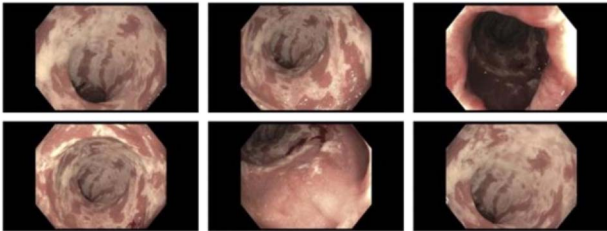
Congestive Ischemic Colitis: A Rare Mimic of Inflammatory Bowel Disease

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Introduction: Patients with inflammatory bowel disease (IBD) commonly present with abdominal pain, diarrhea, hematochezia, and inflammation or ulceration identified on endoscopy. However, these findings are not specific to IBD and lead to a broad differential diagnosis.

Case Description/Methods: A 54-year-old man who underwent sigmoidectomy secondary to recurrent diverticulitis presents 1 year postoperatively with fecal urgency and hematochezia. Colonoscopy at the time of symptom onset identified colonic ulcerations at anastomosis with histology indicating active chronic colitis and proctitis, while the rest of the colon appeared normal. Patient did not have clinical improvement after 6-month mesalamine or steroid trial. Repeat colonoscopy identified severe linear ulceration, friability, congestion, and abnormal vascularity from proximal rectum to anastomosis with rest of colon appearing normal (A). The patient was then diagnosed with indeterminate colitis and initiated adalimumab. Despite adequate drug levels without antibodies as well as steroid taper, patient did not have clinical improvement after 5 months of therapy. Sigmoidoscopy findings were unchanged. Advanced therapy was changed to ustekinumab with additional prednisone taper for which patient did not have clinical response after 8 weeks. Given refractory symptoms and atypical endoscopic findings of inflammation not extending proximal to anastomosis, evaluation for IBD mimics was initiated. A computed tomography angiogram of the abdomen and pelvis was obtained to evaluate vascular patency, which when compared to pre-operative images identified newly hyperemic rectum with marked surrounding perirectal/dependent pelvic varicosities as well as numerous tiny perianal varicosities which extended up to the perianal region. Given vascular findings, the patient was diagnosed with congestive ischemic colitis and established care with interventional radiology to undergo angio-embolization.

Discussion: Congestive ischemic colitis is a rare diagnosis and is the result of vascular congestion leading to colonic ischemia. Normally, the inferior mesenteric vein (IMV) returns blood from the superior rectum, sigmoid, and left colon to the splenic vein, which then merges with the superior mesenteric vein to form the hepatic portal vein (B). However, this patient had IMV ligation during sigmoidectomy, leading to congestion of the rectal venous plexus. This case outlines the importance of differentiation between refractory IBD and IBD mimics (see Figure 1).



[3903] **Figure 1.** Images from colonoscopy revealing severe linear ulceration, friability, congestion, and abnormal vascularity in rectum to anastomosis with colon distal to anastomosis appearing normal.

S3904

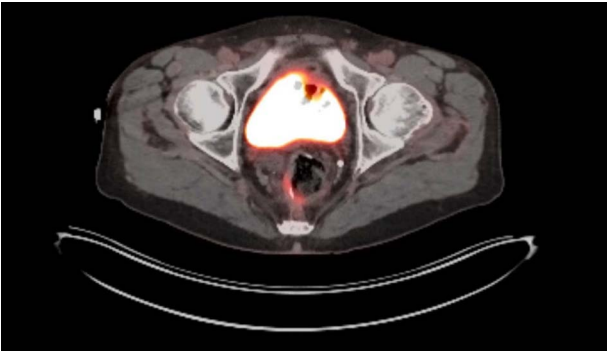
Rare Metastasis of Prostate Cancer in a Male With Ulcerative Colitis Following Creation of an Ileal Pouch

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Introduction: An estimated 1.6 million cases of prostate cancer are diagnosed annually. Common metastatic sites include bones, lymph nodes, liver, and lungs. In this report, we present a case of prostate cancer, initially discovered with routine prostate specific antigen (PSA) monitoring, that metastasized to an ileal pouch-anal anastomosis (IPAA) in a patient with ulcerative colitis (UC).

Case Description/Methods: A 68-year-old man with a history of medically refractory UC treated with IPAA presented with increased bowel movement (BM) frequency despite a grossly normal pouch endoscopic evaluation (pouchoscopy). At this time, the patient was also found to have an elevated PSA. Given concern for prostate cancer in a patient with worsening ileal pouch symptoms, he was referred to gastroenterology (GI) and urology. The patient was then scheduled for a prostatectomy which revealed prostatic adenocarcinoma. Despite the prostatectomy, the patient experienced gradual worsening of pouch symptoms. He had minimal relief despite treatment with antibiotics, diet changes, pelvic floor retraining, and GI psychology evaluation. At follow-up with urology 3 months post-operation, repeat imaging (PSMA positron emission tomography/computed tomography) was negative for metastasis. The patient was referred to medical oncology and ultimately declined androgen deprivation therapy and elected for PSA observation. At 6 months post-prostatectomy, the patient's PSA continued to increase. Repeat pouchoscopy showed congestion in the rectal cuff and mild inflammation. Pouch biopsy revealed metastatic prostate cancer with malignant cells that were PSMA and NKX3.1 positive. Given this biopsy, oncology recommended repeat imaging which showed metastasis in the pouch (Figure 1). The patient ultimately elected to pursue pouch explant.

Discussion: Despite thorough evaluation by numerous specialists, an explanation and treatment plan for the patient's increased BM frequency and discomfort remained elusive. Clinical consideration for metastatic pouch disease must remain on the differential, particularly in patients with prior malignancy. Once diagnosed, prostate cancer treatment presents another hurdle by requiring a multifaceted approach of surveillance, surgery, radiation, hormone therapy, chemotherapy, and/or immunotherapy. Overall, there remains extremely limited information on how to navigate treatment and monitoring in IPAA patients specifically.



[3904] **Figure 1.** Repeat PSMA PET/computed tomography imaging showing postsurgical changes from the radical prostatectomy and J-pouch creation with moderate PSMA expression along the right posterolateral margin of the J pouch that was compatible with metastasis.