Abstract IDDF2019-ABS-0274 Figure 1 Gastroduodenal mass intramural air gastroduodenal intussusception

vomiting, abdominal distension, pain abdomen for 2 weeks. She had an earlier history of pain abdomen for which her UGI endoscopy was done which suggested polyp in the stomach, no biopsy taken. Now she has edema, ascites, distress for one week.

Methods The patient was worked up by blood tests including CBC, LFT, RFT. UGI endoscopy done, CECT abdomen done, ascitic fluid sent for microscopy, biochemical test and cytology. Exploratory laparotomy, abdominal doppler study is being planned by the time of submitting this abstract.

Results Ascitic fluid examination suggested high protein level, lymphocyte predominant fluid, negative malignant cytology. UGI endoscopy revealed gastric outlet obstruction, circumferential, soft, slimy, fungating growth in body and antrum of the stomach, with difficulty endoscopic biopsy was taken, tissue sent to the pathologist. CECT suggested thickened wall of the stomach in body and antrum, Gastroduodenal Intussusception, intramural air in bowel wall suggestive of bowel ischaemia. Complete blood count, Liver function test, renal function test was within normal range. The patient is admitted under GI surgeon for stabilization and definitive leiomyosarcoma treatment. Patient possibly has gastric carcinoma variant which can rarely cause intussusception like appearance after duodenal involvement, the air in gastric duodenal wall layers is rare possibly there is microleaks in the wall or due to rapid growth ischaemic changes, this area of GIT rarely have ischaemia being well vascularized. We will present complete details of histopathology and surgery in the meeting. Malignant ascites patient generally does not develop edema. We will do doppler study of the portal venous system to rule out Hepatic vein, portal vein or inferior vena cava thrombosis. (figure 1)

Conclusions We hereby present a rare case of gastric mass with bowel ischaemia changes, Gastroduodenal Intussusception in an elderly lady presenting with ascites, edema, pain abdomen and vomiting. It can be gastric carcinoma, less likely gastric lymphoma or aggressive leiomyosarcoma. Ascites cytology needs to be repeated two times to exclude malignancy, while exploratory laparotomy will make things very clear, a larger specimen can be sent for histopathology. The patient will need some palliation for gastric outlet obstruction.

IDDF2019-ABS-0276 A RARE CASE OF DUODENAL GIST WITH ENTEROCUTANEOUS FISTULA

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Background Gist accounts for 0.1% to 0.3% of all gi malignancies and duodenal gist is even more rarer. This is an interesting case of duodenal gist with enterocutaneous fistula managed successfully.

Methods A 40-year-old female, operated for misdiagnosed appendicular lump 3 weeks back, presented to us with fecal fistula from scar site and mass in right hypochondrium extending to right iliac fossa region underwent all the investigations followed by exploratory laparotomy + enbloc resection of duodenal mass + right hemicolectomy + excision of fistulous tract + duodenojejunostomy was done.

Results Post surgery period was uneventful

Biopsy: spindle cell type gist, margins free of tumor, mitotic index - 5/50 HPF, high grade, pT4N0Mx

The patient received imatinib therapy post operatively

Conclusions This is a rare case of large duodenal gist infiltrating hepatic flexure and ascending colon with enterocutaneous fistula managed successfully with wedge resection of duodenum avoiding Whipple procedure. Gist when enblock resection done with negative margins without any metastasis, show good prognosis post operatively

IDDF2019-ABS-0282 TICKING TIMEBOMBS DUE TO PANCREATITIS

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Background Visceral arterial pseudo aneurysms are rare and usually involve the splenic artery. They mostly occur in the background of pancreatitis, with trauma being the second most common cause. The detection of the pseudoaneurysm has increased with our lowered threshold of using high-resolution imaging (CT/MRI/Doppler). Most of them are symptomatic and present a dilemma for management. The aim of the study was to identify all patients with abdominal visceral arterial pseudo aneurysms, analyze their clinic-pathological features, management and outcome.

Methods The study was conducted in the Surgical Gastroenterology Department of Osmania Medical College and Hospital. All patients who were diagnosed to have a splenic artery pseudo aneurysm from the January 2012 to July 2016 were included in the study