Labs showed hemoglobin 11 g/dL, platelet count 68,000 /mL, bicarbonate 17 mmol/L, albumin 2.2 g/dL, total bilirubin 6.5 mg/dL, AST/ALT = 52/21 IU/L, lactate 3.2 mmol/L. Chest x-ray was unremarkable. He presented with a typical clinical picture of large ascites needing therapeutic paracentesis, but he was admitted over the weekend due to concern about the high blood lactic acid level. On day 3 of admission, he developed hypotension and respiratory distress. Interval abdominal examination showed increased abdominal distension, tympany on percussion, no tenderness, or signs of peritonitis. His lactic acid trended up to 13 mmol/L, bicarbonate 8.5, pH 7.04, carbon dioxide 23.4. An upright abdominal x-ray showed subdiaphragmatic free air [Figure 1, left]; an abdominal CT confirmed the free air [Figure 1, right], and revealed cirrhosis with portal hypertension and large ascites. Exploratory laparotomy revealed isolated cecal perforation with extensive fecal contamination. Right hemicolectomy was done. Five liters of ascitic fluid was removed intraoperatively. Bacterial culture of ascitic fluid was positive for Bacteroides vulgatus and Lactobacillus hansenii. Blood culture grew Bacteroides stercoris. Surgical pathology reported a transmural infarction of cecum, acute serositis, and viable margins [Figures 2–3]. After the surgery, the patient died on hospital day 6.

**DISCUSSION:** This case report describes a rare isolated cecal infarction in a cirrhotic patient who presented with a typical clinical picture of ascites without abdominal pain or signs of peritonitis. The important warning signal, in this case, was an unexplainable elevated lactic acid level on admission. Abdominal imaging should be easily performed when in doubt as these patients could develop gangrenous bowel, bowel perforation, and peritonitis.

**INTRODUCTION:** B-cell chronic lymphocytic leukemia (CLL) is the most common form of leukemia in the United States. It has a variable presentation with most patients having asymptomatic lymphocytosis. CLL can present with extramedullary involvement. Most commonly this is in the form of skin or central nervous system involvement, though rarely it can present with gastrointestinal involvement.

**CASE DESCRIPTION/METHODS:** We are highlighting a case of a 70-year-old male who presented with complaints of diarrhea for the last 4 months. He was having 4–5 bowel movement a day ranging from semi-solid to watery stools. He denied any history of fevers, abdominal pain, vomiting, weight loss, night sweats, skin rashes, travel history, or exposure to anyone with similar symptoms. On physical examination, his abdomen was soft, non-tender, and without apparent hepatomegaly or splenomegaly. The rest of the system examinations were unremarkable. The initial laboratory evaluation was unremarkable. After failing conservative treatment, a colonoscopy was performed which showed diffuse mucosal nodularities [Image 1 and 2]. Histopathology of the biopsied tissue revealed multiple aggregates for small mature lymphocytes in the submucosa [Image 3]. Immunohistochemical staining revealed a diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma. CT scan revealed extensive bilateral hilar, hilar, and pelvic lymphadenopathy. He subsequently underwent bone marrow biopsy histopathology and flow cytometric immunophenotyping which were consistent with CLL. Oncology started him on chemotherapy and he went into remission from his CLL. On 3- and 6-month follow-ups, the patient was asymptomatic.

**DISCUSSION:** A review of the literature revealed a total of n = 4 prior reported cases where the initial presentation of CLL/SLL was diarrhea. In the existing case reports with similar presentation a mean age of presentation was n = 74 years, ages ranging from 65 to 81 years. They had fecal urgency, abdominal pain, and weight loss as associated symptoms. Only one patient had history of CLL for which he had undergone treatment and was thought to be in remission. Imaging with CT with contrast in all cases revealed abdominal and pelvic lymphadenopathy. Histopathology of the colonc biopsy in all cases revealed lymphocytic infiltration. This patient was treated successfully with chemotherapy and his diarrhea improved. This is a differential to keep in mind in patients with chronic diarrhea, once the more common causes have been ruled out.

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A Case of Rectal Primary Krukenberg Tumor
Geoffrey A. Bader, MD1, Kimberly Zibert, DO1, John Quiles, MD1, Leilani Holbrook, MD1. 1Brooke Army Medical Center, Fort Sam Houston, TX.

INTRODUCTION: Krukenberg Tumors (KTs) are secondary ovarian tumors defined as mucinous signet-ring cell carcinomas. Nearly 30% of ovarian tumors are metastatic in origin, with KT accounting for 1–2% of all ovarian tumors. Worldwide, stomach is the primary site in most KT cases (70%), followed by colorectal and breast. However, in Europe and the USA, colorectal and breast cancers are the most common primary tumors metastasizing to the ovaries. KT occurs in 3–14% of women with colorectal cancer (CRC), with 20% arising from the rectum. The prognosis for KT is poor, although CRC primary KT appears to benefit from more aggressive treatment with cytoreductive surgery and post-adjuvant chemotherapy. We present a case of rectal primary KT to improve awareness of CRC KT in the western population, as well the implications of histological type on management.

CASE DESCRIPTION/METHODS: Our patient is a 48 year old African American female who underwent surgical resection of a 6.6cm complex right ovarian mass seen on MRI after having reported one year of abdominal pain, nausea, and progressive constipation. Ascites was noted prior to surgery. Final surgical pathology specimens demonstrated mucinous carcinoma with signet ring features. Immunohistochemical (IHC) evaluation was CK20+ /CDX2+ and CK7-, suggestive of colorectal primary. Laboratory values were notable for CEA 1.0ng/mL, CA-125 44 U/mL, and the absence of iron deficiency anemia. An upper endoscopy was performed, ruling out gastric malignancy. A colonoscopy revealed a non-traversable malignant appearing stricture 15 cm from the anal verge with biopsies demonstrating poorly differentiated adenocarcinoma with signet cell features. Our patient was lost to follow up for several months as she explored alternative natural therapies before ultimately transitioning to hospice care with palliative FOLFOXIRI.

DISCUSSION: CRCs are a relatively common primary source for KT in the western population. While the median survival of patients with KT is 14 months, there is a small but promising body of evidence that select patients with CRC primary KT may have a survival benefit with optimal cytoreductive surgery and post-adjuvant chemotherapy. IHC markers may help identify the primary tumor, as the pattern of CK20+/CDX2+ and CK7− is classic for a colorectal primary. Our case serves to improve awareness of CRC primary KT, and the unique treatment survival benefits for these patients.

S1677 Presidential Poster Award

Topical Cannabidiol (CBD) for the Treatment of Anal Fissures: A Case Series
Eugene M. Cooper, MD, MHA, FACG1, Nikolas Dial-Lawsky, BSc2. 1GastroCare Bahamas, Nassau, New Providence, The Bahamas; 2The University of the West Indies/Princess Margaret Hospital, Nassau, New Providence, The Bahamas.

INTRODUCTION: An anal fissure is defined as a longitudinal tear in the anal canal distal to the dentate line. It is a common benign condition that may be primary, resulting from local trauma, or secondary, stemming from an underlying disorder such as a malignancy, sexually transmitted infection, or inflammatory bowel disease. The primary symptom is anal pain particularly during