Research Abstracts – Titles and Authors

Good Samaritan Hospital Medical Center, West Islip, NY

1. Pregnancy Rates And Multiple Pregnancy Rates: Does Clomiphene Citrate (CC) Dose Matter?
   Authors: Menashe Ehrenburg, DO; Mary A. Bray, MD; Nassim Virji, PhD; Linda Sung, MD; Gabriel A. San Roman, MD; James R. Stelling, MD.  
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4. Is the Use of Multiple Medications an Independent Predictor of Length of Stay and Probability of Admission?
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Long Beach Medical Center, Long Beach, NY

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Good Samaritan Hospital Medical Center, West Islip, NY

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Newark Beth Israel Medical Center, Newark, NJ

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Research Abstracts
Title: Pregnancy Rates And Multiple Pregnancy Rates: Does Clomiphene Citrate (CC) Dose Matter?

Authors: Menashe Ehrenburg, DO; Mary A. Bray, MD, Nassim Virji, PhD; Linda Sung, MD; Gabriel A. San Roman, MD; James R. Stelling, MD

Objective: To determine pregnancy and multiple pregnancy rates by CC dose. To determine the frequency of dose adjustments made in subsequent CC cycles.


Materials and Methods: Patients undergoing CC with intrauterine insemination (IUI) were analyzed by CC dose and ongoing pregnancy. Dose adjustments between cycles were analyzed. Chi Square analysis was performed.

Results: The ongoing pregnancy rate (PR) with all doses of CC was 12.3%. The rate of twins and triplets was 7.9% and 0.4% with no differences between CC doses, p=0.68.

The dose of CC was altered in subsequent cycles primarily determined by ovarian response observed on ultrasound. The selected dose of CC100 was adjusted significantly less frequently than other clomid doses, p<0.05. The dose of CC50 was increased in 44.3% of cycles and decreased in 1.8% of cycles. CC100 was increased in 19.7% of cycles and decreased in 4.3% of cycles. When comparing CC50 to CC100 the dose was maintained at the same dose for the next cycle 51.6% of the time vs. 72.5% p= <0.0003.

Conclusions: This analysis reveals similar PR at all CC doses. More aggressive dosing was fortunately not associated with a higher twin or high order multiple PR. CC100 would be a good starting dose, because it appears to give a better follicular response as shown by a lower rate of dose adjustments.

Support: None
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

**Title:** EM Residents Use Bedside Ultrasound to Diagnose Appendicitis and Avoid the Radiation of CT scans – The Effect of Feedback

**Authors:** Andrew Flanagan DO, Joseph Artale, DO, Ronald Dvorkin MD, Jason Idelson DO, Diana Kontonotas DO, Andrew Mapley DO, David Teng MD, Steve Zimmerman MD

**Objective:** We wish to demonstrate that in many cases appendicitis can be reliably diagnosed by Emergency Physicians and Residents with a bedside ultrasound examination in the Emergency Department. We hypothesize that a pilot study can identify >30% of cases of appendicitis (as compared to surgical pathology or CT scan if the case is managed non-surgically) with such specificity (few false positives) such that CT scanning would not be required in >30% of cases of appendicitis.

**Methods:** We developed a 4 hour ultrasound training module for Emergency Residents to diagnose appendicitis. They were trained to identify a blind ended tubular and non-ovoid structure >6mm that is not compressible. The residents were blinded to other clinical findings and completed the data collection form before any other imaging studies were performed. Patients were also contacted at 7 days to determine if there was any subsequent pathology.

**Results:** Initially we did not provide feedback to the residents. We found that they were not comfortable with lack of feedback and had low sensitivity. After September 23, 2009 we chose to give residents feedback after their data sheet was submitted. We found that the sensitivity increased, but since this was a change in the protocol, the IRB has not permitted us to report these subsequent results. Presently, the IRB has approved this changed protocol. We will report our findings at the AOCEP Scientific Seminar in September.

**Conclusion:** Feedback may be useful in training Emergency Medicine Residents to reliably identify appendicitis with bedside ultrasound. We will recruit 175 additional cases to determine with a 95% certainty that the sensitivity is >30% and the specificity is >90%. If the findings can be confirmed by our ongoing follow up study, then CT scans could be eliminated in some patients and there would be the potential to decrease the lifetime risk of cancer in some of the 100,000 pediatric cases of appendicitis seen annually.
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

Title: The Institution of a Requirement for Osteopathic Manipulative Therapy in an Emergency Medicine Residency Training Program and its Effect on Emergency Department Operations

Authors: Andrew Mapley DO, David Levy DO, Ronald Dvorkin MD, Curt Cicotte, RN, David Yens PhD. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Background: While all DOs receive formal training in the practice of Osteopathic Manipulative Therapy (OMT), only a minority of practicing physicians use these modalities on a regular basis. No prior publications have addressed OMT use in emergency medicine residency training programs, the patients typically treated, and the impact of OMT on emergency department (ED) throughout time.

Objectives: Our aim was to describe the actual use of OMT treatment modalities and their association with the length of stay (LOS) of patients in our ED.

Methods: This was a retrospective chart review of patients receiving OMT in our ED who were eventually discharged from the ED between July 14, 2005 through May 1, 2010 (3320 visits of 446,189 visits).

The 12 most common diagnoses where a procedure was documented (n=415, 53.9% of procedures) were analyzed for LOS. This was compared to a control group on a 1:5 basis matched for diagnosis, sex and age. Median and average LOS was compared for both groups.

Results: The median LOS was 171 minutes in the group receiving OMT (IQR 123.0-248.5) and 163 minutes in the control group (IQR 104.5-252). There was no significant increase in the median LOS (95% confidence interval [CI] 0-19 minutes). There was no significant difference in the mean LOS for the group receiving OMT vs. Control which were 198.3 minutes (95% CI 187.7-208.9) and 198.2 minutes (95% CI 192.3-204.7) respectively.

Conclusion: We describe the clinical application of OMT by emergency medicine residents in an osteopathic emergency medicine residency program. It is feasible to require the practice of OMT during residency.

Any effect on patient satisfaction, quality of care, and financial costs would require further study. It remains to be seen if imposing a numerical requirement has any appreciable effect on the subsequent practice and skill of the practitioner.
Title:  Is the Use of Multiple Medications an Independent Predictor of Length of Stay and Probability of Admission?

Authors: Shannon Weinstein DO, Ronald Dvorkin MD, David Levy DO, David Yens, PhD
Good Samaritan Hospital Medical Center, Department of Emergency Medicine, West Islip, NY

Objectives: It is required that all patients presenting to the Emergency Department (ED) be asked to provide their current medications and that this list be updated or reconciled when the patient is discharged. Since this information is now readily available, we sought to determine whether there is an association between the number of medications provided to the ED staff and the length of stay (LOS) in the ED and probability of hospital admission.

Methods: We conducted a retrospective cohort study (chart review) of all ED patients seen in the adult ED over a 93 day period. The primary outcome measurements were the length of stay and probability of admission as a function of the number of medications recorded at arrival. Other variables such as age, sex, and triage category were also measured.

Results: Of the 15,398 charts reviewed, 27.7% of patients were admitted and the overall average LOS was 309.7 minutes for all patients and 226.7 minutes for discharged patients. The probability of admission increased by 1.69% (95% Confidence Interval [CI] 1.51% - 1.87%) for each additional medication the patient reported.

There was a correlation between the length of stay for discharged patients and the number of medications recorded. Each additional medication was associated with a 3.8 minute longer LOS (95% CI 2.8 minutes to 4.8 minutes).

Conclusions: The number of medications a patient reported at arrival is a predictor of length of stay and probability of admission, and may be useful in constructing models of ED throughput.
Dept. of Family Practice, Long Beach Medical Center, Long Beach, NY

Title: Stressful Life Events and Symptomatic Nephrolithiasis: A Retrospective Chart Review Pilot Study

Authors: Patrick D. Frisella, D.O.\textsuperscript{1}, Min-Kyung Jung, PhD \textsuperscript{2}, Shaun Wagner, D.O.\textsuperscript{1}, Alina Frolova, D.O.\textsuperscript{1}, Brooke Schneider, D.O.\textsuperscript{1}, Steven Harris, M.D.\textsuperscript{1}

\textsuperscript{1}Department of Medical Education, Long Beach Medical Center, Long Beach, New York.
\textsuperscript{2}Office of Research, New York College of Osteopathic Medicine, Old Westbury, New York

Introduction: Nephrolithiasis affects 12% of the US population. There are many risk factors attributed to the formation of symptomatic renal stones which include a history of recurrent urinary tract infection, Roux-en-Y gastric bypass surgery, gout, inflammatory bowel disease and medications. Formation of symptomatic nephrolithiasis has been shown to take 93 days.

Stressful life events have been associated with symptomatic disease but with limited evidence in the literature. We investigated the impact of stressful life events with respect to age and gender in relation to symptomatic nephrolithiasis.

Methods: A retrospective chart review was conducted of 250 outpatient urologist visits, which included an extensive social history of stressful life events. An inclusion criteria was designed to select charts with a documented first episode of symptomatic nephrolithiasis confirmed by Ultrasound or CT scan, social history that included +/- stressful life events three to six months prior to symptoms and excluded those with history of multiple nephrolithiasis or chronic disease that predisposed to nephrolithiasis. 70 charts were selected and grouped according to positive stressful life events (PSLE) and negative stressful life events (NSLE), gender and age. Life events were then scored using Holmes-Rahe stress inventory scale. Statistics performed using ANOVA and logistic regression analysis.

Results: The PSLE group had an earlier median and average age of onset versus the NSLE group (44.0 vs. 50.5, CI 95% 40.0-48.0 vs. 45.9-55.1 and 42.4 vs. 48.8 p-value = 0.043, respectively). Younger patients (≤ 41 years of age) appear to have a threefold greater risk of having a major life event associated with nephrolithiasis than older patients (p-value = 0.033; OR = 3.27; CI 1.10 to 9.71).

Conclusion: This study demonstrated that stressful life events were associated with an earlier onset of symptomatic nephrolithiasis, warranting further investigation on the direct relationship of stress and disease.
Dept. of Family Practice, Long Beach Medical Center, Long Beach, NY 11562

**Title:** Effects of Prenatal Stress and Prenatal Alcohol Exposure on Dopamine Function and Alcohol Drinking Patterns in an Adult Primate Model

**Author:** Brooke Schneider D.O., Long Beach Medical Center, New York; Mary L. Schneider PhD, University of Wisconsin-Madison, Julie Garson B.S., University of Wisconsin-Madison

**Background:** Alcohol dependence, alcoholism, and fetal alcohol syndrome are serious public health concerns. Fetal alcohol exposed children are often conceived within the context of stressful environments, yet interactions between these exposures are understudied. Individuals with FAS are at a heightened risk for alcohol use disorders; however this has not been studied in a controlled animal model that is similar to humans.

**Objective:** To determine whether prenatal exposures to stress and/or alcohol influence drinking patterns and dopamine and serotonin function in adult primates who were allowed to chronically consume alcohol for six months, and to assess the neurological impact of this alcohol consumption via PET imaging.

**Methods:** The Harlow Primate Laboratory at the University of Wisconsin-Madison has a cohort of 32 rhesus monkeys that have been part of a longitudinal study from conception in which they were prenatally exposed to alcohol and/or stress. These offspring, who as infants and juveniles were found to have altered dopaminergic function, are now adults who are currently being allowed to drink alcohol freely for six months using a state-of-the-art alcohol self-administration paradigm. The monkeys undergo PET imaging to examine dopamine effects before and after chronic alcohol abuse. Eight monkeys have successfully completed the alcohol self-administration study thus far.

**Results:** Correlations were found between the prenatal exposures, dopamine, serotonin, and the amount of alcohol consumed by the adult monkeys. D1R binding was reduced after 6 months of alcohol in hippocampus (p=0.02), temporal cortex (p=0.05) and thalamus (p=0.007). D2R binding was reduced after 6 months of alcohol in multiple brain areas (p<0.01). DAT binding was also reduced in Nucleus Accumbens, globus pallidus, and amygdala (p=0.08). Average daily alcohol consumption was predicted by pre-drinking baseline D2R binding in hippocampus (p<0.10).

**Conclusions:** These results indicate the possibility of an endophenotype related to prenatal alcohol and stress exposure that would provide insights into disease prevention and treatment approaches within this population.
Title: Stereotactic Breast Biopsy and Pathology Outcomes

Authors: Karen S. Woo DO, Terry J Luma MSIII, Susan St. John MD FACS, Ellen Wahba RN, Howard Sussman MD FACS, and Nageswara Mandava MD FACS

Institutions: Peninsula Hospital Center, Far Rockaway NY, and Flushing Hospital Medical Center, Flushing NY

Context/Background: Over 600,000 breast biopsies are performed every year in the U.S. due to increased public awareness and availability of modern mammography with its high resolution. The need for surgical biopsy to evaluate lesions is increasing. Since its introduction in the early 1990’s, stereotactic intervention has been less invasive, quicker, and more cost-effective than performing excisional biopsy with minimal complications.

Objective: We correlated stereotactic breast biopsy results and pathology outcomes in our facility and compared our results to major academic centers. We also wanted to investigate our indications of performing stereotactic biopsy and what resulted in open surgeries.

Methods: Retrospectively, we looked at patients with microcalcifications and non-palpable masses from January 1, 2009 to December 31, 2009 at Flushing Hospital Medical Center. We reviewed 250 patients who underwent vacuum assisted stereotactic biopsy, EVIVA 9 gauge, ages ranged from 23-96 years, average was 53 years old. We utilized PUBMED and Medline databases to research outcomes of stereotactic biopsy and correlated with pathology’s outcomes.

Results: The majority of the cases consisted of in situ tumor and stage I. Only 3 of the stereotactic biopsies inconclusive results lead to using excisional open biopsy to obtain a better specimen. Out of 250 stereotactics, 24 required a subsequent open biopsy because of suspicious pathology from the stereotactic sampling. Five cases were downgraded after open biopsy.

Conclusions: Occasionally, there is a necessity to repeat the biopsy or even perform an excisional biopsy, stereotactic biopsy remains of great value for a community hospital. A majority of the patients avoid surgery all together. There is less scarring which prevents distortion of subsequent imaging. It is more difficult to re-excise a cavity with positive margins than to excise a clip in place. Patients with malignancy can make an informed decision regarding breast conservation without any prior surgery.
Dept. of Surgery, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Carcinoma of the Cecum: Incidence, Diagnosis, and Surgical Treatments

Authors: Dalkeith Facey, D.O. MBA, Sohail Mamdani, D.O.

Objective: The cecum does not lend itself to demonstrating early symptoms and signs of a tumor. Right hemicolectomy remains the preferred surgical treatment of choice for these types of malignancies.

Analysis: A review of 32 right hemicolectomies performed at Jersey City Medical Center from March 2001 to May 2010 is presented. Also, a comparative analysis of these findings were performed.

Results: From the Right Hemicolectomies performed with diagnosis of Cecal Carcinoma, the disease were more prevalent in women (64% versus 36% in male patients) and more likely to occur after the fifth decade.

C. W. Broders presented a review of 62 patients with cancer of the cecum. Sixty one percent of the patients in one cecal cancer study described weakness, weight loss, and fatigue. A later symptom of cancer of the cecum is a palpable mass in the right lower quadrant.

A total of 40 patients with primary carcinoma of the cecum with operation, at Penrose Hospital, were reviewed. Their results showed that female outnumber males by 67.5% to 32.5%. Abdominal pain was the most common presenting complaint, being present in 35% of the cases.

Conclusion: Cecal carcinoma is a significant part of large bowel carcinoma diagnosed in New Jersey. These tumors predominantly afflict older women, and they are not often discovered until later stage with lymph node involvement and sometimes-distant metastasis. In light of these findings, Right Hemicolectomy should be the surgical treatment of choice.
Title: Metastasis Following Plaque Radiotherapy of Small Posterior Uveal Melanoma in 1524 Cases

Authors: Hal Schwartzstein DO¹, Carol L Shields MD², Brad Kligman DO², Michael Alterman DO², Anthony Farah MD², Lalkrushna Malaviya MD², Vishal Desai¹, Elaina Dellacava², David H Perlmutter MD², Rameet Hundle², Renelle Pointdujour MD², Nisha Pulpet Warrier MD², Randee C Miller MD², Mahsa Sohrab MD², Rajesh Shankar², Monisha Mandalaywala MD², Emil Anthony Say MD², Arman Mashayekhi MD², Jerry A Shields MD².

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Background: Posterior uveal melanoma is the most common primary intraocular tumor in adults with an estimated annual incidence of six per million per year in the United States. A longitudinal follow-up study by the Collaborative Ocular Melanoma Study (COMS) Group reported a 5-year cumulative metastasis rate of 25% for medium and large choroidal melanoma. In addition, survival rate following systemic metastasis was only 20% at 1 year and 8% at 2 years. However, several studies have shown a higher metastasis-free survival rate for smaller tumors (< 3 mm in thickness), with each millimeter increase in thickness correlating to higher metastatic rates. We report our experience on treatment of small posterior uveal melanoma (SPUM) and determine the frequency of and risk factors for systemic metastases.

Objective: To determine frequency of metastasis following plaque radiotherapy for treatment of SPUM.

Methods: The research protocol was approved by the Wills Eye Institute Institutional Review Board. The study was a retrospective review of 1524 cases treated in a tertiary care outpatient clinic. Patients included in the study were diagnosed with primary small choroidal melanoma (tumor thickness ≤ 3 mm) and treated with plaque radiotherapy +/- transpupillary thermotherapy (TTT). The main outcome measure was the development of metastasis.

Results: After plaque radiotherapy of SPUM, metastasis developed in 3%, 9%, and 15% of patients in 5, 10, and 15 years. Race (African American or Asian, P = .03), diabetes (P = .001), larger tumor base (P = .04), shorter interval from treatment to tumor recurrence (P < .001), and number of growth risk factors (P = .001) were predictive of metastasis.

Conclusion: Most cases of metastases following plaque radiotherapy of SPUM developed after 5 years following radiation. Metastasis was related to both patient factors (race, diabetes) and tumor factors (tumor base, number of growth risk factors).
Traditional Rotating Internship, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Medical malpractice caps effects on medical specialty and its influence on physician supply

Author: Wayne D. Sherman, DO, MBA, MS
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Purpose: The purpose is to investigate two hypotheses: (1) Medical Malpractice caps have a bigger effect on one specialty more than the other, and (2) Medical Malpractice caps have increased the supply of physicians in states that have caps.

Background: The medical malpractice insurance crisis that begun in the mid 1970s, and resurfaced in the 1980s, is once again threatening the American healthcare system. Malpractice premiums vary considerably across medical specialties, state boarders, and within state counties. Physicians in three states have already immobilized and initiated work stoppages in protest to the rapidly rising malpractice premiums. Currently, thirty-two states have legislation either capping noneconomic damages or limiting total damages. States with caps have experienced a more rapid increase in their supply of physicians.

Methods: Information about State medical liability laws was obtained from the National Conference of State Legislatures, the American Tort Reform Association, and the law office of McCullough, Campbell & Lane. Medical malpractice payment data was obtained from the National Practitioner Data Bank and the General Accounting Office. Physician data was supplied by the U.S. Department of Health and Human Services and the various state medical licensing boards. As this is healthcare policy research, IRB approval was not necessary.

Results: Medical malpractice caps have increased physician supply in rural counties.

Conclusion: Medical malpractice caps have not made a major impact on physician supply statewide. However, the caps have increased physician supply by 3% - 5% in the rural counties. This increase has been most prominent in the surgical specialties and the support specialties. Furthermore, states with caps of $250,000 or less have seen the greatest impact on physician supply.
Dept. of Surgery, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Stapeling Parietex Progrip mesh to gastric band ports vs suturing ports results in improved postop comfort

Authors: Jasmine Weaver DO, Anh-thy Nguyen DO  
Hospital: St. John’s Episcopal Hospital  
Program Director: Nick Gabriel DO  
DME: Sheldon Sirotta DO

Background: Traditionally when performing laparoscopic obesity surgery the access port is sutured in place. This study determines if stapling mesh to the access port instead improves patient pain and comfort.

Objective: The objective of this study is to assess if stapling mesh to gastric band ports instead of suturing ports, improves patient post operative symptoms of pain.

Methods: The research involves a retrospective study that examines 50 patients that underwent laparoscopic obesity surgery. These patients were all operated on by the same surgeons using the same technique other than the method in which the port was secured. 25 charts were reviewed of patients in which the access port was sutured into the abdomen and 25 charts were reviewed of patients in which the access port was secured using staples and mesh. Factors such as cost, pain and overall comfort were compared.

Results: Patients in whom mesh was used had the same report of pain.

Conclusions: Pain is same when mesh is used verses suture. Further conclusions and data are still being developed.
Case Report Abstracts
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

Title: “Pumped Up! A Case Report of a Subclavian DVT in a Weight Lifter”

Authors: Joseph Artale DO, Cynthia Rosenthal DO, Jonathan Golden MD, David Levy DO
Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: We present a case of a patient who presented with clinical findings of an arm deep venous thrombosis (DVT). Initial work-up was negative; however subsequent work-up revealed a subclavian DVT secondary to mechanical vascular compression.

Case description: A 17 year old male with no medical history presented with a three day complaint of right arm swelling. He denied history that could be the cause. He is a lacrosse player who works out daily. On exam, the only significant findings were swelling to the right arm from the shoulder to the fingertip. Plain radiographs and ultrasound of the arm and contrast CT of the chest were normal. Labs revealed elevated CPK of 441 and CK-MB of 8.4. The patient eventually had an MRI of the right shoulder revealing a 4.4cm clot in the subclavian vein possibly in an area of hypertrophy of the scalene. Thrombolysis was performed and warfarin therapy optimized.

Discussion: Paget-von Schrotter syndrome or spontaneous axillo-subclavian venous thrombosis (ASVT), usually appears in healthy individuals. An underlying compressive anomaly at the thoracic outlet frequently due to compression of the subclavian vein between the first rib and the scalene or subclavius tendon is the etiology. Hypercoagulable states can also be a risk factor.

These thrombi are common with catheter-related ASVT but unusual in Paget-von Schrotter syndrome. Embolic complications occur in as many as 36% of patients.

In patients where the maximal chance of unrestricted arm use is of paramount, authors recommend venography and interventional thrombolysis. Patients with residual stenosis can have surgical correction. Stenting has been shown to have a high rate of complications.
Title:  A Punch in the Face: The Case of a Rapidly Expanding Odontogenic Cyst

Authors:  Jacob Bair DO, Eric Decena MD, Stephen Henesch DO, Sarah Miller RPA
          Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: Odontogenic cysts develop within the normal dental follicle that surrounds an unerupted tooth. These cysts can grow very large and can move teeth, but more commonly are relatively small. We describe a young male who presented to the ED with the complaint of right facial swelling of two months that was determined to be a large odontogenic cyst.

Case Description: A 10 year old male with no significant medical history was brought to the emergency department complaining of right facial swelling for two months significantly worsening over the preceding two weeks. The swelling began after he was punched in the face with a soft glove. He had no recent fever, dental pain or recent dental work performed. The patient was well appearing in no distress. Examination was significant for a large amount of swelling over his right cheek/mandibular region without discernable borders. The swelling was non-tender to palpation. The remainder of the exam was non-contributory.

CT of the facial bones demonstrated an expansile septated hypoattenuated mass measuring 9.2x4.7x5.1cm centered about the right mandible and mildly displacing surrounding structures. This was suspicious for a dentigerous cyst.

Discussion: Odontogenic cyst is a broad term describing a variety of cysts defined as epithelial-lined structures derived from odontogenic epithelium and are further subdivided by location and histologic characteristics. Complete history and physical examination along with radiologic examination are the first steps in the evaluation of jaw related cysts and tumors. Fine needle aspiration, open biopsy or excisional biopsy may be necessary for definitive diagnosis.

The case presented is significant for the growth rate and large size of the cyst at presentation to the ED. CT scan is the most appropriate modality for appropriate visualization of the mass. The follow up provided to the patient is of maximal importance as odontogenic masses can require extensive treatment.
Title: Button Battery Ingestion: Not Always Just A Virus.

Authors: John Bishara, DO ¹, Aleksander Dubrovsky, DO ¹, Frank Sun, MD ², Jonathon Golden MD ³, Anthony Rosalia Jr., MD ¹, Catherine Caronia MD²

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Introduction: Button battery ingestions present with a host of variable non-specific symptoms or often with no symptoms, complicating the diagnosis and delaying appropriate treatment. The suspicion of foreign body ingestion should be raised in patients with non-specific symptoms, especially in the toddler age range. This case is an example of a battery ingestion that may have caused severe morbidity if not identified and treated appropriately. The importance of anticipatory guidance and caregiver education cannot be stressed enough regarding foreign body ingestions especially in the younger age group.

Case Presentation: An 18 month old male child presented to the pediatric emergency department with complaints of intermittent fever, poor oral intake, vomiting and diarrhea for one day and nasal congestion treated by Albuterol nebulization three times daily for one week. Due to suspicion of pneumonia, a chest x-ray was performed which demonstrated a circular foreign body at the level of the aortic arch. An otolaryngologist was consulted, and a 30 mm corroded lithium-ion button battery was removed from the child’s esophagus. A chest CT scan revealed severe esophageal ulceration with micro perforation. The child was subsequently admitted to the pediatric floor, placed on IV antibiotics and monitored for mediastinal involvement, progressive perforation and bleeding. He was discharged home after a seven day hospital course with good recovery.

Conclusions: Button battery ingestions have been increasing steadily in recent years. This case underscores how foreign body ingestions with non-specific symptoms may be initially misdiagnosed. This can lead to inappropriate treatment for patients and thus, prevent them from receiving timely treatment adding further insult to injury. Physicians continuously need to provide anticipatory guidance and identify methods of prevention in reducing pediatric foreign body ingestions.
Title: A Crabby situation: Our Limitations

Authors: Kristie Busch DO, Robin Mackoff, DO, Steven Zimmerman MD, Augusto Dasilva MD. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip NY

Introduction: In medicine we use imaging technology every day. The technology has advanced, but has it advanced enough? We present a case where a foreign body should have been seen on x ray, but was only found by incision and dissection due to a few suspicious physicians.

Case Description: A 61 year old male presented with an injury to his right third digit after picking up a crab trap. He had a puncture wound on the volar distal aspect of the digit with streaking. Pain was worse with flexion and extension at the MCP joint. Antibiotics were started for cellulitis and suspected tenosynovitis. The patient was admitted with WBC of 12.6, and normal xray. Our patient was evaluated by plastic surgery and infectious disease with an uneventful hospital course and discharged on day 2. Patient returned 6 days later. He began having swelling, pain and erythema four days after discharge. His right third digit revealed erythema and fluctuance on the volar aspect of the MCP joint. Xray remained normal and a MRI was done in the ED to rule out osteomyelitis verses foreign body. Fluid was seen around the metacarpophalageal and it was decided to take the patient to the OR. During deep dissection the tip of a crab claw was identified piercing the flexor tendon and removed.

Discussion: The exoskeleton of crustaceans is composed of calcium and chitin (polysaccharide and calcium salts) which would be expected to absorb x-rays. The fact that this foreign body was not visible makes this case unique. Literature review was unable to identify a similar case where imaging technology failed to identify a calcium containing foreign body. In retrospect using cat scan may have been a better choice to reveal the specimen. This case illustrates the importance of our clinical suspicion and examination in the emergency department verses technology.
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

Title: **Now That’s A Shock!**

Authors: Frederick Davis DO, Steven Sattler DO, Genevieve McGerald DO, Michael Gray MD. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

**Introduction:** Toxic shock syndrome (TSS) is a shock syndrome caused by the inflammatory response to toxins produced by various bacteria, most commonly Streptococcus and Staphylococcus species. Symptoms may include a prodromal period of 2-3 days with fever and associated chills, nausea, vomiting, diarrhea, abdominal pain, lightheadedness, syncope, myalgias, arthralgias, pharyngitis, headache, confusion, altered mental status, or pain at site of infection.

**Case Description:** A 35 year old male presented to the emergency department for fever of two days duration. His wife reported that the patient appeared to have difficulty with concentration and conversation.

Physical exam revealed a lethargic afebrile Caucasian male with mild cognitive deficits, especially problems with concentration. There was no photophobia and the patient had a supple, non-tender neck. Patient did have some mild tenderness to his right shoulder.

Laboratory findings revealed a normal white count and a mild elevation in transaminases. A lumbar puncture showed an elevated protein with a negative gram stain.

While in the ED the patient developed a fever of 103.0°F and became increasingly lethargic. He developed a petechial rash on his left sole that progressed to both lower legs.

The patient was treated empirically for meningitis and started on Ceftriaxone and Vancomycin. Subsequently, blood cultures would grow *S. Aureus*. After 4 days of treatment, the patient’s mental status returned to normal and he noted persistent pain to his right shoulder. An MRI of the shoulder was consistent with bursitis and was the likely cause of this patient's initial Staph infection.

**Discussion:** Toxic shock syndrome is defined by a temperature higher than 38.9°C, hypotension, the typical diffuse erythroderma followed by desquamation, and involvement of at least three organ systems.

This case highlights the importance of a good physical exam and the need to consider unlikely sources of infection when confronted with a septic patient.
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

Title: Dying to Lose Weight: A Case of Myocardial Infarction Associated with an Over-the-Counter Weight Loss Supplement

Authors: Laura Fil DO, Eric Decena MD, Rikesh Patel MD, David Levy DO
Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: We discuss a case of young male who presented to the Emergency Department with an acute myocardial infarction. An over-the-counter weight loss supplement may have contributed to his acute event secondary to an undeclared ingredient in the product.

Case description: A 34 year old Hispanic male with no previous medical history presented to the Emergency Department with chest pressure for three hours. The pain radiated to both arms and was associated with dyspnea, nausea, and vomiting. His only cardiac risk factor was a prior smoking history. He was taking an over-the-counter weight loss supplement for the past month.

He was in no distress with a pulse of 50 and BP of 146/100; physical examination was otherwise normal. An electrocardiogram revealed an acute inferior-posterior myocardial infarction. During emergency cardiac catheterization a right coronary artery stent was placed. The patient did well and was discharged home three days later.

Discussion: Obesity is an epidemic in the United States. The increasing number of overweight individuals has led to a growing market for fitness products and dietary supplements.

Our patient was taking an over-the-counter weight loss supplement that may have played an important role in the development of his acute myocardial infarction. The ingredients listed were all natural ingredients. However, it was discovered that the product was taken off the market by the FDA because of an undeclared ingredient, didesmethy sibutramine.

The FDA is currently reviewing a study on sibutramine that shows it has minimal weight loss effect and based on the results of the Sibutramine Cardiovascular Outcome Trial (SCOUT) patients with cardiovascular disease had worse cardiovascular outcomes.

This case reminds us that herbal medications and supplements may contain ingredients that can alter the normal physiology of the body and therefore, must be taken into consideration during a patient’s medical evaluation.
Title: Infant with Thrombus within the Ductus Diverticulum

Authors: Heather Grooms D.O. (1) Joel Harnick M.D. (2) Anthony Rosalia Jr. M.D. (1)
Good Samaritan Hospital, West Islip NY (1) Department of Medical Education (2) Division of Pediatric Cardiology, Department of Pediatrics

Introduction: A ductus diverticulum (DD) or aneurysm of the ductus arteriosus (DA) is a saccular or tubular dilation of the DA. DD is considered a rare lesion most commonly diagnosed in the first two months of life. Although DD is usually an incidental finding on echocardiography, it can be associated with severe complications including thromboembolism, infection and rupture leading to death. This case describes an infant who was incidentally diagnosed with a thrombus within the DD after presenting with apparent life-threatening events (ALTEs) that were ultimately felt to be due to gastroesophageal reflux.

Case Description: The patient was the second born of full term discordant twin females with a history of hypothermia and low birthweight requiring a four day stay in the NICU. At 5, 13 and 17 days of life the patient presented with a series of ALTEs. Evaluations by Neurology, Gastroenterology and Cardiology suggested these events were caused by gastroesophageal reflux. As an incidental finding however, an echocardiogram (ECHO) revealed a thrombus within a DD. CT and MRI of the brain performed for the ALTE work-up were within normal limits with no evidence of embolic phenomena. Further evaluation by Hematology revealed no coagulopathies in the patient or her parents, but anticoagulation therapy was initiated to inhibit growth/extension of the thrombus. Subsequent ECHO’s revealed a reduction in size of this thrombus, such that it was no longer within the lumina of the aorta or pulmonary artery requiring no further continuance of anticoagulation therapy.

Discussion: Thrombus of the DD is a lesion potentially associated with high morbidity. Definitive surgical repair has been suggested however conservative management has also been reported in cases where blood flow in the aorta or pulmonary arteries is not compromised where there are no known embolic phenomena. This case was treated conservatively with anticoagulants and close monitoring with good outcome.
Title: The Life Vest Rubbed Him the Wrong Way

Authors: Jacqueline Hernandez, DO, (1) Cynthia Rosenthal DO, (2) Howard Balbi, MD (3)
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Introduction: Staphylococcal Scalded Skin Syndrome (SSSS) is the most severe manifestation in the spectrum of Staphylococcus aureus exotoxin mediated diseases of the skin. The manifestations of SSSS are age related and they include generalized exfoliation in the neonate, and a scarlatiniform eruption and localized bullous impetigo in older children. Toddlers and older infants can have a combination of both in addition to flaky desquamation of the skin. Bacteremia is rare, but dehydration and superinfections may occur with extensive exfoliation. This report describes a child who presented with what initially was thought to be an allergic reaction but was found to have SSSS.

Case presentation: A four year old male presented to the ED with the chief complaint of rash. Several days prior the child had been to a water park where he had been wearing a rented life vest. A rash had developed around his neck, axilla and abdominal areas corresponding to the vest pattern. The child then developed hives and was taken to a pediatrician, who diagnosed him with contact dermatitis, prescribing antipyretics, steroids and antihistamines. Later that day the child developed sloughing of the skin and was admitted to the PICU for IV hydration, antibiotic treatment and pain management. The diagnosis of SSSS was confirmed by a skin biopsy and positive skin, eye and throat cultures for Staphylococcus aureus.

Discussion: Skin infections following water exposure may be caused by a wide variety of organisms. Local trauma or injury coupled with water exposure is a common theme in this type of infection. In this instance as the rash initiated at the areas where the skin was in contact with the vest, the initial diagnosis made was dermatitis. As the rash progressed it became more apparent that the child had developed SSSS. With appropriate treatment the child improved, and was discharged home.
Title: Internal Decapitation: A New Perspective

Authors: Jason Idelson DO, Eric Decena MD, Stephen Henesch DO
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Introduction: Annually, there are approximately 12,000 new cases of spinal cord injury in the United States. Motor-vehicle collisions account for almost half of the injuries. Patients who survive often face devastating physical immobility and a lifetime of related health issues.

Case description: This is a case of a 42 year old male presenting after a high speed motor vehicle collision. He presented on a long board with spinal immobilization in place. He had a GCS of 6, thready pulses, tachypnea and tachycardia. The patient was subsequently intubated and aggressive resuscitation initiated. CT imaging revealed a solitary, large distraction injury at C6/C7. Our patient was stabilized, however, died approximately 48 hours later.

Discussion: Internal decapitation, otherwise known as atlanto-occipital dislocation, describes a rare medical condition in which the skull separates from the spinal column during severe head injury. This case depicts a decapitation injury, however, at the C6/C7 level. While some may think this highlights the importance of cervical collars, there is growing evidence to support that utilizing these collars might cause increased harm through further distracting the spine.

Recent research has proven that applying collars to atlanto-occipital injuries actually increases the damage. In the most recent study in 2010, proper application of an extrication collar resulted in abnormal separation between these two vertebrae. In effect, application of an extrication collar resulted in separation of the head from the spinal column.

This direction is in spite of the absence of proven benefit from spinal immobilization. Quite to the contrary, researchers have demonstrated that rigid spinal immobilization procedures can result in tissue necrosis, increased intracranial pressure, reduced pulmonary function and even death. It is this case which I feel further shows the increasing impact of motor vehicle collisions, and the need to further delineate the role of cervical collars at this time.
Dept. of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip, NY

Title: Elusive Hip Pain That May Take Your Life Away: A Case Report of a Necrotizing Fasciitis

Authors: Melissa Keehn DO, Michelle Gebhard DO, Steven Zimmerman MD, John Tomasula MD
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Introduction: We report a case of a patient who presented to the emergency department with left hip pain. The cause was eventually determined to be an atypical presentation of localized necrotizing fasciitis, which rapidly progressed into profound sepsis and death within less than 24 hours.

Case description: A 67 year-old female presented to the emergency department complaining of sharp left hip and thigh pain for twelve hours. The patient was evaluated 6 hours earlier in Emergency Department, had a normal left hip x-ray and was given a prescription for analgesia. The patient returned due to inability to sleep secondary to the pain.

She was afebrile, normotensive but in moderate painful distress. Her left lower extremity had limited range of motion secondary to pain. Her left thigh had a dusky, 10cm patch of induration over the greater trochanter with slight crepitus on palpation. She was anemic, in metabolic acidosis with an elevated total CK. A left hip CT scan revealed no acute fracture or dislocation but extensive emphysema in the bone and soft tissues.

The patient’s condition deteriorated rapidly during her ED stay. She became significantly hypotensive and was immediately started on intravenous fluids, antibiotics, sodium bicarbonate and vasopressors. She was intubated and taken to the operating room where a radical left hemipelvectomy was performed. The patient survived the surgery but very soon after passed away in the recovery room.

Discussion: Necrotizing fasciitis is a very severe type of bacterial infection, which destroys skin, muscle and the underlying tissue and may do so at an alarming rate. The rate at which this case progressed makes it a compelling and certainly important differential for all medical practitioners to keep in the back of their minds when encountering any patient with vague or mysterious pain out of proportion to the physical findings.
Title: Sometimes You Don’t Have to Look for a Zebra in the Forest: A Case Report of a Celiac Artery Thrombosis, Splenic Infarct, and Pulmonary Embolism

Authors: Steven Keehn DO, Robin Mackoff DO, David Levy DO, Lawrence Womack, MD, Manal Hegazy, MD. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: We report a case of a patient who presented to the emergency department with abdominal pain. The cause was eventually determined to be the rare occurrence of a celiac artery thrombosis leading to splenic infarction. The patient concurrently developed a pulmonary embolism. The patient had no risk factors for these diagnoses or hypercoagulable disorders.

Case description: A 41 year old male presented to the emergency department complaining of four hours of progressively worsening abdominal pain that began suddenly. He had nausea, diaphoresis, and constipation. Over-the-counter gastrointestinal preparations offered no relief.

He was in mild distress and his exam was significant for lower abdomen tenderness. He had a mild leukocytosis. A CT scan of his abdomen and pelvis revealed a splenic infarction and a left common iliac artery aneurysm. A CT scan of his chest revealed a pulmonary embolism. An EKG and echocardiogram were normal. MRA of the mesentery revealed celiac access dissection with occlusion resulting in splenic infarction.

The patient was anticoagulated and unfortunately developed heparin induced thrombocytopenia (HIT). After treatment the patient’s condition improved and he was eventually discharged with a therapeutic INR. Repeat evaluation for a disorder of coagulation after the patient’s condition improved revealed none.

Discussion: Fewer than 180 cases of celiac artery aneurysms have been reported in the medical literature. To have a splenic infarction and simultaneously have a pulmonary embolism without a disorder of coagulation is quite unusual.

Aneurysms of the celiac artery were first described in 1745. This anomaly accounts for 3.6% to 4% of splanchnic artery aneurysms, but have a high risk of mortality if they rupture. The annual incidence ranges from 0.005% to 0.01%. Twelve percent of these patients reported abdominal pain on presentation. It has been shown in patients with hypercoagulable states of which this patient did not have.
Dept. of Pediatrics, Good Samaritan Hospital Medical Center, West Islip, NY

**Title:** Chronic Vomiting in a Child with Trisomy 21 and Abnormal Celiac Serology Weaves a Duodenal Web

**Authors:** Melody Kinsley, D.O., David Gold, M.D.,
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**Introduction:** Vomiting has an extensive differential diagnosis including inflammatory, anatomic, infectious, neurologic, and metabolic causes. Down’s syndrome is a predisposing condition for many gastrointestinal abnormalities including structural anomalies and inflammatory conditions such as celiac disease. An organized diagnostic plan when dealing with high risk patients will expedite the diagnosis and avoid unnecessary testing.

**Case description:** A 6 year old female with Down’s syndrome had chronic vomiting of at least 4 years duration as well as increasingly frequent generalized abdominal pain. The vomiting occurred 2-3 times weekly and was non-bloody, nonbilious, and occurring later in the day. Her mother reported hearing significant fluid gurgling across her abdomen. Her physical exam demonstrated typical Down’s features, and a soft distended abdomen without tenderness or masses. Screening blood work revealed an elevated gliadin IgA and IgG antibodies with negative endomysial and transglutaminase antibodies. Given the increased association of celiac disease in Down’s syndrome, an endoscopy was performed. The endoscopy revealed a markedly dilated duodenal bulb and distal narrowing consistent with a stenosis of the second to third portion of the duodenum. Duodenal biopsies were normal. The patient was sent for an upper GI series which confirmed duodenal stenosis. The patient underwent a duodenotomy and incision of an obstructing duodenal web.

**Discussion:** This case highlights the importance of the association of gastrointestinal entities associated with Down’s syndrome as well as recognizing false positive tests that may be misleading. Elevated gliadin antibodies led to the endoscopy when an imaging study would have established the correct diagnosis. About 10% of Down’s children have gastrointestinal atresia or stenosis. Persistent abnormal symptoms such as chronic vomiting should prompt appropriate diagnostic testing including imaging studies. Investigation for the possibility of duodenal obstruction as a cause for the patients persistent vomiting may have lead to an earlier diagnosis and avoided an endoscopy.
Title: An Unusual Cause of Left Lower Quadrant Pain-Type I EVAR Symptomatic Endoleak Diagnosed Using Bedside Ultrasound

Authors: Diana Kontonotas DO, Sarah Arzt DO, Charles La Rosa MD, Genevieve McGerald DO

Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: Endovascular aneurysm repair (EVAR) has gained acceptance as an alternative to traditional open surgery for repair of abdominal aortic aneurysms (AAAs). A recognized disadvantage is the development of an endoleak. An endoleak is defined as persistent blood-flow outside of the graft and within the aneurysmal sac and are classified based on the source of blood flow. Type I endoleaks may be associated with continued risk of aneurysm rupture and may require urgent intervention.

Case description: A 63 year old male with a past medical history of endovascular repair of an AAA seven years prior presented to the ED complaining of left lower quadrant (LLQ) abdominal pain and chest pain. Upon arrival to the ED, vital signs showed a BP of 230/100. Physical exam revealed a thin man in moderate distress secondary to pain. The lungs were diffusely decreased breath sounds and the abdomen was soft, with a palpable pulsatile mass without an audible bruit. The patient had left periumbilical and LLQ tenderness, no CVAT. There were equal lower extremity pulses and the lower extremities were warm, without edema or cyanosis. A bedside abdominal ultrasound demonstrated blood flow outside of the endograft within the aneurysmal sac. CT scan confirmed the diagnosis of endoleak and the patient then underwent emergent operative angiography and endovascular repair of this symptomatic type 1 endoleak at the left iliac limb.

Discussion: In the emergency department bedside ultrasound has been proven to be useful in the evaluation of the abdominal aorta. EVAR has developed into a frequent and usually successful treatment of AAAs. Delayed type 1 endoleak is a well documented shortcoming of EVAR that results in arterial pressurization of the aneurysmal sac which may lead to AAA rupture. Prompt diagnosis with bedside ultrasound expedited timely successful endovascular re-repair prior to impending rupture of this symptomatic AAA.
Title:  PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Strep)

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Introduction:  Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections (PANDAS) can present as a variety of neuropsychiatric complaints such as obsessive-compulsive behavior or involuntary muscle movements. First described in 1998 by Swedo et. al, PANDAS is becoming an increasingly recognized diagnosis and should be understood by physicians caring for pediatric patients.

Case description:  This case is that of a 3 year old male brought to the emergency department by his parents with a primary complaint of “twitching and jerking” of hands and neck. The parents do not recall any febrile illness, sore throat, skin rash or joint pain. No other significant symptoms or past medical history reported.

On exam, the patient is generally well appearing and has involuntary movements of head, neck and choreiform movements of his extremities. The remainder of the physical exam was unremarkable. Laboratory and radiographic testing was unremarkable with the exception of a grossly elevated ASO titer.

Discussion:  PANDAS, first described in 1998, has been well studied over the past ten years without significant elucidation in the understanding of the mechanism behind the disorder. Researchers believe that the process is an autoimmune condition triggered by Group A Beta Hemolytic Streptococcal (GABHS) infections, such as Strep throat or Impetigo, similar to the mechanism of rheumatic fever.

Considered a clinical diagnosis, the diagnosis of PANDAS can be made by ruling out other etiologies of a patient’s symptoms or by confirming exposure to recent streptococcal infection. In order to make the clinical diagnosis, the following criteria should be met:

- presence of OCD or tic disorder
- onset of symptoms between 3 years of age and puberty
- episodic course of the symptom severity
- association with strep infection
- association with neurological abnormalities

Treatment of children with PANDAS is still controversial and should be managed by a pediatric neurologist.
Title: GBS: Making the Connection

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Introduction: We present a case report of a patient who developed Group A streptococcus (GAS) peritonitis from as ascending infection of her genitourinary tract.

Case description: A 34 year old female presented to the emergency department with fever, dizziness, and lower abdominal pain. She had foul smelling urine and a slight vaginal discharge. Her only sick contact was her husband who had a pharyngitis diagnosed several weeks prior.

Her vital signs were T: 102.2°F, P: 115, BP: 96/65. She appeared comfortable and had an exam significant for lower abdominal tenderness and mild cervical motion tenderness.

The patient received a fluid bolus and acetaminophen with improvement of her fever and tachycardia. She had a WBC count of 11.2 with 39 bands. Other labs and transvaginal sonogram were normal. CT of the abdomen and pelvis showed a bowel ileus without obstruction and a small amount of pre-sacral fluid.

She was given antibiotics and was taken to the OR for an exploratory laparoscopy where a large amount of intra-abdominal purulent material was found; without obvious source of infection.

Blood cultures, intra-abdominal cultures and vaginal cultures were all positive for Group A Streptococcus. The patient denied any recent infections, but stated her husband had a confirmed Group A Streptococcal pharyngitis. The patient later admitted that they had engaged in oral sex while he was ill.

Discussion: GAS is well known to be associated with a variety of human illnesses, including invasive disease associated with high morbidity and mortality. The organism is not, however, considered part of the normal vaginal flora. Therefore, genitourinary tract colonization serving as a reservoir for GAS as a sole causative organism leading to ascending infection, bacteremia, and invasive disease is distinctly unusual. We speculate that her husband was the initial reservoir and transmitted the organism to the patient through genital contact with oral secretions.
Title: Rare Presentation of Undiagnosed Arginase Deficiency

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Introduction: Arginase deficiency is a rare autosomal recessive disorder caused by (a) mutation(s) in the ARG1 gene on chromosome 6q23. It usually becomes symptomatic by early childhood with the first symptoms being neurologic. A favorable outcome can be expected with appropriate treatment. If untreated, symptoms are progressive with plateauing in cognitive development and subsequent loss of developmental milestones.

Case Description: An 18-year-old male with mental retardation, cerebral palsy, seizure disorder and global developmental delay that began in early childhood presented to the ER with a 3-day history of right knee swelling. It was not associated with trauma, pain or recent infection. Physical examination revealed mild swelling of the right knee without erythema or warmth and a mildly distended abdomen without organomegaly. Laboratory findings demonstrated pancytopenia, prolonged prothrombin time unresponsive to vitamin K, elevated transaminases, normal bilirubin and hypoalbuminemia. Imaging of the lower extremities revealed no fracture, but diffuse osteoporosis. Doppler ultrasound showed no evidence of deep venous thrombosis. Abdominal ultrasound revealed splenomegaly, ascites, and a small, echogenic liver suggestive of cirrhosis. Cirrhosis was confirmed by liver biopsy. Further testing revealed an elevated ammonia level of 95. Plasma amino acids showed an elevated arginine level and a diagnosis of arginase deficiency was made. Treatment was initiated using sodium phenylbutyrate and a low protein diet with supplementation of essential amino acids.

Discussion: This case demonstrates portal hypertension and cirrhosis in a neurologically impaired child with undiagnosed arginase deficiency. This child has significant neurologic sequelae that might have been ameliorated with a more prompt diagnosis and treatment. However, it is uncertain if early diagnosis and institution of therapy would have prevented his liver disease. Arginase deficiency should be considered in older children and adults with lower limb spasticity, especially when accompanied by ataxia, seizures, mental retardation or liver abnormalities.
Title: Fatal Drip: A case of sinusitis causing meningitis

Authors: Doni Marie Rivas DO, Genevieve McGerald DO, Patrick Reid MD, Jason Winslow MD, Loretta Rispoli NP. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: Cerebrospinal fluid leak is a serious condition that can occur secondary to either traumatic or atraumatic causes. Detection of the defect causing the leak is imperative to avoid serious life-threatening complications.

Case Description: A 48 year old female presented to the emergency department complaining of a five week history of persistent nasal drip, associated with fever and intermittent headaches for one month. She had been treated with several different antibiotics in the prior 4 months for a presumptive diagnosis of sinusitis. At the time of presentation, the patient was found to be febrile. Nasal congestion with surrounding erythema and clear rhinorrhea were noted. The rest of her physical exam was unremarkable.

Laboratory studies were obtained which demonstrated a leukocytosis. A CT scan of the brain was found to be unremarkable. Antibiotics were administered and the patient underwent a brain MRI and fluoroscopic-guided lumbar puncture. The MRI demonstrated a left superior ethmoid cell defect allowing CSF leakage through the ethmoid sinuses. CSF analysis was suggestive of bacterial meningitis but no organisms were found.

Discussion: Trauma is the most common cause of CSF fistulas. They can also occur secondary to eroding tumors, congenital defects, ENT infections, or increased intracranial pressures. The common result is destruction of the bony architecture resulting in a defect of the cribriform plate. Ascending meningitis complicates a third of cases.

Patients usually present with unilateral clear rhinorrhea secondary to defects in the sphenoid sinus and the ethmoid roof.

If due to traumatic events, small CSF leaks are treated conservatively with antibiotics. Immediate surgical repair is necessary for all others.
Title: Nasal Septal Abscess: A Rare Complication of Acute Sinusitis

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Introduction: Nasal septal abscess (NSA) is an exceedingly rare diagnosis. It is defined as a collection of purulent material between the bony or cartilaginous nasal septum and the overlying mucoperichondrium or mucoperiostium. While nasal trauma accounts for 75-80% of cases, atraumatic causes of NSA, such as sinusitis, are more unusual. A rhinological emergency, NSA may mimic symptoms of other diagnoses including sinusitis. As our case demonstrates, NSA is easily misdiagnosed because of its rarity and similar symptomatology to other conditions.

Case: A 13 year old male presents to the emergency department complaining of increased difficulty breathing through his nose, rhinorrhea, headaches and fevers for six days. Physical exam revealed sinus tenderness, edema and tenderness of the nose with a swollen nasal septum. Our patient was admitted with acute sinusitis and subsequently diagnosed with NSA after physical exam and imaging review by otolaryngology. He immediately underwent incision and drainage. The patient’s symptoms gradually resolved and his septum was found to be well healed at follow up.

Discussion: There is unanimous agreement in the literature that septal abscesses must be promptly identified and treated. Delayed management exposes patients to a myriad of complications ranging from saddle nose deformities to intracranial infections to death. Although sinusitis appeared to be the inciting cause of our patient’s septal abscess, the literature suggests that other possibilities should be considered. Regardless of the cause, promoting physician awareness of this rare condition will lead to earlier diagnosis and treatment in order to prevent the dangerous sequelae of NSA.
Title: An Uncommon Cause of Ascites and Abdominal Pain

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Introduction: Eosinophilic gastroenteritis is a rare disease marked by eosinophilic infiltration of the gastrointestinal tract, as well as peripheral blood eosinophilia. Patients often demonstrate nonspecific gastrointestinal symptoms such as pain, vomiting, diarrhea, weight loss, abdominal distension and anemia. If undiagnosed and untreated, malnutrition, intestinal obstruction and perforation can result. We report a case that presented with pain, ascites and marked eosinophilia.

Case Description: An 11 year old male presented with three weeks of nonradiating epigastric pain not associated with eating and nonbloody diarrhea. He was afebrile, had no sick contacts, no travel history, or other complaints. His initial CBC showed a WBC count of 64.3K with 78% eosinophils. Initial AXR showed abnormal small bowel gas pattern, and abdominal CT revealed moderate ascites and fluid filled intestinal loops with prominent jejunal folds. Eosinophilic gastroenteritis was confirmed by endoscopy/colonoscopy with biopsy and paracentesis (predominantly eosinophils). Corticosteroids were started with symptomatic improvement.

Discussion: Eosinophilic gastroenteritis is a rare disease that often presents with nonspecific signs and symptoms. Up to 80% can have symptoms for years prior to diagnosis. The pathogenesis is uncertain, although eosinophils, Th2 cytokines, and eotaxin play a significant role in the pathogenesis. Eosinophils mediate proinflammatory effects and may induce tissue damage by releasing a variety of toxic factors. Symptoms vary depending on the areas of the GI tract that are involved and the depth of penetration of the eosinophilic infiltrate. Serosal involvement often leads to ascites. Treatment with corticosteroids leads to 90% response rate, though recurrence is high. Elimination diets, surgery, montelukast, sodium cromoglycate, and antihistamines are also used with less success. Intestinal obstruction or more rarely, perforation, can occur. Undiagnosed ascites can cause respiratory compromise. It is important that eosinophilic gastroenteritis be diagnosed in a timely manner especially since the symptoms are so nonspecific and the morbidity can be significant.
Dept. of Pediatrics, Good Samaritan Hospital Medical Center, West Islip, NY

Title: A Rare Case of MoyaMoya and Graves’ Disease

Authors: Melissa Ungeheuer, DO(1), Sarita Duchatelier, MD(2), Michael Pugliese, MD(3), Anthony Rosalia Jr., MD(1)

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Introduction: Moyamoya disease is characterized by gradual occlusion of the internal carotid arteries either bilaterally or unilaterally with growing evidence to suggest that autoimmune dysfunction might be the underlying cause. We present a case of a 16 year old patient with MoyaMoya and Graves’ disease.

Case description: A 16 year old Philippine female with a progressively worsening five day history of slurred speech, chorea and fatigue presented to the Emergency Department. She also described a history of rapid heart rate and weight loss.

Physical exam was within normal limits except for moderate word finding difficulty, difficulty with initial hip movement, tandem walking and heel to shin testing with 4/5 lower limb strength noted.

A Computerized Tomography (CT) scan of the head revealed periventricular and basal ganglia hypodensity indicating stroke. An Electro Encephalogram (EEG) showed diffuse epileptogenic cortical dysfunction. Initial lab work revealed a low TSH and high T3 and T4 levels with high anti-thyroglobulin antibody and Thyrotropin receptor antibody confirming her hyperthyroid state and diagnosis of Graves' disease.

The patient received clonazepam for her chorea, methimazole for her hyperthyroidism and aspirin for stroke prophylaxis. The patient underwent a bilateral revascularization surgery with improvement of her neurologic status at another hospital.

Discussion: MoyaMoya is believed to be caused by increased sympathetic tone in the cervical region leading to vascular occlusion. Over the past 10 years there has been evidence that the disease may be linked to other autoimmune disorders including Hashimoto’s Thyroiditis and Graves’ disease as well as Down syndrome and Sickle-Cell disease. There are however no studies that have looked for a connection between pathologies; which presents first is not certain. It is suggested that the hyperthyroid state up-regulates the sympathetic nerve tone and increases hypercoagulation leading to increased risk of stroke.
Title: A FAST Pitfall: False Positive FAST Exam Caused by Massive Hydronephrosis

Authors: Diana Kontonotas, DO, Sarah Vitello DO, Paul Barbara MD, David Teng MD, Genevieve McGerald DO. Emergency Medicine Residency Program, Good Samaritan Hospital Medical Center, West Islip, NY

Introduction: The Focused Assessment with Sonography for Trauma (FAST) exam has become the standard of care in the evaluation of a trauma patient for intrabdominal or pericardial fluid collections. In many institutions a positive FAST exam in a hemodynamically unstable patient is an indication for an immediate exploratory laparotomy in the operating room. Hemodynamically stable patients with a positive FAST exam can be further evaluated with a CT scan. The FAST exam is now being relied upon to make critical decisions in trauma patients and it is important to identify entities that cause false positive exams.

Case description: We report a case of a 21 y/o bicyclist struck by a car with massive L hydronephrosis, localized to the upper pole of the kidney, causing a false positive FAST exam. Results were confirmed by CT scan.

Discussion: Anechoic fluid detected on FAST exam is indicative of a positive result, however not all anechoic fluid represents hemoperitoneum. Fluid-filled bowel, fluid-filled stomach, ascites, free urine, perinephric fat pads, subcapsular hematomas, renals cysts and fluid filled gallbladders have been reported as other causes of false positive FAST studies. Though a skilled ultrasonographer may be able to differentiate other entities that mimic a positive FAST, it is important for the ED physician to be able to recognize false positive studies to prevent unnecessary laparotomies.
Title: A Case of Urinary Retention and Mild, Bilateral Hydronephrosis Due to an Imperforate Hymen

Authors: Shannon Henning D.O. (1), Jacqueline Yacenda DO (1), Emily Gubert, M.D. (2), Catherine Caronia M.D. (3).

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Introduction: The overall specific incidence of an imperforate hymen is unknown, but is considered a rare event. Rarer still is urinary retention secondary to an imperforate hymen that leads to hydronephrosis. The hypothesized cause of urinary retention is secondary to the retained menstrual products in the vagina that causes compression of the posterior bladder wall and urethra into an angulated position thereby preventing urination.

Case Description: An afebrile, thirteen-year-old Caucasian female presented to the ED with a history of anuria for twelve hours and severe abdominal discomfort. The patient denied sexual activity or the onset of menses but admitted to an intermittent cramping abdominal pain for several months duration. Physical examination revealed a tanner III female and was within normal limits except for a twenty millimeter mass palpated on abdominal exam to the left of and above the umbilicus and a bulging, lemon-sized, mucosa-covered mass protruding from the introitus. Urinary catheterization revealed five hundred cc of clear urine resulting in a decrease in the size of the abdominal mass. An abdominal ultrasound revealed hematometros-hematocolpos and mild bilateral Hydronephrosis. Surgical incision of the hymen allowed for the drainage of one liter of thick, brown retained menstrual blood. A Urinalysis and urine culture was negative for abnormality or infection.

Discussion: Urinary retention secondary to multiple factors such as constipation, urinary tract infection, pelvic disorders, trauma, psychosomatic causes, and posterior urethral valves (in males) are seen in children. However, this case stresses the importance of a complete history and physical examination during annual examinations, in addition to a review of systems on routine evaluation of patients such that possible diagnosis can be made. Thus an imperforate hymen may be diagnosed prior to the secondary presentation of acute urinary retention.
Title: Psychiatric Manifestations of Tuberous Sclerosis

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Introduction: Tuberous sclerosis is characterized by cutaneous lesions, seizures, mental retardation, learning disabilities, developmental delay and behavior problems, such as hyperactivity, aggression, and self-injurious behavior. It is most commonly diagnosed in infancy or childhood. This case illustrates an example of someone who was diagnosed in adulthood, and demonstrates the need to consider a diagnosis of tuberous sclerosis as a rule out for a psychiatric presentation, when seeing a patient with impulsivity, suicidal attempts, and self-injurious behavior because being diagnosed with tuberous sclerosis could have serious implications for the patient and the care givers.

Case History: The patient is a 19 year-old Caucasian female with a past history of major depression and polysubstance dependence who was initially hospitalized in a neurology floor after sustaining a seizure. She had one previous psychiatric hospitalization for overdosing on medication and illicit drugs and a history of cutting herself. She was admitted twice to a neurology unit to evaluate the seizure and both times signed out against medical advice. During the second admission on the neurology unit, her MRI showed two small lesions within subcortical white matter. Her outpatient neurologist informed her that she has tuberous sclerosis and as she was being told this, the patient text messaged some of her friends threatening to hurt herself. Patient was hospitalized on an inpatient psychiatry unit because of concern that she would kill herself with intentional heavy drug use. She was discharged to an inpatient rehabilitation unit in California.

Discussion: This case illustrates that someone with a history of impulsive behavior and long standing history of self-injurious behavior including cutting, drug use, and suicide attempt should receive further workup to evaluate for tuberous sclerosis. Since tuberous sclerosis is an autosomal dominant genetic disorder, there is an increased need for genetic counseling and periodic surveillance for malignancy.
Title:  Supraventricular Tachycardia in Pregnancy

Author:  Eli Cohen, DO
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Introduction:  Arrhythmias are the most common cardiac complication occurring during pregnancy in women without structural heart disease. Paroxysmal supraventricular tachycardia (SVT) is the most common arrhythmia in pregnancy with conservative incidence of 4%. This case is of interest because pregnancy has been identified as a risk factor for paroxysmal SVT. When SVT fails to be self limited or hemodynamic compromise arises, immediate intervention is necessary to prevent harm to mother and fetus.

Case Description:  A 41-year-old African American female presented to the emergency department with palpitations for 2 days. Associated symptoms included fatigue, urinary frequency and two weeks of left flank pain. Otherwise, patient denied fever, nausea, vomiting, chest pain or shortness of breath.

Physical examination was remarkable for pulse 208 bpm, blood pressure 128/77, room air pulse oximetry 98%. Heart sounds were significant for a regular tachycardia. Patient’s abdominal and back exam was significant for left CVA tenderness. Otherwise, no jugular venous distention, palpable thyromegaly, lower extremity edema or calf tenderness was noted.

Initial electrocardiogram revealed supraventricular tachycardia at 206 bpm with left ventricular hypertrophy. Patient was given adenosine 6mg IV rapid push with immediate resolution of tachyarrhythmia. Repeat electrocardiogram revealed normal sinus rhythm at 98 bpm, normal axis, with left ventricular hypertrophy. Laboratory analysis revealed mild white blood cell count elevation with normal differential and a positive urine pregnancy test. Bedside transabdominal ultrasound revealed an intrauterine fetal yolk sac with absence of free pelvic fluid. Patient was monitored for several hours following cardioversion and discharged home.

Discussion:  This case illustrates the importance of understanding cardiac arrhythmias during pregnancy. Prompt intervention ensures positive outcome for mother and fetus. When hemodynamically stable, acute episodes of SVT in pregnancy may be terminated by blocking AV nodal conduction. Additional emphasis on the frequency and management of cardiac arrhythmias during pregnancy is needed.
Dept. of Surgery, Peninsula Hospital Center, Far Rockaway, NY

Title: Unusual Foreign Body Aspiration

Authors: Vadim Avulov DO, Joel Silverman MD, and Ahamed Moideen MD FACS

Institutions: Peninsula Hospital Center, Far Rockaway NY and Flushing Hospital Medical Center, Flushing NY

Introduction: Approximately 35,000 deaths occur each year from foreign body aspiration. Before the 20th century foreign body aspiration was associated with 24% mortality rate and with the advent of endoscopy this rate has decreased to 2%. Children tend to aspirate foodstuff (nuts, seeds, popcorn, fish/chicken bones) whereas adults aspirate non-food objects (coins, clips, pins, pen caps). Aspirated foreign body most commonly lodges in the right main stem bronchus.

Case Description: 35 year-old male with history of Type-I Diabetes, presented to ED complaining of bouts of hemoptysis and a feeling of a sharp, “pinching” sensation in his chest, and constant intermittent cough. Earlier in the week, the patient has been repairing his roof. He appeared to be in no respiratory distress and vitals were stable. We describe a case of an unusual foreign body aspiration, a stack of staples.

Discussion: Flexible, fibrooptic bronchoscopy can be used therapeutically for select foreign body aspirations in the hands of an experienced operator.
Title: An Unusual Case of Incarcerated Sliding Right Inguinal Hernia and Perforated Appendix Presenting as Two Separate Entities: Role of Computed Tomography in Evaluation of Inguinal Hernia

Authors: Belma Doyle DO; Julie Caffrey DO, and Stanley Kim DO FACOS
Institutions: Flushing Hospital Medical Center, Flushing NY and Peninsula Hospital Center, Far Rockaway NY

Introduction: Repair of abdominal wall hernias is one of the most common operations performed by general surgeons in the United States. Complications of inguinal hernias include incarceration (10%) obstruction and strangulation. Given the serious nature of incarceration and propensity towards strangulation, historically physical examination has been viewed as the most important diagnostic tool.

Case Description: An unusual case of a large incarcerated sliding right inguinal hernia containing urinary bladder with subsequently discovered perforated appendix was reported in 37-year-old male. The diagnosis of perforated appendix was made during the herniorrhaphy, requiring an extension of the original incision superolaterally. The appendix was not located within the sliding hernia but appeared to represent a separate entity. This patient did not undergo abdominal computed tomography prior to herniorrhaphy due to the obvious nature of his condition. Omission of this test caused a failure in identification of perforated appendix.

Discussion: The use of abdominal computed tomography to confirm the diagnosis before operative reduction of inguinal hernia, especially when occurring on the right side, appears to be a safe and efficacious adjunct to physical examination.
Title: Massive Gastrointestinal Bleeding Secondary to Rare Jejunal Diverticuli

Authors: Joshua Hourizadeh DO, Nicholas LaGamma MD, Howard Beaton MD FACS

Institutions: Peninsula Hospital Center, Far Rockaway NY and New York Downtown Hospital, NYC

Introduction: Jejunal diverticuli are a relatively common medical condition, yet massive hemorrhage is a rare event. Most diverticuli are clinically silent unless discovered incidentally on imaging studies or presenting with complications, but can create an acute emergency warranting prompt surgical intervention. The intent of this review is to define the pathophysiology, epidemiology, imaging and diagnostic procedures and treatment options for massive hemorrhage from jejunal diverticuli.

Case Description: This is a case of a 57 year old male with massive gastrointestinal bleed. Patient had a medical history of lower back pain due to herniated lumbar disc disease and left knee osteoporosis, taking 4-5 ibuprofen per day for one month. Panendoscopy was performed without revealing any localized site of bleeding. Patient was deteriorating with a severe drop in hemoglobin and hematocrit requiring more than eleven units of packed red blood cells. Emergent surgery noted a segment of jejunal diverticulosis with some areas of bleeding which required resection. The bleeding cause is thought to be due to excessive non-steroidal usage.

Discussion: Evaluation of bleeding jejunal diverticula can be identified by radioisotope-tagged red cells, angiography, or double balloon enteroscopy. Capsule endoscopy has also been used to diagnose jejunal diverticulum; however the risk of retention in the diverticulum has been seen in several cases. The most sensitive imaging studies to detect bleeding jejunal diverticula are the technetium-99m red blood cell scan and mesenteric angiography, with the latter having the advantage of embolization.
Title: Repair of Large Posterior Diaphragmatic Hernia in a 20-year-old Female

Author: Andrea R Hufford, DO, Shahriyour Andaz MD, Rajiv Datta, MD FACS, and Howard Sussman, MD FACS

Institutions: Peninsula Hospital Center Far Rockaway NY and South Nassau Communities Hospitals Oceanside NY

Introduction:
Diaphragmatic hernias are most often congenital or resultant from trauma. Congenital hernias are often identified early after birth with the infant demonstrating respiratory distress. Bochdalek's hernia is the most common diaphragmatic hernia, occurring in approximately 1 in 2500 births and twice as often in males as in females.

Case Description:
A 20-year-old female presents to the emergency department complaining of left chest pain. The pain had been present for over 3 months, but had become significantly greater at time of presentation. The patient reported left sided chest pain, shortness of breath, and pain radiating to left upper back and shoulder. A CT scan was preformed and the patient was found to have a diaphragmatic hernia with herniation of stomach and omentum into the left hemithorax with severe left upper lobe atelectasis. The patient was later taken to the operating room for repair of the diaphragmatic hernia and reduction of herniated stomach and omentum via exploratory laparotomy and left thoracotomy.

Discussion:
Review of similar hernia and related techniques for repair, along with patients initial presentation and delay in identification of the hernia from the patients initial onset of symptoms.
Title: Nitric Oxide in the Treatment of Amiodarone Induced ARDS

Authors: Sajid Ismail DO, Matthew D'Alessandro DO, Rick Conetta MD, and Ahamed Moideen MD FACS

Institution: Peninsula Hospital Center, Far Rockaway NY and Flushing Hospital

Introduction: Amiodarone Induced Acute Lung Injury (AIALI) is a rare but the most dangerous side effect of this widely used antiarrythmic medication. Nitric Oxide use in ARDS has been well documented. We provide a case of AIALI and the successful use of Nitric Oxide. We then discuss a proposed role for the use of Nitric Oxide in the acute phase of AIALI.

Case Description: 64 year old male with a recent history of CABG and mitral valvuloplasty, who underwent elective Aorto bi-iliac bypass. Postoperatively, the patient was easily weaned from the ventilator but experienced respiratory failure late POD#2. The etiology of his pulmonary failure was initially uncertain. Once the diagnosis of Amiodarone Induced Pulmonary Toxicity was made, the patient immediately responded to treatment. This diagnosis is an under recognized etiology of pulmonary failure which can be fatal, but who’s prognosis can be favorable when recognized and treated in a timely fashion. This presentation discusses the recognition, diagnosis, treatment strategies, and prognosis of amiodarone pulmonary toxicity.

Discussion: Amiodarone is a lipophilic chemical which accumulates in high concentrations in macrophages and Type II pneumocytes. AIALI occurs by a cytotoxic and hypersensitive mechanism. Amiodarone accumulates in lysosomes causing a constant basal release of oxygen free radicals. This potentiates pneumocyte sensitivity to oxygen. A second proposed mechanism consists of CD8 lymphocytic infiltration stimulated by cytokine release from alveolar macrophages in response to the presence of Amiodarone.
Title: B Cell Lymphoma Presenting as Mediastinal Mass

Authors: Sangeetha Kolluri DO, Ali Safavi MD FACS, and Howard L Sussman MD FACS

Affiliation: Peninsula Hospital Center, Far Rockaway NY and NSUH-LIJ, New Hyde Park NY

Introduction: Primary mediastinal B cell lymphoma accounts for 5% of all aggressive lymphomas and often presents with symptoms of intrathoracic structure compression, but has a 50-80% cure rate with chemotherapy. The intent of this review is to define the pathophysiology, epidemiology, imaging and diagnostic procedures, as well as treatment options, for PMBL.

Case Description: We present the case of Mr. CH, a 63 year old man complaining of shortness of breath and 17 lb weight loss over 3 weeks. CT revealed an extensive mediastinal mass suspicious for lymphoma vs metastasis from a distinct cancer, significant trachea stenosis, enlarged pancreas and suprarenal masses. Core needle biopsy of the mediastinal mass revealed B cell lymphoma, and chemotherapy was initiated.

Discussion: Flexible bronchoscopy is the gold standard for detection of tracheo-bronchial pathology, but its uses are limited in the hypoxemic patient. Spiral CT permits a rapid acquisition of high-resolution images, but is limited by ability to detect subtle airway stenosis, cranio-caudal disease extent, and relationship between airway stenosis and mediastinum . Virtual bronchoscopy is becoming increasingly accepted as a reasonable alternative to FB, since records the natural contrast between airway and surrounding tissue. VB can also distinguish between intra-luminal tumor and extra-luminal airway compression. However, VB is limited by the inability to sample tissue from tracheal stenosis. FB also enables placement of a self-expandable metallic stent, an especially good option if the patient is not a good surgical candidate because of tracheal stenosis but requires tissue biopsy for diagnosis. Our patient was too unstable for tissue biopsy and was transferred to an outside facility for tracheal stenting with the expectation that his dyspnea would worsen, but ultimately did not require it.
Title: Primary Adenocarcinoma of the Appendix: A rare case and literature review

Authors: Katherine McKenzie DO, Todd Ruiter DO, and Noel Blackman MD
Institution: Peninsula Hospital Center Far Rockaway NY

Introduction: Appendiceal neoplasms occur in <1% of appendectomy specimens, 10% of which are adenocarcinoma. These tumors are often unexpectedly discovered after presenting as acute appendicitis. We describe a patient with primary adenocarcinoma of the appendix.

Case Description: A 74 year old African-American male with a history of colon cancer presented with signs and symptoms consistent with septic shock secondary to perforated appendicitis. Initial abdominal examination revealed a tender right lower abdomen with palpable mass without peritonitis. Rectal and genital examinations were initially unremarkable. A CT scan of the patient’s abdomen was conducted which demonstrated acute appendicitis, possibly ruptured with phlegmon vs. abscess.

Discussion: Up to half of patients have metastatic disease at time of diagnosis, usually with peritoneal spread from rupture of associated inflammatory process. Synchronous colorectal cancer and appendiceal tumors are more often observed in patients at higher risk due to ulcerative colitis, celiac disease and Crohn’s disease.
Title: Choledocholithiasis Resulting In Open Common Bile Duct Exploration After Two Failed Endoscopic Retrograde Cholangiopancreatography

Authors: Jennifer Scagliola DO and Teodorico Arambulo MD FACS
Institution: Peninsula Hospital Center, Far Rockway NY and Flushing Hospital Medical Center, Flushing NY

Introduction: Choledocholithiasis is the presence of gallstones in the common bile duct. This condition causes jaundice, liver cell damage, and is a medical emergency, requiring endoscopic retrograde cholangiopancreatography (ERCP) or surgical treatment.

Case Description: An 82 year old female admitted with acute cholecystitis and cholangitis secondary to obstructive choledocholithiasis. She underwent two ERCPs with failure to extract the common bile duct stone and stent insertion. A laparoscopic cholecystectomy was converted to open and common bile duct exploration with T-tube and Blake drain placement, after the gallbladder was found to be gangrenous and enlarged with an inability to identify the cystic duct origin. Postoperatively the patient’s laboratory values normalized. A T-Tube cholangiogram identified two small stones in the distal common bile duct without evidence of obstruction. The patient was discharged to subacute rehab with her T-tube in place.

Discussion: Management may require several procedures or sessions of the same procedure for successful clearance. Decompression of the biliary tree with either a nasobiliary catheter or a biliary stent as a temporizing measure. 30% of patients in whom a stent has been left in place for large stones have spontaneous disintegration. Open or laparoscopic duct exploration & postcholecystectomy nonoperative techniques such as ERCP or percutaneous transhepatic cholangiography can be done.
Title: Perforated Viscus Repair Resulting in Anastomotic Leak

Authors: David Suarez DO, Robert Davis MD, Howard Sussman MD
Affiliation: St Barnabas Hospital Bronx NY and Peninsula Hospital Center, Far Rockaway NY

Introduction: Emergent situations call for emergent measures. A perforated small or large bowel is a surgical emergency and needs to be dealt with quickly. Despite expedient diagnoses and treatment the prognosis is still poor. There are many factors that contribute to the high morbidity and mortality of these patients.

Case Description: The following is a 71 year old woman with a case of perforated viscus that subsequently went for surgical repair. Despite the poor outcome of this case demonstrates the risks and complications of perforated viscus and its treatment.

Discussion: Small bowel anastomosis in an emergent setting have a high risk of leakage. Nair and colleagues looked at the factors that were predictive of anastomotic disruption after emergent small bowel surgery.
Title: What are the options for immediate versus delayed breast reconstruction and does radiation therapy affect the decision making.

Authors: Elena Vega DO, Robbi Kempner MD, and Gerald Ginsberg MD
Institutions: Peninsula Hospital Center Far Rockaway NY and New York Downtown Hospital NYC

Introduction: Immediate breast reconstruction can be accomplished with autologous tissue flaps or prosthetic breast implants. Delayed or delayed-immediate breast reconstructions are usually reserved for patients who require PMRT.

Case Description: This is a 47 year old female who has a known history of a left breast mass since August of 2008. Mammogram revealed a density in the upper outer quadrant of the left breast. Ultrasound revealed 3 masses and an abnormally enlarged left axillary lymph node. A 3.5 cm mass at 3 o’clock, a 6mm mass at 4 o’clock, and a 7mm mass at 8 o’clock. Biopsies of the two left breast masses were performed. The left breast mass at 3 o’clock showed invasive mammary carcinoma, the 8 o’clock mass showed adenocarcinoma. Fine needle aspiration showed adenocarcinoma. The tumor was ER/PR positive and over expressed Her-2/Neu by Fish studies.

Discussion: Radiation treatment before or after mastectomy usually has a negative impact on the outcome of breast reconstruction and is an important factor when considering options for breast reconstruction.
Dept. of Surgery, Peninsula Hospital Center, Far Rockaway, NY

Title: Case Presentation: A Schematic Approach to Facial Trauma

Authors: Karen S Woo DO, Marcel Scheinman MD FACS
Institution: Peninsula Hospital Center, Far Rockaway NY and South Nassau Communities Hospital, Oceanside NY

Introduction: Maxillo-facial trauma consists of fractures of midface and upper face, caused by extremely violent traumatic impacts. Complex facial injuries require specific methods of reconstruction depending on the type of injury and kind of tissue.

Case Description: We present a 26 year old male who sustained a power saw facial injury. We describe the approach to restore his aesthetic appearance without sacrificing functionality of his anatomical structures.

Discussion: Delayed reconstruction (7-14 days) may be associated with infection, loss of anatomical landmarks (bone loss, tissue swelling), and granulation/fibroosteoid tissue which creates difficulty in the reduction. On the other hand, immediate reconstruction has better aesthetics as seen with our patient.
Dept. of Surgery, Peninsula Hospital Center, Far Rockaway, NY

**Title:** Foreign Object Perforation Mimicking Acute Abdomen

**Authors:** Patty Yu DO, Robert Dragotti DO, Nicholas LaGamma MD, and Sam Kwauk MD FACS

**Institution:** Peninsula Hospital Center, Far Rockaway NY and New York Downtown Hospital, NYC

**Introduction:** Small bowel perforation by a foreign body (FB) is rarely considered due to the fact most foreign bodies may pass through the gastrointestinal tract without complications. Furthermore, many diagnostic studies including CT Scan, and Ultrasound may be helpful in identifying FBs, however, these modalities do not have a high sensitivity. When Foreign Body is suspected, endoscopy and surgery are the mainstay for diagnosis and treatment.

**Case Description:** We present the case of a 77 year old Asian male with a past medical history of CAD, Interstitial Lung Disease, COPD, Atrial Fibrillation controlled by Coumadin, s/p PPM, presented to the ER complaining of worsening right upper quadrant abdominal pain for 5 days. Patient was found to have a small intestinal perforation via a fish bone.

**Discussion:** The mainstay treatment for a small intestinal perforation by an FB is surgical exploration and repair. Additionally, Endoscopy may be used to remove FBs. In cases of ingested FBs, 10-20% of the objects must be removed endoscopically with 1% requiring surgery. With surgical intervention, laparoscopy has been utilized as a procedure that offers precise, visual assessment of the intra-abdominal cavity, allowing prompt intervention as necessary.
Title: Sump Syndrome- A Case Presentation

Authors: Amanda Zucker DO, Sajid Ismail DO, and Martine Louis MD FACS

Institution: Peninsula Hospital Center, Far Rockaway NY and Flushing Hospital Medical Center, Flushing NY

Introduction: Sump Syndrome occurs when biliary drainage and enteric debris (food) accumulate in the distal CBD between the anastomosis with the duodenum and the Ampulla of Vater. Literature shows that the complication rate after Choledochoduodenostomy is approximately 1% and the rate of Sump Syndrome is even lower. Case studies show that ERCP/EST is the most effective way to manage Sump Syndrome.

Case Description: 38 year old Hispanic female presented to ED with a 2 day history of worsening epigastric pain associated with nausea/vomiting, fevers, & chills. The abdominal pain had started 3 weeks prior, but was tolerable with no associated symptoms. An outpatient EGD was scheduled to work up this ongoing pain. Her past medical history is significant for cholelithiasis with an open cholecystectomy at age 25. She had been asymptomatic for 11 years until the 3 weeks leading up to this admission.

Discussion: Thorough review of the current practices and recommendations for the treatment of Sump Syndrome reveal that this patient received the correct care, though delay in treatment may have lead to her increasingly septic picture. Despite this delay, the ERCP/EST was successful and she recovered well. Though a rare late complication of choledochoduodenostomy, Sump Syndrome must be considered in all patients with a history of biliary surgery who present with clinical signs and symptoms of cholangitis.
Title: Newly Categorized, Highly Malignant Childhood Brain Cancer

Authors: Jonathan Couch, D.O.
Department of Neurosurgery, Saint Barnabas Medical Center

Introduction: Of the various CNS neoplasms that arise in children, atypical teratoid/rhabdoid tumors (ATRT) are a relatively newly categorized and highly malignant entity. Unfortunately, the survival of patients diagnosed with an ATRT is only six months. However, on various experimental treatment regimens some longer survival times have been reported in the literature. Due to the scarcity of cases, the clinical management of this rapidly progressing disease remains controversial.

Case Description: This is a 6-year-old female with no significant PMH who presented with lethargy, bitemporal severe headaches, nausea and vomiting and visual changes worsening over the past five days. Upon neurologic exam, the patient was noted to be lethargic. She would respond to verbal stimuli but would drift back to sleep. Imaging studies revealed an intraventricular lesion measuring 4.2 x 2.8 cm in the right lateral ventricle within the foramen of Monroe and in the 3rd ventricle causing obstructive hydrocephalus. Because of the severe hydrocephalus, history of blurry vision and decline in consciousness, the decision to emergently place an external ventricular drain was made with the definitive treatment of tumor resection to follow the subsequent morning. The following morning the patient was brought to the operating room for a right frontal craniotomy for resection of tumor and a septum pellucidotomy using the anterior transcortical approach.

Discussion: ATRT is a rare high grade neoplasm that affects very young children with a median survival of only 6 months. ATRT is rare and no therapy has been proven to deliver long-term survival, nor is there a set of standard protocols. Most patients are enrolled in clinical trials in an attempt to find a cure. Now recovered from surgery, our patient is undergoing an aggressive chemotherapy treatment known as headstart II which will be followed with cranospinal irradiation.
Dept. of Neurosurgery, Saint Barnabas Medical Center, Livingston, NJ

**Title:** Complex spine reconstruction improves functional outcome in patients with metastatic disease

**Authors:** James S. Harman, D.O., Joseph Koziol, M.D., Otakar R. Hubschmann, M.D.  
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**Introduction:** Over 1.4 million new cases of cancer are diagnosed each year in the United States. Historically, distant metastases, particularly to the lungs, liver and spine, represented end stage disease and treatment options were mostly palliative with mortality equivalent to six months. With the newest advances in cancer treatment approximately half of these patients will survive their initial disease and longer survival is expected even with distant metastasis. Spinal metastasis represents a significant cause of morbidity in this patient population and leads to debilitating neurologic dysfunction and pain; therefore, preservation of neurological function, reduction of pain, and stabilization are important in helping patients with spinal metastasis maintain their activities of daily living. The recent advances in chemotherapy and radiation therapy are paralleled by advances in surgical techniques for the treatment of spinal metastasis.

**Case Series Description:** Here we present a novel approach to surgical decompression and stabilization of the thoracic and lumbar spine with metastatic involvement using a posterior bilateral transpedicular approach to the spine for decompression, corpectomy, and instrument stabilization. 12 patients (8 female and 4 male) are included in this series and a total of 13 operations were performed from 2009 to 2010. One patient with plasmacytoma underwent two separate procedures; one in the thoracic spine and one in the lumbar spine. Patient ages ranged from 36 to 72 years old. All 12 patients showed significant neurological improvement post-operatively and all patients were independently functional at 3 month follow-up. There were no mortalities or significant surgical morbidities related to the procedure.

**Discussion:** The role of surgical treatment in spinal metastasis remains important and contributes to increased survival and improved quality of life in these patients. Spinal reconstruction for patients with metastatic disease should remain the standard of care in select populations.
Title: Rheumatoid Arthritis Associated Lung Disease

Authors: Oluyinka Akinbinu, D.O.
St. John’s Episcopal Hospital, Traditional Rotating Internship

Introduction: Rheumatoid Arthritis affects approximately 6.5 million Americans. People with rheumatoid arthritis can also have extraarticular manifestations ranging from rheumatoid nodules, vasculitis, pulmonary and pleural abnormalities, and pericarditis. The pulmonary manifestations of rheumatoid arthritis although common are often asymptomatic and most often occur in males. This case was chosen for discussion because it provides a unique example of the contrary in which the patient with rheumatoid arthritis associated lung disease is female and symptomatic.

Case Description: A 49 year old African American presented to St. John’s Episcopal Hospital with the chief complaint of chest pain, shortness of breath, and cough for two weeks. While in the ER, a CT scan with PE protocol was carried out with no definite PE identified. However a moderate amount of heavy interstitial alveolar opacity was found in the lower and middle lobes. During her hospital stay, she was treated with a course of antibiotics, bronchodilator treatments, and oxygen. Further evaluation was undertaken by ordering a 2D echo, ANA, sed rate, and diagnostic/therapeutic thoracocentesis. The CT was reviewed and nodules within the lung parenchyma in addition to pleuritis evidenced by the inflammation along the pleural cavity were noted. It was concluded that this patient suffered from rheumatoid pleuropulmonary disease with resolving pleuritis. The patient was then placed on a high dose of prednisone and her symptoms shortly thereafter resolved. She was later discharged with instructions to follow up with her rheumatologist for possible immunosuppression therapy for her rheumatoid lung disease.

Discussion: Overall, this case provides an example of how the pulmonary manifestations in rheumatoid arthritis can produce clinical symptoms and appear within females. Although this presentation is not regularly anticipated, clinicians should have a high index of suspicion in those patients diagnosed with rheumatoid arthritis with new onset respiratory complaints.
Title: Identifying patients at increased risk for development of Cauda Equina Syndrome.

Authors: Christopher Alexander, D.O., Dina Galaktionova, D.O.

Introduction: Case being presented describes a delayed development of Cauda Equina Syndrome, occurring one year after acute back injury in our patient. Teaching point in this case includes the possibility of occurrence of Cauda Equina Syndrome several months to a year after low back sprain/strain, demonstrating the need for risk identification and monitoring of patients with back injuries.

Case description: This is a 41-year-old male who presented to clinic with saddle anesthesia and difficulty controlling urination. Patient had a history of lumbosacral sprain/strain due to heavy lifting one year prior to presentation. Previously patient presented with difficulty controlling bowel movements and right lower extremity numbness, tingling, and burning 6/10 pain, which resolved. Patient has a past medical history of diabetes mellitus, hypertension, and lower extremity edema. On physical examination patient had decreased sensation to bilateral groin area and bilateral buttock. On rectal examination, sphincter tone was slightly decreased.

Patient was evaluated in ER, sent for emergent neurosurgical evaluation and intervention. MRI of the lumbar-sacral spine demonstrated L5-S1 large central disc extrusion, obliterating the spinal canal. Patient was emergently taken to the operating room for laminectomy with right medial facetectomy and discectomy. Post-operatively patient recovered well with outpatient physical therapy.

Discussion: This case presents an interesting finding of chronic low back pain developing into disc herniation with obliteration of the spinal canal causing Cauda Equina Syndrome. It is an accepted fact that most men by the age of 40 have asymptomatic disc herniations, however in our patient this became a life threatening condition. Our case is a good example of the importance of considering Cauda Equina Syndrome in a patient with non-specific recurrent radiculopathic symptoms. We need to be able to identify patients at increased risk of developing this syndrome and recommending neurosurgical intervention prior to its development.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Gastrointestinal Bleeding

Author: Joseph L. Altidor, DO
Department of Family Practice, St John’s Episcopal Hospital, Far Rockaway, NY 11691

Introduction: Gastrointestinal bleeding is one of the most common diagnoses encountered in the emergency room, with a significant mortality rate. Many causes can lead to that diagnosis, including upper or lower GI bleed. The management of such problem will vary accordingly. Diverse modifiers can influence the course but thorough and specified exams will be important in resolving this issue and any further consequences.

Case description: This is a 58 yr old sent from a nursing home, for evaluation of vomiting of blood. That started earlier in the day. Coffee ground like material found, no further info given. Physical exam was pretty much benign other than dry, brownish material noted on oral mucosa. Pt denies any pain, or any discomfort; pleural or abdominal. With not much to go on, extensive differential diagnosis pertinent to upper intestinal bleeding were pursued. Aggressive resuscitative measures were instituted, such as IV hydration, airway management, nasogastric tube, placement and diligent consultation with GI for definitive diagnostic and therapeutic intervention.

Conclusion: This case pinpoints the emergent necessity to efficiently diagnose and diligently manage bleeding of the intestinal tract. Astute clinical judgment, with the support of a good medical history and a sound physical exam and the availability much needed subspecialty be it GI surgery was key in resolving this clinical event and make a difference in the life of an individual.
Title: Pulmonary Fat Embolism: Acute Chest Syndrome in Sickle Cell Anemia

Authors: Dhara Amin, D.O., Rhea Ramlal, D.O.
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Introduction: Acute Chest Syndrome (ACS) is a major cause of morbidity and mortality in Sickle Cell Disease. Overall death rate from acute chest syndrome is 1.8% and four times higher in adults than children. One rare cause of acute chest syndrome is bone marrow infarction causing Pulmonary Fat Embolism (PFE). PFE is most commonly identified as a cause of acute chest syndrome on autopsy. It is hypothesized that medullary long bone fat liberated into the circulation during vaso-occlusive infarct were the cause of emboli. Literature review revealed that when PFE is associated with acute chest syndrome, it is characterized by a distinct clinical course and there are safe tests that can facilitate a diagnosis and possibly prevent mortality.

Case Description: A 25 year old Hispanic male with a medical history significant for Asthma and Sickle Cell Anemia was recently discharged from another institution where he was admitted for sickle cell crisis involving left leg pain. He presented to the emergency department complaining of right upper extremity pain. Physical examination was remarkable for tachycardia, right upper extremity pain, and tenderness on palpation of lower back. Upon admission the patient presented with leukocytosis, anemia, decreased hematocrit. Findings on day three, demonstrated worsening anemia, thrombocytopenia and hyponatremia. CXR revealed the development of left perihilar and bilateral lower lobe infiltrate, fluid in right middle lobe fissure and left pleural effusion. Medical management upon admission consisted of I.V fluid hydration, O2 2L/min nasal cannula, analgesics and antibiotics. On hospital day #3 the patient’s symptoms markedly worsened requiring more aggressive analgesic, intubation and ICU transfer. Despite all measures taken the patient died on hospital day #3.

Discussion: This case illustrates the need for physicians to include pulmonary fat embolism in their differential diagnosis when chest syndrome presents with hypoxia and worsening of symptoms.
Title: Cystic neoplasm vs adenoma of the pancreas in a young patient.

Author: Eberechi Anozie, DO MBS
St. John’s Episcopal Hospital, Far Rockaway, NY.

Introduction: Cystic neoplasms of pancreas are less common than solid tumors accounting for about 2% of all pancreatic lesions. There are two types- serous and mucinous. They are thought to arise from the ductal epithelium. The pancreatic serous cystadenomas are also referred to as microcystic adenoma or glycogen rich cystadenoma is the benign type. The mucinous cystic neoplasm ranges from pre malignant to malignant. The uncommon nature of this lesion and its occurrence in the presented age group makes this case remarkable.

Case Report: 21 year obese African American female with past medical history of sickle c trait, presented to the ED with a one day history of severe epigastric pain, radiating to the back that started after a heavy meal. Accompanying symptoms included nausea, non bloody vomiting and early satiety. Patient denies weight loss, alcohol use, smoking, IVDA or any prior surgery. Home medications included birth control pills and PRN motrin. Laboratory finding revealed elevated WBC (18.1) Amylase (380) and Lipase (526); and on CT of the abdomen patient was found to have a large pancreatic head mass measuring 4 by 4cm. Patient was admitted and a pathological examination of the CT guided biopsy of the mass revealed microcystic adenoma vs mucinous cystic neoplasm of the pancreas.

Discussion: Cystic tumors are a rare condition that usually occurs in females with a presentation mean age of about 25. These tumors remain mostly clinically silent and are therefore fairly large in size at the time of presentation. They range from 4-20cms in size. Smaller tumors may be incidentally found on CT and US exams. CT scan is a superior examination and the imaging of choice in lesion depiction and characterization. In US, cluster of grapes and lobulation may be observed and the mass may appear echogenic and solid because of large number of acoustic interfaces. Appropriate diagnosis of these tumors is important since surgical removal of the tumor is associated with a high cure rate. Unresected tumors particularly of the mucinous cystadenoma type can lead to invasive pancreatic cancer, a potentially fatal disorder.
Dept. of Dermatology, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Pemphigus Vulgaris (PV) in Adolescence: A Rare Entity

Authors: Andrea Baratta, DO(1), Christine Papa, DO(2), Albert C. Yan, MD(3)
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Introduction: PV is a potentially life-threatening, chronic autoimmune blistering disorder that is seen in middle-aged women. It is extremely uncommon in childhood but the prognosis is better than that of an adult. Stomatitis is the most common presenting complaint and usually precedes cutaneous lesions. The primary cutaneous lesion of PV is a fragile vesicle or bulla arising on an erythematous but otherwise normal appearing area of skin or mucosa. The fragility of the blister in PV reflects the histopathology which demonstrates loss of cohesion between keratinocytes in the epidermis. This can be confirmed with immunofluorescent studies demonstrating antibodies directed against adhesion proteins between keratinocytes, specifically desmoglein 1 and desmoglein 3.

Case Description: This is a case report of a 15 year old female who presented to the dermatologist with the chief complaint of recurrent, painful blisters of her skin and mucous membranes. The patient underwent a biopsy for histopathology and direct immunofluorescence which revealed, surprisingly a diagnosis of PV. The patient was transferred to the care of Dr. Albert Yan at the Children’s Hospital of Philadelphia. She is currently maintained on oral prednisone and mycophenolate mofetil but continues to have periods of exacerbation.

Discussion: PV is an uncommon diagnosis with an incidence of 0.5-3 cases/100,000. The mean age of onset is 50-60 years making this case in an adolescent female extremely rare. Due to the infrequency, there are no established guidelines for treatment. It is important to raise the awareness of the possibility of PV in adolescents as this chronic debilitating and potentially life-threatening disease may go undiagnosed.
Title: Advances in Chronic Idiopathic Uveitis Management

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Program Director Family Practice - Al Strojan, DO
DME - Sheldon Sirota, DO, DME
DME - Suzanne Sirota Rozenberg, DO, Asst DME

Introduction: Uveitis is a rare ocular disease affecting the Uveal tract: Iris and Ciliary body anteriorly and Choroid posteriorly. It has an extensive differential diagnosis and presents independently or in conjunction with systemic, infectious, rheumatologic, and dermatological diseases. The mainstay of Uveitis treatment is steroid therapy, Cataract surgery and complications management. Although 50% of Uveitis is idiopathic, research promises new diagnostic tools: HLA-B27, IL-12 levels and Uveitis specific CD4+TH1-like pathogenic cells. Also, new chemotherapeutic agents and implantable devices can help prevent blindness.

Case description: 38 year-old-female with chronic idiopathic Uveitis on Prednisone presents with a left sub-mental superficial abscess after pimple picking and chin hair tweezing. Her history includes repeat left Cataract surgery, Hypertension, gastric bypass and head trauma. She has family history of early cardiac related death. Socially, she began smoking cigars for the past 6 weeks after ending her 14 year 1ppd smoking history. Her medications are Prednisone 10mg PO daily, Durezol 0.05% 2 drops OU TID. Physical exam reveals, OS: 3mm non-reactive pupil, intact EOM, decreased peripheral vision, blurry vision, VA: 20/100. OD: 1mm reactive pupil, intact EOM, better peripheral vision and VA: 20/50. There is no conjunctival injection, no color vision--only shades of gray. Head CT shows a medial right orbital wall defect.

Discussion: Preventing Uveitis progression with Prednisone and cycloplegics is imperative. Besides cigar smoking cessation, patient should keep follow-up appointments; apply correct steroid doses without abruptly stopping. Her 3-month Prednisone dose should be changed to 7.5mg to decrease both the risk of glaucoma development from IOP and the risk of a cardiac event. Also, Prednisone taper should be started at 1-month along with adding an NSAID and monitoring for PUD. Also, decreasing right eye synechiae formation by steroids and mydriatics. Additive options include anti-TNF-alpha, immunosuppressants, chemotherapeutic injections, implantable devices and coordinated osteopathic care.
Title: Management of a Dissecting Aortic Aneurysm in the Emergency Room

Authors: Ethan Breen D.O.(1) Elias Tsirakoglou D.O. (1)
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Introduction: Dissection of an aortic aneurysm can be an immediately life-threatening condition that requires rapid diagnosis and treatment. In this case, a 54 year old male presented with chest pain caused by a type A dissecting aortic aneurysm. This case is of interest as it highlights the similar presentations of chest pain caused by different etiologies. Furthermore, the significant mortality associated with type A aortic dissections, with 1% in the first hour, 50% at 2 days, and 75% at 2 weeks, make rapid diagnosis in emergency room settings imperative.

Case Description: A 54 year old male presented to the emergency room with shortness of breath and chest pain for one day. His family history was significant for a father who abandoned him to join the circus as a contortionist. Vital signs on entry were height 6’4”, weight 82kg, 98.6 temp, BP 97/54, pulse 116, RR 16. On physical exam, he was in minimal acute distress secondary to shortness of breath. EKG demonstrated sinus tachycardia at a rate of 106 and ST depressions in leads I, II, V4, and V5. Chest x-ray showed only normal to mildly enlarged heart. Laboratory findings were a BUN/creatinine of 68/2. Patient was given sublingual nitroglycerin and morphine for pain and bolused a liter of normal saline. Later, the patient became diaphoretic and tachypneic, complained of increased chest pain. Cardiac enzymes were now reported as CK 97, CK-MB 10.6, troponin I 2.74 and his BP was 88/44 after 2 liter bolus. At this time, the patient was transferred to a tertiary center for catheterization, where he subsequently expired.

Discussion: This case highlights the need for rapid diagnosis and management of dissecting aortic aneurysm. High levels of suspicion are required in certain cases to promptly diagnosis and manage these patients.
Title: A Unique Case of Polyostotic Langerhan’s Cell Histiocytosis

Authors: Steven Brooks DO, Marina Matatova DO, St. John’s Episcopal Hospital, Department of Family Practice, Far Rockaway, NY

Introduction: Langerhans Cell Histiocytosis (LCH) is a relatively rare dendritic cell disorder with an unclear etiology. Its incidence is 2:1,000,000, most commonly seen in children from 5 to 10 years of age. The diagnosis is confirmed by biopsy and treatment can vary from simple observation to systemic chemotherapy. The four-year event free survival for patients with solitary bone disease approaches 90 percent compared to 58 percent of those with polyostotic bone disease.

Case description: A 10 month old female presented to her pediatrician with a 2-month history of a left temporal region mass. The physical exam was remarkable for the left temporal mass and lab values for microcytic anemia, alkaline phosphatase=1994 and LDH=536. Multiple skull defects were imaged on CT and MRI of head. These defects showed increased activity on bone scan and skeletal survey. The bone biopsy was CD1a and S100 positive. Patient was started on LCH-3 protocol, which included 6-month systemic therapy with vinblastine and prednisone. Patient did well during the course of chemotherapy and has been in remission for 5 years.

Discussion: Although, cases of LCH are rare, they do occur in primary care settings and it is important to recognize them and initiate appropriate therapy. The case discussed is a great example of timely diagnosis and treatment, in which the patient has had a good outcome. However, not all cases have a favorable prognosis and the therapeutic options might be ineffective with several adverse side effects. Furthermore, investigation and research is required for proper therapeutic protocol in the treatment of LCH.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

**Title:** Pulmonary Embolus in Patient in Antiphospholipid Antibody Syndrome in a Patient with Parvovirus B19 Infection

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**Introduction:** Antiphospholipid antibody syndrome is an autoimmune disorder that presents as recurrent venous or arterial thrombosis, as well as pregnancy-related complications such as fetal loss. In this case, a Caucasian female with a pulmonary embolus and negative lower extremity venous Doppler, was worked up for other causes of emboli and was found to have antiphospholipid antibody syndrome. The patient had no history of miscarriages, but was found to have elevated Parvovirus B19 IgG and IgM, leading to possibility of infection acutely being the trigger for antiphospholipid antibody syndrome.

**Case description:** A 58 year old Caucasian female with medical history significant for diabetes, congestive heart failure, hypertension, hypothyroidism, and schizophrenia was originally admitted to psychiatry floor from nursing home for evaluation of suicidal ideation. Patient was later transferred to the medical floor for evaluation of hypotension and fever times two days. Upon transfer to medical floor, D-dimer was noted to be elevated, thus lower extremity Doppler and CTPA were ordered, which revealed a negative lower extremity Doppler, but findings on CT of left lower lobe posterior basal segment subocclusive segmental pulmonary embolus were found. Patient was started on anticoagulants. Approximately two weeks after diagnosis of pulmonary embolus, patient became acutely hypoxic, and transferred to ICU, in which she was found to have a pericardial tamponade. Workup revealed positive IgG and IgM Parvovirus B19 antibodies and anticardiolipin antibodies.

**Discussion:** This case demonstrates an interesting case in which a patient develops pulmonary embolus secondary to antiphospholipid antibody syndrome acutely likely secondary to Parvovirus B19 infection. This case exemplifies the need to maintain a broad differential when working up etiology of pulmonary embolus.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Treatment of Verruca Vulgaris with Nd:YAG 1064nm Laser

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Introduction: Verruca vulgaris (common warts) are caused by HPV infection of the epithelial tissues of the skin and mucous membranes. They occur mostly in children and young adults and are asymptomatic. They often present as well-demarcated, rough, hard nodules or plaques with irregular surfaces. These warts may be found anywhere on the skin, particularly on the dorsum of the hand, between the fingers, and around the nails (periungual). Diagnosis of verruca is based upon clinical appearance. Spontaneous remission of warts occurs in two-thirds of patients within two years; hence, observation is an option for all patients. Treatment of verruca includes using liquid nitrogen therapy, salicylic acid, duct tape, cantharidin, bleomycin, surgical ablation, curettage and desiccation, 5-Fluorouracil, tretinoin, cimetidine, imiquimod, intralesional immunotherapy, pulsed dye laser, CO2 laser. Although Nd:YAG and 532nm KTP lasers were reported to be effective but there is less evidence for their use.

Case description: A 39-year-old female presents to the dermatology office with complaints of a periungual verrucous papule over her right third finger. A diagnosis of verruca vulgaris was made, and liquid nitrogen was used for wart destruction. At her follow-up visits she reported no improvement and wart remained to be of the same size. Subsequently, patient was prescribed topical treatments which include Aldara 5% cream, Veregen 15% ointment, Zyclara, and Replenix but they did not significantly help to decrease the size of the wart. At her tenth visit, patient received Nd:YAG 1064nm laser therapy for wart treatment. After a total of 4 laser treatments the wart was completely destroyed.

Discussion: This case illustrates and supports the effectiveness of using Nd:YAG 1064nm laser therapy for the treatment of verruca vulgaris that has not responded to standard therapies. Early institution of this treatment option can help to prevent wart growth and spreading, and allow for early disease remission.
Dept. of OB/GYN, St. John’s Episcopal Hospital, Far Rockaway, NY

**Title**: Carcinosarcoma of the Ovary

**Authors**: Michelle Coates D.O., Zaira Jorai-Khan D.O.
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**Introduction**: Ovarian cancers are usually diagnosed when patients have symptoms by which time they have advanced disease. The most common presenting symptom is bloating, but patients may also complain of urinary frequency, pelvic fullness, pelvic pain and changes in bowel habits.

Carcinosarcoma of the ovary is rare and makes up less than 1% of all ovarian malignant ovarian tumors. Carcinosarcoma are a mixture of malignant epithelial and malignant mesenchymal components.

**Case Description**: A 46 year old female with medical history of hyperlipidemia, arthritis and hysterectomy for leiomyoma presented with the complaints of pelvic pain and constipation for 5 days. The patient reported a 5lb weight loss, fatigue for 1 month, dysuria, incontinence, flank pain, and bloating.

On physical exam, patient’s abdomen was soft with a large palpable mass from infraumbilical region into the pelvis and in both lower quadrants.

Lab values showed microcytic anemia and CT scan showed a mass-like lesion along the right side of the bladder, pelvic ascites, bilateral hydronephrosis and omental metastases. The patient was admitted for surgical intervention. Cystoscopy, exploratory laparotomy, tumor removal, retroperitoneal ureteral dissection, lysis of adhesions, bilateral oophorectomy and left inguinal node dissection were performed. Findings were a large pelvic mass with cystic and solid components, ascites, omental caking and seeding of the anterior abdominal wall. Pathology returned as carcinosarcoma of the ovary. Patient is currently undergoing chemotherapy.

**Discussion**: This case illustrates an aggressive ovarian cancer, which presented in a unique manner as what appeared to be a bladder tumor. This tumor developed just two years after a hysterectomy in which the ovaries appeared normal. Very little is available in the literature and more research on this rare cancer is recommended.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Utilizing the Inferior Epigastric Artery to Revascularize a Lower Pole Renal Artery Discovered at Time of Renal Transplant

Authors: Destin Delice, D.O., Romeena Tejiram, D.O.
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Introduction: Kidney transplantation is the treatment of choice for end stage renal disease. The ideal renal transplant would be from a living related donor to a recipient with identical HLA matching. However mismatched cadaver renal grafts and non-identical grafts from living donors are also used. In this case a cadaveric donor kidney was utilized. This case is remarkable because the donor kidney had multiple renal arteries, which autopsy studies show can occur 18-30% of the time. The majority of the time this is discovered preoperatively. However with this case there was an added sense of urgency because this anomaly was discovered perioperatively. This finding was extremely critical because if not addressed there would be ischemic injury to the ureter.

Case Description: KT is a 43 year old Vietnamese male with a history of ESRD on Hemodialysis for six years. KT had been on the transplant waiting list for several years and was scheduled for surgery after a left cadaveric kidney was harvested from a 56 year old donor. A donor team harvested the kidney and it was reported that there were two renal arteries. After complete venous and arterial anastomoses of donor kidney it was observed that the lower portion of the kidney was not perfusing. A lower pole renal artery was then discovered and was quickly anastomosed with the inferior epigastric artery. KT had an unremarkable post operative course and was discharged to home.

Discussion: Advances in imaging modalities have greatly increased the use of living donor kidneys and the ability to discover anatomical variations. However in the case of cadaveric donor kidneys many of these modalities are not applicable. Therefore it is the surgeon’s duty preferably at harvest, but also at bench preparation, and even less desirably perioperatively, to take notice of these anatomic variants and to adjust accordingly.
Title: Flail Chest – The Importance of Recognition

Authors: Brett Dolgin, DO, Family Practice Intern, St. John’s Episcopal Hospital, Far Rockaway NY
Jonathan Dell, DO, Traditional Rotating Intern, St. John’s Episcopal Hospital, Far Rockaway NY

Introduction: Flail Chest is a life threatening medical condition that is most commonly seen in cases of significant blunt trauma. Presented is a case of flail chest following a seemingly minor injury. Failure to diagnose such a critical condition can result in significant morbidity and mortality.

Case Description: An 86 y/o male, ZM, presented to the emergency room after being found lying on the ground for an unknown period of time. He was complaining of chest wall pain yet denied any shortness of breath, cough, or palpitations. Vital signs were stable with O2 Saturation of 100% via 2 L nasal canula. Physical exam findings were consistent with minor trauma but included decreased breath sounds bilaterally and minor chest wall deformity. Patient was admitted and doing well on initial therapy. Two days after admission, his respiratory status declined and he developed paradoxical movement of the chest wall. He was admitted to the ICU where he eventually required intubation.

Discussion: Flail chest is a severe and life threatening injury. It occurs in 10 to 20 percent of trauma admissions and has a mortality rate as high as 50 percent. The diagnosis can be missed early in the clinical course due to muscle splinting; however, it is imperative that the diagnosis not be delayed in order to prevent complications, including death. The treatment of flail chest depends in part upon its severity. Pain control is very important in order to decrease muscle splinting and atelectasis. Intercostal nerve blocks and epidural anesthesia are usually the treatments of choice. Intubation and chest tube placement are also required in many cases.

As a life threatening injury, it is critical to quickly and accurately diagnose flail chest. It must be remembered that flail chest may occur with minor injuries, as is discussed in the above case.
Title: Glaucoma secondary to Trauma

Author: Vikrant Donthamsetti, D.O.
St. John’s Episcopal Hospital

Introduction: This case demonstrates the harm of medical noncompliance. When off medication for even just a short time the prognosis of the condition in this case can deteriorate rapidly. The vision in this traumatic glaucoma patient unusually declined. Physicians from primary care modalities through specialties such as ophthalmology can benefit from learning from this case in terms of compliance and efficacy of treatment.

Case Description: A 51 year old African American female with a past history of left eye trauma while playing double dutch as a child presents with loss of peripheral vision. Over years of follow-up, the patient was managed by monitoring visual fields and medicated to control the intraocular pressure. Recently in the last year, she has not been consistently taking her medications causing the pressure to be relatively high. Visual field examinations have rapidly become progressively worse.

Other possibilities for this decline in peripheral vision could be due to other causes of secondary glaucoma-exfoliation of the lens, chronic narrow angle closure, congestion of the trabecular meshwork.

Treatment options include encouraging the patient to follow through on the medications and clinically show her the loss in terms of her visual field exams. The patient may also benefit from selective laser trabeculoplasty or implants. Either with surgical intervention or with solely medical management, the patient will need improved medical compliance to slow progression.

Discussion: This case demonstrates the urgency of management that includes not only the physician but also more importantly the patient. Surgery for glaucomatous conditions is held off till medical management fails. Even then, patients must be followed to ensure patency of the surgical outcome. In the future, compliance should be emphasized through stronger education about the prognosis of a patient’s disease process.
Dept. of Ophthalmology, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Lamellar Ichthyosis with Crystalline Maculopathy

Authors: Fayssal El-Jabali, D.O.; Jeffery Rubin, M.D.
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Introduction: Lamellar ichthyosis is characterized by fish-like, reddened scaly skin. Sjögren-Larsson syndrome (SLS) is a rare disorder characterized by moderately severe lamellar ichthyosis, severe mental deficiency, spastic paresis, keratitis, cataracts, and maculopathy. We report a rare case of only lamellar ichthyosis and associated maculopathy without SLS.

Case description: A 35-year-old woman presented to our retina clinic with blur and decreased visual acuity. Physical examination revealed fish-like, reddened scaly skin consistent with her medical history of lamellar ichthyosis. Color Fundus photos showed glistening crystals scattered throughout both maculae. Her macular OCT (Ocular Coherence Tomography) showed thinning and reflectivity secondary to crystalline deposits. A Fluorescein Angiography (FA) revealed transmission defects of the macular retinal pigment epithelium (RPE).

Discussion: This case illustrates the rare finding of macular crystalline deposits in a patient with lamellar ichthyosis.

Lamellar ichthyosis is an autosomal recessive disorder described as generalized scaling which may resemble fish skin. SLS is a rare autosomal recessive neurocutaneous disorder characterized by moderately severe lamellar ichthyosis, severe mental deficiency, spastic paresis, keratitis, cataracts, and maculopathy. The SLS is also characterized by the triad of: ichthyosis, spastic paraplegia, and mental retardation. Most SLS patients have retinal findings including macular glistening white dots and RPE degeneration. The glistening white dots are scattered in a perifoveal distribution. The RPE changes are described as pale atrophic spots or gray to black circular pigmented spots, and peripheral retinal granular pigmentation. Visual acuity is often decreased in SLS. FA reveals macular transmission defects.

Our patient case is a rare association of the crystalline maculopathy with lamellar ichthyosis. She does not have the typical triad of SLS. Her FA revealed macular transmission defects. Her color fundus photos showed macular crystalline deposits.

Crystalline maculopathy can be associated with multiple disorders but the association of only lamellar ichthyosis with crystalline maculopathy is rare.
Title: Leukemia in Pregnancy

Author: Julie Goodell, DO, Palak Doshi, DO
St. John’s Episcopal Hospital, Far Rockaway, NY

Introduction: Leukemia in pregnancy is rare. It is seen in 1/75,000 pregnancies. When a disease state is seen so infrequently it can make it difficult to recognize signs and symptoms. Reviewing this case may help to identify potential signs and symptoms of this disease during pregnancy which would help diagnose and treat the patients with greater speed.

Case description: A 35-year-old G4P3003 32 weeks and 1 day dated by LMP presented to labor and delivery for evaluation of decreased fetal movement. The patient denied fetal movement for the last two days but had no other complaints. She received prenatal care from an outside provider and denied previous history. Her previous pregnancies were uncomplicated consisting of three NSVDs. Her physical exam was unremarkable except for an ecchymosis noted on the left upper extremity. There was not an adequate fetal heart tracing, so a bedside ultrasound was then performed revealing a fetal heart rate of 60bpm. There was no recovery of fetal heart rate with fetal resuscitation measures; therefore a emergency cesarean section was performed. The initial maternal blood results were received while in the OR revealing a CBC of 53.8/5.8/16.7/2.46. A transfusion of 4 units of PRBC was started as well as antibiotics and MgSO4. Hematology was called and a diagnosis of AML was made. The patient was transferred to a cancer center for treatment and died from complications. The infant also consequently died.

Discussion: Because this illness is such a rare finding in pregnancy it is beneficial to examine this case and the prenatal care to see if there could have been earlier intervention or if there were any signs and symptoms that may be important to recognize if seen in other pregnancies.
Title: Diagnosis and Management of Proximal Humerus Fracture.

Authors: Jay Gorstein DO, Edwin Garcia DO, Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY 11691

Introduction: Proximal humerus fractures are few and far between. Only 10% of all humeral fractures occur in the proximal humerus. Most upper humeral fractures occur in middle-aged and elderly patients. (1) It is estimated that humeral shaft fractures account 1% to 3% of all fractures and approximately 20% of all fractures involving the humerus. (2) Most humeral fractures occur in the third and fifth decades, in women over 50 (72%), and men under 50 (71%). (4,5) Most humeral fractures in adults are the result of trauma, fall, traffic accidents, collision with an object or other violence with trauma occurring directly to the bone, (1,3) The majority of proximal humeral fractures are minimally displaced and can be treated without surgical intervention. (5). Three and four part humeral fractures, especially if intra-articular, are best treated with surgical intervention.

Case Description: 86 year old female, who presents with pain swelling and echymosis to the R arm; after status post fall 5 days ago. Pt. was sent from her primary Md’s office for x-rays for suspicion of humerus fracture. Her Physical exam was non contributory, except for decreased active range of motion of her R arm. There was marked echymosis of the entire arm. However she had full passive range of motion of the shoulder elbow. Radial pulse, skin, and neurovascular components of the arm were intact. There was no pain with supination and pronation of the arm. X-ray of R humerus and shoulder demonstrated: an impacted, comminuted, malaligned, fracture of the proximal humerus. The orthopedic surgeon placed Pt. in an arm sling.

Discussion: Although proximal humerus fractures are not as common, we must be able to recognize, diagnose and treat them. The future humerus fracture management lies in OMT as well.
Title: Peutz-Jeghers Syndrome: Small bowel intussusceptions in a 41yo male
A case presentation and discussion

Authors: Narinder Paul Grewal D.O., Vu Dinh D.O.

Introduction: This case involves the presentation of a rare highly aggressive familial cancer. The uniqueness of this topic beyond its presentation is that this is the second event/presentation of the same disease.

Case Description: A 41yo male presented to the SJEH ED with complaints of abdominal pain, nausea and projectile vomiting for one day. Pt was recently diagnosed with hypertension and not receiving pharmacological therapy. He had a positive surgical history of exploratory laparotomy 20 + years prior for SBO with intussusception when he was in the army. Pt stated no other symptoms, denied fever, SOB, CP. He had a positive social history as a student studying to be a medical technician and he denied illicit or toxic habits. The pt denied any known family history of cancer. The pt underwent exploratory laparotomy where an intussusception was found close to the ileal cecal valve up to the hepatic flexure. Also noted, were three large palpable tumors within the small intestine. Notable findings are that the largest mass was 3x2cm and one smaller lesion was found 15cm from the ligament of Trietz. He tolerated the procedure well and had no post-operative complications. He was discharged on day 5 after being able to tolerate food and was having regular bowel movements. The final pathology reports showed Peutz-Jeghers polyps of small intestine.

Discussion: This case presents the opportunity to revisit the topic of polyposis syndromes with a second occurrence. Due to the fact Peutz-Jeghers is highly recurrent, this case also lends to the topic of doubling time in the subset of recurrent Peutz-Jeghers gastrointestinal cancers and whether it affects the management of the disease.
Dept. of Ophthalmology, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: A Case of Neuroblastoma

Author: Sonia Hernandez D.O., Dept. of Ophthalmology, St. John’s Episcopal Hospital, Far Rockaway, NY 11691

Introduction  Consultation of an 8 ½ month old male with upperlid ecchymosis with no history of trauma was requested. The parents were concerned of patient mishandling while in the hospital. Neuroblastoma is a pediatric disease with an average age of presentation of two years. Ophthalmic findings in this age group with the absence of trauma must raise the index of suspicion for Neuroblastoma.

Case Description: An 8 ½ month old male presented for consultation with chief complaint of one day new onset left upper eyelid ecchymosis. The patient was admitted to the hospital for unexplained high fever unresponsive to IV antibiotic therapy. During hospital admission the parents noted new onset left upper eyelid bruising and no history of recent trauma. Eye examination revealed left upper eyelid ecchymosis and right lower eyelid ecchymosis. Fundus examination revealed asymmetric optic nerve cupping. Imaging testing revealed a pancreatic mass, brain mass involving the parietal and frontal lobes, and bone metastasis to the scapula. A liver biopsy was positive for Neuroblastoma.

Discussion: Neuroblastoma is referred to as a spectrum of neuroblastic tumors that arise from primitive sympathetic ganglion cells. It is the third most common childhood cancer, after leukemia and brain tumors, and is the most common solid extracranial tumor in children. More than 600 cases are diagnosed each year in the United States. Presenting symptoms reflect the location of the tumor and include abdominal masses and periorbital ecchymosis, as seen in our patient. Prognostic factors are tumor-related though distant metastatic disease such as to the bone marrow carries a worse prognosis. Treatment for Neuroblastoma is based on staging and risk category. Surgery is the primary treatment for low risk patients and chemotherapy reserved for unresectable tumors with threatening symptoms. Our patient displayed bone metastasis which has a poor prognosis and currently undergoing chemotherapy.
Title: Polycystic kidney disease predisposes atypical bone fractures

Authors: Ian Horner, DO, James Henry, DO

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Introduction: Multiple complications arise as chronic kidney disease progresses, with the skeletal complication historically termed renal osteodystrophy. Secondary hyperparathyroidism, mineralization defects, adynamic bone, and mixed uremic osteodystrophy comprise the possible pathophysiologies for renal osteodystrophy. In this case, a patient with polycystic kidney disease (on hemodialysis) experienced a first time seizure and an uncommon skeletal event, bilateral glenoid fractures. A literature review resulted only one current trial for predicting fracture risk in patients with renal osteodystrophy.

Case Description: A 42-year old Caucasian male with a past medical history significant for polycystic kidney disease induced end stage renal disease, requiring hemodialysis, presented to the hospital after a first time seizure. The patient’s history and physical were pertinent for generalized weakness, bilateral shoulder pain and reduced range of motion. Laboratory findings were positive for hyponatremia, hypochloremia, hyperphosphotemia, hypocalcemia, elevated parathyroid hormone level, and elevated alkaline phosphatase level. Subsequent imaging revealed bilateral comminuted fractures of the scapula. The patient was admitted with a diagnosis of hyponatremia and seizure. Treatment for laboratory abnormalities included hemodialysis, intravenous fluids, anticonvulsant medication, and mineral supplementation. Treatment for the bilateral glenoid fractures included appropriate bracing. The patient was discharged on day seven on anticonvulsant as well as supplementation with instructions to follow up with nephrology and orthopedic surgery, however, calcium and vitamin D supplementation were not prescribed.

Discussion: Management of progressive renal disease is multisystem and often complicated. Renal osteodystrophy poses a major complication as bone fractures increase mortality and morbidity. In this case, our patient suffered traumatic skeletal injuries, predisposed by chronic renal failure, during a first time seizure. A formal fracture risk assessment and classification system is necessary for preventative care and management for patients with chronic renal disease such as polycystic kidney disease.
Title: The Case of the Disappearing Mesh

Authors: Jacob Johnson DO, Eric Crabtree DO, Nick Gabriel DO
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Introduction: The use of biologic mesh for repair of incisional hernias has been well documented in the literature. This case is unique because it visually depicts a near complete disintegration of the mesh with hernia recurrence. It also describes a novel approach to a ventral incisional hernia using laparoscopic mesh placement repair and component separation.

Case description: A 41 year old female presented with a recurrent ventral incisional hernia. The hernia resulted from a spinal fusion 3 years ago. A laparoscopic ventral incisional hernia repair with biologic mesh was performed 17 months ago without complication until 4 months ago she noticed increased bulging and soreness to her abdomen. The patient was also displeased with the appearance surgical scar. An 8 cm abdominal mass was palpable to her abdomen and an 6 cm defect was felt on deep palpation. A CT scan demonstrated inflammation and tacks consistent with previous repair and a ventral bulge contained within fascial layer. The patient was taken to the operating room for Ex-Lap with abdominal scar revision. During the laparoscopy a ventral defect was seen and prior repair visible from the previous surgical tacks. The defect was repaired with a mesh underlay and a component separation using laparoscopic assistance in addition to abdominoplasty and scar revision. No complications were experienced and the patient was discharged on POD 3. No recurrence was seen at 1 month follow-up.

Discussion: This case describes a new approach to the repair of an incisional hernia. With the combination of laparoscopic and plastic surgical approaches a three layer repair was achieved in the setting of a cosmetically pleasing approach. It is hoped that this multilayer approach will decrease the rate of hernia recurrence.
Title: Partial molar pregnancy in a 55 year old female

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Introduction: A partial molar pregnancy is defined as a placental abnormality involving swollen placental villi and trophoblastic hyperplasia with loss of fetal blood vessels. It is distinguished from a complete molar pregnancy by the presence of fetal, cord, and amniotic elements as well as some normal placental villi. Molar pregnancies are most commonly seen in teenage females and women in their 40s. A typical presentation of a female with a partial molar pregnancy is that of an incomplete abortion.

Case description: A 55-year-old female presented to the ER with chief complaint of heavy vaginal bleeding for 6 weeks. This patient also complained of early satiety and constipation for one month. The patient denied any recent sexual intercourse. Physical examination was unremarkable. The patient's hemoglobin was 8.5 and had a beta HCG of 579,310. The patient was admitted for a work up to rule out choriocarcinoma. The diagnosis of a partial molar pregnancy was made by histologic findings following a complete hysterectomy.

Discussion: The beta HCG levels of a partial molar pregnancy rarely exceed 100,000. Complete molar pregnancies comprise 95% of hydatiform mole diagnoses. Like in most cases of partial molar pregnancy, this diagnosis was made only after histologic and pathologic studies. This case is unique in that its presentation is more like that of a complete molar pregnancy and the patient is older than the typical age range seen in this disease.
Title: A Tearing Eyelid Fistula: A Complication Of Entropion Surgery

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Introduction – An entropion is a progressive condition of inward rotation of the tarsus and eyelid margin commonly encountered in ophthalmology. It may produce an ocular foreign body sensation, ocular discharge, epiphora, superficial keratopathy and corneal scarring. Treatment of entropion is primarily surgical. Postoperative complications reported include recurrent entropion, overcorrection, hematoma formation, eyelid retraction, exposure keratopathy, symblepharon, ptosis, granuloma formation, eyelid necrosis and eyelash loss. The case presented here reflects a unique complication of an eyelid fistula formation as a consequence of surgical entropion correction.

Case description – A 54 year-old male with a history of hypertension and right lower-lid entropion that was repaired a year ago, presented to the Ophthalmology clinic complaining of constant tearing from the right eye for the past few months. He denied any other associated symptoms. A slit lamp examination revealed a right lateral canthal scar with an area of opening lined by normal palpebral conjunctiva, lid margin and eyelash. After fluorescein dye was placed in the right eye, fluorescein-stained tears drained focally from the right lateral canthal opening. As the lateral right canthus was pulled outward, the canthal opening was probed from the inner eyelid. This confirmed the communication from the canthal opening to the fornix. The patient was diagnosed with a fistula of the right lateral canthus, which was thought to have formed due to poorly juxtaposed surgical site during wound closure. This then healed and created an opening in the right canthus, which communicated to the fornix to allow tear drainage.

Discussion – This patient represents the first documented case of an aberrant eyelid fistula formation following an entropion surgery. To prevent this type of complication, the pathophysiology and anatomic basis of entropion must be understood and surgical procedures should be planned accordingly.
Title: Rapid recognition of esophageal intubation in cardiac arrest

Author: Moha Kulkarni, DO
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Introduction: Esophageal intubation is difficult to avoid with improper technique, especially in an emergent situation, such as a cardiorespiratory arrest or major trauma. A case of unrecognized esophageal intubation is presented to signify that chest auscultation alone is not a reliable method for verifying accurate position of an endotracheal tube.

Case description: A 75-year-old male was brought to the emergency department after being found unresponsive by family and intubated by EMS en route. EMS report stated that there were bilateral breath sounds after intubation, therefore ambubag breaths were administered prior to arrival. Upon arrival to the ED, the patient had no detectable blood pressure or pulse, appeared cyanotic, and pulse oximeter showed no reading or waveform. A CO2 detector was immediately attached to the ambubag, which remained purple, and several hundred milliliters of gastric contents were suctioned from the oropharynx. The endotracheal tube was removed, replaced under adequate visualization, and the CO2 detector turned yellow, with symmetric chest wall rise upon ambubag breaths. ACLS protocol was initiated, for a course of multiple rounds. A pulse was unable to be regained, and despite multiple attempts at resuscitation, the patient did not regain vitals and expired after 20 minutes.

Discussion: Multiple previous studies have shown that disposable CO2 detectors register three ranges of CO2 concentration: "A" (purple) indicates low levels and probable esophageal intubation; "B" (beige) indicates moderate levels and probable tracheal intubation with hypocarbia; "C" (yellow) indicates high levels and tracheal intubation. The only reliable means of accurate endotracheal tube position is to proceed with direct laryngoscopy and visualize the tube inside the glottis or, alternatively, to perform expiratory CO2 measurement. In an emergent situation, clinical observation, patient response, chest x-ray films, and arterial blood gas results should be used to corroborate placement of the endotracheal tube.
Title: An uncommon cause of small bowel obstruction: Obturator hernia

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Introduction: Obturator hernia is a rare type of hernia and is an uncommon cause of small bowel obstruction. The preoperative diagnosis is sometimes hard to make due to nonspecific symptoms. In this case, the diagnosis was made at the time of the operation. Early recognition and surgical intervention are necessary to prevent the high morbidity and mortality of this rare condition.

Case description: A 53-year-old Hispanic female with a past medical history of hepatitis C, cirrhosis of the liver on transplant list, vertigo, rib fractures post trauma, cholelithiasis and mitral valve prolapse presented to the hospital with complaint of left lower quadrant abdominal pain for 1.5 weeks. She was recently evaluated previously for the same complaint at another institution where she was treated for urinary tract infection without any other confirmed diagnosis. She reported left inner thigh pain with tight pressure sensation associated with one episode of vomiting and nausea. Physical examination was remarkable for tenderness at left lower quadrant and left inner thigh without any swelling to left thigh or inguinal region or any abdominal distension. Laboratory findings were insignificant except for the CT abdomen and pelvis, which illustrated distal small bowel collapse suspicious for obturator hernia causing small bowel obstruction. She subsequently underwent laparoscopic repair of left incarcerated obturator hernia with mesh and drainage of peritoneal ascites. She tolerated procedure well and was discharged on postoperative day six.

Discussion: This case demonstrates the need for an increase in awareness of the uncommon obturator hernia that can potentially cause small bowel obstruction in the midst of nonspecific symptoms.
Title: Cutaneous Larva Migrans

Author: Robert Levine, DO, Dept. of Dermatology, St John's Episcopal Hospital, Far Rockaway, NY 11691

Introduction: Cutaneous larva migrans is caused by penetration and migration within the epidermis of nematode parasites. It is characterized by erythematous, pruritic, serpiginous plaques usually occurring on the feet or other exposed sites. Although cutaneous larva migrans has a worldwide distribution, it is most commonly seen in warmer climates, such as tropical areas. The infection is acquired by walking barefoot on ground contaminated with animal feces. *Ancylostoma braziliense* and *Ancylostoma caninum* are the two species most frequently involved. Except in rare cases, the parasite remains confined to the epidermis, producing visible tracts and intense pruritis. It is self-limited because the larvae lack the lytic collagenase enzymes needed to cross the epidermal basement membrane. Disease of extended duration is uncommon because the larvae are unable to complete their life cycles in the human body and usually die within 2 months.

Case Description: A 21-year-old Caucasian male presented to a busy private dermatology practice with an intensely itchy rash on his left foot for one month. Prior to the rash starting, he was vacationing in Jamaica, where he had walked barefoot on the beach. The rash started as a red bump and then gradually became an erythematous, serpiginous twisting and winding eruption on the dorsal and dorsolateral aspects of the left foot. He had been to the emergency room a week prior and was misdiagnosed with a fungal infection and was treated unsuccessfully with an antifungal regimen. When we saw him, we made the diagnosis of cutaneous larva migrans based on history and physical exam. Within a week oral albendazole, his rash resolved.

Discussion: This case report illustrates the relatively rare skin disorder, cutaneous larva migrans, in its most classic form. Recognizing this diagnosis early can avoid patient frustration and discomfort. Recent travel history to a tropical location is an important clue.
Title: Progressive Multiple Sclerosis with an initial Presentation of limb paresthesia and facial weakness in a 54 year old Female

Authors: Jayme D. Mancini, DO, PhD, Yating Lee, DO

Introduction: The mean age of onset for multiple sclerosis is 30 years of age, however that for primary-progressive multiple sclerosis is later, 35 to 39 years. More commonly, symptoms initially manifest as relapsing and remitting neuroophthalmologic disorders, parasthesias, or paraplegias, as is described in clinical diagnostic criteria for multiple sclerosis. However, primary-progressive multiple sclerosis has no relapses or remissions. This degeneration may plateau.

Case description: A.C. is 54 yr old F with a history of paraplegia secondary to motor vehicle accident presented with new onset of facial weakness and parasthesia. Pt was initially reported to have upper extremity paresthesia without remission. Then six months later, she spontaneously lost vision of one eye two weeks prior to hospital admission, and regained it a few hours later, however, with decreased visual acuity. She also had new electric pain that radiated from neck down. On physical exam, left sided facial weakness was noted with decreased sensation. MRI demonstrates heterogeneous enhancement and new high signal foci/plaques noted in C4-5 cervical cords and cerebellar peduncle compared to the MRI that she did 6 months ago.

Discussion: This case illustrates how initial presentation of mild facial weakness, turned out to be a new diagnosis of a different medical disease. This case teaches us, that the simplest answer is not always the right one. Patient’s age is atypical for the onset of multiple sclerosis, and her clinical progression decline was faster disability than expected. This is why history, physical exam, ordering appropriate diagnostic tests, and appropriate consults are so important.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Spinal Cord Pathology in a Patient with Lung Cancer – is it just Mets?

Authors: Aboo Mannan, D.O. Sourial Morris Sourial, D.O
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Introduction: It would be logic to consider metastases in a patient who has a solid mass in the lung and spinal cord injury. However, when the onset is sudden in such a patient, the differential will be quite large, and the treatment will be overwhelmingly confusing. Management should be quick and efficient, as life itself is at stake.

Case Description: A 73 year-old male with history of confirmed lung cancer is admitted because of sudden onset of paraplesia and paresthesia, subsequent to acute onset of lower back pain. Examination revealed absence of pedal pulses bilaterally, loss of sensation and decreased muscle strength in the lower extremities. Tenderness to deep palpation on the left lower quadrant was also noted.

Differential diagnosis on admission was arterial insufficiency of the lower extremity, intestinal angina, or a hypercoagulative state secondary to the lung cancer. Despite aggressive medical management, the pain has worsened. An MRI of the spinal cord revealed confusing differential and the patient was transferred to a neurosurgical facility where he underwent an emergent operation, with the aim of not only alleviating the pain and discomfort, but was mainly to save the patient’s life that was at stake.

Discussion: This case illustrates the diverse and confusing pathology in a patient with a lung cancer. No matter what the pathology is, the most important step is to act rapidly, as it is the patient’s life which is at stake here. Considering all possibilities and not be limited to a narrow differentials appears to be worth in order to save a human life.
Dept. of Family Practice, St. John’s Episcopal Hospital Far Rockaway NY 11691

Title: Sturge-Weber Syndrome; a Classic Presentation of a Rare Disease

Author: Charisse McCall, DO
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Introduction: Sturge-Weber syndrome (or encephalotrigeminal angiomatosis) is a congenital neurocutaneous disorder characterized by venous angiomaticous masses in the leptomeninges, calcifications in the cerebral cortex, a capillary malformation of the face (port-wine stain) and abnormal vessels in the ipsilateral eye. Clinically the vascular malformations lead to mental retardation, seizures, hemiplegia, and glaucoma. The pathophysiology is thought to be a persistence of the embryonic vascular plexus. This is a case presentation that exemplifies the classic picture of an uncommon syndrome, having an estimated incidence of 1 in 50,000 children.

Case Description: A 15 year-old Hispanic female with a history of SWS presents to the pediatric office for follow-up care. Her mother reports that the child was born with a port-wine stain over the left side of her face that has become increasingly raised over time. Past medical history includes epilepsy, mental retardation and glaucoma. Physical exam reveals an obese female, oriented to person, with a paucity of speech and mild right sided weakness. There is a reddish-purple patch with areas of nodular elevation on the left side of the face extending from the forehead to chin, also involving the left side of the tongue and gingiva. MRI brain shows atrophy of the left hemisphere with cystic encephalomalacia and calcification, a 15mm lymphangiomatous cyst at the lateral aspect of the globe, and a prominent left facial cutaneous angioma. The patient continues to be followed by neurology and ophthalmology. She has received two treatments of pulsed-dye laser to the capillary malformation on her face with some improvement, but was unable to continue due to financial reasons.

Discussion: Although SWS is a well-defined syndrome, new advancements in neuroimaging, gene mapping, understanding the molecular neuropathology and treating the disfiguring skin lesions have been made. A discussion of the current research will follow.
Dept. of Family Practice, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Aortic dissection presenting as TIA

Authors: Raquel Murphy, DO; Jin Zhang, DO

Introduction: Patients who present with only neurological symptoms and no pain initially challenge the recognition of acute aortic dissection. Aortic dissection is frequently associated with ischemic stroke; however, a high clinical suspicion is necessary when the presentation is atypical.

Case description: We present the atypical clinical picture of aortic dissection which presented as sudden onset of left hemi-paresis or TIA in a 90-year-old previously healthy male who was working at a golf course before the onset of symptoms.

Discussion: Acute aortic dissection usually presents with a sudden, painful, tearing sensation in the chest or back. However, acute aortic dissection may also present atypically without pain and with solely neurological symptoms. We describe a case of painless acute aortic dissection initially which presented as acute left lower extremity weakness and numbness. These neurological symptoms are due to vascular occlusion causing peripheral ischaemic neuropathy. It is important to consider acute aortic dissection in the differential diagnosis of acute neurological syndromes.
Title: The progression of pancreatic adenoma to invasive adenocarcinoma: a case presentation and literature review.

Author: Daniel Mwanza, DO, Department of Surgery, St. John’s Episcopal Hospital, Far Rockaway, New York

Introduction: Until recently, pancreatic adenomas were generally deemed benign and without potential for progression to invasive cancer. Recent literature has identified certain subsets of adenomas, to be on a continuum with malignant subtypes, particularly mucinous cystadenocarcinoma. Review of the literature on MEDLINE and PubMed [1999 – 2009] using English keywords pancreatic adenoma, pancreatic adenocarcinoma, progression of pancreatic adenoma, survival of invasive pancreatic cancer, mucinous cystic neoplasms (MCN), and mucinous cystadenocarcinoma yielded only 5 reported cases.

Case Description: We present a case of a 66 year old female who had been seen 6 years earlier at another institution with vague abdominal pain. Computed tomography (CT) of the abdomen and pelvis, showed a mass in the tail of the pancreas. Biopsies were done and showed the mass to be a mucinous cystadenoma. She was then lost to follow up until 6 years later when she presented to our institution with vague left upper abdominal pain associated with nausea and vomiting. CT scan of the abdomen showed a mass, as previously seen, but increased in size, at the confluence of the tail of the pancreas and the spleen. The patient was taken to the operating room for excisional biopsy. Biopsy results showed the mass to be an invasive mucinous cystadenocarcinoma of the pancreas.

Discussion: Pancreatic cystic neoplasms exist on a continuum ranging from benign to invasive disease. Pancreatic cystadenomas are now known to have an inherent potential for progression to cystadenocarcinoma. The lag time from benign to invasive disease is 5 years. Once diagnosed, these tumors need complete resection and long-term follow-up. The recommendation for long-term observation is based upon data that has shown these tumors to have multifocal pattern from which a new invasive tumor may arise. Recommended follow-up is up to 9 years.
Title: A Case of Spindle Cell Melanoma

Author: Charlotte Noorollah D.O.

Introduction: Spindle cell melanoma is a rare form of melanoma that is locally aggressive and tends to have a high recurrence rate. The clinical appearance can be highly variable and may mimic a variety of lesions. In this case, a Hispanic male with a lesion clinically resembling a keratoacanthoma; a relatively non-aggressive skin cancer that rarely progresses to an invasive or metastatic carcinoma, was diagnosed with a melanoma of the spindle cell type.

Case Description: An 83 year old Hispanic male with a medical history significant for hypertension and prostate cancer presented to the Dermatology clinic with a complaint of a growth on his face for approximately 5-6 months. He denied any pain, neuropathy, bleeding, or constitutional symptoms. Physical examination revealed a 1.5 x 2 cm erythematous nodule with rolled border, telangectasias and central keratotic plug located on the right zygoma, clinically resembling a keratoacanthoma. Shave biopsy of the lesion revealed a spindle cell melanoma that was S100 positive. The patient was referred for surgical excision and metastatic work-up.

Discussion: This case demonstrates the importance of biopsy of all suspicious lesions regardless of suspected aggressive behavior. Clinically, the patient presented with a lesion that would warrant local treatment and that would generally portend a good prognosis and a low risk of metastasis. However, once the diagnosis was established histopathologically, the patients’ prognosis immediately changed necessitating rapid removal and treatment.
Dept. of OB/GYN, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Gartner’s Duct Cyst

Authors: Emmanuel Nwogu DO, Donald Menya DO

Introduction: Gartner’s Ducts are identified in approximately 25% of all adult women, in which nearly 1% can evolve into Gartner’s duct cysts. During embryological development, the mesonephric (Wolffian) ducts develop, form their predetermined structures and later regress; however, remnants often remain until, most often during and after late adolescence, they develop a secretory mechanism, cause dilation of surrounding cells, and thus yield a Gartner’s duct cyst. Classically, the cysts are solitary, unilateral, less than 2 cm in diameter, and are located in the anterolateral vaginal wall of the proximal one-third of the vagina.

Case Description: Patient is a 19 year old G1P0 who presents to the ER with a growth protruding from the introitus of her vagina. Pt noticed lesion 3 days ago. Pt denies any vaginal bleeding, discharge, urinary retention or incontinence but admits to pain during intercourse. Treatment used was surgical excision on a later date.

Discussion: Gartner’s Duct Cysts are generally asymptomatic and most commonly diagnosed upon routine gynecologic examination. Patients usually complain of a skin tag, dysuria, pelvic pressure, itching, dyspareunia, pelvic pain or protrusion of a cyst from the vagina. If it grows to a detectable size, it can be removed surgically or drained.
Dept. of OB/GYN, St. John’s Episcopal Hospital Far Rockaway NY 11691

**Title:** Umbilical cord prolapse

**Authors:** Chinwe Okonkwo, D.O, Vu Nguyen, D.O
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**Introduction:** Umbilical cord prolapse is an obstetrical emergency. It occurs when the umbilical descends alongside or beyond the fetal presenting part. This is life threatening to the fetus since blood flow through the umbilical vessels is compromised by compression of the cord between the fetus, uterus, cervix or pelvic inlet. In this case, an African American female presented with a 7cm umbilical cord prolapse beyond the vagina. Furthermore, the incidence of umbilical cord prolapse ranges from .14% to .62% of all births. Literature review revealed that overt or occult umbilical cord prolapse is a rare event potentially associated with serious fatal/ neonatal complications.

**Case description:** A 39 year old African American G10P8018 at 26weeks + 2days by LMP with no significant past medical or surgical history. Presents via EMS with complains of umbilical cord protruding out of the vagina and heavy vaginal bleed. Vaginal exam revealed fetal parts in the vagina. Bedside ultra sound demonstrated a positive fetal heart tone at 125beats/min, transverse lie and fundal placenta. Patient was placed in trendelenburg position, another resident reached into the vagina and pushed the presenting part out of the pelvic inlet. And with her hand in that position, patient was counseled on treatment options and chances of fetal survival. She consented to an emergency cesarean section. A classical cesarean section was performed. A male infant delivered in 2mins with APGAR of 1,1 and 0. Patient refused autopsy, placenta was sent for pathology. She was discharged home on hospital day 3.

**Discussion:** This case illustrates a rare obstetric emergency with fetal mortality rate of 11%-17%. This was a patient unknown to us who presented as above. Significant risk factors in this case are multiparty and prematurely. Preconceptional counseling of high risk patients is recommended.
Dept. of Surgery, St. John’s Episcopal Hospital, Far Rockaway, NY

**Title:** Surgical Treatment for Symptomatic Gallbladder Dysfunction with Negative Laboratory and Radiological Evidence of Disease

**Authors:** Sara Pace, DO
Department of General Surgery, St. John's Episcopal Hospital

**Introduction:** Gallbladder dyskinesia is a poorly understood diagnosis with distinctly fewer studies than other gallbladder diseases. This case is particularly unique in that a dysfunctional acalculus gallbladder with a normal ejection fraction is present.

**Case Description:** A 26 yo f presented with severe right upper quadrant pain lasting for 24 hours. The pain was associated with nausea, vomiting, and chills. The patient did not have a history of fatty food intolerance, no changes in bowel or urinary habits. She is healthy with no past medical or surgical history. Despite medication, pain in the right upper quadrant persisted. All of the patients following labs were completely negative for abnormalities: CBC, CMP, Hep Profile, UA, Urine culture. In addition the following studies were negative for abnormalities, including cholecystitis and cholelithiasis: abdominal ultrasound, abdominal/pelvic CT, and HIDA. Due to the patients persisting pain, she was taken to the OR for laparoscopic cholecystitis. The gallbladder was covered in adhesions to liver and small bowel suggesting acute on chronic cholecystitis.

**Discussion:** Persistent right upper quadrant pain with nausea and vomiting, despite negative studies, can still be gallbladder disease. Thus, surgical intervention should not be ruled out. Gallbladder dysfunction is an ongoing study due to its various possible causes and unknown pathophysiology.
Title: Urinary retention as a presentation of HIV infection

Author: Nogba Pawoo, DO
Dept. of Family Practice, St. John’s Episcopal Hospital

Introduction: Neurological disease has been described in relation to HIV infection as a result of opportunistic infections or primary manifestation of the disease. Meningitis, HIV encephalopathy have been well documented, however, there is few literature that discuss urinary retention in its relation to HIV infection.

Case description: A 47 year old Hispanic man presented with a chief complaint of dizziness for 2 weeks, urinary retention for 1 day, and fevers. Per the patient the dizziness was associated with headache relieved with Tylenol with no visual disturbances. The urinary retention started that morning and per patient he has never had a similar problem. Pertinent positive on physical exam were a healed craniotomy scar, oral candidiasis, tremor, positive suprapubic tenderness and fullness. A foley was placed provided symptomatic relief, a renal ultrasound and psa level was obtained and was within normal levels. During the course of the patients hospital stay he complained of fevers and a more detailed history was obtained that revealed unintentional weight loss and a history of unprotected sex. HIV test was performed on the patient and came back as reactive. A CD4 count with viral load was obtained on the patient and the patient was placed in Bactrim for PCP pneumonia. The foley was removed during the patients hospital stay and he was able to urinate.

Discussion: Urinary retention as related to HIV infection has been discussed in previous literature as presenting when a patient has a coinfection. There is one case report that discusses a women presenting to the ER with acute urinary retention and undiagnosed HIV infection. These cases raise the question on whether or not someone presents with unexplained urinary retention and all other reasons have been excluded should HIV testing be offered.
Title: Necrotizing Fasciitis as a Complication of Percutaneous Endoscopic Gastrostomy (PEG): A Case Study

Authors: Nhan Pham, DO, St John’s Episcopal Hospital

Introduction: For over three decades, PEG has become a widely performed procedure with an estimated 200,000 procedures performed annually in the United States to provide enteral access for nutritional support(1). Although PEG has a success rate of over 95%, the procedure has a morbidity of 9.4% and mortality of 0.53%(2). Complications includes aspiration, peritonitis, hemorrhage, tube migration, gastrocolocutaneous fistula, wound infection, leakage and blockage(3). Necrotizing fasciitis is a rare complication with a high attendant mortality of 50%(4). In this study, we present a fatal case necrotizing fasciitis of the abdominal wall 4 months after PEG placement.

Case Description: A 74 year old AA F with ASHD, DM, HTN, ESRD, vascular dementia with prior PEG placement presented to our hospital with respiratory failure and sepsis secondary to a stage IV sacral decubitus ulcer. She underwent debridement and end colostomy. Over three months, she was placed on multiple antibiotic regimens without improvement. On routine chest x ray, subcutaneous emphysema was noted on her left abdomen. On exam, there is bullous formation with blisters over the site. During exploratory laparotomy, the patient has extensive necrosis of her abdominal wall and chest secondary to malposition of PEG tube and extravasation of tube feedings into the peritoneal cavity. In three days, the necrosis had spread all the way down to the left knee. The patient expired on post operative day 12.

Discussion: Although necrotizing fasciitis is a rare recognized complications of PEG placement, all previous reported cases of had developed early in the course(5). Initial studies finds that administering broad spectrum antibiotics as well as placement of peg booster three centimeter from the abdominal wall both help decrease the rate of infections and necrotizing fasciitis. More research into this field can help physician better prevent the morbidity and mortality associated with PEG placement.
Title: Maculopapular Rash of Secondary Syphilis Mistaken for Insect Bites

Authors: Phung, Kien, DO, Kim, Ki, DO
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Introduction: The incidence of syphilis within the past few years has been on the rise. Venereal syphilis is divided into various stages, each with its own unique systemic and clinical manifestations. The spectrum of diseases ranges from painless ulcers at the site of inoculation to disseminated infections to vascular and neurologic findings in the latter stages. We report a case of secondary syphilis with typical findings of maculopapular rash noted on the hands and feet of a patient.

Case Description: A 24 year old African-American male presented to the Addabbo Clinic complaining of a 2-week history of “bug bites” in his hands and feet. Patient denied any itch, weight loss, fever, nausea, vomiting, chest pain, abdominal discomfort, or shortness of breath. Patient did not apply any cream or ointment to affected regions. Patient denied previous occurrences. Upon examination, patient had diffuse, non-pruritic, oval, brownish-red macules approximately 0.5cm on the palms of his hands and the plantar surface of his feet. Secondary syphilis was suspected and subsequently confirmed by serologic testing.

Discussion: Secondary syphilis has been described in numerous other case reports. The rash that characterizes this stage is not uncommon, typically described as firm, annular macules and papules usually seen on the head, neck, palms, and soles. Our patient presented with typical findings which he mistaken for “bug bites.” This importance of this case presentation is twofold: to bring about awareness of a common sexually transmitted disease that is on the rise and to highlight the importance of early diagnosis and treatment.
Title: Primary Intraocular Lymphoma: The Masquerade Syndrome

Authors: Matthew Pomykala DO, Azra Idrizovic DO
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Department of Family Medicine
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Introduction: Primary care physicians frequently encounter ocular complaints. Primary Intraocular Lymphoma (PIOL) is an uncommon diagnosis referred to as a masquerade syndrome for many intraocular inflammatory processes. Blurry vision, floaters, without pain or redness is common. Reports indicate between 56-85% of patients will develop intracranial lesions within 29 months. Many patients have been treated for uveitis with refractory results.

Case Description: 61 year old male was evaluated for uveitis. Patient complained of acute change in vision one month prior to visit, blurry vision and floaters in both eyes with mild photosensitivity. The initial impression was bilateral anterior uveitis and vitritis, the patient was placed on ocular steroids ophthalmic. Varicella IgM, EBV-VCA IgG, HLA-B27, HSV I IgG, HSV 1/2 IgM were elevated. Surgical pathology from vitrectomy showed diffuse large B-cell lymphoma with large CD20+ B-lymphocytes. Gram, PAS, and AFB were negative. Immunostains for toxoplasma and HSV-1 antigens were negative. HSV virus was not isolated by rapid ELVIS method, and bacterial cultures were also negative. CT and MRI were negative for central nervous system involvement.

Discussion: PIOL is an uncommon neoplasm with poorly described incidence often termed the Masquerade syndrome. In a patient with consistent vitreo-retinal findings a broad differential is considered including infectious, autoimmune and metastatic etiologies. Many of the diseases that are included in the differential diagnosis can pose significant systemic effects as can PIOL, and therefore, prompt recognition to a specialist can be crucial to visual and health preservation. Complications associated with the vitreoretinal form of PIOL include CNS lymphoma with independent foci, whereas the uveal lymphoma has visceral non-Hodgkin’s lymphoma associations.
Title: “Always on my mind” A Case of Pituitary Apoplexy

Authors: Richard Sayegh, DO; Maleka Rahman, DO
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Introduction: Pituitary Apoplexy is a rare and potentially life threatening conditions that quite commonly may present with vague symptoms often ophthalmologic and neurologic in nature. A thorough understanding of the disease and its possible presentations, as well as heightened awareness by the physician may aid in a more rapid diagnosis that may result in life saving treatment and measures being initiated in a timely fashion.

Case description: A 35-year-old African American female with a medical history significant only for migraine headaches presented to the ophthalmologist for follow up of a headache she recently had for which she was treated by a local ER and discharge home. Since her discharge she developed “blurry vision”, “double vision” and a “droopy eyelid” for which she more recently saw a neurologist who in turn referred her for ophthalmologic evaluation. Ophthalmologic evaluation soon revealed multiple cranial nerve palsies including a 6th Nerve and a Pupil involving Partial 3rd Nerve. These signs as well as the Pt reporting the “worst headache of her life” prompted appropriate rapid management of this pt to the nearest ER for a CT Scan which soon revealed a pituitary mass. She was admitted to ICU, MRI was done revealing small pituitary hemorrhages and microinfarcts. The pt was immediately transferred to a neurosurgical facility for management of Pituitary Apoplexy and intracranial surgery was performed.

Discussion: This case illustrates the benefit of heightened awareness in cases with routine presentations in order to more rapidly diagnose, manage, and treat potentially life threatening conditions. Early institution of this treatment and referral for neurosurgical intervention may have saved this patients life.
Dept. of Surgery, St. John’s Episcopal Hospital, Far Rockaway, NY

**Title:** Ventral hernia repair with several revisions

**Authors:** Brian R. Schwab, D.O. (1), Vikram Palkar, D.O. (1)
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**Background:** Nearly 10% of abdominal operations result in an incisional hernia. The decision to repair is determined upon the size and presence of symptoms of obstruction. The reocurrence rate of a large first-time ventral hernia approaches 50%. Repair of recurrent ventral hernias is even less likely to succeed with a reocurrence rate exceeding 50%. In this case, the patient had a symptomatic large ventral hernia causing a small bowel obstruction who underwent repair. This case serves an example of the potential complications that can occur when repair is known to have high likelihood of recurrence.

**Case Description:** A 52 year-old female, medical history significant for a large ventral hernia and surgical history of a Caesarian section, was admitted with several days of nausea without vomiting. On physical exam she had a large reducible incisional hernia with evidence of high-grade obstruction. She then underwent a ventral hernia repair with mesh placement. Her hospital course was prolonged due to persistent nausea. She was discharged on hospital day 12 with home nursing services for wound care.

Two weeks following discharge, she was readmitted directly to ICU with evidence of high-grade bowel obstruction. She underwent an exploratory laparotomy with lysis of adhesions and new placement of mesh. Her ICU stay was lengthened due to prolonged intubation while treating for nosocomial pneumonia. Once transferred to a general floor, she had recurrent episodes of obstruction. On hospital day 54, per patient's request was transferred to an outside hospital for care.

**Discussion:** This case illustrates the potential for complications that can occur when repairing a large ventral hernia. Multiple revisions were performed with extended hospital course. The decision to undergo the initial repair needs to be performed with the knowledge of high likelihood of recurrence and complication.
Department of Ophthalmology, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Candida endophthalmitis—a diagnostic dilemma

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Introduction: Candida endophthalmitis is a sight-threatening complication of disseminated candidiasis. Factors that could predispose to candidemia and candidal chorioretinitis include recent major surgery, bacterial sepsis, indwelling intravenous catheters, and intravenous drug abuse. Endogenous candidal chorioretinitis usually presents with decreased vision, pain, hazy vitreous and a white circumscribed lesion.

Case Description: A 55 year old male presented to the eye clinic with a one week history of left blurred vision. Five weeks previously he had undergone aortic valve replacement and two weeks postoperatively was diagnosed with Candida Endocarditis. Patient was on IV Amphotericin B therapy. Physical examination revealed the best vision in the left eye 20/200, occasional vitreous cells, an epiretinal membrane and focal areas of thrombi or emboli. FA of the left eye showed normal arterio-venous transit. OCT of the left eye showed vitreomacular adhesion. The impression was that the clinical appearance of this disease is not pathognomonic for Candida Endophthalmitis. One week after the initial visit the patient had a new vitreous opacity on the left eye, typical for Candida Chorioretinitis. Intravitreal Amphotericin B injections were administered. Two months later, his vision improved to 20/40 and the vitreous infiltration resolve.

Discussion: The observation of a classic presentation of fluffy white preretinal and intraretinal infiltrates at the posterior pole extending into the posterior vitreous is diagnostic of endogenous endophthalmitis due to Candida spp., but the patient may present with nonspecific lesions, superficial retinal hemorrhages and/or cotton wool spots, epiretinal membrane, which are most often due to an underlying systemic disease rather than an infection. The high rate of empirical or therapeutic use of systemic antifungal agents appears to cause a lower rate of vitreal extension of retinal processes.
Title: Malaria in Pregnancy: A Case Presentation

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Introduction: A doctor practicing in much of America today may never see a case of malaria, however, obstetricians practicing in New York City must be aware of foreign born disease processes and the risks to both mother and fetus. This poster looks at a case of malaria postpartum and explores the risks of malaria in pregnancy.

Case Description: A 35 year old, G5P2032, female with history of prior cesarean section presents to labor and delivery in active labor 2 days after landing at JFK airport from Nigeria. The patient is rushed to the operating room where a 3860g baby boy is delivered by repeat cesarean section. 30 hours postpartum the patient spikes a fever of 101.8. The patient is started on a regimen of ampicillin and clindamycin to treat empirically for endometritis. 17 hours later the patient again spikes a fever to 101.6. Flagyl is added to the regimen of antibiotics. Peripheral smears and blood cultures are drawn, both are found to be negative. Day 3 the patient continues to spike fevers to 101.2. Infectious disease medicine is called to see the patient and suspecting endometritis with possible pelvic abscess the regimen is changed to Zosyn. Day 4 the patient spikes a fever again. Peripheral smears are redrawn and doxycycline and quinine are started empirically for suspected malaria. After 24 hours of treatment the patient does not spike a fever and states she is feeling better. After 48 hours of antimalarial medications the patient remains afebrile and is discharged home.

Discussion: As our world physically grows smaller the world of medicine must simultaneously grow larger encompassing disease processes foreign to our shores. This review of malaria in pregnancy is an example of how important it is to understand foreign disease, even within the confines of the United States.
Dept. of Dermatology, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Morphea Associated With Celiac Disease

Author: Sanjosh Singh, DO
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Introduction: Morphea is an idiopathic inflammatory disease of the skin characterized by localized, circumscribed sclerotic patches, or plaques with variable pigmentation, including early violaceous or late ivory and hyperpigmented changes. Morphea is classified into plaque, generalized, linear, and deep subtypes according to the clinical presentation and depth of tissue involvement.

Case Description: A 56yo African American female presented to the dermatology office with complaint of a painful rash on her left shoulder. On physical exam, a solitary shiny hyperpigmented plaque with atrophic area within the lesion was noted. Biopsy of the lesion revealed sclerosis with morphea or scleroderma. A diagnosis of localized morphea was then confirmed. Our patient also complained of weight loss and was referred to a gastroenterologist in which a complete work-up was consistent with celiac disease. The patient was then placed on a gluten free diet and noted significant improvement of symptoms. Although morphea is commonly associated with various autoimmune disorders, its presentation with celiac disease is rare. There are only a few documented case reports of its association in current literature.

Discussion: Morphea, also known as localized scleroderma, is a disorder characterized by excessive collagen deposition leading to thickening of the dermis, subcutaneous tissues, or both. The incidence of morphea has been estimated at approximately 25 cases per million population per year. Women are affected approximately 3 times as often as men for all forms of morphea except the linear subtype, which only has a slight female predominance. Extracutaneous involvement is present in 20% of patients more commonly in the linear subtype. Morphea is typically self resolving, however patients may seek treatment for cosmetic reasons in which topical steroids and PUVA therapy may prove helpful.
Title: Efudex as Treatment for Lentigo Maligna?

Author: Shari Sperling, DO

Introduction: Efudex, fluorouracil topical, is an immunomodulator used for the treatment of basal cell carcinoma and actinic keratosis. Its mechanism of action is through inhibition of DNA and RNA synthesis. We present a case of lentigo maligna that responded to treatment with Efudex.

Case Presentation: Patient is an 80 year old Caucasian female who presented with a change of appearance of a lesion on her cheek. Patient was known to us and had been treated for multiple solar keratoses to her forehead with Efudex. The patient noticed a "brown spot" on her cheek and decided to use Efudex on that area without direction. She subsequently returned to the office four weeks after treatment.

On clinical exam prior to treatment, patient had a 2 x 2 cm pigmented patch on her right cheek with a presumed diagnosis of a solar lentigo. After treatment with Efudex, part of the patch became lighter in color, while the other half remained its original color. Dermoscopy revealed peppering. Two biopsies were obtained, one from the hypopigmented area and the other from the unchanged region. The biopsy from the area with fading color revealed an early malignant melanoma in situ, lentigo maligna type. The biopsy from normal skin color showed a proliferation of atypical melanocytes colliding with a pigmented solar keratosis. The entire lesion was subsequently treated with complete excision.

Discussion: Amelanotic melanoma may develop from a pigmented lentigo maligna with treatment with an immunomodulator with clinical clearing of the lesion. However, the underlying histologic findings may still be consistent with a melanoma and may cause confusion in the treatment and staging of melanoma. However, there have been other studies that show the possible role of immunomodulators in the treatment of melanoma.
Introduction: Trigeminal neuralgia is an uncommon disorder characterized by recurrent attacks of lancinating pain in the trigeminal nerve distribution, with an annual incidence of 4.3 per 100,000 people and approximately 15,000 new cases in the United States each year. Carbamazepine is the drug of choice for the initial treatment of trigeminal neuralgia; however, baclofen, gabapentin, and other drugs may provide relief in refractory cases, and neurosurgical treatments may help patients in whom medical therapy is unsuccessful or poorly tolerated.

Case Description: An 87 year-old Caucasian male with trigeminal neuralgia for over 15 years had been to numerous physicians for medical treatments, and had recently consulted with a neurosurgeon who recommended microvascular decompression. The patient and his family opted to explore non-surgical remedies and presented the Western University Clinic to inquire about osteopathic manipulation. Prior to beginning osteopathic manipulative treatment (OMT), he experienced pain intermittently throughout the day, rating 9/10, set off by any number of triggers, with some episodes lasting hours. His treatment regimen included OMT weekly in the clinic, and regular home stretching exercises of the neck and upper extremities. After 6 months of OMT, the patient reported an average of 2 brief episodes weekly, each usually lasting less than one second and the intensity maximally was 7-8/10. He was able to resume some activities of daily living, e.g. shaving, brushing his teeth, without triggering pain attacks.

Discussion: In trigeminal neuralgia, sympathetic nerve fibers from the respective soma of dysfunctional segments/joints can result in abnormal sympathetic tone relayed to the trigeminal nerve ganglia, particularly the trigeminal nucleus caudalis. It therefore follows that treatment should be directed at normalizing this abnormal tone at the level of the dysfunctional segment. Osteopathic manipulative treatment can address these abnormal autonomic reflexes associated with lesions at the segmental level.
Title: An unusual cause of lower extremity paralysis in a child

Author: Heidi Ungar DO,
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Introduction: Atrial myxoma is a common primary cardiac tumor that can present with left or right-sided heart failure, syncope, and 30% of the time with emboli in various arteries that can lead to many unusual presentations.

Case Description: A 4-year-old male presented to the ED with chief complaint of sudden onset lower extremity paralysis. Mother denied seizure history, stated he was a full term delivery without complications and all of his immunizations were up to date. Pt had no past medical history but mom stated he had had an episode of syncope 2 years previously with a negative workup. Physical exam showed a cooperative child who was interacting appropriately with his mother. Pt had flaccid paralysis of both lower extremities and a dilated rectum. Laboratory findings were negative except for a positive CRP and ESR. CT head, C-spine, T-spine, and L-spine were all unremarkable. Pt was transferred to Long Island Jewish for possible diagnosis of Guillain Barre and further evaluation. Pt underwent a contrast enhanced CT there that showed significant stenosis of the aorta from the waist down, most likely caused by an embolus. Hypercoagulopathic studies were sent out. Over the following 24 hours the patient continued to deteriorate. Subsequently, he developed superior mesenteric artery and renal artery emboli. Pt was intubated and supportive measures were conducted. Pt expired on hospital day 2. An autopsy was performed post mortem, which showed the patient had an atrial myxoma that was felt to be responsible for the multiple systemic emboli.

Discussion: This case illustrates a rare presentation of atrial myxomas. It is important to review this case to remember the various causes of syncope and paralysis that may not be obvious in the pediatric population. Perhaps when the patient was previously evaluated for syncope, an echo could have been performed that might have prevented the fatal outcome
Title: Elephantiasis Verrucosa Nostra

Authors: Tara Whelan, DO, Andrea Barrata, DO
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Introduction: Elephantiasis Verrucosa Nostra is a rare, chronic, deforming disorder characterized by hyperkeratosis and papillomatosis of the epidermis with underlying woody fibrosis of the dermis and subcutaneous tissue. Elephantiasis is a clinical description of distinct cutaneous changes associated with a chronic underlying dysfunction in the lymphatic system. While the causes of chronic lymphatic obstruction and stasis are numerous, the most common mechanism is an underlying lymphatic obstruction leading to impaired lymphatic drainage with abnormal accumulation of interstitial fluid and subsequent development of lymphedema. The chronicity of lymphedema leads to changes in the overlying epidermis as it slowly develops a cobblestoned, verrucous appearance. In this case a 74 year-old female presented with chronic lymphedema of the lower extremities with associated cutaneous involvement, exhibiting diffuse verrucous changes to the lower legs and feet. This case is remarkable as Elephantiasis Verrucosa Nostra is a rare condition, and in addition, this patient presented with extensive involvement and impressive clinical features.

Case Description: A 74 year-old female presented to the dermatology clinic complaining of a “rash” to her lower legs that had been present for approximately two years. She had a past medical history of diabetes mellitus, hypertension and CHF. Physical exam revealed multiple firm nodules and verrucous papules and plaques extensively covering the bilateral lower legs. The patient was started on Carmol 40 lotion twice daily and she continues to be followed in the clinic.

Discussion: This case represents an example of the cutaneous changes associated with chronic lymphedema. This uncommon presentation of Elephantiasis Verrucosa Nostra will be discussed, including the challenges that are posed by the limited available treatment options.
Dept. of Surgery, St. John’s Episcopal Hospital, Far Rockaway, NY

Title: Colonic Perforation Secondary to Histoplasmosis in AIDS: Report of a Case and Review of the Literature

Authors: Abrelena Wilson D.O., Jackie Battista D.O., MPH
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Introduction: Gastrointestinal histoplasmosis in patients with acquired immunodeficiency syndrome is common, but clinical presentation of colonic obstruction/perforation is rare. We present an unusual case of a man recently diagnosed with human immunodeficiency virus who developed cecal perforation secondary to Histoplasma capsulatum.

Case description: A 62-years-old Hispanic man with a significant past medical history for HIV with immune reconstitution syndrome, perirectal ulcers, depression, and chronic anemia, presented to the emergency room with two day history of mid-abdominal pain, nausea and vomiting. Seven weeks prior he was treated medically for partial small bowel obstruction secondary to a nonoccluding cecal infiltrating mass, which showed evidence of histoplasmosis.

On physical exam his abdomen had decreased bowel sounds and diffuse lower abdominal tenderness. Initial laboratory showed CEA of 4.3 ug/L and CD-4 131. A diagnostic laparoscopy and exploratory laparotomy revealed a walled off cecal perforation and inflamed appendix with adhesion. He underwent a right hemicolectomy and appendectomy with a functional end-to-end ileocolic anastomosis. During his postoperative course period, he developed HIV induced ITP and sepsis with an acute abdomen. On postoperative day thirteen he underwent an exploratory laparotomy with an abdominal washout for fecal peritonitis. Two days later, he had an end ileostomy and mucous fistula, and splenectomy performed.

Pathologic examination revealed perforated cecum with Histoplasma capsulatum. Due to the patient’s acute respiratory distress syndrome and already immunocompromised status, he expired.

Discussion: Our case showed gastrointestinal complications from histoplasmosis with obstruction and perforation, which is uncommon, but should be considered in patients with HIV/AIDS showing signs/symptoms of gastrointestinal system involvement. In a review of 52 patients with disseminated GI histoplasmosis, only three (6%) presented with obstructing colon mass, which required surgery. Further studies should investigate whether patients with reconstitution syndrome have a higher risk of obstruction and perforation compared to those patients with only HIV.
Title: Anticoagulation in portal vein thrombosis

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Introduction: Portal vein thrombosis is rare disorder resulting from combination of local and systemic prothrombotic risk factors. These risk factors include but not limited to: Liver Cirrhosis, Neoplasm, intrabdominal inflammatory process and coagulation disorder. Clinical symptoms may develop acutely (less than 60 days) or gradually. Acute symptoms, such us abdominal pain develops as result of thrombus expansion to SMV. Chronic signs/ symptoms are resulted from complication of portal hypertension (variceal bleeding, ascites, hypersplenism). Physicians are reluctant starting anticoagualtion in PVT for fear of GI bleeding.

Case description: 59 yrs old African American male with history of DM and HTN presented to hospital with 3 days of chest discomfort on intermittent bases which lasted few hrs at a time. He denied any provoking or alleviating factors. At times, the discomfort is associated with SOB. No significant FH for CAD, cancer or coagulation disorder. On routine lab, Pt’s AST, ALT and bilirubin found to be high. Ultrasound was ordered to r/o hepatobilliary disease. On ultrasound, portal vein was seen with almost total obstruction by thrombus. On further imaging of abdomen/ pelvis and chest using CT with contrast, possible neoplasm in the liver and pancreas was noted. On further lab evaluation, alpha-fetoprotein and LDH found to be high.

Discussion: This case illustrates the physicians’ dilemma initiating anticoagulation treatment of portal vein thrombosis. In a recent multicentre study involving 105 patients, early anticoagulation allowed a 44% recanalization rate of the portal vein at 1 year. In patients with cirrhosis, in the absence of hepatocellular carcinoma, the presence of PVT should stimulate rather than limit the use of anticoagulation treatment.
Eastern Regional Osteopathic Convention 2011

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