A. Ng*, A. Amer, A. Hayes, M. Surgeoner, S. Milburn, P. Walker, T. Muir, R. Wight, M. Hansrani. *James Cook University Hospital, UK*

Introduction: Carotid-pharyngeal fistula is a rare, life threatening condition. Two previous cases have been reported in the literature: due to neck trauma and tonsillar abscess. We report a 3rd case of carotid-pharyngeal fistula in a 62-year-old female 5 years following laryngectomy and radiotherapy for laryngeal cancer.
Case study: This lady presented with haematemesis. Gastroscopy showed a pulsatile mass in the pharynx. CT imaging identified a left common carotid artery fistulating into the pharynx. Collaborative emergency repair was undertaken involving vascular, ENT, plastics and radiology specialists. To control bleeding, the common carotid artery was initially stented using a Viabahn stent, currently not licenced for use in carotid vessels. This was followed by exploration of the neck, bovine patch repair of the carotid and repair of the pharyngeal defect with a myofascial flap. Post-operative recovery was uneventful.
Conclusion: Of the two previously reported cases, one survived, but underwent coil embolization of the internal carotid artery. Although not licenced for this purpose, stenting the common carotid artery prevented haemorrhage and maintained cerebral perfusion in this rare case. Ligation of the common carotid artery would have carried a significant risk of stroke. This emphasises the potential benefits from using off licence stents when deemed clinically necessary.

0235: A RARE MANIFESTATION OF AN UNCOMMON DISEASE: A CASE OF SARCOIDOSIS PRESENTING AS VOCAL CORD PALSY

S. Mastan*, R. Advani, N. Stobbs, N. Kumar. *Wrightington, Wigan and Leigh NHS Foundation Trust, UK*

Introduction: Hoarseness is a common presentation to the Otolaryngologist. The aetiology of this symptom can be a diagnostic challenge due to the vast range of potential diagnoses.
Vocal cord paralysis is a rare complication of sarcoidosis; and its initial presentation with hoarseness due to vocal cord paralysis has been rarely reported.
Case study: A 40-year-old woman was referred to Otolaryngology with a three-month history of persistent hoarseness of voice. Clinical examination was grossly normal. Fibre-optic laryngscopy revealed an immobile left vocal cord – indicating left vocal cord palsy.
Computerised tomography scan showed bilateral hilar and mediastinal lymphadenopthy but no evidence of compression to the recurrent laryngeal nerve. Histological assessment via mediastinoscopy and biopsy revealed granulomatous lymphadenitis with morphological features diagnostic of sarcoidosis. Sarcoidosis causing mediastinal lymphadenopathy compressing the recurrent laryngeal nerve has been previously reported. However, this presentation of mono-neuritis secondary to sarcoidosis is rare[1].
This patient was treated with systemic corticosteroids and later speech therapy.
Conclusion: This case highlights a rare presentation of a multi-systemic disease, the need for a breadth of clinical knowledge by specialists and the importance of a multi-disciplinary team approach to patient care.
[1]Boyd M, Malaisamy S, Le Susanti et al. Right vocal cord paralysis and mediastinal lymphadenopathy.Thorax.2011;**66:**211

0255: NEUROLOGICAL MANIFESTATIONS AS THE INITIAL PRESENTATION OF A RECURRENT SIGMOID DIVERTICULAR ABSCESS

Z. Zhou*, S. Wuppalapati, N.L. Scott. *Royal Preston Hospital, UK*

Introduction: Para-colic abscess formation is the most common complication in complicated diverticular disease. While patients typically present with lower abdominal pain, unusual presentations are occasionally seen. Haematogenous spread with formation of pyogenic liver abscess that caused right upper quadrant pain has been seldom reported. However, neurological manifestations secondary to brain abscess formation are among the rarest presentations observed in complicated diverticular disease.
Case study: A 35-year-old man presented with one-day history of dysarthria, dysphagia and right temporal headache. He had a percutaneous drainage and antibiotic treatment of a sigmoid diverticular abscess 7 months previously. MRI brain showed a right frontal motor cortex lesion, which was initially diagnosed as glioma. A CT angiogram was then performed but showed no vascular abnormality in relation to this lesion. The images were subsequently discussed in the Neurosurgical MDT. A brain abscess with cerebritis and cerebral oedema was diagnosed. A CT scan of abdomen and pelvis later showed an abscess formation in the distal sigmoid colon.
Conclusion: The patient underwent a right fronto-parietal mini-craniectomy and evacuation of cerebral abscess, followed by Hartmann's procedure. The abscess cultures both grew Streptococcus Anginosus. He made a full neurological recovery and was discharged with outpatient parenteral antibiotic therapy.

0257: ACUTE INTRA-ABDOMINAL HAEMORRHAGE: BEWARE OF RED HERRINGS

N. Makwana[2,*], T. Hammond[1]. [1] *Broomfield Hospital, UK;* [2] *Imperial College London, London, UK*

Introduction: We report the case of a male aged 20 presenting with central acute abdominal pain after being punched around his umbilicus during a boxing match the day previously.
Case study: On admission he was haemodynamically stable with a normal haemoglobin. He underwent a CT scan, indicating a grade three splenic laceration. After a period of observation he became haemodynamically unstable and dropped his haemoglobin. He was subsequently taken to theatre for an emergency laparotomy and splenectomy.
Laparotomy found massive blood loss into all four quadrants of the intra-abdominal cavity. The spleen was examined and the laceration was evident, however there was no active bleeding. The laparotomy was continued and with examination of the bowel a giant (15 cm) Meckel's diverticulum was discovered with rupture of its blood supply causing the bleeding. This was resected and the bowel anastomosed. The patient went on to recover well.
Conclusion: This case demonstrates the importance of being aware of uncommon presentations of pathology. It also highlights the dangers of over relying on imaging. In this case the splenic laceration served as a red herring, detracting from the true cause of this patients symptoms caused by an unusually large bleeding Meckel's diverticulum.

0276: PROXIMAL SMALL BOWEL OBSTRUCTION AND STRONGYLOIDES

R. Cui[2,*], S. Dougan[1], P. Leung[2], T. McIntyre[1]. [1] *Kings County Hospital Center Brooklyn, USA;* [2] *SUNY Downstate College of Medicine Brooklyn, USA*

Introduction: An estimated 100 million people worldwide are infected by the parasitic helminth, Strongyloides stercoralis. Resultant strongyloidiasis is typically asymptomatic but can potentially cause intestinal obstruction.
Case study: A 52 year-old man from Grenada with a history of HTLV-1 presented to our safety-net hospital with colicky abdominal pain, bilious vomiting, and anorexia. An abdominal CT showed a high-grade proximal small bowel obstruction and an upper GI series demonstrated circumferential thickening and narrowing of the proximal small bowel. Subsequent esophagogastroduodenoscopy found inflammation and narrowing of the 3rd portion of the duodenum with no evidence of discrete mass. Biopsy of duodenal mucosa showed strongyloides infection. He was treated with Ivermectin and Albendazole and his obstruction resolved. Duodenal obstruction from Strongyloides is a reported but rarely considered cause of small bowel obstruction. Patients tend to be middle-aged males from endemic regions (Latin America, Caribbean Sub-Saharan Africa and Southeast Asia), often with longstanding symptoms and comorbid immunologic disease. Antihelminthics are the treatment of choice.
Conclusion: Strongyloidiasis should be ruled out in patients with distal duodenal and proximal small bowel obstructions. This is particularly important for physicians working in settings that serve a disproportionate amount of patients from regions where strongyloidiasis is endemic.

0279: A CASE LINKING OBSTRUCTIVE SUBMANDIBULAR SIALADENITIS TO POTENTIAL AIRWAY COMPROMISE

M.M.T. Van*, R.D. Gohil, Q. Gardiner. *Ninewells Hospital and Medical School, UK*

Introduction: We report the case of a 70 year old patient who suffered an acute and severe complication from unilateral submandibular sialadenitis.
Case study: Having already been under investigation by ENT for chronic submandibular swelling, her new presentation was in keeping with worsening acute sialadenitis, with additional atypical symptoms of breathing difficulty and dysphonia. Imaging showed this to be due to a submandibular gland sialolith with inflammatory spread to the ipsilateral supraglottis. Medical treatment with watchful airway observation followed by stone retrieval proved successful. We describe differing causes of submandibular sialadenitis and the different modes of infectious and inflammatory spread within the compartments of the neck. There should be a high index of suspicion for potential airway compromise with deep neck space infections that should be managed urgently and efficiently.
Conclusion: An established and common condition such as obstructive submandibular sialadenitis can be complicated by airway compromise during an acute exacerbation. Infection within the deep compartments of the neck can cause airway compromise and vigilance should be kept for atypical symptoms suggesting this.

0292: RECURRENT MAJOR UMBILICAL BLEEDING CAUSED BY OMENTAL VARICES IN TWO PATIENTS WITH UMBILICAL HERNIA AND PORTAL HYPERTENSION

H. Satherley*, I. Sarantitis, H. Varia, S. Pettit. *Blackpool Victoria Hospital, UK*

Introduction: We describe two cases of recurrent major umbilical bleeding in male patients with Childs A alcohol induced liver cirrhosis and portal hypertension.
Case study: Both patients had umbilical hernias with omentum incarcerated in the hernial sac. In both cases imaging (CT and MRI) had shown omental varices without paraumbilical cutaneous varices. Previous reports have shown that venous communication can develop between omental varices and overlying abdominal wall scars resulting in spontaneous bleeding. We concluded that there was a similar mechanism for the umbilical bleeding in our cases and both were successfully treated by excising the umbilicus, ligating the omental varices within the hernial sac, returning the omentum to the abdominal cavity and repairing the hernial defect.
Conclusion: This cause for umbilical bleeding has not been previously reported. We advise that with similar cases excision of the umbilicus and ligation of omental varices is a safe and effective treatment.

0297: AN UNUSUAL PRESENTATION OF ADENOMATOID TUMOUR OF THE SPERMATIC CORD

C. Zabkiewicz*, I. Panagopoulos. *Ysbyty Gwynedd, UK*

Introduction: Adenomatoid tumour is a benign mesothelial neoplasm of the paratesticular region. Most commonly located in the epididymis, it often presents as a painless testicular lump. In the first report of its kind, we describe an adenomatoid tumour of the spermatic cord presenting as incarcerated inguinal hernia.
Case study: A 60-year-old male attended as an emergency with a four day history of acute left groin pain. Examination revealed a tender irreducible lump at the superficial ring of the left inguinal canal, which clinically resembled an acutely incarcerated inguinal hernia. At operation to repair the hernia a nodular mass was apparent adhering the spermatic cord to the superficial ring of the inguinal canal which histopathology later determined to be an infiltrating benign adenomatoid tumour.
Conclusion: This unique case is the first report in published literature of spermatic cord adenomatoid tumour presenting as a presumed general surgical emergency. It highlights the potential complexity of inguinal pathology and difficulty in pre operative diagnosis of these uncommon tumours.

0323: "A PAIN IN THE BUTTOCK" – INFECTION AND THROMBOSIS OF A PERSISTANT SCIATIC ARTERY (PSA) ANEURYSM

H.N. Raghallaigh[1,*], N. Dastur[2]. [1] *Brighton & Sussex University Hospitals NHS Trust, UK;* [2] *Frimley Park Hospital NHS Foundation Trust, UK*

Introduction: A persistent sciatic artery (PSA) is a rare and significant anatomical variant, with an estimated prevalence of 1% and is often subject to aneurysmal disease. Acute presentation may combine symptoms of lower limb ischaemia and a gluteal mass. We describe an interesting case of a PSA aneurysm becoming infected and thrombosed.
Case study: A 66 year-old gentleman presented with a short history of left buttock pain, pyrexia & high inflammatory markers. Emergency imaging described thrombosis of an aneurysmal left PSA within the left buttock, with surrounding pus. Conservative management with targeted IV antibiotics and pus aspiration was our mode of treatment and was ultimately successful. No endovascular intervention was required and lower limb arterial supply remained preserved throughout.
Conclusion: Despite the rarity of this anatomical variant, a PSA with its associated complications is an important pathology to discuss. An aneurysmal, infected PSA poses a difficult pathology to treat and a significant threat to life & limb. We have found no described cases of infected PSA aneurysms and their management in the literature and as such, we feel it important to share our experience of this case and our management with both the vascular and wider surgical community.

0329: "DOUBLE TROUBLE": GALLSTONE ILEUS WITH GALLSTONE IMPACTION IN AN ASCENDING COLONIC TUMOUR

H.N. Raghallaigh*, H. Teixeira, P. Thomas. *Brighton & Sussex University Hospitals NHS Trust, UK*

Introduction: An 85 year-old gentleman presented to A&E with colicky lower abdominal pain and an apparently distended bladder.
Case study: He was a vague historian, describing a past medical history significant only for gallstones. While a urethral catheter was being placed, unusually loud bowel sounds were noted. Minimal resolution of his gross abdominal distension was noted following his catheterisation, and further questioning and examination revealed visible peristalsis, significant weight loss, anorexia and a change in bowel habit. An urgent CT abdomen & pelvis was performed; revealing a large gallstone impacted within the neck of a colonic tumour. No urological pathology was identified. Bowel sounds audible from the end of the bed and visible peristalsis signalled an alternative and more sinister cause for our patients' lower abdominal distension, with CT scanning demonstrating the rare radiological finding of co-existing gallstone ileus and an obstructing colonic tumour, with a large gallstone stuck within the neck of the ascending colonic tumour. We present a selection of these interesting images.
Conclusion: This case serves as a reminder of the many causes of abdominal distension, and the need to think critically about the patient whose symptoms and signs remain following catheterisation.

0331: THE RECURRENCE OF SEVERE PERIANAL CROHNS DISEASE IN A VRAM FLAP RECONSTRUCTION POST DISEASE EXCISION – THE CLINICAL IMPLICATIONS OF EXTRANEOUS CROHNS DISEASE IN FLAP RECONSTRUCTION AND OPTIONS TO CONSIDER

A.Y.H. Loh[1,*], M. Loh[2], C.Y.Y. Loh[3], T. Athanassopoulos[3], M. Davies[3]. [1] *Glasgow Royal Infirmary, Glasgow, UK;* [2] *National University Singapore, Singapore;* [3] *Aberdeen Royal Infirmary, Aberdeen, UK*

Introduction: Crohn's disease is characterized by transmural inflammation resulting in fistulation and abscess formation. Severe perineal disease can result in the "pepper pot" perineum with complex fistulation. Panproctocolectomy and resection of perianal disease is a last resort in this group of patients.
Case study: A 35-year-old gentleman presented with extensive perianal Crohn's disease. He underwent a panproctocolectomy and resection of perianal disease for crohns with a Vertical Rectus Abdominis Myocutaneous (VRAM) flap reconstruction. His disease was managed via an MDT comprising general surgeons, plastic surgeons and gastroenterologists. He presented again, 3 years later with recurrent fistulae, which intermittently discharged. Surgical debridement, with drainage of abscesses was performed and tissue biopsies were taken from the VRAM flap, which appeared macroscopically to be involved. The histological findings have confirmed the presence of Crohn's pathology in the flap when compared with the adjacent tissues.