Case Description/Methods: A 76-year-old-woman was referred to gastroenterology for upper endoscopy due to changes in bowel habits. She endorsed diarrheal symptoms without postprandial pain, weight loss, anemia, or obstructive gastrointestinal (GI) symptoms. During EGD, we discovered an inverted IDD, also known as a windsock diverticulum, with an aperture at its apex. Soft, mobile, and with normal mucosa, the IDD arose from the medial wall of the second portion of the duodenum just proximal to the major papilla. We readily advanced the gastroscope into it. We recognized the classic appearance of the IDD and elected not to biopsy. As she did not report symptoms related to mechanical obstruction of the duodenum or major papilla, diverticulotomy or diverticulectomy was not proposed.
Discussion: IDD is a postulated congenital anomaly that arises in the 7th week of embryonic development due to aberrant recanalization of a duodenal diaphragm. Histologically, the tissue is vascular but there have been no cases published that suggest malignant potential. Our clinical vignette describes this uncommon endoscopic finding incidentally discovered during esophagogastroduodenoscopy for evaluation of diarrhea. Prior cases of IDD claim that patients may present with obstructive GI symptoms, pancreatitis, or bleeding. We will observe for symptoms of post-prandial duodenal obstruction, pancreatitis, and bleeding; and will consider the IDD as a cause of her diarrhea, though this association has not been reported. Gastroenterologists have performed snare diverticulectomy and have used endoscopic submucosal dissection (ESD) scissors and knives for incisional diverticulotomy. Immediate and delayed bleeding may occur requiring hemostatic clips and electrocautery, and close observation is recommended post intervention. In patients with acute small bowel obstruction, laparoscopic partial duodenectomy may be required. Recognizing this benign anomaly will avoid unnecessary diagnostic computed tomography and endoscopic ultrasound exams and morbidity due to complications from endoscopic resection or surgery.

S6100 Presidential Poster Award

Magnetic Balloon-Assisted Double Balloon Enteroscopy for Small Bowel Bleeding: A Case Report

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Introduction: A 69-year-old woman with a history of chronic anemia requiring multiple transfusions and several episodes of gastrointestinal leading to repeated emergency department visits was evaluated. Capsule endoscopy identified a bleeding lesion in the mid-small bowel. Subsequent device-assisted enteroscopy using a short double-balloon enteroscope (155 cm length, 3.2 mm working channel) failed to reach the lesion despite a 2-hour procedure. We therefore decided to employ a novel magnetic balloon anchoring system in order to avoid loop formation and facilitate deep insertion. This system includes a through-the-scope balloon catheter filled with ferromagnetic fluid and anchored via an external abdominal magnet. This setup stabilizes the endoscope, allowing effective loop resolution via retraction and straightening, minimizing scope slippage.
Case Description/Methods: We performed a second enteroscopy using the same scope, assisted by the magnetic balloon anchoring system. The endoscopist advanced the scope using standard double-balloon technique until a loop developed. Under fluoroscopic guidance, the magnetic balloon was inflated and magnetically anchored to the abdominal wall, in conjunction with the overtube and scope balloons. This triple-anchoring approach allowed for effective loop resolution by retracting and straightening the scope. After loop resolution, the magnetic balloon was removed and the scope advanced with standard technique. This loop correction method was performed 7 times, enabling advancement up to 250 cm into the small bowel in just 75 minutes. A 2 mm non-bleeding vascular lesion (Type IIb Yano-Yamamoto Classification) was detected and treated with Argon Plasma Coagulation. At 2-week follow-up, hemoglobin was stable at 9 g/dL with no recurrent bleeding.
Discussion: To our knowledge, this is the first reported case of a magnetic balloon-assisted double-balloon enteroscopy enabling deeper and more efficient small bowel exploration. The triple anchorage system allowed rapid and repeated loop resolution, consistently reducing procedure time and improving scope stability, particularly during Argon Plasma Coagulation. Additionally, the short enteroscope improved maneuverability during the intervention. This case supports the clinical potential of magnetic balloon technology in enteroscopy, particularly in complex or incomplete procedures, enhancing both diagnostic and therapeutic outcomes.

S6101

A Rare Case of Fiber-Induced Small Bowel Obstruction: A Case Report

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Introduction: Small bowel obstruction (SBO) is a common cause of hospital admissions. However, SBO secondary to accidental or iatrogenic ingestion of over-the-counter (OTC) fiber supplements is rare. Although fiber supplements are widely used to promote digestive health, they can pose risks when consumed improperly or in excessive quantities. We present a case of SBO following mistaken ingestion of a large volume of OTC fiber, highlighting the importance of thorough history-taking in identifying unusual causes and demonstrating successful non-operative management.
Case Description/Methods: A 53-year-old man presented with severe abdominal pain, distension, and nausea. History revealed that, in preparation for an outpatient colonoscopy, he inadvertently consumed 13 servings of an OTC fiber supplement instead of the prescribed bowel preparation. He drank 2 scoops of fiber powder in 8 oz of liquid multiple times, completing 13 servings the night before the procedure. Symptoms began shortly after ingestion and he presented the following day. On arrival, he was hemodynamically stable with an elevated lactic acid level (3.6 mmol/L) and leukocytosis (12.24×10^9/L). A computed tomography scan of the abdomen showed findings concerning for SBO with pneumatosis. Surgical consultation was obtained, and a non-operative management plan was initiated. Nasogastric (NG) decompression yielded 1400 mL of gelatinous fluid, resulting in mild symptom improvement. The patient received intravenous fluids and intermittent polyethylene glycol (PEG) lavage through the NG tube. Over time, his NG output decreased, lactic acidosis resolved, and he resumed passing bowel movements with complete resolution of abdominal pain. Following clinical improvement, the NG tube was removed, his diet was advanced, and he was discharged home in stable condition with education on appropriate colonoscopy preparation.
Discussion: This case illustrates the potential for significant morbidity associated with excessive fiber supplementation and the importance of clear communication regarding colonoscopy bowel preparation. It highlights the successful use of conservative management with NG decompression and PEG lavage in resolving fiber-induced SBO. Furthermore, it underscores the importance of a multidisciplinary approach to optimize patient outcomes and avoid unnecessary surgical intervention. Increased clinician awareness of this uncommon etiology can facilitate prompt diagnosis and effective management.

S6102

When TTG-IgA Fails: Diagnostic Insights From an IgG-Dominant Presentation of Celiac Disease

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Introduction: Celiac disease (CD) is an autoimmune disorder affecting ~1% of the population. Diagnosis involves serologic testing and histologic confirmation. The American College of Gastroenterology recommends initial screening with tissue transglutaminase immunoglobulin-A antibodies (TTG-IgA) and total IgA while on a gluten-containing diet. If TTG-IgA is elevated, diagnosis is confirmed via esophagogastroduodenoscopy (EGD) with duodenal biopsies. Here, we present a diagnostically challenging case of CD with an atypical serologic profile.
Case Description/Methods: A 25-year-old woman presented with 3 months of epigastric and left lower quadrant pain radiating to the chest, bloating, intermittent loose stools, heartburn, arthralgias, and a pruritic hand rash. She also experienced a 50–60 lb unintentional weight loss over 6 months. Initial serologies revealed normal total IgA (84), markedly elevated TTG-IgG, and minimally elevated TTG-IgA. She was positive for HLA-DQA105 and HLA-DQB102, consistent with celiac disease susceptibility. Despite the atypical serology—mildly elevated TTG-IgA and markedly elevated TTG-IgG in an IgA-sufficient patient—an EGD and colonoscopy were performed in March 2024. Colonoscopy was unremarkable, but the EGD showed blunted villi in the bulb and second portion of the duodenum. Biopsies revealed patchy villous atrophy, crypt hyperplasia, and increased intraepithelial lymphocytes, consistent with celiac disease. Other causes of enteropathy were ruled out. Repeat serology in August 2024, after 6 months on a gluten-free diet, showed overall improvement, paralleled by symptom resolution.
Discussion: This case highlights the diagnostic dilemma of CD in IgA-sufficient patients with isolated TTG-IgG elevations and only mild TTG-IgA elevation. Traditionally, TTG-IgG is reserved for those with IgA deficiency, and its utility in IgA-sufficient individuals remains poorly defined. Data suggest that isolated TTG-IgG positivity in IgA-sufficient patients has limited diagnostic yield (with 1 study showing only a 3% diagnostic rate), TTG-IgA demonstrates high diagnostic accuracy (with a sensitivity of 90.7% and specificity of 87.4% in adults), and endomysial antibody (EMA) testing offers near-perfect specificity and is often used as a confirmatory test. While these data support current guidelines for celiac disease screening and diagnosis, this case highlights that, especially in atypical scenarios, it is crucial to integrate serologic, endoscopic, histologic, and clinical findings to ensure an accurate diagnosis of CD.

S6103

A Case of Duodenal-Type Follicular Lymphoma With Negative Surveillance Imaging

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Introduction: Duodenal-type follicular lymphoma (DFL) is a B-cell lymphoma that occurs in the duodenum and can be difficult to diagnose given its indolent course and subtle endoscopic findings. This is a case of DFL with negative surveillance scans that was initially diagnosed and treated as mucosa-associated lymphoid tissue (MALT) lymphoma prior to its recognition as a separate disease.
Case Description/Methods: A 76-year-old woman with a history of MALT lymphoma and *Helicobacter pylori* infection diagnosed and treated 10 years prior to presentation with remission presents with continued abdominal pain. The patient presented for an outpatient endoscopic evaluation for disease surveillance. Recent positron emission tomography (PET) scan did not show any abnormal uptake in the stomach or small intestine. The patient's vitals, physical exam, and labs were unremarkable. Esophagogastroduodenoscopy showed normal esophagus and stomach and patchy granular villi in the second portion of the duodenum that was biopsied with cold forceps. Pathology revealed normal gastric mucosa and duodenal-type follicular lymphoma. The patient was recommended to continue her oral proton pump inhibitor and follow up with her hematologist for continued surveillance. The DFL was likely present on initial diagnosis 10 years ago, however, was diagnosed as MALT lymphoma given the recent recognition of DFL as a separate disease entity.
Discussion: DFL can be difficult to diagnose given its nuanced endoscopic features and need for biopsy. Originally classified as MALT, within the past 10 years, DFL has become recognized as a separate diagnosis given its distinct histology and gene expression. While most patients are asymptomatic, abdominal pain and heartburn can occur with some patients having negative surveillance scans as seen in our case. Endoscopic findings of DFL include small, granular lesions between the duodenal villi most commonly in the second portion of the duodenum. Pathology shows lymphoid aggregates infiltrating the lamina propria and immunohistochemical staining demonstrates predominance of CD20-positive B-cells with many cells also expressing CD10 and BCL2, which are characteristic of follicular lymphoma as seen in our patient's histology. DFL is associated with a favorable prognosis given its indolent course and confinement to the submucosa and mucosa with radiation and chemoimmunotherapy used in patients with advanced stages. More studies are needed in order to better understand and identify DFL.