

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, January 17, 2020

7:00am-8:00am

Pugh Classroom, 2nd floor, AHNCI

Zoom Meeting: <https://zoom.us/j/966171364>

Dial US: 646-558-8656

Meeting ID: 966171364

**Cases to be discussed**

|  |  |  |  |
| --- | --- | --- | --- |
| **Case**  | **De-identified patient** | **Reason** | **Presenter** |
| 1 | EH/ MRN: 11823301DOB: 10/23/69 | 50 y/o male with morbid obesity and diabetes who presents with a newly diagnosed rectal cancer.  He had perianal pain, constipation x 8 months, BRBPR, and 10 lb weight loss, prompting a Cologuard, which was positive, prompting a colonoscopy 12/24/19 by Dr. Amin at Indiana Regional Medical Center that showed an annular, fibrotic, vascular mass with stricture 6 cm from the anal verge that was tattooed proximally and distally that was biopsied and was an invasive moderately differentiated adenocarcinoma.  CEA level 12/24/19 was 225.  CT C/A/P 1/13/19 showed mild wall thickening of the rectum at the level of the rectosigmoid junction with 3.7 cm mass in the perirectal fat to the left of midline compatible with patient’s known malignancy and local invasion; gallstones; fatty liver. He was referred to medical oncology, Dr. Boriana Kamenova, radiation oncology, and a surgeon, Dr. Muralidhar Guddeti. Medical oncology wanted a PET scan but he said his blood sugars were unable to be controlled so he never got it. DRE by Dr. McCormick on 1/15 found a thrombosed external hemorrhoid on the left.  Could not reach the tumor. There is circumferential tumor starting on the upper side of the lower rectal valve and extending cephalad. This measure at 11cm from anal verge but this is due to body habitus and anal canal length. Stool spurting through. Sphincter preservation is possible. Review scan and MRI. | JM |
| 2 | JM/ MRN: 352689DOB: 11/26/37 | 82 y/o male with a history of malignant melanoma of the right lower leg diagnosed on 10/17/2013.  He developed rectal bleeding with drop in his hemoglobin.  He was transferred to West Penn Hospital on 12/11/2019 and on 12/13/2019 he underwent a colonoscopic exam revealing mid rectal fungating and ulcerating mass that was obstructing and partially circumferential.  The pathology report was consistent with well-differentiated invasive adenocarcinoma with negative MMR.  CT scan of the abdomen with IV contrast from 12/14/2019 was negative for metastatic disease.  CEA level from 12/15/2019 was 1.5. He had a pelvic MRI on 12/18/19 and this reportedly revealed a mid-rectal mass measuring 2.1 cm and 9 cm from the anal verge and 6.5 cm from the top of the anal sphincter.  There is some infiltration into the mesocolon fat at the level of the tumor while could be due to motion, edema or tumor infiltration making him clinically T2 versus T3 with negative CRM.   He was seen by Dr. Barsouk on 12/31/2019 and a PET-CT scan on 01/08/2020 was done and reportedly revealed a large markedly FDG avid focus seen along the base of the tongue measuring 5.3 cm with SUV of 11.1 and FDG avid lesion with maximum of SUV 7.8 seen within the rectum correlated with the rectal malignancy with no suspicious hypermetabolic osseous lesions or adenopathy.   Dr. Barsouk is referring him to Dr. Bernat at ACMH to evaluate him regarding the base of tongue lesion. Patient saw Dr Arshoun on 1/9/20 and is recommending concurrent chemo/radiation therapy.  Review scans and discuss treatment options. | RF |
| 3 | JD/ MRN: 10686338DOB: 8/28/55 | 64 y/o female with T3 N0 upper rectal cancer.   She was seen on 7/30/2019, and at that time, flexible sigmoidoscopy showed an ulcerated fungated friable mass starting just below the upper rectal valve and extending cephalad that was able to be traversed. TRUS showed a T3 N0 mass. She was presented at the Multidisciplinary Colorectal Cancer Conference on 8/2/2019 at AGH, and the group’s consensus was neoadjuvant chemotherapy followed by a radiation-oncology consult.  She was deemed not to be a radiation candidate due to location of tumor. The patient completed cycle 8 of Folfox on 11/21/2019.  Patient taken to OR on 1/2/20 for laparoscopic robotic proctectomy with diverting loop ileostomy.  NAPRC path review. | JM |
| 4 | RR/ MRN: 692570DOB: 1/16/68 | 51 y/o male with metastatic rectosigmoid cancer (liver mets) He received 6 cycles of FOLFIRI from 9/4/19-11/13/19. His last CT C/A/P was 11/6/19 and showed overall improvement of hepatic and intra-abdominal nodal metastatic disease with slight decent decrease in size of rectosigmoid mass. He was taken to the OR on 1/7/20 for a laparoscopic robotic specific mesorectal excision with creation of coloproctostomy with diverting loop ileostomy and laparoscopic robotic wedge resection of liver lesions x3. Review pathology. | JM |
| 5 | JG/ MRN: 5177820DOB: 12/24/64 | 55 year old male with Crohn's disease s/p total abdominal colectomy and end ileostomy 30 years ago. He presented with bloody rectal discharge and a left inguinal mass about 1.5 months ago. This L inguinal lymph node was biopsied and positive for poorly differentiated adenocarcinoma now with mucinous features and signet ring cell pattern. He underwent a flex sig with Dr. Nosik on 12/23/2019, there was significant anal canal stenosis and the rectal mass was poorly visualized but the biopsy demonstrated poorly differentiated adenocarcinoma of the rectum, MSI-stable. MRI pelvis demonstrated prostate and seminal vesicle invasion of a tumor 4 cm from anal verge, second focus of tumor, T3, and several suspicious pelvic lymph nodes. CT chest/abdomen/pelvis for staging is pending. Requesting imaging and pathology review.  | SN/BR |
| 6 | CM/ MRN: 10227334DOB: 11/12/61 | 58 y/o female diagnosed with stage III rectal cancer s/p neoadjuvant chemoradiotherapy referred here for surgical consultation.  Colonoscopy 9/20/19 at St. Vincent in Erie showed a circumferential, fungating, partially obstructing rectal mass from the dentate line to 10 cm from the anal verge (firm mass was palpable on DRE).  Biopsy showed moderately differentiated adenocarcinoma. There was also a medium-sized, semi pedunculated polyp in the ascending colon that was removed with hot snare and was a tubular adenoma.  CT A/P with contrast 9/25/19 that showed a 2 cm mass in the rectum, subcentimeter lymph node in the ischiorectal fossa and one in the left obturator region, and additional subcentimeter lymph node in the presacral space. There were b/l renal cysts and a T12 hemangioma. CEA from 9/24/19 was 47.9. She saw Dr. Jennifer McQuade (St. Vincent Colorectal Surgery) 9/26/19. Her DRE showed a palpable, hard, fixed, and nearly circumferential mid to distal rectal mass. Rigid sigmoidoscopy demonstrated a nearly circumferential friable mass consistent with adenocarcinoma that measured at approximately 5 centimeters from the anal verge. The patient was unable to tolerate any attempt of negotiating through the mass. MRI pelvis 9/27/19 showed a transmural T3 rectal mass, beginning approximately 6 cm above the distal anal verge, longitudinal dimension of approximately 6 cm.  There was roughly 5-6 mm of invasion of the mesorectal fascia, no T4 component. There were numerous abnormal regional metastatic lymph nodes, largest measuring roughly 1 cm on the left pelvic sidewall. CT chest 9/30/19 showed no evidence of metastatic disease and multiple vertebral body hemangiomas. She was referred for neoadjuvant chemoradiotherapy. She underwent Xeloda plus radiation (25 fractions + 3 rectal boost) 11/7/19-12/18/19. DRE done by Dr. McCormick on 1/9/2020 demonstrated a mass at tip of finger that is not fixed. Sphincter not involved. Tight stricture at lower rectal valve with some visible viable and necrotic tumor visible. Cannot be traversed. Moving to Pittsburgh area.  Seen for consultation/surgery. | JM |
| 7 | JC/ MRN: 10956032DOB: 11/01/85 | 34 y/o male with history of HIV infection and T3-4 N0 M0 anal squamous cell carcinoma.  He was initially diagnosed via intraoperative biopsies on April 2, 2019.  He proceeded to receive chemo radiotherapy with mitomycin and capecitabine (Dr. Asher) and completed radiation with 54 Gy IMRT on August 12, 2019 (Dr. Anolik).  Now with evidence of appropriate immune reconstitution and continued regression of his anal malignancy. Exam on 1/10/2020 by Dr. Reichstein showed left perianal wound 13 mm x 5 mm (down from 2.5 centimeters x 0.5 centimeters). Right inguinal dermal fissure overlying tender lymphadenopathy. Re-presenting at conference, specifically with respect to lymphadenopathy, imaging changes, and role for percutaneous biopsy versus excisional lymph node biopsy to clarify pathology. Asking to review imaging. | AR |

**AHN CME Credit**

**TEXT 412-301-9919**Save this number to your contacts–
You will use this **same** number every week to text your attendance

**Today’s SMS Code: FASWAM**

You must text within **THREE** hours of the tumor board. You will receive a text confirming receipt and then an email to complete the evaluation. Once the evaluation is completed credit is registered.

Objectives

Upon completion of this activity, participants will have a better understanding of decision-making for complex colon and rectal problems and be armed with clinical pathways to improve care.

Accreditation:

Allegheny General Hospital is accredited by the Accreditation Council for Continuing Medical Education to provide continuing education for physicians. Allegheny General Hospital designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure:

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny General Hospital, presenters must disclose all relevant financial relationships, which in the context of their presentation(s), could be perceived as a real or apparent conflict of interest, (e.g., ownership of stock, honoraria or consulting fees). Any identifiable conflicts will be resolved prior to the activity. Any such relationships will be disclosed to the learner prior to the presentation(s).  The speakers have nothing to disclose.

Moderators: Alexander Kirichenko, MD /Dulabh Monga, MD /James McCormick, DO/Richard Fortunato, MD