

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, January 31, 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**

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| **Case**  | **De-identified patient** | **Reason** | **Presenter** |
| 1 | JB/ MRN: 4322531DOB: 12/21/42 | 77 y/o male with new rectal cancer and history of prostate cancer s/p prostatectomy. Went to the ERand required hospitalization for hematochezia at Westmoreland Hospital and underwent a colonoscopy 1/16/20 by Dr. Shetty that showed a frond-like/villous non-obstructing 3 cm x 5 mm rectal mass that was biopsied and was an adenocarcinoma.CT C/A/P on 1/27/20 showed a 1.6 cm right lower lobe nodular consolidation with adjacent tree-in-bud opacities most suggestive of infectious etiology although underlying neoplastic process difficult to exclude.   Minimal rectal wall thickening could relate to patient's known primary.  CEA 2.9. Pelvic MRI done 1/27/20 showed T2N0 disease. Requesting scan review and discuss treatment plan.  | JM |
| 2 | LB/ MRN: 6056690DOB: 4/4/60 | 59 y/o female with a history of stage II rectal cancer.   She had clinical T4N0 rectal cancer and underwent neoadjuvant chemo radiotherapy followed by Laparoscopic robotic proctectomy with colonic pouch-anal anastomosis and diverting loop ileostomy on 12/10/14.  Pathology revealed ypT3N0 well differentiated adenocarcinoma. She then underwent Loop Ileostomy Takedown on 1/22/15.  She underwent adjuvant chemotherapy, which she completed 7/2/15.    CT C/A/P 12/24/18 showed no metastatic disease or recurrent cancer.   CT done 1/15/20 showed 9 mm subcapsular, hypervascular lesion in the superior aspect of the lateral segment left lobe of the liver, increased from 12/24/18 and new from 10/25/16.  No other evidence of metastatic disease chest/abdomen/pelvis.   CEA 1/16/20 was 0.6. She was last seen in the office 12/13/18 and advised to return to the office in 6 months,did not return until 12/9/19. Review all imaging, especially most recent scan.  | JM |
| 3 | DB/ MRN: 2926233DOB: 2/22/52 |  67 y/o male with stage III rectal cancer.  He underwent TNT off protocol, completing neoadjuvant chemotherapy with FOLFOX x 8 cycles 9/5/18 - 11/28/18 followed by chemo radiotherapy 12/19/18 - 2/4/19 followed by extended Xeloda and underwent surgical resection involving Laparoscopic Robotic Total Mesorectal Excision (proctetomy) with creation of hand sewn coloplasty-anal anastomosis, creation of loop ileostomy and takedown of the splenic flexure, and frozen section 4/30/19. Surgical pathology revealed yp T2 N2a MX residual invasive moderately differentiated adenocarcinoma of the rectum, 5/25 lymph nodes positive, perineural and lymphovascular invasion identified. CT C/A/P on 7/3/19 showed possible small, rounded lymph node posterior to the prostate.  He then underwent adjuvant Xeloda x 6 weeks, which he completed 8/27/19.   He underwent rectal EUA 8/29/19 due to rectal bleeding/prolapsing tissue.  Ileostomy Takedown 10/25/19.   Pathology was consistent with ileostomy site.  Seen in office for follow up on 11/22/19 where he was cleared to begin surveillance at next visit.  CT scan done on 1/22/20. | JM |
| 4 | DB/ MRN: 40251DOB: 12/18/59 | 60 y/o male who presented to the ED for rectal bleeding on 10/4/19.  A colonoscopy done on 10/11/19 revealed a rectal mass that was biopsied and confirmed an invasive moderately differentiate adenocarcinoma.   CT scan of the abdomen and pelvis (10/4/19) revealed a semi circumferential wall thickening of the mid to upper rectum suspicious for rectal cancer.  Bibasilar pulmonary nodules concerning for metastases were noted also.   Enlarged inter aortocaval lymph node (1.8 x 1.7 cm), indeterminate but could also represent metastasis.  MRI on 1/22/19 showed a T3N1M1 mid rectal cancer with extension into the mesorectal fat.  His case was presented at tumor conference on 10/25/19 and the consensus was that he would need 3 months of FOLFOX followed by repeat imaging.  Started FOLFOX on 11/5/19 and just received cycle # 6 on 1/14/20 with plans for 2 more cycles. Recent CT scan on 1/8/20 shows partial response and CEA has dropped from 23 to 3.1. Review scans and discuss treatment options. | DM |
| 5 | GP/ MRN: 556705DOB: 7/29/41 | 78 y/o with a history of moderately differentiated distal rectal adenocarcinoma, clinical stage IIa cT3 cN0 M0. The patient underwent colonoscopy by Dr. Kelly Zbanic on 5/15/2019, which showed a 3 cm distal rectal mass with ulceration. Biopsy confirmed moderately differentiated colonic adenocarcinoma.  MRI pelvis on 5/22/2019 revealed a mass extending from the 12 o'clock position to the 5-6 o'clock position. MRI showed T3, N0, CRM negative low rectal cancer. CT chest abdomen pelvis with contrast on 5/22/2019 showed no evidence of metastatic disease. Patient was discussed on 5/31/19 at tumor conference and the recommendation was to begin neoadjuvant chemotherapy followed by limited field radiation. The patient began chemotherapy in June 2019 and completed 8 cycles of FOFLOX ending in October 2019 and finished radiation treatments in November.  Flex and TRUS done on 12/18/19.  Presented at conference on 12/27/19 and the recommendation was to get another MRI and represent.  If imaging reveals anything other than T0 disease, offer proctectomy with end colostomy.   MRI completed on 1/20/20 and reports no identifiable residual rectal tumor.Review scan. | RF |
| 6 | JH/ MRN: 10986702DOB: 4/17/65 | 54 y/o male last discussed at the colorectal conference on 12/6/19. S/P laparoscopic Robotic Right Colectomy 2/6/19.  Pathology revealed a T3N1b poorly differentiated adenocarcinoma with lymphovascular invasion and 2/35 lymph nodes positive.  He received 12 cycles of FOLFOX from 3/4/19 – 8/5/19.  His CEA level 11/19/19 was elevated at 56.3 and CT C/A/P 11/23/19 showed a new low attenuation mass in the anterior segment of the right hepatic lobe highly concerning for metastasis.  CT guided biopsy 12/4/19 that was positive for metastatic adenocarcinoma consistent with colorectal origin.  The group reviewed that he has an aggressive biology of his tumor.  Dr. Kirichenko felt that liver resection would be favored over SBRT due to the location.  Consensus was to proceed with chemotherapy for 3 months and present at liver conference to consider liver resection. Now with rising CEA---12/4—111.0, 12/31—134, 1/28—221.0. CT c/a/p done 1/30. Review scan and discuss treatment options. | NA |
| 7 | AB/ MRN: 11809783DOB: 10/23/54 | 65 y/o male  who  had a screening colonoscopy  on 12/5/19 and was found to have a polyp at 30 cm in the descending colon that was removed and came back as a tubular adenoma,  a large polyp in the rectum that was removed in piecemeal fashion that came back as  a tubulovillous adenoma with focal high-grade dysplasia. He had a robotic transanal excision on 1/14/2020 with surgical pathology revealing T1NX invasive moderately differentiated adenocarcinoma arising in a tubular adenoma with high-grade dysplasia. Carcinoma was noted to invade into the submucosa, all resection margins negative, carcinoma is less than 1 mm from deep margin, no lymphovascular or perineural invasion identified.  CT CAP done on 1/24/20. Review pathology and scans. | JM |
| 8 | GD/ MRN: 11444036DOB: 6/27/57 | 62 y/o male S/P laparoscopic right colectomy, extensive lysis of adhesion, and en bloc partial liver resection on 7/18/19. Pathology revealed invasive moderately to poorly differentiated adenocarcinoma of the cecum. Carcinoma invades through the muscularis propria into the pericolonic adipose tissue and serosal adhesions to the liver. No evidence of carcinoma within the liver parenchyma. Lymphovascular invasion was present. Perineural invasion not present. 14 of 17 LNs positive. Tubular adenoma of the cecum. (T4bN2b) CT chest 7/17/19 revealed pulmonary emboli involving all lung lobes with mild right heart strain and multiple b/l lung masses concerning for metastatic disease.  Liver mets seen on CT done 10/30/19.Received 12 cycles FOLFOX/Bevacizumab (with cycle 2) 8/15/19-1/15/20.CT on 1/20/20. Review scan.  | NA |
| 9 | MA/ MRN: 2653360DOB: 10/6/40 | 79 y/o female referred for EMR of ascending colon polyp. Underwent colonoscopy and EMR of 2.5 cm lesion (previously tattooed) with one large piece and two smaller sections. Clinical Stage T1Nx. Specific Questions: Depth of submucosal invasion. Need path photomicrographs. Discuss management based on path review and surgical resection. Ascending colon CA, need path review. | AK |
| 10 | CF/ MRN: 5335656DOB: 2/8/48 | 71 y/o male with anastomotic recurrence of his ascending colon cancer.  Diagnosed in 2016 and had primary resection. s/p 12 cycles FOLFOX 2017.   Isolated recurrence requiring resection of portion of the liver as well as duodenum 9/20/18.  Capecitabine in 2019. His CEA level has been normal.  Recent CT done 12/3/19 at outside facility.   He underwent surveillance colonoscopy 1/16/20 and was found to have an area of ulceration and friability at the anastomosis which was biopsied and returned as invasive adenocarcinoma.  EGD scheduled for 1/29/20. Requesting scan review. | MV |
| 11 | CA/ MRN: 10915258DOB: 4/8/65 | 54 y/o male with a history of testicular cancer status post-surgery and radiation about 12 years ago being seen for newly diagnosed colon cancer. He had his first screening colonoscopy on 1/8/2020 by Dr. El-Hachem and was found to have a 14 mm polyp in the cecum. This polyp was injected with methylene blue and a piecemeal polypectomy was performed. Surgical pathology revealed invasive adenocarcinoma arising in a tubulovillous adenoma with high grade dysplasia. CEA was 1.7. CT chest abdomen pelvis done on 1/20/20. Review pathology and CT scan.  Discuss treatment options. | JM |

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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:

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