

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, October 18, 2019

7:00-8:00 am

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: 10737378 |  74 y/o male with history of prostate cancer treated with radiation with a newly diagnosed rectal cancer.  He underwent a routine colonoscopy 9/25/19 by Dr. Sharan that showed a 3 cm x 4 cm non-obstructing friable mass at 5 cm proximal to the anus that was biopsied and was an invasive well to moderately differentiated adenocarcinoma; less than 5 mm cecal polyp that was removed and was a tubular adenoma; multiple diminutive hyperplastic-appearing polyps in the rectum that were biopsied and were a tubular adenoma, and severe diverticulosis.  He had a CT A/P 10/4/19 (done at outside facility and to be uploaded).  CT Chest 10/9/19. CEA ordered but not done.  TRUS in office 10/10/19 showed T2N0 rectal cancer.  Pelvic MRI was done 10/10/19.  Will need radiologist to review CT scans and MRI.  | JM |
| 2 | JB/ MRN: 11365382DOB: 5/23/67 | 52 y/o female with newly diagnosed rectal cancer identified on diagnostic colonoscopy performed 10/11/19 (M. Mitre). Staging CT C/A/P and MRI pending. **Request radiology review**. Topic of discussion: locoregional staging, neoadjuvant therapy.  | AR |
| 3 | AS/ MRN: 10974890 | 48 y/o male with history of obesity, Diabetes Mellitus, and HTN with a newly diagnosed rectal cancer.  He had hematochezia x 4-5 months and decreased frequency of bowel movements, prompting a colonoscopy 10/16/19 by Dr. Midian that showed an ulcerated and infiltrative, circumferential, bleeding 5 cm mass of malignant appearance in rectum between 1 cm and 6 cm from the anus that was partially obstructing. Pathology is pending.  The endoscope traversed the lesion, as colonoscope did not pass and the transverse colon was reached.  Visualization of the sigmoid was poor.  CEA on 10/15/19 was 34.2.  Dr. Raj saw pt 10/15/19 and advised genetic counseling and arranged for an appointment with Dr. Kirichenko on Friday.  Previously evaluated by GI in office in 2015 for rectal bleeding and c-scope was advised, but was cancelled.  Flex Sig, possible TRUS, CT C/A/P, and Pelvic MRI to be done 10/16/19.  Need radiology to review. | JM |
| 4 | KS/ MRN: 43146DOB: 10/20/35 | 83 y/o male with hx of prostate cancer (s/p prostatectomy), CLL, and clinical stage T3N2 CRM positive rectal who is s/p 2 cycles of Folfox followed by short course XRT and 3 additional cycles of Folfox completed on 10/9/19. He was seen in follow-up on 10/15/19 and a flex-sig was done which revealed at least a partial luminal response to chemo and radiation.  | JM |
| 5 | DM/ MRN: 639189DOB: 10/24/65 | 53 y/o F with history of rectosigmoid adenocarcinoma with bulky bilobar metastatic diagnosed via CT guided liver biopsy 2/8/19. Has been treated with FOLFIRI/Bev (Mayernik). No colonoscopy prior to/since diagnosis. Now with rectal bleeding & vaginal bleeding. CT C/A/P (10/9/19) notable for contained perforation. **Request radiology review**. Topic of discussion: fecal diversion, candidacy for XRT. | AR |
| 6 | LW/ MRN: 22156DOB: 4/7/61 | 58 year old female with past medical history of diverticulitis complicated by abscess formation and then diagnosed with adenocarcinoma, intestinal type diagnosed on left gluteal skin excision on 5/11/19. The patient was diagnosed with acute sigmoid diverticulitis complicated by pericolonic abscess on 10/22/18 which was drained with a percutaneous drain placed by IR . The patient ultimately followed up with colorectal surgery as an outpatient for planned colonoscopy to rule out malignancy, but due to unresolved pericolonic fluid collections, colonoscopy had to be delayed. It was scheduled for January 7, 2019, but she never had it done, states she did not reschedule for another colonoscopy. She then presented to the AGH on 5/9/19 due to left buttock pain where her drain had been placed in the past. A CT of the abdomen and pelvis on 5/9/19 revealed recurrent inflammatory changes around the distal sigmoid colon, which may represent diverticulitis with surrounding phlegmon. A heterogeneous masslike collection involving the distal sigmoid colon measuring up to 6.0 by 5.8 cm was seen on the scan.She was seen by colorectal surgery during the admission with attempted flexible sigmoidoscopy, but the procedure was unable to be completed due to poor bowel prep. She did undergo excision of a 1 cm firm circular lesion of the left gluteal region at this time as well as placement of bilateral ureteral stents by urology for her hydronephrosis on 5/11/19.  Pathology report from her left gluteal skin excision revealed cutaneous involvement by adenocarcinoma, intestinal type with abundant extracellular mucin. Per pathology report, it was felt this was likely of colorectal origin and may represent either cutaneous involvement by adenocarcinoma via direct extension or cutaneous metastasis. Her case was discussed in the colorectal tumor board and she is now s/p laparoscopic loop colostomy creation on 5/24/18 by Dr. McCormick. Currently on FOLFOX for chemotherapy and had scans recently on 10/09/19. She has been having significant diarrhea and weight loss. Diagnosis: Rectosigmoid cancer.  | GK/GF |
| 7 | JM/ MRN: 11313032DOB: 12/5/52 | Stage IV sigmoid cancer with liver mets diagnosed January 2019. Started FOLFOX 1/30/19. Ostomy secondary to bowel perf 3/13. FOLFOX/cetuximab restarted 4/11/19-8/8/19 (12 cycles). Started 5FU/cetuximab 9/19/19. | NA |
| 8 | JK/ MRN: 4104044DOB: 5/6/32 | 87-year-old male with likely malignant, completely obstructing tumor at 10 cm proximal to anus. Patient presented to Jefferson Hospital for BRBPR, hematochezia starting about one week prior to presentation. He also fell in his bathroom prior to presenting to the ED; CT head showed new acute subdural hemorrhage, CT AP showed focal bowel wall thickening with heterogeneous enhancement and pericolonic lymph nodes in distal sigmoid colon. Transferred to AGH for further evaluation. MRI pelvis revealed T3, N2, CRM negative rectosigmoid mass. CT chest showed no evidence of metastasis. CEA 2.3 ng/mL. Colonoscopy on 10/15/2019 showed a frond-like/villous, fungating, and ulcerated mass in the rectosigmoid colon, 10 cm proximal from the anus. Of note, patient lives alone and has four supportive children. Requesting pathology review from colonoscopy (pending), imaging review (CT, MRI pelvis), and treatment planning. | AR |
| 9 | AS/ MRN: 633658DOB: 10/24/67 | 51 y/o female with a history of metastatic anal SCC with complicated history as summarized: originally diagnosed with clinical stage IIIA (T2N1aM0) squamous cell carcinoma of the anal canal status post chemo radiation with Xeloda and mitomycin, ending in March of 2018.  Subsequent PET imaging performed on February 5, 2019 demonstrated a hypermetabolic right upper lobe focus, as well as a new hypermetabolic posterior mid/upper rectal lesion worrisome for local recurrence. She subsequently underwent right RUL wedge resection on March 1, 2019, with final pathology revealing a poorly differentiated squamous cell carcinoma with basaloid features and negative margins. Admitted to FRH between 6/21-6/27/19 for management of neutropenic enterocolitis versus 5 FU related GI toxicity. **Now has symptomatic colovaginal fistula.** Flexible sigmoidoscopy on 10/8/19 notable for friable, fungating rectosigmoid mass. **Request radiology review** of CT C/A/P dated 8/14/19 and **path review** of flex sig biopsies (Case FHS19-10216). | AR |
| 10 | MM/ MRN: 115304 | 56 y/o female with Stage IV colon cancer of the cecum with metastatic disease to the liver previously discussed at conference in May 2019 with recommendations for chemotherapy. Patient follows with Dr. Raj and has completed 8 cycles of chemo (Folfirinox for 2 cycles switched to Folfox +bevacizumab for remaining cycles). Repeat CT in August 2019 described interval decrease in size of hepatic metastases and right lower quadrant/pelvic lymph node metastases. CEA was 22.0 at diagnosis, down to 3.5 in August.  Would like to discuss recent CT scan from 10/14/19 and possible consideration for combined liver/colon resection. | MV |
| 11 | JC/ MRN: 10798887 | 55 y/o male with stage IV colon cancer (liver metastasis) s/p port insertion and intra-operative colonoscopy with placement of colonic stent for LBO on 6/19/17. Hospitalized Jan 2019 for LBO.  Endoscopic evaluation revealed tumor growing into the lumen of the stent causing a complete LBO.  APC probe was used to burrow a new lumen through the stent relieving the obstruction. He is actively receiving chemotherapy.  Seen in the office 10/16/19 with obstructive symptoms and on exam, stent was occluded by tumor.  Last CT 8/29/19.  Would like to have radiology review imaging and discuss treatment going forward. | JM |
| 12 | KP/ MRN: 759949DOB: 11/8/57 |  62 y/o female referred from OSH for endoscopic resection of large sessile IC valve lesion. Colonoscopy with lesion on cephalad aspect of IC valve, removed piecemeal. Ileocecal valve polyp with HGD; piecemeal resection. | AK |
| 13 | MM/ MRN: 115304DOB: 2/7/63 | 56 y/o female with no significant past medical history was found to have a cecal mass on her routine colonoscopy. Madeline had a colonoscopy done on 5/21/19 which revealed a 5 cm partially obstructed mass in her cecum which was biopsied and path came back consistent with invasive adenocarcinoma, moderately differentiated. MMR is intact. The outside CT TAP showed concern for liver metastasis along with the cecal mass. CEA 5.25.2019 = 22.0. NGS from Foundation one showed - KRAS G13D. She was started on FOLIRINOX on 6/6/19. After 2 cycles of treatment with FOLFIRINOX, patient became significantly neutropenic and developed elevated liver enzymes. She was given cycle 3 with FOLFOX and bevacizumab. Oxaliplatin was held for next few cycles due to transaminitis. She had scans recently on 10/15/19.   | GK/MR |
| 14 | JM/ MRN: 10115643DOB: 8/31/56 | 63 y/o male with history of alcoholic cirrhosis (MELD 12) and recently diagnosed invasive malignancy in sessile transverse colonic polyp resected via EMR on 10/4/19 (Thakkar). Lesion described as pT1 pNx. **Request pathology review** (Case AGS19-24050). **Request radiology review** - CT C/A/P pending. Topic of discussion: review path/imaging, risk stratification in light of significant liver disease and elevated perioperative risk. | AR |

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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