

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, October 25, 2019

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 | DB/ MRN: 40251DOB: 12/18/59 | 59 y/o male with newly diagnosed rectal cancer found during workup for intermittent rectal bleeding x 3 months. Patient presented to ED when rectal bleeding worsened. CT AP on 10/4/2019 showed semi-circumferential wall thickening of the mid to upper rectum suspicious for rectal cancer, bibasilar pulmonary nodules concerning for metastasis, and an indeterminate, enlarged interaortocaval lymph node. Colonoscopy on 10/11/2019 showed a fungating and infiltrative non-obstructing mass in the proximal rectum approximately 5-10 cm from anal verge. Biopsy confirmed moderately differentiated invasive adenocarcinoma. TRUS on 10/16/2019 showed a large, 75% circumferential rectal mass 6 cm from the anorectal junction, occupying the 1st valve, ultrasound identified T3 N1 disease. CEA 23.5 ng/mL. PSA pending. MRI pelvis on 10/22/2019 read pending.CT chest on 10/22/2019 showed multiple bilateral pulmonary nodules compatible with metastasis, mosaic attenuation suggesting small airway disease, probable pulmonary HTN, and calcified coronary artery plaque. **Requesting path review (colonoscopy), imaging review (CT chest, MRI pelvis), and treatment planning.**  | RF |
| 2 | DLW/ MRN: 1012577 | 62 y/o female with a newly diagnosed rectal CA.  She had a positive cologuard test 8/23/19, prompting her first colonoscopy 10/18/19 by Dr. Bradley that showed a 4.5 cm ulcerated rectal mass that was biopsied and 33 colorectal polyps (three 5-7 mm rectal polyps that were removed; Eleven rectosigmoid polyps that were 8-12 mm in size and were removed; Seven rectosigmoid polyps that were 4-6 mm in size and were removed; three sigmoid polyps 5-7 mm in size that were removed; 9 mm descending colon polyp that was removed; three 5-8 mm descending polyps that were removed; three 5-7 mm transverse colon polyps that were removed; two 5-6 mm cecal polyps that were removed).  Pathology results are pending.  CEA level ordered and pending.  CT C/A/P and Pelvic MRI done 10/23/19; Requesting pathology review and radiology review of imaging. | JM |
| 3 | GL/ MRN: 780224DOB: 11/1/41 | 77 y/o male with stage IV rectal cancer (T3cN0M1 with CRM involvement and metastatic to inguinal node). Flexible sigmoidoscopy 8/5/19 showed a mass at the middle rectal valve extending cephalad to the rectosigmoid that was circumferential with the distal edge at 11 cm.  He was discussed at MDCCC 8/9/19 and the plan was to enroll the patient in the FR2 trial and proceed with neoadjuvant chemotherapy with FOLFOX followed by IMRT chemoradiotherapy and restage and potentially then proceed with resection of the primary tumor.  If the node persists on follow up imaging, may remove at the time of resection.  He began chemotherapy on 8/27/19.  His 3rd cycle was delayed 1 week due to platelet count of 70,000 and he received a 25% dose reduction of oxaliplatin on 10/1/19.  He has been delayed in getting his 4th cycle because of low counts. Flex sig 10/21/19 by Dr. McCormick revealed tumor in the upper rectum that was now not able to be traversed. The tumor was friable and there was quite a large luminal component.  These finding were consistent with a poor response to therapy and may be progression despite therapy. | JM |
| 4 | FC/ MRN: 2175296DOB: 8/19/56 | 63-year-old male with synchronous rectal and sigmoid cancers on neoadjuvant FOLFIRI. Patient previously presented at tumor board on 9/20/2019; group consensus was that he start neoadjuvant treatment with upfront chemotherapy (FOLFIRI) followed by chemoradiotherapy. Patient was hospitalized from 10/14/2019 to 10/19/2019 with severe diarrhea, AKI, and poor PO intake (10 days after receiving first chemotherapy session). Patient also diagnosed with pulmonary embolism during this hospitalization, now on Eliquis. **Discuss treatment plan moving forward.**   | RF |
| 5 | MB/ MRN: 10598649 | 57 y/o female who underwent a colonoscopy on 10/8/19 by Dr. Kichler for rectal bleeding and change in bowel habits and was found to have a malignant tumor in the rectum at 7 cm proximal to the anus that was biopsied and came back as moderately to poorly differentiated adenocarcinoma with focal ulceration. Flex-sig at office visit with Dr. McCormick revealed an ulcerated malignant appearing mass at 10 cm that occupied one third of the circumference and 3.5 cm in size. CT C/A/P and MRI Pelvis completed on 10/18/19.   | JM |
| 6 | AY/ MRN: 11703677 | Sigmoidoscopy performed on September 12, 2019 noted to 40 millimeter polyp in the proximal rectum. Biopsy demonstrated tubulovillous adenoma.  CEA: 9/2019 = 6.7.  CT scan of her chest, abdomen and pelvis demonstrated stable pulmonary nodules stable since 2017, and a rectal mass without adenopathy.  Pelvic MRI demonstrated a high rectal mass concerning for carcinoma staged as T2 versus early T3, N0, C RM negative.  Colonoscopy performed by 10/16/19  to cecum identified a 40 millimeter proximal ascending colon mass-biopsies noted tubulovillous adenoma, multiple right-sided and transverse colon polyps-not removed, and the 40 millimeter rectal mass identified on the 3rd valve of Houston.  This was also biopsied as a villous adenoma.  Bowel prep was inadequate and she may have left-sided polyps that were missed.  3D rectal ultrasound performed on 10/16/19 identified T2 N0 rectal cancer 11 centimeters from the anorectal junction (ultrasound was somewhat limited due to tumor size and location).  | RF |
| 7 | FH/ MRN: 11733050 | 85 y/o female presents with hemicircumferential ulcerated mass extending from distal rectum through anal canal with associated large external mass.  Biopsy showing tubulovillous adenoma but highly concerning for adenocarcinoma.  Review CT and MRI. Review Path. Diagnosis: Neoplasm of anorectum | RF |
| 8 | 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 |
| 9 | AK/ MRN: 732488 | 33 y/o  female with recurrent ovarian cancer and peritoneal carcinomatosis seen in consultation 10/17/19 for difficulty evacuating bowels who had GGE 10/18/19 that showed moderate to severe focal narrowing of the transverse colon just proximal to the splenic flexure. S/p exploratory laparotomy with tumor debulking in November 2018. She then underwent radical tumor debulking and rectosigmoid colectomy with ileostomy. She developed ostomy prolapse and per documentation was emergently taken for surgery in June 2019 and was found to have progressive disease. At that time she underwent an exploratory laparotomy, tumor debulking, LAO, reduction of ileostomy with reversal with ileocecectomy, and re-anastomosis by Dr. Runfola at Banner Deser Hospital. She transferred care to Dr. Krivak in August 2019 and at that time reported bowel issues. She was referred to Dr. Amjad of Medical Oncology and a CT C/A/P was also ordered and revealed decreased peritoneal carcinomatosis with decreased cystic hepatic serosal lesion and decreased right subphrenic tissue thickening. It also showed a decreased in the size of multiple visible mesenteric lymph nodes and resolved mediastinal lymph nodes, postsurgical changes of multifocal bowel resection, possible serosal metastatic disease at the level of the RLQ anastomosis, likely resolved or resolving small bowel enteritis with persistent foci of distention and air-fluid levels which could reflect stasis or partial obstruction. Need radiology to review imaging and discuss management. | JM |
| 10 | 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 |
| 11 | 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:

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