

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, October 4, 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 | TL/ MRN: 5435717DOB: 4/1/1966 | 53 y/o female with newly diagnosed rectal cancer. Pt underwent colonoscopy on 9/23/2019 for chronic diarrhea, anorectal bleeding. No prior colonoscopies. Colonoscopy showed a fungating, almost completely obstructing, large mass in rectum 9.5 cm from dentate line. Mass circumferential with only pinpoint lumen. Biopsy showed moderately differentiated adenocarcinoma. Transferred to AGH for higher level of care. CEA 17.1. Pelvic MRI on 9/26/2019 showed a large mid to high rectal tumor, T4bN2, CRM positive with possible extramural venous invasion, invasion of the vaginal cuff, cervix, and lower uterine segment. Flexible sigmoidoscopy and pelvic EUA on 9/28/2019 showed large, invasive rectal cancer 6 cm from anal verge, friable and fixed anteriorly. Mass involves entirety of the cervix, upper 1/3 of posterior vagina. Tumor is palpable within 5 cm of vaginal introitus. Requesting pathology review from colonoscopy, pelvic MRI review, and treatment planning. | RF |
| 2 | RM/ MRN: 10608870 | 84 y/o male with large left sided friable anal margin mass that appears to be extra sphincteric.  He had a normal screening colonoscopy in 2017. He noted a perianal mass in December 2018 that he thought was a hemorrhoid and neglected until the fall of 2019. Pelvic MRI demonstrated T3 N2 disease with positive CRM.Colonoscopy identified extensive rectal cancer extending through the anal canal out to the anal margin.  Clinically making it T4. Here to stage, review path and treatment planning. | RF |
| 3 | AC/ MRN: 11377463 | 34 y/o male with history of PE and clinical T2vs3 N1 rectal cancer who underwent neoadjuvant chemotherapy with FOLFOX x 8 cycles followed by chemoradiotherapy with infusional 5 FU 6/20/19 – 7/31/19.  Flex Sig 8/26/19 showed minimal response with a hemi circumferential mass just below the rectal valve not involving the dentate line or sphincter.  CT C/A/P was done 9/30/19 and would like to review.  Scheduled for Laparoscopic Robotic TME with Diverting Loop Ileostomy 10/15/19. | JM |
| 4 | JC/ MRN: 36021DOB: 8/17/40 | 79 y/o female with clinical stage T2 vs early T3 N0 rectal cancer treated definitively with chemoradiotherapy (4/11/19-5/31/19 with extended chemo completed 6/26/19) in hoping to avoid APR. She was seen on 6/28/19 for a flex sig which revealed an ulcer (near complete clinical response). It was recommended that she start chemotherapy which was started on 7/25/19 and has now completed 5 cycles. She was seen on 9/27/19 in follow-up and on DRE was found to have a 2 cm mass upper anus, left lateral. There was also an ulcer at the dentate but no overt tumor or mass.  | JM |
| 5 | EJ/ MRN: 11213880DOB: 12/11/1960 | 58 y/o male with hx of clinical stage T3N1 rectal cancer s/p 8 cycles if Folfox (completed 7/6/18) followed by chemoradiotherapy (completed 9/20/18) followed by 2 weeks of extended Xeloda who underwent a transanal excision via TEM on 12/21/18 with pathology revealing ypT2NX moderately differentiated adenocarcinoma. He was discussed at conference and the group recommended proceeding with laparoscopic robotic proctectomy with DLI which was done on 1/31/19 with pathology revealing yp T3N0 residual invasive moderately differentiated adenocarcinoma. He underwent ileostomy takedown on 3/5/19 and had surveillance CT C/A/P on 9/11/19 which showed an interval increase in size of a presacral lymph node which could be reactive, malignancy impossible to exclude. \*\*Requesting radiology review\*\* | JM |
| 6 | RH/ MRN: 469412 | 40 y/o male with Ulcerative Colitis and a newly diagnosed colon cancer.  Colonoscopy 9/18/19 by Dr. Lipsitz showed a benign appearing, intrinsic moderate stenosis with ulcerations measuring 4 cm in length at 30 cm proximal to the anus that was traversed with pediatric colonoscope and biopsied and was an invasive moderately differentiated adenocarcinoma; ulcerated mucosa at the base of the cecum that was biopsied and showed fragments of colonic mucosa with mild to moderate acute and chronic inflammation with glandular loss and crypt distortion.  Random biopsies of the colon and rectum were done that showed mild to moderate nonspecific chronic inflammation and terminal ileal biopsy showed no specific pathologic changes.  CEA level 9/25/19 was 2.0.  Plan to review CT A/P 9/11/19 from outside hospital done for abdominal pain and CT Chest 9/25/19. | JM |
| 7 | SH/ MRN: 2124 | 80 y/o female history of colovaginal fistula with colonic obstruction requiring proximal fecal diversion with colostomy in June 2018 as was not a candidate for definitive surgical intervention. Endoscopic evaluations in the past were unsuccessful due to structuring with benign biopsies. Review recent CT scan from 9/10/19, suspicious for malignancy, discuss possible treatment options.  | SN |
| 8 | AR/ MRN: 10723660DOB: 3/11/1971 | 48 y/o male with newly found sigmoid colon mass **LAPAROSCOPIC ROBOTIC TAKEDOWN OF SPLENIC FLEXURE AND OPEN LOW ANTERIOR RESECTION 9/10/19**Patient is stage II with perforation and we would like to discuss adjuvant therapy. | MR |

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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:

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