

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, November 1, 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 | AML/ MRN: 1722796DOB: 10/8/70 | 49 y/o woman with history of lichen sclerosus and stage III vulvar SCC s/p posterior radical vulvectomy, left femoral sentinel lymph node dissection, vulvar reconstruction, bilateral inguinal femoral lymph node dissection on 3/27/19 by Drs. Krivak & Crafton of Gyne-Onc. At that time she also underwent rectal exam under anesthesia (Reichstein). Final pathology revealed focal residual invasive SCC of the vulva, left femoral sentinel lymph node revealed metastatic carcinoma involving one lymph node, left groin node excision was benign and right inguinal nodes benign, negative for metastatic tumor. Biopsy of anus at 12 o'clock verge revealed no diagnostic abnormality, biopsy at 6 o'clock verge revealed lichen sclerosis. She completed chemoradiation on 6/20/19 (cisplatin + 45 Gy, Moffa & Karlovits). **Followed closely for new anal verge mass of 6 weeks' duration, EUA with biopsy on 10/21/19 reveals invasive anal squamous cell carcinoma.** Request review of staging CT C/A/P, treatment discussion. | AR/TK |
| 2 | AC/ MRN: 11377463DOB: 3/2/85 | 34 y/o male with history of PE and clinical T2 vs T3 N1 rectal cancer who underwent neoadjuvant chemotherapy with Folfox x 8 cycles followed by chemoradiotherapy with infusional 5FU 6/20/19-7/3/19. He then underwent a laparoscopic robotic total mesorectal excision (proctectomy) with diverting loop ileostomy on 10/15/19 by Dr. McCormick. Surgical pathology revealed ypT2N0 residual invasive moderately differentiated adenocarcinoma, no lymphovascular or perineural invasion, and 0/16 lymph nodes positive. \*\*NAPRC Pathology Review\*\* | JM |
| 3 | LB/ MRN: 10738155 | 76 y/o female with Multiple Myeloma with an incidentally found rectal cancer.  She is s/p emergent Left Hemicolectomy, Takedown of Splenic Flexure, and Colostomy Creation for perforated left colonic diverticulitis by Dr. Naman 12/5/18.  Pathology revealed perforated diverticulitis.  She was taken back for elective Takedown of Colostomy by Dr. Naman 9/4/19 and intraoperatively; a 2 cm cancer was noted of the proximal rectum.  Pathology revealed a T2N0 moderately differentiated adenocarcinoma.  Last CT A/P 12/5/18.  No CT Chest or CEA level in Epic.  Requesting radiology and pathology review.   | JM |
| 4 | AB/ MRN: 10040670DOB: 10/5/42 | 77 y/o male who underwent a colonoscopy on 9/4/19 by Dr. Inglese and was found to have an 8 mm polyp in the rectum that was sessile and removed and came back as superficially invasive adenocarcinoma moderately differentiated with a foci of lymphovascular invasion and tumor budding. He was referred to Dr. McCormick on 10/8/19 and seen in the office on 10/11/19. A flex-sig was done and revealed no evidence of previous polypectomy scar or recurrence. A TRUS was done and revealed T1N1 rectal cancer. A CT A/P was done which showed a lymph node in the mesorectum suspicious for nodal metastatic disease. Lower EUS with lymph node FNA scheduled for 10/29/19. | JM |
| 5 | MW/ MRN: 11742301DOB: 4/28/65 | 54 y/o male with severe lower back pain and numbness in his right buttock, groin, and leg who saw orthopedic surgery and had a MRI Bony Pelvis done which showed a large enhancing mass centered in the inferior right sacrum with large soft tissue component extending into the right priiformis muscle. Differential consideration favor a solitary metastasis given the presence of a rectosigmoid mass. He was seen by Dr. McCormick on 10/29/19 and flex-sig was done which showed a rectal mass. CT C/A/P to be completed 10/29/19, MRI scheduled for 11/1/19.  | JM |
| 6 | RM/ MRN: 10608870DOB: 10/12/34 | 84 y/o male, originally presented on Oct 4th, with large left sided friable anal margin mass.  Pelvic MRI demonstrated T3 N2disease with positive CRM.  Consensus of group at that time for total neoadjuvant treatment.  Patient started FOLFOX on 10/23/19.  Review recent PET scan which is showing extensive local disease with multiple enlarged perirectal nodes, nodular lesions involving perineum, and penis, left inguinal hypermetabolic adenopathy and erosive lesion involving the right side of coccyx all compatible with metastatic disease.  Subcentimeter hypermetabolic in liver also concerning for metastatic disease. Discuss treatment options. | RF |
| 7 | JK/ MRN: 11741927DOB: 7/6/61 | 58 y/o male who underwent a colonoscopy on 10/15/19 by Dr. Patel for a positive Cologuard test and was found to have a large villous polyp in the rectum (2-3 cm from the anal verge) that measured 5-6 cm and was biopsied and came back as invasive adenocarcinoma, moderately differentiated .There was also a 3-4 cm villous polyp in the proximal ascending colon and another large mass like polyp distal to the villous polyp suggestive of malignancy that was not removed but biopsied and came back as a tubulovillous adenoma.  CT A/P done at OSH showed mild asymmetry of the rectum, thickening of the bladder wall, and mucosal thickening and possible intraluminal mass lesion in the ascending colon. MRI Pelvis revealed T1 vs T2 N0 negative low rectal cancer. TRUS revealed T3 N0.  | JM |
| 8 | JF/ MRN: 11740676 | 62 y/o male with hx of colon polyps who had a colonoscopy done on 10/10/19 and was found to have a 2 mm polyp in the transverse colon that was removed and was a tubular adenoma and a 10 mm polyp found in the rectum that was sessile and removed and came back as rectal adenocarcinoma, moderately differentiated arising in an adenomatous polyp. Cauterized tissue edge positive for invasive malignancy. MRI and CT to be completed 10/22/19. \*\*Requesting pathology review, slides will be obtained from OSH\*\* | JM |
| 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 | GS/ MRN: 132528DOB: 3/11/45 | 74 y/o male diagnosed with invasive moderately to poorly differentiated adenocarcinoma with mucinous features arising in a tubulovillous adenoma with high grad dysplasia.  | AK |
| 11 | WM/ MRN: 240635DOB: 12/26/43 | 75 y/o male with mid-ascending colon, polyps x2. Invasive moderately differentiated adenocarcinoma arising in tubular adenoma with high grade dysplasia. Carcinoma invades at least into mucosa; Carcinoma is present at deep margin; Lymphovascular invasion present; No perineural invasion present.  | AK |

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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