

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, November 15, 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 | RC/ MRN: 1152653 | 52 y/o female with clinical T3N2 rectal cancer who completed neoadjuvant chemoradiotherapy 9/30/19. Seen in the office 10/24/19 and had flex sig.  Plan is to proceed with Laparoscopic Robotic Proctectomy with Diverting Loop Ileostomy.  Would like to review imaging/liver lesions. | JM |
| 2 | KT/ MRN: 301054 | 73 y/o female with hx of T3N2 CRM negative bulky rectal cancer with multiple pulmonary nodules below resolution of PET who is s/p FOLFOX x 8 cycles completed 11/1/19. She was having loose BMs and rectal bleeding and had colonoscopy 5/21/19 that showed an infiltrative non-obstructing medium-sized distal rectal mass that was non-circumferential and 2 cm from the anal verge. Pathology revealed at least intramuscosal moderately differentiated adenocarcinoma. She had MRI Pelvis on 6/3/19.   CEA 5/28/19 was 0.7. CT C/A/P 6/10/19.  Flex Sig by Dr. McCormick 6/27/19 showed a large tumor right posterior just above the anus.  It was tethered but not fixed and was close to but not overtly involving the top of the sphincter complex.  It did not appear to involve the levators.  It was greater than half the circumference and extends up towards the lower rectal valve. (proctectomy with sphincter preservation via TATA may be feasible) Our recommendations were to await PET/CT imaging and present at MDCCC. PET/CT 6/28/19.   She was presented at MDCCC 7/5/19 and group consensus was that this was a T3N2 CMR negative bulky rectal cancer. Plan was to proceed with FOLFOX x 8 cycles and then reassess her pulmonary nodules. If the nodules are not a concern, then plan was to proceed with chemoradiotherapy followed by surgery. She had 8 cycles of FOLFOX from 7/12/19 to 11/1/19. She had a CT C/A/P 9/9/19 in the middle of treatment and 11/8/19.     MRI pelvis 11/8/19.  MRI Liver ordered 11/11/19 to further evaluate liver lesion.  Flex Sig 11/11/19 showed a partial clinical response, with the mass significantly smaller, but still evident on the left side towards the posterior with some tethering to the top of the sphincter complex and it is unclear whether the sphincter will be able to be preserved. Request imaging review/management discussion and plan to enroll in FR2 trial. | JM |
| 3 | KS/ MRN: 43146  DOB: 10/20/35 | 84 y/o male with CLL and clinical stage T3N2 CRM positive rectal cancer who is s/p two cycles of Folfox followed by short course XRT and three additional cycles of Folfox completed on 10/9/19. He was seen in follow-up on 11/7/19 at which time a flex-sig revealed a rectal mass which was biopsied and came back as extensively ulcerated rectal mucosa with at least low grade dysplasia. | JM |
| 4 | AB/ MRN: 5423601  DOB: 9/11/79 | 40 y/o female with clinical stage T3N1 rectal cancer enrolled in the FR2 trial that is s/p 8 cycles of Folfox completed on 7/2/19 followed by bilateral ovarian transposition on 7/18/19 by Dr. Munns followed by concurrent chemoradiotherapy from 7/31/19-9/18/19. She completed cycle #3 of Durvalumab on 11/6/19 and is scheduled for surgery on 12/3/19. She last saw Dr. McCormick on 10/18/19 and flex-sig revealed a partial minimal response. Re-staging imaging completed 11/8/19. | JM |
| 5 | VH/ MRN: 11747523  DOB: 10/24/47 | 72 y/o male with rectal bleeding since July who underwent a flex-sig on 10/7/19 which revealed a 3-4 cm rectal mass just inside the anal verge with biopsy revealing high grade neuroendocrine tumor. PET/CT and MRI Pelvis to be uploaded. Requested slides from OSH for pathology review. | JM |
| 6 | DH/ MRN: 795642  DOB: 8/22/64 | 55 y/o male who had a colonoscopy on 11/4/19 for rectal bleeding and was found to have a 4 cm fungating and ulcerated non-obstructing rectal mass that was biopsied and came back as invasive moderately differentiated adenocarcinoma. CEA came back at 1.7. CT C/A/P completed on 11/8/19 showed a 1.5 x 1.2 cm hypodense liver lesion. Flex-sig at office appt showed tumor from the mid rectal valve to above the upper rectal valve, 60% circumference. MRI Pelvis and MRI Liver ordered. | JM |
| 7 | RK/ MRN: 136096  DOB: 4/15/72 | 47 y/o male patient with metastatic rectal cancer to liver with colonoscopy revealing tumor in the rectum 13 cm from anus. Patient discussed at tumor conference on 7/19/19, where the group recommended 8 cycles of neoadjuvant chemotherapy followed by concurrent chemo/radiotherapy.  He started with FOLFOXIRI with Avastin added on cycle #2, and was recently switched to FOLFIRI and Avastin was held.  Requesting radiology review and surgical options.  Patient to see Dr. Voth for follow up. | MR |
| 8 | WL / MRN: 11454977 | 68 y/o male with clinical T2N0 rectal cancer who completed definitive chemoradiotherapy on 9/18/19.  He had a 25% dose reduction for Xeloda due to thrombocytopenia on 8/22/19.  He was discussed at the Multidisciplinary Colorectal Cancer Conference on 7/5/19 and plan was to refer to Dr. Kirichenko and medical oncology to proceed with definitive chemoradiotherapy.  PET/CT 7/25/19 that showed hypermetabolic rectal wall thickening; borderline enlarged right common iliac/external iliac node with FDG uptake suspicious for metastatic disease; borderline enlarged right femoral lymph node with FDG uptake favored to be reactive in etiology; stable sub 5 mm right lung nodules, could be infectious/inflammatory, but cannot rule out metastatic disease.  He was seen in the office 10/14/19 and on DRE, there was a mobile mass at the tip of the finger posteriorly and to the left that did not involve the sphincter complex.  Flexible sigmoidoscopy showed persistent 3 cm tumor extending above the dentate line to the lower rectal valve posteriorly occupying 25% of the circumference.  Plan was to check a CEA level and to return to the office in 1 month to determine if he has continued response to determine if we can continue with watch and wait vs re-stage and present at the Multidisciplinary Colorectal Cancer Conference and consider transanal excision if appropriate.  CEA level 10/31/19 was 2.1.  Patient was seen in office 11/11/19 and Flex Sig showed a 3 cm rectal mass at the lower rectal valve occupying 1/3 circumference, indicating a partial clinical response, but with persistence.  Plan is to proceed with Robotic Transanal Excision. | JM |
| 9 | DH/ MRN: 11357603  DOB: 6/9/71 | 48 y/o female with metastatic colon cancer; abdominal bloating. Diagnosed 1/31/19. Ongoing stomal bleeding. Fluid collection in right upper quadrant. CEA decreasing from 120 to 60 . Currently on FOLFIRI with plans to continue; CT scans showing response. Palliative consult in progress. CT review requested. | MR |
| 10 | RM/ MRN 11741720  DOB: 7/22/43 | 76 y/o male who  had a screening colonoscopy done 10/16/19 by Dr. Amin in Indiana that identified a neoplasm sigmoid colon –path came back polypoid moderately differentiated adenocarcinoma directly involving the margins of resection, no lymphovascular invasion.  CEA elevated at 3.5. CT chest/abdomen/pelvis done 10/23/19 –no evidence of distant metastatic disease. Had Laparoscopic robotic lower anterior resection 11/6/19. Path review requested. | JM |
| 11 | MM/ MRN: 115304 | 56 y/o female initially diagnosed with Stage IV colon cancer of the cecum with hepatic metastasis, abdominal wall invasion and omental implants in May 2019. Her case was previously discussed at cancer conference on 5/31/19 with recommendations to proceed with neoadjuvant chemotherapy.　Patient completed 8 cycles of chemotherapy　(Folfirinox for 2 cycles, switched to Folfox +bevacizumab for remaining cycles). A repeat CT scan 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　2019.  Patient had repeat CT scan on Monday 10/14/19 in consideration of possible combined resection. Her case was again discussed at conference on 10/18/19 noting unchanged hepatic lesions with evidence of persistent omental implants/peritoneal carcinomatosis. 　Group's consensus was that surgical resection of the liver and colon mass would not be curative and would not recommend surgery. She was seen by Surg Onc and underwent diagnostic laparoscopy with one large omental implant identified that was grossly adherent to the anterior abdominal wall, biopsy consistent with metastatic disease. Presenting to rediscuss possible combined hepatic, colon resection given recent laparoscopic findings | MV/MR/SS |
| 12 | AS/ MRN: 633658  DOB: 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 |

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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