

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, November 8, 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**

|  |  |  |  |
| --- | --- | --- | --- |
| **Case** | **De-identified patient** | **Reason** | **Presenter** |
| 1 | RH/ MRN: 11747081 | 69 y/o male with newly diagnosed rectal cancer.  He underwent a colonoscopy 10/22/19 after 7 months of lower abdominal discomfort, change in bowel habits, and bleeding that showed a malignant appearing lesion of the distal sigmoid colon with central ulceration and heaped up margins that was biopsied and tattooed distally and was a moderately differentiated adenocarcinoma.  He was then evaluated by Dr. Taesun Moon 10/31/19 and underwent a flexible sigmoidoscopy that showed a mass at 10 cm from the anal verge.  CEA level 10/30/19 was 1.0.   CT A/P was done 10/29/19.  Flex sig by JTM 11/5/19 showed a circumferential ulcerated mass in the mid rectum associated with the middle rectal valve at 10cm from the anal verge that was not traversable, and fibroepithelial polyp at dentate line.  CT Chest and Pelvic MRI were done 11/5/19. | JM |
| 2 | JW/ MRN: 10978576  DOB: 04/26/71 | 48 y/o male diagnosed with stage IVa rectal adenocarcinoma (pelvic wall lymph node) initially staged as T3N2 s/p neoadjuvant chemotherapy with Folfox, concurrent chemo radiation with Xeloda, followed by laparoscopic robotic total mesorectal excision (proctectomy) with creation of coloplasty anal anastomosis, creation of loop ileostomy and takedown of the splenic flexure on 7/18/18 by Dr. McCormick with complete pathologic response. He then underwent 4 cycles of adjuvant Folfox with his last treatment being 10/5/2018. Had ct scan done 11/4/19 which showed a 5x7 mm pulmonary nodule in the lingual which is new and raises concern for metastatic disease. Review of scan requested. | NA |
| 3 | PT/ MRN: 10623452  DOB: 6/26/58 | 61 y/o male with retrorectal mass. Patient presents with a soft, non-tender rectorectal mass on examination.  Scans done at Sharon Regional hospital.  Patient is wheelchair bound, is on anticoagulation due to a stroke, has neurologic deficits and is in a deconditioned status making him a poor surgical candidate. Review scans and discuss treatment options. | RF |
| 4 | JK/ MRN: 11741927  DOB: 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 |
| 5 | AML/ MRN: 1722796  DOB: 10/8/70 | 49 y/o female 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 |
| 6 | SH/ MRN: 11674872  DOB: 4/22/76 | 43 y/o male diagnosed with Stage IV colon cancer in June 2019.  Had colonoscopy done 6/28/19 for change in bowel habits, hematochezia.  Obstructing mass at 20 cm. –invasive moderately differentiated adenocarcinoma.  Had exploratory lap at Latrobe Hospital 8/1 peritoneal implant biopsied –metastatic colonic adenocarcinoma.  Loop colostomy done 8/12/19 by Dr. McCormick.  Started FOLFOX 8/23/19, Avastin added with cycle 3.  Completed cycle 6 chemo 11/1.  CT done 11/6 showed decrease in size of sigmoid lesion and liver and omental metastatic disease.  Review recent scan and discuss options. | NA |
| 7 | DM/ MRN: 11607054  DOB: 5/17/69 | 50 y/o male with sigmoid colon cancer and colocutaneous fistula s/p creation of loop ileostomy on 7/18/19. He was previously discussed at conference on 7/12/19 with plan to start systemic chemo followed by restaging with possible plan for palliative resection. He received 6 cycles of Folfox and had a restaging CT C/A/P on 11/4/19. \*\*Requesting imaging review. | AR |
| 8 | JC/ MRN: 329131 | 62 y/o male who initially presented to the office on 7/15/19 with left ischiorectal perirectal abscess with significant associated cellulitis. He was taken to the OR the following day for EUA,  I/D of the abscess with penrose drain placement and fistulotomy of superficial pml anal fistula. Patient improved and penrose drain was removed in the office. Colonoscopy was recommended but not completed. He was seen in the office again on 10/21/19 with recurrent abscess and underwent EUA, I/D of abscess in posterior midline through the anococcygeal ligament and biopsy of fungating, polypoid rectal mass seen at 8cm on proctoscopy. Biopsy was consistent with invasive, moderately differentiated adenocarcinoma. CT scan and pelvic MRI scheduled 10/30/19. Colonoscopy scheduled on 11/1/19. | MV |
| 9 | BH/ MRN: 4561263  DOB: 8/8/62 | 57 y/o female now status post laparoscopic partial gastrectomy, open right colectomy, and open low anterior resection on 10/25/2019 for a large mass occupying the appendix, right colon, terminal ileum, sigmoid colon, and rectum and a stomach wall mass at the greater curvature. Pus and possibly a small amount of mucoid material was expressed from the mass as it was manipulated, which was immediately suctioned and managed. Pre-operative CTAP showed dilated abnormal appearing appendix with thickening and nodular appearance with periappendiceal inflammation, concerning for underlying mucocele and neoplastic process; nodular density seen along greater curvature of stomach and left adrenal nodule. Requesting imaging review (CTAP), pathology review, and discussion of further management. | JM |
| 10 | 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 |
| 11 | RB/ MRN: 10738462 | 81 y/o male with history of squamous cell carcinoma of the anal margin in 2007 s/p radiation therapy alone. In 2012, he underwent wide local excision with flap closure of high-grade dysplasia described as recurrence in situ, resulting in anal stenosis. More recently, he was treated with topical 5FU for 6 weeks for an area of high-grade dysplasia. He underwent exam under anesthesia, high resolution anoscopy with biopsy on 11/1/19. Request pathology review, discuss treatment plan. | AR |
| 12 | MB/ MRN: 4328865  DOB: 8/27/69 | 50 y/o male diagnosed with malignant neoplasm of the ascending colon. Patient had a colonoscopy on 5/15/17 which showed completely obstructing cecal mass, path was positive for moderately differentiated adenocarcinoma. Patient underwent Laparoscopic robotic SILS right colectomy with on bloc resection of anterior abdominal wall and right gonadal vessels with right ureterolysis, and primary repair of umbilical hernia 6/14/17 followed by 12 cycles of FOLFOX. Recent CT showed new and enlarging hyperdense liver lesions concerning for metastases. Please review. | NA |

AHN CME Credit

TEXT 412-301-9919  
save this number to your contacts–  
will use this **same** number every week to text your attendance

**Today’s SMS Code: POXMOD**

You must text within **THREE** hours of the tumor board. You will receive a text confirming receipt and then an email to complete the evaluation. Once the evaluation is completed credit is registered.

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