

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, December 20, 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 | ND/ MRN: 11801564  DOB: 1/8/46 | 73 y/o male with a newly diagnosed rectal cancer. He underwent a colonoscopy on 11/26/19 by Dr. Fadden and was found to have an ulcerated partially obstructing large mass found in the mid rectum and in the distal rectum. The mass was circumferential and measured 3 cm in length and was biopsied and came back as invasive moderately differentiated adenocarcinoma. CEA was 12.1. CT A/P was done on 11/26/19 and showed findings highly suspicious for a rectal mass originating approximately 5.5 cm proximal to the anus, no discrete evidence of lymphadenopathy or infiltrative changes. No definitive evidence of local or distant metastatic disease, fatty infiltration of the liver is noted. A CT chest showed spiculated mass in the inferior aspect of the right middle lobe measuring up to 1.3 cm (recommended biopsy),and a pleural based thickening in the posterior right lung base.  MRI done 12/17/19.  Review MRI and discuss treatment options. | JM |
| 2 | CB/ MRN: 11809535  DOB: 11/27/85 | 34 y/o female that was seen 12/13/19 for a newly diagnosed rectal mass. She had a colonoscopy done on 12/6/19 by Dr. Barnicle for symptoms of hematochezia/diarrhea x 3 months and anemia requiring transfusion and was found to have aconcentric mass in the rectum. The mass was tattooed and biopsied and came back as moderately differentiated invasive adenocarcinoma. MSI testing was positive. MRI Pelvis was done on 12/6/19 and showed asymmetric wall thickening of the rectum measuring approximately 7 cm in length with enhancing pericolonic stranding compatible with rectal neoplasm with multiple adjacent lymph nodes in the mesocolon. CT chest without contrast was normal. A CT A/P done 12/13/19.  She resides in Indiana PA and will have treatment there with Dr. Kamenova at UPMC.  Port to be placed 12/16/19. Review scans and discuss treatment plan. | JM |
| 3 | MW/ MRN: 11742301  DOB: 4/28/65 | 54 y/o male who presented for rectal mass. Per documentation he had been having lower back pain for the past few weeks. He presented to Passavant ER and was given pain medication and steroids and then saw Dr. Snell of Orthopedic Surgery on 10/23/19 and was referred to Dr. Sauber who ordered a MRI lumbar spine which showed abnormal edema in the right aspect of the sacrum. He was then sent for a MRI Bony Pelvis which showed a large enhancing mass centered in the inferior right sacrum with large soft tissue component extending into the right piriformis muscle, differential consideration favor a solitary metastasis given the presence of a recto sigmoid mass. There was also an enhancing recto sigmoid colon mass, consistent with colorectal cancer. CT on 10/29/19 revealed 4.3 cm and 0.9cm right lobe liver lesions compatible with metastases. He was presented at tumor conference on 11/1/19 and the consensus was to treat with the goal of obtaining a complete clinical response with long course radiation with SBRT and infusional chemotherapy.  He then saw Dr. Monga on 10/31/19 and due to his severe pain; he was admitted where he began radiation.  He continued with radiation as an outpatient, receiving 15/30 and on 12/3/19 he received his last radiation treatment due to liver disease progression.  He was started on FOLFOX cycle #1 on 12/6/19 and the plan is for at least 6 cycles with possible radiation after. Review scans and discuss treatment plan. | JM |
| 4 | TL/ MRN: 538679  DOB: 5/27/73 | 46 y/o female with diagnosis of mets rectal cancer to the liver s/p 4 cycles of FOLFOX, will need to review pathology from liver and rectal biopsies as there is possibility for 2 primary malignancies (rectal and cholangiolarCB) and review radiology as well to assess response and formulate a multidisciplinary plan | GF |
| 5 | SK/ MRN: 509594  DIBL 9/16/74 | 45 y/o female with a diagnosis of stage IIIB (T3N1c) sigmoid adenocarcinoma, s/p sigmoid colectomy and finished adjuvant FOLFOX, repeat CT scan in August 2019 showed 1 cm pancreatic head/neck hypodensity. Dr. Finley would like to review images with radiology | GF |
| 6 | JB/ MRN: 11597612 | 54 y/o with pT4 pN1c M0, MSI (+), BRAF (-), CRM (+ at pelvic side wall) moderately differentiated adenoCa of the proximal sigmoid s/p planned resection in June 2019 followed by 4 cycles of adjuvant FOLFOX to the tolerance. Developed bowel perf in November 2019; s/p emergent exploratory laparotomy with bowel resection, ostomy and ureteral stenting. Current PET/CT demonstrates bulk of recurrence within pelvis/abdomen. Here to discuss salvage therapy strategy. | AK |
| 7 | TP/ MRN: 174600  DOB: 10/12/59 | 60 y/o male with history of diverticulitis for which he had loop ileostomy created on 9/25/2019 during laparoscopic converted to open low anterior resection for diverticulitis of the large intestine with abscess formation. Colonoscopy on 12/4/2019 showed a healthy appearing anastomosis and intact staple line, and a frond-like/villous and polypoid non-obstructing, non-bleeding, large mass in the mid rectum measuring 3 cm in length, 2 mm diameter. Biopsy showed tubulovillous adenoma.   MRI pelvis ordered. Review MRI and discuss treatment options. | RF |
| 8 | PS/ MRN: 10894699  DOB: 1/28/45 | 74 y/o male with malignant polyp removed in January of 2018 from the sigmoid colon. Review of pathology in January of 2019 showed an area of adenocarcinoma close to resection margin but did not touch the ink. Segmental colectomy was recommended, which the patient did not pursue.  Recent CT scan demonstrated no evidence of adenopathy or masses or metastatic disease, and a CEA was 3.5.  Colonoscopy done 12/16.  Review MRI | RF |
| 9 | KD/ MRN: 704806  DOB: 10/18/69 | 50 y/o female with colon cancer.  The perianal and digital rectal examinations were normal.    A 30 mm polyp was found in the ascending colon. The polyp was sessile.  The polyp was removed with a hot snare. Resection and retrieval were complete.    A greater than 50 mm polyp was found at 65 cm proximal to the anus. The polyp was sessile. The polyp was too large to remove and in an unusual location. Pieces were able to be hot snared and retrieved but the polyp was not able to be removed. Area was tattooed with an injection of India ink.  A greater than 50 mm polyp was found at 35 cm proximal to the anus. The polyp was semi-pedunculated. The polyp is nearly totally obstructing the lumen at 35 centimeters. Several large pieces are removed with a hot snare but the tumor is too large for me to remove. Path review requested. | JM |
| 10 | JB/ MRN: 100235  DOB: 7/15/48 | 71 y/o female with a history of breast cancer, presents to the office regarding a mesenteric mass.  She went to the ER for back pain 11/11/18 and had a CT A/P done that showed multiple enhancing bladder masses worrisome for bladder neoplasm; 3 cm mass in the sigmoid mesentery suspicious for metastasis; normal sized lymph node in the sub carinal region of uncertain significance.  She was seen by Dr. Rooker 12/7/18 and no bladder mass was seen on cystoscopy.  CT was reviewed and findings were likely secondary to bladder wall trabeculation.  She underwent a follow up CT A/P 10/10/19 for unintended weight loss and abdominal pain that showed increased size of enhancing masses along the bladder wall, which is concerning for a neoplasm; increased size of enhancing mass of the sigmoid mesentery, which is suspicious for metastasis. CEA level 10/16/19 was 4.4.  Colonoscopy with polypectomy done on 11/1/19.  Path negative.  Patient taken to OR on 11/12/19 laparoscopic LAR and creation of coloproctostomy.  Path revealed focus on well differentiated adenocarcinoma of colorectal origin involving pericolonic soft tissue.  Review pathology | JM |
| 11 | JK/ MRN: 11795754  DOB: 12/24/38 | 80 y/o male with stage IV prostate cancer with plan to start Firmagon (mets to the lymph  nodes and concern for peritoneal carcinomatosis and bony mets on bone scan 12/3/19) CT  A/P 11/27/19 that showed concern for appendiceal mucocele and porcelain gallbladder.  Colonoscopy 12/9/19 by Dr. Chintamaneni that showed a 2 mm transverse colon polyp that  was removed and was a tubular adenoma; 3 mm sigmoid polyp that was removed and was a  tubular adenoma; normal ileum; diverticulosis. Prostate nodules and increased firmness of the  prostate was found on DRE. CEA from 12/10/19 is 10.3. PSA from 11/18/19 was 260.2.  On 12/16 patient had a diagnostic laparoscopy, evacuation of mucinous ascites, radical appendectomy, stripping of portion of right lower quadrant peritoneal line for excisional biopsy of carcinomatosis. There was an appendiceal mass and the appendix itself was extremely dilated and had a hole in it that was extruding mucus.  There was mucus staining the right lower quadrant. There was carcinomatosis in all quadrants.  This involved the anterior abdominal wall, omentum, and mesentery. The gallbladder was not able to be assessed as it was caked in the omentum.  Review scans and path.     |  | | --- | |  | | JM |

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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