

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, December 27, 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 | AM/ MRN: 2259694  DOB: 9/28/82 | 37 y/o female with newly diagnosed rectal cancer. She underwent a colonoscopy on 12/17/19 by Dr. Manesh Dhawan for rectal bleeding and change in bowel habits and was found to have an infiltrative and fungating circumferential 7cm mass of malignant appearance found in the rectum at a distance between 3 cm and 10 cm from the anus. The mass was noted to cause a partial obstruction. It was biopsied and results are consistent with invasive moderately differentiated adenocarcinoma. Review MRI and CT scans, and discuss treatment plan. | JM |
| 2 | GP/ MRN: 556705  DOB: 7/29/41 | 78 y/o with a history of moderately differentiated distal rectal adenocarcinoma, clinical stage IIa cT3 cN0 M0. The patient underwent colonoscopy by Dr. Kelly Zbanic on 5/15/2019, which showed a 3 cm distal rectal mass with ulceration. Biopsy confirmed moderately differentiated colonic adenocarcinoma.  MRI pelvis on 5/22/2019 revealed a mass extending from the 12 o'clock position to the 5-6 o'clock position. MRI showed T3, N0, CRM negative low rectal cancer. CT chest abdomen pelvis with contrast on 5/22/2019 showed no evidence of metastatic disease. Patient was discussed on 5/31/19 at tumor conference and the recommendation was to begin neoadjuvant chemotherapy followed by limited field radiation. The patient began chemotherapy in June 2019 and completed 8 cycles of FOFLOX ending in October 2019 and finished radiation treatments in November.  Flex and TRUS done on 12/18/19. Discuss treatment options. | RF |
| 3 | FW/ MRN: 10778362  DOB: 1/10/47 | 72 y/o male with rectal cancer.  Had colonoscopy 7/26/19 prompted by hematochezia that showed a 14 mm semi-pedunculated polyp 12 to 13 cm proximal to the anus that was removed and was an invasive carcinoma with mucinous features and an invasive adenocarcinoma focally that involved cauterized surgical resection margin.  Flexible sigmoidoscopy in the office on 8/12/19 showed an ulcerated area on the middle rectal valve 8 cm from the anal verge with surrounding heaped up mucosal tissues felt to represent the site of previous snare polypectomy although uncertain whether surrounding tissues were reactive or additional polypoid tissue.  Pelvic MRI 8/12/19 that showed T1/T2 N0 mid rectal tumor, CRM negative.  CT C/A/P 8/14/19 showed abnormal eccentric thickening portion of the rectum with milder wall thickening questioned in the distribution of the sigmoid colon and a 7 mm LLL pulmonary nodule.  CEA level 8/14/19 was 1.4. Requesting NAPRC path review.  He was discussed at TB on 8/16/19 and the group consensus was that the recent polypectomy and flexible sigmoidoscopy with tattooing the same day may be affecting the accuracy of the pelvic MRI read.  Pathology's review of the slides indicated there were high risk features of the tumor and that the carcinoma was present at the deep margin.  On exam in the office, the ulcer still remained.  The group consensus was to completely excise this transanally after he had a few months to heal. | JM |
| 4 | JF/ MRN: 11445622  DOB: 6/18/41 | 78 y/o female with clinical T3N1 CRM negative rectal cancer.   She was seen on 4/5/19 and at that time a flex-sig was done which revealed a large hemi-circumferential mass in the distal rectum that was semi-pedunculated and the intraluminal component was greater than the involve of the wall. Pathology came back as moderately differentiated adenocarcinoma involving full thickness of the biopsy segments. She was discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 4/12/19 and clinical trial eligibility (FR2) was discussed. MRI Pelvis was reviewed and revealed extramesorectal lymph nodes and extramural venous invasion. The final treatment plan was 3 months of neoadjuvant chemotherapy followed by chemoradiation and definitive surgery depending on the response. She completed neoadjuvant Folfox May-July, followed by chemoradiotherapy with Xeloda (8/28/19-10/9/19). She did not take the last 5 days of Xeloda but completed radiation.  Seen on 11/8/19 and a flex-sig was done which revealed a 1 cm raised area with polypoid friable tissue in the distal rectum on the lower rectal valve which was biopsied and came back **as invasive moderately differentiated adenocarcinoma**.. Her last pelvic MRI was 11/26/19 and showed significant treatment response, irregular appearance of the mucosa in the posterior lower rectum just above the anus could represent residual T1 vs T2 tumor or scar tissue, no suspicious lymph nodes or evidence of extramural vascular invasion. On 12/17/19 she had a robotic assisted laparoscopic proctectomy with diverting loop ileostomy.  NAPRC path review | JM |
| 5 | 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 |

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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