

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, December 6, 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 | JH/ MRN: 10118944DOB: 5/7/69 | 50 y/o male with Clinical Stage T2 N1 CRM negative rectal cancer, s/p chemoradiotherapy which was completed on 10/7/19 with extended Xeloda finishing on 10/25/19. He was first seen in consultation on 5/28/19 and at the time a flex-sig was done and revealed a tumor occupying 40% of the circumference of the posterior rectum just above the dentate line. He was discussed at conference on 5/31/19 and radiologist review of MRI revealed a 1.1 cm bladder mass that was thought to resemble a transitional cell carcinoma. He was seen by Urology and underwent cystoscopy with TURBT and installation of mitomycin by Dr. Schuyler. Dr. Schuyler plans for surveillance. During treatment he was hospitalized for pneumonia in September.  His Last CEA was 10/25/19 and was 2.1.  Per Rad-Onc (note on 8/21/19) he was treated with definitive chemoXRT in hopes to avoid surgery. Review recent MRI (12/4/19) and discuss surgical intervention. He currently has a surgery hold date of December 17th | JM |
| 2 | KO/ MRN: 2770584DOB: 1/27/50 | 69 y/o male with history of rectal cancer (2014) T4b N2. 28 cycles Folfari/Erbitux 10/23/14-1/28/16. Chemo/XRT 3/7/16-4/18/16. Folfari/Erbitux 5/26/16 – 40 cycles. Planning for surgery. | JM |
| 3 | JF/ MRN: 11445622DOB: 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. It was semi-pedunculated and the intraluminal component is greater than the involvement of the wall. She was discussed at conference on 4/12/19 and clinical trial eligibility (FR2 trial) was discussed. MRI Pelvis also revealed extramesorectal lymph nodes and extramural venous invasion. 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.  Review recent MRI and discuss treatment options. | JM |
| 4 | KB/ MRN: 11597700DOB: 10/29/56 | 63 y/o male diagnosed with mid-high rectal cancer 5/2019. T3 N2 MO. Started 8 cycles Folfox 6/2019, short course radiation, 2 additional cycles Folfox. Most recent CEA 11.70 on 10/28/2019 | JM |
| 5 | CR/ MRN: 5255842DOB: 6/12/62 | 57 y/o male with a history of rectal polyps. MRI on 11/27 showed upper rectal mass T1 or T2 N1. CRM negative. 11/25 colonoscopy showed 30mm polyp in the rectum – tubular adenoma. Path review needed. | AR |
| 6 | KS/ MRN: 4314610/20/35 | 84 y/o male with CLL and clinical stage T3N2 CRM positive rectal cancer, s/p FOLFOX and short course radiation.  Laparoscopic robotic proctectomy with diverting loop ileostomy done 11/21/19.  NAPRC path review. | JM |
| 7 | JF/ MRN: 11740676DOB: 10/7/57 | 62 y/o male who underwent a colonoscopy on 10/10/19 and was found to have a 10 mm polyp in the rectum that was removed and came back as rectal adenocarcinoma, moderately differentiated arising in an adenomatous polyp, cauterized tissue edge positive for invasive malignancy. He is now s/p robotic transanal excision of polypectomy site on 11/8/19 by Dr. McCormick. \*\*Requesting NAPRC pathology review\*\* | JM |
| 8 | BS/ MRN: 721737DOB: 5/23/65 | 54 y/o male who presents with a newly diagnosed distal rectal cancer vs anal cancer, involving the sphincter with locally advanced disease.  He will require chemo radiotherapy. Review scans and pathology. | JM |
| 9 | FH/ MRN: 11733050 | 85 y/o female recently diagnosed with anal SCC s/p full thickness transanal excision on 11/15/2019. Pathology showed SCC, moderately differentiated with background high-grade squamous intraepithelial lesion (AIN 3), cauterized specimen edges involved by carcinoma, and no angiolymphatic or perineural invasion identified. She presented to OSH with generalized malaise, fatigue, and poor PO intake 12 days after the procedure. CT scan showed left perineal fluid collection with significant amount of gas. She was transferred to AGH and underwent debridement of perineum, gluteus, and genitalia on 11/28/2019 for necrotizing soft tissue infection. She had a second surgical debridement and loop sigmoid colostomy creation on 11/29/2019. Medical oncology, radiation oncology, and palliative have been consulted. Patient was previously scheduled to undergo port placement for chemotherapy prior to recent hospitalization. Discuss treatment plan. | RF |
| 10 | JH/ MRN: 10986702DOB 4/17/65 | 54 y/o male with sigmoid colon cancer, stage IIIB. Started Folfiri/Avastin 12/2019. Laparoscopic robotic right colectomy, poorly differentiated adenocarcinoma, lymphovascular invasion, positive modes. 12 cycles of Folfox. Liver biopsy performed 11/27/2019 showed no evidence of malignancy.  | NA |
| 11 | AA/ MRN: 10672819DOB: 8/27/64 | 55 y/o male with colon cancer. 5/29/2019 diverting ostomy. Folfox/Avastin added with a reaction at cycle 6. Requesting scan review | NA |
| 12 | JB/ MRN: 100235DOB: 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 |
| 13 | FS/ MRN: 61539DOB: 11/21/30 | 88 y/o female with no previous colonoscopy, patient was started on Eliquis after which she started having intermittent painless hematochezia. As a result of which the colonoscopy was performed today. No further hematochezia during the prep. Last Colonoscopy: none. The patient's first colonoscopy is today. Diagnosis: Invasive adenocarcinoma | AK |
| 14 | WM/ MRN: 240635DOB: 12/26/43 | 75 y/o male with explained findings of a metastatic neuroendocrine neoplasm in the surgical specimen which did contain a focus of residual adenocarcinoma invading into the muscularis propria with lymphovascular invasion. I explained that this was highly unusual and likely represented a primary neuroendocrine neoplasm in the region, with lymphatic drainage into the involved lymph nodes. The terminal ileum and appendix included in the surgical specimen showed no primary, an area commonly associated with GI neuroendocrine tumors. Diagnosis:  Invasive moderately differentiated adenocarcinoma | AK |
| 15 | VP/ MRN: 11344337DOB: 8/30/52 | 67 y/o female with history of stage 4 colon cancer with mets to lung and liver s/p chemotherapy with complete response.  Now on maintenance 5 FU (with Avastin on hold for surgery).  Review PET scan.  Reversal  scheduled for 12/20/19 | RF |
| 16 | JF/ MRN: 1126661DOB: 4/10/54 | 65 y/o male with history of sigmoid cancer. Review CT, Path, and colonoscopy that were performed on 11/26. | AR |
| 17 | MB/ MRN: 4328865DOB: 8/27/69 | 50 y/o male representing with T3 N2 colon cancer. Previously presented at TB on 11/8/2019 with a suggestion of a MRI which revealed hypervascular liver mets. Completely obstructing cecal mass showed on 5/15 colonoscopy. 12 cycles of Folfox. CT on 10/14/19 showed new and enlarging liver lesions. | NA |
| 18 | KF/ MRN: 11797063 | 57 y/o male with newly diagnosed transverse colon cancer with extensive carcinomatosis. He presented to AGH ED on 11/26/2019 with RUQ abdominal pain, diarrhea, and dyspepsia for 4-5 weeks. Previous colonoscopy was 9-10 years ago. CT AP showed abnormal circumferential wall thickening involving the transverse colon with omental infiltration and somewhat loculated abdominopelvic ascites concerning for malignancy and peritoneal carcinomatosis. CT chest and bone scan showed no evidence of metastatic disease. Colonoscopy showed fungating, nearly-completely obstructing large mass in proximal transverse colon at 70 cm. A semi-pedunculated polyp was found at 55 cm. Scope could not transverse the lesion. Biopsy showed invasive poorly differentiated adenocarcinoma with signet ring cell features. CEA 1,215 ng/mL. Patient underwent exploratory laparotomy and ostomy creation on 12/1/2019. Intraoperatively, the patient was found to have diffuse omental caking and peritoneal carcinomatosis, a large, fixed tumor at the hepatic flexure with mild dilatation of the cecum, and over 3 liters of clear ascites. Palliative and medical oncology on board. Discuss palliative chemotherapy and options. | MV |
| 19 | AY/ MRN: 117036776/21/33 | 86 y/o female presents for sigmoidoscopy after referral from GI which was performed on September 12, 2019?  40 millimeter polyp noted in the proximal rectum. Biopsy demonstrated tubulovillous adenoma.  CEA: 9/2019 = 6.7.  CT scan of her chest, abdomen and pelvis demonstrated stable pulmonary nodules and a rectal mass without adenopathy.  Pelvic MRI demonstrated a high rectal mass concerning for carcinoma staged as T2 versus early T3, N0, and CRM negative.  Colonoscopy performed  10/16/19  to cecum identified a 40 millimeter proximal ascending colon mass-biopsies pending, multiple right-sided and transverse colon polyps-not removed, and the 40 millimeter rectal mass identified on the 3rd valve of Houston. Biopsies done and path read as tubulovilllous adenoma.  3D rectal ultrasound performed on 10/16/19 identified T2 N0 rectal cancer 11 centimeters from the anorectal junction.She was presented at the Multidisciplinary Colorectal Cancer Conference at AGH on 10/25/2019. The group's consensus was to perform a transanal excision, which was done on 11/15/19. Path came back tubulovillous adenoma with high grade dysplasia. Review recent scans and pathology. | RF |
| 20 | RB/ MRN: 10738462DOB: 3/16/38 | 81 y/o male with recurrent anal cancer. Previously discussed on 11/8/19 with a decision to proceed with APR if fit for surgery. Patient and family review PET performed 11/21/19 and planned nutrition consult, Onc rehab, urology consult and palliative consult. Patient is now refusing any treatment/consults per his daughter. Review and discuss. | 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