

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, February 21, 2020

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 | RM/ MRN: 10608870  DOB: 10/12/34 | 85 y/o male who originally presented in Sept of 2019 for an anal mass after an abnormal CT scan.  He had a normal screening colonoscopy in 2017. He noted a perianal mass in December 2018 that he thought was a hemorrhoid and neglected until the fall of 2019. MRI demonstrated T3 N2 disease with positive CRM. Colonoscopy identified extensive rectal cancer extending through the anal canal out to the anal margin.  CT scan of his chest abdomen pelvis at the time demonstrated subcentimeter pulmonary nodules and hepatic nodule, too small to characterize.  Multiple perirectal lymph nodes are identified as well as thickening at the anorectal junction extending 7 centimeters proximal and a 1.3 centimeter left inguinal lymph node.  He was presented at tumor conference on 10/4/19 and the consensus was to start neoadjuvant chemotherapy followed by chemo/XRT.  Chemo started in October 2019 but was put on hold for robotic loop colostomy placement on 12/2/19.  Chemo resumed in mid-December and patient is currently still receiving it.  Recent PET demonstrates no evidence of metastatic disease. Review scans and treatment options. | RF |
| 2 | AB/ MRN: 11809783  DOB: 10/23/54 | 65 y/o male who had a screening colonoscopy  on 12/5/19 and was found to have a polyp at 30 cm in the descending colon that was removed and came back as a tubular adenoma,  a large polyp in the rectum that was removed in piecemeal fashion that came back as  a tubulovillous adenoma with focal high-grade dysplasia. He had a robotic transanal excision on 1/14/2020 with surgical pathology revealing T1NX invasive moderately differentiated adenocarcinoma arising in a tubular adenoma with high-grade dysplasia. Carcinoma was noted to invade into the submucosa, all resection margins negative, carcinoma is less than 1 mm from deep margin, no lymphovascular or perineural invasion identified.  CT CAP done on 1/24/20.  Patient was discussed at tumor conference on 1/31/19 and the consensus was that he was a high risk and should see radiation oncology of which he did on 2/5/20.  CEA on 2/5/20 was 7.3.   MRI completed on 2/14/20. Review MRI and discuss treatment options. | JM |
| 3 | CW/ MRN: 11601557 | 61 y/o male with stage IV rectal cancer. Completed concurrent chemoradiation and is completing systemic FOLFOX right now. Would like to discuss his imaging (especially comparing July 2019, October 2019 and Jan 2020 imaging) and discuss management of the liver. | SS |
| 4 | CS/ MRN: 83728  DOB: 10/21/53 | 66 y/o female that had a colonoscopy on 11/25/19 which showed a possible stenosis in the terminal ileum with small apthous ulcers that could not be biopsied.  The cecum was deformed near the area of the valve as well.   CT enterography done which showed a masslike wall thickening of the terminal ileum with soft tissue extension adjacent to the mesentery.  Carcinoid suspected. She went to the OR on 1/ 30/20 for a laparoscopic robotic right colectomy with extensive LOA and primary repair of ventral hernias on 1/30/2020. Pathology revealed T3N2 MX well differentiated neuroendocrine tumor of the terminal ileum, grade 1 with an associated large mesenteric mass (N2). All resection margins were benign. Lymphovascular and perineural invasion were identified, and eight lymph nodes were negative. Review pathology and discuss treatment options. | 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.   CT scan ON 9/12/19 demonstrated no evidence of adenopathy or masses or metastatic disease, and a CEA was 3.5. MRI on 11/18/19 showed no suspicious abnormalities.  Colonoscopy done 2/10/20 and path revealed no evidence of malignancy.  CEA on 2/3/20 was 2.9 Review scans and treatment options. | RF |
| 6 | TD/ MRN: 73441  DOB: 3/14/49 | 73 y/o male admitted 1/13/2020 with an intestinal obstruction at the level of D2 with a CT scan concerning for a pancreatic head mass. EGD on 1/14-- invasive moderately differentiated adenocarcinoma of the duodenum. Whipple 1/16/20 by Dr. Schiffman. Chest ct on 2/14/20 concerning for mets to lungs and liver. Liver MRI 2/19. CEA increased from 142 on 1/13 to 174 on 2/6. Review scans and discuss treatment options. | NA |

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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:

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