

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, February 7, 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 | PM/ MRN: 11816037DOB: 12/20/63 | 56 y/o woman with newly diagnosed rectal cancer. Staging CT C/A/P and MRI done in Altoona on 1/2/20 - awaiting discs. Has already established with medical oncology (Alkayem) and radiation oncology (Alden) locally with tentative plans to begin neoadjuvant chemoXRT week of 2/10/20. Request radiology of OSH imaging, MDT discussion of management options.   | AR |
| 2 | KS/ MRN: 190326DOB: 10/27/65 | 54 y/o female with a history of Stage IIIB (pT3 pN1b) upper rectal cancer involving the upper rectal valve. She underwent exploratory laparotomy, low-anterior resection with colorectal anastomosis, mobilization of the splenic flexure, lysis of adhesions, pelvic exclusion with omentum, and creation of protective diverting loop ileostomy, ureterolysis, colposcopy, and proctoscopy for a large bowel obstruction on 4/3/2019. Surgical pathology revealed invasive adenocarcinoma, poorly differentiated, negative surgical resection margins, lymphovascular and perineural invasion present, 3/18 lymph nodes positive for metastatic adenocarcinoma. CT chest and MRI abdomen showed no evidence of metastatic disease. She had 12 cycles of chemotherapy from 6/3/2019 through 11/18/2019. CT CAP on 11/20/2019 showed no evidence of metastatic disease in the chest, abdomen, or pelvis. An unchanged 6 mm ground-glass nodule was noted in the right upper lobe. CEA was 3.7 on 11/8/2019 and on 1/28/20 is 21.1.  She had a barium enema on 12/16/19 followed by a colonoscopy on both 1/15 & 2/5/20 prior to takedown which was scheduled for 2/18/20.  Recent PET done on 2/3/20 reveals New hypermetabolic presacral soft tissue density is most compatible with local recurrence of disease, hypermetabolic lymphadenopathy in addition to scattered hypermetabolic peritoneal implants compatible with metastatic disease. A hypermetabolic lesion in the left hepatic lobe is most compatible with hepatic metastasis. Discuss PET scan and treatment options. | RF |
| 3 | KT/ MRN: 301054DOB: 9/20/46 | 73 y/o female diagnosed in May 2019 with T3N2 CRM negative bulky rectal cancer with multiple pulmonary nodules on staging imaging who underwent  FOLFOX x 8 cycles from 7/12/19 to 11/1/19.  CT C/A/P 9/9/19 in the middle of treatment showed mild decrease in the degree of rectal thickening and stable pulmonary nodules.  CT C/A/P 11/8/19 after chemo showed mildly improved degree of distal rectal thickening, 2 hypoechoic areas in the liver (largest 1.8 x 1.3 cm)  and unchanged pulmonary nodules.  MRI pelvis 11/8/19 showed interval decrease size of rectal tumor consistent with T3N0 CRM negative low rectal carcinoma.  Flexible sigmoidoscopy 11/11/19 showed partial clinical response.  Pulmonary nodules were favored to be benign and the liver MRI 11/11/19 was negative for metastatic disease so she proceeded with chemoradiotherapy from 12/3/19-1/13/20. CEA level 1/24/20  <1.8.Dr. McCormick did flex sig on 2/3, which was concerning due to little response from the radiation/chemo since her last scope Plan is for repeat flex sig in office in 4 weeks and surgery at 8 weeks after radiation. Review imaging for treatment planning. | JM |
| 4 | JB/ MRN: 10737378DOB: 9/28/45 | 74 y/o male with history of prostate cancer treated with external beam and high dose brachytherapy. Now with a T1/T2 N0 rectal cancer s/p Robotic Transanal Excision on 1/29/20.  Surgery delayed due to positive pre op stress testand required atherectomy and PCI to the RCA 12/20/19 by Dr. Adib.  Requesting NAPRC path review. | JM |
| 5 | AA/ MRN: 10672819DOB: 8/27/64 | 55 y/o male diagnosed 5/2019 with sigmoid colon cancer with liver mets.Laparoscopic diverting loop colostomy 5/29/2019. Started chemotherapy in early June 2019.  Had 6 cycles FOLFOX then switched to Folfiri/Avastin due to Oxaliplatin reaction.   CT 12/2/19 showed interval improvement in the hepatic lesions with no lesions identified. CEA at diagnosis 230.  84.3 on 12/11.  Colorectal conference on 12/6/19 recommendation was to continue FOLFIRI/Avast in for six months.  Most recent treatment 1/24/20.  SBRT and surgical resection were not recommended at this time. CEA  126 1/22. Ct scan done 1/27/20.  Request scans review and discuss treatment options. | NA |
| 6 | FT/ MRN: 10773744DOB: 4/6/50 | 69 y/o male with a history stage III rectosigmoid cancer and dysplastic cecal polyp. Short course radiation 10/1/18 – 10/5/18. Laparoscopic Robotic Low Anterior Resection 10/10/18 (T3N2a moderately differentiated adenocarcinoma). Adjuvant chemotherapy with FOLFOX x 12 cycles from 11/8/18 – 5/10/19. Loop ileostomy takedown 6/13/19. Laparoscopic Robotic Right Colectomy 10/21/19 and pathology revealed a tubulovillous adenoma with focal high grade dysplasia.  CEA level 1/14/20 was elevated at 15.8 from 5.3 8/12/19. CT C/A/P on 1/27/20 5 mm right hepatic dome lesion. Review scan | NA |
| 7 | CA/ MRN: 10915258DOB: 4/8/65 | 54 y/o male with a history of testicular cancer status post-surgery and radiation about 12 years ago being seen for newly diagnosed colon cancer. He had his first screening colonoscopy on 1/8/2020 by Dr. El-Hachem and was found to have a 14 mm polyp in the cecum. This polyp was injected with methylene blue and a piecemeal polypectomy was performed. Surgical pathology revealed invasive adenocarcinoma arising in a tubulovillous adenoma with high grade dysplasia. CEA was 1.7. CT chest abdomen pelvis done on 1/20/20. Review pathology and CT scan.  Discuss treatment options. | JM |
| 8 | SH/ MRN: 11674872DOB: 4/22/76 | 43 y/o male with stage IV obstructing sigmoid colon cancer with liver metastasis and carcinomatosis diagnosed in June 2019 and new LLE DVT.   S/P exploratory laparoscopy with biopsy and primary umbilical hernia repair on 8/1/19 by outside surgeon who noted carcinomatosis and did not resect primary tumor  (Peritoneal implant positive for metastatic adenocarcinoma) The patient was then referred for HIPEC to Dr. Schiffman, who referred patient to CRS.  He then underwent laparoscopic creation of diverting loop colostomy and port placement on 8/12/2019 by Dr. McCormick, who noted extensive carcinomatosis involving omentum, peritoneum and viscera. Started Folfox 8/23/19 and Avastin added with cycle #3.CT C/A/P 11/6/2019 was reviewed at Multidisciplinary Colorectal Cancer Conference 11/8/2019 and recommended continuing chemotherapy 3 more months and possible SBRT to the liver. Last CEA 1/8/20 1.0. Completed cycle #12 on 1/24/2020. Repeat CT C/A/P on /27/19 showed findings consistent with continued treatment response with decreased conspicuity of the sigmoid lesion as well as decreased size and conspicuity of the left omental nodules. There were also stable sub 5 mm pulmonary nodules. Review scans and discuss treatment options. | JM |
| 9 | CF/ MRN: 5335656DOB: 2/8/48 | 71 y/o male with anastomotic recurrence of his ascending colon cancer.  Diagnosed in 2016 and had primary resection. S/p 12 cycles FOLFOX 2017.   Isolated recurrence requiring resection of portion of the liver as well as duodenum 9/20/18.  Capecitabine in 2019. His CEA level has been normal.  Recent CT done 12/3/19 at outside facility.   He underwent surveillance colonoscopy 1/16/20 and was found to have an area of ulceration and friability at the anastomosis which was biopsied and returned as invasive adenocarcinoma.  EGD scheduled for 1/29/20. Requesting scan review. | MV |
| 10 | TD/ MRN: 10428997DOB: 3/6/54 | 65 y/o who presents to the office to discuss stent placement.  He has a history of stage IIIb colon adenocarcinoma s/p right hemicolectomy in 2015 followed by adjuvant chemotherapy x 2 treatments (stopped due to side effects)  PET/CT at the time, was concerning for metastatic implant. Intraoperatively, he was found to have metastatic nodules throughout his omentum and liver as well as the anterior abdominal wall, near the previous incision, likely arising from the omentum. The mass was resected secondary to pain. Fascial defect was repaired with mesh. He underwent an exploratory laparotomy, resection of abdominal wall for tumor, partial omentectomy, and repair of abdominal wall defect with Tissue Graft on 1/16/19.  Pathology showed metastatic poorly differentiated adenocarcinoma.   He has taken to OR for laparotomy, exploratory, explant of mesh 1/24/19.  Intraoperatively, there was an incarcerated small bowel with dehiscence of tissue graft and obstruction around remaining suture material, but all bowel was viable.  He then underwent adjuvant Lonsurf, which he stopped in July because it 'did nothing.' He then took Vectibex (panitumumab) x 4-5 treatment completed in October, which were stopped due to side effects and not effective. Recently offered Stivarga (regorafenib), but patient stated that side effects outweigh the benefit. His last imaging was a PET scan 12/3/19 that showed interval progression of pulmonary nodules with hypermetabolic activity, interval enlargement of lymph node within the left axilla, interval progression of multifocal abnormal hypermetabolic activity within the liver, all concerning for metastatic disease, and a large ventral hernia containing nondilated small and large bowel within the hernia sac with interval development of soft tissue lesions concerning for peritoneal carcinomatosis. His last colonoscopy was 7/30/19 by Dr. Fraser Stokes and showed a stricture in the mid sigmoid colon and proximal sigmoid colon that was biopsied and was a well differentiated adenocarcinoma; moderate sigmoid diverticulosis. Discuss and review PET scan if available. | 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