

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, March 13, 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 | CL/ MRN: 10912929DOB: 9/1/52 | 67 y/o male with a newly diagnosed rectal mass.  Colonoscopy done 3/4/20 showed a fungating non-obstructing large mass in the rectum with oozing. Biopsies revealed at least high-grade dysplasia (invasive carcinoma can't be entirely ruled out). Also had a 7 mm sessile rectal polyp that was a tubulovillous adenoma and hyperplastic polyp with features of sessile serrated adenoma, two sessile polyps in the descending colon removed which were tubular adenoma and polypoid fragment of colonic mucosa with focal hyperplastic change, a 10 mm sessile transverse colon polyp removed that was a sessile serrated adenoma with low-grade dysplasia, an 8 mm sessile ascending colon polyp removed which was a tubular adenoma, a few small-mouthed diverticula in the sigmoid colon, and internal hemorrhoidsCEA was less than 1.8 on 3/4/20. CT C/A/P done without IV contrast (hx stage III renal insufficiency) on 3/6/20 showed multiple indeterminate b/l pulmonary nodules more extensive in the right lung (up to 6 mm largest in size), gallstones, b/l renal cortical lesions with 2 hyperdense lesions in the left kidney that are indeterminate, and foci of cortical scarring in the left kidney likely related to remote pyelonephritis. MRI pelvis done 3/9/20 showed suspicious mesorectal lymph nodes/tumor deposits. Round, indistinct inferior perirectal lymph nodes are identified. A 6 mm right perirectal lymph node on series 12, image 22 is round and indistinct. A 5 mm right perirectal lymph node on series 12, image 23 is round and indistinct. A 5 mm left perirectal lymph node on series 12, image 18 is round and indistinct. An indistinct presacral lymph node measures 4 mm. T3 N1CRM-negative high rectal mass. Rectal mass was biopsied again on 3/9 by Dr. McCormick.  Results show invasive moderately differentiated adenocarcinoma. Review scans. Discuss treatment option | JM |
| 2 | JL/ MRN: 513994DOB: 1/16/59 | 61 y/o male with hx of stage II rectal cancer. S/P neoadjuvant chemo radiotherapy 2/15 followed by laparoscopic robotic APR with en bloc resection of the right seminal vesicle on 5/20/15. Pathology revealed ypT2N0 moderately differentiated adenocarcinoma. He then underwent adjuvant chemotherapy with Xeloda and completed 5 out of 8 cycles. He developed recurrent small bowel obstructions and underwent laparoscopic hand-assisted lysis of adhesions, release of small-bowel obstruction, and repair of small bowel serosal defect on 11/14/18.  CEA level of 2.5 on 2/11/20. Colonoscopy on 2/13/2020 showed a 25 mm polyp at the surgical stoma which was removed and was fragments of colonic mucosa with epithelial surface erosion, granulation tissue, and chronic inflammatory cell infiltration with stromal fibrosis, and a patent but structured end colostomy with severe stenosis in the sigmoid colon. CT C/A/P from 3/2/20 showed arounded presacral mass, 3.8 x 3 cm, that was peripherally soft tissue attenuating with a central area of lower density that tracks along the sacrum to the level of the prostate and sacral promontory concerning for local recurrence or scar tissue PET scan being done 3/12/20.  Review scans and discuss treatment options.  | JM |
| 3 | BS/ MRN: 721737DOB: 05/23/65 | 54 y/o male with Stage IIIB (cT3 cN2 cM0) moderately differentiated anal squamous cell carcinoma extending into the rectum. Of note his original pathology was reported to have adenomatous glandular cells within the specimen.  He is now s/p definitive radiotherapy concurrent with 5FU/MMC completed 02/06/2020.  In 1 month follow up, physical exam he continues to have tethered posterior mass with minimal response. Flexible scope demonstrating abnormal mucosa surrounding large ulcerated lesion occupying the distal rectum and proximal anal canal s/p biopsy.  To review Pathology of anorectal biopsy on 11/21/2019 and to review pathology of anorectal biopsy on 03/06/2020 | AK |
| 4 | KS/ MRN: 646955DOB: 7/25/56 | 63 y/o female with history of stage IIIB (cT3 cN1a cM0) sigmoid cancer.  OR 5/16/19 by Dr. Voth--laparoscopic sigmoid colectomy.  Pathology revealed a T3N1a moderately differentiated, partially mucin producing adenocarcinoma (1/23 LNs +). Postop, she developed AKI and then CT A/P 5/21/19 showed an anastomotic leak with large volume of extraluminal contrast in the abdomen and pelvis, and large volume of pneumoperitoneum; subcutaneous gas and fluid deep to the skin staples likely representing gas and fluid tracking into the subcutaneous space.  Returned to the operating room 5/21/19 with Dr. Reichstein and underwent laparotomy, washout, and loop end transverse colostomy.  Her abdominal wound was left open for secondary intention healing.  She was transferred to a SNF with IV antibiotics (Rocephin and Flagyl) until 6/2/19, dressing changes, Lovenox x 30 days, protein shakes, and a JP drain in place.  She received 11 cycles of FOLFOX from August 2019 through February 2020 with Dr. Mayernik. Follow-up staging PET-CT performed on February 18, 2020 revealed a new FDG avid lesion within the right abdominal wall soft tissue worrisome for metastasis. Review PET scan. | AR |
| 5 | TH/ MRN: 11444725DOB: 5/13/74 | 45 y/o female s/p recent laparoscopic appendectomy on 2/23/20, with intraoperative findings suggestive of hemorrhagic ovarian cyst and incidental appendicitis. Final pathology demonstrates goblet cell adenocarcinoma infiltrating distal appendix without clear mass effect. Request radiology review of CT A/P and chest - chest imaging pending as of 3/9/20. **Requesting path review.**  | AR |
| 6 | AA/ MRN: 10672819DOB: 8/27/64 | 55 y/o male diagnosed on 5/2019 with sigmoid colon cancer with liver mets. He underwent a laparoscopic diverting loop colostomy 5/29/2019 and started chemo in early June 2019.  He received 6 cycles FOLFOX then was switched to Folfiri/Avastin due to Oxaliplatin reaction. A CT C/A/P was done on 12/2/19 which showed interval improvement in the hepatic lesions with no lesions identified. His CEA at diagnosis was 230 and on 12/11/2019 it was 84.3. He was previously discussed at the Multidisciplinary Colorectal Cancer Conference on 12/6/19 and the recommendation was to continue FOLFIRI/Avastin for six months.  CEA level which was 128 2/5/20 and a repeat CT C/A/P was ordered.  Presented at conference on 2/7/20,. Discussed intrahepatic chemo and a possible trial available at UPMC. Group did discuss y-90 but not an option due to the size of the hepatic mass. Also the group discussed oxaliplatin desensitization with FOLFOX.  Started Oxaliplatin desensitization on 2/13 with FOLFOX.  Had second cycle 2/27.  Tolerating well. Patient went to Johns Hopkins for second surgical opinion.  MRI abdomen ordered by Dr. Burns at JH done here on 3/4/20 showed:1. Interval increased size of multiple hepatic metastatic lesions when compared to the prior CT dated 01/27/2020 as above. 2. Stable size of multiple additional hepatic metastasis.3. Stable, necrotic periportal and additional subcentimeter lymph nodes.4. Stable splenomegaly. 5. Partially imaged sigmoid colonic wall thickening, could represent the known neoplasm. Dr. William Burns saw the patient on 3/5/20.  His recommendation states the he believes he is a good candidate for surgical intervention.  Would treat aggressively and would do 3 surgeries: wedge resection of segment III followed by f/u scan to evaluate vascular anatomy and restaging of the other liver lesions followed by PVE to hytrophy of L (normal) liver followed by extended R hepatectomy followed by resection of primary tumor.  Versus IR localized chemotherapy via liver infusion pump.  Considered primary resection with first surgery but was concerned it would compromise the hepatic procedure.  Less concerned about further mets from the colon so recommends treating liver before proceeding with his colon. .Advise holding chemo 4-5 weeks prior to surgery.Discuss surgical 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:

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Moderators: Alexander Kirichenko, MD /Dulabh Monga, MD /James McCormick, DO/Richard Fortunato, MD