

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, March 20, 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 | RS/ MRN: 680295  DOB: 5/10/71 | 48 y/o male with a newly diagnosed rectal cancer.  Colonoscopy 3/13/20 showed a 6 mm sessile sigmoid polyp (resection was complete, but the polyp tissue was not retrieved) and a fungating partially obstructing malignant mass in the distal rectum.  Biopsy revealed invasive adenocarcinoma in the rectum. TRUS done 3/16 showed tumor growth through the rectal wall invading the prostate capsule focally—T4N0. MRI done 3/16 identified a suspicious mesorectal lymph node –T3N1. Review scans and discuss treatment plan. | JM |
| 2 | DD/ MRN: 196027  DOB: 7/8/55 | 64 y/o female with a newly diagnosed moderately differentiated squamous cell cancer involving the anal canal extending into the distal rectum, T3 N1 MX.  MRI of the liver performed today evaluate for small liver lesions noted on staging CT.  I would like to review her MRI of the pelvis and path of possible and establish a consensus treatment plan. | TC |
| 3 | EB/ MRN: 4328941  DOB: 3/25/65 | 54 y/o male who initially presented WPH EDl with lower GI bleeding, was found to have a mass in the rectum.  Flexible sigmoidoscopy revealed a tumor in the mid rectum covering approximately 40% of right posterior circumference of the rectum, carpeted sessile polyp measuring approximately 5-6 cm extending upward from the 2nd valve.  Biopsies were obtained at that time revealed tubular adenoma.  MRI of the pelvis was performed and was borderline between T2 and T3 due to the motion artifact.  CT scan of the chest abdomen pelvis was negative.   CEA level was 3.9.  DRE and flex sig were performed on 2/11/20. Transrectal US was attempted but unable to be done due to patient discomfort.  Biopsies from flex sig again revealed a tubular adenoma.  Patient taken to OR on 2/12/20 for flex sigmoidoscopy with US under anesthesia. Patient presented at tumor conference on 2/14/20 and the group's consensus was surgical resection of the mass which will include removing the polyp. Treatment plan is dependent on surgical pathology.  Laparoscopic proctectomy with anastomosis and diverting loop ileostomy done on 3/5/20.  Review path and discuss treatment options | SN |
| 4 | FK/ MRN: 64355  DOB: 12/23/34 | 85 y/o male who originally present emergently to ED with pain thought to be possible diverticulitis vs appendicitis. Laparoscopic ilieocecectomy done by Dr Chung on 3/6/20 revealing a T3, N0 perforated cecal cancer (due to perforation) with a final distal resection margin of 3.2 cm.  Patient seen for follow up with Dr Fortunato on 3/18/20. Discuss path and treatment options. | RF |
| 5 | TC/ MRN: 5619287  DOB: 6/1/50 | He underwent colonoscopy on 03/11/20 that revealed a polypoid lesion at 10 cm from the anal verge with biopsy consistent with moderately-differentiated adenocarcinoma.  He subsequently underwent lower EUS on 03/18/20 that demonstrated a small ulcerated tumor in the mid rectum extending from 10-12 centimeters from the anal verge consistent with known adenocarcinoma. Sonographic examination demonstrated a 2.4 centimeter hypoechoic mass, with the majority of the tumor appeared to extend down to the muscularis propria layer; however, there was a small portion where the MP appeared disrupted suggesting an early T3 tumor.  One benign-appearing 3 millimeter lymph node in the perirectal space, suggesting N0 stage.  CT chest/abdomen/pelvis on 03/18/20 demonstrated no evidence of distant metastatic disease. We will arrange for MRI pelvis (with/without) to complete staging work-up as per NCCN guidelines.  We will plan to discuss his case in multidisciplinary manner at Colorectal Conference (either this Friday with AHN group or next Thursday with Jefferson group). If T3 disease then consider neo-adjuvant concurrent chemoradiation therapy (followed by surgery then chemotherapy) or clinical trial. | BT |
| 6 | DW/ MRN: 1012577  DOB: 2/24/57 | 63 y/o female diagnosed with clinical stage III (T1 vs T2N1) rectal cancer, rectosigmoid cancer, and multiple polyps on 10/18/19. She was discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 10/25/19 and genetic testing and neoadjuvant chemotherapy with FOLFOX were recommended followed by proctectomy.  Completed 8 cycles FOLFOX 2/18/20.  Had a laparoscopic robotic proctosigmoidectomy with diverting loop ileostomy on 3/16/20. Requesting NPARC path review. | JM |
| 7 | KT/ MRN: 301054  DOB: 9/20/46 | 73 y/o female diagnosed 5/21/19 with T3N2 CRM negative bulky rectal cancer.  S/P FOLFOX 8 cycles—7/12/19—11/1/19.  Chemo/radiation treatment 12/3/19-1/13/20.  Was evaluated 2/3/20 with flex sig which showed tumor was persistent and largely unchanged. Underwent laparoscopic robotic transabdominal transanal proctectomy with diverting loop ileostomy on 3/11/20. NAPRC path review requested. | JM |
| 8 | MA/ MRN: 885116  DOB: 4/19/66 | 53 y/o female diagnosed with T3N2M0 rectal cancer.  Discussed at colorectal conference on 8/30/19 with recommendation for TNT. Patient subsequently received 8 cycles FOLFOX 9/17/19-12/24/19, followed by concurrent chemo/radiation 1/6/20-2/7/20.  Saw Dr. Voth 3/12/20 for anoscopy which showed good response to treatment but still has residual tumor to proximal dentate line. Is planning for APR. Discuss surgery | MV |
| 9 | BZ/ MRN: 11851754 | 62 y/o male with newly diagnosed adenocarcinoma of the colon. He presented to Butler Memorial Hospital with neck, abdominal pain, and constipation. He was found to have axillary/subclavian left-sided DVT, and CT AP showed a 6.7 x 6.1 cm multicystic lobulated mass in the left upper quadrant, another mass 3.4 cm more medially, and retroperitoneal and left pelvic lymphadenopathy. He underwent CT guided biopsy of the LUQ mass, and pathology showed poorly differentiated adenocarcinoma with perineural invasion, CK7 negative, CK20 positive, CDX2 positive, consistent with GI primary. He was transferred here for a higher level of care. He underwent diagnostic laparoscopy, diverting loop transverse colostomy, flexible sigmoidoscopy, and port placement on 3/16/2020. Medical oncology and palliative on board. Review imaging and treatment planning. Pathology slides from OSH requested. | JM |
| 10 | MN/ MRN: 1504859  DOB: 11/20/52 | 67 y/o male with PMHX of bladder cancer (s/p TURBT and mitomycin C in September 2016) and prostate cancer (s/p prostectomy in December 2016) being seen for a transverse colon mass. He had a colonoscopy done on 1/30/2020 for rectal bleeding and a positive FIT test and was found to have polyps (4-7mm) in the rectosigmoid junction that were removed (tubulovillous adenoma) a 13 mm polyp in the rectosigmoid junction that was removed (tubulovillous adenoma), a 14 mm polyp in the sigmoid colon that was removed (tubulovillous adenoma), a 35 mm mass in the transverse colon that was biopsied and tattooed and was an invasive moderately differentiated adenocarcinoma, and a 15 mm polyp in the transverse colon that was removed. The 35 mm mass in the transverse colon was described as ulcerated and fungating and suggestive of malignancy.  Patient taken to the OR on 3/10/20 for robotic laparoscopic subtotal colectomy.  Review pathology from surgery. | 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