

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, March 6, 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 | DP/ MRN: 740259  DOB: 4/23/56 | 63 y/o male referred by Dr. Kanak for a malignant appearing rectal mass found on colonoscopy. The patient presented to Forbes ED on 3/1/20 with a complaint of 3 days of melena and constipation. He was discharged and underwent colonoscopy 3/3/20 by Dr. Kanak which revealed an infiltrative non-obstructing large mass in the rectum. The mass was non-circumferential and oozing was present. Biopsies are pending at this time.  He had CT C/A/P on 3/4/20 that showed no evidence of metastatic disease and asymmetric left rectal wall thickening suspicious for the mass seen on recent colonoscopy and a 4 mm right middle lobe pulmonary nodule that is probably an intrapulmonary lymph node.  MRI done on 3/5/20 and results are pending. Review path and scans and discuss treatment options. | JM |
| 2 | JL/ MRN: 10261406  DOB: 6/23/58 | 61 y/o male who presented to clinic on 2/25/20 to discuss the next step in management of his recently diagnosed malignant polyp within the rectum.  Patient underwent a diagnostic colonoscopy on 2/7/20 by Dr. Roseman, which this revealed a 15 mm polyp approximately 6 cm from the anus.  It is unclear if the removal was done in 1 piece or piecemeal as this was not specified in the endoscopy report.  Final pathology is consistent with intramucosal adenocarcinoma, resection margins are negative, no angiolymphatic invasion identified.  MSI stable.  CT CAP done at VA hospital. Review scans and discuss treatment options. | SN |
| 3 | CW/ MRN: 11601557  DOB: 9/23/58 | 61 y/o male presented initially with rectal bleeding and cachexia was diagnosed with metastatic mid to low rectal adenocarcinoma without primary symptoms.  Systemic and local workup in July 2019 (MRI p/ CT CAP) staged tumor as T3N2M2, multiple small metastases to both lobes of the liver and lungs bilaterally. Has been managed with preoperative chemotherapy, chemo radiation therapy, most recently completed radiation therapy on 1/30/20.  CEA on 2/20/20 was 5.3 which is up from 3.8 on 1/24/20.  Flex sig done on 2/25/20 shows primary tumor significantly reduced. Tumor is still present approximately 2 cm above the puborectalis, protuberant abdomen. CT on 1/26/20 states that previously noted hepatic metastases were not visualized.  No change to size of tiny pulmonary nodule in right lower lobe, however right upper lobe nodule has decreased in size.  Patient noted to have mega colon. Patient to receive 4 more cycles of FOLFOX from 2/26/20-4/9/20. Discuss surgical options. | SN |
| 4 | DR/ MRN: 11443083  DOB: 9/23/41 | 78 y/o male with clinical stage T3N2 CRM negative low rectal cancer. He was seen in consultation on 5/10/19 and at that time a flex-sig was done which revealed a tumor at the lower rectal valve.  He was then discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 5/17/19 and the group’s consensus was 8 cycles of Folfox followed by short course radiation followed by 1 additional dose of Folfox then surgery. He received 8 cycles of Folfox from 6/5/19-9/24/19 and then received long course radiation from 10/21-12/2/19.  He was advised that he needed Xeloda 3 weeks into receiving radiation however could not afford the co-pay and at that time had two weeks left of radiation and declined infusional 5-FU.  He underwent a laparoscopic robotic proctectomy with diverting loop ileostomy on 2/25/20. NAPRC path review | JM |
| 5 | MB/ MRN: 10598649  DOB: 6/9/62 | 57 y/o female with a history of endometrial cancer and clinical T3N1 rectal cancer.  She was presented at the Multidisciplinary Colorectal Cancer Conference on 10/25/19 and the group recommended FOLFOX with a flex sig Q 2 cycles to assess response.  If she did not respond, the group advised concurrent chemoradiotherapy following upfront chemo followed by surgery. She had 8 cycles of FOLFOX from Nov 2019-2/28/2020.   She was last seen in the office on 3/2/2020 where flex sig showed tumor demonstrating excellent response.  Discuss radiation options:  short course versus long course. | JM |
| 6 | KO/ MRN: 2770584  DOB: 1/27/50 | 70 y/o male diagnosed with T4bN2M1a metastatic rectal cancer in 2014.  S/P chemotherapy -10/23/14-1/28/16 followed by chemoradiotherapy 3/7/16-4/18/16.  Refused surgery and instead continued chemotherapy 5/26/16-5/23/18.  CT 5/21/19 showed recurrence of his primary tumor and recurrence of isolated solitary hepatic metastasis. He saw Dr. Kirichenko 6/6/19 who recommended ablative SBRT to his solitary hepatic metastasis.  He was restarted on Erbitux (cetuximab) and FOLFIRI 6/19/19.  CT C/A/P 8/19/19 that showed no evidence of thoracic metastatic disease, unchanged mild nonspecific pulmonary fibrosis, interval decrease in the size of the right lobe liver metastasis, consistent with partial treatment response, unchanged nonspecific thickening of the rectosigmoid, other chronic/incidental findings as above. He then underwent stereotactic radiation to the right lobe of the liver 9/9/19 – 9/16/19 x 4 treatments. Pelvic MRI 10/21/19 was read as T4bN0 CRM positive low rectal mass, with mass involving the anorectal junction, with involvement of the internal and external sphincters, the mass anteriorly invades the prostate and seminal vesicles; asymmetric urinary bladder wall thickening, as before, that is nonspecific and may be related to combination of cystitis/outflow tract obstruction and prior radiation. He saw Dr. Petursson on 11/14/19 and he wrote that he is not a candidate for radiation, he was advised not to proceed with chemotherapy at this point, and his best option was to proceed with surgery, as recommended by Dr. McCormick.  2/18/20 Dr. McCormick performed a laparoscopic robotic pelvic exenteration including abdominal perineal resection of the rectum, resection of the urinary bladder prostate seminal vesicles and bilateral distal ureters.  Left iliac chain lymph node dissection. Left ureterolysis. Harvest of portion of ileum for conduit with primary ileal to ileal anastomosis. Creation of end colostomy.  Maturation of leoconduit.  The ureteral ileal anastomosis was created by Dr. Cohen/Vemana.  A pelvic reconstruction was performed by Dr. Kang**.** Requesting NAPRC path review. | JM |
| 7 | LM/ MRN: 11812119  DOB: 9/3/37 | 82 y/o female who was referred after a colonoscopy was performed on 12/18/19 showing an endoscopically unresectable cecal mass x 2, endoscopically unresectable proximal ascending colon mass x 1, and a large left lateral mid-rectal mass x 1 at 7 centimeters from the anorectal junction.  Pathology revealed the rectal mass to be a tubulovillous adenoma with focal high grade dysplasia.  All other masses were benign.   CT CAP and MRI done on 1/10/20 with MRI reporting no convincing evidence of a rectal mass.  Questionable polyp versus retained stool in mid rectum.  If treated as a rectal mass, this would be a T1 or T2 N0 CRM negative lesion.  Patient discussed at tumor conference on 1/24/20 and the group consensus was to proceed with transanal excision which was done on 2/26/20.  Review pathology and discuss treatment options. | RF |
| 8 | VC/ MRN: 975915  DOB: 7/15/56 | 63 y/o male referred by Dr. Gary Johnson for a newly diagnosed sigmoid colon mass. He was found to have a positive FIT test which prompted colonoscopy 2/28/2020 by Dr. Ayasso that revealed a fungating non-obstructing large mass in the sigmoid colon. The mass was non-circumferential and measured 7 cm in length. Biopsies revealed invasive moderately differentiated adenocarcinoma.  CEA is pending and CT C/A/P showed focal sigmoid colonic wall thickening that likely corresponds to neoplasm seen on colonoscopy.  Extensive peritoneal carcinomatosis.  Hypodense liver lesion favored to represent cysts or metastases.  Review scans and pathology and discuss treatment options. | 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