

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, April 17, 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 | PP/MRN: 11855687DOB: 11/7/49 | 70 y/o female with a newly diagnosed low rectal cancer. She underwent a colonoscopy on 3/24/2020 by Dr. DeJesus for the anemia and on DRE was found to have a firm rectal mass palpated 0-1 cm from the anal verge.  Colonoscopy revealed an 8 mm polyp in the ascending colon that was sessile and an ulcerated non-obstructing large mass found in the rectum that was partially circumferential (involving ½ of the lumen circumference) and was biopsied and came back as invasive adenocarcinoma, arising from a tubular adenoma with high-grade dysplasia.  CT done at outside hospital on 3/21/20.  MRI Pelvis done 4/14/20 revealed T3 N1 CRM positive low rectal cancer with tumor signal abutment of the left levator. Review scans and discuss treatment plan. | JM |
| 2 | SS/MRN: 11674335DOB: 8/9/67 | 52 y/o male with clinical stage T4N2 CRM positive rectal cancer. He was taken to the OR for a rectal EUA in August 2019, and a friable mass was found approximately 9 cm from the anal verge and biopsied which revealed invasive adenocarcinoma. MRI pelvis was done and revealed extension to the dentate line and involving the left external sphincter. A CT C/A/P was done and showed a hepatic dome lesion suspicious for liver metastases. He was discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 8/23/2019 and the group recommended FOLFOX followed by chemoradiotherapy. He started FOLFOX on 9/3/2019 and completed chemotherapy on 12/10/2019. He then started concurrent chemoradiotherapy (with Xeloda) on 1/6/2020 and completed treatment on 2/13/2020. He received 3 weeks of extended Xeloda, completed on March 6th.  Laparoscopic robotic APR completed on 4/7/20.  NAPRC path review. | JM |
| 3 | GL/MRN: 780224DOB: 11/1/41 | 78 y/o male with stage IV rectal cancer (T3cN0M1 with CRM involvement and metastatic to inguinal node).   Discussed at the Multidisciplinary Colorectal Cancer Conference 8/9/19 and the plan was to enroll him in the FR2 trial, do FOLFOX followed by IMRT chemo/radiotherapy, restage, and potentially proceed with resection of the primary tumor.  Chemotherapy started 8/27/19.  Had 3 cycles, with some delays.   Flex sig 10/21/19-- tumor in the upper rectum now not able to be traversed-- friable with a large luminal component.    Again discussed at the MDCCC 10/25/19 and the group recommended proceeding with chemo/radiation followed by surgery.  Not eligible for the FR2 trial due to chronic osteomyelitis requiring Bactrim for management.  Completed chemo/radiation 12/23/19. Flex sig done  1/20/20 showed a mass in the mid to upper rectum that demonstrated good response to therapy.   The group consensus on 1/24/20 was to proceed with Total Mesorectal Excision followed by tumor profiling/adjuvant chemotherapy.  Clearance for surgery determined that patient had severe LV dysfunction –EF 30-40%.   Underwent heart cath on 2/20, flex sig with stent placement on 2/24, and PCI for RCA stenosis and stent placement on 3/3.  Patient underwent laparoscopic robotic proctectomy with diverting loop ileostomy on 4/8. Requesting NAPRC path review.  | JM |
| 4 | CB/MRN: 11809535DOB: 11/27/85 | 34 y/o female with T3N2M0 rectal cancer.  She was presented at Multidisciplinary Colorectal Cancer Conference on 12/20/19 with recommendation for TNT-- FOLFOX x 8 cycles and restage with MRI to assess CRM status.  Started FOLFOX 1/13/20 at a facility close to her home.  Received cycle7 FOLFOX 4/8.  Had flex sig 4/13 which showed excellent clinical response to chemo. MRI pelvis 4/13.  Scheduled for cycle 8 next week. Review MRI and discuss treatment options. | JM |
| 5 | MW/MRN: 11742301DOB: 04/28/1965 | 54 y/o male with metastatic rectal adenocarcinoma (mismatch repair proficient) diagnosed initially in 10/19. Underwent staging CT TAP significant for mass within upper rectum, 2 liver lesions, along with destructive lesion within right hemi sacrum consistent with metastatic disease, along with mesorectal lymphadenopathy. He was staged as St. IVB (T3N2M1) at that time. Given his initial presentation with significant sacral pain, he was initiated on radiation with concurrent capecitabine (radiosensitizer) and completed 15/21 fractions 200 cGY (3000/5000 cGy prescribed). However, he was noted to have worsening liver metastatic disease, and treatment was then changed to systemic mFOLFOX + Bevacizumab (C1 12/06/19), and has completed 9/12 planned cycles (C9 4/9/20). He has tolerated treatment well, and has demonstrated response in his CEA. He has also undergone tumor profiling, no targetable mutations identified. He underwent restaging CT TAP on 4/9, significant with disease response. We wanted to discuss surgical candidacy for resection of metastasis and primary lesion + management of sacral lesion. | SS |
| 6 | MT/MRN: 97316DOB: 8/13/72 | 47 y/o female with FAP TAC end ileostomy with retained rectal stump no survey due to stricture. She has had a whipple for duodenal polyps. Has active Hep c and is not currently on therapy. She has cystic masses in her pelvis likely ovarian tumor. Chronic pain seeker and does not keep appts, not compliant.  She is an active smoker and unable to quit. Reporting abdominal pain poss from hernia. CT done on 4/11/20. Review scan and discuss management options.   | SN |
| 7 | BL/MRN: 46824DOB: 12/2/59 | 60 y/o male with ESRD on HD 2/2 type 1 diabetes, metastatic sigmoid adenocarcinoma with multiple unresectable liver metastases diagnosed on 2/3/2020 with genetics showing MMR intact, KRAS mutation of exon 3 and PDL 1 of 0%.  He is now s/p 3 cycles of first line mFOLFOX with repeat imaging showing progression of liver metastases.  ECOG status has also declined to 2.  Review scans and discuss options | KM |
| 8 | JT/MRN: 11457552DOB: 1/22/83 | 37 y/o female that had a hysterectomy on 1/6/20 at Westmoreland Hospital for endometriosis.   Path showed microscopic focus of carcinoid tumor, likely secondary.  Saw Dr. Munns for consult—recommended upper and lower endoscopy and also referred to med onc.  Saw Dr. Idrees 2/17.  CT C/A/P on showed no evidence of mets.  Saw Dr. Bradley on 3/3 –PET scan ordered. Showed a moderately gallium avid soft tissue density along/abutting the medial aspect of the cecum, is suspicious for somatostatin receptor positive lesion. Terminal ileum appears to enter the cecum anterior to the aforementioned soft tissue density. Mildly gallium avid non-enlarged mesenteric lymph node anterolateral to the right common iliac artery, is suspicious for metastatic disease.  Mass at the appendiceal orifice consistent with a carcinoid tumor of the appendix.  Colonoscopy done 3/23 showed submucosal non-obstructing mass at the appendiceal orifice consistent with a carcinoid tumor of the appendix.  EGD—small hiatal hernia.  Chromogranin A and urinary 5HIAA ordered.   Recommended right colectomy which was done 4/8/20. Review path.  Discuss treatment. | JM |
| 9 | JM/MRN: 352689DOB: 11/26/37 | 82 y/o male with a history of malignant melanoma of the right lower leg diagnosed on 10/17/2013.  He developed rectal bleeding with drop in his hemoglobin in late 2019.   He was transferred to West Penn Hospital on 12/11/2019 and on 12/13/2019 he underwent a colonoscopic exam revealing mid rectal fungating and ulcerating mass that was obstructing and partially circumferential.  The pathology report was consistent with well-differentiated invasive adenocarcinoma with negative MMR.  CT scan from 12/14/2019 was negative for metastatic disease.  CEA level from 12/15/2019 was 1.5. He had a pelvic MRI on 12/18/19 and this reportedly revealed a mid-rectal mass measuring 2.1 cm and 9 cm from the anal verge and 6.5 cm from the top of the anal sphincter.  There is some infiltration into the mesocolon fat at the level of the tumor while could be due to motion, edema or tumor infiltration making him clinically T2 versus T3 with negative CRM.   He was seen by Dr. Barsouk on 12/31/2019 and a PET-CT scan on 01/08/2020 was done and reportedly revealed a large markedly FDG avid focus seen along the base of the tongue measuring 5.3 cm with SUV of 11.1 and FDG avid lesion with maximum of SUV 7.8 seen within the rectum correlating with the rectal malignancy with no suspicious hypermetabolic osseous lesions or adenopathy. Patient saw Dr. Arshoun on 1/9/20 for his rectal cancer and recommended concurrent chemo/radiation therapy. Patient discussed at tumor conference on 1/17/20 and the group's consensus is that he follow-up with ENT as the tongue lesion is going to be more problematic in the short term.  Dr. Bernat at ACMH did biopsy of tongue lesion on 1/30/20 which was positive for invasive squamous cell carcinoma HPV 16 positive. Patient underwent radiation to the rectum form January 28- March 19.  He also began chemotherapy for his head and neck cancer as well with Erbitux on 2/9/20 however did not complete it due to admission from February 19-March 2nd and it was put on hold. Review scans and discuss treatment options. | RF |
| 10 | RB/MRN: 429462DOB: 9/16/45 | 74 y/o male who presented with a positive colo guard test - July 2019.  Colonoscopy to the splenic flexure in July of 2019 identified no masses but was unable to be advanced due to tortuosity.  Barium enema at that time identified contrast to the transverse colon with stool and no obvious mass. Patient underwent a virtual colonoscopy in December of 2019 that identified no obvious mass lesions, but did identify less than optimal evaluation of the sigmoid colon. He was scheduled for a colonoscopy on March 30, 2020 - but due to the Covid-19 pandemic he cancelled. CT scan demonstrated calcification of his celiac and superior mesenteric arteries and bilateral renal arteries.  He saw vascular surgery and there is concern of intestinal angina. In addition, he saw his pulmonologist for the new pulmonary nodule and states that he is recommended for follow-up CT of the chest in 6 months.  CEA - 1.7—9/17/19. Review scans and discuss treatment options. | RF |
| 11 | DH/MRN: 11609040DOB: 6/21/53 | 66 y/o female who presented to the ED on 6/13/19 with symptomatic anemia.  Colonoscopy planned but aborted. CT done on 6/18/19 showed lesion in liver suspicious for metastatic disease. Exploratory lap with TAH BSO and large bowel resection with anastomosis done on 6/21/19 by Dr. Krivak which revealed a moderately differentiated adenocarcinoma of the cecum/ileocecal valve with lymphovascular invasion present with focus less than 1 mm from mesenteric margin. LN 1/14 positive. Bladder peritoneum positive for involvement by adenocarcinoma.  Staged as T4bN1.  PET scan completed on 8/7/19 showed hypermetabolic activity at the right colonic anastomosis and adjacent mesentery, suspicious for tumor involvement, as well as 2 hypermetabolic suspicious lesions in the liver.  MRI liver done on 8/20/19 confirmed metastases.  Patient underwent chemotherapy with FOLFOX from 9/10/19-1/6/20.  CT on 1/3/20 showed stable liver lesion with new malignancy at bladder dome.  Began FOLFIRI on 1/14/20 and is on it currently. CT done on 4/3/20. Review scans and discuss surgical options. | SN |

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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