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**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, May 1, 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

Password: 921147

**Cases to be discussed**

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| **Case** | **De-identified patient** | **Reason** | **Presenter** |
| 1 | NM/MRN: 609305  DOB: 10/4/40 | 80 y/o male admitted 4/24 for a bleeding rectal mass.  Had just started on Xarelto for his atrial fib.  Had previously been on aspirin and Plavix.   Colonoscopy done 4/26 by Dr. Kanakamedala found an infiltrating, non-obstructing medium-sized mass in the proximal rectum. The mass was non-circumferential. The mass measured three cm in length. Oozing was present. Biopsy result-- invasive moderately differentiated adenocarcinoma India ink injected proximal and distal to the growth for marking. CEA on 4/26 was 2.4.  CT C/A/P showed left posterior rectal wall thickening and a 5 mm LLL pulmonary nodule, but otherwise no metastatic disease.   Patient has an LV pacer/ICD that is not MRI conditional and the ultrasound is out of service so unable to determine local staging.  Dr. McCormick discussed this with Dr. Kanakamedala and it was indicated it was a rectosigmoid mass.    Given the bleeding, patient’s age, and it was believed to be a rectosigmoid mass that was not locally advanced, decision made to proceed with LAR. Discuss patient. Review path next week. | JM |
| 2 | JL/MRN: 796035  DOB: 7/29/66 | 53 y/o male seen for a newly diagnosed rectal cancer. He initially presented to an OSH ER on 2/16/2020 for rectal bleeding. A CT scan was done and revealed circumferential wall thickening within the mid rectum for length of approximately 5 cm from anorectal junction; mildly enlarged, at least 8 sub-centimeter mesorectal fascia lymph nodes. He then had a colonoscopy done on 2/26/2020 by Dr. Brown which showed a fungating and ulcerated partially obstructing large mass found in the mid-rectum. The mass was circumferential and measured 7 cm in length with oozing present. It was biopsied and came back as invasive moderately differentiated colonic adenocarcinoma. MRI Pelvis done on 2/27/2020 showed irregular circumferential enhancing mass in the high and mid rectum extending a length of 8 cm in the craniocaudal dimension. It was staged as T4aN2 with involvement of the right mesorectal fascia and peritoneal reflection. CT chest with contrast revealed multiple small bilateral soft tissue pulmonary nodules with the largest measuring 5mm in the LLL most likely representing noncalcified granuloma. Flex sig done 4/28/20 by Dr McCormick. Review scans and discuss treatment options. | JM |
| 3 | AC/MRN: 5619287  DOB: 6/1/50 | 69 y/o male with T2 vs early T3 N0 rectal cancer. He underwent a colonoscopy on 3/11/2020 by Dr. Kumar and was found to have a polypoid lesion at 10 cm from the anal verge that was biopsied and came back as fragments of adenocarcinoma, moderately differentiated. MRI of Pelvis revealed T2 vs early T3 lesion. CT C/A/P revealed a stable 3 mm pulmonary nodule. CEA was done and came back at 10.5. A flexible EUS was done by Dr. Bridger Clarke and revealed a small ulcerated tumor in the mid rectum extending from 10-12 cm from the anal verge consistent with known adenocarcinoma. The majority of the tumor appeared to extend down to the muscularis propria layer. There was a small portion where the MP appeared disrupted suggesting an early T3 tumor.  Patient was presented at tumor conference by Dr Thomas on 3/27/20 and consensus at that time was to get a TRUS by Dr McCormick which was done on 3/31/20. Review pathology and TRUS and discuss treatment options. | JM |
| 4 | CB/MRN: 4479402  DOB: 10/12/62 | 57 y/o female with history of Stage IIB (pT4a pN0 cM0) perforated rectal cancer that underwent open low anterior resection on 9/23/19 with tumor specific mesorectal excision, left oophorectomy, and intraoperative fiducial marker placement.  Final pathology demonstrated invasive moderately differentiated adenocarcinoma involving the proximal rectum with perforation, clinically consistent with perforation into the left pelvic sidewall as visualized at the time of her resection.  All resection margins were negative for carcinoma.  No lymphovascular invasion was identified, however she did have perineural invasion.  0 of 18 nodes were positive for carcinoma.   Her case was reviewed at multidisciplinary colorectal Oncology Conference on September 27, 2019.  It was recommended that she proceed with a TNT approach with 8 cycles of FOLFOX followed by chemoradiation.  It was suggested that she may benefit from pelvic exclusion in the interim between completing chemotherapy and commencing chemo radiation. She received 12 cycles FOLFOX 10/31/19-4/16/20. CT C/A/P done 4/23/20 showed no evidence of metastatic disease. Review imaging and discuss need for chemo/radiation to left pelvic sidewall and possible pelvic exclusion surgery. | AR |
| 5 | FT/MRN: 10773744  DOB: 4/6/50 | 70 y/o male discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 2/14/20.   History stage III rectosigmoid cancer and dysplastic cecal polyp.  He underwent short course radiation 10/1/18 – 10/5/18 followed Laparoscopic Robotic Low Anterior Resection 10/10/18 (T3N2a moderately differentiated adenocarcinoma) followed by adjuvant chemotherapy with FOLFOX x 12 cycles from 11/8/18 – 5/10/19 and Loop ileostomy takedown 6/13/19.  He then underwent a Laparoscopic Robotic Right Colectomy 10/21/19 and pathology revealed a tubulovillous adenoma with focal high grade dysplasia.   CEA 2/3/20 8.5----16.3 on 3/5/20.   CT C/A/P on 1/27/20 showed a new 5 mm right hepatic dome lesion.    Plan was to repeat CT in 3 months.  CT repeated 4/27  shows large hypodensity seen in the right hepatic dome best seen on series 5, image 1 measuring 3.8 x 2.9 cm this lesion has increased in size/new from prior examination. In the medial aspect of segment 6/7 (series 5, image 23) measuring 1.6 x 1.0 cm and previously 1.0 x 0.8 cm  .Additional parenchymal and peribiliary cysts are noted. Review scans and discuss treatment. | NA |
| 6 | MS/MRN: 11744095  DOB: 7/2/80 | 39 y/o male that is s/p open subtotal abdominal colectomy with ileo-distal sigmoid anastomosis with omental patch to the anastomosis on 4/10/2020 for descending colon tumor. Intraoperative findings included a LBO with extremely dilated colon caused by tumor. Surgical pathology revealed T3N0 moderately differentiated adenocarcinoma with 41 negative lymph nodes. There was perineural invasion present. MSI testing came back intact. CT reveals mass in the inferior right hepatic lobe. Review scans and pathology and discuss treatment options. | JM |
| 7 | BP/MRN: 1061006  DOB: 9/2/44 | 75 y/o female that initially had a laparoscopic robotic SILS right colectomy with liver biopsy on 3/30/16. Pathology revealed a T3N0 invasive moderately to poorly differentiated adenocarcinoma with 23 negative LNs. The liver biopsy negative for metastatic carcinoma. Treated with FOLFOX x 12 cycles completed 10/27/16 by Dr. Mayernik (his note said she was offered this because of the poorly differentiated cells with a rate of recurrence of 25% and she accepted). She had PET/CT, ordered due to findings on CT C/A/P, 12/26/19 that showed an FDG avid mesenteric lymph node, likely metastatic, prompting Laparoscopic Robotic Excision of Mesenteric Mass on 1/15/20.  Intraoperative findings included a nodule noted at the SMA just distal to the lower edge of the pancreas, consistent with imaging, and some peritoneal abnormalities the level of the transverse mesocolon base which were most suspicious for scar but were biopsied to exclude carcinomatosis.  Pathology of the SMA node was read as fibroadipose tissue, negative for metastatic carcinoma, and the peritoneal nodule at base of transverse mesocolon was a reactive appearing lymph node, negative for metastatic carcinoma.  Plan was to repeat PET/CT in 3 months from prior which she had on 3/24/20 (results as above). Repeat PET/CT scan from 3/24/20 showed redemonstration of a 1.2 cm mesenteric node, 11.2 SUV (previously 7.6 SUV) so she was scheduled for exploratory laparotomy with excisional biopsy of mesenteric lymph node on 4/9/20.  Pathology revealed metastatic moderately differentiated adenocarcinoma, consistent with colorectal primary. Discuss options for treatment. | JM |
| 8 | CK/MRN: 855583  DOB: 7/7/58 | 61 y/o male who had a colonoscopy on 10/2/19 by Dr. Abdul-Baki that showed numerous (23 total) colonic polyps that were removed, one in the cecum removed via EMR, that were benign (tubular adenomas and hyperplastic polyps). He was advised to have repeat colonoscopy in 3-6 months. He had an abnormal abdominal CT scan 3/2/20 when he was seen by vascular surgery for peripheral vascular disease. He was also having intermittent abdominal pain and was sent for an abdominopelvic CT angiogram. This showed diffuse omental/mesenteric infiltration, new from the prior exam, and suspicious for a neoplastic process. There was also focal asymmetric fat stranding about the sigmoid (recommended colonoscopy), urinary bladder mural thickening (chronic outlet obstruction vs. cystitis), and a right pelvic mesenteric node seen on series 6, image 319 measuring up to 1.5 cm. Additionally, there are prominent but not pathologically enlarged portacaval nodes as well as numerous not enlarged periaortic, retroperitoneal and iliac nodes. EGD and colonoscopy on 4/1 did not reveal any malignancy—3 tubular adenomas.  Eval of the bladder by urology on 3/27 –per the patient “did not find anything”.  We do not have a note. He had an elevated CEA of 6.7 on 3/13/2020. (Every day smoker.)  CT chest/abdomen/pelvis 3/23- 1. Omental infiltration which is most extensive in the pelvis is strongly suspicious for peritoneal carcinomatosis. 2. Either appendiceal wall thickening or distal sigmoid colonic wall thickening could represent the primary site of tumor but also could represent involvement with serosal metastases. Dr.McCormick did a diagnostic laparoscopy on 4/20- OMENTUM AND MIDLINE PERITONEUM, BIOPSY: METASTATIC POORLY DIFFERENTIATED MUCINOUS ADENOCARCINOMA WITH SIGNET RING CELLS**.**  Review scans and path.  Discuss treatment recommendations. | JM |
| 9 | RK/MRN: 115588  DOB: 9/11/43 | 76 y/o female who is s/p exploratory laparotomy, LOA, takedown of enterocolonic fistula (Indiana pouch), right colectomy (include Indiana pouch and distal aspects of both ureters), small bowel resection for secondary tumor, separate and distinct, excision biopsy with frozen section of small bowel mesenteric mass of frozen section, harvesting and maturation of small bowel conduit for urinary reconstruction (Dr. Bagga implanted the ureters), creation of jejunal-colonic anastomosis, bilateral ureterolysis, bilateral myofascial release for sepation of components, repair of complex abdominal wall defect on 4/3/2020 for enterovesical fistula. Surgical pathology revealed T4b, N2b, MX invasive poorly differentiated adenocarcinoma with 7/41 lymph nodes positive, no lymphovascular invasion. Pathology of the fistula revealed invasive adenocarcinoma; small bowel mesenteric lymph node came back as metastatic adenocarcinoma, intestinal type with prominent mucin. Pathology of small bowel resection came back as portion of small bowel involved by poorly differentiated adenocarcinoma of the colon with 5/14 lymph nodes positive. MSI testing came back intact. Wound re-opened and patient re admitted on 4/25/20. Review scans and pathology and discuss treatment options. | JM |
| 10 | LS/MRN: 624948  DOB: 2/18/49 | 71 y/o female with ascending colonic mass found in colonoscopy in 5/2018. PET/CT showed bulky cecal and colonic mass with extension into the bladder with peritoneal carcinomatosis and mesenteric adenopathy. Baseline CEA was 83.8. Started on FOLFIRI/Avastin with good partial response. Continued until 3/14/19 when she received 11 fractions of palliative radiation to pelvic lesions, as distant metastatic disease was stable. Resumed FOLFIRI/Avastin in April of 2019. PET scans in April and August of 2019 showed stable or improved disease with non-specific RLL lung nodules seen in the August scan. Continued FOLFIRI/Avastin until 1/17/20 when she underwent a right hemicolectomy and right oophorectomy. PET Scan on 3/10/20 showed right hydronephrosis and the patient then had a ureteral stent placed at Shadyside. Follow-up CT scan completed on 4/24/20. The plan is to resume FOLFIRI/Avastin after imaging review. Review of most recent CT scan completed on 4/24/20. | MI |

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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.

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