

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, May 15, 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 | MC/MRN: 10204802DOB: 11/26/41 | 78 y/o female initially presented early in 2019 with new diagnosis of a rectosigmoid cancer.  After presenting her case at multidisciplinary meeting on August 2, 2019, there were concerns for locally advanced intercepted tumor N 2 on the MRI, so the group recommended proceeding with preoperative systemic chemotherapy followed by chemo radiation therapy. She had 8 cycles of FOLFOX which she completed in December 2019 and then went on to complete radiation in February 2020.  She underwent a Robotic laparoscopic proctectomy with diverting loop ileostomy and coloanal anastomosis on 5/7/20. NAPRC path review | SN |
| 2 | RH/MRN: 807747DOB: 2/2/58 | 61 y/o male with T2 N1 mid rectal adenocarcinoma status post TNT chemo radiotherapy with complete response since 12/19.  Patient has a synchronous right renal lesion for which he saw Dr Chaudry on 4/17/20.  He felt it should be treated by either a partial nephrectomy or potentially cryotherapy. Patient was noted to a liver metastases located to the segment 7 although this demonstrated no uptake on the PET scan on 4/10/20.  He will begin SBRT to lesion this month with Dr Wegner. Patient has no evidence of residual tumor within the rectum on flexible endoscopy by Dr Nosik.  Review scans if available and discuss treatment plan. | SN |
| 3 | EB/MRN: 10355386 | 57 y/o female with well to moderate differentiated adenocarcinoma of the ceceum with right lateral pelvic side wall and posterior bladder invasion, s/p right hemicolectomy with partial cystectomy 4/11/2020 , pT4bN1bMx, 2/39 positive lymph nodes, positive margin at right lateral pelvic side wall, systemic staging pending.  | RB |
| 4 | WH/MRN: 88205 | 81 y/o male with history of stage IIa adenocarcinoma now status post SILS extended right colectomy in March 2019. Pathology showed pT3 pN0 disease, negative margins, 0/15 lymph nodes; MLH1, MSH2, MSH6, and PMS2 intact. Colonoscopy on 3/4/2020 showed a new tubulovillous adenoma in the transverse colon just distal to his previous anastomosis. Patient underwent EMR partial polypectomy on 4/21/2020 by Dr. Kulkarni, and biopsy showed moderately differentiated invasive adenocarcinoma arising from a tubulovillous adenoma with high grade dysplasia. He presented to the emergency department on 4/28 with lower GI bleed one week later. He underwent single incision laparoscopic left colectomy on 4/29/2020, and pathology of the ileocolic anastomosis with transverse colon showed few microscopic foci of invasive moderately differentiated adenocarcinoma with focal mucinous features, 0/12 lymph nodes, benign omental tissue, pathologic stage pT2 pN0. Discuss pathology and treatment options. | RF |
| 5 | DR/MRN: 5338269DOB: 5/21/68 | 51 y/o male with family history of colon cancer. Patient seen by Dr.Suwan who performed a colonoscopy on 4/30/20, for change in bowel habits, rectal bleeding and family history of colorectal cancer.  Colonoscopy to the cecum identified a normal colon with mild diverticulosis; however there is a large palpable distal rectal mass.  This was circumferential, friable and biopsies demonstrated moderately poorly differentiated adenocarcinoma.  Micro satellite instability was intact. CT scan of his chest abdomen pelvis demonstrated no evidence of distant metastatic disease, there was significant adenopathy in the pelvis as well as thickened rectal mass in the distal rectum.  Pelvic MRI was performed at Allegheny General Hospital on May 13, 2020 demonstrating T3, N2 disease with likely positive CRM of the pelvic sidewall and left lateral external sphincter.  Both flex sig and rectal US done in office on 5/13/20. Review scans and discuss treatment options. | RF |
| 6 | PJ/MRN: 10329510DOB: 8/8/49 | 70 y/o male had a screening colonoscopy 8/28/19 that showed an 8 cm fungating partially obstructing sigmoid mass.  Laparoscopic robotic low anterior resection on 9/30/19.  Path showed invasive signet ring cell carcinoma with extensive lymphovascular and perineural invasion. Margins negative.   10/27 lymph nodes positive for metastatic carcinoma—pT4a pN2b.  Started FOLFOX 10/25/19.  Oxaliplatin discontinued after cycle 3 due to side effects.  Continued with 5FU for the remaining 9 cycles, completing cycle 12 adjuvant chemo 4/9/20. CEA level has been within normal range.  Had ct scan 5/8/20. Review scan.  | 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:

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:

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny General Hospital, presenters must disclose all relevant financial relationships, which in the context of their presentation(s), could be perceived as a real or apparent conflict of interest, (e.g., ownership of stock, honoraria or consulting fees). Any identifiable conflicts will be resolved prior to the activity. Any such relationships will be disclosed to the learner prior to the presentation(s).  The speakers have nothing to disclose.

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