

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, May 22, 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 | BL/MRN: 776475 | 34 y/o male with newly diagnosed invasive rectal adenocarcinoma. Patient has a history of fall causing paraplegia. Patient was admitted to FRH on 5/8/2020 with concerns for sepsis secondary to an indwelling Foley catheter. CT chest abdomen pelvis on admission showed circumferential mural thickening of the rectum with perirectal and presacral fat stranding induration with several enlarged perirectal lymph nodes. Colonoscopy on 5/12/2020 by Dr. Gottfried showed a rectal mass on perianal exam, malignant appearing tumor in the rectum, and malignant appearing tumor in the colon. Biopsy of the rectal mass revealed invasive moderately differentiated adenocarcinoma. Denies family history of colorectal cancer. MRI pelvis scheduled for 5/14/2020. CEA pending. Requesting imaging review of CT, MRI pelvis and discuss treatment planning. | AR |
| 2 | MC/MRN: 891309DOB: 2/1/68 | 52 y/o male with newly diagnosed distal rectal carcinoma.  Biopsy was positive for adenocarcinoma.  He was being worked up for rectal bleeding and anorectal discomfort.  He underwent colonoscopy and wash in hospital by Dr. Panicco where an ulcerated tumor was found just proximal to the dentate line.  A 2nd lesion was found in the transverse colon which was removed with snare and found to be tubulovillous adenoma.  He denies a family history of colon cancer.  Was diagnosed with a renal infarct and had been seeing Dr Sanjeevi for this.  Etiology was not determined.  Had CT a/p at OSH on 5/12/20.  CT chest and pelvic MRI on 5/15.  CEA on 5/18—2.2. Review scans and discuss treatment. | MV |
| 3 | KS/MRN: 10726890DOB: 12/5/00 | 19 y/o male with newly diagnosed metastatic poorly differentiated adenocarcinoma. Possible sigmoid primary. Admitted 5/14 to FRH. Complaints of 2-3 months crampy abdominal pain, bloating, diarrhea, weight loss 26 lbs. despite eating. Never noticed bleeding.Found to have anemia and partially obstructing sigmoid mass on CT scan as well as a right sided colonic mesenteric mass. Initial concern for possible lymphoma. 5/15 received 1 prbc on Hb 6.8. 5/16 flex sig and biopsy by Dr. Gottfried. Unable to traverse mass. 5/18 port placement. 5/19 pathology resulted poorly differentiated adenocarcinoma as of now. Passing gas and soft stool. Eating regular diet. Review imaging and pathology, discuss treatment plan. | JM |
| 4 | RB/MRN: 3728217DOB: 9/2/61 | 58 y/o male with PMHx significant for T2 urothelial carcinoma of the bladder (s/p emergent open cystoprostatectomy and ileal conduit from a TURP in 8/2019 followed by adjuvant chemo) who was seen for a newly diagnosed rectosigmoid cancer. He has been following closely with Dr. Miske and had a PET/CT on 4/13/2020 to follow-up on bladder cancer, RUL pulmonary nodules, and possible liver metastases which showed no evidence of pulmonary metastases, liver activity to be mildly heterogeneous but no focal space-occupying lesions demonstrated, and increased metabolic activity in the upper rectum where there is wall thickening suspicious for rectal neoplasm. A colonoscopy was done on 4/28/2020 which showed diverticulosis and a likely malignant partially obstructing tumor in the proximal rectum that was biopsied and came back as moderately poorly differentiated invasive adenocarcinoma with focal ulceration and necrosis. MSI testing revealed no loss of expression. Review scans and discuss treatment options. | JM |
| 5 | CW/MRN: 11601557DOB: 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. Discussed at tumor conference on 3/6/20 and the group's consensus was surgical resection of the primary tumor one month after completing chemotherapy while preserving the left colon and anal sphincter if possible. 4 additional cycles of chemo given prior to surgery, which was completed on 4/23/20.Surgery scheduled for 6/4/20.  Discuss surgery and treatment options. | SN |
| 6 | JK/MRN: 11741927DOB: 7/6/61 | 58 y/o male with clinical T2 vs T3 N0 low rectal cancer. He was seen in consultation on 10/25/2019 and at that time DRE revealed a palpable mass at the tip of the finger anteriorly. Mass in the distal rectum occupied 40% of the circumference and was 4 cm in size with central ulceration and heaped up edges. He was discussed at the Multidisciplinary Colorectal Cancer Conference on 11/8/2019 and the group’s consensus was chemoradiotherapy followed by transanal excision. He completed 8 cycles of FOLFOX and then was seen on 1/10/2020 at which time DRE revealed a nodularity anteriorly just above the dentate line, much smaller than prior. Endoscopy exam revealed a tumor which was attenuated demonstrating a good response. He then went on to receive chemoradiotherapy which was completed on 4/17/2020. Flex sig with biopsy done on 5/15/20 and pathology was benign. Review pathology and scans.  Discuss treatment options. | JM |
| 7 | MP/MRN: 708230DOB: 3/13/63 | 57 y/o male with hx of clinical stage T4bN2aM0 rectal cancer s/p neoadjuvant chemoradiotherapy ending in March 2017. He had a complicated surgical history which included laparoscopic robotic converted to open APR with prostatoseminovesiculectomy (Dr. Miller) on 5/24/2017.  Skin graft by for a non-healing abdominal wound. Multiple abdominal washouts for pelvic evisceration of his bowels and foul smell drainage. On 6/7/2017 had abdominal washout and debridement, ostomy revision, and creation of loop ileostomy. Then ileostomy takedown on 10/12/17. He was last seen by Dr. Voth on 5/14/2018 and was advised to follow-up with Urology.  He's been following closely with Dr. Miller of Med-Oncology and had a CT C/A/P on 1/14/2020 which showed a stable irregular presacral soft tissue density with enlarging ovoid fluid collection, now measuring up to 6 cm, which appears to result obstruction of the adjacent distal right ureter. It also showed marked diastasis of the rectus abdominus musculature resulting in wide mouth hernia with ventral bulging of the mid to lower abdominal contents. He was then sent to the ER and seen by Urology and advised to follow-up on an outpatient basis. He saw Dr. Miller in follow-up on 2/25/2020 and plan was for a cysto, bilateral RGP, and possible right stent. On 3/16/2020 he underwent cystoscopy, bilateral retrograde pyelogram, right ureteral stent placement. He last saw Dr. Sarah Miller of Oncology on 4/30/2020 to review a MRI pelvis that was ordered to evaluate a presacral cystic lesion. MRI Pelvis revealed increasing size of complex cystic lesion seen in the presacral collection that communicated with the posterior aspect of the bladder in the expected location of the prostate concerning for fistula and abscess.  It also showed heterogeneous debris within the collection suggests fistula and abscess formation with the possibility of neoplasm difficult to exclude. He was sent to Urology and had a cystoscopy on 5/6/2020 which revealed a fistulous opening in the right side of bladder several cm posterior to the right UO, no tumor or stones seen. He then underwent CT guided drain placement on 5/11/2020.  Pre sacral fluid negative for malignancy.  CEA 5/13—2.4. Discuss options. | MV |
| 8 | KE/MRN: 6015326DOB: 9/2/53 | 66 y/o male with metastatic sigmoid cancer to the liver. He was seen on 12/6/2019 after having a colonoscopy done by Dr. Stevenson which revealed diverticulosis and a neoplastic mass at 12 cm which was biopsied and came back as invasive moderately differentiated adenocarcinoma. At the time of his initial consultation a flexible sigmoidoscopy was done and revealed a tumor in the distal sigmoid approaching the upper rectum that was easily traversed. CT C/A/P revealed malignancy involving the region of the sigmoid colon with retroperitoneal adenopathy with evidence of metastatic disease to the liver. He started chemotherapy on 12/26/2019 and completed cycle #9 on 4/21/2020. He had a restaging CT C/A/P on 4/27/2020 which showed mildly improving hepatic metastatic disease, slightly improving small retroperitoneal lymph nodes as well as mesenteric lymph nodes along the course of the IMA. He was discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 5/8/2020 and at that time the group recommended a diagnostic laparoscopy to evaluate carcinomatosis and a MRI liver to evaluate for possible resection. He had a MRI liver on 5/12/2020 which revealed improving metastatic disease compared to prior PET/CT on 12/23/2019. It also showed a small omental nodule concerning for peritoneal disease although improved from original CT and stable non-enlarged retroperitoneal lymph nodes. He did see Dr. Uemura on 5/13/2020 and they discussed left hepatectomy and 2x partial resection of right side.  Flex sig with biopsy done on 5/15/20. Brief update - no need for imaging review. | JM |
| 9 | TG/MRN: 10706655DOB: 3/11/57 | 63 y/o male that is s/p EUA for fistulizing Crohn’s disease with intraop colonoscopy, local wound exploration, seton placement, and biopsy of perineum on 5/13/2020 (combined case with Dr. Bruning).   Intra-op findings included a bifurcation of the scrotum with a chronic wound centrally with the urethral bulb seen in the base of the wound and a direct hole entering into the rectum and into the right-sided ischiorectal wound. A Foley catheter placed into the urethra through the penis came out through the rectum. Urine was draining from the cephalad aspect of the wound but significant scarring precluded access to the urinary bladder *from this side.* Flex sigmoid was performed and there was a direct access to the ileum at about 20 centimeters consistent with his known enterocolonic fistula. There was difficulty entering the colonic side but ultimately were able to enter into a stenotic and atrophic proximal colon which essentially appeared to have been chronically diverted. The scope was not able to be passed deep into his colon due to loss of compliance and stenosis. There was no evidence of neoplastic process or evidence of acute inflammatory process. The scope was brought back towards the known defect in the rectum connecting to the urinary system and a discrete non-inflamed mature defect above the dentate line anteriorly was found. There was no evidence of active inflammation in the rectum. A seton was placed from the scrotal defect to the ischiorectal wound and secured in place. Multiple biopsies were taken using sharp technique of various aspects of the scrotal wound. Pathology for perineal bx is suspicious for lymphoproliferative disorder, non-Hodgkin lymphoma cannot be ruled out. Review path and scans. | JM |
| 10 | PH/MRN: 412153DOB: 5/7/68 | 51 y/o male metastatic colon cancer to the liver.  He presented to the ER 2/12/20 complaining of epigastric and RUQ pain and underwent a CT A/P 2/13/20 that showed innumerable hypodense liver lesions throughout both hepatic lobes with adjacent nonspecific fat stranding in the RUQ, enlarged spleen, multiple low density lesions in kidneys TSTC, cluster of enlarged mesenteric lymph nodes adjacent to the sigmoid colon, the largest of which is 1.4 cm, mural thickening and luminal narrowing involving a 4 cm segment of sigmoid colon, and colonic diverticulosis.  He was admitted and seen by Dr. Asher in consultation, who ordered a CT Chest, CEA level, and liver biopsy.  He was also seen by the Palliative Care service.  His CEA level 2/13/20 was 884.0.  CT Chest 2/14/20 showed no metastatic disease, partially imaged hepatic masses.  He underwent a CT guided liver biopsy 2/14/20 that was positive for metastatic adenocarcinoma consistent with colorectal primary. FOLFOX started 2/24.  Cetuximab added with cycle 3 on 3/23.  Received cycle 6 on 5/4.  CEA on 5/14 was 9.3.   CT c/a/p done 5/13. Discuss scans and treatment options going forward. | NA |
| 11 | CD/MRN: 411868 | 62-year-old female with likely recurrence of colon adenocarcinoma. The patient initially underwent exploratory laparotomy and distal sigmoid resection with end colostomy for chronic obstructive symptoms and stricture of sigmoid colon by Dr. Murdock in 10/2018. When she presented for reversal in 9/2019, she was found to have a contained cecal perforation with ileocecal stricture and underwent right hemicolectomy with ileocolic anastomosis. Pathology showed moderately differentiated adenocarcinoma in the area of the ileocecal stricture with mucinous features, 17 benign lymph nodes, pT3 pN0. The patient follows with Dr. Barsouk at AVH medical oncology; she did not receive adjuvant therapy. She has had two non-diagnostic colonoscopies in 2018 and 2019 due to poor bowel prep. PET/CT was ordered earlier this month, but was denied by insurance. She was recently admitted to ACS service with a pelvic fluid collection and bilateral hydronephrosis. CRS was consulted due to elevated CEA and concern for recurrence. CEA in 10/2019 was 5.8, now 66.3. CT AP reveals no evidence of metastatic lesions to the liver aside from a new large hematoma within the pelvis. CT chest ordered. Review imaging, discuss treatment options. | SN |
| 12 | AW/MRN: 10048476DOB: 6/21/53 | 66 y/o HIV positive male on HAART Rx came into ER for urinary retention and found to have left groin mass which was biopsied and was positive for SCC and had PET and oncology follow up and found to have fungating anal mass and therefore diagnosed with anal cancer in 5/2019 and on PET had a positive paraoartic LN due to which he was stage as stage IV. He was treated with chemo including Carbo + taxol for 3.5 cycles following which got chemo radiation with capecitabine and one dose of Mitomycin. He finished XRT in 12/2019 and was given two additional cycles of carbo taxol after which he stopped at patients request in 2/2020. Now PET shows worsening SUV in anal canal. Recent visit with Dr Reichstein didn't show any macroscopic evidence of disease recurrence. Since no activity in paraaortic LN, question for tumor board is next step in his care. Surgery vs Additional radiation vs chemo vs observation.  | DS |

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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