

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, May 29, 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 | GH/ MRN: 378279DOB: 12/17/65 | 54 y/o male being seen for newly diagnosed rectal cancer. He had a colonoscopy done on 5/15/2020 by Dr. Kichler which revealed a partially obstructing large mass found in the recto-sigmoid colon beginning at 10 cm proximal to the anus that was partially circumferential and measured 4 cm in length. It was biopsied and came back as well to moderately differentiated invasive adenocarcinoma of the colon arising in a tubular adenoma with focal mucosal erosion. CT and MRI completed on 5/21/20. Review scans and discuss treatment options. | JM |
| 2 | MGP/MRN: 11953091DOB: 2/19/58 | 62 y/o female newly diagnosed rectal cancer.   Rectal bleeding and follow-up colonoscopy showed a near circumferential rectal mass.  Biopsy showed invasive moderately differentiated adenocarcinoma.    Ct c/a/p on 5/22 no evidence of metastatic disease.  MRI shows T2 NO CRM negative, mid-low rectal mass.  Review scans and discuss treatment.   | MV |
| 3 | AN/MRN: 10149488DOB: 3/2/62 | 58 y/o female being seen for a newly diagnosed rectal cancer. She underwent colonoscopy on 5/12/2020 by Dr. Kichler which revealed a 25 mm polyp in the rectum at 1 cm proximal to the anus that was removed via piecemeal, biopsied, and treated with APC and came back as well differentiated colonic adenocarcinoma.  CT C/A/P was done 5/18/2020 and showed diverticulosis, no enlarged lymphadenopathy. MRI done on 5/19/20 which did not show evidence of a rectal mass. Review scans and discuss treatment options | JM |
| 4 | KB/ MRN: 432185DOB: 2/8/41 | 79 y/o male with a newly diagnosed rectal cancer. He had a colonoscopy done on 4/24/2020 and was found to have partially obstructing large mass in the rectosigmoid and in the distal sigmoid colon. The mass was circumferential and measure 10 cm in length. It was biopsied and came back as invasive moderately differentiated adenocarcinoma. A CT C/A/P was completed on 5/19/20 and shows a distal sigmoid colonic mass that is likely T3, and at least N1. CEA came back at 34. MRI completed on 5/22/20. Review scans and discuss treatment options. | JM |
| 5 | MU/MRN: 11852389DOB: 10/27/83 | 36 y/o male with a newly diagnosed rectosigmoid cancer.  Colonoscopy done 5/18/20 notable for a partially obstructing tumor in the sigmoid colon. CT c/a/p done 5/22/20 no sign of metastatic disease.  MRI done 5/27.  Waiting for results.  Review scans and discuss treatments. | AR |
| 6 | 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 |
| 7 | BZ/MRN: 11851754DOB: 3/14/58 | 62 y/o male with recent diagnosis of metastatic, locally advanced colon cancer at the splenic flexure with local involvement at the distal pancreas, metastatic to retroperitoneal and groin lymph nodes.  Patient presented initially with large-bowel obstruction required proximal fecal diversion.   Patient has started chemotherapy with Dr. Apostolova in April.   He was presented at tumor conference on 3/20/20 and the group recommended an inguinal node biopsy to rule out 2 separate malignancies. The group also advised that if the inguinal node biopsy came back as colon cancer this would make him a stage IV cancer. Patient had biopsy on 3/26/20 and it was positive for adenocarcinoma. Review pathology and discuss treatment options. | SN |
| 8 | AB/MRN: 440195DOB: 12/9/1944 | This is a patient with a history of right colon cancer who now has a resected metastasis in the lung. Status post laparoscopic robotic right hemicolectomy for stage 1 T2 N0 M0 invasive moderately differentiated adenocarcinoma of the cecum in January 2019This was a stage I cancer and no adjuvant chemotherapy was recommended.Recurrent adenocarcinoma of the colon with metastasis to 2 adjacent areas in the right lower lobe.  Status post right lower lobectomy and mediastinal lymph node dissection 04/23/2020Consideration for postoperative adjuvant chemotherapy. Iron deficiency anemia and late 2018 secondary to bleeding from her right colon tumor.  This has resolved.  Hemoglobin has been relatively stable with mild drop secondary to recent surgery. Recommendations:  Present at Colorectal tumor Board. 2. Obtain molecular profiling on her resected metastatic disease. 3. Screen her insurance for the use of oral Capecitabine or FOLFOX for a period of 6 months. 4. Check CEA level. 5. Follow-up in 2 weeks for finalizing her treatment recommendations. 6. Surveillance imaging will need to be performed about every 3 months for the 1st 2 years. | GF |
| 9 | 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 |
| 10 | RN/MRN: 11852941DOB: 7/14/58 | 61 y/o male - s/p open appendectomy for perforated appendicitis at OSH on 3/17/20. INVASIVE MUCINOUS ADENOCARCINOMA, MODERATELY DIFFERENTIATED, OF APPENDIX, DISTAL AND MID AREA, WITH APPENDICITIS, RUPTURE AND ACUTE SUPPURATIVE INFLAMMATION TUMOR SIZE, GROSS AND MICROSCOPIC EXAMINATION: APPROXIMATELY 4.7 CMTUMOR INVADES THROUGH THE MUSCULARIS PROPRIA INTO THE SUBSEROSA AND MESOAPPENDIX, BUT DOES NOT EXTEND TO SEROSAL SURFACE, AND ACELLULAR MUCIN INVADES THE VISCERAL PERITONEUM (SEROSAL) LYMPHOVASCULAR INVASION NOT IDENTIFIED PERINEURAL INVASION NOT IDENTIFIED APPENDIX MARGIN IS NEGATIVE MESOAPPENDIX MARGIN, CANNOT BE EVALUATED PATHOLOGIC STAGING (AJCC 8TH EDITION): pT4a, pNX, pMX - CT CAP was negative for metastases. Colonoscopy did not demonstrate additional lesions. He is s/p right hemi-colectomy, tumor debulking and HIPEC with Mitomycin C on 5/8/2020. Is he a candidate for adjuvant chemotherapy? Pathology c/w: Final Diagnosis1. OMENTUM, OMENTECTOMY: A.　MATURE ADIPOSE TISSUE WITH FAT NECROSIS AND FOCAL HEMORRHAGE 　 B.　NEGATIVE FOR TUMOR2. COLON, RIGHT HEMICOLECTOMY:　 　A.　COLONIC MUCOSA (INCLUDING APPENDICEAL ORIFICE) WITH SEROSAL ADHESION 　B.　NEGATIVE FOR MAGLINANCY C.　MARGINS OF RESECTION, NEGATIVE FOR TUMOR　 D.　SEVENTEEN BENIGN PERICOLONIC LYMPH NODES (0/17)3. RETROPERITONEUM, RIGHT SIDE, EXCISION OF "MASS": 　A.　ACELLULAR MUCIN, ASSOCIATED WITH FIBROSIS, HEMOSIDERIN AND GRANULATION TISSUE | SS |

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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