

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, May 8, 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**

|  |  |  |  |
| --- | --- | --- | --- |
| **Case**  | **De-identified patient** | **Reason** | **Presenter** |
| 1 | JL/MRN: 796035DOB: 7/29/66 | 53 y/o 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. Discussed at tumor conference on 5/1/20 with the group recommending TNT. Review scans and discuss treatment options. | JM |
| 2 | NM/MRN: 609305DOB: 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 |
| 3 | JB/MRN: 4322531DOB: 12/21/42 | 77 y/o male diagnosed with clinical T2N0 rectal cancer January, 2020.  Presented at colorectal conference 1/31/20.  MRI showed internal sphincter involvement.  The CT C/A/P was reviewed and there were bilateral lung lesions in the lower lobes felt to be more infectious, that should be watched.  Dr. Kirichenko stated that he had high risk prostate cancer that was inadequately treated (s/p radical prostatectomy in 2015 with focal positive margin at the apex. Postoperative PSA undetectable) and had a PSA recently that was 0.2, concerning for recurrence. The group consensus was to proceed with chemoradiation to the rectum and prostate and extended Xeloda and then reassess.  Patient cannot receive definitive radiation treatment to the rectum due to need to treat the prostate.  Patient finished neoadjuvant chemoradiation to the rectal mass as well as the prostate fossa 4/9, with extended Xeloda finishing 4/23. Flex sig done by Dr. McCormick showed friable scar with ulcer but no mass.  Possible complete response, but too early to determine definitively.  Will reassess in 1 month.  Discuss appropriate restaging | JM |
| 4 | DB/MRN: 2926233DOB: 2/22/52 | 68 y/o male with hx of stage III rectal cancer. He previously underwent TNT off protocol followed by extended Xeloda and underwent surgical resection involving laparoscopic robotic total mesorectal excision (proctectomy) with creation of hand sewn coloplasty-anal anastomosis, creation of loop ileostomy and takedown of the splenic flexure on 4/30/2019. Surgical pathology revealed ypT2N2aMX residual invasive moderately differentiated adenocarcinoma of the rectum with 5/25 lymph nodes positive amd perineural and lymphovascular invasion identified. He then received adjuvant Xeloda x 6 weeks. He underwent EUA on 8/29/19 due to rectal prolapse/prolapsing tissue.  He then underwent ileostomy takedown on 10/25/2019. His last CEA was 2.6 on 2/17/2020. His last CT C/A/P was 4/24/2020 and showed lobulated enhancing right presacral lesion with a new enlarged right external iliac chain lymph node and subcm aortocaval lymph node concerning for recurrent disease. A PET/CT was done on 4/30/20 and showed evidence of FDG avid malignancy with hypermetabolic perirectal mass, multiple hypermetabolic lymph nodes in the pelvic and hypermetabolic mild abdominal retroperitoneal lymph node. Review scans and discuss treatment options. | JM |
| 5 | GP/MRN: 556705 | 78 y/o male with history of moderately differentiated distal rectal adenocarcinoma (cT3 N0 M0) diagnosed in May 2019 status post TNT with complete clinical and MRI response. He completed eight cycles of FOLFOX ending October 2019 and finished radiation treatments in November 2019. Flexible sigmoidoscopy on 4/29/2020 identified an area on the distal valve that was somewhat friable; biopsy demonstrated no aytpia or malignancy. Plan is to continue with watch and wait with follow-up flexible sigmoidoscopy in June. Requesting pathology review and discuss watch and wait vs. definitive proctectomy. | RF |
| 6 | 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 |
| 7 | KE/MRN: 6015326DOB: 9/2/53 | 67 y/o male presented with a 6 month history of abdominal cramping, bleeding, tenesmus, with associated 25 lb weight loss. CT abdomen/pelvis on 11/20/2019 - colonic wall thickening along the mid/distal sigmoid colon, with associated spiculated mass measuring 3.3 cm.  Numerous liver lesions noted, also enlarged retroperitoneal lymphadenopathy noted. Colonoscopy on 12/03/2019 (Dr. Stevenson at Clarion Hospital) - 6 biopsies obtained, consistent with invasive moderately differentiated adenocarcinoma. 12/16/2019 - Cancer Staged IV invasive moderately differentiated adenocarcinoma of colon (sigmoid). Numerous liver lesions noted, consistent with metastatic disease. Retroperitoneal lymphadenopathy noted.  12/26/2019 - Chemotherapy/Treatment OP METASTATIC COLORECTAL MODIFIED FOLFOX 6 (Q 14 DAYS) C1D1: 12/26/19 - C5D1 02/20/20. 2/14/2020 - Flex sig (McCormick). Tumor demonstrates partial response manifest by truncation and shrinking. This is traversable.  2/21/2020 CT TAP - Slightly improving hepatic metastatic disease and abdominopelvic lymphadenopathy. Stable thickening of sigmoid colonic wall and adjacent spiculated soft tissue pelvic mass. Stable 3 mm right upper lobe nodule. 3/10/2020 - FOLFOX and Panitumumab Cycle 1 x 4 cycles. Restaging CT 4/27/20. CEA 56 to 4.8 | DM |
| 8 | EK/MRN: 10001291DOB: 6/13/44 | 75 y/o female presumed metastatic colon cancer with constipation since her youth seen by Dr. Paul Lebovitz with colonoscopy in January 2020. Unable to get past sigmoid colon at 30cm because of significant muscular hypertrophy around her diverticuli. S/P CT colonography on 04/27/2020 demonstrating a short-segment thickening involving the sigmoid colon which extends along the left pelvic side wall concerning for a possible annular constricting lesion.  There is nodularity of soft tissue mass within the omentum measuring 6.9 x 2.9 centimeters.  The rectosigmoid colon was under distended and near nondiagnostic particularly in the sigmoid colon.  Liver also reveals a 1.7 hypodense lesion in the right hepatic lesion. CT of the chest abdomen pelvis on 05/01/2020 demonstrated multiple bilateral pulmonary nodules of varying sizes, likely pulmonary meta stasis.  Hepatic lesions suggestive of meta stasis.  GI factor was difficult to be evaluated.  There was heterogeneous masslike enhancing areas within the peritoneum and pelvis concerning for peritoneal deposits.  Evidence of nonspecific enteritis in the duodenum and jejunum.  There is moderate dilation of the left renal pelvis and left upper ureter with mass like retroperitoneal density slightly enlarged lymph nodes small ascites and small right pleural effusion was noted. Radiology needs reviewed. Pathology pending from liver biopsy to be done on 5-7-2020. Surgical opinion regarding diversion. Lifelong constipation issues. Plan: Chemotherapy with Tempus testing sent on 5-5-2020. | MR |
| 9 | WM/MNR: 365845 | 74 y/o male presented with perforated appendicitis with abscess about 6 months ago. He has right flank induration concerning for subcutaneous tumor. Taken to OR for interval appendectomy pathology c/w: Final Diagnosis:1. 　APPENDIX, LAPAROSCOPIC APPENDECTOMY:　　　　　A.　INVASIVE MUCINOUS ADENOCARCINOMA, MODERATELY DIFFERENTIATED, APPROXIMATELY 2.7 CM IN MAXIMUM DIMENSION (SEE COMMENT)　　　　　B.　TUMOR INVADES THROUGH MUSCULARIS PROPRIA INTO SUBSEROSAL TISSUE (pT3)　　　　　C.　INVASIVE CARCINOMA EXTENDS TO INKED PROXIMAL MARGIN　　　　　D.　NO LYMPHOVASCULAR INVASION OR PERINEURAL INVASION IDENTIFIED　　　　　E.　AREAS OF FAT NECROSISLaparoscopic right colectomy performed earlier this week. He is set up to see rad onc for radiation to the abdominal wall. I will also refer him to med onc. I did not perform HIPEC because he has multiple other medical problems that preclude aggressive perfusion. There was no evidence of carcinomatosis at time of surgery. | SS |
| 10 | RK/MRN: 19229DOB: 5/2/52 | 67 y/o male with T4ANX poorly differentiated signet ring cell carcinoma of the appendix. He previously was seen in Mon Health Medical Center on 2/16/2020 for stabbing abdominal pain. A CT A/P was done which revealed acute appendicitis, likely small perforation at the distal portion of the append with a 13 mm periappendicular fluid collection suspicious for abscess, no free air identified.  He was then taken to the OR and underwent a laparoscopic appendectomy with drain placement on 2/17/2020 by Dr. Kristen Statler. A CEA was done which came back at 4.6. CT chest showed no evidence of pulmonary metastatic disease. He was seen by Dr McCormick on 2/28/2020 and was advised that he needs a right colectomy when completely recovered for laparoscopy appendectomy. Since then he had a colonoscopy done on 4/2/2020 by Dr Mitre which revealed a 10 mm polyp in the sigmoid colon that was removed and was a tubular adenoma with focal high grade dysplasia and a 5 mm polyp in the sigmoid colon that was removed.  Laparoscopic right colectomy performed on 4/28/20.  Review pathology and discuss treatment options. | JM |

**AHN CME Credit**

**TEXT 412-301-9919**Save this number to your contacts
You will use this **same** number every week to text your attendance

**Today’s SMS Code: CAWJUV**

You must text within **24** hours of the tumor board. You will receive a text receipt and a link to confirm attendance and receive credit.

.

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