

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, June 12, 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 | AE/MRN: 11673899  DOB: 8/27/71 | 48 y/o female with newly diagnosed rectal cancer. ER at Heritage Valley Sewickley for rectal bleeding.  Colonoscopy done on 6/4/2020 revealed a 3 mm polyp in the proximal rectum that was removed and a 5 cm mass in the distal rectum that was biopsied. Path pending at this time. Flex sig in office on 6/9/20.  CT CAP and MRI completed on 6/9/20. Review scans, path and discuss treatment options. | JM |
| 2 | KS/MRN: 10726890  DOB: 12/5/00 | 19 y/o male s/p laparoscopic robotic total colectomy with ileorectal anastomosis, diverting loop ileostomy, en bloc resection of partial thickness urinary bladder and right seminal vesicle, right ureterolysis, and drainage of pelvic abscess on 5/26/20. Pathology revealed two separate foci of invasive poorly differentiated adenocarcinoma. Lymphovascular and perineural invasion as well as multiple tumor deposits (largest 4.1 cm) in the mesentery and 19 negative LNs. (T3N1C) Immunohistochemistry results showed loss of nuclear expression of PMS2 in both tumors. Review pathology and discuss treatment options. | JM |
| 3 | SS/MRN: 10721763  DOB: 6/14/62 | 57 y/o female with 2 month history of painful rectal bleeding.  6/2/20-colonoscopy by Dr. Appasamy -- malignant appearing mass within the rectum approximately 7 cm from the anal verge.  Path-adenocarcinoma moderately differentiated.  Flex sig done in office 6/9/20.  Also found to have an anal fissure. Review scans and discuss treatment options. | SN |
| 4 | JS/MRN: 4492667  DOB: 11/15/68 | 51 y/o male who presented with rectal bleeding late 2019. CT in ER revealed lesions suspicious for liver metastasis. Colonoscopy done 12/6/19 showed mass at 40-45cm.  Path –invasive moderately differentiated adenocarcinoma. Liver biopsy done on 12/11/19.  Path revealed metastatic adenocarcinoma.   Patient began neoadjuvant chemo on 2/6/20 with FOLFIRI and Cetuximab and is currently still getting treatment.   Admit 6/4/20 for large bowel obstruction.  Colonoscopy with stent placement by Dr. Fortunato. Discuss treatment options. | RF |
| 5 | WP/MRN: 10601482  DOB: 6/23/87 | 32 y/o male - PMH sig for Crohn's disease diagnosed 1995. Presents with rectal bleeding found to have an appendiceal NET in setting of fulminant crohns proctocolitis. Review path, scans and discuss treatment options. | RF |
| 6 | EL/MRN: 358241  DOB: 3/28/37 | 83 y/o female that underwent a colonoscopy on June 4 for rectal bleeding and Abnormal CT scan.  Radiation induced upper rectal stricture noted with distal sigmoid polypoid lesion.   Biopsy shows FRAGMENTS OF TUBULOVILLOUS ADENOMA WITH FOCAL HIGH GRADE DYSPLASIA. Review imaging and treatment options. | AK |
| 7 | TH/MNR: 5194850  DOB: 7/1/63 | 56 y/o female with a positive FIT test performed in February 2020, screening colonoscopy on 5/21/20.  A 3 cm pedunculated sigmoid mass was identified.  Pathology -microscopic focus of invasive moderately differentiated adenocarcinoma arising in a tubular adenoma with high grade dysplasia.  Review scans and pathology. | RF |
| 8 | PL/MRN: 11293208  DOB: 10/13/60 | 59 y/o female with a hx of stage IV rectosigmoid cancer s/p Laparoscopic Robotic LAR with creation of coloproctostomy and takedown of the splenic flexure 7/25/18. Pathology revealed a T3N1a moderately differentiated adenocarcinoma.  Adjuvant FOLFOX 9/26/18 - 2/13/19.  CT C/A/P 9/26/19 showed 3 new solid hepatic lesions/metastasis and subtle enlargement portacaval lymph node. Robotic assisted laparoscopic converted to open right hepatectomy with intraop US by Dr. Machado on 4/16/20. Pathology consistent with multifocal metastatic adenocarcinoma. Ct 6/4/20 showed several new pulmonary nodules, highly suspicious for pulmonary mets. Review scan and discuss treatment options. | JM |
| 9 | MP/MRN: 708230 | 57 y/o male with history of cT4bN2aM0 rectal cancer status post neoadjuvant chemoradiotherapy ending in 3/2017 and APR with prostatectomy and bladder reconstruction in 5/2017. He had multiple complications following surgery requiring multiple trips to the operating room. He began having pelvic pain and had a small collection of fluid which continued to enlarge. This collection had been percutaneously accessed by IR in 5/2020, and fluid was sent for cytology which was negative for malignancy. This did not relieve his symptoms, and he developed hematuria. He underwent exploratory laparotomy by Dr. Voth, and there was a mucinous tumor recurrence in the pelvis with fistula to the bladder, adhesion to a loop of small bowel. Several implants along the pelvic inlet were noted. Pathology showed metastatic adenocarcinoma with abundant extracellular mucin, CK20 and CDX-2 positive, MSI intact. Requesting pathology review. | MV |
| 10 | TB/MRN: 11955740  DOB: 6/8/66 | 54 y/o female with a history of stage I sigmoid cancer 2012 (T1 N0 M0) s/p sigmoidectomy referred to Gynecology-Oncology for increasing abdominal pain and ascites.  Ultrasound demonstrated mixed solid and cystic mass felt to be ovarian in origin measuring 11.8cm.  CT AP noted a large volume of ascities, a complex cystic mass in the pelvis 11 x 9 cm, and no definite pelvic or retroperitoneal adenopathy. CA-125= 416; CEA = 5.9.  Paracentesis was negative for malignant cells.  No family history of colon, ovarian, uterine or breast cancer.  Last colonoscopy was 2017, normal, told 5 yr. follow-up. Intraop frozen noted adenocarcinoma NOS.  Final path noted metastatic colorectal adenocarcinoma to the omentum, left ovary, right ovary, colon wall penetration out-to-in from the serosa into the muscularis propria without mucosal involvement.  2 of 3 paracolonic lymph nodes were involved.  Negative resection margins of the colon and rectum, both fallopian tubes and uterus. Review CT, path and treatment planning. | RF |
| 11 | CK/MRN: 139158  DOB: 3/18/53 | 66 y/o female with PMH significant for sigmoid colon cancer s/p low-anterior resection and chemo 17 years ago, with history of gastric bypass. Diagnosed with Lynch syndrome Colonoscopy in Feb 2020 lesion at 70cm, path revealed invasive poorly differentiated adenocarcinoma with focal lymphovascular invasion present.    Recent EGD and capsule endoscopy did identify adenomatous polyps of the jejunum with high-grade dysplasia. Presented at tumor conference on 4/10/20 and group recommended Dr. Kulkarni to proceed with device assisted enteroscopy to remove roux limb polyps and evaluate and possibly treat afferent limb/gastric remnant lesions prior to colon resection. Done on 5/5/20.  OR 5/28/20 for laparotomy, gastroesophogostomy, esophagojejunal anastomosis, cholirectal anastomosis, ileoatomy placement by Dr. Fortunato. Discuss treatment plan. | RF |
| 12 | JC/MRN: 732549  DOB: 6/13/1938 | 81 y/o male diagnosed with ascending colon ulcerated submucosal lesion- biopsied. Path showed ganglioneuroma. Discuss how to manage - resect or observe. Review of Colonoscopy pictures, no imaging. | AK |

**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: FOBDEL**

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