

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, June 19, 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 | JP/MRN: 2014559  DOB: 6/28/52 | 67 y/o female with newly diagnosed rectal cancer.  Colonoscopy was attempted on 6/3 but unable to be completed secondary to an ulcerated fungating rectal mass that was unable to be traversed.  Biopsy came back well differentiated adenocarcinoma.  CEA 14.7.  CT c/a/p and MRI done.  Review scans and discuss treatment. | MV |
| 2 | JG/MRN: 5177820  DOB: 12/24/64 | 55 y/o male with history of T4N1M1 rectal cancer and Crohn’s disease. He completed neoadjuvant treatment with FOLFOX from 1/27/2020 – 5/4/2020 and was scheduled for exploratory laparotomy and pelvic exclusion on 6/12/2020. However, the patient presented to WPH ED on 6/11/2020 with a perirectal abscess likely due to localized erosion by rectal mass. CT AP showed a redomonstration of the rectal mass with a new collection of fluid abutting the bladder. The posterior bladder wall was noted to be thickened and loops of small bowel are tethered to this collection. Palliative medicine was consulted during hospitalization, and patient was discharged home with 2-week course of IV ceftriaxone and PO Flagyl. Review imaging, discuss treatment options. | SN |
| 3 | 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 |
| 4 | RH/MRN: 807747  DOB: 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 was noted to a liver metastases located to the segment 7 although this demonstrated no uptake on the PET scan on 4/10/20.  Began SBRT to lesion on 6/3/20.   Patient has no evidence of residual tumor within the rectum on flexible endoscopy by Dr. Nosik on 5/12/20.  Discussed at tumor conference on 5/29/20 with the consensus being to place patient on Watch and Wait protocol and get MRI. Review MRI and discuss treatment options. | SN |
| 5 | SS/MRN: 2535462  DOB: 12/5/80 | 39 y/o female with a history of Stage IV (T3N2M1) due to involvement of external iliac and common iliac lymph nodes, K-RAS mutated adenocarcinoma of the rectum status post neoadjuvant chemoradiation to 5400cGy in 31 fractions followed by LAR on 8/29/2016 and adjuvant chemotherapy with 11 cycles of FOLFOX. Also status post multiple lines of systemic therapy with left lateral segment liver lobectomy on 3/9/2017 and resection of a solitary right lobe metastasis on 4/3/2018. Now with 2 hypermetabolic foci in the liver, one near the hepatic dome and a second more caudally in the right hepatic lobe along with a hypermetabolic omental lesion concerning for metastatic disease. Presenting to discuss management, specifically surgical resection of these lesions. The case will also be presented at Hepatobiliary Tumor Board on Wednesday 6/17/2020. | AVK |
| 6 | CW/MRN: 11601557  DOB: 9/23/58 | 61 y/o male with T3 N3 M1 metastatic rectal cancer to the liver dx in June 2019. He has been managed with chemotherapy, chemoradiation, and completed radiation therapy on 1/30/20.  Patient received an additional four more cycles of FOLFOX from 2/26/2020 to 4/9/2020.  Patient underwent robotic proctectomy with coloanal anastomosis with diverting loop ileostomy on 6/4/20 and was brought back to the OR on 6/14/20 for AP resection and colostomy. NAPRC path review. | JM/SN |
| 7 | CD/MRN: 411868  DOB: 6/4/57 | 63 y/o female with likely recurrence of colon adenocarcinoma. Initially had complicated sigmoid diverticulitis with stricture which required Hartmann's type sigmoidectomy with rectal stump and end colostomy in 2018. Presented for reversal in 9/2019, found to have a contained cecal perforation with ileocecal stricture underwent right hemicolectomy with ileocolic anastomosis. Pathology -- moderately differentiated adenocarcinoma in the area of the ileocecal stricture with mucinous features, 17 benign lymph nodes, and pT3 pN0 -- she did not receive adjuvant therapy. Recently admit-- pelvic fluid collection and bilateral hydronephrosis.  CEA in 10/2019 5.8, now 66.3. Presented at conference on 5/29/20 with the group's consensus to perform a transrectal biopsy of the rectal stump which was done one 6/10/20. Review scans and pathology. | SN |
| 8 | JS/MRN: 11647385 | 39 y/o male with PMHx significant for attenuated FAP and family hx significant for colon cancer and Lynch Syndrome.  Colonoscopy was done on 1/27/2020 and revealed nine 5-20 mm polyps in the ascending colon that were removed and were fragments of tubular adenoma; eight 5-18 mm polyps in the transverse colon that were removed and were fragments of tubular adenoma; five 5-16 mm polyps in the descending colon that were removed and were fragments of tubular adenoma;  five 5-20 mm polyps in the sigmoid colon that were removed and were fragments of tubular adenoma; and one 25 mm polyp in the rectum that was removed and was a tubulovillous adenoma, cauterized edge free of adenomatous change.  He did undergo genetic testing and was found to have a mutation in the APC gene associated with Familial Adenomatous Polyposis.  Discuss case | JM |
| 9 | AG/MRN: 4729270  DOB: 12/23/46 | 73 y/o female with history of Lynch syndrome, adenocarcinoma of the jejunum s/p laparoscopic converted to open small bowel resection and 12 cycles of FOLFOX, uterine cancer, breast cancer, and melanoma, admitted 6/15/2020 with partial small bowel obstruction. Last CT in 12/2019 did not show any evidence of pulmonary or abdominal neoplasm recurrence. Colonoscopy on 6/12/2020 was normal. She presented to Jefferson ED with mild abdominal pain and cramping over the past few weeks. CT AP on 6/15/2020 is concerning for recurrent malignancy. She is scheduled for exploratory laparotomy on 6/18/2020. Review imaging, discuss treatment options. | JM |
| 10 | BZ/MRN: 11851754 | 62 y/o male with a diagnosis of poorly differentiated adenocarcinoma. Presented to Butler Hospital with neck pain and change in bowel habits. He was found to have left brachiocephalic, left subclavian and axillary vein occlusion. Additional work-up with CT AP showed a 6.7 x 6.1 cm multicystic lobulated mass in the left upper quadrant, another mass 3.4 cm more medially, and retroperitoneal and left pelvic lymphadenopathy. He underwent CT guided biopsy of the LUQ mass. Pathology showed poorly differentiated adenocarcinoma, the immunoprofile most consistent with a primary tumor of gastrointestinal (colorectal) origin. He underwent diagnostic laparoscopy, diverting loop transverse colostomy, flexible sigmoidoscopy, and port placement on 3/16/2020. His case was presented at the Multidisciplinary Colorectal Cancer Conference at AGH on 3/20/2020. Due to significant retroperitoneal and inguinal lymphadenopathy and elevated LDH, an inguinal node biopsy to rule out two separate malignancies was recommended. He is s/p ultrasound guided left inguinal lymph node biopsy 3/26/20. Results positive for metastatic adenocarcinoma, intestinal type, loss of nuclear expression of MSH2 and MSH6 mismatch repair proteins, high probability for Lynch syndrome. CT Chest as inpatient showed a 2 cm anterior mediastinal mass which could represent adenopathy or thymoma. AFP 2.9. HCG <1. PET/CT showed a 6.3 x 6.7cm lobulated FDG avid soft tissue mass in the upper left abdomen; slightly inferior and medial to this there is also a 3.7 x 3.9 cm mas; there are multiple pelvic chain FDG avid pathologic lymph nodes within the abdomen in the periportal,retrocrural and retroperitoneal regions; multiple pelvic chain FDG avid pathologic lymph nodes; slight thickening of the medial limbs of both adrenal glands with increased FDG uptake within the thickened medial limbs suggesting possible adrenal mets. The tissue abdominal mass sample was sent for cancer type ID. Results showed 75% probability of small intestine adenocarcinoma, colorectal adenocarcinoma with a relative probability of less than 5%, could not exclude gastroesophageal adenocarcinoma (21% probability). The patient was started on FOLFOX, Bevacizumab added later. Re-staging scans after Cycle 4 of treatment showed response to treatment. | MA |
| 11 | 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 ascites, 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 |
| 12 | SL/MRN: 11413532  DOB: 9/15/60 | 59 y/o with h/o pT3N2 right colon cancer s/p R hemicolectomy followed by partial adjuvant chemo and subsequent pT3N1 sigmoid cancer s/p sigmoid colectomy. No adjuvant therapy given because of poor tolerance previously. Planned for adjuvant RT, found to have growing nodularity adjacent to R psoas muscle over prior scans. Needs radiology review discussion for biopsy and operability? | ZH |
| 13 | 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 |
| 14 | BF/MRN: 10047635  DOB: 9/24/38 | 81 y/o male with history of diffuse metastatic renal cell carcinoma to lungs, vertebrae, ribs, abdomen, and pelvis with invasion into and through the rectosigmoid junction. Patient presented to the hospital with three months of painless hematochezia, requiring several transfusions. He presented to OSH with hemoglobin 5.3 and was transferred to AGH for higher level of care on 6/7/2020. Colonoscopy on 6/8/2020 showed a fungating, ulcerated, partially obstructing mass in the rectosigmoid; biopsy consistent with metastatic renal cell carcinoma. Previous colonoscopy in July 2019 did not show any masses. Patient started palliative radiation on 6/11/2020 with five sessions planned. Hematochezia improved after two sessions, and patient discharged home with plans to continue following with radiation oncology. Review imaging, including CT from 4/2020, discuss treatment options. | SN |

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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