

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, July 24, 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 | MC/MRN: 10362048DOB: 2/6/72 | 48 y/o female with a newly diagnosed rectal cancer. Colonoscopy done on 7/13/2020 patient found to have a frond-like villous and polypoid obstructing large mass found from 7-15 cm proximal to the anus. The mass was partially circumferential (involving 1/3 of the lumen circumference) and measured 8 cm in length. It was biopsied and came back as invasive adenocarcinoma. Flex sig done in office on 7/17/20.  MRI and CT CAP completed.Review scans and discuss treatment options. | JM |
| 2 | DB/MRN: 11821465DOB: 6/8/74 | 46 y/o female with newly diagnosed rectal cancer and presumed lung/liver metastases. Admitted to FRH on 7/16/20 with abdominal pain and fecal urgency. CT C/A/P and MRI pelvis completed on 7/16. Colonoscopy expected for 7/17. Requesting radiology and pathology review.  | AR |
| 3 | VF/MRN: 300787DOB: 4/30/57 | 63 y/o female with a newly diagnosed rectosigmoid cancer.  Screening colonoscopy on 7/16/2020 found a large circumferential malignant appearing tumor at 20 cm that was unable to be traversed. It was biopsied and tattooed and was at least intramucosal adenocarcinoma arising from a tubulovillous adenoma, underlying invasion cannot be ruled out.  Flex sig on 7/21 also found a very tight tumor in the distal sigmoid which could not be traversed and additional biopsies were taken.  CT on 7/21 with evidence of pulmonary and hepatic mets.  Review scan and discuss treatment options. | JM |
| 4 | JS/MRN: 11837560DOB: 7/11/78 | 42 y/o male with clinical stage T3N1 rectal cancer who previously underwent 8 cycles of neoadjuvant FOLFOX on 6/16/2020 followed by laparoscopic robotic total mesorectal excision (proctectomy) with creation of coloplasty anal anastomosis, creation of loop ileostomy, and takedown of the splenic flexure on 7/14/2020. Surgical pathology revealed no evidence of residual adenocarcinoma, no lymphovascular or perineural invasion and 25 lymph nodes negative for carcinoma. \*\*Requesting NAPRC Pathology Review\*\* | JM |
| 5 | JB/MRN: 4322531DOB: 12/21/42 | 77 y/o male with a history of cT2 cN0 rectal cancer diagnosed in January 2020. He was presented at Tumor Board on 1/31/2020, and the group's consensus was to proceed with chemoradiation to the rectum and prostate and extended Xeloda and then reassess. The patient had high risk prostate cancer that was inadequately treated (status post radical prostatectomy in 2015 with focal positive margin at the apex).  Could not receive definitive radiation treatment to the rectum due to need to treat the prostate. Finished neoadjuvant chemoradiation to the rectal mass and prostate fossa on 4/9/2020, and extended Xeloda completed on 4/23/2020. Flexible sigmoidoscopy on 5/4/2020 showed friable scar and granulation tissue, making treatment response difficult to assess. Tumor Board on 5/8/20 recommended repeat MRI pelvis in one month and to include the IMA node station.  MRI done 6/9/20 showed right anterior inferior tumor in the rectum that descends down into the internal sphincter with abnormal appearing lymph nodes. This tumor has decreased in size from original scan to 1.4 cm X 1 cm. The group's consensus was to proceed with APR. Laparoscopic abdominal perineal resection with end colostomy, en-bloc resection of the right seminal vesicle, bilateral ureteral lysis done 7/13/20. NPARC path review requested. | JM |
| 6 | FT/MRN: 10773744DOB: 4/6/50 | 70 y/o male with history of stage III rectosigmoid cancer and dysplastic cecal polyp.  Short course radiation (10/1/18-10/5/18) followed by laparoscopic robotic low anterior resection on 10/10/2018. T3N2a moderately differentiated adenocarcinoma. 12 cycles of adjuvant FOLFOX 11/8/2018-5/10/2019 followed by loop ileostomy takedown on 6/13/2019.   Laparoscopic robotic right colectomy on 10/21/2019 with pathology revealing a tubulovillous adenoma with focal high grade dysplasia.   CT C/A/P on 1/27/2020 which showed a new 5 mm right hepatic dome lesion.  A CEA done at that time was 8.5. He was discussed at the Multidisciplinary Colorectal Cancer Conference on 2/14/2020 with the recommendation to repeat a CT scan in 3 months. Repeat CEA level increased to 16.3.  Repeat CT C/A/P done 4/27/2020 showed a large hypodensity in the right hepatic dome that has increased in size.  Recommendation for chemotherapy followed by repeat imaging.  Discussed at liver conference 5/18/20 and then seen by Dr. Tindall on 5/21/20. Their assessment and recommendation: Two lesions consistent with mets. Start chemo with Dr. Asher. Consider right hepatectomy vs enucleation. No need for MRCP for bil dil, as he had one in 2018 for this reason. It showed benign peribiliary cysts. PSC seems much less likely. No signs of portal HTN.  CEA 7/13/20 remains elevated at 40.5.  Repeat CT c/a/p 7/17/20.  Completed cycle 6 FOLFOX 7/21/20. Review scan.  Discuss case regarding resection/SBRT. | NA |
| 7 | CK/MRN: 139158DOB: 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.NEEDS FOLLOW UP FOR NPARC | RF |
| 8 | PS/MRN: 641551DOB: 3/16/50 | 70 y/o female who had colonoscopy and abnormal CT scan with unexplained weight loss concerning for malignancy.  Review testing and discuss plans. | MV |

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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.

Disclosure:

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Moderators: Alexander Kirichenko, MD /Dulabh Monga, MD /James McCormick, DO/Richard Fortunato, MD