

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, July 31, 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 | MP/MRN: 11953091DOB: 2/19/58 | 62 y/o female with recently diagnosed rectal cancer.  Previously discussed at conference on 5/29/20.  Recommendation was to refer to Gynecology/Oncology for endometrial biopsy.   MRI showed a thickened endometrial lining demonstrating concern for possible endometrial cancer.  Endometrial biopsy showed benign polyp and tissue.  Patient requested combined surgery of a total abdominal hysterectomy with lymph node dissection and low anterior resection with diversion which was done on 7/16/20.  Requesting NPARC path review.   | MV |
| 2 | MCM/MRN: 3380668DOB: 3/29/61 | 59 y/o female presents with approximately 5-6 months of intermittent by worsening obstipation, mucousy discharge from the rectum as well as the rectal bleeding. She was noted to have upper to mid rectal mass on the digital rectal examination, flexible sigmoidoscopy was confirmatory to a mass within the upper rectum abutting the proximal 1st rectal valve mass was circumferential.  Biopsies confirmatory with adenocarcinoma.   Review scans and discuss treatment options. | SN |
| 3 | BS/MRN: 10946002DOB: 6/15/49 | 71 y/o male with history of stage I rectal cancer, diagnosed in July 2018 (initially found to have cancer in a polyp removed via piecemeal followed by standard transanal excision of rectal tissue with pathology revealing benign anorectal tissue. He presented to the office for routine surveillance on 12/6/19 and at that time his CEA was elevated at 10.4 (previously 3.6).   Flex-sig in the office on 12/6/19 revealed a recurrence of early stage rectal cancer.   PET scan suspicious for recurrence and enlarged hypermetabolic left internal iliac nodes. Patient was taken for transanal excision on 12/27/19 and pathology revealed a recurrence of his rectal cancer, stage T2N1a. Colorectal conference on 1/10/20 recommended Folfox (8 cycles) followed by chemoradiotherapy and then surgery.  Received FOLFOX 1/31/2020 -- 5/7/2020. Concurrent chemoradiation from 5/11/2020 --- 6/26/2020.  Flex sig on 7/24 showed complete endoluminal response.  Review scans and discuss treatment. | JM |
| 4 | EJ/MRN: 11213880DOB: 12/11/60 | 59 y/o male with recurrent rectal cancer and was initially diagnosed with stage III rectal cancer in February 2017. He received 8 cycles of FOLFOX followed by concurrent chemoradiotherapy completed on 9/20/2018. He then underwent transanal excision via TEM on 12/21/18 with pathology revealing ypT2NX moderately differentiated adenocarcinoma. He then underwent a laparoscopic robotic TME with creation of coloplasty anal anastomosis, creation of loop ileostomy, and takedown of the splenic flexure on 1/31/19. Pathology revealed yp T3N0 residual invasive moderately differentiated adenocarcinoma, 0/24 lymph nodes positive. He received all treatment upfront therefore no adjuvant chemo was needed and was taken for ileostomy takedown on 3/5/19. He had a repeat CT C/A/P on 1/3/2020 which showed further increase in size of a lymph node just anterior to the sacrum that was felt to represent an IMA station node .Colonoscopy done 1/31/20 revealed a rectal mass concerning for recurrence but path was non conclusive. An EUA was done on 2/20/2020 and pathology confirmed rectal adenocarcinoma. Patient then underwent a laparoscopic robotic abdominal perineal resection with creation of end colostomy on 3/12/2020. Surgical pathology revealed T3N1a recurrent invasive moderately differentiated adenocarcinoma. He has been receiving infusion 5FU and a restaging CT scan was done on 7/13/2020 which showed new enlarged right inguinal lymph node measuring 2.3 x 3.0 cm compatible with metastatic disease. Underwent right inguinal LN excision. Review pathology and discuss treatment options | JM |
| 5 | JS/MRN: 749318DOB: 1/11/56 | 64 y/o male with a history of stage I rectosigmoid adenocarcinoma, status post resection in August 2018. Surgical pathology revealed well-differentiated adenocarcinoma, 26 lymph negative nodes, and resection margins negative. Although the patient had T1 disease, he now has local recurrence. Post-operative complications included anastomotic leak, fascial dehiscence x 2, and fistula formation.  Patient was recently admitted with hypotension and CT a/p showed increasing inflammatory change and soft tissue thickening at the site of the contained leak at the colorectal anastomosis, a presacral fluid collection increasing in size with soft tissue thickening, sigmoid colitis, and cystitis.  MRI on 7/17 showed concern for recurrent tumor.  Taken to the OR on 7/17 for rectal EUA and flex sig.  Pathology revealed recurrent adenocarcinoma.  He has had numerous hospitalizations and SNF admissions in the past 2 years.  Currently his worsening hip pain has left him home bound.  Review scans and discuss treatment options. | MV |
| 6 | AMS/MRN: 11299100DOB: 8/27/72 | 47 y/o female that was diagnosed with colorectal carcinoma in 2016. She underwent surgery in 2016, she had recurrence in 2018 underwent a secondary surgery and had ileostomy placed at that time.  She had her ileostomy reversed in 2019. A EUA for a large cervical ma was done on 7/17/20. Path came back as adenocarcinoma. Review pathology and scans | JM |
| 7 | WD/MRN: 94411DOB: 11/17/69 | 50 y/o male with hx of testicular cancer (treated in 2005 with orchiectomy) who recently was in a MVA and CT A/P was done for abdominal pain and revealed a large 8 cm x 5 cm lipomatous tumor involving the left ischiorectal fossa. A MRI Pelvis was done on 7/23/2020. Requesting imaging review.  | JM |
| 8 | CD/MRN: 411868DOB: 6/4/57 | 62-year-old female with 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, pT3 pN0. She did not receive adjuvant therapy. She was recently admitted due to elevated CEA and concern for recurrence.  CT AP revealed no evidence of metastatic lesions to the liver aside from a new large hematoma within the pelvis. She was presented at conference on 5/29/20 and the group's consensus was to perform a trans rectal biopsy of the rectal stump.   She underwent a TAH, BSO, LAR, and small bowel resection with removal of pelvic mass.  Path revealed adenocarcinoma of pelvic mass.Review path and discuss treatment options | SN |
| 9 | CI/MRN: 10468055DOB: 7/20/67 | 53 y/o female that had a hemorrhoidectomy on 7/17/20.  Biopsy revealed invasive moderately differentiated squamous cell carcinoma with basaloid features.  Last colonoscopy was 6/14/18.  CT scan done 7/28.  Saw med onc and rad onc 7/29.  Review scans and discuss treatment. | MV |
| 10 | CG/MRN: 10318654DOB: 1/19/43 | 77 y/o female with a new history of colon cancer and h/o bladder cancer  in 2014 s/p BCG injections who originally presented with RLQ pain and loose stools to Sewickley hospital and was transferred to AGH for surgical evaluation.  CT A/P showed a right colon mass.  Pre-op CEA is 8.8.  On 5/19 she had a right open colectomy by Dr. McCormick.  She began adjuvant chemo on 7/1/20 and received 1 cycle and presented to ED for dehydration. She continued to have problems with high output from her ileostomy and this was reversed on 7/21/20. An incidental finding of a mass in the right rectus was biopsied at that time and pathology demonstrated adenocarcinoma.  Review pathology and discuss treatment plans | JM |
| 11 | MS/MRN: 11744095DOB: 7/2/80 | 40 y/o male with metastatic colon cancer (mid-descending colon) and 2 liver mets, Stage IV pT3 N0 M1, MMR intact, 4/8/20 CEA 11.2, s/p 6 cycles neoadjuvant FOLFOX, CEA 8.7. 4/8/2020 -   CT Abd Pelvis with contrast: circumferential annular constricting neoplasm involving the mid descending colon. Indeterminate 3 cm hypodense right hepatic lesion on 2-32 and a smaller sub 5 mm hypodense right hepatic lesion on 2-17. CT Chest revealed no evidence of metastatic disease. 4/10/2020 - Surgery (McCormick) Open subtotal colectomy with ileo-distal sigmoid anastomosis with an omental patch to the anastomosis. Intra-operatively the tumor was in the mid-descending colon. A large volume of ascites was suctioned. Review CT scans after neoadjuvant therapy for Stage IV colon cancer with oligometastatic liver metastasis. | DM |
| 12 | MC/MRN: 11975813 | 47 y/o female with anterior abdominal wall fistula draining and transverse colon mass. 7/23 CT abd/pelvis: Large central abdominal mass favored to represent a combination of neoplasm and abscess, likely originating from the transverse colon. The anterior wall of the transverse colon has been eroded, with necrotic tumor/abscess extending through the anterior wall of the transverse colon. The tumor/abscess invades the anterior aspect of the distal stomach as well as multiple small bowel loops inferiorly. Furthermore, there is a fistulous tract communicating between tumor/abscess and the skin surface of the abdominal wall. There is also a fistulous tract containing tumor/abscess extending from this large mass to the dome of the bladder into which a pigtail catheter has been inserted. The findings are highly suspicious for colovesical fistula. Multiple sub centimeter ill-defined hepatic lesions worrisome for metastatic disease. Mildly enlarged lymph nodes in the mesentery, also worrisome for metastasis. 7/22 prelim cytology : ABDOMINAL MASS, TOUCH PREPARATION CYTOLOGY:POSITIVE FOR CARCINOMA, FINAL CLASSIFICATION PENDING CORE BIOPSY AND FURTHER WORKUP | RF |

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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