

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, August 28, 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 | PH/MRN: 10594677  DOB: 12/8/51 | 68 y/o female with a newly diagnosed rectosigmoid mass suspicious for cancer. She had a colonoscopy 7/30/20, her first, which showed a rectosigmoid mass 3.5 cm with central ulceration consistent with primary carcinoma. The mass was biopsied and tattooed and resulted as adenocarcinoma.   CEA of 10.3 on 7/30/20. CT C/A/P done 8/5 showed no evidence of metastatic disease.   Had a laparoscopic robotic LAR on 8/19/20.  Requesting path review. | JM |
| 2 | DR/MRN: 5338269  DOB: 5/21/68 | 52 y/o male with T3N2 low rectal adenocarcinoma with suspected involvement of external sphincter and pelvic sidewall. MMR intact. Expected to complete 8 cycles of FOLFOX at Kittanning on 9/4/20. Most recent CT from 7/7/20 showed rectal mass and mucosal thickening decreased by at least 50% and surrounding lymph nodes decreased as well. Patient had exam with Dr. Fortunato on 8/26/20 indicating full endoscopic resolution of his rectal cancer. Discuss radiation treatment. | JR |
| 3 | 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 redemonstration 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. Patient was discussed at conference on 6/19/20 and the recommendation was to do a pelvic exenteration followed by radiation.  Patient was taken to the OR on 7/16/20 for a pelvic exenteration and left internal iliac node dissection and again on 7/31/20, and 8/3/20 for an Exploratory Laparotomy with small bowel resection, ileal conduit, and ileostomy.  On 8/4/20 he underwent a Rectal exam under anesthesia. Review path and discuss any further treatment options. | JM/SN |
| 4 | DP/MRN: 5732363  DOB: 7/22/61 | 59 y/o female with hx of colon cancer and breast cancer.  She initially presented with symptoms of abdominal pain and fullness in April, 2017. Her PCP obtained a pelvic ultrasound which showed a large loculated complex cystic mass in the midline. CT scan which was done on 5/9/2017 and showed a large apple-core type mass in the proximal descending colon compatible with colonic neoplasm without evidence of obstruction. She was taken to surgery on 5/24/2017 (combined case with Dr. Price and Nosik) for an exploratory laparotomy, radical ovarian cancer tumor debulking, total abdominal hysterectomy, bilateral salpingo-oophorectomy, resection of pelvic mass, and appendectomy with left hemicolectomy with primary anastomosis. Surgical pathology revealed T3N1a well-moderately differentiated mucinous adenocarcinoma with 1/21 lymph nodes positive. A right diaphragm peritoneum biopsy was done and revealed metastatic mucinous adenocarcinoma. Pathology of right ovary was metastatic mucinous adenocarcinoma of colonic origin, fallopian tube benign. Pathology of uterine serosa was metastatic mucinous adenocarcinoma, cervix, ovary, and fallopian tube benign. She saw Dr. Islam and started FOLFOX on 7/10/2017. She started FASLODEX for treatments of recurrent invasive ductal carcinoma (s/p XRT and lumpectomy) on 7/31/2017.  She then had a mastectomy and node dissection in October 2017 with chemo following. Surveillance was done via PET/CT and on 6/5/2020 had a CT A/P due to rising CEA level (5.2) and left leg swelling which showed mucosal thickening distal sigmoid/rectum and soft tissue mass left deep pelvic likely reflecting adenopathy. Colonoscopy done by Dr. Appasamy on 6/10/2020.  An US Pelvis was done on 7/24/2020 which showed in the left adnexa a heterogenous mass. A CT guided biopsy was done and metastatic adenocarcinoma of colorectal origin. A MRI Pelvis was done and showed a 2.4 cm rim enhancing suspected mucinous peritoneal tumor deposit in the left hemipelvis. Discuss treatment options. | JM |
| 5 | RF/MRN: 12065000  DOB: 7/17/69 | 51 y/o female that underwent 1st ever screening colonoscopy and was found to have a 5 millimeter polyp in the rectum. Final pathology noted well differentiated neuroendocrine tumor, grade 1. Chromogranin A was 53. Discuss treatment. | 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:

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