

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, August 7, 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 | 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. A 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 |
| 2 | CL/MRN: 10912929DOB: 9/1/52 | 67 y/o male with a stage III, T3N1 CRM negative high rectal cancer on pelvic MRI diagnosed 3/2020.  Per recommendation at colorectal conference on 3/13/20 patient was started on the TNT protocol and completed neoadjuvant FOLFOX x 8 cycles (4/14/20-7/21/20) .  Flex sig done 8/5 showed excellent response.  Discuss option for next step—no radiation or short course followed by total mesorectal excision. | JM |
| 3 | 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 |
| 4 | SW/MRN: 693034DOB: 6/5/53 | 67 y/o male with history of T3 No colon cancer diagnosed in 3/2019.  Given that the mass was perforated, the clinical staging was reviewed at cancer conference on 3/8/19 and was determined to be consistent with T4 lesion.  The group's consensus at that time was to begin adjuvant chemotherapy.  He completed chemo in August 2019.  CT in March 2020 revealed soft tissue mass abutting the rectal pouch and new liver and pulmonary lesions.  Patient began FOLFIRI with Avastin on 3/30/20 and will finish 12th cycle on 8/31/20.  Review scans and discuss treatment options. | SN/MI |
| 5 | CD/MRN: 411868DOB: 6/4/57 | 62 y/o 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 |
| 6 | VF/MRN: 300787DOB: 4/30/57 | 63 y/o female that was discussed at the Multidisciplinary Colorectal Cancer Conference at AGH on 7/24/2020. She had a screening colonoscopy on 7/16/2020 and was found to have a large circumferential malignant appearing tumor at 20 cm that was unable to be traversed. Biopsy revealed at least intramucosal adenocarcinoma arising from a tubulovillous adenoma. A CT C/A/P was done and revealed a circumferential constricting mass in the rectosigmoid colon with mesorectal lymphadenopathy. There were also multiple liver metastases and pulmonary nodules highly concerning for metastases. A CEA level was done and came back at 669. The group reviewed all imaging and has recommended upfront chemotherapy specifically FOLFOXIRI and Avastin due to increased chance of liver resectability. Dr. McCormick advised that he is placed a colonic stent and a port on 7/24.  Patient had Cycle 1 FOLFOX 7/30.  Treatment did not include Irinotecan or Avastin at this time.  Patient also had consults with Dr. Uemura and Dr. Fernando regarding her liver and lung mets. Asking for pathology review. | JM |

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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