

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, September 13, 2019

7:00am -8:00am

Pugh Classroom, 2nd floor, AHNCI

Zoom Meeting: <https://zoom.us/j/966171364>

Dial US: 646-558-8656

Meeting ID: 966171364

**Cases to be discussed**

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| **Case**  | **De-identified patient** | **Reason** | **Presenter** |
| 1 |  DS/ MRN: 11605232 DOB: 6/12/53 | Patient with newly diagnosed colon cancer who underwent a laparoscopic left hemicolectomy on 8/13/19. Path revealed adenocarcinoma of the descending and transverse colon times 4 tumors. Path review |  RF |
| 2 | TS/ MRN: 294196 | 44 y/o male with newly diagnosed rectal cancer on colonoscopy completed on 9/4/19 for rectal bleeding. Distal proctoscopy in office noted mass at 12cm. CEA 1.8. CT C/A/P and pelvic MRI scheduled Wednesday 9/11/19 | MV |
| 3 | EK/ MRN: 3711331DOB: 11/29/35 | 83-year-old male with recently diagnosed colonic mass. Patient recently underwent PCI to LAD with drug-eluting stent following anterior STEMI on 9/1/2019 at OSH. He was noted to have hematuria after starting Brilinta and hematochezia after switching to Plavix. Colonoscopy on 9/4/2019 showed a 20 mm malignant-appearing, partially obstructing tumor in the ascending colon. Biopsy showed fragments of tubulovillous adenoma (several other polyps were identified but not biopsied). Cardiology recommends a minimum of 4 weeks prior to holding Plavix and starting Cangrelor IV 5 days prior to surgery. Discuss optimal surgical intervention and timing. Pathology review requested (slides being sent from Highlands Hospital for Dr. Miller) CT A/P images being uploaded for review.  | MV |
| 4 | DK/ MRN: 11693086DOB: 4/22/1947 | 72 yo female who presented to GI with rectal bleeding and noted an abnormality on exam. She was then seen by Dr. McCormick on 9/6/19 and a flex-sig was done which showed a rectal mass and biopsy revealed invasive non-keratinizing squamous cell carcinoma. \*\*Requesting pathology review\*\* | JM |
| 5 | KG/ MRN: 1180537DOB: 6/14/1946 | 73 yo female being seen by Dr. Petursson for hemochromatosis who was seen for surveillance on 9/5/19 and reported acute abdominal pain x 3 weeks. CT A/P done on 9/5/19 showed findings consistent with peritoneal carcinomatosis and malignant ascites, asymmetric sigmoid colonic wall thickening, possible representing a primary colonic neoplasm, and trace right pleural effusion.  | JM |
| 6 | DL/ MRN: 588990DOB 3/1/1941 | Diagnosis rectal neuroendocrine tumor; Size 12 mm. Stage pending Well differentiated rectal carcinoid s/p polypectomy | AK |
| 7 | JH/ MRN: 348319DOB: 10/6/47 | This is a patient with microsatellite stable KRAS mutant metastatic colorectal cancer with significant hepatic disease. His recent imaging seems to demonstrate some disease progression in his liver on second-line therapy with irinotecan and Avastin. We will present his case in colorectal tumor board or consideration of alternative treatment. We do not have a current clinical trial available for him. He is clinically stable and maintaining a normal functional capacity. We will continue with his current therapy for now. Need to consider options for 3rd line therapy | GF |
| 8 | CS/ MRN:11602325DOB: 4/11/61 | 58 y.o. female with a newly diagnosed dysplastic colon polyp. She presented to Highlands Hospital ER 8/5/19 for fever and abdominal (RLQ and LLQ) pain worsening over 2 weeks and had a CT A/P without contrast that showed no acute intra-abdominal pathology.  She returned to the ER 8/9/19 for constipation with no BM x 8 days and intractable abdominal pain and underwent a CT A/P 8/10/19 without contrast that showed no acute process and moderate constipation.  She had a CT A/P with and without contrast 8/12/19 that showed no acute CT pathology of the abdomen/pelvis, probable hemangioma periphery right lobe of liver, and probable tiny right adrenal adenoma.  Colonoscopy 8/22/19 by Dr. Bradley showed a 1.5 cm distal transverse colon polyp that was removed in 3 pieces and showed fragments of tubular adenoma with extensive high grade dysplasia, suggestive of intramucosal carcinoma and the margins could not be evaluated; a 5 mm cecal polyp that was removed and was a tubular adenoma; a patent sigmoid anastomosis; diverticuli close to the anastomosis; internal hemorrhoids.(She has a significant past surgical hx including gastric sleeve followed by Roux-en-Y gastrojejunostomy revision, cholecystectomy 4/23/19 complicated by gallbladder fossa abscess treated with antibiotics and drain, diverticulitis s/p sigmoid resection in 1998,  and uterine cancer s/p total abdominal hysterectomy, and hernia repair)Pathology review requested (slides being sent from Highlands Hospital for Dr. Miller); CT A/P images being uploaded for review. | JM |
| 9 | FN/: MR# 11673140 | 62 y.o. male who  underwent a colonoscopy after having a positive Cologuard 7/25/19 by Dr. Moon that showed a 2 cm rectal mass close to the anal verge that occupied ¼ circumference and was biopsied and showed intramucosal carcinoma arising in a tubulovillous adenoma; cannot exclude invasive carcinoma.   Flex sig in office 7/31/19 showed tubulovillous adenoma.  TRUS T1N0.  He is s/p Robotic Transanal Excision of Rectal Mass 9/4/19.  REQUESTING NAPRC PATHOLOGY REVIEW.Discuss clinical management and research opportunities  | 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:

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