

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, September 18, 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 | CL/MRN: 10912929DOB: 9/1/52 | 67 y/o male with clinical stage T3N1 CRM negative mid rectal cancer diagnosed March 2020.  Previously discussed at conference recommendation was TNT. He completed 8 cycles of neoadjuvant FOLFOX from 4/14/2020-7/21/2020 and had a flex-sig done which showed an excellent response. His initial staging MRI was reviewed and showed a 3-4 cm mass in the lumen of the bowel and was T3 based on speculations.   Had MRI of the pelvis followed by short course radiation and then Laparoscopic robotic proctectomy TME with diverting loop ileostomy on 9/2.  Requesting NPARC path review. | JM |
| 2 | JL/MRN: 796035DOB: 7/26/66 | 54 y/o male with MS and clinical stage T3N1 rectal cancer.  He initially presented to an OSH (in Mississippi) for rectal bleeding where a CT scan was done and revealed circumferential wall thickening within the mid rectum and at least 8 sub-centimeter mesorectal fascia lymph nodes. He then had a colonoscopy done on 2/26/2020 which showed a fungating and ulcerated partially obstructing large mass found in the mid-rectum that was biopsied and came back as invasive moderately differentiated colonic adenocarcinoma.  MRI pelvis was done at OSH that showed an irregular circumferential enhancing mass in the high and mid rectum extending to a length of 8cm. It was staged as T4aN2 with involvement of the right mesorectal fascia and peritoneal reflection.  He was discussed at conference and the group recommended placing a colonic stent, and starting total neoadjuvant treatment. He underwent colonic stent placement on 5/5/2020. His imaging (MRI) was obtained and re-presented at MDTB on 5/8/2020 and radiologist present at conference felt it should be staged as T3N1.  He completed 8 cycles of FOLFOX on 9/2/20. Repeat MRI done on 9/14/20. Review MRI and clarify staging.  Discuss short course versus long course radiation. | JM |
| 3 | TM/MRN: 11308201DOB: 9/11/61 | 59 y/o female with hx of metastatic rectal cancer to the lung/liver referred by Dr. Fu, patient’s medical oncologist in Dubois for an abnormal PET/CT scan.She is s/p laparoscopic robotic assisted posterior pelvic exenteration with removal of uterus, right fallopian tube and ovary, rectum, posterior vagina, right pelvic sidewall, bilateral ureterolysis, revision of stoma, takedown of loop colostomy, primary repair of parastomal hernia, and creation and end colostomy by Dr. McCormick and reconstruction of pelvic exenteration defect with myocutaneous flap from abdomen (rectus abdominus) by Dr. Kang on 8/14/19. Pathology revealed a ypT4bN0 moderately differentiated adenocarcinoma with uninvolved circumferential resection margin (4 mm), uninvolved distal resection margin, completely intact mesorectum and a treatment effect score of3*.* Her pathology was reviewed at the Multidisciplinary Colorectal Cancer Conference on 8/23/19 and the group recommended proceeding with adjuvant chemotherapy with 5FU and Avastin for maintenance and close surveillance q 3 months. She was started on FOLFIRI and Avastin on 11/12/19 by Dr. Maofu Fu in Clearfield, PA. The Avastin was stopped due to proteinuria on cycle #3 and she has been just getting FOLFIRI. She recently had a PET/CT on 9/1/20 that showed a newly identified focus of density of metabolic activity along the anterior, right lateral aspect of the surgical bed concerning for recurrent disease and an increase in the size of pulmonary nodules since 2/17/20 concerning for progressing metastatic disease despite metabolic activity remaining within the upper limits of normal. Dr. Grae Schuster, radiation oncology at Dubois, states she is not a candidate for further radiation to this area. Review scan, previous radiation treatment, and discuss options. | JM |
| 4 | MF/MRN: 12149980DOB: 3/30/49 | 71 y/o female presented to OSH with two days of abdominal pain, nausea, vomiting, and mucus per rectum. CT imaging was concerning for aortoenteric fistula, and she was transferred to AGH for further evaluation. CT AP over-read also noted a large amount of gas around an abnormal appearing distal sigmoid colon and upper rectum. Patient underwent open sigmoid resection and end descending colostomy by Dr. Khan on 9/13 for suspected contained perforated diverticulitis. Pathology consistent with invasive moderately differentiated adenocarcinoma with lymphovascular and perineural invasion and positive distal margin. CT chest pending. CEA 3.9. Review imaging, pathology, and discuss treatment plan. | SN |
| 5 | BP/MRN: 5750068DOB: 12/30/37 | 82-year-old female with newly diagnosed sigmoid colon mass. Patient initially presented with worsening abdominal pain and distension for one week. CT AP showed a colon mass with invasion into the bladder dome. CT chest showed a 4 cm pulmonary nodule in the left upper lobe, possibly another primary. Colonoscopy by Dr. Nosik showed a very tortuous colon with numerous large diverticula. Colonoscopy aborted without obtaining biopsies. Previous colonoscopy was 20-30 years ago (also aborted per patient). Patient underwent cystoscopy, and biopsy confirmed adenocarcinoma, consistent with metastatic colon adenocarcinoma. CEA 16.0 ng/mL. Gastrografin enema on 9/14 showed abrupt caliber cutoff at the midsigmoid at the region of the mass. Patient planned to undergo laparoscopic colostomy creation on 9/17 by Dr. Reichstein. Review imaging and pathology from cystoscopy, discuss treatment plan moving forward. | AR |
| 6 | EF/MRN: 290613DOB: 7/2/43 | 77 y/o male with hx of stage IV colon cancer with liver metastasis.   Colonoscopy 2/21/20 showed a fungating, infiltrative, and ulcerated partially obstructing large mass at 70 cm proximal to the anus, likely the ascending colon (unable to visualize the appendiceal orifice/ileocecal valve so exact location is unclear), that was biopsied and tattooed distally and was a moderately differentiated invasive adenocarcinoma;  CT C/A/P 2/26/20 showed a hepatic flexure malignancy and associated enlarged, presumably metastatic lymph nodes, intrahepatic metastases, 10 mm LLL nodule, nonspecific mild mediastinal lymphadenopathy, non-nodular thickening of the left adrenal gland, presumably related to hyperplasia, and regions of pleural thickening presumably related to asbestos related pleural disease.  He received 12 cycles of FOLFOX and is now on maintenance 5 FU.   Per Dr. Finley’s office note from 8/24/20, his liver disease is stable with a near complete response and he recommended addressing the primary tumor. Last CEA was 7.5 on 6/30/20.  Requesting review of scans prior to proceeding with surgery. | 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