GI Malignancies: Cases & Discussion

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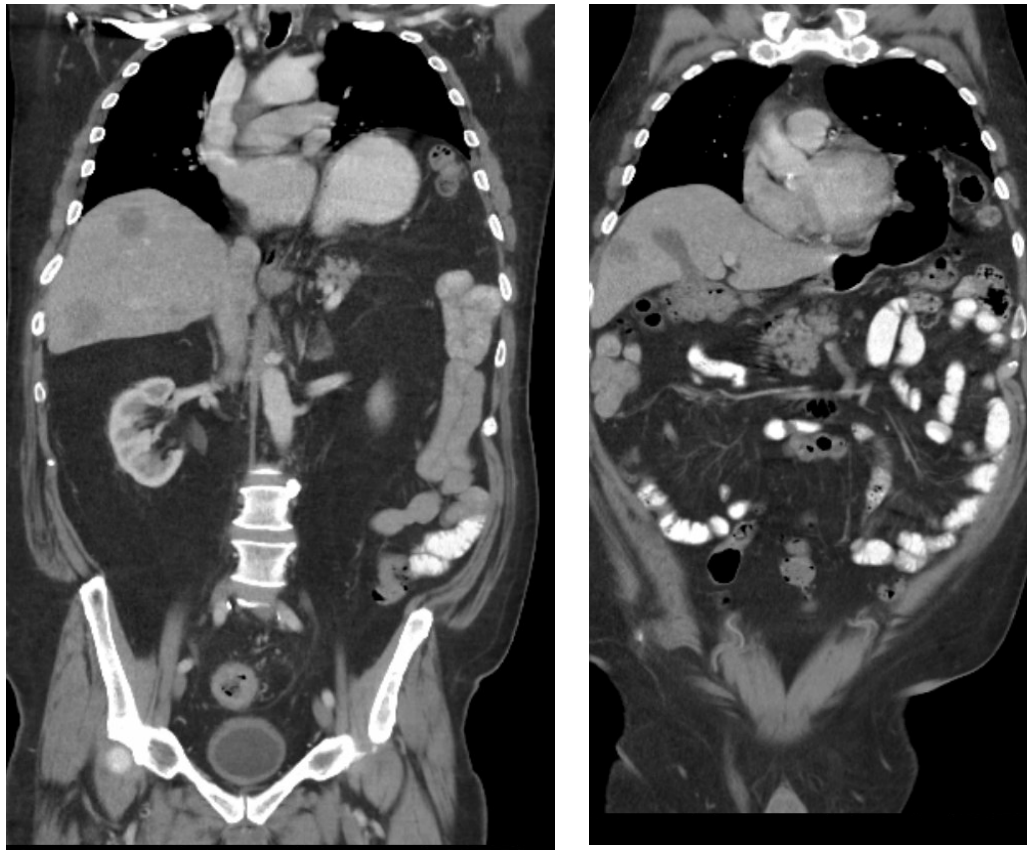
Ochsner MD Anderson Cancer Center

Making Cancer History®

Case 1

- 64 y/o M with no significant PMH presents with weight loss and anemia
- CA 6.0
- CT CAP showed 6 lesions in R hepatic lobe; proximal rectal wall thickening
  - Left lobe volume relatively small



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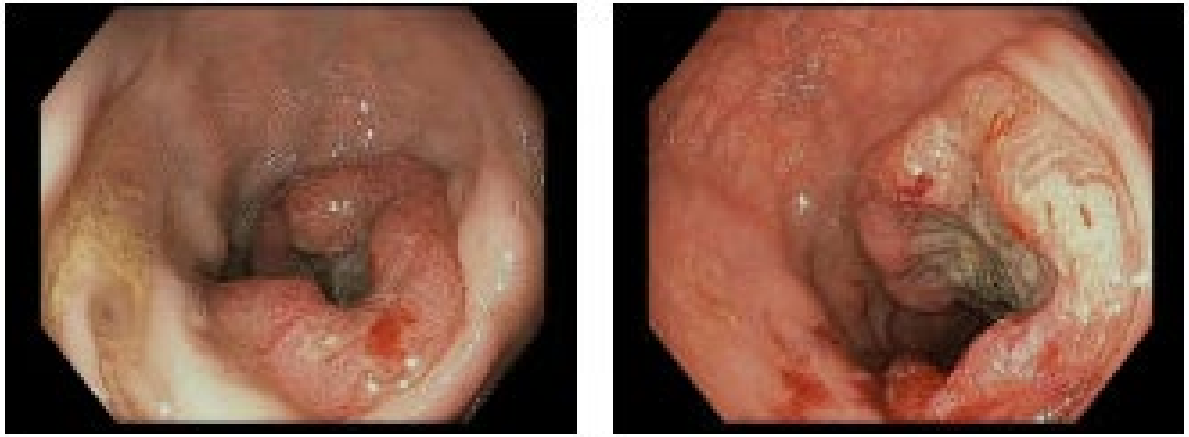
Case 1

- Colonoscopy Findings:
  - Malignant appearing mass in the proximal rectum causing partial obstruction beginning about 12 cm from anal verge
- Pathology:
  - Moderately differentiated invasive adenocarcinoma
  - pMMR by IHC
  - Tumor NGS: CHEK2, APC, FBXW7 mutations. MSS, TMB low.



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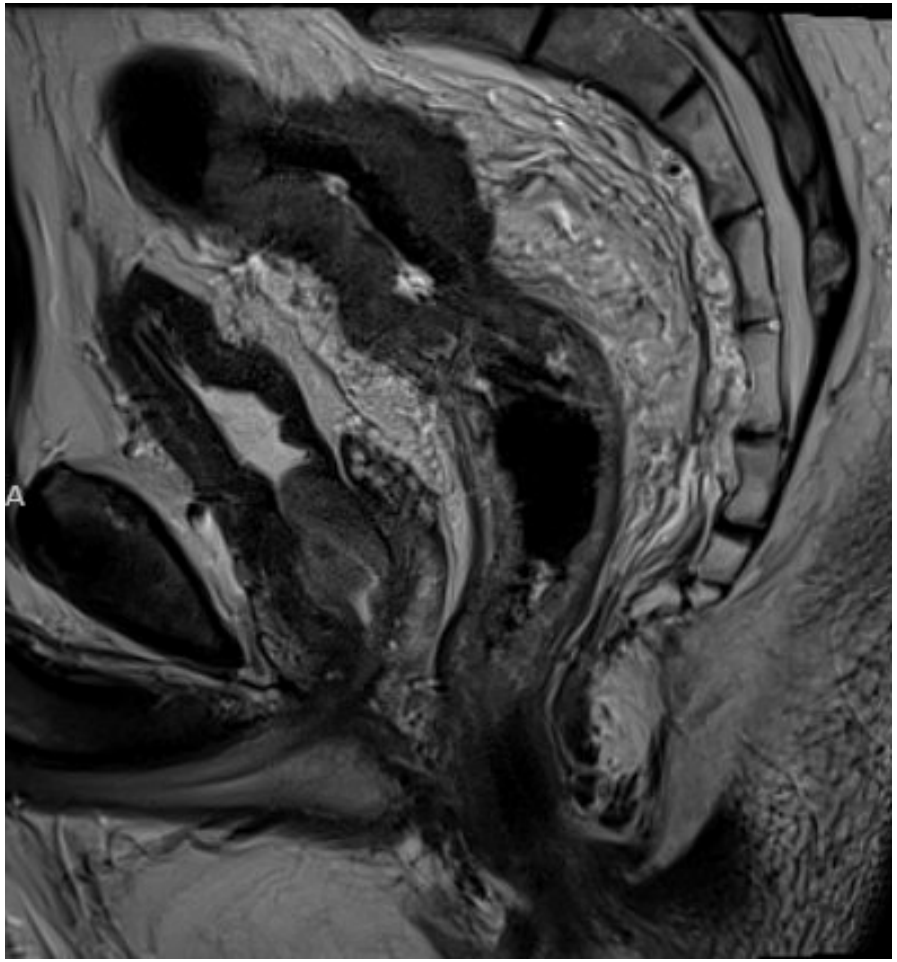
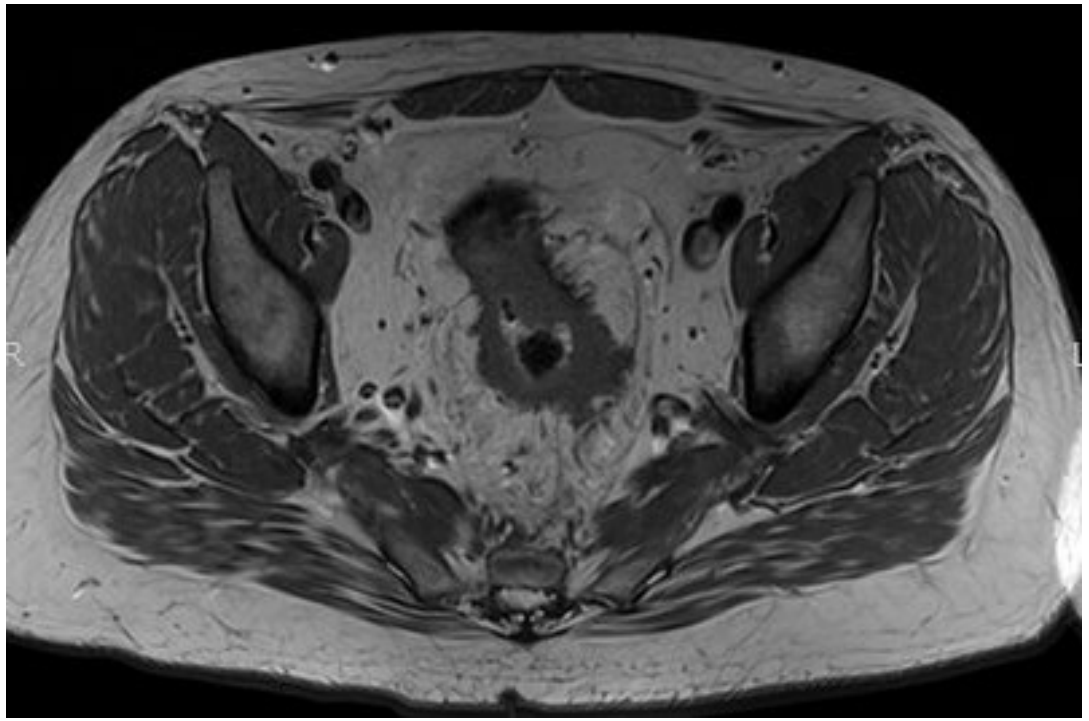
Case 1





- MRI rectum: T4a tumor in upper rectum, + EMVI with 3 suspicious mesorectal lymph nodes. Mesorectal fascia is involved

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Case 1

- In this patient with minimally symptomatic rectal adenocarcinoma with liver metastases, how would you approach/sequence therapy?

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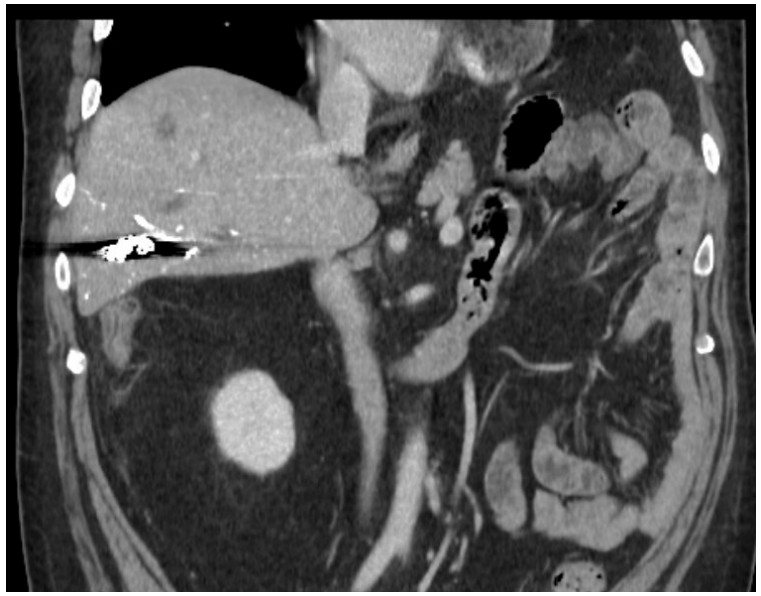
Case 1

- Received short course radiation (25 Gy in 5 Fx) to primary tumor.
- Began mFOLFOX + bevacizumab
- Underwent portal vein embolization to R liver lobe



- CT after 6 cycles of chemotherapy showed scattered hyperdense particles s/p PVE/HVE
- Only 2 hepatic lesions visualized, both in R lobe, both smaller in size

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Case 1

- Completed 3 more months of chemotherapy (6 months total).
- Restaging imaging showed continued response in liver. MRI rectum showed partial response but probable residual tumor.
- Flexible sigmoidoscopy showed “malignant-appearing, intrinsic moderate stenosis in proximal rectum”
- Discussed at tumor board with recommendations for Low Anterior Resection

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Case 1

SPECIMEN

1. Sigmoid colon, rectum, and omentum

2. Proximal donut

3. Distal donut

FINAL PATHOLOGIC DIAGNOSIS

1. Rectum, sigmoid colon, omentum; low anterior resection:
- Invasive adenocarcinoma
- Pathologic stage: ypT3N0
- See synoptic

2. Colon, proximal donut, excision:
- Segment of colon with no diagnostic histopathologic alterations
- Negative for malignancy

3. Colon, proximal donut, excision:
- Segment of colon with no diagnostic histopathologic alterations
- Negative for malignancy

TUMOR SYNOPTIC: (COLON and RECTUM)
Standard(s): AJCC 8th Edition

SPECIMEN
Procedure: Low anterior resection

TUMOR
Tumor Site: Rectum, entirely above the anterior peritoneal reflection
Histologic Type: Adenocarcinoma
Histologic Grade: G1, well differentiated (>95% gland formation)
Tumor Size: 2.5 cm
Tumor Extent: Invades through muscularis propria into pericolorectal tissue
Macroscopic Tumor Perforation: Not identified
Lymphovascular Invasion: Not identified
Perineural Invasion: Not identified

TREATMENT EFFECT:
Residual cancer with evident tumor regression (partial response, score 2)

MARGINS
Margin Status for Invasive Carcinoma: All margins uninvolved by invasive carcinoma and dysplasia
Margin Status for Non-Invasive Tumor: All margins negative for dysplasia
Closest Margin to Invasive Carcinoma: Radial, 1.5 cm

REGIONAL LYMPH NODES
Number of lymph nodes involved: 0
Number of lymph nodes examined: 27
Tumor Deposits: Not identified

PATHOLOGIC STAGE
TNM Descriptors: y, post treatment
pT Category: pT3; Tumor invades through muscularis propria into pericolorectal tissue
pN Category: pN0; No regional lymph node metastasis

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Case 1

- Post-LAR imaging showed stable R liver lesions x 2, no new sites of disease
- Decision made to proceed with R hepatectomy

FINAL PATHOLOGIC DIAGNOSIS

1. GALLBLADDER, CHOLECYSTECTOMY:
Ulcerative and perforated cholecystitis
One benign lymph node (0/1)

2. RIGHT LIVER, PARTIAL HEPATECTOMY:
Consistent with metastatic colorectal adenocarcinoma (2 nodules)
Margins all negative
See comment

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Case 1

- 9 months post liver resection, develops new 1.5 cm metastasis in liver
- What are remaining available treatment options?

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Case 2

- 66 y/o M with history of hepatitis C infection s/p treatment with SVR, cirrhosis, HTN
- Presented with new HCC – 2 cm LI-RADS 5 lesion in segment VIII. AFP at diagnosis 150.
- What are initial options of management in this patient?

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Case 2

- Patient undergoes yttrium-90 radioembolization and liver transplantation evaluation begins.
- Repeat imaging 6 weeks after Y-90 radioembolization shows post-treatment changes in segment VIII. New 3.8 cm lesion is noted with portal vein invasion. Newly enlarged periaortic lymph nodes (2.3 cm, 3.2 cm, 2.8 cm).
- AFP is 170 (from 150 at diagnosis).

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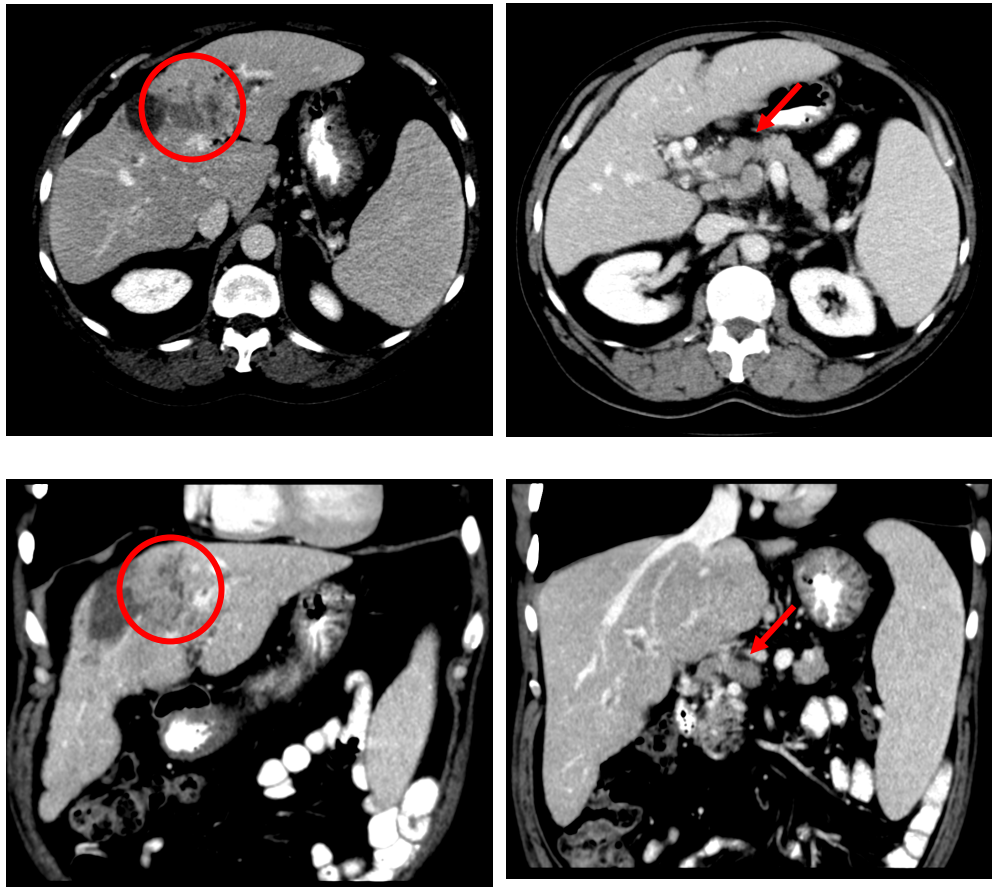
CT Abdomen/Pelvis - Baseline



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Case 2

- What are options for therapy now?

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Case 2

- Patient began atezolizumab cycle 1 and received Y-90 radioembolization to new 3.8 cm lesion three days post-infusion.
- Bevacizumab added to atezolizumab with cycle 2 after EGD confirmed no esophageal varices.

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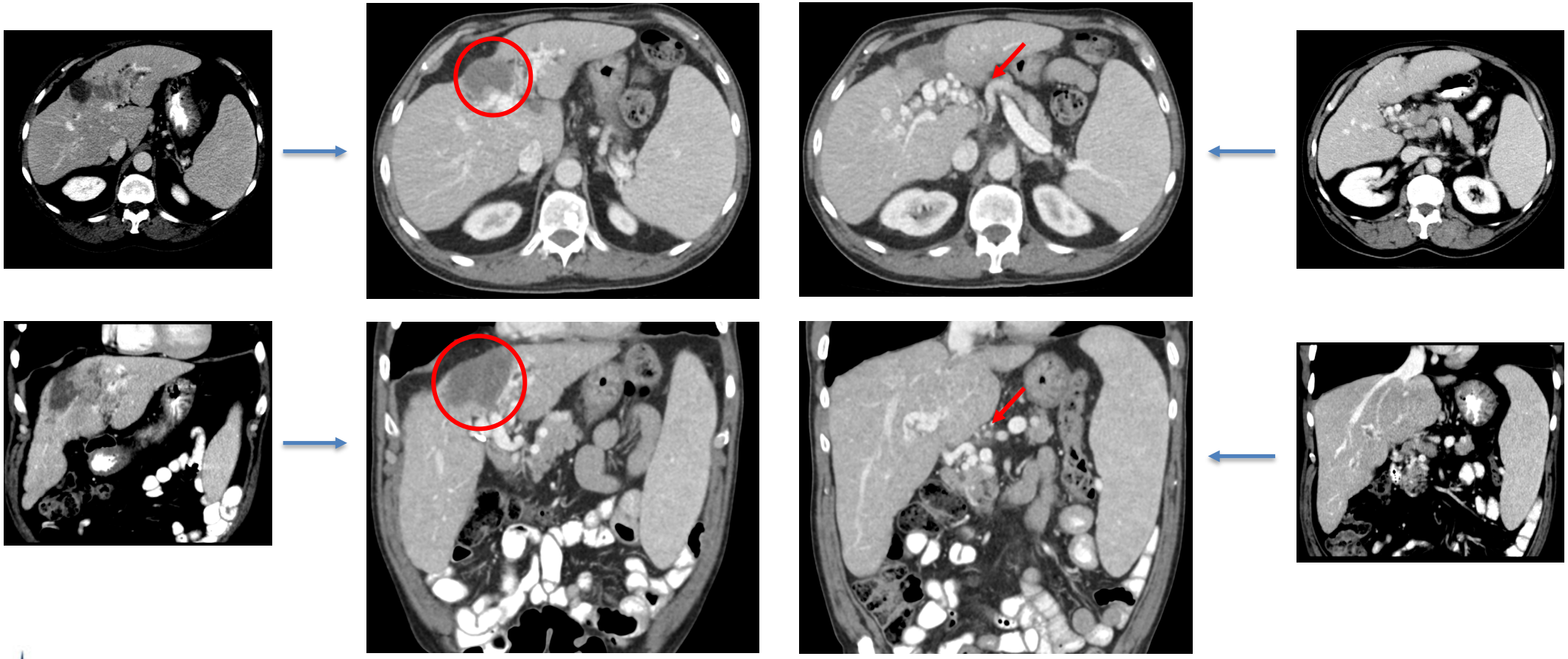
CT Abdomen/Pelvis – 2.5 years later



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Thank you!

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