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Oncology Second Opinion - Extended Written Report

Date: 2022-12-18

Patient: Jane Doe

Discussion:

Jane Doe is a 57 year old woman requesting second opinion for rectal cancer.

The patient has no past medical history prior to this.

6/7/16 abdominal US: multiple RP lymph node enlargement, partly compressing the right iliac vein

6/16/16 colonoscopy: tumor seen with size 2 x 2.5 cm seen 3 cm in the rectum with surface erosion. No other abnormal findings

6/22/16 C# 1 XELOX: improvement in right leg swelling

6/30/16 PET/CT: rectal cancer after chemotherapy, bilateral supraclavicular, mediastinal, right hilar, retroperitoneal, right inguinal lymph node metastases

7/8/16 pathology report from rectal biopsy: broken adenocarcinoma

7/9/16 to 10/14/2016 7 cycles of FOLFIRI + bevacizumab

9/2/16 Chest CT : no active lesions seen in bilateral lungs

9/7/16 CT abdomen: multiple retroperitioneal lymph nodes, small cysts in left kidney

9/29/16 tumor markers normal except CA 72-4 : 16.77 (normal range <6.9)

The patient has a new diagnosis of rectal cancer. She has been started on systemic chemotherapy now and may be experiencing a good response based on imaging. It does not appear that the patient has ever had any

of these distant enlarged lymph nodes or tumors biopsied to confirm diagnosis of metastatic rectal cancer. In the United States this is the standard of care. Distant lymph node enlargement can occur for a variety of reasons including due to infection, inflammation, or a second malignancy such as lymphoma. In that case, the rectal tumor would be treated as a localized disease and systemic therapy would be aimed at treating the second malignancy. My first recommendation would be to biopsy one of these retroperitoneal lymph nodes now to confirm metastatic diagnosis.

Another reason for biopsy of these lesions is to send for appropriate mutational testing. Guidelines suggest that all metastatic colorectal cancers should be evaluated for mutations in KRAS and NRAS. Patients who are wild type for these mutations have been shown to benefit from EGFR targeted therapy with agents such as cetuximab and panitumumab.

The regimens chosen thus far have been appropriate for patients with metastatic rectal cancer. My usual standard of care would be FOLFOX + Avastin as it is usually better tolerated than FOLFIRI + Avastin.

Recommendations:

1) biopsy of distant lesions to confirm metastatic diagnosis. Also the pathology is to be sent for KRAS and NRAS mutation status.

2) continue with FOLFIRI and Avastin or consider switch to FOLFOX and Avastin

3) Repeat CT imaging every 6-8 weeks (every 3-4 cycles) to confirm continued clinical benefit from therapy

4) Please re-consult for further recommendations if patient progresses

Questions:

1) What is broken adenocarcinoma? What is the specific stage of this patient's condition? How do you define staging?

The patient has an adenocarcinoma of the rectum. This is a glandular type cell. The description of "broken" likely refers to the fact that the tissue was in multiple pieces when given to the pathologist. This has no bearing on prognosis or treatment. The patient's stage is likely stage IV but this has never been confirmed with a biopsy of the suspicious distant lymph nodes. I would recommend doing this as soon as possible. Staging in colorectal cancer is from Stage 0 to Stage IV. Stage 0 indicating that there is no invasion of the rectal wall. Stage I and II showing increasing involvement of the rectal wall. Stage III involving local lymph nodes. Stage IV involving distant lymph nodes or distant organs such as liver, lung, bone etc.

2) Recommendations for next step of treatment?

Given the patient is showing a good response, I would recommend continuing the current therapy indefinitely until the patient shows signs of progression or the treatment becomes intolerable. In the meantime, biopsy is critical to confirm metastatic diagnosis and also to send for KRAS and NRAS testing so that it can be determined whether EGFR targeted therapy such as cetuximab or panitumumab is appropriate for the patient.

3) Treatment for severe nausea and vomiting?

I recommend ondansetron 8 mg orally every 8 hours as needed for nausea. If this is not sufficient can add metoclopramide 10 mg po q6 hours prn for nausea. If this is not sufficient dexamethasone 4 mg orally every 12 hours can be given for 3 days post chemotherapy.

4) Clinical trial suitable for the patient? Any latest targeted therapy available?

I would not recommend a clinical trial in this setting a chemotherapy is very effective and the effect would last for about 2 years. In later setting when patient is refractory to treatment, clinical trials can be considered. Targeted therapy available includes bevacizumab and perhaps cetuximab or panitumumab if the patient qualifies.

5) Lifestyle and nutrition? What aspects to pay attention to?

Recommend eating healthy diet with lean meats and vegetables. Red meat may be difficult to digest in the days following chemotherapy and may lead to GI distress or nausea/vomiting. Otherwise no specific diet is recommended.

6) Prognosis?

If this is confirmed to be stage IV colorectal cancer, unfortunately this disease is not curable. The treatment would be aimed at delaying progression of disease, improving survival, and improving symptoms. Average life expectancy is 2 to 2.5 years at this time with approved therapies. This may be improved with drugs that are in development in clinical trials

Electronically Signed by: , MD on 12/18/2022 04:31:54 PM

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