From: "ROOT" <root@sctimst.ac.in>
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Date: 23/09/2024 08:48 AM
Subject: Student CPC

From: "RRC Rishikesh (rrcrishikesh@aiimsrishikesh.edu.in)" <rrcrishikesh@aiimsrishikesh.edu.in>
To: undisclosed-recipients:;
Date: Mon, 23 Sep 2024 00:33:36 +0530
Subject: [EXTERNAL MAIL] Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **Sept 23, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m680934a8d46230cd2bd0cc009fb605cc

Monday, Sept 23, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2519 181 1130

Meeting password: 230924

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Student CPC

(Department of Medical Oncology Hematology)

Pt. Age/sex: 55/F	Clinician-in-Charge: Dr Amit Sehrawat	Discussant: Dr. Anusha M
Dept : Medical Oncology Hematology	Patient in CMR and on regular follow up	Pathology discussant: Dr. Gaurav Nuclear medicine: Dr Vishal

Chief Complaints:

- Bleeding per rectum since 6 months

History of present illness:

Patient was apparently normal 6 months ago when she complained of bleeding per rectum with the bleeding occurring during the beginning of defecation and she used to pass blood streaked stools. She also noticed pain during defecation, dull aching, non radiating, moderate in intensity. No aggravating/ relieving factors. She also complained of tenesmus.

H/o loss of appetite and weight loss + (approximately 40% weight reduced over 6 months)

No h/o pain abdomen, melena, mucus in stools, diarrhea, hard stools

No h/o nausea, vomiting

No h/o other bleeding manifestations

No h/o yellowish discoloration of eyes, cough, hemoptysis, breathlessness

Past medical history: Diagnosed case of Type II diabetes on OHA's with well controlled blood sugars . No past history of tuberculosis, epilepsy, hypertension, bronchial asthma. No previous surgery.

Family history: No significant family history

Personal history: Non-smoker, non-alcoholic, vegetarian and regular sleep pattern, no addiction or allergy

General examination: normal built, conscious, oriented, ECOG PS-4

PR- 115 bpm, regular, normal volume, character, all peripheral pulses felt, BP- 110/7 mm Hg, RR- 20/min, SpO2 99%RA, Temperature 38o C Pallor^{+}, Pedal edema^{-}, Icterus^{-}, Cyanosis^{-}, Clubbing^{-}, Lymphadenopathy^{-}

Systemic Examination:

- Chest- B/L NVBS present, no added sounds, CVS- S1S2 + No added sounds.
- CNS: E4V5M6, No motor or sensory deficit, reflexes normal
- PA: Soft, non-tender, no organomegaly, no shifting dullness, BS+
- DRE: circumferential, ulceroproliferative growth involving the anal verge, extending up to 5cm anteriorly

Investigations:

- Complete blood count: Hb-8.2 gm/dl, WBC- 9,600 cells/ cu mm, platelet count- 4.53 lakh/ cu mm

- Renal function test: S.creatinine-1.1 mg/dl, B, urea- 41 mg/dl, S. Na- 144 meq/L, S. K- 3.8 meq/L, S. uric acid – 5.6 mg/dl
- Liver function test: Total bilirubin- 1.25 mg/dl, T. protein -5.2 gm/dl, S. albumin- 2.8 gm/dl, SGOT- 47 U/L, SGPT- 56 U/L
- PT/ INR- 11/1.25, RBS 108 mg/dl
- Viral markers- Non- reactive
- Serum CEA: 2.48 ng/ml (Normal= <5ng/ml)
- ECG- WNL
- ECHO- WNL

COLONOSCOPY:

- Scope passed upto sigmoid colon. An ulcerated growth noted in anal canal extending upto rectum. Multiple biopsies taken.

CECT CHEST AND ABDOMEN:

- Heterogeneously enhancing asymmetrical circumferential wall thickening is seen in anal canal and distal rectum for a length of 7cm with maximum thickness of 2.8cm. There is infiltration into mesolectal fat. Laterally, it is abutting the left elevator ani muscle. Anteriorly it is infiltrating into vagina.
- Heterogeneously enhancing lymph nodes are seen in mesolectal fat, largest measuring 14mm in SAD
- Liver is normal in size. Heterogeneously enhancing lesion with mild surrounding edema is seen in segments VIII of liver measuring 17 x 18 mm in right lobe of liver.
- Imp: neoplastic anorectal mass with liver metastasis as described.

WHOLE BODY FDG18 PET CT:

- FDG avid circumferential wall thickening with involvement of posterior vaginal wall is noted at distal rectum and anal canal, maximum thickness measuring 3.3cm involving 8.1cm of anorectal segment (SUV max= 18.5)
- FDG avid perirectal, bilateral external iliac and bilateral inguinal lymph nodes are noted, largest measuring 1.6 x 1.1cm at perirectal region (SUV max- 2.7)
- FDG avid hypodense lesions are noted at segment V and VIII of liver, largest measuring 2.8 x 2.8cm at segment VIII (SUV max-10.3)
- Imp: metabolically active circumferential wall thickening with involvement of posterior vaginal wall at distal rectum and anal canal- likely neoplastic in nature.

Provisional diagnosis: Neoplastic lesion of anorectal canal- most probably adenocarcinoma

HISTOPATHOLOGY AND IHC:

- Malignant melanoma- BRAF V600E negative

Final diagnosis: Anorectal malignant melanoma- cT4N1aM1 (stage IV); BRAF V600E negative

Course And Management:

Owing to her Eastern Cooperative Oncology Group Performance Status (ECOG PS) of 4 and nonaffordability of ICIs, after informed decision making, she was started on single agent Temozolomide 200mg/m2 (Day 1-5, q28 days) in April 2021 along with pneumocystis jiroveci prophylaxis as per guidelines. The patient demonstrated clinical response and her ECOG PS improved to 2 by the third cycle. By the 5th cycle, her PS further improved to 0. CMR was first noted after the 7th cycle of temozolomide in November 2021 (Figure 4). Notably, the patient did not experience any grade 3 or 4 toxicities requiring dose modification/ discontinuation of the drug. Further, serial images have demonstrated a persistent CMR, with response for more than 3 years of treatment and counting.

Conclusion:

Though ICIs and targeted therapies are the cornerstones of treatment in metastatic melanoma, this case demonstrates that a small proportion of selected poor PS patients who are otherwise bed/chair bound due to the disease burden may indeed benefit from a trial of an oral agent.