VIRTUAL MDT BOARD

INSTITUTO NACIONAL DE ENFERMEDADES NEOPLÁSICAS
Lima, Perú
November, 2022

Virtual MDT Board

Cases:

- Dr. Jianmartin Galecio, Instituto Nacional de Enfermedades Neoplásicas, Perú
- Dr. Mike Maldonado, Instituto Regional de Enfermedades Neoplásicas, Perú
- Dr. Boris Itkin, Sultan Qaboos Comprehensive Cancer Care and Research Center (SQCCCRC), Oman
- Dr. Ronald Badilla, Hospital Calderón Guardia, Costa Rica
- Dr. Fernando Campos, A. C. Camargo Cancer Center, Brazil
- Dra. Eliza Ramirez, National Institute of Cancer, Paraguay

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Jianmartin Galecio, MD
Medical Oncologist
Instituto Nacional de Enfermedades Neoplásicas
Lima, Perú

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FILIATION:

- **SEX:** Male
- **AGE:** 18 years
- **FROM:** Piura - Perú
- **PERSONAL BACKGROUND:** Denies
- **FAMILY HISTORY OF CANCER:** Denies

CURRENT ILLNESS:

Illness period of **1 year** characterized by pain in the lumbar region that gave way to rest of progressive intensity.

2 months ago, there was a progressive decrease in muscle strength and dysesthesia in the left lower limb, which was exacerbated when standing up and walking.

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Currently, he denies pain, walks better since the surgical procedure, and mobilizes with support.
Physical Exam: ECOG 2
No palpable peripheral adenopathies.
LOTSP, GS (15/15), decreased muscle strength in the right lower limb 4/5 and left lower limb 3/5.

GIANT CELL TUMOR 1° VERTEBRAL D9 - D12

LAMINECTOMY D10-11 + PARTIAL REMOVAL OF TUMOR

02.09.22

13.10.22

INEN

26.10.22

Pathology review:
EPITHELIOID HEMANGIOENDOTHELIOMA
Has improved strength in MMII. MRI shows residual tumor in vertebrae D10-D11, there is no disease at the pulmonary and intra-abdominal level. There are no signs of spinal cord compression at present.
Arrangement: Non-surgical.

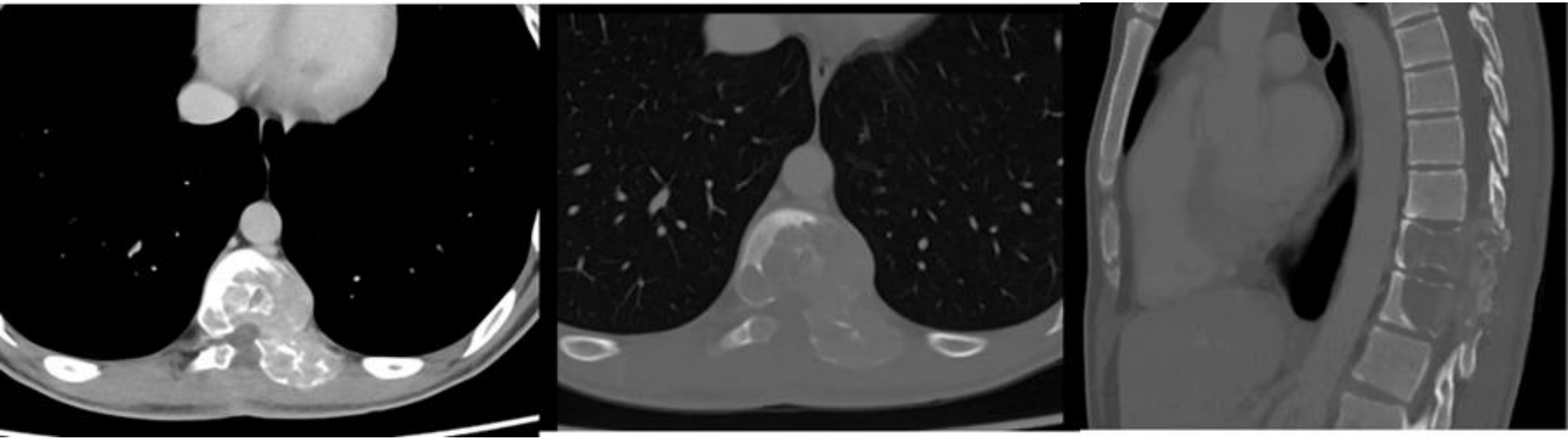
09.11.22

Case is sent to the Multidisciplinary MTB

15.11.22

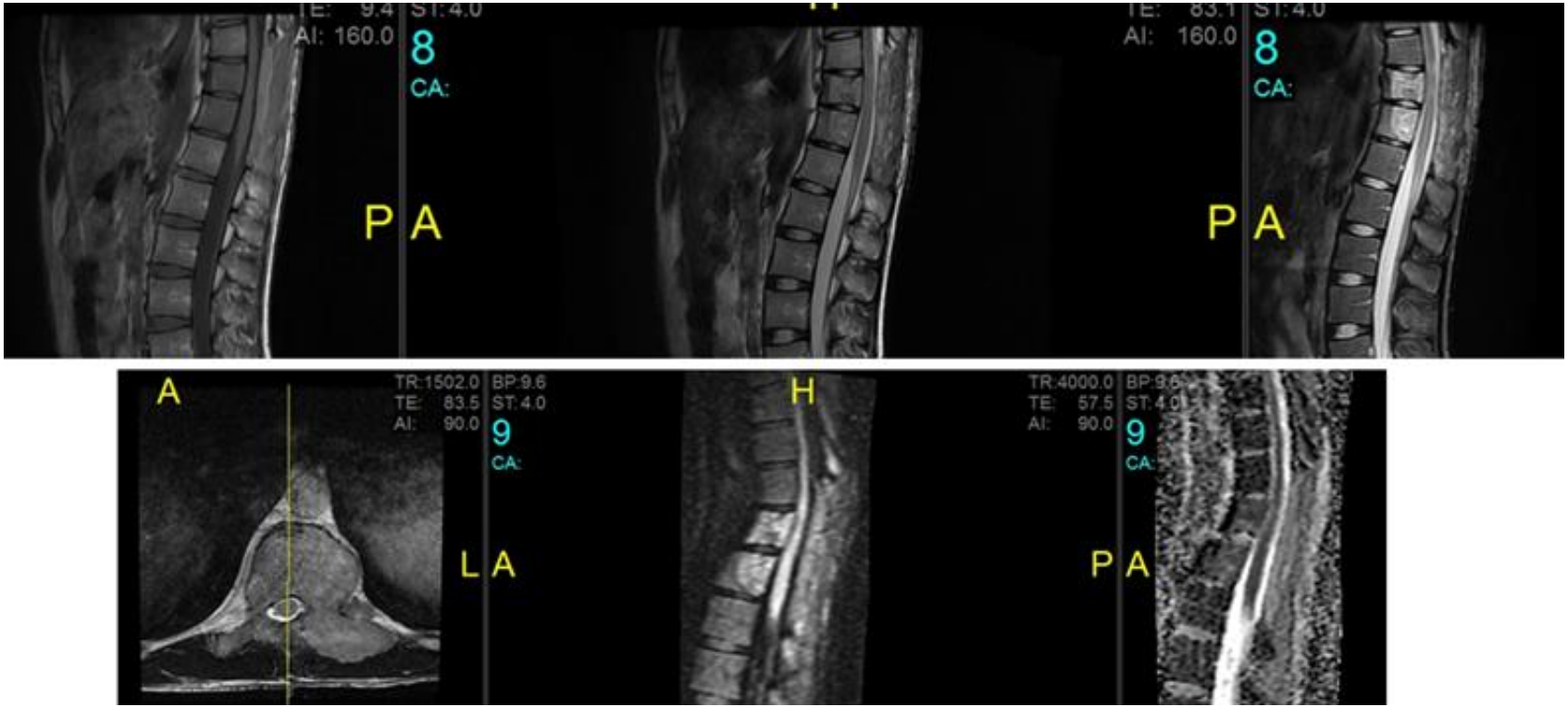
RT:
The patient is eligible to receive external radiotherapy at a dose of 4000 cGy in 16 sessions in tumor lesion fields using the VMAT technique, previous SIMULATION TEM c/c.

Post-surgical state with persistence of lytic lesion with higher density punctate foci in D10-D11 vertebral bodies with involvement of their posterior arches and D9. without spinal cord compression



Post-surgical state with persistence of a lithic lesion with punctiform focal areas of greater density on vertebral bodies D10-D11 with involvement of the and posterior arches. No spinal cord compression .

MRI



Low signal in t1, High signal in t2 and STIR with diffusion restriction

PATHOLOGY out (sept 2022):
Atypical spindle cell proliferation with multinucleated giant cells.

Giant cell tumor G2 with IHC:
Keratin (-)
CD34 (+) in vessels
CD31(+) in vessels
CD68(+)
P53 occasional stromal cell +
S100 (+ partial)
Ki67: 8-10%

REVIEW OF SLIDES FROM ANOTHER INSTITUTION SPINAL COLUMN TUMOR (10.14.20):

DIAGNOSTICO MICROSCOPICO (PARAFINA)

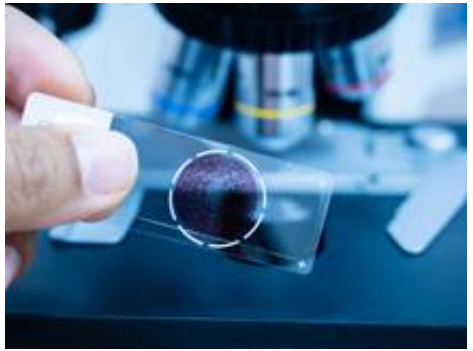
Dx.Morfológico: 91331 Dx.Topográfico: C419

Tumor de columna vertebral (Biopsia), Revsión de láminas de otra institución:

- HEMANGIOENDOTELIOMA EPITELIOIDE.

INMUNOHISTOQUÍMICA (INEN):

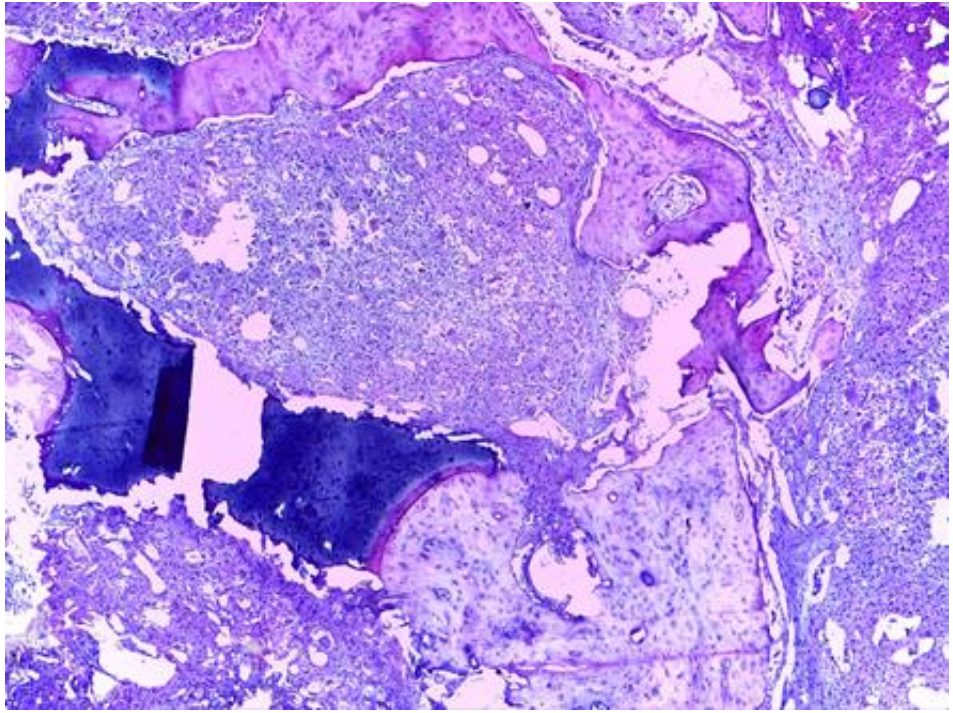
> CD 34	: POSITIVO
> CD 31	: POSITIVO
> FLI-1	: POSITIVO
> EMA	: POSITIVO, FOCAL DÉBIL
> PANQUERATINA	: POSITIVO, DÉBIL
> S-100	: NEGATIVO

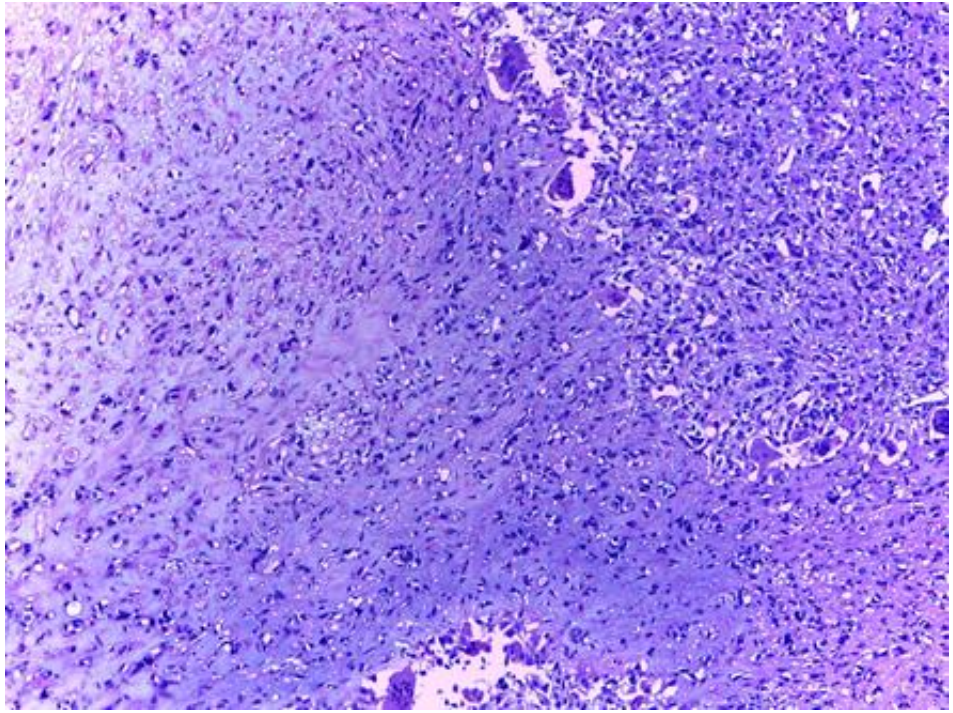


- LA NEOPLASIA PRESENTA AÑADIDO UN COMPONENTE REACTIVO DE CÉLULAS GIGANTES TIPO OSTEOCLASTO, QUE NO FORMA PARTE DE LA NEOPLASIA.

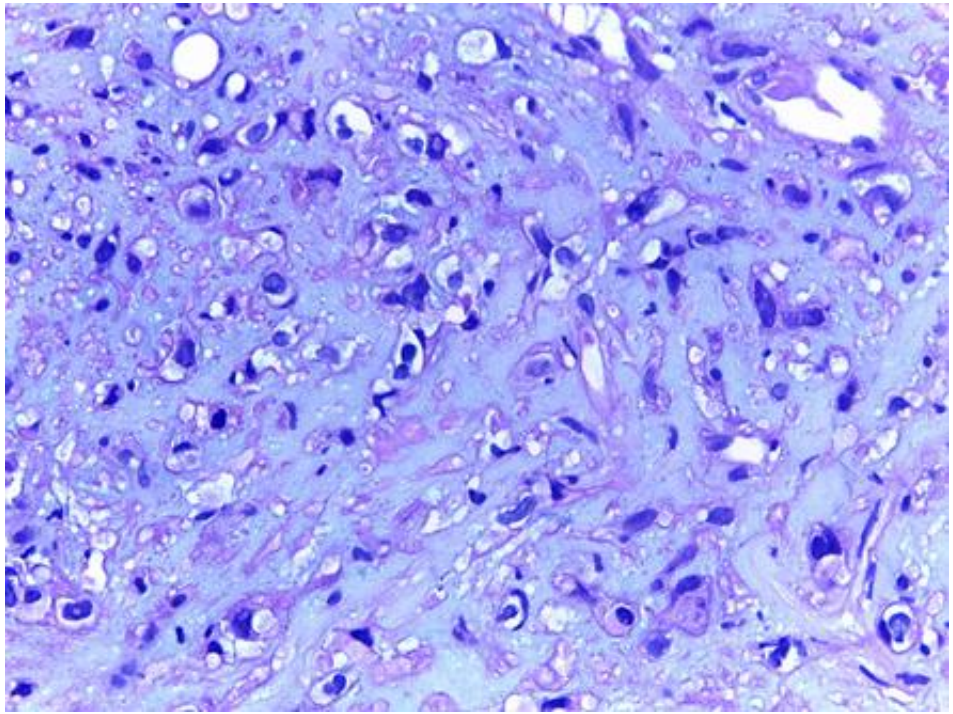
PATHOLOGY

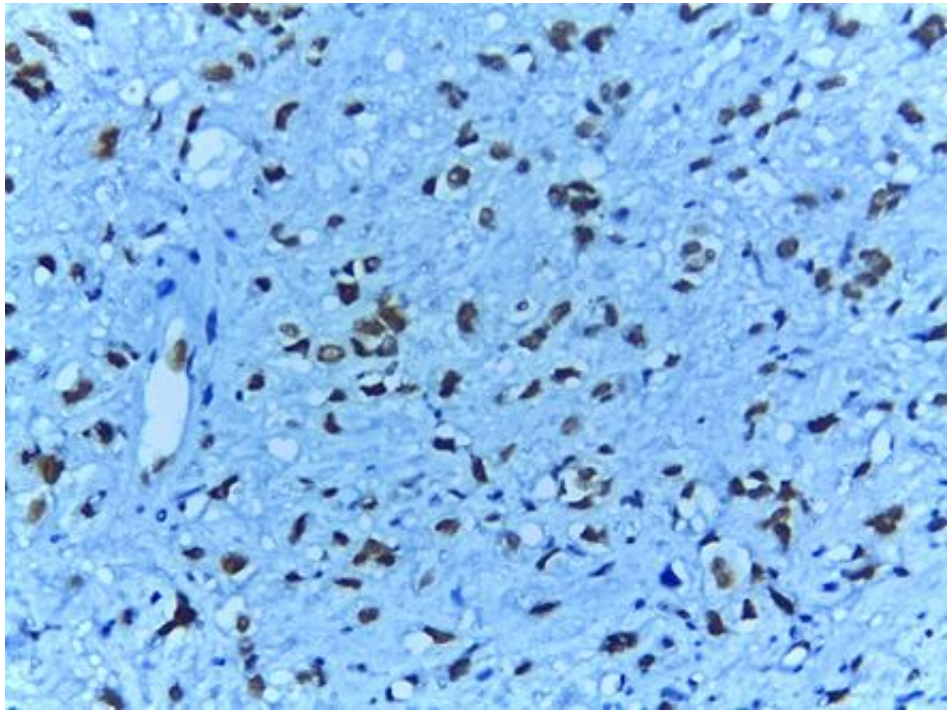
HISTOPATHOLOGY



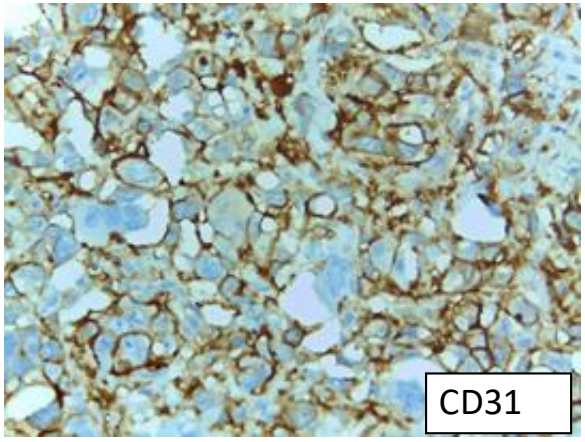


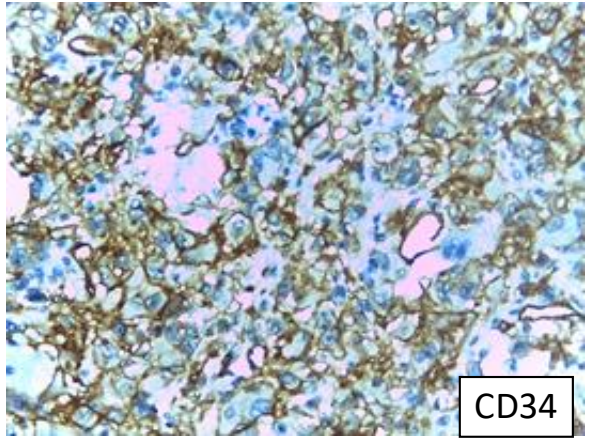
HISTOPATHOLOGY

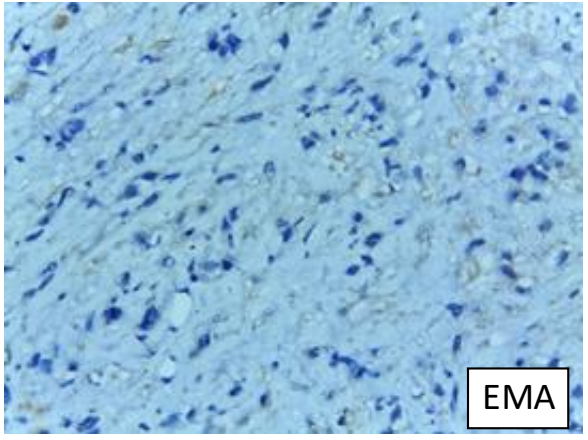


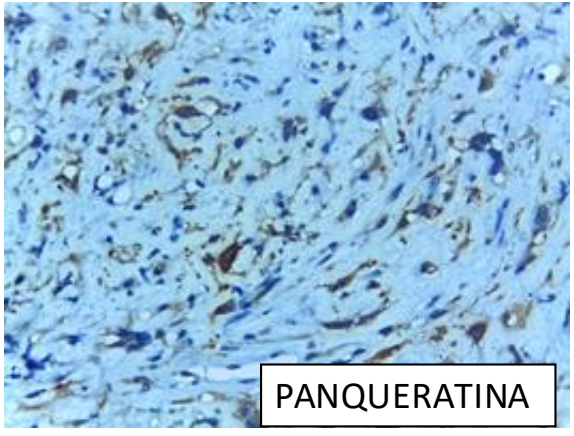


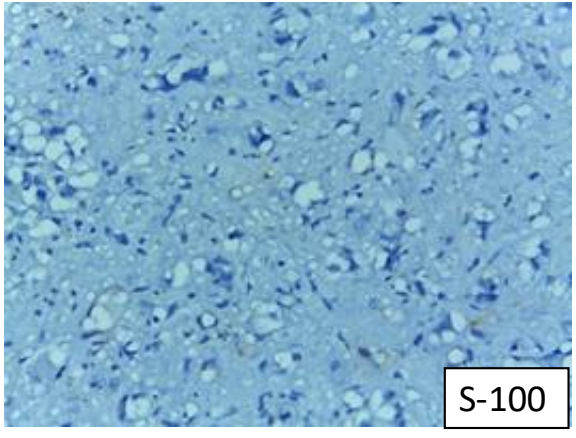
IMMUNOHISTOCHEMISTRY











QUESTIONS:

- **What is the best option to treat this pathology?**
- **Do you recomend chemotherapy after radiotherapy?**
- **Are there any target Therapy as a treatment?**

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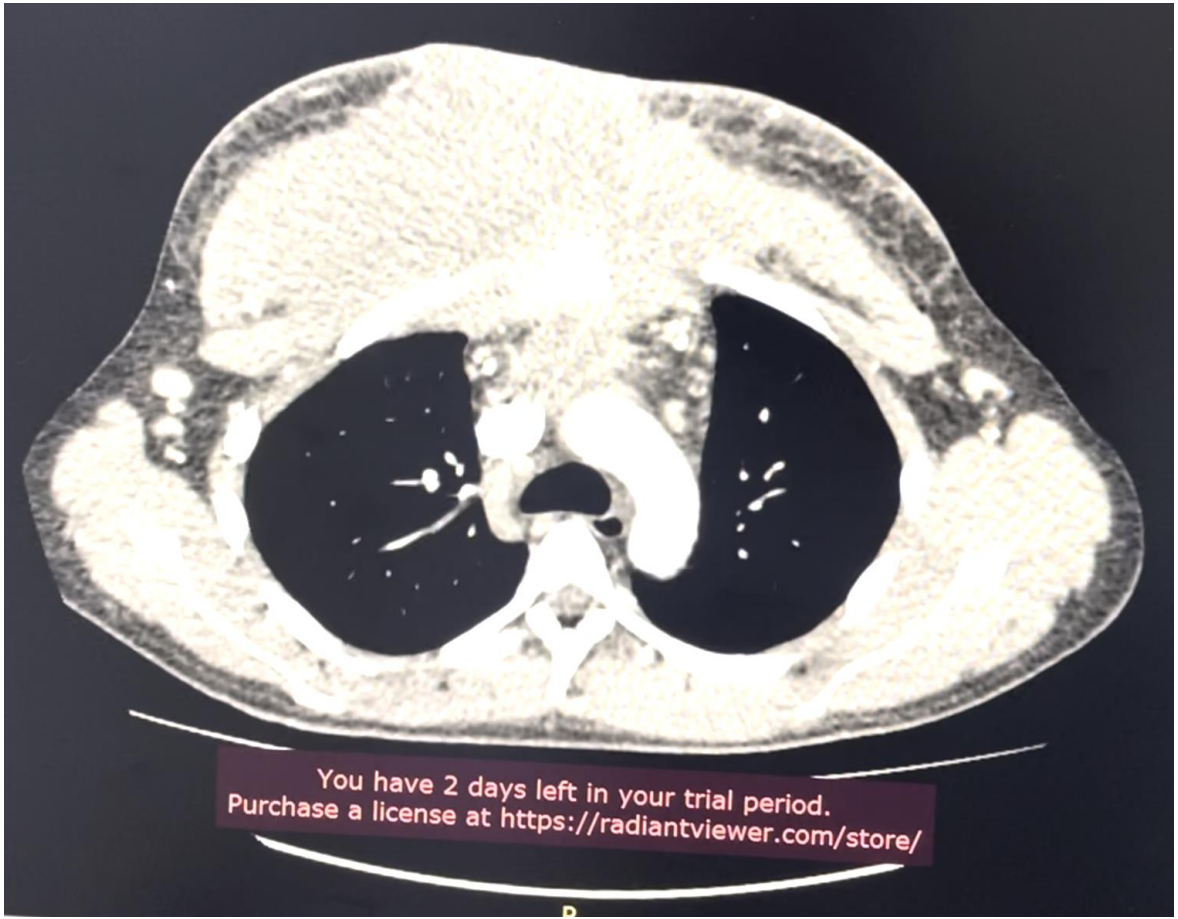
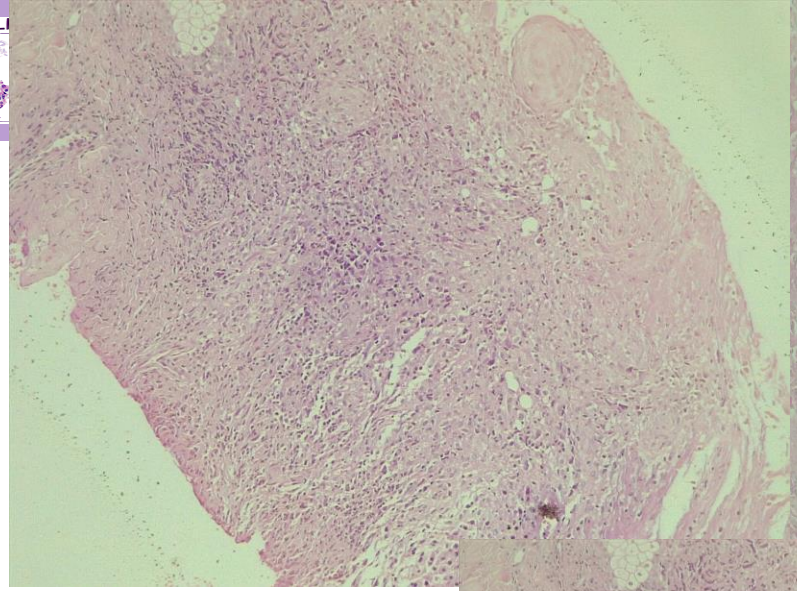
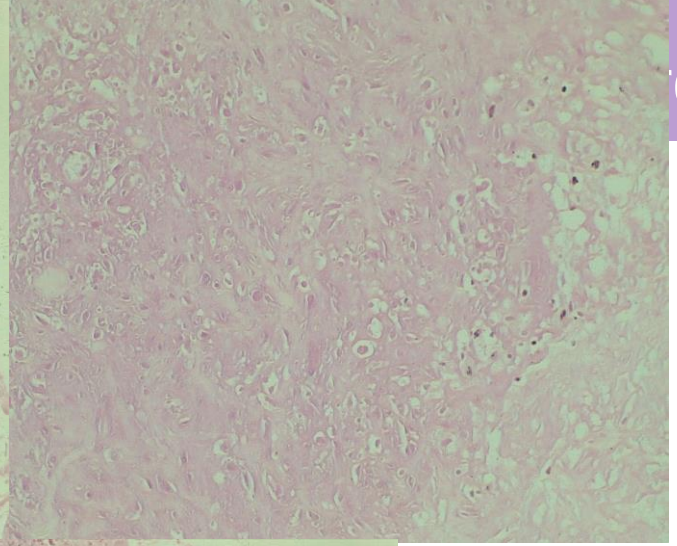
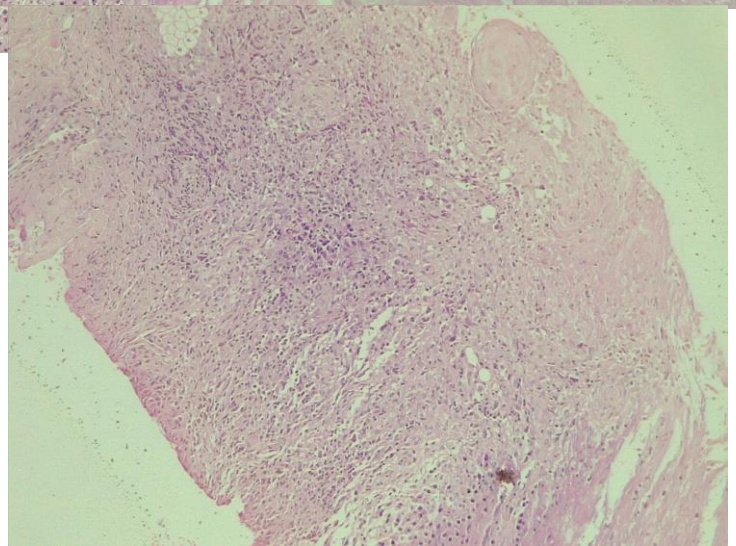
Mike Maldonado, MD
Medical Oncologist
Instituto Regional de Enfermedades Neoplásicas del Norte
La Libertad, Perú

- **23 y/o, male.**
- No comorbidities, No family history.
- He complaint of growing nodule at the chest (anterior).
- Came to IREN on 2.5.2019
- Body examination:
  - Bulging chest and 2 ulcerated wounds of 4 and 2 cm.

CT – picture: 15 – 5 – 2019



Pathology - Pictures

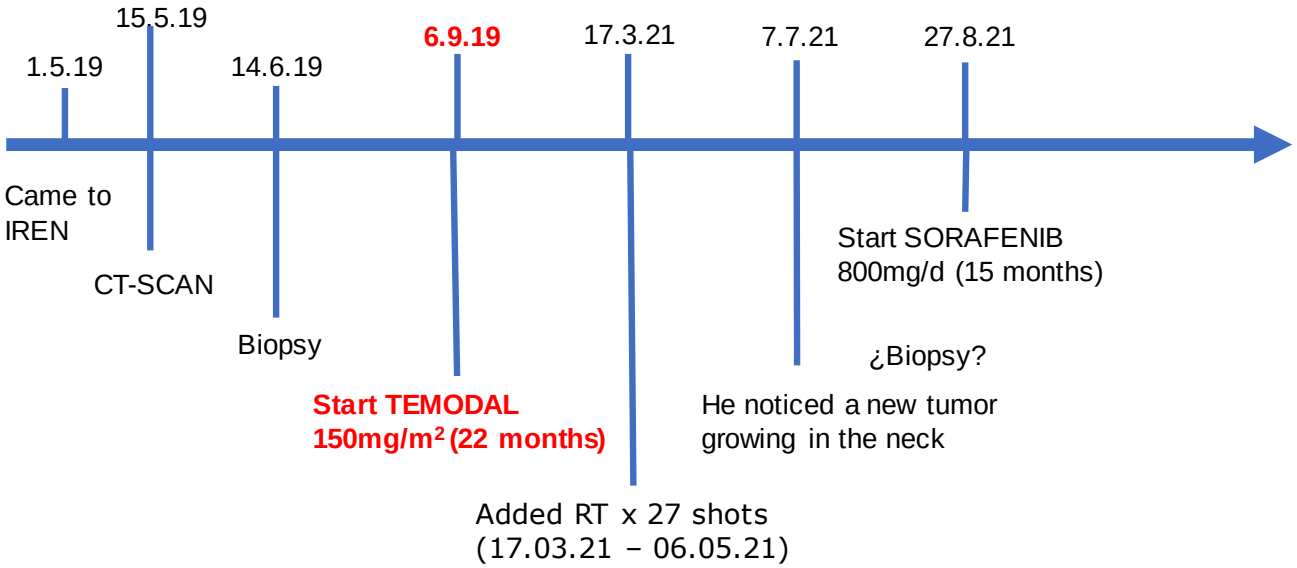
PROTEINA-S-100: NEGATIVE

CD34: VASCULAR ENDOTHELIO EXPRESSION.

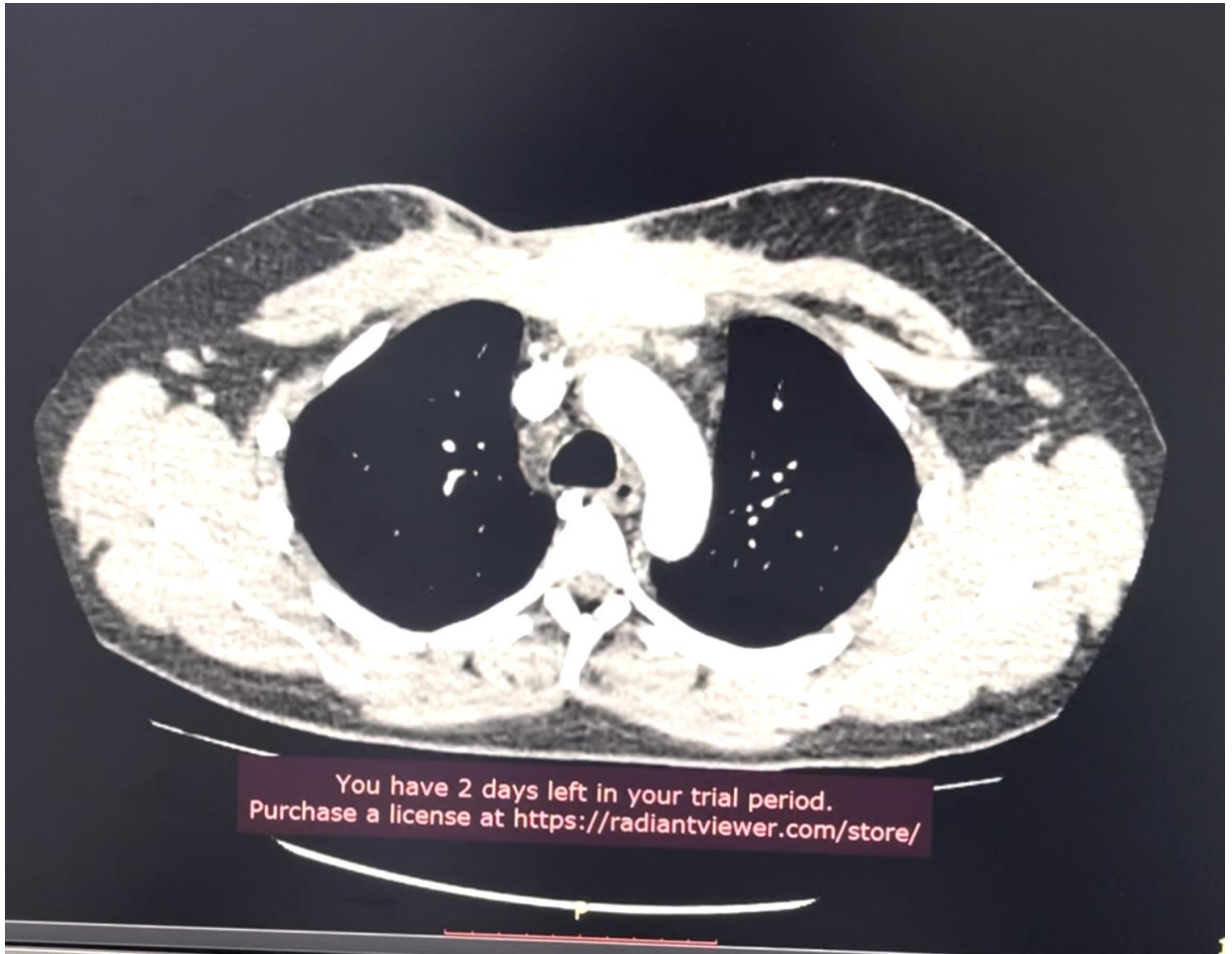
BCL2: POSITIVE.

STAT6: NUCLEAR EXPRESSION IN TUMOR SUBPOBLATION.

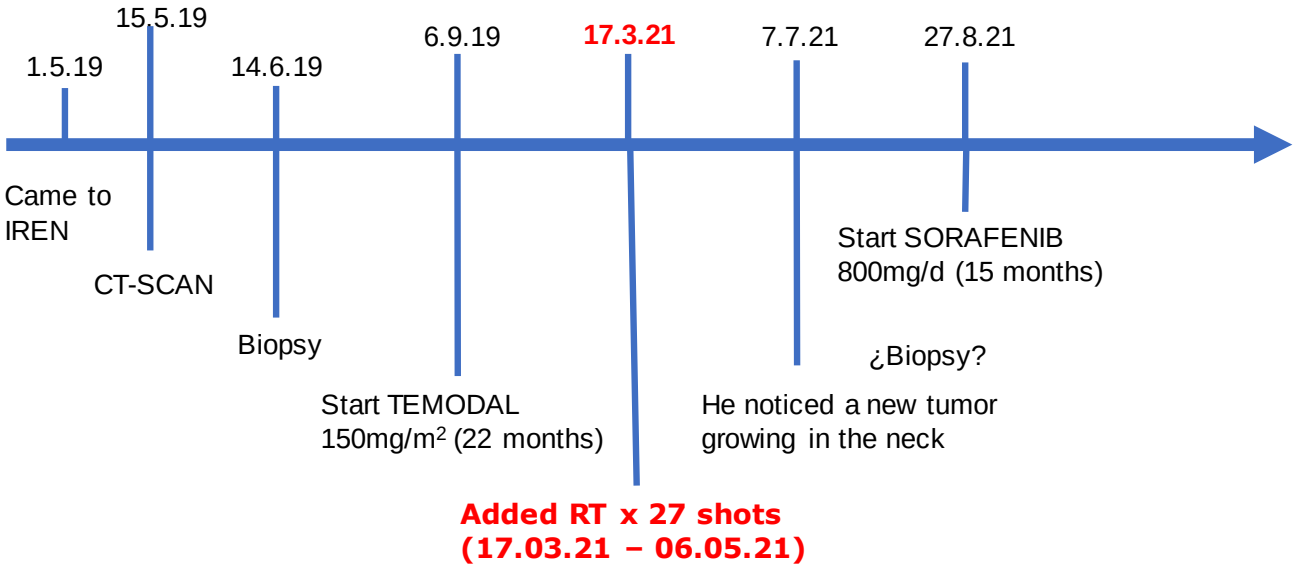
Timeline


1.5.19
15.5.19
14.6.19
6.9.19
17.3.21
7.7.21
27.8.21
Came to IREN
CT-SCAN
Biopsy
Start TEMODAL 150mg/m² (22 months)
Added RT x 27 shots (17.03.21 – 06.05.21)
He noticed a new tumor growing in the neck
¿Biopsy?
Start SORAFENIB 800mg/d (15 months)

CT – picture: 15 – 1 – 2021



Timeline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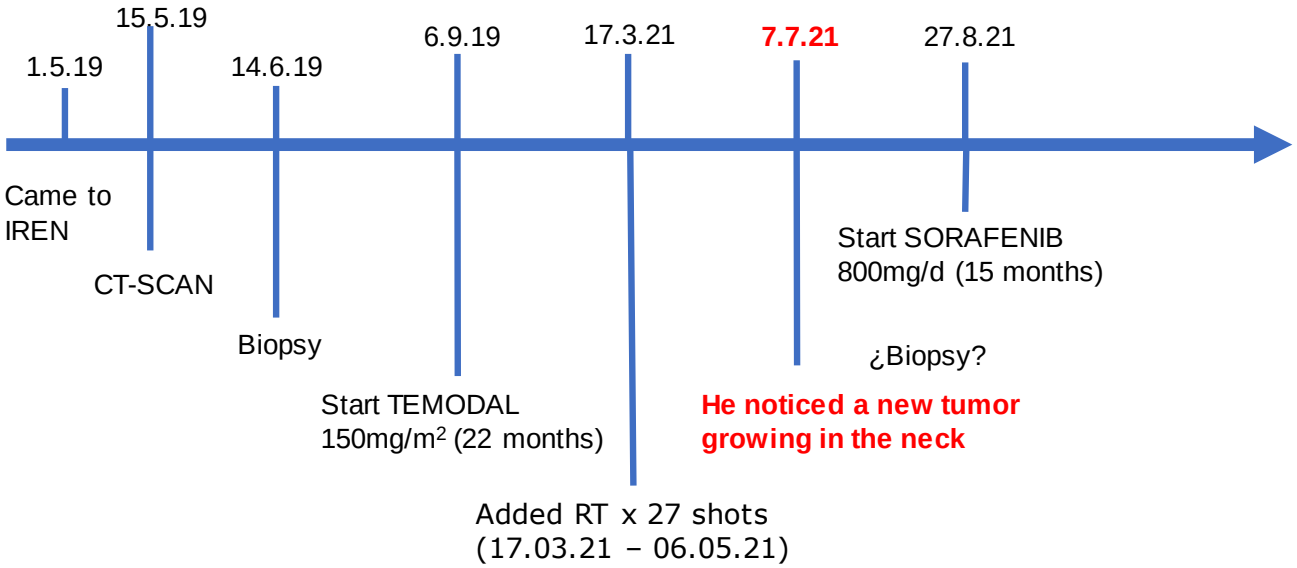
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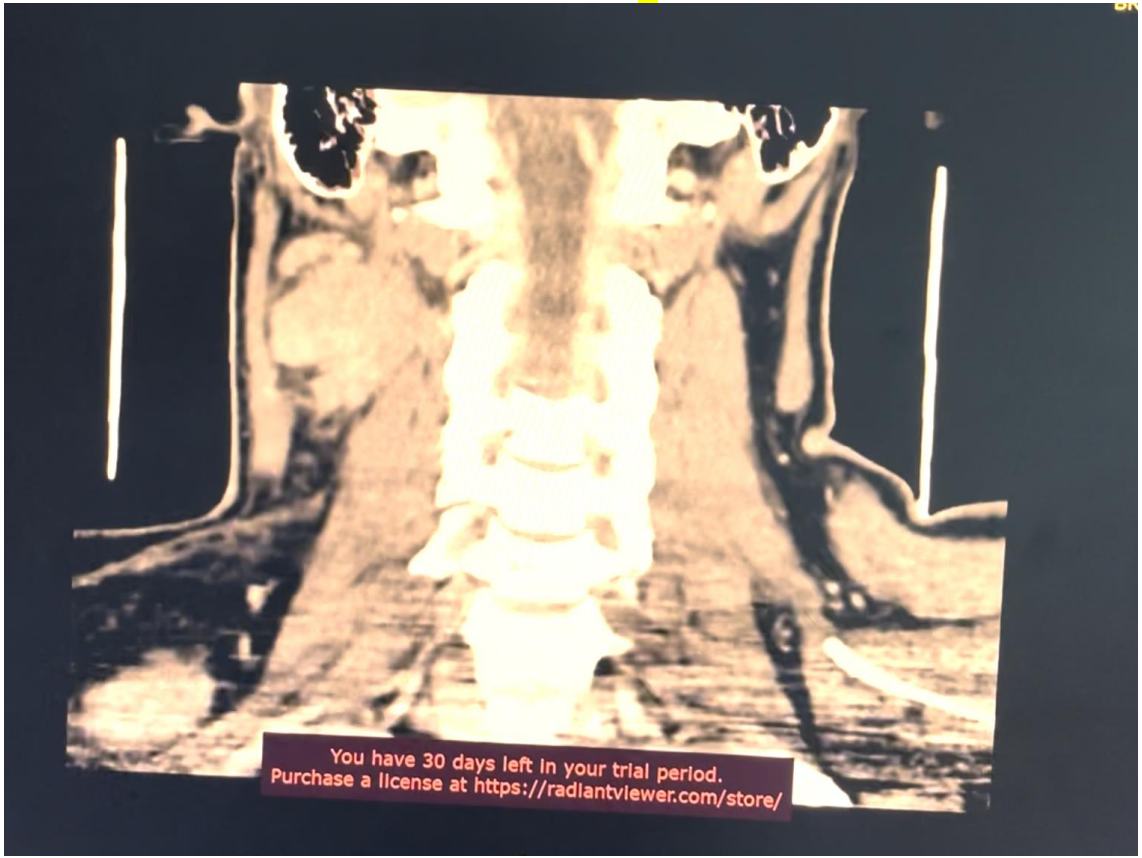
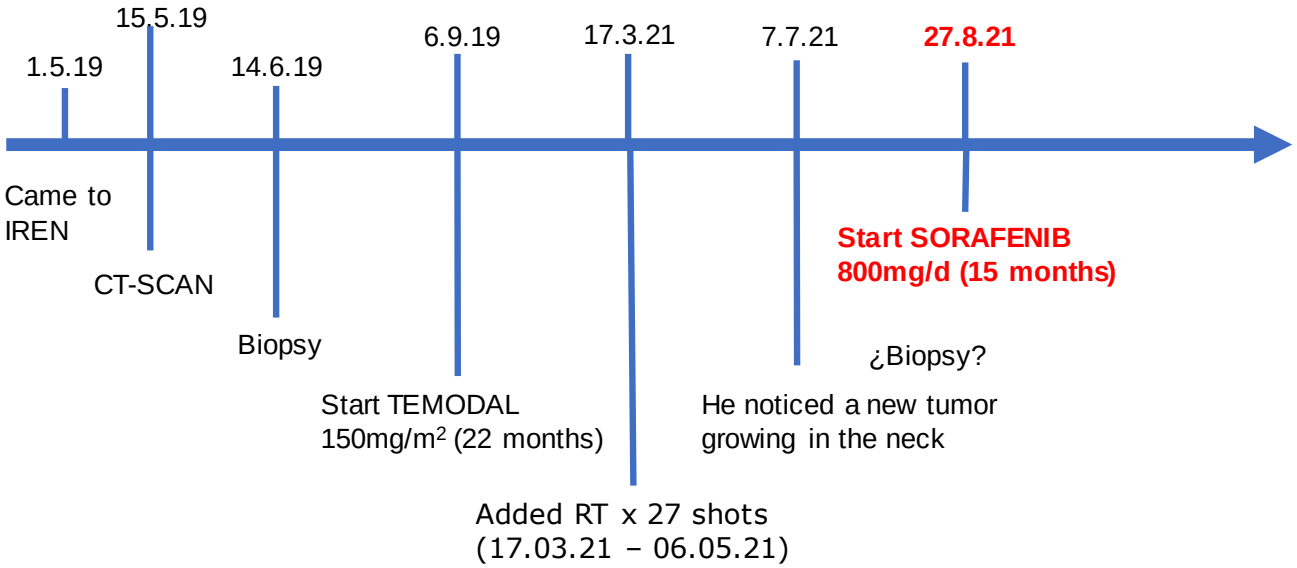
CT – picture: 9 – 7 – 2021



Timeline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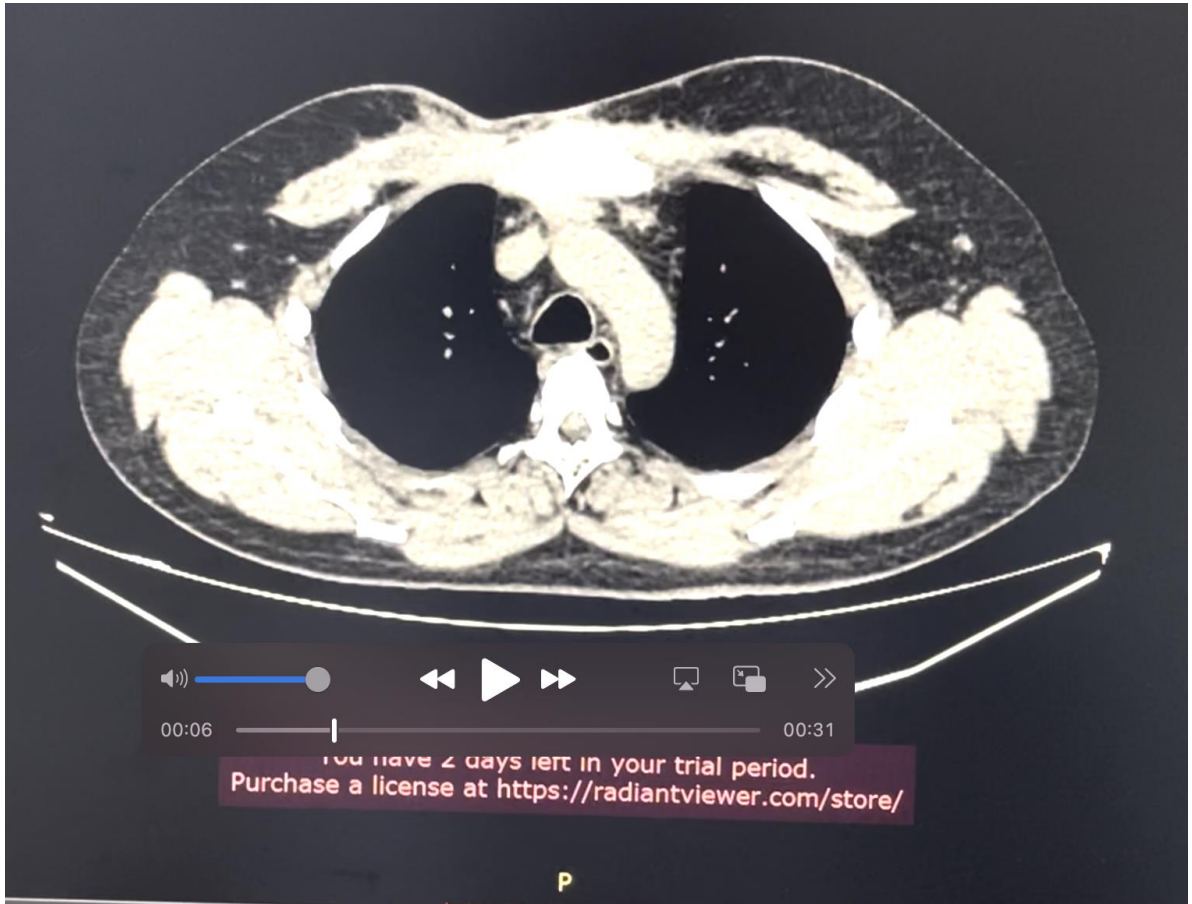
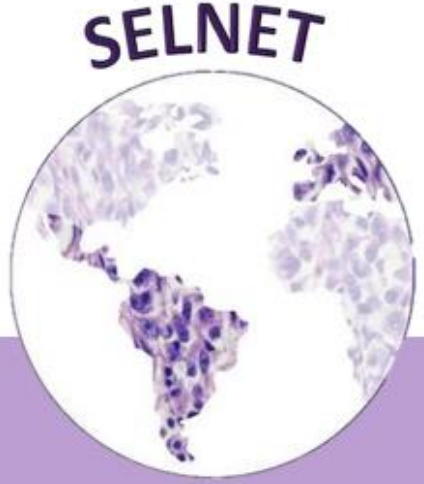
CT – picture: 13 – 5 – 2022



Questions:

- Would you consider NGS for this patient?
- What do you think would be the next step for this patient?
- Do you agreed with the use of radiotherapy in this case?



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Boris Itkin, MD
Medical Oncologist
Sultan Qaboos Comprehensive Cancer Care and Research Center (SQCCCRC), Oman

- 18-years–old, female, no comorbidities
- April 2021 – diagnosed with **Spindle cell / Sclerosing RHABDOMYOSARCOMA** of the right pleura/chest wall, cT = 17 cm
- 17/4/2021 - R1 pleural mass excision via Right postero-lateral thoracotomy. A post-hoc review of the baseline CT found a single lung nodule regarded as metastatic. Accordingly, the disease was reclassified as:
- **Stage IV, IRS clinical group IV, very high risk**.
- **No RT. FIRST LINE 3w VAC** x 8 cycles up to February 2022. First 4 cycles with Doxorubicin, Actinomycin D cycles 5 to 8
- Due to neutrophils recovery delays refractory to G-CSF she was evaluated by a Hematology. Based on antineutrophil antibodies positivity and normal bone marrow biopsy 10.11.2021 hematologists suspected autoimmune neutropenia and she received a prednisolone course.
- NED on periodic images studies

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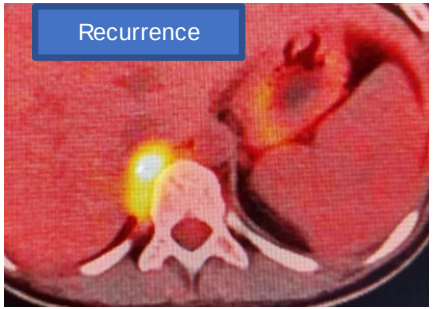
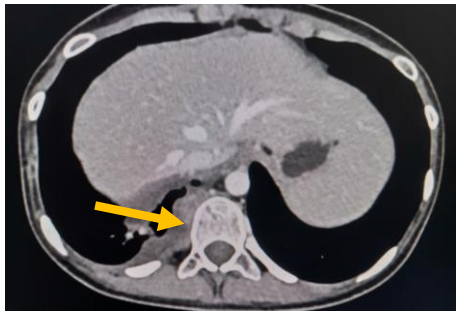
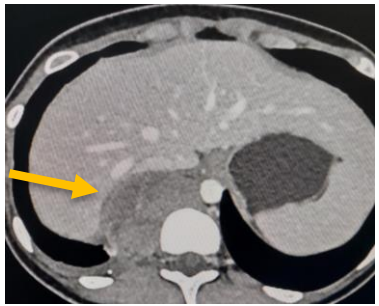
- >PET-CT March 2022 (during VAC) : new intensely avid right paravertebral soft tissue lesions at the level of T11 and T12 = <u>recurrence</u>
- Radiotherapy to local recurrence 30 Gy in #5 up to 24.04.2022
- She was started on **SECOND LINE Vincristine-Irinotecan-Temozolamide.** Dose reduction due to myelotoxicity and delays
- CT after #3 == SD. After #4 VIT discontinued due to protracted neutropenia despite reduced doses and G-CSF. Asymptomatic. She was off treatment for 2 months but CT in late October 2022 showed a significant local progression
- She received **Re-RT** to the paravertebral lesions Nov 2022 and surgical removal is planned



Recurrence



After RT and VIT #3



VIT #4 and 2 months break

Molecular profiling WES Caris

- **MYOD1**

DNA-Tumor Pathogenic Variant Exon 1 | p.L122R

- **PIK3CA**

DNA-Tumor Pathogenic Variant Exon 10 | p.E545K

DNA-Tumor Pathogenic Variant Exon 21 | p.H1047R

- **TP53**

DNA-Tumor Pathogenic Variant

Exon 9 | c.993+1G>C

CNA-Seq DNA-Tumor Deletion Not Detected

Objective: Discuss further management and possible role of PIK3CA directed treatments

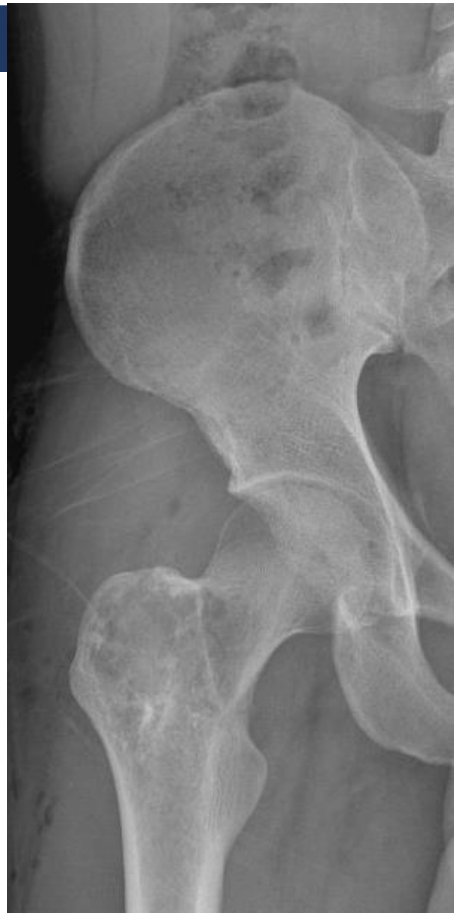
SELNET

Virtual MDT Board

Ronald Badilla, MD
Medical Oncologist
Hospital Calderón Guardia
San José, Costa Rica

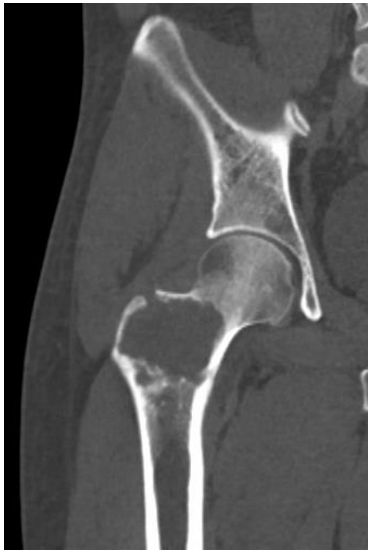
Clinical Record

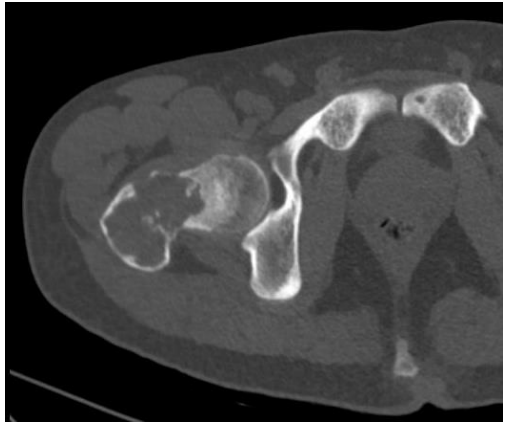
- 29-year-old man
- Firefighter
- No comorbidities
- Previously asymptomatic
- Sudden pain
- Pathological femur fracture



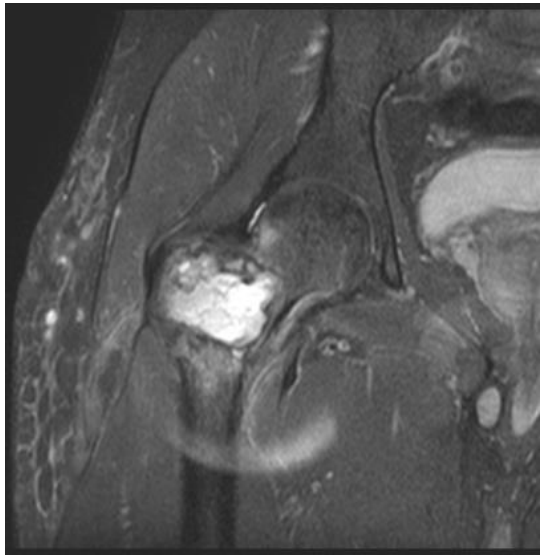
Radiology Images

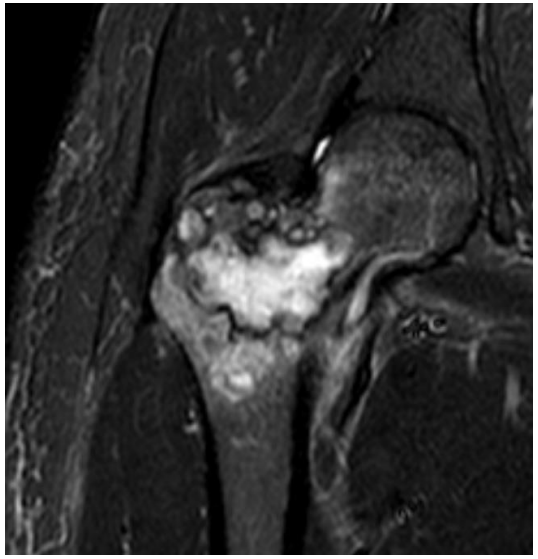
CT

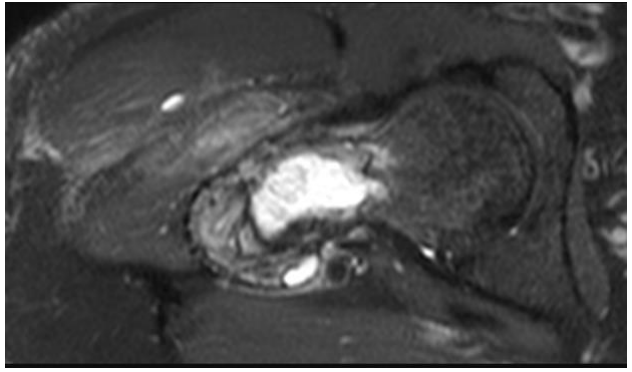




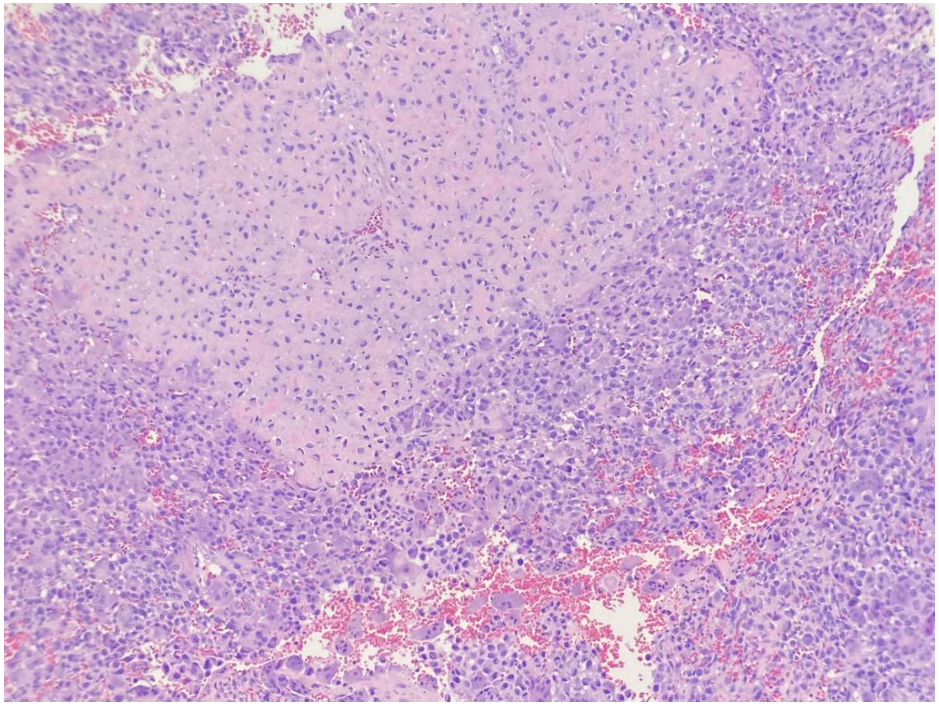
MRI

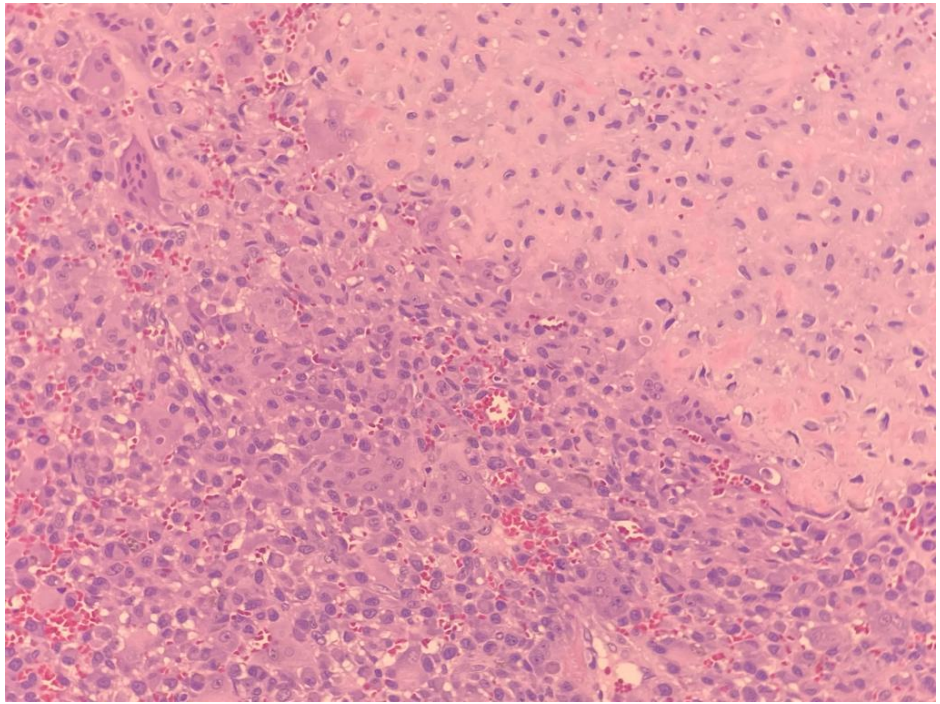






Histology





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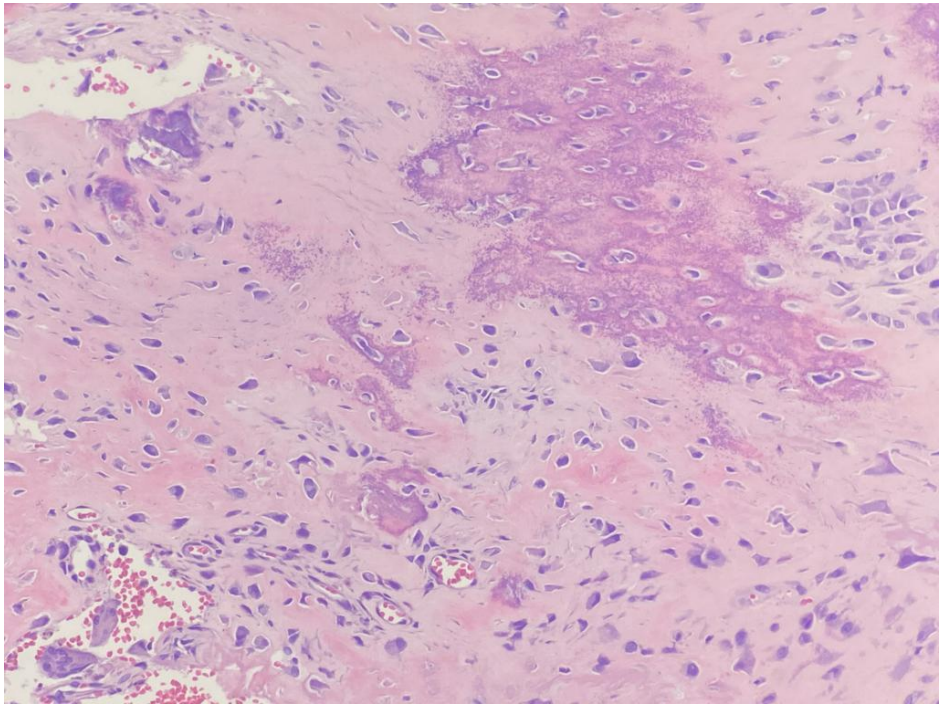

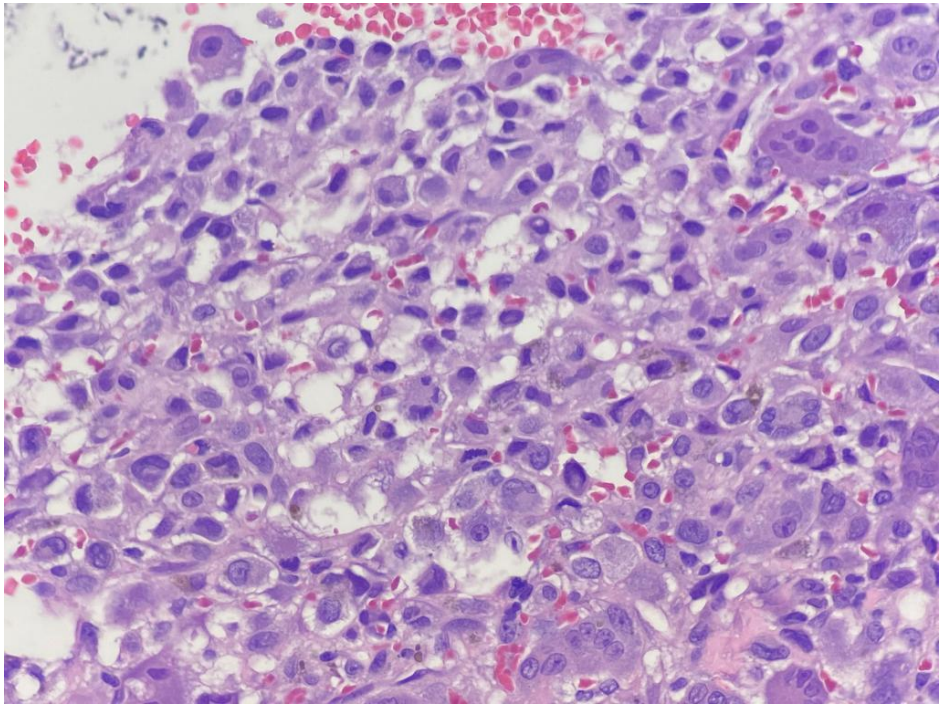

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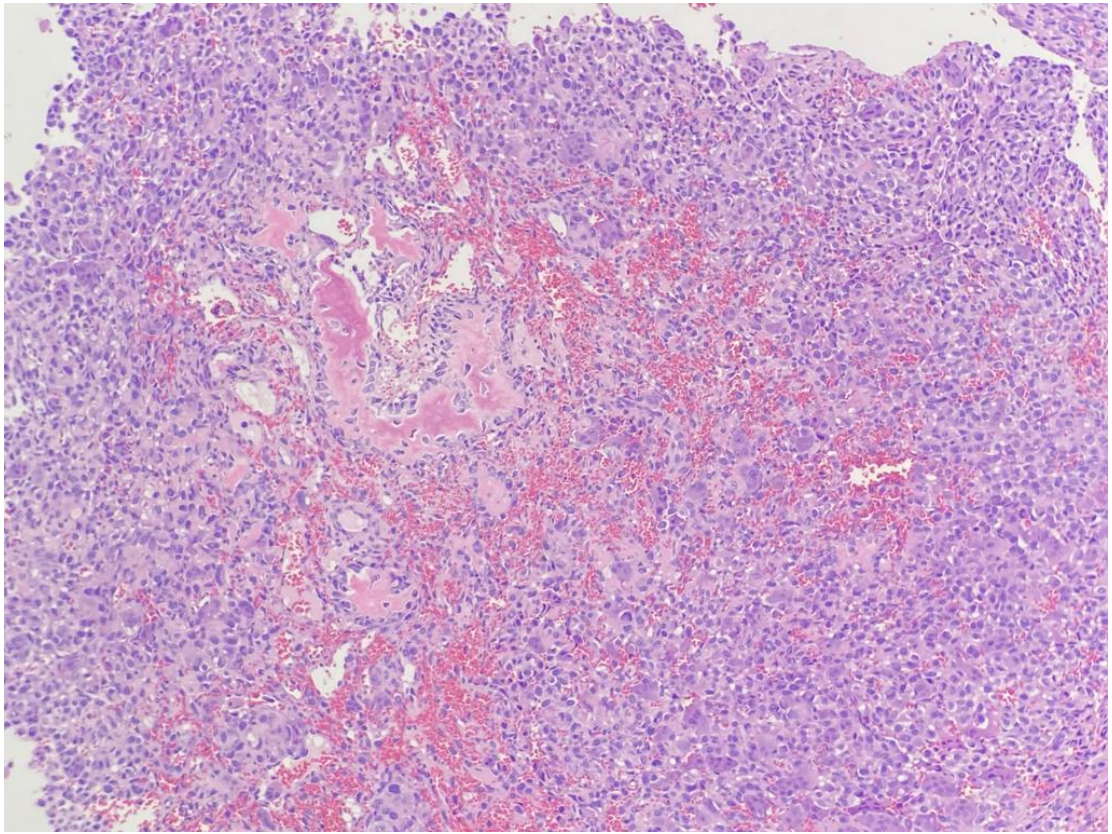
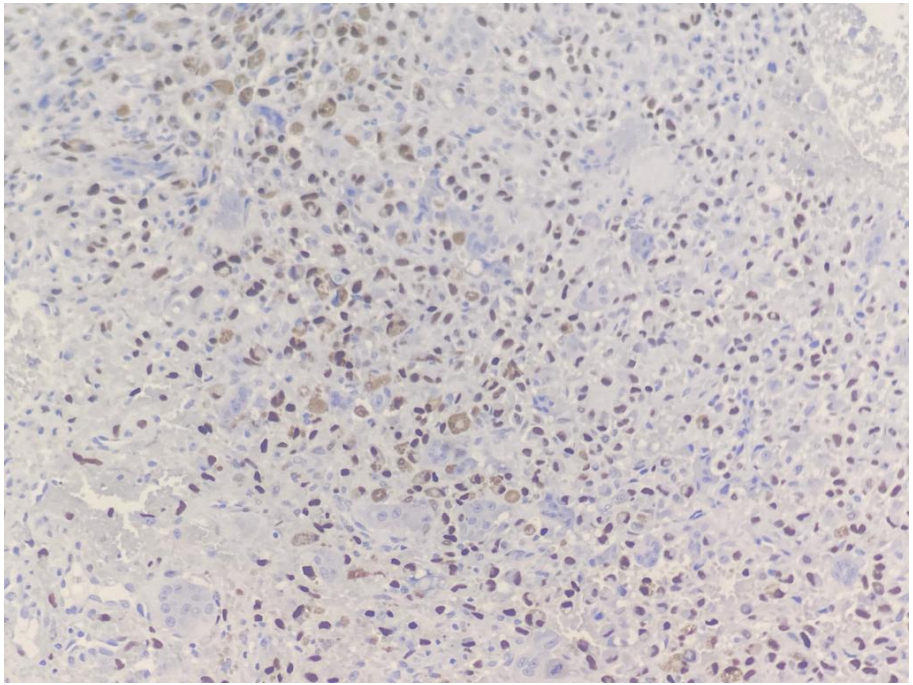
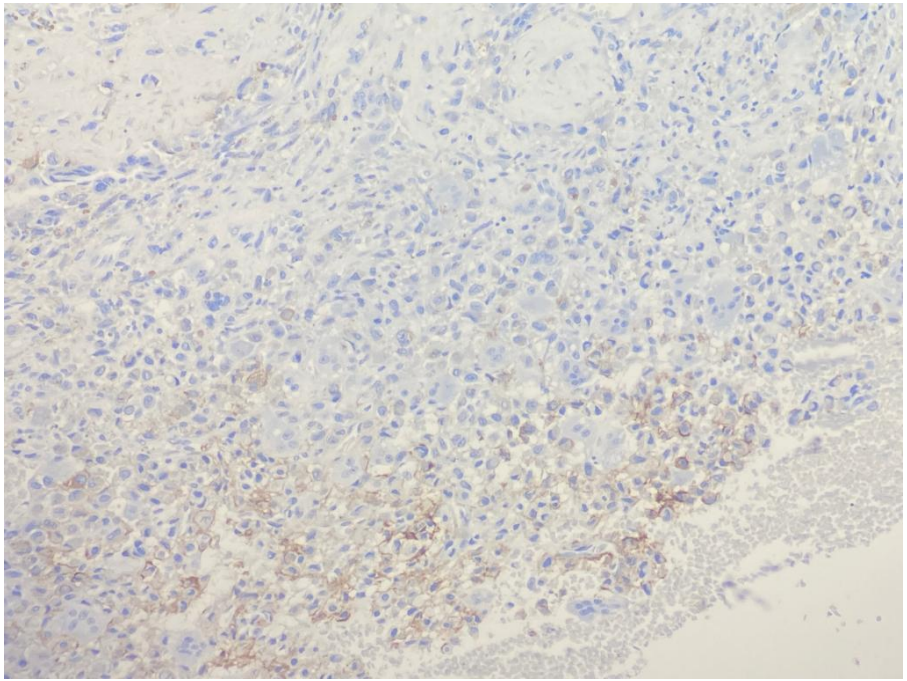


IHC

SATB2



DOG1

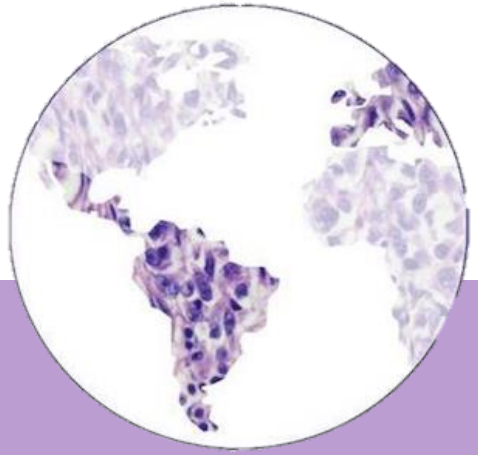


Differential Diagnosis /Discussion

- Atypical chondroblastoma
- Chondroblastoma-like osteosarcoma

H3K36M not available

SELNET



Virtual MDT Board

Fernando Campos, MD
Medical Oncologist
A.C.Camargo Cancer Center
Sao Paulo, Brazil

- 34 yo male

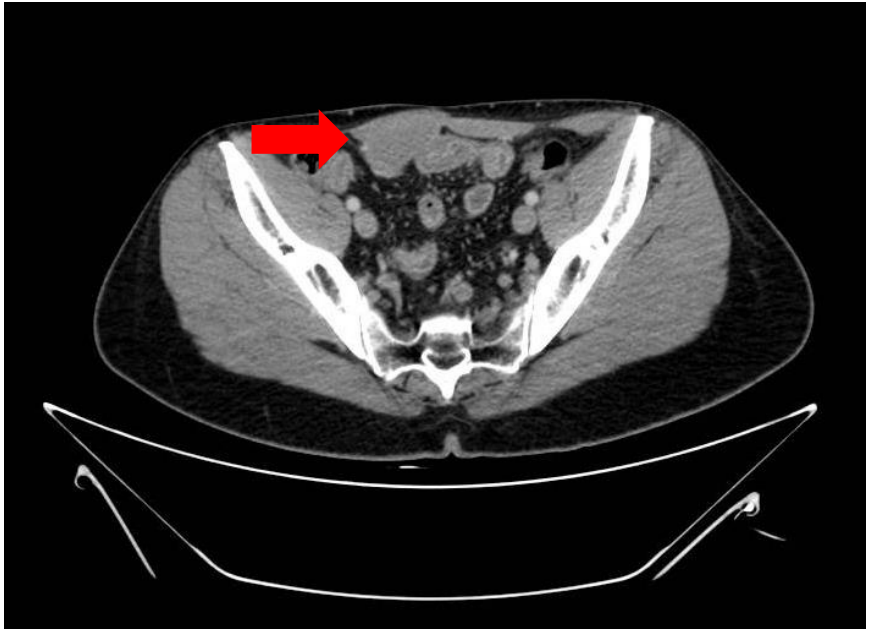
- No comorbidities. No family history of cancer.

ONCOLOGICAL HISTORY:
- 2017: abdominal pain
- Feb/2018: Abdominal CT – solid lobulated mass in the mesogastrium (148x92x130mm)
- Biopsy: desmoplastic small round cell tumor

- Neoadjuvant chemotherapy: Doxo 75/Ifo 9 (6 cyles until October 2018) >> shrinkage of the tumor (25%)
- Dez/2018: Surgery (tumor resection + omentectomy + apendicectomy + linfadenectomy + peritoniectomy) + HIPEC (cisplatin + docetaxel)
- Pathological report: desmoplastic small round cell tumor (15,0 x 7,0 x 7,0 cm; 60% of viable cells).
- Feb/2019: Adjuvant whole abdominal radiotherapy - 3D 30Gy (20x 150cGy)

- Follow up

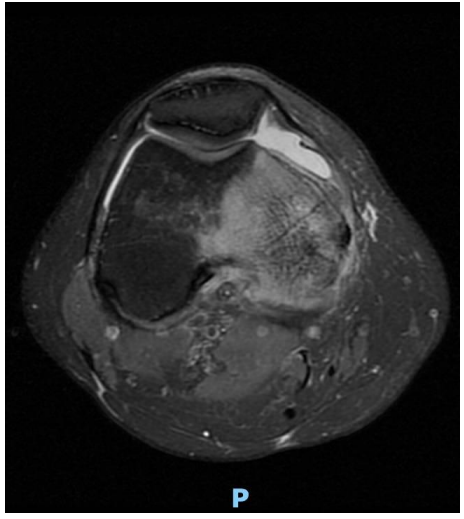
-August 2020: tumor relapse in the abdominal wall
-September 2020: surgery – Pathological report: DSRCT; 5,5 x 4,5 x 2,2 cm.
-Follow up

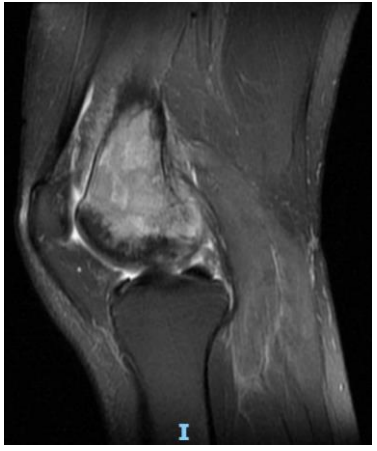


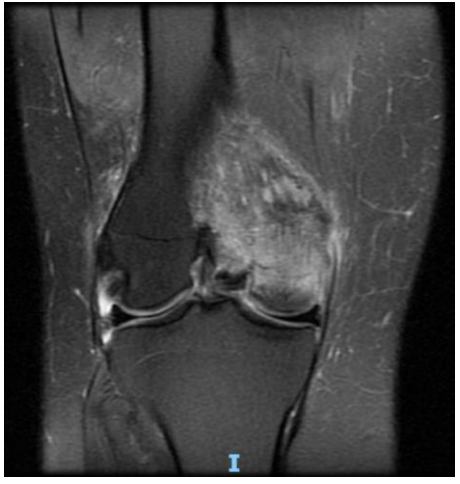
-October 2022: pain in the right knee.

-MRI: **Extensive metaepiphyseal infiltrative bone lesion of the distal femur**, extending to the medial condyle, showing low signal on T1, high on T2 and heterogeneous post-contrast enhancement, **measuring approximately 7.7 cm longitudinally**, suggestive of secondary neoplastic involvement. Extraosseous infiltration can be observed along the external periosteum of the femur, semicircumferentially, including the prefemoral fat region, as well as along the femoral intercondyle region, infiltrating the proximal portion of the posterior cruciate ligament.

-No other sites of disease.







DISCUSSION: TREATMENT

Conservative surgery is feasible?

Chemotherapy – When? What regimen and how many cycles?

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Virtual MDT Board

Eliza Ramirez, MD
Medical Oncologist
National Institute of Cancer
Paraguay

Clinical History

- 54 yo female
- ECOG 3
- The patient came to our center due to a history of pain in the left hypochondrium, asthenia, anorexia, B symptoms, and weight loss.

- A computed tomography scan was performed showing a 23x13 mm pectoral nodule in the subcutaneous plane, multiple poorly defined, diffuse images in the lungs, suggested as secondary. nodules in segments VI and IV of the liver and an irregular polylobulated image in the spleen.

- An ultrasound-guided biopsy of the spleen mass was performed.
- **Pathology Report of the spleen mass biopsy:**
- Littoral cell hemangioma of 2 mm of sample.

- A few days after the biopsy, the patient presented an acute surgical abdomen due to rupture of a splenic subcapsular hematoma and a urgency splenectomy was performed at another center.

- **Pathology Report of the spleen:**
- Vascular neoplasm with tombstone cells compatible with littoral cell angiosarcoma
- **IHC:** ERG +++ and negative for FVIII, CD4, CD8, D240 and CD68. Ki 67 from 40%
- **DX:** Angiosarcoma of the spleen.

- An excisional biopsy of the pectoral nodule was performed, which returned with the same diagnosis, as a secondary lesion.

Discussion

- What can we offer to this patient as a treatment ?
- What is the experience do we have to a propranolol treatment for this neoplasm on this stage ?

Thank you