Greater Manchester &
Cheshire Cancer Network

COLORECTAL CLINICAL SUBGROUP

REFERRAL/MANAGEMENT GUIDELINES

For patients with Anal Cancer

Measures 11-1A-205d/11-1C-110d

14th September 2011

Preface

These guidelines are updated from those from June 2007. Recommended changes from 2007 reflect the establishment of the bi-weekly Anal Cancer Multi-disciplinary Team (MDT) at the Christie (since February 2009) building on the old Regional Anal Cancer MDT. These guidelines should be considered 'dynamic' as there will be further refinements of the protocol following completion of the prospective SupraDistrict anal cancer audit (completion date: August 2010) and quality evaluation of pre-operative imaging.

Christie bi-weekly MDT meeting

- Following the original establishment of a Regional Anal Cancer MDT in 2004, since February 2009, there has been a bi-weekly Anal Cancer MDT at the Christie NHS Foundation Trust.
- The MDT includes a team of colorectal surgeons, clinical oncologists, oncology radiologists, and pathologist supported by a dedicated MDT coordinator, Advanced Nurse Specialist, anal-cancer dedicated Audit Coordinator, and data manager.
- All patients with a new diagnosis of anal cancer from the GMCCN (plus Macclesfield and Leighton hospitals) should be reviewed through this MDT process for consideration of initial treatment.
- Once the patient is referred to this MDT, the MDT will assume full responsibility for the patient.
- Where a presumed 'curative' excision of lesion has been performed for T1 tumours, the histology and clinical case should be reviewed through the Anal Cancer MDT.
- The current lead clinician for the Anal Cancer MDT is Mr Andrew Renehan

Follow-up after initial chemo-radiation

- Despite improvements in chemo-radiation regimens, 20% to 25% of patients with anal cancer have residual or recurrent disease (usually within the first 3 years following initial treatment) and require consideration for salvage surgery.
- Published data from the ACT I trial and the Christie series have shown that invasion through sphincters and a positive resection margin are highly significant negative prognostic factors after salvage surgery.
- To facilitate early detection of local disease failure (and by implication, minimise the numbers of cases with positive resection margins), follow-up of <u>all</u> patients after initial chemo-radiation should through the anal cancer centre.
- Follow-up guidelines after initial chemo-radiation have been agreed through the Anal Cancer MDT.
- The follow-up of patients with anal cancer outside the anal cancer centre should only be in exceptional cases.

Referral after initial chemo-radiation

- Patients with suspicion of residual or recurrent disease after initial chemo-radiation presenting to local hospitals within the Network should be referred without delay to the Anal Cancer MDT.
- Examination under anaesthetic and histological confirmation by biopsy should be performed following review through the Anal Cancer MDT rather than at the local hospital.

Others teams required for management

- In order to manage the complex challenges associated with residual/recurrent disease following chemo-radiation for anal cancer, the multidisciplinary team should include;
  - colorectal surgeons,
  - plastic surgeon,
  - urologist,
  - oncologist,
  - GI or oncology radiologist,
  - pathologist,
  - colorectal cancer nurse specialist and
  - stoma therapist.
- Critical care facilities should be available post-operatively.
- Patients with metastatic disease and/or unresectable local disease should be referred to an anal cancer specific clinical oncologist.
- Patients considered unsuitable for salvage surgery and/or those developing further recurrence should have access to a palliative care team.

Overview of salvage surgery management

- Standard investigations to determine fitness for surgery.
- The extent of disease is determined by: examination under anaesthetic; biopsy (recurrence must be confirmed histologically[1]); CT scan to assess distant disease; MRI scan for evaluation of local disease extent; PET-CT scan for equivocal cases.

- Image-guided lymph node fine needle aspiration or (rarely) surgical biopsy is performed for clinically suspicious groin nodes.
- Surgical resection is determined by the extent of disease. Radical ano-rectal excision is the standard procedure. The operative technique includes wide excision of the anal canal and circumrectal tissue ensuring the widest pelvic floor clearance. As both the abdominal and perineal part of the operation may be technically difficult, two colorectal surgeons working synchronously is recommended.
- Where pre-operative investigations have shown evidence of invasion of adjacent organ/s, *en bloc* excision of the involved structures beyond the anus and rectum should be performed with the assistance of appropriate surgical specialists.
- In view of the high rates of perineal wound breakdown and the long time to perineal wound healing in the majority of patients, plastic reconstruction is usually necessary unless the tissues are very favourable and/or the disease is less than 2 cm at the examination under anaesthetic.
- Following resection and histopathological review, all cases should be discussed at a multidisciplinary meeting. As all patients post-salvage surgery are at risk of further local and/or distant disease, investigators should be encouraged to develop adjuvant chemotherapy trial protocols or enter patients into adjuvant chemotherapy national/ international trials.

Prospective Audit

- A database of patients with anal cancer treated in the North West of England and Network region has been established. This includes collection of patients from 1988, which has been prospective since 1998). To end of 2009, there are over seven-hundred patients.
- This database will be linked with the North West Cancer Intelligence Service.
- There is currently a 18 month (Feb 2009 to Aug 2010) SupraDistrict funded prospective audit of the treatment of anal cancer and benign precursor disease (Christie, CMFT, Stepping Hill, and SMUHT) registered through the Network.

[1] Exceptional require Radical Anorectal excision for symptoms and/or confirmation of disease.

Patients with Anal Intra-epithelial Neoplasia (AIN)

Referral guidelines for these patients are currently being developed.

Mr Andrew Renehan, Clinical Lead for the Anal Cancer MDT

On behalf of the MDT group: Miss Sarah T O'Dwyer, Mr Malcolm Wilson, Mr Paul Fulford, and Mr Jim Hill (Colorectal Surgery); Dr Mark Saunders (Clinical Oncology); Professor Najib Haboubi (Pathology); Dr Rohit Kochhar and Dr Bernadette Carrington (Radiology).