Anal Canal Carcinoma

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Anal Canal Carcinoma

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• Management usually requires multidisciplinary input; therefore concurrent referrals to colorectal cancer surgeon, medical oncology, and radiation oncology is appropriate • MCC Recommended	
A	Diagnosis	Biopsy type, procedure	• Incisional biopsy • The initial role for surgery in the curative management is diagnosis • Most common histology is squamous cell carcinoma; this classification includes cloacogenic, basaloid, and transitional tumours	
B	History and Physical exam		• DRE • Inguinal node palpation • In women - bimanual pelvirectal examination • Proctoscopy	
C	Investigations		• Complete colonoscopy • MRI pelvis for staging and radiation planning • CT chest abdomen pelvis • Confirm adequate renal function (usually serum creatinine will suffice) • Inguinal nodal biopsy if recommended at MCC discussion • HIV testing not routine, but indicated in at risk patients	

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D	Pathology of Diagnostic Specimen		• HPV testing not routinely indicated	
E	Staging		Assign Primary Clinical Stage All cases preferentially to be discussed at MCC	American Joint Committee on Cancer (AJCC) Staging Quick Reference (7th edition)
F	Primary management	Definitive Curative Intent treatment	Surgical excision of bulky inguinal nodes prior to chemoradiation per MCC guidance Radiation: IMRT or 3-D conformal technique Radiation to at-risk nodal beds: mesorectal, inguinofemoral and iliac nodal regions are irradiated on prophylactic and therapeutic basis Treatment interruptions – while it is reasonable to delay radiotherapy for several days to allow recovery from grade 3-4 toxicities, evidence would suggest that increased time to completion of definitive radiation is associated with decreased survival (Ben-Josef JCO 2010) Chemotherapy regimen: FUMTMC(RT) Dose capping: MMC 10 week 1 and 5	Ben-Josef (1) Cancer Care Ontario Adjuvant/ Curative/ Neo-Adjuvant Intent Systemic Therapy

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G	Primary management	Advanced and metastatic disease	Chemotherapy: per CCO Systemic Treatment Funding Model: CISPFU Radiation for specific symptom management issues Focus on palliation and quality of life Referral to palliative care services as appropriate	Cancer Care Ontario Palliative Intent Systemic Therapy
H	Follow up with no evidence of disease		• Regularly scheduled clinical follow-up over a five-year period by experienced specialists is essential since incomplete response or local recurrence may be amenable to salvage surgery. • Biopsy is recommended only when recurrence is suspected, not in routine follow-up of resolving disease	Cancer Care Ontario (CCO) Guideline 2-8 Management of Squamous Cell Cancer of the Anal Canal
I	Recurrent Disease	Locally recurrent disease	• Salvage abdominal perineal resection (by CRC surgeon) • Inguinal node dissection	
J	Controversies		• T1 lesions – role of definitive chemo-radiation versus Radiation alone– requires MCC discussion • Adenocarcinoma - rule out a low rectal primary with a rectal pattern of disease • Neo-adjuvant chemotherapy not recommended at this time based on randomized evidence	

Section	Activity	Activity Description	Details	Reference(s)
			• Role of cisplatin: should not replace MMC unless the latter contraindicated • Role of PET scanning still to be determined in clinical studies	
K	Clinical Trials		• None open at this time	Cancer Centre of Southeastern Ontario Clinical Trials

References

1. Ben-Josef et al. J Clin Oncol 2010;28(34)5061-6

Revisions

- 2014/06/24: Draft created
- 2014/10/15: Edits for clarity prior to discussion at Disease Site Group Chairs Council meeting (2014/10/15)
- 2014/10/16: Edits after discussion and initial approval at Disease Site Group Chairs Council meeting (2014/10/15)
- 2014/10/20: Edits after review by Disease Site Group Chair (J. Biagi), addition of reference links