Network Guidelines
&
Patient Pathways for Anal Cancer

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Version Number	

It is agreed that the Colorectal MDT at Lancashire Teaching Hospitals Foundation NHS Trust is the nominated Network MDT for Anal Cancers.

Pre-treatment assessments are the responsibility of the local colorectal diagnostic teams.

All local Colorectal MDTs should refer patients with anal cancer to the Network Anal MDT at Lancashire Teaching Hospitals Foundation NHS Trust.

DEFINITION

Squamous cell cancer of the anal canal and margin is one of the uncommon cancers of the gastrointestinal tract. The incidence in the United Kingdom is approximately 1500 new cases a year (2014-2017 Cancer Research UK), comprising 1.5% of all gastrointestinal cancers and 4% of anorectal neoplasms.

Anal Canal and Margin Cancers

The anal canal extends from the rectum to the perianal skin and is lined by the mucosa overlying the internal sphincter. This definition includes the anal transition zone and the non-hairbearing and no-sweat gland bearing mucosa extending distally to its junction with the anal skin.

Tumours of the anal margin and perianal skin defined as within 5cm of the anal margin are classified with carcinomas of the anal canal.

T		N		M	
TX	cannot be assessed	NX	cannot be assessed	MX	cannot be assessed
T0	no primary tumour	N0	no regional LN metastasis	M0	No distant metastasis
T_{is}	carcinoma in situ	N1	Metastasis in regional Lymph Nodes	M1	Distant metastasis
T1	<2cm in greatest dimension	N1a	Metastasis in inguinal, Mesorectal, and / or internal iliac Nodes		
T2	>2cm but <5cm in greatest dimension	N1b	Metastasis in external iliac Nodes		
T3	>5cm	N1c	Metastasis in external iliac and in inguinal, mesorectal and / or internal iliac Nodes		
T4	adjacent organ invaded [vagina, urethra, bladder]				

MDT REFERRAL PROTOCOL

- Cases discussed
    - All histologically proven anal canal and anal margin invasive cancers
    - All recurrent anal canal and anal margin invasive cancers

    Patients with histology demonstrating AIN2/3 or AIN 3 should be referred to the ANAL MDT. Patients with AIN 2 and known risk factors (e.g. immunocompromised, Transplantation,etc) should also be referred.

- For MDT discussion the following are required:

    - Formal referral letter with clinical information from the responsible consultant to link oncologist / surgeon
    - Imaging reports e.g. CT, MRI,or USS
    - Histopathology reports
    - Endoscopy report
    - Copy of any operation note

- Imaging required for potentially curative cases
    - CT thorax/abdomen/pelvis
    - MRI pelvis and perineum
    - [PET scan]

- For patients referred the MDT will review:

    - Based on the clinical information provided
    - Relevant radiology will be reviewed by the MDT radiologist
    - Histopathology will be reviewed by the MDT histopathologist

Communication with the Network Anal Cancer team

Anal MDT co-ordinator: Debbie Hall

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MDT THERAPY OPTIONS

Stage 0

- **Tis, N0, M0**
  - Surgical resection of lesions of the perianal area not involving the anal sphincter

Stage I

- **T1, N0, M0**
  - Small tumours of the perianal skin, anal margin or anal canal not involving the anal sphincter may be adequately treated with local resection
  - All other stage I cancers of the anal canal that involve the anal sphincter or are too large for complete local excision are treated with external-beam radiation therapy with or without chemotherapy
  - Radical resection is usually reserved for residual or recurrent cancer in the anal canal after non-operative therapy.

Stage IIA

- **T2, N0, M0**

Stage 11B

- **T3, N0, M0**
  - Some T2 and T3 tumours may be appropriately treated with local resection depending on patient fitness for other treatments, involvement of the sphincter muscles and/or other predictors of recurrence such as tumour differentiation.
  - All other stage II cancers of the anal canal that involve the anal sphincter or are too large for complete local excision are treated with external-beam radiotherapy with or without chemotherapy
  - Radical resection is usually reserved for residual or recurrent cancer in the anal canal after non-operative therapy.

Stage IIIA

- **T1, T2, N1, M0**
    - Treatment as for stage I and II disease, using external-beam radiotherapy with or without chemotherapy
    - Radical resection is usually reserved for continued residual or recurrent cancer in the anal canal after non-operative therapy.

Stage IIIB

- **T4, N0, M0**

Stage IIIC

- **T3, T4, N1, M0**
    - External-beam radiotherapy with or without chemotherapy (as described for stage II).
    - Surgical resection of residual disease at the primary site (local resection or abdominoperineal resection) and unilateral or bilateral superficial and deep inguinal node dissection for residual or recurrent tumour.

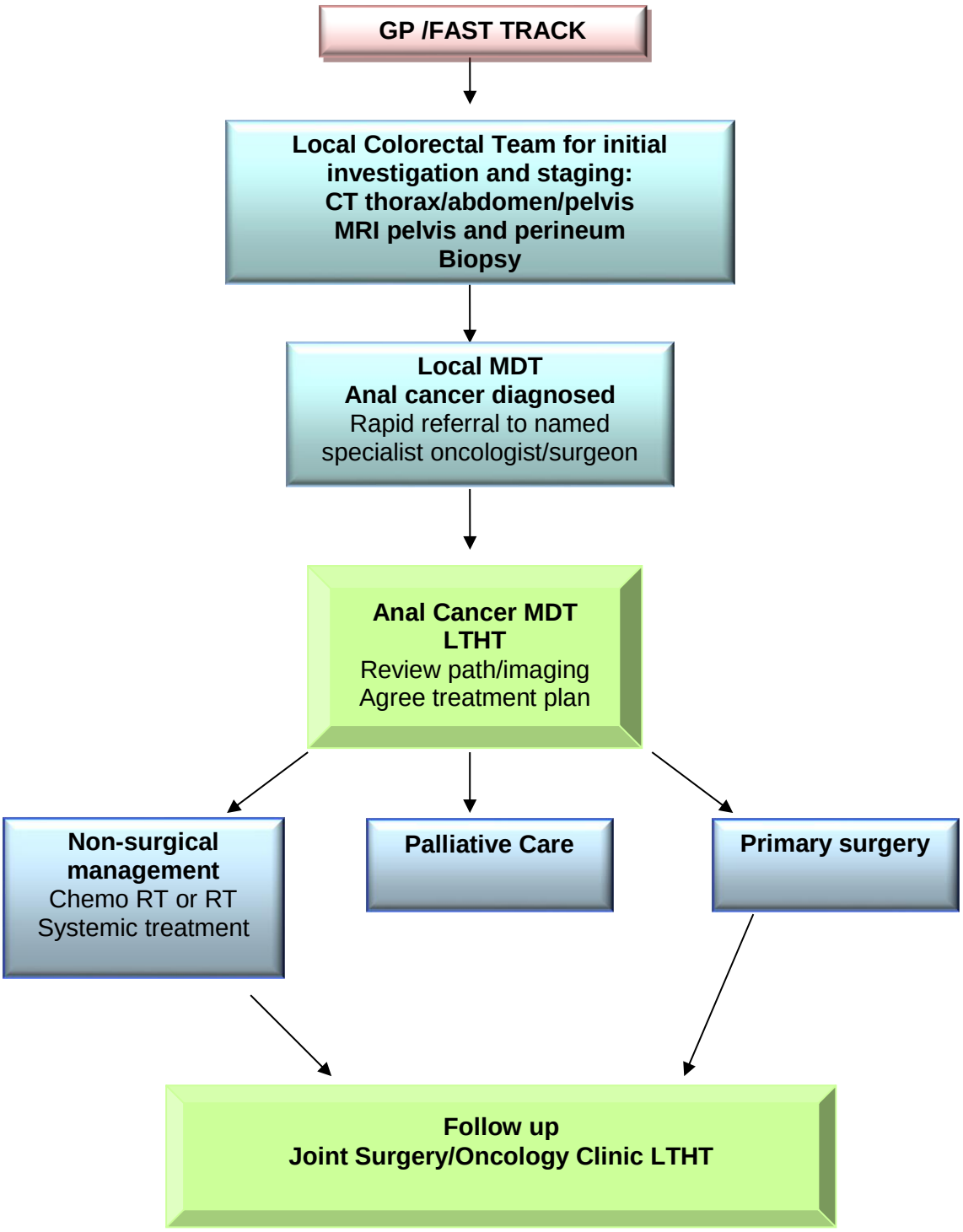
Stage IV

- **Any T, any N, M1**
    - Palliative systemic therapy
    - Palliative external-beam radiotherapy with or without chemotherapy
    - Palliative surgery
    - Referral to Palliative Care/Supportive Care services

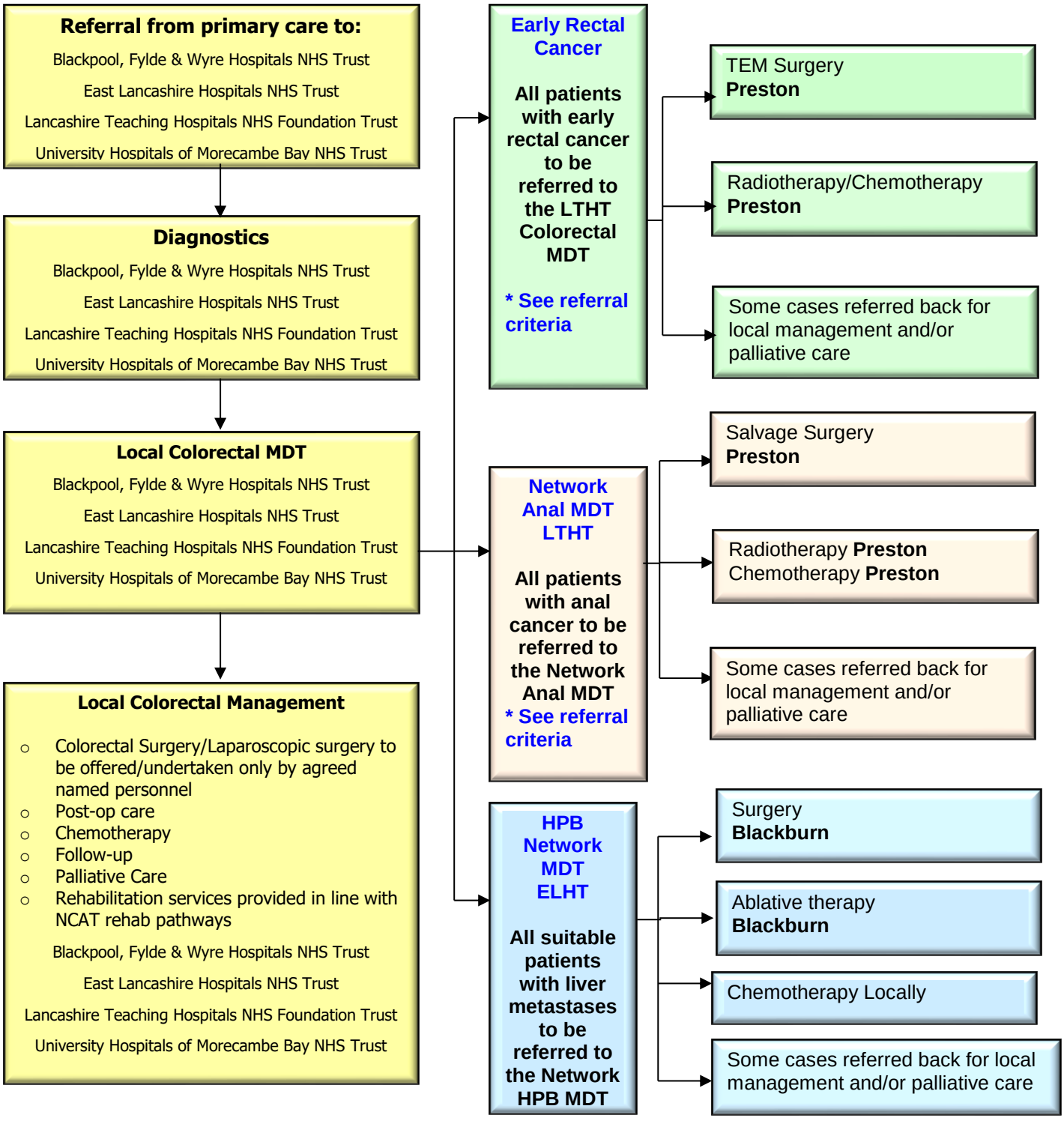
CLINICAL TRIALS

Clinical trials will be discussed and offered to patients with anal cancer where available.

ANAL CANCER PATHWAY



PATIENT PATHWAYS
COLORECTAL, ANAL, EARLY RECTAL AND LIVER METASTESES



Cancer of Unknown Primary

Any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the local CUP MDT

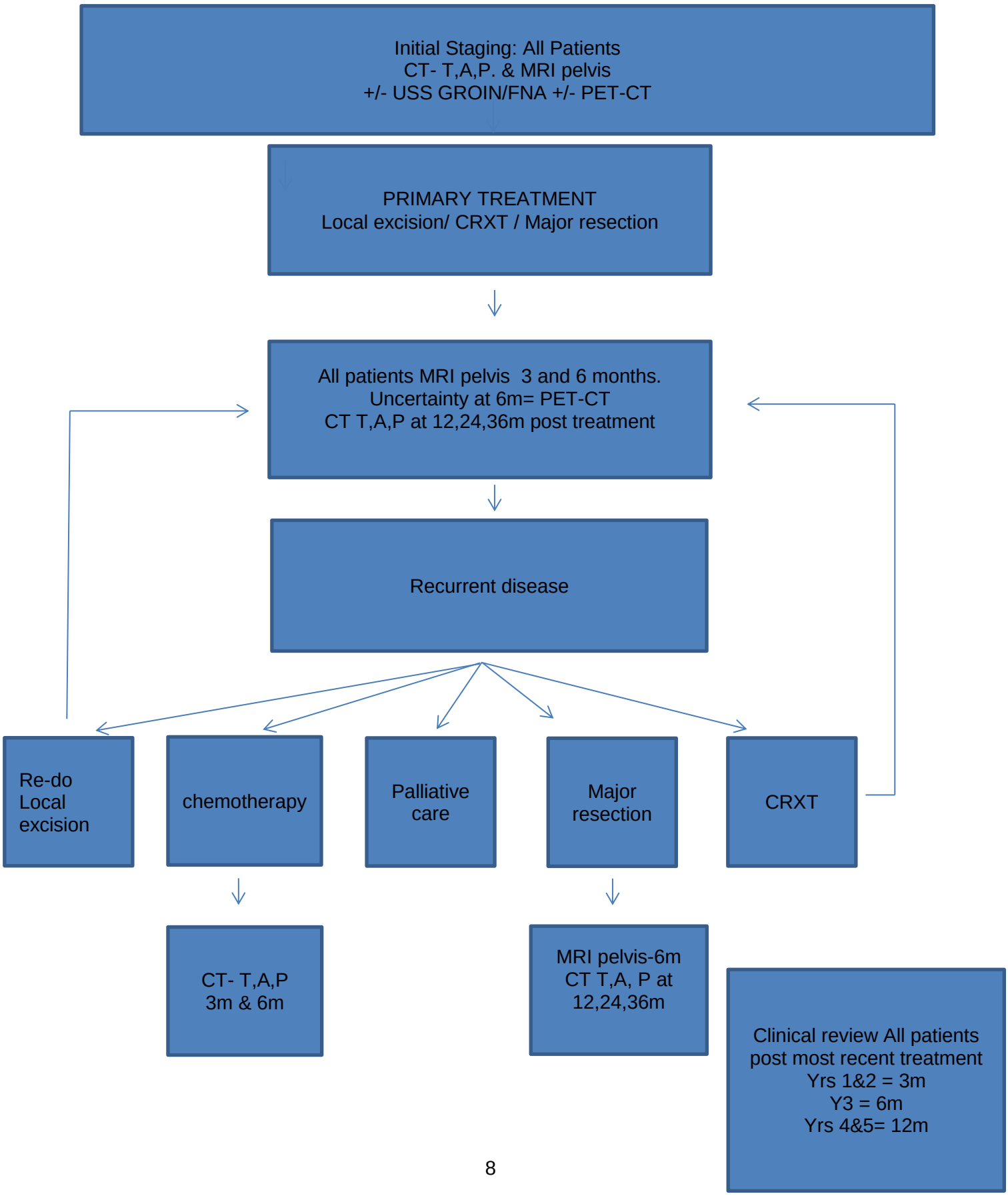
Rehabilitation Pathways

Reference should be made to the NCAT rehabilitation pathways for all stages of treatment:

http://webarchive.nationalarchives.gov.uk/20130513211237/http:/www.ncat.nhs.uk/our-work/living-beyond-cancer/cancer-rehabilitation

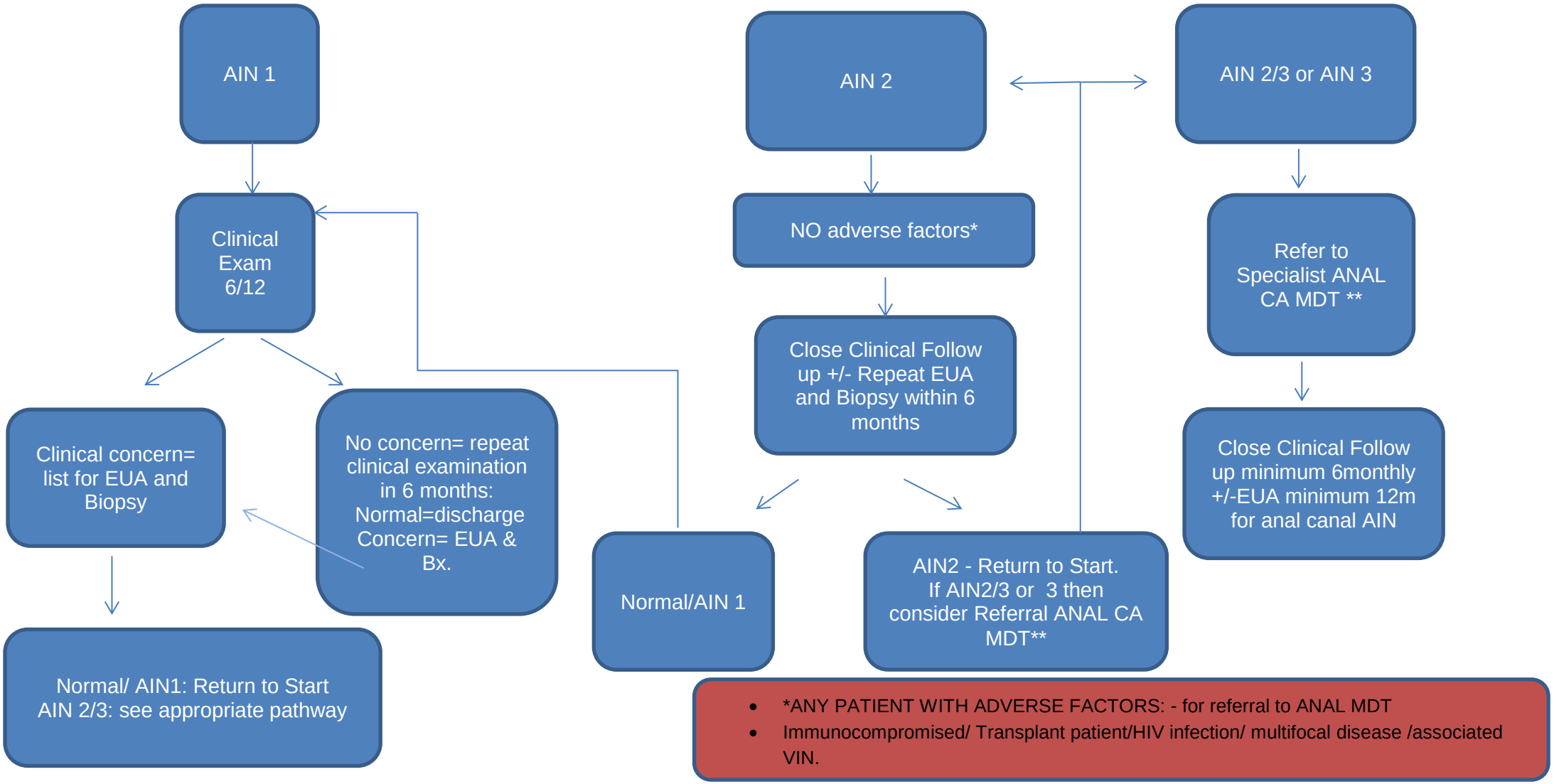
- Diagnosis and care planning; Treatment; Recovery phase; Palliative care and End of Life

Anal Cancer Follow up- Clinical and Imaging. Mitchell



Management of Anal Intraepithelial Neoplasia (AIN)

Mitchell/Williamson/
Parkin/Haston 2022



- *ANY PATIENT WITH ADVERSE FACTORS: - for referral to ANAL MDT
- Immunocompromised/ Transplant patient/HIV infection/ multifocal disease /associated VIN.

**__ANAL CANCER MDT =__ Refer to Dr Williamson/ Mr P Mitchell/Mr E Parkin/Dr J Haston.
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