Greater Manchester Cancer Pathway Board NHS

COLORECTAL CLINICAL SUBGROUP

(Updated) REFERRAL GUIDELINES

For patients with Anal Cancer

(there is a separate guideline in development for the referral and management of AIN)

Circulated to Anal Cancer MDT on 13th September 2023
For full ratification at Anal Cancer MDT Away Day 19th September 2023
Final ratification 26th January 2024

Preface

These guidelines are updated from those dated December 2017. Recommended changes reflect the establishment of the weekly Anal Cancer Multi-disciplinary Team (MDT) at the Christie, since 2018; the expansion to four clinical oncologists managing anal cancer; the wider opportunities to recruit patients to anal cancer trials and research; the establishment of the 4 weekly joint anal cancer clinic in 2013 and the proposed development of the two weekly joint anal cancer clinics in the future; and the recent introduction of High-Resolution Anoscopy for the detection of and surveillance of AIN (Anal Intra-epithelial Neoplasia). These guidelines should be considered 'dynamic' as there will be further refinements as we continuously audit and appraise our diagnostic work-ups, oncological outcomes and as we increasingly move towards appraising patient-reported outcomes (PROs).

There are no major new sections. There are separate guidelines in development for the referral and management of AIN.

Christie Anal Cancer MDT structure

- Since 2018, there has been a weekly dedicated Anal Cancer MDT at the Christie NHS Foundation Trust.
- This MDT was successfully peer-reviewed annually until the COVID-19 pandemic.
- Many of the principles of the Christie anal cancer MDT are reflected in the Association of Coloproctology of Great Britain and Ireland (ACPGBI) 2017 Guidelines – Anal Cancer (1) and the 2021 European Society of Medical Oncology Guidelines (2).
- The MDT includes a team of four clinical oncologists, two colorectal surgeons, dedicated GI radiologists, consultant radiographer and pathologists, supported by a dedicated MDT coordinator and Advanced Nurse Specialists.
- There is currently no dedicated anal cancer data manager.
- All patients with a new diagnosis of anal cancer from the Greater Manchester Cancer Pathway Board (plus Macclesfield and Leighton hospitals) should be reviewed through this MDT process for consideration of initial treatment.
- The Anal Cancer MDT is a source for identification and recruitment of patients into trials.
- Anal margin tumours (within 5 cm of the anal canal), without overlapping involvement of the anal cancer, are relatively uncommon. The presentations and pathways for this patient undergoing ‘curative’ local excision varies. The histology and clinical case should be reviewed through the Anal Cancer MDT.
- The current lead clinician for the Anal Cancer MDT is Professor Andrew Renehan

Scope of the Anal Cancer MDT

The scope of histological diagnoses reviewed by the central Anal Cancer MDT includes the following:

- The majority of histological diagnoses are squamous cell carcinomas (SCC) which are often histologically heterogeneous and may show different patterns including basaloid (previously called cloacogenic), keratinizing, non-keratinizing and the rare pattern of squamous cells with admixed mucin-containing cells (previously called mucoepidermoid)*.
- Less common squamous cell carcinoma subtypes include verrucous carcinoma and Giant Condyloma of Buschke–Lowenstein.
- SCC may occur uncommonly in the rectum – sometimes referred to ectopic SCC.
- Less common anal carcinoma types include: basal cell carcinoma,

adenocarcinoma, neuroendocrine carcinomas and MiNEN.

- True anal cryptal adenocarcinomas are rare, but if this diagnosis is suspected, these cases will be considered on the anal cancer MDT.
- The Anal Cancer MDT reviews anal malignant melanoma in parallel with the Melanoma MDT at the Christie.
- The Anal Cancer MDT is a point of reference for the discussion of complex pre-malignant lesions; anal intra-epithelial neoplasia (AIN), with and without other uro-genital intra-epithelial neoplasia (for example, vulval intra-epithelial neoplasia, VIN) i.e. multi-zonal disease. This is fully discussed in separate AIN guidelines in development.
- The Anal Cancer MDT is a point of reference for the management of patients with AIN and early micro-invasive carcinomas of the anal canal and margin detected through anal cancer screening programme in high-risk individuals. This is fully discussed in separate AIN guidelines in development.

New patients and referral pathway

- These guidelines recognise that there is variation in how the diagnosis of anal cancer is reached at local referring hospitals – for example, through rapid access clinics; new patient examination under anaesthetic; surveillance of high-risk patients
- Where there is a suspicion of anal cancer, a biopsy with histological confirmation should be undertaken.
- After histological diagnosis of anal carcinoma at the local referring hospital, three steps should be initiated in parallel:
  (i) staging CT scan performed at the local hospital;
  (ii) staging MR scan pelvis performed at the local hospital **(this is a change from earlier protocols)**;
  (iii) request for a PET CT scan submitted.

Contacts for direct referrals are as follows:

All referrals to be emailed to central referrals inbox: the-christie.new-referrals@nhs.net

For Leighton, Macclesfield, Pennine (Fairfield General, North Manchester, Rochdale and Royal Oldham) Dr Victoria Lavin – secretary 0161 446 8583

For Tameside, Salford, South Manchester, Trafford and Wigan – Dr Peter Mbanu 0161 956 1039

For Bolton, Manchester Royal Infirmary Stockport: Dr Nooreen Alam (sec): 0161 446 3360

Nurse Specialists: Sarah Mitchell and David Wilson: the-christie.colorectaloncologynurses@nhs.net

The guidance recognises that there is variation in the processes how local referring hospitals refer new patients with anal cancer. Although the number of patients with a new diagnosis of anal cancer per year is small for each local MDT, it is the responsibility of each referring hospital to have processes in place to refer with minimal delay to the central clinical oncology team.

- Where a peri-anal or anal cancer lesion is excised and an unexpected histology of anal carcinoma is reported (e.g. haemorrhoidectomy), all cases should be reviewed through the central Anal Cancer MDT even if where excision is deemed to be 'curative'.
- DPYD testing will be arranged for patients at the first oncology appointment if planned for 5FU chemotherapy.
- HIV and hepatitis screening will take place at the first oncology appointment if indicated.

Formation of pre-treatment colostomy at local hospital

- Up to a quarter of patients with anal cancer will require a pre-treatment colostomy. This is generally indicated because of advanced stage, pain, incontinence (either present at presentation or expected during chemo-radiotherapy).
- The majority of pre-treatment colostomies are performed at the local referring hospital. Wherever possible, the decision to undertake a pre-treatment colostomy should be centrally through the anal cancer MDT.
- The literature often refers to reversal of colostomy after anal cancer treatment. We have monitored the data at the Christie over the past 25 years – and noted that successful reversal of a stoma is exceptionally rare.
- The Anal Cancer MDT, therefore, recommends that when consenting a patient for pre-treatment colostomy in the setting of anal cancer, the surgeon should inform the patient that colostomy will be permanent.
- The Anal Cancer MDT recommends an end colostomy, rather than a loop colostomy, as the latter are associated with a high rate of long-term complications including parastomal hernias and stomal prolapses.
- The end colostomy can be performed as an open laparotomy or laparoscopically.

- The indication of ileostomy in this setting is very uncommon.

Follow-up after initial chemo-radiotherapy

- Despite improvements in chemo-radiotherapy regimens, approximately 18% of patients with anal cancer develop local disease relapse and require consideration for salvage surgery (3).
- A positive resection margin is highly significant negative prognostic factor after salvage surgery (4). By inference, these guidelines support intensive post initial chemo-radiotherapy surveillance to facilitate the early detection of local disease relapse.
- Follow-up of all patients after initial chemo-radiotherapy should be through the Anal Cancer MDT, using agreed follow-up guidelines.

Salvage surgery and other major resection surgery

- There are two nominated anal cancer surgeons who lead on major resections where indicated in patients with anal cancer. Surgical procedures will be performed at the Christie.
- The commonest indication for major resection will be salvage surgery for relapsed disease. This surgery frequently involves more than one surgical team, including oncoplastic surgeon, urological surgeons and gynaecological oncology surgeons.
- Additionally, major surgery in anal cancer may include the following relative and absolute indications: previous pelvic radiotherapy; radioresistant cases like Crohn's disease; giant condylomata and verrucous carcinomas; and anal canal adenocarcinoma. These 'upfront' major resection cases will be preformed at the Christie.

Referral after initial chemo-radiation

- Exceptionally, patients with suspicion of local disease relapse after initial chemo-radiotherapy may present to local hospitals should be referred back without delay to the Anal Cancer MDT.
- Examination under anaesthetic, histological confirmation by biopsy, assessment of resectability, and planning plastic surgery reconstruction 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 local disease relapse following chemo-radiotherapy for anal cancer, the multidisciplinary team includes: colorectal surgeons; plastic surgeons; urologists; oncologists; GI or oncology radiologist; pathologist; colorectal cancer nurse specialist and stoma therapist (4).
- 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.
- Following treatment, many survivors of anal cancer experience chronic long-term late-effects. There are a variety of support systems and allied professionals required for management of these patients including gastroenterology (Dr Caroline Henson); MacMillan; stoma nursing team; and the Pelvic Radiation Disease Association.

Joint anal cancer clinic

- Since 2013, there has been joint 4 weekly Anal Cancer Clinic.
- This clinic is focused on multi-disciplinary clinical input, education and training, and trial recruitment.
- The management of the following are examples of patient sub-groups through this clinic:
  - Surveillance following wide local excision of anal margin cancer
  - Patients with a new diagnosis of AIN and subsequent surveillance
  - Follow-up after salvage surgery for anal cancer local relapse.

Prospective Audit

- A database of patients with anal cancer treated in the North West of England and Network region has been established since 1998.
- In 2014, the database included over 1000 patients.
- The Christie anal cancer database is operated under audit data governance.
- Currently, there is no anal cancer data manager to update these data.

Professor Andrew Renehan, Clinical Lead for the Anal Cancer MDT

And ratified by the core members of the anal cancer MDT group: Professor Mark Saunders, Dr Noo Alam, Dr Victoria Lavin, Dr Peter Mbanu (Clinical Oncology); Mr Hamish Clouston (Colorectal Surgery); Dr Rohit Kochhar, Dr Joseph Mercer, Dr Hugh Burnett, Dr Damian Mullan (Radiology); Dr Bipasha Chakrabarty, Dr Rola Salama (Pathology); Sarah Mitchell; David Wilson, Rachel Connolly, Lisa Wardlow (Cancer Nurse Specialists); Lucy Buckley; Imogen Hemy (Radiotherapy radiographers).

References

1. Geh I, Gollins S, Renehan A, Scholefield J, Goh V, Prezzi D, et al. Association of Coloproctology of Great Britain & Ireland (ACPGBI): Guidelines for the Management of Cancer of the Colon, Rectum and Anus (2017) - Anal Cancer. Colorectal Dis. 2017;19 Suppl 1:82-97.

2. Rao S, Guren MG, Khan K, Brown G, Renehan AG, Steigen SE, et al. Anal cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up(☆). Ann Oncol. 2021;32(9):1087-100.

3. Sekhar H, Malcomson L, Kochhar R, Sperrin M, Alam NN, Chakrbarty B, et al. Temporal improvements in loco-regional failure and survival in patients with anal cancer treated with chemo-radiotherapy: treatment cohort study (1990-2014) [in press]. British Journal of Cancer. 2019.

4. Renehan AG, O'Dwyer ST. Management of local disease relapse Colorectal Disease. 2011;13(s1):44-52.

* Added as a late revision:

WHO Classification of Tumours Editorial Board. Digestive system tumours. Lyon (France): International Agency for Research on Cancer; 2019. (WHO classification of tumours series, 5th ed.; vol. 1)