UCCH Pathway

UCCH Guideline
Anal Carcinoma

Version Jan/2024

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Ein Kompetenznetzwerk des UKE

Guideline Anal Carcinoma

Version 10, Jan/2024

according to TNM classification 8th edition

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Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

TB

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Anal Carcinoma

Work up

- **History**: incl. history of immune suppression, consumption of nicotine
- **Physical examination:** incl. palpation of the groin and digital rectal examination)
- **Lab exam:** Consider SCC, CEA and HIV-serology)
- **Proctoscopy**
- **Biopsy:** Squamous cell histology[1]
- **MRI pelvis**
- **CT chest / abdomen**
- **Gynecologic exam for women** (including screening for HPV related cancer) and consultation concerning fertility and menopause
- **Andrological consultation for men** with desire to have children (possible sperm asservation)
- Facultative:
  - Transanal ultrasound
  - Colonoscopy
  - Ultrasound inguinal lymph nodes
  - PET-CT
  - Cystoscopy
  - Nephro-ureterography
- **Supportive:**
  - Offer contact to self help group
  - Offer psychooncological support

Early tumors
- Anal margin lesion:
  - Tis
  - T1 N0 M0 (well differentiated)
- Anal canal:
  - Microinvasive carcinoma (Tis)

→ Local excision/ surgical resection

→ **Consider in case of inadequate margins:**
- Re-resection and/or
- Local RT +/- flouro-pyrimidine based CT

→ Follow up

Invasive Carcinoma
- Anal margin:
  - T1N0 (poorly differentiated);
  - T2-T4 N0
  - Any T N1-N3 M0
- Anal canal:
  - T1-T4, N1-N3, M0

→ TB → Pathway page 2

Obstructing tumor with subileus / ileus

→ TB → Anus praeter → Pathway page 2

→ TB → Primary surgical resection[2] → Pathway page 2

Distant metastases (T1-T4, N1-N3, M1)

→ TB → **Individual decision depending on clinical findings and patients condition**
- RCT and resection of metastases
- Palliative CT
- Palliative RCT

→ Pathway page 2

→ Pathway page 3

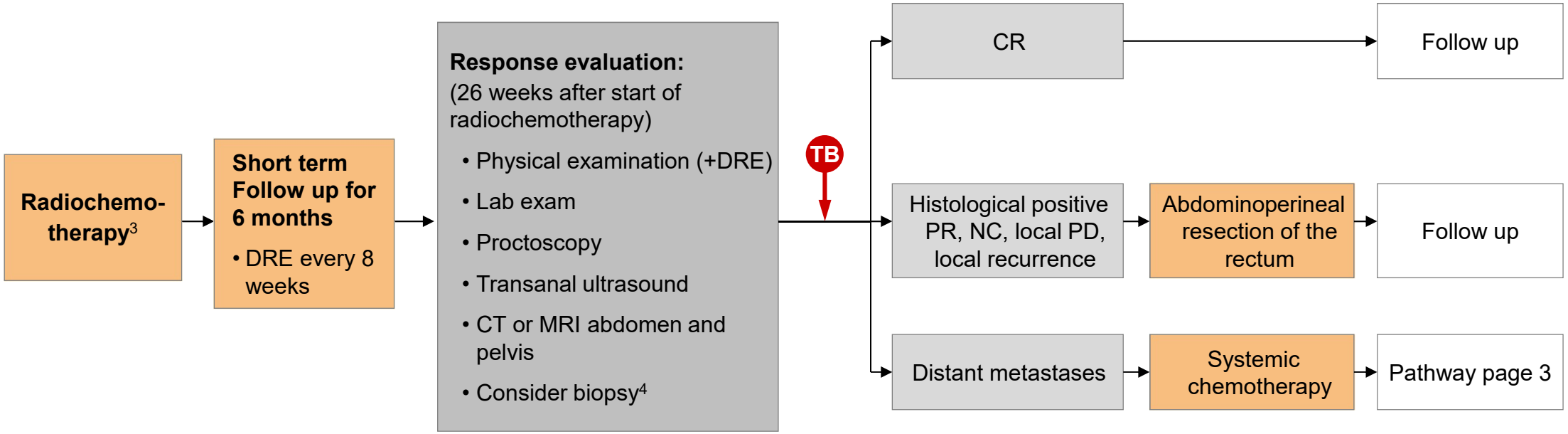
- Consider clinical trial

CT Chemotherapy, RT Radiotherapy, RCT Radiochemotherapy

[1] See UCCH guideline Malignant Melanoma for melanoma histology and UCCH guideline Colorectal Cancer for adenocarcinoma histology

[2] In case of contraindications for radiochemotherapy as Colitis ulcerosa, M. Crohn, previous irradiation of the pelvis for other neoplasms

Pathway page 2: Curative Radiochemotherapy and Surgery

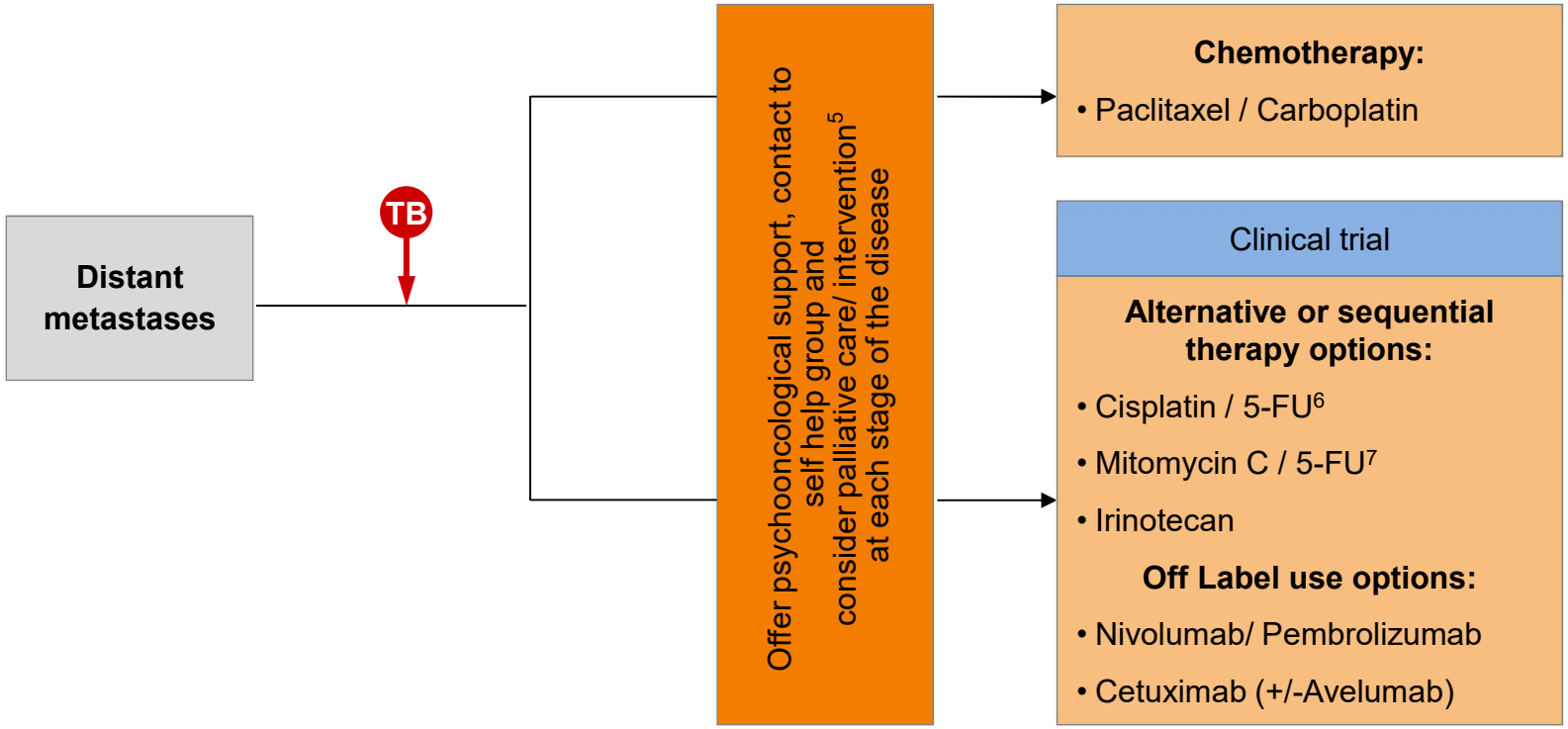


CR Complete remission, PR Partial remission, NC No change, PD Progressive disease,

[3] Curative radiochemotherapy: conformal radiochemotherapy (using IMRT) of the primary tumor, the pelvic (upper field border to L4/L5) and inguinal lymph node stations to 30.6 Gy (36 Gy), the primary tumor, the small pelvis and the inguinal lymph node stations to 36 Gy (45 Gy), boost to involved lymph nodes to 50.4 Gy, boost to the primary tumor to 55,8-59,4 Gy, d/f 1.8 Gy, 5 f/w, in case of extensive pelvic or inguinal lymph node metastases individual modification of target volume and doses, f.e. radiotherapy of the pelvic and inguinal lymph nodes with 45 to 50.4 Gy including primary tumor in PTV 1 up to 45-50.4 Gy with additional boost doses of up to 55.8-59.4 Gy to involved lymph nodes and primary tumor. Simultaneous chemotherapy: Fluoropyrimidine based (either 5-FU 1000 mg/sqm p.d. i.v. as continous infusion over 4 days in week 1 and week 5 of the RT **or** Capecitabine 825 mg/sqm po BID Monday to Friday on each day that RT is given throughout the duration of RT) combined with Mitomycin C (either Mitomycin C i.v. 10 mg/ sqm as bolus injection on day 1 and 29 **or** Mitomycin C i.v. 12 mg/ sqm (capped at 20 mg) as bolus injection on day 1); alternative 5-FU and Cisplatinum.

[4] Confirmation of residual or recurrent disease (routine biopsies are not recommended)

Pathway page 3: Systemic Chemotherapy

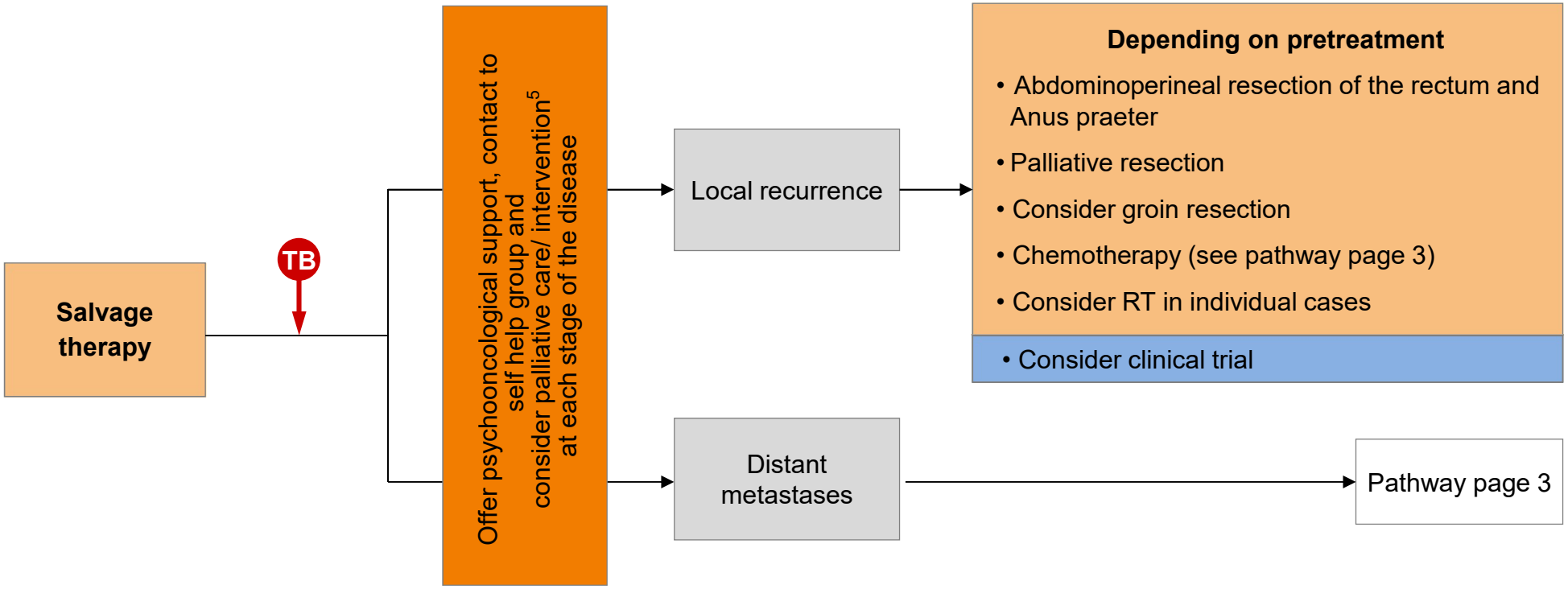


[5] See palliative care screening tool on page 6

[6] Cisplatinum i.v. 80 mg/sqm day 1 (alternative to cisplatinum is carboplatin i.v. AUC 5); 5-FU i.v. 1000 mg/sqm day 1-4, repetition every three weeks

[7] 5-FU i.v. 1000 mg/sqm day 1-4; Mitomycin C 10 mg/sqm day 1 (in mitomycine-C-native patients)

Pathway page 4: Salvage therapy



[5] See palliative care screening tool on page 6

Page 5: Follow up

- **Offer oncologic rehabilitation to the patient**
- After curative intent chemoradiation
  - Initial follow up with digital rectal examination (DRE) **11, 18 and 26 weeks**
  - Response evaluation week 26 post RCT (see pathway page 2)
- History and physical exam including inguinal node palpation and DRE +/- rectoscopy every 3 months for two years, afterwards every 6 months until year five
- Chest, abdominal and pelvic imaging every 6 -12 months until year three**, MRI of the pelvis 12 and 24 months after therapy**
- **Under suspicion of local recurrence optinal PET/CT (not regular payed by health assurances)**
- Offer contact to self-help group and psychooncological support whenever necessary

Page 6: Palliative care screening tool

			Screening items	Points
1.		•	Presence of metastatic or locally advanced cancer	**2**
2.		•	ECOG score (functional status score, performance status)	**0-4**
3.		•	Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)	**1**
4.		•	Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)	**1**
5.		•	Presence of palliative care problems	**1**
	a.	•	Symptoms uncontrolled by standard approaches	**1**
	b.	•	Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	•	Patient/family requests palliative care consult	**1**
	d.	•	Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	•	Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015