Greater Manchester Cancer Pathway Board NHS

COLORECTAL CLINICAL SUBGROUP

(Updated) REFERRAL GUIDELINES

For patients with Anal Cancer

Circulated to MDT on 11th December 2017
For full ratification at MDT AGM 18th January 2018

Preface

These guidelines are updated from those dated June 2012. Recommended changes reflect the establishment of the bi-weekly Anal Cancer Multi-disciplinary Team (MDT) at the Christie, since 2009; the establishment of the joint anal cancer clinic in 2013; and the proposed development of the weekly anal cancer MDT from early 2018. 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).

In these updated guidelines, there are major new sections on pre-treatment colostomy and management of AIN.

Referral of patients with Anal Cancer

Christie Anal Cancer MDT structure

- Since February 2009, there has been a bi-weekly dedicated Anal Cancer MDT at the Christie NHS Foundation Trust.
- This MDT have been successfully peer-reviewed annually since. It is currently the largest Anal Cancer MDT in the UK, with 89 new cases presenting for 2016.
- Many of the principles of the Christie anal cancer MDT are reflected in the Association of Coloproctology of Great Britain and Ireland (ACPGBI) 2011 Position Statement (1) and the 2017 Guidelines – Anal Cancer (2).
- The MDT includes a team of clinical oncologists, colorectal surgeons, dedicated GI 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 old Greater Manchester and Cheshire Cancer Network (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. Currently, the PLATO UK national trial is scheduled to commence recruitment in December 2017.
- 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, and its variants – for example, basaloid/cloacogenic, non-keratinising.
- Other less common carcinomas are: verrucous, basal cell, muco-epidermoid, small cell, neuroendocrine carcinomas.
- 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).
- Going forward, the Anal Cancer MDT will increasingly be a reference for the management of patients with complex AIN and early micro-invasive carcinomas of the anal canal and margin detected through anal cancer screening programme in high-risk individuals.

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) patients referred directly to the clinical oncology team for MR staging scans to be performed at the Christie; and
  (iii) request for a PET CT scan to be performed at the Christie (either directly or through the clinical oncology team).
  (the rationale for this guidance is discussed in the next section).
- Contacts for direct referrals are as follows:
  General fax: 0161 446 3352

For Leighton, Macclesfield, MRI, Salford, South Manchester, Tameside, Trafford, Wigan: Dr Mark Saunders (sec): 0161 4463357

For Bolton, Pennine (Fairfield General, North Manchester, Rochdale Infirmary, Royal Oldham), Stockport: Dr Nooreen Alam (sec): 0161 446 3360

Nurse Specialists: Julie Brewer, Sarah Dunne: 0161 918 7002

- The guidance recognises that there is variation in the processes how local referring hospitals refer new patients with anal cancer. The supra-district audit

(3) identified that in some local referring hospitals the duration from diagnosis to referral has increased with time (mean 11 days in 2004 to mean 22 days in 2009). This may be due to delays from acquiring staging scans and reviewing in the local MDT. 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, all cases should be reviewed through the central Anal Cancer MDT even if where excision is deemed to be 'curative'.

Rationale for direct referral for MR and PET CT scans

The rationales for direct referral for MR scan and request for PET-CT scan are:

- An audit of 102 patients with a new diagnosis of anal cancer (presented to the CSG in December 2011) demonstrated wide variation in MR scan protocols throughout the network. This was associated with assessment problems for standardising staging and chemo-radiotherapy treatment response.
- The audit identified significant changes in managements based on local MR scan reports in ten patients; and MR scans performed at local referral hospitals had to be repeated in 4 patients.
- Since January 2012, all patients with a new diagnosis of anal cancer undergo PET-CT scanning performed at the Christie (as this technology is not widely available throughout the network). It is envisaged that this imaging modality will improve staging and treatment response assessment.
- The impact of these changes on the time from diagnosis, referral to definitive treatment has been continually audited.

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 literature does identify one UK centre where ileostomy is advocated (4) – this is not standard practice. The indication of ileostomy in this setting is very uncommon.

Follow-up after initial chemo-radiotherapy

- Despite improvements in chemo-radiotherapy regimens, approximately 20% of patients with anal cancer develop local disease relapse and require consideration for salvage surgery.
- A positive resection margin is highly significant negative prognostic factor after salvage surgery (5). By inference, these guidelines support intensive post initial chemo-radiotherapy surveillance to facilitate the early detection of local disease relapse.
- Follow-up of <u>all</u> patients after initial chemo-radiotherapy should be through the Anal Cancer MDT, using agreed follow-up guidelines.

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 <u>without delay</u> 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 (5).

- 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, attended by Dr Mark Saunders, Professor Renehan and Mr Paul Fulford.
- This clinic is focused on multi-disciplinary clinical input, education and training, and trial recruitment.
- The management of the following patient sub-groups are through this clinic:
  - Surveillance following wide local excision of anal margin cancer
  - Management of complex AIN cases with and without CIN/ VIN
  - 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.
- The Christie anal cancer database is the core framework for the ACPGBI National Anal Cancer Database (operated through Dendrite).

Patients with Anal Intra-epithelial Neoplasia (AIN)

- In accordance with the 2017 ACPGBI guidelines (2) “All cases of AIN II and III should be reviewed and subsequently managed by the specialist Anal Cancer MDT.”

- In accordance with the 2017 ACPGBI guidelines (2) “All suspicious anal lesions should be excised or biopsied. Targeted biopsy of anal lesions suspicious for AIN is mandatory in high-risk groups to exclude invasive disease.”
- There are several misconceptions, and indeed misinformed social stigmata, associated with the occurrence of AIN. The Anal Cancer MDT includes a patient information sheet on the aetiology and management of AIN.
- 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).
- Going forward, the Anal Cancer MDT will increasingly be a reference for the management of patients with complex AIN and early micro-invasive carcinomas of the anal canal and margin detected through anal cancer screening programme in high-risk individuals.

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December 2017

Professor Andrew Renehan, Clinical Lead for the Anal Cancer MDT

And ratified by the core members of the anal cancer MDT group: Dr Mark Saunders, Dr Noo Alam (Clinical Oncology); Professor Sarah T O’Dwyer, Mr Malcolm Wilson, Mr Paul Fulford, (Colorectal Surgery); Dr Rohit Kochhar, Dr Bernadette Carrington, Dr Damian Mullin (Radiology); Dr Bipasha Chakrabarty (Pathology); Julie Brewer,

Sarah Dunne, Rebecca Halstead (Cancer Nurse Specialists); Lucy Davidson (Radio therapy radiographer).