

Saudi Oncology Society clinical management guideline series

Anal canal cancer 2014

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Anal canal cancer is a rare cancer both world-wide and in the Kingdom of Saudi Arabia (KSA). In 2010, a total of only 27 cases were diagnosed in KSA, 18 males and 9 females representing 0.3% of all cases diagnosed in the Saudi population.¹ The age standardized rate was 0.3/100,000 for males and 0.2/100,000 for females.

The evidence adopted in these guidelines is rated at 3 levels: 1) Evidence level (EL)-1 (highest level) evidence from phase III randomized trials or meta-analyses; 2) EL-2 (intermediate-level) evidence from good phase II trials or phase III trials with limitations; and 3) EL-3 (low-level) from retrospective or observational data and/or expert opinion. This easy-to-follow grading system is convenient for the reader and allows accurate assessment of the applicability of the guidelines in individual patients.²

All cases of anal canal cancer should preferably be seen or discussed in a multidisciplinary form.

1. Pre-treatment evaluation

- 1.1 History and clinical examination including inguinal lymph node palpation and rigid anoscopy
- 1.2 Blood count, liver, and renal function levels
- 1.3 Chest x-ray
- 1.4 Computed tomography (CT) scan of abdomen and pelvis
- 1.5 Magnetic resonance imaging (MRI) of pelvis
- 1.6 Fine needle aspiration of inguinal lymph nodes if clinically palpable
- 1.7 Human immunodeficiency virus testing in selected cases

2. Staging

The American Joint Commission on Cancer (AJCC)- 2007 pathological staging system will be used.³

3. Treatment

- 3.1 Localized disease (clinical stage T1-4, N0-1). Concurrent chemoradiotherapy⁴ (EL-2)
 - 3.1.1 Chemotherapy: 5-fluorouracil and mitomycin C on day one and 29 of radiation therapy⁵ (EL-1). Alternatively, oral capecitabine at a dose of 825 mg/m² twice daily on each day of radiation can be used⁶ (EL-3)

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- 3.1.2 Radiotherapy: 45 Gy administered as 1.80 Gy per fraction in 25 fractions to the pelvis and inguinal node area + 5.4-9.0 Gy boost to the tumor bed⁷
- 3.2 Localized disease (clinical stage T_{any} N2-3). Concurrent chemoradiotherapy⁸
 - 3.2.1 Chemotherapy: 5-fluorouracil and mitomycin C on day one and 29 of radiation therapy (EL-2). Alternatively, oral capecitabine at a dose of 825 mg/m² twice daily on each day of radiation can be used⁶ (EL-3)
 - 3.2.2 Radiotherapy: 45 Gy administered as 1.80 Gy per fraction in 25 fractions to the pelvis and inguinal node area + 5.4-9.0 Gy boost to the tumor bed and inguinal node area
- 3.3 Metastatic disease. Palliative chemotherapy with 5-fluorouracil and cisplatin⁹ (EL-2). Consider palliative radiation to local disease
- 3.4 Recurrent disease
 - 3.4.1 Local recurrence or persistent disease post-chemoradiotherapy:
 - 3.4.1.1 Persistent disease is defined as positive biopsy at 3 months from end of chemoradiotherapy
 - 3.4.1.2 Recurrent disease should be biopsy proven
 - 3.4.1.3 Anal recurrence. Consider abdominoperineal resection¹⁰ (EL-2)
 - 3.4.1.4 Inguinal lymph nodes recurrence. Consider groin lymph node dissection (EL-3) or groin irradiation if not carried out earlier ± chemotherapy: 5-fluorouracil and mitomycin C¹¹ (EL-3)
 - 3.4.2 Distant recurrence: see section 3.3
- 3.5 Follow up.
 - 3.5.1 Every 4 months in the first year and every 6 months thereafter for 5 years, then annually with digital rectal examination and inguinal palpation (EL-3)
 - 3.5.2 CT scan of abdomen and pelvis annually for the first 3 years (EL-3)

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