Network Guidelines
&
Patient Pathways for Anal Cancer

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Authors	**PM/EP/DW/JH**
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-hair bearing 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
    - Anal high grade squamous intra-epithelial lesion (aHSIL) (previously known as AIN3 or AIN2 p16 positive)
    - Anal low grade squamous intra-epithelial lesions (aLSIL) (previously AIN1 or AIN2 p16 negative) in patients who are immunocompromised e.g. transplantation, HIV 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 and slides for central pathology review
    - Endoscopy report (if applicable)
    - Copy of any operation note

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

  * Patients with an anal mass who have HSIL only on biopsy still require MRI & CT because the biopsy may be non-representative. Patients with benign-looking anal HSIL or HSIL found incidentally on excisional biopsy do not require imaging.

- 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: colorectal.mdt@lthtr.nhs.uk
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Colorectal/Anal Cancer Nurse Specialists (Based at LTHT)

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Colorectal Specialist Nurse Office 01772 522371

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**
  - Some T2 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 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
  -

Stage 11B

- **T3, N0, M0** .
  - Stage 2 cancers of the anal verge and anal canal cancers 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 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**
  - Treatment 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 IIIC

- **T3, T4, N1, M0**
  - Treatment 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

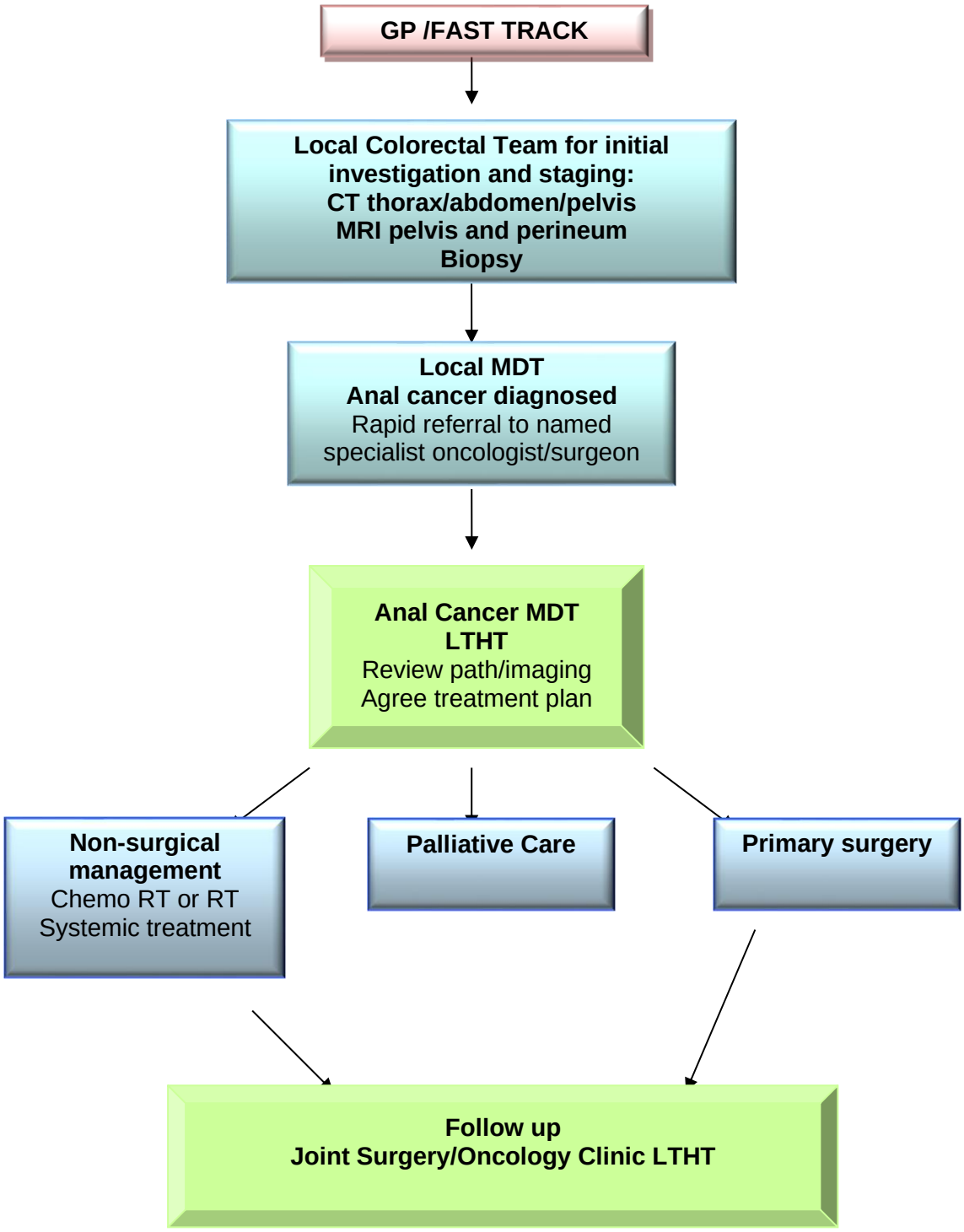
Stage IV

- **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



Anal Cancer Follow up- Clinical and Imaging

Updated Apr 2025
DW/JH/EP/PM

NETWORK ANAL CANCER MDT
Thursday pm
colorectal.mdt@lthtr.nhs.uk
Referral to Mr Mitchell/Mr Parkin or Dr Haston/Dr Williamson must include: Referral Letter, Operation/Endoscopy note, Imaging and Histology reports.

Initial Staging: All Patients
Biopsy
CT- TAP. & MRI pelvis
PET-CT (T3-4N_{any} and T_{any}N1)
USS +/- FNA suspicious inguinal nodes

Stage I-III disease

Local excision *

(Chemo)-Radiotherapy

Stage IV

Palliative Radiotherapy

Systemic treatment

Follow up imaging as clinically indicated

Supportive management

3-month post treatment MR pelvis/clinical examination

If concern for no response/progression or significant residual disease, consider early EUA/surgical assessment

6-month post treatment MR pelvis/clinical examination

No evidence of residual or recurrent disease

Clinical review appointment frequency (after most recent treatment)
Year 1: 3 monthly
Year 2: 4 monthly
Year 3: 6 monthly
Year 4:12 monthly
Discharge at 5 years

CT TAP at
1 year
2 years
3 years

†In patients in whom rectal examination is not possible consider MR pelvis at 2 years

EUA/biopsy

MR pelvis

If concern for residual /recurrent disease

If no previous RT

Confirmed recurrent/residual disease

Salvage resection**

Systemic treatment if unresectable or not suitable for resection

Supportive management

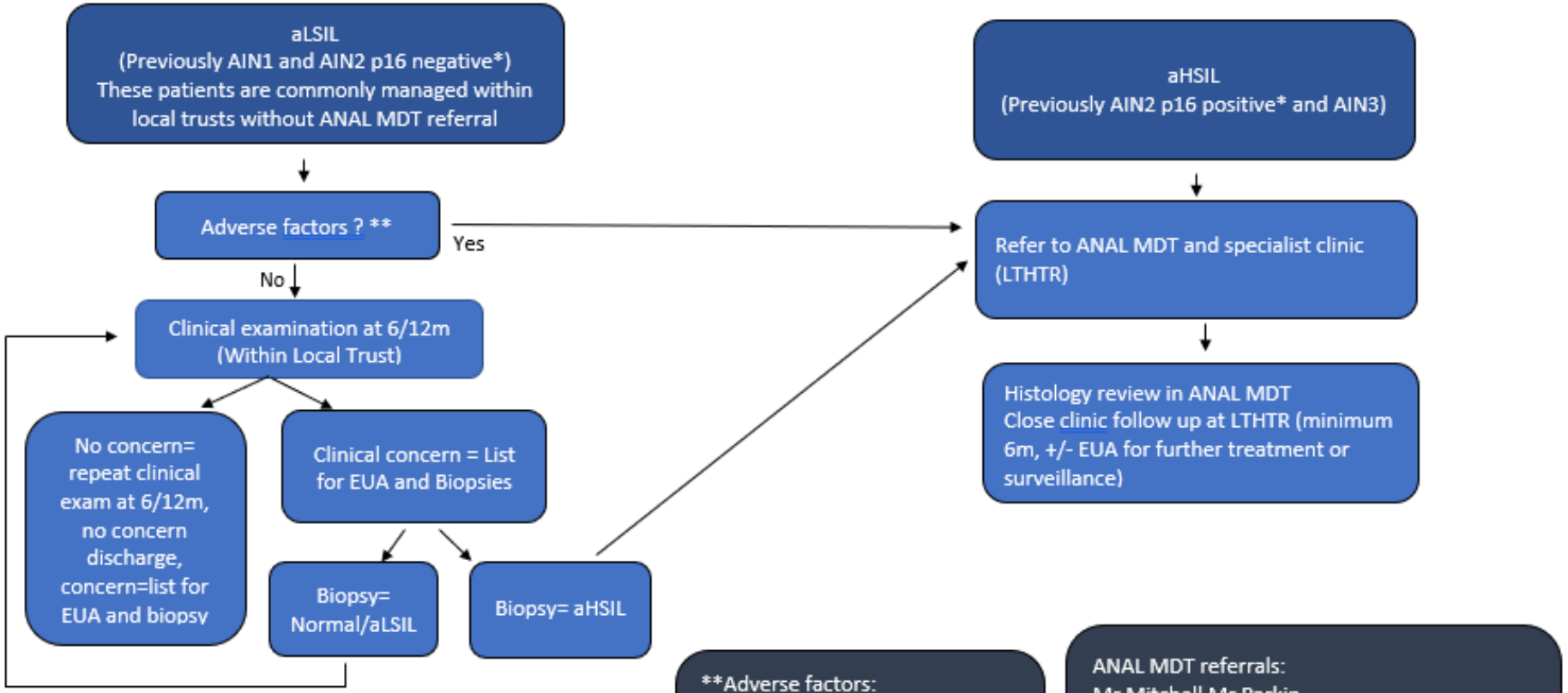
Further local excision

*Selected T1/2 if clinically appropriate after MDT discussion and clinical review
** These patients have a pelvic MRI at 6 months post-surgery then standard follow up

PM/EP 2025

Management of Anal Squamous Intra Epithelial Lesions

Previously referred to Anal Intra epithelial Neoplasia (AIN), this term has now been replaced with Anal Low/High Grade Squamous intra epithelial lesions (aLSIL and aHSIL)



*p16 – this is a tumour suppressor protein identified by immunohistochemistry testing. Presence is associated with High grade lesions.

**Adverse factors:

- Immunocompromised
- HIV
- Multi focal disease (e.g. vaginal or vulval LSIL/HSIL)
- Transplant patients

ANAL MDT referrals:
Mr Mitchell Mr Parkin
Lancs. Teaching Hosp. NHS Foundation Trust
EMAIL: colorectal.mdt@lthtr.nhs.uk
Referrals to include referral letter, Operation/endoscopy report, histology.