Special Communication

# Saudi Oncology Society clinical management guideline series

## Anal canal cancer 2014

*Shouki N. Bazarbashi, MBBS, Ali M. Alzahrani, MBChB, FRCR, Mohammed M. Rahal, MD, PhD, Ahmed S. Al-Shehri, MBChB, FRCPC, Ali H. Aljubran, MD, Nasser A. Alsanea, MBChB, Omar A. Al-Obeed, MBBS, FRCSC, Magdy S. Kandil, MD, PhD, Jamal E. Zekri, MBBCh, FRCP (UK), Ashwaq A. Al Olayan, MBBS, Abdullah A. Alsharm, MD, Khaled S. Balaraj, MD, FRCPC.*

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 chemoradiotherapy[4] (EL-2)
     - 3.1.1 Chemotherapy: 5-fluorouracil and mitomycin C on day one and 29 of radiation therapy[5] (EL-1). Alternatively, oral capecitabine at a dose of 825 mg/m$^2$ twice daily on each day of radiation can be used[6] (EL-3)

*From the Section of Medical Oncology (Bazarbashi, Aljubran), Oncology Center, Section of Colon and Rectal Surgery (Alsanea), Department of Surgery, Department of Oncology (Zekri), Section of Radiation Oncology (Balaraj), Oncology Center, King Faisal Specialist Hospital and Research Center, Oncology Department (Alzahrani, Kandil) Prince Sultan Military Medical City, Department of Surgery (Al-Obeed), King Khalid University Hospital, King Saud University, Department of Oncology (Alolayan), King Abdulaziz Medical City, Medical Oncology Department (Alsharm), King Fahad Medical City, Riyadh, Department of Oncology (Rahal), Oncology Center, King Fahad Specialist Hospital, Dammam, and the Department of Oncology (Al-Shehri), Princess Nora Oncology Center, King Abdulaziz Medical City, Jeddah, Kingdom of Saudi Arabia.*

*Received 15th July 2014. Accepted 13th October 2014.*

*Address correspondence and reprint request to: Dr. Shouki N. Bazarbashi, Oncology Center, King Faisal Specialist Hospital and Research Center, PO Box 3354 (MBC 64), Riyadh 11211, Kingdom of Saudi Arabia. Tel. +966 (11) 4423935. E-mail: Bazarbashi@gmail.com*

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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 bed[7]

3.2 Localized disease (clinical stage $T_{any}$ N2-3). Concurrent chemoradiotherapy[8]

- 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/m$^2$ twice daily on each day of radiation can be used[6] (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 cisplatin[9] (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 resection[10] (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-fluorouraciland mitomycin C[11] (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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**Disclosure**. Authors have no conflict of interests, and the work was not supported or funded by any drug company.