



The Treatment and Therapy of Anal Cancer

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DESCRIPTION

The methods for treating anal cancer are listed here, along with information on salvage therapy, restricted localised disease, metastatic disease, and other unique issues.

Limited localized disease

Current primary recommendations for non-metastatic anal cancer include concurrent chemotherapy and radiation therapy (Stage I-III; any T, any N, M0). Mitomycin and 5-fluorouracil (5-FU) are two common medications; 5-FU can be replaced with capecitabine. Given inconsistent clinical trial findings, there is some debate about whether cisplatin should be used instead of mitomycin in limited-stage cancer. The National Comprehensive Cancer Network (NCCN) recommends 5FU plus cisplatin and radiation therapy as a category 2B treatment.

Mitomycin + 5-FU + radiotherapy

- Continuous IV infusion of 5-FU at a dose of 1000 mg/m²/day on days 1-4 and 29-32 (the daily maximum dose of 5-FU is 2000 mg) together with a 10 mg/m² IV bolus of mitomycin on days 1 and 29 (maximum 20 mg per dose)
- Radiotherapy (RT) should be administered at all disease stages; a minimum of 45 Gy should be administered over 5 weeks.
- Patients with T3, T4, or node-positive illness or those who have residual disease after receiving an initial 45 Gy may be considered for further RT of 9-14 Gy.
- Cisplatin can be used in place of 5-FU; it offers comparable rates of complete remission (CR) and colostomy.

Mitomycin+capecitabine+RT

- Mitomycin 10 mg/m² days 1 and 29 along with concurrent RT; Capecitabine 825 mg/m² PO BID, Monday through Friday, on each day that RT is administered, for the length of RT (usually 28 treatment days).
- Mitomycin 12 mg/m² IV bolus day 1 along with concurrent RT and capecitabine 825 mg/m² PO BID days 1-5 weekly for six weeks

Metastatic disease

Stage IV (any T, any N, M1): Platinum-based chemotherapy is frequently used to treat metastatic illness. Regimens might contain 5-FU or other substances.

5-FU(FOLFOX) with cisplatin

- 5-FU 1000 mg/m²/d IV continuous infusion on days 1-4 with Cisplatin 60 mg/m² day 1; repeat every 3 weeks.
- 5-FU 750 mg/m²/d IV continuous infusion on days 1-4, along with cisplatin 75 mg/m² on day 1; repeat every 4 weeks.
- Oxaliplatin 85 mg/m² IV on day 1, Leucovorin 400 mg/m² IV on day 1, 5-FU 400 mg/m² IV bolus on day 1, then 1200 mg/m²/d × 2 days (total 2400 mg/m² over 46-48 hours) are the dosages for mFOLFOX. IV infusion that is ongoing.
- Repeat every two weeks.

Carboplatin and paclitaxel

- Area under the curve for carboplatin (AUC) 5 (see Carboplatin AUC Dose Calculation (Calvert formula)) Repeat every 21 days with IV day 1+Paclitaxel 175 mg/m² IV day 1.
- Following the failure of more conventional treatments, patients may receive the following types of therapy:
- Pembrolizumab 200 IV q3wk or 400 mg IV q6wk until disease progression or intolerable toxicity, or up to 24 months in patients without disease progression.

Salvage treatment

- After chemoradiotherapy, salvage therapy may be required for recurrent or persistent illness.
- Local recurrences can sometimes be effectively treated surgically, although locally recurring anal squamous cell carcinoma is more problematic and has a higher mortality rate.
- In a 1999 analysis of 185 patients who received radiotherapy or chemoradiotherapy between 1976 and 1996, a total of 42 patients went on to develop local failure. Of these patients, 26 underwent salvage therapy that included abdominoperineal

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resection, and of these patients, 43% had long-term 5-y survival and control of their disease.

- Additionally, 25 patients in the trial by Flam et al. who had post-treatment biopsies that were positive underwent salvage chemotherapy with cisplatin and 5-FU. Of the 22 patients who underwent subsequent biopsies, 12, or 55 percent, had post-treatment biopsies that were negative; four of these 12 patients were still disease-free at four years. Depending on the patient's performance condition and the level of local failure, either cisplatin or 5-FU is a viable alternative.

Surgical management

- Surgical excision is only necessary in a very small number of situations (maximum invasion 3 mm to basement membrane and less than 7 mm horizontal spread)
- Consider supplementary radiation therapy if the margins are positive, which should be less than 2 mm for the anal canal and less than 1 cm for the perianal.
- Possibly entirely removed during initial biopsy

Based on the clinical scenario, radical surgery such as

abdominoperineal resection (APR) should be considered, along with lymph node dissection.

Additional factors

- Consider CD4 count analysis and HIV testing for patients with clinical risk indicators.
- In HIV-positive patients, there is no need to alter the course of treatment; however, patients with low CD4 counts and a history of problems such opportunistic infections or malignant malignancies may choose to reduce their mitomycin dosage.
- Mitomycin plus 5-FU: The second dosage of mitomycin is decreased from 10 mg/m² to 7.5 mg/m² if the nadir WBC count is less than 2400 but greater than 1000/L or if the nadir platelet count is greater than 50,000 but less than 85,000/L.
- The second dose of mitomycin is decreased from 10 mg/m² to 5 mg/m² if the nadir WBC count is less than 1000/L or if the platelet count is less than 50,000/L.
- Delay treatment for one week if the WBC count is less than 2400/L or the platelet count is less than 85,000/L on day 28.