Diagnosis and management

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A high index of suspicion and targeted biopsy yields the diag nosis, whereas multiple (mapping) biopsies give an indication of the extent and overall severity of the disease. AIN /uni00A0 III should be regularly monitored clinically and, if necessary , by r Jean Lugol , 1786–1851, French physician, Lugol’s iodine was first made in 1829. o ff er colposcopy of the anus (anoscopy), utilising 5% acetic acid with Lugol’s iodine to assess in vivo the dysplastic areas - of the anus. The a ff ected areas show up white and can be biopsied. Focal disease may be excised and local excision is e ff ective for lesions <30% of the circumference of the anus. More widespread disease can be dealt with surgically by wide local excision and closure of the resultant defect by flap or skin graft, with or without covering colostomy (especially if there is intra-anal disease). However, for a condition with uncertain malignant potential, this approach should be used with caution as it carries with it significant morbidity . Anal mapping uses a 3-mm corneal punch biopsy , and a total of 8–12 biopsies allows for adequate mapping of most disease. An operative map or photograph is helpful. Examination of - the vulva, vagina and cervix is also needed as female patients are at risk of other anogenital intraepithelial neoplasia; it is recommended that those with AIN /uni00A0 III have a yearly cervical smear test. The grade and extent of anal disease determines management. Localised or focal AIN is defined as <30% of the anal circumference, whereas extensive AIN involves more than 30% of the circumference. Lesions involving <30% of the anal circumference can be simply excised with the resulting wound left to granulate or closed as appropriate. AIN /uni00A0 III lesions involving >30% of the anal margin or canal cannot be excised as the risk of severe anal stenosis is significant. The remaining areas are regularly observed at 6-monthly intervals. AIN /uni00A0 I/II and AIN /uni00A0 III have di ff ering natural histories. Topical imiquimod (5%) or oral retinoids have some e ff ect - on the progression of dysplasia and can cause regression by at least two histological grades. Other newer options may include anti-HPV trea tment; vaccination may reduce the incidence in the long term. AIN /uni00A0 I/II has an indolent course except in immunocompe - tent patients, for whom 12-monthly anoscopy is recommended. Patients with AIN /uni00A0 III and multicentric intraepithelial neoplasia should be managed by clinicians with an interest in this disease and require a multidisciplinary approach involving gynaeco - logical specialists. Immuno-incompetent patients (including those with HIV) are considered separately in view of the higher progression rates and poorer results, with higher recurrence - rates after surgery compared with immunocompetent patients. These require extended follow-up with 6-monthly anoscopy .

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