MALIGNANT TUMOURS Malignant lesions of the anus an

MALIGNANT TUMOURS Malignant lesions of the anus and anal canal

Anal malignancy is rare and accounts for less than 2% of all large bowel cancers; however, the incidence is rising, with a direct association with HPV infection, AIN and immuno - - suppression. The crude incidence rate is 0.65 per 100 /uni00A0 000 in the UK. The male-to-female ratio is approximately 1:2. The great majority are SCCs . Those arising below the epeat dentate line are usually keratinising, whereas those above are non- keratinising squamous, variously termed basaloid, cloacogenic or transitional. There is now broad consensus that both are similar in their presentation and response to treatment and should be treated as carcinomas whether keratinising or not. Adenocarcinomas are the next most common and are thought to arise from anal glands. Other tumours include melanoma, lymphoma, sarcoma and tumours of perianal skin. Squamous cell carcinoma Anal SCC usually presents with pain and bleeding, thus it is often initially misdiagnosed as a benign condition, highlighting the need for a level of suspicion and adequate examination. A mass, pruritus or discharge is less common. Advanced tumours may cause faecal incontinence by invasion of the sphincters and, in women, anterior extension may result in anovaginal fistulation. On examination, anal margin tumours look like malignant ulcers, with raised indurated edges (Figure 80.40 There may be associated HPV lesions. Anal canal tumours are palpable as irregular indurated tender ulceration. Sphincter involvement may be evident. Involvement of perirectal and groin lymph nodes may be palpable on examination. Investigation An examination under anaesthetic allows detailed assessment of the tumour size, involvement of regional nodes and adja cent structures and the opportunity to obtain a biopsy for histological examination. Management MRI scanning of the pelvis and CT of the chest, abdomen and pelvis allows locoregional and distant staging. Positron emission tomography (PET)-CT is increasingly used and may help in equivocal inguinal node assessment. Norman D Nigro , 1912–2009, surgeon, Wayne State University , Detroit, MI, USA. resection; however, since the late 1970s chemoradiotherapy (Nigro) has become the primary treatment. The UK Co ordinating Committee on Cancer R esearch (UKCCCR) Anal Cancer Trial (ACT /uni00A0 I) found that chemoradiation with radiotherapy (50.5 /uni00A0 Gy) gave superior local control compared with radiotherapy alone while the ACT /uni00A0 II trial found similar outcomes when chemoradiotherapy using cisplatin/5 - fluorouracil (5-FU) was compared with mitomycin/5-FU. The longer infusion time required to administer cisplatin/5-FU has led to the preferred use of the mitomycin/5-FU combination. Curr ent trials (ACT /uni00A0 III, ACT /uni00A0 IV and ACT /uni00A0 V) are investigating more personalised treatment protocols, including local excision only for small tumours and a combination of excision

along with varying radiotherapy regimes for other tumours. Radical surgical excision by abdominoperineal resection is indicated in those with residual tumour, complications of treatment, incontinence or fistula after tumour resolution and recurrent disease. Despite good results with chemoradio - therapy , 20–25% of patients will ha ve an incomplete tumour response or local disease recurrence. After thorough assess - ment, these patients may require radical abdominoperineal resection as a salv age procedure. Locally extensive disease may require pelvic exenterative procedures that usually entail peri - neal r econstruction using a myocutaneous flap. Enlarged regional inguinal lymph nodes are common and may be secondary to inflammation rather than malignancy . Histological/cytological confirmation is mandatory . Positive nodes are treated by chemoradiotherapy . Radial groin dissec - tion has a high morbidity .

Figure 80.40 Anus squamous cell carcinoma.

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