TREATMENT OPTIONS FOR THOSE WITH ANAL CARCINOMA

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One of the great success stories in general over the last decade has been the use of combined modality - chemotherapy and radiation - for those with anal carcinoma.

In the past, this was a disease treated with radical surgery resulting in colostomy. The advantage of chemotherapy/radiation success is control of the disease and maintenance of the anal sphincter meaning no colostomy and a high degree of freedom from disease recurrence.

New data using chemotherapy/radiation was recently presented by Doci et al from the National Cancer Institute of Italy evaluating 35 patients with anal carcinoma. In a descriptive article from The Journal of Clinical Oncology, the authors describe their treatment approach and results.

Previous studies have shown that chemotherapy and radiation combined gives results and outcomes comparable to those of radical surgery, however, function of the anus and rectum is maintained. Surgery is only used for cancers that progress despite therapy. The Italian National Cancer Institute's previous studies had used 5FU (5 Fluorouracil) and Mitomycin with external beam radiation therapy for treatment of anal carcinoma with complete responses of 87%. Unfortunately, recurrence of cancer was noted in 24% of patients after an average of eight months.

In an attempt to improve treatment outcome, a new chemotherapy protocol was commenced using Cisplatin and 5FU. Cisplatin represented a replacement of Mitomycin.

Between 1991 and 1995, 35 patients were enrolled in this approach. Cancer was described as squamous cell in 30 and basaloid in 5. Treatment included two chemotherapy cycles of 5FU and Cisplatin with concurrently administered pelvic radiation. A 24 hour infusion of 5FU daily on Day 1, 2, 3 and 4 was administered with Cisplatin administered on Day 1. This chemotherapy treatment was repeated 21 days later.

Radiation was started on the first day using the linear accelerator delivering treatment to anal and perineum area as well as lower and middle pelvic sites including the inguinal and external iliac lymph nodes. Total dosage of 5400 to 5800 rad was administered. A third cycle of chemotherapy was given in younger patients who had tolerated the previous treatments well.

Toxicity included transient nausea or vomiting and lowering of blood count in some as well as local side effects including irritation to the skin and surrounding anal/rectal area as well as diarrhea. Topical treatments were administered and were successful in general.

Complete response of the anal cancer in metastatic lymph nodes was assessed in 33 of 35 patients. There was complete regression generally evident at two months. Nine patients with metastatic cancer to the lymph nodes also had a complete response at the lymph node site. Two patients had a partial response. Follow-up at 37 months on average showed that 94% of patients are alive without cancer. Of the 33 patients who had complete responses, two patients or 6% had local recurrence. One patient had abdominal perineal resection and is disease-free 46 months after surgery. A second patient had developed HIV (human immuno virus) and has liver metastasis.

One patient had a long-standing anal fistula and developed an abscess requiring surgery. Overall, of 35 patients, 33 are alive without disease and 30 have normal anal function.

These results are obviously highly encouraging. The authors "stress the feasibility of the treatment, the toxicity and the complication rates of which none exceed those observed with 5FU plus Mitomycin. However it is possible that further modification of the schedule could reduce toxicity; in particular, we are changing the administration of Cisplatin from a single high dose to repeated low doses with the aim to reduce nausea and vomiting."

In concluding, it is noted that "the overall results of the present experience are highly encouraging. However, as suggested by others the activity of this regimen should be tested in Phase III randomized studies before it can be entered into the standard clinical practice. These data further support the indication to treat epidermoid cancer of the anal canal with combination chemotherapy and radiation as primary treatment. Surgery can be reserved as salvage treatment when residual tumor or local recurrence is detected."

Thus, ongoing research is showing further benefit for those with invasive cancer. Anal cancer once a disease requiring extensive surgery is now treated successfully in the majority with combined chemotherapy and radiation, maintaining anal control and freedom of disease.

We also have other innovative treatments available such as stereotactic body radiosurgery. Body radiosurgery allows us to focus beams of radiation more precisely. We have used it for anal cancer for those who have metastases and whose cancer growth has caused pain or seem to need an additional dose. Where we aim the beam, we have a control rate of about 80 to 90%. Control rate is defined as cessation of growth, shrinkage or disappearance of the tumor in the treated field.

We have seminars open to the public to explain stereotactic body radiosurgery in more detail. We also have a hot line at 212-CHOICES or send e-mail questions to gil.lederman@rsny.org.