

ANAL HEALTH PROTOCOLS

1. SCREENING FOR ANAL CARCINOMA

Rationale: Anal cancer is an unusual cancer with an incidence rate of 2/100,000 in the general population but up to 35/100,000 in HIV negative MSM; a rate comparable to that of cervical cancer prior to widespread screening programs. Among HIV infected patients, added risk factors for anal cancer include a history of receptive anal intercourse, a history of having > 10 sexual partners, a history of anal warts (RR 11.5) and cigarette smoking (RR 1.9 to 5.2) while CD4 < 500 is a risk factor for HSIL (RR 7.5). The incidence of anal cancer does not appear to be decreasing in the HAART era.

Unfortunately, at this time screening tests such as anal Pap smears or high-resolution anal colposcopy have not been shown to improve the detection or outcome of anal cancer. Until validated screening and treatment methodologies for anal cancer are established we propose the following protocol for the care of patients at special risk of anal cancer:

- i. All gay or bisexual men AND heterosexual men and women with a history of anal warts should have an *annual* visual inspection of the anus, palpation of the perianal tissues a digital rectal exam (DRE) and anoscopy.
- ii. All persons with ongoing anal symptoms or anal warts should have *semi-annual* visual inspection of the anus, palpation of the perianal tissues, anoscopy and a DRE.
- iii. All persons with suspicious findings on examination (e.g., a palpable mass or unexplained induration, leukoplakia) should be referred to general surgery clinic for evaluation and possible biopsy (*biopsy will not be done at the first surgery clinic visit but scheduled in the OR at a later date*).
- iv. Rectal bleeding at or just above anal sphincter should arouse suspicion for cancer – mistaking this for hemorrhoidal bleeding can delay diagnosis.

2. MANAGEMENT OF ANAL WARTS

Rationale: The evaluation and treatment of anal warts pose special problems given 1) their association with the development of anal cancer, 2) their possible location within the anal canal and 3) their high recurrence rate. There are several proven therapies for anal warts including liquid nitrogen, 5% imiquimod cream, laser and electrocautery and surgical excision. Choosing between treatments needs to be individualized and may follow the following recommendations:

- i. Any lesion that has features suspicious for cancer (e.g. ulceration, bleeding, especially firm or with undermining of adjacent tissues) should prompt immediate referral to surgery for diagnosis and excision.
- ii. Bulky lesions that are less likely to respond to topical therapies should prompt a surgery referral.

- iii. Patients with lesions within the anal canal that are not readily accessible to liquid nitrogen or topical treatments should be referred to surgery for excision.
- iv. Patients with non-bulky but accessible lesions that are not responding to conventional therapy can be referred to dermatology.
- v. Remember to follow up on pathology results for any patient undergoing a biopsy/excision even if you did not perform the procedure.

REFERENCES

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3. D'Souza G, Wiley DJ, Li X, Chmiel JS, Margolick JB, Cranston RD, Jacobson LP. Incidence and epidemiology of anal cancer in the multicenter AIDS cohort study. J Acquir Immune Defic Syndr. 2008 Aug 1;48(4):491-9.