LONDON CANCER
NORTH AND EAST

Standards for patients diagnosed with anal cancer in the *London Cancer* Integrated Cancer System

(incorporating Operational Policy and Guidelines)

Version 1.1 FINAL (May 2014)

Foreword

This document sets out the proposed model of care for the anal cancer services provided by the primary care services and hospital trusts which are grouped in the integrated cancer system of *London Cancer* (North and East) serving a population of 3.2 million. The model of care is supported by *London Cancer* and trusts are expected to work within this framework. It reflects current best practice which is achievable within the NHS with an objective of improving outcomes from anal cancer in London. Primary care services and Trusts which are unable to achieve the high level of service required by *London Cancer* will need to address provision of service issues and if improvement is not possible then reconfiguration of services will need to be a consideration.

Within the model of care is the framework for improving services and policies on delivery of care and advice on raising concerns on standards of delivery of care.

Professor Kathy Pritchard-Jones

Chief Medical Officer, *London Cancer*

Mr Michael Machesney

Pathway Director for Colorectal Cancer and Consultant Colorectal Surgeon, Barts Health NHS Trust

Agreed: 09 January 2014

These Standards (including Operational Policy and Guidelines) were developed and agreed by consensus opinion of all interested members of the Pathway Standards and Governance sub-group of the *London Cancer* Pathway Board for Colorectal Cancer. They are intended to provide guidance for Colorectal MDTs across the *London Cancer* ICS. These Standards are approved by the *London Cancer* Pathway Board for Colorectal Cancer.

The hospitals that comprise *London Cancer* are as follows:	MDT Lead Clinician
Barking, Havering and Redbridge NHS Trust	
Queens Hospital Romford	Dr Sherif Raouf
King George Hospital Ilford	
Barnet and Chase Farm Hospitals NHS Trust	Mr Daren Francis
Barts Health NHS Trust	
Newham General Hospital	Mr Roger Le Fur
The Royal London Hospital	Mr Shafi Ahmed
Whipps Cross University Hospital	Mr Pasquale Giordano
Homerton University Hospital NHS Foundation Trust	Miss Helen Pardoe-Colorectal Lead Mr Sanjaya Wijeyekoon-Anal Neoplasia Lead
North Middlesex University Hospital NHS Trust	Mr Romi Navaratnam
Princess Alexandra Hospital NHS Trust	Miss Vardhini Vijay
Royal Free London NHS Foundation Trust	Mr Olagunju Ogunbiyi
University College London Hospitals NHS Foundation Trust	Mr James Crosbie-Anal Cancer Lead
Whittington Health NHS Trust	Mr Jonathan Wilson

Contents

PART ONE: INTRODUCTION AND ADMINISTRATIVE ARRANGEMENTS

1.0 Introduction

In line with the first principle of the Calman-Hine report (1995),[1] the purpose of this operational policy is to provide a summary guide for the management of patients with cancer of the anus. The *London Cancer* integrated cancer system (ICS) must ensure uniformly high quality of care in primary, secondary and tertiary centres for all its patients. The policy should be regarded as a template for best practice. The policy has been developed as an aid to all health practitioners involved in the patient's medical management from primary care through referral, treatment and follow-up. The overall policy for *London Cancer* is that all patients with proven or suspected anal cancer are treated by members of multi-disciplinary teams with a special interest and expertise in anal cancer. The case for changing cancer services in London was published in March 2010.[2] The overarching theme in the case for change is that the lack of progress in implementing coordinated cancer services across London means that, although services are excellent in some instances, they are not so everywhere and so provide patients with fragmented care. Survival outcomes for all cancers in Londoners suggest that about 1,000 more lives a year are lost compared with the best outcomes in Europe.

The guidelines have been developed to comply with peer review requirements and to work towards fulfilment of the goals of the integrated cancer system *London Cancer*.

1.1 London Cancer Integrated Cancer System priorities

London Cancer's three priorities to achieve by 2015 are:

- Improve one year survival for patients within *London Cancer*.
- Improve patients' self-reported experience of the care they receive.
- Increase participation in clinical trials and innovative studies to a third of all patients

London Cancer ICS continues to develop cancer services across the North central London and East London sectors through the establishment of tumour-specific pathway boards and generic services boards such as radiation, chemotherapy and nursing. The establishment of common standards and practice across the network deliver a high standard of care and integrate with the extensive clinical and laboratory-based research infrastructure in North and East London.

1.2 Distribution of the *London Cancer* ICS Standards of Care for Anal Cancer

All hospitals within London ICS must agree clear policies at local and regional level for the management of anal cancer.

---

[1] Calman–Hine Report, *A Report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales. A Policy Framework for Commissioning Cancer Services – The Calman–Hine Report.* London: Department of Health, 1995.

[2] NHS Commissioning Support for London, Cancer services: case for change, 2010

These policies are designed to ensure the co-ordination of high quality care between Cancer Centres, Cancer Units, palliative care, primary care and community services.

This standard operating procedure should be circulated through the medical committees of the respective trusts (acute and primary care) by the locality lead to bring the referral model to the attention of the local primary care physicians and the locality surgical and medical teams who receive all referrals. Distribution of policy and amendments to leads will be by the *London Cancer* Pathway Board Pathway Manger for anal cancer, Sarah How (sarah.how@londoncancer.org).

There should be rapid and efficient communication systems for liaison and cross-referral between all levels of service, including primary care, psychologists, cancer genetic specialists, sexual health physicians, gynaecologists, surgeons, social workers and palliative care.

2.0 The *London Cancer* ICS Anal Cancer MDT configuration, aims and membership

Named hospitals within *London Cancer* covered by the guidelines **(Measure 11-1C-127d)**

- Barnet Hospital (part of Barnet and Chase Farm Hospitals NHS Trust)
- Chase Farm Hospital (part of Barnet and Chase Farm Hospitals NHS Trust)
- Homerton University Hospital
- King George Hospital, Ilford (part of Barking Havering and Redbridge University Hospital NHS Trust)
- Newham University Hospital (part of Barts Health NHS Trust)
- North Middlesex University Hospital NHS Trust
- Princess Alexandra Hospital NHS Trust
- Queens Hospital, Romford (part of Barking Havering and Redbridge University Hospital NHS Trust)
- St. Bartholomew's Hospital (part of Barts Health NHS Trust)
- The Royal Free Hospital
- The Royal London Hospital (part of Barts Health NHS Trust)
- Whittington Health NHS Trust
- University College London Hospitals NHS Foundation Trust
- Whipps Cross University Hospital (part of Barts Health NHS Trust)

2.1 Location of anal cancer MDTs in the network configuration (Measure 11-1C-127d)

The trusts hosting meetings for the *London Cancer* anal MDT are Queens Hospital, Romford (BHRUT) and the Royal Free Hospital (RFH).

Trust	Lead clinician	Time of MDT meeting	Location of meeting	Link up arrangements
BHRUT	Dr Sherif Raouf	Thursday 12-12.30pm (alternate weeks)	Education Centre Queen's Hospital Romford	Videoconference with BartsHealth (Royal London Hospital) Videoconference with HUH
RFH	Dr Grant Stewart	Monday 8.30-8.45am (weekly)	videoconference seminar room, 2nd Floor	Videoconference with NMH Videoconference with UCLH

The *London Cancer* Anal Cancer MDT has two multidisciplinary teams to which all patients with invasive carcinoma of the anal canal should be referred for discussion of treatment. All patients can be referred to either MDT for discussion.

- Anal cancer salvage surgery is carried out by designated surgeons (Tier 3 surgical services for anal cancer).
- The surgeons designated as core surgical members for the anal cancer MDT should manage all salvage procedures.
- Dedicated oncologists specialising in anal cancer and designated as core members of the anal cancer MDT should manage chemoradiotherapy regimes.
- All colorectal MDTs refer patients with anal cancer and neoplasia to the *London Cancer* Anal MDT.
- Designation of Tier 1 – 3 centres and clinicians will be undertaken by *London Cancer*
- After discussion at the anal cancer MDT, superficially invasive squamous cell carcinoma (SISCCA) may be managed with local excision, incisional biopsies and de-functioning stoma procedures can be carried out at the patients' local trust to improve patient experience. (Tier 2 surgical services for anal cancer)
- After discussion at the anal cancer MDT, incisional biopsy and de-functioning stoma procedures may be carried out at the patients' local trust to improve patient experience. (Tier 1 surgical services for anal cancer)
- SISCCA (after excision) and high grade squamous intraepithelial lesions (HSIL) of the anal canal and perianal skin should be considered for high resolution anoscopy (HRA) assessment and follow up. Malignancies of the perianal skin, anal verge and anal canal should be considered for long term HRA follow up after successful chemoradiotherapy treatment.(Tier 2 surgical services for anal cancer)

London Cancer Designated Hospitals for surgical services for anal cancer

Tier 1 Provision of Surgical Services	Tier 2 Provision of Surgical Services	Tier 3 Provision of Surgical Services
Chase Farm	Homerton University Hospital	The Royal Free Hospital (Hampstead)
Princess Alexandra Harlow	North Middlesex University Hospital	Queens Hospital (Romford)
Newham General Hospital		The Royal London Hospital (Whitechapel)
Whittington		University College Hospital London.
Whipps Cross Hospital		
Barnet		

N.B. Barnet Hospital currently refers patients to the anal MDT at Mount Vernon Hospital.

2.2 Aims and Objectives of the *London Cancer* Anal Cancer Multi-disciplinary Team

- Decide on the optimum management for patients with anal cancer in a multidisciplinary meeting setting.
- Provide information, advice and support for local colorectal MDTs within *London Cancer* to ensure all patients and their carers have the best management throughout the course of the illness.
- Give all patients and carers a point of contact (key contact) within the multi-disciplinary team, for any queries relating to an individual's management.
- Provide treatment and follow up for these patients and ensure that every patient with anal cancer receives multi-disciplinary management with appropriate oncological input.
- Using clinical guidelines the core team members of the MDT, having agreed the identity of the patient, decide on the appropriate modality of specialist care for the patient.
- Provide a rapid onward referral service for patients who require more specialised management in particular, provide co-ordination between subspecialty MDTs in discussion of patients with multi-focal / multi-centric disease.
- Ensure a robust mechanism for the follow up of patients who have been referred to specialist teams.
- Once diagnosis has been made, ensure prompt communication to the General Practitioner within 24 hours

- Participate in *London Cancer* Colorectal Pathway Board audit projects and present results to *London Cancer* Colorectal Pathway Board. At least one core member will attend *London Cancer* Colorectal Pathway Board meetings.

- Implement service improvement – this should include process mapping and action planning.

- Ensure that protocols / guidelines / standard operating procedures are developed / updated for all aspects of management / diagnosis / treatment of patients with anal cancer.

2.3 Administrative arrangements of the Anal MDT

Trust	Lead clinician	Time of MDT meeting	Name of MDT coordinator	Contact details of MDT coordinator
BHRUT	Dr Sherif Raouf	Thursday 12-12.30pm (alternate weeks)	Caroline Bruce	Caroline.bruce1@nhs.net Fax number 01708 435331 01708 435000 ext. 3726 07730 667 373
RFH	Dr Grant Stewart	Monday 8.30-8.45am (weekly)	Kiri Freer	kirifreer@nhs.net 020 7794 0500 ext: 35829

3.0 The Anal Cancer Steering Group

Aims

- The Anal Cancer Pathway Board sub-group supports the overall aims of the network by facilitating the collaboration of providers of anal cancer services in the network to provide seamless care based on best practice. Primarily, it provides a forum for the exchange of information and the development of collaborative working practices.

- The Leads for this group are Dr Sherif Raouf and Dr Grant Stewart

Terms of Reference

- To gain consensus on the most appropriate configuration of anal cancer services in the network.

- To develop common guidelines and protocols for referral, management, audit and teaching.

- To co-ordinate the implementation of national and regional policies with respect to the anal cancer service.

- To develop an information base together with more comprehensive and effective systems for collecting data.

- To set/agree performance targets and monitor the volume and quality of patient care against these targets – including the implementation of audit programmes.

- To arrange joint meetings between the two MDT meetings at least twice a year
- To arrange presentation of outcomes and data sets for the whole of *London Cancer* at the joint MDT meetings.

4.0 Referral Guidelines

4.1 Referrals from General Practitioners

- Referrals are received from Primary care, as under the 'Two Week Wait' referral system, Urgent or routine GP referrals.
- Two Week Rule (TWR) (NICE referral guidelines issue date June 2005 (Guideline 27) available on www.nice.org.uk). Adherence is monitored by the Trust.
- Patients referred by their GP with anal cancer under the two week rule are seen accordingly.
- These should be completed on the appropriate two week wait form and faxed or e-mailed to the Target wait office via dedicated fax lines. These patients will receive an appointment within two weeks of referral.

4.2 Routine referrals

- The consultant vetting these referrals may decide upon reading the information given in the letter, on the priority the referral should receive.
- Other hospitals in the network through the Single Point of Referral Office as detailed above.

4.3 Non-colorectal MDT clinicians' referral

- Patients who are diagnosed unexpectedly or incidentally with anal cancer, or known patients are diagnosed with recurrent or metastatic disease by clinicians who are not members of a colorectal MDT should within 24 hours of a definitive diagnosis contact a core member. Fax, email, letter or telephone can be used. The consultant referring the patient should inform the patient of the diagnosis and referral.

4.4 Sexual Health referral/ tertiary referral

- Patients identified with occult micro-invasive disease (SISCCA) at HRA are sometimes referred to the service from out of area with SISCCA or diagnosed via sexual health clinics.
- Tertiary referral patients will be discussed in the London Cancer Anal MDT and the advice communicated in a timely manner to the referring clinician for locally-delivered treatment if appropriate by letter.

4.5 MDT Meetings

- All patients with a suspected anal cancer may undergo the following investigations prior to referral to the MDT and the images and results should be made available to the anal cancer MDT meeting:

  - Blood tests to include FBC, U&E'S, LFT'S,
  - HIV.
  - Examination +/- EUA+/- HRA.
  - CT abdomen/thorax/pelvis; +/- USS of groin
  - MRI pelvis
  - Cervical smear
  - Colposcopy

- The MDT co-ordinator will be responsible for producing the final list of patients to be discussed by the MDT meeting. The coordinator will distribute the list to all core members of the MDT meeting irrespective of the trust they are employed in.

- A discussion will take place regarding further investigations and/or treatment plan.

- A key worker for the patient is identified.

- All decisions are recorded on the MDT form by the co-ordinator who will then ensure it is signed off by the chairperson.

- The MDT decisions must be recorded and available in the patient notes at any trust where they are receiving treatment.

- The clinical nurse specialist (CNS) will contact the patients where appropriate and inform them of either the treatment plan or of an outpatient appointment with the consultant to inform them of the plan. The CNS will ensure that patients have outpatient appointments where necessary. The CNS will also inform the patient's local CNS of the outcome of the MDT on the day of the MDT, including any reasons why a patient may not have been discussed.

- If issues arise in the interim, the CNS will bring the patient back to the MDT to be re-discussed.

- All patients will be reviewed in the MDT after operative treatment once histology results are available, or at the conclusion of Oncological treatments.

  The diagnosis, investigations, treatment plan, subsequent referrals and dates of investigations will be recorded on all patients presented to the MDT meeting on the MDT proforma.

- After a patient is given a diagnosis of anal cancer, the patient's general practitioner must be informed of the diagnosis by the end of the following working day. This the responsibility of the MDT coordinators based at the RFH and Queen's Hospital Romford.

5.0 The Anal Multi-disciplinary Team Meeting (MDT)

5.1 Referral Protocol

- All referrals will be sent to the MDT coordinator of either the East or North meeting of the *London Cancer* Anal Cancer MDT.

- The referral must include all staging information in a Single Point of Referral package sent from the cancer referrals office.

- For referrals outside of the network, the same protocol applies.

- All patients with anal cancer will be discussed at the MDT. It will be the responsibility of the Multidisciplinary Team to document the decisions of the MDT and to implement the management of the patient. The MDT outcome form will be faxed to the referring clinician and to the patient's GP.

5.2 Preparation for the MDM

- A list of patients to be discussed must reach the MDT co-ordinator and comprise of a completed proforma, the GP contact details including fax number and the relevant staging information.

- All new cases of anal cancer should be discussed once fully staged in this multi-disciplinary team setting. Patients should be re-discussed in this setting at each stage of their treatment where major management decisions are taken.

- This list will be sent to the core MDT members.

5.3 Outcome of the MDM

These meetings are recorded in detail with the following records produced:

- Attendance register

- An individual treatment plan for each case discussed.

- The team in charge of the patient at the time of the meeting, the Radiotherapy Review Specialist and the CNS are responsible for the immediate communication of any planning decisions to the hospital responsible for treating anal cancer. On agreeing a treatment strategy and start date with the patient, the MDT coordinator should be informed to allow the proforma to be completed as evidence of this discussion.

- Referrals from the Surgical Team to the Oncologists and vice-versa will be agreed during the meeting and the Anal MDT proforma accepted as the formal referral letter.

- It will be the responsibility of the Anal Cancer MDT co-ordinator to ensure these proformas are faxed to the GP within 24 hours of the meeting and this is fed back to the referring trust to allow effective audit of this process.

5.4 Procedure for governing how referrals are to be handled on patients who require emergency treatment before the next scheduled meeting

- Emergency decisions on patient management taken between meetings should be documented in the patient's notes.

- The decisions should be based on consultations between consultant members of the MDT.

- The documentation should include details of all correspondence whether in the form of telephone calls, e-mails or letters exchanged between consultants.

- All such cases should then be discussed in retrospect at the next MDT meeting.

- Where there is differing opinion on patient care or if further information about treatment is required, this information will be presented at the beginning of the following weeks MDT meeting for discussion.

5.5 Membership of the MDT / Cover Arrangements

- The core member or their cover should attend 100% of the meetings except in exceptional circumstances of which the core member themselves should be present at 66% of meetings.

- Core Team of the anal cancer meeting must consist of:

- A single named lead clinician with agreed list of responsibilities for the MDT who should then be a core team member.
- At least one and no more than two consultant surgical core members.
- At least one and no more than two consultant clinical oncology core members under whose care all curative chemotherapy and/or radiotherapy (including chemo-radiotherapy) for anal cancer takes place, for the patients of the MDT[3]
- Clinical Nurse Specialist, with responsibility for discussing patient issues
- Histopathologist
- Imaging specialist
- MDT co-ordinator
- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers
- a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT

- Extended Team of the anal cancer meeting:

The extended members of the MDT are not required to attend the weekly MDM but are available for referral when required for patients.

The extended team must consist of:

- gynaecologist with a surgical practice in the treatment of vulval cancer
- plastic surgeon
- HRA (High Resolution Anoscopy) Specialist

- Palliative care, occupational therapy, physiotherapy and social care are available via referral at each hospital.

5.6 MDT Meeting Audits

[3] In the radiotherapy department(s) which hosts the radiotherapy practice of the MDT there should be no more than two clinical oncologists who practice radiotherapy (as a single modality or as part of chemotherapy) for anal cancer, and they should be core members of the MDT.

Cancer Data

- The Lead Clinician of each anal cancer MDT meeting is responsible for overseeing the collection of the relevant data for submission to national cancer databases for all cases discussed at the MDT. The host Trust for the MDT meetings has a responsibility to ensure that processes are in place for the collection of sufficient information for patients to be reviewed clinically; tracking patients regarding the treatment across all hospitals in *London Cancer*; and annual audits.

- The RFH anal cancer MDT is responsible for submitting the anal cancer data for the *London Cancer* ICS to the national databases for the period April 2012-31st March 2014. This is to ensure accuracy of data submission.

Minimum Datasets

- Locally developed database to allow the collection of the two week waiting times is maintained by the MDT co-ordinators and the target wait office.

Audits

- There are agreed audits within *London Cancer*

- The following is a list of audits that are carried out throughout the year and presented at the operational policy annual review meetings

- Audit of attendance

- Audit of total number of cases per year. This will include:
  - The number discussed at each MDM
  - The proportion of new and follow up.

- A Network-wide audit to monitor that all suitable cases are being referred to the team and all radiotherapy and all salvage surgery undertaken by designated clinicians. This will involve pathology data

- Patient satisfaction survey

5.7 Operational policy annual review meeting

- The MDT holds at least one operational policy review meeting every year. The meeting discusses reviews, agrees and records a number of operational policies.

- Other core members are asked to notify the Lead Clinician prior to the operational policy annual review meeting of any other policies and topics they wish to discuss.

NB Barnet Hospital

A minority of patients initially seen at Barnet Hospital may be discussed at the Mount Vernon Cancer Centre anal MDM on Mondays, and will subsequently be seen there. Patient choice may influence whether they are seen at MVCN or any of the *London Cancer* anal cancer hospitals, with factors such as geographical distance taken into consideration.

6.0 Patient Care

- The care of patients with anal cancer will be co-ordinated by the CNS at the trust where treatment is given with input from the core nurse specialists.

- The care of patients undergoing salvage surgery will co-ordinated by the CNS at the host trust where the salvage surgery has occurred with advice and input from the core CNS of the patient's local trust.

- This role will include liaising with the members of the MDT and ensuring their availability to the patient whenever necessary.

- At diagnosis the CNS at the local trust should be present and assist in the completion of the key contact form.

- If the CNS is unable to be present, the consultant responsible for the patients care should complete the key contact form.

- Copies of the key contact form will be filed in the patients notes, forwarded to the patient, GP and the CNS.

- In line with recommended best practice, patients will be offered copies of their clinic letters.

- The CNS will ensure that all patients will be offered clear and comprehensive written information on:

  Nature of the disease
  Diagnostic procedures being undertaken
  Treatment options available
  Likely outcomes of treatment in terms of benefits, risks and side effects
  Contact details for the core members of specialist team
  Psychological Support
  Social Support
  Contact with the stoma nurse specialist team

  The CNS will offer written information to the patient at the appropriate times. This information may be given at either the patient's local trust or at the tier 2 or tier 3 Trust. It should be documented by each CNS who sees the patient the information offered and given to the patient.

7.0 Patient Choice

- All 2 week wait referrals will be contacted by phone and offered a choice of suitable appointments. Following this written confirmation will be sent (in accordance with trust policy).
- Patients requiring colonoscopy will be given choice of appointment time and date in person when booking the investigation.
- It is anticipated that patients requiring CT / MRI / other investigation will be able to choose and book the date of their first diagnostic test and follow-up tests.
- Patients requiring outpatient treatment will be offered a choice of suitable appointment times by the doctor or nurse who books the treatment with the day care unit.
- Patients requiring *elective* admission for their first treatment will be asked to indicate preferred date(s) for their admission. Every attempt will be made to admit the patient on their preferred day. If no bed is available on that day the patient will be contacted by the bed manager and another suitable date will be arranged.

8.0 Service Improvement

- The *London Cancer* Anal Cancer MDT will have a nominated service improvement lead.
- They are responsible for the continued appraisal and improvement of the anal cancer service including patient pathway mapping.
- Proposals for service improvement and actions plans will be discussed annually and agreed by the core members.

PART TWO: CLINICAL PROCEDURES

1.0 Diagnostic process

Suspected malignant lesions of the anal canal may be assessed by –

- Examination of anus and rectum under anaesthetic (EUA) and biopsy
- CT chest, abdomen and pelvis
- MRI pelvis
- PET CT
- Assessment of inguinal lymph nodes – where suspicious biopsy or FNA
- High resolution anoscopy (HRA) gynaecological assessment in women including colposcopy for CIN/VIN/VAIN
- Penile assessment for PIN in men
- Consider need for HIV testing
- Consider need for colonoscopy/flexible sigmoidoscopy

2.0 Primary Treatment

- Patients with anal cancer should be considered for national trials.
- For other patients the standard non-surgical treatment is chemo radiation.

Treatment for anal squamous cell carcinomas:

- The care of the patient will be the joint responsibility of the relevant oncology team and the surgical / medical team, in conjunction with other members of the MDT.
- For T2 and greater disease, the vast majority of anal cancer will be treated by primary chemotherapy/radiotherapy
- Following initial biopsy and staging, patients should be referred to a medical oncologist or clinical oncologist nominated by the *London Cancer* Anal MDT for chemotherapy and radiotherapy.
- Early localised anal cancers T1 or SISCCA without any evidence of metastatic disease in a medically fit patient should / can be treated by primary surgery (wide local excision) after which close HRA follow up is required. .
- The surgery should be carried out by a colorectal surgeon.

- Post-operative histology should be discussed at the *London Cancer* MDT.

- The patient should be advised of the options and be given written information about their operation. The CNS should be present at this consultation to answer any further questions and for support.
- On completion of chemo and radiotherapy, the patient's care may revert back to the surgical team, if necessary, with consideration of referral for HRA follow up.

- Skin cancers, including malignant melanoma and Pagets, arising in the anal and perianal region should be discussed in the local skin MDT and where appropriate referred on to the specialist skin MDT. If surgery is required then a referral may be made to the *London Cancer* Anal MDTs, hosted by the Colorectal MDTs at The Royal Free and BHRUT at Queen's Romford for further management. Patients with pre-malignant conditions may also be referred to the local colorectal MDT by a local skin MDT depending on the specialist expertise available.

Adenocarcinoma of the anal canal is managed as per rectal cancer guidelines
Melanoma of the anal cancal is managed as per melanoma guidelines.

3.0 Recurrent disease

Local recurrence

- Patients who have biopsy proven recurrent local disease should be considered for an Abdomino-perineal excision (APER).

- Salvage surgery for anal cancer should only occur under the supervision of the designated surgeons for the anal cancer MDT.(Tier 3 designated Hospital)

- If appropriate the patient should be offered a laparoscopic assisted approach.

Palliative Care

- Any in-patients with specialist palliative care needs can be referred to the multi-professional hospital-based Palliative Care Team for assessment and advice.

- The palliative care team will, where appropriate, arrange follow-up by the relevant Community Palliative Care Team when the patient is discharged home.

- If a patient requires ongoing care in a specialist palliative care unit, either for end of life care or for symptom control, then the Team will, where appropriate, refer the patient to the relevant local hospice.

- All of the hospices provide a range of services including:
    - Day care
    - Admission for symptom relief
    - Terminal care
    - Bereavement counselling
    - Pain clinics

- Complementary medicine
- Lymphoedema management services
- Psychological support
- Help with benefits and social care issues.

- Hospices within *London Cancer*:

Name	Address
The Margaret Centre	Whipps Cross University Hospital NHS Trust, Whipps Cross Road, Leytonstone, London E11 1NR
St Joseph's Hospice	Mare Street ,Hackney, London, E8 4SA
St Francis Hospice	Havering Atte Bower, Romford. Essex, RM4 1QH
North London Hospice	47 Woodside Avenue, North Finchley, London N12 8TT
Marie Curie Hospice	Hampstead, 11 Lyndhurst Gardens, London NW3 5NS
St John and St Elizabeth Hospice	60 Grove End Road, St John's Wood, London NW8 9NH

4.0 Follow-up

Follow up as per protocol designated below.

- Follow up of patients with anal cancer depends on stage and modality of management and will be decided upon by the MDT, but in general is as follows:

- If a patient is to receive adjuvant chemotherapy they are followed up by the Oncologist /Surgical team.

- If a patient's condition is palliative, they should be followed up by the Palliative care team.

- PET CT, CT, HRA, flexible sigmoidoscopy and EUA and biopsy may be used for suspicion of recurrence.

- All follow up should be for 5 years: Patients with lower ano-genital dysplasia and HIV positive and other immunosuppressed individuals may require lifelong follow up.

- All female patients must be offered advice on regular vaginal dilatation after chemoradiation.

- High risk patients are those
  - T4 tumours and/or lymph node positivity
  - Anal cancer in the presence of fistulae
  - Immuno-compromised patients
  - Patients intolerant of treatment

5.0 Anal Intraepithelial Neoplasia (AIN)

The Lower Anogenital Squamous Terminology Standardization Project for HPV-Associated Lesions: background and consensus recommendations from the College of American Pathologists and the American Society for Colposcopy and Cervical Pathology. (LAST)

High-grade Squamous Intraepithelial Lesions (HSIL) disease (previously called AIN2/3)

- Protocol for management of HSIL. The LAST guidelines replace the ACP advice (2012).

- Suggested SISCCA definition is a subdivision of T1 cancer by AJCC current definition of <2cm:
- Has an invasive depth of <3 mm from the basement membrane of the point of origin,
- AND
- Has a horizontal spread of <7mm in maximal extent
- AND
- Has been completely excised

- Microinvasive disease defined as 1mm or less in depth (measured from the basement membrane) and is particularly suitable fortreatment with wide local excision or excision and ablation after discussion at the anal cancer MDT.

- In cases of difficulty with what was in old classification AIN 2, it is recommended to use p16 immunohistochemistry staining to distinguish between HSIL and its mimics and to distinguish HSIL from LSIL.

Background: There is evidence that high-grade squamous intraepithelial lesions (HSIL) are the precursor to squamous anal cancer[1]. Clearance of high-grade cervical intraepithelial neoplasia prevents development of cervical cancer[2,3]. The aetiology of anal cancer, cervical cancer and some of the vulvar cancers are similar, with Human Papilloma Virus (HPV) infection being implicated in 90-93% of cases of anal disease[4]. This protocol has been developed based on available evidence and through management of AIN disease over two decades.

1) No previous cancer diagnosis

- HRA assessment for suspected anal neoplasia disease (within 6 weeks of referral)
- Targeted biopsies for (HSIL/AIN) confirmation at HRA
- Treatment appointment (within 6 weeks of HSIL confirmation)
- Topical treatment (e.g.: 5% imiquimod / trichloroacetic acid) /5 fluorouracil) should be considered particularly for widespread or multifocal disease. Duration of treatment to be discussed in MDT and dependent on follow up HRA findings Referral for laser ablation within 6 months of HSIL confirmation or on failure of topical management.
- Follow-up: 1st follow-up after ablative treatment at 6 months
- Other follow-up depends on patient immune status; if immune compromised seen every 6 months; if immune competent annual follow-up. If new disease detected, treated within 3 months (ablative/topical treatment) and followed-up at 6 months as above; thereafter based on immune status, as above.

2) Previous cancer diagnosis

- HSIL disease may antedate, co-exist and/or develop after the treatment of anal cancer.
- First HRA assessment, at 3 – 6 months after completion of chemoradiotherapy / surgery. Biopsies taken for suspected HSIL disease.
- Treatment with laser ablation within 3 months of HSIL confirmation.
- Follow-up at 6 months from treatment/assessment (when no disease found).

- Further follow-up every 6 months for HRA assessment for new disease, irrespective of immune status.

3) Multifocal neoplasia

- HSIL is a multifocal disease HPV-related that involves the external perianal region as well as the anal canal the vulva, cervix and vagina in women, and the penis in men. Multifocal disease is more common in the immune-compromised and in women who have had cervical or vulvar neoplasia. Often vulval HSIL is contiguous with perianal HSIL disease.
- Management of multifocal disease in women is best done through a multidisciplinary team. A multidisciplinary team of a dermatologist, gynaecology oncologist, colorectal surgeon and an HRA specialist is recommended to deal with such cases.
- Patients ideally referred within 6 months of first diagnosis/suspicion of multifocal disease for HRA examination
- It will form good clinical practice to assess patients with multifocal neoplasia for immune compromised states, including HIV infection.
- During HRA assessment, a complete examination of all areas (cervix, vagina, vulva, perianal region as well as anal canal) is made. Targeted biopsies, from areas suspected of HSIL, are taken.
- Laser ablative treatment is planned based on the area of involvement as well as the number of anatomical regions involved. Topical treatment may be considered as adjuvant management.
- Management and timing of treatment is discussed at MDT.
- Extensive disease (e.g.: 4 quadrant – perianal involvement) may necessitate a staged approach over several appointments spaced a number of months apart Patients are brought back every 3 months until treatment is completed.
- Follow-up: every 6 months for life.

6.0 The Pathophysiology of Anal Cancer

- Worldwide, squamous cell anal cancer is increasing. Rates in the general population are 1/100,000 however in men who have sex with men (MSM) this rises by a factor of ten. In HIV positive MSM, the rates are up to 100 times that of the general population.
- Anal cancer is 90-95% due to HPV infection. HPV 16 and 18 are the most prevalent oncogenic HPV virus types. This pathology should be eradicated by HPV vaccination. Vaccination should include boys as well as girls to ensure maximum coverage and herd immunity.
- All patients who are immunosuppressed are at increased risk of HPV-related carcinomas and intraepithelial neoplasia
- The surgical definition of the anal canal, proposed by the American Joint Committee on Cancer (AJCC), is the most widely accepted. By its definition, the anal canal extends from the apex of the anal sphincter complex to the palpable intersphincteric groove at the distal edge of the internal sphincter muscle.
- Eighty five percent of anal tumours arise within the anal canal.
- The other fifteen percent are mainly squamous cell carcinomas of the skin of the anal verge. These latter tumours usually have a less aggressive course than anal canal tumours. Cancer which occasionally develops in long standing fistulous tracts can present in a delayed and advanced manner. Anal cancers are classified as epithelial tumours, non-epithelial tumours and malignant melanoma.

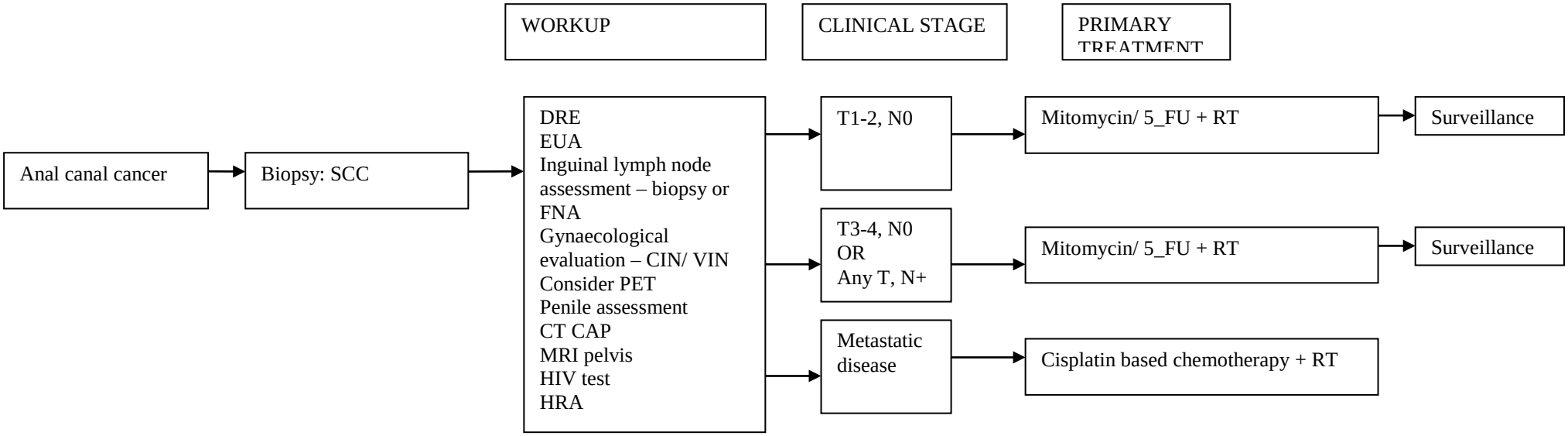
7.0 Reference List

- Guidance on Commissioning Cancer Services: Improving outcomes in Colorectal Cancer, The Manual. NHS Executive.
- NSSG Network Guidelines for the Management of Patients with Colorectal Cancer – October 2007.
- Manual of Cancer Services Standards, DoH December, 2000.
- Nathan M. Treatment of anal intraepithelial neoplasia: has it come of age? AIDS 2013;27:651-2.
- Mc Credie MR, Sharples KJ, Paul C et al. natural history of cervical neoplasia and risk of invasive cancer in women with cervical intraepithelial neoplasia3: a retrospective cohort study. Lancet Oncology 2008;9:425-34.
- Trent cancer registry. Profile of cervical cancer in England. Incidence, mortality and survival. October 2012.
- De Vuyst H, Clifford GM, Nascimento MC et al. Prevalence and type distribution of human papillomavirus in carcinoma and intraepithelial neoplasia of the vulva, vagina and anus: a meta-analysis. International Journal of Cancer 2009;124:1626-36.
- J Low Genit Tract Dis. 2012 Jul;16(3):205-42.The Lower Anogenital Squamous Terminology Standardization Project for HPV-Associated Lesions: background and consensus recommendations from the College of American Pathologists and the American Society for Colposcopy and Cervical Pathology.
- Darragh TM, Colgan TJ, Cox JT, Heller DS, Henry MR, Luff RD, McCalmont T, Nayar R, Palefsky JM, Stoler MH, Wilkinson EJ, Zaino RJ, Wilbur DC; Members of LAST Project Work Groups.
- AIDS 2005, 19:1407–1414 Anal intraepithelial neoplasia in the highly active antiretroviral therapy era among HIV-positive men who have sex with men Joel M. Palefsky et al

APPENDICES

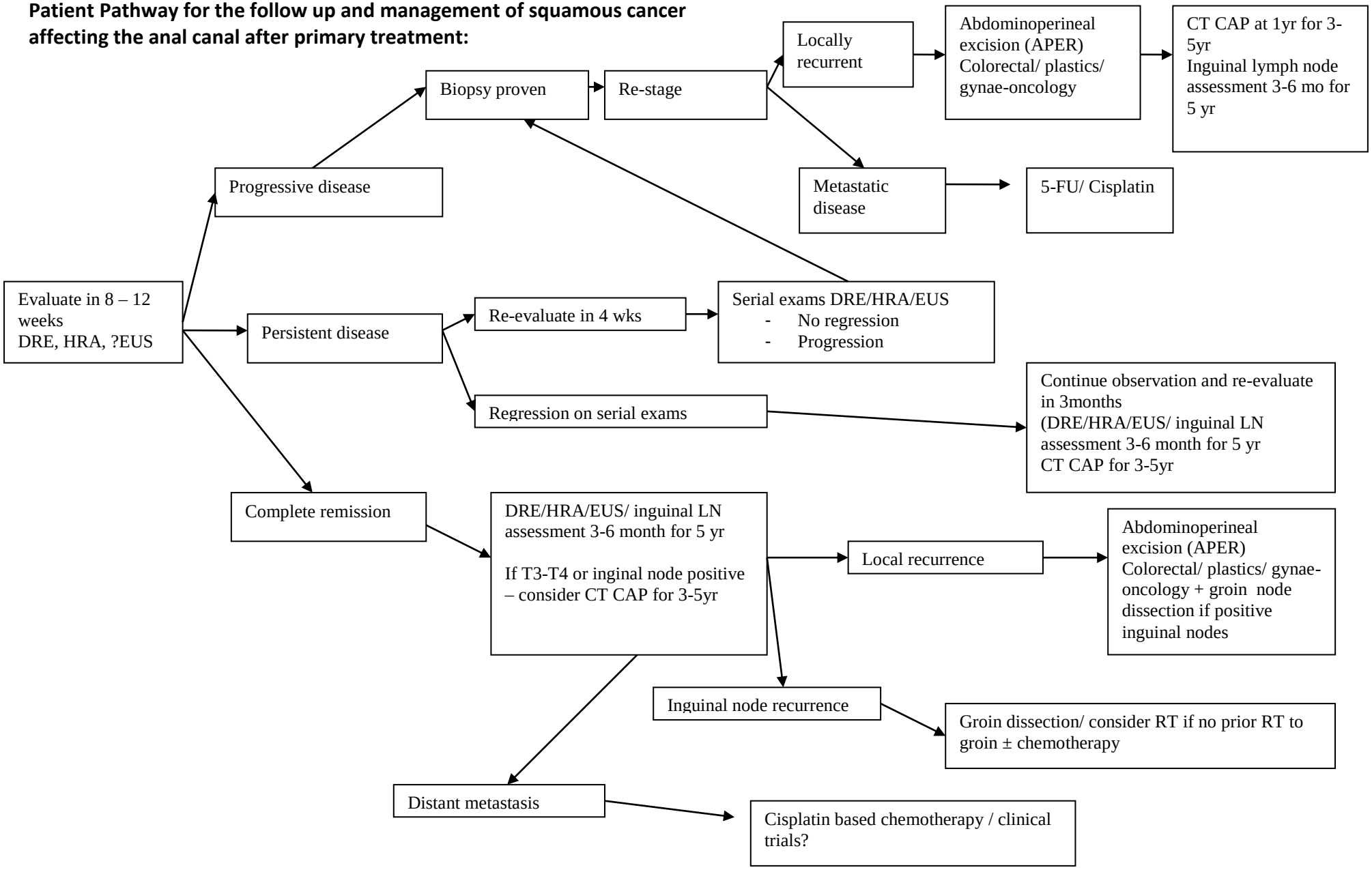
Appendix A: Patient Pathway Mapping

Patient Pathway for the investigation and primary management of squamous cancer affecting the anal canal:

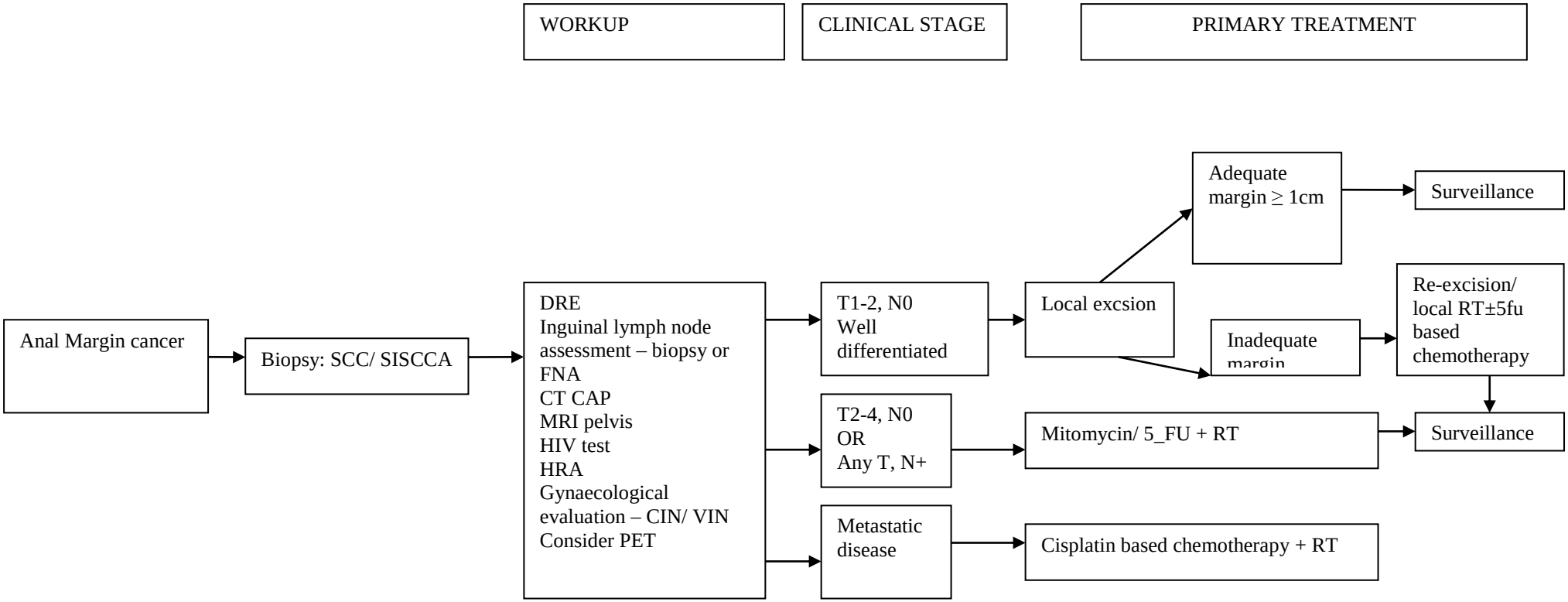


Supported by key worker throughout the journey, acting as a point of contact.

Patient Pathway for the follow up and management of squamous cancer affecting the anal canal after primary treatment:



Patient Pathway for patients with squamous cancer affecting the anal margin:



Supported by key worker throughout the journey, acting as a point of contact.

Appendix B: Radiotherapy guidelines

LONDON CANCER NORTH AND EAST	PROTOCOL FOR INTENSITY MODULATED RADIOTHERAPY FOR ANAL CANAL CANCER					
Created by:	Dr. S. Raouf / Dr G. Stewart	Issue No.:	3	Issue Date:	draft	
Checked by:	L. Crees	Authorised by:		S. Naidu	Issued by:	N. Norris

TNM Classification

Primary Tumour

TX Primary tumour cannot be assessed
T0 No evidence of primary tumour
Tis Carcinoma in situ
T1 Tumour 2 cm or less in greatest dimension
T2 Tumour more than 2 cm but not more than 5 cm in greatest dimension
T3 Tumour more than 5 cm in greatest dimension
T4 Tumour any size directly invades other organs e.g. vagina, urethra, bladder (involvement of the rectal wall, perirectal skin, subcutaneous tissue or sphincter muscle(s) alone is not classified as T4)

Regional Lymph Nodes

NX Regional lymph nodes cannot be assessed
N0 No regional lymph node metastasis
N1 Metastasis in perirectal lymph node(s)
N2 Metastasis in unilateral internal iliac and/or unilateral inguinal lymph nodes(s)
N3 Metastasis in perirectal and inguinal lymph nodes and/or bilateral internal iliac and/or inguinal lymph nodes

Pre-treatment assessment

- History and examination.
- Proctoscopy, EUA and biopsy. Histopathology results should be available.
- Staging CT chest and abdomen. PET-CT is preferable
- MRI pelvis
- Blood tests - FBC, U+E, LFTs.
- EDTA assessment of GFR if considering cisplatin
- Any other investigations considered necessary – this may include HIV testing
- All patients should have been discussed at the Anal cancer MDT Meeting and the management strategy agreed.
- Patients should be given information sheets at their clinic attendance and afforded the opportunity to discuss the treatment options in full.
- Patients may require additional support and should be referred to other healthcare professionals as appropriate e.g. to dietician, counsellor or stoma nurse.
- Infertility and potential fertility preservation strategies should be discussed with all male patients and with all female patients of child-bearing age. Effective contraception should also be discussed with all patients due to have pelvic radiotherapy.

- Informed consent is required for all patients and a signed consent form should be attached to Radiotherapy Referral form.
- The Radiotherapy Referral form should be completed in full, stipulating the patient's RCR Category and Target Breach Date. Specific planning instructions should be documented and the form handed in as per local guidelines.

PATIENT SELECTION:

Suitability: All patients with good performance status and GFR > 50 ml / min should be treated with Chemo / Radiotherapy:

Current conformal radiation fields treat unnecessary areas like genitals and skin.
CTV to conform to volume and the use of IMRT will allow maximum normal tissue sparring.

Note **Chemo:** MMC 10mg/m^2 Day 1
Xeloda 600mg/m^2 bd. Day 1-14 and 22-35

PLANNING:

Image Acquisition:

1. Patients will be scanned with a full bladder.
2. Patients are scanned supine, using the same immobilisation as for standard anal canal treatment. An anal marker should be used.
3. Patients are scanned after injection of intravenous contrast and administration of oral contrast (provided there is no contraindication for the use of contrast).
4. Patients will be scanned from 2cm sup to the top of L5 to 7cm below the anal marker with 2.5mm slices.

Target Volumes:

Areas of interest:
1. tumour
2. Nodal spread – Peri rectal, mesorectal, Interior / Exterior iliac and inguinal.

The treatment is delivered to 2 target volumes as ACT II (note change in superior border)

Volumes: GTV = Anal canal and any extent of tumour

GTV 1 = GTV + 2cm all around
2cm inferior making sure the skin is covered at the anus. If perianal skin is involved ensure suitable bolus is added

Mesorectal – to cover Peri rectal and mesorectal LN
Extend above GTV1 up to peritoneal reflection.

Pre-sacral nodes: extends up to L5/S1 for T3 – 4 tumours or any involved mesorectal LNs.
Extend 2 cm above the bottom of the SIJ only for T1 – 2 tumours with no mesorectal LNs

Rt Nodes – All nodal regions from Interior iliac to inguinal nodes on right side, with the use of IV contrast all vessels are delineated and then grown by 1cm as CTV Rn.

Lt Nodes – Same as right on left side, as CTV Ln.

CTV 1 = [GTV 1 or Meso] or [CTV Rn or CTV Ln] then add CTV1 + presacral nodes
(Boolean op.)

PTV 1 = CTV 1 + 1cm. (to minimise normal tissue doses, add 0.5cm post and lat)

No inguinal node -

PTV 2 = GTV 1

Positive inguinal node -

CTV 2 = [GTV 2 or meso] or [nodal group involved or presacral nodes]
Boolean op.

PTV 2 = CTV 2 + 1cm.

Normal Tissue Contouring:

Normal tissues outlined include bladder, femoral heads, pelvic bones, genitalia and small bowel. The normal tissues will be outlined as solid organs by defining the outer wall of bladder and bowel.
Bladder should be outlined from base to dome, excluding the CTV.
Any small bowel within 2cm of PTV should be outlined separately.
Genitalia should be delineated throughout the volume for both males and females.

Further normal tissue structures are then created with a Boolean subtraction of PTV1 in order to facilitate dose optimisation.

Refer to the Male/ Female Pelvis Normal Tissue RTOG Consensus Contouring Guildelines.

Dose Prescription:

Prescribed dose will be 53.2Gy in 28 fractions over 5½ weeks.
Treatment will be delivered using a simultaneous integrated boost (SIB) .technique

No inguinal node:
Dose to PTV1 will be 39.2Gy with a minimum dose coverage (defined as to 98 % of target volume) of 95%.
This would equate to 37.24Gy (or 70% of total prescription dose).

Dose to PTV2 will be 53.2Gy with a minimum 95% isodose coverage.

Positive Inguinal Node:
Dose to PTV1 will be 50.4Gy with a minimum dose coverage (defined as to 98% of target volume) of 95%.
This would equate to 47.88Gy (or 90% of total dose prescription).
Dose to PTV2 will be 53.2Gy with a minimum 95% isodose coverage.

All cases:

Minimum and maximum doses to the PTVs (to 98% and 2% of the volume respectively) and median dose will be recorded.
Hot spots will not exceed 105% of the prescribed dose.

Doses will be recorded in accordance with ICRU Report 83: Prescribing, Recording, and Reporting Photon-Beam Intensity-Modulated Radiation Therapy (2010).

Optimal Normal Tissue Dose Constraints:

Bladder	
V30	80%
V40	40%
V50	0%
Small Bowel	
V30	40%
V40	30%
V50	0%
Genitalia	
V30	45%
V40	10%
V48	0%
Pelvic Bones	
V15	45%
V20	30%
V50	0%
Femoral Heads	
V45	5%
V55	0%

Assessment and Treatment of Patient with Anal Carcinoma

TNM Classification

Primary Tumour

TX Primary tumour cannot be assessed
T0 No evidence of primary tumour
Tis Carcinoma in situ
T1 Tumour 2 cm or less in greatest dimension
T2 Tumour more than 2 cm but not more than 5 cm in greatest dimension
T3 Tumour more than 5 cm in greatest dimension
T4 Tumour any size directly invades other organs e.g. vagina, urethra, bladder (involvement of the rectal wall, perirectal skin, subcutaneous tissue or sphincter muscle(s) alone is not classified as T4)

Regional Lymph Nodes

NX Regional lymph nodes cannot be assessed
N0 No regional lymph node metastasis
N1 Metastasis in perirectal lymph node(s)
N2 Metastasis in unilateral internal iliac and/or unilateral inguinal lymph nodes(s)
N3 Metastasis in perirectal and inguinal lymph nodes and/or bilateral internal iliac and/or inguinal lymph nodes

Pre-treatment assessment

- History and examination.
- Proctoscopy, EUA and biopsy. Histopathology results should be available.
- Staging CT chest, abdomen and pelvis. PET-CT may be performed
- MRI pelvis
- Ultrasound guided biopsy of suspicious or enlarged inguinal nodes
- Blood tests - FBC, U+E, LFTs.
- Any other investigations considered necessary – this may include HIV testing
- All patients should be discussed at the Anal Cancer MDT Meeting and the management strategy agreed.
- Patients should be given information sheets at their clinic attendance and afforded the opportunity to discuss the treatment options in full.
- Patients may require additional support and should be referred to other healthcare professionals as appropriate e.g. to dietician, counsellor or stoma nurse.
- Infertility and potential fertility preservation strategies should be discussed with all male patients and with all female patients of child-bearing age. Effective contraception should also be discussed with all patients due to have pelvic radiotherapy.

- Informed consent is required for all patients and a signed consent form should be attached to Radiotherapy Management Plan form.
- The Radiotherapy Management Plan form should be completed in full, stipulating the patient's RCR Category and Target Breach Date. Specific planning instructions should be documented and the form handed in as per local guidelines.
- The Radiotherapy Review Specialist will liaise with Chemotherapy Day Unit to organise the patient's attendance for chemotherapy work-up and PICC line insertion.

Radiotherapy Planning

Patient Positioning and Image Acquisition

- Patients with anal margin tumours may be scanned and treated prone with the use of a "belly-board" to enable accurate positioning of bolus. In all other patients, and those with margin tumours but where patient mobility or body habitus precludes prone treatment, the patient may be scanned and treated supine.
- In patients with anal margin tumours or extension of tumour onto the perianal, perineal or gluteal skin, bolus should be applied by the treating clinician at planning to ensure adequate dose to this area.
- If possible, an anal marker should be placed at scanning to define the clinical position of the anal margin. In patients who are to be treated supine, this should be taped to the approximate position for scanning.
- Bowel preparation is not usually possible for anal cancer patients. Bladder preparation should be followed such that the bladder is comfortably full for planning and treatment.
- Intravenous contrast is required for all patients receiving radical treatment.
- Patients will be scanned from 2cm superior to the top of L5 to 7cm below the anal marker with 3mm slices.

Patients may be treated in a 2-phase technique (in line with the ACT II trial protocol) but it anticipated that most will be treated with an IMRT solution with an integrated phase II. This work instruction includes details of "conventional planning volumes" and "IMRT planning volumes". The technique to be used must be specified on the Radiotherapy Review Form.

Conventional Planning Volumes

GTV

- Visible tumour as seen on CT and PET-CT, taking into account the data from clinical examination and MRI.
- Positive nodes on PET or biopsy should be defined as separate nodal GTVs.

PTV

- Phase I: Includes GTV and all areas at risk of microscopic disease (inguinofemoral nodes and pelvic nodes). Always allow a minimum 3cm margin around any GTV in all directions. Field borders should be defined on the posterior beam, using the same isocentre as the phase II volume will have.
- Field Borders:
    - Superior border: the more superior of (i) 2cm above the inferior aspect of the Sacro-Iliac Joints or (ii) 3cm above superior limit of macroscopic disease including involved lymph nodes 2 cm above inferior aspect of SI joints

    - Lateral borders: approximately mid-point of femoral neck (to cover inguinal nodal area)
    - Inferior border: 3cm below anal verge or 3cm below inferior extent of tumor for anal margin tumors. Be mindful that the inferior border of the phase 2 will be more than 3cm below the GTV and the phase I inferior border should match or exceed this.
- Phase II: PTV = GTV(s) + 3 cm

IMRT planning volumes

GTV

- Visible tumour as seen on CT and PET-CT, taking into account the data from clinical examination and MRI.
- Positive nodes on PET or biopsy should be defined as separate nodal GTVs.

Gross CTV

- GTV (anal primary and involved nodes) + 2cm, trimmed to barriers of spread

Mesorectal CTV

- The entire mesorectum from the peritoneal reflection cranially to at least 3cm below the GTV caudally. The cranial extent of this CTV may be amended in low, early, node-negative disease.

Pelvic Vessels

- Delineate the external and internal iliac vessels bilaterally from the bifurcation of the common iliac vessels to the proximal femoral artery

Nodal CTV

- Pelvic Vessels + 0.7cm, trimmed to patterns of spread and amended to include any obvious nodal regions (paying particular attention to the inguinal regions)
- In node positive patients, the Nodal CTV should match the nodal portions of the Gross CTV.

Presacral CTV

- The pre-sacral nodal territory up to the L5/S1 interspace for patients with T3/4 disease or any involved mesorectal lymph nodes
- The nodal territory can be abbreviated to 2cm above the inferior aspect of the sacro-iliac joints in patients with T1/2 tumours with no mesorectal lymph node involvement.

CTV1

- Merges Gross CTV, Mesorectal CTV, Nodal CTV and Pre-sacral CTV into one structure. This should be checked again for coverage of patterns of spread and trimmed from barriers to spread.

PTV1

- CTV1 + 0.5cm posteriorly and laterally and 1.0cm in all other directions.

PTV2

- Gross CTV + 0.5cm posteriorly and laterally and 1.0cm in all other directions.

- It must be ensured that the PTV1 and 2 inferior and lateral extents are compared and it is ensured that the PTV2 volume matches or is within the PTV1 volume.

Radiotherapy Treatment

- The clinician must approve, sign and date treatment images, plan and associated documentation.
- The treatment card must be signed or counter signed by a consultant or authorised registrar including treatment policy and dose prescription.
- Patients should routinely receive oral ciprofloxacin 250mg b.d. prophylaxis commencing on fraction 6 of radiotherapy.

Policy and Radiation prescription

CURATIVE TREATMENT

Conventional 2-phase technique

PHASE 1

30.6 Gy in 17 # over 3 weeks and 2 days

PHASE 2

19.8 Gy in 11# over 2 weeks and 1 day

For bulky tumours, consider dose escalation to 23.6Gy in 13# over 2 weeks and 3 days

TOTAL DOSE

50.4 Gy in 28# over 5 weeks and 3 days

Consider 54 Gy in 30# for bulky tumours

IMRT

These doses are the equivalent of a radical treatment dose of 54.6Gy in 1.8Gy fractions for a/b of 2Gy; and 35GY in 1.8Gy fractions. They therefore represent a slight dose increase in the radical dose from ACT2 style dosing and a correction for overall treatment time for the elective volume.

PTV1 = PTV53.2
53.2Gy in 28 daily fractions over 5 weeks and 3 days (1.9Gy/fration)
Dose should be prescribed to the mean dose of PTV 53.2

PTV2 – PTV39.2
39.2Gy in 28 daily fractions over 5 weeks and 3 days (1.4Gy per fraction)
90% of the dose to the 39.2 dose level = 37.24Gy which equates to the 70% isodose with reference to 53.2Gy

Chemotherapy

All patients receiving concurrent chemotherapy should have a peripherally inserted central catheter (PICC line). Fitting of the PICC and chemotherapy administration is via the 2NA Chemotherapy Day Unit at the Royal Free London. Disconnection of the 5-FU pump may be devolved to the Finchley Memorial Infusion Suite when appropriate.

Radiotherapy to start no sooner than 2 hours after start of 5FU infusion

- For patients < 70 years old and no other significant co-morbidities:
    - Mitomycin C 12 mg/m2 iv bolus (max 20mg) on day 1
    - 5-Fluorouracil 1000 mg/m2 continuous infusion days 1-4 and days 29-32.
    - In selected patients where platinum therapy may be beneficial, Cisplatin 60mg/m2 may be substituted for the mitomycin and delivered in weeks 1 and 5.

- For patients >70 years or those with significant co-morbidities:
    - Mitomycin C 10 mg iv bolus on day 1
    - 5-Fluorouracil 750 mg/m2 continuous infusion days 1-4 and days 29-32

Consider reducing 5FU dose if diarrhoea is severe at Week 5.

PALLIATIVE TREATMENT FOR SYMPTOMATIC CONTROL (IF WIDESPREAD METASTATIC DISEASE)

- 30Gy in 10# over 2 weeks +/- chemotherapy (Mitomycin C/5FU)

Or

- 20Gy in 5# over 1 week

Or

- 8Gy in 1# single fraction

CRITICAL ORGANS AND TOLERANCE DOSES

- Normal tissues outlined include bladder, femoral heads, pelvic bones, genitalia and small bowel.
- Bladder should be outlined from base to dome, excluding the CTV.
- Any small bowel within 2cm of PTV should be outlined separately.
- Genitalia should be delineated throughout the volume for both males and females.

Bladder	
V30	80%
V40	40%
V50	0%
Small Bowel	
V30	40%

V40	30%
V50	0%
Genitalia	
V30	45%
V40	10%
V48	0%
Pelvic Bones	
V15	45%
V20	30%
V50	0%
Femoral Heads	
V45	5%
V55	0%

Clinical Assessment during Radiotherapy

- Set up on machine to be seen if requested by clinician. On treatment imaging, including daily kilovoltage imaging should follow standard departmental protocols. Cone-Beam CT may be used fractions 1-3 and then weekly to assess soft tissue reproducibility not evident on kilovoltage imaging.
- Weekly review at on-treatment clinic to inspect perineum and natal cleft.

Toxicity

- Skin reaction
    - For dry desquamation severe erythema apply aqueous cream
    - For moist desquamation, apply appropriate dressing e.g mepitel
- Pain control
    - lignocaine gel (not anusol) topically
    - oral analgesia
    - consider topical morphine
- Diarrhoea/proctitis
    - loperamide, codeine phosphate
- Admit to ward for symptom control if problems with pain control or hygiene, as gaps in treatment significantly increase risk of recurrence.
- Reinforce motivation as regime is difficult to tolerate both physically and psychologically. Refer to counsellor if necessary.

Gaps in Radiotherapy Treatment

- Though the Royal College of Radiologists no longer classifies Anal Cancer Treatment as RCR Category 1, the consensus at London Cancer level is that departments should continue to treat such patients as Category 1. Gaps should therefore be avoided when possible.
- Consider weekend treatment if bank holidays or unscheduled breaks in treatment occur as per the departmental policy 'Radiotherapy Department Strategy for the Management of any potential interruption in treatment or prolongation of time schedules' GEN /P-28.

Follow-up

- Follow up 4-6 weeks after treatment completion in the Tuesday Morning Dr Stewart Outpatient Clinic
- 2-3 monthly follow up in the first year with Digital Rectal Examination
- MRI at 6 monthly intervals for 3 years in high-risk disease. Low-risk disease may require only one baseline post-treatment MRI.
- If evidence of persistent disease then requires EUA and biopsy +/- salvage surgery

Side Effects of Radiotherapy Treatment

Acute radiation reaction (settles 4-6 weeks after completing treatment)

Common effects -
- Diarrhoea
- Proctitis
- Lethargy
- Desquamation
- Urinary frequency

Late radiation reaction (side effects occurring after 6 months)

Possible effects
- Anal dysfunction
- Persistent proctitis
- Change in bowel habit
- Telangiectasia
- Vaginal fibrosis
- Infertility

Appendix C: End of Treatment Summary

TRUST LOGO

End of Treatment Summary

The *London Cancer* Living With And Beyond Cancer Board strongly advocates and supports the use of the National Cancer Survivorship Initiative (NCSI) treatment summary document across all pathways. For more information, please see here: http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/treatment-summary/. To access the end of treatment summary template, please click here: http://www.ncsi.org.uk/wp-content/uploads/Treatment-Summary-Template1.doc.

Treatment Summary
Insert GP Contact Details and Address

Insert Trust Logo

Dear Dr X

Re: Add in patient name, address, date of birth and record number
Your patient has now completed their initial treatment for cancer and a summary of their diagnosis; treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

<table>
<tr><td>Diagnosis:</td><td>Date of Diagnosis:</td><td>Organ/Staging

Local/Distant</td></tr>
<tr><td colspan="2">Summary of Treatment and relevant dates:</td><td>Treatment Aim:</td></tr>
<tr><td colspan="2" rowspan="2">Possible treatment toxicities and / or late effects:</td><td>Advise entry onto primary care palliative or supportive care register

Yes / No</td></tr>
<tr><td>DS 1500 application completed

Yes/No

Prescription Charge exemption arranged

Yes/No</td></tr>
<tr><td colspan="2" rowspan="2">Alert Symptoms that require referral back to specialist team:</td><td>Contacts for re referrals or queries:

In Hours:

Out of hours:</td></tr>
<tr><td rowspan="2">Other service referrals made: (delete as nec)
District Nurse
AHP
Social Worker
Dietician
Clinical Nurse Specialist
Psychologist
Benefits/Advice Service
Other</td></tr>
<tr><td colspan="2">Secondary Care Ongoing Management Plan: (tests, appointments etc)

.</td></tr>
<tr><td colspan="3">Required GP actions in addition to GP Cancer Care Review (e.g. ongoing medication, osteoporosis and cardiac screening)</td></tr>
<tr><td colspan="3">Summary of information given to the patient about their cancer and future progress:</td></tr>
<tr><td colspan="3">Additional information including issues relating to lifestyle and support needs:</td></tr>
</table>

Completing Doctor: **Signature:** **Date:**

Appendix D: Information for patients

- Macmillan 'Anal Cancer' PDF information sheet
- Macmillan 'Mitomycin' PDF information sheet (if appropriate)
- Macmillan 'Fluorouracil' PDF information sheet (if appropriate)
- Macmillan 'Peripherally inserted central catheters' PDF information sheet (if appropriate)
- Patient Portal information
- Beating Bowel Cancer 'Your Services' booklet outlining support services
- Beating Bowel Cancer 'Eating Well' booklet
- Macmillan 'Discharge Home from Hospital' booklet
- Contact card of named nurse
- Support services
- Macmillan Centre information leaflet
- Prescriptions advice leaflet
- 'Living with a stoma' booklet (available from Stoma Care Clinical Nurse Specialist, printed by various companies)

Useful websites for patient information:

http://www.macmillan.org.uk/Cancerinformation/Cancertypes/Anal/Analcancer.aspx

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Radiotherapy/Sideeffects/Pelvic_men.aspx

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Radiotherapy/Pelvicradiotherapyinwomen/Pelvicradiotherapyinwomen.aspx

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Radiotherapy/Pelvicradiotherapyinmen/Pelvicradiotherapyinmen.aspx

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Radiotherapy/Pelvicradiotherapyinmen/Sexualeffects.aspx

http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Radiotherapy/Sideeffects/Pelvic_women.aspx

NB: Information Prescriptions is being introduced within the network and will allow patients to access information on psychological and social issues as well as the above information.

Appendix E: MDT contact details

Core MDT members

***London Cancer* Anal Cancer MDT (North)**		
Role	**Core member/Cover**	**Core member/Cover**
Colorectal Surgeons	Mr James Crosbie (UCLH) 020 3457 7890 ext. 79454 james.crosbie@uclh.nhs.uk	Prof Marc Winslet (RFH)0207 794 0500 ext. 34832 marc.winslet@nhs.net
Clinical Oncology Radiotherapy	Dr Grant Stewart **(*London Cancer* Anal Cancer MDT Lead Clinician)** (RFH) 020 7794 0500 Ext. 34476 grantstewart1@nhs.net Lucinda Melcher (NMUH) lucinda.melcher@nhs.net	Dr Glen Blackman (UCLH) 020 3447 9481 glen.blackman@uclh.nhs.uk
Radiology	Dr James Bell (RFH) 0207 794 0500 ext. 34150/ 34152 james.bell@royalfree.nhs.uk	Dr Peter Wylie (RFH) 0207 794 0500 ext. 34091 peterwylie@nhs.net
Histopathology	Dr Ian Clark ian.clark1@nhs.net	Prof Marco Novelli marco.novelli@nhs.net
Clinical Nurse Specialist	Amina Evans (RFH) 020 7472 6299 (Direct Line)/ 0207 794 0500 x 31940 bleep 712597 Amina.evans@nhs.net	Jacquie Peck (UCLH) 020 3447 9188 /07949 596391 jacquie.peck@uclh.nhs.uk jacquie.peck@nhs.net
MDT Co-ordinator	Kiri Freer (RFH) 020 794 0500 ext. 35829 kiri.freer@nhs.net	Jennifer Holland jenniferholland@nhs.net

***London Cancer* Anal Cancer MDT (East)**		
Role	**Core member/Cover**	**Core member/Cover**
Colorectal Surgeons	Mr S Banerjee 01708 504331 saswata.banerjee@bhrhospitals.nhs.uk	Mr M.A. Thaha 0203 594 1799 mathaha@bartshealth.nhs.uk

Clinical Oncology Radiotherapy	Dr Sherif Raouf **(*London Cancer* anal cancer MDT (East) lead clinician)** sherif.raouf@bhrhospitals.nhs.uk	Dr A Sibtain 020 76018350 Amen.Sibtain@bartsandthelondon.nhs.uk
Radiology	Dr J Gutmann 01708 435000 (Ext. 2843) Jacques.Gutmann@bhrhospitals.nhs.uk	No confirmed cover
Histopathology	Dr I Saeed 01708 435000 (Ext. 2812) Ibtisam.Saeed@bhrhospitals.nhs.uk	Dr Peter Tanner 01708 435000 (Ext. 2811) peter.tanner@bhrhospitals.nhs.uk
Clinical Nurse Specialist	Alison Ray 01708 435000 (Ext. 3876/Dect 6624) Alison.Ray@bhrhospitals.nhs.uk	Dianne Cook 0208 970 8042 diane.cook@bhrhospitals.nhs.uk
MDT Co-ordinator	Caroline Bruce 01708 435521 Caroline.Bruce@bhrhospitals.nhs.uk	Eleanor Flack 01708 435521 eleanor.flack@bhrhospitals.nhs.uk

North London Anal MDT extended membership		
Role	**Name**	**Contact**
Plastic Surgeon	Prof. Peter Butler (RFH) Mr Patrick Mallucci (RFH)	0207 794 0500 ext. 31302 0207 794 0500 ext. 38944
Gynaecologist	Dr Tim Mould	Tim.mould@uclh.nhs.uk
Radiotherapy Review Specialist	Yan Bramayanto	0207 794 0500 x 35627 bleep 2308 yan.bramayanto@nhs.net
Clinical Trials Nurse	Lorraine Hurl (NMH) Aderonke Adebiyi (RFH) Adoracion Jayme (UCLH)	Contact details needed 0207 794 0500 x 35590 Aderonke.adebiyi@nhs.net Adoracion.Jayme@uclh.nhs.uk
Liaison Psychiatrist	Dr Nora Turjanski (RFH)	Contact details needed
Clinical Psychologist	Sahil Suleman (UCLH)	Sahil.suleman@uclh.nhs.uk
Counsellor	Elaine Heywood (RFH)	0207 794 0500 x 35395 Elaine.heywood@nhs.net
Palliative Care	Philip Lodge (RFH)	philip.lodge@nhs.net
Nutrition/ Dietician	Jose Bennel (RFH) Kerri Stewart (UCLH) (UCLH)	0207 794 0500 x 38408 Jose.bennel@nhs.net Kerri.stewart@uclh.nhs.uk

East London anal MDT extended membership		
Anal Cancer Consultant	Mr Joseph Huang 01708 503184 Mr Sanjaya Wijeyekoon	joseph.huang@bhrhospitals.nhs.uk Sanjaya.Wijeyekoon@homerton.nhs.uk
Hepatobiliary	Mr A Abraham	020 73777439 Ajit.Abraham@bartsandthelondon.nhs.uk
Clinical Nurse Specialists	Kim Martin-Lumbard Marion Allison Anne Smart Luisa Price Waveney Stanford Lindsay Steward Veronica Winslow Noreen Chindawi	020 7377 7000 (Ext. 6317) Kim.Martin-Lumbard@bartsandthelondon.nhs.uk 020 73773155 Marion.allison@bartsandthelondon.nhs.uk 020 74764000 Anne.smart@newhamhealth.nhs.uk 020 85107852 luisa.price@homerton.nhs.uk 02085395522 Waveney.stanford@whippsx.nhs.uk 02085395522 Lindsay.steward@whippsx.nhs.uk 0203 594 1783 veronica.winslow@bartshealth.nhs.uk07960 384 641 Noreen.Chindawi@homerton.nhs.uk
HRA specialists	Dr M Nathan Dr A De-Masi Mr Sanjaya Wijeyekoon Miss Tamzin Cuming	Mayura.nathan@homerton.nhs.uk Anke.de-masi@homerton.nhs.uk Sanjaya.wijeyekoon@homerton.nhs.uk Tamzin.cuming@homerton.nhs.uk
Palliative Care	Bid Newport Tracey Wells	01708 435000 (Ext. 2082) Bid.Newport@bhrhospitals.nhs.uk 01708 435000 (Ext. 2081) Tracey.Wells@bhrhospitals.nhs.uk
Nominated Person for User Issues	Alison Ray	01708 503116 Alison.Ray@bhrhospitals.nhs.uk
Clinical Oncology Radiotherapy	Dr C Cottrill 020 76018350 Chris.Cottrill@bartsandthelondon.nhs.uk	

Appendix F: MDT roles and responsibilities

1. Responsibilities of the Anal Cancer MDT Lead Clinicians

- Agree and implement a strategic plan for developing consistent, high quality services across the ICS, in discussion with the Director of Cancer Services and Senior Management Team.
- To lead multi-professional and multidisciplinary team working, and ensure all health care professionals understand their personal responsibilities to work within published standards.
- To exercise accountability for the Anal Cancer Service. To engage in the work of the Pathway Board in developing protocols and guidelines, and agree pathways of clinical care.
- To develop and establish a minimum data set, analyse outcomes and encourage clinical audit activity.
- To set standards and goals to achieve accreditation by the peer review process.
- To set policy standards for the effective dissemination of information to patients.
- To highlight resource and other constraints to the Pathway Board Director and Executive of *London Cancer* if necessary.
- To encourage research opportunities and establish protocols for entering patients into clinical trials.
- Ensure co-ordination with Palliative Care services.
- To participate in discussions on trust-wide Cancer Services and Strategy.
- To support the CNSs and other members of the Anal Cancer Team, and encourage professional development.
- To attend and Chair the *London Cancer* Anal Cancer MDT meetings.
- Ensure each patient discussed has a clear treatment plan.

2. Responsibilities of the Anal Cancer MDT co-ordinator

- Liaising with Surgeons, Gastroenterologists, Oncologists, Radiologists, Histopathologists, HRA specialist and Secretaries when preparing for the weekly MDT meeting. To ensure that all relevant referral information and investigation results are available for the meeting.
- Ensure that the MDT form is completed and signed by the chairperson for each patient discussed and a copy is inserted into the patient's notes.
- To fax or e-mail written communication of the outcome of the MDT to the MDT coordinator and CNS at the referring trust, ideally on the day of the MDT or within 24 hours
- Track the patient pathway as per the 2 WW pathway

- Produce a breach report on all patients who have breached the 2 WW pathway, present it to the Lead Clinicians of the Anal Cancer MDT (North and East) and send the report to cancer services managers at referring and treating trust.
- An attendance record for every meeting will be kept by the MDT Co-ordinator. It is the responsibility of the individual members to sign the attendance record.
- Any patient on the list and not discussed (notes, films or results missing, lack of time) will automatically be added to the following week's list.
- The Co-ordinator collects/validates the dataset for waiting times.
- The Co-ordinator will input data for the Anal Cancer Audit.

3. Responsibility of the Clinical Nurse Specialist/Key Worker

The Key Worker Policy

The term key worker is new to Cancer Measures in 2004 (NICE). It can however be equated successfully to the "named nurse" concept although it does not strictly have to be a nurse. The following has been agreed:

- The key worker is a named clinician from the core membership of each operational tumour site-specific multi-disciplinary team.
- Each site-specific team will agree "who" the key worker is at an operational group meeting and /or a multi-disciplinary clinical meeting.
- The name of the key worker will be written on the MDT proforma
- All patients will be made aware of whom their key worker is and have the right to ask for another named clinician.
- The key worker will provide a contact number for all the patients for whom they act as the key worker.
- The key worker may not be any other person other than a health care professional.
- The key worker may be differing persons at various stages of the care trajectory

3.1 Responsibilities of the Key Worker

With the agreement of the patient, the Key Worker will:

- Ensure the named principal clinician is identified and made known at each stage of the patient's journey
- Act as the main contact person for the patient and carer at a specific point in the pathway.
- Offer support, advice and provide information for patients and their carers, accessing services as required.
- Ensure continuity of care along the patient's pathway and that all relevant plans are communicated to all members of the MDT involved in that patient's care.
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patients care.
- Ensure that when handover of Key Worker role is indicated, it is implemented in full consultation with the patient and carer and the patient is provided with revised contact details.
- Ensure that the next Key Worker has the appropriate information about the patient to fulfil the role.

- Support the patient in identifying their needs, review these as required and co-ordinate care using the Holistic Needs Assessment, accordingly.

- Liaise and facilitate communication between the patient, carer and appropriate health professionals and vice versa.

- Assist to empower patients as appropriate.

Other responsibilities include:

- Be present with the patient at time of diagnosis
- Be key worker for patient
- Coordination of the patient pathway in conjunction with MDT Coordinator
- Completion of end of treatment summary
- Provide patient information
- Holistic needs assessment
- Provide psycho-social support from pre-diagnosis onwards
- Ensuring GP is notified of diagnosis with 24 hours in conjunction with MDT Coordinator
- Attend MDT meetings as per peer review guidelines
- Education and training for people managing anal cancer patients
- Contributing to the MDT discussion and patient assessment / care planning decisions in the meeting
- Providing expert nursing advice and support to other health professionals managing anal cancer patients
- Be involved in clinical audit and research within the unit.

Appendix G: 2WW GP referral proforma

LONDON CANCER NORTH AND EAST

Suspected Colorectal Cancer 2ww Referral Form

For Choose and Book referrals, attach this template to a referral in Choose and Book within 24 hours of creating the request - an appointment must be made for the patient before they leave the practice.

Please X the corresponding box for the hospital the referral is being made to and fax/send within 24 hours.

☐ **Barnet** Fax: 020 8375 1977 Tel: 020 8370 9079	☐ **Chase Farm** Fax: 020 8375 1977 Tel: 020 8370 9079	☐ **BHRUT** Fax: 01708 435 074/ 01708 435 367 Tel: 01708 435 065	☐ **Barts & London** Fax: 020 594 3278 Tel: 020 767 3333
☐ **Homerton** Fax: 020 8510 7832 Tel: 020 8510 5099	☐ **Newham** Fax: 020 7363 8818 Tel: 020 7363 8817	☐ **North Middlesex** Fax: 020 8887 2663/4 Tel: 020 8887 2662	☐ **Princess Alexandra** Fax: 01279 827 171 Tel: 01279 827 550
☐ **Royal Free** Fax: 020 7433 2950 Tel: 020 7443 9757	☐ **UCLH** Fax: 020 3447 9932 Tel: 020 3447 9599	☐ **Whipps Cross** Fax: 020 8928 8836 Tel: 020 8535 6856	☐ **Whittington** Fax: 020 7288 5621/3793 Tel: 020 7288 3070

PATIENT DETAILS (Please complete in block capitals)	**GP DETAILS (Please complete in block capitals)**
Forename: **Surname:** **Address:** **Post code:** **Date of Birth:** / / **Sex:** M ☐ F ☐ **NHS Number:** **Has the patient previously visited the hospital?** **Y** ☐ **N** ☐ **Hospital Unit Number:**	**Date referral sent:** **Name of referrer:** **Address:** **Post code:** **Phone number:** **Fax number:** **Transport required: Y** ☐ **N** ☐ **Interpreter required: Y** ☐ **N** ☐ **Language:**
IMPORTANT: To be able to contact the patient within 48 hours of referral (day and evening), please provide patients preferred contact phone details	**Home:** **Daytime:**

REFERAL INFORMATION (Must be completed*)*

- ☐ **Rectal bleeding and looser stool and/or increased frequency* of ≥ 3 weeks duration (age 40 and over)**
- ☐ **Rectal bleeding without change in bowel habit with no obvious cause ≥ 3 weeks duration (age 50 years and over)**
- ☐ **Change of bowel habit (tendency to looser stools) persisting for 3 weeks or more without bleeding (age 50 years and over)**
- ☐ **Abdominal mass thought to be large bowel cancer (any age)**
- ☐ **Palpable rectal mass (any age)**
- ☐ **Males of any age with Hb ≤ 11g/100ml; Ferritin ≤30 mg/dL; MCV ≤ 79 iron deficiency picture**
  Hb Ferritin MCV
- ☐ **Non menstruating female with Hb ≤ 10g/100ml; Ferritin ≤30 mg/dL; MCV ≤ 79 iron deficiency picture**
  Hb Ferritin MCV
- ☐ **Other high clinical suspicion of colorectal cancer**

Duration of Symptoms: **Is patient fit for straight to test: Y** ☐ **N** ☐

Rectal examination - preferred for 2 week wait referrals with rectal symptoms
Findings:
Reason not performed:

Family History of cancer including age of their diagnosis:
Any other relevant symptoms not covered by the guidelines:

☐ **I confirm that I have discussed the possibility with the patient that the diagnosis may be cancer**

PLEASE INCLUDE WITH THIS PROFORMA PAST MEDICAL HISTORY, MEDICATIONS AND RESULTS AND YOUR REFERRAL LETTER IF APPROPRIATE

Guidance for all Colorectal Referrals

2WW Referral – Outpatients appointment within 2 weeks

- New rectal bleeding and / or change in bowel habit to looser stools in patients over 50 and in patients over 40 years of age if any of the following
  - Inflammatory bowel disease
  - Previous polyps
  - Family history (first degree relative with colorectal cancer before age 45)

- Iron deficiency anaemia without obvious cause
  - Men – HB ≤11, Ferritin ≤30 mg/dL
  - Non menstruating female – HB ≤10, Ferritin ≤30 mg/dL

- Palpable rectal or abdominal mass thought to be large bowel or anal in origin

Referral letters for these patients are required to be attached with the proforma. This does not have to be a written letter but will be a print out of the computerised patient records which includes PMH, drug history, allergies and blood results.

All ages
Definite, palpable, right sided, abdominal mass

Definite, palpable, rectal (not pelvic) mass

Unexplained iron deficiency anaemia
AND:
[ ] Male with a Hb of < 11g/dl
[ ] Non menstruating female with a Hb of < 10g/dl
GP MUST submit ferritin and Hb result.

Over 40 years
[ ] Rectal bleeding WITH a change of bowel habit towards looser stools &/or increased frequency ***³3 wks***

Over 50 years
Rectal bleeding persisting ***³3wks*** *WITHOUT a change in bowel habit or anal symptoms (e.g. soreness, discomfort, itching, prolapse, pain)*

Change in bowel habit to looser stools &/or more frequent stools persisting ***³3 wks*** *WITHOUT rectal bleeding*

Urgent Referral – Outpatients appointment within 4 weeks

- Previously diagnosed colorectal or anal cancer with new symptoms, please refer to the treating consultant unless the patient wishes to change hospitals then an urgent referral to them
- Patient with persistent low risk symptoms but with other worrying factors such as positive family history
- If the patient has had a Colonoscopy, CT colonography or CT Faecal tagging within 2 year which was normal refer as an urgent referral

Routine Referral – Outpatients appointment within 6 weeks

- Rectal bleeding with anal symptoms
- Rectal bleeding with obvious external visible cause such as prolapsed piles, rectal prolapse and anal fissures
- Abdominal pain not associated with other high risk symptoms such as iron deficiency anaemia, palpable abdominal or rectal mass or pain due to intestinal obstruction

NB: Please note that blood tests sent on a GP form will not be available on the hospital computer system at some hospitals therefore please send with the referral.

If you wish to discuss any clinical issues relating to this referral please contact:

Barnet Hospital	**Tel:** 020 8216 5446
Chase Farm Hospital	**Tel:** 020 8375 1981
Barking, Havering and Redbridge University Hospitals NHS Trust	**Cancer Referrals Office** **Tel:** 01708 435 065
Barts and the London Hospital	**Mr Shafi Ahmed;** *Consultant Colorectal Surgeon* **Tel** *via switchboard*: 020 3416 5000
Homerton University Hospital NHS Foundation Trust	**Ms Helen Pardoe;** *Consultant Colorectal Surgeon* **Tel:** 020 8510 7953
Newham University Hospital	**Kemi Fatukasi** *CNS* Tel: 020 7363 8187 *Switchboard*: 020 3416 5000
North Middlesex University Hospital NHS Trust	**Sue Williams** *Colorectal CNS* s.williams17@nhs.net
Princess Alexandra Hospital NHS Trust	**Colorectal CNS** **Tel:** 01279 827 182 *Mon- Fri: 0800-16.00*
Royal Free London NHS Foundation Trust	**Regina Raymond** *Colorectal CNS* **Tel:** 020 7794 0500 ext. 33923 - Bleep 1367 regina.raymond@nhs.net
University College London NHS Foundation Trust	**Jacquie Peck** *Colorectal and Anal Cancer CNS* **Tel:** 020 7380 9188 jacquie.peck@nhs.net