招待講演 1

PERIANAL AND ANAL CANAL NEOPLASMS

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For purposes of this presentation, the classification of histological typing of intestinal tumors used by the World Health Organization was adopted. The anal canal refers to the area above the dentate line while the anal margin the area below the dentate line.

I. ANAL MARGIN NEOPLASMS

- A. Squamous cell carcinoma
- B. Basal cell carcinoma
- C. Bowen's disease
- D. Perianal Paget's disease

II. ANAL CANAL NEOPLASMS

- A. Carcinoma (1. Squamous cell, 2. Basaloid (cloacogenic), 3. Mucoepidermoid, 4. Adenocarcinoma)
- B. Malignant Melanoma
- C. Sarcoma

Over the past decade there has been a major change in the treatment of anal carcinoma from what was once believed to be primarily an operative therapy to primarily a non-operative therapy. The various therapeutic options available for treatment are as follows:

1. LOCAL EXCISION-for patients with very small, well differentiated lesions, poor risk patients, or patients who refuse other therapy. Reported five year survival has ranged from 45% to 83%.

2. ABDOMINOPERINEAL RESECTION-the traditional form of therapy. Reported five year survival has ranged from 24% to 71%.

3. RADICAL RADIATION-Treatment with modern megavoltage external-beam radiation has resulted in a wide range of five year survival rates (18% to 79%). Treatment protocols for both dosage and duration differ from center to center. The series with the best survival rate may have included some anal margin carcinomas, which would favorably bias the results. The rates of serious complications (skin radiation necrosis, ulcerations, severe pain, fistulae, or sinus) following external-beam radiation depend on the radiation dosage and techniques and have generally been between 15 and 33 per cent. Minor complication rates have been reported as high as 33 per cent and major complications rates as high as 77 per cent.

4. COMBINATION CHEMOTHERAPY AND RADIOTHERAPY-proposed by Nigro et al, is the most frequently adopted form of therapy for anal canal carcinoma. In this protocol, 5-fluorouracil is given as a continuous intravenous infusion for 4 days, and mitomycin C as a single intravenous bolus injection, in conjunction with 3000 cGy of external-beam radiation to the pelvis. The 5-fluorouracil infusion is subsequently repeated 6 weeks following the end of radiation therapy. Toxicity is modest and complete regression rates have ranged from 27% to 100%. Projected 5 year survival rate is 83%.

5. INGUINAL LYMPH NODES-prophylactic groin dissection is generally not recommended. Subsequent lymphadenopathy is treated as it develops.

REFERENCES

- Nivatvongs S. Perianal and anal canal neoplasms. In: Gordon PH, Nivatvongs S. Principles and Practice of Surgery for the Colon, Rectum and Anus. Quality Medical Publishing, St. Louis, MO. 1992:401-17