Establishing A Regional Management Pathway for Peri-Anal and Anal Cancers and Pre-Cancers in a Moderate Prevalence HIV Setting

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Introduction

There is a rising incidence of anal cancer in the UK.¹ People living with HIV (PLWH) are at an increased risk of anal cancer and pre-cancer, and this is especially so amongst men who have sex with men (MSM). Sexual transmission of high risk Human Papilloma Virus (HPV), smoking and older age are contributing factors. Screening for anal cancer has not been found to be cost effective by some groups² and a wide difference in screening or testing methods exists nationally. BHIVA guidelines state centres should incorporate a pathway of managing suspected peri-anal and anal cancers and pre-cancers.³

Methods

Our aim was to collate data on current screening and referral methods for peri-anal and anal lesions within our region to guide establishing a regional management pathway. An online survey was sent to specialists involved in managing PLWH. This included trainees and Consultants in Infectious Disease and Genito-urinary medicine (GUM). They were asked the methods used, if any, in routine clinics for identifying PLWH with anal and peri-anal cancers and pre-cancers, and whether there was a local established management pathway.

Results

23 responses to the survey were received, largely from within GUM. 65% of respondents were Consultants. 33% of respondents stated that they regularly screened PLWH for peri-anal and anal lesions; the majority by enquiring about symptoms or carrying out proctoscopy examination, largely in men who have sex with men and PLWH with known anogenital warts. Only one Infectious Diseases specialist felt comfortable in using a proctoscope, and 67% of clinicians did not feel that they could be involved in the annual surveillance of peri-anal and anal intra-epithelial neoplasia.

References

- Cancer Research UK <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/anal-cancer/incidence#heading-Two> [Accessed May 2017]
- Czoski-Murray C, Karnon J, Jones R, Smith K, Kinghorn G. Cost-effectiveness of screening high risk HIV-positive men who have sex with men (MSM) and HIV-positive women for anal cancer. Health Technol Assess 2010;14(53).
- Fakoya A, Lamba H, Mackie N *et al* British HIV Association, BASHH and FSRH guidelines for the management of the sexual and reproductive healt of people living with HIV infevtion. HIV Medicine 2008;9(681-720)

Discussion

The results have supported the need for the implementation of a peri-anal and anal cancer and pre-cancer management pathway within our HIV regional network (see below), alongside further education and streamlining of screening within the region.

VIN / AIN pathway for North East & Cumbria HIV clinical network

January 2017

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This pathway applies to people living with HIV infection (please see alternative pathway to those attending sexual health who are HIV negative)

Some facts:

Anal cancer rates per 100,000 person /years (USA meta-analysis): 131 MSM HIV+, 46 other HIV+ men, 30 HIV+ women, 2 men without HIV, 0 women without HIV ¹.

50% of AIN III progress to anal cancer in people living with HIV, compared with 10% in immunocompetent ². It is recommended that ideally a couple of colorectal surgeons develop expertise to see AIN in each region ³.

Terminology used in this pathway:

PAIN refers to intraepithelial neoplasia that can be seen without use of a proctoscope (literature often calls this AIN)

AIN refers to intraepithelial neoplasia that is internal and can only be seen with a proctoscope

Proctoscopy refers to examination without use of colposcope- like facilities and aceto-white

Anoscopy refers to examination with the use of colposcope-like facilities and aceto-white (currently not available in north east)

Screening for rectal cancer / AIN / VIN:

BHIVA recommends patients should 'report lumps noted in the anal canal'. Primary screening with cytology and anoscopy is not recommended. HIV centres should