LOCALLY ADVANCED ANAL CANCER TREATED WITH RADIO-CHEMOTHERAPY AND REGIONAL DEEP HYPERTHERMIA. FOLLOW-UP DATA IN 13 PATIENTS

Dall'Oglio S.[1], Romano M.[1], Oliani C.[2], Palazzi M.[1], Grandinetti A.[1], Gabbani M.[1], Maluta S.[1]
[1]Radiotherapy Department, University Hospital of Verona, Italy, Telephone: +390458122478, E-mail: stefano_61@tiscali.it; [2]Medical Oncology Department, ULSS 5 Montecchio Maggiore, Italy

Background:

Locally advanced anal cancer is well treated with combined-modality treatment (CMT) - concomitant chemotherapy and radiotherapy -, with an overall survival (OS) at 3 years of 65% and 72% in the UKCCR and EORTC trials respectively, and a 5 years OS of 69% in the RTOG trial. Nevertheless, the percentage of patients that required colostomy after CMT was 23% and 10% in the UKCCCR and RTOG trials. Due to the good results of regional hyperthermia (HT) in rectal cancer, we wondered if adding HT in locally advanced anal cancer could improve the prognosis, avoiding salvage surgery.

Methods:

From December 2000 to May 2006, 13 patients (9 women and 4 men, median age 59, range 29 - 74) were referred to our Institution for locally advanced, biopsy proven, anal cancer. There were 11 squamous cell carcinomas, 1 adenocarcinoma, 1 small cell carcinoma. 10 patients were T3 N0 M0, one T3 N2 M0, one T3 N3 M0, one T4 N2 M0. No patients were HIV positive. CMT was delivered as follows: chemotherapy consisted of 5-FU (1,000 mg/m2 per day on days 1-4 and 29-33) and bolus mitomycin (10 mg/m2 on day 1 and 29), concomitantly with irradiation. Radiotherapy consisted of 62 Gy, with a 4-field box irradiation of the inferior pelvis (52 Gy in 2-Gy fractions, with a split of 2 weeks after the first 26 Gy), followed by a 10-Gy boost on tumour site. Inguinal and internal iliac nodal irradiation was performed in positive patients. Regional HT was performed once weekly, together with radiotherapy.

Results:

No HT-related toxicity was observed; one patient had a radiotherapy-induced grade-2 skin toxicity. Two patients underwent partial remission but after 4 and 6 months they relapsed, requiring surgery (abdomino-perineal resection). Two patients had complete remission, but after 6 - 12 months they had local, nodal and distant (bone/liver) relapse; they died after 1 - 2 years from the end of the treatment. Another patient (small cell cancer) had a no-change of the disease, and after 6 months she developed bone metastasis. The other 8 patients (62%) had a complete remission and are still in stable disease.

Conclusions:

CMT-HT was well tolerated. The presence of long-term survivors suggests us to keep HT in our treatment protocol.