Associazione Italiana Radioterapia e Oncologia clinica

Società Italiana di Radiobiologia

Discussione poster 1

A PATTERN OF CARE REPORT ON THE MANAGEMENT OF PATIENTS WITH SCC OF THE ANUS – A STUDY BY THE GASTROINTESTINAL STUDY GROUP OF AIRO (AIRO GI)

Pierfrancesco Franco MD, PhD, MPH candidate

Dipartimento di Medicina Traslazionale, Università del Piemonte Orientale, Novara

Dipartimento di Radioterapia Oncologica, AOU 'Maggiore della Carità', Novara

E-mail: pierfrancesco.franco@uniupo.it

@Pier_Franco_MD

ESTRO

EORTC Quality of Life Group

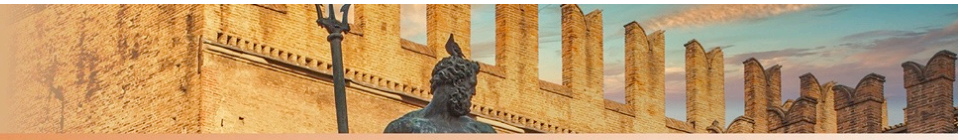
UPO UNIVERSITÀ DEL PIEMONTE ORIENTALE

ESO European School of Oncology

ESCO

Associazione Italiana Radioterapia e Oncologia clinica

Società Italiana di Radiobiologia



DICHIARAZIONE

Relatore: Pierfrancesco Franco

Come da nuova regolamentazione della Commissione Nazionale per la Formazione Continua del Ministero della Salute, è richiesta la trasparenza delle fonti di finanziamento e dei rapporti con soggetti portatori di interessi commerciali in campo sanitario.

- Posizione di dipendente in aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE)**
- Consulenza ad aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE)**
- Fondi per la ricerca da aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE)**
- Partecipazione ad Advisory Board **(NIENTE DA DICHIARARE)**
- Titolarità di brevetti in compartecipazione ad aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE)**
- Partecipazioni azionarie in aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE)**
- Altro

To survey clinical practice in SCC on the anus in Italy

3. Results

Among the 165 RT departments documented in Italy by AIRO (as per 2018), a total of 71 centres (43%) participated in the present survey. Among them, 58 participants (82%) fully completed the questionnaires and their answers were considered for the current analysis. Detailed characteristics of the participants and centres can be found in Table 1. Most of the respondents work in public and/or university hospitals (75.8%), in the northern part of the country (65.5%). The clinical experience of the paticipants was almost equally split between below (48.3%) and above (51.7) 10 years. The vast majority of the centres (88.0%) treats less than 20 anal cancer patients per year.

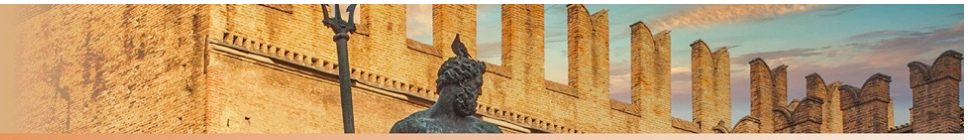
Table 1. Characteristics of the participants and centres.

Radiotherapy facility	N(%)
Public	30 (51.7)
Accredited private hospital	7 (12.1)
University Hospital	14 (24.1)
Accredited cancer center (IRCCS)	7 (12.1)
Operating region in Italy	
Northern Italy	38 (65.5)
Center Italy	13 (22.4)
Southern Italy	7 (12.1)
Years of experience in RT	
<5	10 (17.2)
5-10	18 (31.1)
11-15	9 (15.5)
>15	21 (36.2)
Anal cancer patients treated/year	
<10	23 (39.7)
11-20	28 (48.3)
21-30	6 (10.3)
>30	1 (1.7)
MDT dedicated to anal cancer	
Yes	54 (93.1)
No	4 (6.9)

Legend: N: number; IRCCS: Istituto di Ricovero e Cura a carattere scientifico; RT: radiotherapy; MDT: Multidisciplinary Team.

Staging examinations (multiple answers allowed)	N(%)
Rigid anal-rectal endoscopy	49 (84.5)
Colonoscopy	30 (51.7)
GYN evaluation + colposcopy	13 (22.4)
Contrast-enhanced CT scan (thorax-abdomen)	50 (86.2)
Pelvic MRI	56 (96.5)
Whole-Body ^{18}FDG-PET	39 (67.2)
Endoscopic ultrasound	19 (32.8)
Attitude towards pelvic MRI at diagnosis	
Mandatory	50 (86.2)
Optional but useful	6 (10.3)
Second-level exmination	2 (3.5)
Useless	0 (0)
Attitude towards ^{18}FDG-PET at diagnosis	
Mandatory	22 (37.9)
Optional but useful	20 (34.5)
Second-level examination	16 (27.6)
Useless	0 (0)
Inguinal biopsy/fine needle aspiration of suspicious node	
Always	3 (5.2)
Only if clinically palpable lymph node detected on CT (size >1 cm) and ^{18}FDG-PET avidity	1 (1.7)
Only in case of clinically palpable lymph node detected on CT (size >1 cm) and borderline ^{18}FDG-PET avidity	30 (51.7)
Only in case of clinically palpable lymph node detected on CT (size >1 cm) without ^{18}FDG-PET avidity	5 (8.6)
Never	19 (32.8)
HIV screening (on blood or saliva)	
Always	29 (50.0)
Sometimes	16 (27.6)
Only in case of risk factors	7 (12.1)
Never	6 (10.3)
(HPV) p16 IHC detection on biopsy specimen	
Always	34 (58.6)
Sometimes	21 (36.2)
Only in young patients	0 (0)
Only in clinical trials	3 (5.2)
Never	0 (0)
Role of the multidisciplinary team	
Standard approach for all patients	51 (87.9)
Necessary only in selected cases	5 (8.6)
Not applicable to my clinical practice	2 (3.5)

Legend: N: number; GYN: gynaecological; CT: computed tomography; MRI: magnetic resonance imaging; FDG-PET: fluorodeoxy-glucose-positron emission tomography; HIV: human immunodeficiency virus; HPV: human papilloma virus; IHC: immunohistochemistry.



Results - 1

Imaging for GTV definition (both primary tumor and lymphnodes) (multiple answers allowed)	N (%)
Planning CT	8 (13.8)
Pelvic CT	19 (32.8)
Pelvic MRI	52 (89.7)
^{18}FDG-PET	45 (77.6)
RT delivery technique (multiple answers allowed)	
3DCRT	0 (0)
IMRT	10 (17.2)
Volumetric IMRT	52 (89.7)
Tomotherapy	12 (20.7)
MRgRT	0 (0)
Primary tumor boost (multiple answers allowed)	
EBRT - Sequential boost	26 (44.8)
EBRT - SIB	49 (84.5)
EBRT - Electrons	2 (3.4)
Endocavitary or Contact BRT	3 (5.2)
Interstitial BRT	4 (6.9)
Treatment after local excision for T1N0 tumor with risk factors	
Exclusive RT with definitive dose	21 (36.2)
RT-CHT with RT dose de-escalation	13 (22.4)
RT-CHT with definitive RT dose	17 (29.3)
RT with dose de-escalation	2 (3.5)
Others	5 (8.6)
RT dose to primary tumor GTV for T1-T2 tumors (dose range) (multiple answers allowed)	
45-45.9 Gy	2 (3.5)
50-50.4 Gy	27 (46.5)
54-55 Gy	34 (58.6)
56-59.4 Gy	7 (12.1)
≥ 60 Gy	4 (6.9)
RT dose to primary tumor GTV for T3-T4 tumors (dose range) (multiple answers allowed)	
53 Gy	1 (1.7)
54-55-5 Gy	36 (62.1)
56-59.4 Gy	19 (32.8)
≥ 60 Gy	13 (22.4)
Dose to elective volumes (multiple answers allowed)	
30.6 Gy	1 (1.7)
36-37.5 Gy	2 (3.5)
42-42.5 Gy	5 (8.6)
45-45.9 Gy	55 (94.8)
49.5 Gy-50.4 Gy	11 (18.9)
> 54 Gy	3 (5.2)
Dose to involved nodes (sized < 3 cm) (multiple answers allowed)	
40 Gy	1 (1.7)
45 Gy	1 (1.7)
50-51 Gy	34 (58.6)
52-53.2 Gy	6 (10.3)
54-56 Gy	19 (32.8)
59-59.4 Gy	2 (3.5)
≥ 60 Gy	4 (6.9)
Dose to involved nodes (sized > 3 cm) (multiple answers allowed)	
45 Gy	1 (1.7)
50-50.4 Gy	4 (6.9)
52-52.5 Gy	2 (3.5)
54-56 Gy	50 (86.2)
59-59.4 Gy	3 (5.2)
≥ 60 Gy	5 (8.6)

Legend: N: number; GTV: gross tumor volume; RT: radiotherapy; CT: computed tomography; MRI: magnetic resonance imaging; ^{18}FDG-PET: fluorodeoxyglucose-positron emission tomography; 3DCRT: 3-dimensional conformal radiotherapy; IMRT: intensity modulated radiotherapy; MRgRT: magnetic resonance guided radiotherapy; EBRT: external beam radiotherapy; SIB: simultaneous integrated boost; BRT: brachytherapy; CHT: chemotherapy.

Table.4 Combined modality treatment

CHT regimens concurrent to RT	N(%)
5FU-MMC	41 (70.6)
5FU-CDDP	3 (5.2)
Cape-MMC	11 (19.0)
Cape-CDDP	1 (1.7)
Others	2 (3.5)
Number of MMC cycles in case of 5FU-MMC or Cape-MMC	
1 cycle (week 1 of RT)	9 (15.5)
2 cycles (week 5-6 of RT)	47 (81.0)
Other	2 (3.5)
MMC dose in case of 5FU-MMC or Cape-MMC (1 MMC cycle)	
10 mg/m^2	21 (80.7)
12 mg/m^2	2 (7.8)
10-12 mg/m^2	3 (11.5)
MMC dose in case of 5FU-MMC or Cape-MMC (2 MMC cycle)	
10 mg/m^2	31 (91.2)
12 mg/m^2	1 (2.9)
10-12 mg/m^2	2 (5.9)
Screening for DPYD genotype	
Yes	46 (79.3)
No	12 (20.7)
Use of Cape concurrent to MMC or CDDP and RT	
Standard of care (daily practice)	20 (34.4)
Investigational (within clinical trial only)	4 (6.9)
Upon patient's preference or in case of challenges for CVC placement	32 (55.2)
Other	2 (3.5)
Use of CDDP as alternative to MMC concurrent to 5FU or Cape and RT	
Equivalent to MMC	8 (13.8)
Inferior to MMC	8 (13.8)
Only in case of clinical contraindication to MMC	41 (70.7)
Other	1 (1.7)
Use of induction chemotherapy	
Standard	1 (1.7)
Not standard	19 (32.8)
Only in case of extensive pelvic involvement or extra-pelvic disease	38 (65.5)
Other	0 (0)
Use of consolidation CHT after RT-CHT	
Standard	0 (0)
Not standard	44 (75.9)
In case of high-risk disease (locally advanced tumors with nodal involvement)	11 (18.9)
Other	3 (5.2)
CHT regimen for induction CHT	
5FU-CDDP	33 (56.9)
5FU-MMC	17 (29.3)
Other	4 (6.9)
None	4 (6.9)
CHT regimen for consolidation CHT	
5FU-CDDP	4 (6.9)
5FU-MMC	3 (5.2)
Other	4 (6.9)
None	47 (81.0)
Type of definitive RT-CHT in HIV+ve patients submitted to HAART	
Standard CHT-RT	12 (20.7)
Standard CHT-RT in patient with normal CD4+ve count	23 (39.6)
Standard CHT-RT in patient with normal CD4+ve count and undetectable viral RNA	12 (20.7)
CHT dose reduction	4 (6.9)
Use of alternative CHT regimens (i.e. CDDP over MMC)	7 (12.1)
Standard first-line chemotherapy for advanced or metastatic disease	
CDDP-5FU	36 (62.0)
CBDCA + Paclitaxel	19 (32.8)
(Modified) Docetaxel + CDDP + 5FU	3 (5.2)

Legend: N: number; CHT: chemotherapy; RT: radiotherapy; 5FU: 5-fluorouracil; Cape: capecitabine; MMC: mytomicin C; CDDP: cisplatin; Mg: milligrams; M^2: square meters; DPYD: dihydropyrimidine dehydrogenase; CVC: central venous catheter; HIV: human immunodeficiency virus; +ve: positive; HAART: highly active antiretroviral therapy; CD4: cluster of differentiation 4; RNA: ribonucleic acid; CBDCA: carboplatin.

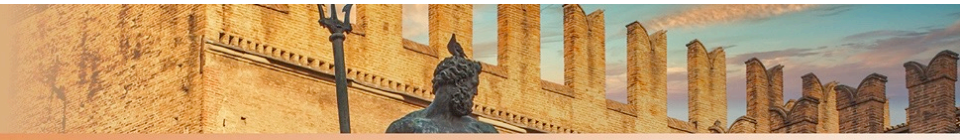
Results - 2

Table 5. Response assessment, salvage therapies and follow up.

Optimal timing for restaging after the end RT-CHT	N(%)
8 weeks	6 (10.3)
3 months	10 (17.2)
6 months	20 (34.6)
> 6 months	5 (8.6)
26 weeks	17 (29.3)
Imaging examination for restaging after RT-CHT (multiple answers allowed)	
Abdomino-pelvic contrast-enhanced CT scan	26 (44.8)
Pelvic contrast-enhanced MRI	53 (91.4)
^{18}FDG PET-CT	34 (58.6)
Abdominal US	20 (34.5)
Bioptic evaluation for response assessment	
Always	2 (3.5)
Only if persistent disease is suspected or a residual scar is present	16 (27.6)
Only if persistent disease is suspected	31 (53.4)
I decide according to tumor clearance during RT-CHT	9 (15.5)
Never	0 (0)
Opinion about salvage surgery for recurrent/persistent disease	
Always curative	14 (24.1)
Curative in about half of patients	7 (12.1)
Never curative	0 (0)
My opinion is normally validated by tumor board	36 (62.1)
Other	1 (1.7)
Treatment for local relapse	
Exclusive surgery when feasible	54 (93.0)

Re-irradiation + CHT with palliative intent	0 (0)
Exclusive CHT	2 (3.5)
Re-irradiation + pre-operative CHT + eventual surgery	2 (3.5)
Management of late toxicity in long-term survivors	
Done by the radiation oncologist	35 (60.3)
Done by other specialists (medical oncologist, surgeon)	2 (3.5)
Based on tumor board management	21 (36.2)
Follow up timing	
Every 3 months for the first 5 years	1 (1.7)
Every 6 months for the first 5 years	2 (3.5)
Every 3 months for the first year then every 6 months for the next 4 years	18 (31.0)
Every 3 months for the first 2 years then every 6 months for the next 3 years	35 (60.3)
Other	2 (3.5)

Legend: N: number; RT: radiotherapy; CHT: chemotherapy; CT: computed tomography; MRI: magnetic resonance imag-



medicina

MDPI

Article

A Pattern of Care Report on the Management of Patients with Squamous Cell Carcinoma of the Anus—A Study by the Italian Association of Radiotherapy and Clinical Oncology (AIRO) Gastrointestinal Tumors Study Group

Pierfrancesco Franco [1,2,*], Giuditta Chiloiro [3], Giampaolo Montesi [4], Sabrina Montrone [5], Alessandra Arcelli [6,7], Tiziana Comito [8], Francesca Arcadipane [9], Luciana Caravatta [10], Gabriella Macchia [11], Marco Lupattelli [12], Marina Rita Niespolo [13], Fernando Munoz [14], Elisa Palazzari [15], Marco Krengli [1,2], Francesca Valvo [16], Maria Antonietta Gambacorta [3], Domenico Genovesi [10,17] and Giovanna Mantello [18]

Thanks for your attention

Pierfrancesco Franco MD, PhD, MPH candidate

Dipartimento di Medicina Traslazionale, Università del Piemonte Orientale, Novara

Dipartimento di Radioterapia Oncologica, AOU 'Maggiore della Carità', Novara

E-mail: pierfrancesco.franco@uniupo.it

twitter @Pier_Franco_MD

On behalf of AIRO GI Study Group