Letter to the Editor

Anal Squamous Cell Carcinoma: An Infrequent Challenge in the Management of Ulcerative Colitis Under Combination Therapy

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Ulcerative colitis [UC] patients have a known higher risk for development of colorectal cancer than the general population. 1 Anal squamous cell carcinoma [ASCC] is an infrequent tumour, with an incidence of approximately 1–2/100,000 among inflammatory bowel disease [IBD] patients. 2,3 The incidence seems higher in Crohn’s disease [CD] than in UC. Fistulas and chronic wounds in perianal CD tend to be a risk factor for the development of ASCC, as are smoking, infection with human papilloma virus [HPV] and immunosuppression. 4

We recently saw a 70-year-old lady with a previous diagnosis of UC [proctosigmoiditis] for 10 years. She was referred to our unit to initiate biological therapy, being refractory to conventional therapy. Infliximab [IFX] therapy was indicated [regular dosing and intervals, in combination with azathioprine 2.5 mg/kg/day], and after induction she still presented with moderate-to-severe UC [partial Mayo score of 7], without additional features at rigid proctoscopy. After 6 months, in a colonoscopy that aimed to check for mucosal healing, a 2.5-cm nodular mass that was not identified before biological therapy was palpated in the upper anal canal. Biopsies and immunohistochemistry confirmed the diagnosis of ASCC. She had no inguinal lymph nodes, and radiological tests demonstrated absence of metastatic disease. The patient had previous episodes of faecal incontinence to gas and liquid stool.

After multidisciplinary discussion, the patient underwent a total proctocolectomy and end ileostomy [Figure 1A], following oncological principles [extra-sphincteric proctectomy]. Histology demonstrated extensive inflammation of the rectum and left colon, and an ASCC of 2.5 cm [Figure 1-B, C] with T2N1M0 staging. No postoperative complications were observed, and complete perineal healing was achieved after 6 weeks.

A systematic review described 33 cases of ASCC in IBD patients [7 in UC and 26 in CD]. 2 Perianal fistulising CD can facilitate chronic HPV infection in addition to immunosuppression, and that is probably the reason for ASCC being more frequent in CD than in UC. 2,3,4 Regarding surgical therapy, most of the cases described were treated similarly; primary surgical resection and neoadjuvant therapy [radiotherapy and chemotherapy] are reserved for larger tumours. The patient had no indications for a pouch procedure, due to poor sphincter function. Regarding the risk factors previously described, our patient was a non-smoker and had no previous HPV infection. That means that immunosuppression with combination therapy [IFX and azathioprine] was the only known risk factor for the development of the tumour.

Although infrequent, ASCC can represent a challenge in clinical practice in the management of UC, mainly in patients under immunosuppression. Repeated rectal examinations and special attention are key to early diagnosis and adequate treatment. Surgical therapeutic options should be individualised, and not always is a sphincter-preserving operation indicated.

Figure 1. Surgical specimen and histology of the anal squamous cell carcinoma. A: Specimen of total proctocolectomy with inflamed left colon and rectum. B: Anal squamous cell carcinoma of the upper anal canal, and inflamed rectum. C: Histological features of the anal squamous cell carcinoma.
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