5 Initial Presentation, Evaluation and Management of Acute Anorectal Malignancies

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Unfortunately, malignancies of the anorectum are rising in incidence (Fig. 5.1). Therefore, it is fairly common for providers to encounter them in their practice. If discovered by a primary care physician, patients are often referred to gastroenterology, surgery, and/or oncology either sequentially or simultaneously. It is important that surgeons are invested in the relationships with referring colleagues, to inform them about why surgeons prefer to see the patient early in the discovery of their diagnosis. Surgeons have a unique role in the care of rectal and anal cancers, as they are typically at the center of the care plan (Fig. 5.2). The responsibility which lies with surgeons is twofold: (1) determining if upfront resection is the best option and (2) tracking the response to multimodality therapy.

Additionally, the surgeon may be the patient's *only* provider that will perform and document the three-part exam of the anorectum: (1) external exam, (2) digital anorectal exam (DARE), and (3) anoscopy/sigmoidoscopy.

In terms of presentation in the urgent or emergent setting, it is actually *not* common for anorectal malignancies to present acutely. In general, these are slow-growing lesions, and when they originate in a location superior to the dentate line, they are usually insensate. The built-in physiology of the rectum allows for small distensions to be accommodated for with corresponding rectal wall relaxation. In other words, if there was sudden distension of the rectum, the patient would immediately feel it and perhaps perceive it as pain. But when there is slow growth of a tumor over time, the natural adaptive mechanisms of accommodation are triggered, and these lesions are usually not perceived at all. Instead, the patient will present with symptoms of difficult defecation. This can be characterized by tenesmus, fullness, pelvic pressure, or, more generally, constipation. It is critical to keep in mind that many patients also harbor tremendous embarrassment and sometimes even self-blame. Many attribute their changes in bowel habits to self-deprecating comments about their "bad diet," and the like.

Sometimes, if an external lesion is felt by the patient directly or suspected to be present (often patients will avoid touching or looking at their perineum, so they may not even realize), then that may trigger further embarrassment for the patient. They will often refer to their issue as "My hemorrhoids are flaring up again," and this kind of dismissal of their problem as something that is common in the general public. If patients down-play their issues, chronically, it can lead to delays in seeking medical attention. Ultimately, when they reach a point of intolerability, they

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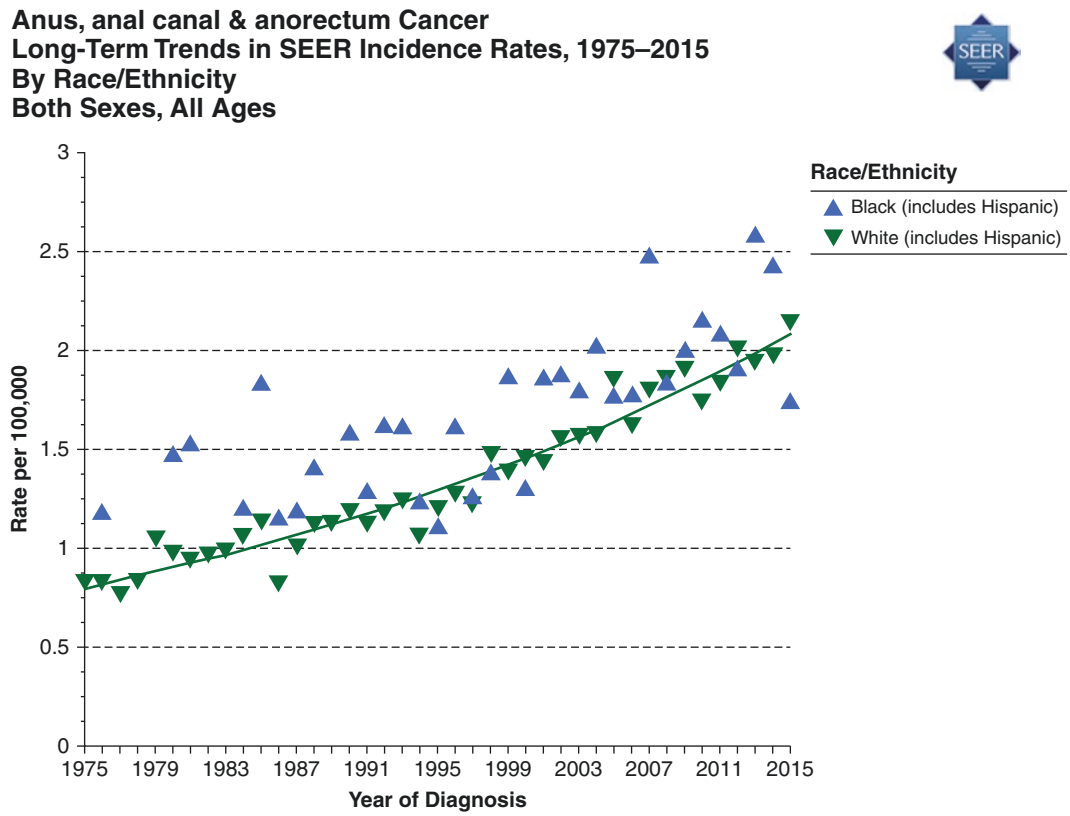

Fig. 5.1 Long-term incidence rates of cancers of the anus, anal canal, and anorectum. SEER incidence of anal cancer (triangle) over the past 20 years

may present to the urgent care setting or the emergency room setting with bleeding, discomfort, or a mass.

The Importance of Compassionate Care During the Active/Participatory Anorectal Exam

As providers, the acute part of the patient's presentation is this: *providers* need to be *acutely* sensitive to the patient's psychological state and fragility. It is of utmost importance that when an exam is performed, the patient feels cared for and reassured and that no comments about our observations (or surprise!) are made to the patient during the exam. Asking questions or giving instructions during the exam is a great way to avoid the natural tendency to say "Oh, my!" or "Wow!". Even if providers are amazed by what they see/feel upon turning the patient, they must refrain from making these kinds of side comments that would cause the patient further embarrassment or undue fear.

The following is a description of an active/participatory anorectal exam. The provider should examine patients in the left lateral Sim's position (Fig. 5.3). Start by resting the left hand on the patient's hip, so the patient won't be alarmed by the initial touch. Then, ask the patient to reach around and hold up their right gluteus. Having the patient's own hand present in that area is reassuring to them. At that point, the provider places their right hand on top of the patient's right hand, again, trying to prevent them from flinching and tensing. Ultimately, the provider needs to come down to the anal area and use their index finger and thumb in opposing directions to spread the external anal canal to see if there are any protrusions. The prone jackknife position (sometimes referred to as the knee-chest position) can cause tremendous suffering in patients who are already fearful of what may be discovered. This position can also detract from a good exam when Valsalva is needed.

The physical examination can be performed with the team member (nurse, student, or resident) and surgeon together. Usually, this will be the abdominal examination, digital rectal examination, anoscopy, and, if available, sigmoidoscopy. To explain why so many people are involved, say "It's good to have multiple sets of eyes on this so we don't miss anything" or "I'm going to need a hand with some of the instruments and your positioning so I have a few helpers." For male physicians, it is often good practice to have a female member of the team present during the pelvic and anorectal exams of women patients. A team-oriented physical examination also helps to sell the care team as a competent unit.

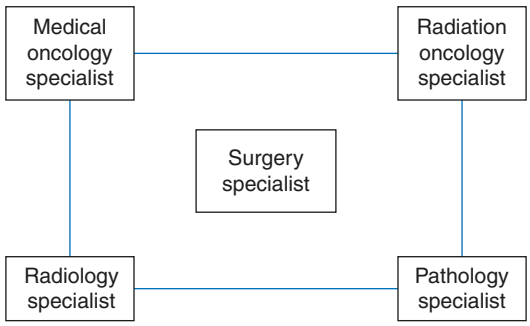

Fig. 5.2 Multidisciplinary team members who assess patients in need of rectal cancer treatment

Patients do not like to be exposed, so try to position the table so that the patient's head faces the door. Consider installing a curtain to be drawn in front of the exam room door. Patients feel vulnerable not being able to see what the care provider is about to do. Talk the patient through every part of the examination. Have them concentrate on motions of the muscles in the area. This actually helps them relax. For example, watch them squeeze the anal muscles. When the patient can elicit a squeeze on command, it is easier for them to then do the opposite motion (relax). Next, have them bear down against a cupped, gloved hand before performing any internal exams. Often, lesions will protrude past the anal canal when the patient bears down. Bearing down (Valsalva) is extremely difficult for a patient to do in the prone jackknife position, which is why the lateral Sim is preferable. If something prolapses, it gives you a sense of what to expect on digital.

About the digital exam: predict and verbalize what the patient may experience and give a warning that a finger is entering the anus or vagina. If a speculum or anoscope is an important part of the examination, then estimate and verbalize the size of the instrument relative to the provider's

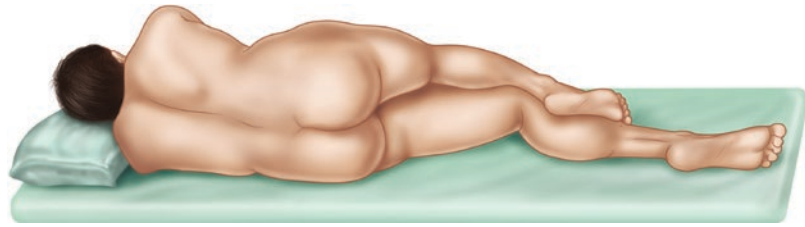

Fig. 5.3 Left lateral Sim's position

finger. Let the patient know that if they experience an urgency to defecate, it is a normal response. Remind them not to move if a cramp occurs.

If pain is elicited with the exam, perform the painful examination only once. If there is no perception of pain, the step may be repeated by another examiner, with the introduction "you are going to feel another finger now." Depending upon the working diagnosis, pain may be predicted with some manipulations. Some exams will not be painful. In any case, an effort to minimize pain will endear you to your patient. For example, lubricate the finger or instrument liberally and be gentle. If you see an obvious fissure (crack in the anoderm in the posterior or anterior midline), do not feel obligated to perform a digital rectal examination or anoscopy on the first visit.

Another tip: sometimes, asking the patient to push out against your finger not only relaxes the muscles but also gives the patient an action to focus on so that he or she won't immediately tense up when sensing your hand nearby.

Comprehensive Documentation of the Examination of the Patient with a Suspected Anorectal Malignancy

In addition to the abdominal exam, noting liver size, abdominal girth, pain, and masses, a groin exam must also be included and is best tracked if documented as a separate line item (i.e., under groin or lymphatics). In terms of timing of the exam, palpating for inguinal lymph nodes can usually be undertaken as part of the abdominal exam when the patient is in the standing and supine positions. Malignancies in the lower rectum and anus can frequently metastasize to these areas.

Table 5.1 lists a suggested order of the awake outpatient exam for suspected anorectal malignancy.

When a provider encounters a lesion, care should be taken to note its size, laterality, and location relative to the anal canal. Annotations should be easily *reproducible*. Colorectal surgical specialists prefer anatomical terms: anterior,

Table 5.1 Suggested order of the awake outpatient visit for suspected anorectal malignancy

Clinical component of visit	Documentation should detail
Focused history	Changes in Weight Constitution Stool habits or caliber Appetite Pelvic pressure or pain Presence of bleeding (related to defecation) Abdominal bloating Personal endoscopic history Family history, family endoscopic history
Clinical exam – part 1 (ok for patient to remain clothed)	Cervical nodes Heart/lung sounds Abdominal palpation Groin palpation
Clinical exam – part 2 (patient needs to be undressed from waist down)	Repeat abdominal exam, looking for scars Repeat groin exam, feeling for inguinal lymph nodes Anorectal exam (see Table 5.2) Administration of enema (if needed)
Anoscopic/office endoscopic exam	Anoscopy (see Table 5.2) Endoscopy, rigid vs. flexible (note distance, laterality)
Patient counseling (best if patient gets redressed and family is with patient)	Next steps Acquisition of tissue and imaging Multidisciplinary team meeting (tumor board presentation) Return to office for discussion of clinical plan

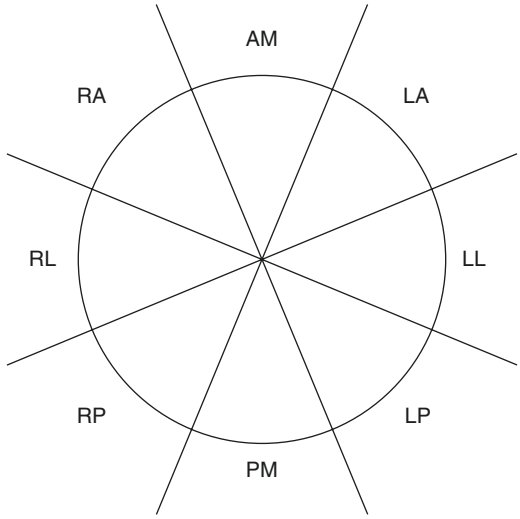

Fig. 5.4 Octants of the anorectal exam. A or AM anterior or anterior midline, LA left anterior, L or LL left or left lateral, LP left posterior, P or PM posterior or posterior midline, RP right posterior, R or RL right or right lateral, RA right anterior

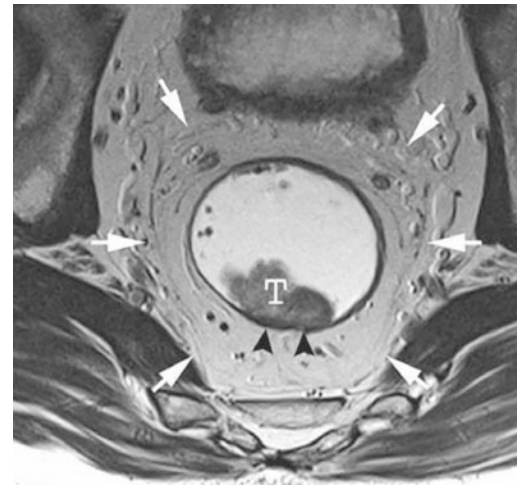

Fig. 5.5 High-resolution MRI image through polypoid rectal adenocarcinoma (labelled T) invading the submucosa but sparing the muscularis propria (T2 tumor). The dark signal along periphery of the rectum (black arrowheads) at the site of the tumor indicates that the tumor has not invaded the muscularis propria. The mesorectal fascia (white arrows) demarcates the mesorectal fat surrounding the rectum

posterior, left, and right. Further divide the anorectum into octants (Fig. 5.4). The "o'clock" designations are only helpful if the patient's position is clearly *and repeatedly* noted (i.e., prone jackknife, lateral decubitus – left or right), so therefore, they are vulnerable to confusion.

When conducting and documenting a lesion in a woman, estimate the size of the perineal body. A provider can get in the habit of doing this in a quick and reproducible way if they are familiar with their own finger's measurements. For example, if the distance from the tip of the thumb to the first knuckle is approximately 2.5 cm, it can be easily documented that a woman's perineal body is approximately 2 cm. When it is less than 2 cm, the provider may worry about and counsel her on having issues with compromise and thinning after chemoradiation. When palpating a lesion that is in the mid- or upper rectum, knowing the finger's measurements is also helpful for the reproducibility of the exam. Providers can annotate it and relate it to referring providers as such: "With my size-6-gloved index finger, I can feel the distalmost aspect of the lesion, but only on Valsalva." This may help guide the radiologist in their role of staging the patient. The best way to stage rectal cancers is by obtaining high-resolution magnetic resonance imaging (MRI) with modern phased array coil which uses specialized sequencing and planning. If oriented to depict surrounding structures relative to the tumor location, then the bowel wall layers can be more easily differentiated (Fig. 5.5). When a radiologist knows where to expect the tumor (based on your clinical description on the radiology order form [Fig. 5.6]), it can reduce healthcare costs.

Lastly, in the clinical documentation, give reference to the patient's resting anal tone and squeeze tone (absent, mild, moderate, strong). These components of the exam are critical to note in this initial evaluation because things may change after surgery or chemoradiation therapy. Table 5.2 lists the essential components of the documented clinical exam for a patient with a suspected anorectal malignancy.

Radiology Imaging Request Form

URGENCY __ Routine __ Emergent __ Sedated MRI MRN _____ Date _____

__ Suggested time frame: ___within a week, and prior to next GI tumor board_____

__ Do you need results read urgently? __ Patient to hand carry disk (CD)?

Patient Name _____ DOB _____ / _____ / _____

Phone Number _____ Can detailed message be left? __ Yes __ No

Patient Height _____ Patient Weight _____ LMP _____ / _____ / _____

Imaging Requested (please be specific):

1st Imaging Request	Diagnosis code (ICD)	History/Symptoms
CT Scan of chest, abdomen and thorax	C20 Rectal Cancer	Newly diagnosed Rectal CA in a smoker, please r/o distant mets
2nd Imaging Request	Diagnosis code (ICD)	History/Symptoms
MRI of pelvis Rectal cancer protocol	C20 Rectal Cancer	Anterior location, 8 cm from anal verge, ~ 3 cm in size, mobile mass relative to prostate
3rd Imaging Request	Diagnosis code (ICD)	History/Symptoms

Ordering Provider (First/Last/Title) _____

Clinic Name _____ Specialty _____

Clinic Contact _____ Tax ID Number _____

In the event a radiologist needs to relay results urgently, please provide an emergency/after-hours contact number:

Emergency Number _____ Daytime Number _____ Fax Number _____

Do results need to go to someone other than the ordering provider? If so, please complete the following information:

Provider Name _____ Clinic/Specialty _____

Phone Number _____ Fax Number _____

Is the patient scheduled? If yes, please provide location and date: _____

Important: Incomplete or illegible forms will be returned, resulting in a delay of scheduling for patient.

Routine Exams: Routine exams are generally processed within 48 hours. Patients will be contacted to schedule after that time.

Urgent Exams: If imaging study is needed within three business days, fax the quest form, notating "emergent." The order will be processed within 24 hours; the patient will be contacted to schedule the exam. PROVIDERS: If the patient has not been contacted within 24 hours after the fax has been sent, please contact the Radiology Appointing Center.

All MRI requests must be accompanied by a completed MRI Questionnaire.

Provider Signature: _____

Fig. 5.6 Sample radiology order form for MRI rectal cancer protocol

Table 5.2 Essential components of the anorectal clinical exam for a patient with a suspected anorectal malignancy

Documentation of anorectal exam	Questions to consider during the exam and to document
External exam	1. Quality of skin/hygiene 2. Presence of blood 3. Presence of extruding masses or fissure 4. Appearance of the anus at rest (some patients will have a patulous anus, meaning that the anus is open at rest, and the rectal vault is seen) 5. Action of muscles on command to squeeze 6. Sensitivity of external area to light touch 7. Valsalva against cupped hand. Does anything protrude or prolapse? If so, does the protrusion/prolapse reduce spontaneously?
Digital anorectal exam (DARE)	1. Finger dilation of the anus and lubrication of the anus in preparation for anoscopy 2. Resting tone, squeeze tone (weak, normal, strong) 3. Any masses/ulcers/polyps palpated? (note size, distance, and laterality) 4. Perform a DARE again during a Valsalva 5. Presence of blood on finger 6. Presence of impacted stool (if stool is present, administration of enema to aid anoscopy)
Anoscopy	1. Quality of rectal mucosa 2. Visibility of dentate line and anal transition zone 3. Accessibility of lesion (if lesion is present) to awake tissue acquisition (biopsy) 4. Documentation of size, distance, and laterality (if possible) 5. Presence and character of blood/mucous

The Role of Endoscopy at Initial Presentation

If a new lesion is discovered in the anorectum, the next part of the patient's work-up usually involves scheduling them for a colonoscopy and/or exam under anesthesia. However, proctoscopy can be performed in the office or in the urgent care setting as a same-encounter experience. In order for the provider to choose the next best step on the work-up algorithm (Fig. 5.7) and to distinguish between an anal lesion and a rectal lesion, it is useful to first focus on the patient's symptoms. Did the patient present with acute pain and are they in pain at present time? If so, their lesion is most likely encroaching on the anal canal, which is sensate (in some patients, disproportionally sensate). While an active/participatory external anal exam is essential for these patients in pain, the DARE, anoscopy, and proctoscopy should be avoided if moderate sedation cannot be easily provided in the setting of that encounter in real time.

If the patient is not in pain and no pain is elicited with the first three steps of the active/participatory anorectal exam ((1) external exam, (2) digital exam, (3) anoscopy), then an exam room-based proctoscopy can be considered.

Proctoscopic exam at initial presentation can be offered in two ways: rigid and flexible. They are discussed in detail in the next chapter.

Anal Exam Under Anesthesia

For a patient who presents with acute pain, uncontrolled bleeding, or obstruction and the cause of these issues is highly suspicious of an anorectal origin, an anal exam under anesthesia (EUA) should be booked.

When surgeons put some thought and preparation into their "preference card" or "pick sheet" (the documents that the operating room team uses to pick surgical instrumentation, supplies, positioning, and draping), it can greatly streamline the process of booking patients. The goals of the visit to the procedure room are:

1. Provide sedation (anesthesia).
2. Administer analgesia (this may result in the first time a patient experiences substantial pain relief).

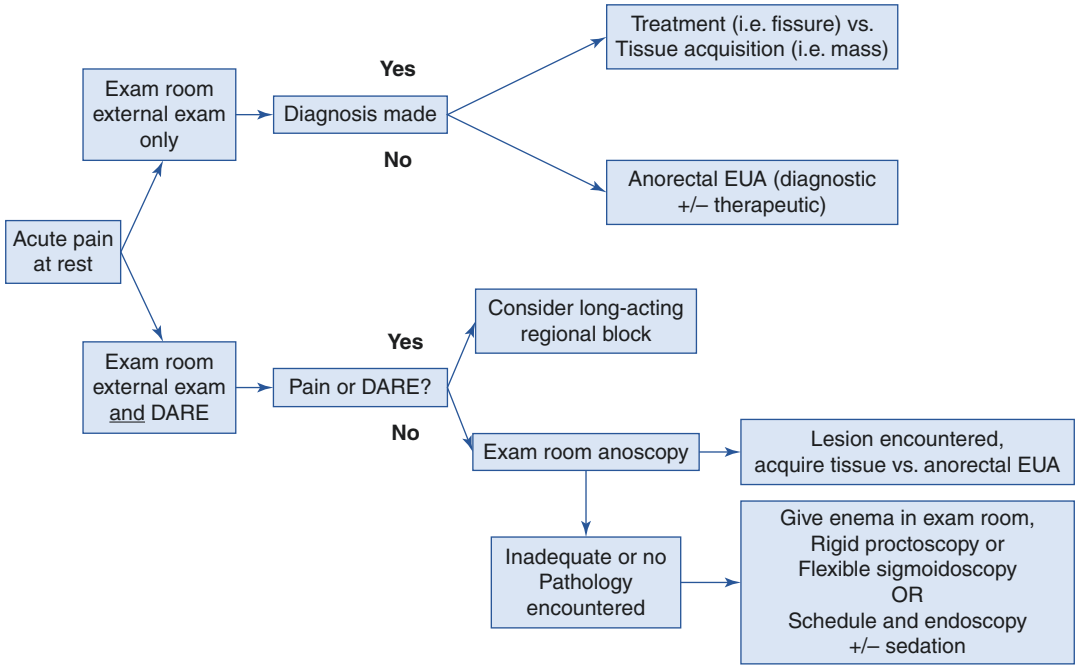

Fig. 5.7 Clinical decision-making algorithm based on presenting symptom (pain, bleeding, obstruction)

3. Obtain a more detailed exam, noting pertinent positives and negatives (which areas are spared).
4. Obtain tissue (if accessible).
5. Dilate and empty the rectal vault (if the patient is obstructed).

To meet these goals, very few instruments are actually necessary (Fig. 5.8).

Excellent exams can be achieved in the lithotomy or high lithotomy position. This positioning is less burdensome on the team in the operating room, allows the anesthesia colleague ample access to the airway, allows placement of an under-buttock collection bag (which is imperative in bleeding cases and in obstructed or near-obstructed cases needing dilation and evacuation), and, when minimal draping is used (clean, but not necessarily sterile), can provide for visual access by all of the team members. Streamlining an instrument set, avoiding sterile drapes, and using the proper waste containers (there is little for the use of biohazard red bags unless the items to be disposed of are soaked in blood) can greatly lessen the healthcare costs. As a general rule of thumb, in terms of relative sterility, what the institution is used to employing for cases performed in the endoscopy suite is acceptable for use in the operating room when doing an anal EUA.

Fig. 5.8 Streamlined "anal minor set"

Antibiotics need not be given, and because these anal EUA cases are very short (usually no more than 30 minutes), using of sequential compression devices only on selective patients will help with ease of access to the anorectum.

Excellent lighting is critical. Invariably, the lamps in the procedure room are not able to focus

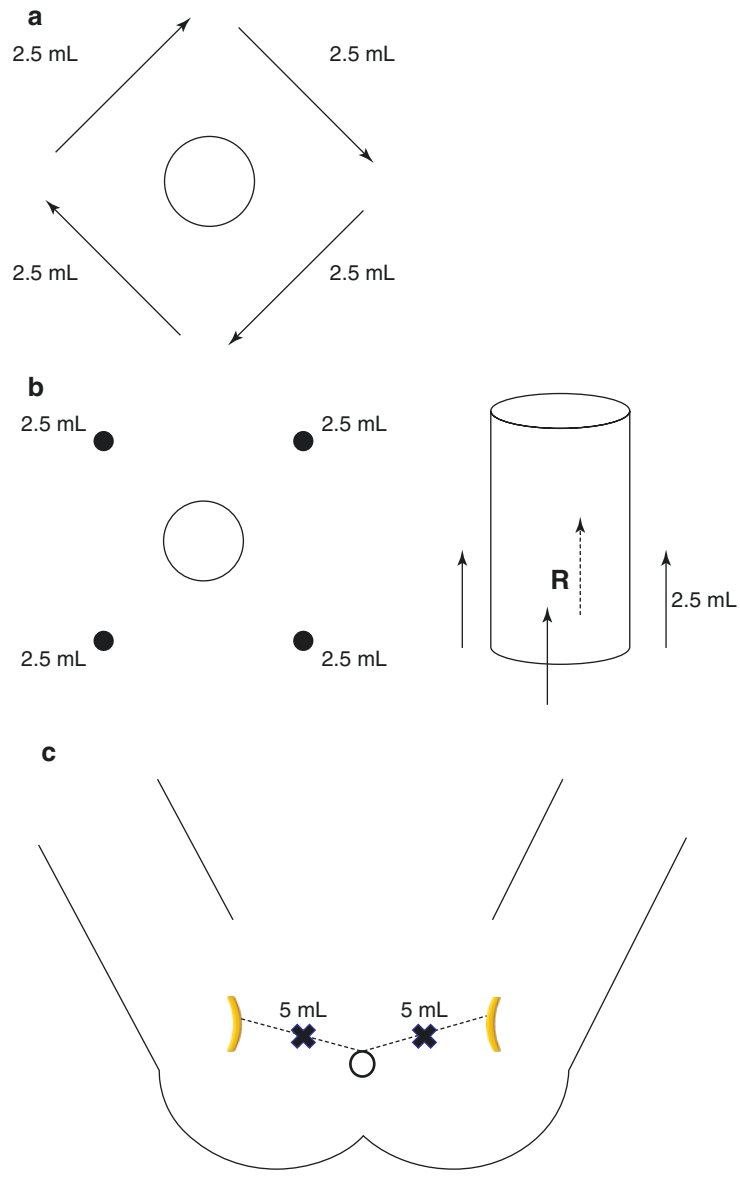

Fig. 5.9 Perianal and pudendal block. (**a**) Start with a superficial anal block using a total of 10 mL of injectate, evenly divided. (**b**) Inject the next 10 mL parallel to the rectum, starting the injection from at least four points. Inject on the way in and way out. (**c**) With the last 10 mL of injectate, divide it equally to do a 5 mL pudendal block on each side. Palpate the ischium, and find the halfway point between the ischium and the anterior aspect of the anus (labelled in this figure as X). Inject the 5 mL in a fan distribution at the location of the X

down narrowly enough to put light through the anal canal and into the rectum. Therefore, a headlamp should be worn or available. Lighted anoscopes can be helpful, though they require a capital investment by the institution. If a flexible endoscope is available, it can be held by an assistant to provide not only focused lighting but also a magnified view.

When the patient is to be positioned prone, many anesthesia providers will be more comfortable with endotracheal intubation prior to flipping the patient. However, when a patient is positioned in high lithotomy, the anesthesia provider may be comfortable with laryngeal mask ventilation. Patients in pain should receive general anesthesia. The goals of care enumerated above can be achieved without general anesthesia for those patients who have no pain on presentation. In those cases, conscious sedation is adequate.

To provide the patients who are in pain with longer term pain relief, consider giving a perianal and pudendal block (Fig. 5.9). This can be done with Marcaine injectate or with liposomal-bound bupivacaine products. In rare cases of pain,

inserting a catheter-directed infusion pump for slow delivery of local anesthesia may be necessary, but not if it will delay the next steps of their work-up and treatment (MRI, radiation, etc.). When the next step of the treatment course is radiation, the pain experienced by patients from a mass is usually greatly alleviated, even after the first dose.

For obstructing lesions, Hegar dilators can be used, keeping in mind that the contents on the other side of the dilator can be under pressure. The use of face masks and eye protection is of utmost importance to the providers involved. Dilation, at the minimum, should be performed to the level of a suction device. Those that have a straight or tapered tip (rather than a tulip tip) are preferred. Ideally, dilation and lavage should be done so that a pediatric endoscope (usually a pediatric gastroscope) can be inserted and a reasonable view can be obtained. In the acute setting, obstructed patients may have a large burden of solid stool proximal to the lesion. Administering Gastrografin solution as a lavage will help break up the inspissated stool. Proximal diversion of these patients is discussed in more depth in a subsequent chapter.

Patients who are acutely bleeding will only bleed further after tissue biopsy is performed, but the conundrum is that the tissue biopsy is critical in choosing the next step in the plan of care. The patient should be medically optimized prior to the biopsy. Is the patient anticoagulated or have a known diagnosis of a coagulation disorder? Can their condition be reversed temporarily? Is the platelet count sufficient? Is there a need for pre-biopsy transfusion of blood and/or blood products?

For patients who are acutely bleeding from a malignancy, if the next step in the treatment algorithm is radiation, initiating this will greatly slow the bleeding. Radiation causes an obliterative end arteritis that will aid in slowing or stopping the bleeding. Endoscopic techniques for bleeding rectal polyps will be detailed in the subsequent chapter.

Shuja et al. have described that radiation therapy can be initiated as a therapeutic option for gastrointestinal cancers that present with bleeding.

Tissue Diagnosis and Documentation of EUA

Anal cancer staging is based on size. Treatment is based in part on stage but also on proximity/involvement of the anal canal. Treatment of anal cancers which involve the canal differs from treatment of rectal cancer as anal cancer relies more heavily on non-operative management using the Nigro protocol. Treatment strategies of rectal cancers have evolved remarkably in the past decade and will be thoroughly discussed in subsequent chapters. Table 5.3 provides a quick reference for staging and subsequent treatment considerations.

Table 5.3 Staging for anal cancer versus rectal cancer

Cancer type	AJCC stage		TNM stage	Characteristics
Anal cancer	Stage 0		Tis N0 M0	Cancer limited to mucosa No LN involvement No metastasis to distant sites
	Stage 1		T1 N0 M0	<2 cm No LN involvement No metastasis to distant sites
	Stage 2	a	T2 N0 M0	2–5 cm No LN involvement No metastasis to distant sites
		b	T3 N0 M0	>5 cm + LN involvement No metastasis to distant sites
	Stage 3	a	T1–2 N1 M0	<5 cm + LN involvement No metastasis to distant sites

Table 5.3 (continued)

Cancer type	AJCC stage		TNM stage	Characteristics
		b	T4 N0 M0	Cancer of any size which has grown into nearby organ(s), such as the vagina, urethra, prostate gland, or bladder No LN involvement No metastasis to distant sites
		c	T3–4 N1 M0	<2 cm +/− Local organ ingrowth + LN involvement No metastasis to distant sites
	Stage 4		Any T Any N M1	A cancer of any size +/− Local organ ingrowth +/− LN involvement + Metastasis to distant organs such as the liver, brain, bone, or lungs
Rectal cancer	Stage 0		Tis N0 M0	Cancer limited to mucosa No LN involvement No metastasis to distant sites
	Stage 1		T1 or T2 N0 M0	Spread to the submucosa (T1) or Spread to muscularis propria (T2) No LN involvement No metastasis to distant sites
	Stage 2	a	T3 N0 M0	Spread to outermost layers of the colon/rectum but not through them No LN involvement No metastasis to distant sites
		b	T4a N0 M0	Spread through wall of the colon/rectum but not to nearby organs No LN involvement No metastasis to distant sites
		c	T4b N0 M0	Spread to nearby tissues or organs No LN involvement No metastasis to distant sites
	Stage 3	a	T1 or T2 N1 or N1c M0	Spread to the submucosa (T1) Spread to muscularis propria (T2) + 1–3 nearby LNs (N1) + Areas of fat near LNs (N1c) No metastasis to distant sites
			T1 N2a M0	Spread to the submucosa + 4–6 LNs No metastasis to distant sites
		b	T3 or T4a N1 or N1c M0	Spread to outermost layers of the colon/rectum (T3) or visceral peritoneum (T4a), not to nearby organs + 1–3 LNs (N1a/N1b) or areas of fat near LNs (N1c) No metastasis to distant sites
			T2 or T3 N2a M0	Spread to muscularis propria (T2) or Spread to outermost layers of the colon/rectum (T3) + 4–6 LNs No metastasis to distant sites
			T1 or T2 N2b M0	Spread to the submucosa (T1) or Spread to muscularis propria (T2) + >6 LNs No metastasis to distant sites
		c	T4a N2a M0	Spread through wall of the colon/rectum, not to nearby organs + 4–6 LNs No metastasis to distant sites

(continued)

Table 5.3 (continued)

Cancer type	AJCC stage		TNM stage	Characteristics
			T3a or T4a N2b M0	Spread to outermost layers of the colon/rectum (T3) Visceral peritoneum (T4a), not nearby organs + >6 LNs No metastasis to distant sites
			T4b N1 or N2 M0	Spread to nearby organs + LN or Areas of fat near LNs No metastasis to distant sites
	Stage 4	a	Any T Any N M1a	+/− Spread through wall of the colon/rectum +/− LN involvement Spread to one distant organ or distant LNs but not distant part of peritoneum
		b	Any T Any N M1b	+/− Spread through wall of the colon/rectum +/− LN involvement Spread to >1 distant organ but not distant part of peritoneum
		c	Any T Any N M1c	+/− Spread through wall of the colon/rectum +/− LN involvement Spread to distant part of peritoneum +/− distant organs

Adapted from American Joint Commission on Cancer

Conclusion

In summary, honesty, humility, and communication are the keys to success in establishing a trusting relationship with your patient at the first encounter. Examining the patient in the most comfortable position (left lateral Sim's) will allow them to relax and provide for a more thorough exam. Clear documentation using anatomic landmarks (as opposed to "o'clocks") is always preferred. If there is benefit from an anorectal exam under anesthesia in the operating room, the high lithotomy position, streamlined equipment set, and clean, but not necessarily sterile, bags and sheets to drape will help to conserve personpower and reduce the environmental impact. Lastly, approaching each situation from the patient's perspective is always the best practice.

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