

*Dear Editor,*

We read with interest the article by Maccabe et al on the excision of early anal squamous cell carcinoma (ASCC) in which 12/39 were fully excised and 18/28 R1 resections had adjuvant chemoradiation (CRT) [1].

Although excision of T1 cancers is increasing, this is without robust clinical trial data. High-resolution anoscopy (HRA) using magnification and 5% acetic acid enhancement for anal and perianal inspection [2] enables any precancerous anal high-grade squamous intraepithelial lesion (HSIL) to be detected and better delineates small ASCC. We recently published a paper in which HRA was used successfully for ASCC follow-up, including after excision of small ASCC [3].

In this UK series, in which 50% of patients had some form of immune suppression, we used HRA to detect HSIL in 74% of the 23 patients whose ASCC had been treated with excision only with no adjuvant chemoradiation (EO). HSIL were found in only 13% of the 30 followed up after treatment with primary CRT. This number included six whose excision had been R1 and who went on to CRT. Follow-up was similar to Maccabe's in both EO and CRT groups at 39–46 months. HSIL were treated with ablation. There were no local recurrences in the 23 EO patients and one in the primary CRT group: this was perianal with a 0.6 mm depth of invasion and was treated with an R0 excision. Of the six EO patients with an R1 resection and subsequent CRT, none recurred and none had further HSIL.

In our study, none of the 23 patients managed with EO had positive resection margins (1 mm), and all but two were from the perianus. In contrast, Maccabe et al had 28/39 positive margins and 10/28 had no adjuvant CRT. The anal canal R1 resection rate was significantly worse than the perianal; however, both were concerning. Like others [4], we believe that adjuvant CRT should be recommended for R1 ASCC resections in preference to re-resection of positive margins, especially for anal canal or T2 ASCC. Six of 39 (15%) recurred in Maccabe et al's paper, compared with 3/60 (5%) in our series which included two of our seven patients who had already had a previous local recurrence of ASCC at study entry: one of these proceeded to CRT and one underwent further successful excision only. All three recurrences were preceded by HSIL detection and there have been no further recurrence or metastases more than 24 months later.

CRT has negative effects on quality of life and can be avoided if the excised ASCC is R0 and is perianal, as Maccabe et al rightly conclude. However, their R1 resection rate calls for a radical change in how small anal cancers are managed. Highly prevalent HSIL at the site of ASCC excision should be detected and

treated [5]. HRA and treatment of HSIL would likely reduce the recurrence rate that Maccabe et al described in their paper; in addition, the use of HRA for the ASCC excision itself may reduce the R1 resection rate.

We encourage colorectal surgeons involved in the treatment of anal neoplasia to seek training in HRA.