Coordinatori:
Francesca Valvo, Cynthia Aristei,
Marco Lupattelli, Vincenzo Fusco

Sede del corso
- PAVIA: 13 GIUGNO 2014
- PERUGIA: 18 SETTEMBRE 2014
- RIONERO IN VULTURE : 31 OTTOBRE 2014

Gruppo AIRO
Patologie Gastroenteriche

La Radioterapia nel carcinoma del Canale Anale: Indicazioni e criteri guida di trattamento

II Sessione: *La Multidisciplinarietà dei Trattamenti*
Moderatori: M. Aieta (Rionero in Vulture) – G. Latorre (Rionero in Vulture) – S. Parisi (San Giovanni Rotondo)

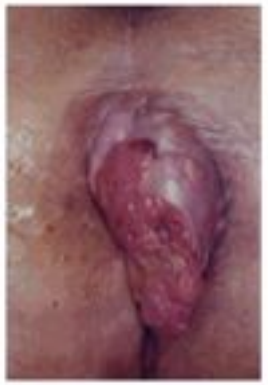
10.45 La radiochemioterapia – G. Mantello (Ancona)

FU.MI.R

MITOMICINA
10 mg / mq bolo 1° g

5 - FU
1000 mg/ mq/ 24 h i. c. 1°- 4°g

ERT 30Gy


Pre - Radiochemioterapia


Post - Radiochemioterapia

2014

IL FUMIR

COMPIE 40 ANNI

Nigro N - Dis Colon Rectum - 1974

TRIALS STORICI

ACT - I (LANCET 1997)	**FUMI-RT**	**RT**
EORTC 22861 (JCO 1997)	**FUMI-RT**	**RT**
RTOG 8704 (JCO 1996)	**FUMI-RT**	**FU-RT**
	FAVOREVOLE	SFAVOREVOLE

TRIALS STORICI: risutati

TRIAL	treatment	GAP Week	RC % 6 W	REC %	CFS % 5aa	Colostomy Rate % 5aa	OS % 5aa
ACT - I	**FUMI-RT 45 + 15**	*6*	*39*	*32*	*47*	*23*	*65*
	RT 45 + 15	*6*	*30*	*57*	*37*	*39*	*58*
EORTC 22861	**FUMI-RT 45 + 15/20**	*6*	*80*	*32*	*72*	*--*	*72*
	RT 45 + 15/20	*6*	*54*	*50*	*40*	*--*	*65*
RTOG 8704	**FUMI-RT 45 +9**	*4-6*	*92* *4-6 W*	*16*	*71* 4aa	*9*	*67*
	FU-RT 45 + 9	*4-6*	*86*	*34*	*59*	*22*	*65*

Mod Glynne Jones 2011

TRIALS STORICI: tossicita' acuta

	High-Grade Acute Toxicity: GI	High-Grade Acute Toxicity: GU	High-Grade Acute Toxicity: Dermatologic	High-Grade Acute Toxicity: Hematologic
UKCCCR (ACT I) [4]	"severe"	"severe"	"severe"	"severe"
RT	2%	0.3%	14%	0%
RT/5FU/MMC	5%	1%	17%	11%
EORTC [5]	Grade 3-4		Grade 3-4	Grade 3-5
RT	8%	NR	50%	NR
RT/5FU/MMC	20%	NR	57%	4%
RTOG 87-04 [7]	Grade 4-5 Non heme	Grade 4-5 Non heme	Grade 4-5 Non heme	Grade 4-5
RT/5FU	4%	4%	4%	8%
RT/5FU/MMC	7%	7%	7%	26%

2D – 3DCRT

mod da ZAGARS TM – ONCOLOGY - 2010

Maggior guadagno =
Controllo locale

UPDATE 13 ANNI ACT - I

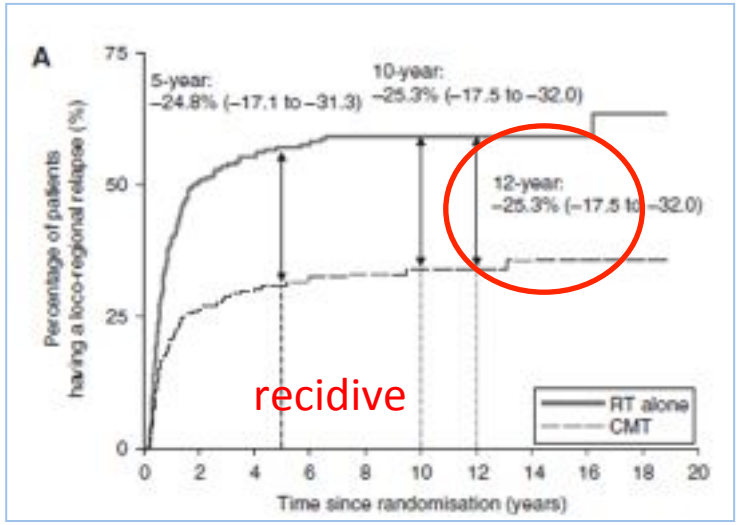
FUMI-RT vs RT

British Journal of Cancer (2010) 102, 1123 – 1128

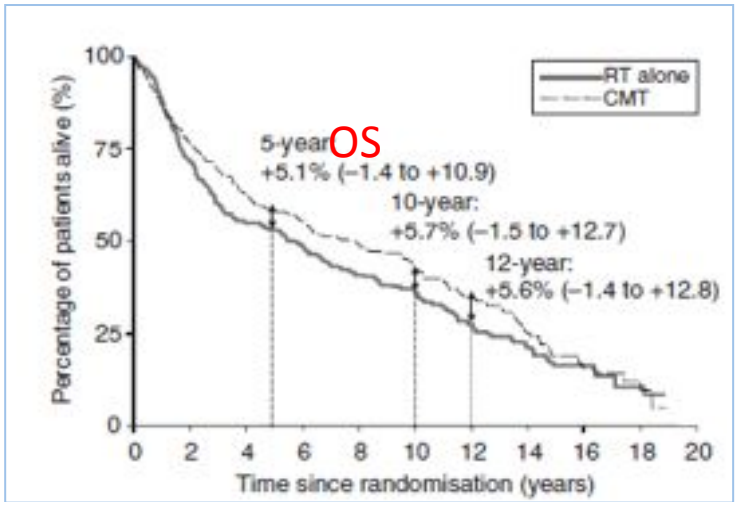
www.bjcancer.com

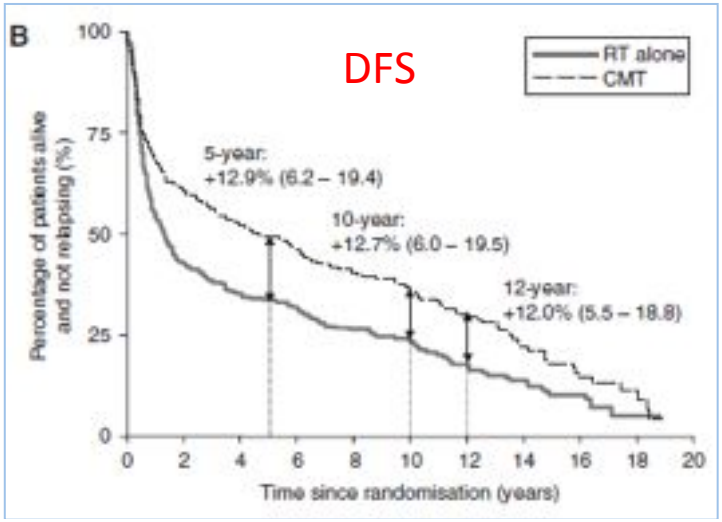
Chemoradiation for the treatment of epidermoid anal cancer: 13-year follow-up of the first randomised UKCCCR Anal Cancer Trial (ACT I)

J Northover[1], R Glynne-Jones[*,1], D Sebag-Montefiore[2], R James[3], H Meadows[4], S Wan[5], M Jitlal[6] and J Ledermann[7]



GUADAGNO 25% a 5 aa

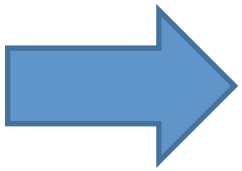




Punti critici

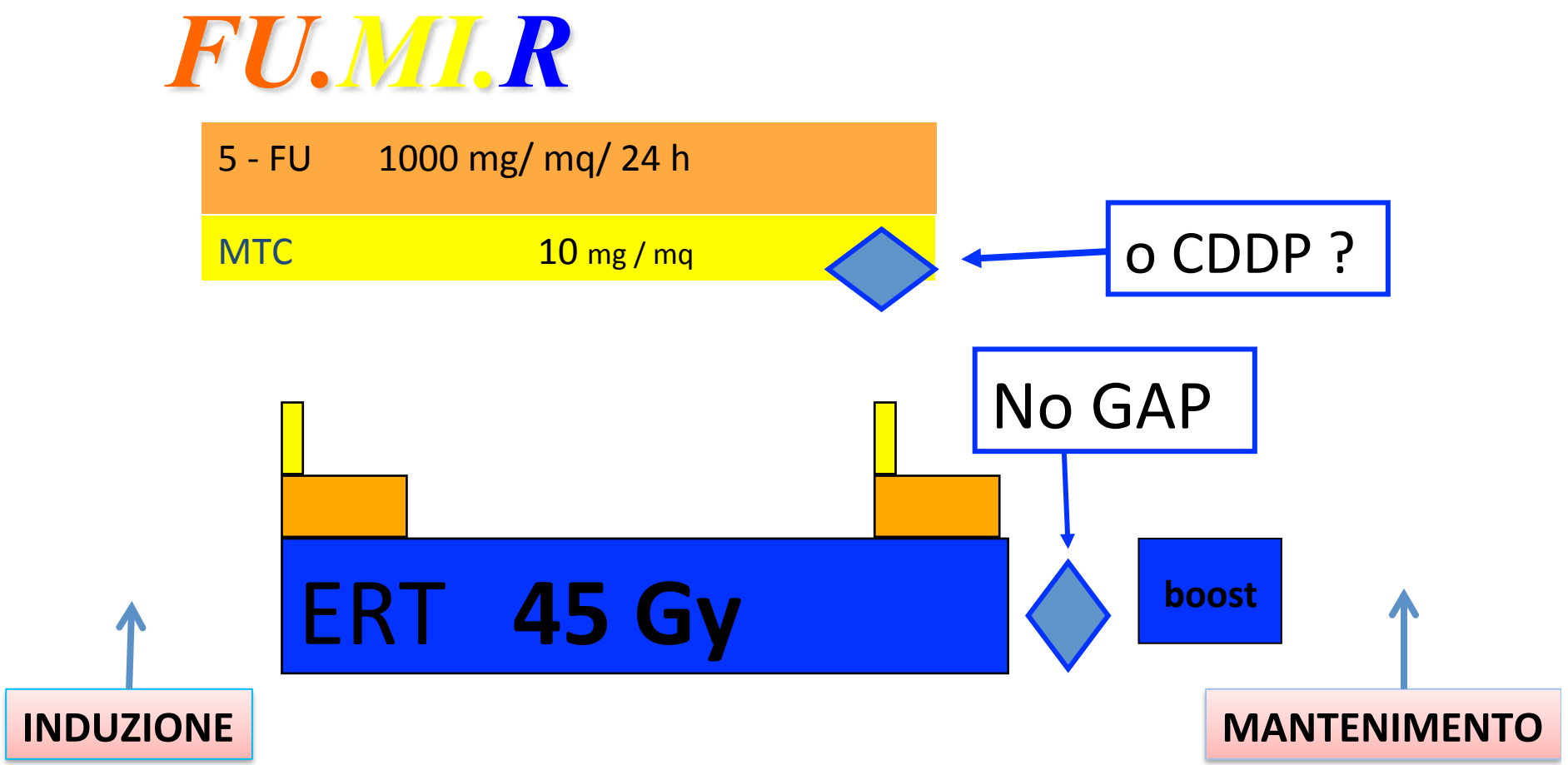
- Inserimento gap
- Precoce valutazione risposta
- Causa colostomia non riportata
- Difficile gestione malattia metastatica
- Tossicita' non trascurabile

OBIETTIVI
NUOVI STUDI



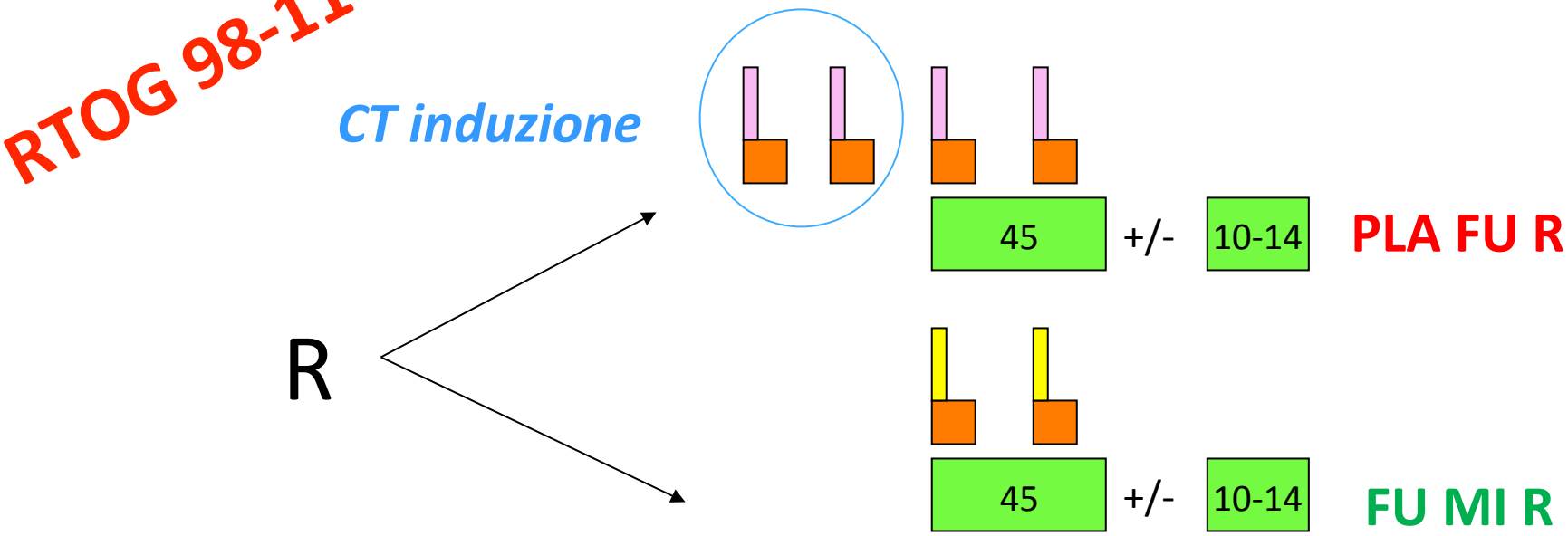
> RC
< COLOSTOMIA
< TOSSICITA'
< METASTASI

FUMIR : quale ottimizzazione /alternativa



FUMI-RT vs CT INDUZIONE + PLAFU-RT

RTOG 98-11



	DFS 5y %	OS 5y %	LOC FAILURE 5y %	DIST META 5y %	COLOSTOMY %
FUMIR	60	75	25	15	10
PLAFUR	54	70	33	19	19

Ajani J. A. *JAMA* 2008

FUMI-RT vs CT INDUZIONE + PLAFU-RT

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

UPDATE
RTOG 98-11

Long-Term Update of US GI Intergroup RTOG 98-11 Phase III Trial for Anal Carcinoma: Survival, Relapse, and Colostomy Failure With Concurrent Chemoradiation Involving Fluorouracil/Mitomycin Versus Fluorouracil/Cisplatin

Leonard L. Gunderson, Kathryn A. Winter, Jaffer A. Ajani, John E. Pedersen, Jennifer Moughan, Al B. Benson III, Charles R. Thomas Jr, Robert J. Mayer, Michael G. Haddock, Tyvin A. Rich, and Christopher G. Willett

RECIDIVE LOCALI

METASTASI

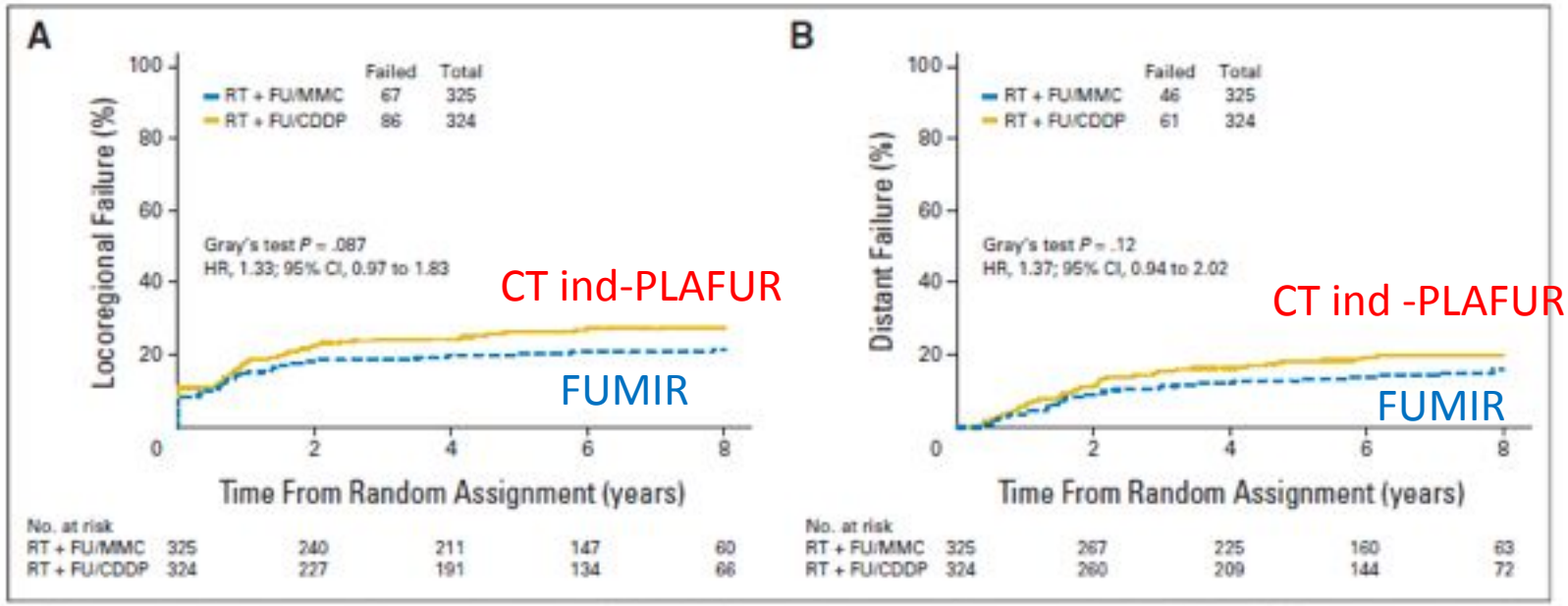
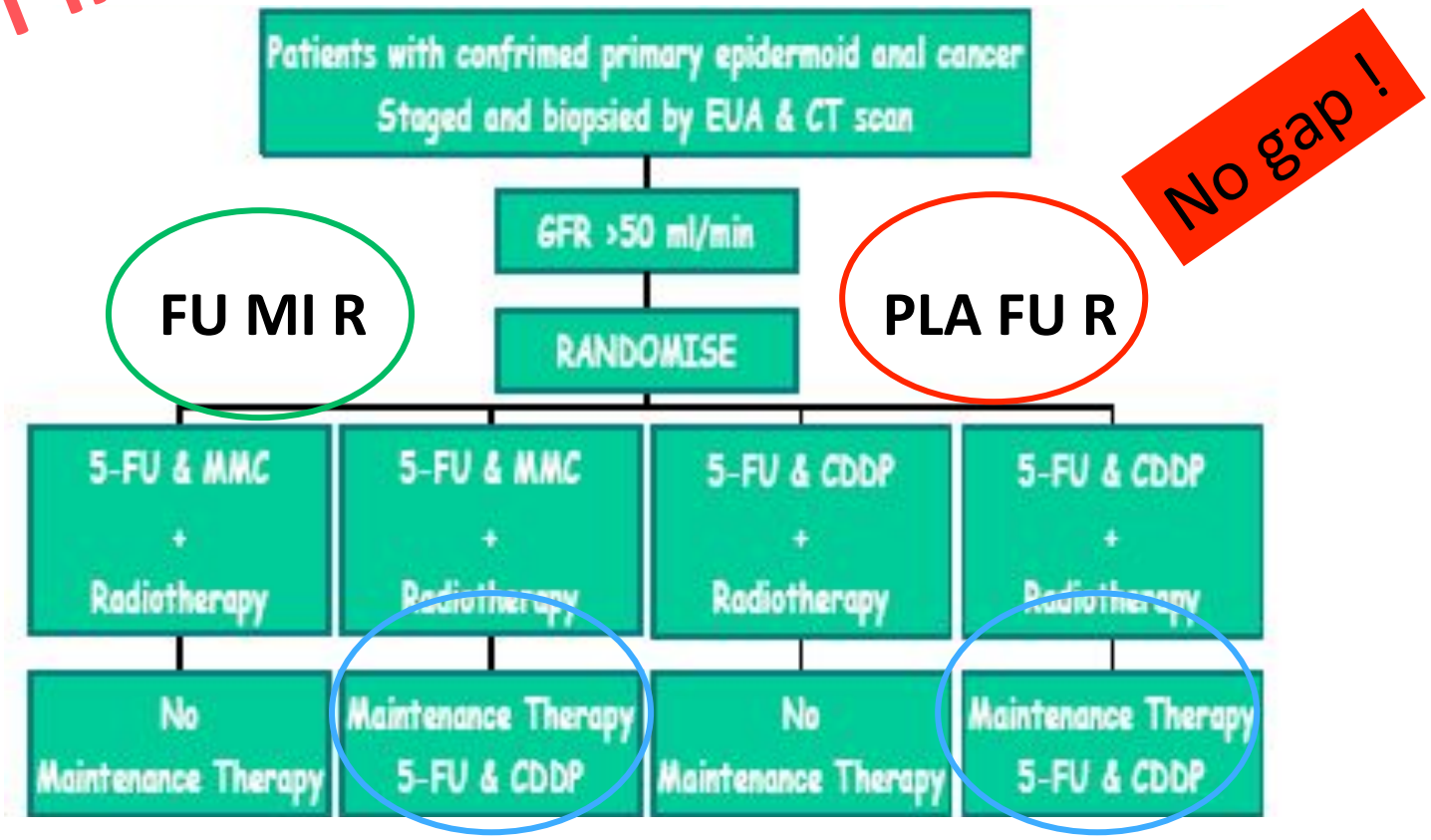


Fig 3. Impact of radiation therapy plus fluorouracil/mitomycin (RT + FU/MMC) *v* radiation therapy plus fluorouracil/cisplatin (RT + FU/CDDP) on (A) locoregional failure (P = .087) and (B) distant failure (P = .12). HR, hazard ratio.

FUMI-RT vs PLAFU-RT +/- CT mantenimento

ACT II



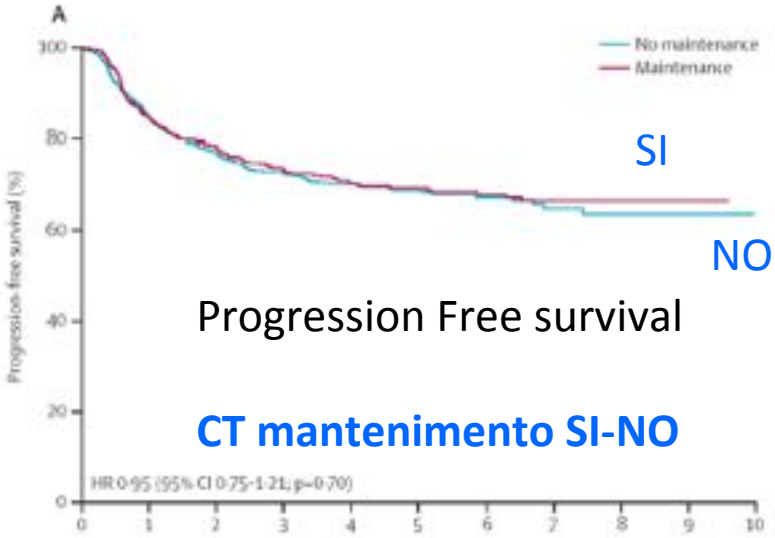
Chem di mantenimento

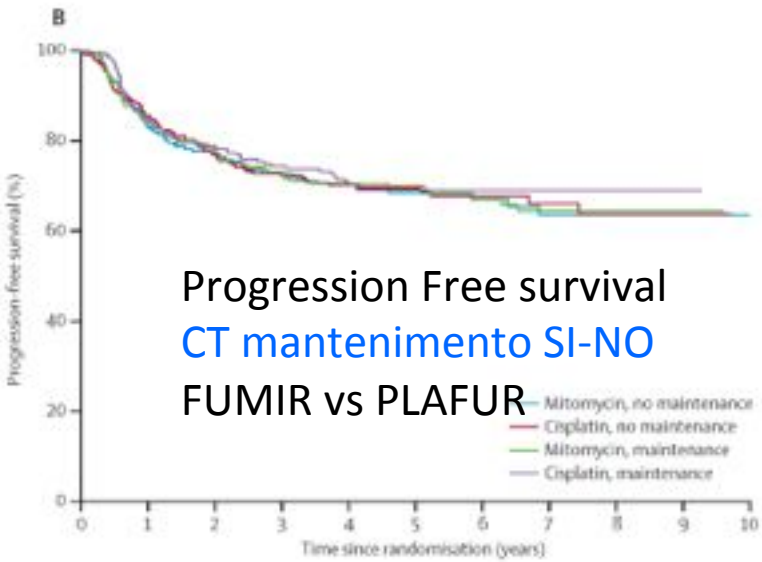
FUMI-RT vs PLAFU-RT +/- CT mantenimento

ACT II

Mitomycin or cisplatin chemoradiation with or without maintenance chemotherapy for treatment of squamous-cell carcinoma of the anus (ACT II): a randomised, phase 3, open-label, 2×2 factorial trial

Roger D James*, Robert Glynne-Jones*, Helen M Meadows, David Cunningham, Arthur Sun Myint, Mark P Saunders, Timothy Maughan, Alec McDonald, Sharadah Essapen, Martin Leslie, Stephen Falk, Charles Wilson, Simon Gollins, Rubina Begum, Jonathan Ledermann, Latha Kadalayil, David Sebag-Montefiore





www.thelancet.com/oncology Vol 14 May 2013

FUMI-RT vs PLAFU-RT +/- CT mantenimento

ACT II

Mitomycin or cisplatin chemoradiation with or with
maintenance chemotherapy for treatm
carcinoma of the anus (ACT II)
open-label, 2×2 fac

Roger D James, Sun Myint, Mark P Saunders, Timothy Maughan,
Wilson, Simon Gollins, Rubina Begum, Jonathan Ledermann,

Ottima risposta a 26 settimane

	Mitomycin group (n=432)	Cisplatin group (n=431)
Complete response	391 (90·5%)	386 (89·6%)
Partial response	14 (3·2%)	24 (5·6%)
Stable disease	5 (1·2%)	6 (1·4%)
Progressive disease	22 (5·1%)	15 (3·5%)

Table 2: Primary tumour response at 26 weeks

www.thelancet.com/oncology Vol 14 May 2013

FUMI-RT vs PLAFU-RT +/- CT mantenimento

ACT II

Conclusions:

- **CR (95%) and RFS (75%) at 3 yrs**

  (excellent outcome influenced by the absence of a gap in the RT schedule).

- **no difference** in CR rates between **MMC and CDDP**

- **no difference** in RFS rates **with or without maintenance chemotherapy**.

PLAFU-RT +/- CT induzione +/- HDRT

ACCORD 03

Chem di induzione

End point :

Colostomy Free Survival

VOLUME 30 · NUMBER 16 · JUNE 1 2012

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

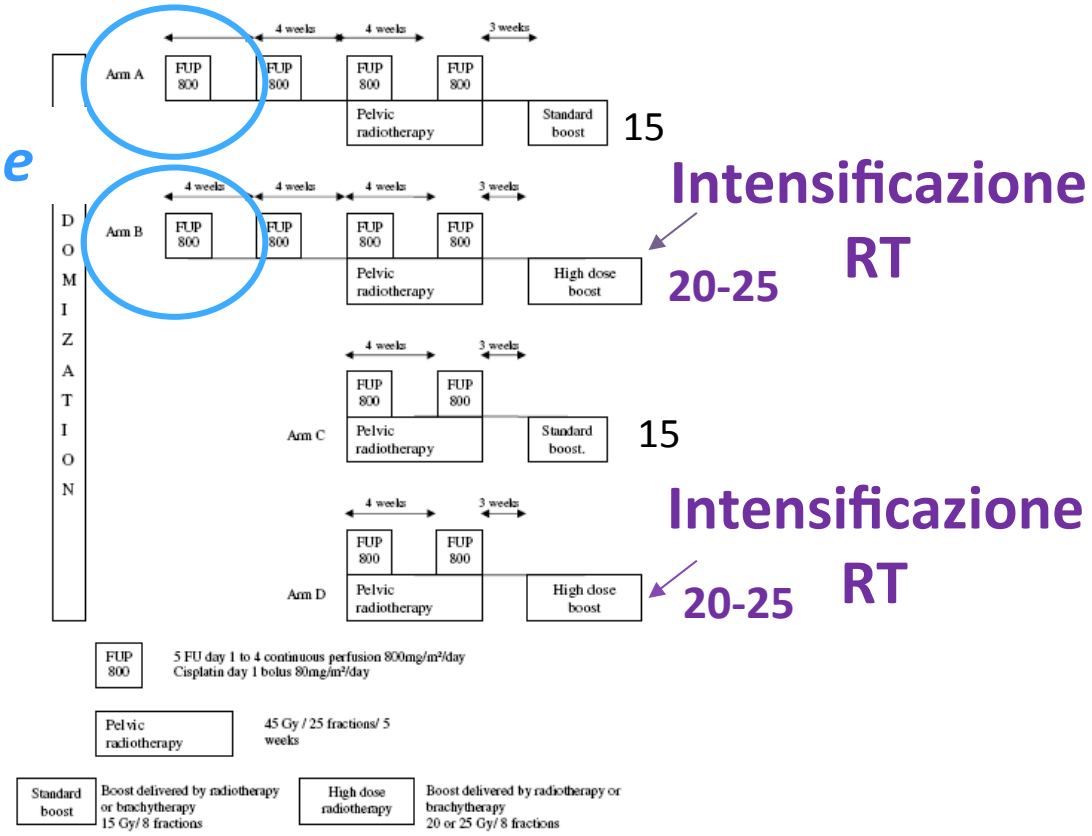
JCO 2012

Induction Chemotherapy and Dose Intensification of the Radiation Boost in Locally Advanced Anal Canal Carcinoma: Final Analysis of the Randomized UNICANCER ACCORD 03 Trial

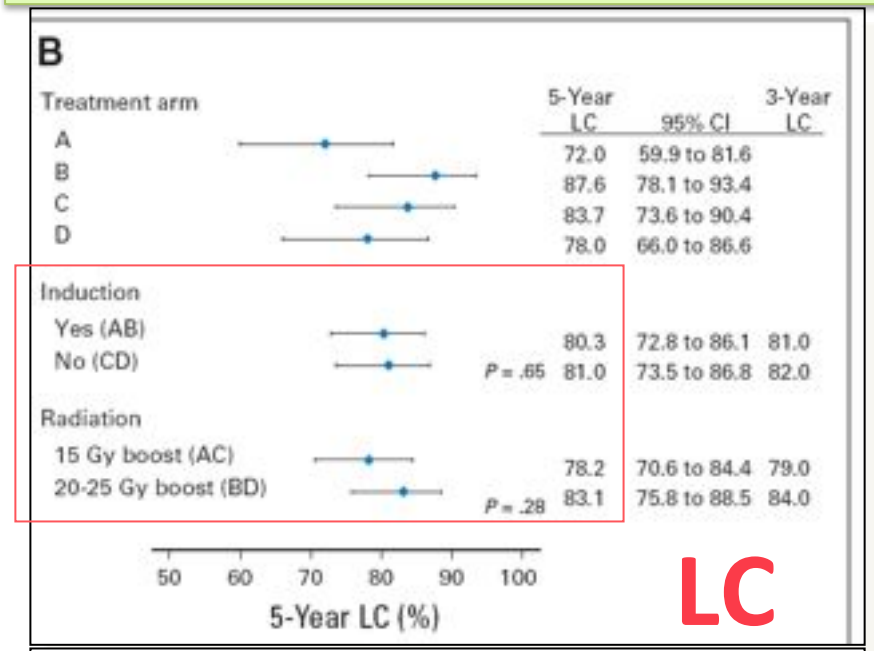
Didier Peiffert, Laetitia Tournier-Rangeard, Jean-Pierre Gérard, Claire Lemanski, Eric François, Marc Giovannini, Frédérique Cvitkovic, Xavier Mirabel, Olivier Bouché, Elisabeth Luporsi, Thierry Conroy, Christine Montoto-Grillot, Françoise Mornex, Antoine Lusinchi, Jean-Michel Hannoun-Lévi, Jean-François Seitz, Antoine Adenis, Christophe Hennequin, Bernard Denis, and Michel Ducreux

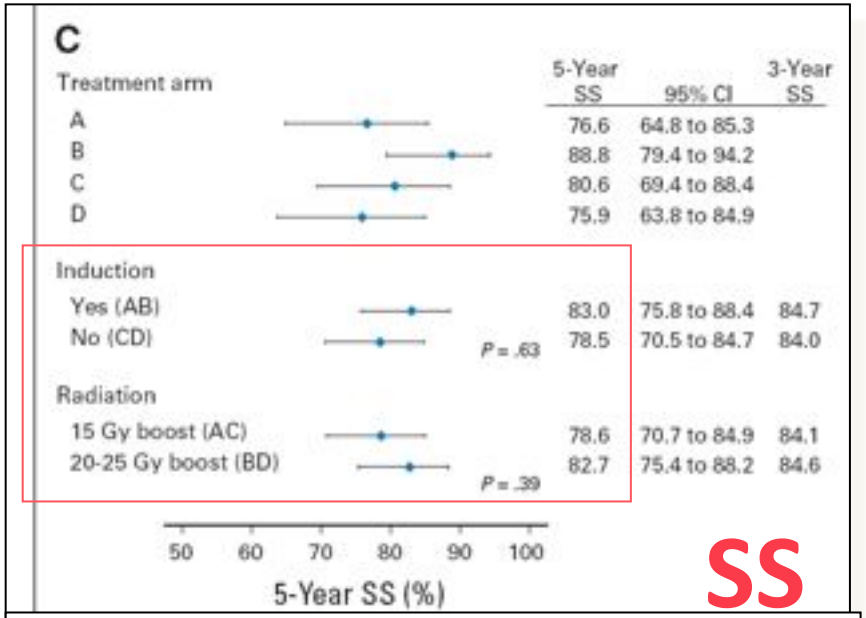
Didier Peiffert, Laetitia Tournier-Rangeard, Elisabeth Luporsi, Thierry Conroy, EA 4360 Centre, Alexis Vautrin and Nancy University, Vandoeuvre-lès-Nancy, France; Jean-Pierre Gérard, Eric François, Jean-Michel Hannoun-Lévi, Centre Antoine Lacassagne, Nice, France; Michel Ducreux, Institut Gustave Roussy, Villejuif, France; Claire

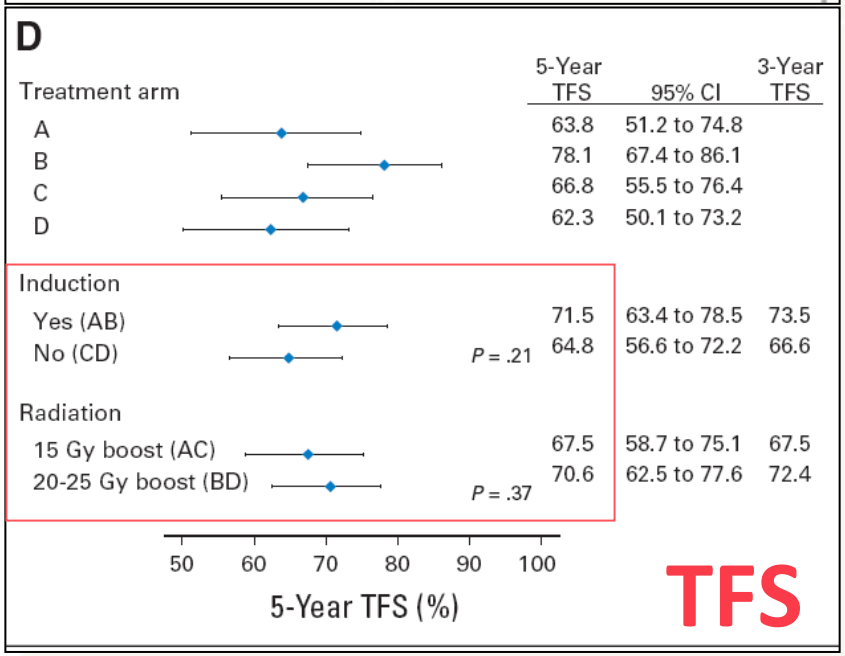
L. Tournier-Rangeard et al. / Radiotherapy and Oncology 87 (2008) 391–397

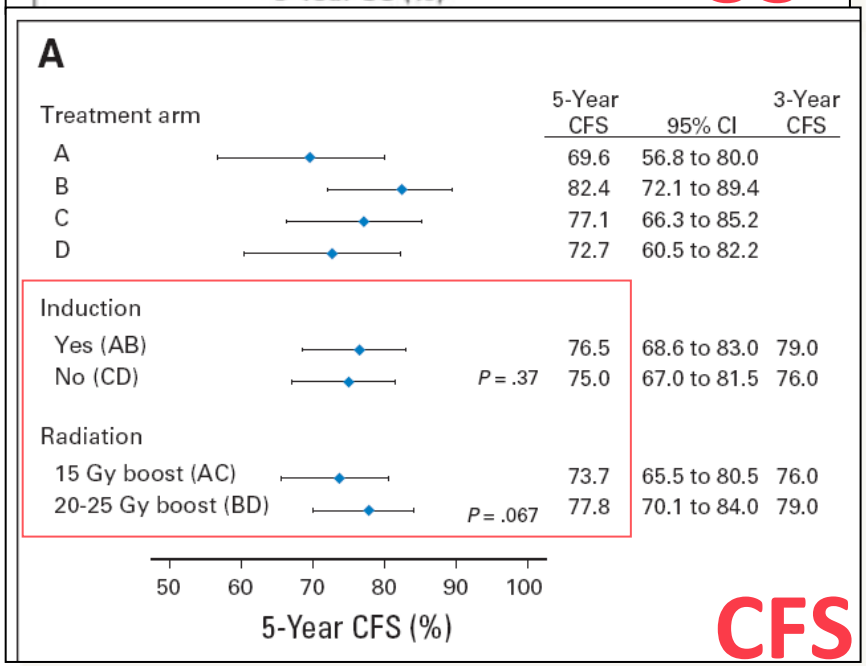


PLAFU-RT +/- CT induzione +/- HDRT



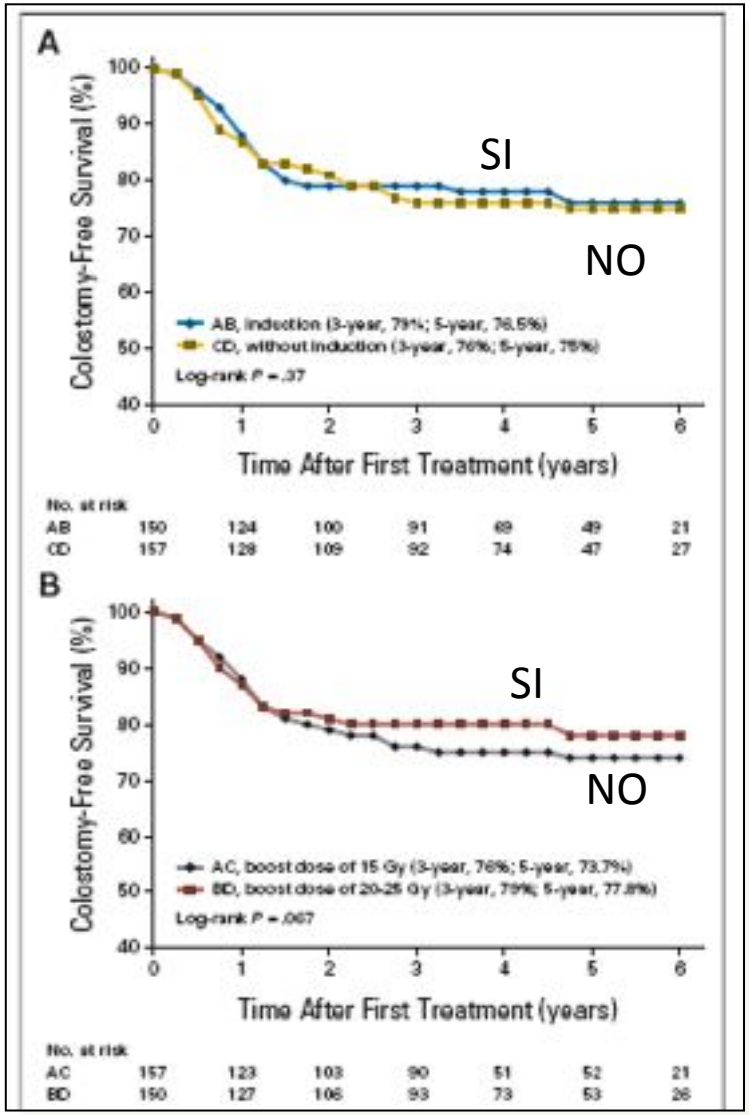






PLAFU-RT +/- CT induzione +/- HDRT

ACCORD 03



CT induzione

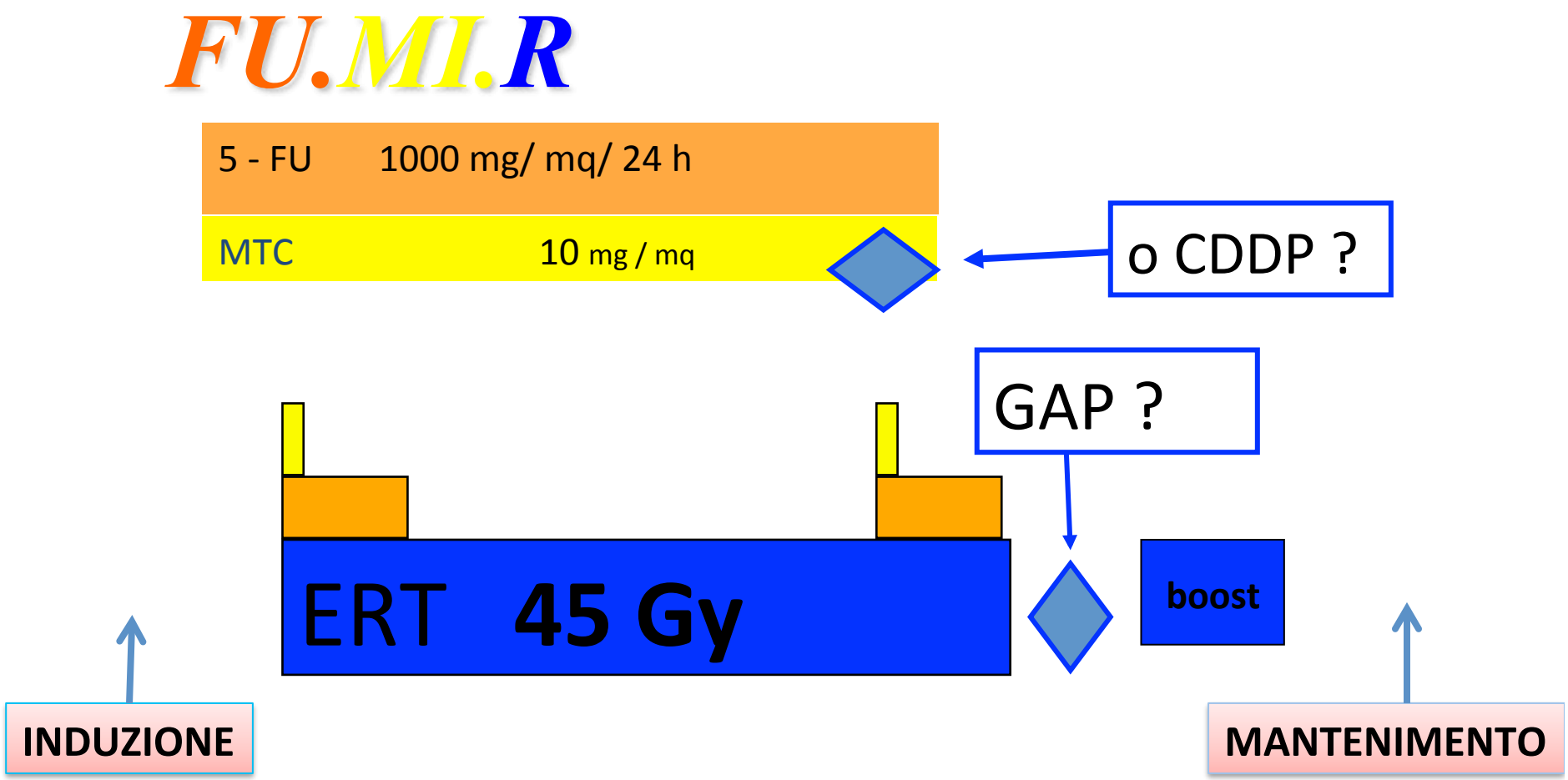
HDRT

RISULTATI NUOVI TRIALS CONCLUSI

TRIAL	treatment	GAP d	RC % 26w	DFS% 5aa	CFS % 5aa	Colostomy Rate % 5aa	OS % 3-5 aa
RTOG 98-11	**FUMI-RT 45-59**	*10*	-	*60*	-	*10*	*75*
	ind **PLAFU-RT 45-59**	*10*	-	*54*	-	*19*	*70*
ACT -II	**FUMI-RT 50** +/- mant	*0*	*26w 94.5*	*75*	-	*5*	*85*
	PLAFU-RT 50 +/- mant	*0*	*26w 95*	*75*	-	*4*	*84*
ACCOR D-03	Ind **PLAFUR 45+15**	0	-	70	*69*	-	76
	Ind **PLAFUR HD 45+25**			78	*82*		*89*
	PLAFUR 45+15 **PLAFUR HD 45+25**	0	-	67 68	*77 72*	-	80 ***76***

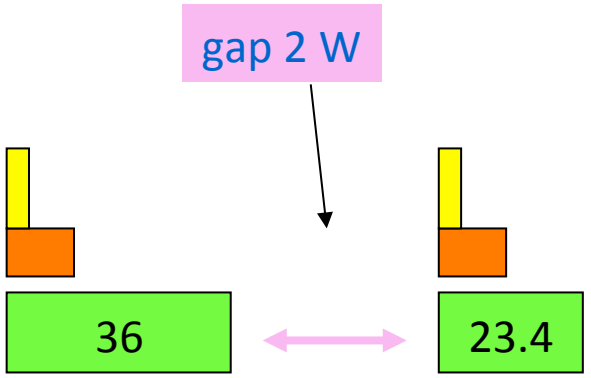
Mod Glynne Jones 2011

TEMPO TOTALE/ GAP / DOSE TOTALE



Tempo totale /gap

RTOG 92-08



FU MI R

	DFS	OS	LC	loco-reg REC	M	COLOSTOMY RATE %	Colostomy FS	Tox G4 %
RTOG 9208 JOHN 1996 (SPLIT)	**53** 5y %	**67** 5y %		**29** 5y %	**18** 5y %	**25**	**58** 5y %	**24**
RTOG 8704	**73** 4y %	**76** 4y %	**84** 4y %	**16** 4y %	--	**9**	**71** 4y %	**23**

Tempo totale /gap

UPDATE
RTOG 92-08

ELSEVIER

Int. J. Radiation Oncology Biol. Phys., Vol. 72, No. 1, pp. 114–118, 2008

0360-3016/08/$–see front matter

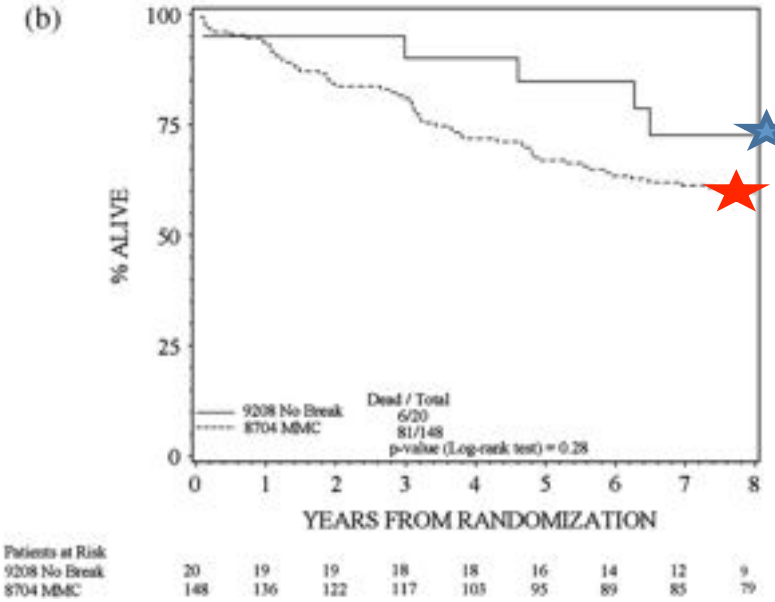
doi:10.1016/j.ijrobp.2007.12.027

CLINICAL INVESTIGATION **Anal Canal**

EVALUATION OF PLANNED TREATMENT BREAKS DURING RADIATION THERAPY FOR ANAL CANCER: UPDATE OF RTOG 92-08

ANDRE KONSKI, M.D.,* MIGUEL GARCIA, JR., M.S.,† MADHU JOHN, M.D.,‡ RICHARD KRIEG, M.D.,§ WAYNE PINOVER, D.O.,‖ ROBERT MYERSON, M.D.,¶ AND CHRISTOPHER WILLETT, M.D.**

arm of RTOG 92-08 to the Mitomycin-C arm of RTOG 87-04



9208 SENZA SPLIT

8704 MMC

MIND THE GAP……..

Int. J. Radiation Oncology Biol. Phys., Vol. 81, No. 5, pp. 1488–1494, 2011

0360-3016/$ - see front matter

ELSEVIER

doi:10.1016/j.ijrobp.2010.07.1995

CLINICAL INVESTIGATION **Anus**

"MIND THE GAP"—THE IMPACT OF VARIATIONS IN THE DURATION OF THE TREATMENT GAP AND OVERALL TREATMENT TIME IN THE FIRST UK ANAL CANCER TRIAL (ACT I)

ROB GLYNNE-JONES, F.R.C.R.,* DAVID SEBAG-MONTEFIORE, F.R.C.R.,† RICHARD ADAMS, F.R.C.R.,‡ ALEC MCDONALD, F.R.C.R.,§ SIMON GOLLINS, F.R.C.R.,‖ ROGER JAMES, F.R.C.R.,†† JOHN M. A. NORTHOVER, F.R.C.S.,‡‡ HELEN M. MEADOWS, M.SC.,§§ AND MARK JITLAL, M.SC. §§ FOR THE UKCCCR ANAL CANCER TRIAL WORKING PARTY

CONCLUSION

These data question the effectiveness of the principle of boost RT delivered after a gap of 6 weeks or more after completion of initial treatment of 45 Gy. The majority of patients achieving local disease control will already have done so after their initial phase of radiation or chemoradiation treatment. This hypothesis is consistent with the original evidence from Nigro, where patients with a tumor of ≤5 cm achieved local control after chemoradiation to 30 Gy (48). Hence, the higher doses of a boost delivered after a long delay may contribute to an increased risk of late morbidity rather than local control. We recommend the whole RT course be completed in as short a time as possible, and with the avoidance of split course treatments.

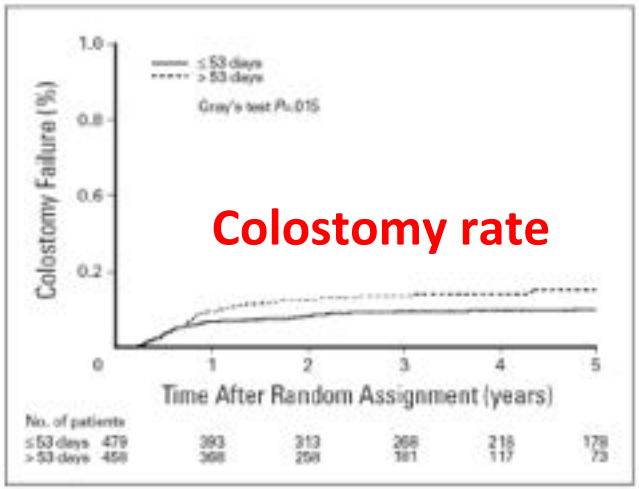
Tempo totale /gap

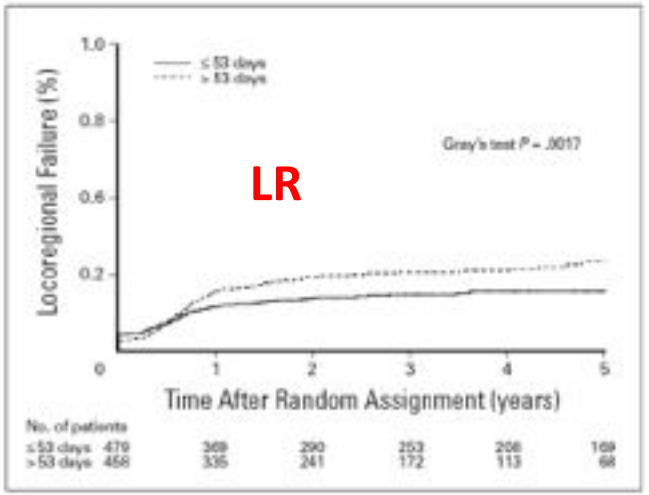
Pooled
RTOG 87-04
RTOG 98-11

VOLUME 28 · NUMBER 34 · DECEMBER 1 2010
JOURNAL OF CLINICAL ONCOLOGY
ORIGINAL REPORT

Impact of Overall Treatment Time on Survival and Local Control in Patients With Anal Cancer: A Pooled Data Analysis of Radiation Therapy Oncology Group Trials 87-04 and 98-11

Edgar Ben-Josef, Jennifer Meyghan, Jaffer A. Ajani, Marshall Flam, Leonard Gunderson, JimDavid Pollock, Robert Myerson, Ravi Arne, Seth A. Rosenthal, and Christopher Willett





Tempo TOTALE < 53 GIORNI

Tempo totale /gap

PARADAC: conclusions

- a longer duration of radiation therapy is detrimental to the outcome of patients in general
- In the dose range 50.4 to 59 Gy, there is a trend for lower doses to be preferred
- Comparing 2 weeks gap to 0 weeks of gap when the dose is in the range 55-59.4 Gy suggests that there is unlikely a difference in effect between a somewhat higher dose given with a gap and a somewhat lower dose given with no gap.

RTC

Effect of the dose without gap

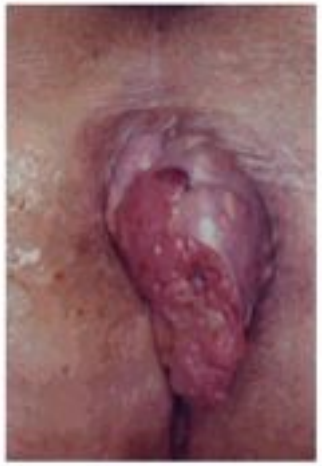
Size and location matter

No effect of dose between 50 and 60 Gy

977 pts, 220 events

PARADAC
Project surveying and pooling data on RT parameters in phase II and III trials in anal cancer (O. Matzinger & J. Lorent).

TEMPO DI RISPOSTA



Pre - Radiochemioterapia

Post - Radiochemioterapia

…….the median time to complete clinical regression after irradiation was about 3 months, and that some cancers could take up to 12 months to disappear.

This suggests that decisions to base further treatment on the presence of a residual mass that is not clearly progressing, at any time less than even several months after the initial course of therapy, may lead to over-treatment.

CUMMINGS B.J. Int.J Radiation Oncol Biol Phys 1991

TEMPO DI RISPOSTA

ACT II

FU**MI**-RT vs **PLA**FU-RT
+/- **CT mantenimento**

Optimum time to assess complete clinical response (CR) following chemoradiation (CRT) using mitomycin (MMC) or cisplatin (CisP), with or without maintenance CisP/5FU in squamous cell carcinoma of the anus: Results of ACT II.

		Absolute risk difference (95% CI)	
Pts with CR		CR rate %	MMC
Week 11	429	65.6	57.9
Week 18	527	75.4	76.2
Week 26	582	83.5	84.0

CR 26 w = + 29%

202/695 (29%) pts not in CR at 11 weeks were CR at 26 weeks

Optimum time to assess complete clinical response (CR)> = 26 weeks

TEMPO DI RISPOSTA

Tabella 1: Risposte Complete ottenute durante il follow up ecografico

	1 mese	2 mesi	3 mesi	4 mesi	6 mesi	8 mesi	10 mesi	12 mesi	14 mesi
RC n°	0/21	0/21	3/21	6/21	11/21	14/21	18/21	20/21	21/21
(%)	(0%)	(0%)	(14.3%)	(28.6%)	(52.4%)	(66.7%)	(85.7%)	(95.2%)	(100%)

- il 28.6 % RC a 4 mesi;
- la metà dei pazienti ha risposto entro 6 mesi;
- il 100% delle RC è stato registrato solo dopo 14 mesi di follow up ecografico.

Una chirurgia demoliva a 6 mesi, come suggerito dalle linee guida per i pazienti con residuo di malattia, sarebbe stata inappropriata per i 10 pazienti che hanno invece presentato risposta completa tardivamente, tra 8 e 14 mesi.

TEMPO DI RISPOSTA

Ruolo della PET

ELSEVIER

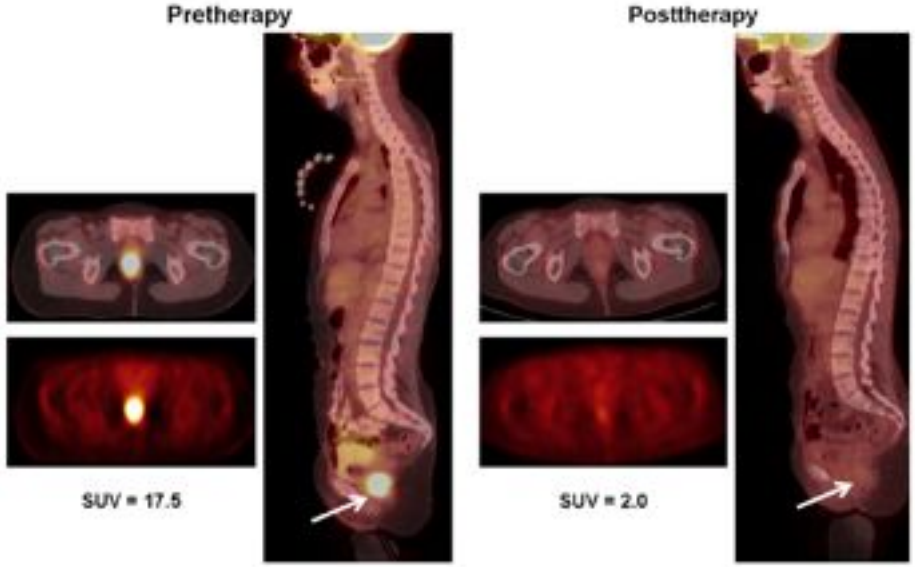
Int. J. Radiation Oncology Biol. Phys., Vol. 71, No. 1, pp. 180–185, 2008

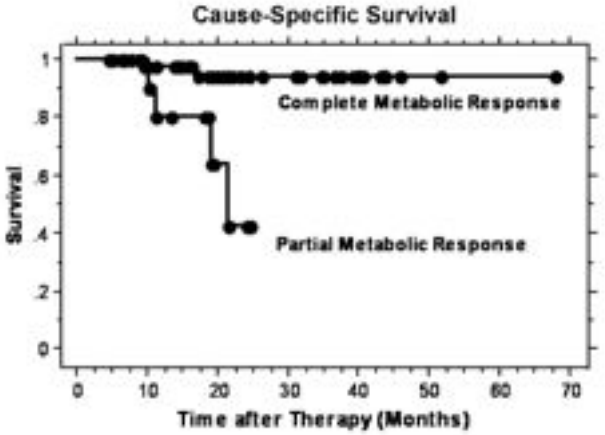
0360-3016/08/$–see front matter

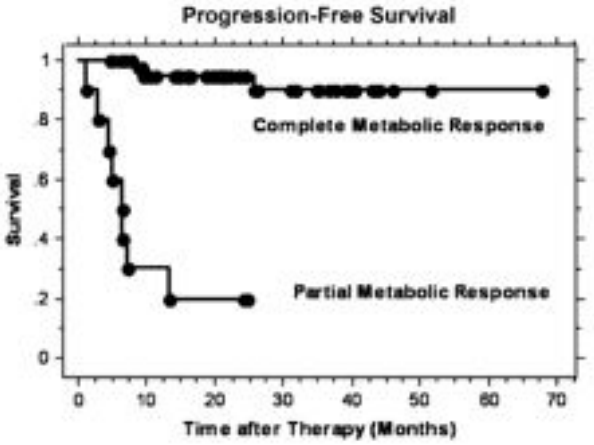
doi:10.1016/j.ijrobp.2007.09.005

TUMOR RESPONSE AND SURVIVAL PREDICTED BY POST-THERAPY FDG-PET/CT IN ANAL CANCER

JULIE K. SCHWARZ, M.D., PH.D.,* BARRY A. SIEGEL, M.D.,†‡ FARROKH DEHDASHTI, M.D.,†‡
ROBERT J. MYERSON, M.D., PH.D.,*‡ JAMES W. FLESHMAN, M.D.,‡§ AND PERRY W. GRIGSBY, M.D.,*







TEMPO MEDIO DI RISPOSTA PET 2.1 MESI

RIDUZIONE TOSSICITA’

RTOG 0529

TRIALS ONGOING: IMRT

RTOG 0529

A Phase II Evaluation of Dose-Painted IMRT in Combination with 5-Fluorouracil and Mitomycin-C for Reduction of Acute Morbidity in Carcinoma of the Anal Canal

SCHEMA (5/31/07)

5-FU + Mitomycin-C and IMRT		
R	**5-FU + Mitomycin-C**	**IMRT**
E		
G	• Mitomycin-C on days 1 and 29	The prescription dose scheme will depend on staging as
I		follows: (see Section 6.0 for complete details)
S	• 5-FU by **96-hour** continuous infusion (M-F)	• T2N0: 28 fractions over 5.5 weeks
T	beginning on day 1 and	• T3N0 or T4N0: 30 fractions over 6 weeks
E	again on day 29	• N+: 30 fractions over 6 weeks
R	**Note:** Days 1 and 29 are based on calendar days	

See Section 5.0 for pre-registration requirements.

RIDUZIONE TOSSICITA’

TRIALS ONGOING:
IMRT

RTOG 0529

RTOG 0529: A Phase 2 Evaluation of Dose-Painted Intensity Modulated Radiation Therapy in Combination With 5-Fluorouracil and Mitomycin-C for the Reduction of Acute Morbidity in Carcinoma of the Anal Canal

Lisa A. Kachnic, MD,* Kathryn Winter, MS,† Robert J. Myerson, MD,‡ Michael D. Goodyear, MD,§ John Willins, PhD,* Jacqueline Esthappan, PhD,‖ Michael G. Haddock, MD,‖ Marvin Rotman, MD,¶ Parag J. Parikh, MD,‡ Howard Safran, MD,# and Christopher G. Willett, MD**

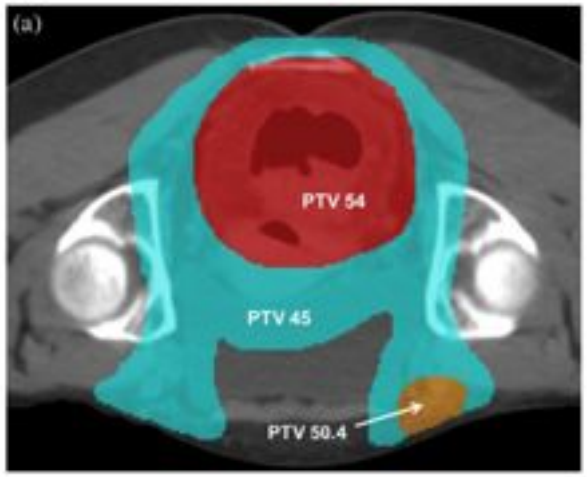


Table 5 Comparisons of acute treatment-related adverse events*

Adverse events	0529 (n=52)	98-11 (Arm 1†) (n=325)	*P* value (1-sided proportions test‡)
Grade 2+			
GI/GU§	40 (77%)	249 (77%)	.50
Derm	39 (75%)	271 (83%)	.10
GI	38 (73%)	237 (73%)	.50
GU	8 (15%)	66 (20%)	.18
Heme	38 (73%)	275 (85%)	.032
Overall	49 (94%)	318 (98%)	.12
Grade 3+			
GI/GU	11 (21%)	120 (37%)	.0052
Derm	12 (23%)	159 (49%)	<.0001
GI	11 (21%)	117 (36%)	.0082
GU	1 (2%)	11 (3%)	.52
Heme	30 (58%)	201 (62%)	.29
Overall	43 (83%)	283 (87%)	.23

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HIV+

VOLUME 26 · NUMBER 3 · JANUARY 20 2008

JOURNAL OF CLINICAL ONCOLOGY

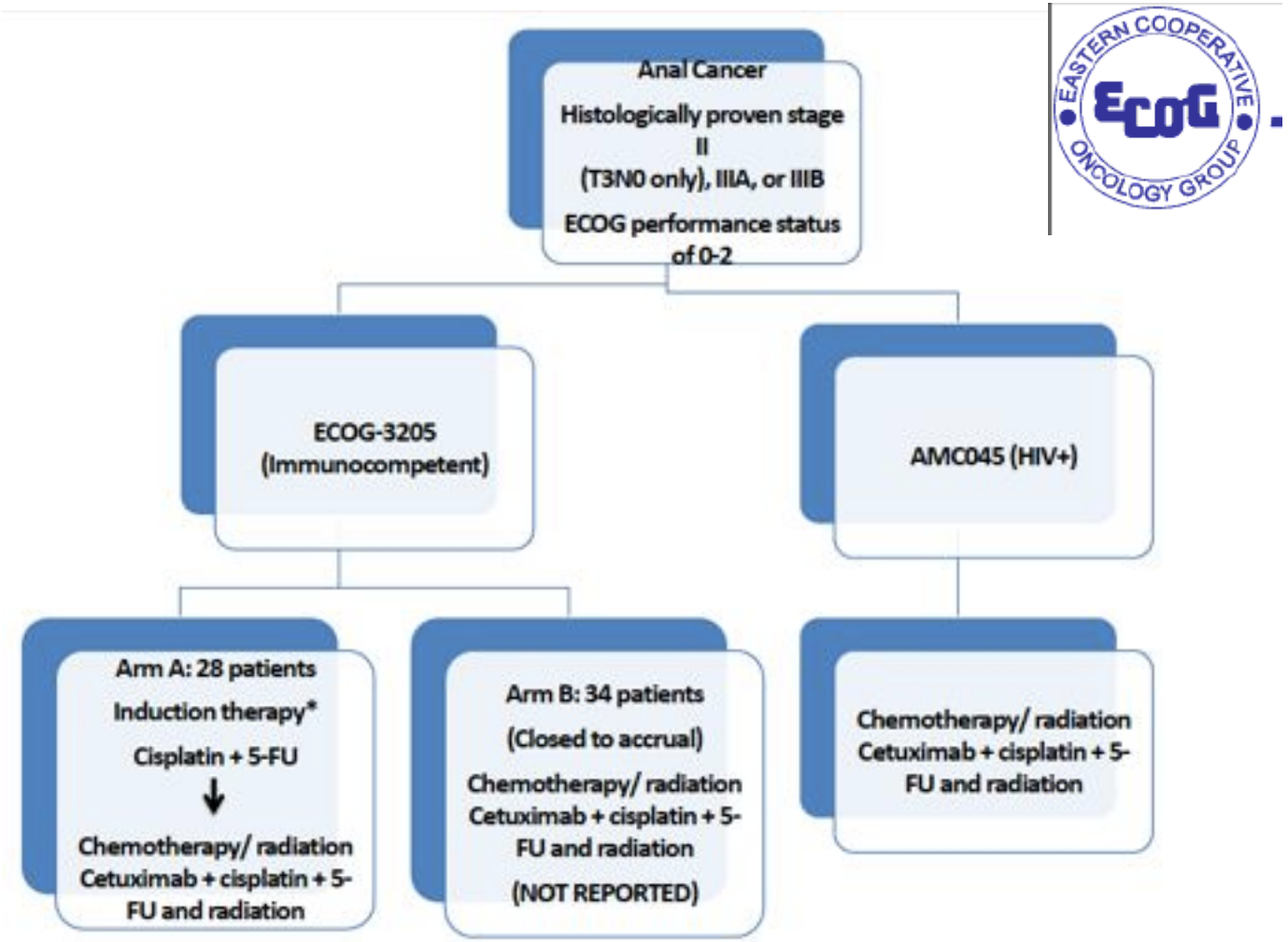
ORIGINAL REPORT

Human Immunodeficiency Virus–Associated Squamous Cell Cancer of the Anus: Epidemiology and Outcomes in the Highly Active Antiretroviral Therapy Era

Elizabeth Y. Chiao, Thomas P. Giordano, Peter Richardson, and Hashem B. El-Serag

TRIALS ONGOING:
RUOLO CETUXIMAB – INCLUSIONE HIV+

ECOG 3205
AMC045



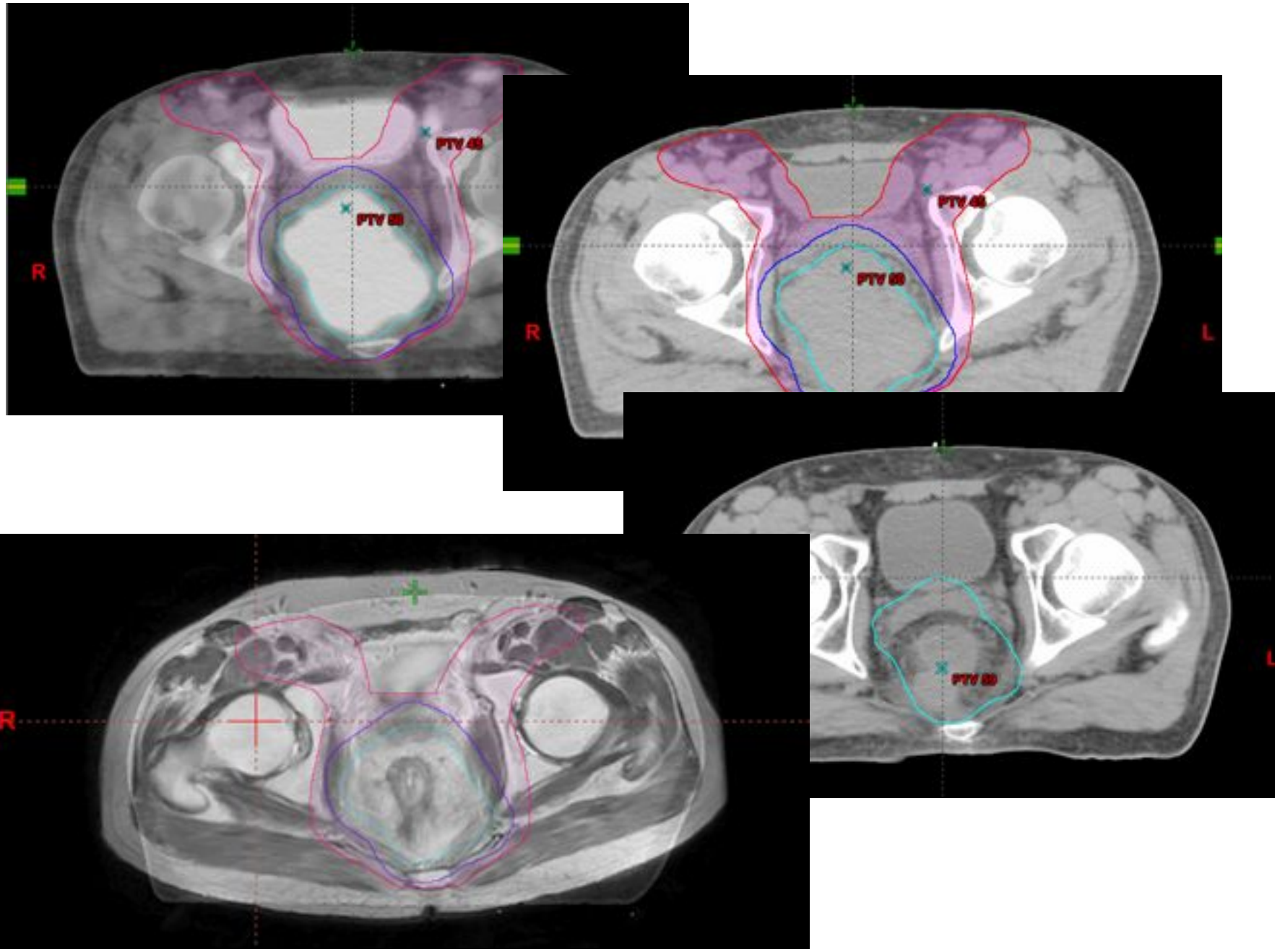
TRIALS ONGOING:
RUOLO CETUXIMAB – INCLUSIONE HIV+

ECOG 3205
AMC045

Phase II trials of cetuximab (CX) plus cisplatin (CDDP), 5-fluorouracil (5-FU) and radiation (RT) in immunocompetent (ECOG 3205) and HIV-positive (AMC045) patients with squamous cell carcinoma of the anal canal (SCAC): Safety and preliminary efficacy results.

ASCO 2012

	HIV+ AMC045	HIV- E3205
No.	45	28
Stage I/II/III	24%/42%/34%	11%/50%/39%
Completed protocol therapy	37 (82%)	22 (79%)
Type I/II adverse events	2 (4%)/0	1 (4%)/1 (4%)
Colostomy rate	7% (1-18%)	14% (4-33%)
2 year PFS rate (95% CI)	80% (61-90%)	92% (81-100%)
2 year OS rate (95% CI)	89% (73-96%)	93% (83-100%)


PTV 45
PTV 50
R
PTV 45
PTV 50
R
L
PTV 50
L
R

EVIDENZE CONSOLIDATE

- Lo schema **FUMIR** e' lo standard di trattamento (Ib,A)
- Il trattamento combinato con **5FU + MMC** e' migliore della Radioterapia esclusiva. (fase III EORTC, UKCCR – ACT I) (Ib,A)
- L'impiego della **5FU + MMC** e' vantaggioso rispetto al solo 5FU (fase III RTOG 8704/ECOG 1289) (Ib,A)
- La **pausa programmata** (SPLIT) puo' compromettere i risultati (Fase III ACT I, Pooled RTOG 8704 – 9811, ACT II, PARADAC) (Ib,A).

- Il **CDDP** rappresenta una valida alternativa alla MMC soprattutto laddove sia necessario evitare la tossicità ematologica. (fase II Rich TA 1993, Doci R 1996, Martenson JA 1997, Gerard JP1998, Peiffert D 1997 e fase III ACT II) **(Ib,B)**

  E3205, AMC045 (HIV+)

- L'utilizzo di una **chemioterapia di mantenimento** dopo la fase di radiochemioterapia concomitante non modifica la sopravvivenza libera da recidiva pertanto non e' consigliato. (fase III UK ACT II) **(Ib,B)**

- La **chemioterapia di induzione** con CDDP+5FU ha portato a risultati contrastanti (fase III RTOG 98-11, **ACCORD 03**) pertanto il suo impiego non puo' essere considerato uno standard di trattamento. (Ib,B)

- **Una dose totale di radioterapia superiore a 59 Gy** nel trattamento combinato non ha dimostrato beneficio aggiuntivo (fase III ACCORD-03). **(Ib,B)**
  - **TRA 50 E 59 NON VI E' DIFFERENZA SIGNIFICATIVA - NON VI E' DIFFERENZA TRA 55 SENZA SPLIT E 59.4 CON SPLIT (POOLED PARADAC)**

- La **valutazione della risposta clinico-strumentale** deve essere effettuata dopo 12 settimane dal termine del trattamento radio chemioterapico **(Ib,A)**
  - **La chirurgia di salvataggio dovrebbe essere proposta non prima di 26 settimane** (rev ACT II 2012) **(Ib,B)**

Risultati attesi:
….Controllo locoregionale
Buona qualita’ di vita
Preservazione sfintere anale…

Team multidisciplinare

Diagnosi

↓

Terapia

↓

Follow up

Mod. Gambacorta ESTRO33