Cervical Cancer

Gynecologic oncologists provide surgical expertise for the treatment of primary, advanced, or recurrent cervix cancer.

Women are likely to benefit from pretreatment evaluation by a gynecologic oncologist if they have:

- A Suspicious visible growth on the cervix
- A Pap smear report suggesting invasive carcinoma
- A biopsy report confirming invasive carcinoma

Clinical staging of cervical cancer (FIGO):

- Clinical examinations should be conducted by experienced examiners and may be performed under anesthesia.
- Examinations/tests should include inspection, palpation, colposcopy, endocervical curettage, hysteroscopy, cystoscopy, proctoscopy, intravenous pyelography, and x-ray examinations of lungs and skeleton.
- Conization of the cervix is considered a clinical examination.
- Suspected bladder or rectal involvement should be confirmed histologically
- If there is a question about the most appropriate stage, the earlier stage should be assigned.
- Additional studies such as CT scan, or MRI may also be needed. Definitive therapy is prescribed based on clinical staging. Although controversial, pretreatment surgical staging may allow alteration in treatment schema or field to improve outcome.

Radical or modified radical hysterectomy and lymph node dissection (including sentinel lymph node identification with Technetium-99) are potentially curative for women with early-stage (up to stage 1B1 and IIA) cervical cancer.

In specific clinical situations adjunctive treatment including radiation or chemotherapy following radical surgery improves outcome.

In selected cases, fertility-sparing treatments/procedures, including neoadjuvant chemotherapy (Day 1 Paclitaxel 175mg/m², Day 2 Cisplatin 75mg/m², Day 2 Ifosfamide 5g/m², Day 3 Mesna 5g/m² Q 3weeks X 3 cycles), cervical conization or radical abdominal trachelectomy, may be performed.

Determination of disease extent is essential to successful treatment. In some situations, pretreatment surgical staging allows a more rational therapeutic plan, although overall survival benefit and morbidity are debated.
A combined approach using chemotherapy (concurrent cisplatin-based, Cisplatin 40mg/m² Qweek) and radiation (external-beam and brachytherapy) improves outcome in those women with advanced disease (stage IIB and greater).

Treatment for pregnant patients with invasive carcinoma of the cervix should be individualized on the basis of evaluation of maternal and fetal risks.

Patients with squamous cell cancers and those with adenocarcinomas should be managed similarly, except for those with microinvasive disease. Criteria for microinvasive adenocarcinomas have not been established.

Follow-up:

- Following treatment for cervical carcinoma, patients should be monitored regularly with visits every 3-4 months for the first 2 years and twice yearly visits subsequently to year 5, with Pap tests annually and chest x-rays annually for up to 5 years
- Shared-care with the referring physician is strongly encouraged. It involves alternating the follow-up visits between the gynecologic oncology team and the referring physician.

Relevant Clinical Trials:

1. McG 0201: A phase I/II study to evaluate the safety and tolerance of RSR13 administered to patients receiving a course of Cisplatin and radiation therapy for locally advanced carcinoma of the cervix
2. RTOG C-0116: A two part phase I/II study of extended field external irradiation and intracavitary brachytherapy combined with chemotherapy (weekly Cisplatin-arm-1) and Amifostine (weekly Cisplatin and Amifostine-arm 2) in carcinoma of the cervix with positive para-aortic or high common iliac lymph nodes

Reference:

SGO guidelines Gynecol Oncol 78;S1-S13, 2000
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