MANAGEMENT OF CERVICAL CANCER PATHWAYS

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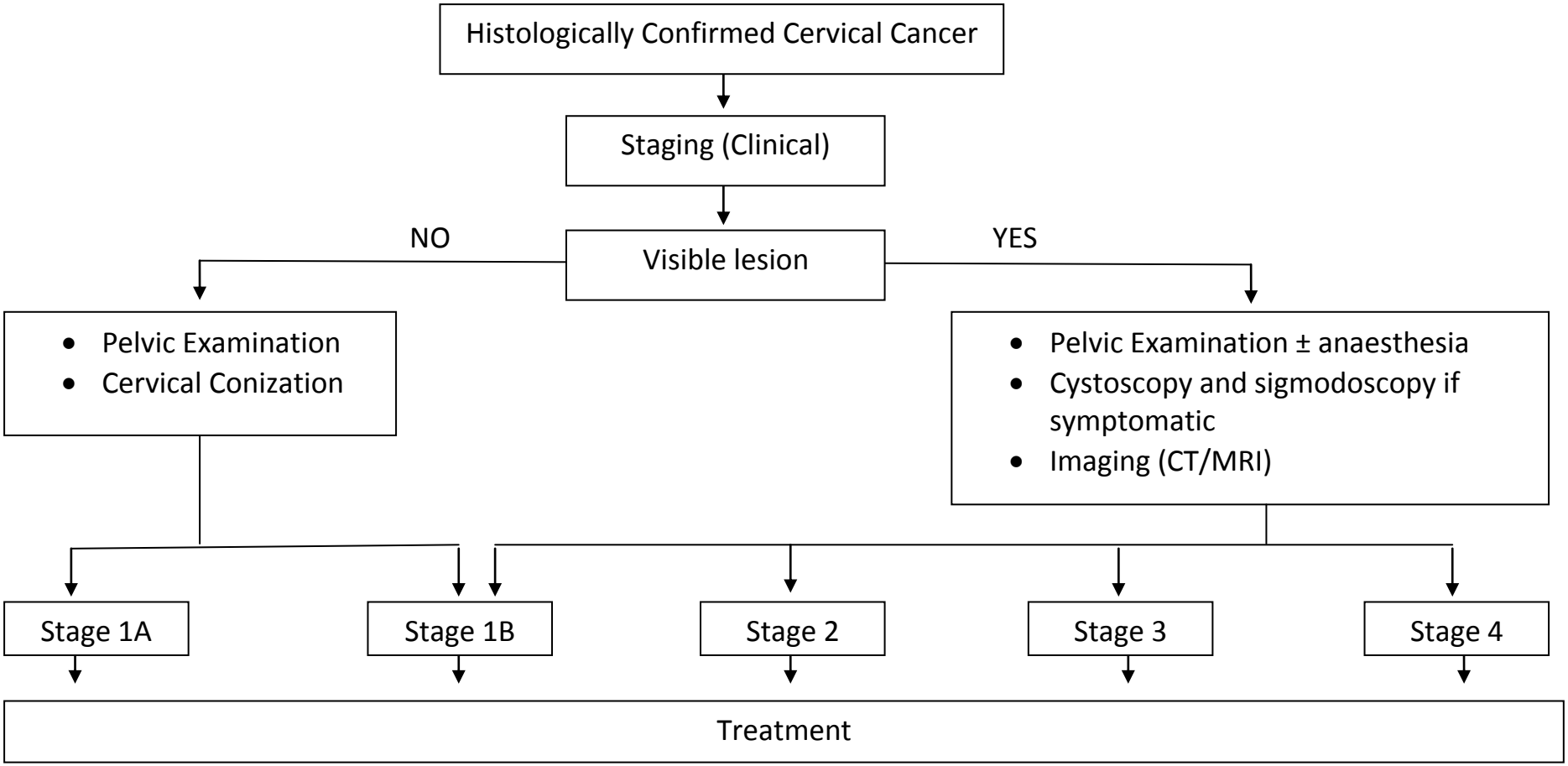
Assessment of Cervical Cancer



- FIGO staging is based on clinical examination, a thorough pelvic examination with/without anaesthesia is mandatory
- Office pelvic examination has high accuracy in early FIGO stage (85.4% for stage 1B1, 77.4% for stage 1B2) but low accuracy in FIGO stage 2 (35.5% for stage 2A, 20.5% for stage 2B)
- Radiological staging is important to assess prognostic factors such as tumour size, parametrial and pelvic side invasion, adjacent organ invasion and lymph node metastases.
- Tumour diameter ≤20mm serves as a strong predictor for absence of parametrial involvement

- Surgery is the preferred modality of treatment for early stage cervical cancer with similar survival outcomes compared with radiotherapy.
- Surgery has advantage of preserving coital and ovarian function in young patients.
- It is advisable to wait for 6-12mths after radical trachelectomy before attempting pregnancy to allow healing and exclude early recurrence.
- Ovarian preservation is safe during radical surgery in young patients with early stage SCC. The incidence of subsequent complication in retained ovaries is rare. However in adenocarcinoma, BSO should be performed.
- The role of definitive concurrent chemoradiotherapy (CCRT) in FIGO stage 1B2 and above is well established. This consists of external beam radiotherapy over 5-6wks concurrent with weekly cisplatin-based chemotherapy and brachytherapy.
- Extended field RT with/without chemotherapy may be considered for cervical cancer patients with para-aortic LN involvement.
- Intracavitary brachytherapy is essential part of RT in delivering high dose radiation to tumour while relatively sparing surrounding tissues such as rectum

If planned for concurrent chemoradiation (CCRT):

- Get RTU Appointment with the following results:
    1. HPE report
    2. CT-TAP report
    3. Pre-chemotherapy workout
        - FBC + DC
        - BUSE/Creat, Ca/Mg/PO4
        - LFT
        - Hepatitis B & C
        - 24-hr urine creatinine

** If patient has logistic issues, you can arrange and explain to the patient to send 24-hr urine creatinine on her RTU appt date, in which BUSE/Creat and other blood investigations can be taken on the same day.

Follow up

Post-Primary Treatment

Follow up	Assessment
• **3mthly x 2 yr** (consider to alternate with RTU appt, eg: 3mth in gynaeoncology clinic and the subsequent 3mth in RTU clinic. • **6mthly x 3 yrs** • **Yrly subsequently** (should return back to polyclinic follow-up)	• Symptom • Pelvic examination • Cervical Smear

- *The majority of cervical cancer recurrences are detected within 1st 2 yrs after primary treatment.*
- *58% recurrences occur in the pelvis, 65% are symptomatic,*
- *In symptomatic patient, 53% recurrences are found by exclusive pelvic examination. All asymptomatic pelvic recurrences are diagnosed by pelvic examination.*
- *Cervical/vault smears are not indicated to detect asymptomatic recurrence as it does not permit earlier detection of recurrence and does not increase survival*
- *MRI/CT should be considered to assess potential clinical recurrence in symptomatic patients.*

Adapted from Malaysia Clinical Practice Guidelines Management of Cervical Cancer (2nd Edition) 2015