



Presentation and referral	Diagnosis and symptoms	Radiological staging
Surgery	Treatment during pregnancy	Chemoradiotherapy/radiotherapy
Treatment of anaemia	Radiation induced complications	Hormone replacement therapy
Sexual morbidity	Lymphoedema	Follow up
Detection of relapsed disease	Management of recurrent disease	Complications in advanced disease
Renal failure	Thrombosis	Haemorrhage

## PRESENTATION AND REFERRAL

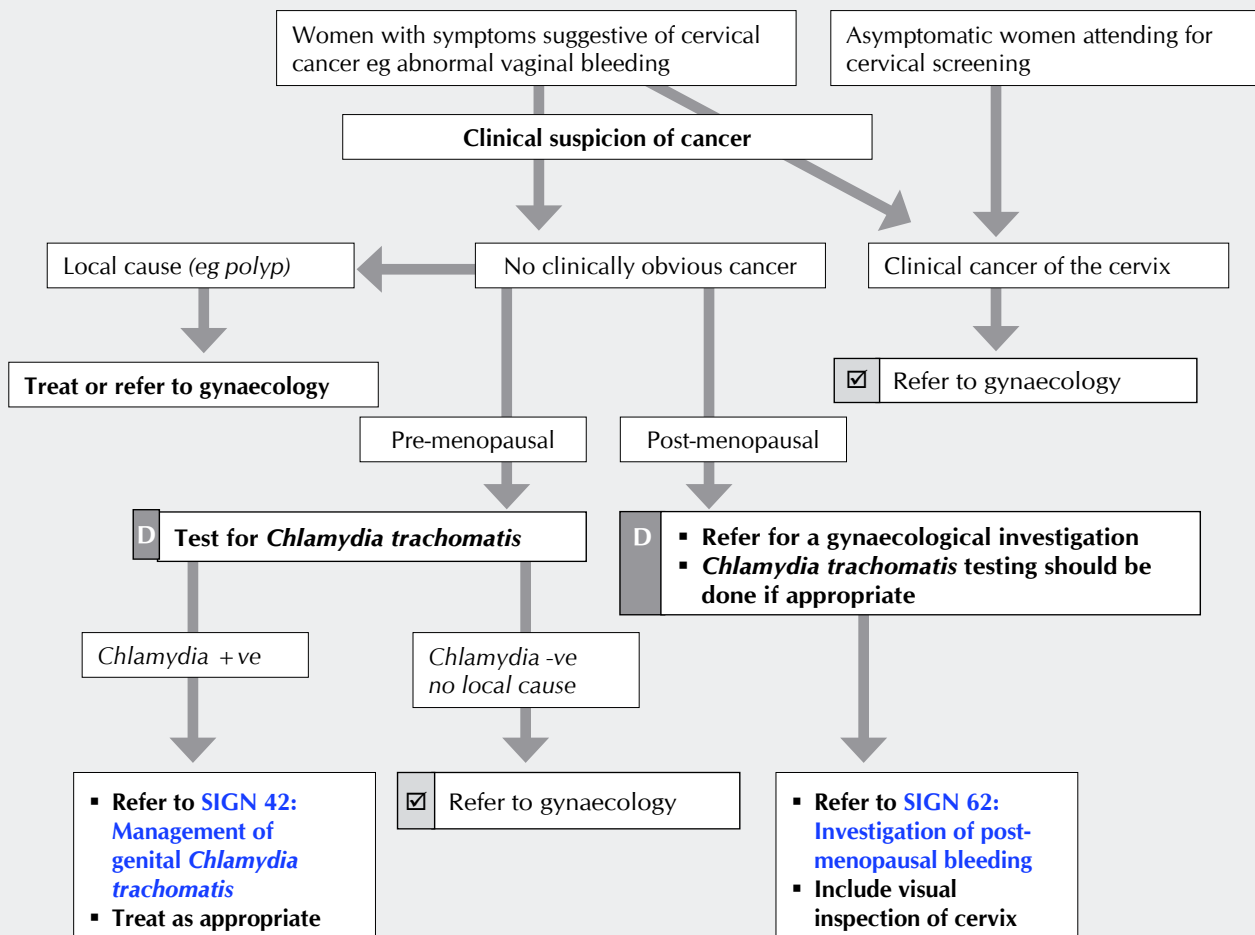
- D** Pre-menopausal women presenting with abnormal vaginal bleeding should be tested for *Chlamydia trachomatis*.
- D**
  - Post-menopausal women presenting with abnormal vaginal bleeding should be referred for gynaecological investigation.
  - *Chlamydia trachomatis* testing should be done if appropriate.
- C** An unscheduled smear is not recommended outwith the screening programme.

## DIAGNOSIS AND SYMPTOMS

### Signs and symptoms that may suggest cervical cancer

- inter-menstrual bleeding (IMB)
- post-coital bleeding (PCB)
- post-menopausal bleeding (PMB)
- abnormal appearance of the cervix (suspicion of malignancy)
- vaginal discharge (blood stained)
- pelvic pain

## ALGORITHM FOR THE INVESTIGATION OF POST-COITAL BLEEDING



## RADIOLOGICAL STAGING

- B** All patients with visible, biopsy proven cervical carcinoma (except those with **FIGO IV** disease) should have an MRI scan.
- C** The MRI scan should include:
- thin section T2 weighted images perpendicular to the cervix, and
  - sequences to include urinary tract and para-aortic nodal areas.
- B**
- Post contrast spiral CT should be considered as an alternative to MRI in patients who cannot have MRI.
  - Women who have clinically apparent **FIGO stage IV** disease should have post contrast spiral or multislice CT scans of chest abdomen and pelvis.
- C** Patients not suitable for surgery should be considered for a PET scan.
- C** If imaging cannot exclude bladder or bowel involvement, cystoscopy and sigmoidoscopy should be used for staging.

## SURGERY

- B** Radical surgery is recommended for **FIGO IB1** disease if there are no contraindications to surgery.
- D** Removal of pelvic lymph nodes is not recommended during treatment for **FIGO IA1** disease.
- D** Pelvic lymph nodes should be removed if **FIGO IA2** disease is present.
- C** Women requesting fertility conservation should be offered radical trachelectomy and pelvic lymph node dissection, providing the tumour diameter is less than 2 cm and no lymphatic-vascular space invasion is present.
- D** Women with early stage disease and no LVSI (**FIGO IA2 and microscopic IB1**) requesting fertility conservation may be offered cold knife conisation or large loop excision of the transformation zone combined with pelvic lymph node dissection.
- D** Laparoscopic-vaginal radical hysterectomy should not be offered to patients with tumour diameter greater than 2 cm.

## TREATMENT DURING PREGNANCY

- C** For pregnant women with cervical cancer, the choice of therapeutic modality should be decided in the same manner as for non-pregnant patients.
- C** For pregnant women diagnosed with cervical cancer before 16 weeks of gestation, immediate treatment is recommended.
- C** For pregnant women with early stage disease (**FIGO IA1, IA2, IB**) diagnosed after 16 weeks of gestation, treatment may be delayed to allow fetal maturity to occur.
- C** For pregnant women with advanced disease (**FIGO 1B2 or greater**) diagnosed after 16 weeks of gestation, consideration for delay must be based on gestational age at time of diagnosis.
- An individualised treatment plan should be determined, in consultation with the patient, by the multidisciplinary team, which should include an obstetrician.

## CHEMORADIOTHERAPY/RADIOTHERAPY

- A** Any patient with cervical cancer considered suitable for radical radiotherapy treatment should have concurrent chemoradiotherapy with a platinum based chemotherapy, if fit enough.
- B** Patients who have undergone surgery for cervical carcinoma and have positive nodes should be considered for adjuvant treatment with concurrent chemoradiotherapy with platinum based chemotherapy.
- B** Patients who have undergone surgery for cervical carcinoma, have negative nodes and any two of the following risk factors should be considered for adjuvant treatment with radiotherapy, if fit enough:
- greater than a third stromal invasion
  - lymphovascular space invasion
  - tumour diameter of > 4 cm.
- D** Concurrent chemoradiation should be considered in preference to radiation alone.
- D** Brachytherapy should be considered an essential component of radical radiotherapy or chemoradiotherapy.

## TREATMENT OF ANAEMIA

- C** Patients with cervical carcinoma undergoing radiotherapy or chemoradiotherapy should have their haemoglobin level monitored and corrected if it falls below 12 g/dl.

## TREATMENT OF RADIATION INDUCED COMPLICATIONS

Patients should have access to specialist multiprofessional teams for treatment and management of severe radiation induced complications.

**B** Rectal or oral sucralfate is not recommended to reduce acute radiation induced proctitis.

**D** Rectal sucralfate may be considered to reduce late radiation induced proctitis.

## HORMONE REPLACEMENT THERAPY

**C** HRT is recommended for women who have lost ovarian function as a result of treatment for cervical cancer.

## SEXUAL MORBIDITY

The sexual function and concerns of women diagnosed with cervical cancer should be assessed prior to treatment.

**C** Women should be offered a vaginal stent or dilator to prevent post-radiotherapy vaginal complications.

**B** Information about female sexual function should be offered to patients by a relevantly trained healthcare professional using a model of care that involves addressing motivational issues and teaching behavioural skills.

**C** Patients should be offered support sessions by a designated member of their care team, as soon as possible after treatment, which may include one or more of the following:

- relaxation
- personalised information about their disease and treatment
- emotional support and care.

## LYMPHOEDEMA

**D** Patients with lymphoedema, or at risk of lymphoedema, should have access to appropriate information.

**D** Patient review should include identification and recording of lower limb lymphoedema.

**D** Patients with symptoms suggestive of lymphoedema should be referred early for assessment by a designated lymphoedema practitioner.

**D** Patients with severe or poorly controlled lymphoedema should be offered decongestive lymphatic therapy with a specialist lymphoedema practitioner.

## STAGING CRITERIA FOR LYMPHOEDEMA

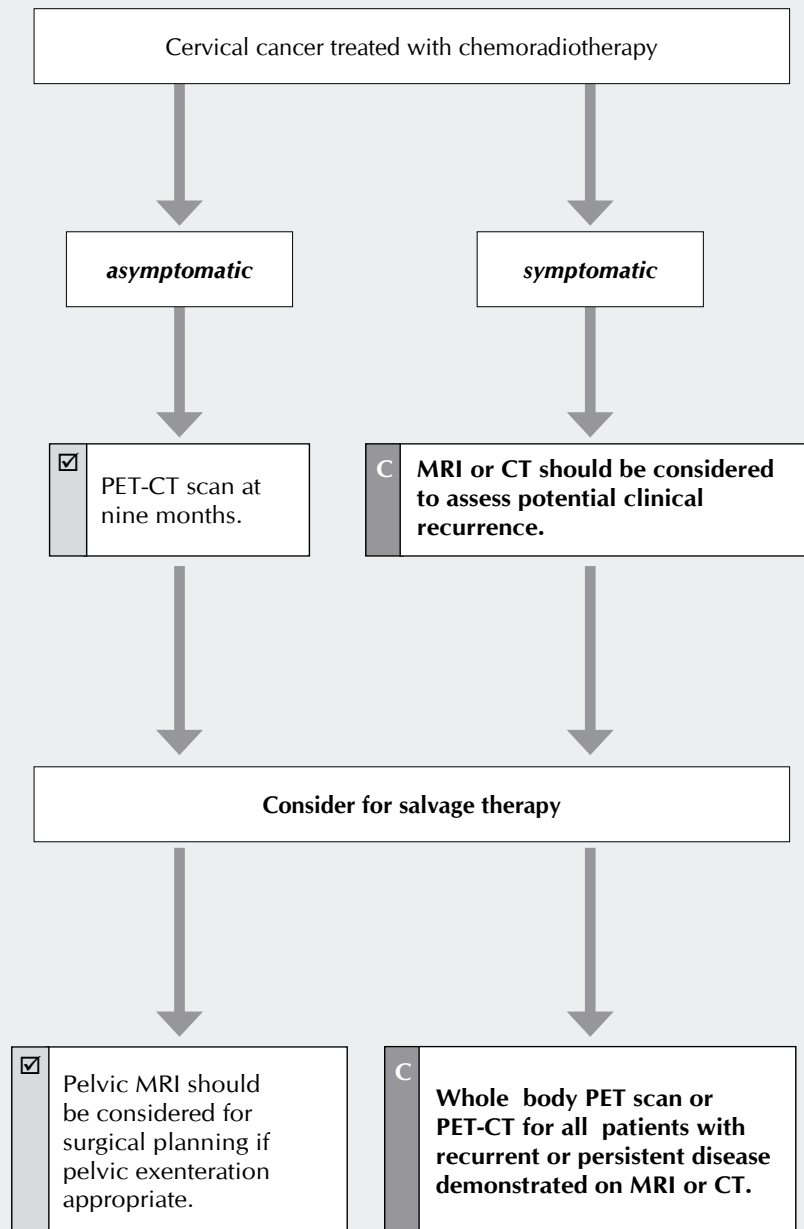
Stage	Criteria
0	Subclinical stage, where swelling is not evident but lymphatic damage has occurred.
1	Early onset of oedema that subsides with elevation.
2	Pitting oedema that does not subside on elevation.
3	Oedema with fibrotic changes.
4	Skin and tissue changes including thickening, skin folds, fat deposits and warty overgrowths.

## FOLLOW UP

Patients should be followed up every four months for at least two years.

**D** History taking and clinical examination should be carried out during follow up of patients with cervical cancer to detect symptomatic and asymptomatic recurrence.

**D** Cervical cytology or vault smears are not indicated to detect asymptomatic recurrence of cervical cancer.



**D** Pelvic exenteration should be reserved as salvage surgery for women with recurrent cervical cancer in the central pelvis whose chemoradiotherapy has failed.

**B** Palliative chemotherapy should be offered to women with FIGO stage IVB or recurrent cervical carcinoma, after discussion of the relative benefits and risks, with either:

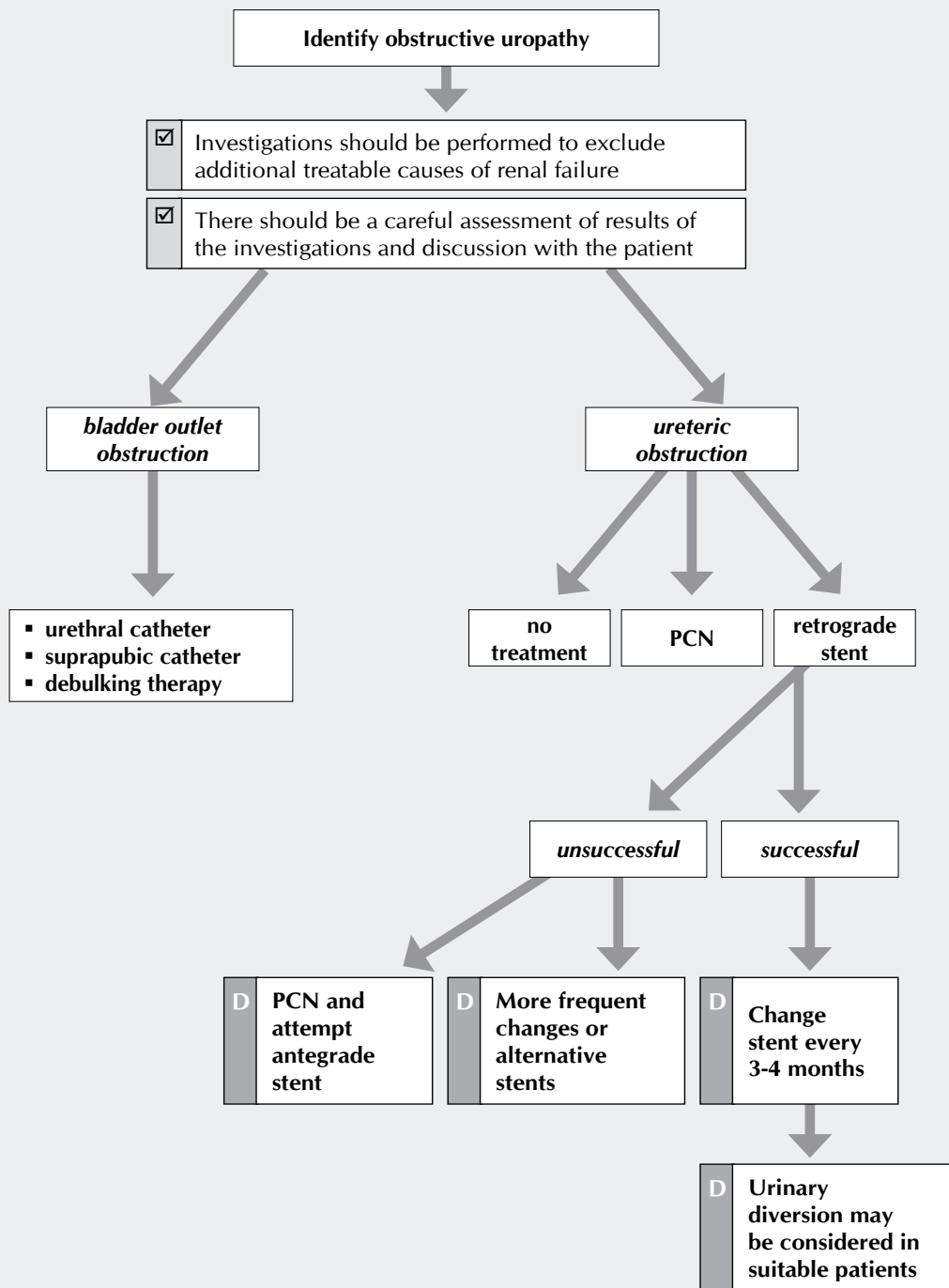
- cisplatin 50 mg/m<sup>2</sup> on day 1 plus topotecan 0.75 mg/m<sup>2</sup> on days 1 to 3 every 3 weeks, or
- cisplatin 50 mg/m<sup>2</sup> on day 1 plus paclitaxel 135 mg/m<sup>2</sup> every 3 weeks.

Cisplatin and topotecan combination should be restricted to cisplatin naïve patients.

☑ Patients with incurable cervical cancer should be managed on an individual basis.

RENAL FAILURE

ALGORITHM FOR MANAGEMENT OF RENAL FAILURE IN PATIENTS WITH CERVICAL CANCER



THROMBOSIS

C Low molecular weight heparin (LMWH) should be considered for treatment of DVT and prevention of recurrent thromboembolism.

D Compression garments, in conjunction with LMWH and early walking exercises should be considered in patients with DVT.

HAEMORRHAGE

☑ If a minor haemorrhage occurs:

- systemic causes of bleeding should be excluded
- drugs that may exacerbate bleeding should be discontinued
- antibiotics should be considered if sepsis is present.

D Treatment for minor haemorrhage may include:

- oral tranexamic acid or aminocaproic acid
- tranexamic acid applied topically to superficial fungating wound
- tranexamic acid by rectal or bladder instillation
- a single fraction of radiotherapy.



- ☑
  - The multidisciplinary team should routinely screen for the presence of psychological distress and be aware of risk factors for very high levels of psychological distress from the point of diagnosis onwards (including during follow-up review phases).
  - Multidisciplinary teams across healthcare settings should have agreed protocols for psychological distress assessment and management. These should include recommendations for referral and care pathways.
  - Liaison psychiatry and clinical psychology services should be contacted if the results from distress screening raise concerns about the psychological well-being of a patient.

**D Patients with cervical cancer should be offered psychological support at the time of diagnosis and at intervals throughout their management.**

**D Information about local support services should be made available to patients.**

**D Carers, families and dependants should be made aware of support available including local and national organisations.**

FIGO STAGING CLASSIFICATION FOR CANCER OF THE CERVIX UTERI



FIGO stage	Description
<b>0</b>	Carcinoma in situ (pre-invasive carcinoma)
<b>I</b>	Cervical carcinoma confined to uterus (extension to corpus should be disregarded)
<b>IA</b>	Invasive carcinoma diagnosed only by microscopy. All macroscopically visible lesions – even with superficial invasion – are stage IB
<b>IA1</b>	Stromal invasion no greater than 3.0 mm in depth and 7.0 mm or less in horizontal spread
<b>IA2</b>	Stromal invasion more than 3.0 mm and not more than 5.0 mm with a horizontal spread 7.0 mm or less <sup>a</sup>
<b>IB</b>	Clinically visible lesion confined to the cervix or microscopic lesion greater than IA2
<b>IB1</b>	Clinically visible lesion 4.0 cm or less in greatest dimension
<b>IB2</b>	Clinically visible lesion more than 4.0 cm in greatest dimension
<b>II</b>	Tumour invades beyond the uterus but not to pelvic wall or to lower third of the vagina
<b>IIA</b>	Without parametrial invasion
<b>IIB</b>	With parametrial invasion
<b>III</b>	Tumour extends to pelvic wall and/or involves lower third of vagina and/or causes hydronephrosis or non-functioning kidney
<b>IIIA</b>	Tumour involves lower third of vagina no extension to pelvic wall
<b>IIIB</b>	Tumour extends to pelvic wall and/or causes hydronephrosis or non-functioning kidney
<b>IV</b>	Tumour invades mucosa of bladder or rectum and/or extends beyond true pelvis <sup>b</sup>
<b>IVB</b>	Distant metastasis

*a: The depth of invasion should not be more than 5 mm taken from the base of the epithelium, either surface or glandular, from which it originates. The depth of invasion is defined as the measurement of the tumour from the epithelial-stromal junction of the adjacent most superficial epithelial papilla to the deepest point of invasion. Vascular space involvement, venous or lymphatic, does not affect classification.*

*b: The presence of bullous oedema is not sufficient to classify a tumour as stage IV.*

