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clinical recommendations

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Cervical cancer: ESMO Clinical Recommendations for diagnosis, treatment and follow-up

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incidence

The crude incidence of cervical cancer in the European Union is 13.2/100 000 and the crude mortality rate is 5.9/100 000 women/year.

diagnosis

Pathological diagnosis should be made according to the World Health Organization classification based on a surgical biopsy.

staging

Routine staging includes clinical with gynecological examination, blood counts, routine chemistry including renal and liver function tests. MRI is superior to CT scan for tumor extension assessment and MRI is equal to CT scan for nodal assessment. MRI should be preferred to CT scan and include pelvic and abdominal imaging [III, A]. A thoracic CT scan may be included for metastasis assessment. SCC dosage in squamous cell carcinoma may be useful in patient follow-up if initially increased. Surgical pelvic and para-aortic nodal staging are optional and PET is under evaluation.

The most widely used classification is FIGO (Fédération Internationale de Gynécologie et d'Obstétrique) based on clinical examination.

treatment

Multidisciplinary treatment planning is mandatory, based on tumor size and extension.

FIGO stage IA1

Standard treatment consists of conization with free margins or simple hysterectomy (according to patient age) [III, B]. In the case of lympho-vascular space involvement, pelvic lymphadenectomy is recommended [III, B]. In patients with pelvic node involvement, standard treatment consists of complementary concomitant chemoradiation [I, B].

FIGO stage IA2

Surgery is the standard. Options consist of conization or trachelectomy in young patients and simple or radical hysterectomy in other patients [III, B]. Pelvic lymphadenectomy is required [III, B]. In patients with pelvic node involvement, standard treatment consists of complementary concomitant chemoradiation [I, B].

FIGO stage IB1

There is no standard treatment. Options consist of surgery, external irradiation plus brachytherapy or combined radio-surgery [III, B].

Standard surgery consists of radical hysterectomy, bilateral oophorectomy (optional) and pelvic lymphadenectomy. Conservative surgery can be proposed for a tumor with excellent prognostic factors. Combined radio-surgery usually consists of preoperative brachytherapy followed 6–8 weeks later by surgery. In patients treated with upfront surgery or preoperative brachytherapy followed by surgery presenting pelvic node involvement, standard treatment consists of complementary concomitant chemoradiation [I, B].

FIGO stage IB2–IVA

Concomitant chemoradiation represents the standard [I, A]. This modality is superior to radiotherapy alone for local control, metastasis rate, disease-free and overall survival, with an increase in toxic (gastrointestinal and haematological) side-effects [I, A]. Patients with advanced stage III and IVA may benefit less than patients with stage IB2–IIA/B. Platinum-based regimens for chemoradiation remain the standard. External irradiation is combined with brachytherapy and the total treatment duration should remain <55 days [III, B]. Complementary extrafascial hysterectomy is an option.

Neoadjuvant chemotherapy remains controversial and is currently under investigation by the EORTC (55994).

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FIGO stage IVB

Platinum-based combination chemotherapy has potential benefit [III, B].

locoregional and metastatic recurrence

For most patients palliative chemotherapy is the standard option. Pelvic surgery (exenteration in most cases) and radiotherapy are an option in selected cases.

follow-up

Clinical with gynaecological examination including PAP smear (cave changes in patients irradiated) are performed every 3 months for the first 2 years, every 6 months for the next 3 years and yearly thereafter [III, C].

note

Levels of evidence [1–IV] and grades of recommendation [A–D] as used by the American Society of Clinical Oncology are given in square brackets. Statements without grading were considered justified standard clinical practice by the expert authors and the ESMO faculty.

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