Management Dilemmas in Cervical Cancer

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Cervical Cancer

**Magnitude of the Problem:**

- 500,000 new cases identified each year
- 80% of the new cases occur in developing countries
- At least 200,000 women die of cervical cancer each year
- Cervical cancer is the third most common cancer worldwide
- YET - Cervical cancer is a preventable disease

Please see notes page.
Cervical Cancer

Incidence and Death in relation to detection of CIS

Clinical Features: -

• Symptoms: -
  – Asymptomatic in early cases/ preclinical stage
  – Haemorrhage- Metrorrhagia / Post coital.
    • Bleeding is usually severe in cauliflower like exophytic growths.
  – Discharge- watery, offensive, blood stained
  – Cachexia and Pain-In advanced cases.
Cervical Cancer

Clinical Features: -

• Signs: -
  – An obvious growth may or may not be present
  – When an obvious growth is present, it may be exophytic cauliflower like or endophytic, ulcerative and scirrhouos
  – Cervix is usually indurated and hard to feel, friable, easily bleeds on touch and its mobility may be restricted or lost.
  – In cases of endocervical growths, the Cx is expanded, firm and feels barrel shaped.

Diagnosis: -

• PAP smear examination
• Colposcopy
• Biopsy: -
  – Excisional biopsy is preferable to punch biopsy
  – Employing Schiller’s test / Acetic acid test helps in selecting the biopsy site where the growth is not obvious.
  – Cone biopsy in early cases
• Endocervical curettage
Cervical Cancer

**Histopathology**
- Squamous Cell (>90%)
- Adenocarcinoma (5%)
- Clear Cell
- Mesonephric

**Staging: -Always Clinical**
- 0: Carcinoma-in-situ
- Ia: Microinvasive (Ia1, Ia2)
- Ib: Invasive (>5mm FIGO, >3mm SGO)
- IIa: Upper 2/3 of vagina
- IIb: Parametrial involvement (not to PSW)
- IIIa: Lower 1/3 of vagina
- IIIb: PSW or hydronephrosis/nonfunctional kidney
- IVa: Bladder or rectal mucosa
- IVb: Distant metastases
Cervical Cancer

Staging: -Techniques

- Complete physical Exam, Pelvic Exam, Rectal Exam.
  - if needed, examination under anaesthesia, should be done.
- Ultrasonography
- Chest X ray
- IVP
- Cystoscopy
- Proctosigmoidoscopy

Cervical Cancer

THE TREATMENT DILEMMA

SURGERY

RADIOTherapy
Treatment of Cervical Cancer

Options: -

- Stage I A-I. (<1mm).
  - Conization
  - Simple Hysterectomy -- vaginal / abdominal
  - Type I Hysterectomy (Extra fascial)
- Stage I A-II. (1 – 3mm, Lymph node - 1%).
  - Type II Hysterectomy (Modified radical Hysterectomy-Removal of medial half of uterosacral and cardinal ligaments and smaller margin of vagina)

Options: -

- Stage I B & II A.
  - Type III Hysterectomy (Radical hysterectomy with removal of most of utero sacral and cardinal ligaments, upper 1/3 rd of vagina, pelvic lymphadenectomy) followed by
  - Post operative irradiation
- Bulky Lesions & stage II B
  - Full irradiation followed 3 - 4 weeks later by
  - Type II Hysterectomy
Treatment of Cervical Cancer

**Options:**

- Recurrent disease: - as per previous treatment
  - RT → Exenteration
  - Surgery → RT
- Stage III & IV: - Radiation / ??Exenteration
- Radiation, as primary treatment is an option in all stages.
- Chemotherapy - as adjunct to RT or for palliation

Radical Hysterectomy

**Key Points:**

- Removes corpus, cervix, parametria, upper third of vagina
- Uterine arteries divided at origin
- Ureters dissected through tunnel
- Uterosacral ligaments divided near rectum
- Typically combined with LND
- Oophorectomy not mandatory
Radical Hysterectomy

**Technique:** -

- Abdominal exploration
- Assessment of operability
- Ligation and section of ovario pelvic fold and round ligament
- Dissection of pelvic lymphnodes
- Dissection of ureter
- Separation of bladder
- Ligation of uterine vessels

Radical Hysterectomy

**Technique:** -

- Dissection of ureter from cardinal ligament
- Cleaning of paravescial and pararectal fossa
- Opening of rectovaginal septum
- Clamping and transection of uterosacral and cardinal ligament
- Transection of vagina
- Hemostasis and drainage
- Reperitonisation
Radical Hysterectomy

**Complications:**

- Acute: → Hemorrhage, Trauma, Sepsis, Thrombophlebitis, Pulmonary Embolism, Small Bowel obstruction, Febrile Morbidity, UVF - 1-2%, VVF - < 1%,
- Primary mortality - 1%
- Sub Acute: → Neurogenic bladder dysfunction
- Chronic → Lymphocyst, Ureteral stricture

**Advantages:**

- More thorough assessment of the spread and type of lesion
- Preservation of ovaries if desired
- Retention of more functional vagina
- Less morbidity and less recurrence
- Special conditions like
  - Large Adnexal masses
  - Fibromyoma
  - Radioresistant growth
  - Unsuitable for intracavitary irradiation
  - Central recurrence after radiotherapy
Schauta Operation

An Alternative surgery: -

- Adopted as Mitra’s Operation In India as an alternative to Wertheim’s Hysterectomy.
- It's an extended Vaginal Hysterectomy.
- Comprises of removal of entire Uterus and Adenexae with most of the vagina and medial portion of parametria, by vaginal route.
- Though primary mortality is low (<1%) lymph nodes cannot be removed. So it should be followed by
  - Post operative radiation or
  - Taussig’s extra peritoneal Lymphadenectomy

Radiation

Complications: -

Acute: -
- Perforation
- Fever
- Diarrhea
- Bladder spasm

Chronic: -
- Proctitis
- Cystitis-UTI
- Fistula
- Enteritis
- Femoral head necrosis
- Ureteric stenosis
- Rectal stricture
Special Category

**Difficult to deal:**

- Invasive Cancer discovered on Cone Biopsy
- Cervical Stump Carcinoma
- Invasive Carcinoma found after simple hysterectomy
- Cervical Cancer in Pregnancy
- Large Barrel shaped lesion

Follow Up

- At 2-3 Months interval ---- 2 year
- At 3-4 Months interval ---- Next 2-4 year
- At 6 Monthly interval ----- Rest of the life
- ?Tumour markers
Cervical Cancer

Five-Year Survival: -

![Graph showing five-year survival rates for different stages of cervical cancer.](image)

from Grigsby, P.W., et.al Radiother Oncol 12:289, 1988

Please see notes page.

Conclusion

- “Prophylaxis - better than cure” - Never more True
- Pre treatment evaluation and Proper staging is a must.
- Surgery and radiation are complimentary. So proper team is essential- Surgeon and Radiotherapist should join hands.
- Stage for stage, little progress has been made in lowering mortality rates.
- However, the overall mortality rate is decreasing because more patients are having their cancers diagnosed in early states of disease.
Conclusion

- Five year survival - stage IA – 100 %, IB - 85 - 90 %, stage IIA- 70 - 75 %
- Many physicians are discouraged with the results of cancer therapy.
- However, the opportunity is there for all physicians to make an early diagnosis in Ca Cx and to protect the women from this dreadful disease.
- Those women saved from the ravages of cervical cancer shall call their physicians blessed.

“Days are gone when a patient with gynaecological malignancy could be treated by a surgeon or a radiotherapist in isolation”. -Stallworthy
At the service of women

Thank You