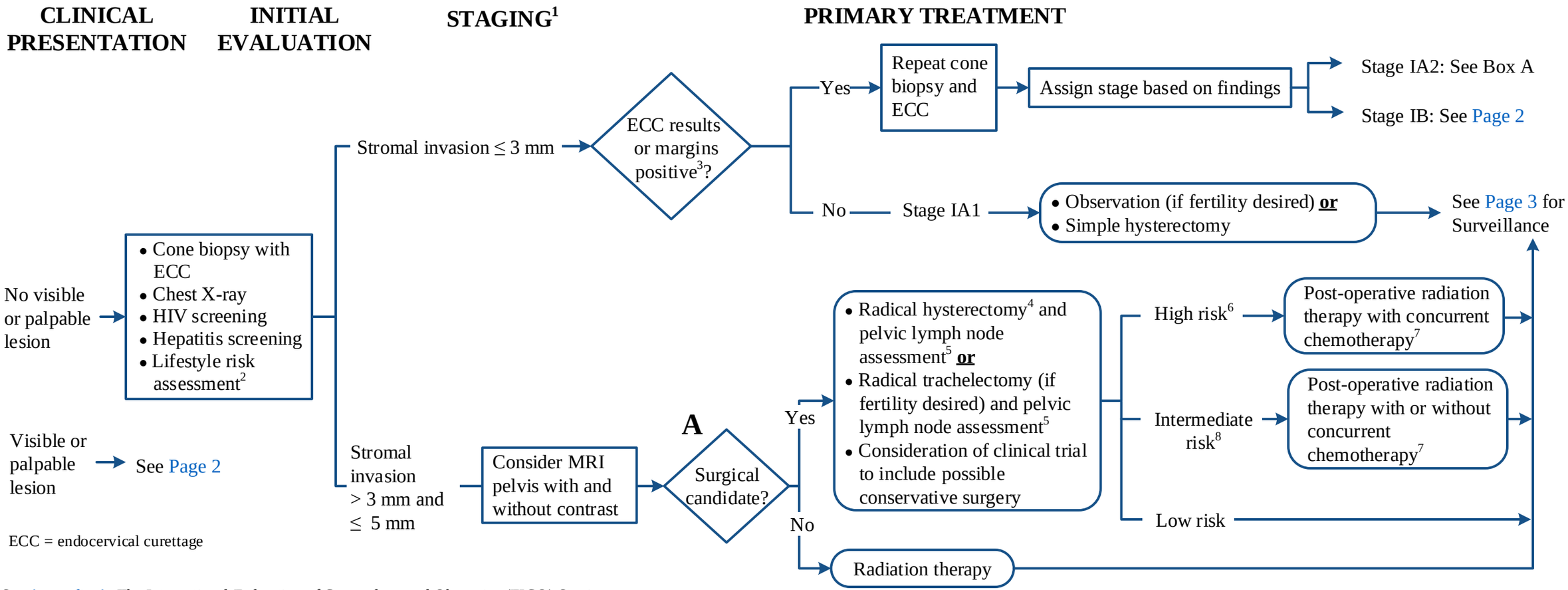
THE UNIVERSITY OF TEXAS MD Anderson Cancer Center
Making Cancer History®

Invasive Cervical Cancer: Squamous Cell, Adenocarcinoma, Adenosquamous

Note: If available, clinical trials should be considered as preferred treatment options for eligible patients (www.mdanderson.org/gynonctrials). Other co-morbidities are taken into consideration prior to treatment selection. All patients with invasive cervical cancer should be referred to a Gynecologic Oncologist.



ECC = endocervical curettage

[1] See Appendix A: The International Federation of Gynecology and Obstetrics (FIGO) Staging
[2] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[3] Positive margins includes dysplasia
[4] All procedures should be done open; minimally invasive surgery is no longer acceptable for radical hysterectomy or trachelectomy
[5] Lymphtic mapping with sentinel lymph node biopsy and/or lymph node dissection
[6] High risk factors: positive nodes, positive margins, and/or parametrial involvement
[7] Weekly cisplatin
[8] Intermediate risk factors: stromal invasion, capillary lymphatic space involvement and/or large clinical tumor diameter. See Appendix B: Gynecological Oncology Group (GOG) Sedlis Criteria

Department of Clinical Effectiveness V11
Approved by the Executive Committee of the Medical Staff on 04/21/2020

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Disclaimer: *This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.*

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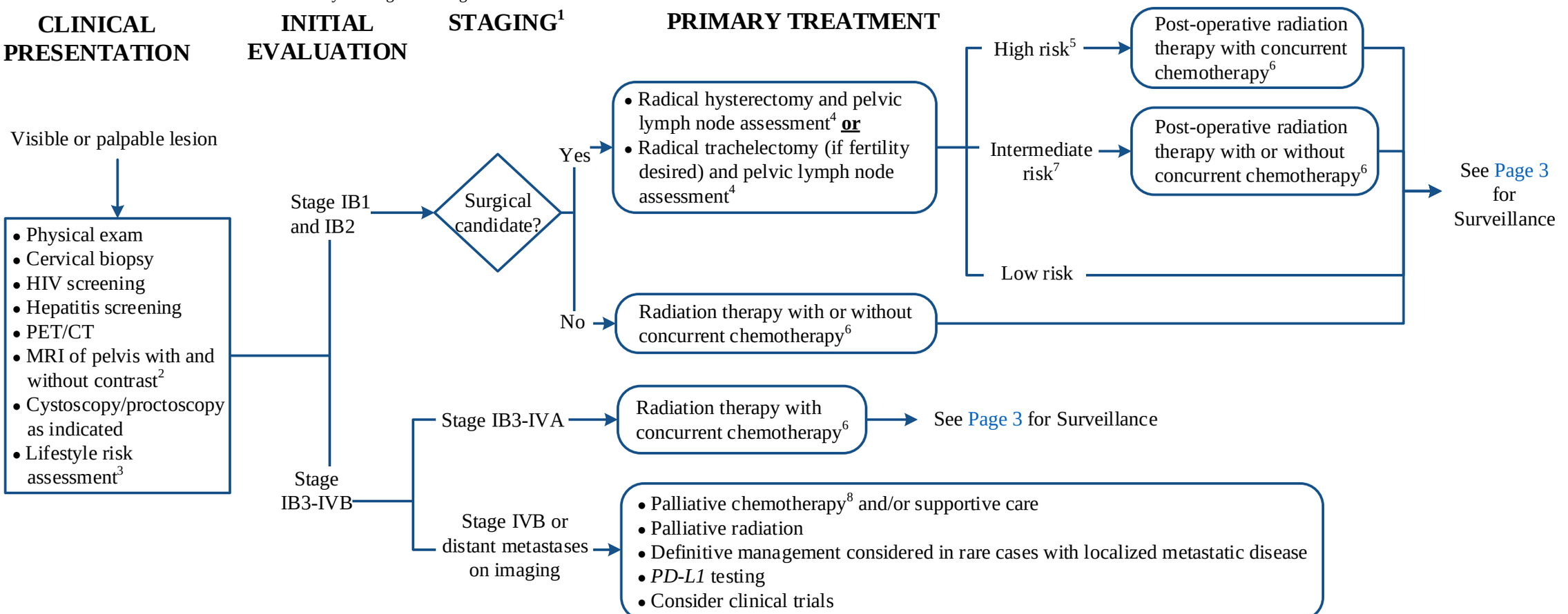

[1] See Appendix A: The International Federation of Gynecology and Obstetrics FIGO Staging
[2] MRI should be completed on all patients receiving definitive radiation and all patients undergoing trachelectomy
[3] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Lymphatic mapping with sentinel lymph node biopsy and/or lymph node dissection
[5] High risk factors: positive nodes, positive margins, and/or parametrial involvement
[6] Weekly cisplatin
[7] Intermediate risk factors: stromal invasion, capillary lymphatic space involvement and/or large clinical tumor diameter. See Appendix B: Gynecology Oncology Group (GOG) Sedlis Criteria.
[8] Taxol cisplatin and avastin

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SURVELLIANCE

- Interval history and physical
- Cervical/vaginal cytology annually
- Imaging including chest x-ray as clinically indicated
- Recommended use of vaginal dilator after radiation treatment
- Consider vaginal estrogen cream[1] and/or bone care for radiated patients
- Vitamin D level
- Exenteration surveillance based on clinical indications

RECURRENCE

Recurrence?

Yes

- PET
- Consider additional imaging as clinically indicated
- *PD-L1* testing

No

Continue surveillance

TREATMENT

Recurrence in central pelvis

- No prior radiation therapy → Radiation therapy with concurrent chemotherapy[2]
- Prior radiation therapy →
  - Consider pelvic exenteration
  - Consider palliative care if not a candidate for pelvic exenteration

Isolated regional recurrence →

- Surgical resection **or**
- Radiation therapy **or**
- Chemotherapy[3] **or**
- Combined modality **or**
- Consider palliative care

Multiple sites of metastatic disease →

- Palliative care
- Chemotherapy[3] and consideration of clinical trial participation

DISPOSITION

Individualized follow-up based on clinical indications and treatment plan

[1] Long term use of vaginal estrogen requires progesterone
[2] Weekly cisplatin
[3] See Appendix C: Recurrent or Metastatic Chemotherapy Regimens

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APPENDIX A: The International Federation of Gynecology and Obstetrics (FIGO) Staging

Stage	Description
I	**Carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded)** **IA:** Invasive carcinoma which can be diagnosed only by microscopy, with deepest invasion < 5 mm[1] **IA1:** Measured stromal invasion < 3 mm in depth **IA2:** Measured stromal invasion ≥ 3 mm and < 5 mm in depth **IB:** Invasive carcinoma with measured deepest invasion ≥ 5 mm (greater than stage IA), lesion limited to the cervix uteri[2] **IB1:** Invasive carcinoma ≥ 5 mm depth of stromal invasion and < 2 cm in greatest dimension **IB2:** Invasive carcinoma ≥ 2 cm and < 4 cm in greatest dimension **IB3:** Invasive carcinoma ≥ 4 cm in greatest dimension
II	**Carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina** **IIA:** Involvement limited to the upper two-thirds of the vagina without parametrial invasion **IIA1:** Invasive carcinoma < 4 cm in greatest dimension **IIA2:** Invasive carcinoma ≥ 4 cm in greatest dimension **IIB:** With parametrial involvement but not up to the pelvic wall
III	**The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or non-functioning kidney and/or involves pelvic and/or paraaortic lymph nodes**[3] **IIIA:** Tumor involves lower third of the vagina, with no extension to the pelvic wall **IIIB:** Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney (unless known to be due to another cause) **IIIC:** Involvement of pelvic and/or paraaortic lymph nodes, irrespective of tumor size and extent (with r and p notations)[3] **IIIC1:** Pelvic lymph node metastasis only **IIIC2:** Paraaortic lymph node metastasis
IV	**IVA:** Spread or growth to adjacent organs **IVB:** Spread to distant organs

[1] Imaging and pathology can be used, when available, to supplement clinical findings with respect to tumor size and extent, in all cases

[2] The involvement of vasuclar/lymphatic spaces does not change the staging. The lateral extent of the lesion is no longer considered.

[3] Notation of r (imaging) and p (pathology) to indicate the findings that are used to allocate the cases to stage III: If imaging indicates pelvic node metastasis, r should be added to the stage allocation *e.g.*, stage IIICr. If staging confirmed with pathological findings, p should be added to the stage allocation *e.g.*, IIICp. The type of imaging modality or pathology technique should be documented. When in doubt, the lower staging should be assigned.

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APPENDIX B: Gynecology Oncology Group (GOG) Sedlis Criteria

LVSI	Stromal Invasion	Tumor Size
Positive	Deep third	Any
Positive	Middle third	≥ 2 cm
Positive	Superficial third	≥ 5 cm
Negative	Deep or middle third	≥ 4 cm

LVSI = lymphovascular space invasion

APPENDIX C: Recurrent or Metastatic Chemotherapy Regimens

First Line	Second Line
• Paclitaxel, cisplatin and bevacizumab • Paclitaxel and cisplatin • Paclitaxel and carboplatin • Topotecan and cisplatin • Cisplatin and gemcitabine • Cisplatin • Carboplatin • Paclitaxel • Paclitaxel (protein-bound)	• Bevacizumab • Docetaxel • Fluorouracil • Gemcitabine • Ifosfamide • Irinotecan • Mitomycin • Topotecan • Pemetrexed • Vinorelbine • Pembrolizumab

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SUGGESTED READINGS

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