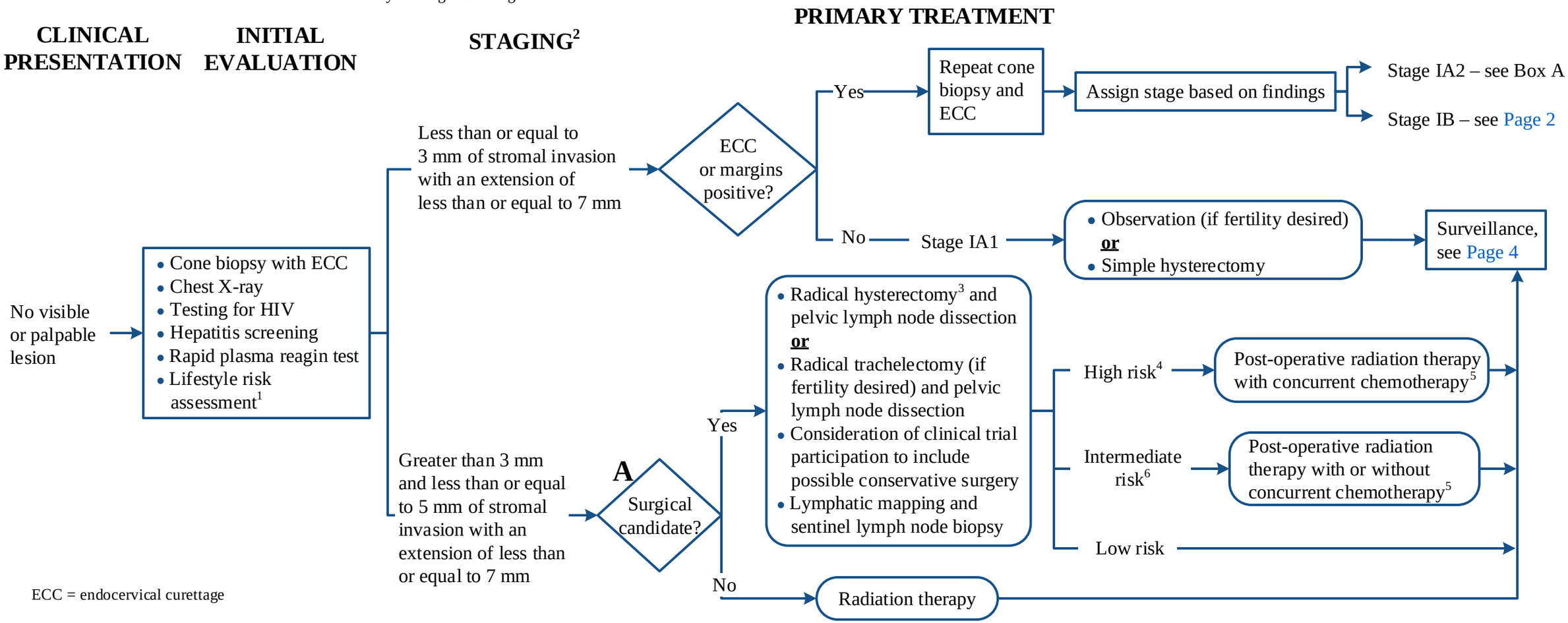
THE UNIVERSITY OF TEXAS MD Anderson Cancer Center
Making Cancer History®

Invasive Cervical Cancer: Squamous Cell, Adenocarcinoma, Adenosquamous

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson, including the following: MD Anderson's specific patient population; MD Anderson's services and structure; and MD Anderson's clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant women.

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 Physical Activity, Nutrition, and Tobacco Cessation Algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[2] See Appendix A for FIGO Staging
[3] Hysterectomy may be performed through open or minimally invasive techniques based on surgeon/patient discretion
[4] High risk factors are positive nodes, positive margins, or parametrial involvement
[5] Weekly cisplatin
[6] Intermediate risk factors: stromal invasion, capillary lymphatic space involvement and large clinical tumor diameter. Refer to Appendix B for GOG Sedlis Criteria.

Department of Clinical Effectiveness V10
Approved by the Executive Committee of the Medical Staff on 03/27/2018

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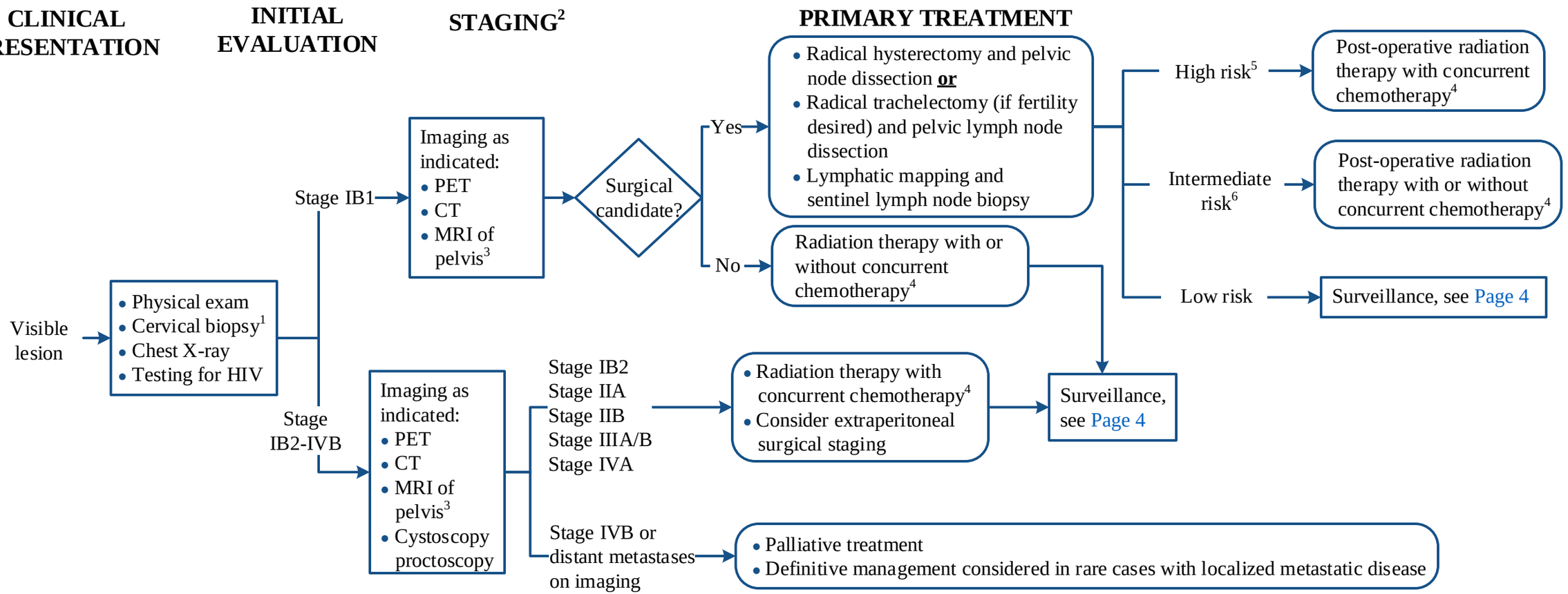

[1] Relative indications in favor of primary radiation therapy are: positive nodes, extensive lymphovascular space involvement, deep stromal invasion
[2] See Appendix A for FIGO Staging
[3] All trachelectomy patients should get MRI
[4] Weekly cisplatin
[5] High risk factors are positive nodes, positive margins, or parametrial involvement
[6] Intermediate risk factors: stromal invasion, capillary lymphatic space involvement and large clinical tumor diameter. Refer to Appendix B forGOG Sedlis Criteria.

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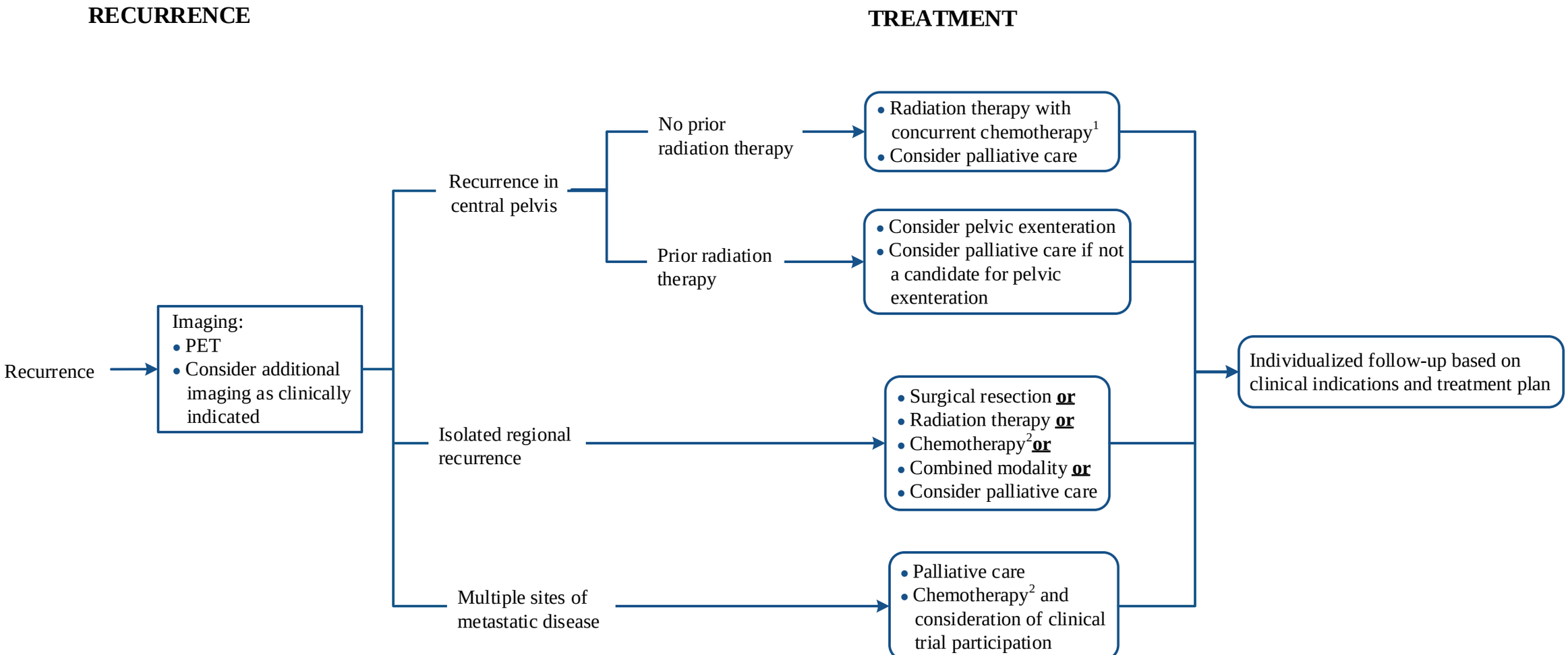

[1] Weekly cisplatin
[2] See Appendix C for Chemotherapy Regimens

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Surveillance:

- Interval history and physical
- Cervical/vaginal cytology annually
- Laboratory assessment (CBC, BUN, creatinine) as clinically indicated
- Imaging including chest x-ray as clinically indicated
- Recommended use of vaginal dilator after radiation treatment
- Consider vaginal estrogen cream and/or bone care for radiated patients
- Exenteration surveillance based on clinical indications

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APPENDIX A: 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 less than or equal 5 mm and largest extension less than or equal 7 mm **IA1:** Measured stromal invasion less than or equal to 3 mm in depth and extension of less than or equal 7 mm **IA2:** Measured stromal invasion greater than 3 mm and less than or equal 5 mm with an extension of less than or equal 7 mm **IB:** Clinically visible lesions limited to the cervix uteri or pre-clinical cancers greater than stage IA[1] **IB1:** Clinically visible lesion less than or equal 4 cm in greatest dimension **IB2:** Clinically visible lesion greater than 4 cm in greatest dimension
II	**Cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina** **IIA:** Without parametrial invasion **IIA1:** Clinically visible lesion less than or equal 4 cm in greatest dimension **IIA2:** Clinically visible lesion greater than 4 cm in greatest dimension **IIB:** Without obvious parametrial invasion
III	**Tumor extends to the pelvic wall and/or invovles lower third of the vagina and/or causes hydronephrosis or non-functioning kidney**[2] **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
IV	**IVA:** Spread or growth to adjacent organs **IVB:** Spread to distant organs

[1] All macroscopically visible lesions even with superficial invasion are allotted to stage IB carcinomas. Invasion is limited to a measured stromal invasion with a maximal depth of 5 mm and a horizontal extension of less than or equal to 7 mm. Depth of invasion should not be greater than 5 mm taken from the base of the epithelium of the original tissue superficial or glandular. The depth of invasion should always be reported in mm, even in those cases with "early (minimal) stromal invasion" (~1 mm). The involvement of vascular/lymphatic spaces should not change the stage allotment.

[2] On rectal examination, there is no cancer-free space between the tumor and the pelvic wall. All cases with hydronephrosis or non-functioning kidney are included, unless they are known to be due to another cause.

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APPENDIX B: Gynecology Oncology Group Sedlis Criteria

LVSI	Stromal Invasion	Tumor Size
Positive	Deep third	Any
Positive	Middle third	greater than or equal to 2 cm
Positive	Superficial third	greater than or equal to 5 cm
Negative	Deep or middle third	greater than or equal to 4 cm

APPENDIX C: Chemotherapy Regimens

	First Line	Second Line
Recurrence or Metastatic Therapy	• 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

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SUGGESTED READINGS

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DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Gynecologic Oncology Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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