Survivorship – Cervical Cancer (Includes Vulvar and Vaginal)

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.

ELIGIBILITY

- Cervical, vulvar, or vaginal cancer
- Vulvar cancer treated with radiotherapy 5 years post-treatment and NED
- Cervical and vaginal cancer 5 years post-treatment and NED

CONCURRENT COMPONENTS OF VISIT

- Annual history and physical exam with:
  - Cervical cytology
  - Pelvic exam

SURVEILLANCE

- Consider the following:
  - Colonoscopy
  - Bone Health (see Survivorship - Gynecologic Cancer: Bone Health algorithm)
  - Sexual health

MONITORING FOR LATE EFFECTS

- Patient education, counseling, and screening:
  - Patient education regarding radiotherapy complications
  - Suggest use of vaginal dilator after radiation therapy
  - Lifestyle risk assessment
  - Cancer screening
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
  - Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
  - Consider cardiovascular risk reduction

RISK REDUCTION/EARLY DETECTION

- Assess for:
  - Distress management (see Distress Screening and Psychosocial Management algorithm)
  - Social support
  - Financial stressors

PSYCHOSOCIAL FUNCTIONAL

- Continue survivorship monitoring

DISPOSITION

- New primary or recurrent disease?
  - Yes
    - Return to primary treating physician
      - Primary Oncologist to discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative
  - No
    - Continue survivorship monitoring

NED = no evidence of disease

1 GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

2 See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

3 Includes breast, colorectal, liver, lung, pancreatic, and skin cancer screening

4 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health

Approved by the Executive Committee of the Medical Staff on 09/19/2023
SUGGESTED READINGS


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)


Continued on next page
SUGGESTED READINGS - continued


DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Gynecologic Survivorship workgroup 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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