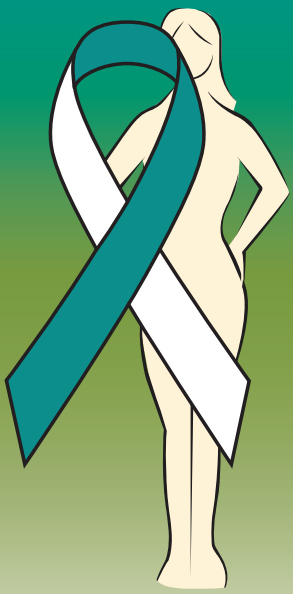
QUICK REFERENCE FOR HEALTHCARE PROVIDERS

MANAGEMENT OF CERVICAL CANCER
(SECOND EDITION)



Ministry of Health Malaysia
Malaysian Gynaecological Cancer Society
Malaysian Oncological Society
Academy of Medicine Malaysia

KEY MESSAGES

1. Cervical cancer is the second most common cancer among women in Malaysia & is potentially curable.
2. A definitive diagnosis of cervical cancer is made by histopathological examination of cervical tissue.
3. Histopathological reports of cervical cancer should include core histological data, following standards & datasets for reporting cancers (Dataset for histological reporting of cervical neoplasia - 3rd Edition).
4. All newly diagnosed cervical cancer should be clinically staged according to the Revised FIGO Cervical Cancer Staging 2009 before initiating treatment. Radiological imaging may be offered to provide additional information on nodal status and systemic spread.
5. In the management of cervical cancer, patients should be thoroughly counselled & be involved in the decision-making process.
6. In early stage cervical cancer (up to FIGO stage IIA, excluding bulky disease stage IB2 & IIA2), surgery is the preferred modality of treatment. Definitive concurrent chemoradiation therapy (CCRT) is an alternative to surgery. Adjuvant chemoradiotherapy should be considered in patients with high risk of recurrence.
7. In locally advanced cervical cancer (FIGO stage IIB to IVA, including bulky disease stage IB2 & IIA2), CCRT is the primary modality in which treatment time should not exceed 8 weeks.
8. Post-treatment cervical cancer patients may be followed up every 3 months in the first year, 4 months in the second year, 6 months in the third to fifth year & annually thereafter.
9. The treatment of cervical cancer in pregnancy should be individualised with multi-disciplinary team involvement.
10. Cervical cancer patients should receive palliative care especially in advanced disease & preferably referred to a palliative care team.
11. Psychosocial assessment & psychoeducation should be offered for cervical cancer patients.

This Quick Reference provides key messages & a summary of the main recommendations in the Clinical Practice Guidelines (CPG) Management of Cervical Cancer (Second Edition). Details of the evidence supporting these recommendations can be found in the above CPG, available on the following websites:
Ministry of Health Malaysia: www.moh.gov.my
Academy of Medicine Malaysia: www.acadmed.org.my
Malaysian Gynaecological Cancer Society: www.themgcs.blogspot.com
Malaysian Oncological Society : www.malaysiaoncology.org
Also available as a mobile app for Android &IOS platform: MyMaHTAS

CLINICAL PRACTICE GUIDELINES SECRETARIAT
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Medical Development Division, Ministry of Health Malaysia
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RISK FACTORS FOR CERVICAL CANCER

- >3 sexual partners
- early sexual intercourse (<17 years old)
- first delivery before age of 17
- high parity (≥7 full term pregnancies)
- >10 years' use of oral contraceptive
- smoking
- lower socioeconomic status

CLINICAL PRESENTATION FOR CERVICAL CANCER

Most patients are asymptomatic. Common presenting symptoms:

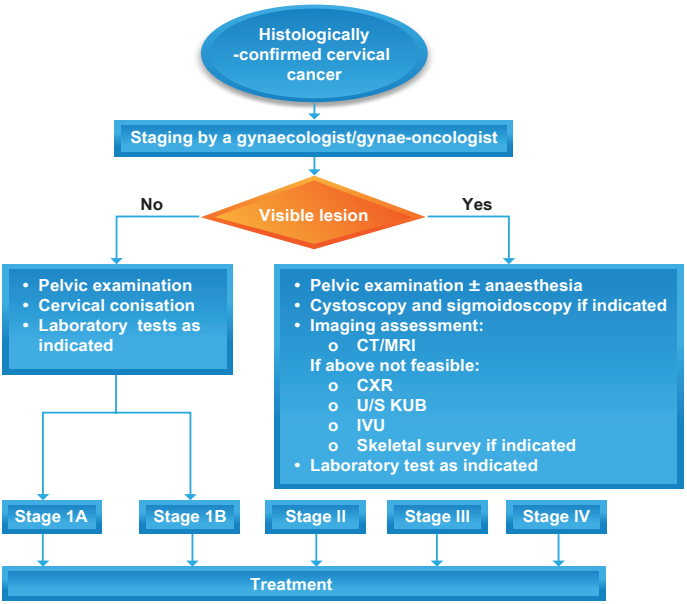
- postmenopausal bleeding
- vaginal discharge
- post-coital bleeding
- abdominal pain

TIME FRAME FOR REFERRAL OF ABNORMAL CYTOLOGY TO GYNAECOLOGY CLINIC

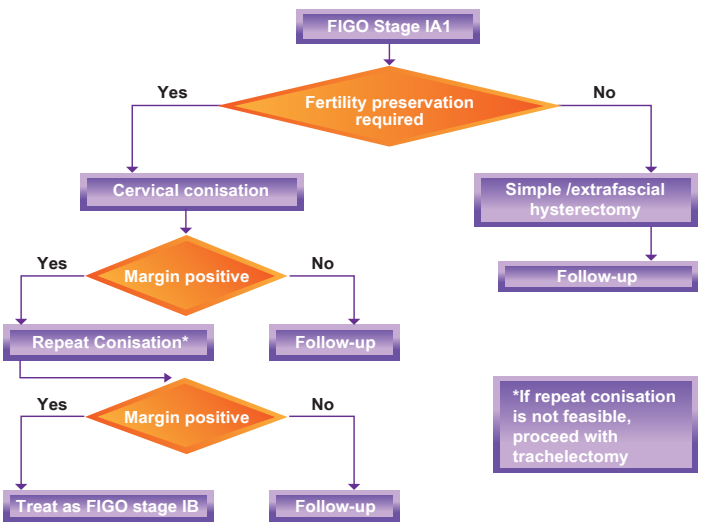
Time frame for referral	Criteria
Within 8 weeks	• After three consecutive inadequate samples • After three tests reported as inflammatory smear in a series • One test reported as AGC-US or AGC-H • After two tests reported as LSIL or ASCUS* *HPV DNA testing should be considered if available. If positive for high risk HPV, to refer for colposcopy.
Within 4 weeks	• One test reported as HSIL
Within 2 weeks	• One test reported as possible invasion • One test reported as possible glandular neoplasia • Women with symptoms of postcoital bleeding particularly >40 years, intermenstrual bleeding & persistent vaginal discharge

Patients should receive definitive treatment within 31 days of agreeing to their care plan or within 62 days on the referral pathway.

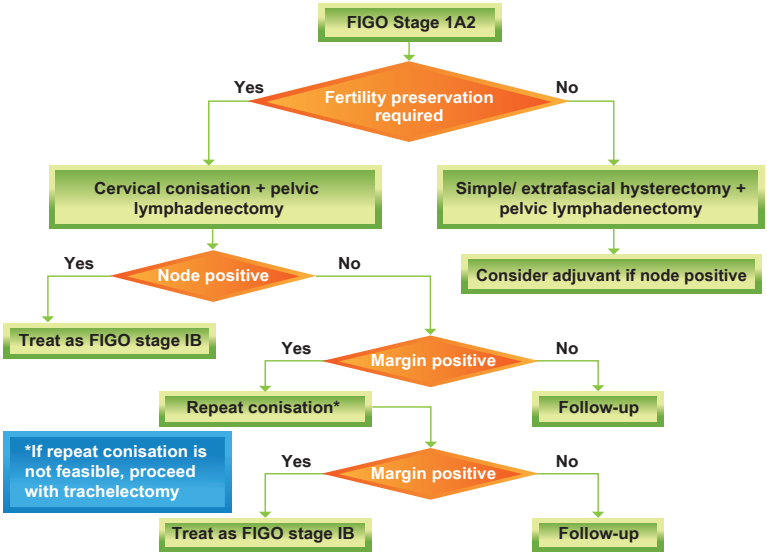
ALGORITHM 1. ASSESSMENT OF CERVICAL CANCER



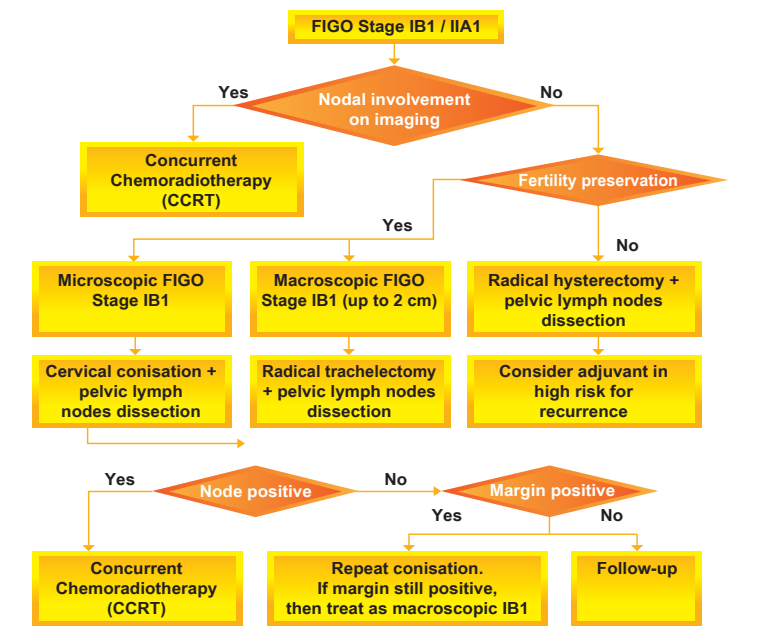
ALGORITHM 2. MANAGEMENT OF FIGO STAGE IA1



ALGORITHM 3. MANAGEMENT OF FIGO STAGE IA2



ALGORITHM 4. MANAGEMENT OF FIGO STAGE IB1/IIA



COMMON CHEMOTHERAPY AGENTS FOR CERVICAL CANCER

Chemotherapy drug	Common side effects	Comments
Cisplatin	• Peripheral neuropathy • Nausea, vomiting • Myelosuppression • Nephrotoxicity • Ototoxicity	• Adequate hydration & urinary output at least 24 hours after administration • Obtain baseline renal function, (serum creatinine, creatinine clearance) at every cycle. Observe for cumulative renal toxicity. • Recommend to perform baseline audiography • Observe for anaphylactic-like reactions during infusion
Carboplatin	• Electrolyte imbalance (hyponatraemia, hypomagnesaemia, hypocalcaemia, hypokalaemia) • Nausea, vomiting • Myelosuppression	• Monitor renal function (serum creatinine, creatinine clearance) • Observe for anaphylactic-like reactions during infusion
Paclitaxel	• Alopecia • Nausea, vomiting • Myelosuppression • Peripheral neuropathy • Arthalgia/myalgia	• Monitor for hypersensitivity reaction during infusion
Gemcitabine	• Fever • Nausea,vomiting • Myelosuppression • Increased hepatic transaminases	• Monitor liver function
Topotecan	• Myelosuppression • Nausea, vomiting	• Monitor for symptoms of interstitial lung disease
5-Fluorouracil	• Diarrhoea	• Monitor for hand-foot syndrome
Mitomycin-C	• Myelosuppression	• Observe for extravasation (vesicant) • Monitor for haemolytic-uraemic syndrome

To monitor full blood count & serum electrolytes prior to every cycle of chemotherapy.

COMMON CERVICAL CANCER RELATED COMPLICATIONS

No.	Palliative Care Issues	Suggested treatment
1	Pain	• Follow CPG Management of Cancer Pain (2010) http://www.moh.gov.my/attachments/6098.pdf
2	Malignant/malodourous wounds	• Topical metronidazole • Activated carbon dressing • Curcumin ointment
3	Venous thrombosis	• Follow CPG Prevention and Treatment of Venous Thromboembolism (2013) http://www.moh.gov.my/attachments/9005.pdf
4	Haemorrhage	• Palliative radiotherapy • Fibrinolytic inhibitors
5	Fistulae	• Fistula repair • Formation of ileal conduit • Stoma formation for entero-vaginal fistula • Percutaneous nephrostomy or ureteric stenting for urological fistulae
6	Lymphoedema	• Exercise & movement • Compression garment • Multilayer bandaging • Lymphatic massage
7	Ureteric obstruction	• Retrograde stenting • Percutaneous nephrostomy with/without antegrade stenting • Conservative management
8	Malignant bowel obstruction	• Surgical treatment o Corrective & non corrective laparotomy o Venting tube insertion o Stent insertion • Medical treatment for symptomatic relief o Opioids o Anti-emetics o Anti-spasmodics o Anti-secretory drugs o Steroids
9	Psychosexual problem	• Cognitive Behavioural Therapy • Counselling • Relaxation • Information-based intervention • Social support

REVISED FIGO CERVICAL CANCER STAGING 2009

Stage	Description
I	The carcinoma is strictly confined to the cervix (extension to the uterus corpus should be disregarded).
IA	• Invasive cancer identified only microscopically (all gross lesion even with superficial invasion are Stage IB cancers). • Invasion is limited to measured stromal invasion with a maximum depth of 5 mm & no wider than 7 mm. • IA1: Measured invasion of stroma ≤3 mm in depth & ≤7 mm in width • IA2: Measured invasion of stroma >3 mm & <5 mm in depth & ≤7 mm in width
IB	Clinical lesions confined to the cervix, or preclinical lesions greater than stage IA. • IB1: Clinical lesions no greater than 4 cm in size • IB2: Clinical lesions >4 cm in size
II	The carcinoma extends beyond the uterus, but has not extended onto the pelvic wall or to the lower third of vagina.
IIA	Involvement up to the upper 2/3. No obvious parametrial involvement. • IIA1: Clinically visible lesion ≤4 cm • IIA2: Clinically visible lesion >4 cm
IIB	Obvious parametrial involvement but not onto the pelvic sidewall.
III	The carcinoma has extended onto the pelvic sidewall. On rectal examination, there is no cancer-free space between the tumour & pelvic sidewall. The tumour involves the lower third of the vagina. All cases of hydronephrosis or non-functioning kidney should be included unless they are known to be due to other causes.
IIIA	Involvement of the lower vagina but no extension onto the pelvic sidewall.
IIIB	Extension onto the pelvic sidewall, or hydronephrosis/non-functioning kidney.
IV	The carcinoma has extended beyond the true pelvis or has clinically involved the mucosa of the bladder &/or the rectum.
IVA	Spread to adjacent pelvic organs.
IVB	Spread to distant organs.