The carcinoma is strictly confined to the cervix (extension to the uterus corpus should be disregarded).

- **I**
  - **IA**
    - Microscopic invasive cancer identified only microscopically (all gross lesions even with superficial invasion are Stage IB cancers).
    - Invasion 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

  - 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

The carcinoma extends beyond the uterus, but has not extended onto the pelvic wall or to the lower third of vagina.

- **II**
  - **IIA**
    - Clinically visible lesion ≤4 cm
    - **IIA2**: Clinically visible lesion >4 cm
  - Obvious parametrial involvement but not onto the pelvic sidewall.
  - **IIB**: 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.
  - **III**
    - Involvement of the lower vagina but no extension onto the pelvic sidewall.
    - 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.
    - Spread to adjacent pelvic organs.
    - Spread to distant organs.
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
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

<table>
<thead>
<tr>
<th>Time frame for referral</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 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

Histologically-confirmed cervical cancer

Staging by a gynaecologist/gynae-oncologist

Visible lesion

- Pelvic examination
- Cervical conisation
- Laboratory tests as indicated

No

Yes

Stage 1A

Stage 1B

Stage II

Stage III

Stage IV

Treatment

ALGORITHM 2. MANAGEMENT OF FIGO STAGE IA1

FIGO Stage IA1

Fertility preservation required

Yes

Cervical conisation

Yes

Margin positive

 Repeat Conisation*

No

Follow-up

Yes

Margin positive

Treat as FIGO stage IB

No

Follow-up

No

Simple/extrafascial hysterectomy

Follow-up

*If repeat conisation is not feasible, proceed with trachelectomy

Node positive Margin positive

Radical hysterectomy + pelvic lymph nodes dissection

Microscopic FIGO Stage IB1

Macroscopic FIGO Stage IB1 (up to 2 cm)

Consider adjuvant in high risk for recurrence

Cervical conisation + pelvic lymph nodes dissection

Radical trachelectomy + pelvic lymph nodes dissection

Concurrent Chemoradiotherapy (CCRT)

Concurrent Chemoradiotherapy (CCRT)

Repeat conisation. If margin still positive, then treat as macroscopic IB1

Follow-up

Yes

No

No

Yes

Follow-up
ALGORITHM 3. MANAGEMENT OF FIGO STAGE IA2

FIGO Stage 1A2

Yes

Fertility preservation required

No

Cervical conisation + pelvic lymphadenectomy

Yes

Node positive

No

Simple/ extrafascial hysterectomy + pelvic lymphadenectomy

Consider adjuvant if node positive

Treat as FIGO stage IB

Repeat conisation*

Yes

Margin positive

No

Follow-up

*If repeat conisation is not feasible, proceed with trachelectomy

ALGORITHM 4. MANAGEMENT OF FIGO STAGE IB1/IIA

FIGO Stage IB1 / IIA1

Yes

Nodal involvement on imaging

No

Concurrent Chemoradiotherapy (CCRT)

Yes

Fertility preservation

No

Microscopic FIGO Stage IB1

Cervical conisation + pelvic lymph nodes dissection

Yes

Node positive

No

Concurrent Chemoradiotherapy (CCRT)

Repeat conisation.
If margin still positive, then treat as macroscopic IB1

Follow-up

Macroscopic FIGO Stage IB1 (up to 2 cm)

Radical trachelectomy + pelvic lymph nodes dissection

Consider adjuvant in high risk for recurrence

Radical hysterectomy + pelvic lymph nodes dissection

Yes

Margin positive

No

Repeat conisation.
If margin still positive, then treat as macroscopic IB1

Follow-up
## COMMON CHEMOTHERAPY AGENTS FOR CERVICAL CANCER

<table>
<thead>
<tr>
<th>Chemotherapy drug</th>
<th>Common side effects</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>No.</th>
<th>Palliative Care Issues</th>
<th>Suggested treatment</th>
</tr>
</thead>
</table>
| 2   | Malignant/malodorous wounds | • Topical metronidazole  
• Activated carbon dressing  
• Curcumin ointment |
| 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  
• Corrective & non corrective laparotomy  
• Venting tube insertion  
• Stent insertion  
• Medical treatment for symptomatic relief  
• Opioids  
• Anti-emetics  
• Anti-spasmodics  
• Anti-secretory drugs  
• Steroids |
| 9   | Psychosexual problem   | • Cognitive Behavioural Therapy  
• Counselling  
• Relaxation  
• Information-based intervention  
• Social support |
### REVISED FIGO CERVICAL CANCER STAGING 2009

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