EVOLUTION OF THE SURGICAL MANAGEMENT OF CERVICAL CANCER

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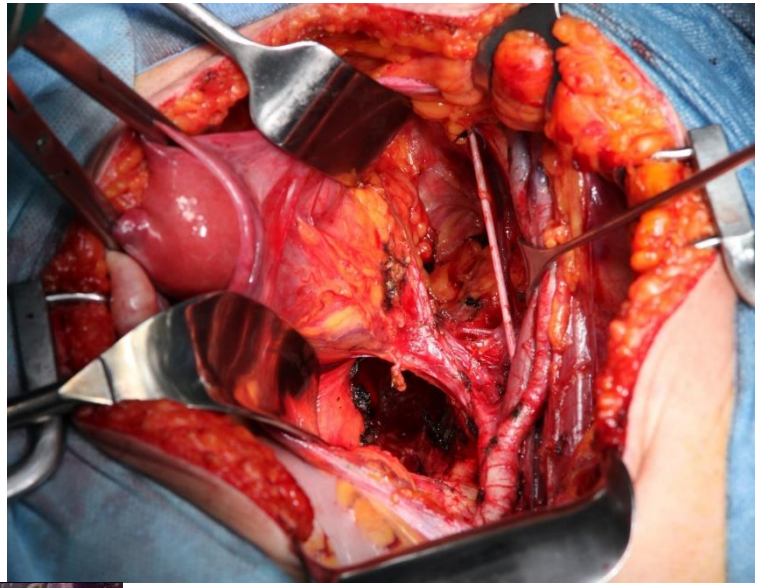
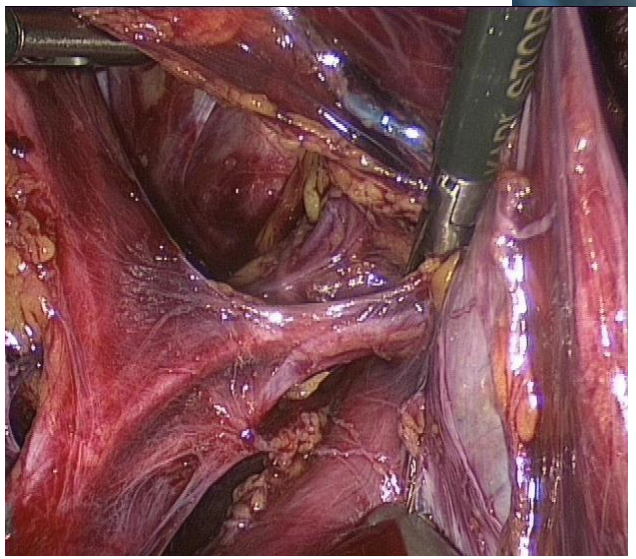
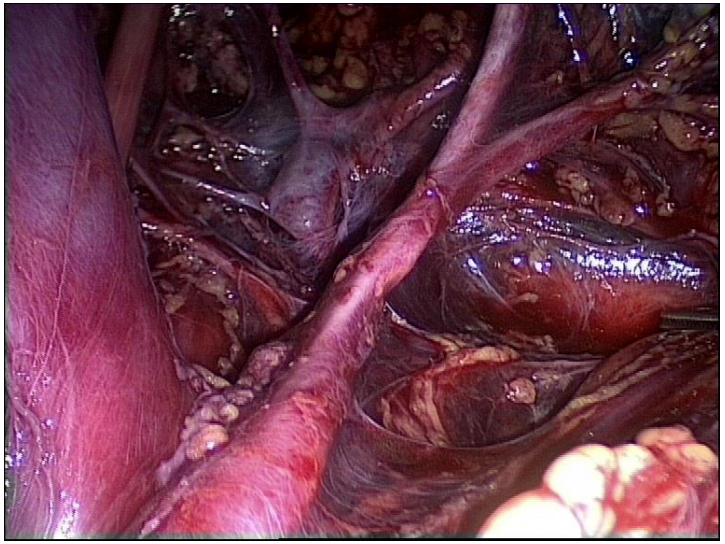
Roles of surgery

1. Surgical management

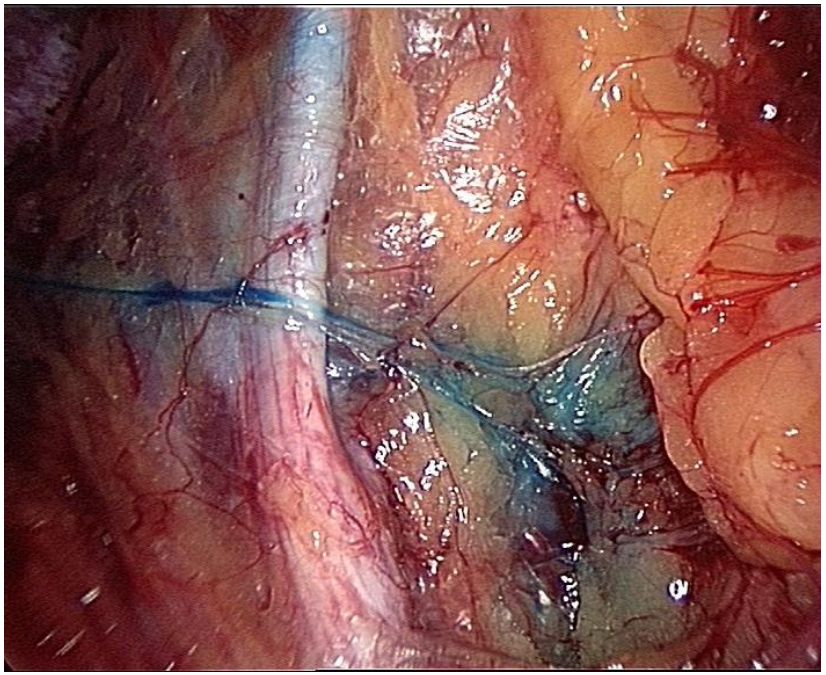


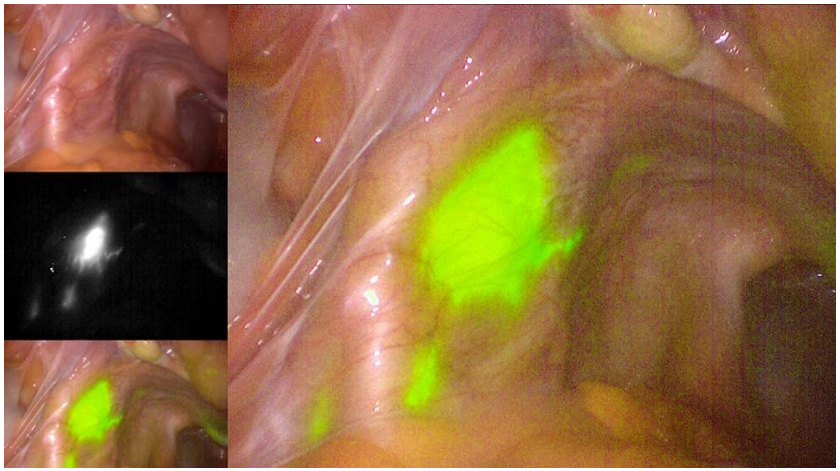




Roles of surgery

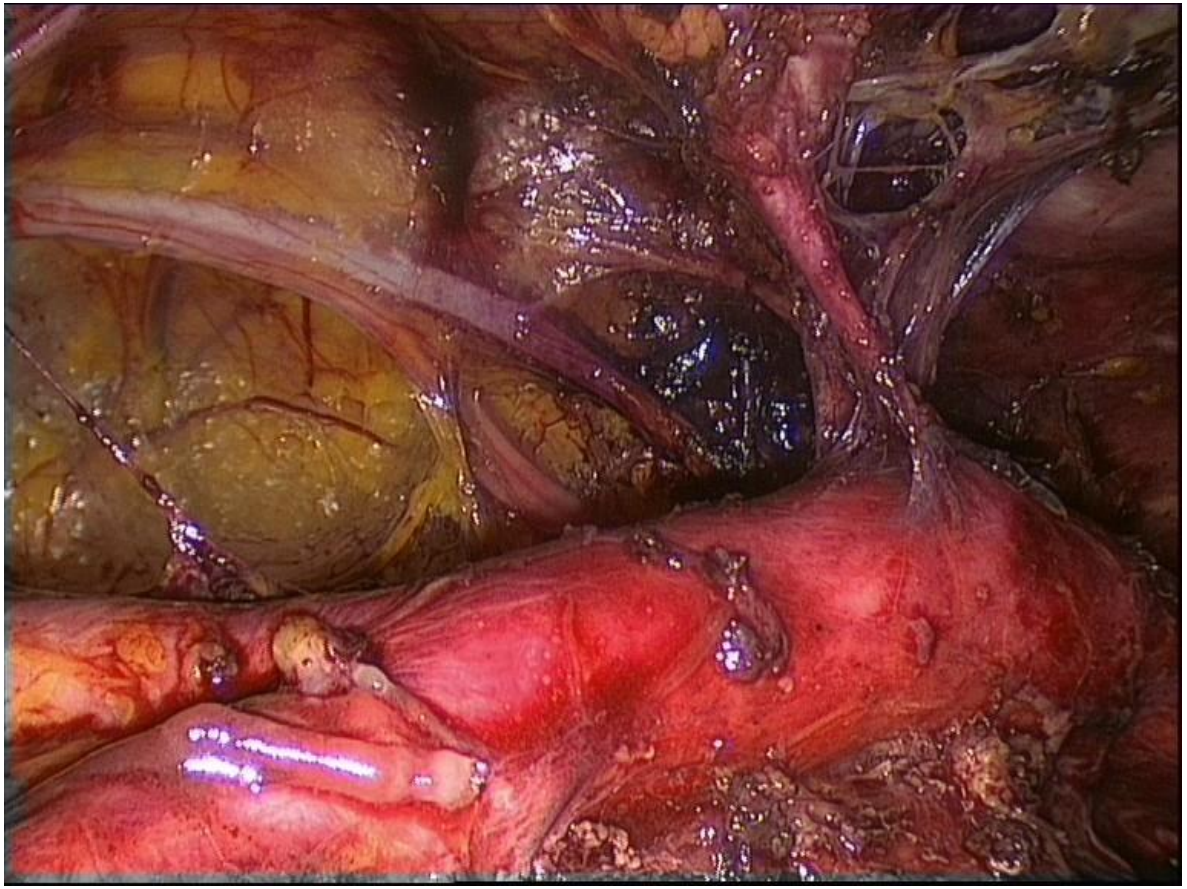
2.1 Staging (early)

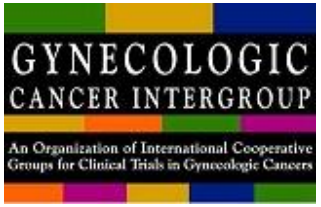




Roles of surgery

2.2 Staging (advanced)





New ESGO-ESTRO-ESP Guidelines on Cervical Cancer Management

ESGO SOPs

- Step 1 - Nomination of multidisciplinary international development group
- Step 2 - Identification of scientific evidence
- Step 3 - Formulation of guidelines
- Step 4 - External evaluation of the guidelines - International review
- Step 5 - Integration of international reviewers´ comments

ESGO Guidelines

- Collaboration with other leading European societies (ESMO, ESTRO, ESP, SIOPe)
- Multidisciplinary panels of a total of over 100 renowned experts involved in working groups over the past two years
- Over 300 international reviewers from 61 countries involved in the review (incl. patients) and evaluation

Special thanks to all contributors!!


OFFICE PARK 3
Bauteil 1
Bauteil 2
FIT FABRIK
café+co Bar

General statement

Treatment planning should be made on a **multidisciplinary basis** (generally at a **tumor board meeting**) and based upon the comprehensive and precise knowledge of prognostic and predictive factors for oncological outcome, morbidity and quality of life.

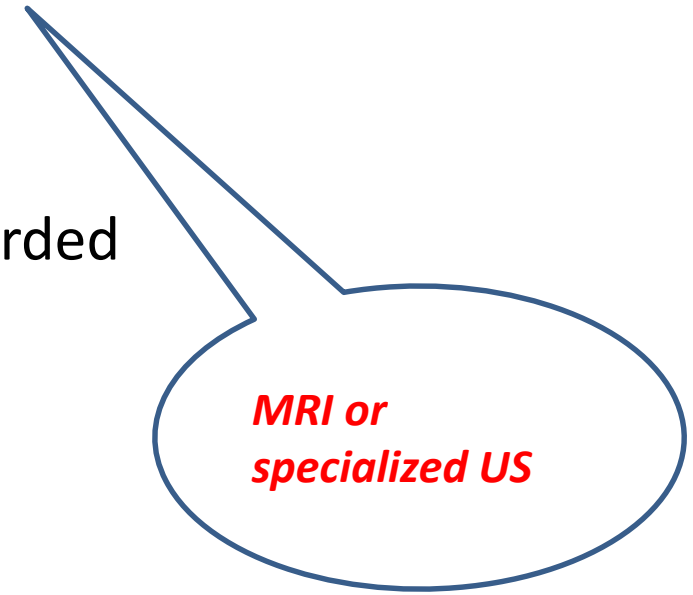
Patients should be carefully counseled on the suggested treatment plan, and potential alternatives, including risks and benefits of all options.

Clinical staging

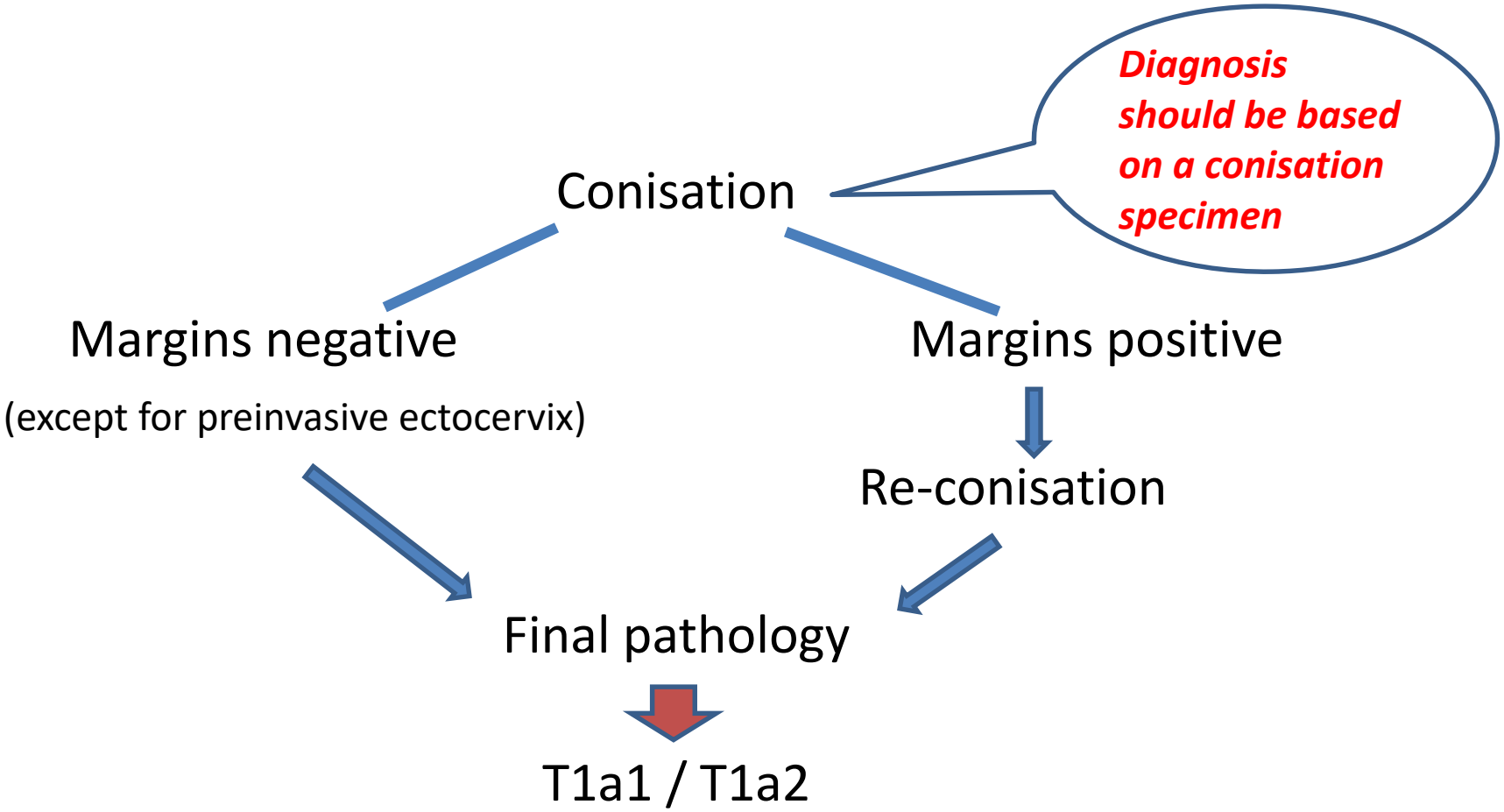
Patients with cervical cancer should be staged
according to the **TNM classification**

based on a **correlation of various diagnostic modalities**
(integrating physical examination, imaging and pathology)

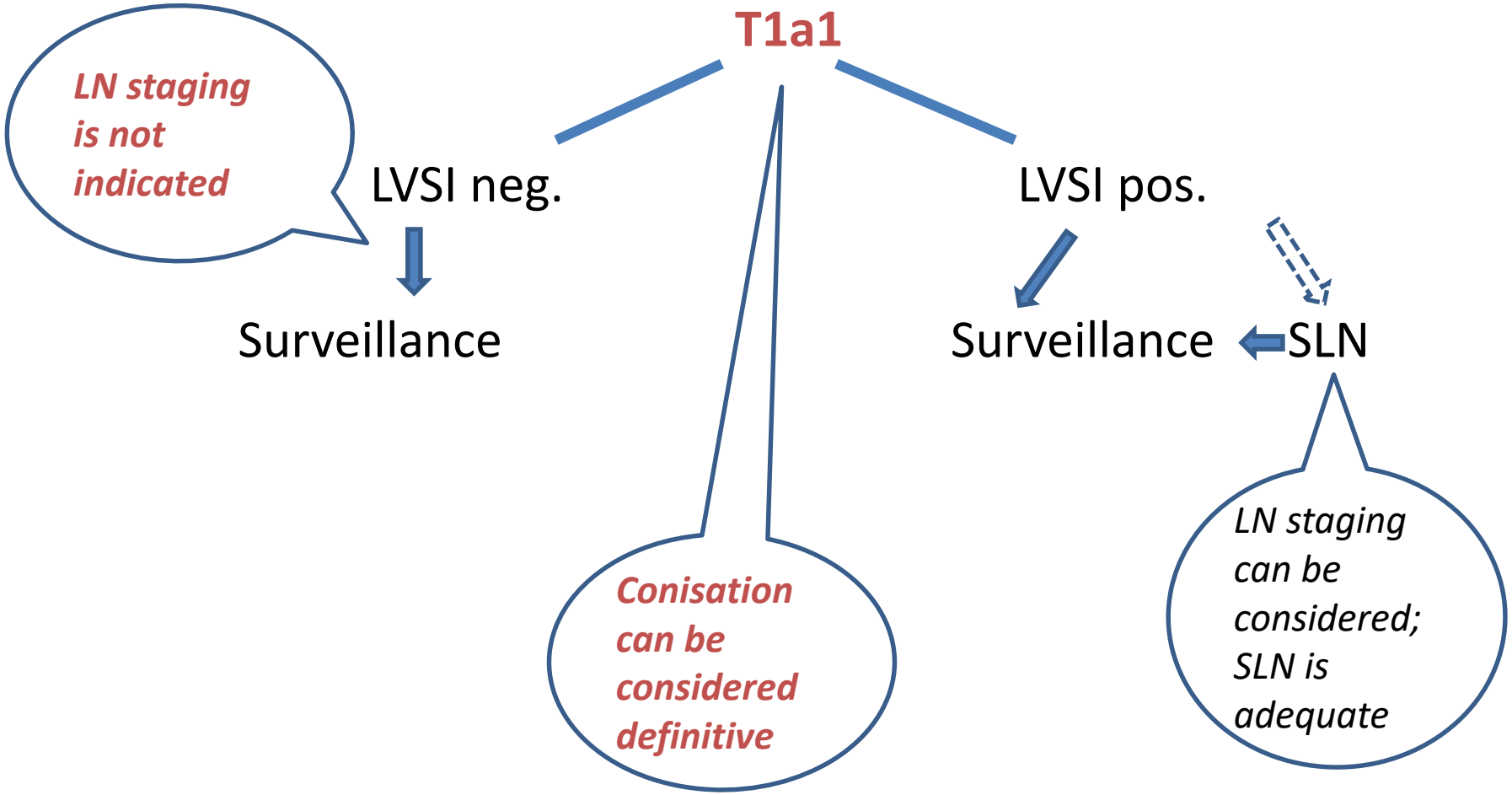
the method i.e. clinical (c), imaging (i)
and or pathological (p) should be recorded



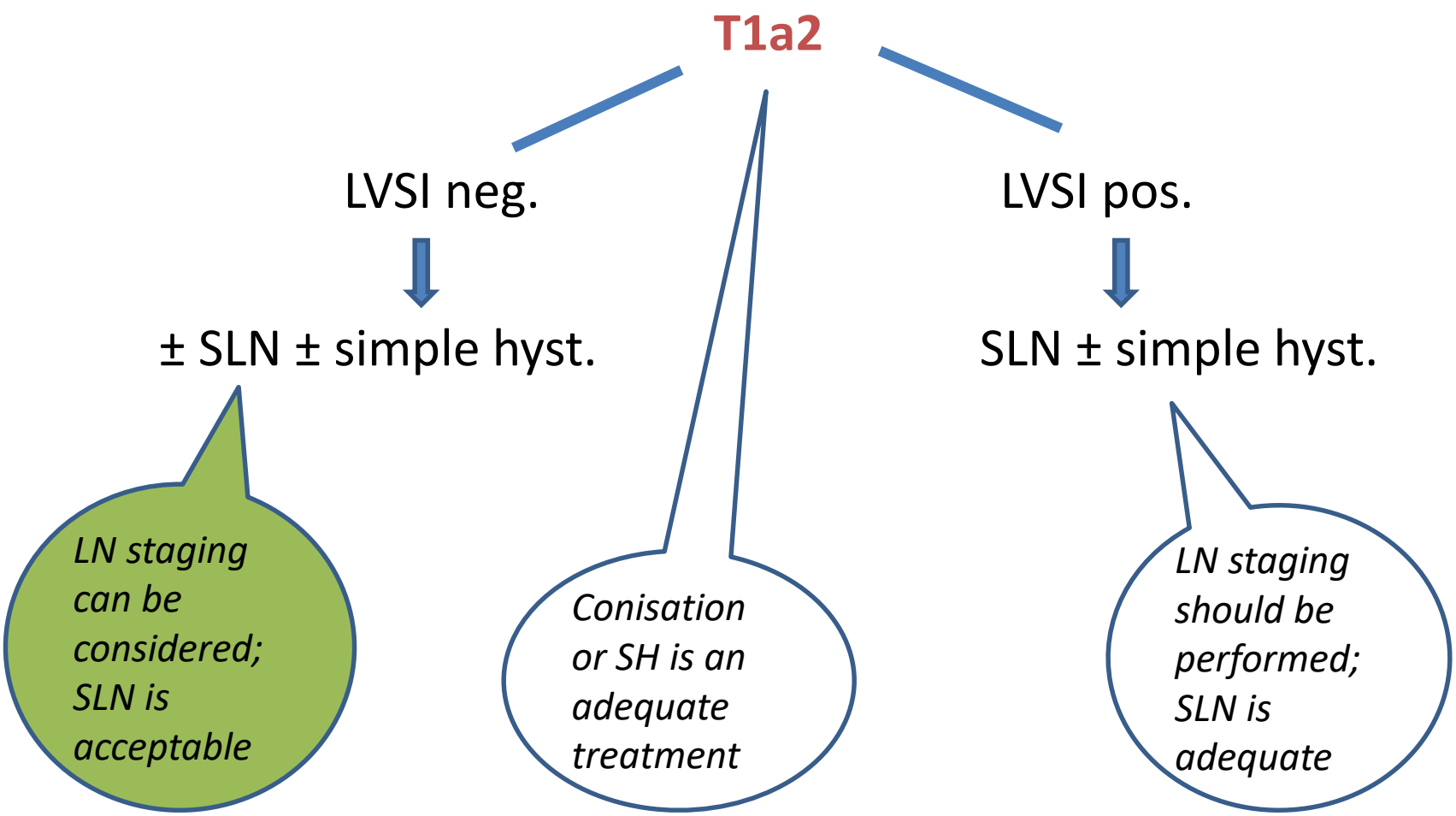
T1a


Diagnosis should be based on a conisation specimen
Conisation
Margins negative
(except for preinvasive ectocervix)
Margins positive
Re-conisation
Final pathology
T1a1 / T1a2

T1a


T1a1
LN staging is not indicated
LVSI neg.
LVSI pos.
Surveillance
Surveillance
SLN
Conisation can be considered definitive
LN staging can be considered; SLN is adequate

T1a

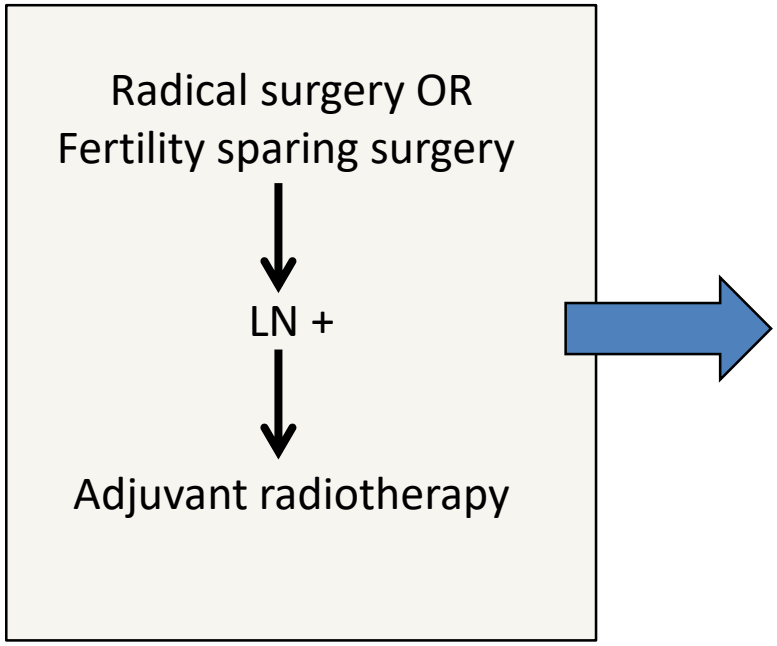

T1a2
LVSI neg.
± SLN ± simple hyst.
LVSI pos.
SLN ± simple hyst.
LN staging can be considered; SLN is acceptable
Conisation or SH is an adequate treatment
LN staging should be performed; SLN is adequate

T1b1/T2a1

Treatment strategy should aim for the avoidance of combining radical surgery and radiotherapy due to the highest morbidity after combined treatment.

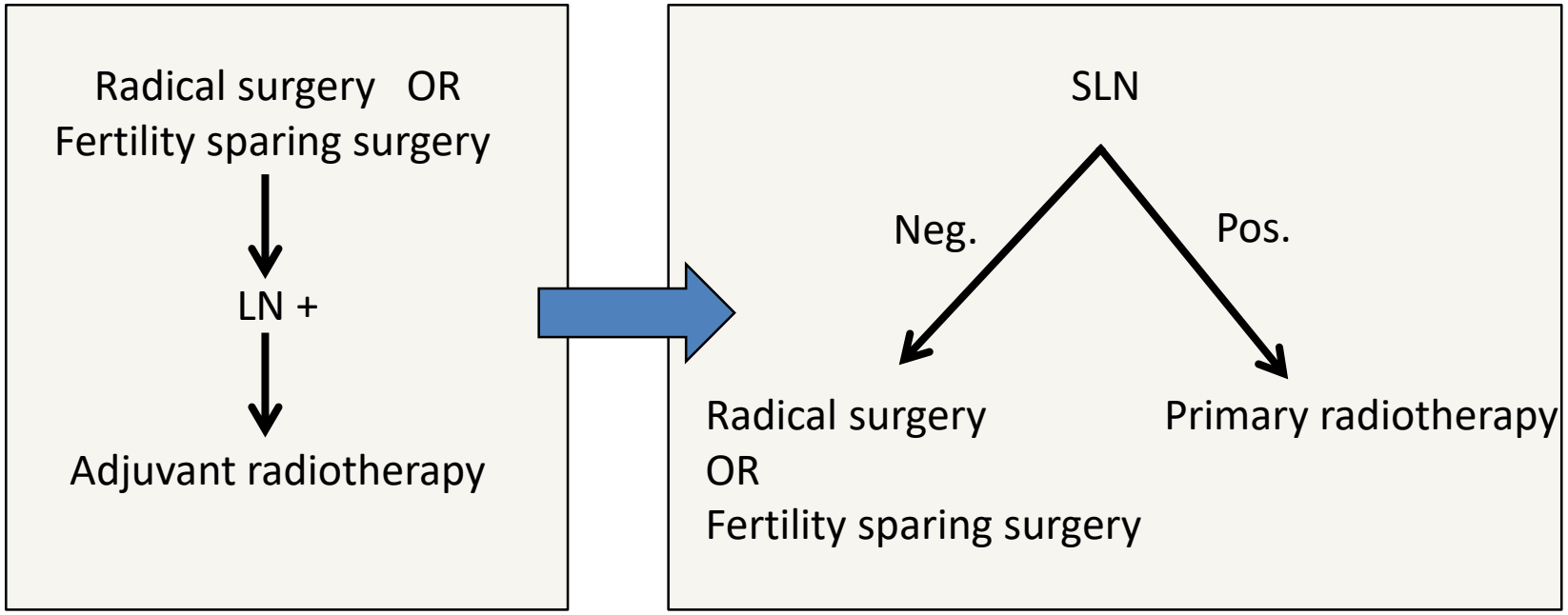
T1b1/T2a1

Old process



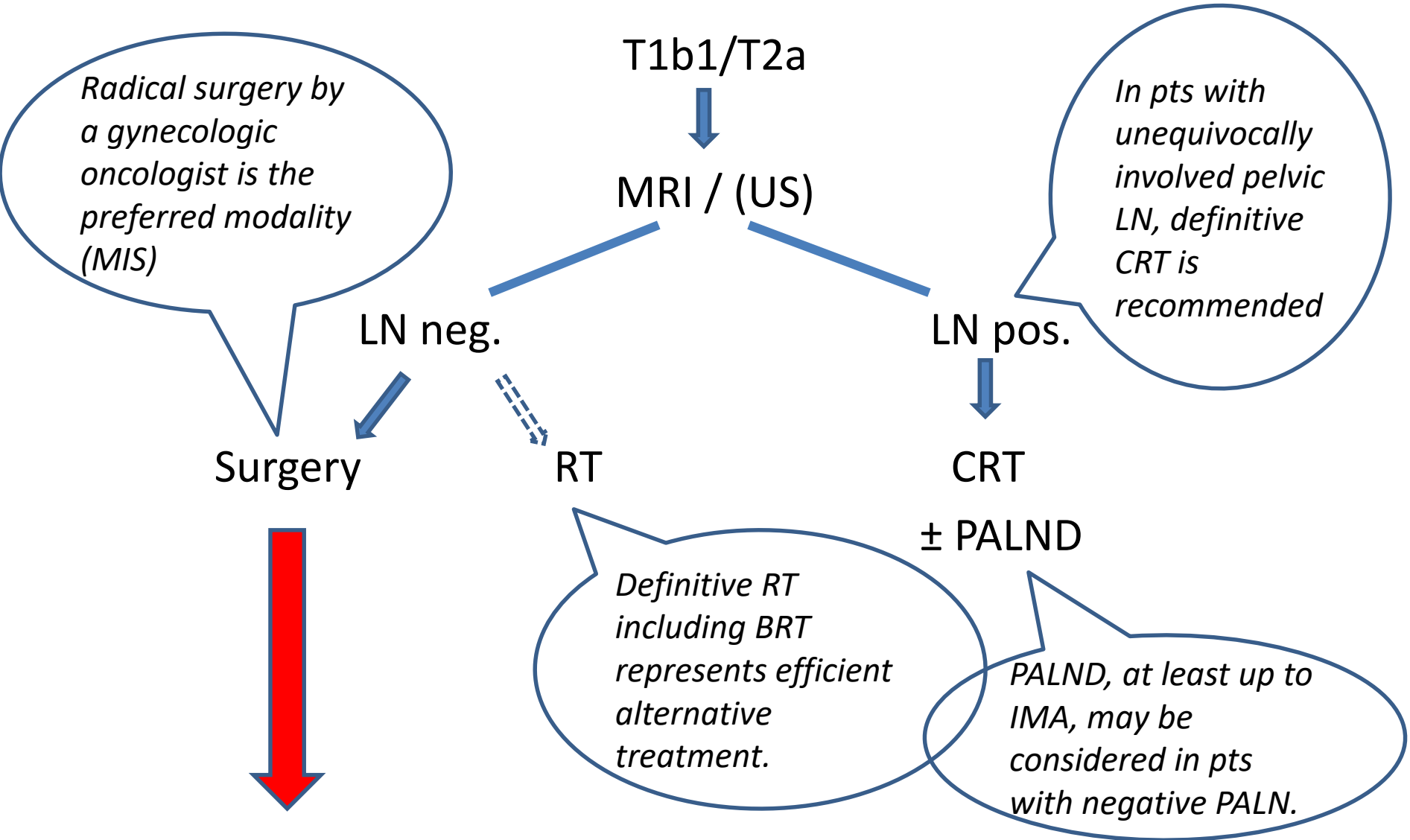
T1b1/T2a1

New process



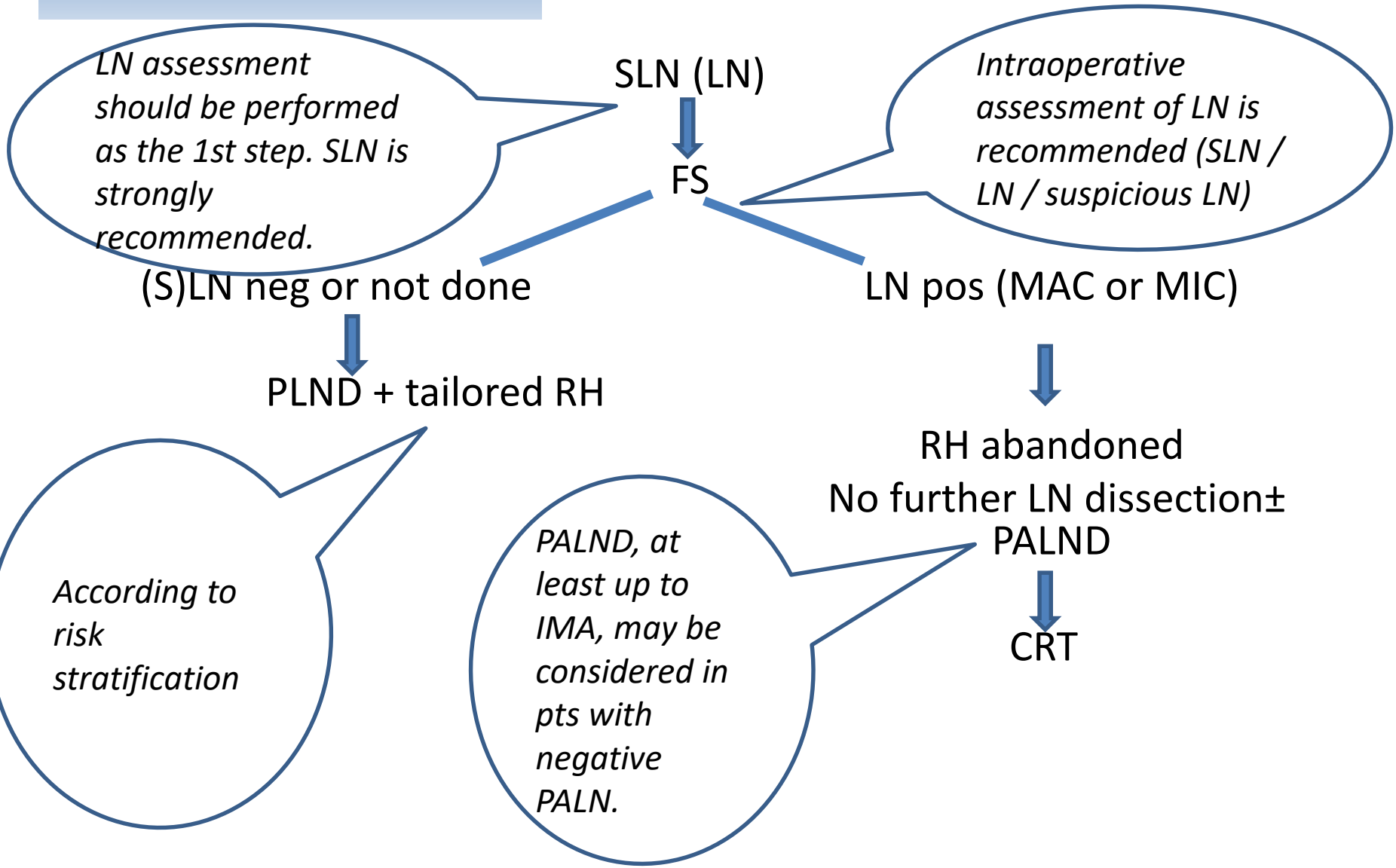
T1b1/T2a1

Role of radiologic assessment



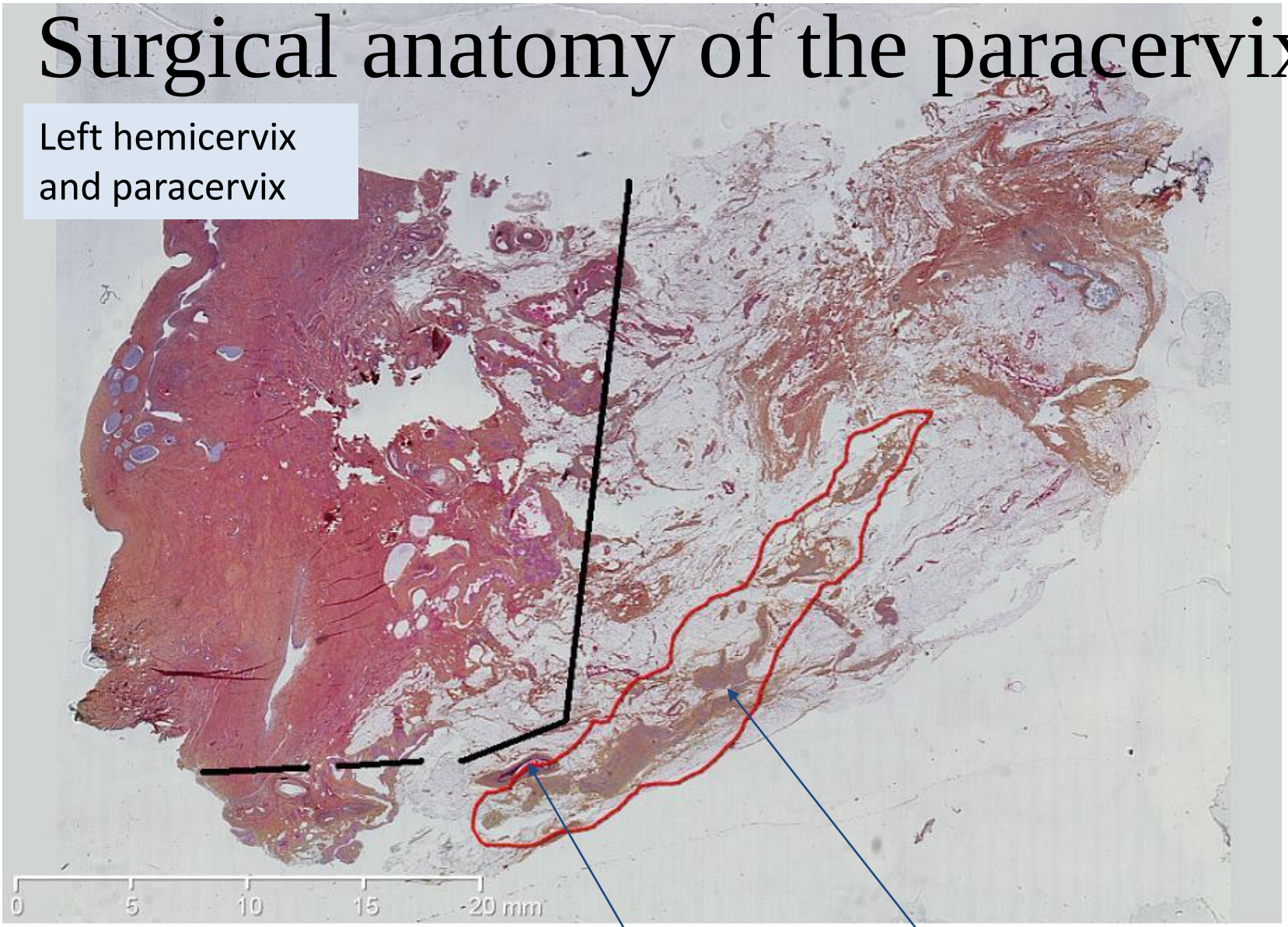
T1b1/T2a1

Surgical process



Surgical anatomy of the paracervix

Left hemicervix
and paracervix



Tailoring surgery

Querleu-Morrow classification (update 2017)

Type of RH	Lateral parametrium	Ventral parametrium	Dorsal parametrium
Type A	Halfway between cervix and ureter	Minimal	Minimal
Type B1	At the ureteral bed	Partial excision of the vesicouterine lig	Partial excision of the recto-uterine/-vaginal lig
Type B2	B1 + paracervical LND	B1	B1
Type C1	At the iliac vessels transversally, at the uterine vein horizontally	Excision of the vesicouterine lig (cranial to the ureter)	At the rectum (hypogastric nerve is spared)
Type C2	C1 + caudal part	At the bladder (incl. vesico-vaginal lig)	At the sacrum

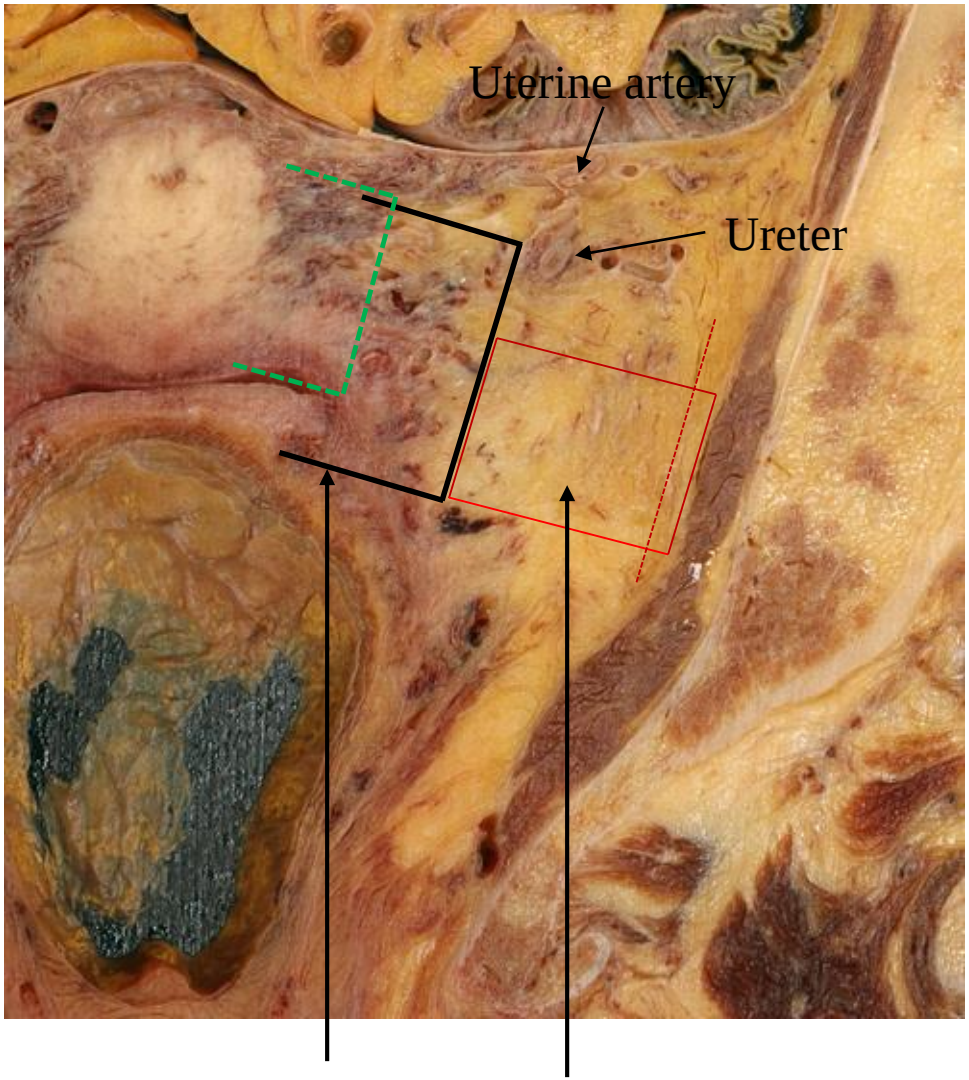
Classification of radical hysterectomies /trachelectomies

A

B1

B2

C1



Tailoring surgery

Risk groups according to prognostic factors and suggested type of radical hysterectomy

Risk group	Tumor size	LVSI	Stromal invasion	Type of rad hyst
LR	< 2 cm	Neg	Inner 1/3	B1 (A)
IR	≥ 2 cm	Neg	Any	B2 (C1)
	< 2 cm	Pos	Any	
HR	≥ 2 cm	Pos	Any	C1 (C2)

T1b1/T2a1

Post surgical process

Final histology

LN neg AND
Parametria neg AND
Vaginal margins neg

LN pos OR
Parametria pos OR
Vaginal margins pos

Combination of risk factors
(LVSI, Tumor size, Stromal invasion)

Adjuvant (C)RT

FU ⟸ No

Yes ⟹ ± Adjuvant RT

Adjuvant RT should be considered.

T1b1/T2a1

Post surgical process

Final histology

LN neg AND

Parametria neg AND

Vaginal margins neg

Combination of risk factors

(LVSI, Tumor size, Stromal invasion)

FU ⟸ NO Yes ⟹ ± Adjuvant RT

When an adequate type of radical hysterectomy has been performed, observation is an alternative approach…

Adjuvant RT should be considered.

T1b1/T2a1

Back to presurgical decision

Final histology

LN neg AND

Parametria neg AND

Vaginal margins neg

Combination of risk factors

(LVSI, Tumor size, Stromal invasion)

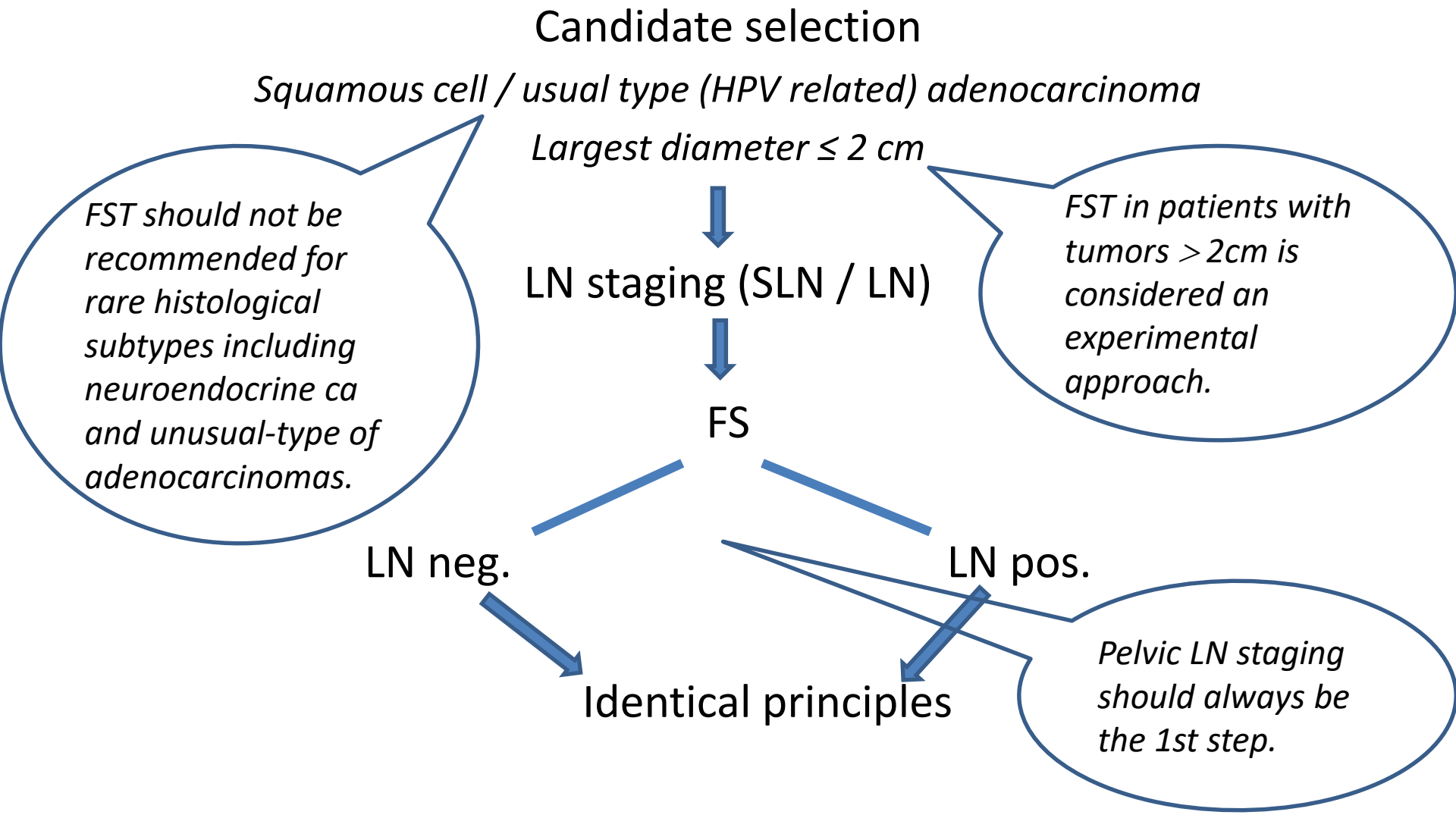
FU ⟸ NO

Yes ⟹ ± Adjuvant RT

If a combination of risk factors is known at diagnosis, which would require an adjuvant treatment, definitive radiochemotherapy and brachytherapy can be considered without previous radical pelvic surgery.

T1b1/T2a1

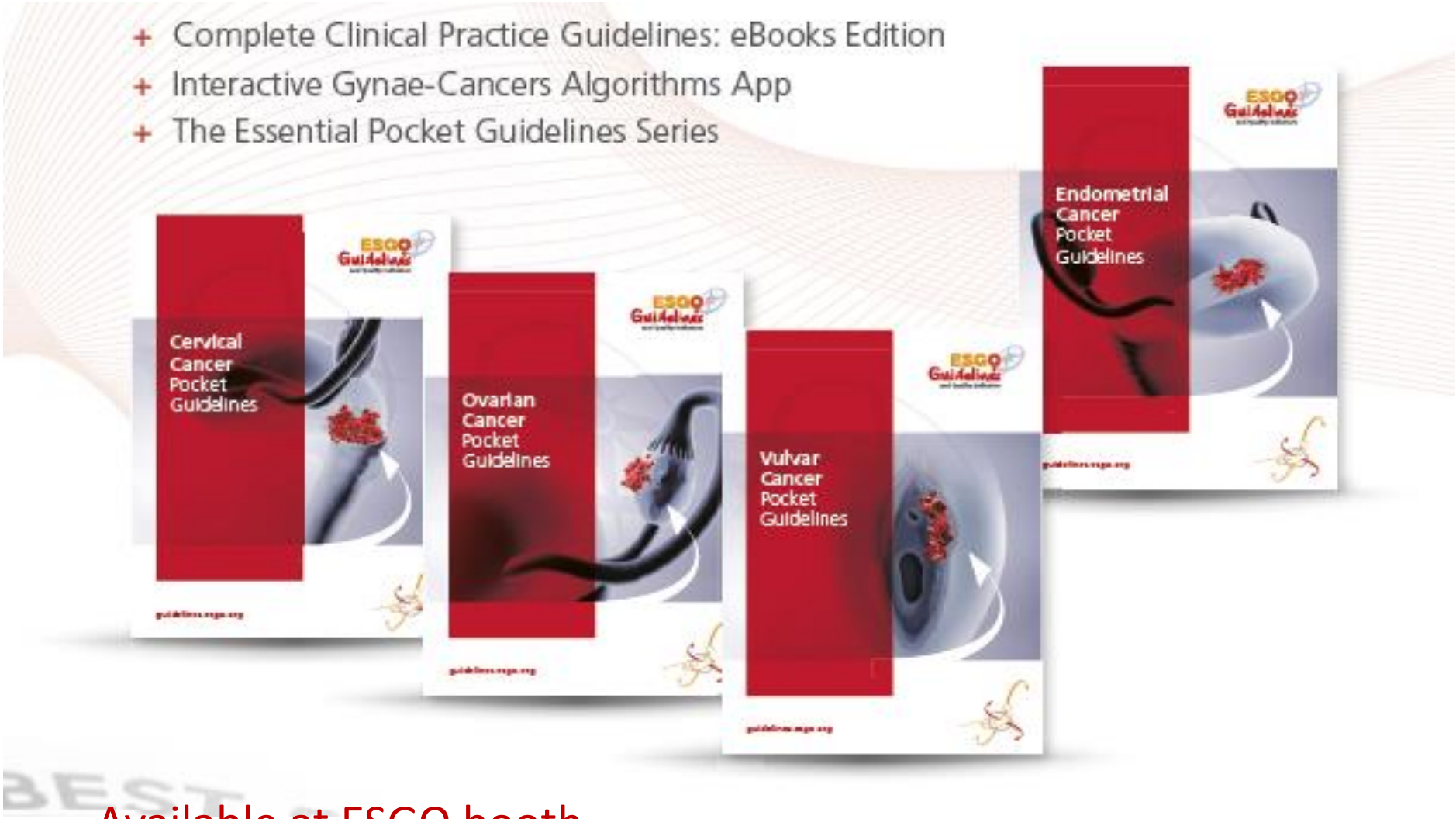
Fertility sparing



T > 1b1

- Treatment strategy should aim for avoiding the combination of radical surgery and postoperative external radiotherapy, due to the significant increase of morbidity and no evident impact on survival *(grade C)*
- **Definitive platinum-based chemoradiotherapy and brachytherapy is the preferred treatment**) *(grade A)*
- Paraaortic (at least up to inferior mesenteric artery) lymph node dissection may be considered before chemoradiotherapy and brachytherapy. Pelvic lymph node dissection is not required *(grade C)*
- *Radical surgery is an alternative option in stage IB2*, in particular in patients without negative risk factors (combinations of tumour size, LVSI, and/or depth of stromal invasion).

ESGO Pocket Guidelines Series



Available at ESGO booth

ESGO ALG APP

Cervical Cancer Guide

شكراً على اهتمامكم

Thank you for your attention

Merci pour votre attention