

# The Management of Cervical Cancer

## Pathway of Care

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## 1.0 Pathway Overview

### Primary Care

#### Refer:

- Lesions suspicious of cancer of cervix on speculum examination

**2WW  
Referral**

### Secondary Care

#### (Specialist or Affiliated Designated Stand Alone Diagnostic Units)

- Assessment
- Diagnosis
- Imaging
- The CNS should always be present when bad news is given
- Regardless of whether diagnostic assessments are undertaken in a specialist or designated stand alone units all diagnosed Cervical cancers are to be discussed at the Specialist **MDM**

Described in sections 4.2, 4.3, 4.5 & 4.6 below

#### Stand Alone Diagnostic Units

Stage 1A<sub>1</sub> patients may be considered for surgery in the local setting. Consider treatment in the Specialist Centre for SLND if 1A<sub>1</sub> Gr 3 and LVSI +

ALL other stages of cervical cancer to have treatment undertaken at the Specialist Centre

#### Specialist MDT

All stages of cervical cancer above 1A<sub>1</sub> to surgery undertaken at Specialist Centre. Consider treatment in the Specialist Centre for SLND if 1A<sub>1</sub> Gr 3 and LVSI +

- Regardless of where surgery is undertaken any post- surgical upstaging must be discussed at the Specialist MDM and treatment plans modified if appropriate
- All cases of Cervical cancer to be considered for entry into an appropriate clinical trial
- Patients will be followed up according to the Gynae TSSG agreed protocols set out in section 6
- Women with recurrent/metastatic disease will have their cases reviewed by the MDT in order to optimise their treatment options
- Women who fall into the age categories specified by the Children's and Young Peoples IOG will be managed in association with designated TYA MDTs

GP decision to refer to first appointment no more than 14 days

Date of decision to treat to date of first treatment – no more than 31 days

GP Decision to refer to first treatment no more than 62 days

## 2.0 Purpose

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To describe the process for ensuring that all Cervical Cancer cases diagnosed within the Kent & Medway region are managed by the East and West Kent Gynaecological Oncology Centres, achieving a coordinated seamless patient pathway in accordance with the best possible evidence based practice; and to facilitate advancement in the specialty in the field of cervical cancer management.

## 3.0 Scope

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This Pathway of Care (PoC) applies to all cases and suspected cases of cervical malignancy within the Kent & Medway area. The Kent & Medway Cancer Collaborative (KMCC) Cervical Cancer specification of delivery of care requires all Trusts within the area to adopt an agreed policy. The aim of the guidelines is to ensure that all patients with suspected cervical carcinoma are appropriately referred and investigated and any patient with a confirmed cervical carcinoma receives care and treatment in accordance with the best possible evidence based practice available within the region.

The policy covers the following:

- Access
- Initial Assessment
- Investigations
- Gynaecological oncology multidisciplinary meeting
- Surgical and non-surgical treatment.
- Recurrent disease
- Follow up

## 4.0 Policy

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### 4.1 Access

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All patients with suspected cervical cancer to be referred within 24 hours to a gynaecology rapid assessment colposcopy clinic, based in each major acute hospital within Kent & Medway. Patients will be seen within 2 weeks of decision to refer. Patients may be seen in the colposcopy suite to facilitate assessment and biopsy. Symptoms such as post coital, inter menstrual bleeding and brownish watery discharge in younger women are not very specific and should be referred to general gynae clinic for further assessment. HOWEVER speculum examination should be performed in these cases and any suspicious looking cervix SHOULD be referred on this 2 week wait pathway. Note that a normal sized uterus does not exclude cervical cancer.

### 4.2 Initial Assessment

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- Full history and bi manual pelvic examination
- Speculum examination with visualisation of the cervix +/- colposcopy

### 4.3 Diagnostic Biopsy – Cervical Tumours

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- Cervical biopsy - directed punch biopsy or diagnostic loop biopsy of the lesion is usually sufficient.

### 4.4 Gynaecological Oncology Multidisciplinary Meeting

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All cervical cancer patients should be referred to the Cancer Centre and reviewed at the Multi Disciplinary Team (MDT) meeting, where possible prior to undergoing first definitive treatment. Case discussion should include review of:

- Histology from biopsy if already performed
- Imaging – CT and MRI
- Discussion of management options (i.e. radical surgery / chemo-radiotherapy), and discussion of suitability for recruitment into clinical trials

Cases should also be discussed following surgery to review histology and management plan and in the event of disease recurrence.

### 4.5 Investigations

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- FBC
- U&E
- LFTs
- Other tests if clinically indicated

### 4.6 Imaging

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- MRI pelvis for assessment of tumour dimensions and local spread of disease
- CT chest, abdo and pelvis
- Biopsy of any other suspicious areas that may alter management.

Note: Full details of the KMCC imaging guidance are located on the KMCC website:- <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

### 4.7 Pathology

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All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:- <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

## 4.8 Examination under anaesthetic, cystoscopy and sigmoidoscopy

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- EUA and cystoscopy may be performed in the centre to plan management. Sigmoidoscopy should be available and performed if there is any suggestion of bowel involvement. This should be performed under general anaesthetic to get a proper assessment.
- Where it is deemed appropriate prophylactic stent insertion may be performed.
- Following staging patients may be recruited to trials according to their stage and current trial recognition.

## 4.9 Treatment – Cervical Cancers:

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*The following protocol is with reference to squamous cell carcinoma, adenocarcinoma and adenosquamous cancer of the cervix.*

Other histological subtypes such as neuroendocrine and lymphoma will have individualised treatment and may be treated primarily with chemotherapy with or without radiotherapy and surgery.

Surgical treatment should be tailored with the aims of local clearance of tumour.

**Patients who are to have radical treatment (surgery and / or radiotherapy) should receive advice concerning lymphoedema.**

### 4.9.1 Stage 1 (Ref: Appendix 1)

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Women undergoing surgery should have either an abdominal or laparoscopic route of surgery depending on the surgeon's preference. The choice of abdominal incision rests with the surgeon.

Surgery for Stage 1a1 tumours (See Appendix 1) should involve:

Large loop excision of the transitional zone (LETZ) loop or knife cone biopsy

If women have completed their families consideration after discussion with the patient can be given to: -  
Total abdominal, Total laparoscopic, Lap assisted hysterectomy or vaginal hysterectomy +/- cuff of vagina  
Bilateral salpingo-oophorectomy may be considered depending on the clinical indications.

In patients with stage 1a1 grade 3 and Lymph-vascular space invasion (LVSI) present in the tumour consideration may be given to discussion with the patient as to the benefits of lymph nodal dissection or sentinel lymph node detection (SLND).

Surgery for Stage 1a2 (see appendix 1) should involve simple hysterectomy and pelvic lymphadenectomy / or SLND (open or laparoscopic). For fertility preserving surgery please see below.

Surgery for Stage 1b1 tumours (see appendix 1) should involve: Radical hysterectomy, with bilateral pelvic lymphadenectomy / or SLND (see appendix).

In women who wish to conserve fertility, provided the woman has a tumour less than 2 centimetres (cm) in size, then a Trachelectomy / Radical Trachelectomy can be offered with laparoscopic bilateral pelvic lymphadenectomy / SLND. Pre-operative counselling for this procedure should outline the newer nature of this treatment compared to radical hysterectomy, nevertheless favourable outcome data is now available. East Kent patients may be referred to the West Kent Gynae Oncology centre for this procedure.

In women who do not wish to consider fertility, alternatives to an abdominal Wertheim's hysterectomy include a Schauta's radical vaginal hysterectomy, with bilateral laparoscopic pelvic lymphadenectomy / SLND, or radical laparoscopic hysterectomy with laparoscopic bilateral pelvic lymphadenectomy / SLND.

As with radical trachelectomy, women offered these procedures would be selected on the grounds of a small 2cm, central tumour. Relative contraindications would be a size of the uterus bigger than 12 cm, or previous abdominal or pelvic surgery. FIGO stage 1a2 and very small volume superficially invasive tumours may be managed by conisation and laparoscopic lymphadenectomy / SLND.

It is reasonable to retain the ovaries if there is no other reason to remove them. The decision is based on clinical grounds and the patient's preference after discussion with their managing surgeon. If retained, ovarian transposition can be performed to remove the ovaries out of the pelvic radiotherapy field should the woman subsequently prove to require this treatment. Bilateral salpingectomy should be discussed with the patient who wishes to preserve ovaries to reduce risk of ovarian/tubal ca in the future.

Where intraoperative assessment suggests bulky pelvic or para aortic nodal disease, then this should be sent for frozen section and debulked where possible. Should intra operative frozen section confirm metastatic disease then consideration should be given to abandoning the hysterectomy operation and offering chemoradiotherapy treatment. Careful inspection and sampling of the para aortic nodes in these circumstances can dictate whether to offer a para aortic nodal strip radiotherapy, if metastatic disease is confirmed. After MDT discussion patients may be considered for laparoscopic Lymphadenectomy as an initial surgical staging procedure to determine management strategy.

Following radical surgery with or without adjuvant chemoradiation treatment, women should be offered clinical assessment with colposcopy after three months. A post treatment baseline MRI scan of the pelvis should be performed 6 months following treatment.

#### 4.9.2 Stage 2 – Stage 4 disease (See Appendix 1)

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These women may undergo examination under anaesthetic (EUA) and cystoscopy staging procedure.

Women with FIGO Stage 2A1 disease can be considered for radical hysterectomy. Patients with early FIGO Stage 2B disease could also proceed to radical surgery on the basis of patient preference, but only after detailed discussions regarding the possibility of requiring adjuvant chemoradiotherapy and discussion regarding surgical and radiation-related morbidity. Surgical staging with laparoscopic pelvic lymphadenectomy can be considered in all cases before progressing to radical hysterectomy, particularly for Stage 1B2, 2A and early 2B cases. Node-positive patients proceed directly to chemoradiotherapy, whilst node-negative patients proceed to radical hysterectomy. There may be a role for debulking of bulky nodal disease prior to chemoradiotherapy.

Otherwise, chemoradiotherapy is the standard management pathway for potentially curable disease at Stage 1B2 and above.

Neo-adjuvant chemo therapy followed by radical surgery could be considered in individual cases.

Para aortic lymph sampling (laparoscopic or open) can be helpful in selecting patients for para aortic strip radiotherapy treatment.

Careful note should be made of the kidney function and ureteric status with consideration given to ureteric stenting to preserve renal function.

Consider early referral to palliative care.

Three months following a course of chemoradiation treatment, women should be offered clinical assessment with colposcopy and if necessary EUA and biopsy to confirm the treatment effect. A post treatment baseline scan of the pelvis should be performed 4-6 months following treatment. If central residual disease is confirmed, without evidence of distant metastases, consideration should be given to

offering to simple abdominal hysterectomy or exenteration, if necessary, to remove the residual focus of disease if the woman is otherwise fit and healthy without any other major comorbidity.

### 4.9.3 Advanced Disease

Multidisciplinary discussion should be held to optimize management regime which may include:

- Palliative radiotherapy for inoperable disease and to stop bleeding and help symptom control
- Radiotherapy to confirm malignant fixed nodal masses. Fine needle aspiration (FNA) or open biopsy undertaken
- Appropriate surgery may be considered for palliation of bleeding, bulk reduction and symptom relief
- The palliative care team should be involved
- Palliative chemotherapy should be considered

### 4.9.4 High grade neuroendocrine tumours

Rare histological types should be discussed by the MDT and possibly referred for an opinion to the Royal Marsden MDT. Consideration should be given to neoadjuvant chemotherapy and possible interval surgery and / or definitive chemoradiotherapy.

### 4.9.5 Adjuvant treatment - Radiotherapy

Knowledge of the pelvic lymph nodal status, completeness of excision and performance status is helpful in deciding on the benefits of adjuvant radiotherapy.

<b>FIGO Stage</b>	<b>Negative pelvic nodes</b>	<b>&gt; 1 positive pelvic node or incomplete excision</b>
1a2, 1b 1, 2A1	Complete excision - No radiotherapy  Incomplete excision consider further surgery and/or radiotherapy/chemoradiotherapy	EBRT and vault HDR. Concomitant platinum based chemotherapy
1b 2 and other stage 2	EBRT and vault HDR	EBRT and vault HDR
3	Concomitant platinum based chemotherapy	Concomitant platinum based chemotherapy
4	Consider chemo- radiotherapy as above depending on spread of disease	Consider chemo-radiotherapy as above depending on spread of disease

If para aortic nodes are enlarged on post-operative CT scan and biopsy or lymphadenectomy confirms metastatic disease, then treatment with a para aortic strip may be considered.



## 4.10 Recurrent Disease

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Women with symptoms suggesting possible disease recurrence should be investigated with MRI and CT. If recurrent disease is confirmed as radical treatment including exenteration is to be considered a CT-PET scan should be performed to exclude distant/multifocal disease.

Multidisciplinary discussion should be held to optimise management regime which may include:

- Radiotherapy if not suitable for excision and maximum dose not already given
- Radiotherapy or palliation for inoperable disease
- In some circumstances exenterative surgery may be considered; a detailed discussion of the process and potential morbidity of exenterative surgery should be held in association with the CNS. This should include a realistic discussion about prognosis. Patients wishing to consider post radiation exenteration should be assessed for suitability by the MDT and if appropriate referred urgently to a designated supranetwork referral centre.

## 5.0 Oncological Provision

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**All patients will be considered for entry into a clinical trial where possible.**

Radiotherapy schedules are as defined in the Kent Oncology Centre Quality Systems Clinical Protocols (Disease Management and Radiotherapy Protocols).

Chemotherapy schedules are as defined by the agreed standard chemotherapy schedules and will in due course be incorporated as part of the Electronic Prescribing Project.

### 5.1 Cervical Cancer

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Patients with potentially curable disease who are not considered suitable for radical surgery or offer a preference for non-surgical treatment will be referred to clinical oncologist for consideration of radical radiotherapy using concurrent Cisplatin chemotherapy. Those patients considered unsuitable for chemotherapy will be considered for radical radiotherapy alone. The majority of these patients will be treated with intracavity brachytherapy in addition to their external beam radiotherapy. Patients with suspected or confirmed involved retroperitoneal lymph nodes will also be considered for extended radiotherapy fields.

Patients who have undergone radical surgery who have risk factors for recurrence will be considered for adjuvant radiotherapy with or without concurrent Cisplatin chemotherapy.

Patients who are shown to have unexpected cervical cancer after hysterectomy for other indications will also be considered for adjuvant pelvic radiotherapy. (With or without concurrent Cisplatin chemotherapy.)

Patients who have disease limited to the pelvis who are not considered suitable for radical treatment will be considered for palliative radiotherapy.

Patients with disease that has extended outside the pelvis will be referred to clinical oncologists for consideration of palliative platinum based combination or single agent chemotherapy. Patients with persisting focal symptoms will also be considered for palliative radiotherapy. Patients with recurrent and subsequent metastatic disease who are not considered suitable for surgical salvage will also be considered for palliative chemotherapy.

Patients who remain potentially responsive to chemotherapy will be considered for second line palliative chemotherapy.

At all stages early involvement of the specialist nurses and palliative care team will be considered and made available to the patients.

Note: Full details of the KMCC oncology guidance can be found on the KMCC website:-  
<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/gynae-tssg/>

## 6.0 Follow Up

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All patients who have undergone radical treatment (surgical and / or radiation) will have a post-treatment MRI scan of the pelvis at 6 months following completion of treatment. This scan is intended to assess for potentially salvageable early disease recurrence and provide baseline imaging for future reference.

## 7.0 Supportive and Palliative Care

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Palliative care provision should be made for all patients:

- Hospital teams, including the Clinical Nurse Specialists for gynae cancer patients
- Primary Health Care Team would provide for palliative care at home
- General Practitioner should be informed of management decision changes as soon as possible

The management of symptoms, psychological, social and spiritual issues, and the communication of the diagnosis and any associated problems, should be within the domain of all health care professionals.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be appropriately supported and given appropriate information. However, in accordance with the recommendations set out in various revised Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:

- Complex symptom management issues, which are difficult to manage
- Difficulties in adjusting to the diagnosis or disease progression
- Psychological and family issues – such as communication problems within the family
- Spiritual issues – such as the challenging of belief system/faith/cultural values as a result of the cancer

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:

- At the Multidisciplinary Team Meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages.

## 8.0 Data Collection

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Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Details of the Cancer Waiting Times dataset are available from:

[http://www.datadictionary.nhs.uk/data\\_dictionary/messages/clinical\\_data\\_sets/data\\_sets/national\\_cancer\\_waiting\\_times\\_monitoring\\_data\\_set\\_fr.asp](http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp)

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

[http://www.ncin.org.uk/collecting\\_and\\_using\\_data/data\\_collection/cosd.aspx](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx)

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by National Cancer Registration Service.

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Details of these datasets are available from:

<http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer>

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, systemic anti-cancer therapy (SACT), diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

## 9.0 Children, Teenagers and Young Adults

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Children and Young People (CYP) with Gynaecological Cancers will be treated in accordance with principles set out in the CYP IOG.

All children and Young People up to the age of 18 must be referred to the CYP Principal Treatment Centre which for KMCC is based at the Royal Marsden.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principal Treatment Centre does not necessarily mean that treatment will be undertaken at that centre; shared care management protocols may allow some treatments to be undertaken locally.

## 10.0 Personnel and Contact Information

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A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://kmcc.nhs.uk/tumour-sites/terms-of-reference/>

## 11.0 References

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1. Improving Outcomes in Gynaecological Cancers: The Research Evidence NHS Executive. DOH, July 1999.
2. Guidance for Purchasers: Improving Outcomes in Gynaecological Cancers – The Manual
3. Clinical Recommendations for the Management of Vulval Cancer; “Setting Standards to Improve Women’s Health”. The Royal College of Obstetricians and Gynaecologists, July 1999
4. NHS Cancer Referral Guidelines HSC2000/013

## 12.0 Appendix 1

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### REVISED FIGO staging 2009: Cervical carcinoma

#### Stage I

Stage I is carcinoma strictly confined to the cervix; extension to the uterine corpus should be disregarded.

- Stage IA: Invasive cancer identified only microscopically. All gross lesions even with superficial invasion are stage Ib cancers. Invasion is limited to measured stromal invasion with a maximum depth of 5 mm\* and no wider than 7 mm. [*Note: \*The depth of invasion should not be more than 5 mm taken from the base of the epithelium, either surface or glandular, from which it originates. Vascular space involvement, either venous or lymphatic, should not alter the staging.*]
- **Stage IA1: Measured invasion of the stroma no greater than 3 mm in depth and no wider than 7 mm diameter.**
- **Stage IA2: Measured invasion of stroma greater than 3 mm but no greater than 5 mm in depth and no wider than 7 mm in diameter.**
- Stage IB: Clinical lesions confined to the cervix or preclinical lesions greater than stage IA.
- **Stage IB1: Clinical lesions no greater than 4 cm in size.**
- **Stage IB2: Clinical lesions greater than 4 cm in size.**

#### Stage II

Stage II is carcinoma that extends beyond the cervix but has not extended onto the pelvic wall or the lower third of the vagina.

- Stage IIA: No parametrial involvement. (*Involvement of up to the upper two thirds of the vagina*).
- **Stage IIA1: Clinically visible lesion less than or equal to 4cm in greatest dimension.**
- **Stage IIA2: Clinically visible lesion greater than 4cm in greatest dimension.**
- **Stage IIB: Obvious parametrial involvement, but not onto the pelvic sidewall.**

#### Stage III

Stage III is carcinoma that has extended onto the pelvic sidewall. On rectal examination, there is no cancer-free space between the tumor and the pelvic sidewall. The tumor involves the lower third of the vagina. All cases with a hydronephrosis or nonfunctioning kidney should be included, unless they are known to be due to other causes.

- **Stage IIIA: No extension onto the pelvic sidewall but involvement of the lower third of the vagina.**
- **Stage IIIB: Extension onto the pelvic sidewall or hydronephrosis or nonfunctioning kidney.**

#### Stage IV

Stage IV is carcinoma that has extended beyond the true pelvis or has clinically involved the mucosa of the bladder and/or rectum.

- **Stage IVA: Spread of the tumor onto adjacent pelvic organs.**
- **Stage IVB: Spread to distant organs.**

## 13.0 Glossary

Acronyms in common usage throughout KMCC documentation:

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
EUA	Examination Under Anaesthetic
FNA	Fine Needle Aspiration
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCA	Kent & Medway Cancer Alliance
KMCC	Kent & Medway Cancer Collaborative
LSESN	London & South East Sarcoma Network
LLETZ	Large loop excision to the transitional zone
LVSI	Lymph-vascular space invasion
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non-Surgical Oncology Group <i>(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs)</i>
PoC	Pathway of Care <i>(K&amp;M agreed disease site specific clinical guidelines)</i>
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RCP	Royal College of Physicians
RAT	Research and Trial Group <i>(Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda)</i>
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
SACT	Systemic Anti-Cancer Therapy
TSSG	Tumour Site Specific Group
TYA	Teenager & Young Adult
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

## 14.0 Document Administration

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27/10/05	0.2	Flow chart update based on revised text set out in draft 1	A.Jackson
30/11/05	0.3	Updated text	A.Papadopolous
01/12/05	1.0	Updates agreed 30/11/05	A.Jackson
31/03/06	2.0	Oncology Provision – published	A.Jackson/J.Summers
March 09	2.1	Minor amendment to surgery and radiology	Gynae DOG
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January 2010	3.1	Updates agreed – published	Gynae DOG
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June 2012	4.2	Draft - changed to new format; updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	L.Caine/S.Stanley/ C.Tsatsaklas
July 2012	4.3	Amendment to radical trachelectomy pathway	J.Waters
September 2012	5.0	FINAL – data collection section updated/ final changes made in Gynae DOG 19/09/12 – agreed/published	A.Brittle/Gynae DOG/ C.Tsatsaklas/I.Vousden
May 2014	5.1	Draft – TSSG approved changes inc. removal of KMCN, DOGs, replace with KMCC, TSSG etc	J.Waters/C.Tsatsaklas/Gynae TSSG
May 2014	6.0	FINAL – approved by TSSG 1/5/2014	J.Waters/Gynae TSSG
June 2014	6.0	FINAL/Published – ratified by the Operational & Quality Group (25/6/14)	Operational & Quality Group
July 2017	6.1	Revised draft which now requires TSSG ratification	A.Papadopoulos/N.Aluwalia
September 2017	6.2	Comments added, final draft version	N.Aluwalia
October 2017	7.0	Final published version following O&Q Ratification	N.Aluwalia/ O&Q Group

February 2020	8.0	Revised publication from new Chair	R. Iyer/A. Wiltshire
August 2022	9.0	Final – Revision of document nearing expiry date	R. Iyer / A. Wiltshire



