Algorithm for the Diagnosis of Cancer of the Uterine Cervix
(GYNE-004)

Patient presents with abnormal bleeding (to general practitioner or gynecologist) → Cervical Cancer Screening (by general practitioner or gynecologist)

Physical exam & cytology sample

Abnormal cervical cytology suspicious of cervical cancer

Biopsy at colposcopy if no visible lesion OR biopsy of clinically visible lesion

Referral to Gynecologic Oncologist

Primary Surgery & Staging
History & clinical exam, cone biopsy as indicated, blood work (CBC, LFT, renal function studies), exam under anesthesia (cystoscopy/proctoscopy), imaging optional for clinical stage 1A1, for clinical stage 1B1 MRI recommended and may include chest xray, PET-CT

Incidental Diagnosis of Cervical Cancer

Clinical Stage IA

Clinical Stage IB

Clinical Stage II A

Clinical Stage II B / III A / IV

Recurrent Disease

See Algorithm for the Management of Early Stage Cancer of the Uterine Cervix (GYNE-004)

See Algorithm for the Management of Advanced Stage and Recurrent/Persistent Cancer of the Uterine Cervix (GYNE-004)
Follow-up and Surveillance
Counsel patients about potential recurrence symptoms.
For the first 2 years patients should be followed closely by a physician experienced in the surveillance of cancer patients. Follow-up visits should be held every 3 to 4 months.
After the first 2 years, the patient can be discharged to the primary care physician. Follow-up visits should be held annually and include annual cytology.
All follow-up visits should include a history and complete physical examination (including speculum exam with bimanual pelvic/rectal examination).

Chemotherapy (CT) & Radiotherapy (RT)

<table>
<thead>
<tr>
<th>Regimens</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chemotherapy:</strong> Cisplatin (40mg/m²) (max=80) IV over 1 hour, q1wk x 5-6 cycles during EBRT</td>
<td></td>
</tr>
<tr>
<td><strong>Radiation therapy:</strong> Pelvic RT 45-50.4 Gy in 25-28 fractions (1.8-2.0 Gy per fraction) over 5-5.5 wks; intracavitary brachytherapy may include HDR or PDR techniques; boost to parametria given as indicated</td>
<td></td>
</tr>
</tbody>
</table>
Follow-up and Surveillance
Counsel patients about potential recurrence symptoms. For the first 2 years patients should be followed closely by a physician experienced in the surveillance of cancer patients. Follow-up visits should be held every 3 to 4 months. After the first 2 years, the patient can be discharged to the primary care physician. Follow-up visits should be held annually and include annual cytology.

All follow-up visits should include a history and complete physical examination (including speculum exam with bimanual pelvic/rectal examination).

Chemotherapy (CT) & Radiotherapy (RT)
- **Chemotherapy:** Cisplatin (40mg/m²) (max=80) IV over 1hour, q1wk x 5-6 cycles during EBRT
- **Radiation therapy:** Pelvic RT 45-50.4 Gy in 25-28 fractions (1.8-2.0 Gy per fraction) over 5-5.5 wks; intracavitary brachytherapy may include HDR or PDR techniques; boost to parametria given as indicated

Algorithm for the Management of Advanced Stage and Recurrent/Persistent Cancer of the Uterine Cervix (GYNE-004)

**Clinical Stage IB2 & IIA**
- Pelvic RT + Concurrent CT followed by Brachy
- Radical Hysterectomy + Pelvic Lymphadenectomy
- +/- Para-aortic Lymphadenectomy

**Clinical Stage IIB/ IIIA/ IV**
- Consider RT (Palliative, radical, or EBRT)
- +/- CT with brachytherapy

**Recurrent/Persistent Disease**
- Investigations May Include:
  - History and clinical examination, blood work (CBC, LFT, renal function studies), imaging (may include chest x-ray, CT-PET chest/abdomen/pelvis, or MRI pelvis)

**Potentially curable pelvic recurrence**
- +/- CT with brachytherapy

**Incurable pelvic recurrence**
- Palliative RT +/- CT

**Extra-pelvic recurrence**
- Clinical Trial
- +/- Palliative CT
- +/- Palliative RT