



NCG RESOURCE STRATIFIED GUIDELINES FOR CERVIX CANCER



Summary of Imaging and Management Recommendations for Optimal and Minimal Resources Setting in Cervix Cancer

Disease	Optimal	Optional	Remarks
Imaging			
Stage FIGO 2018			
Early cervical cancer (stage IA1, IA2, IB1,IB2 and IIA1)	<p>Biopsy and Lab Investigations (Complete Blood Count, Liver and Renal Function Tests, HIV status)</p> <p>MRI abdomen and pelvis.</p> <p>CECT abdomen and pelvis, if available, otherwise USG abdomen and pelvis.</p> <p>Chest X-ray</p> <p>For ectocervical tumors < 2 cm,USG alone can also be considered.</p>		<p>EUA is preferred if there is a discrepancy in clinical staging and MRI findings of parametrial involvement.</p> <p>MRI should be considered in patients who desire fertility preservation</p>
Locally advanced Cervical cancer (IB3,IIA2-IVA)	<p>Biopsy and Lab Investigations (Complete Blood Count, Liver and Renal Function Tests, HIV status)</p> <p>MRI pelvis</p> <p>CECT abdomen and pelvis, if available, otherwise USG abdomen and pelvis</p> <p>Chest X-ray</p> <p>CT Thorax in patients with Paraaortic nodes (IIIC2) for adequate systemic staging</p> <p>Cystoscopy /Procto-</p>	<p>PETCT may also be used to determine paraaortic nodal involvement especially in situations wherein FNAC not feasible.</p>	<p>EUA is preferred if there is a discrepancy in clinical staging and MRI findings of parametrial involvement.</p> <p>As incidence of lymph node metastasis is high, CECT is preferred over USG. PET CT may be additionally used if clinically indicated.</p> <p>MR Pelvis may provide additional information for</p>

	sigmoidoscopy with or without biopsy to confirm bladder / rectal mucosa involvement		primary tumor including adjacent organ involvement
Management	Optimal	Optional	Remarks
FIGO stage			
IA1	Type A Radical Hysterectomy or Conization or Radical trachelectomy if fertility desired or Radical BT 60 Gy to point A.	Consider ovarian transposition in premenopausal patients	Patients with positive LVSI should be referred for PLND or assessment for the need for adjuvant pelvic RT
IA2	Type B radical hysterectomy and pelvic lymphadenectomy or Radical trachelectomy and PLND if fertility is desired Or Radical BT alone 65-70 Gy point A.	Consider ovarian transposition in premenopausal patients.	Patients with LVSI should be assessed for the presence of other risk factor(s) for recommending adjuvant radiation
IB1,IB2 and IIA1	Type C 1/C 2 radical hysterectomy with PLND. Open surgery is the procedure of choice. or Upfront 3DCRT and BT with or without chemotherapy followed by Image based 3D Brachytherapy with prescription to Point A or High Risk CTV. Postoperative adjuvant radiation in those with postoperative two or three intermediate risk factors (size > 4 cm, LVSI, deep stromal	Para-aortic lymph node assessment. Radical trachelectomy and PLND in suitable cases of stage IB1, if fertility is desired. Intensity Modulated Radiotherapy may be associated with reduced acute toxicity.	Preoperative thorough assessment of size, parametrial involvement, and nodal status is recommended to avoid adjuvant treatment. Patients with nodes > 1 cm in size should be considered as stage IIIC1 and offered upfront CRT. If the decision is made to operate in the presence of equivocal nodes on imaging, then frozen section should be used to assess nodes. Surgery should be abandoned if nodes are positive on frozen section

	<p>infiltration). Concurrent chemotherapy to be added in the case of any high-risk features (vaginal cut margins, nodes, or parametria positive). 3DCRT represents the current standard of care for postoperative RT. Additional BT should be considered after EBRT. Image based planning recommended.</p> <p>Patients with adenocarcinoma and > 2cm in size and an additional risk factor may be considered for adjuvant radiation</p>		
IB3,IIA2,IIB,IIIA,IIIB	<p>Concurrent pelvic chemoradiation (3DCRT) and 3D CT/MR BT with prescription to Point A or High risk CTV</p>	<p>Radical RT alone (in patients who are unable to tolerate concurrent chemoradiation as a result of low creatinine clearance or advanced age)</p>	<p>No prophylactic stenting is recommended in patients with IIIB and hydronephrosis. Percutaneous nephrostomy and DJ stenting should be avoided in patients with deranged creatinine > 3 g/dL; such patients should be considered for palliative hypofractionated RT</p>
IIIC1	<p>Concurrent pelvic chemoradiation (3DCRT) and CT/MR-based BT Patients with positive nodes should be considered for nodal dose escalation to 55-60 Gy equivalent. Image guided Intensity Modulated Radiotherapy can be used in patients requiring nodal dose escalation or wherein radiation field is extended in abdomen to adequately cover common iliac</p>	<p>Radical RT alone (in patients who are unable to tolerate concurrent chemoradiation as a result of low creatinine clearance or advanced age)</p>	<p>Use of neoadjuvant chemotherapy is not routinely recommended. However, may be discussed within multidisciplinary team if patients have nodal conglomerates > 3 cm in diameter wherein poor response is anticipated to concurrent chemoradiation.</p>

	nodes with additional margin		
IIC2	Extended Field Radiation with concurrent chemotherapy. Image guided IMRT or 3DCRT followed by CT/MR-based BT		Use of neoadjuvant chemotherapy is not routinely recommended. However, may be discussed within multidisciplinary team if patients have nodal conglomerates > 3 cm in diameter wherein poor response is anticipated to concurrent chemoradiation.
IVA	<p>If focal bladder/rectal infiltration, then upfront pelvic chemoradiation (3DCRT). This should be followed by cystoscopy/rectosigmoidoscopy, then CT/MR-based BT or Radical RT alone (in patients who are unable to tolerate concurrent chemoradiation as a result of low creatinine clearance or advanced age)</p> <p>Patients with focal bladder/rectal infiltration and additional large paraaortic nodes may be considered for 2-4 cycles of neoadjuvant chemotherapy followed by re-evaluation with cystoscopy and nodal response, then decide on extended-field radiation and concurrent chemotherapy followed by BT v palliative RT</p> <p>Patients with frank bladder infiltration may be considered for upfront palliative RT and/or palliative chemotherapy.</p> <p>Palliative care reference</p>	Select patients with IVA disease may be considered for exentration after pelvic RT, depending on treatment response, patient wishes, and the availability of infrastructure and expert	-

	<p>should be done early on in patients who are planning for palliative treatment</p> <p>Pain Clinic referral to be made for optimal pain control</p>		
IVB	<p>Palliative chemo and Palliative RT to metastatic sites. Paclitaxel, Cisplatin, Carboplatin, Gemcitabine, 5 Flououracil are active agents that can be considered in combination either upfront or after progression on first line chemotherapy. Upto 6 cycles in first line setting are considered optimal.</p> <p>Palliative care reference should be done early on in patients who are planning for palliative treatment</p> <p>Patients with good performance status and oligometastasis may be considered for radical doses of pelvic RT and Brachytherapy in addition to systemic chemotherapy.</p> <p>Stereotactic Radiation to oligometastatic sites.</p> <p>Patients with nodal only metastasis can be considered for involved field radiation and systemic therapy.</p>	<p>The use of targeted agents such as Bevacizumab remains optional.</p>	<p>-Recommendations for stage IV B disease have been modified in 2019 on the basis of large database analysis demonstrating survival benefit of local treatment and Phase II RCT demonstrating survival benefit of stereotactic RT to oligo metastatic sites.</p>