Post Treatment Surveillance for Women with Invasive Cervical Cancer

Goal: Early detection of a central pelvic recurrence can change the outcome therefore close follow up by a practitioner experienced with the disease is warranted.

- These guidelines apply to women who have completed primary therapy (radical hysterectomy or radiation therapy with chemo) and are without evidence of disease.
- Minimally invasive cancers treated with cone biopsy and dysplasias are not addresses in this guideline.
- Invasive cervical cancer has become an infrequent disease where Pap screening programs are in place. (this is a very small group of patients)
- Either radiation therapy or radical hysterectomy can be curative in low stage disease while radiation is the only treatment option for higher stage disease.
- Metastasis is usually to the local lymph nodes or lungs.
- Recurrence/progression of disease is usually in the pelvis and may present as;
  - local pain/bone pain
  - vaginal bleeding/abnormal cytology
  - lymph obstruction with leg edema
  - ureteral obstruction with hydronephrosis
  - bowel compression/constipation/obstruction
- Isolated local recurrence can be treated with curative intent by radiation therapy or pelvic exenteration. This potential for curative therapy makes early detection by surveillance imperative.
- Recurrence other than isolated local recurrence does poorly. Radiation and chemo can be used as palliative therapy. Comfort care may be most appropriate.
- There are no tumor markers for cervical cancer.
- Screening for other malignancies and options for hormone replacement are not altered with this diagnosis.
- Recurrence is most likely first found on physical. This makes the pelvic examination the mainstay of follow up. For these patients the pelvic exam can be difficult to interpret with radiation or surgical changes. *A consistent provider experienced with cervical cancer is recommended.*

Scheduled follow up

Clinical Exam 4 times each year for the first 5 years

1. Pelvic with Pap and rectal and general physical with lymph nodes
2. History and ROS focused on pelvic urinary and bowel symptoms
3. Biopsy/FNA for any suspicious masses

Imaging Studies

1. IVP or CT to look for ureteral obstruction/hydronephrosis at least yearly X 5 years
2. CXR yearly for 5 years
3. CT of Abd/Pelvis based on Clinical Exam

Consultation with Gynecologist

1. OB/Gyn staff is available for follow up visits in field clinics and at ANMC X 5years
2. At least yearly for patients with no evidence of disease
3. When recurrence is diagnosed or suspected
4. Whenever treatment plan or follow up is changed

Reference:

Johnson, FE, Virgo KS, Edge SB. *Cancer Patient Follow-up*. St. Louis: Mosby Yearbook. 1997