STANDARD OPERATING PROCEDURE

Cervical Cancer

Special Region (1)

Union of Myanmar

Version: (1)

Effective Date: 24 May 2026

Review Date: 24 May 2027

Approved by: Internal Medicine Unit

Cervical Cancer

Incidence

Globally, cervical cancer is the fourth most common. In Myanmar, cervical cancer is the second commonest female cancer and the leading cause of morbidity and mortality.

Risk Factors

- High parity
- Early age of sexual activity
- Women with multiple sexual partners, women married to man with multiple sexual
- Cigarette smoking and combined oral contraceptive pills has been identified as a significant

risk factor because it reduces the local immune system of the cervix.

- Patients with immunodeficiency (HIV patient, organ transplant recipient)

Clinical Features

Symptoms

- Asymptomatic in early stage.
- Abnormal vaginal bleeding (post-coital bleeding, intermenstrual bleeding) or postmenopausal

bleeding and passing out blood stained or foul smelled white discharge.

- Pelvic pain, purulent vaginal discharge and fever.
- In advanced stage, metastatic symptoms depending on site of metastasis, anaemia, renal failure,

venous thrombosis and cachexia. Signs

- Anaemia, supraclavicular lymph node enlargement and cachexia should be examined.
- There is no visible lesion in early stage. There may be cervical mass or nodule, fungating

polypoidal growth or ulcer in later stage. Hard barrel shaped cervix can be felt in endocervical growth.

- Vaginal involvement should be examined.
- Per rectal examination to detect rectal involvement and parametrial involvement.

Investigations

- If the lesion is not well-visualized, colposcopic directed biopsy or if lesion is visible cervical

punch biopsy should be taken.

- When diagnosis is confirmed, further investigations for extent of disease should be done.

(CXR, Ultrasound preferably TVS, MRI to detect the extent of spread, CT, PET CT.) Staging (FIGO staging of cervical cancer, 2018)

I. The carcinoma is strictly confined to the cervix (extension to the uterine corpus does not affect

the stage) IA: Invasive carcinoma that can be diagnosed only by microscopy, with maximum depth of invasion < 5 mm IA 1: Measured stromal invasion < 3 mm in depth IA 2: Measured stromal invasion ≥ 3 mm and < 5 mm in depth IB: Invasive carcinoma with measured deepest invasion ≥ 5 mm (greater than Stage IA), lesion limited to the cervix uteri IB 1: Invasive carcinoma ≥ 5 mm depth of stromal invasion, and < 2 cm in greatest dimension IB 2: Invasive carcinoma ≥ 2 cm and < 4 cm in greatest dimension IB 3: Invasive carcinoma ≥ 4 cm in greatest dimension

II. The carcinoma invades beyond the uterus, but has not extended onto the lower third of the

vagina or to the pelvic wall. IIA: Involvement limited to the upper two-thirds of the vagina without parametrial involve- ment IIA 1: Invasive carcinoma < 4 cm in greatest dimension IIA 2: Invasive carcinoma ≥ 4 cm in greatest dimension IIB: With parametrial involvement but not up to the pelvic wall

III. The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or

causes hydronephrosis or non-functioning kidney and/or involves pelvic and/or para-aortic lymph nodes IIIA: The carcinoma involves the lower third of the vagina, with no extension to the pelvic wall IIIB: Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney (unless known to be due to another cause) IIIC: Involvement of pelvic and/or para-aortic lymph nodes, irrespective of tumor size and extent IIIC 1: Pelvic lymph node metastasis only IIIC 2: Para-aortic lymph node metastasis

IV. The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the

mucosa

- f the bladder or rectum. (A bullous oedema, such as, does not permit a case to be allotted to

Stage IV) IVA: Spread to adjacent pelvic organs IVB: Spread to distant organs

Management

In early stages, both surgery and radiotherapy are equally effective. Stage IA 1 - Invasive cervical cancer with stromal invasion < 3 mm in depth In women who have completed childbearing or elderly women, total extrafascial hysterectomy is recommended. If fertility is desired, cervical conization with close follow up can be considered. Stage IA 2 - Invasive cervical cancer with stromal invasion ≥ 3 mm and < 5 mm In low risk cases, simple extrafascial hysterectomy with pelvic lymphadnectomy. Modified radical hysterectomy plus pelvic lymphadenectomy can be done. Women desiring future fertility - cervical conization with laparoscopic pelvic lymphadenectomy

- r trachelectomy with pelvic lymphadenectomy can be considered.

Stage IB 1 - Invasive carcinoma ≥ 5 mm depth of stromal invasion and < 2 cm in greatest diameter Type C radical hysterectomy with pelvic lymphadenectomy is the standard treatment, but modified radical hysterectomy can be considered with pelvic lymphadenectomy. Women desiring future fertility, trachelectomy with pelvic lymphadenectomy can be considered. For Stage IB 2, IIA 1 Surgery or radiotherapy can be given. Type C radical hysterectomy with pelvic lymphadenectomy can be performed.

For Stage IB 3, IIA 2 Concurrent chemoradiation is the preferred treatment. Neoadjuvant chemotherapy followed by radical surgery and pelvic lymphadenectomy can be considered. For Stage IIB to IVA Concurrent chemoradiaton is the standard treatment. Stage IVB - Spread to distant organs Concurrent chemoradiation or palliative treatment can be considered. Indications for Adjuvant Radiotherapy . Positive lymph nodes . Parametrial involvement . Positive margin, Tumor close to the margin . Deep stromal invasion . High risk patients (e.g., tumour > 4 cm) . Patients who has not undergone staging operation (e.g., TAH for myoma uterus) Recurrent disease Recurrence after surgery may be treated with concurrent chemoradiation. Central recurrence after radiotherapy may be managed by pelvic exenteration (removal of tumour, bladder, rectum) and needs surgical expertise. Follow-up Appointments should be offered at the multidisciplinary clinics or at the Oncology Unit or at tertiary care level.

- 6 weeks post-operatively
- Every 3 months for 2 years
- 6 monthly for 3 years
- Annually after 5 years

Detailed history and thorough physical examination including pelvic examination is mandatory. Need to check any complications of treatment and tumor recurrence. The necessary investigations will be performed according to the symptoms of the patient. Refer to Gynae-oncology center if there is recurrence of the tumor.

References

1. Obstetrics and Gynaecology Myanmar management Guidelines, 2024

2. Obstetrics and Gynaecology An evidence-based Text book for MRCOG