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Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Cervical Cancer

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***Nadeem R. Abu-Rustum, MD Ω/Chair**
Memorial Sloan Kettering Cancer Center

***Catheryn M. Yashar, MD §/Vice Chair**
UC San Diego Moores Cancer Center

Sarah Bean, MD ≠
Duke Cancer Institute

Kristin Bradley, MD §
University of Wisconsin
Carbone Cancer Center

Susana M. Campos, MD, MPH, MS †
Dana-Farber/Brigham and Women's
Cancer Center

Hye Sook Chon, MD Ω
Moffitt Cancer Center

Christina Chu, MD Ω
Fox Chase Cancer Center

David Cohn, MD Ω
The Ohio State University
Comprehensive Cancer Center -
James Cancer Hospital and
Solove Research Institute

Marta Ann Crispens, MD Ω
Vanderbilt-Ingram Cancer Center

Shari Damast, MD §
Yale Cancer Center/
Smilow Cancer Hospital

Christine M. Fisher, MD, MPH §
University of Colorado Cancer Center

Peter Frederick, MD Ω
Roswell Park Cancer Institute

David K. Gaffney, MD, PhD §
Huntsman Cancer Institute
at the University of Utah

Robert Giuntoli II, MD Ω
Abramson Cancer Center at
the University of Pennsylvania

Ernest Han, MD, PhD Ω
City of Hope
National Medical Center

Warner K. Huh, MD Ω
O'Neal Comprehensive
Cancer Center at UAB

John R. Lurain III, MD Ω
Robert H. Lurie Comprehensive Cancer
Center of Northwestern University

Andrea Mariani, MD Ω
Mayo Clinic Cancer Center

David Mutch, MD Ω
Siteman Cancer Center at Barnes-
Jewish Hospital and Washington
University School of Medicine

Christa Nagel, MD Ω
Case Comprehensive Cancer Center/
University Hospitals Seidman Cancer
Center and Cleveland Clinic Taussig
Cancer Institute

Larissa Nekhlyudov, MD, MPH †
Dana-Farber/Brigham and Women's
Cancer Center

Amanda Nickles Fader, MD Ω
The Sidney Kimmel Comprehensive
Cancer Center at Johns Hopkins

Steven W. Remmenga, MD Ω
Fred & Pamela Buffett Cancer Center

R. Kevin Reynolds, MD Ω
University of Michigan
Rogel Cancer Center

Rachel Sisodia Ω
Massachusetts General Hospital
Cancer Center

Todd Tillmanns, MD Ω
St. Jude Children's Research Hospital/
The University of Tennessee Health Science Center

Stefanie Ueda, MD Ω
UCSF Helen Diller Family
Comprehensive Cancer Center

Renata Urban, MD Ω
Fred Hutchinson Cancer Research Center/
Seattle Cancer Care Alliance

Emily Wyse ¥
Patient Advocate

NCCN
Nicole McMillian, MS

Continue

Ω Gynecologic oncology
‡ Internal medicine
† Medical oncology
§ Radiotherapy/Radiation oncology
≠ Pathology
¥ Patient advocacy
* Discussion Section Writing Committee



[NCCN Cervical Cancer Panel Members](#) [Summary of the Guidelines Updates](#)

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[Stage IA1 \(no LVSI\), Stage IA1 \(with LVSI\) and Stage IA2, Stage IB1 and Select IB2 \(Fertility Sparing\) \(CERV-2\)](#)

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The NCCN Guidelines for Cervical Cancer include the management of squamous cell carcinoma, adenosquamous carcinoma, and adenocarcinoma of the cervix.

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Clinical Trials: NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, [click here: nccn.org/clinical_trials/member_institutions.aspx](#).

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See [NCCN Categories of Evidence and Consensus](#).

NCCN Categories of Preference: All recommendations are considered appropriate.

See [NCCN Categories of Preference](#).



Updates in Version 1.2020 of the NCCN Guidelines for Cervical Cancer from Version 4.2019 include:

CERV-1

- Clinical Stage: Revised to Incidental finding of invasive cancer at simple (*extrafascial*) hysterectomy. (Also for CERV-9)

CERV-4 Primary Treatment (Non-Fertility Sparing)

- Primary Treatment:
 - ▶ Stage IB1, IB2 and Stage IIA1: Revised, Pelvic EBRT + brachytherapy (~~total point A dose: 80–85 Gy~~) ± concurrent platinum-containing chemotherapy
 - ▶ Stage IB3 and Stage IIA2: Revised, "Definitive pelvic EBRT + concurrent platinum-containing chemotherapy + brachytherapy (~~total point A dose ≥85 Gy~~) category 1 for primary chemoradiation)
- Footnote q revised: Concurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant) ~~or cisplatin plus 5-fluorouracil~~. (Also for CERV-5, CERV-6, CERV-7, CERV-8, CERV-9, and CERV-11)
- Footnote regarding point A dose removed: "The traditional dose would be 75–80 Gy to total point A dose."

CERV-5

- Surgical Findings; Positive pelvic nodes and/or Positive surgical margin and/or Positive parametrium: "*Imaging workup for metastatic disease*" was added prior to adjuvant treatment.

CERV-6

- Stage IB3, Stage IIA2; Additional Workup: Revised, "Surgical staging (category 2B): ~~Extraperitoneal or laparoscopic lymph node dissection~~."

CERV-7

- Imaging Results; Positive adenopathy by CT, MRI, and/or PET (FIGO 2018 Stage IIICr)
 - ▶ Primary Treatment for Pelvic node positive; Para-aortic lymph node negative: Revised, "~~Extraperitoneal or laparoscopic lymph node dissection~~ *Surgical staging of para-aortic nodes*"
- Footnote w is new: *Consider ablative therapy for 1–5 metastatic lesions (category 2B) if the primary has been controlled. (Palma D, Olson R, Harrow S, et al. Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): a randomised, phase 2, open-label trial. Lancet 2019;393:2051-2058.)* (Also for CERV-8)

CERV-9

- Column header revised: Incidental finding of invasive cancer after simple (*extrafascial*) hysterectomy:
 - ▶ Stage IA1 with LVSI or Stage IA2/IB or Positive margins/gross residual disease
 - ◇ Treatment for Positive margins, gross residual disease, positive imaging, or primary tumor characteristics meeting Sedlis criteria: The bifurcation of "Imaging negative for nodal disease" and "Imaging positive for nodal disease" was removed. Patients with positive nodes by imaging are now redirected to page CERV-7 (Positive adenopathy by CT, MRI, and/or PET [FIGO Stage IIICr])

CERV-10

- Surveillance
 - ▶ Second bullet revised: "Cervical/vaginal cytology screening annually as indicated..."
 - ▶ Third bullet revised: "~~Imaging as indicated based on symptoms or examination findings suspicious for recurrence~~ *Stage-dependent imaging for follow-up*"
- Footnote aa revised: "Regular cytology can be considered for detection of lower genital tract dysplasia *and for immunocompromised patients*, although its value in detection of recurrent cervical cancer is limited. The likelihood of picking up asymptomatic recurrences by cytology alone is low.

[Continued](#)

UPDATES

**CERV-A Principles of Pathology**

- Pathologic assessment for carcinoma
 - ▶ First arrow sub-bullet: Uterus
 - ◊ Diamond sub-bullet revised: ~~Circumferential~~ *Tumor width horizontal extent in mm*
 - ◊ Diamond sub-bullet removed: Longitudinal length horizontal extent in mm (no longer included in FIGO 2018 staging)
 - ▶ Last arrow sub-bullet Sub-bullet revised: Consider MMR/MSI, or PD-L1, and/or *NTRK gene fusion testing* for patients with recurrent, progressive, or metastatic disease
- The following footnotes are new:
 - ▶ *According to the 2018 International Endocervical Adenocarcinoma Criteria and Classification (IECC), morphologic features (luminal mitotic figures and apoptosis) can be used to distinguish between human papillomavirus (HPV)-associated endocervical adenocarcinomas and non-HPV-associated adenocarcinomas. Tumors can be further subtyped based on morphologic features.*
 - ▶ *Evaluation of histologic pattern of invasion for endocervical adenocarcinomas is an emerging concept. Three clinically significant histologic patterns of invasion for endocervical adenocarcinoma have been described. Tumors with so-called pattern A invasion (defined by well-demarcated glands with round contours, an absence of single cells, an absence of desmoplastic stromal response, and no lymphatic vascular invasion) have excellent survival and do not have lymph node metastases or recurrences. (Diaz De Vivar A, Roma AA, Park KJ, et al. Invasive endocervical adenocarcinoma: proposal for a new pattern-based classification system with significant clinical implications: a multi-institutional study. Int J Gynecol Pathol 2013;32:592-601.)*
 - ▶ Footnote d revised: Ultrastaging commonly entails serial sectioning of the SLN and review of multiple H&E stained sections and with or without cytokeratin immunohistochemistry for all blocks of the SLN. There is not a standard protocol for lymph node ultrastaging.

CERV-B Principles of Imaging**1 of 3**

- Initial Workup
 - ▶ Stage I
 - ◊ Non-Fertility Sparing
 - Sub-bullet revised: Whole-body PET/CT (*preferred*) or chest/abdomen/pelvic CT or *PET/MRI* in FIGO stage ~~IB3~~ *≥IB1*.
 - Sub-bullet removed: Consider whole body PET/CT or chest/abdomen/pelvic CT in FIGO stage IB1–IB2. Recommendations were incorporated into another bullet.
 - ▶ Fertility Sparing
 - Sub-bullet revised: Consider Whole-body PET/CT (*preferred*) or chest/abdomen/pelvic CT in FIGO stage IB1–IB2.
 - ▶ Revised staging: Stage II–IVA

2 of 3

- Follow-up/Surveillance: Imaging recommendations were added for *Stage IVB or recurrence*.

CERV-C Principles of Evaluation and Surgical Staging**1 of 7**

- Types of Resection and Appropriateness for Treatment of Cervical Cancer
 - ▶ Fourth bullet revised: "The standard and historical *recommended* approach for radical hysterectomy is with an open abdominal approach (*category 1*). ~~Previous iterations of the guidelines indicated that radical hysterectomy could be performed via open laparotomy or minimally invasive surgery (MIS) laparoscopic approaches, using either conventional or robotic techniques. However, several key contemporary reports have questioned the presumed therapeutic equivalency of open vs. MIS approaches. A prospective randomized trial demonstrated...~~"
 - ▶ Bullet removed: Given recently presented findings of significantly poorer survival outcomes with the minimally invasive approach compared to the open approach in a randomized controlled trial of women with early-stage cervical cancer, women should be carefully counseled about the short-term versus long-term outcomes and oncologic risks of the different surgical approaches.

[Continued](#)**UPDATES**

**CERV-C Principles of Evaluation and Surgical Staging****3 of 7**

- Footnote c is new: *In the phase III randomized FILM trial, indocyanine green (ICG) was shown to be non-inferior to isosulfan blue dye. (Frumovitz M, Plante M, Lee PS et al. Near-infrared fluorescence for detection of sentinel lymph nodes in women with cervical and uterine cancers (FILM): a randomised, phase 3, multicentre, non-inferiority trial. Lancet Oncol 2018;19:1394-1403).*

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- Footnote g is new: *There is no standard protocol for ultrastaging. Ultrastaging typically includes serial sectioning of the gross lymph node with review of H&E with or without cytokeratin IHC staining. See Principles of Pathology (CERV-A).*

5 of 7 Table 1: Resection of Cervical Cancer as Primary Therapy

- Surgical approach recommendations were revised as follows:
 - Comparison of Hysterectomy Types
 - ◊ Extrafascial Hysterectomy (Type A): *Vaginal or laparotomy or minimally invasive*
 - ◊ Modified Radical Hysterectomy (Type B): *Laparotomy or minimally invasive*
 - ◊ Radical Hysterectomy (Type C1): *Laparotomy or minimally invasive*
 - Comparison of Fertility-Sparing Trachelectomy Types
 - ◊ Radical Trachelectomy: *Vaginal or laparotomy or minimally invasive (category 2B for MIS)*
- Footnote m is new: *There is a lack of data on oncologic outcomes for minimally invasive surgical approaches to trachelectomy.*

CERV-D Principles of Radiation**1 of 6**

- General Principles: Third bullet revised, Brachytherapy is a critical component of definitive therapy for all patients with primary cervical cancer who are not candidates for surgery. This is performed using an intracavitary ± and/or an interstitial approach.

2 of 6

- Treatment Information-External Beam
 - Second bullet revised: *"IMRT may be helpful in minimizing the dose to the bowel and..."*
- Dosing Prescription Regimen - External Beam
 - Bullet revised: *"Coverage of microscopic nodal disease requires an EBRT dose of approximately 40–45 Gy (in conventional..."*

3 of 6

- Definitive Radiation Therapy for an Intact Cervix
 - Bullet revised: *"...The primary cervical tumor is then boosted, using brachytherapy, with an additional 30 to 40 Gy using either image guidance (preferred) or to point A (in low dose-rate [LDR] equivalent dose), for a total point A dose (as recommended in the guidelines) of 80 Gy for small-volume cervical tumors or ≥85 Gy for larger-volume cervical tumors. For very small tumors (medically inoperable IA1 or IA2 EQD2 D90 doses of 75–80 Gy may be considered). Grossly involved unresected nodes may be evaluated for boosting with an additional 10 to 15 Gy of highly conformal (and reduced-volume) EBRT. With higher doses, especially of EBRT, When using image guidance for EBRT, care must be taken to exclude or severely limit the volume of normal tissue..."*
- Post-hysterectomy Adjuvant Radiation Therapy
 - Bullet revised: *"...At a minimum, the following should be covered: upper 3 to 4 cm of the vaginal cuff, the parametria, and immediately adjacent nodal basins (such as the external and internal iliacs, obturator and presacral nodes). For documented nodal metastasis, the superior border of the radiation field should be appropriately increased (as previously described). A dose of 45 to 50 Gy in standard fractionation with IMRT is generally recommended..."*

[Continued](#)**UPDATES**

**CERV-D Principles of Radiation (continued)**

5 of 6

• **Dosing Prescription Regimen - Brachytherapy**

- ▶ **Second bullet revised:** "...The goals of care would include an equivalent dose at 2 Gy (EQD2) to the high-risk CTV (HR-CTV) with a *D90* of ≥ 80 –85 Gy; however, with large disease or poor response dose goals should be *HR-CTV D90* ≥ 87 Gy..."
- ▶ **Third bullet revised:** "...Clinicians using high dose-rate (HDR) brachytherapy would depend on the linear-quadratic model equation to convert nominal HDR dose to point A to a biologically equivalent LDR dose to point A (<http://www.americanbrachytherapy.org/guidelines/>). Multiple brachytherapy schemes have been used when combined with EBRT. However, one of the more common HDR approaches is 5 insertions with tandem and colpostats, each delivering 6 Gy nominal dose to point A. This scheme results in a nominal HDR point A dose of 30 Gy in 5 fractions..."
- ▶ **Bullet removed:** Image-guided brachytherapy is encouraged with prescribing to a HR-CTV. The most common historical dosing parameters for brachytherapy use a system that includes specifying the dose at point A and incorporates specific guidelines for "radioactive source loading and distribution of activity" within the uterus and vagina, based on anatomic considerations. Doses are also calculated at standardized point B and bladder and rectal points. Current efforts at 3D image-guided brachytherapy seek to optimize implant dose coverage of the tumor, while potentially reducing the dose to adjacent bladder, rectum, and bowel structures. Nonetheless, the weight of experience and tumor control results and the majority of continuing clinical practice have been based on the point A dosing system. Attempts to improve dosing with image-guided brachytherapy should take care not to underdose tumors relative to the point A system dose recommendations.

CERV-F Systemic Therapy Regimens for Cervical Cancer

- **"Strongly consider clinical trial" was removed from the page title.** This recommendation is listed in the guideline footer.
- **Chemoradiation**
 - ▶ **Other Recommended Regimens:** Cisplatin/fluorouracil was removed as an option.
- **Recurrent or Metastatic Disease**
 - ▶ **First-line combination therapy**
 - ◇ The following agents were moved from the list of Preferred Regimens and added to the list of Other Recommended Regimens:
 - Cisplatin/paclitaxel (category 1)
 - Carboplatin/paclitaxel (category 1 for patients who have received prior cisplatin therapy)
 - Topotecan/paclitaxel/bevacizumab (category 1)
 - Topotecan/paclitaxel
 - ▶ **Second-line therapy**
 - ◇ *Larotrectinib or entrectinib for NTRK gene fusion-positive tumors (category 2B)* was listed as an option. It was preference stratified as "Useful in certain circumstances."
- **Footnote g is new:** [See NCCN Guidelines for the Management of Immunotherapy-Related Toxicities.](#)



WORKUP

- History and physical (H&P)
- Complete blood count (CBC) (including platelets)
- Cervical biopsy, pathologic review^a
- Cone biopsy as indicated^b
- Liver function test (LFT)/renal function studies
- Imaging^c
- Smoking cessation and counseling intervention if indicated ([See NCCN Guidelines for Smoking Cessation](#))
- Consider HIV testing^d
- Consider examination under anesthesia (EUA) cystoscopy/proctoscopy^e (≥ stage IB3)
- Consider options for fertility sparing

CLINICAL STAGE

Stage IA1

[See Primary Treatment \(Fertility Sparing\) \(CERV-2\)](#)

[See Primary Treatment \(Non-Fertility Sparing\) \(CERV-3\)](#)

Stage IA2

[See Primary Treatment \(Fertility Sparing\) \(CERV-2\)](#)

Stage IB1

[See Primary Treatment \(Non-Fertility Sparing\) \(CERV-3\) and \(CERV-4\)](#)

Stage IB2

Stage IIA1

[See Primary Treatment \(Non-Fertility Sparing\) \(CERV-4\)](#)

Stage IB3

[See Primary Treatment \(CERV-4\) and \(CERV-6\)](#)

Stage IIA2

Stage IIB

[See Primary Treatment \(CERV-6\)](#)

Stage III

Stage IVA

Stage IVB

[See Treatment \(CERV-12\)](#)

Incidental finding of invasive cancer at simple (extrafascial) hysterectomy

[See Treatment \(CERV-9\)](#)

^aSee [Principles of Pathology \(CERV-A\)](#).

^bSee [Discussion](#) for indications for cone biopsy.

^cSee [Principles of Imaging \(CERV-B\)](#).

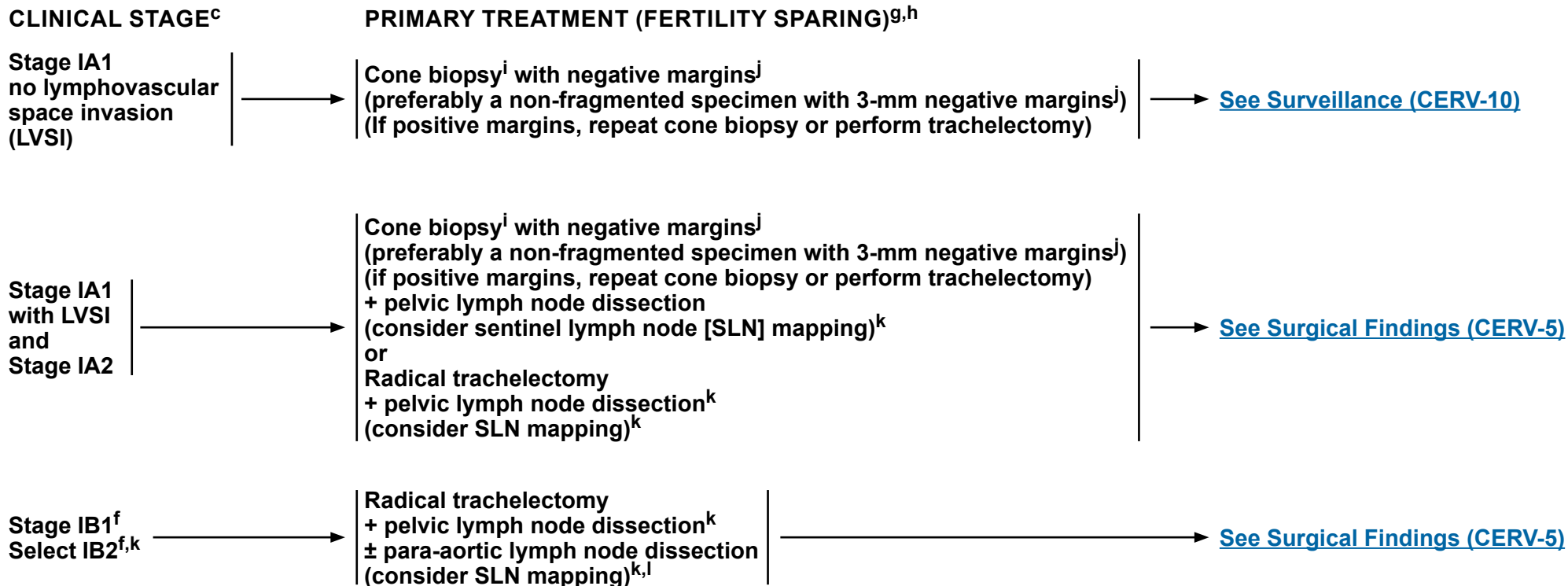
^dConsider HIV testing, especially in younger patients. Patients with cervical cancer and HIV should be referred to an HIV specialist and should be treated for cervical cancer as per these guidelines. Modifications to cancer treatment should not be made solely on the basis of HIV status.

^eFor suspicion of bladder/bowel involvement, cystoscopy/proctoscopy with biopsy is required.

All staging in guidelines is based on updated 2018 FIGO staging. ([See ST-1](#))

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



^cSee [Principles of Imaging \(CERV-B\)](#).

^fFertility-sparing surgery for stage IB has been most validated for tumors ≤2 cm. Small cell neuroendocrine histology and gastric type adenocarcinoma (also known as minimal deviation adenocarcinoma or adenoma malignum) are not considered suitable tumors for this procedure.

^gThere are no data to support a fertility-sparing approach in small neuroendocrine tumors, gastric type adenocarcinoma, or adenoma malignum. Total hysterectomy after completion of childbearing is at the patient's and surgeon's discretion, but is strongly advised in women with continued abnormal pap smears or chronic persistent HPV infection.

^hConsultation with reproductive endocrinology fertility experts is suggested.

ⁱCold knife conization (CKC) is the preferred method of diagnostic excision, but loop electrosurgical excision procedure (LEEP) is acceptable, provided adequate margins and proper orientation are obtained. Endocervical curettage (ECC) should be added as clinically indicated.

^jNegative for invasive disease or histologic high-grade squamous intraepithelial lesion (HSIL) at margins.

^kSee [Principles of Evaluation and Surgical Staging \(CERV-C\)](#).

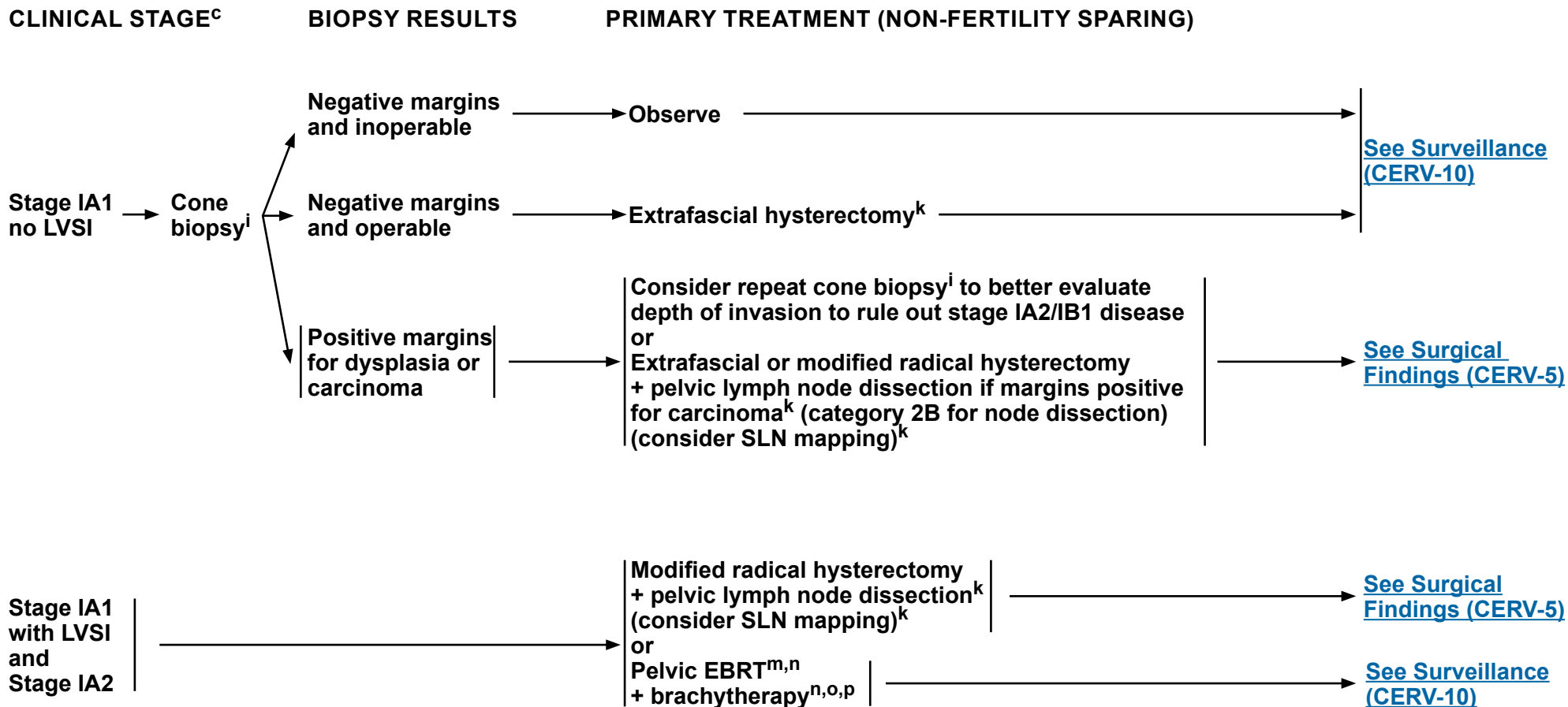
^lFor SLN mapping, the best detection rates and mapping results are in tumors <2 cm.

Note: All recommendations are category 2A unless otherwise indicated.

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NCCN Guidelines Version 1.2020 Cervical Cancer



^cSee Principles of Imaging (CERV-B).

ⁱCKC is the preferred method of diagnostic excision, but LEEP is acceptable, provided adequate margins and proper orientation are obtained. ECC should be added as clinically indicated.

^kSee Principles of Evaluation and Surgical Staging (CERV-C).

^mRadiation can be an option for medically inoperable patients or those who refuse surgery.

ⁿSee Principles of Radiation Therapy (CERV-D).

^oThese doses are recommended for most patients based on summation of conventional external-beam fractionation and low dose-rate (40–70 cGy/h) brachytherapy equivalents. Modify treatment based on normal tissue tolerance, fractionation, and size of target volume. (See Discussion)

^pThe traditional dose would be 70–80 Gy to total point A dose.

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CLINICAL STAGE ^c	PRIMARY TREATMENT (NON-FERTILITY SPARING)	
Stage IB1, IB2 and Stage IIA1	Radical hysterectomy + pelvic lymph node dissection ^k (category 1) ± para-aortic lymph node dissection (category 2B) (consider SLN mapping) ^{k,l} or Pelvic EBRT ^{m,n} + brachytherapy ^{n,o} ± concurrent platinum-containing chemotherapy ^q	→ See Surgical Findings (CERV-5)
		→ See Surveillance (CERV-10)
Stage IB3 and Stage IIA2 (also see CERV-6 for additional recommendations for non-primary surgery patients)	Definitive pelvic EBRT ⁿ + concurrent platinum-containing chemotherapy ^q + brachytherapy ^{n,o} (category 1 for primary chemoradiation) or Radical hysterectomy + pelvic lymph node dissection ^k ± para-aortic lymph node dissection (category 2B) or Pelvic EBRT ⁿ + concurrent platinum-containing chemotherapy ^q + brachytherapy ^{n,o} + adjuvant hysterectomy ^r (category 3)	→ See Surveillance (CERV-10)
		→ See Surgical Findings (CERV-5)
		→ See Surveillance (CERV-10)

^cSee [Principles of Imaging \(CERV-B\)](#).

^kSee [Principles of Evaluation and Surgical Staging \(CERV-C\)](#).

^lFor SLN mapping, the best detection rates and mapping results are in tumors <2 cm.

^mRadiation can be an option for medically inoperable patients or those who refuse surgery.

ⁿSee [Principles of Radiation Therapy \(CERV-D\)](#).

^oThese doses are recommended for most patients based on summation of conventional external-beam fractionation and low dose-rate (40–70 cGy/h) brachytherapy equivalents. Modify treatment based on normal tissue tolerance, fractionation, and size of target volume. ([See Discussion](#))

^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^rThis approach can be considered in patients whose extent of disease, response to EBRT, or uterine anatomy precludes adequate coverage by brachytherapy.

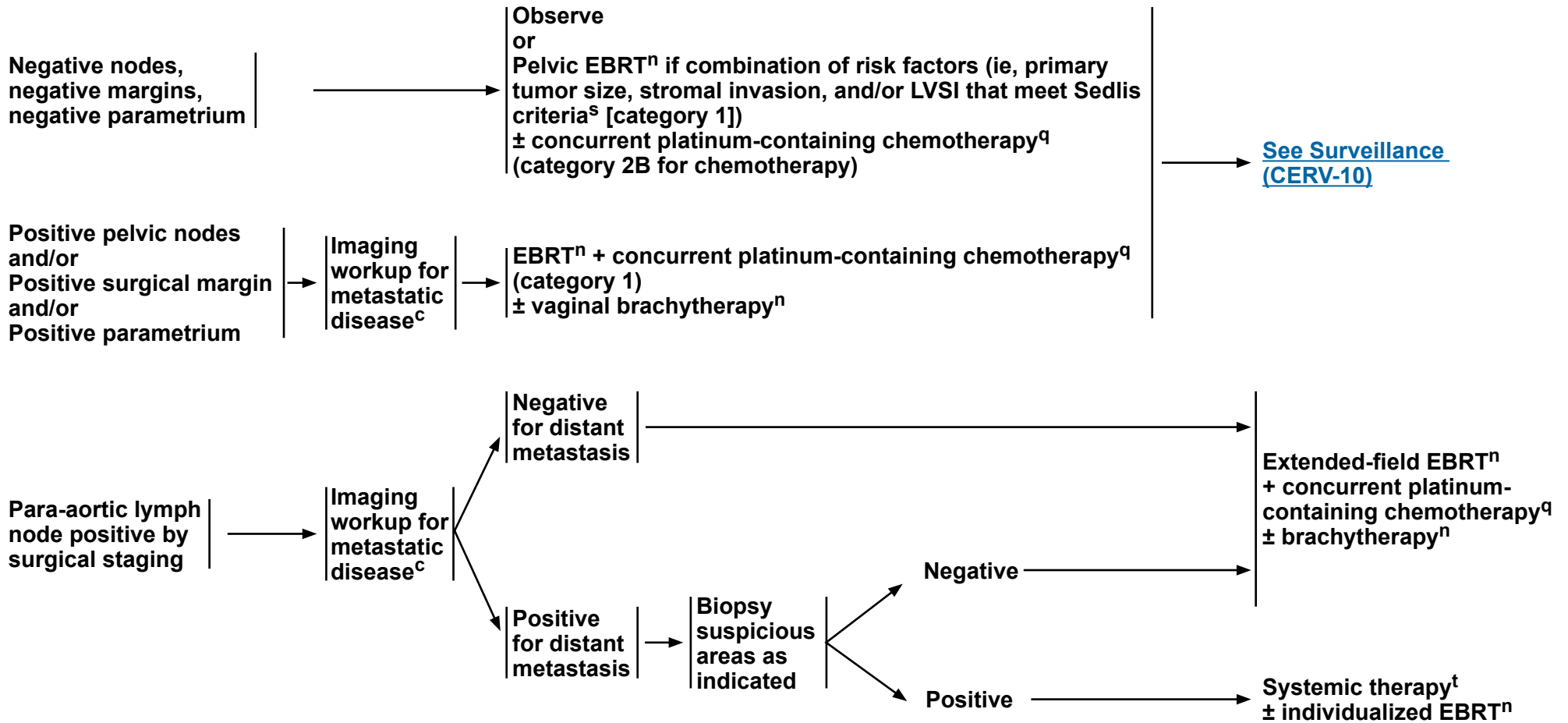
Note: All recommendations are category 2A unless otherwise indicated.

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SURGICAL FINDINGS

ADJUVANT TREATMENT



[See Surveillance \(CERV-10\)](#)

^cSee Principles of Imaging (CERV-B).

ⁿSee Principles of Radiation Therapy (CERV-D).

^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^sRisk factors may not be limited to the Sedlis criteria. See Sedlis Criteria (CERV-E).

^tSee Systemic Therapy Regimens for Cervical Cancer (CERV-F).

Note: All recommendations are category 2A unless otherwise indicated.
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[See Surveillance \(CERV-10\)](#)

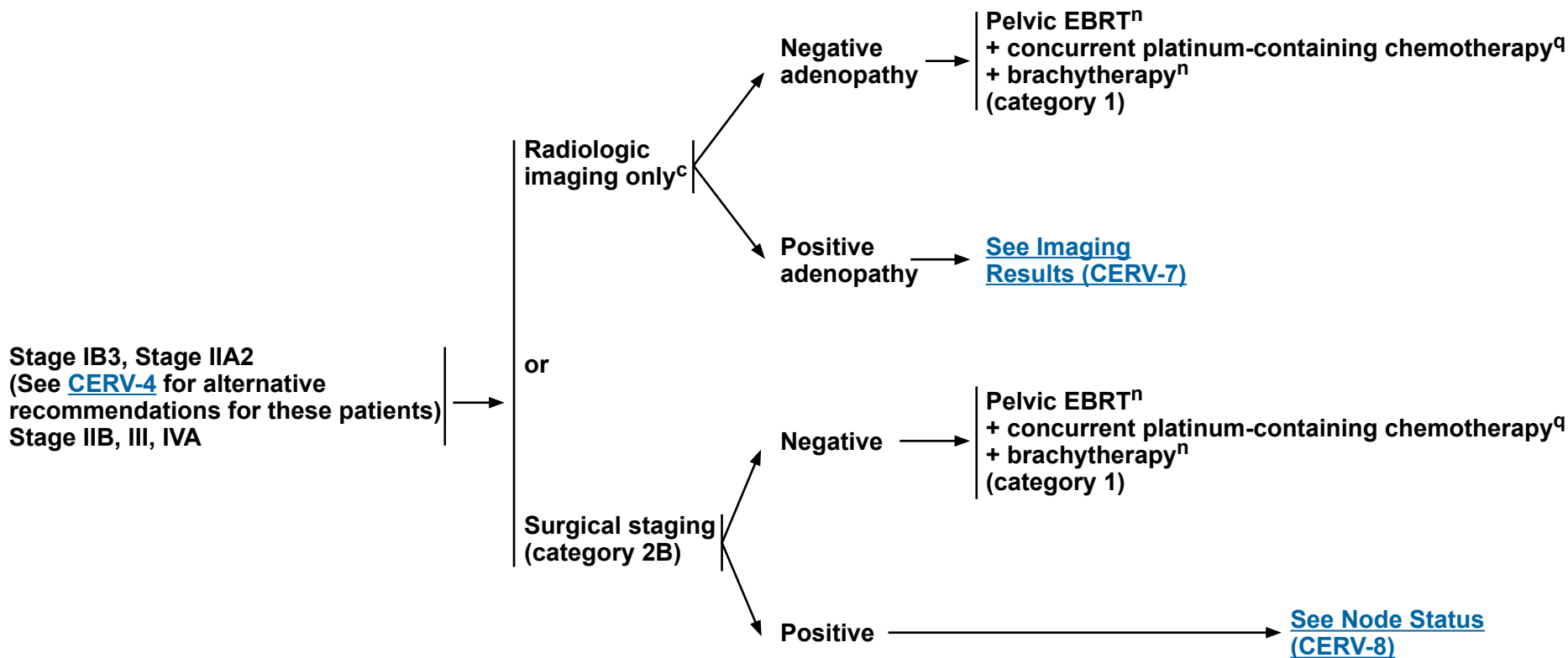




CLINICAL STAGE

ADDITIONAL WORKUP

PRIMARY TREATMENT



^cSee [Principles of Imaging \(CERV-B\)](#).

ⁿSee [Principles of Radiation Therapy \(CERV-D\)](#).

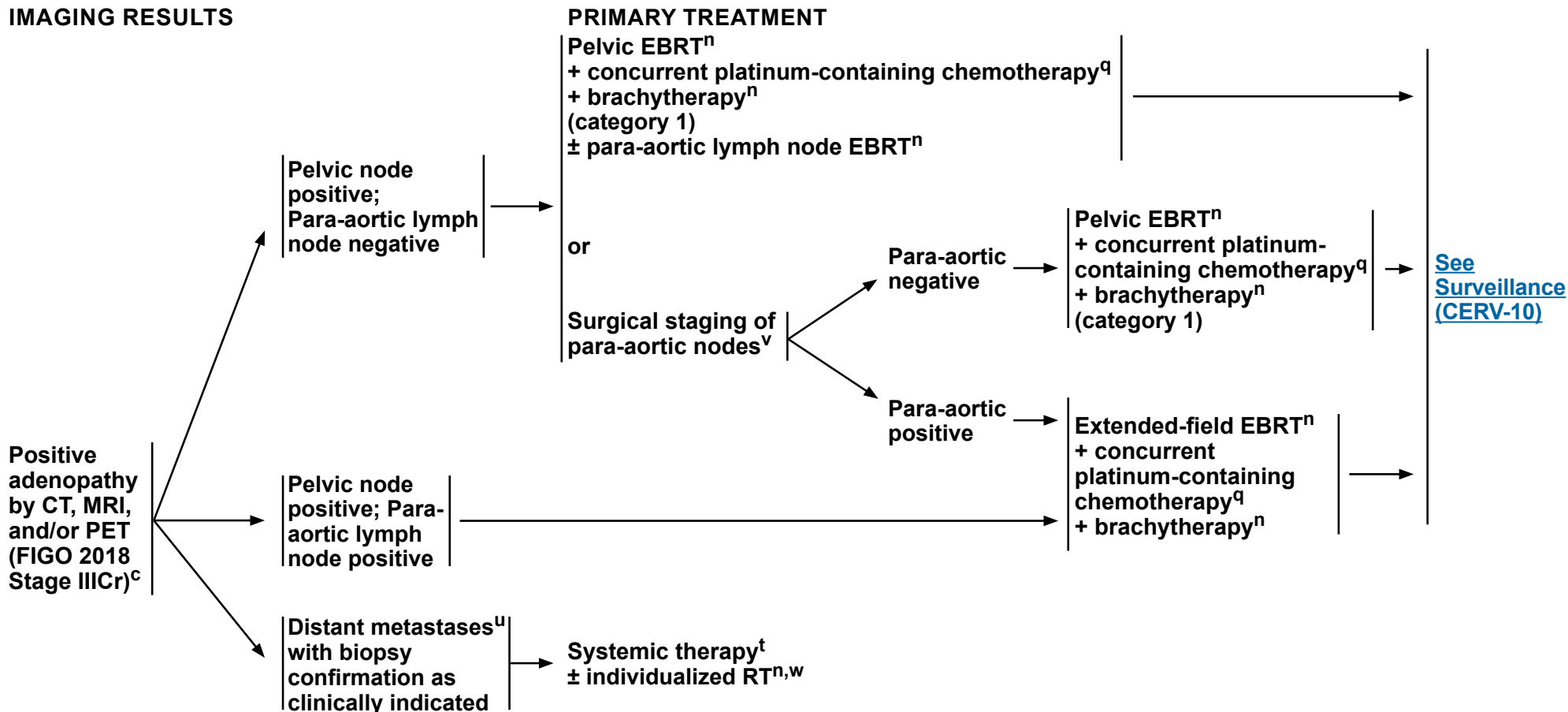
^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[See Surveillance
\(CERV-10\)](#)

IMAGING RESULTS



^cSee Principles of Imaging (CERV-B).

ⁿSee Principles of Radiation Therapy (CERV-D).

^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^tSee Systemic Therapy Regimens for Cervical Cancer (CERV-F).

^uPatients with distant metastatic disease confined to the supraclavicular nodes may be treated definitively. (Kim JY, Kim JY, Kim JH, et al. Curative chemoradiotherapy in patients with stage IVB cervical cancer presenting with paraortic and left supraclavicular lymph node metastases. Int J Radiat Oncol Biol Phys 2012;84:741-747.)

^vConsider postoperative imaging (abdominal/pelvic CT or MRI with contrast) to confirm the adequacy of node removal.

^wConsider ablative therapy for 1–5 metastatic lesions (category 2B) if the primary has been controlled. (Palma D, Olson R, Harrow S, et al. Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): a randomised, phase 2, open-label trial. Lancet 2019;393:2051-2058.)

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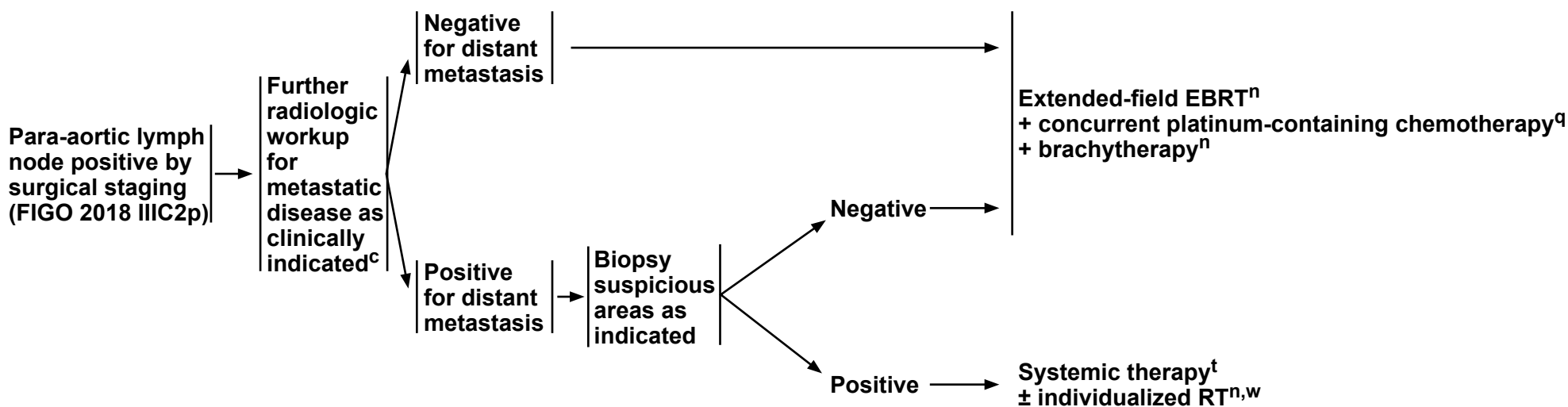
[See Surveillance \(CERV-10\)](#)

SURGICAL NODE STATUS (ALSO SEE [CERV-6](#))

PRIMARY TREATMENT

Pelvic lymph node positive and para-aortic lymph node negative by surgical staging (FIGO 2018 IIC1p)

Pelvic EBRTⁿ
+ concurrent platinum-containing chemotherapy^q
+ brachytherapyⁿ
(category 1)



^cSee Principles of Imaging (CERV-B).

ⁿSee Principles of Radiation Therapy (CERV-D).

^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^tSee Systemic Therapy Regimens for Cervical Cancer (CERV-F).

^wConsider ablative therapy for 1–5 metastatic lesions (category 2B) if the primary has been controlled. (Palma D, Olson R, Harrow S, et al. Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): a randomised, phase 2, open-label trial. *Lancet* 2019;393:2051-2058.)

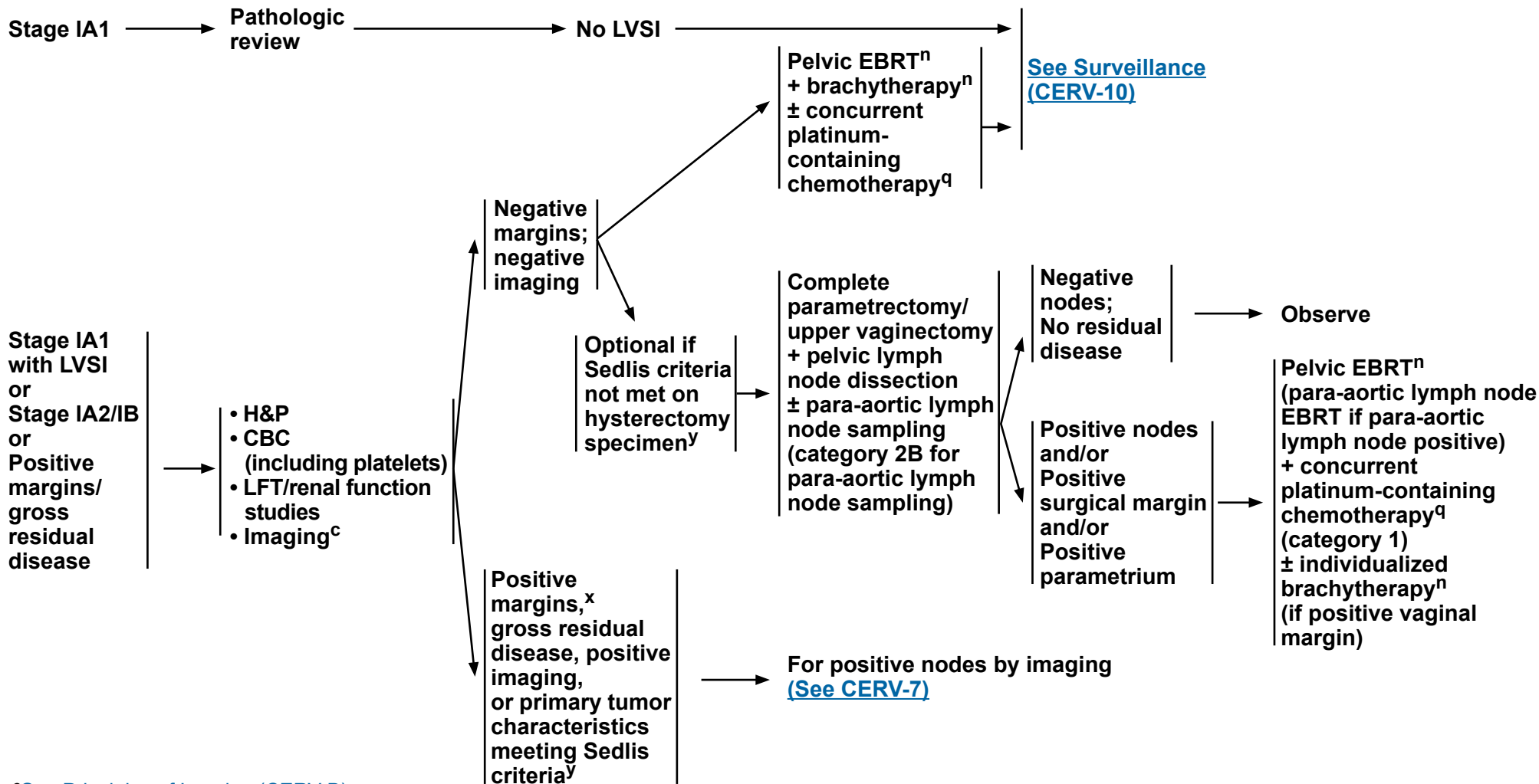
Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[See Surveillance \(CERV-10\)](#)



INCIDENTAL FINDING OF INVASIVE CANCER AFTER SIMPLE (EXTRAFASCIAL) HYSTERECTOMY

TREATMENT



^cSee Principles of Imaging (CERV-B).

ⁿSee Principles of Radiation Therapy (CERV-D).

^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^xInvasive cancer at surgical margin.

^ySee Sedlis Criteria (CERV-E).

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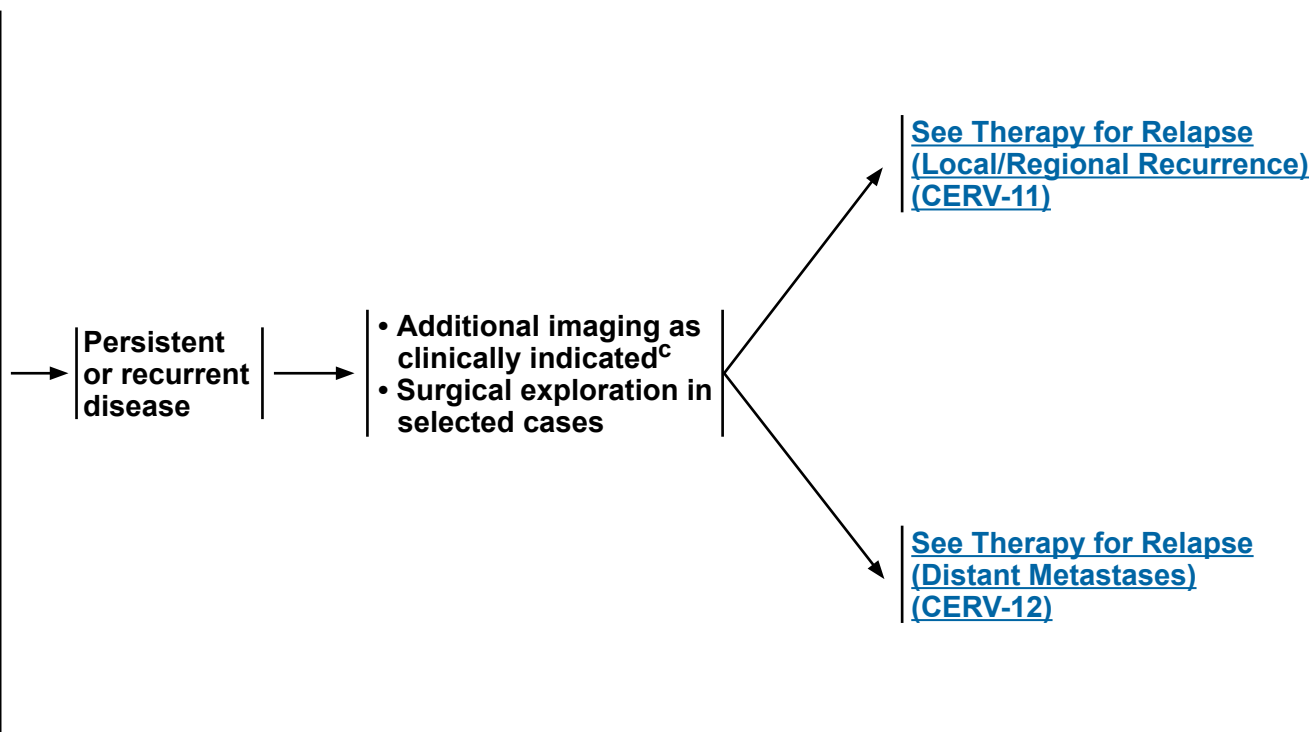
[See Surveillance
\(CERV-10\)](#)



SURVEILLANCE^z

- **Interval H&P**
every 3–6 mo for 2 y,
every 6–12 mo for 3–5 y,
then annually based on patient’s risk of
disease recurrence
- **Cervical/vaginal cytology screening**
annually^{aa,bb} as indicated for the detection of
lower genital tract neoplasia
- **Stage-dependent imaging for follow-up^{c,cc}**
- **Laboratory assessment (CBC, blood urea
nitrogen [BUN], creatinine) as indicated**
based on symptoms or examination findings
suspicious for recurrence
- **Patient education regarding symptoms**
of potential recurrence, periodic self-
examinations, lifestyle, obesity, exercise,
sexual health (eg, vaginal dilator use,
lubricants/moisturizers, hormone replacement
therapy), smoking cessation, nutrition
counseling, and potential long-term and late
effects of treatment ([See NCCN Guidelines
for Survivorship](#) and [NCCN Guidelines for
Smoking Cessation](#))

WORKUP



^cSee Principles of Imaging (CERV-B).

^zSalani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10.

^{aa}Regular cytology can be considered for detection of lower genital tract dysplasia and for immunocompromised patients, although its value in detection of recurrent cervical cancer is limited. The likelihood of picking up asymptomatic recurrences by cytology alone is low.

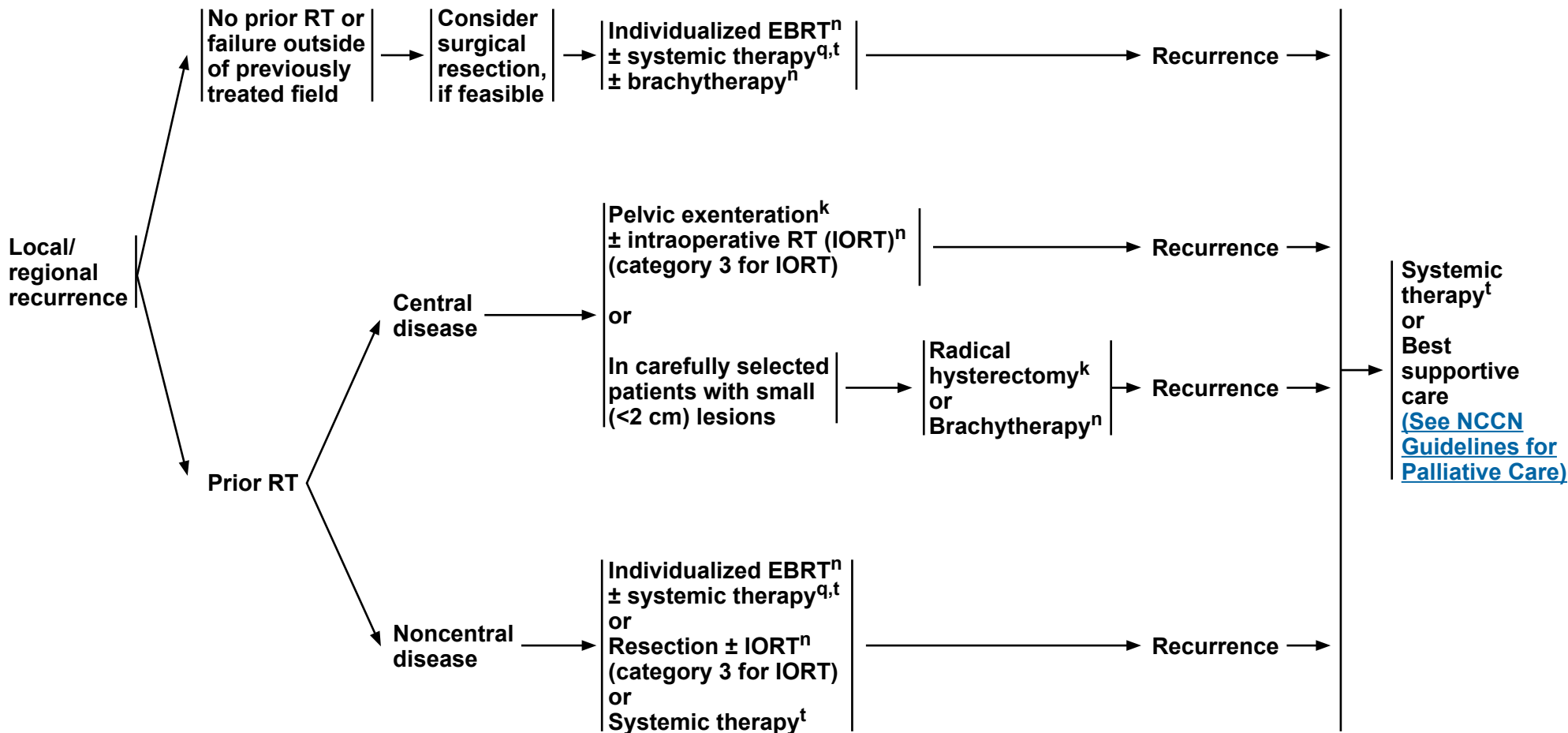
^{bb}The accuracy of cytology results may be affected in patients who have received pelvic radiation.

^{cc}Recurrences should be proven by biopsy before proceeding to treatment planning.

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Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



THERAPY FOR RELAPSE



^kSee Principles of Evaluation and Surgical Staging (CERV-C).

ⁿSee Principles of Radiation Therapy (CERV-D).

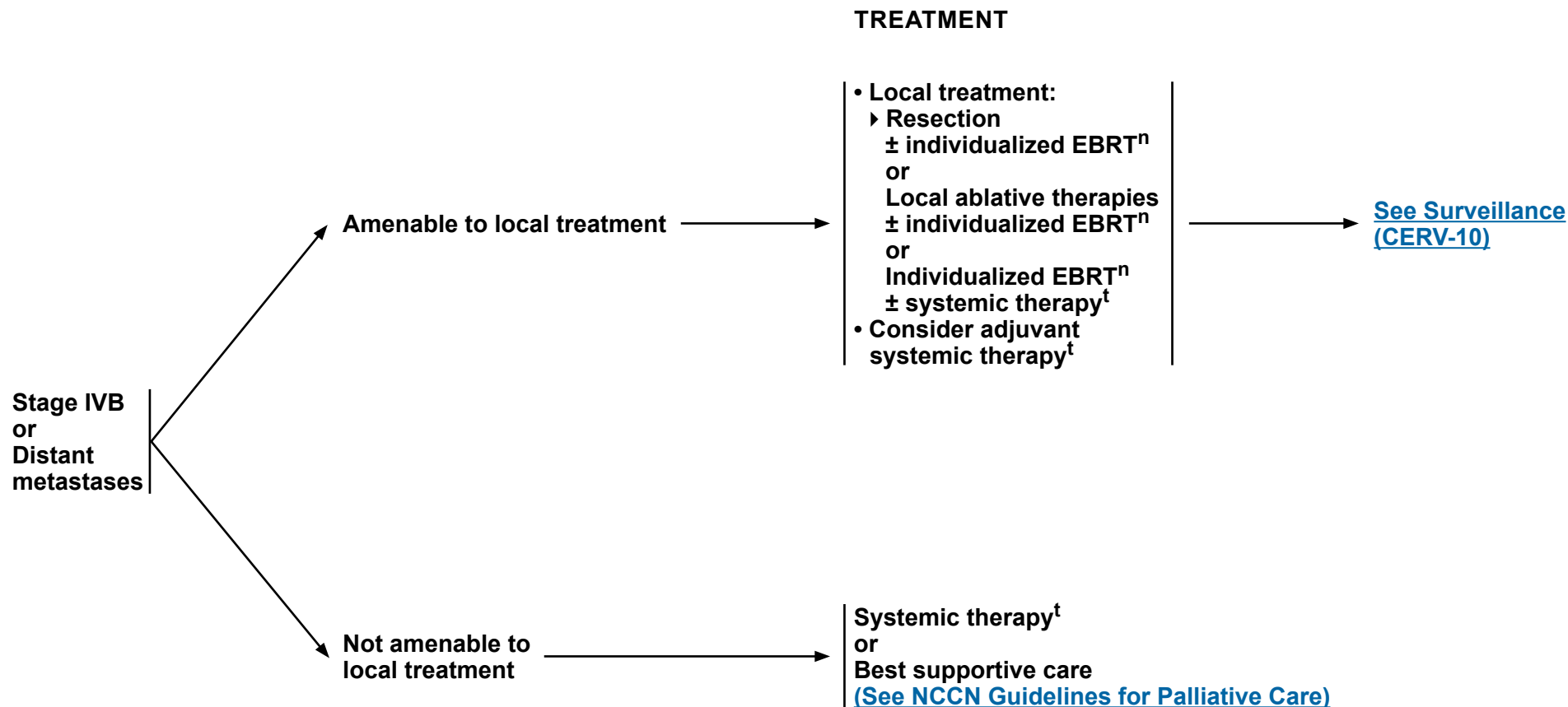
^qConcurrent platinum-containing chemotherapy with EBRT utilizes cisplatin as a single agent (or carboplatin if cisplatin intolerant).

^tSee Systemic Therapy Regimens for Cervical Cancer (CERV-F).

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ⁿSee Principles of Radiation Therapy (CERV-D).

^tSee Systemic Therapy Regimens for Cervical Cancer (CERV-F).

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**PRINCIPLES OF PATHOLOGY¹**

- **Procedure:**
 - ▶ **Radical hysterectomy**
- **Pathologic assessment for carcinoma:**
 - ▶ **Uterus**
 - ◇ **Hysterectomy type (where applicable)**
 - ◇ **Tumor site**
 - ◇ **Tumor size, including greatest dimension and additional two dimensions**
 - ◇ **Histologic type^a**
 - ◇ **Histologic grade**
 - ◇ **Stromal invasion (depth of invasion in mm/cervical wall thickness in mm)^b**
 - ◇ **Tumor width extent in mm**
 - ◇ **Surgical resection margin status**
 - **If negative, include closest margin and distance to closest margin (in mm)^c**
 - **If positive, include location of positive margin^c**
 - ◇ **Lymphovascular invasion (does not impact FIGO 2018 staging²)**
 - ▶ **Other tissue/organ involvement (parametrium, vaginal cuff, fallopian tubes, ovaries, peritoneum, omentum, other)**
 - ▶ **Lymph nodes (when resected)**
 - ◇ **SLNs should undergo ultrastaging for detection of low-volume metastasis^d**
 - ◇ **Non-SLNs do not require ultrastaging and can be processed as per routine protocols**
 - ◇ **Include the number of lymph nodes with isolated tumor cells, micrometastasis, and macrometastasis**
 - ◇ **Isolated tumor cells are noted as pN0(i+)**
 - ▶ **Consider MMR/MSI, or PD-L1, and/or *NTRK* gene fusion testing for patients with recurrent, progressive, or metastatic disease^{3,4}**

^aAccording to the 2018 International Endocervical Adenocarcinoma Criteria and Classification (IECC),⁵ morphologic features (luminal mitotic figures and apoptosis) can be used to distinguish between human papillomavirus (HPV)-associated endocervical adenocarcinomas and non-HPV-associated adenocarcinomas. Tumors can be further subtyped based on morphologic features.

^bEvaluation of histologic pattern of invasion for endocervical adenocarcinomas is an emerging concept.^{6,7,8} Three clinically significant histologic patterns of invasion for endocervical adenocarcinoma have been described. Tumors with so-called pattern A invasion (defined by well-demarcated glands with round contours, an absence of single cells, an absence of desmoplastic stromal response, and no lymphatic vascular invasion) have excellent survival and do not have lymph node metastases or recurrences. (Diaz De Vivar A, Roma AA, Park KJ, et al. Invasive endocervical adenocarcinoma: proposal for a new pattern-based classification system with significant clinical implications: a multi-institutional study. *Int J Gynecol Pathol* 2013;32:592-601.)

^cWhile reporting of this information is not required, knowledge of this information is useful for multidisciplinary treatment planning.

^dUltrastaging commonly entails serial sectioning of the SLN and review of multiple H&E-stained sections with or without cytokeratin immunohistochemistry for all blocks of the SLN. There is not a standard protocol for lymph node ultrastaging.

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Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)

CERV-A
1 OF 2



PRINCIPLES OF PATHOLOGY (REFERENCES)

- ¹Krishnamurti U, Movahedi-Lankarani S, Bell DA, et al. Protocol for the Examination of Specimens from Patients with Primary Carcinoma of the Uterine Cervix. College of American Pathologists 2018.
- ²Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280.
- ³Minion LE, Tewari KS. Cervical cancer - State of science: From angiogenesis blockade to checkpoint inhibition. *Gynecol Oncol* 2018; Mar;148(3):609-621.
- ⁴Chung HC, Schellens JH, Delord J-P, et al. Pembrolizumab treatment of advanced cervical cancer: Updated results from the phase 2 KEYNOTE-158 study. *J Clin Oncol* 2018;36; (suppl; abstr 5522).
- ⁵Stolnicu S, Barsan I, Hoang L, et al. International Endocervical Adenocarcinoma Criteria and Classification (IECC): A New Pathogenetic Classification for Invasive Adenocarcinomas of the Endocervix. *Am J Surg Pathol* 2018 Feb;42(2):214-226.
- ⁶Diaz De Vivar A, Roma AA, Park KJ, et al. Invasive endocervical adenocarcinoma: proposal for a new pattern-based classification system with significant clinical implications: a multi-institutional study. *Int J Gynecol Pathol* 2013 Nov;32(6):592-601.
- ⁷Roma AA, Mistretta TA, Diaz De Vivar A, et al. New pattern-based personalized risk stratification system for endocervical adenocarcinoma with important clinical implications and surgical outcome. *Gynecol Oncol* 2016 Apr;141(1):36-42.
- ⁸Spaans VM, Scheunhage DA, Barzaghi B, et al. Independent validation of the prognostic significance of invasion patterns in endocervical adenocarcinoma: Pattern A predicts excellent survival. *Gynecol Oncol* 2018;151:196-201.

Note: All recommendations are category 2A unless otherwise indicated.

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**PRINCIPLES OF IMAGING^{a,1-9}****Initial Workup****• Stage I****▶ Non-Fertility Sparing**

- ◊ Consider chest imaging with plain radiography (chest x-ray). If an abnormality is seen, then chest CT without contrast may be performed.
- ◊ Consider pelvic MRI with contrast to assess local disease extent (preferred for FIGO stage IB2–IB3).
- ◊ Whole-body PET/CT (preferred) or chest/abdomen/pelvic CT or PET/MRI in FIGO stage ≥IB1.
- ◊ For patients who underwent total hysterectomy (TH) with incidental finding of cervical cancer, consider whole-body PET/CT or chest/abdomen/pelvic CT to evaluate for metastatic disease and pelvic MRI to assess pelvic residual disease.

▶ Fertility Sparing

- ◊ Consider chest imaging with plain radiography (chest x-ray). If an abnormality is seen, then chest CT without contrast may be performed.
- ◊ Pelvic MRI (preferred) to assess local disease extent and proximity of tumor to internal cervical os; perform pelvic transvaginal ultrasound if MRI is contraindicated.
- ◊ Whole-body PET/CT (preferred) or chest/abdomen/pelvic CT in FIGO stage IB1–IB2.
- ◊ Other imaging should be based on symptomatology and clinical concern for metastatic disease.^b

• Stage II–IVA

- ▶ Whole-body PET/CT (preferred) or chest/abdomen/pelvic CT to evaluate for metastatic disease.
- ▶ Consider pelvic MRI with contrast to assess local disease extent.
- ▶ Other initial imaging should be based on symptomatology and clinical concern for metastatic disease.^c
- ▶ For patients who underwent TH with incidental finding of cervical cancer, consider whole-body PET/CT or chest/abdomen/pelvic CT to evaluate for metastatic disease and pelvic MRI with contrast to assess pelvic residual disease.

^aMRI and CT are performed with contrast throughout the guidelines unless contraindicated. Contrast is not required for screening chest CT.

^bThese factors may include abnormal physical exam findings or pelvic, abdominal, or pulmonary symptoms.

^cThese factors may include abnormal physical exam findings, bulky pelvic tumor (>4 cm), delay in presentation or treatment, and pelvic abdominal or pulmonary symptoms.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)
[References](#)

CERV-B
1 OF 3



PRINCIPLES OF IMAGING^{a,1-9}

Follow-up/Surveillance

• Stage I

▶ Non-Fertility Sparing

- ◊ Imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease.^b
- ◊ For patients with FIGO stage IB3 or patients who required postoperative adjuvant radiation or chemoradiation due to high-risk factors,^d a whole-body PET/CT may be performed at 3–6 months after completion of treatment.

▶ Fertility Sparing

- ◊ Consider pelvic MRI with contrast 6 months after surgery and then yearly for 2–3 years.
- ◊ Other imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease.^b

• Stage II–IV

- ▶ Whole-body PET/CT (preferred) or chest/abdomen/pelvic CT with contrast within 3–6 months of completion of therapy.
- ▶ Consider pelvic MRI with contrast at 3–6 months post completion of therapy.
- ▶ Other imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease.^e

• Stage IVB or Recurrence

- ▶ Imaging as appropriate (CT, MRI, or PET/CT) to assess response or determine further therapy.

Suspected Recurrence or Metastasis

- Whole-body PET/CT.
- Consider pelvic MRI.

^aMRI and CT are performed with contrast throughout the guidelines unless contraindicated. Contrast is not required for screening chest CT.

^bThese factors may include abnormal physical exam findings or pelvic, abdominal, or pulmonary symptoms.

^dRisk factors may include positive nodes, positive parametria, positive margins, or local cervical factors ([See Sedlis Criteria CERV-E](#)).

^eThese factors may include abnormal physical exam findings such as palpable mass or adenopathy, or new pelvic, abdominal, or pulmonary symptoms.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[References](#)



PRINCIPLES OF IMAGING REFERENCES

- ¹Salani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10.
- ²Atri M, Zhang Z, Dehdashti F, et al. Utility of PET-CT to evaluate retroperitoneal lymph node metastasis in advanced cervical cancer: Results of ACRIN6671/GOG0233 trial. *Gynecol Oncol* 2016;142:413-419.
- ³Rajendran JG, Greer BE. Expanding role of positron emission tomography in cancer of the uterine cervix. *J Natl Compr Canc Netw* 2006;4:463-469.
- ⁴Lakhman Y, Akin O, Park KJ, et al. Stage IB1 cervical cancer: role of preoperative MR imaging in selection of patients for fertility-sparing radical trachelectomy. *Radiology* 2013;269:149-158.
- ⁵Elit L, Reade CJ. Recommendations for follow-up care for gynecologic cancer survivors. *Obstet Gynecol* 2015;126:1207-1214.
- ⁶Sala E, Rockall AG, Freeman SJ, et al. The added role of MR imaging in treatment stratification of patients with gynecologic malignancies: what the radiologist needs to know. *Radiology* 2013;266:717-740.
- ⁷Balleyguier C, Sala E, Da Cunha T, et al. Staging of uterine cervical cancer with MRI: guidelines of the European Society of Urogenital Radiology. *Eur Radiol* 2011;21:1102-1110.
- ⁸Sala E, Micco M, Burger IA, et al. Complementary prognostic value of pelvic MRI and whole-body FDG PET/CT in the pretreatment assessment of patients with cervical cancer. *Int J Gynecol Cancer* 2015;25:1461-1467.
- ⁹Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280.

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**PRINCIPLES OF EVALUATION AND SURGICAL STAGING^a****Types of Resection and Appropriateness for Treatment of Cervical Cancer**

- Treatment of cervical cancer is stratified by stage as delineated in the Guidelines.
- Microinvasive disease, defined as FIGO stage IA1 with no lymphovascular space invasion (LVSI), has less than a 1% chance of lymphatic metastasis and may be managed conservatively with cone biopsy for preservation of fertility (with negative margins) or with simple hysterectomy when preservation of fertility is not desired or relevant. The intent of a cone biopsy is to remove the ectocervix and endocervical canal en bloc using a scalpel. This provides the pathologist with an intact, non-fragmented specimen without electrosurgical artifact, which facilitates margin status evaluation. If a loop electrosurgical excision procedure (LEEP) is chosen for treatment, the specimen should not be fragmented, and care must be undertaken to minimize electrosurgical artifact at the margins. The shape and depth of the cone biopsy may be tailored to the size, type, and location of the neoplastic lesion. For example, if there is concern for invasive adenocarcinoma versus adenocarcinoma in situ in the cervical canal, the cone biopsy would be designed as a narrow, long cone extending to the internal os in order not to miss possible invasion in the endocervical canal. Cone biopsy is indicated for triage and treatment of small cancers where there is no likelihood of cutting across gross neoplasm. In cases of stage IA1 with LVSI, a conization (with negative margins) with pelvic SLN mapping/lymphadenectomy is a reasonable strategy.
- Radical hysterectomy with bilateral pelvic lymph node dissection (with or without SLN mapping) is the preferred treatment for FIGO stage IA2, IB1, IB2, and select IB3–IIA1 lesions when fertility preservation is not desired. Radical hysterectomy results in resection of much wider margins compared with a simple hysterectomy, including removal of parts of the cardinal and uterosacral ligaments and the upper 1–2 cm of the vagina; in addition, pelvic and sometimes para-aortic nodes are removed. The Querleu and Morrow classification system¹ is a modern surgical classification that describes degree of resection and nerve preservation in three-dimensional (3D) planes of resection.² Procedural details for the most commonly used types of hysterectomy are described in Table 1 (see [CERV-C 5 of 7](#)).
- The standard and recommended approach for radical hysterectomy is with an open abdominal approach (category 1). A prospective randomized trial³ demonstrated that minimally invasive radical hysterectomy was associated with lower rates of disease-free survival (DFS) and overall survival (OS) than open abdominal radical hysterectomy. Moreover, two recent epidemiologic studies also demonstrated that minimally invasive radical hysterectomy was associated with shorter OS than open surgery among women with stage IA2–IB1 cervical cancer.^{4,5} See [Discussion](#) for additional details.

^aRecommendations by stage are based on the revised 2018 FIGO staging (Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280). However, trial data cited within this section utilized the 2009 FIGO staging system.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)
[References](#)

CERV-C
1 OF 7

**PRINCIPLES OF EVALUATION AND SURGICAL STAGING^a****Types of Resection and Appropriateness for Treatment of Cervical Cancer — continued**

- Para-aortic lymph node dissection for staging is typically done to the level of the inferior mesenteric artery (IMA). The cephalad extent of dissection can be modified based on clinical and radiologic findings.
- The radical vaginal trachelectomy with laparoscopic lymphadenectomy procedure (with or without SLN mapping) offers a fertility-sparing option for carefully selected individuals with stage IA2 or stage IB1 lesions (less than 2-cm diameter). The cervix, upper vagina, and supporting ligaments are removed as with a type B radical hysterectomy, but the uterine corpus is preserved. In the more than 300 subsequent pregnancies currently reported, there is a 10% likelihood of second trimester loss, but 72% of patients carry their gestation to 37 weeks or more.⁶ The abdominal radical trachelectomy is a reasonable fertility-sparing strategy. It provides larger resection of parametria than the vaginal approach,⁷ is suitable for select stage IB1–IB2 cases, and has been utilized in lesions between 2–4 cm in diameter. The operation mimics a type C radical hysterectomy.^{b,1,2,7-10}
- Advanced-stage disease, including FIGO stage IIB and above, is not usually treated with hysterectomy, as delineated in the Guidelines. The majority of advanced-stage disease in the United States is treated with definitive chemoradiation. In some countries, select cases of stage IIB may be treated with upfront radical hysterectomy or neoadjuvant chemotherapy followed by radical hysterectomy.
- Recurrent or persistent disease in the central pelvis following radiation therapy may potentially be cured with the pelvic exenteration procedure. Preoperative assessment for exenteration is designed to identify or rule out distant metastasis. If the recurrence is confined to the pelvis, then surgical exploration is carried out. If intraoperative margin and node assessment are negative, then resection of pelvic viscera is completed. Depending on the location of the tumor, resection may include anterior exenteration, posterior exenteration, or total pelvic exenteration. In cases where the location of tumor allows for adequate margins, the pelvic floor and anal sphincter may be preserved as a supralelevator exenteration. Table 2 summarizes the tissues typically removed with differing types of pelvic exenteration ([See CERV-C 6 of 7](#)). These are highly complex procedures and should be performed in centers with a high level of expertise for exenteration procedures. Primary pelvic exenteration (without prior pelvic radiation) is restricted to the rare case where pelvic radiation is contraindicated or to women who received prior pelvic radiation for another indication and then developed a metachronous, locally advanced cervical carcinoma and further radiation therapy is not feasible.

^aRecommendations by stage are based on the revised 2018 FIGO staging (Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280). However, trial data cited within this section utilized the 2009 FIGO staging system.

^bFor a description of a type C radical hysterectomy, [see Table 1 \(CERV-C 5 of 7\)](#).

Note: All recommendations are category 2A unless otherwise indicated.

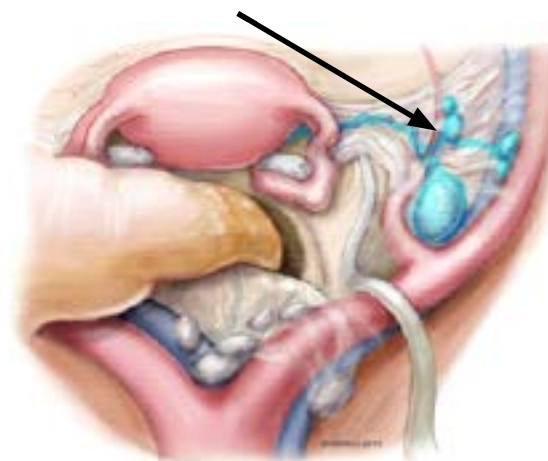
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)
[References](#)

CERV-C
2 OF 7

PRINCIPLES OF EVALUATION AND SURGICAL STAGING^a**Sentinel Lymph Node Mapping for Cervical Cancer:**

- SLN mapping as part of the surgical management of select stage I cervical cancer is considered in gynecologic oncology practices worldwide. While this technique has been used in tumors up to 4 cm in size, the best detection rates and mapping results are in tumors less than 2 cm.¹¹⁻¹⁵ This simple technique utilizes a direct cervical injection with dye^c or radiocolloid technetium-99 (99Tc) into the cervix, usually at 2 or 4 points as shown in Figure 1 (below). The SLNs are identified at the time of surgery with direct visualization of colored dye; a fluorescent camera is used if indocyanine green (ICG)¹⁶ was used, and a gamma probe is used if 99Tc was used. SLNs following a cervical injection are commonly located medial to the external iliac vessels, ventral to the hypogastric vessels, or in the superior part of the obturator space (Figure 2). SLNs usually undergo ultrastaging by pathologists, which allows for higher detection of micrometastasis that may alter postoperative management.^{4,17}

Figure 1: Options of SLN Cervical Injection Sites^dFigure 2: SLNs (blue, arrow) After Cervical Injection Are Commonly Located Medial to the External Iliac, Ventral to the Hypogastric, or in the Superior Part of the Obturator Space^d

^aRecommendations by stage are based on the revised 2018 FIGO staging (Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280). However, trial data cited within this section utilized the 2009 FIGO staging system.

^cIn the phase III randomized FILM trial, indocyanine green (ICG) was shown to be non-inferior to isosulfan blue dye. (Frumovitz M, Plante M, Lee PS et al. Near-infrared fluorescence for detection of sentinel lymph nodes in women with cervical and uterine cancers (FILM): a randomised, phase 3, multicentre, non-inferiority trial. *Lancet Oncol* 2018;19:1394-1403).

^dFigures 1 and 2 are reproduced with permission from Memorial Sloan Kettering Cancer Center. © 2013 Memorial Sloan Kettering Cancer Center.

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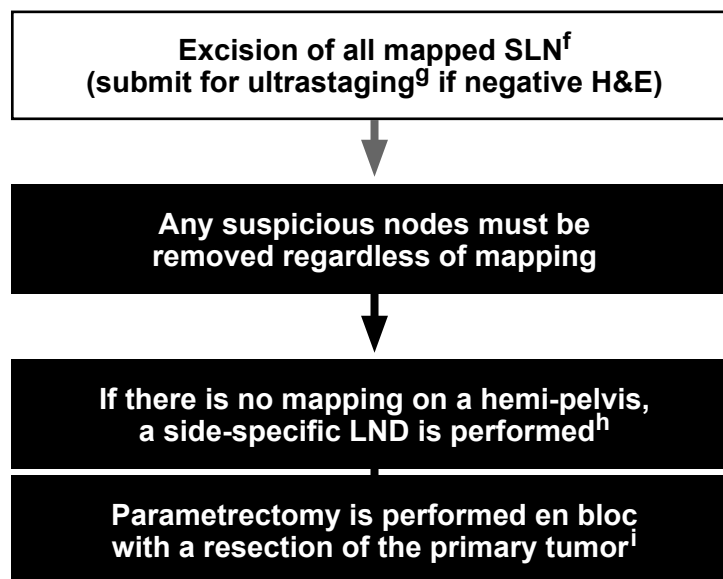
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[References](#)

CERV-C
3 OF 7

PRINCIPLES OF EVALUATION AND SURGICAL STAGING WHEN SLN MAPPING IS USED

The key to a successful SLN mapping is adherence to the SLN algorithm, which requires the performance of a side-specific nodal dissection in cases of failed mapping and removal of any suspicious or grossly enlarged nodes regardless of mapping (Figure 3).

Figure 3: Surgical/SLN Mapping Algorithm for Early-Stage Cervical Cancer^e



H&E: Hematoxylin and eosin staining
LND: Lymphadenectomy
SLN: Sentinel lymph node

^eReproduced with permission from Cormier B, Diaz JP, Shih K, et al. Establishing a sentinel lymph node mapping algorithm for the treatment of early cervical cancer. *Gynecol Oncol* 2011 Aug;122:275-280.

^fIntracervical injection with dye, 99Tc, or both.

^gThere is no standard protocol for ultrastaging. Ultrastaging typically includes serial sectioning of the gross lymph node with review of H&E with or without cytokeratin IHC staining. [See Principles of Pathology \(CERV-A\)](#).

^hIncluding interiliac/subaortic nodes.

ⁱExceptions made for select cases ([see CERV-C 1 of 7](#)).

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[Continued](#)

PRINCIPLES OF EVALUATION AND SURGICAL STAGING

TABLE 1: Resection of Cervical Cancer as Primary Therapy^j

Comparison of Hysterectomy Types				Comparison of Fertility-Sparing Trachelectomy Types	
	Extrafascial Hysterectomy (Type A) ^k	Modified Radical Hysterectomy (Type B) ^k	Radical Hysterectomy (Type C1) ^k	Simple Trachelectomy	Radical Trachelectomy ^l
Indication	Stage IA1	Stage IA1 with LVSI and IA2	Local disease without obvious metastasis, including: Stage IB1-IB2 Selected stage IB3-IIA1	Carcinoma in situ and stage IA1	Stage IA2-IB1 Select IB2
Intent	Curative for microinvasion	Curative for small lesions	Curative for larger lesions	Curative for microinvasion Fertility preserved	Curative for select stage IA2-IB2 Fertility preserved
Uterus	Removed	Removed	Removed	Spared	Spared
Ovaries	Optional removal	Optional removal	Optional removal	Spared	Spared
Cervix	Completely removed	Completely removed	Completely removed	Majority removed (approximately 5 mm of the cranial aspect of the cervix typically left for cerclage)	Majority removed (approximately 5 mm of the cranial aspect of the cervix typically left for cerclage)
Vaginal margin	Minimal	1–2 cm margin	Upper 1/4 to 1/3 of vagina	Minimal	1–2 cm margin
Ureteral Dissection	Not mobilized	Ureters unroofed and dissected from cervix	Ureters unroofed and dissected from cervix and from lateral parametria	Not mobilized	Ureters unroofed and dissected from cervix
Paracervix/Parametrial resection	None	Resection at the level of ureter bed (horizontal resection 1–2 cm)	Divided at medial aspect of internal iliac vessels. The deep margin is the deep uterine vein	Resected at cervical border	Resection at the level of ureter bed (horizontal resection 1–2 cm)
Recto-uterine (Uterosacral ligaments)	Divided at cervical border	1–2 cm dorsal from cervix (preserves hypogastric nerve plexus)	Type C1 is nerve preserving, divided at least 2 cm dorsal from cervix	Divided at cervical border	1–2cm dorsal from cervix (preserves hypogastric nerve plexus)
Bladder	Mobilized caudal to cervix	Mobilized to upper vagina	Mobilized to middle vagina	Mobilized to peritoneal reflection	Mobilized to upper vagina
Rectum	Not mobilized	Mobilized below cervix	Mobilized below middle vagina	Mobilized to peritoneal reflection	Mobilized below cervix
Surgical approach	Vaginal or laparotomy or minimally invasive	Laparotomy	Laparotomy	Vaginal or laparotomy or minimally invasive ^m	Vaginal or laparotomy or minimally invasive (category 2B for MIS) ^m

^jCibula D, Abu-Rustum NR, Benedetti-Panici P, et al. New classification system of radical hysterectomy: Emphasis on a three-dimensional anatomic template for parametrial resection. *Gynecol Oncol* 2011;122:264-268.

^kThe Querleu and Morrow surgical classification system describes the degree of resection and nerve preservation for radical hysterectomy in three-dimensional planes and updates the previously used Piver-Rutledge-Smith classifications. (Querleu D, Morrow CP. Classification of radical hysterectomy. *Lancet Oncol* 2008;9:297-303.)

^lFertility-sparing radical trachelectomy is most validated for lesions ≤2 cm in diameter. Small cell neuroendocrine histology and gastric type adenocarcinoma are not considered suitable tumors for this procedure.

^mThere is a lack of data on oncologic outcomes for minimally invasive surgical approaches to trachelectomy.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)

PRINCIPLES OF EVALUATION AND SURGICAL STAGING

TABLE 2: Resection of Locally Recurrent Cervical Cancer with No Distant Metastasis[‡]

Comparison of Infralevator Exenteration Types				Comparison of Supralevator Exenteration Types	
	Anterior	Posterior	Total	Posterior	Total
Indication	Central pelvic recurrence Primary therapy for select FIGO stage IVA when primary radiation not feasible				
Intent	Curative				
Uterus, tubes, ovaries	Removed if still present	Removed if still present	Removed if still present	Removed if still present	Removed if still present
Vagina	Removed	Removed	Removed	Removed	Removed
Bladder and urethra	Removed	Preserved	Removed	Preserved	Removed
Rectum	Preserved	Removed	Removed	Removed	Removed
Anal sphincter	Preserved	Removed	Removed	Preserved, colonic anastomosis possible	Preserved, colonic anastomosis possible
Reconstruction options Urinary system	Ileal conduit or Continent diversion	N/A	Double barrel wet colostomy, [¶] ileal conduit, or continent diversion	N/A	Double barrel wet colostomy, [¶] ileal conduit, or continent diversion
Reconstruction options GI system	N/A	End colostomy	Double barrel wet colostomy [¶] or end colostomy	End colostomy or anastomosis with temporary ileostomy	Double barrel wet colostomy, [¶] end colostomy, or anastomosis with temporary ileostomy
Neovaginal reconstruction options	Myocutaneous flap (rectus, gracilis, etc.), or split-thickness skin graft with omental J-flap				

[‡]Cibula D, Abu-Rustum NR, Benedetti-Panici P, et al. New classification system of radical hysterectomy: Emphasis on a three-dimensional anatomic template for parametrial resection. *Gynecol Oncol* 2011;122:264-268.

[¶]Backes FJ, Tierney BJ, Eisenhauer EL, et al. Complications after double-barreled wet colostomy compared to separate urinary and fecal diversion during pelvic exenteration: time to change back? *Gynecol Oncol* 2013 Jan;128:60-64.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

References



PRINCIPLES OF EVALUATION AND SURGICAL STAGING REFERENCES

- ¹Querleu D, Morrow CP. Classification of radical hysterectomy. *Lancet Oncol* 2008;9:297-303.
- ²Cibula D, Abu-Rustum NR, Benedetti-Panici P, et al. New classification system of radical hysterectomy: emphasis on a three-dimensional anatomic template for parametrial resection. *Gynecol Oncol* 2011;122:264-268.
- ³Ramirez PT, Frumovitz M, Pareja R, et al. Minimally invasive versus abdominal radical hysterectomy for cervical cancer. *N Engl J Med* 2018;379:1895-1904.
- ⁴Melamed A, Margul DJ, Chen L, et al. Survival after minimally invasive radical hysterectomy for early-stage cervical cancer. *N Engl J Med* 2018;379:1905-1914.
- ⁵Melamed A, Margul DJ, Chen L, et al. Survival after minimally invasive radical hysterectomy for early-stage cervical cancer. *N Engl J Med* 2018;379:1905-1914.
- ⁶Plante M, Gregoire J, Renaud MC, Roy M. The vaginal radical trachelectomy: an update of a series of 125 cases and 106 pregnancies. *Gynecol Oncol* 2011;121:290-297.
- ⁷Einstein MH, Park KJ, Sonoda Y, et al. Radical vaginal versus abdominal trachelectomy for stage IB1 cervical cancer: a comparison of surgical and pathologic outcomes. *Gynecol Oncol* 2009;112:73-77.
- ⁸Piver MS, Rutledge F, Smith JP. Five classes of extended hysterectomy for women with cervical cancer. *Obstet Gynecol* 1974;44:265-272.
- ⁹Wethington SL, Sonoda Y, Park KJ, et al. Expanding the indications for radical trachelectomy: a report on 29 patients with stage IB1 tumors measuring 2 to 4 centimeters. *Int J Gynecol Cancer* 2013;23:1092-1098.
- ¹⁰Wethington SL, Cibula D, Duska LR, et al. An international series on abdominal radical trachelectomy: 101 patients and 28 pregnancies. *Int J Gynecol Cancer* 2012;22:1251-1257.
- ¹¹Lintner B, Saso S, Tarnai L, et al. Use of abdominal radical trachelectomy to treat cervical cancer greater than 2 cm in diameter. *Int J Gynecol Cancer* 2013;23:1065-1070.
- ¹²Bats AS, Mathevet P, Buenerd A, et al. The sentinel node technique detects unexpected drainage pathways and allows nodal ultrastaging in early cervical cancer: insights from the multicenter prospective SENTICOL study. *Ann Surg Oncol* 2013;20:413-422.
- ¹³Eiriksson LR, Covens A. Sentinel lymph node mapping in cervical cancer: the future? *BJOG* 2012 Jan;119:129-133.
- ¹⁴Cormier B, Diaz JP, Shih K, et al. Establishing a 01/14/20 lymph node mapping algorithm for the treatment of early cervical cancer. *Gynecol Oncol* 2011;122:275-280.
- ¹⁵Altgassen C, Hertel H, Brandstädt A, et al. Multicenter validation study of the sentinel lymph node concept in cervical cancer: AGO Study Group. *J Clin Oncol* 2008;26:2943-2951.
- ¹⁶Frumovitz M, Plante M, Lee PS, et al. Near-infrared fluorescence for detection of sentinel lymph nodes in women with cervical and uterine cancers (FILM): a randomised, phase 3, multicentre, non-inferiority trial. *Lancet Oncol* 2018;19:1394-1403.
- ¹⁷Cibula D, Abu-Rustum NR, Dusek L, et al. Prognostic significance of low volume sentinel lymph node disease in early-stage cervical cancer. *Gynecol Oncol* 2012;124:496-501.

Note: All recommendations are category 2A unless otherwise indicated.

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PRINCIPLES OF RADIATION THERAPY

General Principles

- The use of CT-based treatment planning and conformal blocking is considered the standard of care for external-beam RT (EBRT). MRI is the best imaging modality for determining soft tissue and parametrial involvement in patients with advanced tumors. In patients who are not surgically staged, PET imaging is useful to help define the nodal volume of coverage, and may be useful postoperatively to confirm removal of abnormal nodes.
- RT is directed at sites of known or suspected tumor involvement. EBRT is directed to the pelvis with or without the para-aortic region.
- Brachytherapy is a critical component of definitive therapy for all patients with primary cervical cancer who are not candidates for surgery. This is performed using an intracavitary and/or an interstitial approach.
- For the majority of patients who receive EBRT for cervical cancer, concurrent platinum-containing chemotherapy (either cisplatin alone [carboplatin if cisplatin intolerant], or cisplatin + 5-fluorouracil) is given during the time of EBRT.
- Optimal results are achieved when treatment is completed within 8 weeks.

General Treatment Information

• Target Volumes

- ▶ Concepts regarding the gross target volume (GTV), clinical target volume (CTV), planning target volume (PTV), organs at risk (OARs), internal organ motion, and dose-volume histogram (DVH) have been defined for use in conformal radiotherapy, especially for intensity-modulated radiation therapy (IMRT).
- ▶ Very careful attention to detail and reproducibility (including consideration of target and normal tissue definitions, patient and internal organ motion, soft tissue deformation, and rigorous dosimetric and physics quality assurance) is required for proper delivery of IMRT and related highly conformal technologies. Routine image guidance, such as cone-beam CT (CBCT), should be used for defining daily internal soft tissue positioning.
- ▶ The volume of EBRT should cover the gross disease (if present), parametria, uterosacral ligaments, sufficient vaginal margin from the gross disease (at least 3 cm), presacral nodes, and other nodal volumes at risk. For patients with negative nodes on surgical or radiologic imaging, the radiation volume should include the entirety of the external iliac, internal iliac, obturator, and presacral nodal basins. For patients deemed at higher risk of lymph node involvement (eg, bulkier tumors; suspected or confirmed nodes confined to the low true pelvis), the radiation volume should be increased to cover the common iliacs as well. In patients with documented common iliac and/or para-aortic nodal involvement, extended-field pelvic and para-aortic radiotherapy is recommended, up to the level of the renal vessels (or even more cephalad as directed by involved nodal distribution). For patients with lower 1/3 vaginal involvement, the bilateral groins should be covered as well.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)

CERV-D
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**PRINCIPLES OF RADIATION THERAPY****General Treatment Information—Continued****Treatment Information - External Beam**

- EBRT is delivered using multiple conformal fields or intensity-modulated volumetric techniques, such as IMRT/volumetric-modulated arc therapy (VMAT)/tomotherapy.
- IMRT is helpful in minimizing the dose to the bowel and other critical structures in the post-hysterectomy setting¹ and in treating the para-aortic nodes when necessary. These techniques can also be useful when high doses are required to treat gross disease in regional lymph nodes. However, conformal external beam therapies (such as IMRT or stereotactic body radiation therapy, SBRT) should not be used as routine alternatives to brachytherapy for treatment of central disease in patients with an intact cervix.
- A parametrial boost of 5 to 10 Gy can be considered in select cases with bulky parametrial/pelvic sidewall disease after completion of initial whole pelvic radiation.
- IMRT can be planned to deliver a higher dose to gross disease in the lymph nodes, while simultaneously delivering a lower dose to control microscopic disease to the other targets, termed a simultaneous integrated boost (SIB). Using a combination of IMRT with SIB can deliver higher doses to grossly positive nodal disease in a shorter time frame, while sparing normal tissues. In general, an SIB target may be boosted up to approximately 2.10 to 2.2 Gy/fraction, depending on target and OAR volumes. At times, additional external boosts may be necessary. Target doses for nodes can range from 54 to 63 Gy, with strict attention to the contribution from brachytherapy, and respecting normal tissue doses while paying attention to adjacent normal tissue doses.
- SBRT is an approach that allows for delivery of very high doses of focused EBRT in 1–5 fractions and may be applied to isolated metastatic sites; consideration can be given for limited disease in the re-irradiation setting.^{2,3}

Dosing Prescription Regimen - External Beam

- Coverage of microscopic nodal disease requires an EBRT dose of approximately 40–45 Gy (in conventional fractionation of 1.8–2.0 Gy daily possibly with an SIB if IMRT is used), and highly conformal boosts of an additional 10–20 Gy may be considered for limited volumes of gross unresected adenopathy, with consideration of the dose given by brachytherapy. For the majority of patients who receive EBRT for cervical cancer, concurrent platinum-containing chemotherapy (either cisplatin alone [carboplatin if cisplatin intolerant], or cisplatin + 5-fluorouracil) is given during the time of EBRT.

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)**CERV-D**
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PRINCIPLES OF RADIATION THERAPY

General Treatment Information—Continued

Definitive Radiation Therapy for an Intact Cervix

- In patients with an intact cervix (ie, those who do not have surgery), the primary tumor and regional lymphatics at risk are typically treated with definitive EBRT to a dose of approximately 45 Gy (40–50 Gy). The volume of the EBRT would depend on the nodal status as determined surgically or radiographically (as previously described). The primary cervical tumor is then boosted, using brachytherapy, with an additional 30 to 40 Gy using either image guidance (preferred) or to point A (in low dose-rate [LDR] equivalent dose), for a total point A dose (as recommended in the guidelines) of 80 Gy for small-volume cervical tumors or ≥85 Gy for larger-volume cervical tumors. For very small tumors (medically inoperable IA1 or IA2 EQD2 D90 doses of 75–80 Gy may be considered). Grossly involved unresected nodes may be evaluated for boosting with an additional 10 to 15 Gy of highly conformal (and reduced-volume) EBRT. When using image guidance for EBRT, care must be taken to exclude or severely limit the volume of normal tissue included in the high-dose region(s) ([see Discussion](#)).

Posthysterectomy Adjuvant Radiation Therapy

- Following primary hysterectomy, the presence of one or more pathologic risk factors may warrant the use of adjuvant radiotherapy. At a minimum, the following should be covered: upper 3 to 4 cm of the vaginal cuff, the parametria, and immediately adjacent nodal basins (such as the external and internal iliacs, obturator and presacral nodes). For documented nodal metastasis, the superior border of the radiation field should be appropriately increased (as previously described). A dose of 45 to 50 Gy in standard fractionation with IMRT is generally recommended.⁴ Grossly involved unresected nodes may be evaluated for boosting with an additional 10 to 20 Gy of highly conformal (and reduced-volume) EBRT. With higher doses, especially of EBRT, care must be taken to exclude or severely limit the volume of normal tissue included in the high-dose region(s) ([see Discussion](#)).

Intraoperative Radiation Therapy

- IORT is a specialized technique that delivers a single, highly focused dose of radiation to an at-risk tumor bed or isolated unresectable residual disease during an open surgical procedure.⁵ It is particularly useful in patients with recurrent disease within a previously radiated volume. During IORT, overlying normal tissue (such as bowel or other viscera) can be manually displaced from the region at risk. IORT is typically delivered with electrons using preformed applicators of variable sizes matched to the surgically defined region at risk, which further constrains the area and depth of radiation exposure to avoid surrounding normal structures.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

[Continued](#)CERV-D
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PRINCIPLES OF RADIATION THERAPY

General Treatment Information—Continued

Treatment Information - Brachytherapy

- **Brachytherapy is a critical component of definitive therapy for all patients with primary cervical cancer who are not candidates for surgery. This is usually performed using an intracavitary approach, with an intrauterine tandem and vaginal colpostats. Depending on the patient and tumor anatomy, the vaginal component of brachytherapy in patients with an intact cervix may be delivered using ovoids, ring, or cylinder brachytherapy (combined with the intrauterine tandem). For more advanced disease, or without sufficient regression, interstitial needles may allow increased dose to the target, while minimizing dose to the normal tissues. MRI immediately preceding brachytherapy may be helpful in delineating residual tumor geometry. When combined with EBRT, brachytherapy is often initiated towards the latter part of treatment, when sufficient primary tumor regression has been noted to permit satisfactory brachytherapy apparatus geometry. In highly selected, very early disease (ie, stage IA2), brachytherapy alone (without EBRT) may be an option.**
- **In rare cases, patients whose anatomy or tumor geometry renders intracavitary brachytherapy infeasible may be best treated using an interstitial approach; however, such interstitial brachytherapy should only be performed by individuals and at institutions with appropriate experience and expertise, and early referral for timely use of their expertise is critical.**
- **In selected post-hysterectomy patients (especially those with positive or close vaginal mucosal surgical margins), vaginal cylinder brachytherapy may be used as a boost to EBRT. The prescription is typically to the vaginal surface or at 5 mm below the surface. Typical fractionation schemes include 5.5 Gy X 2 fractions dosed at 5 mm or 6 Gy X 3 dosed at the vaginal surface.**
- **SBRT is not considered an appropriate routine alternative to brachytherapy.**

Note: All recommendations are category 2A unless otherwise indicated.

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[Continued](#)

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**PRINCIPLES OF RADIATION THERAPY****Dosing Prescription Regimen - Brachytherapy**

- **Point A**, representing a paracervical reference point, has been the most widely used dosing parameter to date. However, limitations of the point A dosing system include the fact that it does not take into account the three-dimensional (3D) shape of tumors, nor individual tumor to normal tissue structure correlations. Typical point A prescription doses are 5.5 Gy X 5 fractions for early disease and 6 Gy X 5 for large tumors or those demonstrating a poor response.
- There is evidence that image-guided brachytherapy improves outcomes and decreases toxicity. MRI gives the best soft tissue imaging for residual disease and while it is best to have an MRI with the instruments in place, an MRI prior to brachytherapy can help guide therapy. In the absence of MRI, CT can be used but is inferior for determination of residual disease and contouring is less accurate. The goals of care would include an equivalent dose at 2 Gy (EQD2) to the high-risk CTV (HR-CTV) with a D90 of 80–85 Gy; however, with large disease or poor response dose goals should be HR-CTV D90 \geq 87 Gy. Normal tissues should be limited according to published guidelines with 2-cc rectal dose \leq 65–75 Gy, sigmoid 2-cc dose \leq 70–75 Gy, and 2-cc bladder dose \leq 80–90 Gy. If those parameters cannot be achieved, supplemental dosing with interstitial needles should be considered.⁶⁻⁹
- The point A dose recommendations provided in the NCCN Guidelines are based on traditional, and widely validated, dose fractionation and brachytherapy at LDRs. In these provided dose recommendations, for EBRT, the dose is delivered at 1.8–2.0 Gy per daily fraction. For brachytherapy, the dose at point A assumes an LDR delivery of 40–70 cGy/h. Clinicians using high dose-rate (HDR) brachytherapy would depend on the linear-quadratic model equation to convert nominal HDR dose to a biologically equivalent LDR dose. (<http://www.americanbrachytherapy.org/guidelines/>). Multiple brachytherapy schemes have been used when combined with EBRT. However, one of the more common HDR approaches is 5 insertions with tandem and colpostats, each delivering 6 Gy nominal dose. This scheme results in a nominal HDR dose of 30 Gy in 5 fractions, which is generally accepted to be the equivalent to 40 Gy to point A (tumor surrogate dose) using LDR brachytherapy. Another reasonable choice that has been well-studied in European trials for intracavity dosing to the high-risk CTV is 28 Gy in 4 fractions.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.



PRINCIPLES OF RADIATION THERAPY REFERENCES

- ¹Klopp, AH, Yeung AR, Deshmukh S, et al. A phase III randomized trial comparing patient-reported toxicity and quality of life (QOL) during pelvic intensity modulated radiation therapy as compared to conventional radiation therapy. *Int J Radiat Oncol Biol Phys* 2016;96:S3.
- ²Choi CW, Cho CK, Yoo SY, et al. Image-guided stereotactic body radiation therapy in patients with isolated para-aortic lymph node metastases from uterine cervical and corpus cancer. *Int J Radiat Oncol Biol Phys* 2009;74:147-153.
- ³Higginson DS, Morris DE, Jones EL, et al. Stereotactic body radiotherapy (SBRT): Technological innovation and application in gynecologic oncology. *Gynecol Oncol* 2011;120:404-412.
- ⁴Klopp AH, Yeung AR, Deshmukh SW et al. Patient-reported toxicity during pelvic intensity-modulated radiation therapy: NRG Oncology-RTOG 1203. *J Clin Oncol* 2018;36(24):2538-2544.
- ⁵del Carmen MG, McIntyre JF, Goodman A. The role of radiation therapy (IORT) in the treatment of locally advanced gynecologic malignancies. *Oncologist* 2000;5:18-25.
- ⁶Haie-Meder C, R Potter, E Van Limbergen E, et al. Recommendations from Gynaecological (GYN) GEC-ESTRO Working Group (I): concepts and terms in 3D image based 3D treatment planning in cervix cancer brachytherapy with emphasis on MRI assessment of GTV and CTV. *Radiother Oncol* 2005;74:235-245.
- ⁷Pötter R, Georg P, Dimopoulos JC, et al. Clinical outcome of protocol based image (MRI) guided adaptive brachytherapy combined with 3D conformal radiotherapy with or without chemotherapy in patients with locally advanced cervical cancer. *Radiother Oncol* 2011;100:116-123.
- ⁸Pötter R, Haie-Meder C, Van Limbergen E, et al. Recommendations from gynaecological (GYN) GEC ESTRO working group (II): concepts and terms in 3D image-based treatment planning in cervix cancer brachytherapy-3D dose volume parameters and aspects of 3D image-based anatomy, radiation physics, radiobiology. *Radiother Oncol* 2006;78:67-77.
- ⁹Viswanathan AN, Erickson BA. Three-dimensional imaging in gynecologic brachytherapy: a survey of the American Brachytherapy Society. *Int J Radiat Oncol Biol Phys* 2010;76:104-109.

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**SEDLIS CRITERIA FOR EXTERNAL PELVIC RADIATION AFTER RADICAL HYSTERECTOMY IN NODE-NEGATIVE, MARGIN-NEGATIVE, PARAMETRIA-NEGATIVE CASES¹⁻⁴**

LVSI	Stromal Invasion	Tumor Size (cm) (determined by clinical palpation)
+	Deep 1/3	Any
+	Middle 1/3	≥2
+	Superficial 1/3	≥5
-	Middle or deep 1/3	≥4

LVSI: Lymphovascular space invasion

¹Modified with permission from Sedlis A, Bundy BN, Rotman MZ, et al. A randomized trial of pelvic radiation therapy versus no further therapy in selected patients with stage IB carcinoma of the cervix after radical hysterectomy and pelvic lymphadenectomy: a gynecologic oncology study group. *Gynecol Oncol* 1999;73:177-183.

²Delgado G, Bundy B, Zaino R, et al. Prospective surgical-pathological study of disease-free interval in patients with stage IB squamous cell carcinoma of the cervix: a Gynecologic Oncology Group study. *Gynecol Oncol* 1990;38:352-357.

³Rotman M, Sedlis A, Piedmont MR, et al. A phase III randomized trial of postoperative pelvic irradiation in stage IB cervical carcinoma with poor prognostic features: follow-up of a gynecologic oncology group study. *Int J Radiat Oncol Biol Phys* 2006;65:169-176.

⁴Risk factors may not be limited to the Sedlis criteria.

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SYSTEMIC THERAPY REGIMENS FOR CERVICAL CANCER^a

Chemoradiation		
<p>Preferred Regimens</p> <ul style="list-style-type: none"> • Cisplatin • Carboplatin if patient is cisplatin intolerant 		
Recurrent or Metastatic Disease		
First-line combination therapy ^{b,c}	Possible first-line single-agent therapy ^c	Second-line therapy ^e
<p>Preferred Regimens</p> <ul style="list-style-type: none"> • Cisplatin/paclitaxel/bevacizumab^{d,1} (category 1) • Carboplatin/paclitaxel/bevacizumab^d <p>Other Recommended Regimens</p> <ul style="list-style-type: none"> • Cisplatin/paclitaxel (category 1)^{2,3} • Carboplatin/paclitaxel^{4,5} (category 1 for patients who have received prior cisplatin therapy) • Topotecan/paclitaxel/bevacizumab^{d,1} (category 1) • Topotecan/paclitaxel¹ • Cisplatin/topotecan⁶ 	<p>Preferred Regimens</p> <ul style="list-style-type: none"> • Cisplatin³ <p>Other Recommended Regimens</p> <ul style="list-style-type: none"> • Carboplatin⁷ • Paclitaxel^{8,9} 	<p>Preferred Regimens</p> <ul style="list-style-type: none"> • Pembrolizumab for PD-L1–positive^f or MSI-H/dMMR tumors⁹ <p>Other Recommended Regimens (All agents listed here are category 2B unless otherwise noted)</p> <ul style="list-style-type: none"> • Bevacizumab^d • Albumin-bound paclitaxel • Docetaxel • Fluorouracil • Gemcitabine • Ifosfamide • Irinotecan • Mitomycin • Pemetrexed • Topotecan • Vinorelbine <p>Useful in Certain Circumstances</p> <ul style="list-style-type: none"> • Larotrectinib or entrectinib for <i>NTRK</i> gene fusion-positive tumors (category 2B)

^aCisplatin, carboplatin, docetaxel, and paclitaxel may cause drug reactions ([See NCCN Guidelines for Ovarian Cancer--Management of Drug Reactions \[OV-C\]](#)).

^bCost and toxicity should be carefully considered when selecting an appropriate regimen for treatment.

^cIf not used previously, these agents can be used as second-line therapy as clinically appropriate.

^dAn FDA-approved biosimilar is an appropriate substitute for bevacizumab.

^eReferences for second-line therapy are provided in the [Discussion](#).

^fRecommended for disease progression on or after chemotherapy in patients whose tumors express PD-L1 (CPS ≥1) as determined by an FDA-approved test.

^g[See NCCN Guidelines for the Management of Immunotherapy-Related Toxicities](#).

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.





SYSTEMIC THERAPY REGIMENS FOR CERVICAL CANCER REFERENCES

- ¹Tewari KS1, Sill MW, Long HJ 3rd, et al. Improved survival with bevacizumab in advanced cervical cancer. *N Engl J Med* 2014 Feb 20;370:734-743.
- ²Monk BJ, Sill MW, McMeekin DS, et al. Phase III trial of four cisplatin-containing doublet combinations in stage IVB, recurrent, or persistent cervical carcinoma: a Gynecologic Oncology Group study. *J Clin Oncol* 2009;27:4649-4655.
- ³Moore DH, Blessing JA, McQuellon RP, et al. Phase III study of cisplatin with or without paclitaxel in stage IVB, recurrent, or persistent squamous cell carcinoma of the cervix: a gynecologic oncology group study. *J Clin Oncol* 2004;22:3113-3119.
- ⁴Moore KN, Herzog TJ, Lewin S, et al. A comparison of cisplatin/paclitaxel and carboplatin/paclitaxel in stage IVB, recurrent or persistent cervical cancer. *Gynecol Oncol* 2007;105:299-303.
- ⁵Kitagawa R, Katsumata N, Shibata T, et al. Paclitaxel plus carboplatin versus paclitaxel plus cisplatin in metastatic or recurrent cervical cancer: the open-label randomized phase III trial JCOG0505. *J Clin Oncol* 2015;33:2129-2135.
- ⁶Long HJ 3rd, Bundy BN, Grendys EC Jr., et al. Randomized phase III trial of cisplatin with or without topotecan in carcinoma of the uterine cervix: a Gynecologic Oncology Group Study. *J Clin Oncol* 2005;23:4626-4633.
- ⁷Weiss GR, Green S, Hannigan EV, et al. A phase II trial of carboplatin for recurrent or metastatic squamous carcinoma of the uterine cervix: a Southwest Oncology Group study. *Gynecol Oncol* 1990;39:332-336.
- ⁸Tinker AV, Bhagat K, Swenerton KD, Hoskins PJ. Carboplatin and paclitaxel for advanced and recurrent cervical carcinoma: the British Columbia Cancer Agency experience. *Gynecol Oncol* 2005;98:54-58.
- ⁹McGuire WP, Blessing JA, Moore D, et al. Paclitaxel has moderate activity in squamous cervix cancer. A Gynecologic Oncology Group study. *J Clin Oncol* 1996;14:792-795.

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**Table 1: International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging of Cancer of the Cervix Uteri (2018)**

Stage	Description
I	The carcinoma is strictly confined to the cervix (extension to the corpus should be disregarded).
IA	Invasive carcinoma that can be diagnosed only by microscopy with maximum depth of invasion ≤ 5 mm ^a
IA1	Measured stromal invasion ≤ 3 mm in depth
IA2	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 with size measured by maximum tumor diameter ^b
IB1	Invasive carcinoma >5 mm depth of stromal invasion and ≤ 2 cm in greatest dimension
IB2	Invasive carcinoma >2 cm and ≤ 4 cm in greatest dimension
IB3	Invasive carcinoma >4 cm in greatest dimension
II	The cervical 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 invasion
IIA1	IIA1 Invasive carcinoma ≤ 4 cm in greatest dimension
IIA2	Invasive carcinoma >4 cm in greatest dimension
IIB	With parametrial invasion 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 paraaortic lymph nodes
IIIA	Carcinoma involves 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 paraaortic lymph nodes (including micrometastases) ^c , irrespective of tumor size and extent (with r and p notations).
IIIC1	Pelvic lymph node metastasis only
IIIC2	Paraortic lymph node metastasis
IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to stage IV
IVA	Spread of the growth to adjacent organs
IVB	Spread to distant organs

^aImaging and pathology can be used, when available, to supplement clinical findings with respect to tumor size and extent, in all stages. Pathological findings supercede imaging and clinical findings.

^bThe involvement of vascular/lymphatic spaces should not change the staging. The lateral extent of the lesion is no longer considered.

^cIsolated tumor cells do not change the stage but their presence should be recorded.

^dAdding notation of r (imaging) and p (pathology) to indicate the findings that are used to allocate the case to Stage IIIC. Example: If imaging indicates pelvic lymph node metastasis, the stage allocation would be Stage IIIC1r, and if confirmed by pathologic findings, it would be Stage IIIC1p. The type of imaging modality or pathology technique used should always be documented.

Reprinted from: Bhatla N, Berek JS, Fredes MC, et al. Revised FIGO Staging for carcinoma of the cervix uteri. *Int J Gynecol Obstet* 2019;145:129-135 and Corrigendum to "Revised FIGO Staging for carcinoma of the cervix uteri" [*Int J Gynecol Obstet* 2019;145:129-135] *Int J Gynecol Obstet* 2019;147:279-280. Copyright 2019, with permission from International Federation of Gynecology and Obstetrics.



NCCN Categories of Evidence and Consensus	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN Categories of Preference	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.



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Discussion

This discussion is being updated to correspond with the newly updated algorithm. Last update 03/29/19.

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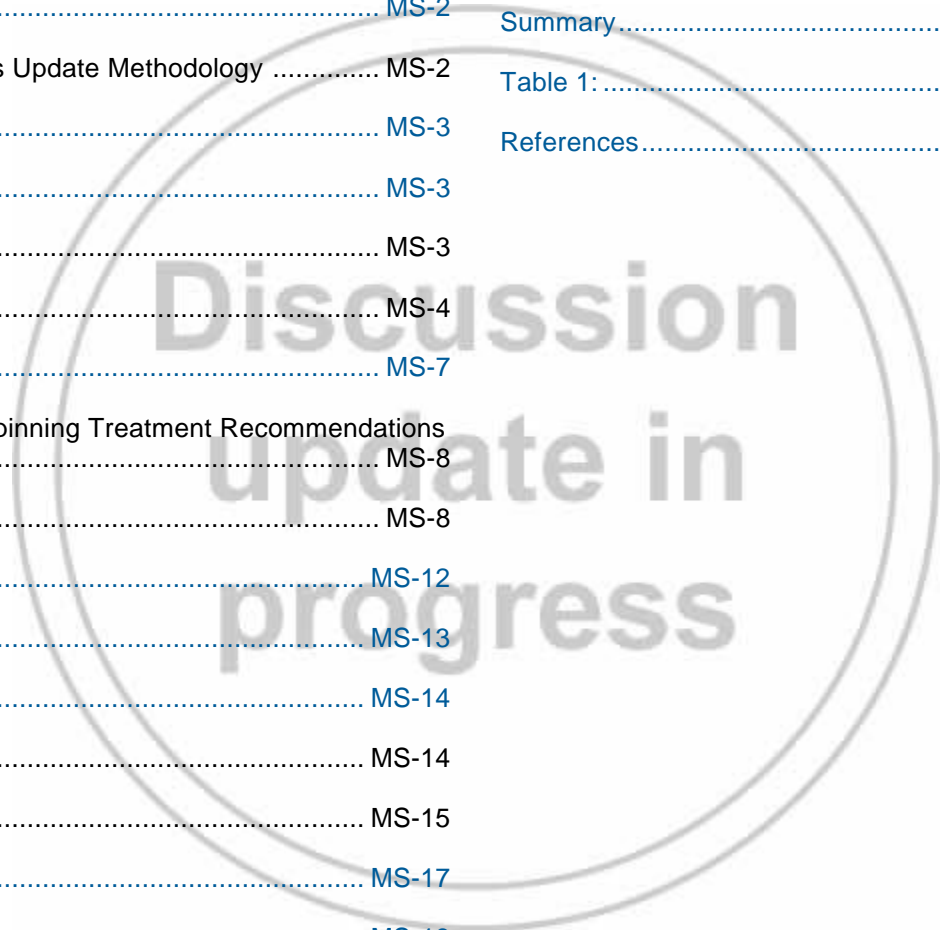
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Overview

An estimated 13,170 new cases of carcinoma of the uterine cervix (ie, cervical cancer) will be diagnosed in the United States in 2019, and 4250 people will die of the disease.¹ Cervical cancer rates are decreasing among women in the United States, although incidence remains high among Hispanic/Latino, Black, and Asian women.²⁻⁵ However, cervical cancer is a major world health problem for women. The global yearly incidence of cervical cancer in 2012 was 528,000; the annual death rate was 266,000.⁶ It is the fourth most common cancer in women worldwide,^{7,8} with 85% of cases occurring in developing countries—where cervical cancer is a leading cause of cancer death in women.^{6,9}

Persistent human papillomavirus (HPV) infection is the most important factor in the development of cervical cancer.^{10,11} The incidence of cervical cancer appears to be related to the prevalence of HPV in the population. In countries with a high incidence of cervical cancer, the prevalence of chronic HPV is approximately 10% to 20%, whereas the prevalence in low-incidence countries is 5% to 10%.⁷ Immunization against HPV prevents infection with the types of HPV against which the vaccine is designed and, thus, is expected to prevent specific HPV cancer in women.¹²⁻¹⁶ Other epidemiologic risk factors associated with cervical cancer are a history of smoking, parity, oral contraceptive use, early age of onset of coitus, larger number of sexual partners, history of sexually transmitted disease, certain autoimmune diseases, and chronic immunosuppression.^{17,18} Smoking cessation should be advised in current smokers, and former smokers should continue to avoid smoking (see the [NCCN Guidelines for Smoking Cessation](#) and <http://smokefree.gov/>).

Squamous cell carcinomas account for approximately 80% of all cervical cancers and adenocarcinoma accounts for approximately 20%. In developed countries, the substantial decline in incidence and mortality of squamous cell carcinoma of the cervix is presumed to be the result of

effective screening, although racial, ethnic, and geographic disparities exist.^{2,3,19,20} However, adenocarcinoma of the cervix has increased over the past 3 decades, probably because cervical cytologic screening methods are less effective for adenocarcinoma.²¹⁻²⁴ Screening methods using HPV testing may increase detection of adenocarcinoma. Vaccination with HPV vaccines may also decrease the incidence of both squamous cell carcinoma and adenocarcinoma.^{23,25}

By definition, the NCCN Guidelines cannot incorporate all possible clinical variations and are not intended to replace good clinical judgment or individualization of treatments. “Many exceptions to the rule” were discussed among the members of the cervical cancer panel during the process of developing these guidelines.

Literature Search Criteria and Guidelines Update Methodology

Prior to the update of this version of the NCCN Guidelines® for Cervical Cancer, an electronic search of the PubMed database was performed to obtain key literature in cervical cancer published between 2017 and 2018, using the following search terms: cervical cancer or cervical carcinoma or carcinoma of the cervix. The PubMed database was chosen as it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase II; Clinical Trial, Phase III; Clinical Trial, Phase IV; Guideline; Randomized Controlled Trial; Meta-Analysis; Systematic Reviews; and Validation Studies.

The PubMed search resulted in 170 citations and their potential relevance was examined. The data from key PubMed articles as well as articles from additional sources deemed as relevant to these Guidelines and discussed by the panel have been included in this version of the Discussion section

(eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel's review of lower-level evidence and expert opinion.

The complete details of the Development and Update of the NCCN Guidelines are available at www.NCCN.org.

Diagnosis and Workup

These NCCN Guidelines discuss squamous cell carcinoma, adenosquamous carcinoma, and adenocarcinoma of the cervix.

Neuroendocrine carcinoma, small cell tumors, glassy-cell carcinomas, sarcomas, and other histologic types are not within the scope of these guidelines.

The earliest stages of cervical carcinoma may be asymptomatic or associated with a watery vaginal discharge and postcoital bleeding or intermittent spotting. Often these early symptoms are not recognized by the patient. Because of the accessibility of the uterine cervix, cervical cytology or Papanicolaou (Pap) smears and cervical biopsies can usually result in an accurate diagnosis. Cone biopsy (ie, conization) is recommended if the cervical biopsy is inadequate to define invasiveness or if accurate assessment of microinvasive disease is required. However, cervical cytologic screening methods are less useful for diagnosing adenocarcinoma, because adenocarcinoma in situ affects areas of the cervix that are harder to sample (ie, endocervical canal).^{5,24} The College of American Pathologists (CAP) protocol for cervical carcinoma is a useful guide (<https://cap.objects.frb.io/protocols/cp-femalereproductive-uterine-cervix-18protocol-4100.pdf>). This CAP protocol was revised in August 2018 and reflects recent updates in AJCC staging (ie, AJCC Cancer Staging Manual, 8th edition).

Workup for these patients with suspicious symptoms includes history and physical examination, complete blood count (CBC) (including platelets),

and liver and renal function tests. Recommended radiologic imaging includes chest radiograph, CT, or combined PET/CT, and MRI as indicated (eg, to rule out disease high in the endocervix).^{26,27} For detailed imaging recommendations by stage and planned treatment approach, see *Principles of Imaging* in the NCCN Guidelines for Cervical Cancer). Smoking cessation and counseling, as well as HIV testing (especially in younger patients), are recommended. Cystoscopy and proctoscopy are only recommended if bladder or rectal extension is suspected (ie, for \geq stage IB3). Options for fertility sparing should be considered.

Principles of Staging and Surgery

Clinical Staging

The panel has updated the guidelines according to the revised 2018 FIGO staging system.²⁸ The definitions for lesion size and microinvasion for stage I have been revised. For stage IA, the lateral extent of the lesion no longer affects staging. Stage IB is now divided into 3 subgroups as follows: IB1 includes invasive carcinomas ≥ 5 mm and < 2 cm in greatest diameter; IB2 includes tumors 2–4 cm; and IB3 designates tumors ≥ 4 cm. Consideration of nodal metastasis has also been revised; radiology (r) or pathology (p) findings may be used to assess retroperitoneal nodal involvement and are indicated for stage IIIC. Nodal involvement is now designated as stage IIIC, which is subdivided into IIIC1 for pelvic nodes only, and IIIC2 for para-aortic node involvement. Importantly, lymphovascular space invasion (LVSI) does not alter the FIGO classification. FIGO did not include LVSI because pathologists do not always agree on whether LVSI is present in tissue samples. Some panel members believe that patients with stage IA1 who have extensive LVSI should be treated using stage IB1 guidelines.²⁸

Although staging and treatment recommendations by stage have been revised according to FIGO 2018 in the algorithm, much of the data cited within this section utilized the previous 2009 FIGO staging system.^{29,30}

Surgical Staging

Pathologic Assessment

Surgicopathologic factors may be used to guide the extent of surgical staging and treatment decisions. Findings from pathologic assessment of the surgical specimen should be carefully documented. Important elements of primary tumor evaluation include tumor site; primary tumor volume (in multiple dimensions); histologic type and grade; stromal invasion; surgical margin status; and the presence of lymphovascular invasion. When resected, the number of lymph nodes with isolated tumor cells, micrometastases, and macrometastases should be recorded. When sentinel lymph node (SLN) mapping is performed, SLNs should undergo ultrastaging for detection of low-volume metastasis; non-sentinel nodes do not require ultrastaging. Other important factors include tumor involvement of tissues/organs such as the parametrium, vaginal cuff, fallopian tubes, ovaries, peritoneum, omentum, and others.

The “Sedlis Criteria,” which are intermediate risk factors used to guide adjuvant treatment decisions, include: 1) greater than one-third stromal invasion; 2) capillary lymphatic space involvement; or 3) cervical tumor diameters more than 4 cm.³¹ However, potentially important risk factors for recurrence may not be limited to the Sedlis Criteria. Additional risk factors for consideration include tumor histology (eg, adenocarcinoma component)^{32,33} and close or positive surgical margins.^{34,35}

Recent findings suggest that predictive factors for lymph node metastasis in endocervical adenocarcinoma may differ from squamous cell carcinoma. Data from retrospective studies suggest that the pattern of cervical stromal invasion and presence of LVSI, but not primary tumor size, predict risk of nodal metastasis. Alternative classification systems incorporating stromal invasion pattern have been proposed for adenocarcinoma.³⁶⁻³⁸ These systems remain to be validated for clinical use.

Conservative/Fertility-Sparing Approaches

Fertility-sparing approaches may be considered in highly selected patients who have been thoroughly counseled regarding disease risk as well as prenatal and perinatal issues.³⁹ Consultation with reproductive endocrinology fertility experts is suggested.

Microinvasive disease (FIGO stage IA1 with no LVSI) is associated with an extremely low incidence of lymphatic metastasis,⁴⁰⁻⁴³ and conservative treatment with conization is an option (category 2A) for individuals with no evidence of LVSI. In stage IA1 individuals with evidence of LVSI, a reasonable conservative approach is conization (with negative margins) in addition to SLN mapping algorithm or pelvic lymphadenectomy.

The goal of conization is *en bloc* removal of the ectocervix and endocervical canal; the shape of the cone can be tailored to the size, type, and location of the lesion (ie, narrow, long cone in cases of suspected invasive adenocarcinoma). The panel recommends cold knife conization as the preferred approach to conization. However, LEEP (loop electrosurgical excision procedure) is acceptable as long as adequate margins, proper orientation, and a non-fragmented specimen without electrosurgical artifact can be obtained.⁴⁴⁻⁴⁹ Endocervical curettage should be added as clinically indicated.

Select patients with stage IA2 and IB1, especially for those with tumors of less than 2 cm in diameter, may be eligible for conservative surgery.^{50,51} Radical trachelectomy may offer a reasonable fertility-sparing treatment option for patients with stage IA2, IB1, and select IB2 cervical cancer with lesions that are less than or equal to 2 cm in diameter.⁵²⁻⁵⁴ In a radical trachelectomy, the cervix, vaginal margins, and supporting ligaments are removed while leaving the main body and fundus of the uterus intact.⁵⁵ Laparoscopic pelvic lymphadenectomy accompanies the procedure and can be performed with or without SLN mapping (see *Lymph Node Mapping and Dissection* below). Due to their aggressive nature, tumors of

small cell neuroendocrine histology are considered inappropriate for radical trachelectomy.⁵⁶ Trachelectomy is also inappropriate for treating gastric type cervical adenocarcinoma and adenoma malignum (minimal deviation adenocarcinoma) due to their diagnostic challenges and potentially aggressive nature.⁵⁷

Vaginal radical trachelectomy (VRT) may be used for carefully selected patients with lesions of 2 cm diameter or less.⁵⁸⁻⁶⁰ Abdominal radical trachelectomy (ART) provides a broader resection of the parametria^{52,60} than the vaginal approach and is commonly used in stage IB1 lesions. Multiple case series have evaluated safety and outcomes with vaginal versus abdominal approaches to radical trachelectomy,^{58,61-63} including systematic reviews on VRT⁶⁴ and ART.⁶⁵ A limited number of studies have specifically examined this approach in patients with tumors between 2 cm and 4 cm in diameter and reported safe oncologic outcomes; however, as expected, more patients in this subgroup will require adjuvant therapy that may reduce fertility.⁶⁶⁻⁶⁸

Studies that examined pregnancy in women who underwent radical trachelectomy have provided differing success rates. One case series of 125 patients with cervical cancer who underwent VRT reported 106 pregnancies among 58 women.⁵⁹ In a systematic review of 413 women who underwent ART, 113 women attempted pregnancy and 67 (59%) successfully conceived.⁶² However, miscarriage and pre-term labor rates were elevated among women who underwent radical trachelectomy.^{59,69-71}

Non-Fertility-Sparing Approaches

The Querleu and Morrow surgical classification system^{72,73} describes the degree of resection and nerve preservation for radical hysterectomy in three-dimensional planes and updates the previously used Piver-Rutledge classifications.⁷⁴ Approaches to hysterectomy include simple/extrafascial hysterectomy (Type A), modified radical hysterectomy (Type B), and radical hysterectomy (Type C).^{75,76}

For patients with IA1 disease, cone excision, simple/extrafascial hysterectomy, and modified radical hysterectomy are options. Radical hysterectomy with bilateral pelvic lymph node dissection (with or without SLN mapping) is the preferred treatment approach for patients with FIGO stage IA2, IB1, IB2, and IIA1 cervical cancers. Radical hysterectomy is preferred over simple hysterectomy due to its wider paracervix margin of resection that also includes aspects of the cardinal and uterosacral ligaments, upper vagina, pelvic nodes, and at times, para-aortic nodes. In the United States, definitive chemoradiation is typically preferred over radical surgery for select patients with FIGO IB3 lesions and the vast majority of FIGO stage IIA2 or greater cervical cancers. Abroad, select FIGO IB3-IIB cases may be treated with radical hysterectomy or neoadjuvant chemotherapy followed by radical hysterectomy.

For recurrent or persistent cervical cancers that are confined to the central pelvis (ie, no distant metastasis), pelvic exenteration may be a potentially curative surgical option.^{77,78} Discussion of the various approaches to pelvic exenteration are offered by Chi and colleagues,⁷⁵ and in the Gynecologic Oncology Group (GOG) Surgical Manual.⁷⁶

Lymph Node Mapping and Dissection

Sentinel Lymph Node Mapping

Recent data suggest that SLN biopsy may be useful for decreasing the need for pelvic lymphadenectomy in patients with early-stage cervical cancer.^{79,80}

Prospective studies generally support the feasibility of SLN detection in patients with early-stage cervical cancer and suggest that extensive pelvic lymph node dissection may be safely avoided in a significant proportion of early-stage cases.⁷⁹⁻⁹⁰

Meta-analyses of pooled data from SLN mapping studies have generated SLN detection rates of 89% to 92% and sensitivity of 89% to 90%.^{91,92} Factors determined to be important for detection included laparoscopy, dual blue dye/radiocolloid tracer approaches, and pathologic assessment using immunohistochemistry. However, based on a recent metaanalysis, indocyanine green (ICG) tracer appears to provide similar overall and bilateral detection rates to the standard dual blue dye/technetium-99 approach.⁹³ The randomized phase III FILM trial demonstrated that ICG tracer identified more SLNs (overall and bilateral) than blue dye.⁹⁴

Study data also highlight limited sensitivity of this approach and potential to miss SLN micrometastases and isolated tumor cells using intraoperative assessment (ie, frozen section or imprint cytology).^{82,86,88} The sensitivity of this approach appears to be better in patients with tumors equal to or less than 2 cm in diameter.^{79,81,83,95} Ultrastaging of detected SLNs has been shown to provide enhanced detection of micrometastases.^{84,85}

The SENTICOL longitudinal study demonstrated the utility of SLN mapping to uncover unusual lymph drainage patterns.^{83,96} It also highlighted limited agreement between lymphoscintigraphy and intraoperative SLN mapping.⁹⁶ Additionally, this study revealed that bilateral SLN detection and biopsy provided a more reliable assessment of sentinel nodal metastases and led to fewer false negatives than unilateral SLN biopsy.⁸⁰ Generally, research supports ipsilateral lymphadenectomy if no sentinel nodes are detected on a given side of the pelvis as outlined in the SLN mapping algorithm.^{79,80,97}

Based on these collective data, the panel recommends consideration of SLN mapping algorithm and emphasizes that best detection and mapping results are in tumors of less than 2 cm diameter. Adherence to the SLN mapping algorithm is important; surgeons should perform side-specific nodal dissection in any cases of failed mapping and remove all suspicious or grossly enlarged nodes regardless of SLN mapping.⁷⁹

Para-Aortic Lymph Node Assessment

Studies of the incidence and distribution of lymph node metastases in women with stage IB to IIB cervical cancers suggest that para-aortic lymph node involvement is closely tied to the presence of pelvic lymph node metastases, larger primary tumor size (>2 cm), and metastasis to the common iliac nodes.^{98,99}

Analysis of outcomes data from 555 women who participated in GOG trials (GOG 85, GOG 120, and GOG 165) revealed a more positive prognosis for patients who underwent surgical exclusion of para-aortic lymph node involvement versus those who underwent radiographic determination of para-aortic node involvement.¹⁰⁰ One study examined the efficacy of extending the radiation therapy (RT) field to the para-aortic region in patients with para-aortic lymph node involvement, and showed therapeutic benefit especially in patients with small-volume nodal disease.¹⁰¹ A randomized controlled trial examining surgical versus radiologic staging and treatment of para-aortic lymph node involvement is ongoing.¹⁰²

The panel recommends para-aortic lymph node dissection for patients with ≥ stage IB1 disease.

Minimally Invasive Surgical Approaches

The standard and historical approach for radical hysterectomy is with an open abdominal approach.

Previous iterations of the guidelines had indicated that radical hysterectomy could be performed either via open laparotomy or minimally invasive surgery (MIS) laparoscopic approaches, using either conventional or robotic techniques. Data from previous retrospective reviews and prospective observational studies demonstrated oncologic outcomes following conventional laparoscopic radical hysterectomy that were comparable to open abdominal approaches after 3 to 6 years of follow-up.¹⁰³⁻¹⁰⁶ Similarly, multicenter retrospective reviews and matched

cohort studies showed comparable oncologic outcomes (disease recurrence and survival rates) for open abdominal and robotic radical hysterectomy after 3 to 5 years of follow-up.¹⁰⁶⁻¹⁰⁹ Additionally, a systematic review and meta-analysis of data from 26 studies found that laparoscopic and robotic radical hysterectomy approaches appeared to provide equivalent intraoperative and short-term postoperative outcomes.¹¹⁰

However, several key contemporary reports have questioned the presumed therapeutic equivalency of open vs MIS approaches. A recently published prospective randomized trial demonstrated that minimally invasive radical hysterectomy was associated with lower rates of DFS and OS than open abdominal radical hysterectomy.¹¹¹ This phase III LACC trial (NCT00614211) was designed to provide a definitive comparison of outcomes data in patients with early-stage cervical cancer undergoing total abdominal radical hysterectomy (TARH) or total laparoscopic radical hysterectomy/total robotic radical hysterectomy. At closure, 319 patients had received MIS (84% laparoscopy, 16% robotic) and 312 patients underwent a TARH. Ninety-two percent of participants in both surgical arms had stage IB1 disease. MIS was associated with lower rate of disease-free survival than open surgery (3-year DFS, 91.2% vs. 97.1%; HR 3.74; 95% CI, 1.63 to 8.58), as well as a decrease in overall survival (3-year OS, 93.8% vs. 99.0%; HR 6.00; 95% CI, 1.77 to 20.30).¹¹¹ MIS did not meet predetermined non-inferiority criteria compared with standard-of-care laparotomy ($P = 0.88$).

Two other recent epidemiologic studies also demonstrated that minimally invasive radical hysterectomy was associated with shorter OS than open surgery among women with stage IA2-IB1 cervical cancer.^{112,113} Melamed, et al reported on a SEER-based cohort study that compared females with stage IA2 or IB1 cervical cancer who underwent laparotomy ($n = 1236$) or MIS ($n = 1225$).¹¹² Four-year mortality was higher among patients undergoing MIS versus laparotomy (9.1% versus 5.3%, $P = 0.002$).

Relative survival rates were stable prior to the adoption of MIS techniques (2000-2006), but a significant decline was noted in the years following adoption. Margul, et al examined National Cancer Database data from 2010 to 2013 to compare outcomes of patients with stage IB1 cervical cancer who underwent radical hysterectomy performed by open abdominal versus MIS approaches.¹¹⁴ Although MIS was associated with decreased surgical morbidity and costs, patients with tumor sizes ≥ 2 cm who underwent MIS had decreased 5-year survival compared to those undergoing open radical hysterectomy (81.3% vs. 90.8%, $P < .001$).¹¹⁴

These most recent findings stand in contradiction to the earlier referenced series that had suggested therapeutic equivalency of MIS compared to open approaches along with the MIS-associated potential advantages of decreased hospital stay and more rapid patient recovery.^{106,107,109,110,115-118}

Given the recently presented findings of poorer oncologic outcomes and survival with the MIS techniques compared to open laparotomy, women should be carefully counseled about the oncologic risks and potential short-term benefits of the different surgical approaches.

Primary Treatment

Note: Recommendations by stage are based on the revised 2018 FIGO staging by Bhatla, et al.²⁸ However, trial data cited within this section primarily utilized the previous 2009 FIGO staging system.^{29,30}

The primary treatment of early-stage cervical cancer is either surgery or RT. Surgery is typically reserved for early-stage disease, fertility-preservation, and smaller lesions, such as stage IA, IB1, IB2, and selected IIA1.¹¹⁹ The panel agrees that concurrent chemoradiation is generally the primary treatment of choice for stages IB3 to IVA disease based on the results of 5 randomized clinical trials.^{120,121} Chemoradiation can also be used for patients who are not candidates for hysterectomy. Although few

studies have assessed treatment specifically for adenocarcinomas, they are typically treated in a similar manner to squamous cell carcinomas.¹²²⁻¹²⁴

Pelvic RT or chemoradiation will invariably lead to ovarian failure in premenopausal women.¹²⁵ To preserve intrinsic hormonal function, ovarian transposition may be considered before pelvic RT for select women younger than 45 years of age with squamous cell cancers.^{126,127}

Important Phase III Clinical Trials Underpinning Treatment Recommendations

A randomized Italian study compared RT alone versus radical hysterectomy and lymph node dissection in patients with clinical early-stage disease (stage IB–IIA).¹²⁸ Adjuvant RT was given to those with parametrial extension, less than 3 cm of uninvolved cervical stroma, positive margins, or positive nodes. Identical outcomes were noted for patients treated with radiation versus surgery, with (or without) postoperative radiation, but higher complication rates were noted for the combined modality approach.

Concurrent chemoradiation, using platinum-containing chemotherapy (cisplatin alone [preferred] or cisplatin/fluorouracil), is the treatment of choice for stages IB3, II, III, and IVA disease based on the results of randomized clinical trials.¹²⁹⁻¹³⁴ These trials have shown that the use of concurrent chemoradiation results in a 30% to 50% decrease in the risk of death compared with RT alone. Although the optimal concurrent chemotherapy regimen to use with RT requires further investigation, these trials clearly established a role for concurrent cisplatin-containing chemoradiation. Based on these data, the NCI issued an alert stating that strong consideration should be given to using chemoradiation instead of RT alone for invasive cervical cancer.¹³⁴ Long-term follow-up of 3 of these trials has confirmed that concurrent cisplatin-containing chemoradiation improves progression-free survival (PFS) and overall survival when compared with RT with (or without) hydroxyurea.¹³⁵⁻¹³⁷ A recent

meta-analysis reported that chemoradiotherapy leads to a 6% improvement in 5-year survival (hazard ratio [HR], 0.81; $P < .001$).¹³⁸ A large, population-based registry analysis in Canada (n = 4069) confirmed that chemoradiotherapy improved outcomes when compared with RT alone.¹³⁹

Although chemoradiation is tolerated, acute and long-term side effects have been reported.^{138,140,141} Concurrent single-agent cisplatin chemoradiation may be preferred over cisplatin/fluorouracil chemoradiation due to lesser toxicity.^{121,142} Concurrent carboplatin (preferred if cisplatin intolerant) or non-platinum chemoradiation regimens are options for patients who may not tolerate cisplatin-containing chemoradiation.^{138,143-148} Carboplatin has been added to the guidelines as a preferred radiosensitizing agent for patients who are cisplatin intolerant.

Note that when concurrent chemoradiation is used, the chemotherapy is typically given when the external-beam pelvic radiation is administered.¹²¹ The panel believes that using “systemic consolidation” (ie, adding chemotherapy after chemoradiation) should only be used in clinical trials (eg, OUTBACK [ANZGOG-0902/GOG 274, NCT01414608] and RTOG 724 [NCT00980954]).¹⁴⁹

Early-Stage Disease

After careful clinical evaluation and staging, the primary treatment of early-stage cervical cancer is either surgery or RT. The treatment schema is stratified using the FIGO staging system. A fertility-sparing algorithm may be applied for select patients with stage IA, IB1, and certain cases of IB2 disease. Fertility-sparing surgery is generally not recommended for patients with small cell neuroendocrine tumors, gastric type adenocarcinoma, or adenoma malignum (minimal deviation adenocarcinoma) because of its high-risk nature and a paucity of data.

Stage IA1 Disease

Recommended options for stage IA1 disease depend on the results of cone biopsy and whether patients 1) want to preserve their fertility; 2) are medically operable; or 3) have LVSI. The extent of the lymph node dissection depends on whether pelvic nodal disease and/or LVSI are present and the size of the tumors. SLN mapping can be considered.

Fertility-Sparing

For patients who desire fertility preservation, cone biopsy with or without pelvic lymph node dissection is recommended.^{90,150,151}

The goal of cone biopsy is margins that are negative for invasive disease and high-grade squamous intraepithelial lesion (HSIL). For patients with negative margins after cone biopsy and no findings of LVSI, observation may be an option if fertility preservation is desired. For patients with positive margins after cone biopsy, options include repeat cone biopsy to better evaluate depth of invasion (to rule out stage IA2/IB disease) or a radical trachelectomy. In studies of patients who had positive margins after conization, predictors of residual disease included positive endocervical curettage, combined endocervical margin and endocervical curettage, and volume of disease.^{34,152,153}

For patients with stage IA1 disease with LVSI, conization (with negative margins) plus laparoscopic pelvic SLN mapping/lymphadenectomy is a reasonable strategy. In addition, these patients may also be treated with a radical trachelectomy and SLN mapping/pelvic lymph node dissection.^{63,154-157}

After childbearing is complete, hysterectomy can be considered for patients who have had either radical trachelectomy or a cone biopsy for early-stage disease if they have chronic, persistent HPV infection, they have persistent abnormal Pap tests, or they desire this surgery.

For young (<45 years) premenopausal women with early-stage squamous cell carcinoma who opt for ovarian preservation (ie, hysterectomy only), the rate of ovarian metastases is low.^{158,159}

Non-Fertility-Sparing

For medically and technically operable patients with stage IA1 disease who do not desire fertility preservation, extrafascial (ie, simple) hysterectomy is commonly recommended for patients without LVSI and with either negative margins after cone biopsy or with positive margins for dysplasia. For patients with positive margins for carcinoma, modified radical hysterectomy is recommended with SLN mapping/pelvic lymph node dissection (category 2B for node dissection). SLN mapping can be considered. Physicians can also consider repeat cone biopsy to better evaluate depth of invasion. If LVSI is present, then modified radical hysterectomy with SLN mapping/pelvic lymph node dissection is recommended. For patients with negative margins after cone biopsy, observation is recommended for those who are medically inoperable or those who refuse surgery.

Stage IA2 Disease

Recommendations for stage IA2 depend upon whether a patient wishes to preserve her fertility and if the disease is medically operable.

Fertility-Sparing

For patients who wish to preserve their fertility, radical trachelectomy and pelvic lymph node dissection is recommended. SLN mapping can also be considered. Cone biopsy followed by observation is another option if the margins are negative and pelvic lymph node dissection is negative.

Non-Fertility-Sparing

For medically operable patients who do not desire fertility preservation, recommended treatment includes either surgery or RT. The recommended surgical option is radical hysterectomy and bilateral pelvic lymph node

dissection. SLN mapping can also be considered. Para-aortic node dissection is indicated for patients with known or suspected pelvic nodal disease. Less radical surgical approaches for patients with stage IA2 disease are the subject of ongoing investigation.^{153,160}

Pelvic external beam RT (EBRT) with brachytherapy (traditionally 70–80 Gy to total point A dose) is a treatment option for patients who are medically inoperable or who refuse surgery.¹⁶¹ These doses are recommended for most patients based on summation of conventional external-beam fractionation and low dose-rate (40–70 cGy/h) brachytherapy equivalents. Treatment should be modified based on normal tissue tolerance, fractionation, and size of target volume or on biologic equivalence calculations when using high dose-rate brachytherapy.

Stage IB and IIA Disease

Depending on their stage and disease bulk, patients with stage IB or IIA tumors can be treated with surgery, RT, or concurrent chemoradiation. Fertility-sparing surgery is only recommended for patients with stage IB1 or select cases of stage IB2 disease (see next section). A combined PET/CT scan can be performed to rule out extrapelvic disease before deciding how to treat these patients. The GOG considers that surgical staging is an option for patients with advanced cervical cancer. Radiologic imaging is recommended for assessing stage IB3 and IIA2 tumors (see *Principles of Imaging* in the NCCN Guidelines for Cervical Cancer).

Stage IB1: Fertility-Sparing

For patients who desire fertility preservation, radical trachelectomy and pelvic lymph node dissection with (or without) para-aortic lymph node dissection is an option for stage IB1 and select cases of IB2 disease, but typically only for tumors 2 cm or less in the NCCN Guidelines for Cervical Cancer].^{52,154-157,162} SLN mapping can also be considered. Tumors that are 2 to 4 cm have to be carefully selected for a fertility-sparing approach as

many of these patients may require postoperative adjuvant therapy due to pathologic risk factors (eg, Sedlis Criteria or positive nodes). However, some surgeons suggest that a 2cm cutoff may be used for vaginal trachelectomy, whereas a 4cm cutoff may be used for abdominal trachelectomy.¹⁶³ In one study, oncologic outcomes were similar after 4 years when comparing radical trachelectomy with radical hysterectomy for patients with stage IB1 cervical carcinoma.⁵² Stage IB1 or IB2 small cell neuroendocrine histology, gastric type adenocarcinoma, and adenoma malignum are not considered suitable for fertility-sparing surgery.

Stage IB and IIA: Non-Fertility-Sparing

For stage IB1, IB2, and IIA1 disease, primary surgery consists of radical hysterectomy plus bilateral pelvic lymph node dissection (category 1), with (or without) para-aortic lymph node dissection (category 2B for para-aortic lymph node dissection).^{128,164} SLN mapping can also be considered for stages IB1, IB2, and IIA1. Panel members feel that surgery is the most appropriate option for patients with stage IB1, IB2, or IIA1 disease, whereas concurrent chemoradiation is the most appropriate option for those with stage IB3 or IIA2 disease based on randomized trials.^{128-130,132,133} Thus, the primary surgical option is a category 1 recommendation for patients with stage IB1, IB2, or IIA1 disease; however, primary chemoradiation is the category 1 recommendation for those with stage IB3 or IIA2 disease. Para-aortic node dissection may be performed for patients with larger tumors and suspected or known pelvic nodal disease. Some panel members feel that a pelvic lymph node dissection should be performed first and if negative, then the radical hysterectomy should be performed. If the lymph nodes are positive, then the hysterectomy should be abandoned; these patients should undergo chemoradiation. For patients with stage IB1, IB2, or IIA tumors (including those who are not candidates for hysterectomy), another option is combined pelvic EBRT and brachytherapy with (or without) concurrent platinum-containing chemotherapy. Preferred radiosensitizing regimens include cisplatin or

carboplatin for patients who are cisplatin-intolerant. Other recommended regimens include cisplatin/fluorouracil. Although concurrent chemoradiation has been proven effective in the definitive treatment of more advanced-stage disease, this approach has not been specifically studied in patients with stage IB1, IB2, or IIA1 disease. Careful consideration of the risk/benefit ratio should be undertaken in these patients with smaller tumors.

For patients with clinical stage IB3 or IIA2 tumors who are treated with definitive radiation, concurrent cisplatin-containing chemotherapy has been shown to significantly improve patient survival. The panel recommends definitive EBRT with concurrent platinum-containing chemotherapy and brachytherapy (traditionally 75–80 Gy to total point A dose). Again, treatment should be modified based on normal tissue tolerance, fractionation, and size of target volume. Primary chemoradiation has a category 1 recommendation.^{129,130}

For stage IB3 or IIA2 tumors, the panel had a major disagreement about recommending adjuvant hysterectomy (category 3) (also known as completion surgery) after primary chemoradiation.¹²⁹ Adjuvant hysterectomy after RT has been shown to improve pelvic control, but not overall survival, and is associated with increased morbidity.¹⁶⁵ A recent Cochrane review examined whether the addition of hysterectomy to standard non-surgical treatments benefitted women with locally advanced cervical cancer, finding insufficient data to demonstrate a survival benefit associated with surgery.¹⁶⁶ The morbidity is higher after completion surgery, but this may be reduced using a laparoscopic technique.¹⁶⁷⁻¹⁷⁰ Although routine completion hysterectomy is not typically performed, this approach may be considered in patients whose extent of disease or uterine anatomy precludes adequate coverage by brachytherapy.

Advanced Disease

This category has traditionally included patients with stage IIB to IVA disease (ie, locally advanced disease). However, many oncologists now include patients with IB3 and IIA2 disease in the advanced disease category. For patients with more advanced tumors who are undergoing primary chemoradiation, the volume of RT is critical and guided by assessment of nodal involvement in the pelvic and para-aortic nodes. Radiologic imaging studies (including PET/CT) are recommended for stage IB2 or greater disease, especially for evaluation of nodal or extrapelvic tumor (see *Principles of Imaging* in the NCCN Guidelines for Cervical Cancer). MRI is useful to describe local disease extent and assist in radiation treatment planning. However, needle biopsy of extrauterine abnormality can be considered for questionable imaging findings. Surgical staging (ie, extraperitoneal or laparoscopic lymph node dissection) is also an option (category 2B) for these patients.¹⁷¹ Surgical staging may also detect microscopic nodal disease that is not discernable with radiologic imaging.¹⁷²

For patients without nodal disease or with disease limited to the pelvis only through surgical staging, treatment consists of pelvic EBRT with concurrent platinum-containing chemotherapy and brachytherapy (category 1).^{120,121,130,132-134,173} Currently, acceptable concurrent platinum-containing regimens include either weekly cisplatin (preferred), carboplatin (preferred if cisplatin intolerant), or cisplatin/fluorouracil, given every 3 to 4 weeks during RT. An international phase III randomized trial reported that concurrent cisplatin/gemcitabine and EBRT followed by 2 additional cycles of cisplatin/gemcitabine after RT improved PFS and overall survival when compared with a standard regimen of concurrent cisplatin with pelvic EBRT.¹⁷⁴ However, this trial is controversial because of changes in its statistical design and because the reported superior regimen of concurrent cisplatin/gemcitabine and EBRT has unresolved toxicity issues.¹⁷⁴⁻¹⁷⁷

However, for patients with positive para-aortic and pelvic lymph nodes by imaging, imaging workup for metastatic disease is recommended.

Extended-field EBRT, concurrent platinum-containing chemotherapy, and brachytherapy is recommended. Patients with positive para-aortic lymph nodes who are positive for distant metastases are treated with systemic chemotherapy with (or without) individualized EBRT.¹⁷⁸

Metastatic Disease

For patients who present with distant metastatic disease (ie, stage IVB), primary treatment is often platinum-containing chemotherapy (see *Therapy for Metastatic Disease* in this Discussion). In these situations, individualized EBRT may be considered for control of pelvic disease and other symptoms.¹⁷⁸

Adjuvant Treatment

Adjuvant treatment is indicated after radical hysterectomy depending on surgical findings and disease stage. Observation is appropriate for patients with stage IA2, IB or IIA1 disease who have negative nodes, negative margins, negative parametria, and no cervical risk factors after radical hysterectomy (Sedlis Criteria). However, adjuvant treatment is indicated after radical hysterectomy if pathologic risk factors are discovered.

Pelvic EBRT is recommended (category 1) with (or without) concurrent platinum-containing chemotherapy (category 2B for chemotherapy) for patients with stage IA2, IB, or IIA1 disease who have *negative* lymph nodes after surgery but have large primary tumors, deep stromal invasion, and/or LVSI.^{31,179-182} Recommended radiosensitizing regimens include cisplatin (preferred), carboplatin (preferred if cisplatin intolerant), or cisplatin/fluorouracil.

Adjuvant pelvic RT alone versus no further therapy was tested in a randomized trial (GOG 92) of selected patients with node-negative stage

IB carcinoma of the cervix after hysterectomy and pelvic lymphadenectomy.³¹ Patients were considered to have “intermediate-risk” disease and were eligible for this trial if they had at least 2 of the following risk factors (commonly referred to as Sedlis Criteria): 1) greater than one-third stromal invasion; 2) capillary lymphatic space involvement; or 3) cervical tumor diameters more than 4 cm. Patients with positive lymph nodes or involved surgical margins were excluded. At 2 years, the recurrence-free rates were 88% for adjuvant RT versus 79% for the no-adjuvant-treatment group. After long-term follow-up (12 years), an updated analysis confirmed that adjuvant pelvic RT increased PFS; a clear trend towards improved overall survival was noted ($P = .07$).¹⁷⁹ The role of concurrent cisplatin/RT in patients with intermediate-risk disease is currently being evaluated in an international phase III randomized trial (GOG 263, NCT01101451).

Potentially important risk factors for recurrence may not be limited to the Sedlis Criteria” (ie, stromal invasion, LVSI, primary tumor size). Additional risk factors for consideration include tumor histology (eg, adenocarcinoma component)^{32,33} and close or positive surgical margins.^{34,35}

Postoperative pelvic EBRT with concurrent platinum-containing chemotherapy (category 1)¹³¹ with (or without) vaginal brachytherapy is recommended for patients with positive pelvic nodes, positive surgical margin, and/or positive parametrium; these patients are considered to have “high-risk” disease. Vaginal brachytherapy may be a useful boost for those with positive vaginal mucosal margins. Adjuvant concurrent chemoradiation significantly improves overall survival for patients with high-risk, early-stage disease (those with positive pelvic nodes, parametrial extension, and/or positive margins) who undergo radical hysterectomy and pelvic lymphadenectomy.¹³¹ The Intergroup trial 0107/GOG 109 showed a statistically significant benefit of adjuvant pelvic radiation with concurrent cisplatin and fluorouracil in the treatment of

patients with stage IA2, IB, or IIA disease who had positive lymph nodes, positive margins, and/or microscopic parametrial involvement found at surgery.¹³¹ A recent study re-evaluated these findings from GOG 109 in a population-based cohort (n = 3053) in the National Cancer Database, confirming the survival benefit of adjuvant chemoradiation but suggesting that this benefit may be best realized in patients with lymph node involvement.¹⁸³

Depending on the results of primary surgery, imaging may be recommended to determine whether distant metastases are present. In women who are positive for distant metastases, perform biopsy of suspicious areas as indicated. For patients without distant metastases, recommended treatment is extended-field EBRT (including pelvic and para-aortic lymph nodes) with concurrent platinum-containing chemotherapy and with (or without) brachytherapy. Recommended radiosensitizing regimens include cisplatin (preferred), carboplatin (preferred if cisplatin intolerant), or cisplatin/fluorouracil. For patients with distant metastases, recommended treatment is systemic chemotherapy with (or without) individualized EBRT.¹⁷⁸

Although neoadjuvant chemotherapy followed by surgery has been used in areas where RT is not available, data suggest no improvement in survival when compared with surgery alone for early-stage cervical cancer¹⁸⁴⁻¹⁸⁶ or locally advanced cervical cancer.^{187,188} A meta-analysis of data on patients with stage IB1 to IIA cervical cancer found that neoadjuvant chemotherapy may reduce the need for adjuvant RT by decreasing tumor size and metastases, but indicated no overall survival benefit.¹⁸⁸ However, data from a second meta-analysis suggested that response to neoadjuvant chemotherapy was a strong prognostic factor for PFS and overall survival.^{189,190} Outside of the clinical trial, the panel does not recommend the use of neoadjuvant chemotherapy.

Surveillance

The panel agrees with the new Society of Gynecologic Oncology's recommendations for post-treatment surveillance.¹⁹¹ The recommended surveillance is based on the patient's risk for recurrence and personal preferences. History and physical examination is recommended every 3 to 6 months for 2 years, every 6 to 12 months for another 3 to 5 years, and then annually. Patients with high-risk disease can be assessed more frequently (eg, every 3 months for the first 2 years) than patients with low-risk disease (eg, every 6 months).

Annual cervical/vaginal cytology tests can be considered as indicated for detection of lower genital tract dysplasia (eg, for those who have had fertility-sparing surgery). Some clinicians have suggested that rigorous cytology follow-up is not warranted because of studies stating that Pap smears did not detect recurrences in patients with stage I or II cervical cancer who were asymptomatic after treatment.¹⁹¹⁻¹⁹³ Noting the inherent differences between these patients and the general screening population, the panel does not recommend workup of low-grade squamous dysplasia detected during surveillance, but suggests that patients should follow up with a provider with specific expertise in this area. It is important to emphasize good clinical evaluation and a high index of suspicion, because the detection rate of recurrent cervical cancer is low using cervical and vaginal cytology alone.¹⁹⁴

For patients with stage I disease, follow-up imaging should be based on symptomatology and clinical concern for recurrent/metastatic disease, such as abnormal physical exam finding or new pelvic, abdominal, or pulmonary symptoms. If fertility-sparing treatment was provided, pelvic MRI should be considered 6 months after surgery and yearly for 2 to 3 years. PET/CT can be considered if metastasis is suspected.¹⁹⁵ For patients with stage II disease or greater, PET/CT (preferred) or CT should be performed within 3 to 6 months of completing therapy; pelvic MRI is

optional. Additional imaging should be guided by symptomatology and clinical concern for recurrent/metastatic disease. Specific indications and recommendations for surveillance imaging are detailed in *Principles of Imaging* in the NCCN Guidelines for Cervical Cancer.^{191,196-204}

Many other tests remain optional based on clinical indications, such as semiannual CBCs, blood urea nitrogen (BUN), and serum creatinine determinations. Patients with persistent or recurrent disease need to be evaluated using additional imaging studies as clinically indicated and surgical exploration in selected cases followed by therapy for relapse (see next section).²⁰⁵

Patient education regarding symptoms suggestive of recurrence is recommended (eg, vaginal discharge; weight loss; anorexia; pain in the pelvis, hips, back, or legs; persistent coughing). Patients should also be counseled on healthy lifestyle, obesity, nutrition, exercise, sexual health, hormone replacement therapy, and potential long-term and late effects of treatment. Smoking cessation and abstinence should be encouraged.¹⁹¹ See the [NCCN Guidelines for Survivorship](#), the [NCCN Guidelines for Smoking Cessation](#), and <http://www.cancer.org/treatment/survivorship>.

Patients who have received RT for cervical cancer may experience vaginal stenosis and dryness and should receive education on important issues regarding sexual health and vaginal health. Providers should inform patients about regular vaginal intercourse and/or vaginal dilator use and on the use of vaginal moisturizers/lubricants (eg, estrogen creams). Anecdotal evidence suggests that vaginal dilators may be used to prevent or treat vaginal stenosis.²⁰⁶ Dilator use can start 2 to 4 weeks after RT is completed and can be performed indefinitely.

Cervical cancer survivors are at risk for second cancers.²⁰⁷ Data suggest that patients who undergo RT for pelvic cancers are at risk for radiation-induced second cancers, especially at radiated sites near the

cervix (eg, colon, rectum/anus, urinary bladder); therefore, careful surveillance is appropriate for these patients.^{208,209}

Therapy for Relapse

Recurrences should be proven by biopsy before proceeding to treatment planning for recurrent disease.

Locoregional Therapy

Patients with a localized recurrence of cervical cancer after initial treatment may be candidates for radical retreatment; options include: 1) RT and/or chemotherapy; or 2) surgery.^{120,210} After treatment for relapse, long-term, disease-free survival rates of approximately 40% have been reported in some situations.²¹¹

For patients who experience locoregional recurrences who have not undergone previous RT or who experience recurrences outside of the previously treated RT field, therapy for relapse includes tumor-directed EBRT with (or without) chemotherapy and/or brachytherapy; surgical resection can be considered if feasible. Typically, the chemoradiation for recurrence uses cisplatin or carboplatin as single agents or cisplatin/fluorouracil.^{212,213} However, in those patients who have relapsed soon after completing initial chemoradiation with these regimens, alternative concurrent chemotherapy agents such as carboplatin, paclitaxel, and gemcitabine may be considered.

Patients with central pelvic recurrent disease after RT should be evaluated for pelvic exenteration, with (or without) intraoperative RT (IORT), although IORT is category 3.²¹⁴⁻²²¹ Surgical mortality is generally 5% or less, with survival rates approaching 50% in carefully selected patients.²¹⁷ Concomitant measures with these radical procedures include adequate rehabilitation programs dealing with the psychosocial and psychosexual consequences of the surgery as well as reconstructive procedures.^{216,222-224}

Although exenteration is the common surgical approach in postradiation patients with isolated central pelvic relapse, radical hysterectomy or brachytherapy may be an option in carefully selected patients with small central lesions (<2 cm).

For patients with noncentral recurrent disease, options include EBRT with (or without) chemotherapy, resection with (or without) IORT (category 3 for IORT), or chemotherapy (see the [NCCN Guidelines for Palliative Care](#)), or participation in a clinical trial. Patients who experience recurrence after second-line definitive therapy, either surgery or RT, have a poor prognosis. They can be treated with systemic therapy or best supportive care, or can be enrolled in a clinical trial.

Therapy for Metastatic Disease

Patients who develop distant metastases, either at initial presentation or at relapse, are rarely curable. For highly selected patients with isolated distant metastases amenable to local treatment, occasional long-term survival has been reported with: 1) surgical resection with (or without) EBRT; 2) local ablative therapies with (or without) EBRT; or 3) EBRT with (or without) chemotherapy. Systemic adjuvant chemotherapy can be considered. For example, patients who may benefit from aggressive local therapy for oligometastatic disease include those with nodal, lung, liver, or bone metastases.^{225,226} Following local therapy, additional adjuvant chemotherapy can be considered. For most other patients with distant metastases, an appropriate approach is a clinical trial, chemotherapy, or best supportive care (see NCCN Guidelines for Palliative Care at www.NCCN.org).

The palliation of pelvic recurrences in heavily irradiated sites that are not amenable to local pain control techniques or to surgical resection is difficult. These sites are generally not responsive to chemotherapy. Adequately palliating the complications of pain and fistulae from these

recurrences is clinically challenging (<http://emedicine.medscape.com/article/270646-overview>). However, short courses of RT may provide symptomatic relief to patients with bone metastases, painful para-aortic nodes, or supraclavicular adenopathy.^{178,227,228}

Chemotherapy is often recommended for patients with extrapelvic metastases or recurrent disease who are not candidates for RT or exenterative surgery. Patients whose disease responds to chemotherapy may have relief from pain and other symptoms. If cisplatin was previously used as a radiosensitizer, combination platinum-based regimens are preferred over single agents in the metastatic disease setting based on several randomized phase III trials (see next paragraph).^{229,230} However, responses to chemotherapy are often of short duration and survival is rarely increased.

First-Line Combination Chemotherapy

Cisplatin has been considered the most effective agent for metastatic cervical cancer.²³¹ However, most patients who develop metastatic disease have received concurrent cisplatin/RT as primary treatment and may no longer be sensitive to single-agent platinum therapy.^{229,230} Cisplatin-containing combination chemotherapy regimens, such as cisplatin/paclitaxel/bevacizumab (preferred regimen, category 1), cisplatin/paclitaxel (preferred, category 1), and cisplatin/topotecan (category 2A), have been extensively investigated in clinical studies.^{229,230,232-235} A randomized phase III study (GOG 169) in 264 patients compared cisplatin/paclitaxel versus cisplatin alone for metastatic, recurrent, or persistent cervical cancer. Patients receiving the 2-drug combination had a higher response rate (36% vs. 19%) and improved PFS (4.8 months vs. 2.8 months; $P > .001$) compared to single-agent cisplatin, although no improvement was seen in median survival.²²⁹ Patients who

responded to cisplatin/paclitaxel had a significant improvement in quality of life.

Another randomized phase III study (GOG 179) in 294 patients investigated cisplatin/topotecan versus cisplatin alone for recurrent or persistent cervical cancer. The topotecan combination regimen was shown to be superior to single-agent cisplatin with respect to overall response rate (27% vs. 13%, $P = .004$), PFS (4.6 months vs. 2.9 months; $P = .014$), and median survival (9.4 months vs. 6.5 months; $P = .017$).²³⁰ The FDA (U.S. Food and Drug Administration) has approved cisplatin/topotecan for advanced cervical cancer. However, the cisplatin/paclitaxel or carboplatin/paclitaxel regimens are less toxic and easier to administer than cisplatin/topotecan.²³⁶

A phase III trial (GOG 204) compared 4 cisplatin-doublet regimens (cisplatin/paclitaxel, cisplatin/topotecan, cisplatin/gemcitabine, and cisplatin/vinorelbine) in 513 patients with advanced metastatic or recurrent cancer.²³⁴ The trial was closed early based on futility analysis, because it was apparent that the cisplatin/topotecan, cisplatin/gemcitabine, and cisplatin/vinorelbine regimens were not superior to the control arm of cisplatin/paclitaxel. No significant differences in overall survival were seen; however, the trends for response rate, PFS, and overall survival (12.9 months vs. 10 months) suggest that cisplatin/paclitaxel is superior to the other regimens. Cisplatin/paclitaxel was associated with less thrombocytopenia and anemia (but with more nausea, vomiting, infection, and alopecia) than the other regimens.

A recent randomized phase III trial (GOG 240) studied the addition of bevacizumab to combination chemotherapy regimens (cisplatin/paclitaxel/bevacizumab or topotecan/paclitaxel/bevacizumab) in 452 patients in the first-line setting of metastatic, persistent, or recurrent cervical cancer. Analysis of pooled data from the two chemotherapy regimens revealed significant improvements in overall survival among

patients receiving bevacizumab (16.8 months vs. 13.3 months; $P = .007$).²³⁵ While topotecan/paclitaxel (category 2A) was not shown to be superior to cisplatin/paclitaxel, it may be considered as an alternative in patients who are not candidates for cisplatin.²³⁵ While bevacizumab led to higher toxicity (eg, hypertension, thromboembolic events, gastrointestinal fistula), it was not associated with a statistically significant decrease in patient-reported quality of life ($P = .27$).²³⁷ A 2017 systemic review and meta-analysis of data from 19 trials of systemic therapy for patients with recurrent, persistent, or metastatic cervical cancer found a trend towards improved OS for the addition of bevacizumab to cisplatin/paclitaxel or topotecan/paclitaxel when compared with all other non-bevacizumab-containing chemotherapy regimens.²³⁸ Both bevacizumab-containing regimens are included as preferred category 1 options for treating persistent, recurrent, or metastatic cervical cancer.

Recently published data from a phase III randomized trial (JCOG0505) suggested that carboplatin/paclitaxel was non-inferior to cisplatin/paclitaxel in 253 women with metastatic or recurrent cervical cancer.²³⁹ Many physicians use carboplatin/paclitaxel because of ease of administration and tolerability.²⁴⁰ Results from JCOG0505 showed that the carboplatin/paclitaxel (TC) regimen was non-inferior to cisplatin/paclitaxel (TP) in terms of median overall survival (18.3 months for TP vs. 17.5 months for TC; HR = 0.994 (90% CI, 0.79–1.25); $P = .032$) and non-hospitalization periods were significantly longer for patients receiving TC.²³⁹ However, among patients who had not received prior cisplatin, OS for TC and TP was 13.0 and 23.2 months, respectively (HR = 1.571; 95% CI, 1.06–2.32).²³⁹ Based on these data, the panel recommends carboplatin/paclitaxel as a preferred category 1 option for patients who have received prior cisplatin therapy (category 2A for other indications).

A recent systematic review of the data on cisplatin/paclitaxel and carboplatin/paclitaxel regimens also suggested that lower toxicity

carboplatin-based regimens appear to be an equally effective alternative to cisplatin-containing regimens for treating recurrent or metastatic cervical cancer.²⁴¹ Based on the collective findings from GOG 240 and JGOG0505, the panel has opted to include carboplatin/paclitaxel/bevacizumab as an additional preferred regimen for recurrent or metastatic cervical cancer (category 2A). Based on the previous studies, cisplatin/paclitaxel and carboplatin/paclitaxel have become the most widely used systemic regimens for metastatic or recurrent cervical cancer. However, for patients who may not be candidates for taxanes, cisplatin/topotecan remains a reasonable alternative regimen.²³⁰ In 2019, the panel voted to remove cisplatin/gemcitabine as a first-line combination therapy option. Non-platinum regimens are also being studied and may be considered in patients who cannot tolerate platinum-based chemotherapy.²⁴²

Single Agents

Cisplatin is generally regarded as the most active agent and is recommended as the preferred first-line single-agent chemotherapy option for recurrent or metastatic cervical cancer; reported response rates are approximately 20% to 30%, with an occasional complete response.^{229,231,243,244} Overall survival with cisplatin is approximately 6 to 9 months. Both carboplatin and paclitaxel have each been reported to be tolerable and efficacious and are also possible first-line single-agent chemotherapy options.²⁴⁵⁻²⁴⁸ Therefore, palliation with single agents—cisplatin, carboplatin, or paclitaxel—is a reasonable approach in patients with recurrent disease not amenable to surgical or radiotherapeutic approaches.

Pembrolizumab has been added as a preferred regimen for second-line option for treating PD-L1–positive or MSI-H/dMMR cervical tumors (category 2A).²⁴⁹⁻²⁵¹ Other recommended agents (all category 2B) that have shown responses or prolongation of PFS and may be useful as second-line therapy include bevacizumab,²⁵² albumin-bound paclitaxel (ie,

nab-paclitaxel),²⁵³ docetaxel,²⁵⁴ fluorouracil,²⁵⁵ gemcitabine,²⁵⁶ ifosfamide,^{257,258} irinotecan,²⁵⁹ mitomycin,²⁶⁰ pemetrexed,²⁶¹ topotecan,^{262,263} and vinorelbine.²⁶⁴

Other Agents

Targeted therapies and biologics have an established role for selected cases of cervical cancer. Pembrolizumab and bevacizumab have been included in the guidelines for treating recurrent or metastatic disease. Use of these and other targeted or biologic agents remain an active area of investigation.

Drug Reactions

Virtually all drugs have the potential to cause adverse reactions, either during or after infusion.²⁶⁵ In cervical cancer treatment, drugs that more commonly cause adverse reactions include carboplatin, cisplatin, docetaxel, liposomal doxorubicin, and paclitaxel. Most of these drug reactions are mild infusion reactions (ie, skin reactions, cardiovascular reactions, respiratory or throat tightness), but more severe allergic reactions (ie, life-threatening anaphylaxis) can occur.^{266,267} In addition, patients can have severe infusion reactions and mild allergic reactions. Infusion reactions are more common with paclitaxel.²⁶⁸ Allergic reactions (ie, true drug allergies) are more common with platinum agents (eg, cisplatin).^{268,269}

Management of drug reactions is discussed in the NCCN Guidelines for [Ovarian Cancer](#).²⁶⁸ Importantly, patients who experienced severe life-threatening reactions should not receive the implicated agent again unless evaluated by an allergist or specialist in drug desensitization. If a mild allergic reaction previously occurred and it is appropriate to re-administer the drug, a desensitization regimen is recommended even if the symptoms have resolved. Various desensitization regimens have been published and should be followed.²⁶⁹⁻²⁷¹ Patients must be desensitized with

each infusion if they have had a previous reaction. Almost all patients can be desensitized.²⁶⁵ To maximize safety, patients should be desensitized in the intensive care unit.²⁶⁵

Best Supportive Care

Patients with refractory systemic cancer warrant a comprehensive coordinated approach involving hospice care, pain consultants, and emotional and spiritual support, individualized to the situation (see the NCCN Guidelines for [Palliative Care](#)).

Incidental Cervical Cancer

Invasive cervical carcinoma is sometimes found incidentally after extrafascial hysterectomy. Workup for these patients includes history and physical examination, CBC (including platelets), and liver and renal function tests. Recommended radiologic imaging includes chest radiography, CT, or combined PET/CT; MRI may be performed if indicated to rule out gross residual disease. However, imaging is optional for patients with stage IB1 or smaller tumors.

No definitive data are available to guide the appropriate adjuvant treatment of these patients. Surveillance is recommended for patients with stage IA1 cervical cancer who do not have LVSI. For patients with either stage IA1 with LVSI, stage IA2/IB disease, or positive margins/gross residual disease, the panel believes that a reasonable treatment schema should be based on the status of the surgical margins. If margins are positive and imaging is negative for nodal disease, then pelvic RT with concurrent platinum-containing chemotherapy with (or without) individualized brachytherapy is recommended. Recommended radiosensitizing regimens include cisplatin (preferred), carboplatin (preferred if patient is cisplatin-intolerant), or cisplatin/fluorouracil.

If margins or imaging is negative in stage IA2 or greater tumors, options include: 1) pelvic RT with brachytherapy, with (or without) concurrent platinum-containing chemotherapy; or 2) if Sedlis Criteria are not met on the hysterectomy specimen, consideration of complete parametrectomy, upper vaginectomy, and pelvic lymph node dissection with (or without) para-aortic lymph node sampling (category 2B for para-aortic lymph node sampling). Typically, observation is recommended for patients with negative lymph nodes and no residual disease. However, chemoradiation with (or without) vaginal brachytherapy is recommended for subsequent findings of positive nodes, surgical margins, and/or parametrium.

For hysterectomy specimens with positive margins, gross residual disease, positive imaging, or primary tumor characteristics meeting Sedlis Criteria, pelvic EBRT with concurrent platinum-containing chemotherapy (with individualized brachytherapy for positive vaginal margins) is recommended.³¹

Radiation Therapy

RT is often used in the management of patients with cervical cancer either 1) as definitive therapy for those with locally advanced disease or for those who are poor surgical candidates; or 2) as adjuvant therapy following radical hysterectomy for those who have one or more pathologic risk factors (eg, positive lymph nodes, parametrial infiltration, positive surgical margins, large tumor size, deep stromal invasion, LVSI).

The algorithm provides general RT dosage recommendations, which should not be interpreted as stand-alone recommendations because RT techniques and clinical judgment are an essential part of developing an appropriate treatment regimen.

Optimum staging of disease to precisely delineate the primary tumor volume and draining lymph nodes, including abdominopelvic radiologic studies (CT, MRI, or combined PET/CT scans), is recommended in

patients with stage IB2, IIA2, or advanced-stage tumors. Contemporary imaging studies must be correlated with careful assessment of clinical findings to define tumor extent, especially with regard to vaginal or parametrial extension.

Radiation Treatment Planning

Technologic advances in imaging, computer treatment planning systems, and linear accelerator technology have enabled the more precise delivery of radiation doses to the pelvis. However, physical accuracy of dose delivery must be matched to a clear understanding of tumor extent, potential pathways of spread, and historical patterns of locoregional recurrence to avoid geographic misses.

CT-based treatment planning with conformal blocking and dosimetry is considered standard care for EBRT. Brachytherapy is a critical component of definitive therapy in patients with cervical cancer who are not candidates for surgery (ie, those with an intact cervix); it may also be used as adjuvant therapy. Brachytherapy is typically combined with EBRT in an integrated treatment plan. MRI imaging immediately preceding brachytherapy may be helpful in delineating residual tumor geometry. Stereotactic body radiotherapy (SBRT) allows delivery of very high doses of focused external beam radiation and may be applied to isolated metastatic sites.^{272,273}

Routine image guidance, such as cone-beam CT (CBCT), may be helpful in defining daily internal soft tissue positioning. Concepts regarding the gross target volume (GTV), clinical target volume (CTV), planning target volume (PTV), organs at risk (OARs) and dose-volume histogram (DVH) have been defined for use in conformal radiotherapy, especially for IMRT.²⁷⁴⁻²⁷⁶

Point A, representing a paracervical reference point, has been the most widely used, validated, and reproducible dosing parameter used to date.

However, limitations of the Point A dosing system include the fact that it does not take into account the three-dimensional shape of tumors, nor individual tumor to normal tissue structure correlations. There are increasing efforts to use and standardize image-based volumetric brachytherapy approaches using MR, CT or ultrasound – international validation efforts are underway (EMBRACE, NCT00920920).²⁷⁷⁻²⁸⁰

For patients with locally advanced cancers, initial radiation treatment of 40 to 45 Gy to the whole pelvis is often necessary to obtain tumor shrinkage to permit optimal intracavitary placements. With low dose-rate intracavitary systems, total doses from brachytherapy and external-beam radiation to point A of at least 80 Gy are currently recommended for small tumors, with doses of 85 Gy or higher recommended for larger tumors (http://www.americanbrachytherapy.org/guidelines/cervical_cancer_taskgroup.pdf).¹²⁰

For lesions in the lower one third of the vagina, the inguinal lymph nodes must be treated. The use of extended-field radiation to treat occult or macroscopic para-aortic lymph node disease must be carefully planned to ensure an adequate dose (45 Gy for microscopic disease) without exceeding bowel, spinal cord, or renal tolerances.²⁸¹ General recommendations for radiation volumes and doses are discussed in the algorithm.

Intensity-modulated RT (IMRT) is becoming more widely available; however, issues regarding target definition, patient and target immobilization, tissue deformation, toxicity, and reproducibility remain to be validated.²⁸²⁻²⁸⁹ Initial phase II hematologic toxicity data from RTOG 418 suggested that limiting the volume of bone marrow treated with IMRT was an important consideration for patients with cervical cancer who were receiving concurrent chemotherapy.²⁹⁰ The recently reported TIME-C trial (RTOG 1203, NCT01672892) compared post-hysterectomy patients receiving adjuvant IMRT or standard four-field RT to determine whether

IMRT reduced acute toxicity. Among the 278 patients with cervical and endometrial cancer included in the analysis, pelvic IMRT was associated with significantly lower scores for gastrointestinal and urinary toxicity than standard RT.²⁹¹

Several retrospective analyses suggest that prolonged RT treatment duration has an adverse effect on outcome.²⁹²⁻²⁹⁶ Extending the overall treatment beyond 6 to 8 weeks can result in approximately a 0.5% to 1% decrease in pelvic control and cause specific survival for each extra day of overall treatment time. Thus, although no prospective randomized trials have been performed, it is generally accepted that the entire RT course (including both EBRT and brachytherapy components) should be completed in a timely fashion (within 8 weeks); delays or splits in the radiation treatment should be avoided whenever possible.

Normal Tissue Considerations

Planning for RT in cervical cancer must take into account the potential impact on surrounding critical structures, such as rectum, bladder, sigmoid, small bowel, and bone. Acute effects (ie, diarrhea, bladder irritation, fatigue) occur to some degree in most patients undergoing radiation and are typically magnified by concurrent chemotherapy. However, acute effects can often be managed with medications and supportive care, and they generally resolve soon after completion of radiation. To avoid treatment-related menopause, ovarian transposition can be considered before pelvic RT in select young patients (<45 years with early-stage disease).¹²⁵⁻¹²⁷

After therapy for cervical cancer, late side effects may include potential injury to bladder, rectum, bowel, and pelvic skeletal structures.²⁹⁷ The risk of major complications (eg, obstruction, fibrosis/necrosis, and fistula) is related to the volume, total dose, dose per fraction, and specific intrinsic radiosensitivity of the normal tissue that is irradiated.^{281,298,299} Careful

blocking in order to minimize normal tissue exposure while maintaining tumor coverage is critical for optimal outcomes. In addition, patient-related conditions (ie, inflammatory bowel disease, collagen-vascular disease, multiple abdominal/pelvic surgeries, history of pelvic inflammatory disease, diabetes) influence determination of radiation dose and volumes.

For most patients, it is generally accepted that the whole pelvis can tolerate an external-beam radiation dose of 40 to 50 Gy. Gross disease in the parametria or unresected nodes may be treated with tightly contoured external-beam boosts to 60 to 65 Gy. Intracavitary brachytherapy boosts require attention to proper placement of the applicators within the uterus and against the cervix and vaginal apex, as well as appropriate packing to maximally displace the bladder and rectum. SBRT is not considered an appropriate routine alternative to brachytherapy.

Cervical Cancer and Pregnancy

Cervical cancer is the most frequently diagnosed gynecologic malignancy in pregnant women; however, most women have stage I disease.³⁰⁰⁻³⁰³ Invasive cervical cancer during pregnancy creates a clinical dilemma and requires multidisciplinary care.^{300,304} Women must make the difficult decision either to delay treatment until documented fetal maturity or to undergo immediate treatment based on their stage of disease.^{301,304} Women who delay treatment until fetal maturity should have their children delivered by cesarean section.^{303,305,306} Radical trachelectomy with preservation of pregnancy has been successfully performed in a few pregnant patients with early-stage cervical cancer.^{53,307-309}

Patients with early-stage disease may prefer to have radical hysterectomy and node dissection instead of RT to avoid radiation fibrosis and to preserve their ovaries. Patients with stage I disease who delay treatment until fetal maturity can undergo cesarean section with concurrent radical hysterectomy and pelvic node dissection. For those choosing RT,

traditional RT with (or without) chemotherapy protocols (described previously) may need to be modified.³⁰³

Summary

Cervical cancer is decreasing in the United States because of the wide use of screening; however, it is increasing in developing countries (~275,000 deaths/year), because screening is not available to many women. Effective treatment for cervical cancer (including surgery and concurrent chemoradiation) can yield cures in 80% of women with

early-stage disease (stages I–II) and in 60% of women with stage III disease. The hope is that immunization against HPV (using vaccines) will prevent persistent infection with the types of HPV against which the vaccine is designed, and will therefore prevent specific HPV cancer in women.^{15,16,310}

Discussion
update in
progress

**Table 1:****Estimates of the Relative Risk of Death in Five Clinical Trials of Concurrent Chemotherapy and Radiotherapy**

Study*	FIGO Stage	Control Group	Comparison Group	Relative Risk of Death in Comparison Group
Keys et al.†	IB2	Radiotherapy	Radiotherapy plus weekly cisplatin	0.54
Rose, Bundy, Watkins et al.†	IIB-IVA	Radiotherapy plus hydroxyurea	Radiotherapy plus weekly cisplatin	0.61
			Radiotherapy plus cisplatin, fluorouracil, and hydroxyurea	0.58
Morris et al.†	IB2-IVA	Extended-field radiotherapy	Radiotherapy plus cisplatin and fluorouracil	0.52
Whitney et al.	IIB-IVA	Radiotherapy plus hydroxyurea	Radiotherapy plus cisplatin and fluorouracil	0.72
Peters et al.	IB or IIA (selected postoperatively)	Radiotherapy	Radiotherapy plus cisplatin and fluorouracil	0.50

Abbreviation: FIGO, International Federation of Gynecology and Obstetrics.

*See Discussion for all references.

†These studies have been updated (see Discussion).

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References

1. Siegel RL, Miller KD, Jemal A. Cancer statistics, 2019. *CA Cancer J Clin* 2019;69:7-34. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30620402>.
2. Barnholtz-Sloan J, Patel N, Rollison D, et al. Incidence trends of invasive cervical cancer in the United States by combined race and ethnicity. *Cancer Causes Control* 2009;20:1129-1138. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19253025>.
3. Wang SS, Carreon JD, Gomez SL, Devesa SS. Cervical cancer incidence among 6 asian ethnic groups in the United States, 1996 through 2004. *Cancer* 2010;116:949-956. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20029972>.
4. Howe HL, Wu X, Ries LAG, et al. Annual report to the nation on the status of cancer, 1975-2003, featuring cancer among U.S. Hispanic/Latino populations. *Cancer* 2006;107:1711-1742. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16958083>.
5. Sherman ME, Wang SS, Carreon J, Devesa SS. Mortality trends for cervical squamous and adenocarcinoma in the United States. Relation to incidence and survival. *Cancer* 2005;103:1258-1264. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15693030>.
6. Cervical Cancer: Estimated Incidence, Mortality and Prevalence Worldwide in 2012. International Agency for Research on Cancer and World Health Organization; 2012. Available at: http://globocan.iarc.fr/Pages/fact_sheets_cancer.aspx. Accessed January 26, 2015.
7. Parkin DM, Bray F, Ferlay J, Pisani P. Global cancer statistics, 2002. *CA Cancer J Clin* 2005;55:74-7108. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15761078>.
8. Kamangar F, Dores GM, Anderson WF. Patterns of cancer incidence, mortality, and prevalence across five continents: defining priorities to reduce cancer disparities in different geographic regions of the world. *J Clin Oncol* 2006;24:2137-2150. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16682732>.
9. Jemal A, Bray F, Center MM, et al. Global cancer statistics. *CA Cancer J Clin* 2011;61:69-90. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21296855>.
10. Kjaer SK, Frederiksen K, Munk C, Iftner T. Long-term absolute risk of cervical intraepithelial neoplasia grade 3 or worse following human papillomavirus infection: role of persistence. *J Natl Cancer Inst* 2010;102:1478-1488. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20841605>.
11. Rodriguez AC, Schiffman M, Herrero R, et al. Longitudinal study of human papillomavirus persistence and cervical intraepithelial neoplasia grade 2/3: critical role of duration of infection. *J Natl Cancer Inst* 2010;102:315-324. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20157096>.
12. Villa LL, Costa RL, Petta CA, et al. Prophylactic quadrivalent human papillomavirus (types 6, 11, 16, and 18) L1 virus-like particle vaccine in young women: a randomised double-blind placebo-controlled multicentre phase II efficacy trial. *Lancet Oncol* 2005;6:271-278. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15863374>.
13. Ault KA. Effect of prophylactic human papillomavirus L1 virus-like-particle vaccine on risk of cervical intraepithelial neoplasia grade 2, grade 3, and adenocarcinoma in situ: a combined analysis of four randomised clinical trials. *Lancet* 2007;369:1861-1868. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17544766>.
14. Quadrivalent vaccine against human papillomavirus to prevent high-grade cervical lesions. *N Engl J Med* 2007;356:1915-1927. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17494925>.
15. Arbyn M, Dillner J. Review of current knowledge on HPV vaccination: an appendix to the European Guidelines for Quality Assurance in Cervical Cancer Screening. *J Clin Virol* 2007;38:189-197. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17258503>.

16. Rambout L, Hopkins L, Hutton B, Fergusson D. Prophylactic vaccination against human papillomavirus infection and disease in women: a systematic review of randomized controlled trials. *CMAJ* 2007;177:469-479. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17671238>.
17. Comparison of risk factors for invasive squamous cell carcinoma and adenocarcinoma of the cervix: collaborative reanalysis of individual data on 8,097 women with squamous cell carcinoma and 1,374 women with adenocarcinoma from 12 epidemiological studies. *Int J Cancer* 2007;120:885-891. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17131323>.
18. Dugue PA, Rebolj M, Garred P, Lynge E. Immunosuppression and risk of cervical cancer. *Expert Rev Anticancer Ther* 2013;13:29-42. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23259425>.
19. Bray F, Loos AH, McCarron P, et al. Trends in cervical squamous cell carcinoma incidence in 13 European countries: changing risk and the effects of screening. *Cancer Epidemiol Biomarkers Prev* 2005;14:677-686. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15767349>.
20. Watson M, Saraiya M, Benard V, et al. Burden of cervical cancer in the United States, 1998-2003. *Cancer* 2008;113:2855-2864. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18980204>.
21. Bray F, Carstensen B, Moller H, et al. Incidence trends of adenocarcinoma of the cervix in 13 European countries. *Cancer Epidemiol Biomarkers Prev* 2005;14:2191-2199. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16172231>.
22. Wang SS, Sherman ME, Hildesheim A, et al. Cervical adenocarcinoma and squamous cell carcinoma incidence trends among white women and black women in the United States for 1976-2000. *Cancer* 2004;100:1035-1044. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14983500>.
23. Castellsague X, Diaz M, de Sanjose S, et al. Worldwide human papillomavirus etiology of cervical adenocarcinoma and its cofactors: implications for screening and prevention. *J Natl Cancer Inst* 2006;98:303-315. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16507827>.
24. Sasieni P, Castanon A, Cuzick J. Screening and adenocarcinoma of the cervix. *Int J Cancer* 2009;125:525-529. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19449379>.
25. Dahlstrom LA, Ylitalo N, Sundstrom K, et al. Prospective study of human papillomavirus and risk of cervical adenocarcinoma. *Int J Cancer* 2010;127:1923-1930. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20473898>.
26. Siegel CL, Andreotti RF, Cardenas HR, et al. ACR Appropriateness Criteria(R) pretreatment planning of invasive cancer of the cervix. *J Am Coll Radiol* 2012;9:395-402. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22632665>.
27. Patel S, Liyanage SH, Sahdev A, et al. Imaging of endometrial and cervical cancer. *Insights Imaging* 2010;1:309-328. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22347925>.
28. Bhatla N, Berek JS, Cuello Fredes M, et al. Revised FIGO staging for carcinoma of the cervix uteri. *Int J Gynaecol Obstet* 2019;145:129-135. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30656645>.
29. Pecorelli S. Revised FIGO staging for carcinoma of the vulva, cervix, and endometrium. *Int J Gynaecol Obstet* 2009;105:103-104. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19367689>.
30. Pecorelli S, Zigliani L, Odicino F. Revised FIGO staging for carcinoma of the cervix. *Int J Gynaecol Obstet* 2009;105:107-108. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19342051>.
31. Sedlis A, Bundy BN, Rotman MZ, et al. A randomized trial of pelvic radiation therapy versus no further therapy in selected patients with stage IB carcinoma of the cervix after radical hysterectomy and pelvic lymphadenectomy: A Gynecologic Oncology Group Study. *Gynecol Oncol* 1999;73:177-183. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10329031>.
32. Ryu SY, Kim MH, Nam BH, et al. Intermediate-risk grouping of cervical cancer patients treated with radical hysterectomy: a Korean Gynecologic

Oncology Group study. Br J Cancer 2014;110:278-285. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24357798>.

33. Noh JM, Park W, Kim YS, et al. Comparison of clinical outcomes of adenocarcinoma and adenosquamous carcinoma in uterine cervical cancer patients receiving surgical resection followed by radiotherapy: a multicenter retrospective study (KROG 13-10). Gynecol Oncol 2014;132:618-623. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24486605>.

34. Diaz ES, Aoyama C, Baquing MA, et al. Predictors of residual carcinoma or carcinoma-in-situ at hysterectomy following cervical conization with positive margins. Gynecol Oncol 2014;132:76-80. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24262876>.

35. Estape RE, Angioli R, Madrigal M, et al. Close vaginal margins as a prognostic factor after radical hysterectomy. Gynecol Oncol 1998;68:229-232. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/9570971>.

36. Parra-Herran C, Taljaard M, Djordjevic B, et al. Pattern-based classification of invasive endocervical adenocarcinoma, depth of invasion measurement and distinction from adenocarcinoma in situ: interobserver variation among gynecologic pathologists. Mod Pathol 2016;29:879-892. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27174588>.

37. Roma AA, Mistretta TA, Diaz De Vivar A, et al. New pattern-based personalized risk stratification system for endocervical adenocarcinoma with important clinical implications and surgical outcome. Gynecol Oncol 2016;141:36-42. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27016227>.

38. Rutgers JK, Roma AA, Park KJ, et al. Pattern classification of endocervical adenocarcinoma: reproducibility and review of criteria. Mod Pathol 2016;29:1083-1094. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27255163>.

39. Bentivegna E, Gouy S, Maulard A, et al. Oncological outcomes after fertility-sparing surgery for cervical cancer: a systematic review. Lancet

Oncol 2016;17:e240-253. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27299280>.

40. Ueki M, Okamoto Y, Misaki O, et al. Conservative therapy for microinvasive carcinoma of the uterine cervix. Gynecol Oncol 1994;53:109-113. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8175008>.

41. Al-Kalbani M, McVeigh G, Nagar H, McCluggage WG. Do FIGO stage IA and small ($\leq 2\text{ cm}$) IB1 cervical adenocarcinomas have a good prognosis and warrant less radical surgery? Int J Gynecol Cancer 2012;22:291-295. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22080884>.

42. Webb JC, Key CR, Qualls CR, Smith HO. Population-based study of microinvasive adenocarcinoma of the uterine cervix. Obstet Gynecol 2001;97:701-706. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11339919>.

43. Sevin BU, Nadji M, Averette HE, et al. Microinvasive carcinoma of the cervix. Cancer 1992;70:2121-2128. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/1394041>.

44. Huang LW, Hwang JL. A comparison between loop electrosurgical excision procedure and cold knife conization for treatment of cervical dysplasia: residual disease in a subsequent hysterectomy specimen. Gynecol Oncol 1999;73:12-15. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10094873>.

45. Miroshnichenko GG, Parva M, Holtz DO, et al. Interpretability of excisional biopsies of the cervix: cone biopsy and loop excision. J Low Genit Tract Dis 2009;13:10-12. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19098600>.

46. Greenspan DL, Faubion M, Coonrod DV, et al. Compliance after loop electrosurgical excision procedure or cold knife cone biopsy. Obstet Gynecol 2007;110:675-680. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17766617>.

47. Fanning J, Padratz J. Cold knife conization vs. LEEP. Are they the same procedure? *J Reprod Med* 2002;47:33-35. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11838307>.
48. Simmons JR, Anderson L, Hernandez E, Heller PB. Evaluating cervical neoplasia. LEEP as an alternative to cold knife conization. *J Reprod Med* 1998;43:1007-1013. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/9883402>.
49. Kim MK, Kim MA, Kim JW, et al. Loop electrosurgical excision procedure findings for identification of patients with early-stage cervical cancer suitable for less radical surgery. *Int J Gynecol Cancer* 2012;22:1214-1219. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22801033>.
50. Bouchard-Fortier G, Reade CJ, Covens A. Non-radical surgery for small early-stage cervical cancer. Is it time? *Gynecol Oncol* 2014;132:624-627. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24480237>.
51. Kato T, Takashima A, Kasamatsu T, et al. Clinical tumor diameter and prognosis of patients with FIGO stage IB1 cervical cancer (JCOG0806-A). *Gynecol Oncol* 2015;137:34-39. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25662625>.
52. Diaz JP, Sonoda Y, Leitao MM, et al. Oncologic outcome of fertility-sparing radical trachelectomy versus radical hysterectomy for stage IB1 cervical carcinoma. *Gynecol Oncol* 2008;111:255-260. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18755500>.
53. Abu-Rustum NR, Tal MN, DeLair D, et al. Radical abdominal trachelectomy for stage IB1 cervical cancer at 15-week gestation. *Gynecol Oncol* 2010;116:151-152. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19878979>.
54. Ramirez PT, Pareja R, Rendon GJ, et al. Management of low-risk early-stage cervical cancer: should conization, simple trachelectomy, or simple hysterectomy replace radical surgery as the new standard of care? *Gynecol Oncol* 2014;132:254-259. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24041877>.
55. Dargent D, Martin X, Sacchetoni A, Mathevet P. Laparoscopic vaginal radical trachelectomy: a treatment to preserve the fertility of cervical carcinoma patients. *Cancer* 2000;88:1877-1882. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10760765>.
56. Viswanathan AN, Deavers MT, Jhingran A, et al. Small cell neuroendocrine carcinoma of the cervix: outcome and patterns of recurrence. *Gynecol Oncol* 2004;93:27-33. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15047210>.
57. Young RH, Clement PB. Endocervical adenocarcinoma and its variants: their morphology and differential diagnosis. *Histopathology* 2002;41:185-207. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12207781>.
58. Cao DY, Yang JX, Wu XH, et al. Comparisons of vaginal and abdominal radical trachelectomy for early-stage cervical cancer: preliminary results of a multi-center research in China. *Br J Cancer* 2013;109:2778-2782. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24169350>.
59. Plante M, Gregoire J, Renaud MC, Roy M. The vaginal radical trachelectomy: an update of a series of 125 cases and 106 pregnancies. *Gynecol Oncol* 2011;121:290-297. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21255824>.
60. Abu-Rustum NR, Sonoda Y, Black D, et al. Fertility-sparing radical abdominal trachelectomy for cervical carcinoma: technique and review of the literature. *Gynecol Oncol* 2006;103:807-813. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16837027>.
61. Einstein MH, Park KJ, Sonoda Y, et al. Radical vaginal versus abdominal trachelectomy for stage IB1 cervical cancer: a comparison of surgical and pathologic outcomes. *Gynecol Oncol* 2009;112:73-77. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18973933>.
62. Wethington SL, Cibula D, Duska LR, et al. An international series on abdominal radical trachelectomy: 101 patients and 28 pregnancies. *Int J*

Gynecol Cancer 2012;22:1251-1257. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22914213>.

63. Abu-Rustum NR, Sonoda Y. Fertility-sparing surgery in early-stage cervical cancer: indications and applications. J Natl Compr Canc Netw 2010;8:1435-1438. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/21147906>.

64. Beiner ME, Covens A. Surgery insight: radical vaginal trachelectomy as a method of fertility preservation for cervical cancer. Nat Clin Pract Oncol 2007;4:353-361. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/17534391>.

65. Pareja R, Rendon GJ, Sanz-Lomana CM, et al. Surgical, oncological, and obstetrical outcomes after abdominal radical trachelectomy - a systematic literature review. Gynecol Oncol 2013;131:77-82. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/23769758>.

66. Lintner B, Saso S, Tarnai L, et al. Use of abdominal radical trachelectomy to treat cervical cancer greater than 2 cm in diameter. Int J Gynecol Cancer 2013;23:1065-1070. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/23722476>.

67. Wethington SL, Sonoda Y, Park KJ, et al. Expanding the indications for radical trachelectomy: a report on 29 patients with stage IB1 tumors measuring 2 to 4 centimeters. Int J Gynecol Cancer 2013;23:1092-1098. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23714706>.

68. Lanowska M, Mangler M, Speiser D, et al. Radical vaginal trachelectomy after laparoscopic staging and neoadjuvant chemotherapy in women with early-stage cervical cancer over 2 cm: oncologic, fertility, and neonatal outcome in a series of 20 patients. Int J Gynecol Cancer 2014;24:586-593. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24469326>.

69. Shepherd JH, Spencer C, Herod J, Ind TEJ. Radical vaginal trachelectomy as a fertility-sparing procedure in women with early-stage cervical cancer-cumulative pregnancy rate in a series of 123 women.

BJOG 2006;113:719-724. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/16709216>.

70. Park JY, Kim DY, Suh DS, et al. Reproductive outcomes after laparoscopic radical trachelectomy for early-stage cervical cancer. J Gynecol Oncol 2014;25:9-13. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24459575>.

71. Gizzo S, Ancona E, Saccardi C, et al. Radical trachelectomy: the first step of fertility preservation in young women with cervical cancer (Review). Oncol Rep 2013;30:2545-2554. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24065029>.

72. Cibula D, Abu-Rustum NR, Benedetti-Panici P, et al. New classification system of radical hysterectomy: emphasis on a three-dimensional anatomic template for parametrial resection. Gynecol Oncol 2011;122:264-268. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/21592548>.

73. Querleu D, Morrow CP. Classification of radical hysterectomy. Lancet Oncol 2008;9:297-303. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/18308255>.

74. Piver MS, Rutledge F, Smith JP. Five classes of extended hysterectomy for women with cervical cancer. Obstet Gynecol 1974;44:265-272. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/4417035>.

75. Chi DS, Abu-Rustum NR, Plante M, Roy M. Cancer of the cervix. In: Rock JA, Jones HW, eds, eds. TeLinde's Operative Gynecology, 10th ed. Philadelphia: Lippincott Williams and Wilkins; 2008:1227.

76. Whitney CW, Spirtos NM. Gynecologic Oncology Group Surgical Procedures Manual. Philadelphia: Gynecologic Oncology Group; 2009. Available at: <https://gogmember.gog.org/manuals/pdf/surgman.pdf>. Accessed April 18, 2014.

77. Sardain H, Lavoue V, Redpath M, et al. Curative pelvic exenteration for recurrent cervical carcinoma in the era of concurrent chemotherapy

and radiation therapy. A systematic review. *Eur J Surg Oncol* 2015;41:975-985. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/25922209>.

78. Chiantera V, Rossi M, De Iaco P, et al. Morbidity after pelvic exenteration for gynecological malignancies: a retrospective multicentric study of 230 patients. *Int J Gynecol Cancer* 2014;24:156-164. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24362721>.

79. Cormier B, Diaz JP, Shih K, et al. Establishing a sentinel lymph node mapping algorithm for the treatment of early cervical cancer. *Gynecol Oncol* 2011;122:275-280. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/21570713>.

80. Lecuru F, Mathevet P, Querleu D, et al. Bilateral negative sentinel nodes accurately predict absence of lymph node metastasis in early cervical cancer: results of the SENTICOL study. *J Clin Oncol* 2011;29:1686-1691. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/21444878>.

81. Altgassen C, Hertel H, Brandstadt A, et al. Multicenter validation study of the sentinel lymph node concept in cervical cancer: AGO Study Group. *J Clin Oncol* 2008;26:2943-2951. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/18565880>.

82. Bats AS, Buenerd A, Querleu D, et al. Diagnostic value of intraoperative examination of sentinel lymph node in early cervical cancer: a prospective, multicenter study. *Gynecol Oncol* 2011;123:230-235. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21893335>.

83. Bats AS, Mathevet P, Buenerd A, et al. The sentinel node technique detects unexpected drainage pathways and allows nodal ultrastaging in early cervical cancer: insights from the multicenter prospective SENTICOL study. *Ann Surg Oncol* 2013;20:413-422. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22911367>.

84. Cibula D, Abu-Rustum NR, Dusek L, et al. Bilateral ultrastaging of sentinel lymph node in cervical cancer: Lowering the false-negative rate and improving the detection of micrometastasis. *Gynecol Oncol*

2012;127:462-466. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22943880>.

85. Cibula D, Abu-Rustum NR, Dusek L, et al. Prognostic significance of low volume sentinel lymph node disease in early-stage cervical cancer. *Gynecol Oncol* 2012;124:496-501. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/22120175>.

86. Fader AN, Edwards RP, Cost M, et al. Sentinel lymph node biopsy in early-stage cervical cancer: utility of intraoperative versus postoperative assessment. *Gynecol Oncol* 2008;111:13-17. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/18684499>.

87. Lecuru F, Bats A, Mathevet P, et al. Impact of sentinel lymph node biopsy on staging of early cervical cancer: Results of a prospective, multicenter study [abstract]. *J Clin Oncol* 2009;27(Suppl 18):Abstract CRA5506. Available at:
<http://meeting.ascopubs.org/cgi/content/abstract/27/18S/CRA5506>.

88. Slama J, Dunder P, Dusek L, Cibula D. High false negative rate of frozen section examination of sentinel lymph nodes in patients with cervical cancer. *Gynecol Oncol* 2013;129:384-388. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/23395889>.

89. van de Lande J, Torrenza B, Raijmakers PGHM, et al. Sentinel lymph node detection in early stage uterine cervix carcinoma: a systematic review. *Gynecol Oncol* 2007;106:604-613. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/17628644>.

90. Andikyan V, Khoury-Collado F, Denesopolis J, et al. Cervical conization and sentinel lymph node mapping in the treatment of stage I cervical cancer: is less enough? *Int J Gynecol Cancer* 2014;24:113-117. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24335661>.

91. Wu Y, Li Z, Wu H, Yu J. Sentinel lymph node biopsy in cervical cancer: A meta-analysis. *Mol Clin Oncol* 2013;1:1025-1030. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24649288>.

92. Kadkhodayan S, Hasanzadeh M, Treglia G, et al. Sentinel node biopsy for lymph nodal staging of uterine cervix cancer: a systematic review and meta-analysis of the pertinent literature. *Eur J Surg Oncol* 2015;41:1-20. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25454828>.
93. Ruscito I, Gasparri ML, Braicu EI, et al. Sentinel Node Mapping in Cervical and Endometrial Cancer: Indocyanine Green Versus Other Conventional Dyes-A Meta-Analysis. *Ann Surg Oncol* 2016;23:3749-3756. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27160526>.
94. Frumovitz M, Plante M, Lee PS, et al. The FILM Trial: A randomized phase III multicenter study assessing near infrared fluorescence in the identification of sentinel lymph nodes (SLN) [Abstract]. *Gynecologic Oncology* 2018;149:7. Available at: <https://doi.org/10.1016/j.ygyno.2018.04.023>.
95. Eiriksson LR, Covens A. Sentinel lymph node mapping in cervical cancer: the future? *BJOG* 2012;119:129-133. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21917113>.
96. Bats AS, Frati A, Mathevet P, et al. Contribution of lymphoscintigraphy to intraoperative sentinel lymph node detection in early cervical cancer: Analysis of the prospective multicenter SENTICOL cohort. *Gynecol Oncol* 2015;137:264-269. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25727652>.
97. Darlin L, Persson J, Bossmar T, et al. The sentinel node concept in early cervical cancer performs well in tumors smaller than 2 cm. *Gynecol Oncol* 2010;117:266-269. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20167355>.
98. Sakuragi N, Satoh C, Takeda N, et al. Incidence and distribution pattern of pelvic and paraaortic lymph node metastasis in patients with Stages IB, IIA, and IIB cervical carcinoma treated with radical hysterectomy. *Cancer* 1999;85:1547-1554. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10193945>.
99. Huang H, Liu J, Li Y, et al. Metastasis to deep obturator and para-aortic lymph nodes in 649 patients with cervical carcinoma. *Eur J Surg Oncol* 2011;37:978-983. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21907530>.
100. Gold MA, Tian C, Whitney CW, et al. Surgical versus radiographic determination of para-aortic lymph node metastases before chemoradiation for locally advanced cervical carcinoma: a Gynecologic Oncology Group Study. *Cancer* 2008;112:1954-1963. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18338811>.
101. Gouy S, Morice P, Narducci F, et al. Prospective multicenter study evaluating the survival of patients with locally advanced cervical cancer undergoing laparoscopic para-aortic lymphadenectomy before chemoradiotherapy in the era of positron emission tomography imaging. *J Clin Oncol* 2013;31:3026-3033. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23857967>.
102. Frumovitz M, Querleu D, Gil-Moreno A, et al. Lymphadenectomy in locally advanced cervical cancer study (LiLACS): Phase III clinical trial comparing surgical with radiologic staging in patients with stages IB2-IVA cervical cancer. *J Minim Invasive Gynecol* 2014;21:3-8. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23911560>.
103. Chen Y, Xu H, Li Y, et al. The outcome of laparoscopic radical hysterectomy and lymphadenectomy for cervical cancer: a prospective analysis of 295 patients. *Ann Surg Oncol* 2008;15:2847-2855. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18649105>.
104. Puntambekar SP, Palep RJ, Puntambekar SS, et al. Laparoscopic total radical hysterectomy by the Pune technique: our experience of 248 cases. *J Minim Invasive Gynecol* 2007;14:682-689. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17980327>.
105. Nam JH, Park JY, Kim DY, et al. Laparoscopic versus open radical hysterectomy in early-stage cervical cancer: long-term survival outcomes in a matched cohort study. *Ann Oncol* 2012;23:903-911. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21841155>.

106. Wang YZ, Deng L, Xu HC, et al. Laparoscopy versus laparotomy for the management of early stage cervical cancer. *BMC Cancer* 2015;15:928. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26596955>.
107. Sert BM, Boggess JF, Ahmad S, et al. Robot-assisted versus open radical hysterectomy: A multi-institutional experience for early-stage cervical cancer. *Eur J Surg Oncol* 2016;42:513-522. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26843445>.
108. Mendivil AA, Rettenmaier MA, Abaid LN, et al. Survival rate comparisons amongst cervical cancer patients treated with an open, robotic-assisted or laparoscopic radical hysterectomy: A five year experience. *Surg Oncol* 2016;25:66-71. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26409687>.
109. Park DA, Yun JE, Kim SW, Lee SH. Surgical and clinical safety and effectiveness of robot-assisted laparoscopic hysterectomy compared to conventional laparoscopy and laparotomy for cervical cancer: A systematic review and meta-analysis. *Eur J Surg Oncol* 2017;43:994-1002. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27546015>.
110. Shazly SA, Murad MH, Dowdy SC, et al. Robotic radical hysterectomy in early stage cervical cancer: A systematic review and meta-analysis. *Gynecol Oncol* 2015;138:457-471. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26056752>.
111. Ramirez PT, Frumovitz M, Pareja R, et al. Minimally Invasive versus Abdominal Radical Hysterectomy for Cervical Cancer. *N Engl J Med* 2018. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30380365>.
112. Melamed A, Margul DJ, Chen L, et al. Survival after Minimally Invasive Radical Hysterectomy for Early-Stage Cervical Cancer. *N Engl J Med* 2018. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/30379613>.
113. Margul DJ, Yang J, Seagle BL, et al. Outcomes and costs of open, robotic, and laparoscopic radical hysterectomy for stage IB1 cervical cancer. *Journal of Clinical Oncology* 2018;36:5502-5502. Available at: http://ascopubs.org/doi/abs/10.1200/JCO.2018.36.15_suppl.5502.
114. Margul DJ, Yang J, Seagle BL, et al. Outcomes and costs of open, robotic, and laparoscopic radical hysterectomy for stage IB1 cervical cancer [Abstract]. *Journal of Clinical Oncology* 2018;36:5502-5502. Available at: http://ascopubs.org/doi/abs/10.1200/JCO.2018.36.15_suppl.5502.
115. Nevis IF, Vali B, Higgins C, et al. Robot-assisted hysterectomy for endometrial and cervical cancers: a systematic review. *J Robot Surg* 2016. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27424111>.
116. Lowe MP, Chamberlain DH, Kamelle SA, et al. A multi-institutional experience with robotic-assisted radical hysterectomy for early stage cervical cancer. *Gynecol Oncol* 2009;113:191-194. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19249082>.
117. Nezhat FR, Datta MS, Liu C, et al. Robotic radical hysterectomy versus total laparoscopic radical hysterectomy with pelvic lymphadenectomy for treatment of early cervical cancer. *JSLG* 2008;12:227-237. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18765043>.
118. Cantrell LA, Mendivil A, Gehrig PA, Boggess JF. Survival outcomes for women undergoing type III robotic radical hysterectomy for cervical cancer: a 3-year experience. *Gynecol Oncol* 2010;117:260-265. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20153886>.
119. ACOG practice bulletin. Diagnosis and treatment of cervical carcinomas. Number 35, May 2002. American College of Obstetricians and Gynecologists. *Int J Gynaecol Obstet* 2002;78:79-91. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12197489>.
120. Gaffney DK, Erickson-Wittmann BA, Jhingran A, et al. ACR Appropriateness Criteria(R) on Advanced Cervical Cancer Expert Panel on Radiation Oncology-Gynecology. *Int J Radiat Oncol Biol Phys* 2011;81:609-614. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21215531>.
121. Monk BJ, Tewari KS, Koh W-J. Multimodality therapy for locally advanced cervical carcinoma: state of the art and future directions. *J Clin*

Oncol 2007;25:2952-2965. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17617527>.

122. Gien LT, Beauchemin MC, Thomas G. Adenocarcinoma: a unique cervical cancer. *Gynecol Oncol* 2010;116:140-146. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/19880165>.

123. Baalbergen A, Veenstra Y, Stalpers LL, Ansink AC. Primary surgery versus primary radiation therapy with or without chemotherapy for early adenocarcinoma of the uterine cervix. *Cochrane Database Syst Rev* 2010:CD006248. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/20091590>.

124. Park JY, Kim DY, Kim JH, et al. Outcomes after radical hysterectomy in patients with early-stage adenocarcinoma of uterine cervix. *Br J Cancer* 2010;102:1692-1698. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/20531414>.

125. Wo JY, Viswanathan AN. Impact of radiotherapy on fertility, pregnancy, and neonatal outcomes in female cancer patients. *Int J Radiat Oncol Biol Phys* 2009;73:1304-1312. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/19306747>.

126. Pahisa J, Martinez-Roman S, Martinez-Zamora MA, et al. Laparoscopic ovarian transposition in patients with early cervical cancer. *Int J Gynecol Cancer* 2008;18:584-589. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/18476952>.

127. Morice P, Juncker L, Rey A, et al. Ovarian transposition for patients with cervical carcinoma treated by radiosurgical combination. *Fertil Steril* 2000;74:743-748. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/11020517>.

128. Landoni F, Maneo A, Colombo A, et al. Randomised study of radical surgery versus radiotherapy for stage Ib-IIa cervical cancer. *Lancet* 1997;350:535-540. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/9284774>.

129. Keys HM, Bundy BN, Stehman FB, et al. Cisplatin, radiation, and adjuvant hysterectomy compared with radiation and adjuvant hysterectomy for bulky stage IB cervical carcinoma. *N Engl J Med* 1999;340:1154-1161. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10202166>.

130. Morris M, Eifel PJ, Lu J, et al. Pelvic radiation with concurrent chemotherapy compared with pelvic and para-aortic radiation for high-risk cervical cancer. *N Engl J Med* 1999;340:1137-1143. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10202164>.

131. Peters WA, Liu PY, Barrett RJ, et al. Concurrent chemotherapy and pelvic radiation therapy compared with pelvic radiation therapy alone as adjuvant therapy after radical surgery in high-risk early-stage cancer of the cervix. *J Clin Oncol* 2000;18:1606-1613. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10764420>.

132. Whitney CW, Sause W, Bundy BN, et al. Randomized comparison of fluorouracil plus cisplatin versus hydroxyurea as an adjunct to radiation therapy in stage IIB-IVA carcinoma of the cervix with negative para-aortic lymph nodes: a Gynecologic Oncology Group and Southwest Oncology Group study. *J Clin Oncol* 1999;17:1339-1348. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10334517>.

133. Rose PG, Bundy BN, Watkins EB, et al. Concurrent cisplatin-based radiotherapy and chemotherapy for locally advanced cervical cancer. *N Engl J Med* 1999;340:1144-1153. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10202165>.

134. Thomas GM. Improved treatment for cervical cancer--concurrent chemotherapy and radiotherapy. *N Engl J Med* 1999;340:1198-1200. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10202172>.

135. Rose PG, Ali S, Watkins E, et al. Long-term follow-up of a randomized trial comparing concurrent single agent cisplatin, cisplatin-based combination chemotherapy, or hydroxyurea during pelvic irradiation for locally advanced cervical cancer: a Gynecologic Oncology Group Study. *J Clin Oncol* 2007;25:2804-2810. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17502627>.

136. Eifel PJ, Winter K, Morris M, et al. Pelvic irradiation with concurrent chemotherapy versus pelvic and para-aortic irradiation for high-risk cervical cancer: an update of radiation therapy oncology group trial (RTOG) 90-01. *J Clin Oncol* 2004;22:872-880. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14990643>.
137. Stehman FB, Ali S, Keys HM, et al. Radiation therapy with or without weekly cisplatin for bulky stage 1B cervical carcinoma: follow-up of a Gynecologic Oncology Group trial. *Am J Obstet Gynecol* 2007;197:1-6. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17980189>.
138. Chemoradiotherapy for Cervical Cancer Meta-Analysis C. Reducing uncertainties about the effects of chemoradiotherapy for cervical cancer: a systematic review and meta-analysis of individual patient data from 18 randomized trials. *J Clin Oncol* 2008;26:5802-5812. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19001332>.
139. Pearcey R, Miao Q, Kong W, et al. Impact of adoption of chemoradiotherapy on the outcome of cervical cancer in Ontario: results of a population-based cohort study. *J Clin Oncol* 2007;25:2383-2388. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17557951>.
140. King M, McConkey C, Latief TN, et al. Improved survival after concurrent weekly cisplatin and radiotherapy for cervical carcinoma with assessment of acute and late side-effects. *Clin Oncol (R Coll Radiol)* 2006;18:38-45. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16477918>.
141. Tan LT, Zahra M. Long-term survival and late toxicity after chemoradiotherapy for cervical cancer--the Addenbrooke's experience. *Clin Oncol (R Coll Radiol)* 2008;20:358-364. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18395427>.
142. Gaffney DK, Du Bois A, Narayan K, et al. Practice patterns of radiotherapy in cervical cancer among member groups of the Gynecologic Cancer Intergroup (GCIG). *Int J Radiat Oncol Biol Phys* 2007;68:485-490. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17336465>.
143. Cetina L, Garcia-Arias A, Uribe MdJ, et al. Concurrent chemoradiation with carboplatin for elderly, diabetic and hypertensive patients with locally advanced cervical cancer. *Eur J Gynaecol Oncol* 2008;29:608-612. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19115688>.
144. Dubay RA, Rose PG, O'Malley DM, et al. Evaluation of concurrent and adjuvant carboplatin with radiation therapy for locally advanced cervical cancer. *Gynecol Oncol* 2004;94:121-124. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15262129>.
145. Higgins RV, Naumann WR, Hall JB, Haake M. Concurrent carboplatin with pelvic radiation therapy in the primary treatment of cervix cancer. *Gynecol Oncol* 2003;89:499-503. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12798718>.
146. Lorvidhaya V, Chitapanarux I, Sangruchi S, et al. Concurrent mitomycin C, 5-fluorouracil, and radiotherapy in the treatment of locally advanced carcinoma of the cervix: a randomized trial. *Int J Radiat Oncol Biol Phys* 2003;55:1226-1232. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12654431>.
147. Wong LC, Ngan HY, Cheung AN, et al. Chemoradiation and adjuvant chemotherapy in cervical cancer. *J Clin Oncol* 1999;17:2055-2060. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10561258>.
148. Tharavichitkul E, Lorvidhaya V, Kamnerdsupaphon P, et al. Combined chemoradiation of cisplatin versus carboplatin in cervical carcinoma: a single institution experience from Thailand. *BMC Cancer* 2016;16:501. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27435245>.
149. Mileskin LR, Narayan K, Moore KN, et al. A phase III trial of adjuvant chemotherapy following chemoradiation as primary treatment for locally advanced cervical cancer compared to chemoradiation alone: Outback (ANZGOG0902/GOG0274/RTOG1174) [abstract]. *Journal of Clinical Oncology* 2014 32:abstract TPS5632. Available at: http://abstracts.asco.org/144/AbstView_144_132544.html.

150. Koliopoulos G, Sotiriadis A, Kyrgiou M, et al. Conservative surgical methods for FIGO stage IA2 squamous cervical carcinoma and their role in preserving women's fertility. *Gynecol Oncol* 2004;93:469-473. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15099964>.

151. Wright JD, Nathavitharana R, Lewin SN, et al. Fertility-conserving surgery for young women with stage IA1 cervical cancer: safety and access. *Obstet Gynecol* 2010;115:585-590. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20177290>.

152. Tierney KE, Lin PS, Amezcua C, et al. Cervical conization of adenocarcinoma in situ: a predicting model of residual disease. *Am J Obstet Gynecol* 2014;210:366 e361-365. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24370689>.

153. Yoneda JY, Braganca JF, Sarian LO, et al. Surgical treatment of microinvasive cervical cancer: analysis of pathologic features with implications on radicality. *Int J Gynecol Cancer* 2015;25:694-698. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25742569>.

154. Bernardini M, Barrett J, Seaward G, Covens A. Pregnancy outcomes in patients after radical trachelectomy. *Am J Obstet Gynecol* 2003;189:1378-1382. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14634572>.

155. Boss EA, van Golde RJT, Beerendonk CCM, Massuger LFAG. Pregnancy after radical trachelectomy: a real option? *Gynecol Oncol* 2005;99:152-156. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16140367>.

156. Plante M, Renaud M-C, Hoskins IA, Roy M. Vaginal radical trachelectomy: a valuable fertility-preserving option in the management of early-stage cervical cancer. A series of 50 pregnancies and review of the literature. *Gynecol Oncol* 2005;98:3-10. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15936061>.

157. Marchiolo P, Benchaib M, Buenerd A, et al. Oncological safety of laparoscopic-assisted vaginal radical trachelectomy (LARVT or Dargent's operation): a comparative study with laparoscopic-assisted vaginal radical

hysterectomy (LARVH). *Gynecol Oncol* 2007;106:132-141. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17493666>.

158. Landoni F, Zanagnolo V, Lovato-Diaz L, et al. Ovarian metastases in early-stage cervical cancer (IA2-IIA): a multicenter retrospective study of 1965 patients (a Cooperative Task Force study). *Int J Gynecol Cancer* 2007;17:623-628. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17309669>.

159. Shimada M, Kigawa J, Nishimura R, et al. Ovarian metastasis in carcinoma of the uterine cervix. *Gynecol Oncol* 2006;101:234-237. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16300819>.

160. Kokka F, Bryant A, Brockbank E, Jeyarajah A. Surgical treatment of stage IA2 cervical cancer. *Cochrane Database Syst Rev* 2014:CD010870. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24874726>.

161. Small W, Jr., Strauss JB, Jhingran A, et al. ACR Appropriateness Criteria(R) definitive therapy for early-stage cervical cancer. *Am J Clin Oncol* 2012;35:399-405. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22810416>.

162. Raju SK, Papadopoulos AJ, Montalto SA, et al. Fertility-sparing surgery for early cervical cancer—approach to less radical surgery. *Int J Gynecol Cancer* 2012;22:311-317. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22237381>.

163. Li J, Wu X, Li X, Ju X. Abdominal radical trachelectomy: Is it safe for IB1 cervical cancer with tumors ≥ 2 cm? *Gynecol Oncol* 2013;131:87-92. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23872192>.

164. Landoni F, Maneo A, Cormio G, et al. Class II versus class III radical hysterectomy in stage IB-IIA cervical cancer: a prospective randomized study. *Gynecol Oncol* 2001;80:3-12. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11136561>.

165. Keys HM, Bundy BN, Stehman FB, et al. Radiation therapy with and without extrafascial hysterectomy for bulky stage IB cervical carcinoma: a randomized trial of the Gynecologic Oncology Group. *Gynecol Oncol*

2003;89:343-353. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/12798694>.

166. Kokka F, Bryant A, Brockbank E, et al. Hysterectomy with radiotherapy or chemotherapy or both for women with locally advanced cervical cancer. *Cochrane Database Syst Rev* 2015;4:CD010260.

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25847525>.

167. Colombo PE, Bertrand MM, Gutowski M, et al. Total laparoscopic radical hysterectomy for locally advanced cervical carcinoma (stages IIB, IIA and bulky stages IB) after concurrent chemoradiation therapy: surgical morbidity and oncological results. *Gynecol Oncol* 2009;114:404-409.

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19555996>.

168. Touboul C, Uzan C, Mauguen A, et al. Prognostic factors and morbidities after completion surgery in patients undergoing initial chemoradiation therapy for locally advanced cervical cancer. *Oncologist* 2010;15:405-415. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/20332143>.

169. Huguet F, Cojocariu OM, Levy P, et al. Preoperative concurrent radiation therapy and chemotherapy for bulky stage IB2, IIA, and IIB carcinoma of the uterine cervix with proximal parametrial invasion. *Int J Radiat Oncol Biol Phys* 2008;72:1508-1515. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/18676093>.

170. Cetina L, Gonzalez-Enciso A, Cantu D, et al. Brachytherapy versus radical hysterectomy after external beam chemoradiation with gemcitabine plus cisplatin: a randomized, phase III study in IB2-IIB cervical cancer patients. *Ann Oncol* 2013;24:2043-2047. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/23609186>.

171. Kohler C, Mustea A, Marnitz S, et al. Perioperative morbidity and rate of upstaging after laparoscopic staging for patients with locally advanced cervical cancer: results of a prospective randomized trial. *Am J Obstet Gynecol* 2015;213:503 e501-507. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/25986030>.

172. Goff BA, Muntz HG, Paley PJ, et al. Impact of surgical staging in women with locally advanced cervical cancer. *Gynecol Oncol* 1999;74:436-442. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10479506>.

173. Rose PG. Combination therapy: New treatment paradigm for locally advanced cervical cancer? *Nat Rev Clin Oncol* 2011;8:388-390. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/21629215>.

174. Duenas-Gonzalez A, Zarba JJ, Patel F, et al. Phase III, open-label, randomized study comparing concurrent gemcitabine plus cisplatin and radiation followed by adjuvant gemcitabine and cisplatin versus concurrent cisplatin and radiation in patients with stage IIB to IVA carcinoma of the cervix. *J Clin Oncol* 2011;29:1678-1685. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/21444871>.

175. Thomas G. Are we making progress in curing advanced cervical cancer? *J Clin Oncol* 2011;29:1654-1656. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/21444860>.

176. Swisher EM, Swensen RE, Greer B, et al. Weekly gemcitabine and cisplatin in combination with pelvic radiation in the primary therapy of cervical cancer: a phase I trial of the Puget Sound Oncology Consortium. *Gynecol Oncol* 2006;101:429-435. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/16337995>.

177. Rose PG, Degeest K, McMeekin S, Fusco N. A phase I study of gemcitabine followed by cisplatin concurrent with whole pelvic radiation therapy in locally advanced cervical cancer: a Gynecologic Oncology Group study. *Gynecol Oncol* 2007;107:274-279. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17688925>.

178. Lutz ST, Chow EL, Hartsell WF, Konski AA. A review of hypofractionated palliative radiotherapy. *Cancer* 2007;109:1462-1470. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17330854>.

179. Rotman M, Sedlis A, Piedmonte MR, et al. A phase III randomized trial of postoperative pelvic irradiation in Stage IB cervical carcinoma with poor prognostic features: follow-up of a gynecologic oncology group study.

Int J Radiat Oncol Biol Phys 2006;65:169-176. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/16427212>.

180. Monk BJ, Wang J, Im S, et al. Rethinking the use of radiation and chemotherapy after radical hysterectomy: a clinical-pathologic analysis of a Gynecologic Oncology Group/Southwest Oncology Group/Radiation Therapy Oncology Group trial. *Gynecol Oncol* 2005;96:721-728. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15721417>.

181. Chernofsky MR, Felix JC, Muderspach LI, et al. Influence of quantity of lymph vascular space invasion on time to recurrence in women with early-stage squamous cancer of the cervix. *Gynecol Oncol* 2006;100:288-293. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16182347>.

182. Marchiole P, Buenerd A, Benchaib M, et al. Clinical significance of lympho vascular space involvement and lymph node micrometastases in early-stage cervical cancer: a retrospective case-control surgico-pathological study. *Gynecol Oncol* 2005;97:727-732. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15943983>.

183. Trifiletti DM, Swisher-McClure S, Showalter TN, et al. Postoperative Chemoradiation Therapy in High-Risk Cervical Cancer: Re-evaluating the Findings of Gynecologic Oncology Group Study 109 in a Large, Population-Based Cohort. *Int J Radiat Oncol Biol Phys* 2015;93:1032-1044. Available at:

184. Gong L, Lou JY, Wang P, et al. Clinical evaluation of neoadjuvant chemotherapy followed by radical surgery in the management of stage IB2-IIB cervical cancer. *Int J Gynaecol Obstet* 2012;117:23-26. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22265255>.

185. Eddy GL, Bundy BN, Creasman WT, et al. Treatment of ("bulky") stage IB cervical cancer with or without neoadjuvant vincristine and cisplatin prior to radical hysterectomy and pelvic/para-aortic lymphadenectomy: a phase III trial of the gynecologic oncology group. *Gynecol Oncol* 2007;106:362-369. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17493669>.

186. Ryzewska L, Tierney J, Vale CL, Symonds PR. Neoadjuvant chemotherapy plus surgery versus surgery for cervical cancer. *Cochrane Database Syst Rev* 2010:CD007406. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20091632>.

187. Katsumata N, Yoshikawa H, Kobayashi H, et al. Phase III randomised controlled trial of neoadjuvant chemotherapy plus radical surgery vs radical surgery alone for stages IB2, IIA2, and IIB cervical cancer: a Japan Clinical Oncology Group trial (JCOG 0102). *Br J Cancer* 2013;108:1957-1963. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23640393>.

188. Kim HS, Sardi JE, Katsumata N, et al. Efficacy of neoadjuvant chemotherapy in patients with FIGO stage IB1 to IIA cervical cancer: an international collaborative meta-analysis. *Eur J Surg Oncol* 2013;39:115-124. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23084091>.

189. Landoni F, Sartori E, Maggino T, et al. Is there a role for postoperative treatment in patients with stage Ib2-IIb cervical cancer treated with neo-adjuvant chemotherapy and radical surgery? An Italian multicenter retrospective study. *Gynecol Oncol* 2014;132:611-617. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24342439>.

190. Ye Q, Yuan HX, Chen HL. Responsiveness of neoadjuvant chemotherapy before surgery predicts favorable prognosis for cervical cancer patients: a meta-analysis. *J Cancer Res Clin Oncol* 2013;139:1887-1898. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24022086>.

191. Salani R, Khanna N, Frimer M, et al. An update on post-treatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncology (SGO) recommendations. *Gynecol Oncol* 2017;146:3-10. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28372871>.

192. Bodurka-Bevers D, Morris M, Eifel PJ, et al. Posttherapy surveillance of women with cervical cancer: an outcomes analysis. *Gynecol Oncol* 2000;78:187-193. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10926801>.

193. Morice P, Deyrolle C, Rey A, et al. Value of routine follow-up procedures for patients with stage I/II cervical cancer treated with combined surgery-radiation therapy. *Ann Oncol* 2004;15:218-223. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14760112>.

194. Elit L, Fyles AW, Devries MC, et al. Follow-up for women after treatment for cervical cancer: a systematic review. *Gynecol Oncol* 2009;114:528-535. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19560188>.

195. Gee MS, Atri M, Bandos AI, et al. Identification of Distant Metastatic Disease in Uterine Cervical and Endometrial Cancers with FDG PET/CT: Analysis from the ACRIN 6671/GOG 0233 Multicenter Trial. *Radiology* 2018;287:176-184. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29185901>.

196. Sala E, Micco M, Burger IA, et al. Complementary Prognostic Value of Pelvic Magnetic Resonance Imaging and Whole-Body Fluorodeoxyglucose Positron Emission Tomography/Computed Tomography in the Pretreatment Assessment of Patients With Cervical Cancer. *Int J Gynecol Cancer* 2015;25:1461-1467. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26397068>.

197. Balleyguier C, Sala E, Da Cunha T, et al. Staging of uterine cervical cancer with MRI: guidelines of the European Society of Urogenital Radiology. *Eur Radiol* 2011;21:1102-1110. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21063710>.

198. Sala E, Rockall AG, Freeman SJ, et al. The added role of MR imaging in treatment stratification of patients with gynecologic malignancies: what the radiologist needs to know. *Radiology* 2013;266:717-740. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23431227>.

199. Elit L, Reade CJ. Recommendations for Follow-up Care for Gynecologic Cancer Survivors. *Obstet Gynecol* 2015;126:1207-1214. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26551194>.

200. Rajendran JG, Greer BE. Expanding role of positron emission tomography in cancer of the uterine cervix. *J Natl Compr Canc Netw* 2006;4:463-469. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16687094>.

201. Atri M, Zhang Z, Dehdashti F, et al. Utility of PET-CT to evaluate retroperitoneal lymph node metastasis in advanced cervical cancer: Results of ACRIN6671/GOG0233 trial. *Gynecol Oncol* 2016;142:413-419. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/27178725>.

202. Brooks RA, Rader JS, Dehdashti F, et al. Surveillance FDG-PET detection of asymptomatic recurrences in patients with cervical cancer. *Gynecol Oncol* 2009;112:104-109. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18929403>.

203. Schwarz JK, Siegel BA, Dehdashti F, Grigsby PW. Association of posttherapy positron emission tomography with tumor response and survival in cervical carcinoma. *JAMA* 2007;298:2289-2295. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18029833>.

204. Sironi S, Picchio M, Landoni C, et al. Post-therapy surveillance of patients with uterine cancers: value of integrated FDG PET/CT in the detection of recurrence. *Eur J Nucl Med Mol Imaging* 2007;34:472-479. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17106701>.

205. Chung HH, Jo H, Kang WJ, et al. Clinical impact of integrated PET/CT on the management of suspected cervical cancer recurrence. *Gynecol Oncol* 2007;104:529-534. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17049971>.

206. Wolfson AH, Varia MA, Moore D, et al. ACR Appropriateness Criteria(R) role of adjuvant therapy in the management of early stage cervical cancer. *Gynecol Oncol* 2012;125:256-262. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22155418>.

207. Chaturvedi AK, Kleinerman RA, Hildesheim A, et al. Second cancers after squamous cell carcinoma and adenocarcinoma of the cervix. *J Clin Oncol* 2009;27:967-973. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19114696>.

208. Chaturvedi AK, Engels EA, Gilbert ES, et al. Second cancers among 104,760 survivors of cervical cancer: evaluation of long-term risk. *J Natl Cancer Inst* 2007;99:1634-1643. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17971527>.
209. Kumar S, Shah JP, Bryant CS, et al. Radiation-associated endometrial cancer. *Obstet Gynecol* 2009;113:319-325. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19155901>.
210. Hong JH, Tsai CS, Lai CH, et al. Recurrent squamous cell carcinoma of cervix after definitive radiotherapy. *Int J Radiat Oncol Biol Phys* 2004;60:249-257. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15337563>.
211. Thomas GM, Dembo AJ, Myhr T, et al. Long-term results of concurrent radiation and chemotherapy for carcinoma of the cervix recurrent after surgery. *Int J Gynecol Cancer* 1993;3:193-198. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11578344>.
212. Kim JS, Kim SY, Kim KH, Cho MJ. Hyperfractionated radiotherapy with concurrent chemotherapy for para-aortic lymph node recurrence in carcinoma of the cervix. *Int J Radiat Oncol Biol Phys* 2003;55:1247-1253. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12654434>.
213. Chung YL, Jian JJ, Cheng SH, et al. Extended-field radiotherapy and high-dose-rate brachytherapy with concurrent and adjuvant cisplatin-based chemotherapy for locally advanced cervical cancer: a phase I/II study. *Gynecol Oncol* 2005;97:126-135. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15790448>.
214. Marnitz S, Dowdy S, Lanowska M, et al. Exenterations 60 years after first description: results of a survey among US and German Gynecologic Oncology Centers. *Int J Gynecol Cancer* 2009;19:974-977. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19574795>.
215. Berek JS, Howe C, Lagasse LD, Hacker NF. Pelvic exenteration for recurrent gynecologic malignancy: survival and morbidity analysis of the 45-year experience at UCLA. *Gynecol Oncol* 2005;99:153-159. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16054678>.
216. Goldberg GL, Sukumvanich P, Einstein MH, et al. Total pelvic exenteration: the Albert Einstein College of Medicine/Montefiore Medical Center Experience (1987 to 2003). *Gynecol Oncol* 2006;101:261-268. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16426668>.
217. Morley GW, Hopkins MP, Lindenauer SM, Roberts JA. Pelvic exenteration, University of Michigan: 100 patients at 5 years. *Obstet Gynecol* 1989;74:934-943. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/2586960>.
218. Fleisch MC, Pantke P, Beckmann MW, et al. Predictors for long-term survival after interdisciplinary salvage surgery for advanced or recurrent gynecologic cancers. *J Surg Oncol* 2007;95:476-484. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17192947>.
219. Tran PT, Su Z, Hara W, et al. Long-term survivors using intraoperative radiotherapy for recurrent gynecologic malignancies. *Int J Radiat Oncol Biol Phys* 2007;69:504-511. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17560736>.
220. Rutledge FN, Smith JP, Wharton JT, O'Quinn AG. Pelvic exenteration: analysis of 296 patients. *Am J Obstet Gynecol* 1977;129:881-892. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/930972>.
221. Symmonds RE, Pratt JH, Webb MJ. Exenterative operations: experience with 198 patients. *Am J Obstet Gynecol* 1975;121:907-918. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/1115180>.
222. Soper JT, Secord AA, Havrilesky LJ, et al. Comparison of gracilis and rectus abdominis myocutaneous flap neovaginal reconstruction performed during radical pelvic surgery: flap-specific morbidity. *Int J Gynecol Cancer* 2007;17:298-303. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17291272>.
223. Mirhashemi R, Averette HE, Lambrou N, et al. Vaginal reconstruction at the time of pelvic exenteration: a surgical and psychosexual analysis of techniques. *Gynecol Oncol* 2002;87:39-45. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12468340>.

224. Turns D. Psychosocial issues: pelvic exenterative surgery. *J Surg Oncol* 2001;76:224-236. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11276026>.

225. Im JH, Yoon HI, Kim S, et al. Tailored radiotherapeutic strategies for disseminated uterine cervical cancer patients. *Radiat Oncol* 2015;10:77. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25884833>.

226. Kim JY, Kim JY, Kim JH, et al. Curative chemoradiotherapy in patients with stage IVB cervical cancer presenting with paraortic and left supraclavicular lymph node metastases. *Int J Radiat Oncol Biol Phys* 2012;84:741-747. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22898382>.

227. Smith SC, Koh WJ. Palliative radiation therapy for gynaecological malignancies. *Best Pract Res Clin Obstet Gynaecol* 2001;15:265-278. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11358401>.

228. Spanos WJ, Jr., Perez CA, Marcus S, et al. Effect of rest interval on tumor and normal tissue response--a report of phase III study of accelerated split course palliative radiation for advanced pelvic malignancies (RTOG-8502). *Int J Radiat Oncol Biol Phys* 1993;25:399-403. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7679668>.

229. Moore DH, Blessing JA, McQuellon RP, et al. Phase III study of cisplatin with or without paclitaxel in stage IVB, recurrent, or persistent squamous cell carcinoma of the cervix: a gynecologic oncology group study. *J Clin Oncol* 2004;22:3113-3119. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15284262>.

230. Long HJ, 3rd, Bundy BN, Grendys EC, Jr., et al. Randomized phase III trial of cisplatin with or without topotecan in carcinoma of the uterine cervix: a Gynecologic Oncology Group Study. *J Clin Oncol* 2005;23:4626-4633. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15911865>.

231. Thigpen T, Shingleton H, Homesley H, et al. Cis-platinum in treatment of advanced or recurrent squamous cell carcinoma of the cervix: a phase II study of the Gynecologic Oncology Group. *Cancer*

1981;48:899-903. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7196794>.

232. Moore DH. Chemotherapy for advanced, recurrent, and metastatic cervical cancer. *J Natl Compr Canc Netw* 2008;6:53-57. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18267059>.

233. Tao X, Hu W, Ramirez PT, Kavanagh JJ. Chemotherapy for recurrent and metastatic cervical cancer. *Gynecol Oncol* 2008;110:67-71. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18533239>.

234. Monk BJ, Sill MW, McMeekin DS, et al. Phase III trial of four cisplatin-containing doublet combinations in stage IVB, recurrent, or persistent cervical carcinoma: a Gynecologic Oncology Group study. *J Clin Oncol* 2009;27:4649-4655. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19720909>.

235. Tewari KS, Sill MW, Penson RT, et al. Bevacizumab for advanced cervical cancer: final overall survival and adverse event analysis of a randomised, controlled, open-label, phase 3 trial (Gynecologic Oncology Group 240). *Lancet* 2017;390:1654-1663. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28756902>.

236. Zigelboim I, Wright JD, Gao F, et al. Multicenter phase II trial of topotecan, cisplatin and bevacizumab for recurrent or persistent cervical cancer. *Gynecol Oncol* 2013;130:64-68. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23591400>.

237. Penson RT, Huang HQ, Wenzel LB, et al. Bevacizumab for advanced cervical cancer: patient-reported outcomes of a randomised, phase 3 trial (NRG Oncology-Gynecologic Oncology Group protocol 240). *Lancet Oncol* 2015;16:301-311. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25638326>.

238. Rosen VM, Guerra I, McCormack M, et al. Systematic Review and Network Meta-Analysis of Bevacizumab Plus First-Line Topotecan-Paclitaxel or Cisplatin-Paclitaxel Versus Non-Bevacizumab-Containing Therapies in Persistent, Recurrent, or Metastatic Cervical Cancer. *Int J*

Gynecol Cancer 2017;27:1237-1246. Available at:
<https://www.ncbi.nlm.nih.gov/pubmed/28448304>.

239. Kitagawa R, Katsumata N, Shibata T, et al. Paclitaxel Plus Carboplatin Versus Paclitaxel Plus Cisplatin in Metastatic or Recurrent Cervical Cancer: The Open-Label Randomized Phase III Trial JCOG0505. J Clin Oncol 2015;33:2129-2135. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/25732161>.

240. Moore KN, Herzog TJ, Lewin S, et al. A comparison of cisplatin/paclitaxel and carboplatin/paclitaxel in stage IVB, recurrent or persistent cervical cancer. Gynecol Oncol 2007;105:299-303. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/17303230>.

241. Lorusso D, Petrelli F, Coinu A, et al. A systematic review comparing cisplatin and carboplatin plus paclitaxel-based chemotherapy for recurrent or metastatic cervical cancer. Gynecol Oncol 2014;133:117-123. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/24486604>.

242. Leath CA, 3rd, Straughn JM, Jr. Chemotherapy for advanced and recurrent cervical carcinoma: results from cooperative group trials. Gynecol Oncol 2013;129:251-257. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/23280089>.

243. Thigpen JT, Blessing JA, DiSaia PJ, et al. A randomized comparison of a rapid versus prolonged (24 hr) infusion of cisplatin in therapy of squamous cell carcinoma of the uterine cervix: a Gynecologic Oncology Group study. Gynecol Oncol 1989;32:198-202. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/2910782>.

244. Pectasides D, Kamposioras K, Papaxoinis G, Pectasides E. Chemotherapy for recurrent cervical cancer. Cancer Treat Rev 2008;34:603-613. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/18657909>.

245. McGuire WP, Arseneau J, Blessing JA, et al. A randomized comparative trial of carboplatin and iproplatin in advanced squamous carcinoma of the uterine cervix: a Gynecologic Oncology Group study. J

Clin Oncol 1989;7:1462-1468. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/2674333>.

246. Weiss GR, Green S, Hannigan EV, et al. A phase II trial of carboplatin for recurrent or metastatic squamous carcinoma of the uterine cervix: a Southwest Oncology Group study. Gynecol Oncol 1990;39:332-336. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/2258080>.

247. Kudelka AP, Winn R, Edwards CL, et al. An update of a phase II study of paclitaxel in advanced or recurrent squamous cell cancer of the cervix. Anticancer Drugs 1997;8:657-661. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/9311440>.

248. McGuire WP, Blessing JA, Moore D, et al. Paclitaxel has moderate activity in squamous cervix cancer. A Gynecologic Oncology Group study. J Clin Oncol 1996;14:792-795. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/8622025>.

249. Le DT, Durham JN, Smith KN, et al. Mismatch repair deficiency predicts response of solid tumors to PD-1 blockade. Science 2017;357:409-413. Available at:
<https://www.ncbi.nlm.nih.gov/pubmed/28596308>.

250. Frenel JS, Le Tourneau C, O'Neil B, et al. Safety and Efficacy of Pembrolizumab in Advanced, Programmed Death Ligand 1-Positive Cervical Cancer: Results From the Phase Ib KEYNOTE-028 Trial. J Clin Oncol 2017;35:4035-4041. Available at:
<https://www.ncbi.nlm.nih.gov/pubmed/29095678>.

251. Chung HC, Schellens JH, Delord J-P, et al. Pembrolizumab treatment of advanced cervical cancer: Updated results from the phase 2 KEYNOTE-158 study [abstract]. J Clin Oncol 2018 36. Available at:
<https://meetinglibrary.asco.org/record/160523/abstract>.

252. Monk BJ, Sill MW, Burger RA, et al. Phase II trial of bevacizumab in the treatment of persistent or recurrent squamous cell carcinoma of the cervix: a gynecologic oncology group study. J Clin Oncol 2009;27:1069-1074. Available at:
<http://www.ncbi.nlm.nih.gov/pubmed/19139430>.

253. Alberts DS, Blessing JA, Landrum LM, et al. Phase II trial of nab-paclitaxel in the treatment of recurrent or persistent advanced cervix cancer: A gynecologic oncology group study. *Gynecol Oncol* 2012;127:451-455. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/22986144>.

254. Garcia AA, Blessing JA, Vaccarello L, Roman LD. Phase II clinical trial of docetaxel in refractory squamous cell carcinoma of the cervix: a Gynecologic Oncology Group Study. *Am J Clin Oncol* 2007;30:428-431. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/17762444>.

255. Look KY, Blessing JA, Gallup DG, Lentz SS. A phase II trial of 5-fluorouracil and high-dose leucovorin in patients with recurrent squamous cell carcinoma of the cervix: a Gynecologic Oncology Group study. *Am J Clin Oncol* 1996;19:439-441. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/8823469>.

256. Schilder RJ, Blessing J, Cohn DE. Evaluation of gemcitabine in previously treated patients with non-squamous cell carcinoma of the cervix: a phase II study of the Gynecologic Oncology Group. *Gynecol Oncol* 2005;96:103-107. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/15589587>.

257. Coleman RE, Harper PG, Gallagher C, et al. A phase II study of ifosfamide in advanced and relapsed carcinoma of the cervix. *Cancer Chemother Pharmacol* 1986;18:280-283. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/3802384>.

258. Sutton GP, Blessing JA, McGuire WP, et al. Phase II trial of ifosfamide and mesna in patients with advanced or recurrent squamous carcinoma of the cervix who had never received chemotherapy: a Gynecologic Oncology Group study. *Am J Obstet Gynecol* 1993;168:805-807. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/8456884>.

259. Verschraegen CF, Levy T, Kudelka AP, et al. Phase II study of irinotecan in prior chemotherapy-treated squamous cell carcinoma of the cervix. *J Clin Oncol* 1997;15:625-631. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/9053486>.

260. Wagenaar HC, Pecorelli S, Mangioni C, et al. Phase II study of mitomycin-C and cisplatin in disseminated, squamous cell carcinoma of the uterine cervix. A European Organization for Research and Treatment of Cancer (EORTC) Gynecological Cancer Group study. *Eur J Cancer* 2001;37:1624-1628. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/11527687>.

261. Miller DS, Blessing JA, Bodurka DC, et al. Evaluation of pemetrexed (Alimta, LY231514) as second line chemotherapy in persistent or recurrent carcinoma of the cervix: a phase II study of the Gynecologic Oncology Group. *Gynecol Oncol* 2008;110:65-70. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/18455781>.

262. Bookman MA, Blessing JA, Hanjani P, et al. Topotecan in squamous cell carcinoma of the cervix: A Phase II study of the Gynecologic Oncology Group. *Gynecol Oncol* 2000;77:446-449. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/10831357>.

263. Muderspach LI, Blessing JA, Levenback C, Moore JL. A Phase II study of topotecan in patients with squamous cell carcinoma of the cervix: a gynecologic oncology group study. *Gynecol Oncol* 2001;81:213-215. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/11354055>.

264. Muggia FM, Blessing JA, Method M, et al. Evaluation of vinorelbine in persistent or recurrent squamous cell carcinoma of the cervix: a Gynecologic Oncology Group study. *Gynecol Oncol* 2004;92:639-643. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/14766259>.

265. Castells MC, Tennant NM, Sloane DE, et al. Hypersensitivity reactions to chemotherapy: outcomes and safety of rapid desensitization in 413 cases. *J Allergy Clin Immunol* 2008;122:574-580. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/18502492>.

266. Sampson HA, Munoz-Furlong A, Campbell RL, et al. Second symposium on the definition and management of anaphylaxis: summary report--second National Institute of Allergy and Infectious Disease/Food Allergy and Anaphylaxis Network symposium. *Ann Emerg Med* 2006;47:373-380. Available at:

<http://www.ncbi.nlm.nih.gov/pubmed/16546624>.

267. Manivannan V, Decker WW, Stead LG, et al. Visual representation of National Institute of Allergy and Infectious Disease and Food Allergy and Anaphylaxis Network criteria for anaphylaxis. *Int J Emerg Med* 2009;2:3-5. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19390910>.

268. Lenz HJ. Management and preparedness for infusion and hypersensitivity reactions. *Oncologist* 2007;12:601-609. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17522249>.

269. Markman M, Zanotti K, Peterson G, et al. Expanded experience with an intradermal skin test to predict for the presence or absence of carboplatin hypersensitivity. *J Clin Oncol* 2003;21:4611-4614. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14673050>.

270. Lee CW, Matulonis UA, Castells MC. Rapid inpatient/outpatient desensitization for chemotherapy hypersensitivity: standard protocol effective in 57 patients for 255 courses. *Gynecol Oncol* 2005;99:393-399. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16054201>.

271. Lee CW, Matulonis UA, Castells MC. Carboplatin hypersensitivity: a 6-h 12-step protocol effective in 35 desensitizations in patients with gynecological malignancies and mast cell/IgE-mediated reactions. *Gynecol Oncol* 2004;95:370-376. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15491759>.

272. Higginson DS, Morris DE, Jones EL, et al. Stereotactic body radiotherapy (SBRT): Technological innovation and application in gynecologic oncology. *Gynecol Oncol* 2011;120:404-412. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21194733>.

273. Choi CW, Cho CK, Yoo SY, et al. Image-guided stereotactic body radiation therapy in patients with isolated para-aortic lymph node metastases from uterine cervical and corpus cancer. *Int J Radiat Oncol Biol Phys* 2009;74:147-153. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18990511>.

274. Jadon R, Pembroke CA, Hanna CL, et al. A systematic review of organ motion and image-guided strategies in external beam radiotherapy

for cervical cancer. *Clin Oncol (R Coll Radiol)* 2014;26:185-196. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24566332>.

275. Eminowicz G, Hall-Craggs M, Diez P, McCormack M. Improving target volume delineation in intact cervical carcinoma: Literature review and step-by-step pictorial atlas to aid contouring. *Pract Radiat Oncol* 2016;6:e203-213. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27032573>.

276. Klopp AH, Yeung AR, Deshmukh S, et al. A Phase III Randomized Trial Comparing Patient-Reported Toxicity and Quality of Life (QOL) During Pelvic Intensity Modulated Radiation Therapy as Compared to Conventional Radiation Therapy. *Int J Radiat Oncol Biol Phys* 2016;96:S3. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27675895>.

277. Potter R, Georg P, Dimopoulos JC, et al. Clinical outcome of protocol based image (MRI) guided adaptive brachytherapy combined with 3D conformal radiotherapy with or without chemotherapy in patients with locally advanced cervical cancer. *Radiother Oncol* 2011;100:116-123. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21821305>.

278. Haie-Meder C, Potter R, Van Limbergen E, et al. Recommendations from Gynaecological (GYN) GEC-ESTRO Working Group (I): concepts and terms in 3D image based 3D treatment planning in cervix cancer brachytherapy with emphasis on MRI assessment of GTV and CTV. *Radiother Oncol* 2005;74:235-245. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15763303>.

279. Yoshida K, Jastaniyah N, Sturdza A, et al. Assessment of Parametrial Response by Growth Pattern in Patients With International Federation of Gynecology and Obstetrics Stage IIB and IIIB Cervical Cancer: Analysis of Patients From a Prospective, Multicenter Trial (EMBRACE). *Int J Radiat Oncol Biol Phys* 2015;93:788-796. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26530747>.

280. Viswanathan AN, Erickson BA. Three-dimensional imaging in gynecologic brachytherapy: a survey of the American Brachytherapy Society. *Int J Radiat Oncol Biol Phys* 2010;76:104-109. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19619956>.

281. Erickson-Whitmann B, Rownd J, Khater K. Biologic and physical aspects of radiation oncology. In: Barakat R, Markman M, Randall M, eds. Principles and Practice of Gynecology Oncology, 5th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:325-380.

282. Lim K, Small W, Jr., Portelance L, et al. Consensus guidelines for delineation of clinical target volume for intensity-modulated pelvic radiotherapy for the definitive treatment of cervix cancer. Int J Radiat Oncol Biol Phys 2011;79:348-355. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20472347>.

283. Loiselle C, Koh WJ. The emerging use of IMRT for treatment of cervical cancer. J Natl Compr Canc Netw 2010;8:1425-1434. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21147905>.

284. Beriwal S, Gan GN, Heron DE, et al. Early clinical outcome with concurrent chemotherapy and extended-field, intensity-modulated radiotherapy for cervical cancer. Int J Radiat Oncol Biol Phys 2007;68:166-171. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17321070>.

285. Chen M-F, Tseng C-J, Tseng C-C, et al. Clinical outcome in posthysterectomy cervical cancer patients treated with concurrent Cisplatin and intensity-modulated pelvic radiotherapy: comparison with conventional radiotherapy. Int J Radiat Oncol Biol Phys 2007;67:1438-1444. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17394944>.

286. Chen M-F, Tseng C-J, Tseng C-C, et al. Adjuvant concurrent chemoradiotherapy with intensity-modulated pelvic radiotherapy after surgery for high-risk, early stage cervical cancer patients. Cancer J 2008;14:200-206. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18536561>.

287. Salama JK, Mundt AJ, Roeske J, Mehta N. Preliminary outcome and toxicity report of extended-field, intensity-modulated radiation therapy for gynecologic malignancies. Int J Radiat Oncol Biol Phys 2006;65:1170-1176. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16730136>.

288. Small W, Mell LK, Anderson P, et al. Consensus guidelines for delineation of clinical target volume for intensity-modulated pelvic radiotherapy in postoperative treatment of endometrial and cervical cancer. Int J Radiat Oncol Biol Phys 2008;71:428-434. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18037584>.

289. Erpolat OP, Alco G, Caglar HB, et al. Comparison of hematologic toxicity between 3DCRT and IMRT planning in cervical cancer patients after concurrent chemoradiotherapy: a national multi-center study. Eur J Gynaecol Oncol 2014;35:62-66. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24654465>.

290. Klopp AH, Moughan J, Portelance L, et al. Hematologic toxicity in RTOG 0418: a phase 2 study of postoperative IMRT for gynecologic cancer. Int J Radiat Oncol Biol Phys 2013;86:83-90. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23582248>.

291. Klopp AH, Yeung AR, Deshmukh S, et al. Patient-Reported Toxicity During Pelvic Intensity-Modulated Radiation Therapy: NRG Oncology-RTOG 1203. J Clin Oncol 2018;36:2538-2544. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29989857>.

292. Fyles A, Keane TJ, Barton M, Simm J. The effect of treatment duration in the local control of cervix cancer. Radiother Oncol 1992;25:273-279. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/1480773>.

293. Girinsky T, Rey A, Roche B, et al. Overall treatment time in advanced cervical carcinomas: a critical parameter in treatment outcome. Int J Radiat Oncol Biol Phys 1993;27:1051-1056. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8262826>.

294. Lanciano RM, Pajak TF, Martz K, Hanks GE. The influence of treatment time on outcome for squamous cell cancer of the uterine cervix treated with radiation: a patterns-of-care study. Int J Radiat Oncol Biol Phys 1993;25:391-397. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8436516>.

295. Perez CA, Grigsby PW, Castro-Vita H, Lockett MA. Carcinoma of the uterine cervix. I. Impact of prolongation of overall treatment time and timing of brachytherapy on outcome of radiation therapy. *Int J Radiat Oncol Biol Phys* 1995;32:1275-1288. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7635767>.

296. Petereit DG, Sarkaria JN, Chappell R, et al. The adverse effect of treatment prolongation in cervical carcinoma. *Int J Radiat Oncol Biol Phys* 1995;32:1301-1307. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7635769>.

297. Eifel PJ, Levenback C, Wharton JT, Oswald MJ. Time course and incidence of late complications in patients treated with radiation therapy for FIGO stage IB carcinoma of the uterine cervix. *Int J Radiat Oncol Biol Phys* 1995;32:1289-1300. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7635768>.

298. Forrest JL, Ackerman I, Barbera L, et al. Patient outcome study of concurrent chemoradiation, external beam radiotherapy, and high-dose rate brachytherapy in locally advanced carcinoma of the cervix. *Int J Gynecol Cancer* 2010;20:1074-1078. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20683420>.

299. Perez CA, Grigsby PW, Lockett MA, et al. Radiation therapy morbidity in carcinoma of the uterine cervix: dosimetric and clinical correlation. *Int J Radiat Oncol Biol Phys* 1999;44:855-866. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10386643>.

300. Van Calsteren K, Heyns L, De Smet F, et al. Cancer during pregnancy: an analysis of 215 patients emphasizing the obstetrical and the neonatal outcomes. *J Clin Oncol* 2010;28:683-689. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19841323>.

301. Fukushima K, Ogawa S, Tsukimori K, et al. Can we diagnose invasive cervical cancer during pregnancy as precise as in nonpregnant women?: maternal and perinatal outcome in pregnancies complicated with cervical cancers. *Int J Gynecol Cancer* 2009;19:1439-1445. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20009904>.

302. Smith LH, Danielsen B, Allen ME, Cress R. Cancer associated with obstetric delivery: results of linkage with the California cancer registry. *Am J Obstet Gynecol* 2003;189:1128-1135. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/14586366>.

303. Swenson RE, Goff BA, Koh W-J, et al. Cancer in the pregnant patient. In: Hoskins WJ, Perez CA, Young RC, eds. *Principles and Practice of Gynecologic Oncology*, 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2004 1279-1311.

304. Sadler L, Sykes P. How little is known about cervical cancer in pregnancy? *Ann Oncol* 2005;16:341-343. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15722461>.

305. Morice P, Narducci F, Mathevet P, et al. French recommendations on the management of invasive cervical cancer during pregnancy. *Int J Gynecol Cancer* 2009;19:1638-1641. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19955951>.

306. Sood AK, Sorosky JI. Invasive cervical cancer complicating pregnancy. How to manage the dilemma. *Obstet Gynecol Clin North Am* 1998;25:343-352. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/9629575>.

307. van de Nieuwenhof HP, van Ham MAPC, Lotgering FK, Massuger LFAG. First case of vaginal radical trachelectomy in a pregnant patient. *Int J Gynecol Cancer* 2008;18:1381-1385. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18298565>.

308. Ben-Arie A, Levy R, Lavie O, et al. Conservative treatment of stage IA2 squamous cell carcinoma of the cervix during pregnancy. *Obstet Gynecol* 2004;104:1129-1131. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15516424>.

309. Gurney EP, Blank SV. Postpartum radical trachelectomy for IB1 squamous cell carcinoma of the cervix diagnosed in pregnancy. *Am J Obstet Gynecol* 2009;201:e8-e10. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19695559>.

310. Chan JK, Berek JS. Impact of the human papilloma vaccine on cervical cancer. J Clin Oncol 2007;25:2975-2982. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17617529>.

