Staging Issues in Cervical Cancer

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Worldwide cervical cancer is third most common cancer, but diagnostic, therapeutic problems continue in developing countries where it is most common cancer in women. Very few women report at operable stage. For those subjected to surgery, intraoperative findings, histopathology provides information for continuing or abandoning surgery, adjuvant therapy af suǍÆaÑM diaraopemop hpe-a infor

(18.20%) had cancer breast and 2516 (43.87%) had gynecological cancers. A total of 1923 had cervical cancer, (33.54% of cancers in women, 76.43% of all gynecological cancers). Of all cases of cervical cancer 13.05% were planned for radical hysterectomy, study subjects (Table 1).

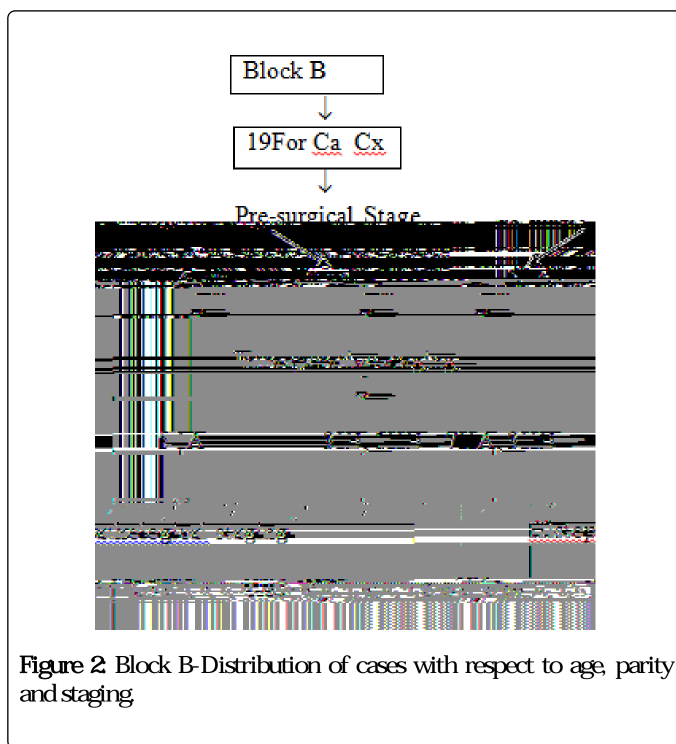

Figure 2: Block B-Distribution of cases with respect to age, parity and staging.

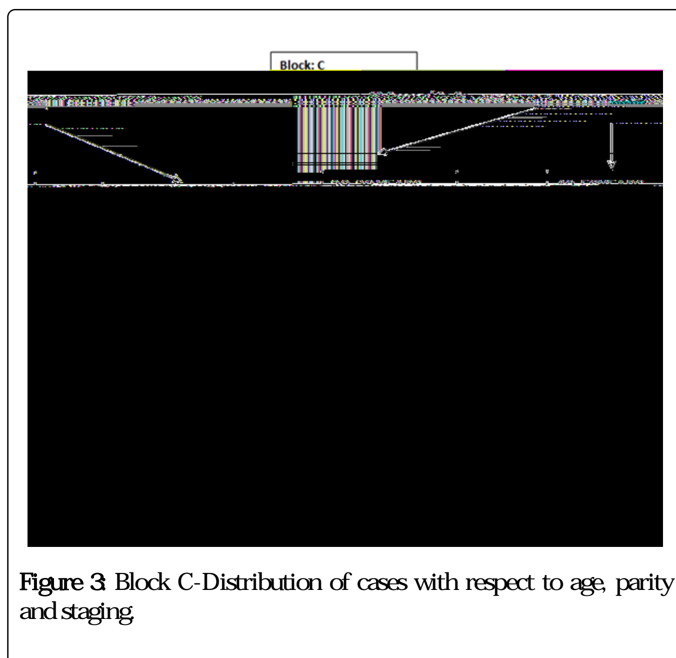

Figure 3: Block C-Distribution of cases with respect to age, parity and staging.

In Block C, 19 were for radical hysterectomy. Of 8 with IIA1, one had parametrial on histopathology, (staged IIB). In Block D, of 39 cases planned for surgery with stage IIA1, in two cases bladder involvement was diagnosed intraoperative (stage IV A) and hence procedure was abandoned. In Block E, of total 38 women planned, 22 (57.89%) were for stage IIA1, 11 (50.00%) of them continued to be of the same stage histopathologically and in 10 (45.50%) parametrial involvement was diagnosed histopathologically (IIB). (8 (36.40%) IIB, 2 (9.1%) IIIB) and in one (4.5%) of stage IIA1 intraoperative bladder involvement was detected (stage IVA) and hence procedure was abandoned. Of forty six cases planned for radical hysterectomy in Block F, of 12 (26.08%) of stage IA1, one (8.3%) turned out to be in-situ cancer postoperative histopathology. Of 13 (28.3%) operated for IB1, one (7.7%) had malignant mixed mullerian tumour (MMMT) and of 21 (45.60%) operated for IIA1 also, one (4.8%) was having MMMT on histopathology of operative specimen (Figures 1-4).

Overall of 251 women who were planned for radical hysterectomy, 61 (21.91%) were operated for stage IA, 68 (27.09%) stage IB1, 122 (48.60%) stage IIA1.On correlating clinical and intraoperative staging of 55 cases clinically diagnosed as stage IA(A1+A2), 41 (74.54%) remained stage IA intraoperative also, 7 (12.72%) turned out to be IIA1 and 7 (12.72%) IIB. Of 68 women with clinical stage IB1, 53 (77.94%) remained of same stage intraoperative, 11 (16.17%) were IIA1 and 6(8.82%) IIB. Of 122 cases operated with clinical stage IIA1, intraoperative staging was IA in 3(2.45%), IB1 in 2 (1.63%), IIA1 in 88 (72.13%), IIB in 24 (19.67%), IIIB in 7 (5.73%) and 8 (6.55%) had stage IV A disease. So 28% women would not have been posted for surgery if they were known to be, of the stage they were found intraoperative, (clinical under staging of disease), over staging was only in 2 % cases. On correlating clinical, surgical specimen histopathological staging it was revealed that of 55 clinical stage IA, 42 (76.36%) were as stage IA (A1,A2) , 7 (12.72%) were IIA1, 3 (5.45%) were IIB and three were in situ disease (5.45%). Of 68 with clinical stage IB1, 51 (75.00%) were as IB1, 11 (16.17%) IIA1 and 6 (8.82%) were of stage IIB. Of 122 cases with clinical stage IIA1, the staging was IA (A1,A2) in one, IB1 in two, 74 remained IIA1, 32 were IIB, 4 IIIB, 7 were IV A and two were MMMT. So over all 36% women would not have been opened up for surgery if their staging was known preoperatively.

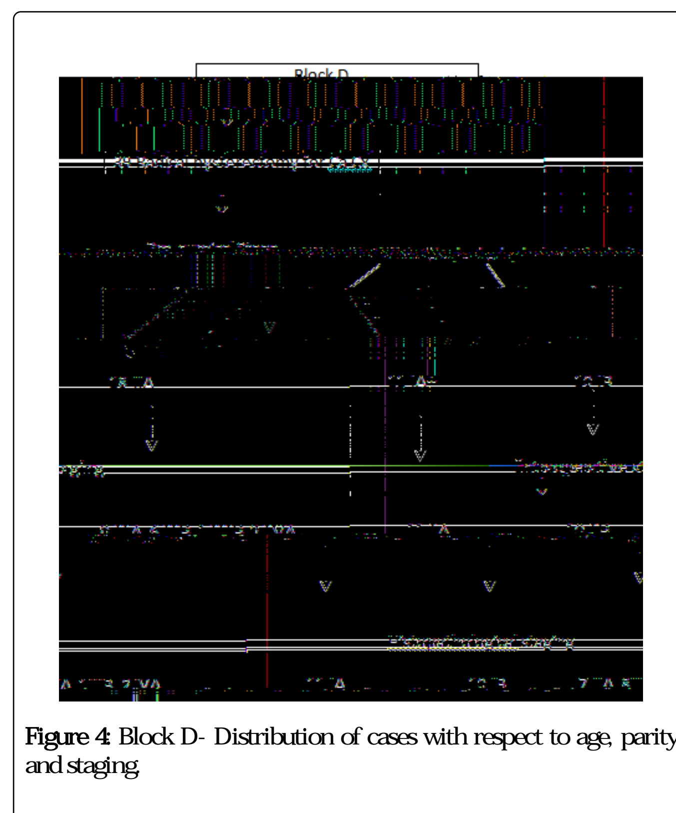

Figure 4: Block D- Distribution of cases with respect to age, parity and staging.

Discussion

Cervical cancer is seventh in the frequency amongst overall cancers, third most common cancer among women worldwide, with an

estimated 500,000 new cases diagnosed every year [9,10] . Attempts continue to be made for prevention and if cancer occurs, to provide the best of therapy for quality life and to prevent death for which appropriate staging is critical. Patients considered poor surgical candidates, because of their comorbidities like cardiac, pulmonary, and renal diseases, coagulopathy etc. are not operated even if these are in operable stage for obvious reasons. Many gynaecologic oncologists favour non-operative treatment in elderly patients also. years of age is cited as the limit for consideration of radical hysterectomy by some [17], however others have found morbidity and survival of older patients comparable to younger ones [18]. it seems prudent to determine whether a surgical approach is appropriate and safe, based

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