一、本共識依下列參考資料修改版本：

NCCN Clinical Practice Guidelines in Oncology- Cervical cancer V.2.2015

2009年Revised FIGO staging for carcinoma of the Vulva, Cervix, and Endometrium

國家衛生研究院之『子宮頸癌臨床指引』

二、制訂人員：

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WORK UP

- H&P
- CBC (including platelets)
- Cervical biopsy, pathologic review
- Cone biopsy as indicated [a]
- LFT/renal function studies
- Imaging
  (optional for ≦ stage IB1):
  > Chest x-ray
  > CT or PET-CT scan
  > MRI as indicated

Optional [3] (≧Stage IB2):
> EUA cystoscopy/proctoscopy [b]

- Consider HIV testing (category 3)
- Tumor markers (SCC,or CEA,CA-125)
- Smoking cessation and counseling intervention

CLINICAL STAGING

Stage IA1	See Primary Treatment (Fertility Sparing)(CERV- 2) See Primary Treatment (Non-Fertility Sparing)(CERV- 3)
Stage IA2 Stage IB1	See Primary Treatment(Fertility Sparing) (CERV-2) See Primary Treatment (Non-Fertility Sparing))(CERV- 3) and (CERV- 4)
Stage IIA1	See Primary Treatment (Non-Fertility Sparing)(CERV- 4)
Stage IB2 Stage IIA2	See Primary Treatment (CERV-4) and (CERV-6)
Stage IIB Stage IIIA, IIIB Stage IVA	See Primary Treatment (CERV-6)
Incidental finding of invasive cancer at simple hysterectomy	See Primary Treatment (CERV-9)

[a] See Discussion for indications for cone biopsy (MS-2).

[b] For suspicion of bladder/bowel involvement, cystoscopy/ proctoscopy with biopsy is required.

All staging in guideline is based on updated 2010 FIGO staging. (See ST-1)

CLINICAL STAGE	PRIMARY TREATMENT (FERTILITY SPARING) [d]	
Stage IA1 (no lymphovascular space invasion [LVSI])	→ Cone biopsy[e] with negative margins (preferably a non-fragmented specimen with 3-mm negative margins) (If positive margins, repeat cone biopsy or perform trachelectomy)	→ See Surveillance (CERV-10)
Stage IA1 (with LVSI) and Stage IA2	→ Cone biopsy[e] with negative margins (preferably a non-fragmented specimen with 3-mm negative margins- if positive margins, repeat cone biopsy or perform trachelectomy) + pelvic lymph node dissection ± para-aortic lymph node sampling [category 2B] or Radical trachelectomy + pelvic lymph node dissection (± para-aortic lymph node sampling [category 2B])	→ See Surgical Findings (CERV-10)
Stage IB1 [c]	→ Radical trachelectomy + pelvic lymph node dissection[f] ± para-aortic lymph node sampling	→ See Surgical Findings (CERV-10)

第CERV-2頁

[c] Fertility-sparing surgery for stage IB1 has been most validated for tumors ≤2 cm. Small cell neuroendocrine histology and adenoma malignum are not considered suitable tumors for this procedure.

[d] No data support a fertility-sparing approach in small cell neuroendocrine tumors or minimal deviation adenocarcinoma (also known as 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.

子宮頸癌臨床指引 (Cancer of the Cervix)

CLINICAL STAGE | **BIOPSY RESULTS** | **PRIMARY TREATMENT (Non-FERTILITY SPARING)**

Stage IA1 (no LVSI) → Cone biopsy[e]

- Negative margins and inoperable → Observe → **See Surveillance (CERV-10)**
- Negative margins and operable → Extrafascial hysterectomy[f] → **See Surveillance (CERV-10)**
- Positive margins for dysplasia or carcinoma → Extrafascial or modified radical hysterectomy + pelvic lymph node dissection if margins positive for carcinomaf (category 2B for node dissection) → **See Surgical Findings (CERV-5)**

  or

  Consider repeat cone biopsy[e] to better evaluate depth of invasion → **See Surgical Findings (CERV-5)**

Stage IA1 (with LVSI) and Stage IA2 →

- Modified radical hysterectomy + pelvic lymph node dissection[f] ± para-aortic lymph node sampling (category 2B) → **See Surgical Findings (CERV-5)**
- or Pelvic RT [h,i] + brachytherapy (total point A dose: 70-80 Gy) [j] → **See Surgical Findings (CERV-10)**

第CERV-3頁

[e] Cold 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.

[f] **See Principles of Radiation Therapy for Cervical Cancer (CERV-A).**

[h] Radiation can be an option for medically inoperable patients or those who refuse surgery

[i] **See Principles of Radiation Therapy for Cervical Cancer (CERV-B).**

[j] 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. Modify treatment based on normal tissue tolerance. (**See Discussion**)

子宮頸癌臨床指引 (Cancer of the Cervix)

CLINICAL STAGE | **PRIMARY TREATMENT (Non-FERTILITY SPARING)**

Stage IB1 and Stage IIA1 →

- Radical hysterectomy
  + pelvic lymph node dissection[f]
  ± para-aortic lymph node sampling
  (category 1 f or primary surgery)
  → **See Surgical Findings (CERV-5)**

  or

- Pelvic RT [h,i]
  + brachytherapy (total point A dose: 80-85 Gy) [j]
  ± concurrent cisplatin-containing chemotherapy [k]
  → **See Surveillance (CERV-10)**

Stage IB2 and Stage IIA2 (also see CERV-6 for alternative recommendations for these patients) →

- Definitive Pelvic RT [i]
  + concurrent cisplatin-containing chemotherapy [k]
  + brachytherapy (total point A dose ≥85 Gy) [j]
  (category 1 for primary chemoradiation)
  → **See Surveillance (CERV-10)**

  or

- Radical hysterectomy
  + pelvic lymph node dissection[f]
  ± para-aortic lymph node sampling (category 2B)
  → **See Surgical Findings (CERV-5)**

  or

- Pelvic RT [i]
  + concurrent cisplatin-containing chemotherapy[k]
  + brachytherapy (total point A dose 75-80 Gy) [j]
  + adjuvant hysterectomy (category 3)
  → **See Surgical Findings (CERV-10)**

[f] **See Principles of Radiation Therapy for Cervical Cancer (CERV-A).**

[g] For SLN mapping (category 2B), the best detection rates and mapping results are in tumors <2 cm.

[h] Radiation can be an option for medically inoperable patients or those who refuse surgery

[i] **SeePrinciples of Radiation Therapy for Cervical Cancer (CERV-B).**

[j] 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. Modify treatment based on normal tissue tolerance. (**See Discussion**)

[k] Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.

子宮頸癌臨床指引 (Cancer of the Cervix)

SURGICAL FINDINGS **ADJUVANT TREATMENT**

Negative nodes, negative margins, negative parametrium → Observe
or
Pelvic RT[i] if combination of high-risk factors (category 1)
(ie, primary tumor size, stromal invasion, and/or LVSI that meet Sedis criteria[l]
± concurrent cisplatin-based chemotherapy[k] (category 2B for chemotherapy)

Positive pelvic nodes and/or Positive surgical margin and/or Positive parametrium → Pelvic RT[e] + concurrent cisplatin-containing chemotherapy[k] (category 1)
± vaginal brachytherap[i]

→ See Surveillance (CERV-10)

Para-aortic lymph node positive by surgical staging → Chest CT or PET-CT scan

- Negative for distant metastasis → Para-aortic lymph node RT [i] + concurrent cisplatin-containing chemotherapy[k] + pelvic RT[i] ± brachytherapy[i]
- Positive for distant metastasis → Consider biopsy of suspicious areas as indicated
  - Negative → Para-aortic lymph node RT [i] + concurrent cisplatin-containing chemotherapy[k] + pelvic RT[i] ± brachytherapy[i]
  - Positive → Systemic therapy[m] ± individualized RT[i]

See Surveillance (CERV-10)

CERV-5頁

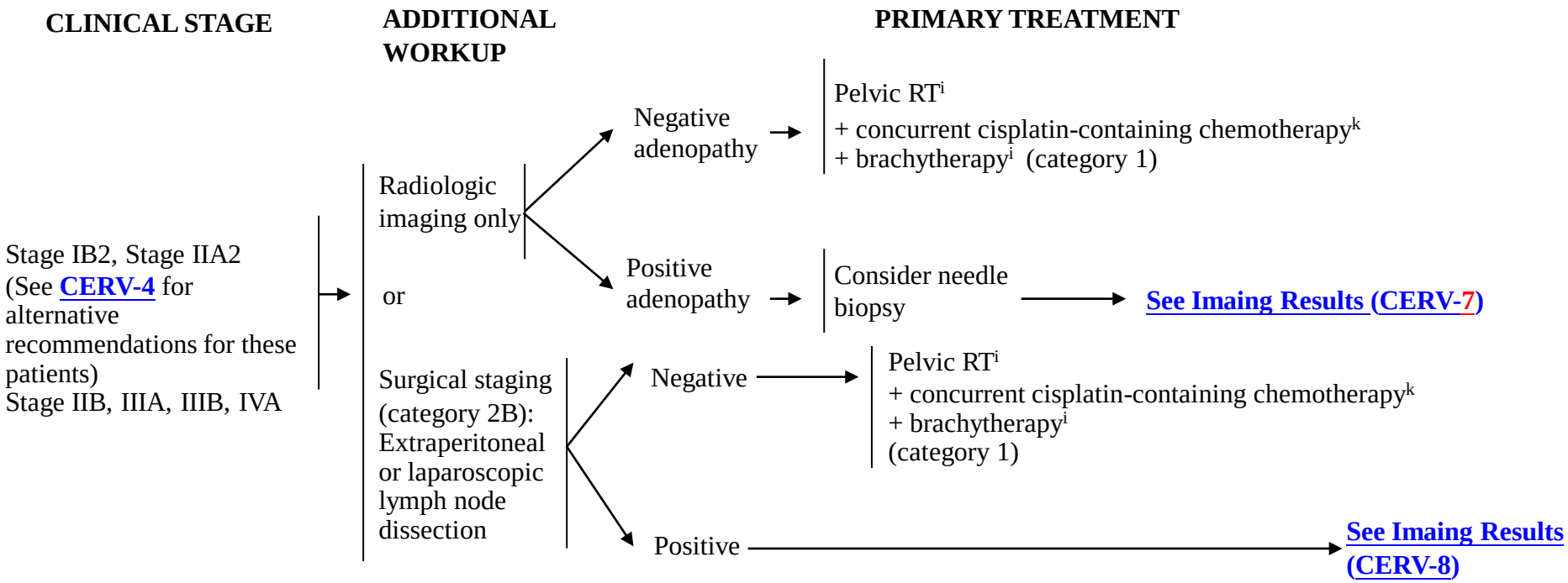
[i] See Principles of Radiation Therapy for Cervical Cancer (CERV-A).

[k] Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.

[l] Risk factors may not be limited to the Sedlis criteria. See Sedlis Criteria (CERV-C).

[m] See Principles of Radiation Therapy for Cervical Cancer (CERV-A).

子宮頸癌臨床指引 (Cancer of the Cervix)



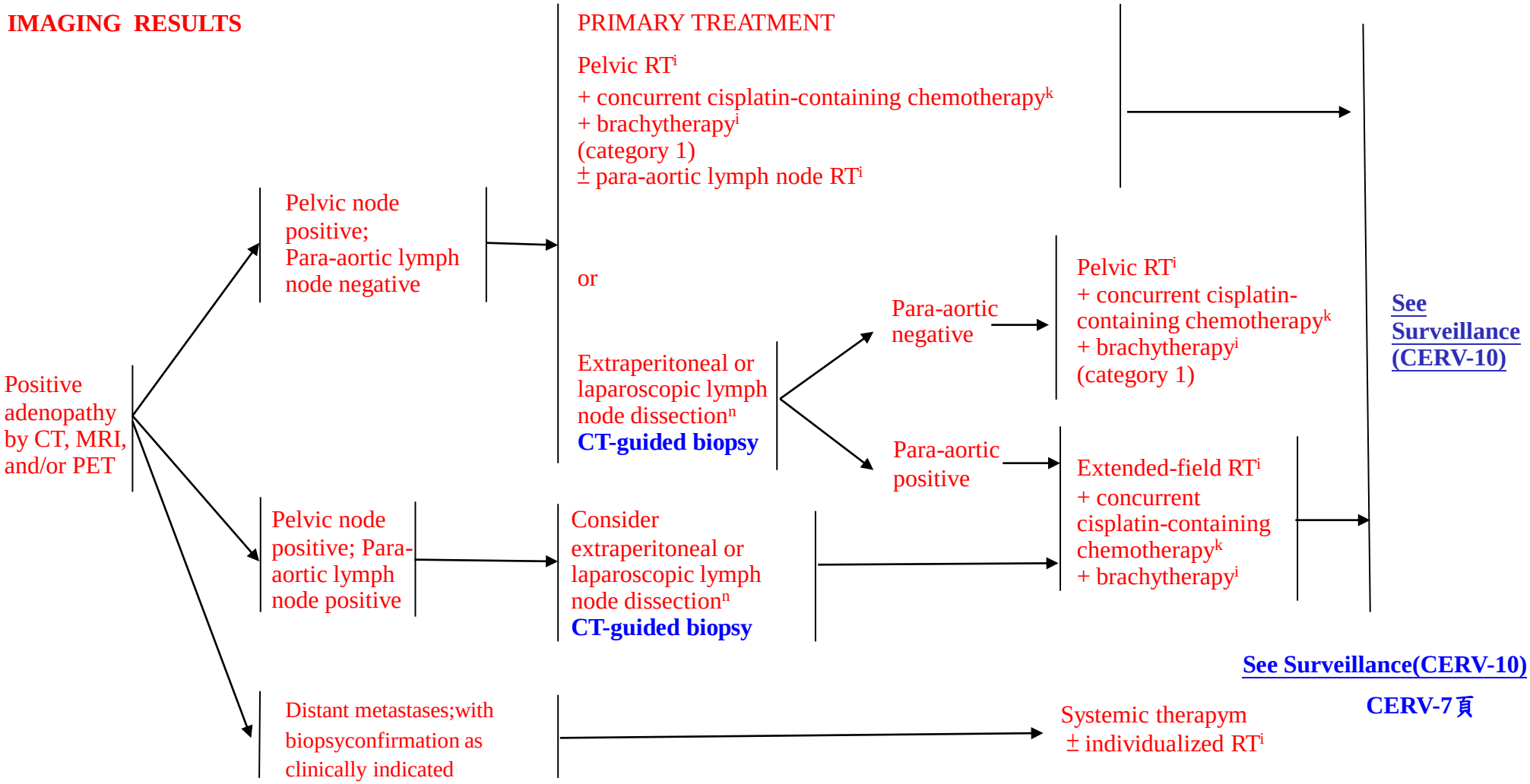
[i] See Principles of Radiation Therapy for Cervical Cancer (CERV-B).

[k] Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.

See Surveillance(CERV-10)

Stage IB2, IIA2; Stage IIB, IIIA, IIIB, IVA

PRIMARY TREATMENT



[i] See Principles of Radiation Therapy for Cervical Cancer (CERV-B).

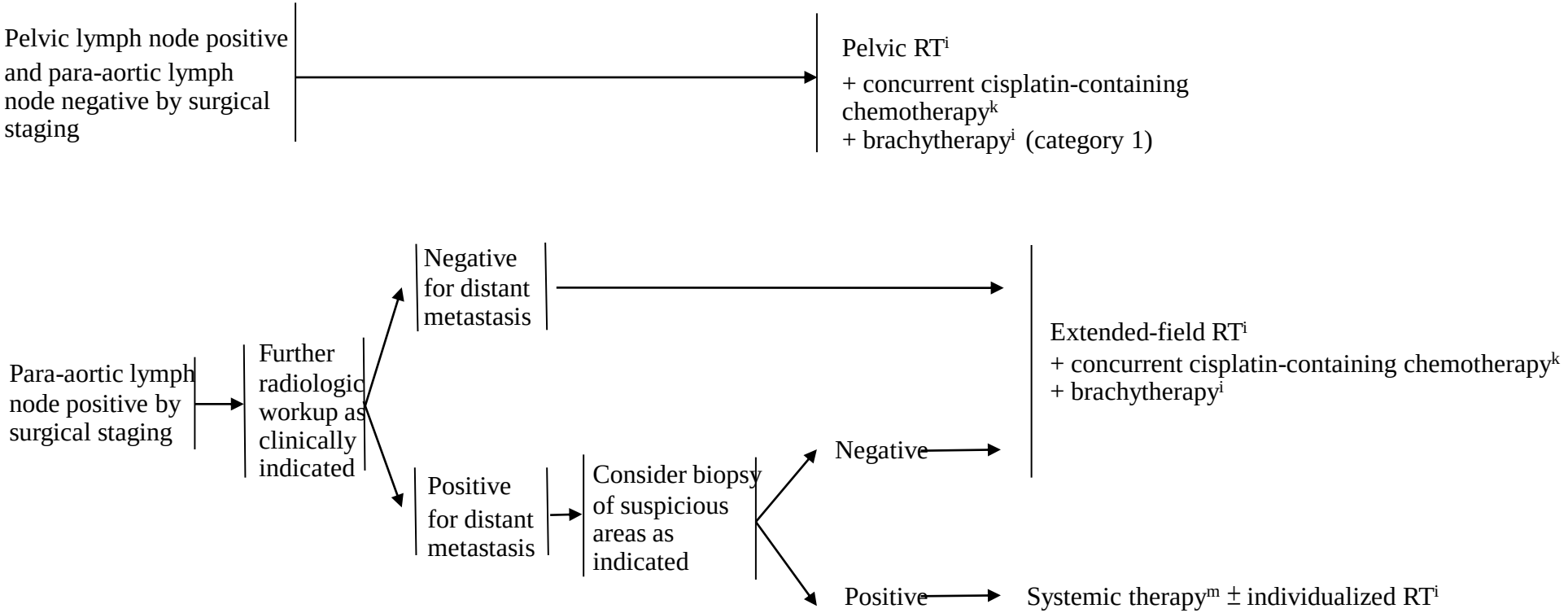
[k] Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.

[m] See Chemotherapy Regimens for Recurrent or Metastatic Cervical Cancer (CERV-D).

[n] Consider postoperative imaging to confirm the adequacy of node removal.

Stage IB2, IIA2; Stage IIB, IIIA, IIIB, IVA
NODE STATUS

PRIMARY TREATMENT

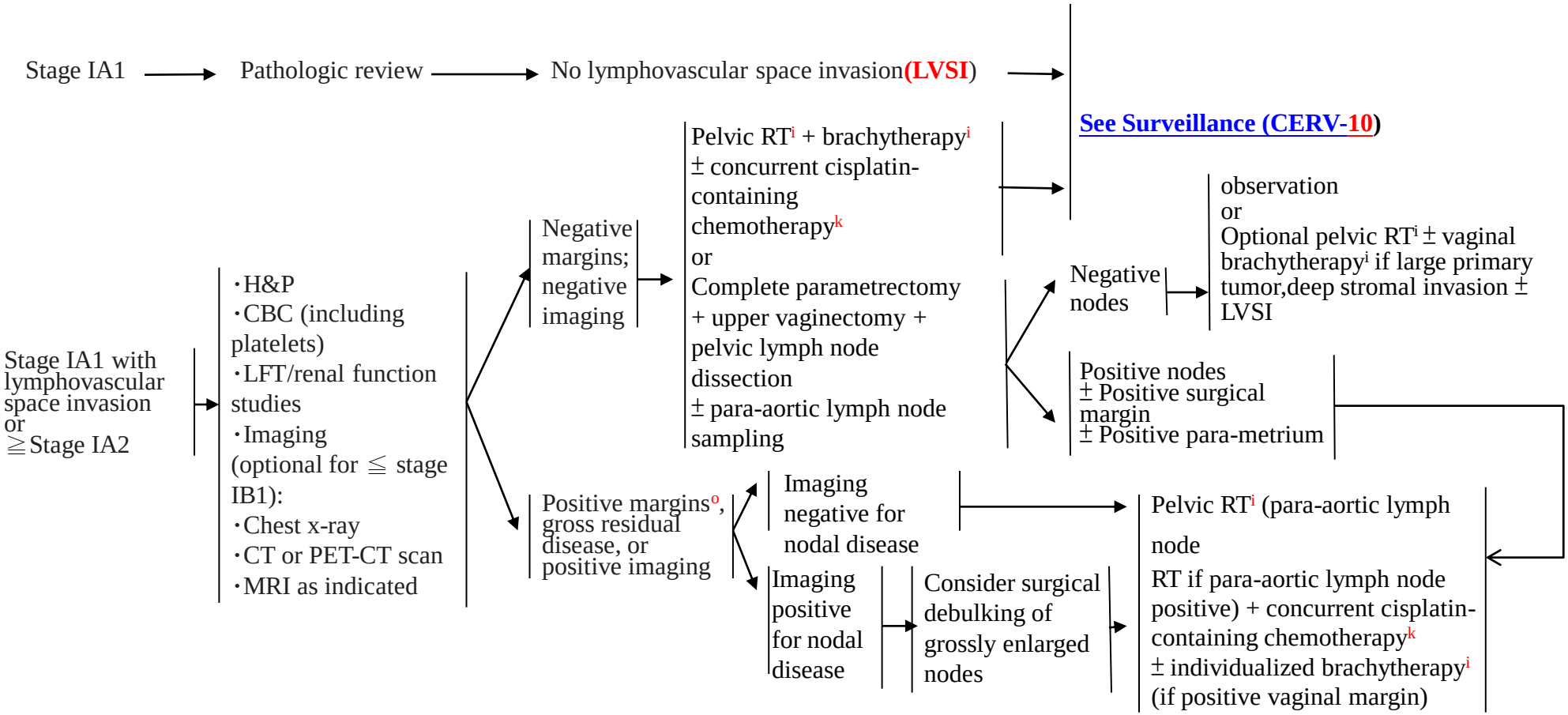


CERV-8頁

[i] See Principles of Radiation Therapy for Cervical Cancer (CERV-B).
[k] Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.
[m] See Chemotherapy Regimens for Recurrent or Metastatic Cervical Cancer (CERV-C).
[l] Gemcitabine (out –of -pocket)

INCIDENTAL FINDING OF INVASIVE CANCER AT SIMPLE HYSTERECTOMY

PRIMARY TREATMENT



See Surveillance (CERV-10)
CERV-9頁

i See Principles of Radiation Therapy for Cervical Cancer (CERV-B).
k Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.
o Invasive cancer at surgical margin.

SURVEILLANCE[p]

- **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 annually** [q]
  as indicated for the detection of lower genital tract neoplasia
- **Imaging (chest radiography, CT,PET, PET/CT, MRI)** as indicated based on symptoms or examination findings suspicious for recurrence [r]
- **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, lifestyle,obesity, exercise, and nutrition counseling (**See NCCN Guidelines for Survivorship**)
- Patient education regarding sexual health, vaginal dilator use, and vaginal lubricants/moisturizers (eg, estrogen creams)

WORKUP

Persistent or recurrent disease →
- Additional imaging as clinically indicated
- Surgical exploration in selected cases

→ **See Therapy for Relapse (Local/regional recurrence) (CERV-11)**

→ **See Therapy for Relapse (Distant metastases) (CERV-12)**

CERV-10頁

THERAPY FOR RELAPSE

Distant metastases

- Amenable to local treatment →
  - Local treatment:
    Resection ± RT
    or
    Local ablative therapies ± RT
    or
    RT[i] ± concurrent chemotherapy[k]
  - May consider systemic adjuvant chemotherapy[m]

  → **See Surveillance (CERV-10)**
- Not amenable to local treatment →
  Clinical trial
  or
  Chemotherapy[m]
  or
  Best supportive care (**See NCCN Guidelines for Palliative Care**)

CERV-12頁

p Salani R, Backes FJ, Fung MF, et al. Posttreatment surveillance and diagnosis of recurrence in women with gynecologic malignancies: Society of Gynecologic Oncologists recommendations. Am J Obstet Gynecol 2011;204:466-478.

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

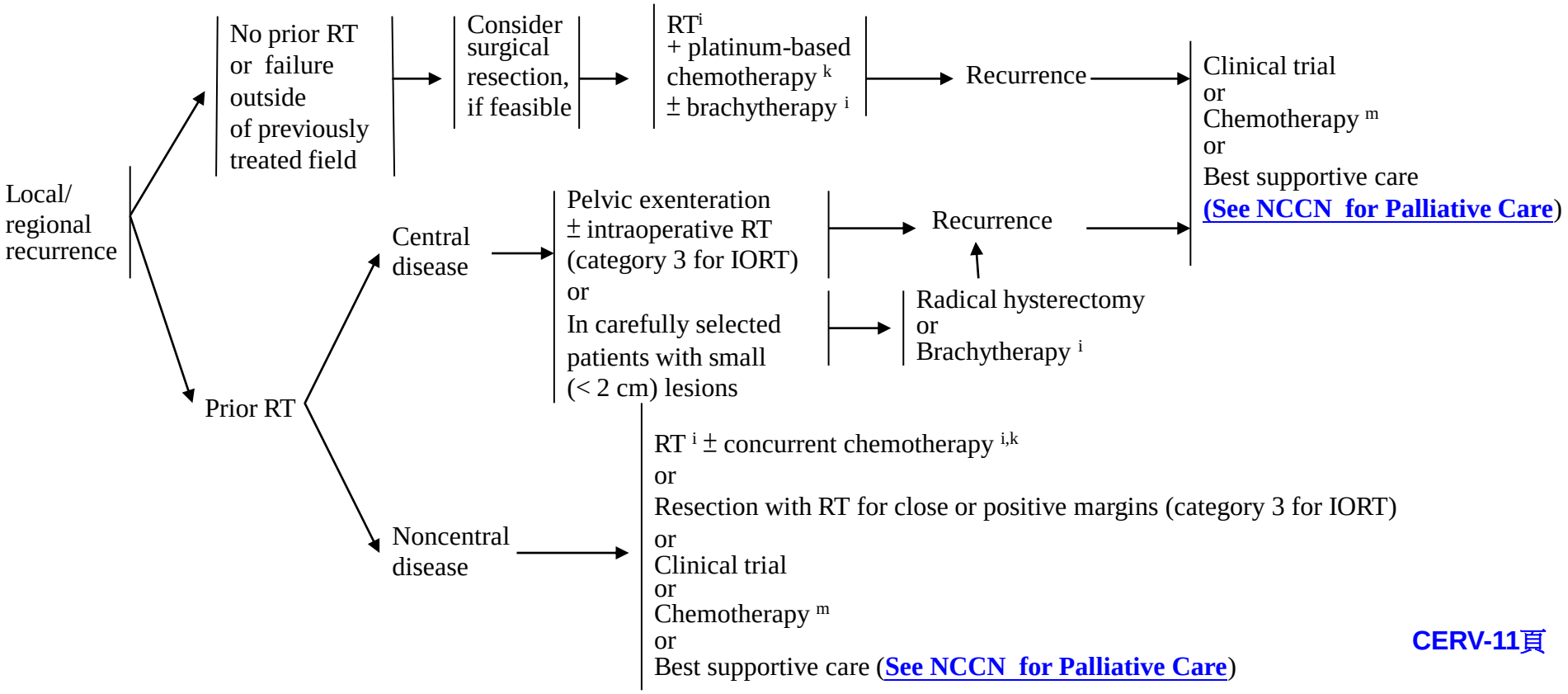
r A single PET-CT scan performed at 3-6 months after chemoradiation for locally advanced cervical cancer can be used to suggest early or asymptomatic persistence/recurrence. Other imaging studies (such as chest x-ray, CT scan, MRI, and subsequent PET-CT) may also be used to assess or follow recurrence when clinically indicated but are not recommended for routine surveillance. (**See Discussion**). Recurrences should be proven by biopsy before proceeding to treatment planning.

i **See Principles of Radiation Therapy for Cervical Cancer (CERV-B).**

k Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.

l **See Chemotherapy Regimens for Recurrent or Metastatic Cervical Cancer (CERV-D).**

THERAPY FOR RELAPSE



CERV-11頁

i See Principles of Radiation Therapy for Cervical Cancer **(CERV-B).**
k Concurrent cisplatin-based chemotherapy with RT utilizes cisplatin as a single agent or cisplatin plus 5-fluorouracil.
m See Chemotherapy Regimens for Recurrent or Metastatic Cervical Cancer **(CERV-).**

Staging

American Joint Committee on Cancer (AJCC 7th)

FIGO Stage	Primary Tumor (T)	TNM Categories
	Primary tumor cannot be assessed	TX
	No evidence of primary tumor	T0
	Carcinoma in situ (preinvasive carcinoma)	Tis
I	Cervical carcinoma confined to uteri (extension to corpus should be disregarded)	T1
IA	Invasive carcinoma diagnosed only by microscopy. Stromal invasion with a maximal depth of 5.0 mm measured from the base of the epithelium and a horizontal spread of 7.0 mm or less. Vascular space involvement, venous or lymphatic, does not affect classification	T1a**
IA1	Measured stromal invasion 3.0 mm or less in depth and 7.0 mm or less in horizontal spread	T1a1
IA2	Measured stromal invasion more than 3.0 mm and not more than 5.0 mm with a horizontal spread 7.0 mm or less	T1a2
IB	Clinically visible lesion confined to the cervix or microscopic lesion greater than T1a/IA2.	T1b
IB1	Clinically visible lesion 4.0 cm or less in greatest dimension	T1b1
IB2	Clinically visible lesion more than 4.0 cm in greatest dimension	T1b2
II	Cervical carcinoma invades beyound uterus but not to pelvic wall or to lower third of vagina	T2
IIA	Tumor without parametrial invasion	T2a
IIA1	Clinically visible lesion 4.0 cm or less in greatest dimension	T2a1
IIA2	Clinically visible lesion more than 4 cm in greatest dimension	T2a2
IIB	Tumor with parametrial invasion	T2b
III	Tumor extended to the pelvic wall and/or involves the lower third of the vagina and/or cases with hydronephrosis or nonfunctioning kidney	T3
IIIA	Tumor involves lower third of the vagina, no extension to pelvic wall.	T3a
IIIB	Tumor extends the pelvic wall and/or causes hydronephrosis or non-functioning kidney	T3b
IVA	Tumor invades bladder or rectum, and/or extends beyond true pelvis (bullous edema is not sufficient to classify tumor T4)	T4

***FIGO staging no longer includes Stage 0 (Tis)**
****All macroscopically visible lesions—even with superficial invasion—are T1b/IB**

FIGO Stage	Regional Lymph Nodes (N)	TNM Categories
	Regional lymph nodes cannot be assessed	Nx
	No regional lymph nodes metastasis	N0
IIIB	Regional lymph nodes metastasis	N1

FIGO Stage	Distant Metastasis (M)	TNM Categories
	No distant metastasis (no pathologic M0; use clinical M to complete stage group)	M0
IVB	Distant metastasis (including peritoneal spread, involvement of supraclavicular or mediastinal lymph nodes, lung, liver, or bone)	M1

CLINICAL and PATHOLOGIC (FIGO 2008)

GROUP	T	N	M
0	Tis	N0	M0
I	T1	N0	M0
IA	T1a	N0	M0
IA1	T1a1	N0	M0
IA2	T1a2	N0	M0
IB	T1b	N0	M0
IB1	T1b1	N0	M0
IB2	T1b2	N0	M0
II	T2	N0	M0
IIA	T2a	N0	M0
IIA1	T2a1	N0	M0
IIA2	T2a2	N0	M0
IIB	T2b	N0	M0
III	T3	N0	M0
IIIA	T3a	N0	M0
IIIB	T3b	Any N	M0
	T1-3	N1	M0
IVA	T4	Any N	M0
IVB	Any T	Any N	M1

*FIGO no longer includes Stage 0 (Tis)

HISTOLOGIC GRADE (NOTTINGHAM COMBINED HISTOLOGIC GRADE IS RECOMMENDED)

GX	Grade cannot be assessed
G1	Low combined histologic grade (favorable)
G2	Intermediate combined histologic grade (moderately favorable)
G3	High combined histologic grade (unfavorable)

CERV-14頁

Chemotherapy regimens for stage IIB cervical cancer

CCRT type:
1) Concurrent cisplatin-containing chemotherapy (category 1) ;

CERV-15頁

update

NCCN最新乳癌最新指引是**2015 V.2**，之前本院參考版本是**2014 V.1**。

『CERV-1頁』:「CLINICAL STAGING」分類，同NCCN Guidelines『CERV-1頁』。

『CERV-2頁』：「PRIMARY TREATMENT (FERTILITY SPARING)」，同NCCN Guidelines『CERV-2頁』。因本院無" Consider sentinel lymph node [SLN] mapping [category 2B])"故刪除。

『CERV-3頁』：「PRIMARY TREATMENT (Non-FERTILITY SPARING)」，同NCCN Guidelines『CERV-3頁』。因本院無" Consider sentinel lymph node [SLN] mapping [category 2B])"故刪除。

『CERV-4頁』：「PRIMARY TREATMENT (Non-FERTILITY SPARING)」，同NCCN Guidelines『CERV-4頁』。因本院無" Consider sentinel lymph node [SLN] mapping [category 2B])"故刪除。

『CERV-5頁』：「ADJUVANT TREATMENT」，同NCCN Guidelines『CERV-5頁』。

『CERV-6頁』：不變。

『CERV-7頁』修改成同NCCN Guidelines『CERV-7頁』，「PRIMARY TREATMENT」處增加" CT-guided biopsy"，因本院有此技術。

『CERV-8頁』：不變。

『CERV-9頁』：不變。

『CERV-10頁』：修改成同NCCN Guidelines『CERV-10頁』。

『CERV-11頁』：不變。

『CERV-12頁』：不變。