PIPADOR REVISION

MRCOG Part 1 Revision Notes

Cervical Cancer

CLINICAL MANAGEMENT • LECTURE 501

VISUAL EXAMINATION REVISION NOTES

2026 Edition

501

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Cervical Cancer

Presentation, FIGO 2018 staging and BGCS-based management of cervical cancer, including pregnancy

HPV	FIGO 2018	Chemo- radiation	Pembro- lizumab
Cause	Imaging and pathology allowed	IB3–IVA	Advanced/ recurrent

■ KEY FACTS: Learning objectives

- Define cervical cancer, its histological types and FIGO 2018 staging.
- Describe presentation, diagnosis and staging investigations.
- Describe management by stage (BGCS), fertility-sparing options, cervical cancer in pregnancy, follow-up and prevention.

501.1 Key definitions

Term	Definition
Cervical cancer	Malignancy of the cervix — SCC ≈ 75%, adenocarcinoma ≈ 20–25%, others (neuroendocrine) rare
Microinvasive (stage IA)	Invasive cancer diagnosed only by microscopy — IA1 ≤ 3 mm depth, IA2 > 3 to ≤ 5 mm
LVSI	Lymphovascular space invasion — ↑ nodal risk
Radical hysterectomy	Removal of uterus, cervix, parametria and upper vagina with pelvic lymphadenectomy
Radical trachelectomy	Removal of cervix and parametria preserving the uterus — fertility-sparing for small tumours
Chemoradiation	External beam radiotherapy + brachytherapy with concurrent weekly cisplatin

■ IN PLAIN ENGLISH: Cervical cancer

Cervical cancer is caused by persistent **high-risk HPV** and is largely **preventable** through vaccination and screening. Small cancers are cured with surgery; larger ones are treated with chemoradiation.

501.2 Presentation and diagnosis

- Symptoms: postcoital, intermenstrual or postmenopausal bleeding
  - Discharge
  - Pain
  - Advanced — leg oedema, hydronephrosis, fistula. Many are screen-detected.
- **Urgent 2WW referral** if the cervix looks abnormal (NICE NG12) — colposcopy and biopsy; do not rely on a cytology result.
- Staging investigations: **MRI pelvis** (tumour size, parametria)

- CT chest/abdomen or PET-CT (nodes, distant)
- EUA ± cystoscopy/sigmoidoscopy if indicated
- FIGO 2018 allows imaging and pathology findings (node involvement = IIIC).

501.3 Staging

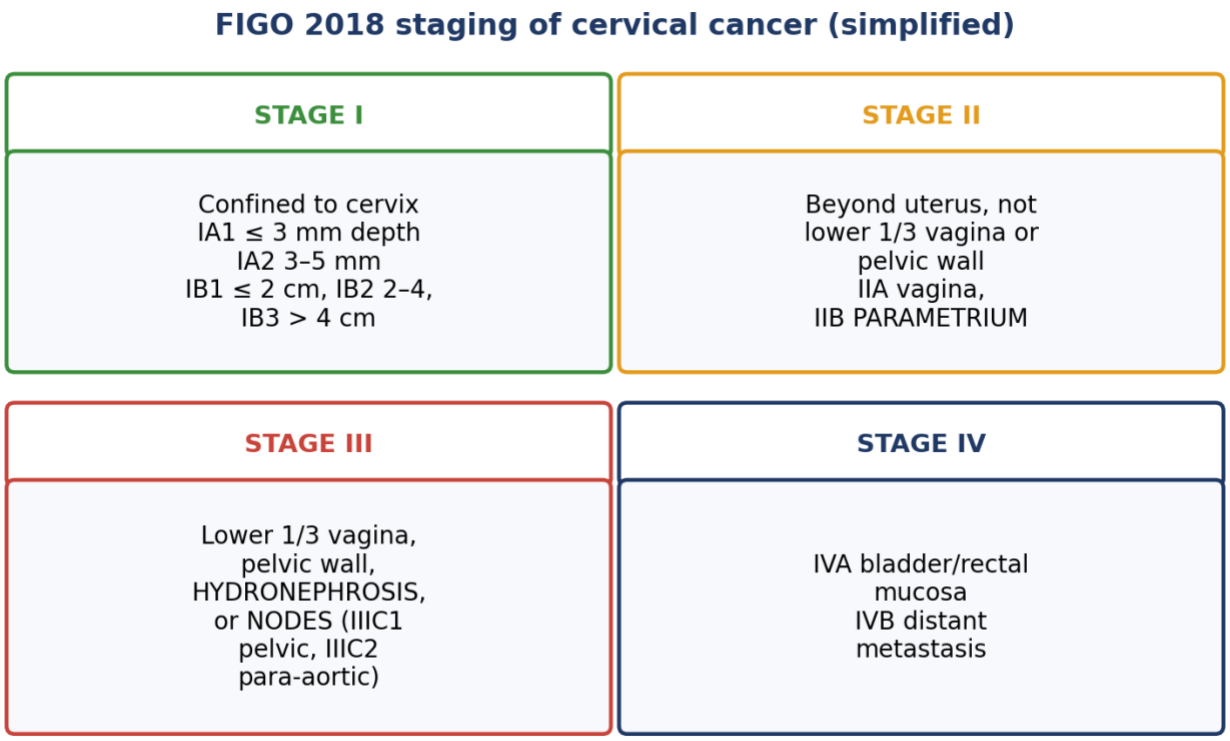


Figure 501.1 — FIGO 2018 staging (simplified)

501.4 Management (BGCS)

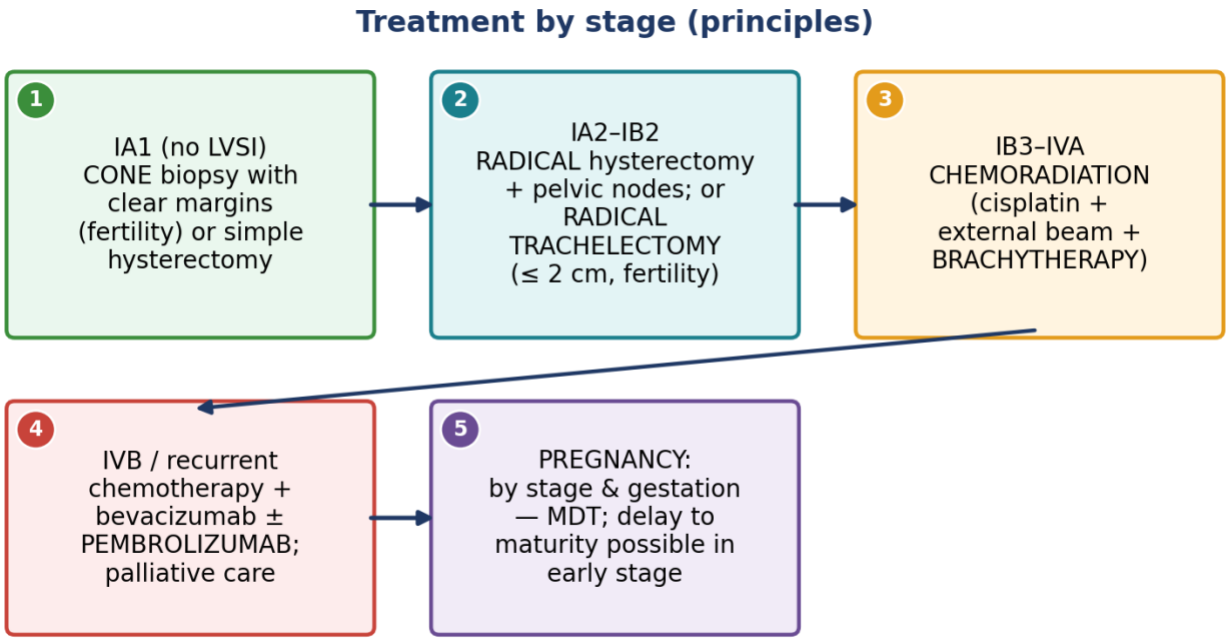


Figure 501.2 — Treatment by stage

Stage	Management
IA1 (no LVSI)	Cone biopsy/LLETZ with clear margins (fertility-sparing) or simple hysterectomy
IA1 with LVSI, IA2	Cone/simple trachelectomy or radical trachelectomy/hysterectomy + pelvic node assessment (sentinel nodes)
IB1–IB2 (≤ 4 cm)	• Radical hysterectomy + pelvic lymphadenectomy — OPEN approach preferred (LACC trial: worse survival with minimally invasive) • Radical trachelectomy for tumours ≤ 2 cm wishing fertility • Adjuvant (chemo)radiation if positive nodes/parametria/margins
IB3, II–IVA	• Primary chemoradiation (weekly cisplatin + EBRT + brachytherapy) • Avoid combining radical surgery and radiotherapy where possible (morbidity)
IVB / recurrent	• Platinum-based chemotherapy (carboplatin/paclitaxel) ± bevacizumab ± pembrolizumab (PD-L1 positive) • Palliative radiotherapy • Pelvic exenteration for central recurrence
Ovarian function	• Ovarian transposition before pelvic radiotherapy in young women • HRT after radiotherapy-induced menopause

501.5 Special situations and follow-up

- **Pregnancy**: MDT management by stage and gestation — early stage may allow delay until fetal maturity
  - Neoadjuvant chemotherapy possible from the 2nd trimester
  - CS birth (avoid tumour) ± radical hysterectomy at CS.
- Follow-up: clinical review (history and examination) every 3–6 months for 2 years then 6–12-monthly to 5 years
  - Imaging if symptoms
  - Manage late effects of radiotherapy (vaginal stenosis — dilators, bowel/bladder toxicity, lymphoedema, menopause).
- Prevention: HPV vaccination (one dose of Gardasil 9 in the UK schedule), HPV primary screening 25–64.

■ COMMON PITFALLS

Reassurance from a normal smear in a woman with a suspicious cervix.

Minimally invasive radical hysterectomy for early cervical cancer.

Combining radical surgery and radiotherapy unnecessarily.

501.6 Must-know summary

■ EXAM TIP

- HPV-driven; SCC ≈ 75%; abnormal-looking cervix → urgent colposcopy/biopsy (not cytology).
- Stage with MRI ± PET-CT; FIGO 2018 includes nodes (IIIC).
- IA1: cone; IA2–IB2: radical hysterectomy (open) or radical trachelectomy (≤ 2 cm); IB3–IVA: chemoradiation; IVB: chemo ± bevacizumab ± pembrolizumab.
- Pregnancy: MDT by stage/gestation; prevention: vaccination + screening.

■ MNEMONIC / MEMORY AID

Cervix treatment — 'Small → Surgery; Big → Beams (chemoradiation); Spread → Systemic'.