

Does Conservative Surgical Management of Early Stage Cervical Cancer Represent a Persistent Dilemma in Young Patients?



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Submission: March 21, 2017; Published: March 30, 2017

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Editorial

Nowadays, cervical cancer (CC) is the most common malignancy of the female reproductive system and the fourth most common cancer in general female population [1,2]. The disease is more prevalent among young women and related directly with persistent HPV infection [1,2]. Especially in developing countries CC represents almost 12% of all malignancies in women [1,2]. Additionally, the mortality rate from CC is almost 10-14 times higher in poor and less developed countries (Melanesia, Middle and Eastern Africa), when compared with developed ones (Western Asia, Western Europe, Australia and New Zealand) [1,2].

Based on recently published recommendations and guidelines, the primary management of CC depends mainly on disease stage and could be either surgical or non-surgical (radiotherapy, chemoradiotherapy) [3-5]. Nevertheless, the type and extend of surgical procedure and the type of non-surgical approach should be thoroughly individualized according to disease stage, histologic subtype, fertility issues and patient's general performance status [3,5-7]. According to the abovementioned, conservative management could be offered in well selected young patients with early stage CC and intense desire for future fertility, after extensive and detailed counseling regarding disease recurrence, future fertility, pregnancy complications and perinatal issues [3,5-9]. In contrast, conservative therapeutic approach should be avoided in CC patients having rare histologic subtypes with aggressive or possibly aggressive clinical behavior (small cell neuroendocrine carcinoma, minimal deviation adenocarcinoma and gastric type adenocarcinoma) [3,10,11].

Patients with FIGO stage IA1 disease without lymphovascular space invasion (LVSI), could be treated with cervical cone excision only [3,5-7,12-14]. This is based on the fact that in

this patients' subgroup, the risk of lymphatic metastasis or recurrent disease is very low (0.8% and 0.6% respectively) [15-18]. The procedure could be performed with cold knife or loop and both ectocervix and endocervical canal should be removed in a single specimen having at least 3 mm clear margins for pre-invasive or invasive disease [3,5,7]. In most cases, cold knife conization (CKC) provides many advantages compared to loop electrosurgical excision procedure (LEEP), regarding accurate evaluation of marginal status in conization specimens [7,19,20]. However in case of cone margin involvement, cervical conization should be repeated or radical trachelectomy should be offered and discussed with the patient [3,7].

Patients with FIGO stage IA1 disease and LVSI, could be treated with cervical conization or radical trachelectomy, with additional pelvic lymph node dissection and sampling of paraaortic lymph nodes [3,5-7,13,14,21-23]. In this patient subgroup, the risk of lymphatic metastasis or recurrent disease is significantly higher (8.2% and 3.1% respectively) [7,16-18]. Particularly in cases with marginal involvement, conization should be repeated or radical trachelectomy should be offered and discussed with the patient [3,7,22,23].

Likewise, patients with FIGO stage IA2 disease, could be treated with radical trachelectomy, pelvic lymph node dissection and sampling of paraaortic lymph nodes [3,5-7,9,22,24,25]. This is based on the fact that the risk of lymphatic metastasis is almost 8% in this stage, while the risk of recurrent disease is essentially greater in the LVSI subgroup (15.7% and 1.7% respectively) [7,15,16,18,26]. In addition, cervical conization with pelvic lymphadenectomy and paraaortic lymph node sampling is an alternative therapeutic approach for patients with FIGO stage IA2 disease and no cone margins or lymph node involvement [3,5-7,14,21,22].

Patients with FIGO stage IB1 disease, are in even higher risk for lymphatic metastasis (14.9%) and disease recurrence [15,27]. Tumor size more than 2 cm, depth of stromal invasion greater than 50% and presence of LVSI, represent some dismal prognostic factors [24,25]. Consequently, only in patients with FIGO stage IB1 disease and tumor size up to 2 cm, should be offered fertility sparing approach with radical trachelectomy, pelvic lymph node dissection and sampling of paraaortic lymph nodes [3,5-7,9,22,24,25,28]. The procedure of radical trachelectomy could be performed via vaginal or abdominal approach, as there are no important differences regarding oncologic outcome [7,29]. Moreover, some studies evaluating the role of abdominal radical trachelectomy in FIGO stage IB1 CC with tumor size more than 2 cm, are very promising [30,31].

In conclusion, the conservative management of early stage CC is possible in well selected young patients with intense desire for future fertility [3,5-7]. However, all of them should have a thorough preoperative assessment and a detailed counseling regarding disease recurrence, impaired cervical function, fertility issues, miscarriages and preterm labor [7,9].

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DOI: [10.19080/OAJS.2017.03.555611](https://doi.org/10.19080/OAJS.2017.03.555611)

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