

Optimal care pathway for women with cervical cancer

Quick reference guide



Please note that not all women will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Immunisation: Human papillomavirus (HPV) vaccination is offered to 12-13 year-olds through the National Immunisation Program.

Screening: The National Cervical Screening Program offers a five-yearly HPV test for women aged 25-74 years and aims to detect

early changes in the cervix.

HPV-vaccinated women still require cervical screening tests because the HPV vaccine does not protect against all oncogenic HPV types.

Primary health practitioners are crucial in encouraging women

to screen regularly.

Prevention: Cervical cancer is preventable through HPV immunisation and screening.

Risk factors: Long-term infection with certain types of HPV is known to be the cause of most cervical cancers.

Step 2

Presentation, initial investigations and referral

General/primary practitioner investigations: The five-yearly cervical screening test involves an oncogenic HPV test and reflex liquid-based cytology. Women with a positive oncogenic HPV (16/18) test result should be referred directly for colposcopic assessment, informed by the result of the reflex liquid-based cytology. Women with a positive oncogenic HPV (not 16/18) test result with a reflex liquid-based cytology result of possible high-grade lesion or high-grade lesion should be referred directly for colposcopic assessment.

A negative screening test should not preclude investigations of symptoms suggesting cervical cancer.

Signs and symptoms: A woman with symptoms at any age or vaccination status should be investigated. Early cervical cancer may be asymptomatic.

Symptoms may include:

- postcoital bleeding
- intermenstrual bleeding
- postmenopausal bleeding
- dyspareunia
- unusual or bloodstained vaginal discharge.

Symptoms of advanced cervical cancer may include pelvic pain, extreme fatigue, kidney failure, leg pain/swelling and lower back pain.

A diagnosis of cervical cancer should be considered if:

- abnormal cervical screening test

- signs and symptoms
- abnormal appearance of the cervix on clinical examination.

Referral: If the diagnosis is suspected or confirmed with initial tests, referral to a gynaecological oncologist who is a member of a multidisciplinary team is optimal.

Communication – lead clinician to:

- provide information that clearly describes who they are being referred to and why, and the timeframe for appointments
- support the woman while waiting for the specialist appointment.

Step 3

Diagnosis, staging and treatment planning

Diagnosis: After a medical history and examination, consider the following sequence of investigations:

- gynaecological examination
- colposcopic assessment
- cervical biopsy for confirmation of diagnosis
- cone biopsy (conisation)/type 3 excision
- complete blood count
- liver and renal function tests
- pelvic ultrasound.

For obvious abnormalities, a colposcopy should be undertaken within two weeks of referral.

Investigations should be completed within two weeks of specialist review.

Staging: Staging for cervical cancer is clinical but

aided by chest x-ray, CT/MRI/PET as appropriate.

Treatment planning: Newly diagnosed women should be discussed in a multidisciplinary team meeting.

Issues regarding fertility, early menopause and changes to sexual function should be addressed.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician¹ to:

- discuss a timeframe for diagnosis and treatment with the woman/carer
- explain the role of the multidisciplinary team
- provide appropriate information or refer to support services as required.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Where possible, avoid sequential multimodality treatment.

Treatment options

Surgery: Surgery is typically reserved for women who have small tumours found only within the cervix (early-stage disease and smaller lesions). In selected cases surgery for fertility preservation may be possible.

Radiation therapy: Concurrent chemoradiation is generally the primary treatment of choice if it is anticipated that surgery will not remove all disease. In women with high-risk disease, postoperative radiation therapy plus/minus chemotherapy following surgery should be offered. Where possible, these patients should be identified upfront and considered

for definitive chemoradiation to minimise the toxicities of trimodality treatment.

Chemotherapy and other systemic therapy: Chemotherapy may be used as part of primary chemoradiation or adjuvant chemoradiation. It may also be used as neoadjuvant treatment in patients who have metastatic disease outside of the pelvis.

For more information refer to the 2016 guidelines available at <http://wiki.cancer.org.au/australia/guidelines:Cervical_cancer/Screening>.

Palliative care: Early referral can improve quality of life. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the woman/carer including the intent of treatment and expected outcomes
- discuss advance care planning with the woman/carer where appropriate
- discuss the treatment plan with the woman's general practitioner.

Step 5

Care after initial treatment and recovery

Ongoing assessment of the effects of treatment-related menopause is required. Cancer survivors should be provided with the following.

Treatment summary (provide a copy to the woman/carer and her general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals

- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the woman/carer and her general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the woman/carer
- inform the woman/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the woman's general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Patients with metastatic or recurrent cervical cancer are commonly symptomatic. Some cases of recurrent disease will be detected by routine follow-up in a woman who is asymptomatic.

Treatment: Where possible, refer the woman to the original multidisciplinary team. Treatment will depend on the location, the extent of recurrence, previous management and on the woman's preferences.

Palliative care: Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

Communication: The lead clinician should explain the treatment intent, likely outcomes and side effects to the woman/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the woman/carer
- establish transition plans to ensure the woman's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.