XXII ASSEMBLEA MaNGO MILANO

STANDARD TREATMENTS AND NEW DIRECTIONS IN GYNAECOLOGICAL CANCERS

MILANO June 26th-29th, 2025

Responsabili Scientifici:
NICOLETTA COLOMBO, FRANCESCO RASPAGLIESI

MaNGO

CRITICAL ANALYSIS ON SURGICAL INDICATIONS

Giorgio Bogani, M.D., Ph.D.

Disclosures

- Consultant for Novartis AG pharma
- Consultant for Fondazione Serono
- Consultant for Corcept Therapeutics
- Founding from Janssen
- Funding from Astellas
- Founding from the Italian Ministry of Health (GR2019)

INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

ESGO/ESTRO/ESP Guidelines for the management of patients with cervical cancer – Update 2023*

David Cibula,[1,2] Maria Rosaria Raspollini,[3] François Planchamp ,[4] Carlos Centeno,[5] Cyrus Chargari ,[6] Ana Felix,[7,8] Daniela Fischerová ,[1,2] Daniela Jahnn-Kuch,[9] Florence Joly,[10] Christhardt Kohler,[11,12] Sigurd Lax,[13,14] Domenica Lorusso,[15,16] Umesh Mahantshetty,[17] Patrice Mathevet,[18] Raj Naik,[19] Remi A Nout,[20,21] Ana Oaknin ,[22,23] Fedro Peccatori,[24] Jan Persson,[25,26] Denis Querleu ,[15,27] Sandra Rubio Bernabé ,[28] Maximilian P Schmid,[29] Artem Stepanyan ,[30] Valentyn Svintsitskyi,[31] Karl Tamussino,[32] Ignacio Zapardiel ,[33] Jacob Lindegaard[34]

OPEN ACCESS

Cervical Cancer, Version 1.2024

Featured Updates to the NCCN Guidelines

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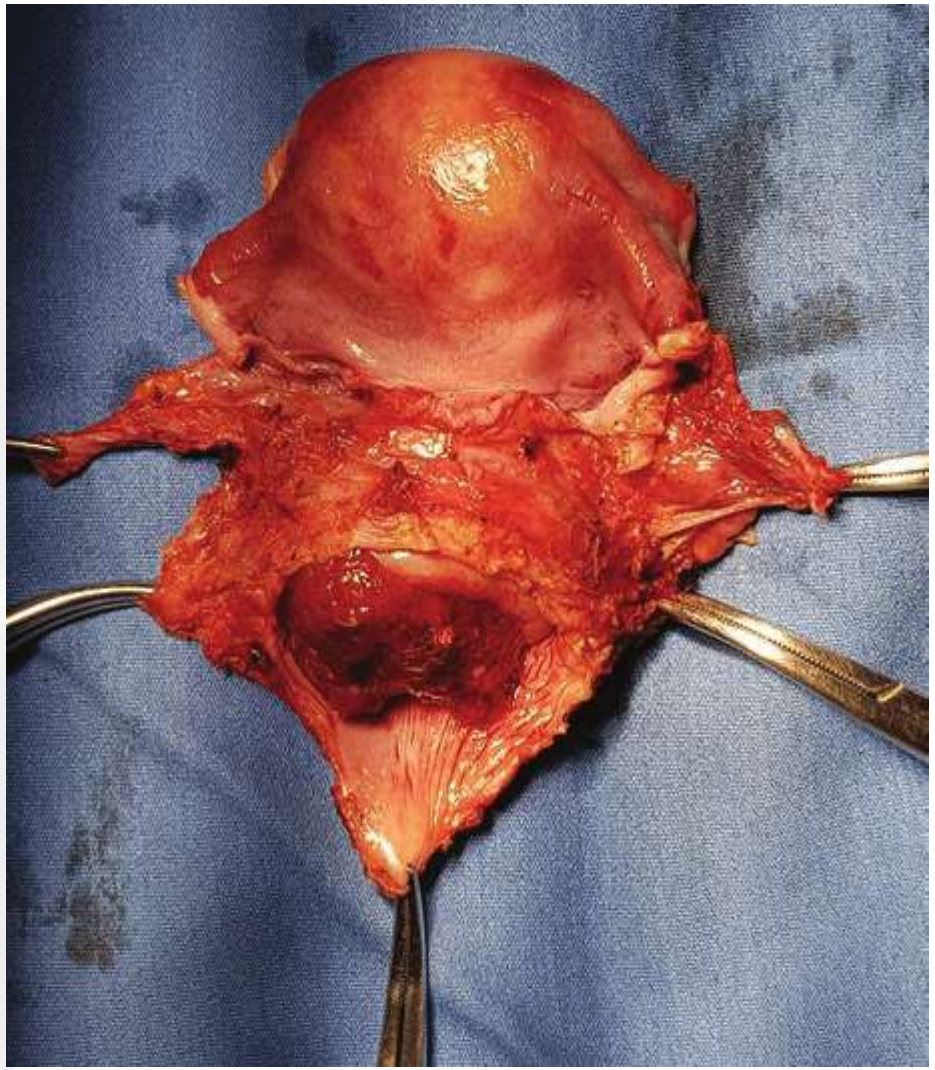
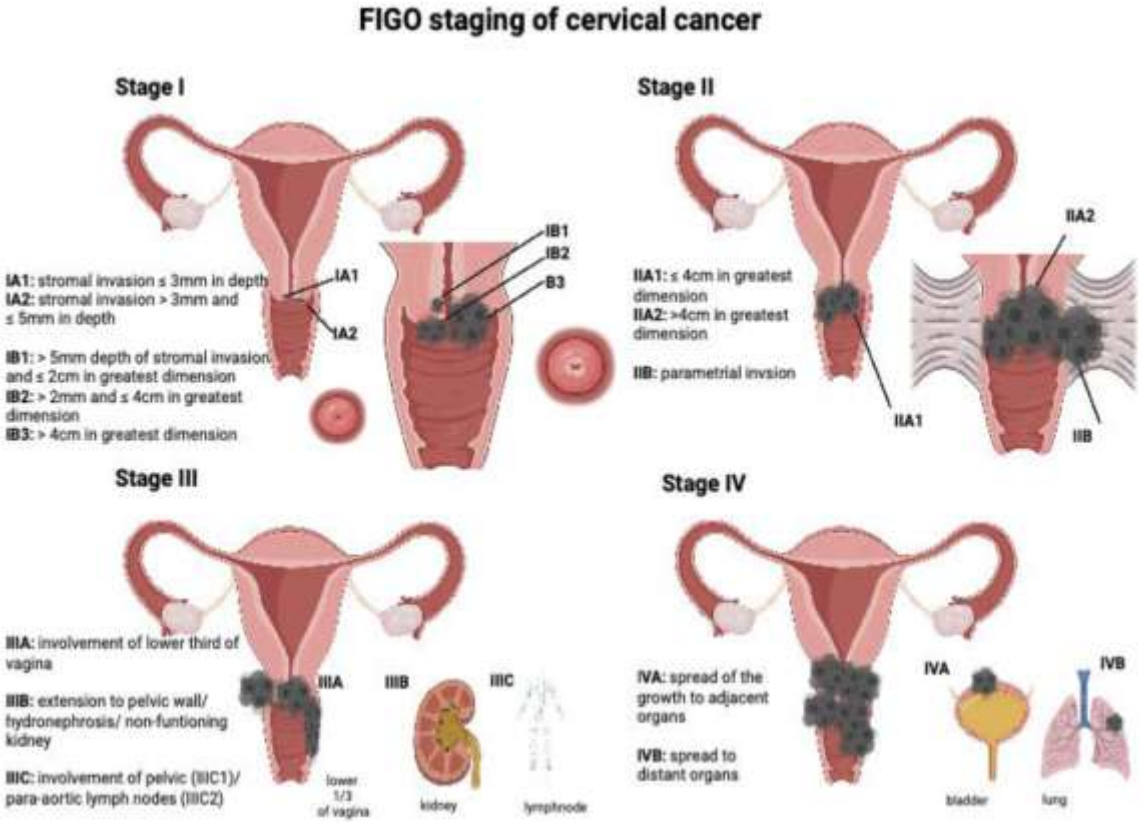


CERVICAL CANCER TREATMENT: SURGERY IN THE EARLY-STAGE



Radical surgery by a gynecological oncologist is the preferred treatment modality. Laparotomy is the standard approach for all procedures which include radical parametrectomy [I, A].

I			Carcinoma strictly confined to the cervix
			Invasive carcinoma with maximum depth of invasion ≤ 5 mm
	IA	IA1	Stromal invasion ≤ 3 mm in depth
		IA2	Stromal invasion > 3 mm and ≤5 mm in depth
			Deepest invasion > 5 mm; lesion limited to cervix uteri with size measured according to maximum tumor diameter
	IB	IB1	>5 mm depth of stromal invasion and ≤2 cm in greatest dimension
		IB2	>2 cm and ≤4 cm in greatest dimension
		IB3	>4 cm in greatest dimension
II			Invasion beyond the uterus, but no extension into the lower third of the vagina or to the pelvic wall
			Involvement limited to the upper two thirds of the vagina without parametrial invasion
	IIA	IIA1	≤4 cm in greatest dimension

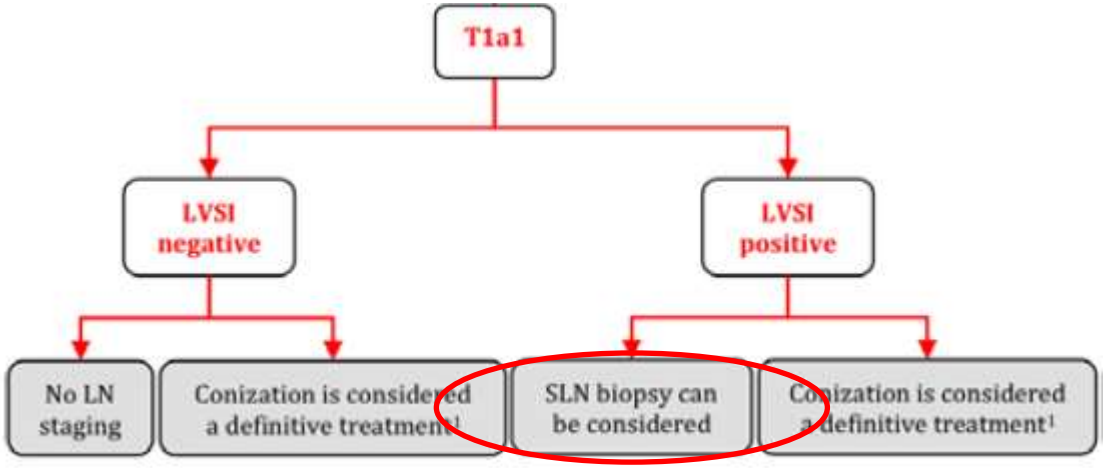
Management of stage T1a1 disease

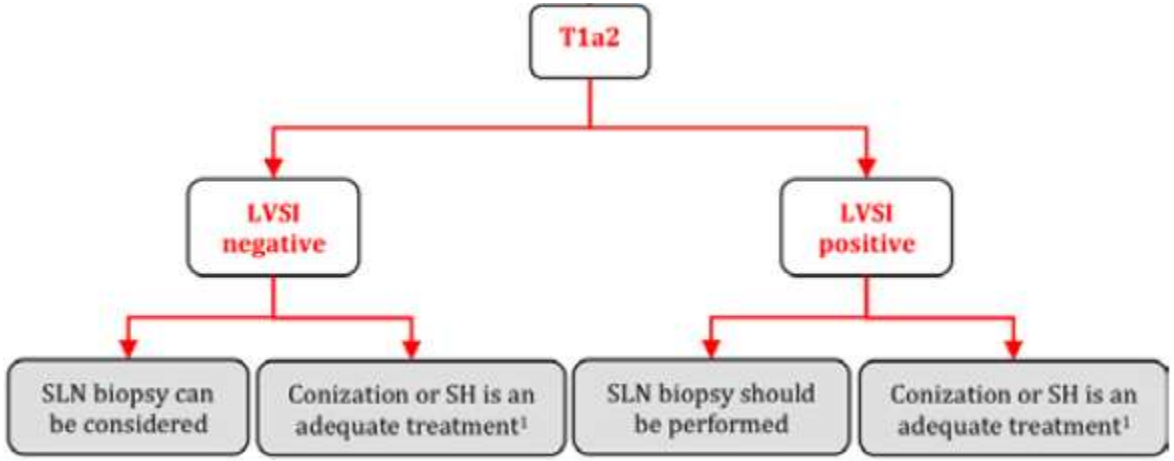
✓	Management of patients with stage T1a1 disease should be individualized depending on the age, the desire for fertility preservation and the presence or absence of LVSI.
✓	In case of positive margins (except for preinvasive disease in ectocervix), a repeat conisation should be performed to rule out more extensive invasive disease.
B	Lymph node staging is not indicated in T1a1 LVSI-negative patients but can be considered in T1a1 LVSI-positive patients. Sentinel lymph node biopsy (without additional pelvic lymph node dissection) is an acceptable method of lymph node staging.
C	Conisation can be considered a definitive treatment as hysterectomy does not improve the outcome.
C	Radical surgical approaches such as radical hysterectomy or parametrectomy represent overtreatment for patients with T1a1 disease.

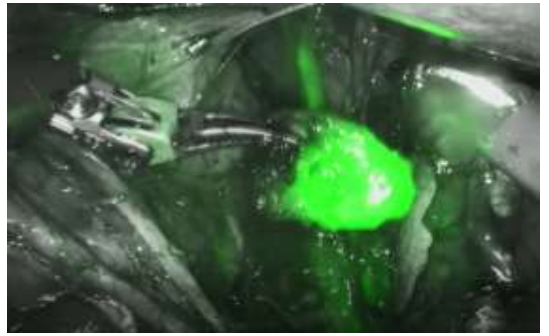
Management of stage T1a2 disease

C	In patients with stage T1a2 disease, conisation alone or simple hysterectomy is an adequate treatment.
C	Parametrial resection is not indicated.
B	Lymph node staging can be considered in LVSI-negative patients but should be performed in LVSI-positive patients. Sentinel lymph node biopsy alone (without additional pelvic lymph node dissection) appears to be an acceptable method of LN staging.
✓	Routine completion of hysterectomy is not recommended after conservative management of stage T1a disease.

CERVICAL CANCER TREATMENT: LSVI

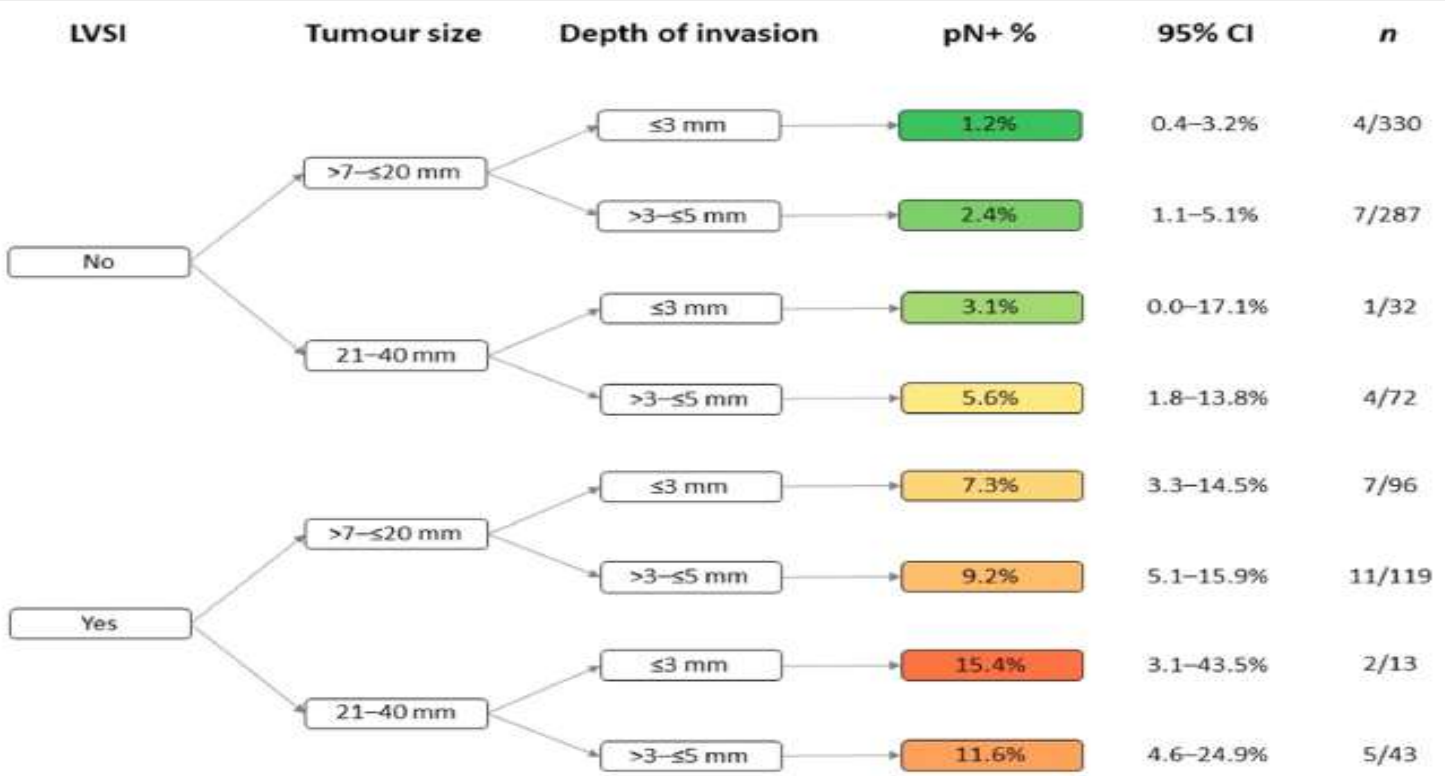






Risk factors for lymph node metastasis in women with FIGO 2018 IA cervical cancer with a horizontal spread of > 7 mm

Hans H.B. Wenzel [a,*], Tine H. Schnack [b,c], Maaike A. Van der Aa [a], Pernille T. Jensen [d,e,f], Claus K. Høgdall [b], Anna Norberg Hardie [g], Henrik Falconer [g], Ruud L.M. Bekkers [h,i], Dutch, dANish and sweDish gynaEcoLogIcal ONcology (DANDELION) research group



Characteristics	Odds ratio (95 % confidence interval)
Lymphovascular space invasion	
No	(ref.)
Yes	4.26 (2.24–8.32)[a]
Depth of invasion	
≤ 3 mm	(ref.)
> 3 mm - ≤ 5 mm	1.40 (0.73–2.80)
Tumour size	
≤ 20 mm	(ref.)
21–40 mm	1.83 (0.87–3.64)
Histology	
Squamous cell carcinoma	(ref.)
Adenocarcinoma	1.27 (0.63–2.46)

Risk factors for lymph node metastasis in women with FIGO 2018 IA cervical cancer with a horizontal spread of > 7 mm

Hans H.B. Wenzel [a,*], Tine H. Schnack [b,c], Maaike A. Van der Aa [a], Pernille T. Jensen [d,e,f], Claus K. Høgdall [b], Anna Norberg Hardie [g], Henrik Falconer [g], Ruud L.M. Bekkers [h,i], Dutch, dANish and sweDish gynaEcoLogIcal ONcology (DANDELION) research group

LVSI	Tumour size	Depth of invasion	Histology	pN+ %	95% CI	*n*
No	>7–≤20 mm	≤3 mm	Squamous	1.4%	0.0–4.1%	3/219
			Adeno	0.9%	0.0–5.4%	1/111
		>3–≤5 mm	Squamous	0.6%	0.0–3.6%	1/169
			Adeno	5.1%	2.1–10.9%	6/118

MANAGEMENT OF STAGES T1b1/T2a1

General recommendation

B Treatment strategy should aim for the avoidance of combining radical surgery and radiotherapy due to the highest morbidity after combined treatment.

Surgical treatment

B Radical surgery by a gynaecological oncologist is the preferred treatment modality. Minimal invasive approach is favored.

B The standard lymph node staging procedure is systematic pelvic lymphadenectomy. Sentinel node biopsy before pelvic lymphadenectomy is strongly recommended. Combination of blue dye with radiocolloid or use of indocyanine green alone are the recommended techniques.

✓ Lymph node assessment should be performed as the first step of surgical management. Intraoperative assessment of lymph node status (frozen section) is recommended. All sentinel nodes from both sides of the pelvis and/or any suspicious lymph nodes should be sent for frozen section. If sentinel node is not detected, intraoperative assessment of the pelvic lymph nodes should be considered.

MANAGEMENT OF STAGES T1b1/T2a1

General recommendation

B Treatment strategy should aim for the avoidance of combining radical surgery and radiotherapy due to the highest morbidity after combined treatment.

- Route of surgery
- Surgical radicality
- How to predict adjuvant therapy
- Nodal status (LND/SNM)

CERVICAL CANCER: SURGICAL ROUTE

The European Society of Gynaecological Oncology/European Society for Radiotherapy and Oncology/European Society of Pathology Guidelines for the Management of Patients With Cervical Cancer

David Cibula, MD, Richard Pötter, MD,† François Planchamp, MSc,‡ Elisabeth Avall-Lundqvist, MD,§ Daniela Fischerova, MD,* Christine Haie Meder, MD,|| Christhardt Köhler, MD,¶ Fabio Landoni, MD,# Sigurd Lax, MD,** Jacob Christian Lindegaard, MD,†† Umesh Mahantshetty, MD,‡‡ Patrice Mathevet, MD,§§ W. Glenn McCluggage, MD,|||| Mary McCormack, MD,¶¶ Raj Naik, MD,## Remi Nout, MD,*** Sandro Pignata, MD,††† Jordi Ponce, MD,‡‡‡ Denis Querleu, MD,‡ Francesco Raspagliesi, MD,§§§ Alexandros Rodolakis, MD,|||||| Karl Tamussino, MD,¶¶¶ Pauline Wimberger, MD,### and Maria Rosaria Raspollini, MD*****

- Para-aortic lymph node dissection, at least up to inferior mesenteric artery, may be considered in locally advanced cervical cancer with negative para-aortic lymph nodes on imaging for staging purposes (grade C).
- Equivocal extrauterine disease is to be considered for biopsy to confirm or rule out metastatic disease and to avoid inappropriate treatment. Tru-Cut (core-cut) biopsy is the preferred option than fine-needle aspiration biopsy because it allows histological assessment of the tissue.

MANAGEMENT OF STAGE T1a

Diagnosis of Stage T1a Disease

- Diagnosis of T1a cancer should be based on a conization (or excision) specimen examined by an expert pathologist. Management must be based on an expert pathology review, with accurate measurement of the maximum horizontal 2 dimensions, depth of invasion, margin status, coexisting

MANAGEMENT OF STAGES T1b1/T2a1

General Recommendation

- Treatment strategy should aim for the avoidance of combining radical surgery and radiotherapy because of the highest morbidity after combined treatment (grade B).

Negative Lymph Nodes on Radiological Staging—Surgical Treatment

- Radical surgery by a gynecologic oncologist is the preferred treatment modality. Minimally invasive approach is favored (grade B).
- The standard lymph node staging procedure is systematic pelvic lymphadenectomy. Sentinel node biopsy before pelvic lymphadenectomy is strongly recommended. Combination of blue dye with radiocolloid or use of indocyanine green alone is the recommended technique (grade B).

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Minimally Invasive versus Abdominal Radical Hysterectomy for Cervical Cancer

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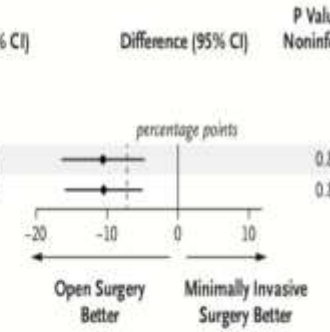
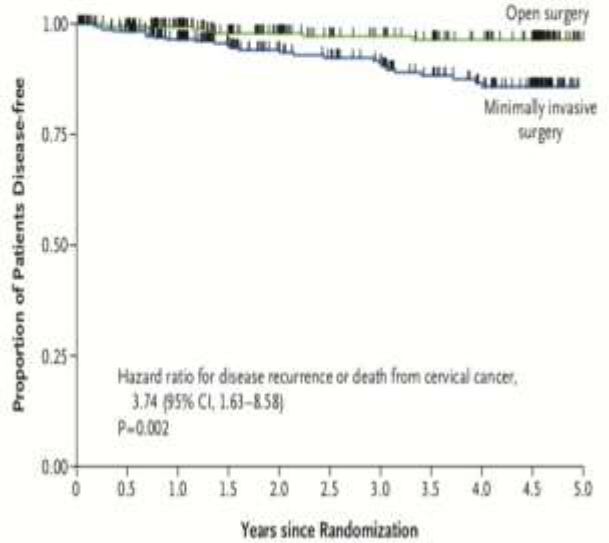
ABSTRACT

A

Population	Disease-free Survival Rate at 4.5 Yr (95% CI)		Difference (95% CI)	P Value for Noninferiority
	Minimally Invasive Surgery	Open Surgery		
	percent		percentage points	
Intention-to-treat population	86.0 (79.7–90.4)	96.5 (92.7–98.4)		0.87
Per-protocol population	87.1 (81.0–91.3)	97.6 (94.1–99.0)		0.88



B



No. at Risk											
Open surgery	312	280	236	187	163	144	134	123	104	90	7
Minimally invasive surgery	319	292	244	192	167	155	142	121	102	80	5

The results showed that the 4.5-year disease-free survival rate was **86.0% with minimally invasive surgery** and **96.5% with open surgery**.

INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

Patterns of recurrence after laparoscopic versus open abdominal radical hysterectomy in patients with cervical cancer: a propensity-matched analysis

Giorgio Bogani,[1] Fabio Ghezzi,[2] Luis Chiva ,[3] Baldo Gisone,[4] Ciro Pinelli,[4] Andrea Dell'Acqua,[1] Jvan Casarin,[4] Antonino Ditto,[1] Francesco Raspagliesi[5]

Site of recurrence	Patients recurring after open abdominal radical hysterectomy (n=70)	Patients recurring after laparoscopic radical hysterectomy (n=35)	P value
Vaginal vault	18 (25%)	6 (17%)	0.46
Pelvic lymph nodes	6 (8%)	2 (5%)	0.71
Pelvic cavity	24 (34%)	26 (74%)	**<0.001**
Extrapelvic lymph nodes	9 (13%)	7 (20%)	0.39
Carcinomatosis	1 (1.5%)	6 (17%)	**0.005**
Abdominal	64 (91%)	29 (82%)	0.47
Distant/hematogenous dissemination	11 (15%)	7 (20%)	0.59

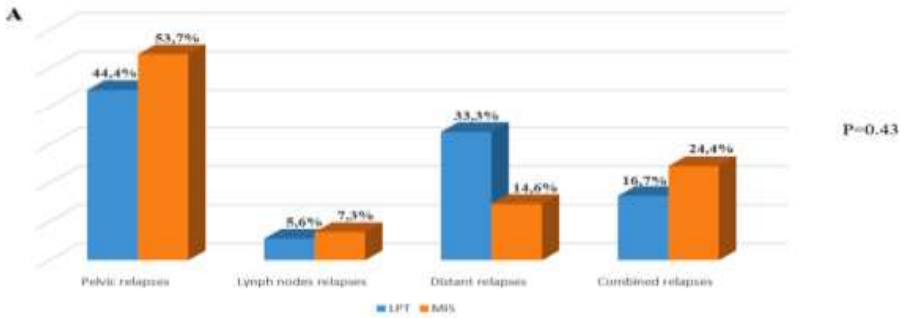
Data are expressed in number (%).

Conclusions Patients undergoing laparoscopic radical hysterectomy are at higher risk of developing intrapelvic recurrences and peritoneal carcinomatosis. Further evidence is needed in order to corroborate our findings.

> Eur J Surg Oncol. 2023 Nov;49(11):107047. doi: 10.1016/j.ejso.2023.107047. Epub 2023 Sep 10.

Patterns of recurrence in FIGO stage IB1–IB2 cervical cancer: Comparison between minimally invasive and abdominal radical hysterectomy

Giacomo Corrado [1], Luigi Pedone Anchora [2], Simone Bruni [3], Isabella Sperduti [4], Camilla Cerelli [2], Benito Chiofalo [3], Andrea Giannini [3], Ottavia D'Oria [5], Nicolò Bizzarri [2], Francesco Legge [6], Francesco Cosentino [7], Luigi Carlo Turco [7], Enrico Vizza [3], Giovanni Scambia [8],



P=0.43

Conclusions

MIS, in FIGO stage IB1-IB2 cervical cancer, is not associated with different relapse patterns compared to ARH, nor with a higher risk of distance metastasis and finally, without significant difference in term of DFS and OS. More studies are needed to determine the factors that modify the site of relapse.

CERVICAL CANCER: SURGICAL ROUTE

GYNECOLOGIC ONCOLOGY

Practice patterns and 90-day treatment-related morbidity in early-stage cervical cancer

Giorgio Bogani[a,*,1], Violante Di Donato[a,1], Giovanni Scambia[b], Fabio Landoni[c], Fabio Ghezzi[d], Ludovico Muzii[a], Pierluigi Benedetti Panici[a], Francesco Raspagliesi[e], The investigator of the Italian Gynecological Cancer Study Group[2]

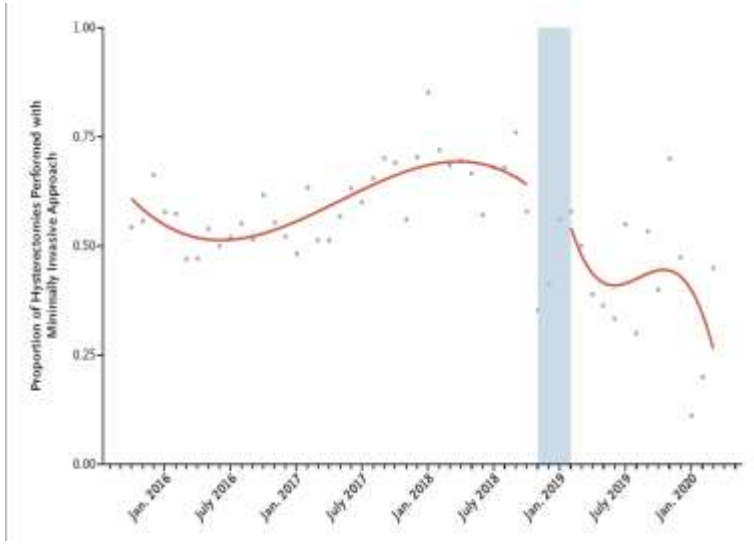
Conclusions

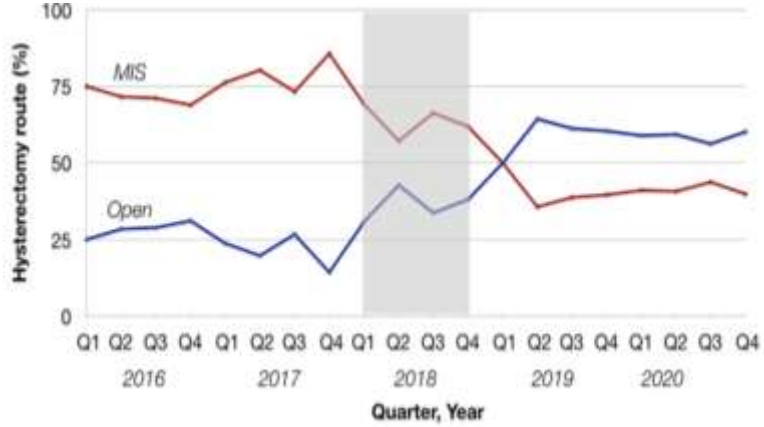
The present investigation highlighted that in referral centers the shift from minimally invasive to open radical hysterectomy does not influence 90-day surgery-related morbidity.

AJOG

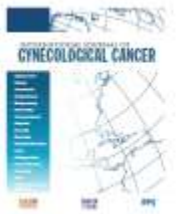
Practice patterns and complications of hysterectomy for invasive cervical cancer after the Laparoscopic Approach to Cervical Cancer trial

Gabriella Schivardi, MD[a,b] · Jvan Casarin, MD[b,c] · Elizabeth B. Habermann, PhD[d] · Katherine A. Bews, MS[d] · Carrie L. Langstraat, MD[b] · William Cliby, MD[b] · Giuseppe Cucinella, MD[b] · Luigi A. De Vitis, MD[a,b] · Pedro T. Ramirez, MD[f] · Giovanni D. Aletti, MD[a,e] · Andrea Mariani, MD, MS[b] · Francesco Multinu, MD, MS[a,b] Show less





The role of protective monover

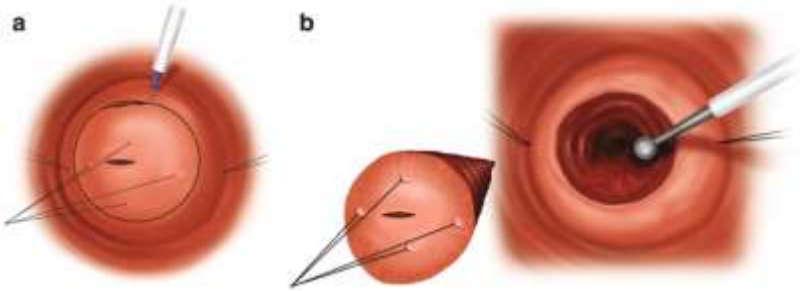


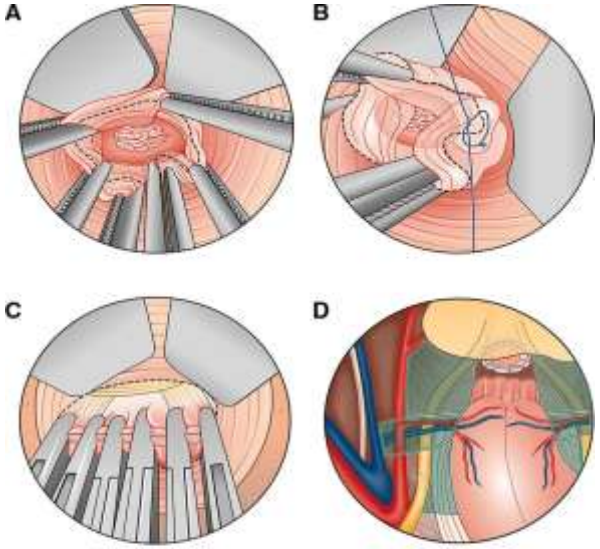
SUCCOR cone study: conization before radical hysterectomy

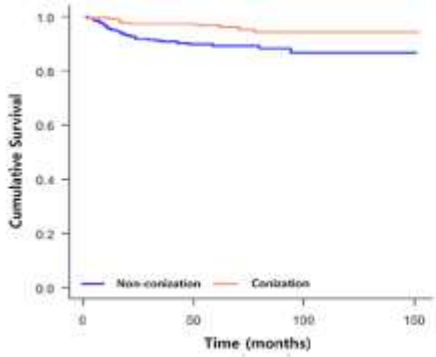
Enrique Chacon ,[1] Nabil Manzour ,[2] Vanna Zanagnolo,[3] Denis Querleu ,[4] Jorge M Núñez-Córdoba,[5] Nerea Martin-Calvo,[6] Mihai Emil Căpîlna,[7] Anna Fagotti,[8] Ali Kucukmetin,[9] Constantijne Mom,[10] Galina Chakalova,,[11] Aliyev Shamistan,[12] Antonio Gil Moreno,[13,14] Mario Malzoni,[15] Fabrice Narducci,[16] Octavio Arencibia,[17] Francesco Raspagliesi,[18] Tayfun Toptas ,[19] David Cibula,[20] Dilyara Kaidarova,[21] Mehmet Mutlu Meydanli ,[22] Mariana Tavares,[23] Dmytro Golub,[24] Anna Myriam Perrone ,[25] Robert Poka ,[26] Dimitrios Tsolakidis,[27] Goran Vujić,[28] Marcin A Jedryka ,[29] Petra L M Zusterzeel,[30] Jogchum Jan Beltman,[31] Frederic Goffin,[32] Dimitrios Haidopoulos,[33] Herman Haller,[34] Robert Jach,[35] Iryna Yezhova,[36] Igor Berlev,[37] Margarida Bernardino,[38] Rasiah Bharathan,[39] Maximilian Lanner,[40] Minna M Maenpaa,[41] Vladyslav Sukhin ,[42] Jean-Guillaume Feron,[43] Robert Fruscio ,[44,45] Kersti Kukk,[46] Jordi Ponce,[47] Jose Angel Minguez ,[48] Daniel Vázquez-Vicente ,[49] Teresa Castellanos,[49] Felix Boria ,[50] Juan Luis Alcazar ,[51] Luis Chiva ,[52] The SUCCOR study group

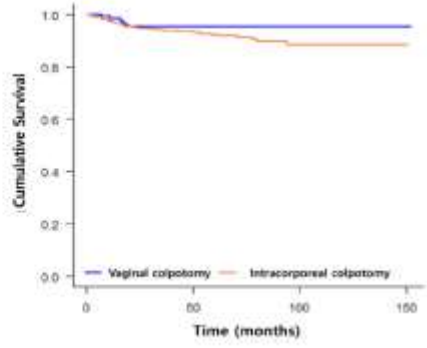
SUCCOR study: an international European cohort observational study comparing minimally invasive surgery versus open abdominal radical hysterectomy in patients with stage IB1 cervical cancer

Luis Chiva ,[1] Vanna Zanagnolo,[2] Denis Querleu,[3] Nerea Martin-Calvo,[4] Juan Arévalo-Serrano,[5] Mihai Emil Căpîlna,[6] Anna Fagotti,[7] Ali Kucukmetin,[8] Constantijne Mom,[9] Galina Chakalova,[10] Shamistan Aliyev,[11] Mario Malzoni,[12] Fabrice Narducci ,[13] Octavio Arencibia,[14] Francesco Raspagliesi,[15] Tayfun Toptas,[16] David Cibula,[17] Dilyara Kaidarova,[18] Mehmet Mutlu Meydanli ,[19] Mariana Tavares,[20] Dmytro Golub,[21] Anna Myriam Perrone ,[22] Robert Poka,[23] Dimitrios Tsolakidis,[24] Goran Vujić,[25] Marcin A Jedryka ,[26] Petra L M Zusterzeel,[27] Jogchum Jan Beltman,[28] Frederic Goffin,[29] Dimitrios Haidopoulos,[30] Herman Haller,[31] Robert Jach,[32] Iryna Yezhova,[33] Igor Berlev,[34] Margarida Bernardino,[35] Rasiah Bharathan,[36] Maximilian Lanner,[37] Minna M Maenpaa,[38] Vladyslav Sukhin ,[39] Jean-Guillaume Feron,[40] Robert Fruscio,[41,42] Kersti Kukk,[43] Jordi Ponce,[44] Jose Angel Minguez,[45] Daniel Vázquez-Vicente ,[45] Teresa Castellanos,[45] Enrique Chacon,[46] Juan Luis Alcazar ,[47] et al,. On behalf of the SUCCOR study Group







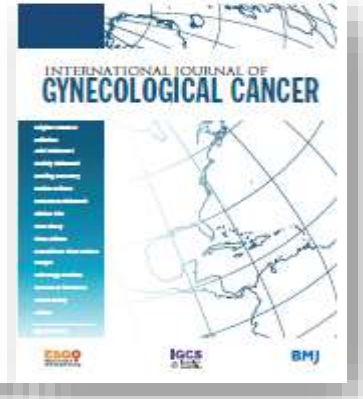


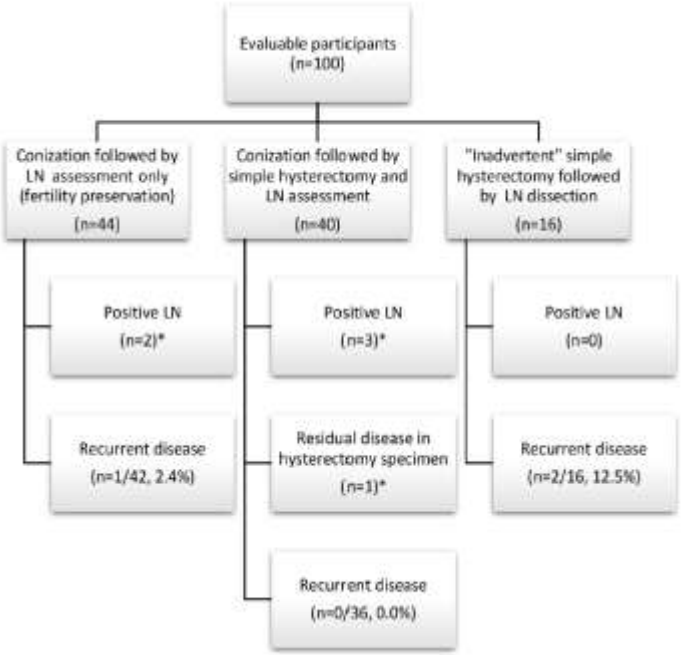
SURGICAL RADICALITY

<2 cm

ConCerv: a prospective trial of conservative surgery for low-risk early-stage cervical cancer

Kathleen M Schmeler ,[1] Rene Pareja ,[2] Aldo Lopez Blanco,[3] Jose Humberto Fregnani,[4] Andre Lopes,[5] Myriam Perrotta,[6] Audrey T Tsunoda,[7] David F Cantú-de-León,[8] Lois M Ramondetta,[1] Tarinee Manchana,[9] David R Crotzer,[10] Orla M McNally,[11] Martin Riege,[12] Giovanni Scambia,[13] Juan Manuel Carvajal,[14] Julian Di Guilmi,[15] Gabriel J Rendon ,[16] Preetha Ramalingam,[17] Bryan M Fellman,[18] Robert L Coleman,[19] Michael Frumovitz ,[1] Pedro T Ramirez[1]





HIGHLIGHTS

- Conservative surgery was associated with a 3.5% recurrence rate in women with low-risk cervical cancer.
- The rate of positive lymph nodes was 5%, with lymph node assessment recommended in this low-risk population.
- Further study is needed to determine long-term outcomes and optimal pathologic criteria for conservative surgery.

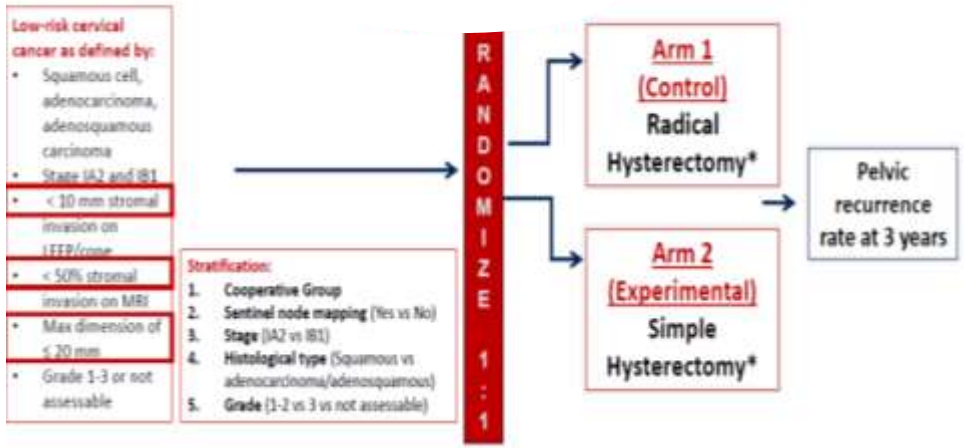
CERVICAL CANCER: LESS RADICAL SURGERY

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Simple versus Radical Hysterectomy in Women with Low-Risk Cervical Cancer

Marie Plante, M.D., Janice S. Kwon, M.D., Sarah Ferguson, M.D., Vanessa Samouëlian, M.D., Gwenael Ferron, M.D., Amandine Maulard, M.D., Cor de Kroon, M.D., Willemien Van Driel, M.D., John Tidy, M.D., Karin Williamson, M.D., Sven Mahner, M.D., Stefan Kommoss, M.D., Frederic Goffin, M.D., Karl Tamussino, M.D., Brynhildur Eyjólfsdóttir, M.D., Jae-Weon Kim, M.D., Noreen Gleeson, M.D., Lori Brotto, Ph.D., Dongsheng Tu, Ph.D., and Lois E. Shepherd, M.D., for the CX.5 SHAPE investigators*



SHAPE TRIAL – CONCLUSIONS

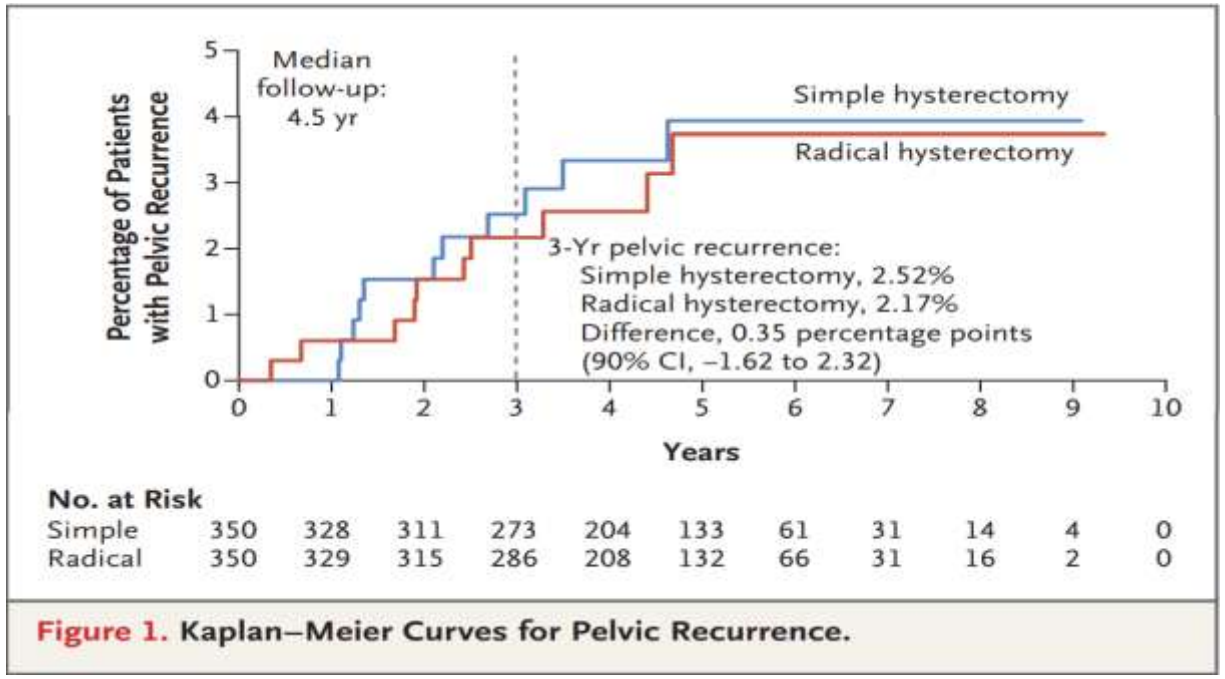
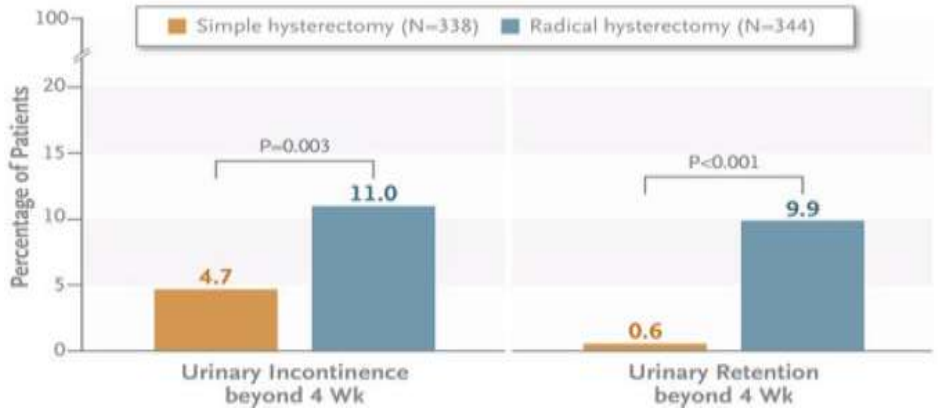


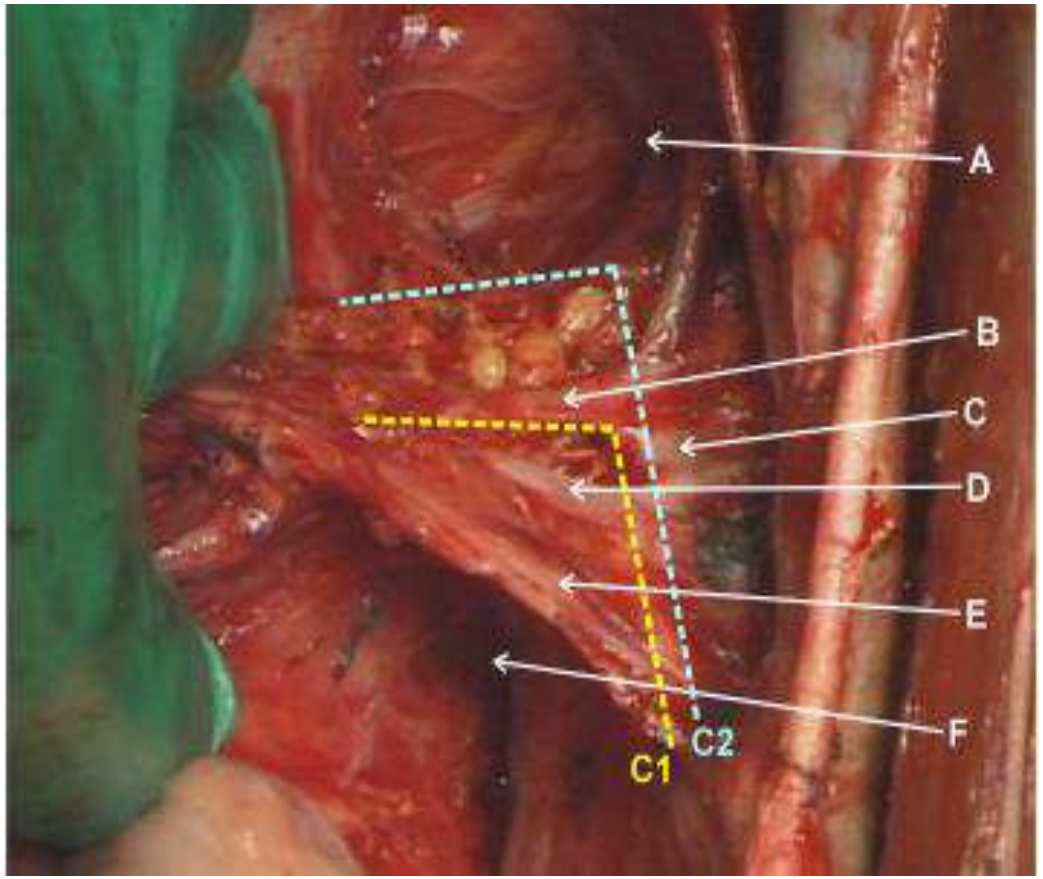
Figure 1. Kaplan–Meier Curves for Pelvic Recurrence.



- In early-stage **low-risk** cervical cancer, pelvic recurrence rate at three years with **simple hysterectomy** was **not inferior** to radical hysterectomy.
- **Fewer urological** surgical complications following **simple hysterectomy**
- **Better quality of life and sexual health** measures were seen following **simple hysterectomy**

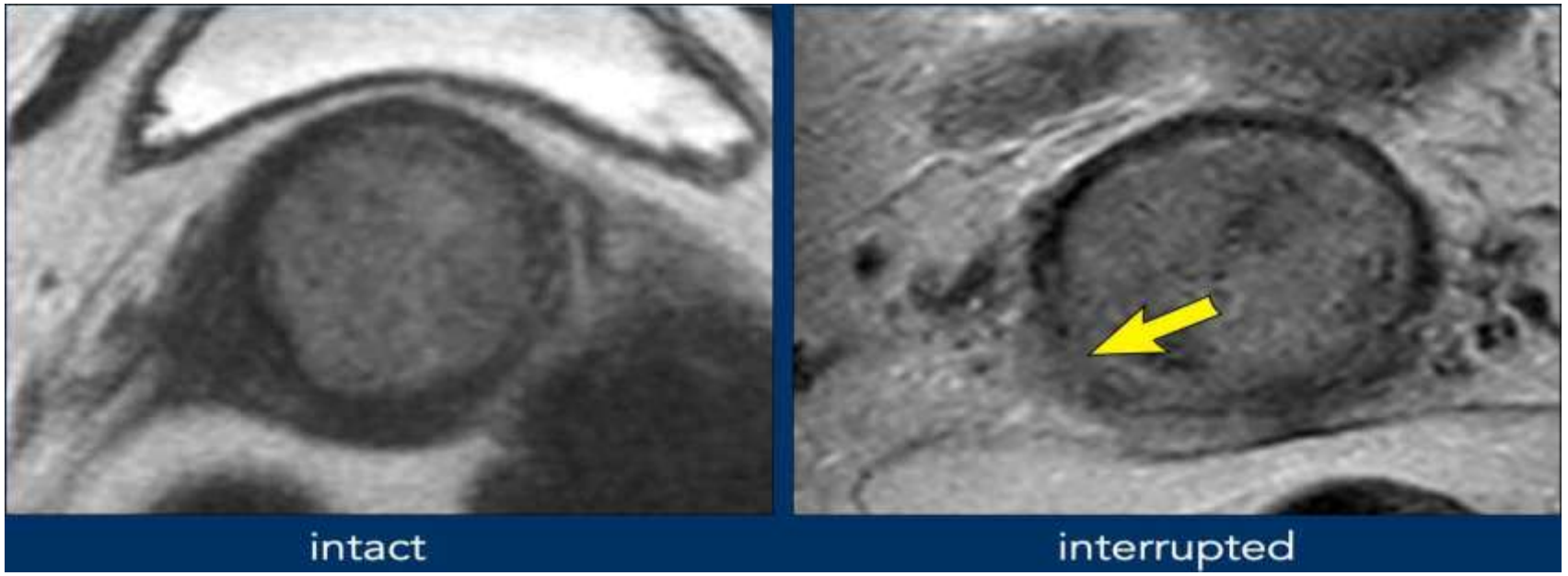
CERVICAL CANCER: TAILORED SURGERY

Risk Group	Tumor Size	LVSI	Stromal Invasion	Type of Radical Hysterectomy*
Low risk	<2 cm	Negative	Inner 1/3	B1 (A)
Intermediate risk	≥2 cm	Negative	Any	B2 (C1)
	<2 cm	Positive	Any	
High risk	≥2 cm	Positive	Any	C1 (C2)



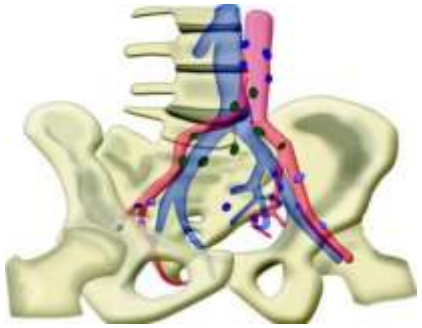
HOW TO PREDICT THE NEED OF ADJUVANT THERAPY

>2 cm



NODAL STAGING

ESGO
European Society of Gynaecological Oncology



EJC
EUROPEAN JOURNAL OF CANCER

2020

Sentinel lymph node mapping and intraoperative assessment in a prospective, international, multicentre, observational trial of patients with cervical cancer: The SENTIX trial

David Cibula [1] • Roman Kocian [1] • Andrea Plaikner • ... Daniela Fischerova [1] • Kristyna Nemejcova • Christhardt Kohler • Show all authors • Show footnotes

Type of SLN involvement	SLN frozen section outcome (%)		
	Sensitivity	False negatives	NPV
Macrometastases	72·4	27·6	97·8
Micrometastases	9·5	90·5	94·7
Isolated tumour cells	0	100	96·7
Macrometastases + micrometastases	46·0	54·0	92·5
Macrometastases + micrometastases + isolated tumour cells	37·1	62·9	89·2

Intraoperative frozen section misses **54% of positive lymph nodes!**

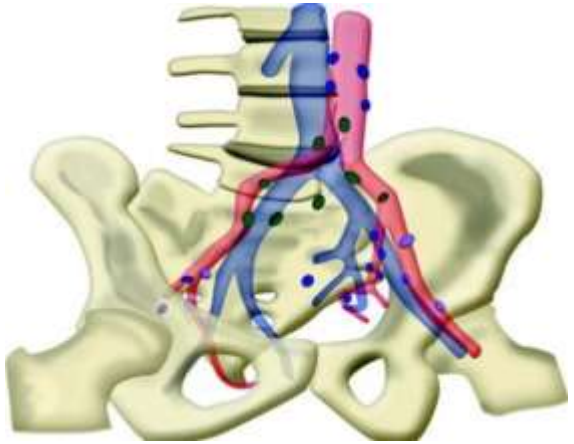
Lymphnode metastasis detection rate is doubled with sentinel technique with ultrastaging

SENTICOL - 2

Senticol
Prospective multicentre study
FIGO IA1 LVSI + to IB1
SLN Biopsy + PLND/PALND

92.0% Sensitivity
98.2% NPV

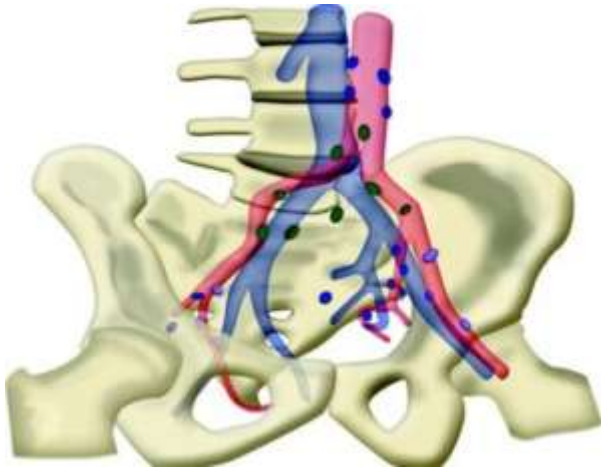
for node metastasis detection



Senticol II
RCT, Multicentre
FIGO IA1 LVSI+, IB1, IB2, IIA1
SNL Biopsy alone vs SNL + PLND
Lymphatic morbidity was significantly lower in the SN arm (31.4%) vs SN+ PLND arm (51.5%; p 0.0046).
3-year recurrence-free survival was not significantly different (92.0% in SN arm and 94.4% in SN + PLND arm).

Lécuru, Fabrice et al. *Journal of clinical oncology* vol. 29,13 (2011): 1686-91. doi:10.1200/JCO.2010.32.0432

Mathevet, Patrice et al" *European journal of cancer (Oxford, England : 1990)* vol. 148 (2021): 307-315. doi:10.1016/j.ejca.2021.02.009



FOCUS ON ONCOLOGICAL OUTCOMES

On going → 2026

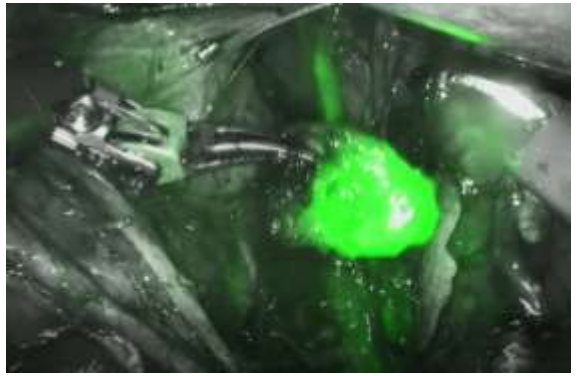
SENTICOL III: an international validation study of sentinel node biopsy in early cervical cancer. A GINECO, ENGOT, GCIG and multicenter study

Fabrice R Lecuru [1], Mary McCormack [2], Peter Hillemanns [3], Amelie Anota [4], Mario Leitao [5], Patrice Mathevet [6], Ronald Zweemer [7], Keiichi Fujiwara [8], Vanna Zanagnolo [9], Ane Gerda Zahl Eriksson [10], Emma Hudson [11], Gwenael Ferron [12] and Marie Plante [13]

On going → 2026

Sentinel lymph node biopsy versus pelvic lymphadenectomy in early-stage cervical cancer: a multi-center randomized trial (PHENIX/CSEM 010)

Hua Tu [# 1], He Huang [# 1], Bingna Xian [1], Jibin Li [2], Ping Wang [3], Weidong Zhao [4],



The European Society of Gynaecological Oncology/European Society for Radiotherapy and Oncology/European Society of Pathology Guidelines for the Management of Patients with Cervical Cancer

2018

David Cibula[1] · Richard Pötter[2] · François Planchamp[3] · Elisabeth Avall-Lundqvist[4] · Daniela Fischerova[1] · Christine Haie-Meder[5] · Christhardt Köhler[6] · Fabio Landoni[7] · Sigurd Lax[8] · Jacob Christian Lindegaard[9] · Umesh Mahantshetty[10] · Patrice Mathevet[11] · W. Glenn McCluggage[12] · Mary McCormack[13] · Raj Naik[14] · Remi Nout[15] · Sandro Pignata[16] · Jordi Ponce[17] · Denis Querleu[3] · Francesco Raspagliesi[18] · Alexandros Rodolakis[19] · Karl Tamussino[20] · Pauline Wimberger[21] · Maria Rosaria Raspollini[22]

5.7.2 Stage T1b2/T2a2 and involved lymph nodes on radiological staging

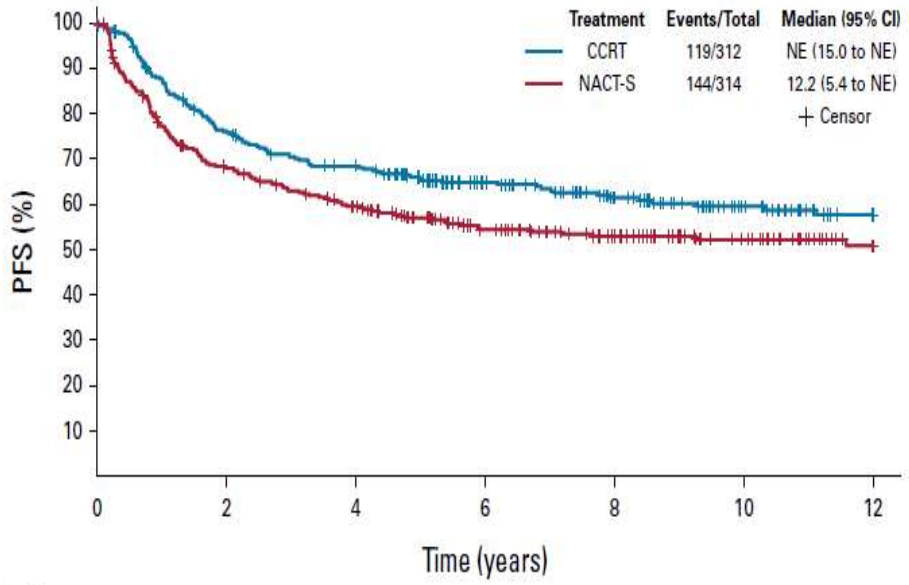
NOW IB3

A Definitive chemoradiotherapy and brachytherapy are recommended in patients with unequivocally involved PLNs on imaging (see Principles of radiotherapy).

5.7.3 Stage T2b, T3a/b, T4a

A Definitive platinum-based chemoradiotherapy and brachytherapy are recommended (see Principles of radiotherapy).

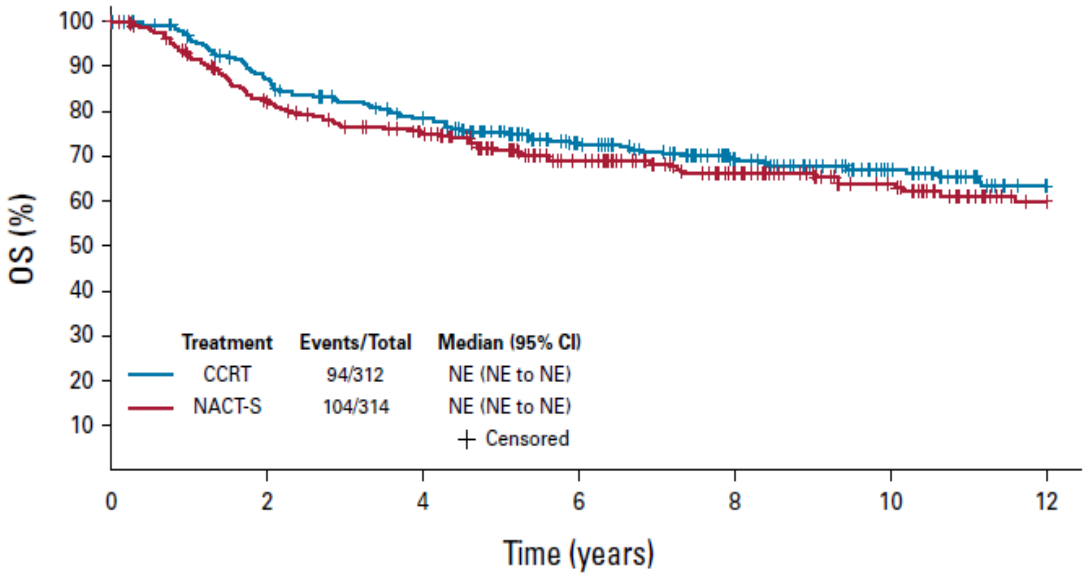
CERVICAL CANCER: EORTC-55994



No. at risk:

CCRT	312	230	202	145	107	75	49
NACT-S	314	203	170	123	94	66	38

	Event/Total	Median (95% CI)[a]	Hazard Ratio (95% CI)[b]	Survival Estimates (95% CI)[a]	*P*
Treatment					.010[c]
CCRT	119/312	NE (15.0 to NE)	0.72 (0.57 to 0.93)	5: 65.6 (59.9 to 70.7)	
NACT-S	144/314	12.2 (5.4 to NE)	Reference	5: 57.0 (51.1 to 62.4)	



No. at risk:

CCRT	312	262	228	162	121	84	54
NACT-S	314	245	213	157	117	80	43

	Event/Total	Median (95% CI)[a]	Hazard Ratio (95% CI)[b]	Survival Estimates (95% CI)[a]	*P*
Treatment					.240[c]
CCRT	94/312	NE (NE to NE)	0.84 (0.64 to 1.12)	5: 75.5 (70.2 to 80.0)	
NACT-S	104/314	NE (NE to NE)	Reference	5: 71.7 (66.2 to 76.5)	

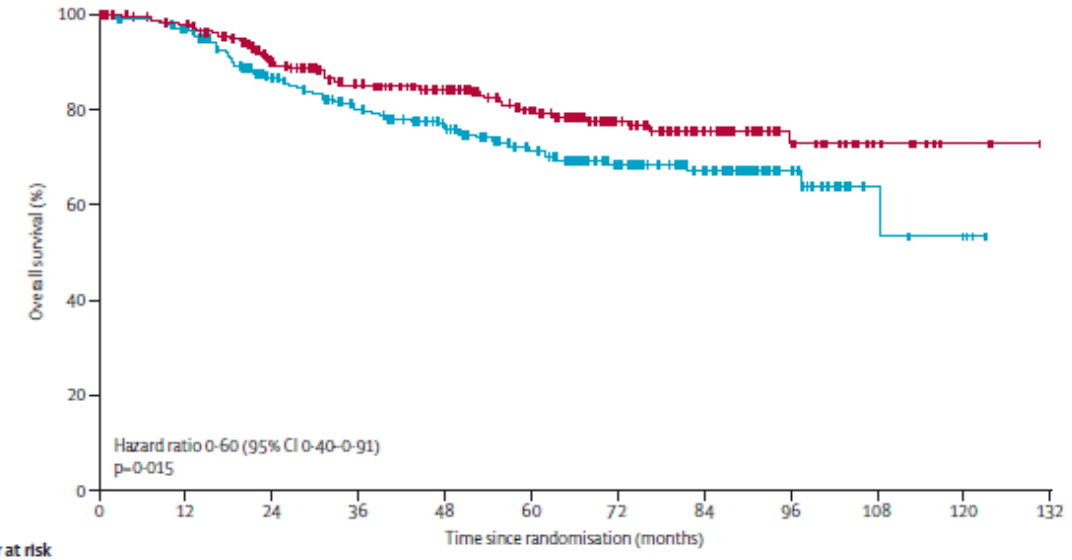
Neoadjuvant Chemotherapy in Locally Advanced Cervical Cancer: Review of the Literature and Perspectives of Clinical Research

ANGIOLO GADDUCCI and STEFANIA COSIO

Authors	Stage	Histology	CT regimen	pts	DFS	OS
Sardi (22)	Ib>2 cm	SCC	CDDP + VCR + BLEO[a]	Ib_1 41	After 8 years of follow-up	OS: 82%
				Ib_2 61	After 9 years of follow-up	OS: 80%
Chang (23)	Ib2-IIa2	SCC, AD-ADS	CDDP + VCR + BLEO[b]	68		5-y: 70%
Benedetti (24)	Ib-III	SCC	different platinum-based regimen[c]	210	5-y: 55.4%	5-y: 58.9%
Huang (25)	Ib2-IIa2	SCC, AD-ADS	CDDP + VCR + BLEO[d]	162	5-y: 65%	5-y: 69%
Buda (26)	Ib2-IV	SCC	CDDP +PTX+IFO[e]	96	4-y: 71%	
			CDDP+IFO[f]	108	4-y: 65%	
Katzumata (27)	Ib2-IIb	SCC	BLEO + VCR + MIT-C + CDDP[g]	67	5-y: 59.9%	5-y: 70%
Chen (28)	Ib2-IIb	SCC, AD, ADS	CDDP + MIT-C + 5-FU[h]	72		4-y: 71%
Lissoni (29)	Ib2-IVa	SCCA	CDDP + PTX + IFO[e]	74	5-y: 71%	5-y: 78%
			CDDP + PTX[i]	80	5-y: 64%	5-y: 72%
Angioli (30)	Ib2-IIb	SCC, AD-ADS	CDDP+PTX[l]	115	5-y: 61%	5-y: 77%
Shoji (31)	Ib2-IIIb	SCC	CDDP+CPT-11[m]	42	5-y: 67.2%	5-y: 68%
Mori (32)	Ib2-IIb>4cm	SCC	Nedaplatin+CPT-11[n]	32	5-y: 78.8	5-y: 89.7%

CERVICAL CANCER: CHEMO-RADIATION

Induction chemotherapy followed by standard chemoradiotherapy versus standard chemoradiotherapy alone in patients with locally advanced cervical cancer (GCIG INTERLACE): an international, multicentre, randomised phase 3 trial



Number at risk (number censored)												
Chemoradiotherapy alone	250 (0)	230 (13)	186 (33)	157 (49)	132 (66)	105 (86)	75 (112)	48 (138)	24 (163)	6 (179)	3 (181)	0 (184)
Induction chemotherapy with chemoradiotherapy	250 (0)	240 (5)	196 (31)	169 (48)	150 (65)	118 (90)	83 (122)	55 (148)	26 (176)	9 (193)	4 (199)	0 (202)

	Induction chemotherapy with chemoradiotherapy (n=250)	Chemoradiotherapy alone (n=250)
Cisplatin cycles completed		
Five cycles	169 (68%)	197 (79%)
At least four cycles*	212 (85%)	224 (90%)
Main reasons for fewer than five cycles		
Adverse events leading to discontinuation	68 (27%)	33 (13%)
Haematological	34	4
Non-haematological	20	25
Both	14	4
Other reasons not due to toxicity	13 (5%)	20 (8%)
Radiotherapy		
Received definitive EBRT on or off trial†	246 (98%)	239 (96%)
Received EBRT on trial	242 (97%)	231 (92%)
IMRT	102 (42%)	93 (40%)
3DCRT	140 (58%)	138 (60%)
Received extended field EBRT	22 (9%)	20 (9%)
Received brachytherapy	238 (98%)	224 (97%)
2D point A	46 (19%)	49 (22%)
3D point A	120 (50%)	107 (48%)
3D HRCTV D90	72 (30%)	68 (30%)
Did not receive brachytherapy on trial	4 (2%)	7 (3·0%)
Received EBRT boost	3 (1%)	6 (2·6%)
No boost	1 (<1%)	1 (<1%)
Did not receive EBRT on trial	8 (3%)	19 (8%)
Had radiotherapy outside trial	4 (50%)	8 (42%)
Ineligible or discontinued	1 (13%)	5 (26%)
No EBRT	1 (13%)	1 (5%)
Unknown	2 (25%)	5 (26%)
Median overall treatment time, days	45 (36–70)	45 (37–88)
Median total EQD2, Gy (% ≥78 Gy)‡	79·4 (69·8)	80·0 (71·4)
Median total HRCTV D90 EQD2 (IGABT), Gy‡	86·6	86·8

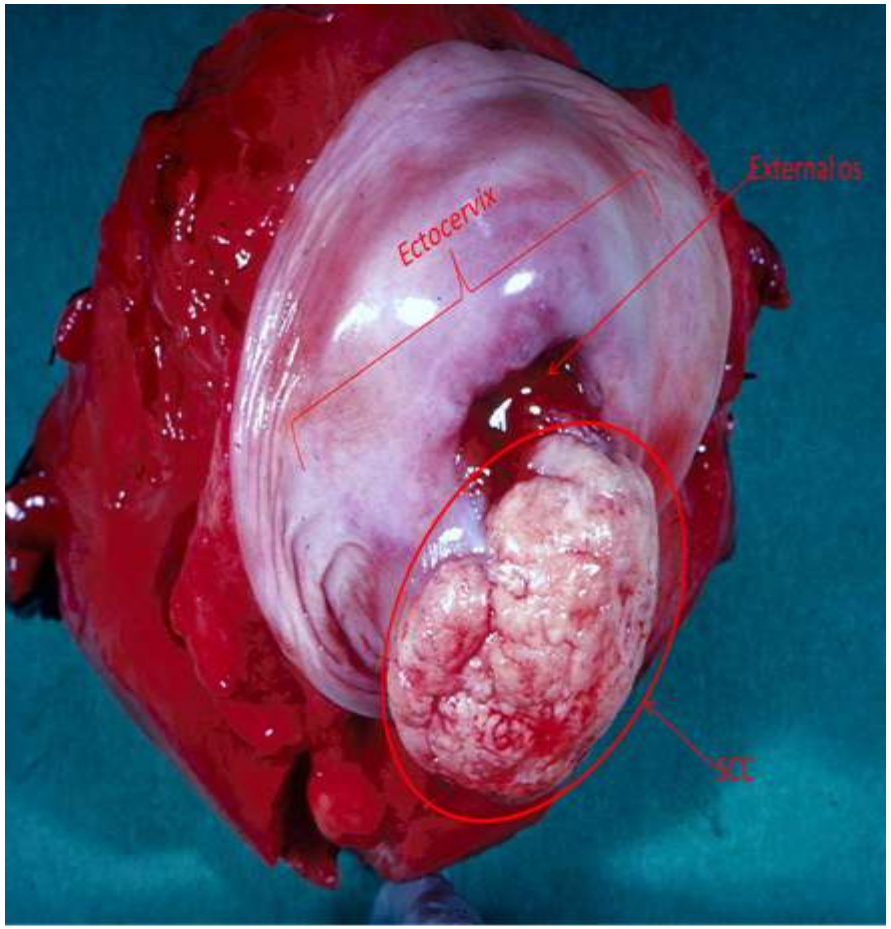
CERVICAL CANCER: ICI ERA

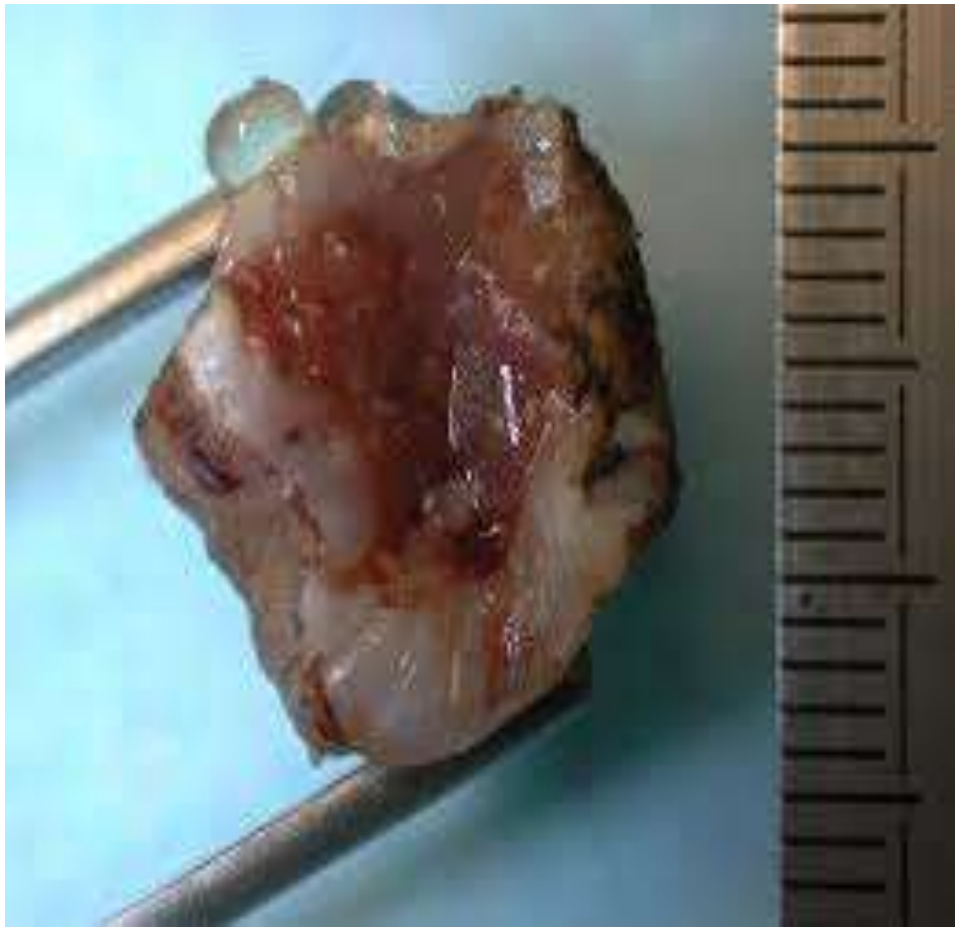
Immunotherapy in locally advanced cervix cancer: A critical appraisal of the FDA indication based on ENGOT-CX11/GOG-3047/KEYNOTE-A18

Neoadjuvant chemotherapy plus camrelizumab for locally advanced cervical cancer (NACI study): a multicentre, single-arm, phase 2 trial

Kezhen Li, Jing Chen*, Yingjie Hu*, Yan-Zhou Wang*, Yuanming Shen*, Gang Chen*, Wenju Peng, Zixuan Fang, Bairong Xia, Xiaojun Chen, Kun Song, Yingmei Wang, Dongling Zou, Yan-Chun Wang, Yingyan Han, Xue Feng, Jing Yuan, Shuaiqingying Guo, Xiaolin Meng, Chenzhao Feng, Yin Chen, Jie Yang, Junpeng Fan, Jianliu Wang, Jihui Ai†, Ding Ma†, Chaoyang Sun†*

CERVICAL CANCER: FERTILITY-SPARING

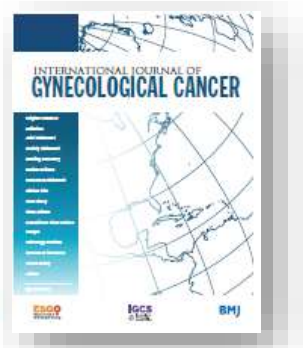




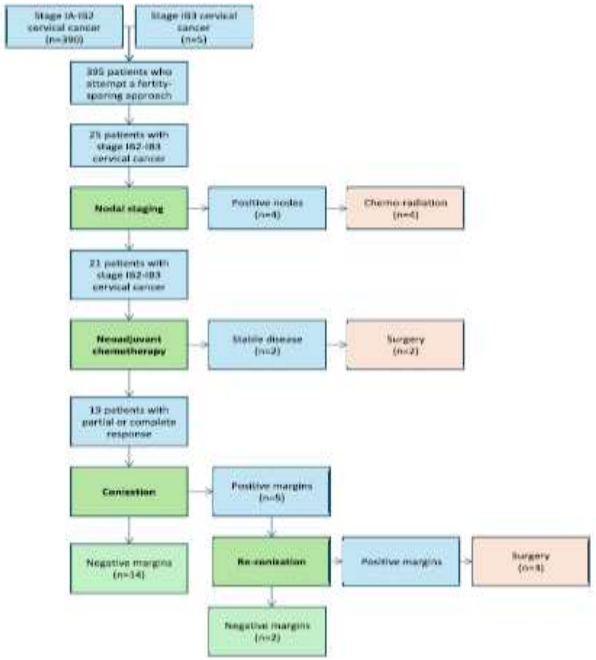
FONDAZIONE IRCCS
ISTITUTO NAZIONALE
DEI TUMORI

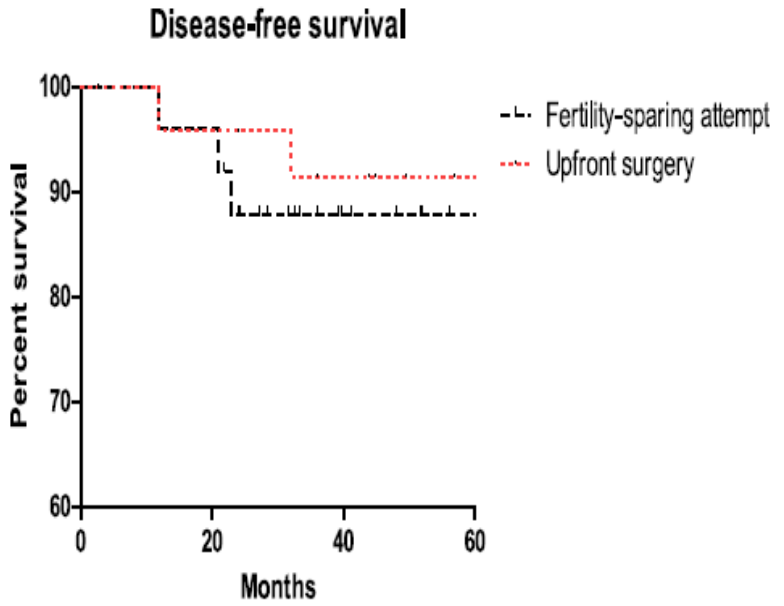
Chemo-conization in Early-sTage cERvical caNcer >2 cm scheduled for fertilItY-sparing approach: an analysis of the ETERNITY project

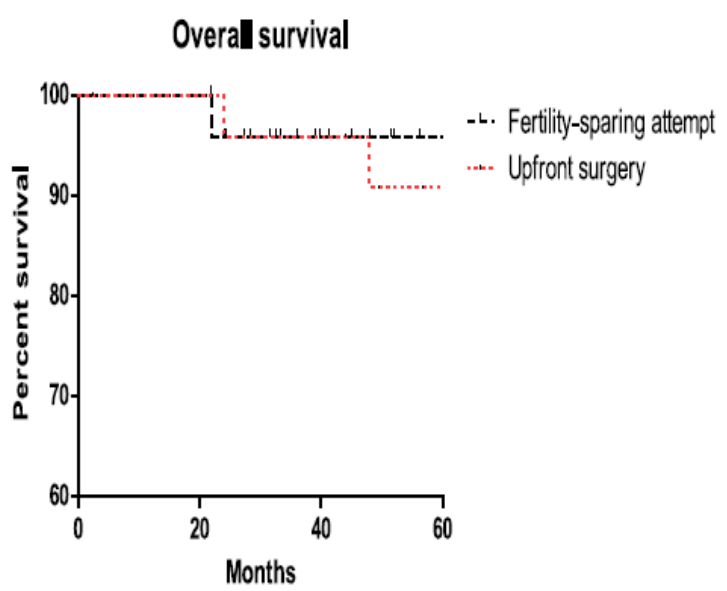
Giorgio Bogani[a,*], Giovanni Scambia[b,c], Mario Malzoni[d], Jvan Casarin[e], Giuseppe Vizzielli[f,g], Frédéric Amant[h], Francesco Raspagliesi[a], the Investigators of the ETERNITY Project[i]



2-4 cm







CERVICAL CANCER:

EARLY-STAGE CERVICAL CANCER

FERTILITY-SPARING SURGERY

MULTIDICIPLINARY APPROACH

REFERRAL CENTERS


ONCOLOGIA
GINECOLOGICA
DEGLI OPPOSTI
MILANO
22-23 NOVEMBRE
2024