



## Evidence-Based Series #4-16: Section 1

# Follow-up for Women after Treatment for Cervical Cancer: Guideline Recommendations

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The full Evidence-based Series #4-16 is comprised of 3 sections  
and is available on the CCO website (<http://www.cancercare.on.ca>)

PEBC Gynecology Cancer DSG page at:

<http://www.cancercare.on.ca/toolbox/qualityguidelines/diseasesite/gyn-ebs/>

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## QUESTION

What is the most appropriate follow-up strategy for patients with cervical cancer who are clinically disease-free after receiving primary treatment? Of clinical interest, do differences in follow-up strategies influence patient outcomes related to recurrence, survival, or quality of life?

## TARGET POPULATION

This practice guideline applies to women who are clinically disease free after receiving potentially curative primary treatment for cervical cancer.

## INTENDED USERS

This practice guideline is geared towards clinicians involved in the care and follow-up of women who have received treatment for cervical cancer.

## ROLE OF FOLLOW-UP

The role for the follow-up of women with cervical cancer who have been treated with curative intent includes the identification of complications related to treatment and intervening if recurrent disease occurs. The majority of women who recur with cervical

cancer are not curable; however, for those with a central pelvic recurrence and no evidence of distant disease, there is a potential for cure with additional therapy.

## RECOMMENDATIONS

At this time, there are no systematic reviews of randomized controlled trials, individual randomized controlled trials, or prospective cohort designs comparing one follow-up strategy to another and comparing different time intervals of follow-up on the clinical outcomes of interest.

The Gynecology Cancer Disease Site Group offers the following recommendations, based on their expert consensus opinion informed by evidence from retrospective studies.

- Patients need to be informed about symptoms of recurrence, because the majority of women have signs or symptoms of recurrence that occur outside of scheduled follow-up visits.
- Follow-up care after primary treatment should be conducted and coordinated by a physician experienced in the surveillance of cancer patients. Continuity of care and dialogue between the health care professional and patient may well enhance and facilitate early cancer recurrence detection and help avoid duplication of surveillance testing and effort.
- A reasonable follow-up strategy involves follow-up visits every three to four months within the first two years, and every six to 12 months from years 3 to 5.
- After five years of recurrence-free follow-up, the patient should return to annual assessment with a history, general physical, and pelvic examination with cervical/vaginal cytology performed by the primary care physician.
- At a minimum, follow-up visits should include a patient history and complete physical examination.
  - Symptoms elicited during the patient history should include general performance status, lower back pain especially if it radiates down one leg, vaginal bleeding, or unexplained weight loss.
  - A physical examination should attempt to identify abnormal findings related to general health and/or those that suggest vaginal, pelvic sidewall, or distant recurrence. Since central pelvic recurrences are potentially curable, the physical examination should include a speculum exam with bimanual and pelvic/rectal examination.
- The routine use of other investigations in asymptomatic patients is not advocated as their role has yet to be evaluated in a definitive manner.
  - There is little evidence to suggest that vaginal vault cytology adds significantly to the clinical exam in detecting early disease recurrence. If cytology is performed as part of routine follow-up after surgery for cervical cancer, its role would be to detect new precancerous conditions of the vagina and should be no more frequent than once a year. An abnormal cytology result that suggests the possibility of neoplasia warrants colposcopic evaluation and directed biopsy for histologic confirmation.
  - The role of abdominal or pelvic computed tomography, magnetic resonance imaging scans, positron emission tomography, or ultrasound as part of routine follow-up has not been fully evaluated in prospective studies.
  - Use of serum markers such as squamous cell carcinoma antigen or cancer antigen 125 have shown promise in predicting surgical findings, or in the post-radiotherapy course when disease is present; however, their role in following patients post-treatment has yet to be determined.

## Reviewed Evidence

- Seventeen retrospective studies reported follow-up strategies with recurrence and survival outcomes for women who were disease free after primary treatment for cervical cancer. The retrospective studies were highly heterogeneous, thus only general patterns with consistency in direction of effect can be gleaned from the data.
  - In nine studies that reported data, 62% to 89% of cervical cancer recurrences were detected within two years of primary treatment. In the six studies that reported data, a minimum of 89% of recurrences were detected by five years.
  - Fifteen of the 17 retrospective studies reported whether recurrences were symptomatic or asymptomatic. Approximately two thirds of patients presented with symptoms (range 46% to 87%), and approximately one third of patients were asymptomatic (range 4% to 54%).
  - Scheduled follow-up visits varied from a low of nine visits to a potential high of 28 visits over five years. Most studies followed similar intervals: follow-up visits every three to four months within in the first two years, every six months for the next three years, then annually to year 10 or discharge.
  - While not consistently reported, physical examination and vaginal vault cytology were the most common follow-up tests performed across the 17 retrospective studies. A median of 52% of recurrences across the studies were detected by physical exam, and a median of 6% were detected by vaginal vault cytology.
  - Of the studies that reported on the routine use of chest x-ray, abdominal and pelvic ultrasound, positron emission tomography, computed tomography, magnetic resonance imaging, intravenous pyelography, or tumour markers, the reporting was generally inconsistent, and the impact of asymptomatic recurrence detection upon survival was not known.

## RELATED GUIDELINES

- Program in Evidence-based Care Evidence-based Series #4-20 *Chemotherapy for Recurrent, Metastatic, or Persistent Cervical Cancer.*

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