

Cervical Cancer

[Disclaimer](#)

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Background – About Cervical Cancer

- The most common cervical cancer is squamous cell carcinoma, accounting for 80% of cases. Adenocarcinoma is less common and more difficult to diagnose because it starts higher in the cervix, and features on both cytology and clinical examination may be more subtle.
- Women who have not had cervical screening tests have a cervical cancer rate of 1 in 90. Up to 1 in 200 cases are fatal.
- In 2016, there were 903 new cases diagnosed in Australia, and 250 Australian women died from cervical cancer.
- The mean age at diagnosis is 52 years.
- Prognosis depends on the degree of local spread.
 - Cervical cancer can be effectively treated when it is found early.
 - Most women with early cervical cancer will be cured.
 - In Australia, the five-year survival rate for women diagnosed with cervical cancer is 72%.
- Persistent human papillomavirus (HPV) infection is linked to the vast majority of cases of cervical cancer.
 - Less than 10% of persistent HPV infections lead to carcinoma in situ.
 - High-risk HPV strains include 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, and 59.
 - Gardasil vaccination can prevent persistent infection from HPV 16, 18 (high risks for cervical cancer), 6 and 11 (high risks for genital warts), and has led to decrease in incidence of high-grade cervical dysplasia.
- The stages of cervical cancer:
 - Stage I: The cancer cells are present only within the cervix.
 - Stage II: The tumour has spread into surrounding structures such as the upper part of the vagina or tissues next to the cervix.
 - Stage III: The tumour has spread more widely to surrounding structures such as the lower part of the vagina or to the sides of the pelvis. Sometimes a tumour that has spread to the pelvis may cause a hydronephrosis.
 - Stage IV: The tumour has spread to the bladder or bowel or beyond the pelvic area. This stage includes tumours that have spread into the lungs, liver, or bone, although these are not common.

Assessment

Practice Point

Ask about vaginal sexual contact

The only women at negligible risk of cervical cancer are those that have never had vaginal sexual contact (irrespective of sexual orientation).

Negative cervical screening does not exclude cervical cancer.

1. **Ask** and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the **specific cultural and spiritual needs** of each patient.

Ask if the patient identifies as being of Aboriginal or Torres Strait Islander origin

If a patient or their family want to know why you are asking this question, you may reply with:

- *We ask this question of everyone.*

- It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.
- This information helps our practice and the health care providers we refer you to, to provide culturally safe care.

For more information, see [principles for care provision for Aboriginal and Torres Strait Islander Peoples](#).

Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People

- Consider **advice for communicating** with Aboriginal and Torres Strait Islander people.
 - **Advice for communicating with Aboriginal and Torres Strait Islander people**
 - Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.
 - Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.
 - Consider the role of factors such as gender, kinship, family ties, language barriers and socio-economic issues.
 - Offer the patient:
 - the option of seeing a health professional of the same gender or if this is not possible, referral to another [service](#).
 - the option to have support person present, such as a family member, a community member, or an Elder.
 - access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See also [Integrated Team Care Program](#).
- Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on **decision-making**.
 - **Respecting Aboriginal and Torres Strait Islander people's decision-making processes**
 - Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.
 - If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.
- Be aware the term "survivor" may have negative connotations for historical reasons.
- Proactively explore and monitor symptoms of **pain**.
 - **Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people**

Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.

 - Offer patients the option to discuss their needs with a health professional of the same gender.
 - If available, use a pain tool that is culturally appropriate for the local community.
 - Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.
 - Be aware of:
 - significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.
 - fears that pain relief medicines may accelerate the passing of the patient.
- Understand how the concept of **family** is different for Aboriginal and Torres Strait Islander people.

Considerations when discussing family with Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people:

- *the concept of family is broader than being genetically related.*
- *be sensitive when taking a family history, as discussing members of the stolen generation may be distressing*
- *Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).*

- Be supportive and understanding if **appointments** are missed, and facilitate follow-up or rebooking.

Appointments for Aboriginal and Torres Strait Islander people

- *Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.*
- *The following supports may facilitate this process:*
 - *Recall and reminders*
 - *ITC funding*
 - *Referral to an Aboriginal Liaison officer, support, or health worker.*
- Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.
- Ensure contact details are up to date.
- If available, use **assessment tools and resources** designed specifically for Aboriginal and Torres Strait islander people.

Aboriginal and Torres Strait Islander assessment tools and resources

See SCNAT-IP – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.

2. Assess for *risk factors*, including **diethylstilboestrol (DES) in utero:**

Risk factors

- *Lack of regular cervical screening*
- *HPV infection*
- *Previous high-grade lesion on cervical screening*
- *Family history of cervical cancer in first-degree relative*
- *Smoking (increases 2 to 5 times)*
- *Low socio-economic status*
- *No HPV vaccination history*
- *Immunodeficiency e.g., HIV infection is associated with a 6 times higher risk of cervical cancer*
- *Immunosuppression treatment for autoimmune diseases*
- *Combined oral contraceptive use*
- *Young age of first sexual intercourse, particularly if aged < 14 years*
- *Multiple previous sexual partners, or a partner with multiple previous partners*
- *Concurrent chlamydia and HPV infection*

Diethylstilboestrol (DES) in utero

DES is a synthetic female hormone that was used to treat threatened miscarriage and other pregnancy complications between 1946 and 1971 in Australia.

- **Women who took DES during pregnancy (DES mothers)**

- Have a 30% increased risk for breast cancer.
- Encourage DES mothers to inform their children who had in utero exposure to DES (DES daughters and sons).

- **Women exposed to DES in utero (DES daughters)**

DES daughters are at increased risk of:

- breast cancer (if aged > 40 years),
- clear cell adenocarcinoma of the vagina and/or cervix,
- structural abnormalities in the reproductive tract, and
- pregnancy complications including: miscarriage, tubal (ectopic) pregnancy, infertility and premature birth.

Screening for DES daughters:

- Women exposed to DES in utero should be offered annual co-test (HPV and liquid based cytology) and colposcopic examination of the lower genital tract.
- Screening should start at any time and continue indefinitely.
- Referral to an experienced [colposcopist](#) if any abnormality detected.
- All DES daughters aged > 40 years, should have an annual mammogram and medical breast check, as well as doing a monthly breast self-examination.

- **Men exposed to DES in utero (DES sons)**

Increased risk of:

- abnormally small testes,
- undescended testes,
- low sperm counts, and
- non-cancerous epididymal cysts.

- DES grandsons and granddaughters – no conclusive evidence of increased risk, further long-term studies are needed.

For more information, see Better Health Channel – [DES](#)

3. Take a history and check for symptoms.

Symptoms may include:

- Abnormal bleeding, including:
 - postcoital bleeding.
 - intermenstrual bleeding.
 - irregular or heavy menstrual bleeding.
 - postmenopausal bleeding.
- Dyspareunia
- Vaginal discomfort
- Abnormal vaginal discharge
- Urinary symptoms:
 - Painless haematuria
 - Urinary frequency – chronic
- Bowel symptoms:

- Painless, fresh rectal bleeding
- Altered bowel habit
- Poorly localised *pelvic pain*
- Late symptoms, implicating complications:
- Lower back pain – referred from bulky or ulcerative mass on cervix
- Leg oedema – indicating pelvic wall involvement or lymphatic obstruction

4. Complete an **examination**.

Examination

- Speculum inspection of cervix with good light source is essential. Note abnormal findings, including any:
 - white or red patches, ulcers, or irregular tumours.
 - cervical polyps (benign).
 - hormonal changes such as **nabothian cysts**, or **ectropion**

Nabothian cysts

- Benign mucus-filled cysts on the surface of the cervix
- Occur when stratified squamous epithelium of the ectocervix grows over the columnar epithelium of the endocervix, blocking cervical crypts and trapping cervical mucus

Ectropion

- Large reddish area on the ectocervix surrounding the external os.
- More common in younger women and women on oestrogen-containing contraceptives, and is a normal finding.
- Collect a cervical sample from the outer edge of the ectropion



Ectropion

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- distortion or scarring of cervix – due to trauma from childbirth or previous surgery (LLETZ or cone biopsy).
- Perform a bimanual examination. Check for unusual pelvic masses or bulkiness.
- If clinically suspicion of cervical cancer, check for signs of metastases. Signs include:
 - Local lymphadenopathy
 - Distant – supraclavicular lymphadenopathy
 - Locally advanced disease – ureteric obstruction

5. Decide whether there is a **high suspicion for cervical cancer**. If there is a high index of suspicion, complete a full bimanual pelvic examination and request [colposcopy](#) or

a [gynaecological oncology review](#) even if subsequent tests or cervical screening test are normal. See [Cervical Screening](#) pathway.

High suspicion of cancer

Consider high suspicion of cancer if:

- Post-coital bleeding in a woman aged > 35 years.
- Intermenstrual or abnormal bleeding including post-menopausal.
- Previously diagnosed with high grade changes on screening and new symptoms.
- Other risk factors including HPV and HIV.
- Groin or supraclavicular lymphadenopathy.

6. Consider a differential diagnosis.

Differential diagnosis

- [Cervical erosion \(ectropion\)](#)
- [Cervicitis/chlamydia](#)
- Dysfunctional uterine bleeding
- Atrophic vaginitis
- Endometrial hyperplasia or [endometrial cancer](#)
- Fibroids
- Pelvic inflammatory disease
- IUCD side-effects

7. Arrange investigations:

- Perform [cervical screening](#).
 - In symptomatic women, perform a co-test – Human papillomavirus (HPV) with liquid-based cytology (LBC).
 - Note a negative cervical screening co-test should not preclude referral in a patient with suspicious symptoms.
- Consider STI screening, particularly [HIV](#). Chlamydia is a common cause of post-coital bleeding in younger women.
- Following diagnosis, staging investigations may include MRI and PET scan, as directed by the treating gynae-oncology team.
- Consider referring DES daughters for a [colposcopy](#) by a colposcopist experienced with this cohort.

8. Consider and ask about the impact of possible diagnosis on the patient's:

- Psychological state (distress, [anxiety](#) and/or [depression](#))
- Family and relationships (e.g. risk of domestic stress, impact on family and children)
- Sexuality and intimate relationships
- Work related and/or financial concerns (e.g., job insecurity, concern over sick leave entitlements)

Management

1. Refer for prompt gynae-oncology review if:

- high suspicion of cancer or visible suspicious cervical mass, even if cervical screening tests are normal.
- invasive squamous cell carcinoma (SCC), adenocarcinoma, or glandular abnormalities including adenocarcinoma in situ are detected.
- persistent abnormal bleeding, even with a normal cervical screening test result.

2. Refer for [colposcopy](#) if:
 - oncogenic human papillomavirus (HPV) types 16 and/or 18 detected on cervical screening test.
 - other oncogenic HPV types (not 16 or 18) are detected, and
 - there is a possible or definite high-grade squamous intraepithelial lesion (HSIL), or
 - any suspected or definitive glandular abnormality.
 - persistently positive HPV test (any type) 12 months after the finding of possible or definite low-grade intraepithelial lesion (LSIL), regardless of LBC result.
 - aged 70 to 74 years and tests positive for any oncogenic HPV type.
 - aged ≥ 35 years with postcoital bleeding with a normal cervical screening test.
3. If any abnormality detected on cervical screening, refer DES daughters to an experienced colposcopist with interest/expertise in DES. Consider referral to the [The Royal Women's Hospital DES Follow-Up Clinic](#), phone **(03) 9344-5077**.
4. If appropriate for fertility preservation, arrange referral to a [gynaecologist or gynaec-oncologist](#) to discuss options, and consider early referral to a [fertility specialist](#) if not already arranged.
5. Advise the patient that treatment options depend on tumour staging, and are decided upon by the [gynaecological oncology team](#) They may include:
 - **Surgery**
 - *Extent is determined by stage.*
 - *Early stage 1A can be treated by local surgical excision of cervix to preserve fertility.*
 - *Radical surgery includes removal of a vaginal cuff, paracervical tissues and pelvic lymph nodes and has higher morbidity (including bladder, bowel and sexual dysfunction, usually short term).*
 - *Surgery is usually only performed where there is a low risk of nodal disease, to avoid the risk of adjuvant radiotherapy.*
 - *Laparoscopic radical surgery is becoming more common reducing hospital stays to 1 to 2 days.*
 - *For younger women:*
 - *Ovarian preservation is common with squamous cell carcinoma (less common with adenocarcinoma).*
 - *Uterine preservation may be possible to preserve fertility for low risk (small) tumours, even when radical surgery is indicated.*
 - **Radiotherapy**
 - *Usually combines pelvic (external beam) treatment with brachytherapy*
 - *Used as primary treatment, and in conjunction with surgery (less common)*
 - *Common side effects (likely to be long term):*
 - *Bowel and bladder complications*
 - *Lymphoedema*
 - **Chemotherapy**
 - *Adjuvant, concurrent, or palliative.*

6. Follow-up after initial diagnosis and treatment by reviewing the patient's cancer **multidisciplinary discharge summary** provided by the gynaecology oncology service.

Cancer treatment summary letter

Most importantly should include:

- *risk of recurrence and intentions of treatment.*
- *goals and quantitative benefit of proposed treatment.*
- *risks of treatment.*
- *what the patient has been told.*

Usually includes:

- *diagnostic tests performed and results.*
- *tumour characteristics and other factors determining prognosis.*
- *type and date of treatments and a treatment summary.*
- *expectations of disease course, including expected discharge from oncology services.*
- *interventions and treatment plans from other health professionals.*
- *a process for rapid re-entry to specialist medical services for suspected recurrence.*
- *a list of symptoms that might need prompt investigation.*
- *a list of supportive care services provided and a plan for community care services, including what each service is to provide.*
- *contact information for key care providers.*

7. If patient identifies as Aboriginal or Torres Strait Islander, understand their **specific cultural and spiritual needs** when discussing and delivering treatment options.

Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People

- *Offer referral to culturally appropriate social and emotional wellbeing [services](#).*
- *Consider including an [expert](#) in the multidisciplinary team, to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.*
- *Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living.*

Prevention

1. If the patient has never had or is unsure if a full course given, consider HPV vaccination.
 - Note HPV vaccination is not routinely recommended for adults aged ≥ 19 years, but some patients may benefit from vaccination.
 - Women aged < 45 years may benefit from HPV vaccination (Gardasil9) to increase their coverage of non-HPV 16 or 18 subtypes.
 - Consider the likelihood of previous and future exposure to HPV.
2. Promote safe sex practices.
3. Encourage [cervical screening](#).
4. Recommend [smoking cessation](#).

Referral

- Refer for prompt [gynaecological referral](#) or [gynaecological oncology review](#) if:
 - high suspicion of cancer or visible suspicious cervical mass, even if cervical screening tests are normal.
 - invasive SCC, adenocarcinoma, or glandular abnormalities including adenocarcinoma in situ are detected.
 - persistent abnormal bleeding, even with a normal cervical screening test result.
- Refer for [colposcopy](#) if
 - oncogenic HPV types 16 and/or 18 detected on cervical screening test.
 - other oncogenic HPV types (not 16 or 18) are detected, and
 - there is a possible or definite HSIL, or
 - any suspected or definitive glandular abnormality.
 - persistently positive HPV test (any type) 12 months after the finding of possible or definite low-grade intraepithelial lesion (LSIL), regardless of LBC result.
 - aged 70 to 74 years and tests positive for any oncogenic HPV type.
 - aged ≥ 35 years with postcoital bleeding with a normal cervical screening test.
 - high suspicion for cervical cancer.
- If any abnormality detected on cervical screening, refer DES daughters to an experienced colposcopist with interest/expertise in DES. Consider referral to the [The Royal Women's Hospital DES Follow-Up Clinic](#), phone (03) 9344-5077.
- If appropriate, arrange referral to a [gynaecologist or gynae-oncologist](#) to discuss options, and consider early referral to a [fertility specialist](#).
- If Aboriginal or Torres Strait Islander patient, offer referral to **specific Indigenous services**. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

Referral Options for Aboriginal and Torres Strait Islander people

- For hospital referrals, consider engaging support from the [Aboriginal Hospital Liaison Officers](#).
- For community referrals, consider referral to an Aboriginal Community Controlled Health [service](#).
- For care coordination, support and advocacy throughout treatment, consider referral to [Integrated Team Care Program](#).

Information

For health professionals

Further information

- Cancer Australia – [Gynaecological Cancers: A Handbook for Aboriginal and Torres Strait Islander Health Workers and Health Practitioners](#)
- Cancer Council Australia – [Guidelines for the Management of Screen-detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding](#)

For patients

- Cancer Australia – [Cervical Cancer](#)
- Cancer Council:
 - [Cervical Cancer: Aboriginal and Torres Strait Islander Cancer Information](#)
 - [Fertility and Cancer](#) [84 page PDF]
 - [Understanding Cervical Cancer](#) [72 page PDF]

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