Many physicians are discouraged with the results of cancer therapy. However, the opportunity is there for all physicians to make an early diagnosis in all the gynecologic cancers except those in the tube and ovary. Stage for stage, little progress has been made in lowering mortality rates, but the overall mortality rate is decreasing because more patients are having their cancers diagnosed in early states of disease. This achievement is to the everlasting credit of the practicing doctors who have, by training and motivation, been successful in establishing early diagnosis as a protection for the women of the United States. Those women saved from the raves of cancer shall call their physicians blessed.
## ACS Statistics, 1992:

<table>
<thead>
<tr>
<th></th>
<th>Incidence</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corpus</td>
<td>32,000</td>
<td>4,400</td>
</tr>
<tr>
<td>Ovary</td>
<td>21,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Cervix</td>
<td>13,500</td>
<td>5,600</td>
</tr>
<tr>
<td>Other</td>
<td>4,500</td>
<td>1,000</td>
</tr>
</tbody>
</table>
RISK FACTORS:

**Cervix**
- HPV, HPV, HPV...
- Smoking
- Immunosuppression
- Low beta-carotene intake

**Corpus**
- Hyperestrogenism
- Nulliparity
- Hypothyroidism
- Obesity
- Diabetes
- Atypical Hyperplasia
Histopathology

Cervix
- Squamous Cell (85%)
- Adenocarcinoma
- Clear Cell
- Mesonephric

Corpus
- Endometrioid AdenoCA (80%)
- Papillary Serous AdenoCA
- Clear Cell AdenoCA
- Squamous Cell
- Sarcomas (LMS, ESS, MMMT)

HISTOPATHOLOGY

Cervix
Squamous Cell (85%)
Adenocarcinoma
Clear Cell
Mesonephric

Corpus
Endometrioid AdenoCA (80%)
Papillary Serous AdenoCA
Clear Cell AdenoCA
Squamous Cell
Sarcomas (LMS, ESS, MMMT)
STAGING

Cervix
Clinical

Corpus
Surgical
CERVICAL CA STAGING:

0: Carcinoma-in-situ
Ia: Microinvasive (Ia₁, Ia₂)
Ib: Invasive (>5mm FIGO, >3mm SGO)
IIa: Upper 2/3 of vagina
IIb: Parametrial involvement (not to PSW)
IIIa: Lower 1/3 of vagina
IIIb: PSW or hydronephrosis/nonfunctional kidney
IVA: Bladder or rectal mucosa
IVb: Distant metastases
Cervical CA

- Pelvic exam
- CXR
- SMA-7
- Cystoscopy
- Proctoscopy
- IVP

**Not allowed:** MRI, CT, lymphangiography, surgical findings
PREINVASIVE LESIONS:

Cervix
- SIL
  (W/U by colposcopy)
- Tx: CO₂ Laser, LEEP, Cryosurgery

Corpus
- Atypical Hyperplasia
  (W/U by EMBx, D+C/hyst)
- Tx: Progestins, hysterectomy, ?GnRH-a
Treatment of Cervical Cancer:

- All stages: Radiation but...
- Microinvasive CA: Simple TAH, ?cone
- Stage Ib,(some IIa), <45 yo: prefer rad hyst/LND
- Bulky tumor > 3 cm → RT (+/- chemo)
- Recurrent dz: s/p RT → Exenteration s/p surgery → RT
- Chemotx plays role as adjunct to RT or for palliation
Treatment of Cervical Cancer:

- Removes corpus, cervix, parametria, upper third of vagina
- Uterine arteries divided at origin
- Ureters dissected through tunnel
- Uterosacral ligaments divided near rectum
- Typically combined with LND
- Oophorectomy not mandated
Complications of Radical hysterectomy/LND:

- Bladder/rectal dysfunction
- Lymphocyst/lymphedema
- Urethral strictures
- Ureterovaginal fistula
Complications of Radiation Tx:

**ACUTE**
- Perforation
- Fever
- Diarrhea
- Bladder spasm

**CHRONIC**
- Proctitis
- Cystitis (a/w UTI)
- Fistula
- Enteritis
**Endometrial CA Staging:**

(Add tumor grade to each stage)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia</td>
<td>Limited to endometrium</td>
</tr>
<tr>
<td>Ib</td>
<td>&lt; 1/2 myoetrial thickness</td>
</tr>
<tr>
<td>Ic</td>
<td>&gt; 1/2 myoetrial thickness</td>
</tr>
<tr>
<td>Ila</td>
<td>Cervical glandular involvement</td>
</tr>
<tr>
<td>Iib</td>
<td>Cervical stromal involvement</td>
</tr>
<tr>
<td>IIa</td>
<td>Uterine serosa, positive washings, or adnexal involvement</td>
</tr>
<tr>
<td>IIb</td>
<td>Vaginal metastases</td>
</tr>
<tr>
<td>IIc</td>
<td>Positive lymph nodes</td>
</tr>
<tr>
<td>IVa</td>
<td>Bladder or bowel mucosa</td>
</tr>
<tr>
<td>IVa</td>
<td>Distant metastases</td>
</tr>
</tbody>
</table>
Treatment of Endometrial Adenocarcinoma:

- Surgical staging in majority of patients (Extrafascial TAH/BSO, washings, +/- LND)
- No adjuvant RT if Ia, G1-2 (Ib 1-2) with favorable histology
- Adjuvant RT for High-risk pts
- Progestins not useful for primary dz
- Chemo does not appear to be helpful
High-Risk Patients:

- Deep myometrial invasion
- Positive nodes
- Grade 3 tumor
- Clear cell, papillary serous, squamous or undifferentiated histologies
- Positive peritoneal cytology
- Other extra-uterine spread
Primary Treatment of Uterine Sarcoma:

- Surgical staging
- Single-agent chemotx, depending on histology and stage (ADR for LMS, ESS; IFX for MMMT)
- RT does not appear to alter survival
**Primary Treatment of Uterine Sarcoma:**

Many physicians are discouraged with the results of cancer therapy. However, the opportunity is there for all physicians to make an early diagnosis in all the gynecologic cancers except those in the tube and ovary. Stage for stage, little progress has been made in lowering mortality rates, but the overall mortality rate is decreasing because more patients are having their cancers diagnosed in early states of disease. This achievement is to the everlasting credit of the practicing doctors who have, by training and motivation, been successful in establishing early diagnosis as a protection for the women of the United States. Those women saved from the raves of cancer shall call their physicians blessed.

- Barber, 1980

**Source URL:** http://www.obgyn.net/tutorial/cancer-uterine-corpus-and-cervix-0

**Links:**