

RELEVANCE OF SURGICAL TREATMENT OF CERVICAL CANCER.

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Annotation: Cervical cancer (CC) is one of the most common malignancies in women worldwide [1]. The attitude towards cancer as an incurable disease, inevitably leading to painful death, has been formed for decades, mainly during the period when there were no effective drugs and treatment methods. Indeed, not so long ago in modern history, an oncologist's diagnosis was perceived as an unambiguous death sentence, and every case of recovery was regarded as a miracle. Now the situation has changed dramatically: new research methods have emerged, personalised treatment methods have been developed, taking into account the peculiarities of each individual's organism [9]. A common malignant disease of the organs of the female reproductive system. Modern gynaecological oncology has great opportunities for the treatment of pathology. One of the most effective ways is still considered to be surgery. The choice of intervention protocol depends on the stage of process development, the woman's desire to have children in the future, and other factors [11].

Keywords: Cervical cancer, uterine extirpation, cervical conisation.

Relevance : The adequate extent of surgical intervention for stage IA1 RRMS is cervical conization followed by scraping of the remaining part of the cervical canal and, if indicated, of the uterine cavity in the absence of tumour in the resection margins and scraping from the remaining part of the cervical canal (I,A). In the presence of concomitant gynaecological pathology or in the absence of the need to preserve reproductive function in patients with stage IA1 RSM, uterine extirpation (type I surgery) is possible. In stage IA2 RSM, modified extended uterine extirpation (type II) is indicated (II,B). In case of contraindications to surgical treatment, radiotherapy (RT) may be performed (total focal dose on t.A - 70-80 Gy). If it is necessary to preserve childbearing function in a patient with stage IA2 RSM according to FIGO and NCCN recommendations, it is possible to perform wide cervical conization with extraperitoneal or laparoscopic pelvic lymphadenectomy or extended trachelectomy (type II) (II,A) [3]. Uterine extirpation or uterine extirpation with appendages is recommended for stage IA1 RRMS in patients with completed reproductive function or who are peri- or post-menopausal. [4].

In cervical lesions corresponding to stage TA2, the incidence of regional lymph node involvement increases to 12%, so pelvic lymphadenectomy should be included in the treatment protocol [7, 34]. Wertheim's operation or extended uterine extirpation with ovarian transposition are recommended.

If it is necessary to preserve reproductive function, it is possible to remove the cervix with pericervical tissue, with retroperitoneal or laparoscopic pelvic lymphadenectomy (stages Ia, with unfavourable prognostic factors, Ia2, Ib1). [5,6].

If it is necessary to preserve reproductive function, it is possible to remove the cervix with pericervical tissue, retroperitoneal or laparoscopic pelvic lymphadenectomy (stages Ia, with unfavourable prognostic factors, Ia2, Ib1).



In patients of reproductive age, the ovaries can be preserved and transpositioned outside the pelvis if postoperative radiotherapy is likely. Ovarian transposition can be performed for highly and moderately differentiated squamous cell carcinoma in the absence of vascular embolism [7].

Materials and methods: The material of the study was literature data presented in scientific articles, textbooks, journals.

Results: Indications for vaginal trachelectomy are currently considered to be under 40 years of age, desire to preserve fertility, no infertility, tumour size less than 2 cm, stage IA-IB1 (FIGO), no tumour at the cervical resection margin, no metastases to regional lymph nodes. Abdominal extended trachelectomy is usually performed for larger tumours (2-4 cm). According to L. Ungar et al. (2005), this intervention is possible for tumours up to 6 cm in diameter. Progression was noted in only 1 of 101 patients with stage IB1-IB2 RSCM (the patient had vitreous cell RSCM) (L. Ungar et al., 2008, unpublished data). To date, this clinic has the greatest experience in performing abdominal extended trachelectomy. Table 1 presents data of different authors on the rate of RCC recurrence and fertility in patients who underwent abdominal extended trachelectomy. Abdominal extended trachelectomy was performed on 15 patients with stage IA1-IB1 RRMS in the gynaecological department of the N.N. Blokhin Russian Cancer Centre of the Russian Academy of Medical Sciences. No recurrences were noted, one patient had a pregnancy, which unfortunately ended in spontaneous abortion in the second trimester. By 2007, 520 vaginal dilated trachelectomies had been described in the literature. Their results were analysed by P. Dursun et al (2007). The median age of the patients was 31 years and the median follow-up period was 48 months (1-176 months). Squamous cell cancer was diagnosed in 60% of patients, and adenocarcinoma in 40%. According to H. Hertel et al. (2006), the rate of progression after extended vaginal trachelectomy for squamous cell cancer and adenocarcinoma is not statistically significantly different. In 88% of patients the tumour size did not exceed 2 cm. The overall recurrence rate was 4.2%, the incidence of fatal outcomes due to the underlying disease was 2.8%. The experience of performing extended trachelectomy continues to accumulate. It is already clear that this operation will take its place among the surgical interventions performed for invasive RRMS. More than 100 years have passed since the first description of extended uterine extirpation by E. Wertheim, who initiated the modern surgical treatment of invasive RRMS. And today this method is being developed and improved, continuing to be the cornerstone of the treatment of this severe pathology[2]. Cytological results are usually graded according to the 5-point Papanicolaou system (1943), which has been adopted in many countries. The sensitivity of the Papanicolaou smear for RRMS is 85-95%. Screening for RSM should be started after the first sexual intercourse. Frequency of screening: annually for the first 2 years, then every 2-3 years in case of negative smears. Discontinuation of screening is possible in women 70 years of age and older with intact cervix who have had 3 or more consecutive negative cytological results in the last 10 years[8]. The study by Sardi JE et al (1997) provides definitive data on the treatment of patients with stage IB1-B2 RRMS. In this study, a group of patients treated with neoadjuvant CT followed by surgery and radiation was compared with a group of patients operated on at first stage and then treated with LT. The treatment regimen was vincristine, 1 mg/m² on day 1, cisplatin, 50 mg/m² on day 1, bleomycin, 25 mg/m² 6-hour infusion on days 1-3. There were 3 courses of treatment with an interval of 10 days. Overall survival in stage IB RRMS was significantly higher among patients treated with neoadjuvant CT (81% versus 66% in the control group after 8 years of follow-up, $p < 0.05$). In addition, the incidence of pelvic recurrence was significantly

higher in the control group (17% versus 7%, $p < 0.001$), although the incidence of distant metastases was not significantly different (8% versus 5%). For stage IB2 RRMS, resectability was higher in patients treated with neoadjuvant CT (100% versus 85%, $p < 0.01$). Morphological risk factors such as the presence of tumour emboli in lymphatic and blood vessels, infiltration of the parametrium and metastatic lymph node involvement were absent in the majority of patients treated with neoadjuvant RT ($p < 0.001$).

Clinical studies on the use of induction therapy followed by surgical treatment have shown that tumour volume reduction under the influence of drug treatment allows to perform radical surgery in the majority of initially inoperable patients. Preoperative CT does not increase the number of intra- and postoperative complications. Neoadjuvant CT has been shown to reduce the incidence of lymph node metastases in RSMCs [10]. In HSIL (CIN III) it is recommended to perform a knife biopsy of the cervix (cone-shaped) or cone-shaped radiofrequency biopsy of the cervix followed by separate diagnostic scraping of the cervical canal (the remaining part) and, if indicated, of the uterine cavity for therapeutic and diagnostic purposes (12,13). Convincing level of recommendation - B (level of evidence - 2) Comment: if the diagnosis is histologically confirmed and there are no tumour cells in the resection margins and scrapings from the remaining part of the cervical canal, the given surgical volume is considered adequate. Performing uterine extirpation does not improve treatment outcomes [14]. If HSILs are found in the cervical resection margins or in the remaining cervical scrapings, repeat conization is recommended if fertility preservation is desired. However, uterine extirpation (Piver type I) may be offered to women who are not interested in fertility preservation and to postmenopausal patients. In young patients (up to 45 years of age), removal of the uterus may preserve ovarian function. - For patients with stage IA1 RRMS (stromal invasion 3 mm) it is recommended to perform a cone-shaped biopsy of the cervix followed by diagnostic scraping of the remaining part of the cervical canal [13]. Level of evidence - C (level of evidence - 4) - Level of evidence - B (level of evidence - 2) It is recommended that radical hysterectomy be considered in patients with stage IA1 RRMS not interested in fertility preservation and postmenopausal patients (Piver type I surgery) [15]. Level of evidence - A (level of evidence - 2) - Radical hysterectomy using primarily laparoscopic access is recommended in patients with stage IA2-IB1 RSCM [16]. Level of evidence - A (level of evidence - 1) Comment: The results of a prospective randomised trial demonstrated statistically significantly lower overall and recurrence-free survival in patients with stage IA2-IB1 RSCM operated on in the volume of extended extirpation. Therefore, patients with stage IA2-IB1 RRMS should be familiarised with the results of this study and warned about the risks of worsening oncological outcomes when performing extended uterine extirpation by laparoscopic access [17].

Conclusion: In premature stages of RRMS, excellent oncological results of surgical interventions can be achieved using both laparotomy and laparoscopic access.

In patients with locally spreading RRMS already after neoadjuvant chemotherapy the use of endovideosurgical technique allows to Devan to achieve the necessary degree of radicality while maintaining the the advantages of minimally invasive treatment.

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