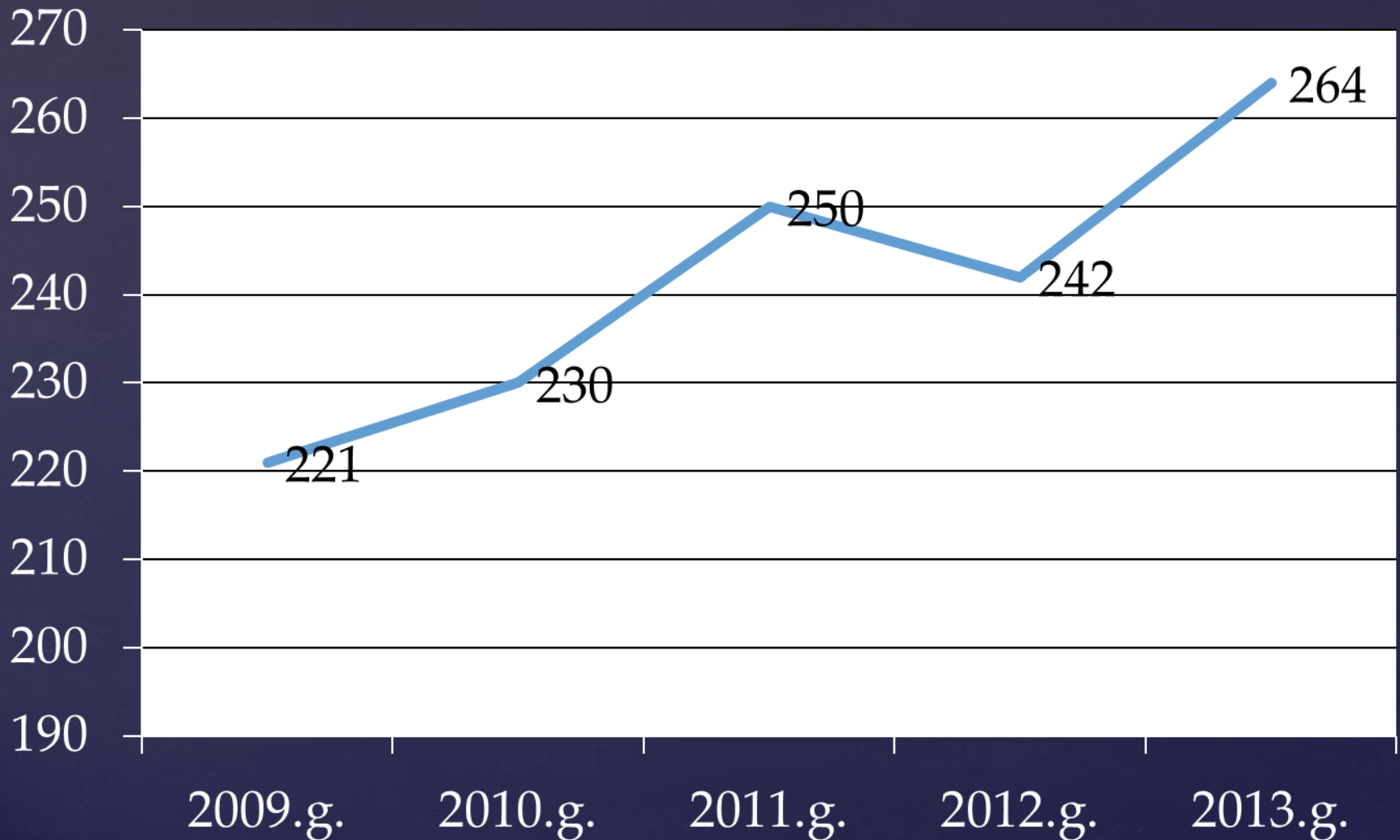


Dzemdes kakla vēzis

Pēcdiploma izglītības lekcija 2015

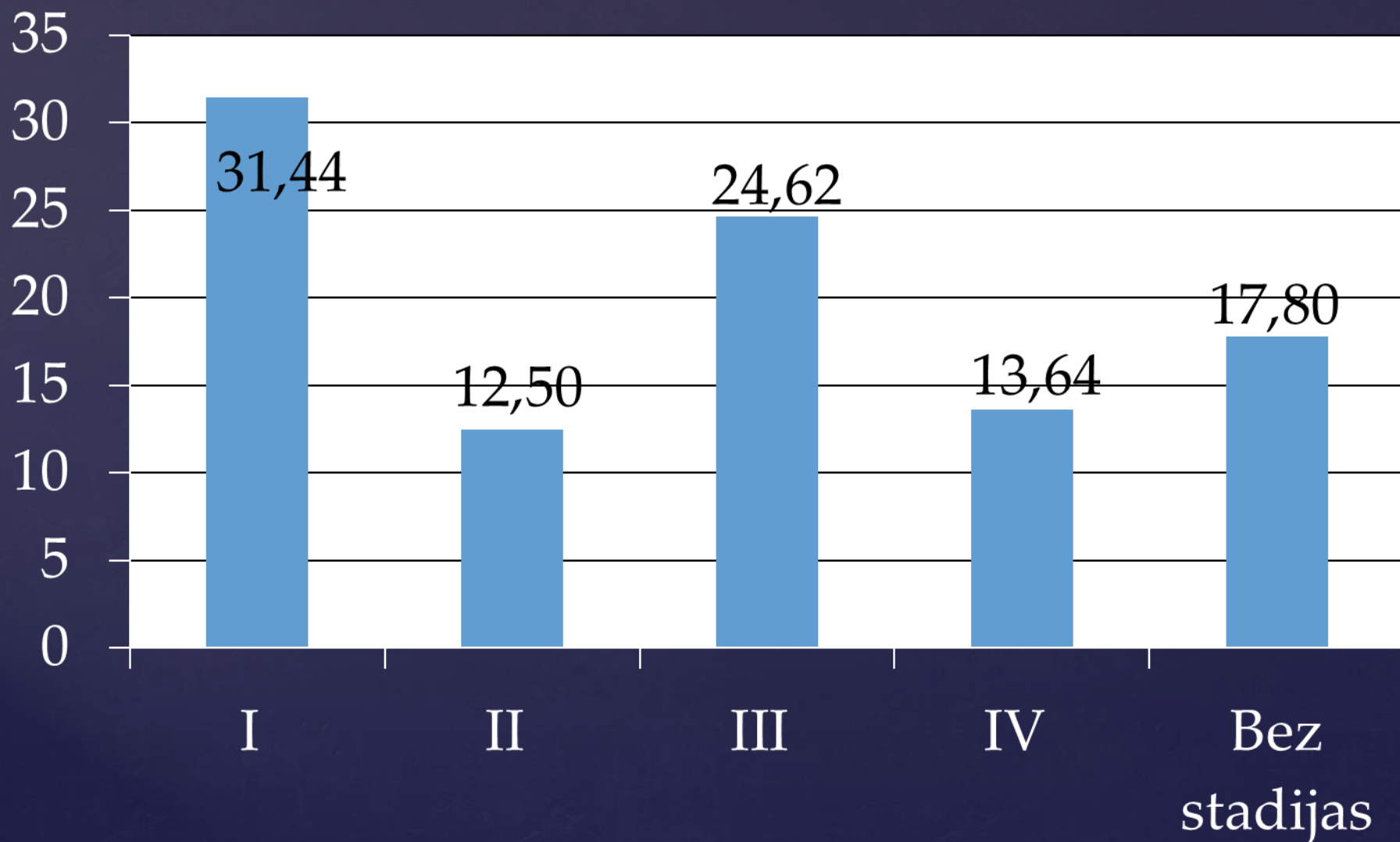
Dr.med.R.Mačuks

Saslimstība 2009. - 2013.g.

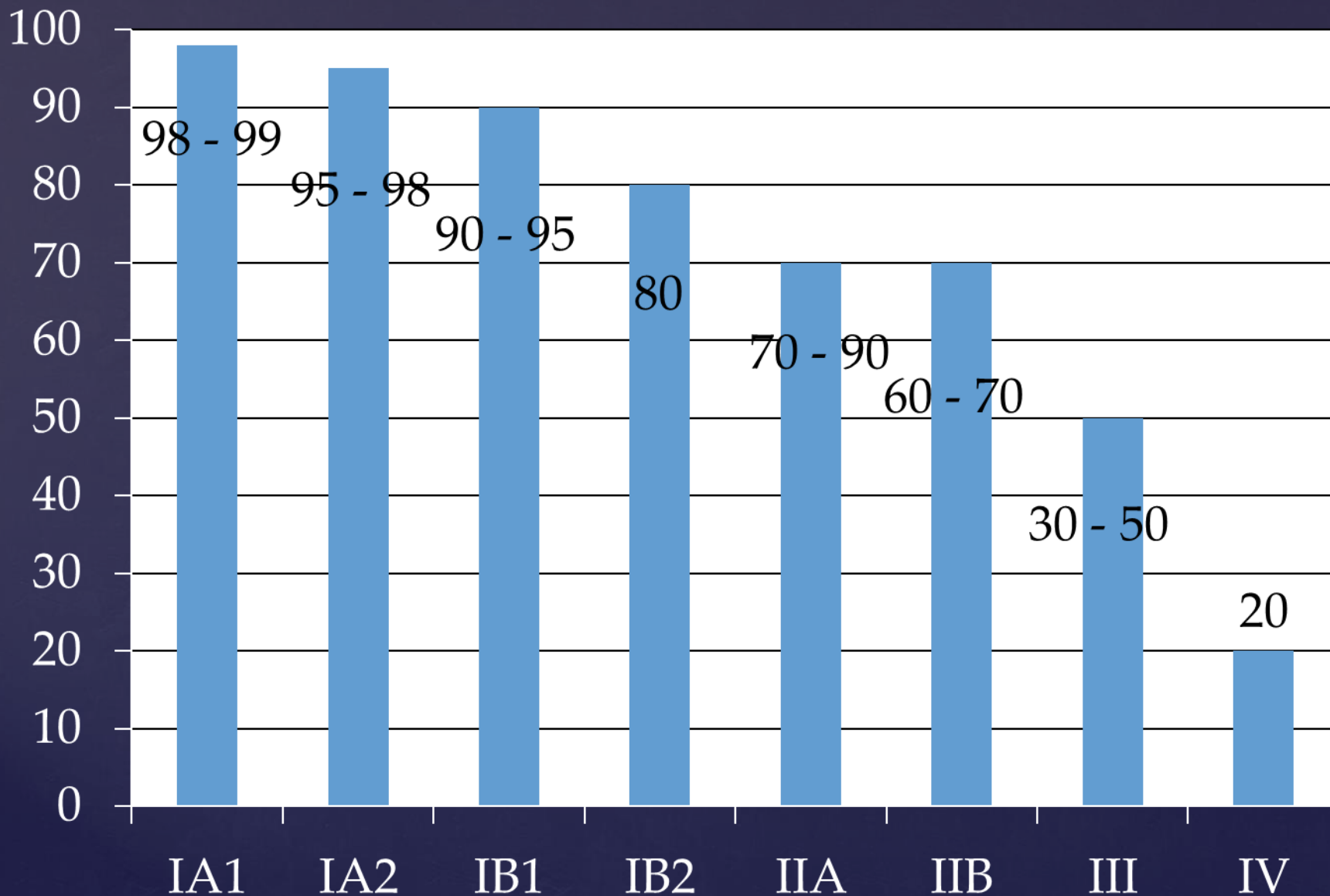


2013.g. DzKV skrīningā atklāts 26 sievietēm

Sadalījums pa stadijām 2013.g., %



5 gadu dzīvildze pa stadijām, %



Sadalījums pa vecuma grupām 2013.g.



Riska faktori

Smoking and cervical cancer: pooled analysis of the IARC multi-centric case--control study.

Plummer M¹, Herrero R, Franceschi S, Meijer CJ, Snijders P, Bosch FX, de Sanjosé S, Muñoz N; IARC Multi-centre Cervical Cancer Study Group.

| Smēķēšana | Relatīvais risks |
|--------------------|------------------|
| Jebkad anamnēzē | 1.8 |
| Patreiz smēķējošām | 2.3 |

Eur J Cancer. 2010 Jan;46(2):405-11. doi: 10.1016/j.ejca.2009.09.015. Epub 2009 Oct 12.

Cigarette smoking is an independent risk factor for cervical intraepithelial neoplasia in young women: a longitudinal study.

Collins S¹, Rollason TP, Young LS, Woodman CB.

| Smēķēšana | Relatīvais risks |
|-------------------------|------------------|
| 10 cig./dienā un vairāk | 2.1 |

Cancer Epidemiol Biomarkers Prev. 2005 May;14(5):1165-70.

Smoking is a risk factor for cervical intraepithelial neoplasia grade 3 among oncogenic human papillomavirus DNA-positive women with equivocal or mildly abnormal cytology.

McIntyre-Seltman K¹, Castle PE, Guido R, Schiffman M, Wheeler CM; ALTS Group.

| Smēķēšana | Relatīvais risks |
|----------------------------|------------------|
| Vairāk, kā 2 paciņas dienā | 3.3 |
| Vairāk, kā 11 gadus | 2.1 |

Role of parity and human papillomavirus in cervical cancer: the IARC multicentric case-control study.

Muñoz N¹, Franceschi S, Bosetti C, Moreno V, Herrero R, Smith JS, Shah KV, Meijer CJ, Bosch FX; International Agency for Research on Cancer. Multicentric Cervical Cancer Study Group.

| | Number of cases/controls | Odds ratio (95% CI)* | Odds ratio (95% CI)† |
|--|---------------------------------|-----------------------------|-----------------------------|
| Number of full-term pregnancies | | | |
| Nulliparous | 57/24 | 1.00 (0.59–1.70) | 1.00 (0.55–1.81) |
| 1–2 | 279/59 | 2.31 (1.71–3.13) | 1.81 (1.31–2.52) |
| 3–4 | 450/70 | 3.73 (2.89–4.83) | 2.55 (1.95–3.34) |
| 5–6 | 353/48 | 5.00 (3.66–6.86) | 2.83 (2.02–3.96) |
| ≥7 | 534/52 | 8.29 (5.99–11.48) | 3.82 (2.66–5.48) |
| p (test for trend) | .. | <0.0001 | 0.0002 |

Squamous-cell carcinomas include invasive and in-situ carcinomas. *Adjusted for study centre and age. †Adjusted for study centre, age, education, smoking status, age at first intercourse, number of sexual partners, oral contraceptive use, and history of Papanicolaou smears.

The relationship between HIV infection and cervical intraepithelial neoplasia among women attending two family planning clinics in Nairobi, Kenya.

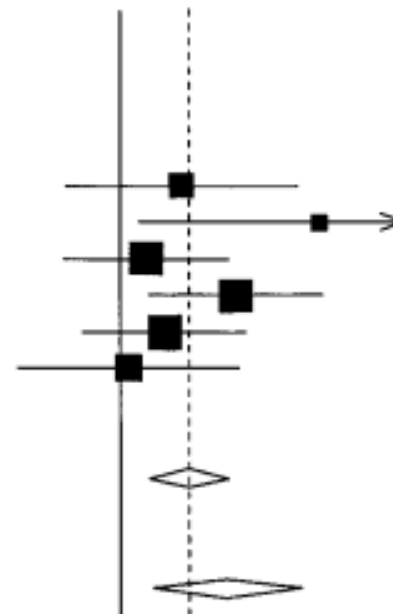
Maggwa BN¹, Hunter DJ, Mbugua S, Tukei P, Mati JK.

| | |
|------------------|------------------|
| HPV pozitīvām | Relatīvais risks |
| HIV -1 infekcija | 2.78 |

Herpes simplex virus-2 as a human papillomavirus cofactor in the etiology of invasive cervical cancer.

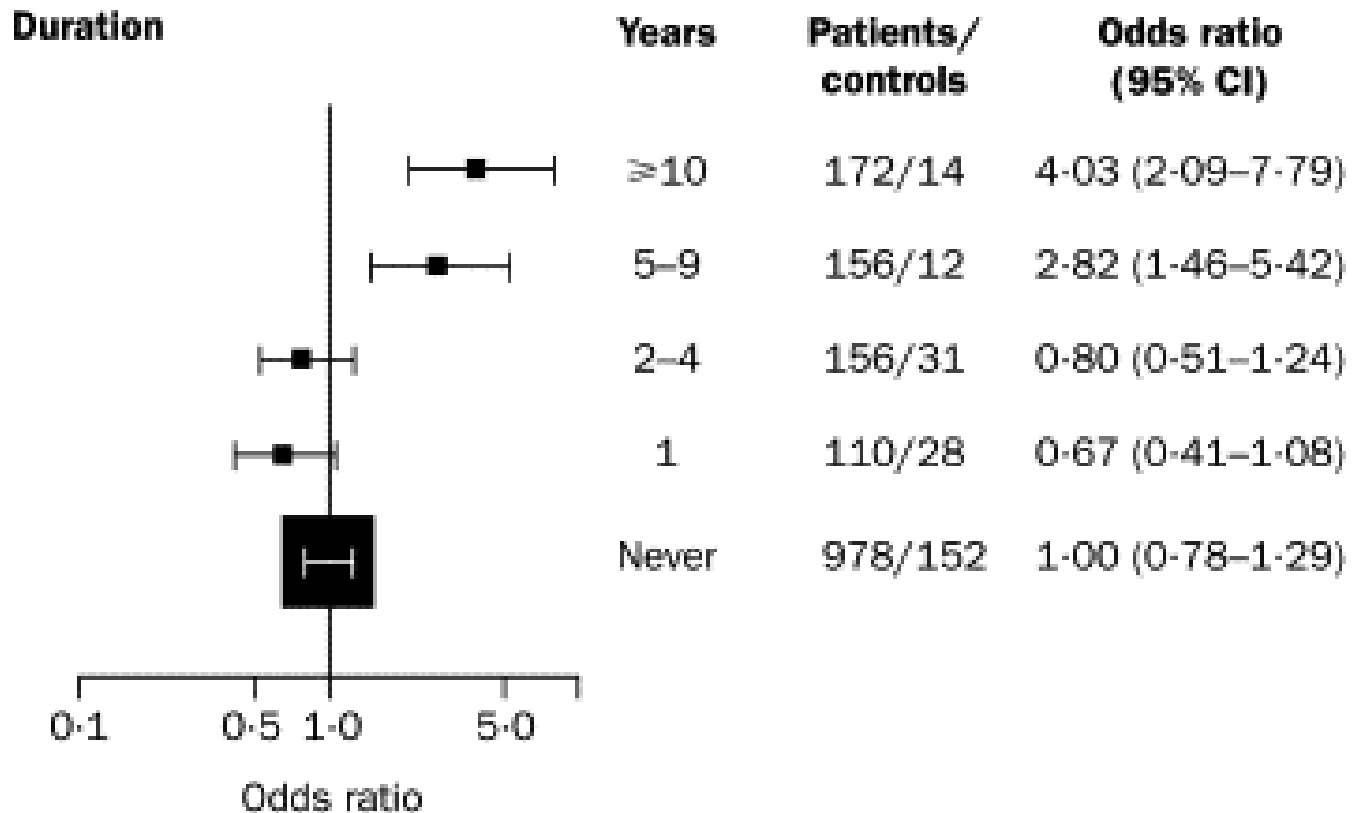
Smith JS¹, Herrero R, Bosetti C, Muñoz N, Bosch FX, Eluf-Neto J, Castellsaqué X, Meijer CJ, Van den Brule AJ, Franceschi S, Ashley R; International Agency for Research on Cancer (IARC) Multicentric Cervical Cancer Study Group.

| Studies | Case patients | Control subjects | OR | 95% CI |
|--|--------------------------------------|--------------------------------------|-------------|---------------------|
| | HSV2 ⁺ /HSV2 ⁻ | HSV2 ⁺ /HSV2 ⁻ | | |
| Squamous-cell carcinoma | | | | |
| Thailand | 118/78 | 5/6 | 2.02 | 0.55 to 7.39 |
| The Philippines | 97/212 | 1/32 | 9.64 | 1.24 to 74.74 |
| Morocco | 58/94 | 11/25 | 1.36 | 0.53 to 3.44 |
| Peru | 92/67 | 8/21 | 3.71 | 1.39 to 9.92 |
| Brazil | 79/62 | 14/16 | 1.67 | 0.66 to 4.17 |
| Colombia | 42/25 | 10/7 | 1.10 | 0.31 to 3.85 |
| Spain | 11/63 | 0/8 | ∞ | 0.34 to ∞ |
| All squamous-cell carcinoma | 497/601 | 49/115 | 2.19 | 1.41 to 3.40 |
| All Adeno/adeno-adenosquamous carcinoma | | | | |
| | 43/52 | 39/100 | 3.37 | 1.47 to 7.74 |



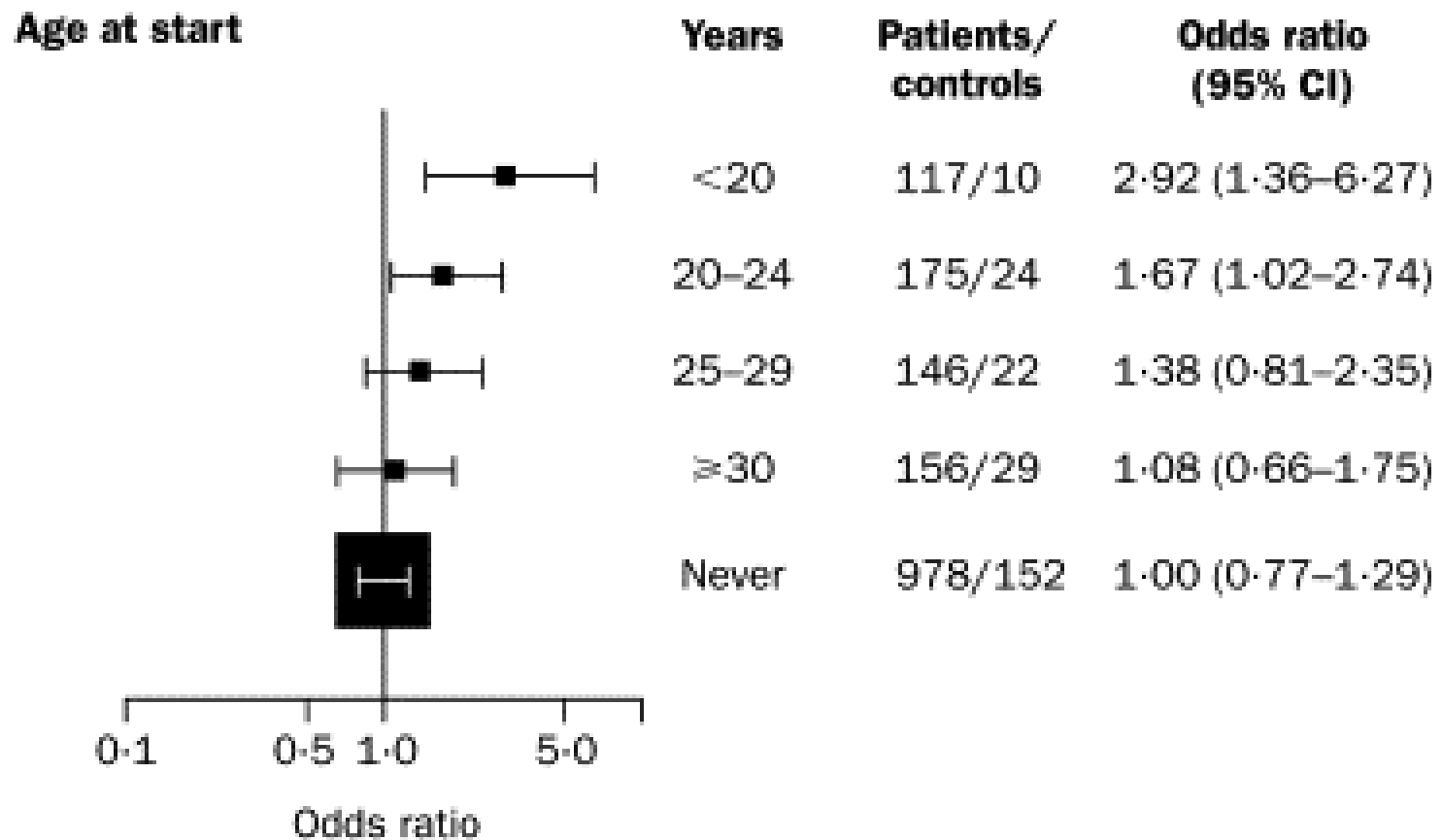
Effect of oral contraceptives on risk of cervical cancer in women with human papillomavirus infection: the IARC multicentric case-control study.

Moreno V¹, Bosch FX, Muñoz N, Meijer CJ, Shah KV, Walboomers JM, Herrero R, Franceschi S; International Agency for Research on Cancer. Multicentric Cervical Cancer Study Group.



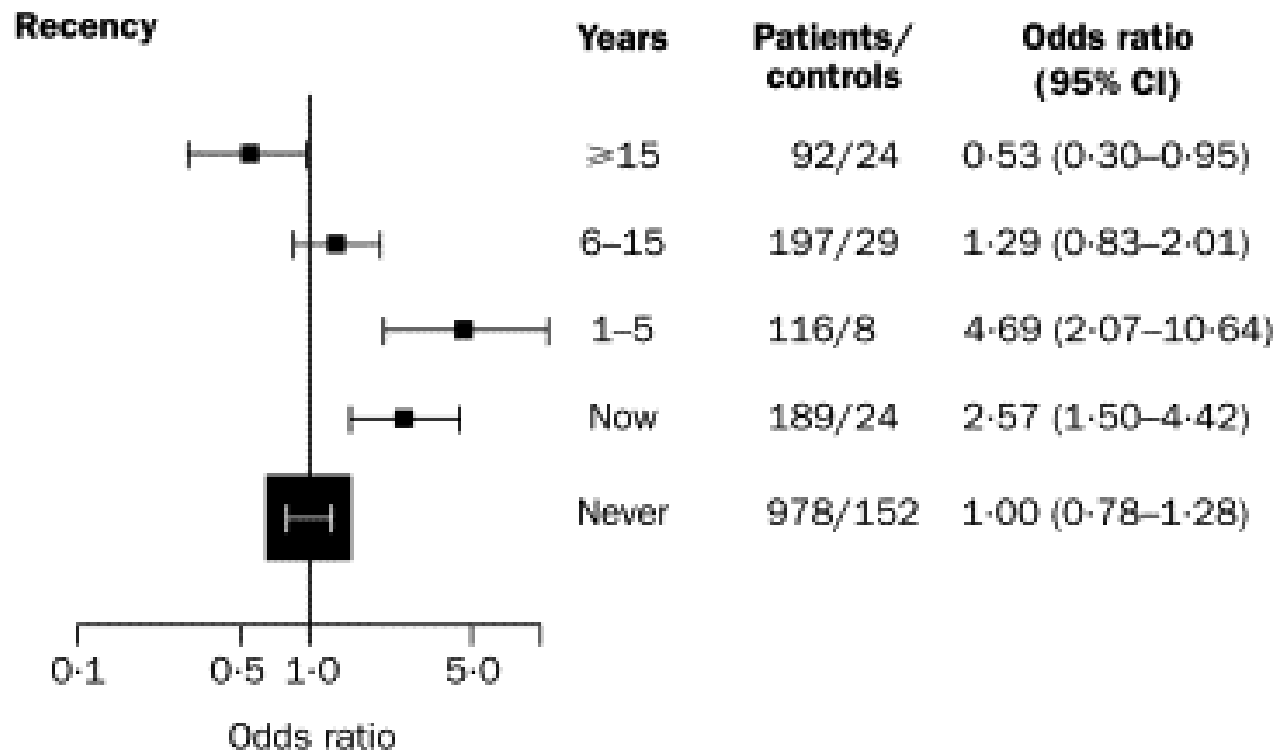
Effect of oral contraceptives on risk of cervical cancer in women with human papillomavirus infection: the IARC multicentric case-control study.

Moreno V¹, Bosch FX, Muñoz N, Meijer CJ, Shah KV, Walboomers JM, Herrero R, Franceschi S; International Agency for Research on Cancer. Multicentric Cervical Cancer Study Group.



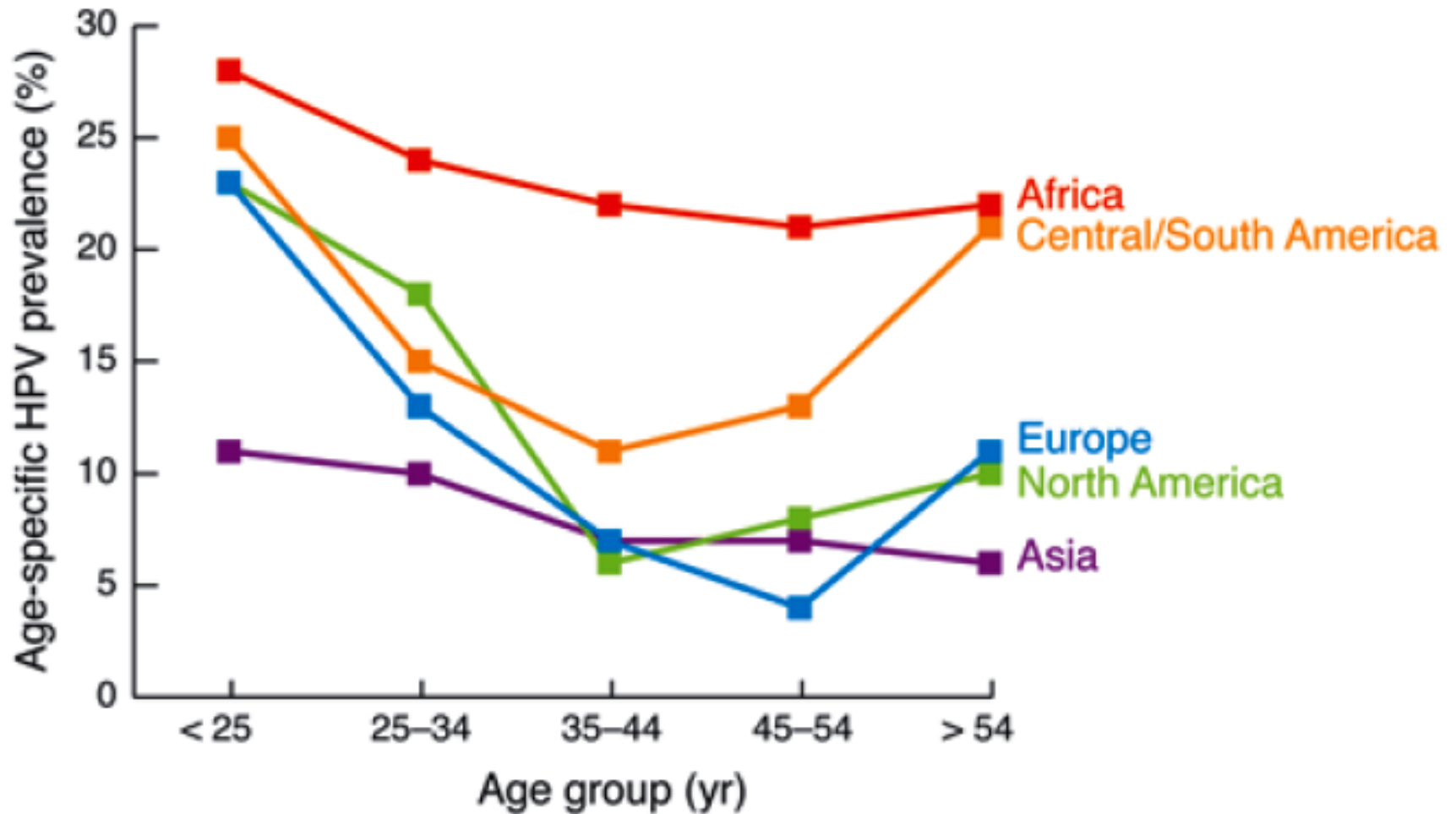
Effect of oral contraceptives on risk of cervical cancer in women with human papillomavirus infection: the IARC multicentric case-control study.

Moreno V¹, Bosch FX, Muñoz N, Meijer CJ, Shah KV, Walboomers JM, Herrero R, Franceschi S; International Agency for Research on Cancer. Multicentric Cervical Cancer Study Group.



Patogēnēze

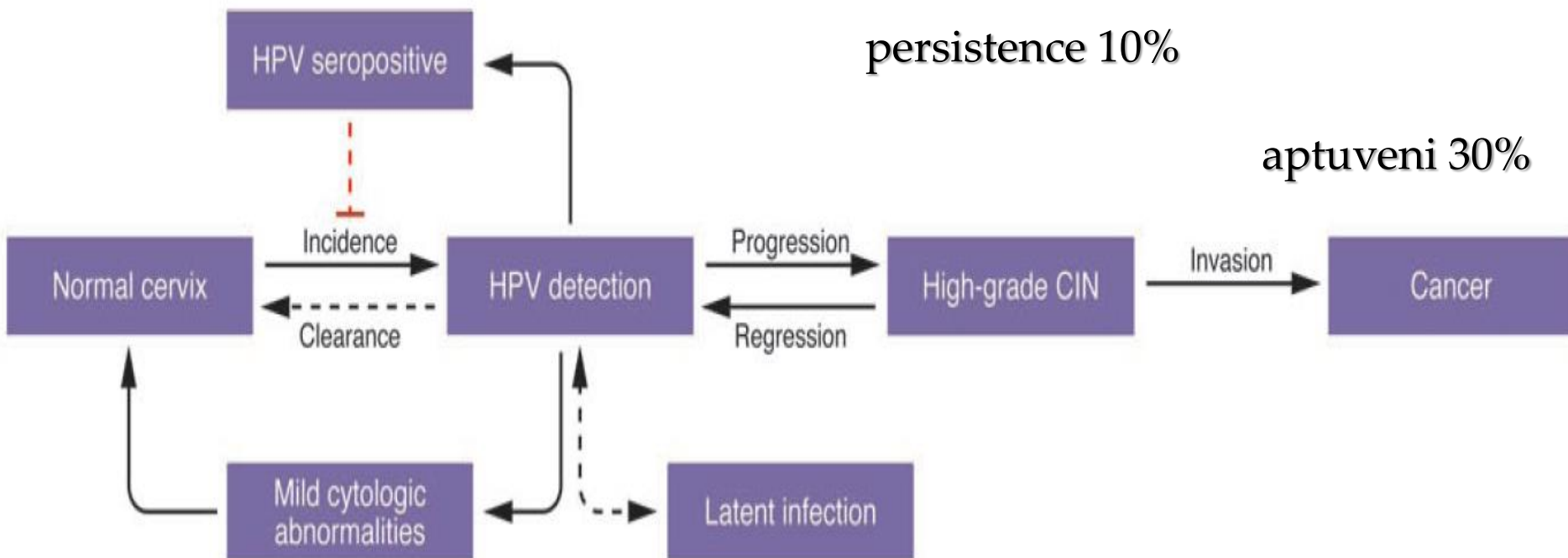
Ar vecumu saistītā HVP prevalence



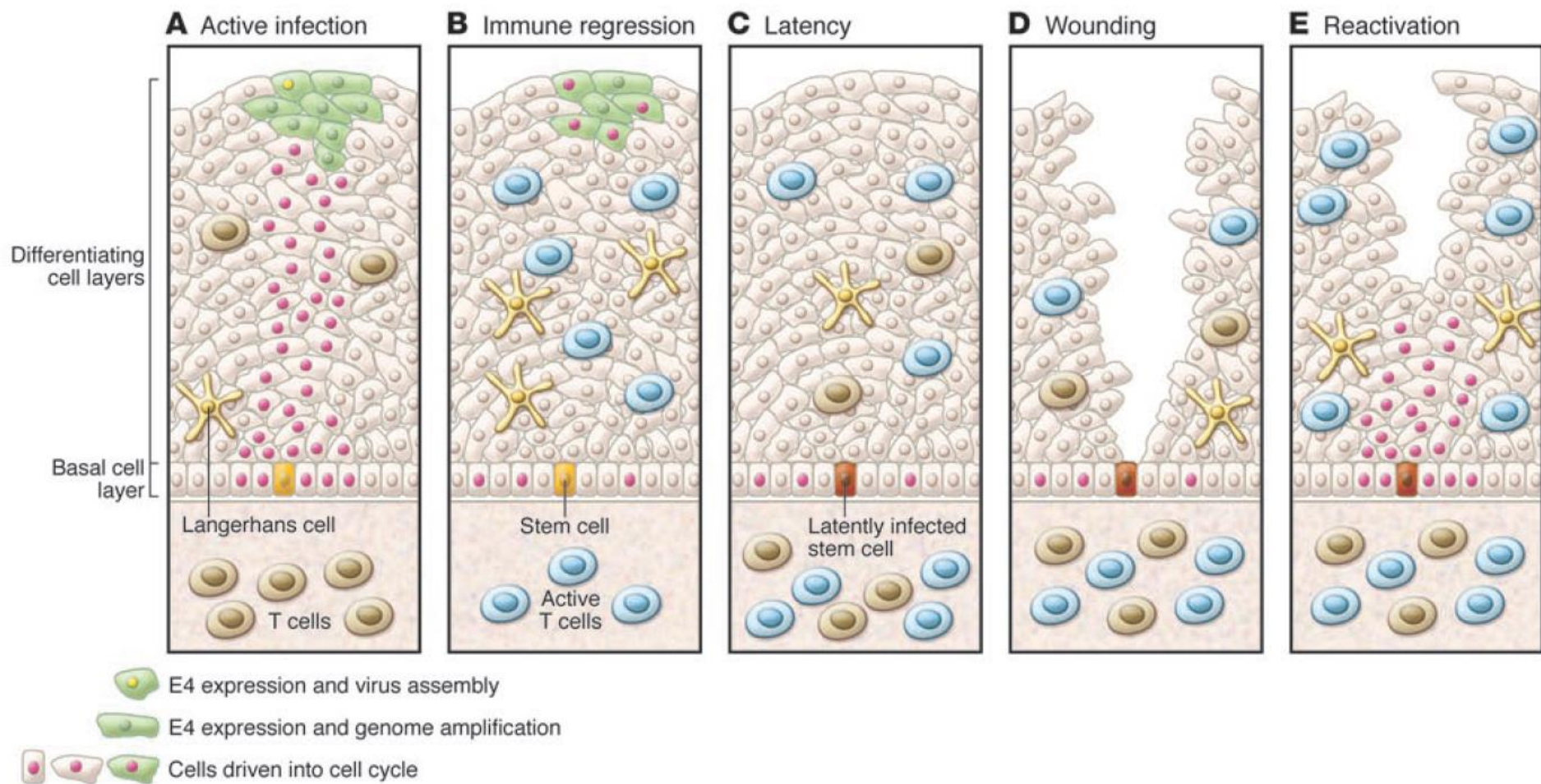
The known unknowns of HPV natural history.

Gravitt PE¹.

30% - 46% pirmo 24 – 36 mēnešu laikā



Viena HPV gēna kopija uz 40–1,000 šūnām pēc HPV vīrusa regresijas pretēji 75 HPV gēna kopijām uz katru šūnu aktīvas vīrusa infekcijas laikā



Sievietes izmeklēšanas algoritms pēc citoloģiskā testa rezultātu saņemšanas

| Citoloģiskais rezultāts | | Novērošanas programma, ko nodrošina ginekologs vai ģimenes ārsts |
|-------------------------|--|---|
| A0 | Testēšana bez rezultāta | Atkārtot testu pēc 3 mēnešiem |
| | | Mērķbiopsija, lietojot KS, ja, atkārtojot testu, nevar nolasīt |
| | | Mērķbiopsija, lietojot KS, ja pēc terapijas kursa nevar nolasīt |
| A1 | Nav atrasts intraepiteliāls bojājums | Nav ieteikumu – iziet no skrīninga, ja vecums ≥ 67 gadi Uzaicinājums uz nākamo skrīninga raundu pēc 3 gadiem programmas ietvaros, ko nodrošina dienests |
| A2 | ASC-US: neskaidras nozīmes daudzkārtainā Plakanā epitēlija šūnu atipiskās izmaiņas | Atkārtot testu 2 reizes ar 6 mēnešu starplaiku. Ja nepieciešams, papildus izmeklēt un ārstēt. |
| | | Ja 3 reizes veicot testu, ir A2, mērķbiopsija, lietojot KS. |

Sievietes izmeklēšanas algoritms pēc citoloģiskā testa rezultātu saņemšanas

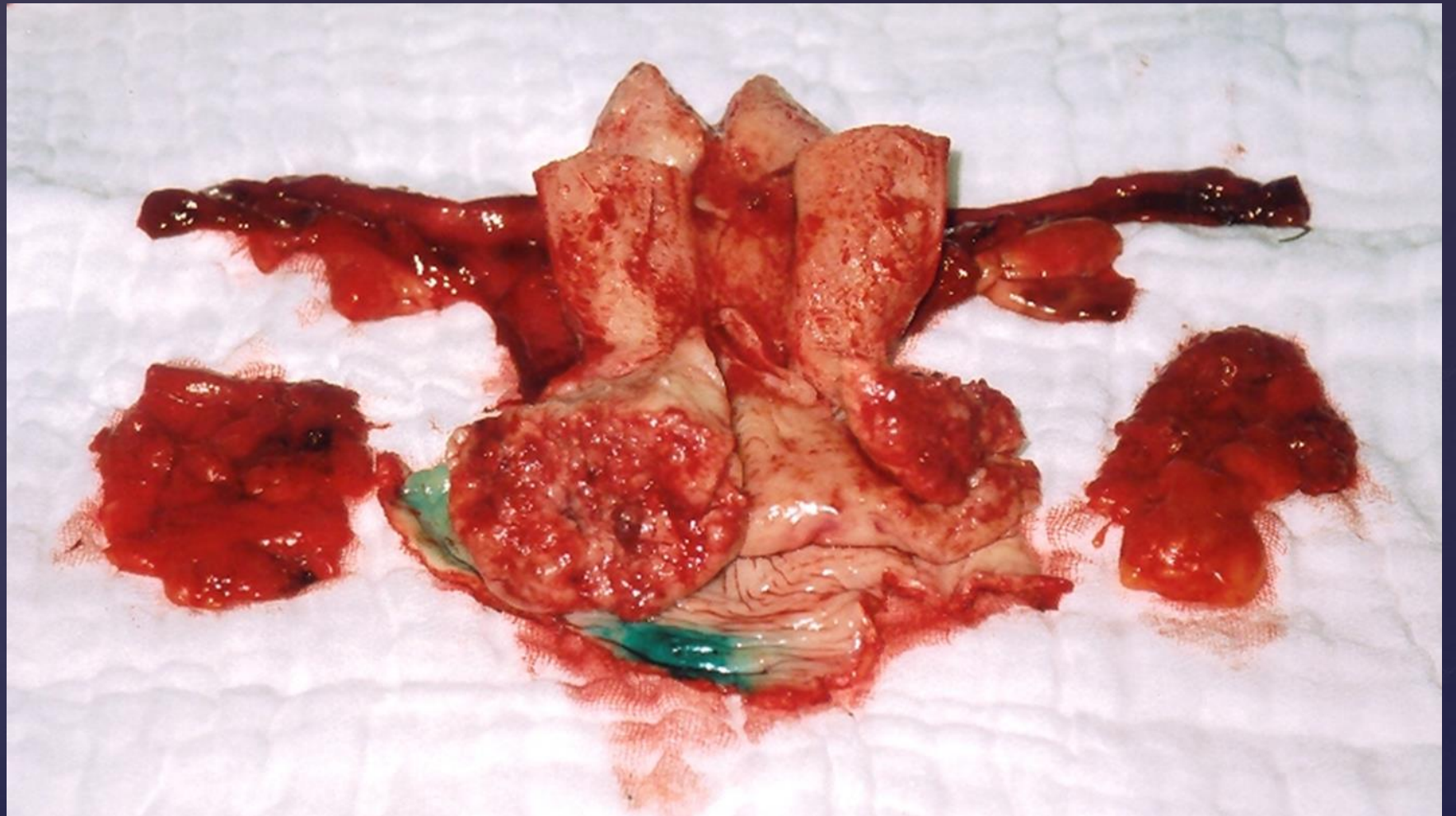
| | | |
|----|---|---|
| A4 | HSIL: vidēja /smaga displāzija | <p>Mērķbiopsija, lietojot KS</p> <p>Atkārtot testu pēc 6 mēnešiem, ja biopsijā nav CIN</p> <p>Ekscīzija KS kontrolē, ja biopsijā CIN 2/3</p> |
| A5 | AGUS: neskaidras nozīmes glandulārā epitēlija šūnu atipiskās izmaiņas | <p>KS, kuras laikā izvērtē mērķbiopsijas vai diagnostiskas ekscīzijas nepieciešamību</p> <p>Ja biopsijas vai diagnostiskās ekscīzijas materiālā nav CGIN vai CIN, izvērtēt iekšējo dzimumorgānu patoloģiju izmeklēšanas nepieciešamību un/vai atkārtot testu pēc 6 mēnešiem,</p> <p>Ekscīzija KS kontrolē, ja biopsijā CGIN vai CIN 2/3</p> |
| A6 | Malignizācijas pazīmes | Nosūta konsultācijai pie onkoloģijas ginekologa |
| A7 | Saplīsis stikliņš | Atkārtot testu pēc 3 mēnešiem programmas ietvaros |

Stadijas noteikšana

Vai vienādi saprotam rakstīto?

| | | |
|-----|---|------|
| IA | Invasive carcinoma diagnosed only by microscopy. All macroscopically visible lesions – even with superficial invasion – are Stage IB/T1b | T1a |
| IA1 | Stromal invasion no greater than 3.0 mm in depth and 7.0 mm or less in horizontal spread | T1a1 |
| IA2 | Stromal invasion more than 3.0 mm and not more than 5.0 mm with a horizontal spread 7.0 mm or less ^a | T1a2 |
| IB | Clinically visible lesion confined to the cervix or microscopic lesion greater than IA2/T1a2 | T1b |
| IB1 | Clinically visible lesion 4.0 cm or less in greatest dimension | T1b1 |
| IB2 | Clinically visible lesion more than 4 cm in greatest dimension | T1b2 |





Histerektomija pēc konizācijas

The influence of time intervals between loop electrosurgical excision and subsequent hysterectomy on the morbidity of patients with cervical neoplasia.

Tae Kim Y, Sung Yoon B, Hoon Kim S, Hoon Kim J, Wook Kim J, Won Park Y.

Department of Obstetrics and Gynecology, Yonsei University College of Medicine, C.P.O. Box 8044, Seoul 120-752, Korea.

Yonsei klīnika Korejā

338 totālas histerektomijas pēc konizācijas

| | | |
|-------------------|---------------------|--------------------|
| 210 | 88 | 40 |
| 48 h laikā | 48h – 6 ned. | > 6.ned. |

Secinājums – nav atšķirību komplikāciju sastopamībā

The influence of interval between conization and laparoscopic radical hysterectomy on the morbidity of patients with cervical cancer.

[Li H](#), [Jiang JY](#), [Li H](#), [Chen K](#), [Shao XG](#).

The Second Affiliated Hospital of China Medical University, ShenYang, China.

2005. – 2011.g. Terciārās aprūpes centrā

95 LPS radikālas histerektomijas pēc konizācijas

17

līdz 6 ned.

38

pēc 6 ned.

40

bez konizācijas

Secinājums – komplikācijas biežāk grupā «līdz 6 ned.»

Kad veikt elektroekscīziju –
pirms vai pēc menstruācijām?

Bleeding after loop electrosurgical excision procedure performed in either the follicular or luteal phase of the menstrual cycle: a randomized trial.

Paraskevaïdis E, Davidson EJ, Koliopoulos G, Alamanos Y, Lolis E, Martin-Hirsch P.

Department of Obstetrics and Gynecology, Ioannina University Hospital, Ioannina, Greece. vangelispar@hotmail.com

Table 1. Group Characteristics

| | Follicular phase (<i>n</i> = 30) | Luteal phase (<i>n</i> = 30) | <i>P</i> |
|------------------------------------|---|-------------------------------------|-------------------|
| Age (y) | 30.9 ± 4.7 | 32.6 ± 5.3 | .196* |
| Usual duration of menses (d) | 5.3 ± 1.4 | 5.1 ± 1.2 | .559* |
| Number of parous women | 15 | 16 | .796 [†] |
| Vaginal delivery (at least one) | 11 | 12 | .791 [†] |
| Depth of excision (mm) | 11.4 ± 2.3 | 11.7 ± 2.5 | .628* |
| CIN 1 on pathology | 11 | 13 | .819 [†] |
| CIN 2-3 on pathology | 16 | 15 | .819 [†] |
| No CIN on pathology | 3 | 2 | .819 [†] |

CIN = cervical intraepithelial neoplasia.

* Student *t* test.

[†] χ^2 test.

Table 2. Comparative Results in Both Groups

| | | Follicular phase (4th–6th day) | Luteal phase (16th–18th day) | <i>P</i> |
|--|-----------------|-----------------------------------|---------------------------------|----------|
| Colposcopist impression of intraoperative bleeding (%) | Mild | 26 (86.7) | 18 (60.0) | .02 |
| | Moderate/severe | 4 (13.3) | 12 (40.0) | .02 |
| Difficulty in controlling bleeding during LEEP (%) | Mild | 26 (86.7) | 23 (76.7) | NS |
| | Moderate/severe | 4 (13.3) | 7 (23.3) | NS |
| HCT levels (mean \pm SD) | HCT difference* | 0.9 (\pm 1.9) | 3 (\pm 2.15) | .001 |
| | HCT 1 | 36.63 (\pm 2.24) | 36.87 (\pm 1.98) | NS |
| | HCT 2 | 35.73 (\pm 2.59) | 33.87 (\pm 2.70) | .008 |
| Days of bleeding/woman (mean \pm SD) | Heavy | 2.93 (1.2) | 3.83 (1.18) | .004 |
| | Moderate | 3.6 (1.16) | 5.93 (1.8) | .001 |
| | Mild/spotting | 3.93 (1.26) | 5.43 (1.45) | .001 |
| Anxiety (%) | | 3 (10.0) | 12 (40.0) | .007 |

LEEP = loop electrosurgical excision procedure; NS = not significant; HCT = hematocrit; SD = standard deviation.

* Difference between the preoperative and postoperative HCT levels.

Nosūtījums morfoloģiskai izmeklēšanai

- Invāzijas dziļumu un plašumu
- LVSI (atšķirīga taktika IA stadijā)

| Invāzija | MTS risks iegurņa l/m | |
|----------|-----------------------|--------|
| | - LVSI | + LVSI |
| 0 - 3mm | 0.5% | 4.7% |
| 3 - 5 mm | 3.4% | 11.1% |

Pēcoperācijas materiālā svarīgi norādīt visu izoperēto limfmezglu skaitu

Dzemes kakla vēža stadijas noteikšana

- Nepieciešama gan FIGO, gan TNM
- Klīniska vai ķirurģiska stadijas noteikšana?

| Klīniska | Ķirurģiska |
|---|---|
| Bimanuāla izmeklēšana | + I/m biopsijas vai sist. iegurņa un/vai paraaortāla limfadenektomija |
| Kolposkopija, Cistoskopija, Rektoromanoskopija | |
| Konizācija / biopsija / cervikālā kanāla abrāzija | |
| Krūškurvja Rtg | |
| I/v urogrāfija, USS nierēm | |
| Nepieciešamības gadījumā: | |
| CT krūškurvim/ vēdera dob.org. | |
| MR mazajam iegurnim | |

Surgical versus radiographic determination of para-aortic lymph node metastases before chemoradiation for locally advanced cervical carcinoma: a Gynecologic Oncology Group Study.

Gold MA, Tian C, Whitney CW, Rose PG, Lanciano R.

Department of Obstetrics and Gynecology, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA.

3 pētījumu meta-analīze

| | |
|----------------|---|
| GOG 85 | RT + hydroxyurea vai cisplatīns un 5-FU |
| GOG 120 | RT + cisplatīns vai hydroxyurea vai cisplatīns un 5-FU un hydroxyurea |
| GOG 165 | RT + cisplatīns vai 5-FU |

685 pacientes, FIGO IIB – IVA

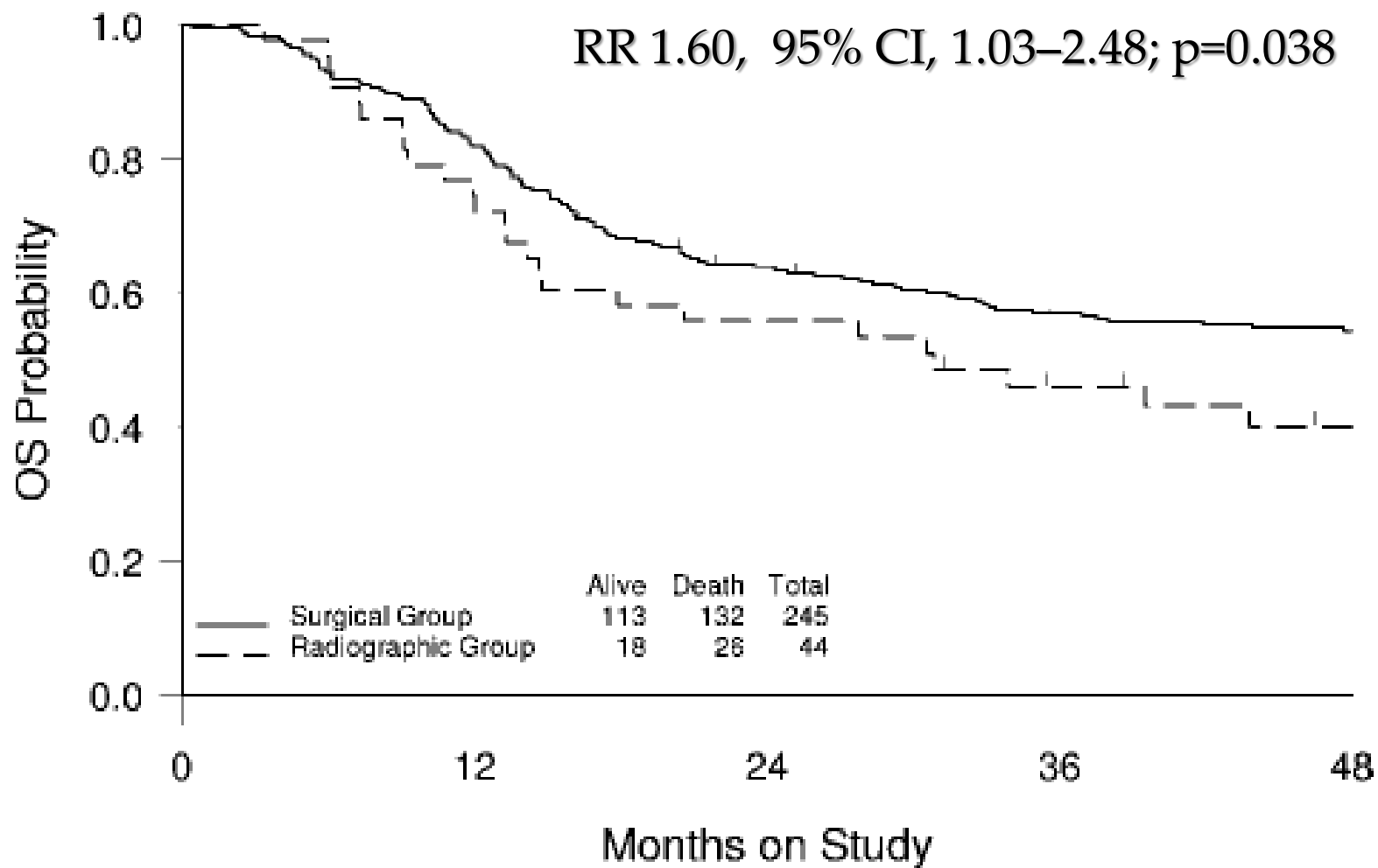
Ķirurģiski noteikta stadija

n=555

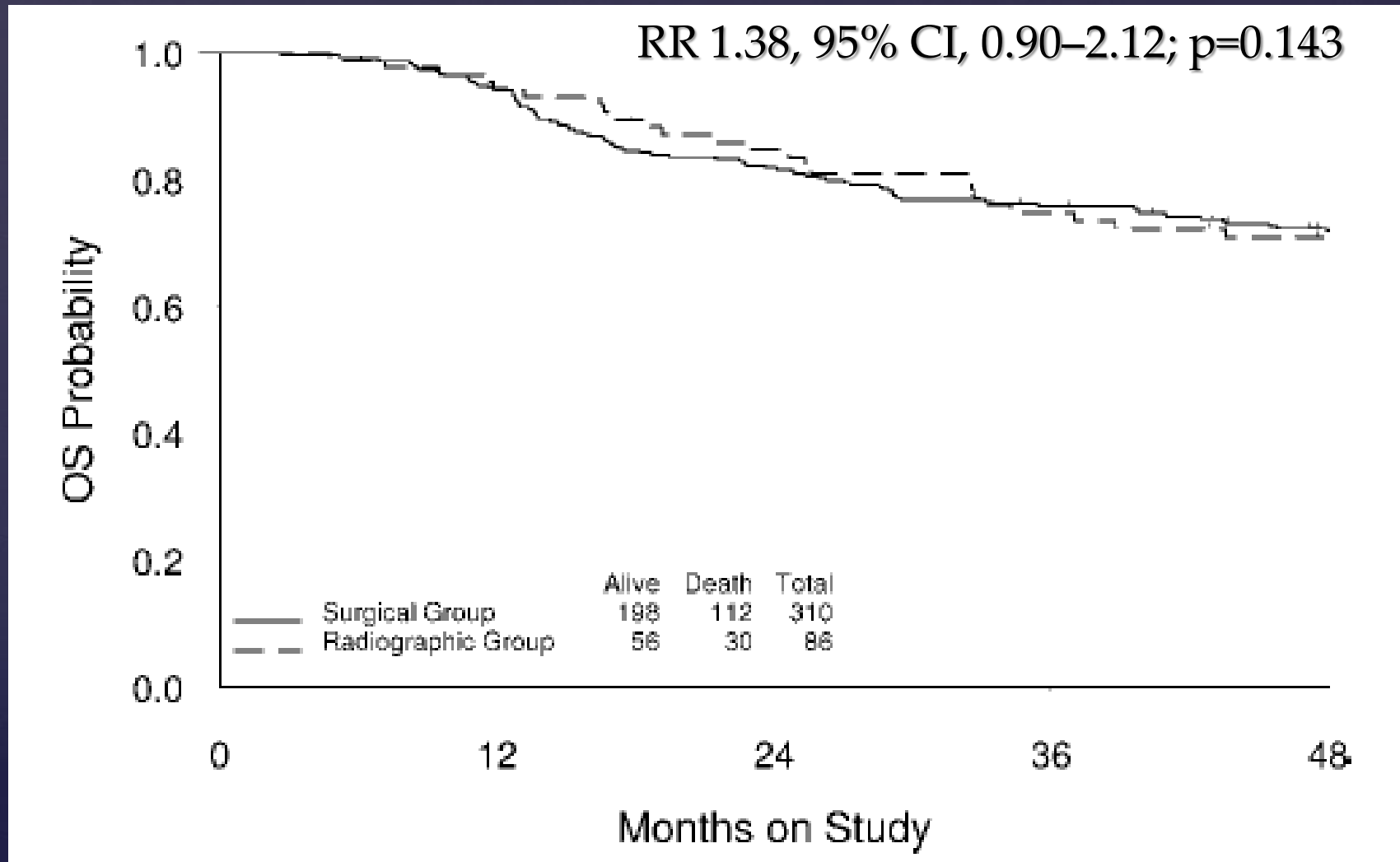
Klīniski noteikta stadija

n=130

Dzīvildze FIGO III/IV stadijā klīniski / ķirurģiski noteiktai stadijai



Dzīvildze FIGO II stadijā klīniski / ķirurģiski noteiktai stadijai



Limfmezglu novērtēšana izmantojot CT / MR

NCCN vadlīnijas

- H&P
- CBC, platelets
- Cervical biopsy, pathologic review
- Cone biopsy as indicated
- Chest x-ray, PET/CT scan,
CT/MRI (optional for \leq stage IB1)
- LFT/renal function studies

Optional (\geq Stage IB2):

- EUA cystoscopy/proctoscopy^a

ESMO un FIGO

doscopy if symptomatic. Chest x-ray and renal evaluation (which may consist of renal ultrasound, IVP, CT or MRI) are mandatory. CT and/or MRI and/or PET may provide some information on nodal status or systemic spread.

Cik bieži CT/MR varētu sagaidīt palielinātus iegurņa
vai para-aortālos l/m IB - IIA stadijā?

Lymphatic spread of cervical cancer: an anatomical and pathological study based on 225 radical hysterectomies with systematic pelvic and aortic lymphadenectomy.

Benedetti-Panici P, Maneschi F, Scambia G, Greggi S, Cutillo G, D'Andrea G, Rabitti C, Coronetta F, Capelli A, Mancuso S.

Department of Obstetrics and Gynecology, Catholic University, Rome, Italy.

| | IB-IIA <4 cm n = 66 | IB-IIA >4 cm – IV n = 159 |
|----------------------------|------------------------|------------------------------|
| Pacienšu skaits ar mts l/m | 14 (21%) | 38 (23%) |

| Metastasis diameter | Early stage | NACT treated |
|---------------------|-------------|--------------|
| ≤2 mm | 31 (17%) | 66 (32%) |
| >2, ≤5 mm | 57 (31%) | 70 (34%) |
| >5, ≤10 mm | 61 (34%) | 48 (24%) |
| >10, ≤20 mm | 26 (14%) | 20 (10%) |
| >20 mm | 6 (3%) | — |
| Total | 181 | 204 |

82 – 90 % metastātiskie l/m < 10mm

Datortomogrāfiskās, ultrasonogrāfiskās un klīniskās izmeklēšanas precizitāte audzēja izplatības novērtēšanai pacientēm ar dzemdes kakla vēzi

- ❑ RAKUS Latvijas Onkoloģijas centra 6.nodaļā
- ❑ 80 pacientes ar IA2 – IIA stadiju (2010. – 2012.g.)
- ❑ Radikāla histerektomija

| CT limfmezglu iesaiste | | Morfoloģiski |
|------------------------|----|--------------|
| Jā | 6 | 2 |
| Nē | 62 | 11 |
| Aizdomīgi | 12 | 2 |

- ❑ CT jutība un specifiskums – 26,7% un 77,5%
- ❑ Klīniskā / ķirurģiskā stadija - 18,75 % stadijas paliel.

Lokālā stāvokļa novērtēšana – MR un USS

Ultrasound Obstet Gynecol. 2008 May;31(5):560-6. doi: 10.1002/uog.5295.

Preoperative local staging of endometrial cancer: transvaginal sonography vs. magnetic resonance imaging.

Savelli L, Ceccarini M, Ludovisi M, Fruscella E, De Iaco PA, Salizzoni E, Mabrouk M, Manfredi R, Testa AC, Ferrandina G.

Department of Obstetrics and Gynecology, University of Bologna, Bologna, Italy. luca.savelli@aosp.bo.it

| | <i>Histology: myometrial infiltration</i> | | | <i>Sensitivity (%)</i> | <i>Specificity (%)</i> |
|--------------|---|-----------|--------------|------------------------|------------------------|
| | $\geq 50\%$ | $< 50\%$ | <i>Total</i> | | |
| TVS | | | | 84 | 83 |
| $\geq 50\%$ | 27 | 7 | 34 | | |
| $< 50\%$ | 5 | 35 | 40 | | |
| Total | 32 | 42 | 74 | | |
| MRI | | | | 84 | 81 |
| $\geq 50\%$ | 27 | 8 | 35 | | |
| $< 50\%$ | 5 | 34 | 39 | | |
| Total | 32 | 42 | 74 | | |

| | <i>Histology: cervical involvement</i> | | | <i>Sensitivity (%)</i> | <i>Specificity (%)</i> |
|------------|--|-----------|--------------|------------------------|------------------------|
| | <i>Yes</i> | <i>No</i> | <i>Total</i> | | |
| TVS | | | | 93 | 92 |
| Yes | 13 | 5 | 18 | | |
| No | 1 | 55 | 56 | | |
| Total | 14 | 60 | 74 | | |
| MRI | | | | 79 | 87 |
| Yes | 11 | 8 | 19 | | |
| No | 3 | 52 | 55 | | |
| Total | 14 | 60 | 74 | | |

Ārstēšana

Terapijas izvēle atbilstoši stadijām

IA1

Totāla histerektomija
vai
Novērošana, ja paciente vēlas saglabāt
fertilitāti vai ir neoperabla
+ iegurņa limfadenektomija, ja ir LVSI

Novērošana

Limfmezglu
morfoloģiskais
novērtējums pēc
operācijas

IA2

Radikāla histerektomija
+ iegurņa limfadenektomija
± paraaortālo limfmezglu biopsijas
vai

Brahiterapija
± staru terapija iegurnim
vai

Radikāla trahelektomija
+ iegurņa limfadenektomija
± paraaortālo limfmezglu biopsijas

Limfmezglu
morfoloģiskais
novērtējums pēc
operācijas

Novērošana

IB1
IIA1

Radikāla histerektomija
+ iegurņa limfadenektomija
± paraaortālo limfmezglu biopsijas
vai
Staru terapija iegurnim+ brahiterapija
vai
Radikāla trahelektomija, ja audzējs ≤ 2 cm
+ iegurņa limfadenektomija
± paraaortālo limfmezglu biopsijas

Operācijas laikā
izdalīto l/m
morfoloģiskais
novērtējums

Novērošana

IB2
IIA2

Staru terapija iegurnim
+ vienlaicīga ķīmijterapija ar cisplatīnu
+ brahiterapija
vai
Radikāla histerektomija
+ iegurņa limfadenektomija
+ paraaortālo limfmezglu biopsijas
vai
Staru terapija iegurnim
+ vienlaicīga ķīmijterapija ar cisplatīnu
+ brahiterapija
+ adjuvanta histerektomija

Novērošana

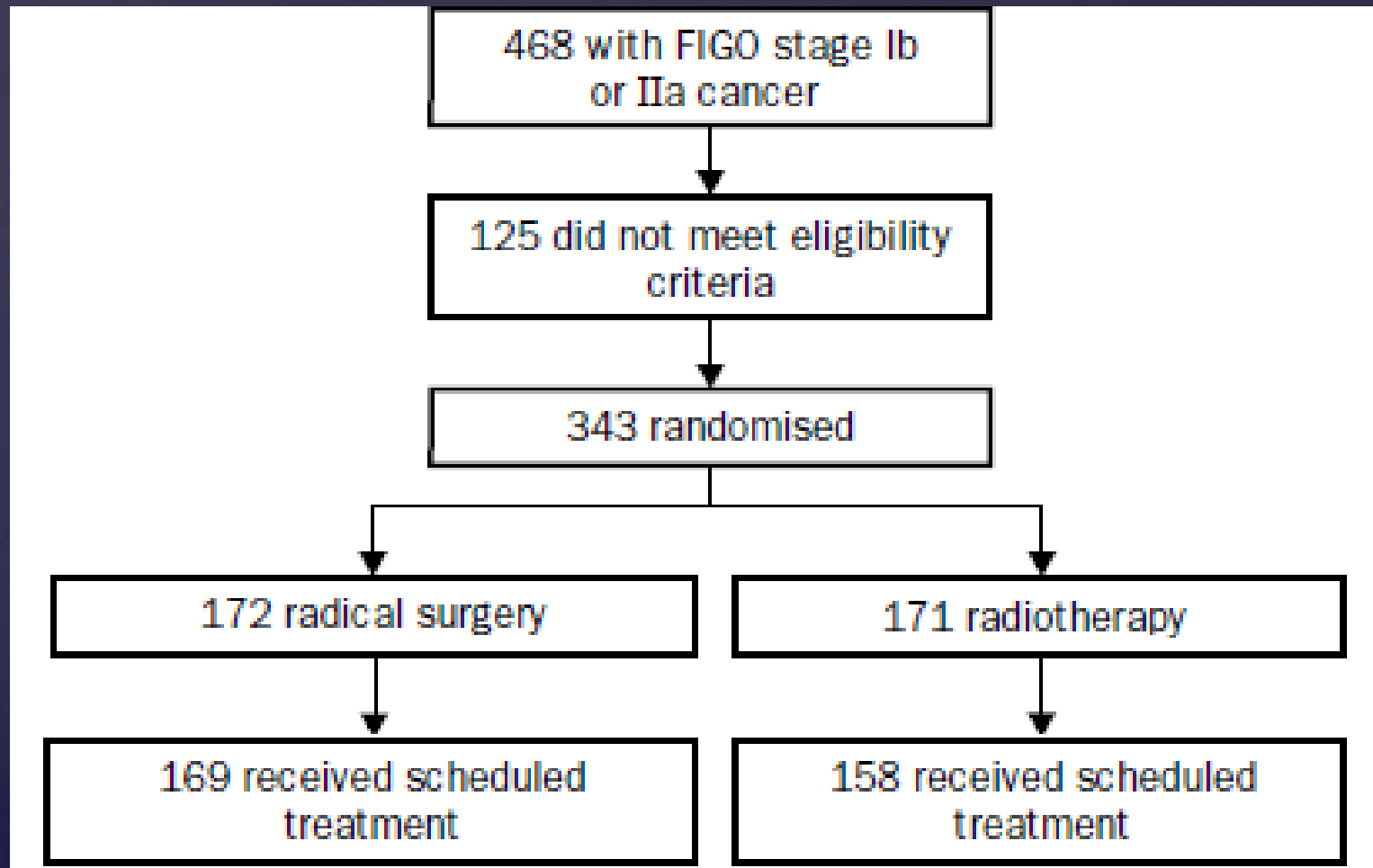
Operācijas laikā
izdalīto l/m
morfoloģiskais
novērtējums

Novērošana

Randomised study of radical surgery versus radiotherapy for stage Ib-IIa cervical cancer.

Landoni F, Maneo A, Colombo A, Placa F, Milani R, Perego P, Favini G, Ferri L, Mangioni C.

III Clinica Ostetrico Ginecologica, University of Milan, Italy.

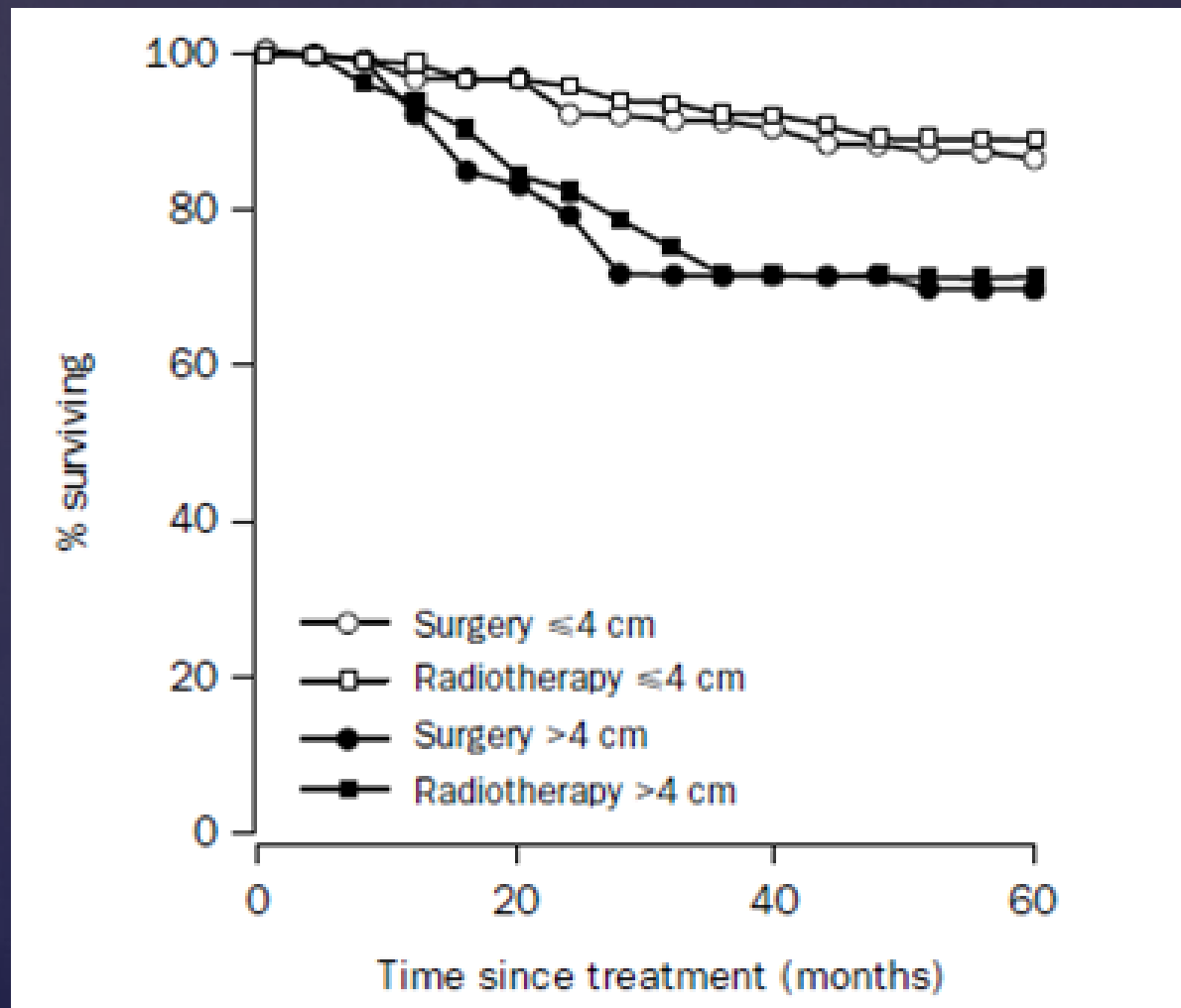


Lancet. 1997 Aug 23;350(9077):535-40.

Randomised study of radical surgery versus radiotherapy for stage Ib-IIa cervical cancer.

Landoni F, Maneo A, Colombo A, Placa F, Milani R, Perego P, Favini G, Ferri L, Mangioni C.

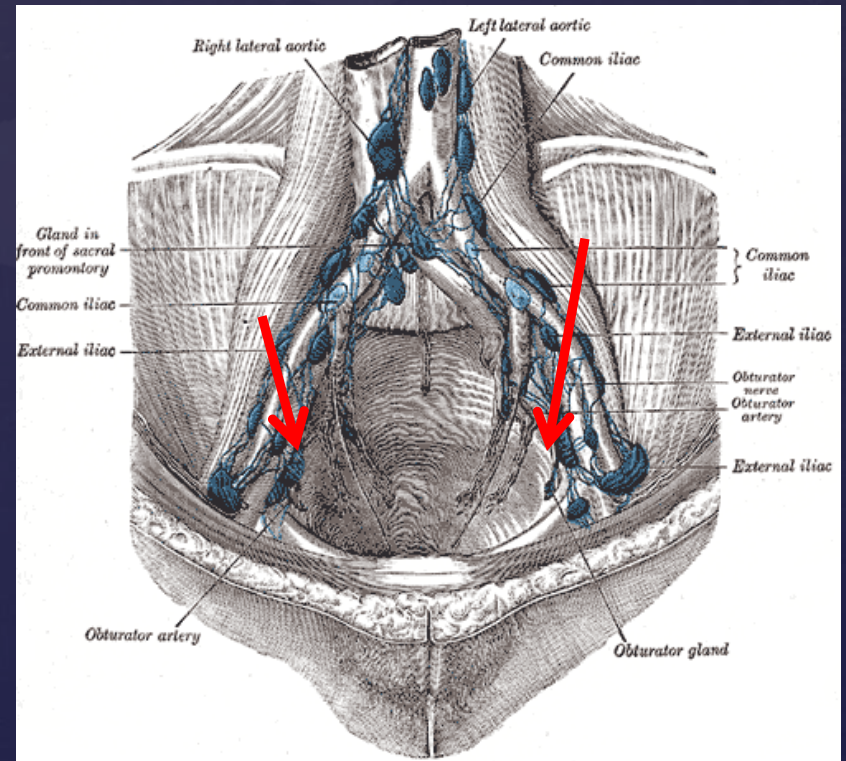
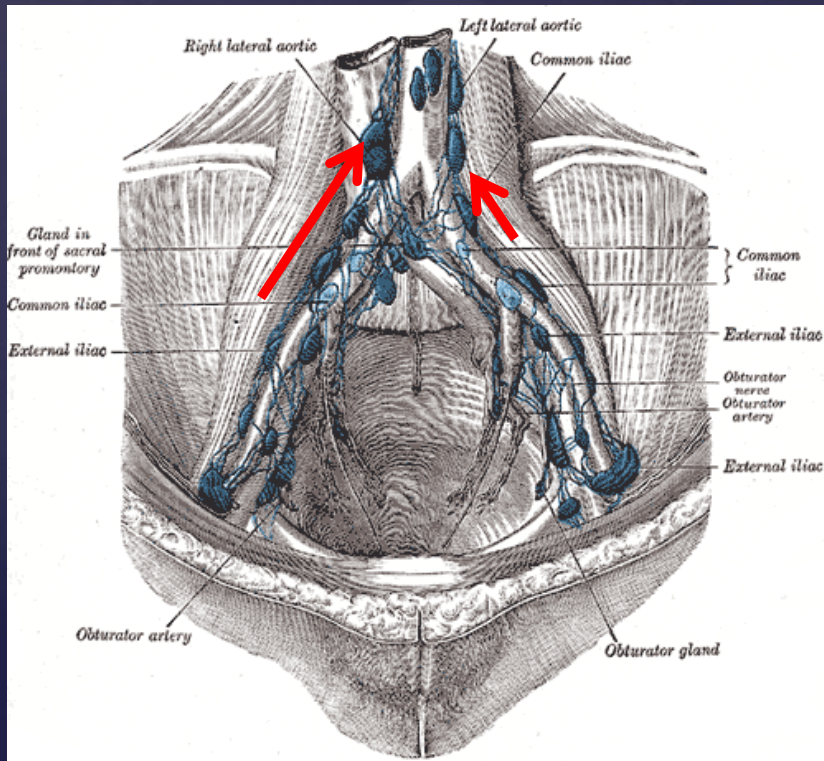
III Clinica Ostetrico Ginecologica, University of Milan, Italy.



Nozīmīgākais faktors - iegurņa limfmezglu stāvoklis

Ja IR metastāzes,
veic para-aortālu
limfadenektomiju

Ja NAV metastāzes,
veic radikālu
histerektomiju



IA2 – IIA stadijā

Wertheima operācija
jeb
Radikāla histerektomija

2. un 3. tips



- Cito histoloģija
- Sentinel mezgls
- Sentinel tehnika nav apstiprināta vadlīnijās, bet tiek rutīnā izmantota tādos centros, kā Charite un MSKCC
- Laparaskopiskās iemaņas un 10-20 procedūras «learning curve»

Adjuvanta terapija

Recidīva riska Faktoru Kombinācija:

- Liels primārais audzējs (>4cm)
- Dziļa invāzija stromā (invāzija >1/3)
- LVSI

NAV mts l/m
NAV RFK

NAV mts l/m
IR RFK

IR mts l/m vai
audzējs rezekcijas
līnijā vai
mikrosk.izplatība
parametrijos

Novērošana

Staru ±
ķīmijterapija

Staru +
ķīmijterapija

Cervical cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]

N. Colombo^{1,2}, S. Carinelli³, A. Colombo⁴, C. Marini⁵, D. Rollo¹ & C. Sessa^{5,6}, on behalf of the ESMO Guidelines Working Group*

¹Department of Gynecologic Oncology, European Institute of Oncology, Milan, Italy; ²Department of Gynecologic Oncology, Università Milano-Bicocca, Milan, Italy; ³Department of Pathology, European Institute of Oncology, Milan, Italy; ⁴Department of Radiotherapy, Alessandro Manzoni Hospital, Lecco, Italy; ⁵Department of Medical Oncology, Oncology Institute of Southern Switzerland, Bellinzona, Switzerland; ⁶Unit of New Drugs and Innovative Therapies, Department of Medical Oncology–O.U. Medicine, San Raffaele Hospital, Fondazione Centro San Raffaele del Monte Tabor, Milan, Italy

Adjuvant CT/RT if risk factors (LVSI, G3, positive resection margins, multiple nodes)

Concurrent chemotherapy and pelvic radiation therapy compared with pelvic radiation therapy alone as adjuvant therapy after radical surgery in high-risk early-stage cancer of the cervix.

Peters WA 3rd, Liu PY, Barrett RJ 2nd, Stock RJ, Monk BJ, Berek JS, Souhami L, Grigsby P, Gordon W Jr, Alberts DS.

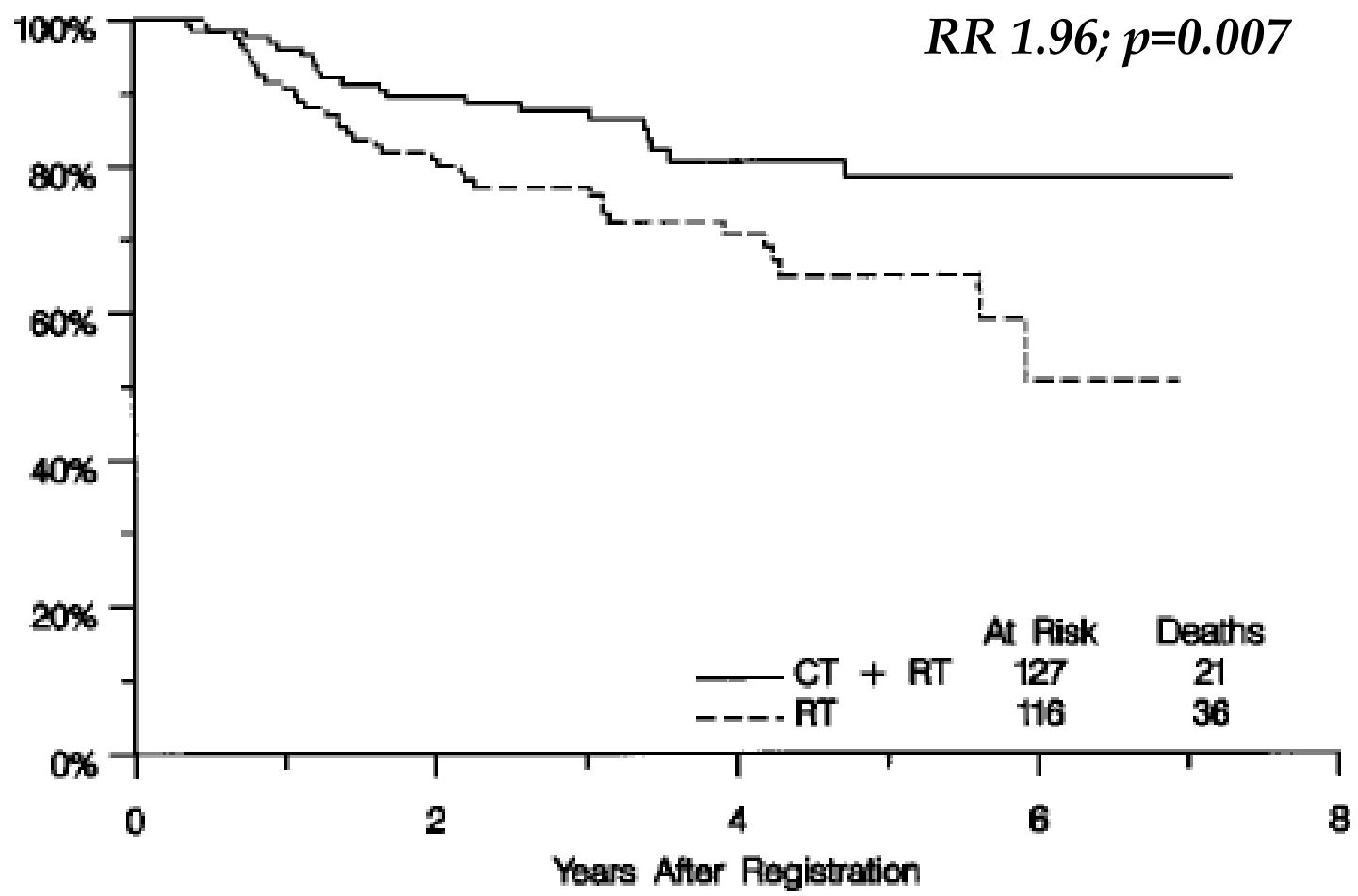
Puget Sound Oncology Consortium, Seattle, WA, USA.

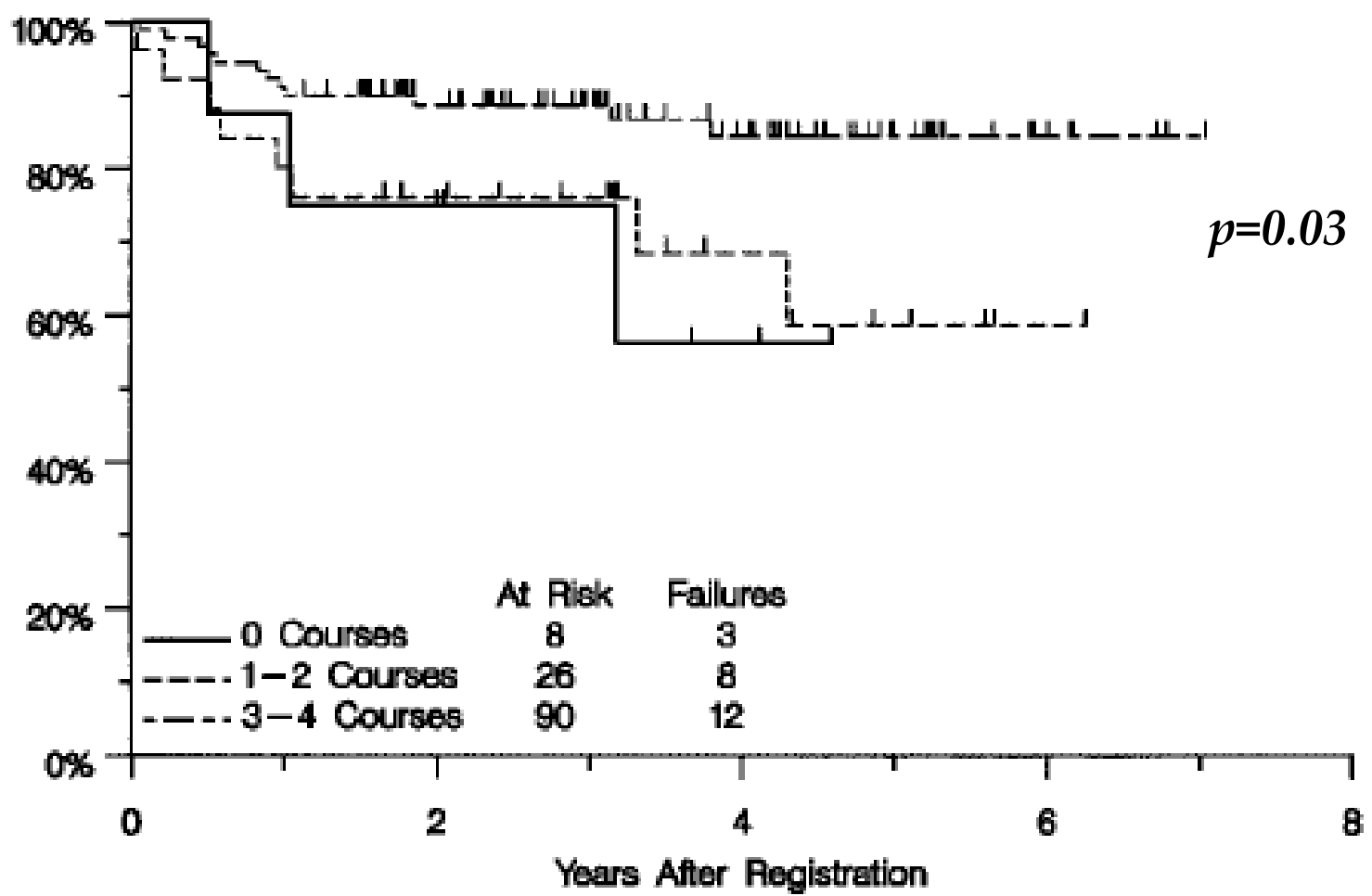
268 pacientes, IA2 – IIA, pēc Radikālas histerektomijas

- **Metastāze l/m un/vai**
- **Audzējs rezekcijas līnijā un/vai**
- **Izplatība uz parametrijiem**

**Staru / ķīmijterapija
n=127**

**Staru terapija
n=116**





Toksicitāte

Staru / ķīmijterapija
n=122

27 (Grade 4) epizodes
21 pacientei

Biežākās blaknes:

- Caureja
- Granulocitopēnija
- Leikopēnija
- Slikta dūša
- Vemšana

Staru terapija
n=112

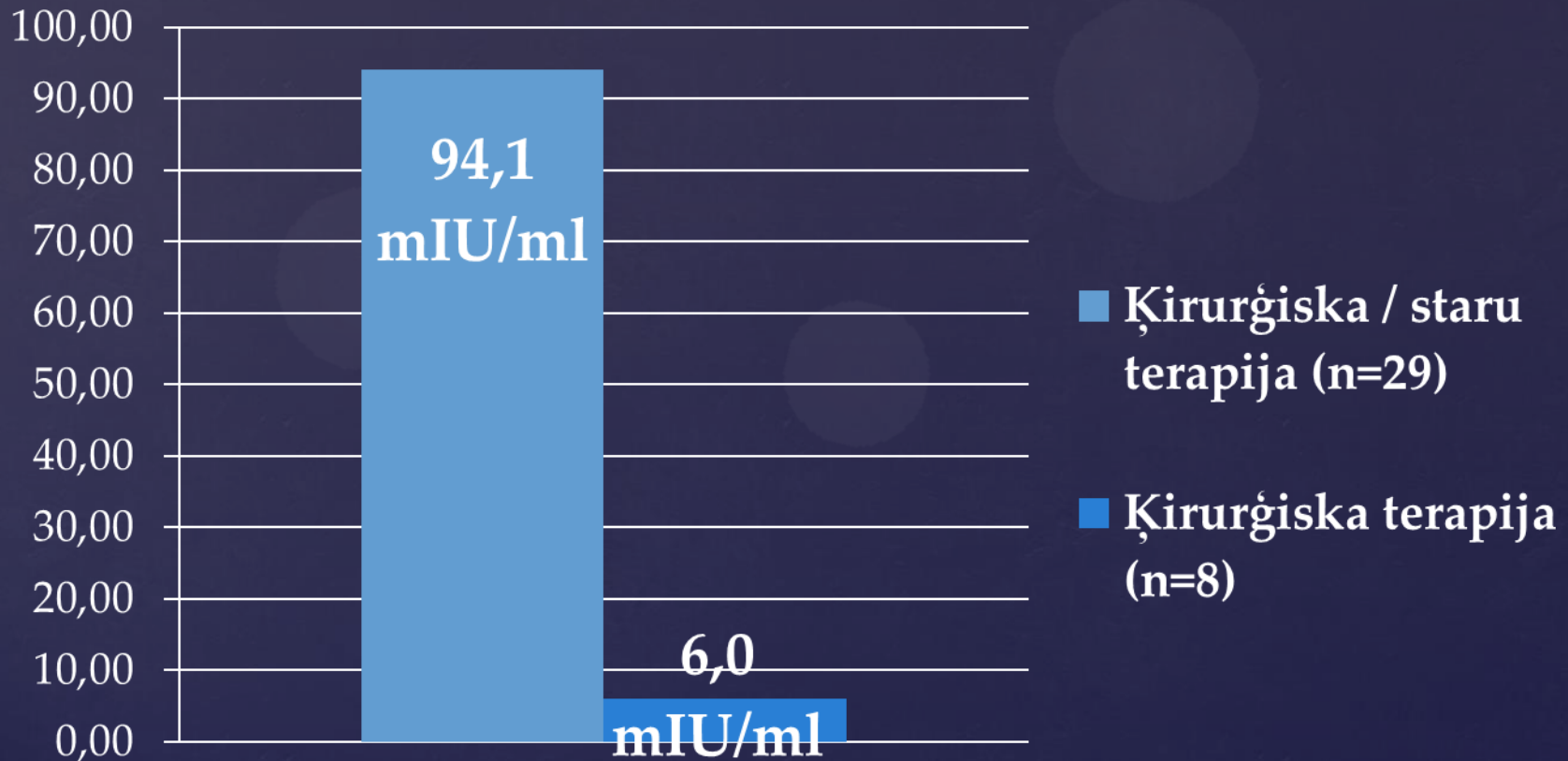
4 (Grade 4) epizodes
4 pacientēm

SWOG Kritēriji

- 0 = Nav toksicitātes
- 1 = Viegla
- 2 = Vidēja
- 3 = Smaga
- 4 = Dzīvību apdraudoša
- 5 = Fatāla

The influence of adjuvant radiotherapy on ovarian function, menopausal symptoms and quality of sexual life in cervical cancer patients

Natalija Berza^{1*}, Jurgis Vitols², Juris Vitols², Aigars Reinis³, Ingus Skadins³, MD, Ronalds Macuks^{1,4}



FSH koncentrācija normas robežās 10.3% pacienšu (4.0-25.0 mIU/mL)

| Symptoms | Surgery (n=8) | Surgery and radiotherapy (n=29) | P value * |
|----------------------------|---------------|---------------------------------|-----------|
| Hot flushes | 0 | 26 | < 0.01 |
| Increased sweating | 2 | 25 | < 0.01 |
| Feeling concern, worried | 1 | 18 | 0.01 |
| Depressed mood | 2 | 12 | 0.37 |
| Concentration difficulties | 0 | 16 | < 0.01 |
| Weakness | 1 | 24 | < 0.01 |
| Skin dryness | 0 | 12 | 0.03 |
| Fragility of hair and nail | 0 | 17 | < 0.01 |
| Increased heart rate | 0 | 12 | 0.03 |
| Headache | 1 | 7 | 0.46 |
| Frequent mood changes | 1 | 16 | 0.03 |
| Decreased libido | 1 | 17 | 0.02 |
| Sleep disorders | 1 | 12 | 0.12 |
| Urinary incontinence | 1 | 12 | 0.12 |
| Weight gain | 2 | 10 | 0.57 |
| Vaginal dryness | 1 | 18 | 0.01 |

*Mann-Whitney U test

Limfedēma pēc staru terapijas

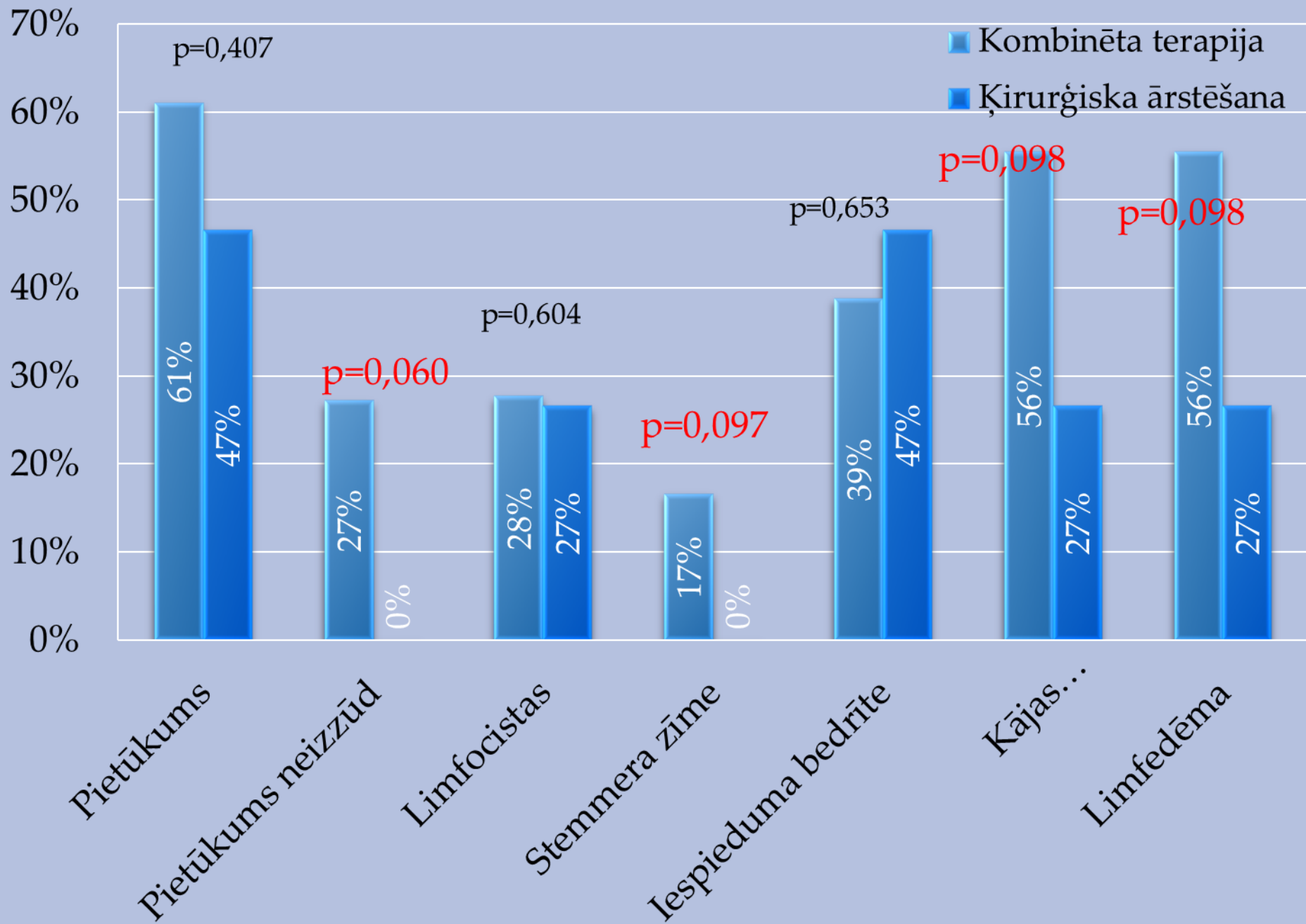
MUTISKĀS UZSTĀŠANĀS • Onkoginekoloģijas aktualitātes
ORAL PRESENTATIONS • Highlights of onkogynaecology

LIMFOSTĀZE PĒC ĶIRURĢISKAS UN ADJUVANTAS STARU TERAPIJAS PACIENTĒM AR DZEMDES KAKLA VĒZI

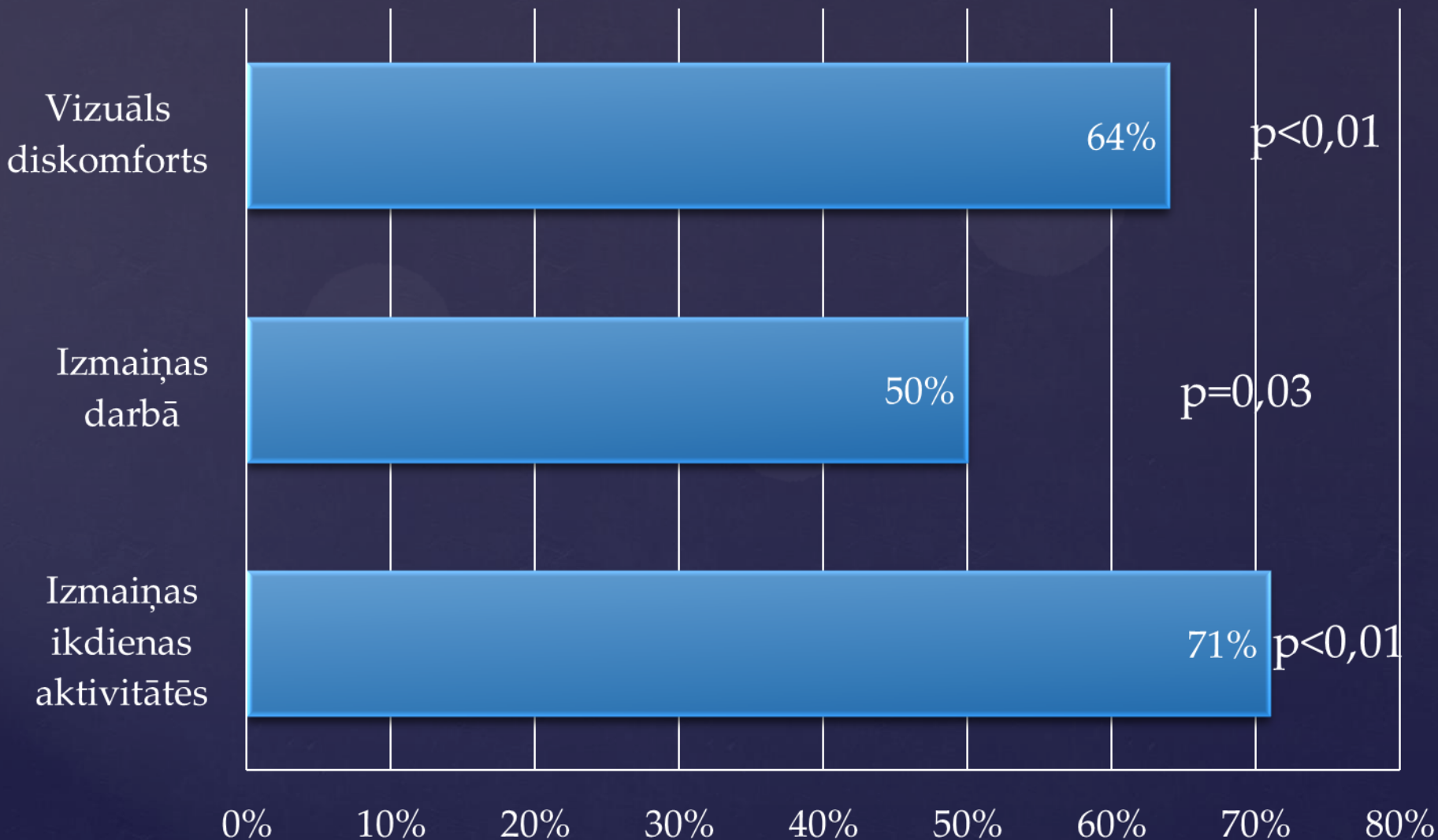
Jurģis Vītols¹, Mačuks R.²

1 – LU ginekoloģijas un dzemdniecības rezidents

2 – Rīgas Austrumu klīniskās universitātes slimnīca, Latvijas Onkoloģijas centrs



Dzīves kvalitātes izmaiņas pacientēm ar limfedēmu



Ārstēšana IIB – IV stadijā

| Study | FIGO Stage | Control Group | Comparison Group | Relative Risk of Death in Comparison Group |
|-----------------------------|--------------------------------------|-------------------------------|--|--|
| Keys et al. | IB2 | Radiotherapy | Radiotherapy plus weekly cisplatin | 0.54 |
| Rose, Bundy, Watkins et al. | IIB-IVA | Radiotherapy plus hydroxyurea | Radiotherapy plus weekly cisplatin | 0.61 |
| | | | Radiotherapy plus cisplatin, fluorouracil, and hydroxyurea | 0.58 |
| Morris et al. | IB2-IVA | Extended-field radiotherapy | Radiotherapy plus cisplatin and fluorouracil | 0.52 |
| Whitney et al. | IIB-IVA | Radiotherapy plus hydroxyurea | Radiotherapy plus cisplatin and fluorouracil | 0.72 |
| Peters et al. | IB or IIA (selected postoperatively) | Radiotherapy | Radiotherapy plus cisplatin and fluorouracil | 0.50 |

Pelvic irradiation with concurrent chemotherapy versus pelvic and para-aortic irradiation for high-risk cervical cancer: an update of radiation therapy oncology group trial (RTOG) 90-01.

Eifel PJ, Winter K, Morris M, Levenback C, Grigsby PW, Cooper J, Rotman M, Gershenson D, Mutch DG.

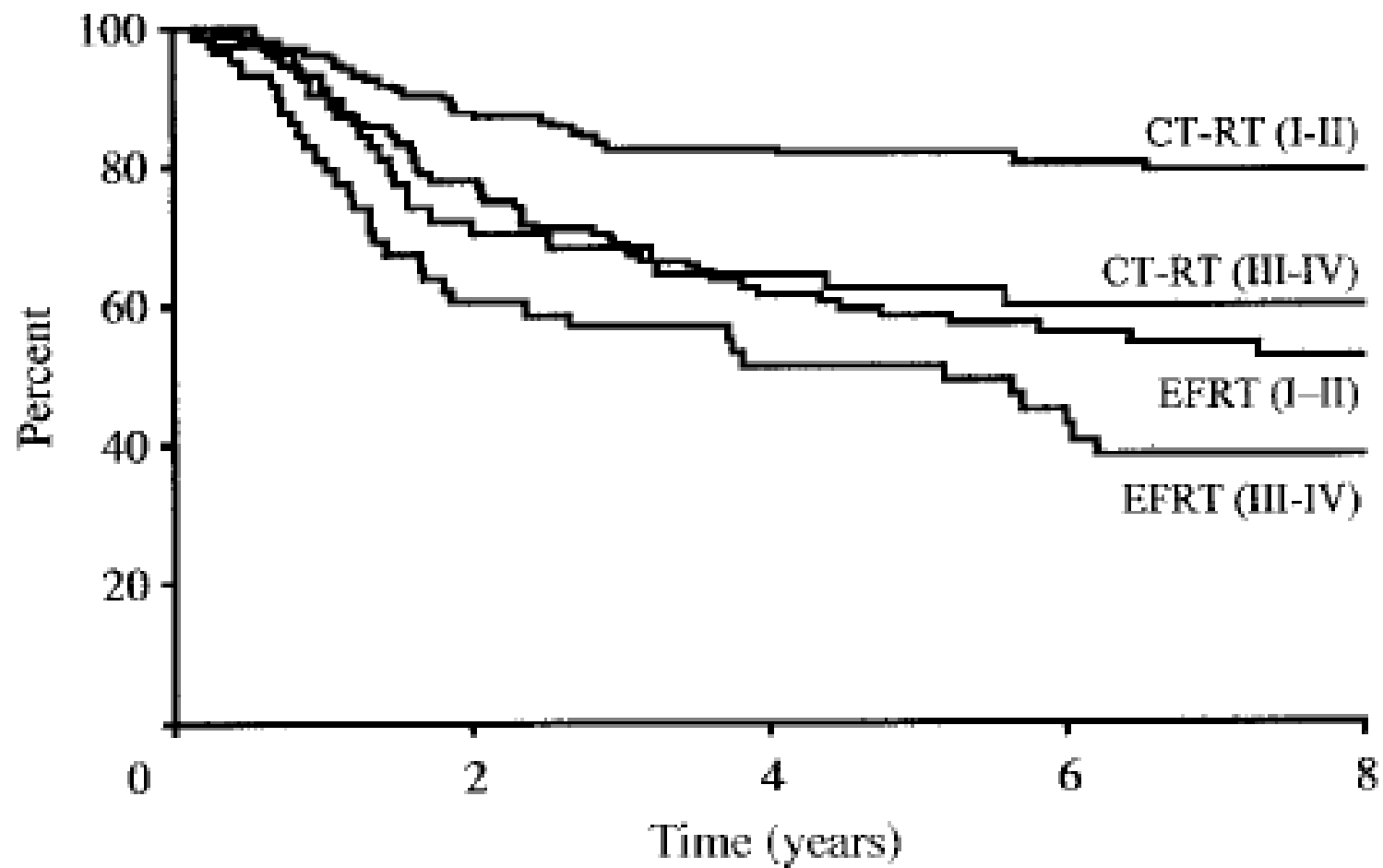
Department of Radiation Oncology, Unit 97, The University of Texas M.D. Anderson Cancer Center, 1515 Holcombe Blvd, Houston, TX 77030, USA. peifel@mdanderson.org

389 pacientes:

- IIB un IVA stadija;
- IB vai IIA, ja audzējs >5cm;
- morfoloģiski verificētas mts 1/m

**Paplašināts ST lauks
n=195**

**Staru / ķīmijterapija
n=194**



Adenokarcinoma un plakanšūnu karcinoma

Adenocarcinoma: a unique cervical cancer.

Gien LT¹, Beauchemin MC, Thomas G.

| Author, year [ref] | Number of patients (n) | Stage | 5-Year survival (%) | | p-Value |
|---------------------------|-------------------------|---------|---------------------|-----|---------|
| | | | AC | SCC | |
| Hopkins et al., 1991 [36] | 959 (203 AC, 756 SCC) | I | 60 | 90 | <0.0001 |
| | | II | 47 | 62 | 0.01 |
| | | III | 8 | 36 | 0.002 |
| Eifel et al., 1995 [9] | 1767 (229 AC, 1538 SCC) | IB | 72 | 82 | <0.01 |
| Chen et al., 1999 [37] | 3678 (302 AC, 3376 SCC) | Overall | 67 | 81 | 0.0009 |
| | | I | 76 | 81 | 0.0039 |
| | | II | 63 | 75 | 0.0103 |
| | | III | 29 | 42 | |
| | | IV | 0 | 26 | |
| Lai et al., 1999 [2] | 891 (134 AC, 757 SCC) | IB & II | 74 | 83 | 0.0136 |
| Irie et al., 2000 [39] | 255 (57 AC, 198 SCC) | Overall | 78 | 92 | 0.0034 |
| | | IB | 96 | 94 | NS |
| | | II | 61 | 90 | 0.0007 |

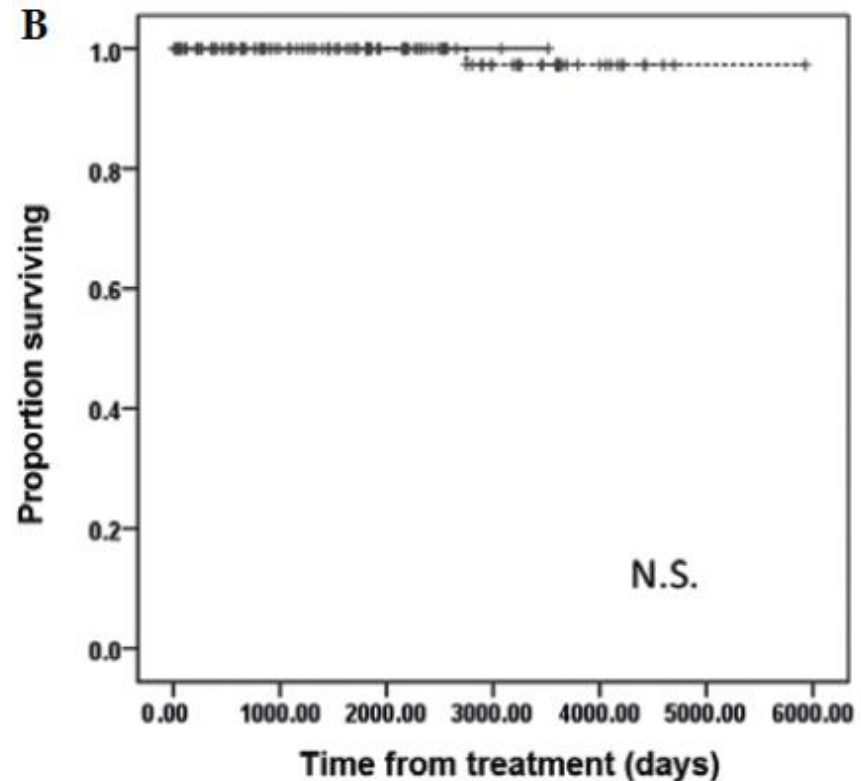
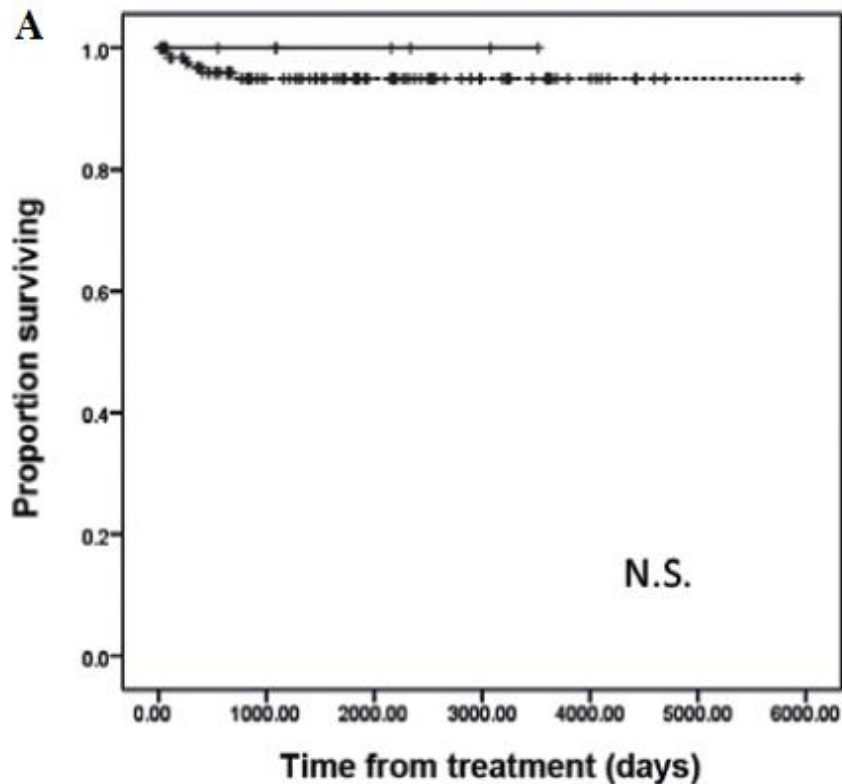
| | SCC (n= 636) | AC (n= 139) | P value |
|-----------------------------|--------------|---------------|---------|
| Recurrence | 36 | 20 | <0.001 |
| Recurrence rate, % | 5.7 (36/636) | 14.4 (20/139) | |
| Patterns of recurrence, (%) | | | 0.124 |
| Locoregional | 10/36 (27.8) | 6/20 (30.0) | 0.860 |
| Lymphatic | 18/36 (50.0) | 5/20 (25.0) | 0.068 |
| Hematogenous/distant | 8/36 (22.2) | 9/20 (45.0) | 0.076 |
| Primary treatment, (%) | | | 0.530 |
| Surgery alone | 6/36 (16.6) | 1/20 (5.0) | 0.402 |
| Surgery + adj. RT | 11/36 (30.6) | 6/20 (30.0) | 0.965 |
| Surgery + adj. CCRT | 19/36 (52.8) | 13/20 (65.0) | 0.376 |

Comparison of outcomes between squamous cell carcinoma and adenocarcinoma in patients with surgically treated stage I-II cervical cancer.

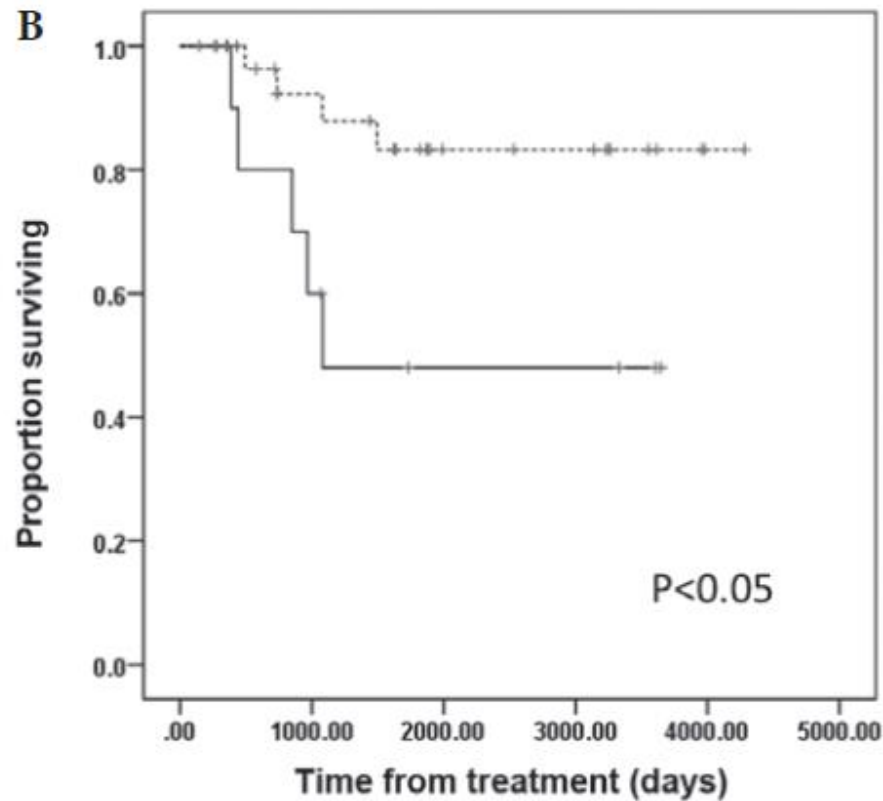
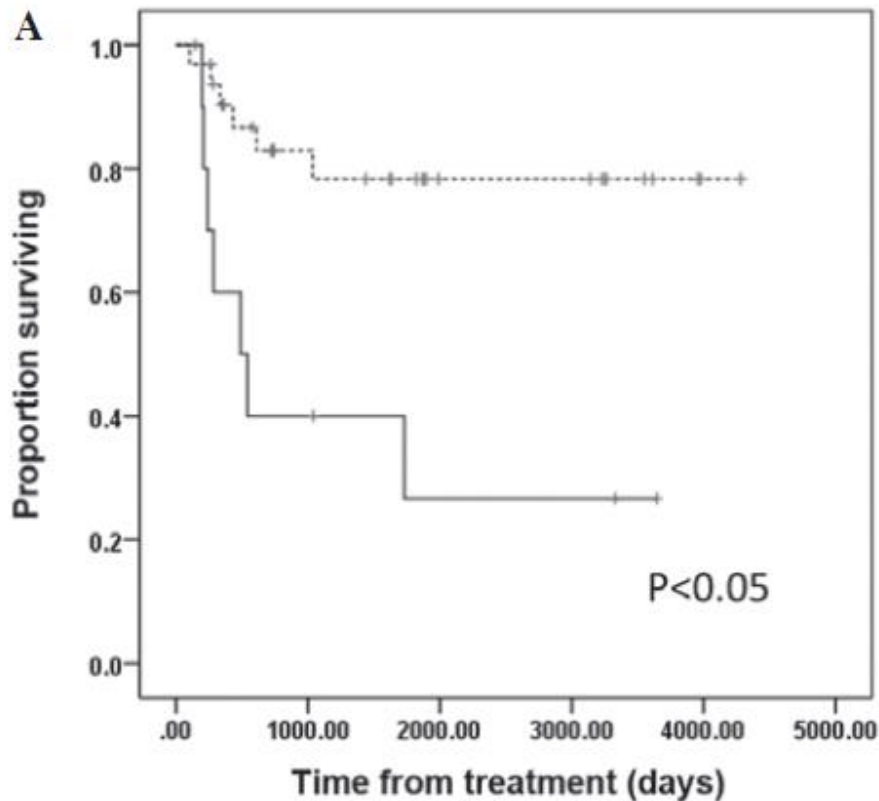
Yamauchi M¹, Fukuda T¹, Wada T¹, Kawanishi M¹, Imai K¹, Hashiguchi Y¹, Ichimura T¹, Yasui T¹, Sumi T¹.

| Characteristics | AD n=91 (%) | SCC n=364 (%) | P-value |
|----------------------------|----------------|------------------|---------|
| Age, years (mean ± SD) | 53.2±13.2 | 46.9±12.7 | <0.001 |
| FIGO stage | | | <0.001 |
| IA1 | 5 (5.5) | 130 (35.7) | |
| IA2 | 2 (2.2) | 8 (2.2) | |
| IB1 | 45 (49.5) | 124 (34.1) | |
| IB2 | 8 (8.8) | 23 (6.3) | |
| IIA1 | 0 (0) | 1 (0.02) | |
| IIA2 | 0 (0) | 16 (4.4) | |
| IIB | 31 (34.1) | 62 (17.0) | |
| Lymph node metastasis | | | NS |
| No | 73 (80.2) | 317 (87.1) | |
| Yes | 18 (19.8) | 47 (12.9) | |
| Postoperative treatment | 31 (34.1) | 66 (18.1) | <0.001 |
| CCRT | 6 (19.4) | 20 (30.3) | |
| RT | 7 (22.6) | 41 (62.1) | <0.001 |
| CT | 18 (58.1) | 5 (7.6) | |

No slimības brīvais intervāls (A) un kopējā dzīvildze (B) IA stadijā



No slimības brīvais intervāls (A) un kopējā dzīvildze (B) pacientēm pēc adjuvantas terapijas



Novērošana

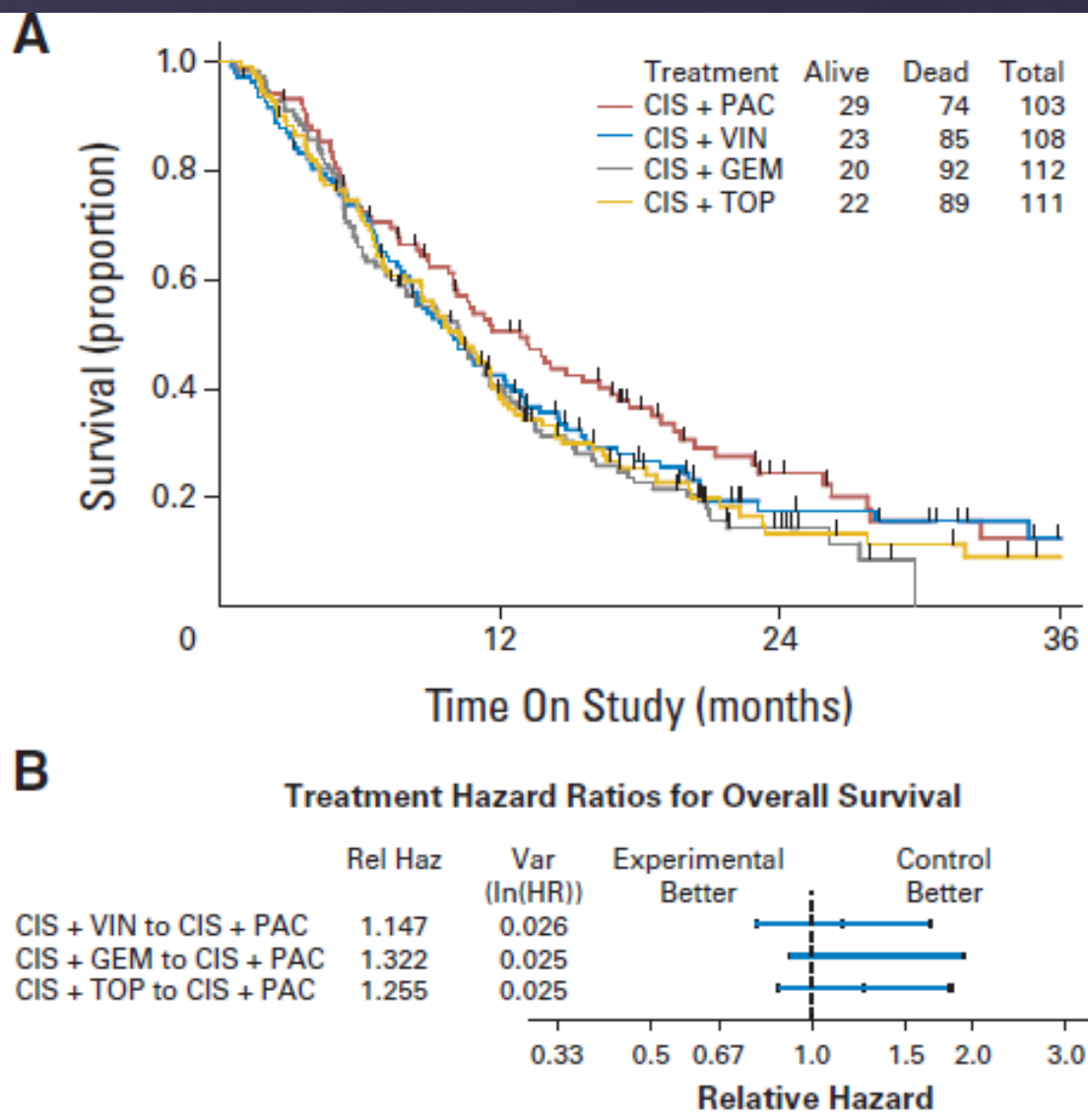
1. Anamnēze un fizikāla izmeklēšana pēc noteiktiem intervāliem
2. Dzemdes kakla/maksts citoloģiski izmeklējumi ik pēc 3-6 mēnešiem 2 gadus, pēc tam ik pēc 6-12 mēnešiem 3-5 gadus, pēc tam reizi gadā
3. Krūškurvja rentgenogrāfija reizi gadā 5 gadus
4. Pilna asins analīze, urīnviela, kreatinīns asinīs ik pēc 6 mēnešiem (pēc indikācijām)
5. CT vai PET, ja ir klīniskas indikācijas
6. Ieteicams lietot maksts dilatatorus pēc staru terapijas (ja nepieciešams)
7. Pacienšu izglītošana simptomu atpazīšanā agrīnai slimības recidīva konstatācijai:
 - asiņaini, smērējoši izdalījumi no dzimumceļiem,
 - sāpes vēdera lejasdaļā,
 - sāpes vai pietūkums kājās,
 - ķermeņa svara zudums,
 - jebkādi citi simptomi, kuri nav bijuši agrāk.

Recidīvs

Phase III trial of four cisplatin-containing doublet combinations in stage IVB, recurrent, or persistent cervical carcinoma: a Gynecologic Oncology Group study.

Monk BJ, Sill MW, McMeekin DS, Cohn DE, Ramondetta LM, Boardman CH, Benda J, Cella D.

University of California, Irvine Medical Center, Orange, CA 92868, USA. bjmonk@uci.edu



Terapijas radītās komplikācijas

N Engl J Med. 1999 Apr 15;340(15):1154-61.

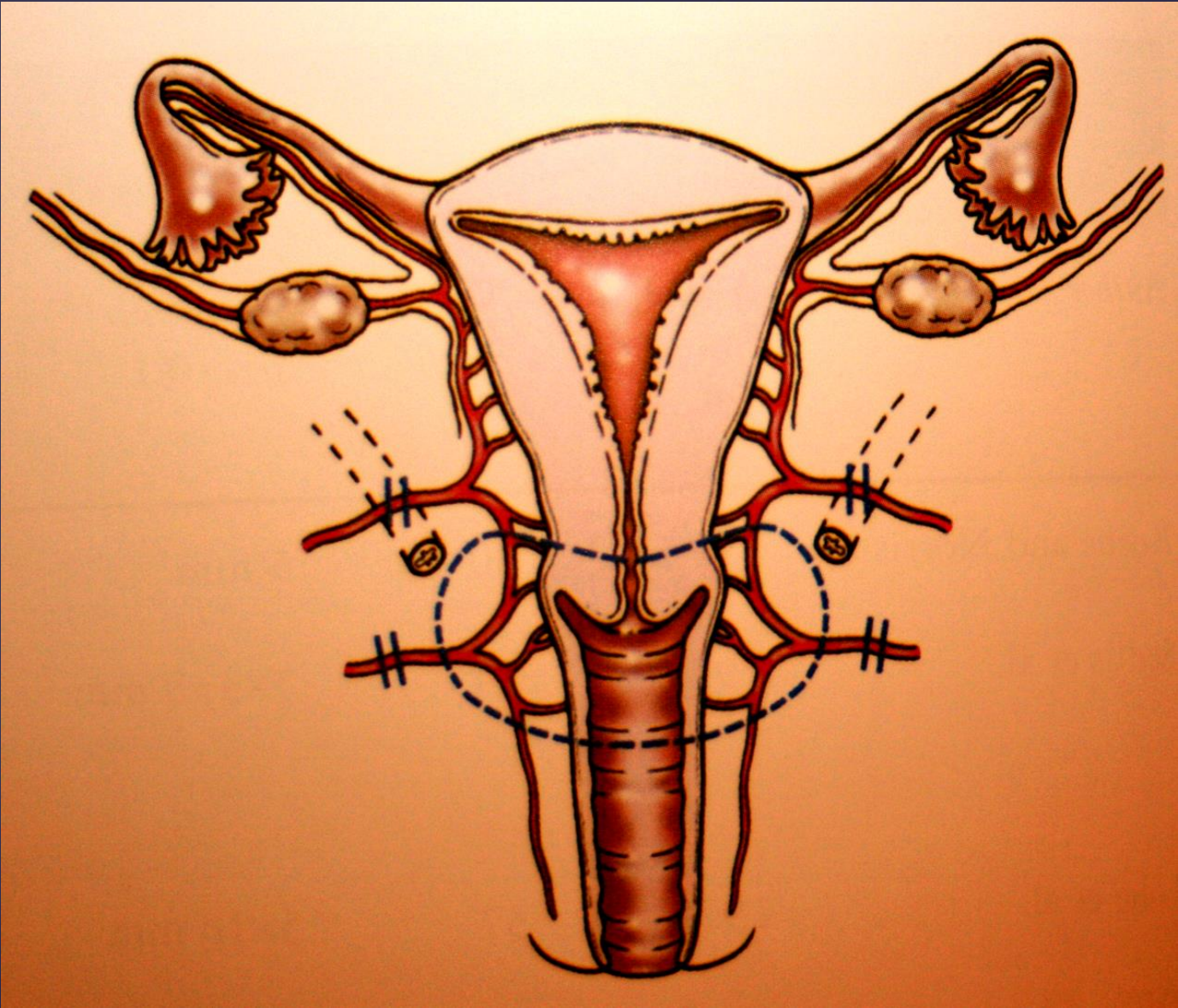
Cisplatin, radiation, and adjuvant hysterectomy compared with radiation and adjuvant hysterectomy for bulky stage IB cervical carcinoma.

Keys HM, Bundy BN, Stehman FB, Muderspach LI, Chafe WE, Suggs CL 3rd, Walker JL, Gersell D.

Department of Radiation Oncology, Albany Medical College, NY, USA.

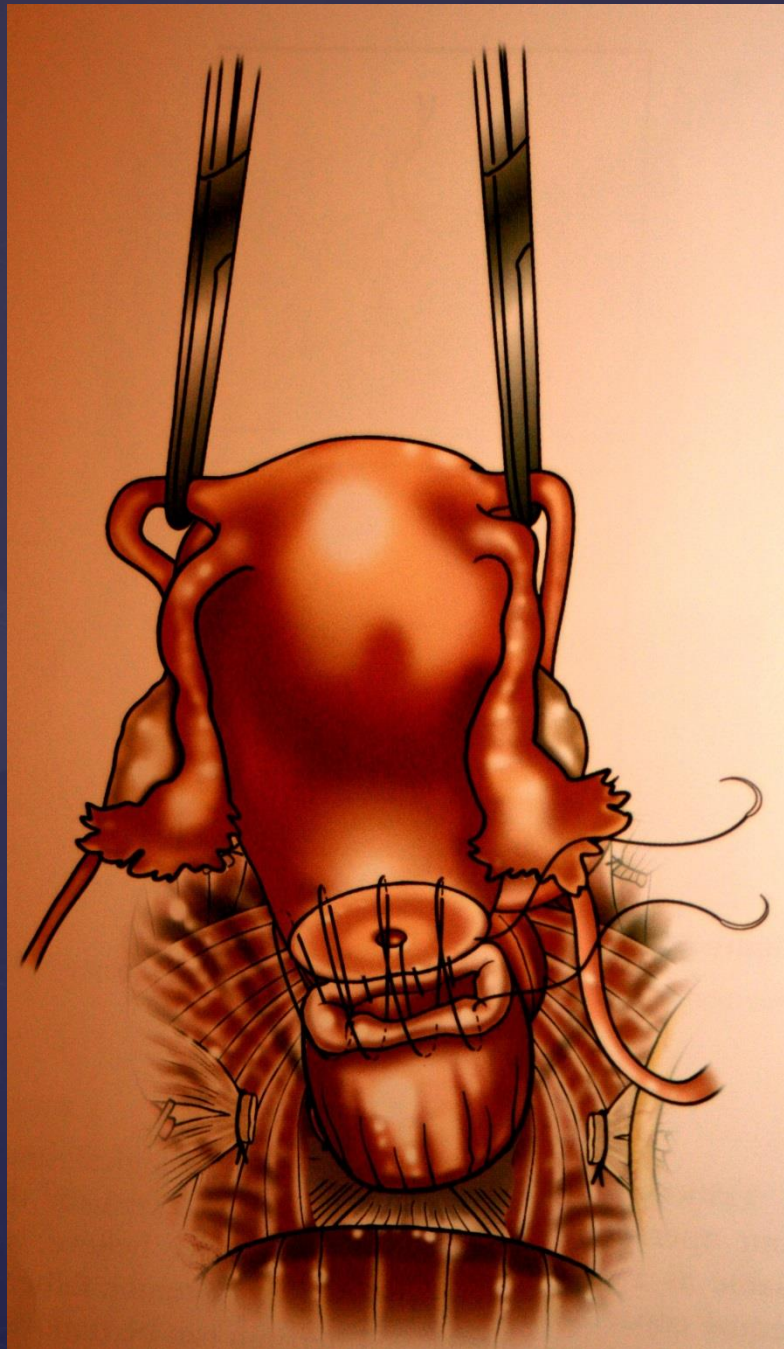
| ADVERSE EFFECT | RADIOTHERAPY ALONE (N=186) | | | | | RADIOTHERAPY AND CISPLATIN (N=183) | | | | |
|------------------|----------------------------|------------|------------|------------|------------|------------------------------------|------------|------------|------------|------------|
| | GRADE 0 | GRADE 1 | GRADE 2 | GRADE 3 | GRADE 4 | GRADE 0 | GRADE 1 | GRADE 2 | GRADE 3 | GRADE 4 |
| | number of patients | | | | | | | | | |
| Hematologic | 149 | 18 | 16 | 3 | 0 | 42 | 36 | 66 | 33 | 6 |
| Gastrointestinal | 114 | 36 | 27 | 4 | 5 | 51 | 57 | 49 | 17 | 9 |
| Genitourinary | 145 | 24 | 11 | 5 | 1 | 123 | 43 | 14 | 1 | 2 |
| Cutaneous | 165 | 10 | 7 | 3 | 1 | 158 | 18 | 7 | 0 | 0 |
| Neurologic | 184 | 0 | 1 | 1 | 0 | 167 | 6 | 8 | 2 | 0 |
| Other | 163 | 7 | 11 | 4 | 1 | 137 | 24 | 10 | 9 | 3 |

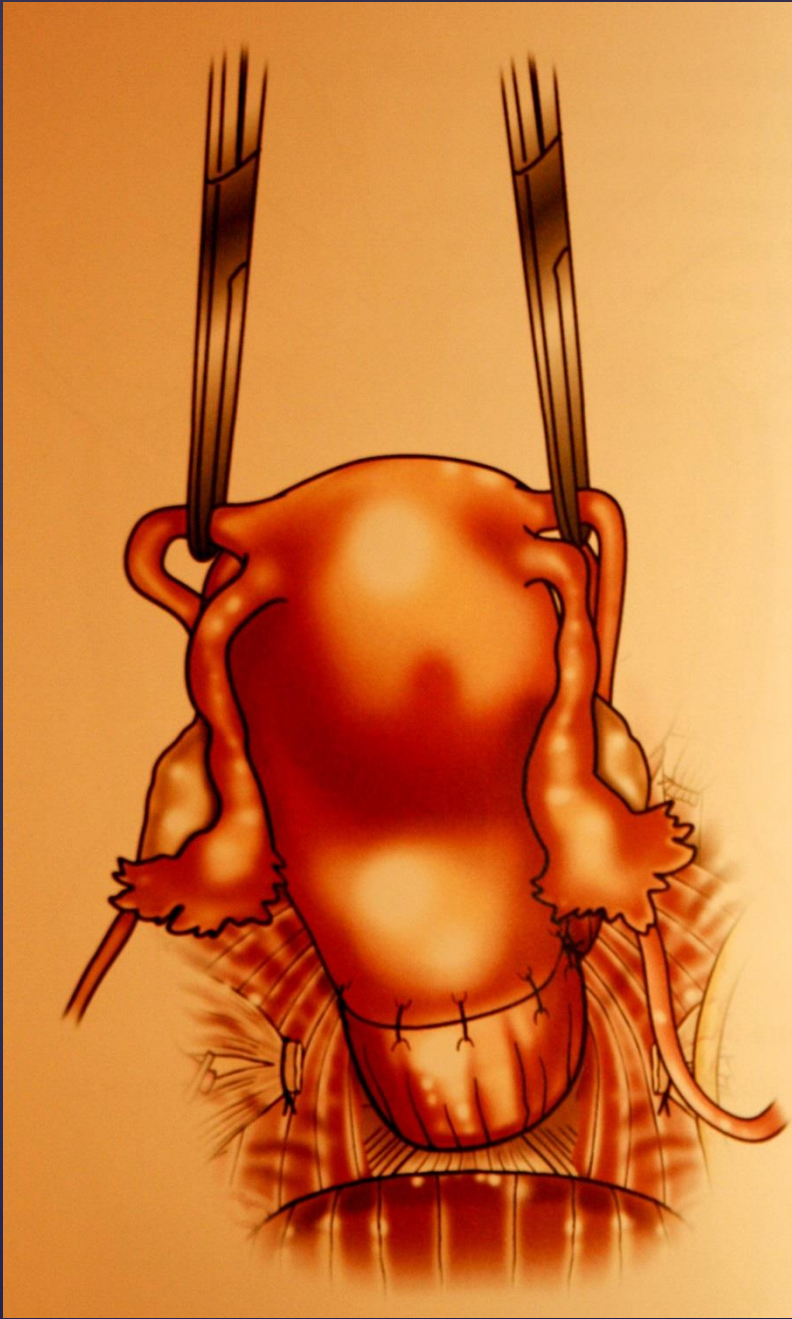
Trahelektomija

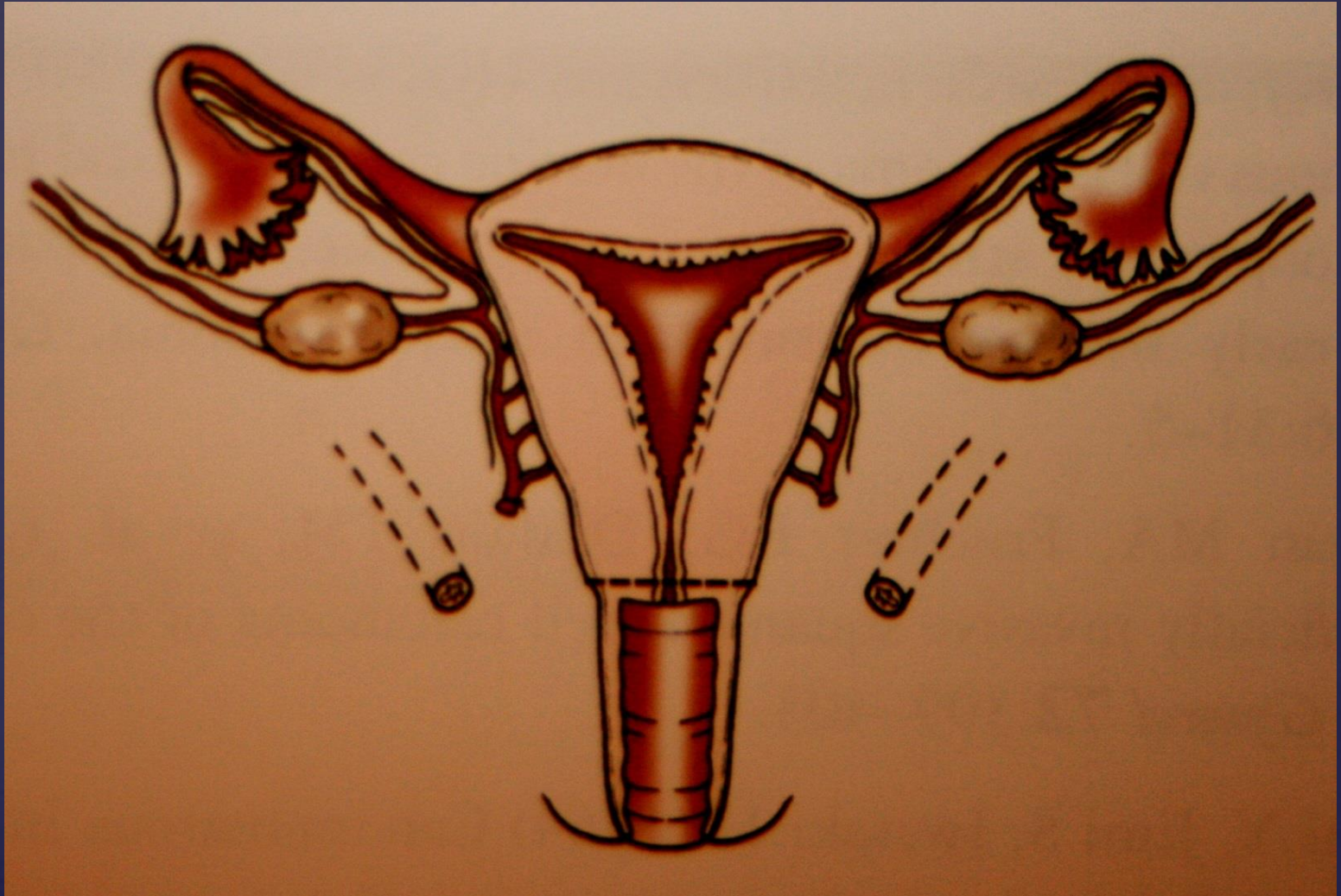


Indikācijas radikālai trahelektomijai

- Jauna sieviete, kura vēlas saglabāt reproduktīvo funkciju
- nav neauglības pazīmes
- intakta cervikālā kanāla augšējā 1/3
- plakanšūnu karcinoma
- adenoskvamoza karcinoma un adenokarcinoma (?)
- audzējs ≤ 2 cm
- nav LVSI
- nav metastāžu limfmezglos







Abdominal radical trachelectomy: Is it safe for IB1 cervical cancer with tumors ≥ 2 cm?

Li J¹, Wu X, Li X, Ju X.

| | Nishio | Cibula | Ungar | Kim | Wethington |
|--|--------------|------------------------|--------------------------------------|--------------|--|
| Location | Tokyo, Japan | Prague, Czech Republic | Budapest, Hungary/London, UK/NY, USA | Seoul, Korea | Prague, Czech Republic/Boston, USA/NY, USA |
| Period | 2002–2008 | 2001–2008 | 1997–2002 | 2004–2009 | 1999–2011 |
| Planned ART, <i>n</i> | 71 | 24 | 33 | 32 | 101 |
| Patients with spared fertility, <i>n</i> (%) | 61 (85.9) | 17 (70.8) | 30 (90.9) | 27 (84.3) | 70 (69) |
| LNM (%) | 15/71 (21.1) | 4/24 (16.7) | 2/33 (6.1) | 4/32 (12.5) | 19/101 (18.8) |
| LVS1 (%) | 31/71 (43.7) | 2/24 (8.3) | 8/33 (24.2) | 4/32 (12.5) | 47/101 (47) |
| Average age, years (range) | 33 (26–44) | 32.4 (23–37) | 30.5 (23–37) | 29 (22–37) | 31 (19–43) |
| <i>Histology</i> | | | | | |
| • SCC (%) | 58 (95.1) | 14 (58) | 26 (86.7) | 20 (74.1) | 40 (40) |
| • AC (%) | 2 (3.3) | 10 (42) | 1 (3.3) | 6 (22.2) | 54 (53) |
| • Other (%) | 1 (1.6) | 0 | 3 (10) | 1 (3.7) | 7 (7) |
| <i>Size</i> | | | | | |
| • <2 cm/recurrence | 5/13 | 0/3 | 0/9 | 1/8 | – |
| • > 2 cm/recurrence | | | | | |
| Recurrences | 6/61 (9.8) | 1/17 (5.9) | 0/30 (0) | 1/27 (3.7) | 4/70 (5.7) |

Abdominal radical trachelectomy: Is it safe for IB1 cervical cancer with tumors ≥ 2 cm?

Li J¹, Wu X, Li X, Ju X.

| No. | Age | Tumor Size (cm) | Histology | Risk factor | Follow-up (m) | Result |
|-----|-----|-----------------|----------------|-----------------------------------|---------------|--------|
| 1 | 29 | 2.5 | Squamous | DSI | 13.0 | NED |
| 2 | 24 | 3.0 | Adenocarcinoma | LVSI | 14.0 | NED |
| 3 | 26 | 2.0 | Squamous | DSI, LVSI | 14.0 | NED |
| 4 | 31 | 2.0 | Squamous | LVSI | 27.0 | NED |
| 5* | 29 | 4.0 | Adenocarcinoma | Single positive pelvic lymph node | 4.0 | NED |
| 6 | 35 | 2.5 | Squamous | DSI | 10.0 | NED |
| 7 | 38 | 2.5 | Squamous | DSI LVSI | 21.0 | NED |
| 8 | 25 | 4.0 | Squamous | LVSI | 20.0 | NED |
| 9* | 28 | 2.0 | Squamous | Single positive pelvic lymph node | 21.0 | NED |
| 10 | 36 | 2.5 | Adenosquamous | DSI LVSI | 21.0 | NED |
| 11 | 23 | 3.0 | Squamous | DSI, LVSI | 18.0 | NED |
| 12 | 25 | 3.0 | Squamous | DSI | 19.0 | NED |
| 13 | 27 | 2.5 | Squamous | DSI | 31.0 | NED |
| 14 | 28 | 4.0 | Squamous | DSI, LVSI | 31.0 | NED |
| 15 | 27 | 3.5 | Squamous | DSI | 31.0 | NED |
| 16 | 30 | 2.0 | Squamous | DSI | 32.0 | NED |
| 17 | 30 | 3.0 | Squamous | DSI | 44.0 | NED |
| 18 | 30 | 4.0 | Squamous | LVSI | 73.0 | NED |
| 19 | 29 | 2.0 | Squamous | DSI, LVSI | 67.0 | NED |
| 20 | 28 | 3.0 | Squamous | LVSI | 108.0 | NED |

Surgical, oncological, and obstetrical outcomes after abdominal radical trachelectomy - a systematic literature review.

Pareja R¹, Rendón GJ, Sanz-Lomana CM, Monzón O, Ramirez PT.

| Author | No. of planned trachelectomies | Trachelectomy done, n (%) | Fertility preserved, n (%) | Attempting to conceive, n (%) | Pregnancies | Miscarriages | | Deliveries | |
|-------------------|--------------------------------|---------------------------|----------------------------|-------------------------------|-------------|----------------|----------|-----------------|---------|
| | | | | | | 1st term | 2nd term | At term | Preterm |
| Ungar (2005) | 33 | 30 (90.9) | NR | NC | 3 | 1 | 0 | 2 | 0 |
| Pareja (2008) | 15 | 15 (100) | 14 (93.3) | 6/14 (42.8) | 3 | 0 | 0 | 2 | 1 |
| Nishio (2009) | 71 | 61 (85.9) | 57 (80.2) | 29/57 (50.8) | 4 | 0 | 0 | 2 | 2 |
| Jeremic (2009) | 12 | 11 (91.6) | 10 (83.3) | NR | NR | NR | NR | NR | NR |
| Yao (2010) | 10 | 10 (100) | 10 (100) | NR | 2 | 0 | 0 | 1 | 1 |
| Du (2011) | 68 | 60 (88.2) | 60 (88.2) | 15/60 (25) | 8 | 1 ^a | | 3 | 2 |
| Li (2011) | 64 | 62 (96.8) | 59 (92.1) | 10/59 (16.9) | 2 | 0 | 0 | 1 | 0 |
| Nick (2011) | 25 | 24 (96) | 21 (84.0) | 11/21 (52.3) | 3 | 1 | 1 | 0 | 1 |
| Saso (2012) | 30 | 30 (100) | NR | NC | 3 | 0 | 1 | 2 | 0 |
| Muraji (2012) | 23 | 21 (91.3) | 20 (86.9) | NR | 1 | 0 | 0 | 0 | 1 |
| Karateke (2012) | 8 | 8 (100) | 8 (100) | NR | 3 | 0 | 1 | 1 | 1 |
| Wethington (2012) | 101 | 81 (80) | 70 (69.3) | 38/70 (54.2) | 31 | 3 | 6 | 16 ^b | |
| Case reports | 25 | 25 (100) | 22 (88%) | 4/17 (23.5) ^c | 12 | 3 ^a | | 5 | 3 |
| Total | 485 | 438 (90.3) | | 113/298 (37.9) | 75 | 9 | 9 | 35 | 12 |

Surgical, oncological, and obstetrical outcomes after abdominal radical trachelectomy - a systematic literature review.

Pareja R¹, Rendón GJ, Sanz-Lomana CM, Monzón O, Ramirez PT.

Obstetric outcome of abdominal vs. vaginal radical trachelectomy.^a

| Parameter | Abdominal | Vaginal |
|---|-------------------------|-------------------|
| No. of patients planned trachelectomy | 485 | 1088 ^b |
| Pregnancies, n | 75 | 436 |
| Pregnancy rate overall | 16.2% | 24.0% |
| Fertility preserved, n (%) | 413 ^c (85.1) | 992 (91.1) |
| Pregnancy rate among women with preserved fertility | 18.1% | 43.9% |
| Deliveries, n | 47 | 279 |
| Delivery rate among women with preserved fertility | 11.3% | 28.1% |
| Rate of pregnancy loss | 24% | 30% |

Vai iespējama jatroģēna
disseminācija operācijas laikā?

Incisional site metastasis in a patient with cervical carcinoma: a case report and review of the literature.

Iavazzo C¹, Madhuri K, Tailor A, Butler-Manuel S.

Vidējais recidīva laiks 14 mēneši (1.5 - 45 mēneši)

33 no 42 plakanšūnu karcinomas

8 no 42 adenokarcinomas

1 no 42 adenoskvamoza karcinoma

Skin metastasis from carcinoma of the uterine cervix.

Imachi M¹, Tsukamoto N, Kinoshita S, Nakano H.

1190 pacientes pēc dzemdes kakla vēža terapijas

Recidīvs ādā 15 pacientēm (1.3%)

9 pacientēm iniciāli metastāzes ādā

3 pacientēm dzīvildze > 12 mēn.

0.9% plakanšūnu karcinoma

5.8% adenokarcinoma

Klīniskie piemēri

Paciente Una, 43 g.v., konizācijas materiāls

Makroskopija

Dz. kakla audu fragm. 1,5x1x0,6cm (A1-5).

Mikroskopija

Dzemes kakla gļotāda klāta ar daudzkārtainu plakanu epitēliju, ar smagas pakāpes displāziju, izčūlojumu. Vietām konstatē atipiskas epiteliālas šūnas invazīvi augošas bez pārragošanās (invāzijas dziļums 4mm, platums 6mm), invāzija atsevišķos sinusa tipa limfvados.

Ekscīzijas līnijas: vienā preparātā dziļajā ekscīzijas līnijā konstatē audzēja augšanu, materiāls ar elektrotermisku bojājumu.

Veikti sērijas griezumī.

Slēdziens

Plakanšūnu karcinoma GII.

pT1aNxM0.

Paciente Una, 43 g.v., operācijas materiāls

Nr.1. Limfmezgli: Kopējais skaits 10(0,1-0,8 cm diametrā) – reaktīvas izmaiņas, stromas fibroze, lipomatoze; metastāzes nekonstatē.

Nr.2. Limfmezgli: Kopējais skaits 7(0,1-1 cm diametrā) – reaktīvas izmaiņas, stromas fibroze, lipomatoze; metastāzes nekonstatē.

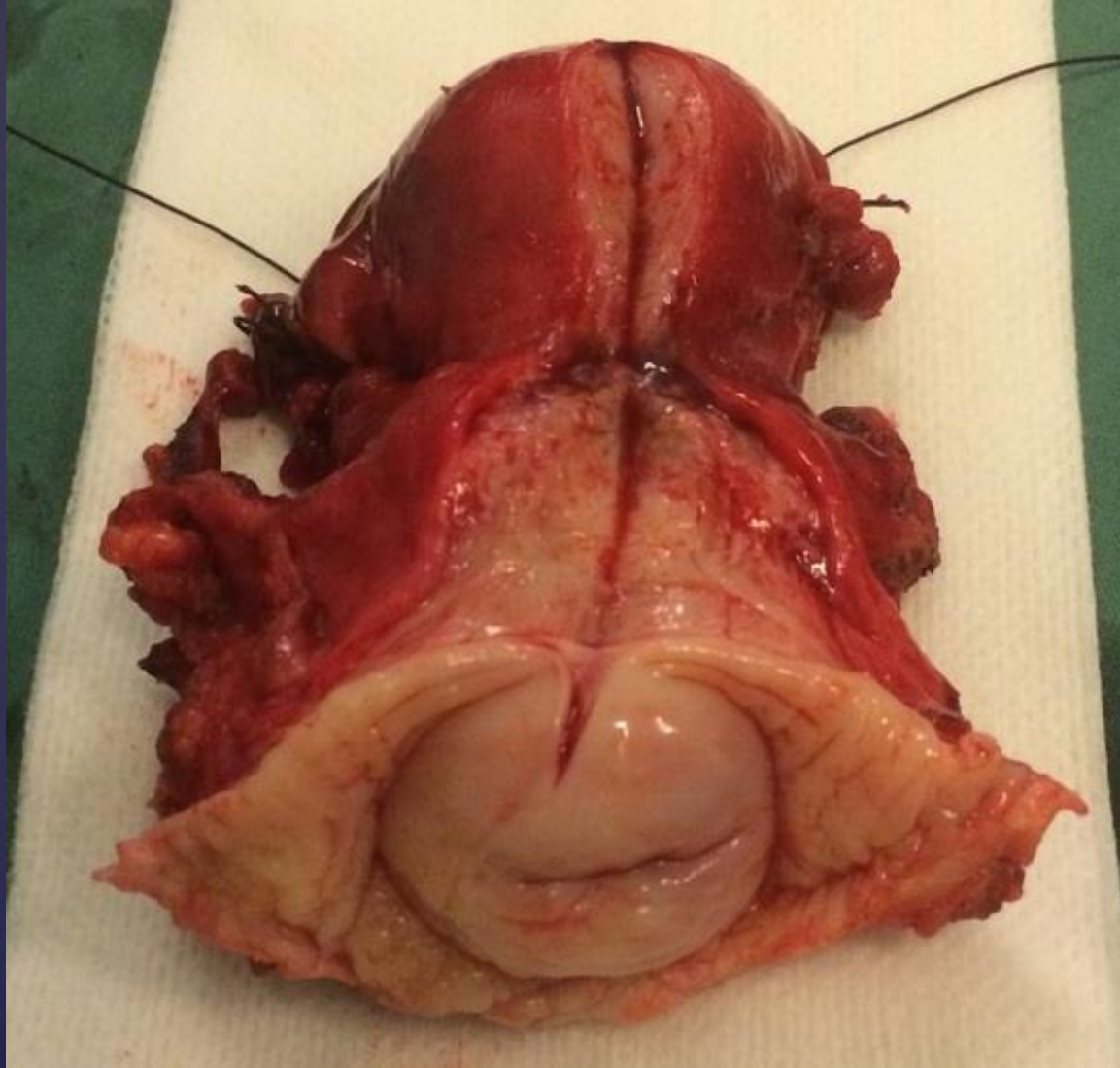
Nr.3. Ekscīzijas līnijas: audu tūska; audzēja augšanu nekonstatē.

Kakls, kanāls – hronisks mazaktīvs cervicīts Nabothi cistas, Grade-3 plakanšūnu karcinoma bez pārragošanās, solīdas uzbūves nekrozēm, asins izplūdumiem, paaugstinātu mitotisko aktivitāti (ap 8 mitozēm redzes laukā) ar izeaugšanu kanālā, izeaugšana sinusa tipa limfvados. Bet bez vaskulāras un bez perineirālas invāzijas. Invāzijas dziļums līdz 7-8mm, invāzijas platums līdz 15mm. Iekšējā mute – sienas tūska, audzēja augšanu nekonstatē. Endometrijs – endometrija dziedzeri ar proliferatīvām izmaiņām, adenomioze. Mezglī – leiomiomatozi mezgli.

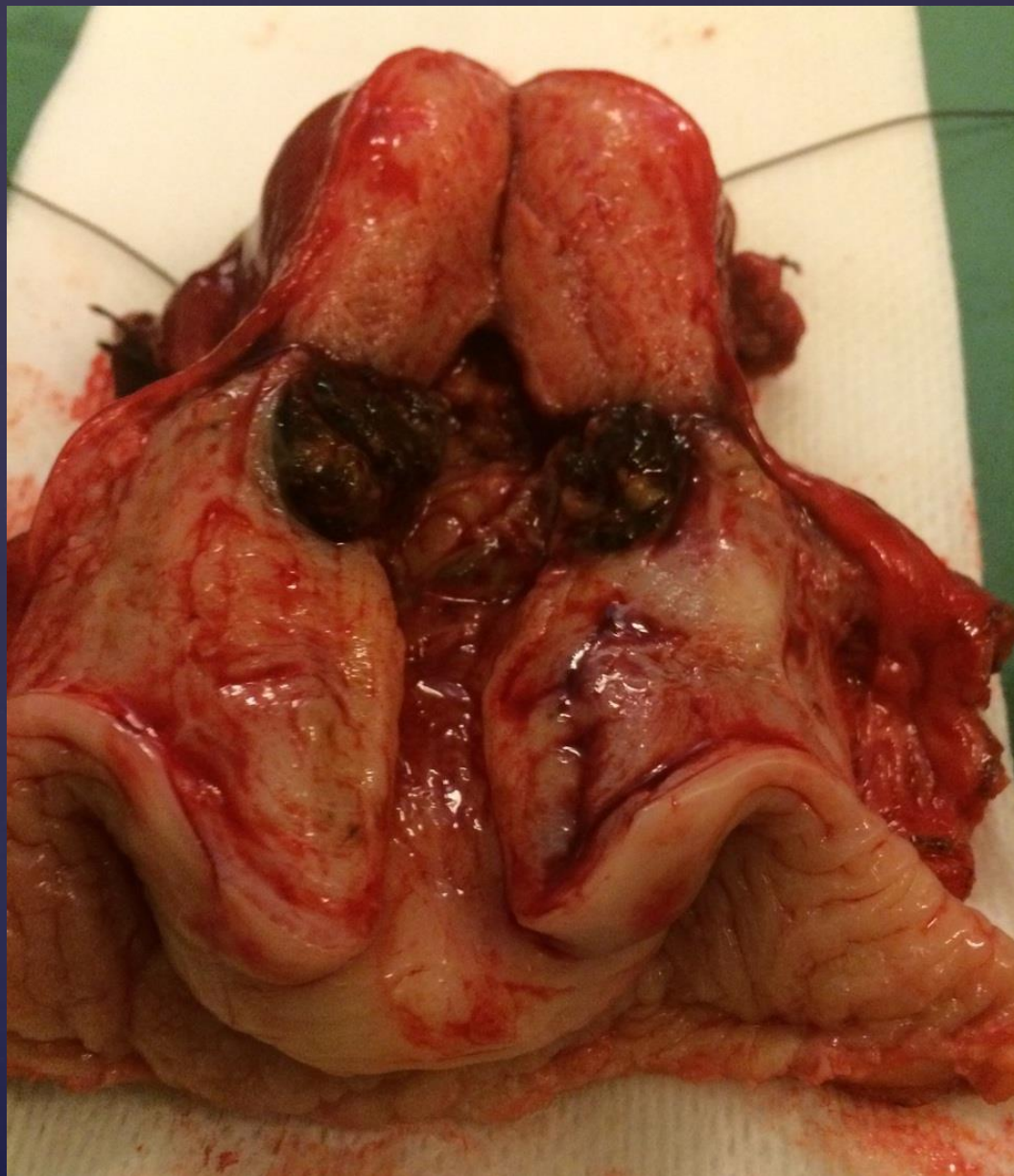
Audzējs vietām pozitīvs uz p63.

Stadija: pT_{1b1}N₀M₀ G₃

Paciente Madara, 25 g.v., operācijas materiāls



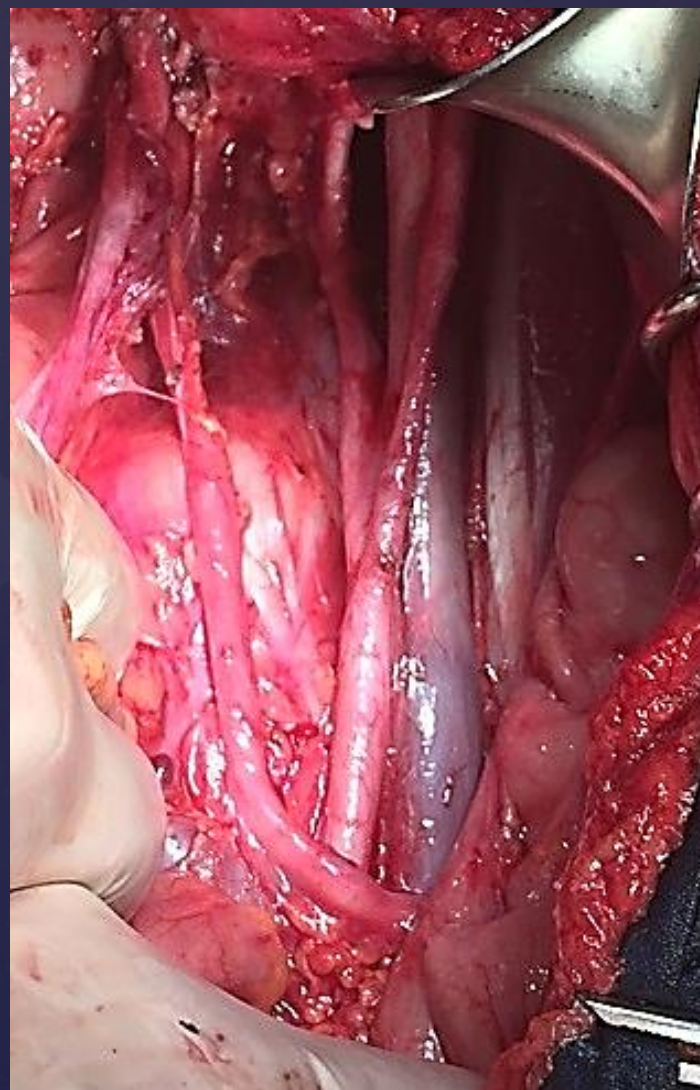
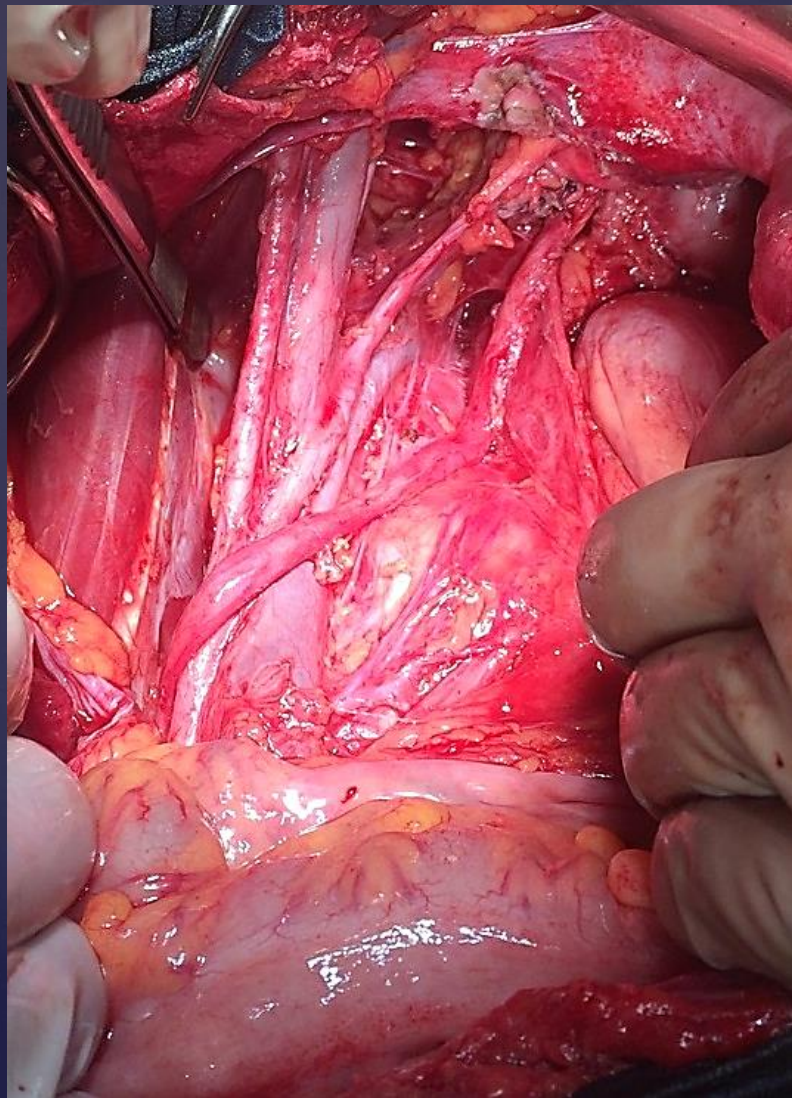
Paciente Madara, 25 g.v., operācijas materiāls



Paciente Madara, 25 g.v., operācijas materiāls



Paciente Madara, 25 g.v., Radikāla histerektomija jeb
Wertheima tipa operācija



Paciente Madara, 25 g.v., Radikāla histerektomija jeb
Wertheima tipa operācija

