Section 14: Follow-up following treatment for gynaecological cancer

Cervical cancer follow-up

Participants who have received treatment for cervical cancer are generally under the follow-up care of specialist services. Follow-up of participants following treatment of cervical cancer is usually determined by the type of cervical cancer and stage at diagnosis and the risk of recurrence. Follow-up is usually more frequent during the first two to three years following treatment and is determined by the treating gynaecological oncology team. Most participants diagnosed with cervical cancer are unenrolled in the NCSP programme as further management is based on specialist recommendations. The exception is those participants with very early stage cervical cancer (Stage 1A1). Follow-up recommendations for this group are discussed in detail below.

Follow-up and surveillance of participants who have undergone curative-intent treatment for cervical cancer provides an opportunity to identify recurrence as early as possible, enabling additional treatment or early symptom control. Recurrence is most likely to occur within the first two to three years following treatment and participants are often symptomatic. [1,2]

Symptoms may include abnormal vaginal bleeding, a vaginal lesion or mass, abdominal or pelvic pain, abdominal distention or bloating, urinary symptoms and/or weight loss. It is important to encourage participants to seek advice if symptoms occur between scheduled follow-up appointments. [1,2] The use of cervical or vaginal cytology is not reliable for detecting recurrence of gynaecological cancers [1]

If participants present to primary care with abnormal symptoms, it is important to undertake a physical examination including palpation of pelvic lymph nodes and an abdominal and pelvic examination including a speculum examination (looking for any signs of ulceration or bleeding, a visible lesion, mass or nodule), bimanual and rectovaginal examination (feeling for a palpable mass or any fullness). [1]

If abnormal findings are detected on examination or if there are symptoms of concern, urgently refer the participant to a gynaecologist. Also arrange appropriate

investigations while awaiting the appointment, e.g. pelvic ultrasound if there is a suspected mass, fine needle aspirate if nodes are palpable.

There is a growing field of research regarding the use of HPV testing in the follow-up of people treated for cervical cancer. [3-7] However, the research at present is limited and these guidelines are based on consensus decision.

For any participants with non-HPV related cervical cancer follow-up guidance will be determined by the Gynaecology Oncologist. For additional information please refer to the New Zealand Gynaecological Cancer Group Guidelines

https://www.health.govt.nz/publication/gynaecologic-cancer-follow-new-zealand-gynaecological-cancer-group-guidelines

Stage 1A1 squamous cell carcinoma surgery only

Participants treated by surgery either LLETZ/cone biopsy or hysterectomy for a stage 1A1 squamous cell cervical cancer should have a Test of Cure HPV test at 6 and 18 months following treatment. [5 The] 6-month follow-up test should be taken in the secondary care setting (either colposcopy or gynaecology clinic) and subsequent follow-up can occur in primary care if the first HPV test result is not detected.

If the participant had a total hysterectomy, after completing Test of Cure HPV test (two consecutive negative HPV tests 12 months apart) they can cease screening and will be unenrolled from the NCSP.

If the participant had a LLETZ or cone biopsy, after completing a Test of Cure HPV test (two consecutive negative HPV tests 12 months apart) they can return to regular interval screening and will remain enrolled in the NCSP.

If HPV is detected (any type) during the Test of Cure period participants should be referred to colposcopy. If there is an HPV detected test result after the completion of Test of Cure management, they should be managed as per the primary HPV screening guidelines.

Stage 1A1 adenocarcinoma surgery only

Participants treated by LLETZ, cone biopsy or hysterectomy with stage 1A1 adenocarcinoma should have a Test of Cure co-test test at 6 and 18-months following treatment. The 6-month follow-up tests should be taken in the secondary

care setting (either colposcopy or gynaecology clinic) and subsequent follow-up can occur in primary care if the first co-test results are both negative. Following two consecutive negative Test of Cure co-tests the participant can return to regular interval screening.

If the participant had a total hysterectomy, after completing a Test of Cure co-test (two consecutive negative co-tests 12 months apart), they can cease screening and will be unenrolled from the NCSP.

If HPV is detected (any type) during the Test of Cure period participants should be referred to colposcopy. If there is an HPV detected test after the completion of a Test of Cure, further management should as per the primary HPV screening guidelines.

Stage 1A2 + squamous cell and adenocarcinoma

Participants with stage 1A2+ squamous cell carcinoma and adenocarcinoma should be managed as per the specialist Gynaecological Oncologists recommendation. These participants are unenrolled from the register.

Any further tests that are performed will be recorded in the NCSP Register but will not be tracked by the NCSP i.e. no reminder letters will be sent to the participant from the register. Laboratories will not give a screening recommendation in test reports as further management is determined by specialist gynaecologists, not the NCSP.

Primary radiotherapy for gynaecological cancer

For participants treated with primary radiotherapy for gynaecological cancer, cervical cytology, HPV testing, or co-testing **is not recommended** after treatment as these treatments can cause abnormal appearances in that can mimic high-grade changes and lead to false positive cytology results. In addition, the clinical harms outweigh the benefits of screening in this group of participants due the effects of the radiation treatment. [1 2]

RECOMMENDATIONS – FOLLOW-UP FOLLOWING TREATMENT FOR CERVICAL CANCER	
R14.01 Follow-up after local excision for stage 1A1 squamous cell carcinoma	**Consensus-based recommendation** A Test of Cure HPV test should be performed at 6 and 18 months following treatment. Following two consecutive HPV not detected results the participant can return to regular interval screening.
R14.02 Follow-up after a hysterectomy for stage 1A1 squamous cell carcinoma	**Consensus-based recommendation** Test of Cure HPV test should be performed at 6 and 18 months following treatment. Following two consecutive HPV not detected tests the participant can cease screening.
R14.03 Follow-up after local excision for stage 1A1 adenocarcinoma	**Consensus-based recommendation** A Test of Cure co-test should be performed at 6 and 18 months following treatment. Following two consecutive negative co-tests the participant can return to regular interval screening.
R14.04 Follow-up after a hysterectomy for stage 1A1 adenocarcinoma	**Consensus-based recommendation** A Test of Cure co-test should be performed at 6 and 18 months following treatment. Following two consecutive negative Test of Cure co-tests the participant can cease screening.
R14.05 Follow-up after primary radiotherapy for gynaecological cancer	**Consensus-based recommendation** Cytology or co-testing is not recommended following treatment with primary radiotherapy for gynaecological cancer.
R14.06 Follow-up care for participants in secondary care	**Practice point** If a participant is receiving follow-up in secondary care, it can be helpful to place a recall in primary care recall systems to check with the participant that these appointments have occurred (the recall can be reset once a follow-up letter is received).

Screening following Gynaecological cancer

The management of other gynaecological cancers such as endometrial cancer or ovarian cancer is outside the scope of these guidelines. However, it is important to clarify the role of HPV testing and co-testing following treatment for other gynaecological cancers that are not cervical or vaginal. Non-cervical/vaginal gynaecological cancer is not associated with HPV infection and therefore an HPV

not detected test result does not exclude cancer recurrence.

International evidence has shown that endometrial cancer recurrence is more likely be detected through participants presenting with symptoms or clinical examination. Cytology does not add any clinical benefit in detecting endometrial cancer recurrence. [8 9]

Participants who have had a hysterectomy for gynaecological cancer such as endometrial or ovarian cancer with a normal screening history can cease screening and will be unenrolled from the NCSP. Primary HPV screening or co-testing **is not recommended** [8 9]

If a participant has a prior high grade squamous prior to hysterectomy and they have not completed a Test of Cure HPV test, this should be undertaken. If the HPV Test of Cure is not detected on two consecutive occasions the participant can cease screening.

It is recommended that participants who have had a sub-total hysterectomy should continue with cervical screening as per the current primary HPV screening guidelines.

RECOMMENDATIONS – FOLLOW UP FOLLOWING TREATMENT FOR ENDOMETRIAL CANCER	
R14.07 Follow-up after a sub-total hysterectomy for treatment of gynaecological cancer	**Consensus-based recommendation** Participants should continue with cervical screening as per the primary HPV screening guidelines.
R14.08 Follow-up after a total hysterectomy for gynaecological cancer	**Consensus-based recommendation** Participants can cease screening if they have a normal screening history prior to a total hysterectomy. HPV or co-testing is not recommended.
R14.09 Follow-up care for participants in secondary care	**Practice point** If a participant is receiving follow-up in secondary care, it can be helpful to place a recall in primary care recall systems to check with the participant that these appointments have occurred (the recall can be reset once a follow-up letter is received).

Follow-up following pelvic radiation for non-gynaecological cancers

HPV screening following pelvic radiation for non-gynaecological cancers (e.g. rectal or bladder cancer) can be considered on an individual basis where feasible; for example, the vagina can be accessed for both screening and assessment.

It is important screen takers counsel participants/whānau of the harms and benefits of screening as assessment and treatment can be very limited in some cases. The diagnosis of HPV will cause distress without an ability to alter the natural history of the disease. Radiation changes often means that the anatomy can be altered resulting in difficult and painful examinations. Cytological testing can result in false positive cytology changes which are due to radiation-induced change alone.

HPV testing in this situation should be participant-specific but in most cases **may not be feasible** or result in any change in participant outcomes. The participant/whānau may decide to opt off regular HPV screening after thorough discussion and consent.

References

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