Cervical Cancer: 85% are squamous cell, ~15% are adenocarcinoma

**Typical HPI:**
- Abnormal vaginal bleeding (eg. after intercourse - or between periods, or menorrhagia)
- Abnormal (yellow, odorous) vaginal discharge
- Low back pain
- Painful sexual intercourse (dyspareunia)
- Painful urination (dysuria)

**Past History**
- Constipation
- Blood in the urine (hematuria)
- Urinary obstruction and thus back pain
- Leg oedema
- HPV infection
- Sexually active
- Smoker

**Physical examination**

**LOOK FOR**
- Weight loss
- Anaemic pallor
- Dehydration

**PALPATE FOR**
- Abdo mass
- Lymphadenopathy
- Hepatomegaly
- Bony tenderness

**Screening any woman aged 18 to 70**
PAP smear: Most early changes detected, 90-95% accurate women after onset of sexual activity, or >age 20, should have a smear EVERY 2 YEARS
If positive, smears should be repeated every year.
Women with ASC-US, ASC-H, or low-grade CIN should repeat smears in 3 to 6 months and be tested for HPV.
Women with high-grade CIN or frankly malignant Pap smears should have colposcopic-directed cervical biopsy.

**Laboratory investigations**

**FBC**
- Looking for evidence of anaemia from blood loss

**Liver Function Tests**
- Looking for metastasis to liver

**Kidney Function Tests**
- Looking for renal disease secondary to hydronephrosis

**Serum Electrolytes**
- Only what is to be expected with renal failure

**Colposcopy and Biopsy**
- Definitive diagnostic measure, together with visualisation and pap smear
- Acetic acid wash stains DNA; white-staining cervix? Means you have CIN! Can you see its upper limit? NO? excise the Os of Cervix; “cone biopsy”

**Imaging investigations**

**CHEST X-RAY**
- Staging for mets

**CT of abdomen, thorax and skull**
- Staging for direct extension, nodes and mets

**Bronchoscopy or Thoracoscopy**
- To aid in staging (biopsy sample microscopy)

**Needle Biopsy**
- Like bronchoscopy; small chance of pneumothorax

**Bone Scan**
- For staging

**Staging**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Ia</td>
<td>Microscopic disease (CIN)</td>
</tr>
<tr>
<td>Ib or Ila</td>
<td>Clinically visible but confined to cervix, &lt;4cm</td>
</tr>
<tr>
<td>Ib2</td>
<td>Still in situ but &gt; 4 cm</td>
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<tr>
<td>Ib3</td>
<td>Spread to 2/3ds of vagina but NOT perimetrium</td>
</tr>
<tr>
<td>Ib3b</td>
<td>Spread to perimetrium but not sidewall of pelvis</td>
</tr>
<tr>
<td>Ib3a</td>
<td>All the way down the vagina but not pelvic wall</td>
</tr>
<tr>
<td>Ib3b</td>
<td>Spread to pelvic wall and ureter</td>
</tr>
<tr>
<td>Ib4</td>
<td>Spread to bladder or rectum</td>
</tr>
<tr>
<td>Ib4b</td>
<td>Distant metastasis</td>
</tr>
</tbody>
</table>

**Pattern of Spread**

extrapelvic lymph nodes, liver, lung, and bone

**Prognosis and follow-up**

Close monitoring of blood while on chemo and radiation; CT scans between every 2 cycles, check tumour burden
Cytologic screening at three-month intervals for the first two years after treatment and Half-yearly thereafter