Pan Birmingham NHS
Cancer Network

Guideline for Trachelectomy

Version History

Version	Date	Summary of Change/Process
1.0	24.11.08	Approved by the Governance Committee Chair
1.1	10.08.11	Reviewed and updated by Kavita Singh and sent to Gynae NSSG for reviewing
1.2	30.08.11	Reviewed and updated by Kavita Singh
1.3	09.09.11	Reviewed and updated by members of the Gynae NSSG
1.4	20.09.11	Reviewed and approved by Guidelines Sub Group on 20 September 2011
1.5	14.11.11	With comments from Kavita Singh
2.0	15.11.11	Reviewed and endorsed by Guidelines Sub Group

Date Approved by Network Governance	**November 2011**

Date for Review	**November 2014**

Changes between version 1 and version 2

This guideline has updated the changes in surgical techniques, indication and follow up of patients undergoing trachelectomy for management of their early cervical cancer at Pan Birmingham Gynae Cancer Centre (PBGCC).

1. Scope of the Guideline

This guideline has been developed to include the indications for, and follow up of, patients undergoing trachelectomy for cervical cancer.

2. Background to Trachelectomy

2.1 This is fertility preserving surgery aimed at preserving the uterus in women who are desirous of future pregnancy. There are different types of trachelectomy and different surgical approaches to this procedure.

2.2 Trachelectomy can be a simple or radical trachelectomy. Simple trachelectomy involves a supravaginal amputation of cervix. Radical trachelectomy involves removal of cervix with the parametrium and vaginal cuff. Trachelectomy can be accompanied with a cervical cerclage to prevent cervical incompetence.

2.3 Over 400 cases have been performed world wide and in these cases there have been 171 pregnancies reported with 109 live births. In these cases there was a slightly higher than average risk of miscarriage (29%) and preterm delivery rate of 20%.

2.4 Within Pan Birmingham Cancer Network trachelectomy is carried out at the Gynaecology Cancer Centre at Sandwell and West Birmingham Hospitals NHS Trust.

Guideline Statements

3. Indications

3.1 Simple trachelectomy

a) persistent CIN/CGIN with flushed or short ectocervix as a result of previous multiple loop treatments.
b) stage 1A1/1A2 cervical cancer where the knife cone biopsy is not feasible because of flushed ectocervix.
c) superficial low volume stage 1B1 cervical cancer (depth <3mm and transverse spread <10mm).

3.2 Radical trachelectomy is recommended for stage 1b1 cervical cancer.

4. Inclusion criteria

a) Premenopausal women desirous of future pregnancy.
b) No evidence of pelvic node metastases.
c) Cervical tumour at least 1 cm away from internal cervical os on MRI.

5. Exclusion criteria

a) clear cell or serous carcinoma.
b) Neuroendocrine carcinoma.
c) squamous cell carcinoma and adenocarcinomas with deep stromal invasion +LVSI.

6. Route of surgery

6.1 Simple trachelectomy is performed through a vaginal approach.

6.2 Radical trachelectomy: Vaginal approach has been most commonly used for this procedure. However abdominal and laparoscopic approaches are now being gradually favoured in view of the radicality of excision of parametrium. At PBGCC laparoscopic radical trachelectomy is an accepted surgical route. Fertility outcome data after abdominal and laparoscopic radical trachelectomy has not been published as an insufficient number of cases have been performed worldwide via these routes.

6.3 Two stage treatment is preferred. Firstly laparoscopic pelvic lymphadenectomy and secondly, only in absence of metastatic disease, a trachelectomy is performed. Evidence suggests avoidance of parametrectomy is safe for stage 1A2 and radical trachelectomy for 1B1 cervical cancer.

7. Role of cervical cerclage with trachelectomy

Cervical cerclage is applied using ethilon sutures / Mersilene tape with knot tied and buried at 6 o'clock position. Limitations of cerclage are cervical stenosis, cryptomenorrhea and dysmenorrhea. Abandonment of elective cerclage and instead recommending its insertion in second trimester of pregnancy in selected cases is acceptable.

8. Follow up after trachelectomy

8.1 All cases following trachelectomy should be followed up at the Cancer Centre. All patients are encouraged to avoid pregnancy for the first 6 months to ensure adequate healing, and no persistence or recurrence of disease.

8.2 There is no standardised protocol for follow up of patients after trachelectomy. Follow up visits are aimed to:

a) detect recurrence of disease.
b) treat any ongoing complications of procedure.
c) seek early guidance from obstetric colleagues if patient becomes pregnant.

9. Interval and duration of follow up

All patients will be offered 6 monthly visits for the first 2 years.

10. Modalities of Follow Up

These include:

a) clinical examination.
b) smear (isthmic and vaginal vault).
c) colposcopy.
d) cross sectional imaging.
e) HPV typing.
f) obstetric management.

10.1 Clinical Examination
This includes history, speculum and examinations of the vagina and rectum.

10.2 Smear
Endocervical brush and vault LBC will be performed twice in the first year followed by yearly smears for ten years at the Cancer Centre. Endometrial cells are disregarded as detected in >50% of these smears.

10.3 Colposcopy
Benefit of colposcopy is doubtful but examination on the colposcopy couch makes easy visualisation and facilitates examination. Colposcopy is often unsatisfactory because of the hidden transformation zone. Colposcopy and biopsies are recommended only as a follow up of abnormal smears.

10.4 Imaging
MRI has been recommended at 6 and 12 months in other centres and until there is more data available it is not a recommended practice unless it is for investigation for any ongoing symptoms.

10.5 HPV typing
Its role is doubtful but in women with persistent smear abnormalities, HPV typing may assist in selecting cases that may benefit from completion hysterectomy after their childbearing.

10.6 Obstetric management
All patients should be registered with a nominated obstetrician managing high risk pregnancies. The obstetrician is encouraged to communicate with the gynaecologist. Antibiotic prophylaxis, prenatal steroid therapy and elective caesarean are recommended.

Monitoring of Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2013

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