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Guideline 4-16 Version 3

A Quality Initiative of the Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Follow-up for Cervical Cancer

Members of the Follow-up for Cervical Cancer Expert Panel

Report Date: May 23, 2025

Guideline 4-16 Version 2 was reviewed in 2025 and ENDORSED by the Follow-up for Cervical Cancer Expert Panel.
(See Section 6: Document Assessment and Review for details)

Guideline 4-16 Version 3 comprises 6 sections. You can access the summary and full report here:
https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/476

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Elit L, Fyles AW, Oliver TK, Devries-Aboud MC, Fung-Kee-Fung M; Members of the Gynecology Cancer Disease Site Group of Cancer Care Ontario's Program in Evidence-based Care. Follow-up for women after treatment for cervical cancer. Curr Oncol. 2010 Jun;17(3):65-9.

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Guideline 4-16 Version 3: Section 1

Follow-up for Cervical Cancer: Recommendations Summary

GUIDELINE OBJECTIVE

This guideline was written to provide guidance on the most appropriate follow-up strategy for patients with cervical cancer who are clinically disease-free after receiving primary treatment. This guideline is an update of a previous version, which was published in 2009. The update was initiated when the members of the Program in Evidence-Based Care (PEBC) Gynecologic Cancer Disease Site Group become aware of new publications related to follow-up for the target population. The Disease Site Group members wanted to determine whether this new evidence would result in modifications to the existing recommendations.

TARGET POPULATION

This practice guideline applies to women who are clinically disease free and asymptomatic after receiving potentially curative primary treatment for cervical cancer. This guideline does not apply to the follow-up of women who have been treated for cervical precancer.

INTENDED USERS

This practice guideline is for clinicians involved in the care and follow-up of women who have received treatment for cervical cancer.

May 2025: Some recommendations have been modified to align with guidance from the Ontario Cervical Screening Program (OCSP) https://www.cancercareontario.ca/en/types-of-cancer/cervical/screening. Also, some other minor wording changes were made that are *explained in* ***Section 6.***

RECOMMENDATIONS

- Follow-up care after primary treatment should be conducted and coordinated by a physician experienced in the surveillance of patients with cancer. Continuity of care and dialogue between the healthcare professional and patient about symptoms of recurrence may enhance and facilitate early cancer recurrence detection because the majority of women who develop a recurrence have symptoms and signs that occur outside scheduled follow-up visits.

Added May 2025 (See Section 6 for details):

1. **Patients who had stage 1A1 cervical cancer and retained their cervix.** These patients should be followed with HPV testing according to the OCSP guideline and use the follow-up strategy below. https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/cervical-screening-recommendations-summary. Hysterectomy can be considered once childbearing is complete or cervix cannot be adequately followed.

2. **Patients who had a hysterectomy.** These patients should be considered for vaginal vault testing according to the OCSP guidance for vaginal vault testing and use the follow-up strategy below. https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/43336.

3. **Patients who had 1A2 and beyond cervical cancer and retained their cervix.** These patients are not covered in the OCSP. Hysterectomy can be considered once childbearing is complete or cervix cannot be adequately followed.

4. **Patients who had radiation with or without chemotherapy.** Follow-up with HPV/cytology is not recommended for these patients. It is fairly standard to order MRI after three months post radiation/chemotherapy. Patients should receive a physical exam or an MRI when a physical exam is difficult to perform, incomplete, or challenging to interpret.

Follow-up for Groups 1 to 3:

Follow-up to Five Years

- A reasonable follow-up strategy involves visits at the following intervals in either a colposcopy or cancer clinic:
    - every four to six months within the first two years.
    - every six to 12 months from years 3 to 5.
- At a minimum, follow-up visits should include a patient history and a complete physical examination.
    - Symptoms elicited during the patient history should include general performance status, lower back pain (especially if it radiates down one leg), vaginal bleeding, or unexplained weight loss. Focused imaging or testing appropriate to findings is warranted.
    - A physical examination should attempt to identify abnormal findings related to general health and/or those that suggest vaginal, pelvic sidewall, or distant recurrence. Because central pelvic recurrences are potentially curable, the physical examination should include a speculum examination with bimanual and pelvic/rectal examination. Focused imaging or testing appropriate to findings is warranted.
    - For patients with a cervix, HPV and cytology testing (co-test) at each visit.
    - For patients without a cervix, a single test vault at 6 to 12 months post-hysterectomy is recommended. For those patients with a negative vault HPV test, there is no evidence available suggesting that ongoing vault testing is beneficial. For those with positive HPV test, colposcopy of the vaginal vault is recommended to rule out a vaginal lesion. Ongoing surveillance is up to the discretion of the treating physician.
- Because their role has not been evaluated in a definitive manner, the following investigations *are not advocated*:
    - Positron emission tomography (PET) with computed tomography (PET-CT).
    - Other imaging or biomarker tests in asymptomatic patients.

Follow-up Beyond Five Years

- After five years of recurrence-free follow-up:
    - Patients with 1A2 and beyond with a cervix may return to primary care follow-up at the discretion of the treating physician.
    - Primary care follow-up should include a history and general physical, including pelvic examination performed by the primary care physician that is consistent with standards for well-woman care; however, some patients with treatment complications may require more prolonged follow-up at the cancer centre.

Follow-up for Group 4:

Follow-up to Five Years

- A reasonable follow-up strategy involves visits at the following intervals at a cancer clinic:
    - every four to six months within the first two years,
    - every six to 12 months from years 3 to 5.
- At a minimum, follow-up visits should include a patient history and a complete physical examination.

- Symptoms elicited during the patient history should include general performance status, lower back pain (especially if it radiates down one leg), vaginal bleeding, or unexplained weight loss. Focused imaging or testing appropriate to findings is warranted.
- A physical examination should attempt to identify abnormal findings related to general health and/or those that suggest vaginal, pelvic sidewall, or distant recurrence. Because central pelvic recurrences are potentially curable, the physical examination should include a speculum examination with bimanual and pelvic/rectal examination. Focused imaging or testing appropriate to findings is warranted.

- After three months post-treatment, because their role has not been evaluated in a definitive manner, the following investigations *are not advocated*:
  - Positron emission tomography (PET) with computed tomography (PET-CT), or biomarker tests.

Follow-up Beyond Five Years

- After five years of recurrence-free follow-up:
  Primary care follow-up should include a history and general physical, including pelvic examination performed by the primary care physician that is consistent with standards for well-woman care; however, some patients with treatment complications such as those related to radiotherapy may require more prolonged follow-up at the cancer centre.