Trachelectomy an Option in Cervical Ca Patients

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Santa Monica, Calif. — Fertility-sparing trachelectomy is a safe and effective option for carefully selected women with cervical cancer, Dr. John H. Shepherd reported at the biennial meeting of the International Gynecologic Cancer Society.

In a case series of 141 women treated with this surgery between 1994 and 2006, so far there have been 69 pregnancies, 33 live births, and only 4 recurrences of cancer, said Dr. Shepherd of St. Bartholomew's Hospital, London.

According to Dr. Shepherd, the principle of the operation is to remove the cervix, the lower cervical tissue up to the uterine isthmus, and the upper 2 cm of the vagina. The procedure preserves the body of the uterus. "Our standard is to put in a cervical cerclage—or we can call it an isthmic cerclage—into the remaining isthmus before performing a vaginal-isthmic anastomosis and restoring the continuity of the birth canal," he said.

The procedure is appropriate for women whose cancer is in stage Ia2, stage Ib1, and for selected cases that are at stage IIa. In addition to the stage, consideration should be given to the size of the tumor, its pathology and grade, the age of the woman, the status of her lymph nodes and whether there has been lymphovascular space invasion, her fertility status, any comorbidities, and, of course, her wishes.

Among the 141 women who elected the procedure, the average age was 31 years. Almost all—98%—had stage Ib1 disease. Two of the women had stage Ia2 disease with poor prognoses, and one had stage IIa disease. About one-third of the women had lymphovascular space invasion. Histologic type was squamous in 64% of the women, adenocarcinoma in 31%, adenosquamous in 3%, and other in 3% (percentages exceed 100% because of rounding).

After final pathology, physicians recommended completion treatment for 19 of the women (13%), with most opting for chemotherapy and radiotherapy. One woman with a single positive lymph node refused completion treatment, went on to have a child, and has had no recurrences after 3 years. Two patients with close margins also refused completion treatment.

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There have been relatively few surgical complications, and Dr. Shepherd said that even those few have declined as the surgical team ascended the learning curve. Ureteric damage and uterine perforation were the most common perioperative complications. Two of the three cases of ureteric damage were caused by extensive microscopic disease involving the bladder that was not detected prior to surgery. Both uterine perforations were caused by overzealous insertion of cervical sounds.

Other complications included seven cases of isthmic stenosis, five cases of temporary thigh numbness, four cases of stitch expulsion, and three cases of amenorrhea. In all, there were 24 women with fertility issues after surgery. Among these were the seven women with isthmic stenosis, who required dilatation; two cases of apareunia, probably psychosexual in nature; three cases of endometriosis; and six cases that required in vitro fertilization.

So far there have been 33 pregnancies among 24 of the 141 women in the series. Of the 27 miscarriages, 16 occurred in the first trimester and 11 occurred in the second. At the time of Dr. Shepherd's talk, four additional women have become pregnant.

"We have a significant prematurity rate, [approximately one-fourth of which] I would regard as severe prematurity [24-31 weeks]," Dr. Shepherd said. "This is probably related to the extent of the surgery we decided to carry out up to the isthmus." An additional fourth of the women delivered between 32 and 35 weeks, and the remaining 50% delivered successfully by classical cesarean section at 36-38 weeks.

"Premature delivery we believe is initiated by premature spontaneous rupture of membranes, and this is due to the absence of a cervical plug leading to ascending infection," he said. "We would recommend that antibiotics in the second trimester should be considered." ■