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# Actualités sur la prise en charge chirurgicale des cancers du col de l'utérus

OncoBFC Soirée Gynécologie

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Dr Hélène COSTAZ  
Dr Claire TOUBIN

*28 Mars 2023*



## **Surgical treatment**

(T1a, T1b1 – T1b3, FST, Cancer in pregnancy,  
Cancer from specimen after hysterectomy)

## **ESGO/ESTRO/ESP Guidelines for the management of patients with cervical cancer**

David Cibula

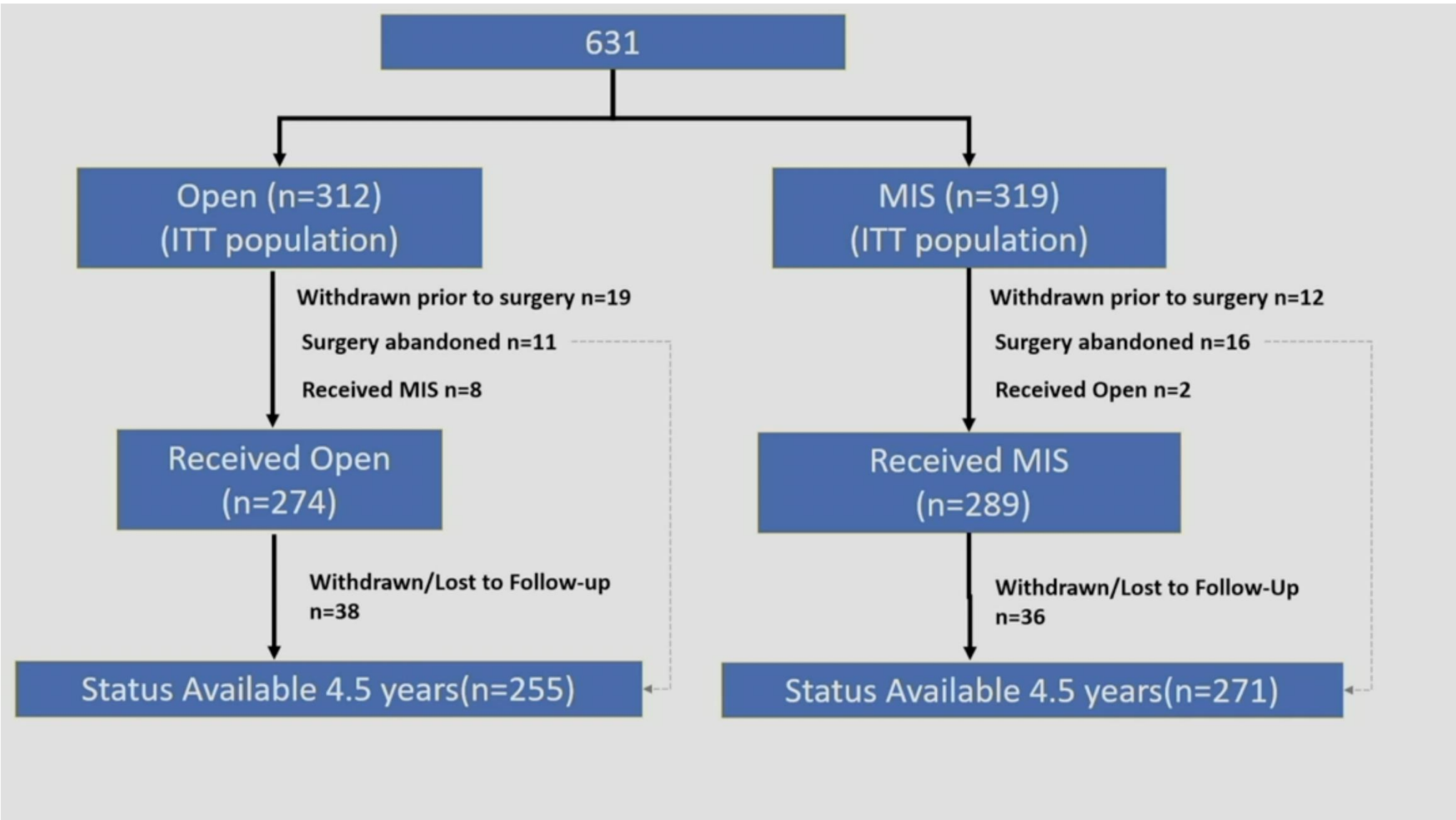
Department of Obstetrics and Gynecology, General University Hospital in Prague  
First Faculty of Medicine, Charles University, Prague, Czech Republic

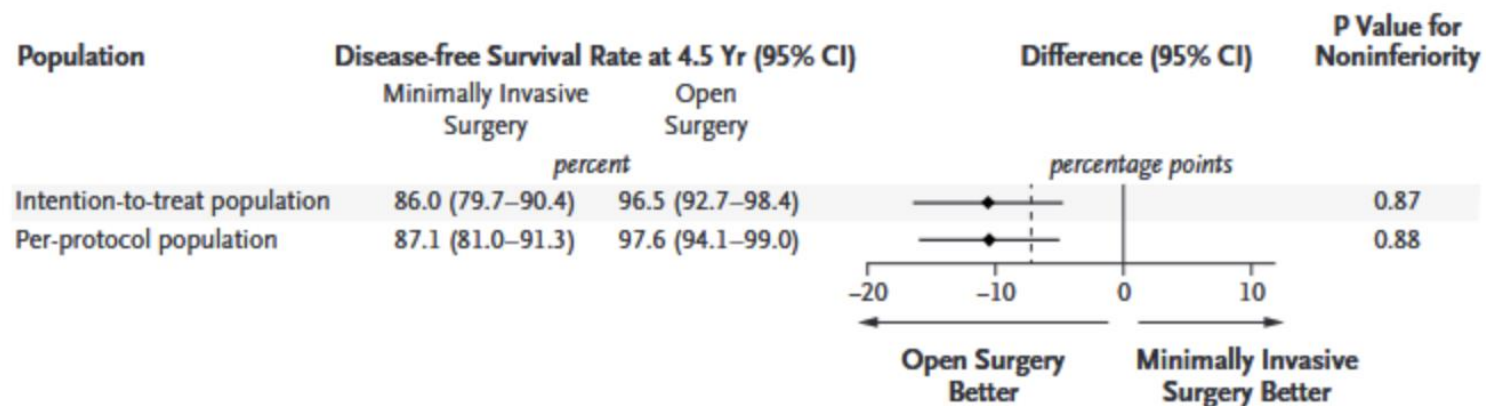
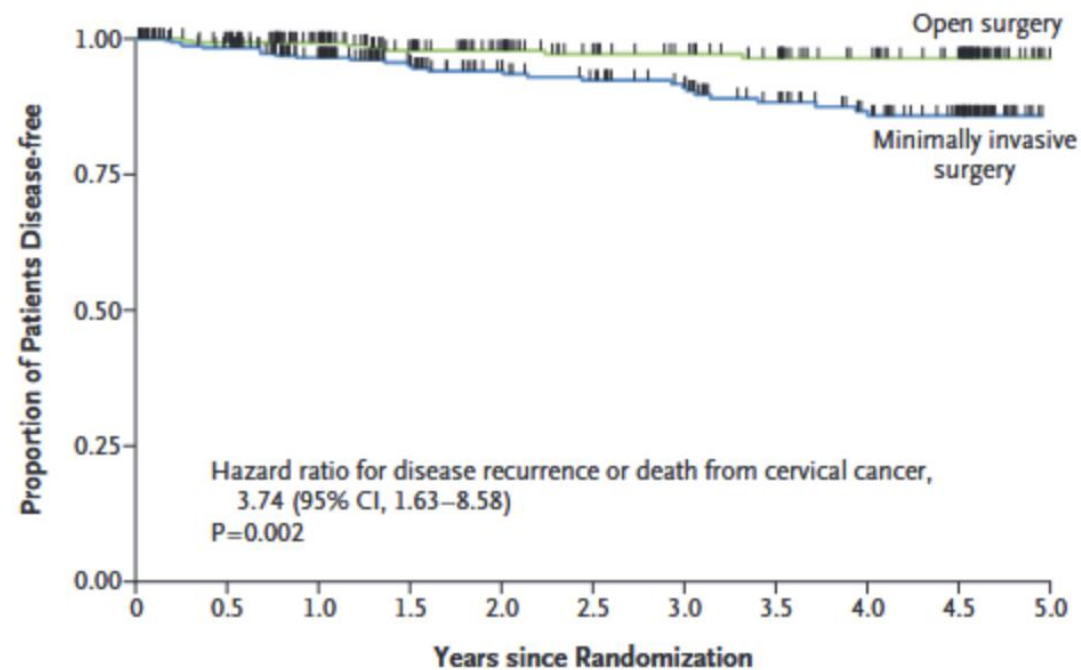


# **Open vs Minimally Invasive Radical Hysterectomy in Patients with Early-Stage Cervical Cancer (LACC Trial): Final Analysis**

**Pedro T. Ramirez, MD  
Professor**

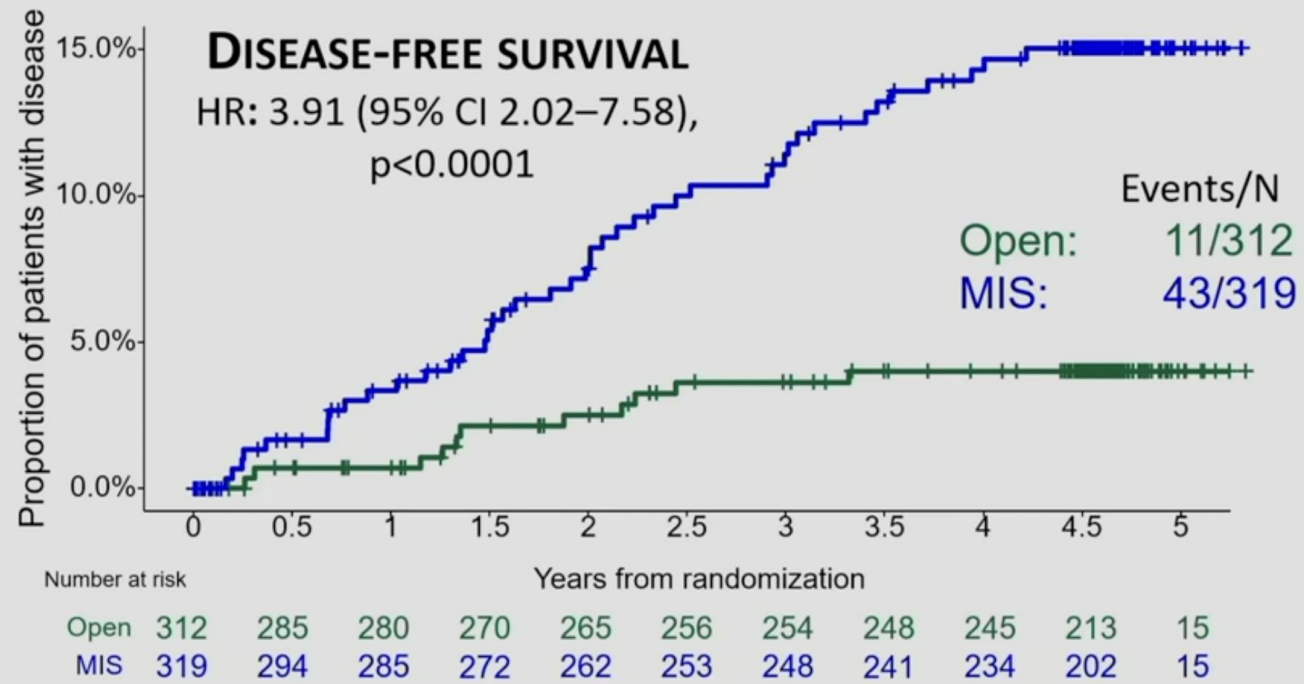
**Department of Gynecologic Oncology & Reproductive Medicine  
The University of Texas MD Anderson Cancer Center**

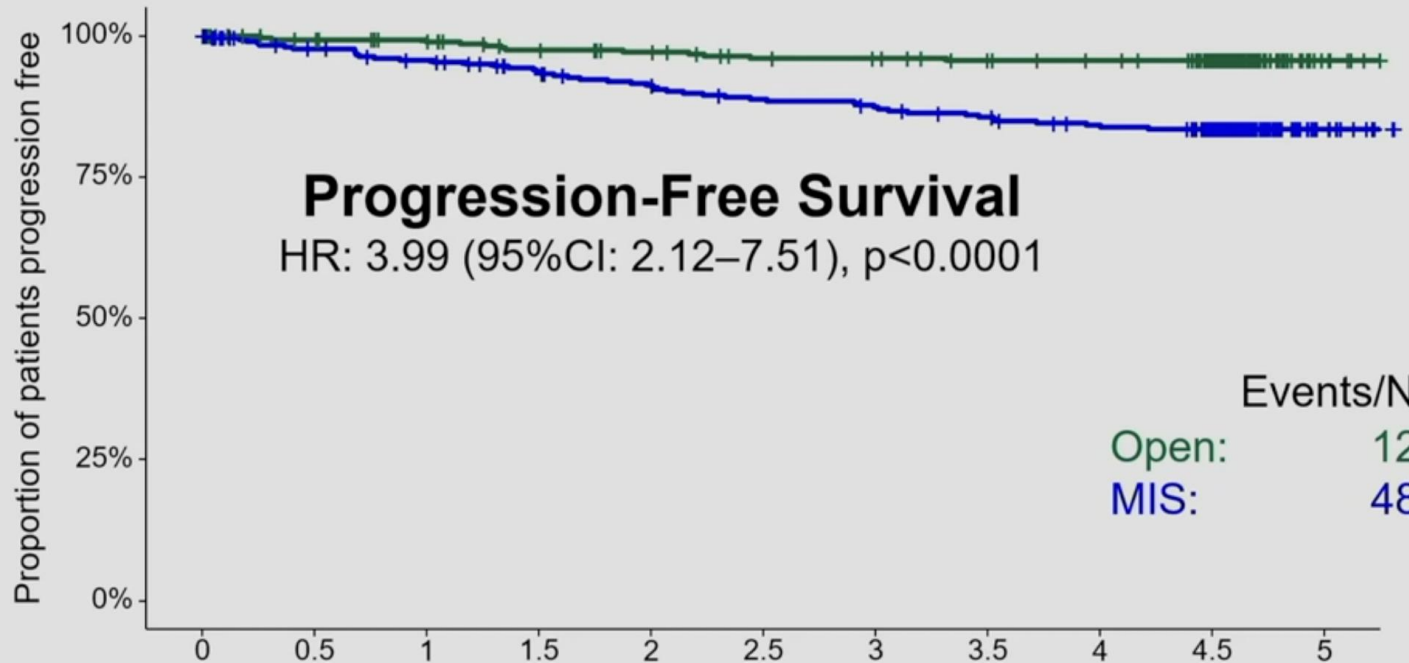


**A****B****No. at Risk**

Open surgery	312	280	236	187	163	144	134	123	104	90	7
Minimally invasive surgery	319	292	244	192	167	155	142	121	102	80	5

**Figure 1. Estimates of Disease-free Survival.**



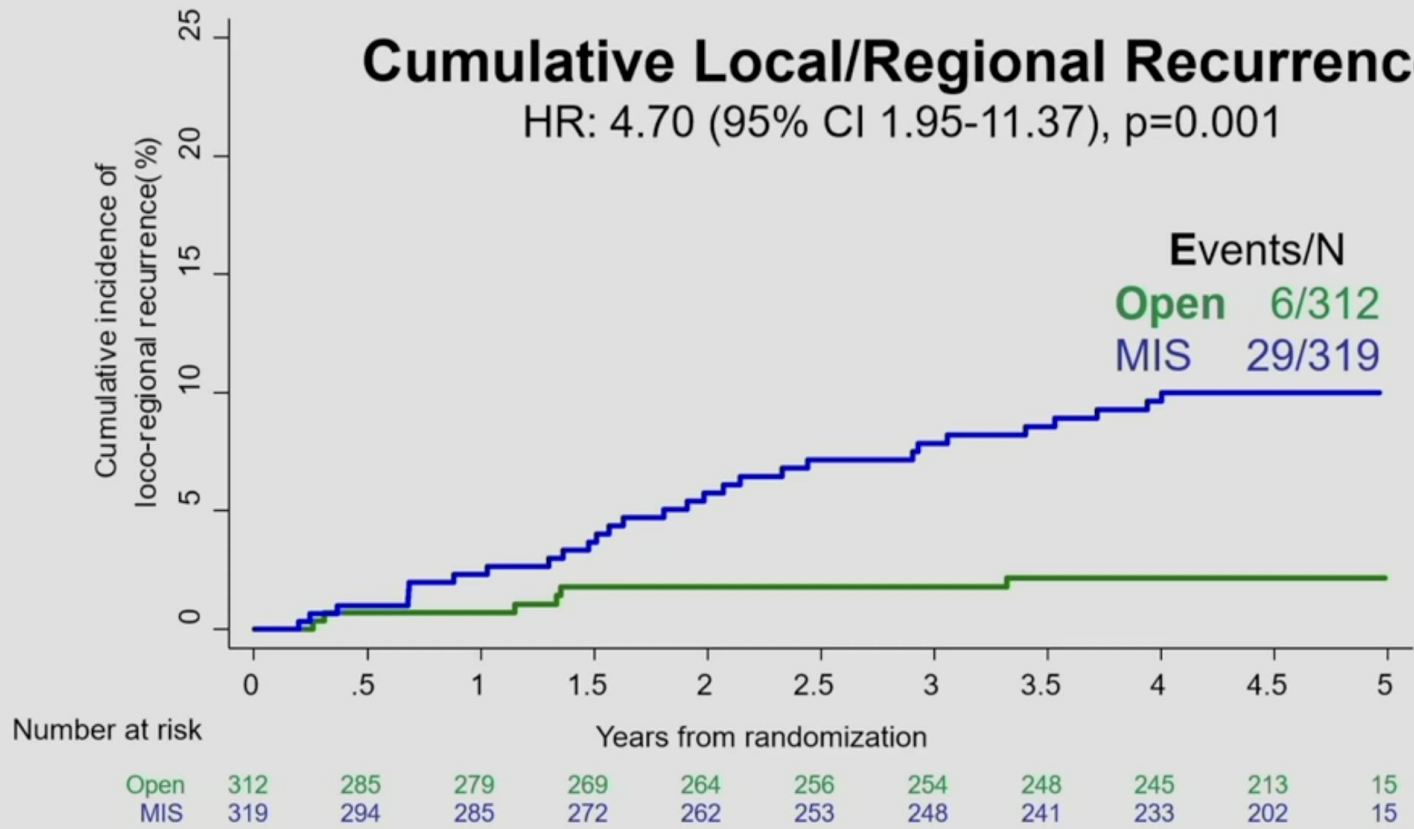


Events/N  
 Open: 12/312  
 MIS: 48/319

	Number at risk										
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5
Open	312	285	279	269	264	256	254	248	245	213	15
MIS	319	294	285	272	262	253	248	241	233	202	15

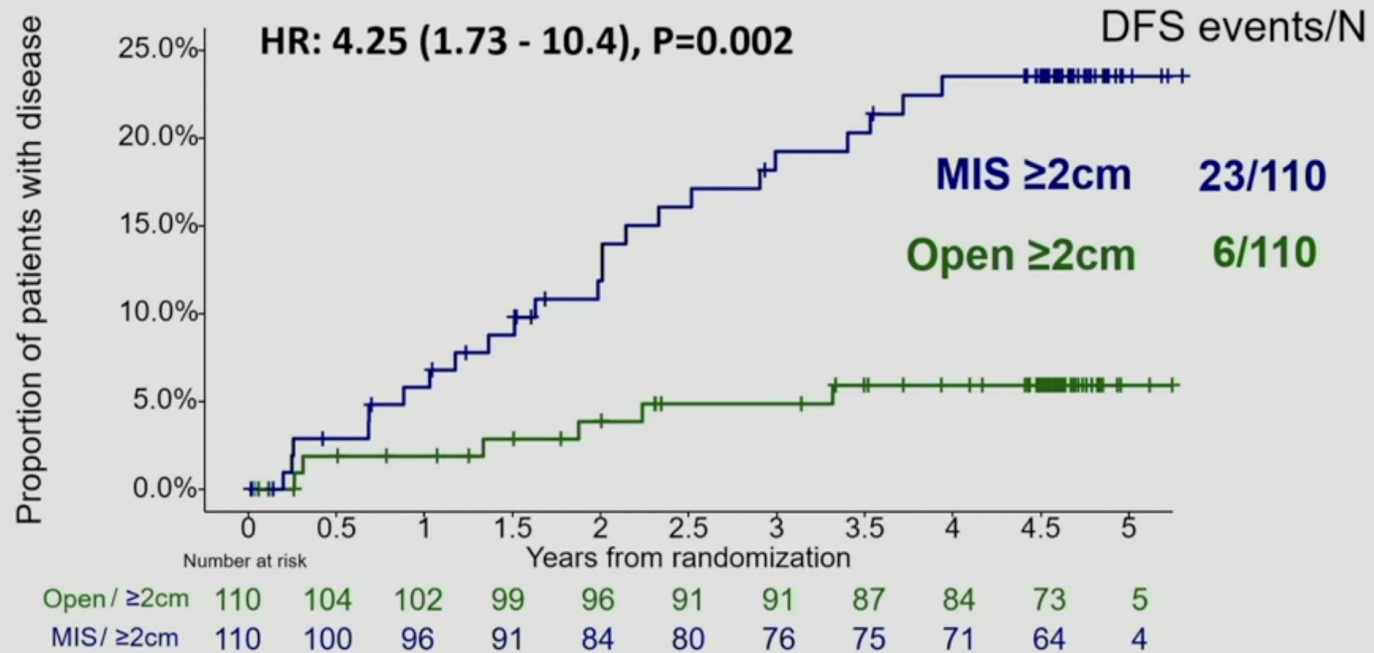
# Cumulative Local/Regional Recurrence

HR: 4.70 (95% CI 1.95-11.37), p=0.001

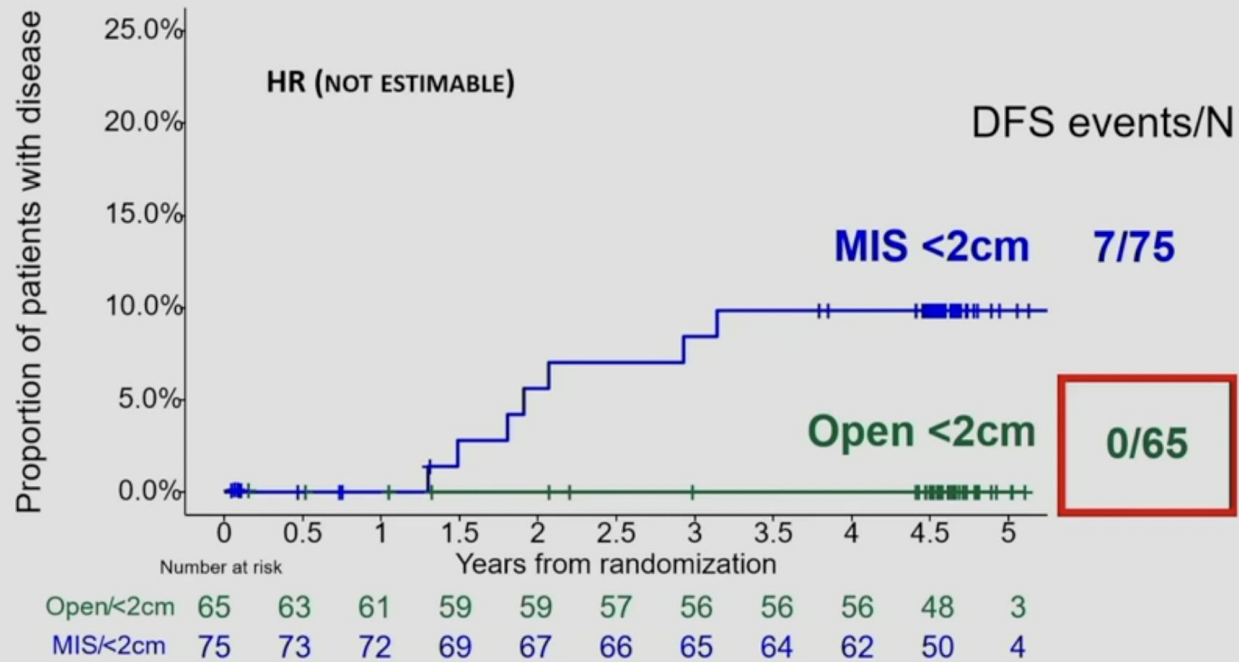




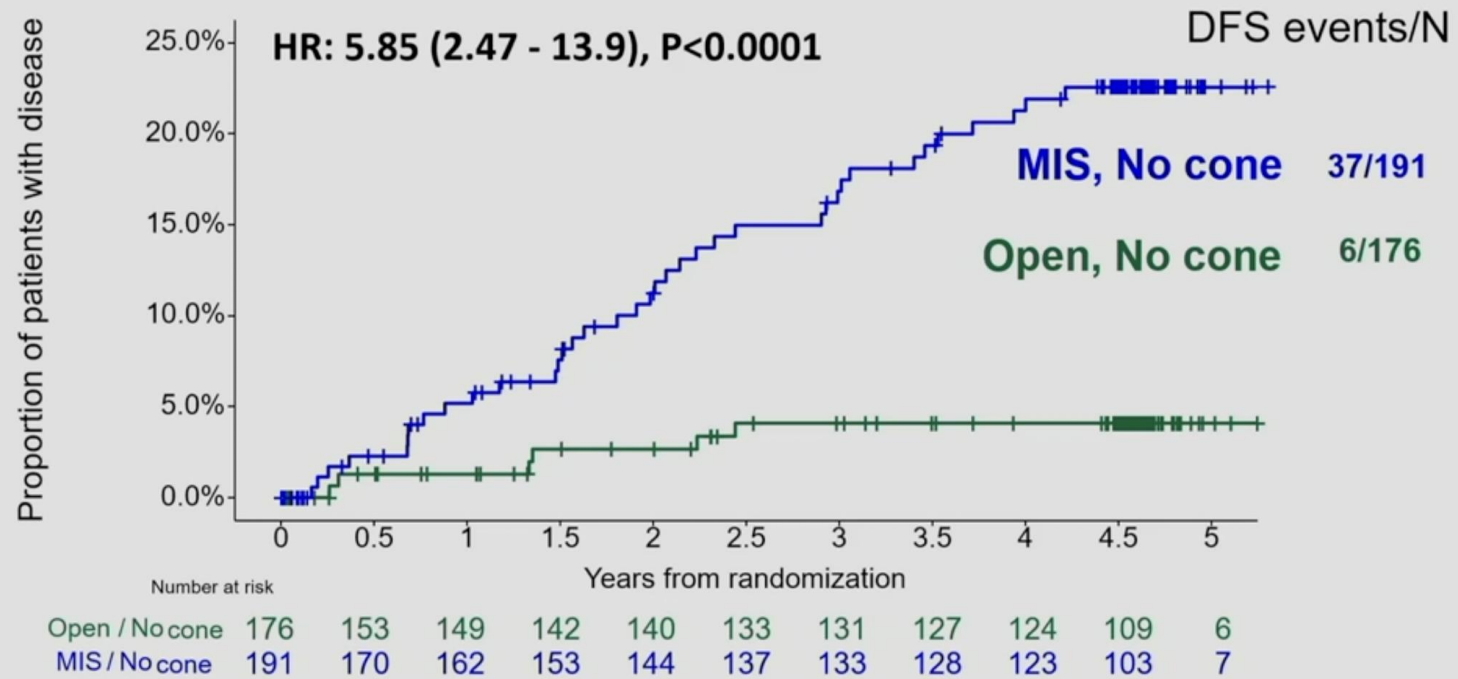
# TUMOR SIZE: OUTCOMES IN $\geq 2$ CMS



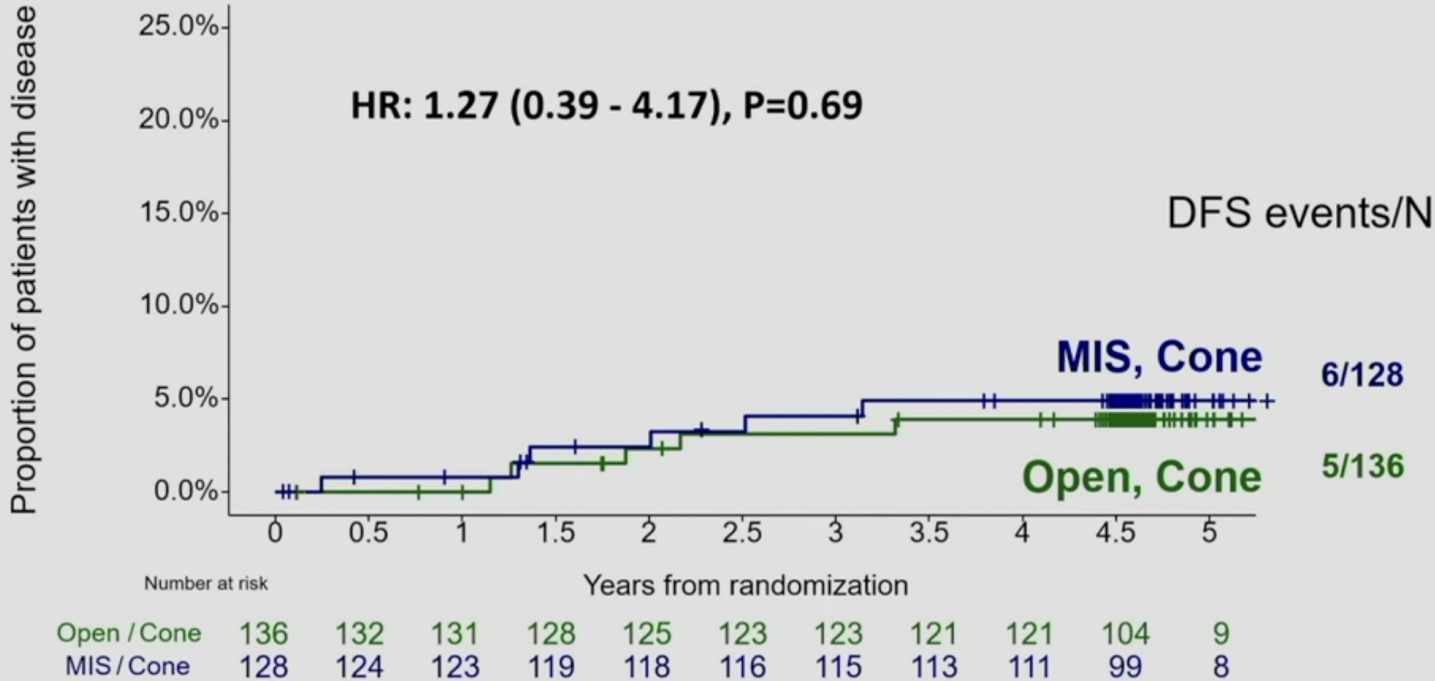
# TUMOR SIZE: OUTCOMES IN <2 CMS



## CONIZATION OUTCOMES: NO PREVIOUS CONE



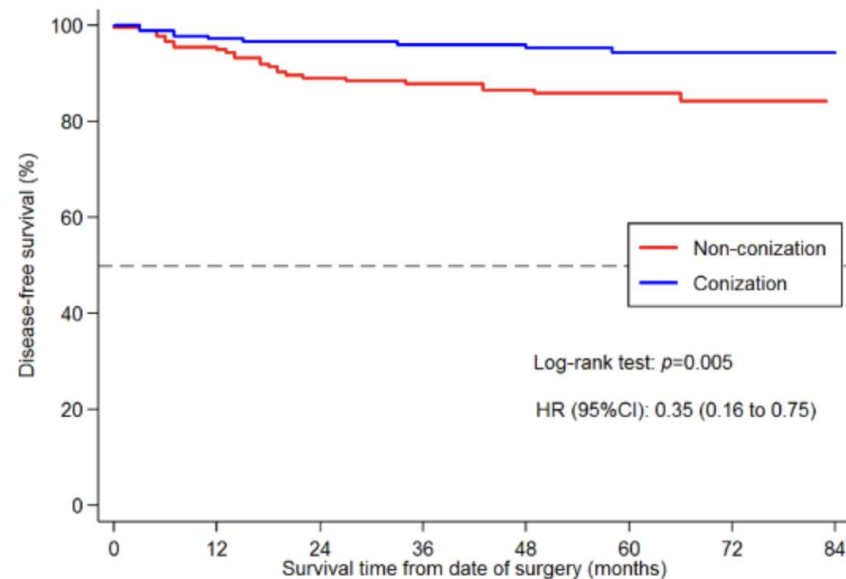
# CONIZATION OUTCOMES: PREVIOUS CONE





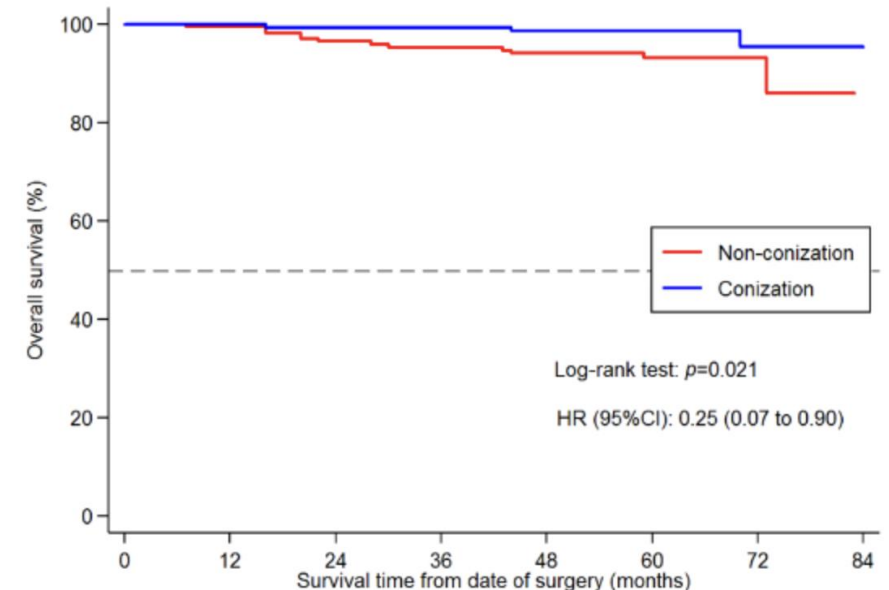
## SUCCOR cone study: conization before radical hysterectomy

Enrique Chacon<sup>1</sup>, Nabil Manzour<sup>2</sup>, Vanna Zanagnolo<sup>3</sup>, Denis Querleu<sup>4</sup>, Jorge M Núñez-Córdoba<sup>5</sup>, Nerea Martín-Calvo<sup>6</sup>, Mihai Emil Căpîlna<sup>7</sup>, Anna Fagotti<sup>8</sup>, Ali Kucukmetin<sup>9</sup>, Constantijne Mom<sup>10</sup>, Galina Chakalova<sup>11</sup>, Aliyev Shamistan<sup>12</sup>, Antonio Gil Moreno<sup>13,14</sup>, Mario Malzoni<sup>15</sup>, Fabrice Narducci<sup>16</sup>, Octavio Arencibia<sup>17</sup>, Francesco Raspagliesi<sup>18</sup>, Tayfun Toptas<sup>19</sup>, David Cibula<sup>20</sup>, Dilyara Kaidarova<sup>21</sup>, Mehmet Mutlu Meydanli<sup>22</sup>, Mariana Tavares<sup>23</sup>, Dmytro Golub<sup>24</sup>, Anna Myriam Perrone<sup>25</sup>, Robert Poka<sup>26</sup>, Dimitrios Tsolakidis<sup>27</sup>, Goran Vujic<sup>28</sup>, Marcin A Jedryka<sup>29</sup>, Petra L M Zusterzeel<sup>30</sup>, Jogchum Jan Beltman<sup>31</sup>, Frederic Goffin<sup>32</sup>, Dimitrios Haidopoulos<sup>33</sup>, Herman Haller<sup>34</sup>, Robert Jach<sup>35</sup>, Iryna Yezhova<sup>36</sup>, Igor Berlev<sup>37</sup>, Margarida Bernardino<sup>38</sup>, Rasiyah Bharathan<sup>39</sup>, Maximilian Lanner<sup>40</sup>, Minna M Maenpää<sup>41</sup>, Vladyslav Sukhin<sup>42</sup>, Jean-Guillaume Feron<sup>43</sup>, Robert Fruscio<sup>44,45</sup>, Kersti Kukk<sup>46</sup>, Jordi Ponce<sup>47</sup>, Jose Angel Minguez<sup>48</sup>, Daniel Vázquez-Vicente<sup>49</sup>, Teresa Castellanos<sup>49</sup>, Felix Boria<sup>50</sup>, Juan Luis Alcazar<sup>51</sup>, Luis Chiva<sup>52</sup>, The SUCCOR study group



Number at risk		0	12	24	36	48	60	72	84
Non-conization	178	164	150	142	132	82	17	0	
Conization	183	169	159	153	141	82	20	1	

**Figure 2** Hazard ratios (HR) and 95% confidence intervals for the risk of relapse by type of conization (with or without).

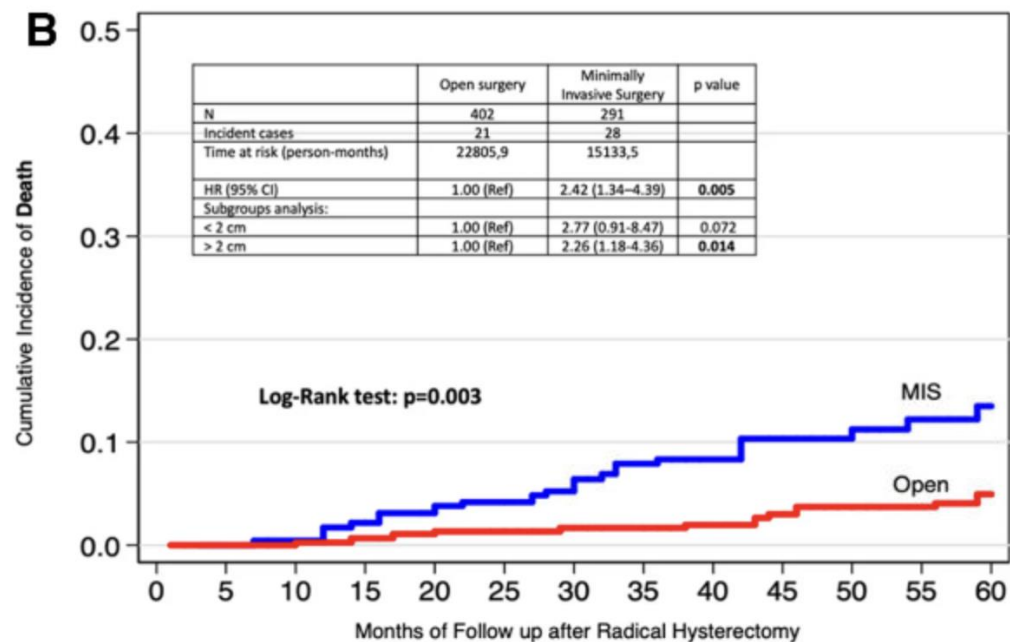
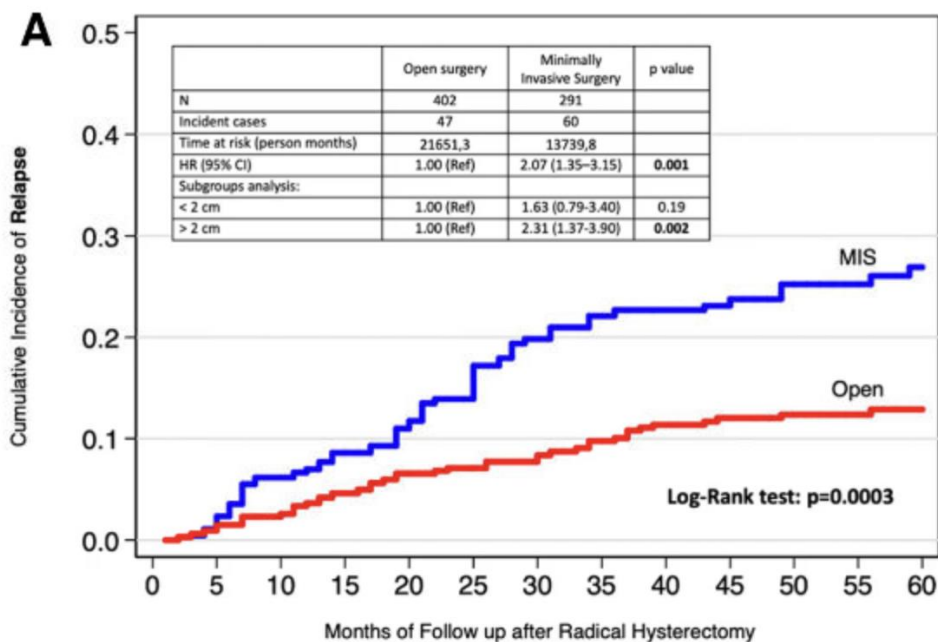


Number at risk		0	12	24	36	48	60	72	84
Non-conization	181	174	165	156	142	87	19	0	
Conization	186	175	163	158	145	86	21	1	

**Figure 3** Hazard ratios (HR) and 95% confidence intervals for overall survival by type of conization (with or without).

# SUCCOR study: an international European cohort observational study comparing minimally invasive surgery versus open abdominal radical hysterectomy in patients with stage IB1 cervical cancer

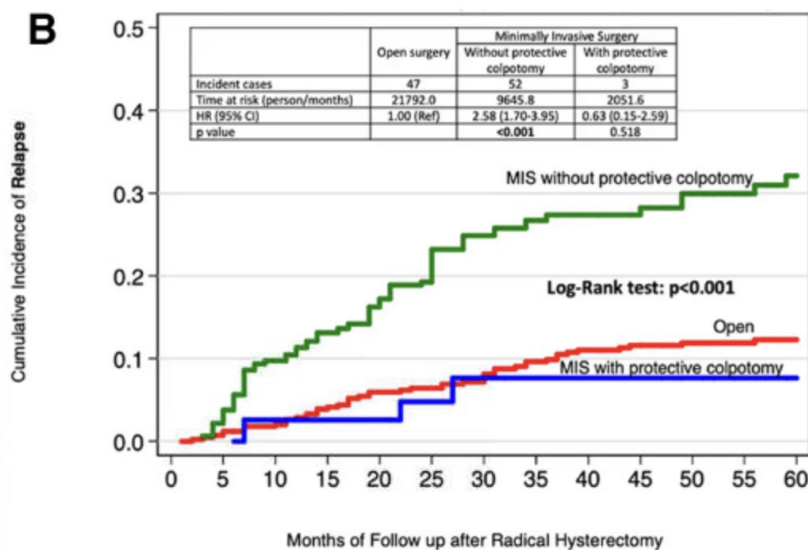
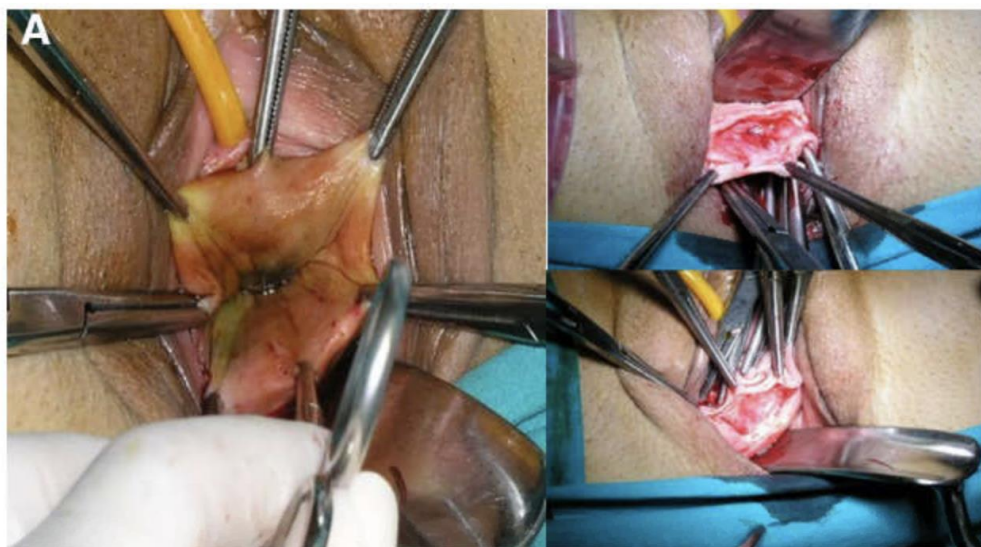
Luis Chiva<sup>1</sup>, Vanna Zanagnolo<sup>2</sup>, Denis Querleu<sup>3</sup>, Nerea Martin-Calvo<sup>4</sup>, Juan Arévalo-Serrano<sup>5</sup>, Mihai Emil Căpîlna<sup>6</sup>, Anna Fagotti<sup>7</sup>, Ali Kucukmetin<sup>8</sup>, Constantijne Mom<sup>9</sup>, Galina Chakalova<sup>10</sup>, Shamistan Aliyev<sup>11</sup>, Mario Malzoni<sup>12</sup>, Fabrice Narducci<sup>13</sup>, Octavio Arencibia<sup>14</sup>, Francesco Raspagliesi<sup>15</sup>, Tayfun Toptas<sup>16</sup>, David Cibula<sup>17</sup>, Dilyara Kaidarova<sup>18</sup>, Mehmet Mutlu Meydanli<sup>19</sup>, Mariana Tavares<sup>20</sup>, Dmytro Golub<sup>21</sup>, Anna Myriam Perrone<sup>22</sup>, Robert Poka<sup>23</sup>, Dimitrios Tsolakidis<sup>24</sup>, Goran Vujic<sup>25</sup>, Marcin A Jedryka<sup>26</sup>, Petra L M Zusterzeel<sup>27</sup>, Jogchum Jan Beltman<sup>28</sup>, Frederic Goffin<sup>29</sup>, Dimitrios Haidopoulos<sup>30</sup>, Herman Haller<sup>31</sup>, Robert Jach<sup>32</sup>, Iryna Yezhova<sup>33</sup>, Igor Berlev<sup>34</sup>, Margarida Bernardino<sup>35</sup>, Rasiyah Bharathan<sup>36</sup>, Maximilian Lanner<sup>37</sup>, Minna M Maenpaa<sup>38</sup>, Vladyslav Sukhin<sup>39</sup>, Jean-Guillaume Feron<sup>40</sup>, Robert Fruscio<sup>41,42</sup>, Kersti Kukk<sup>43</sup>, Jordi Ponce<sup>44</sup>, Jose Angel Minguez<sup>45</sup>, Daniel Vázquez-Vicente<sup>45</sup>, Teresa Castellanos<sup>45</sup>, Enrique Chacon<sup>46</sup>, Juan Luis Alcazar<sup>47</sup>, et al., On behalf of the SUCCOR study Group



**Figure 2** (A) Hazard ratios and 95% confidence intervals for the risk of relapse by type of surgical approach. Adjusted cohort using inverse probability weighting by propensity scores. (B) Hazard ratios and 95% confidence intervals for the overall survival by type of surgical approach. Adjusted using inverse probability weighting by propensity scores.

# SUCCOR study: an international European cohort observational study comparing minimally invasive surgery versus open abdominal radical hysterectomy in patients with stage IB1 cervical cancer

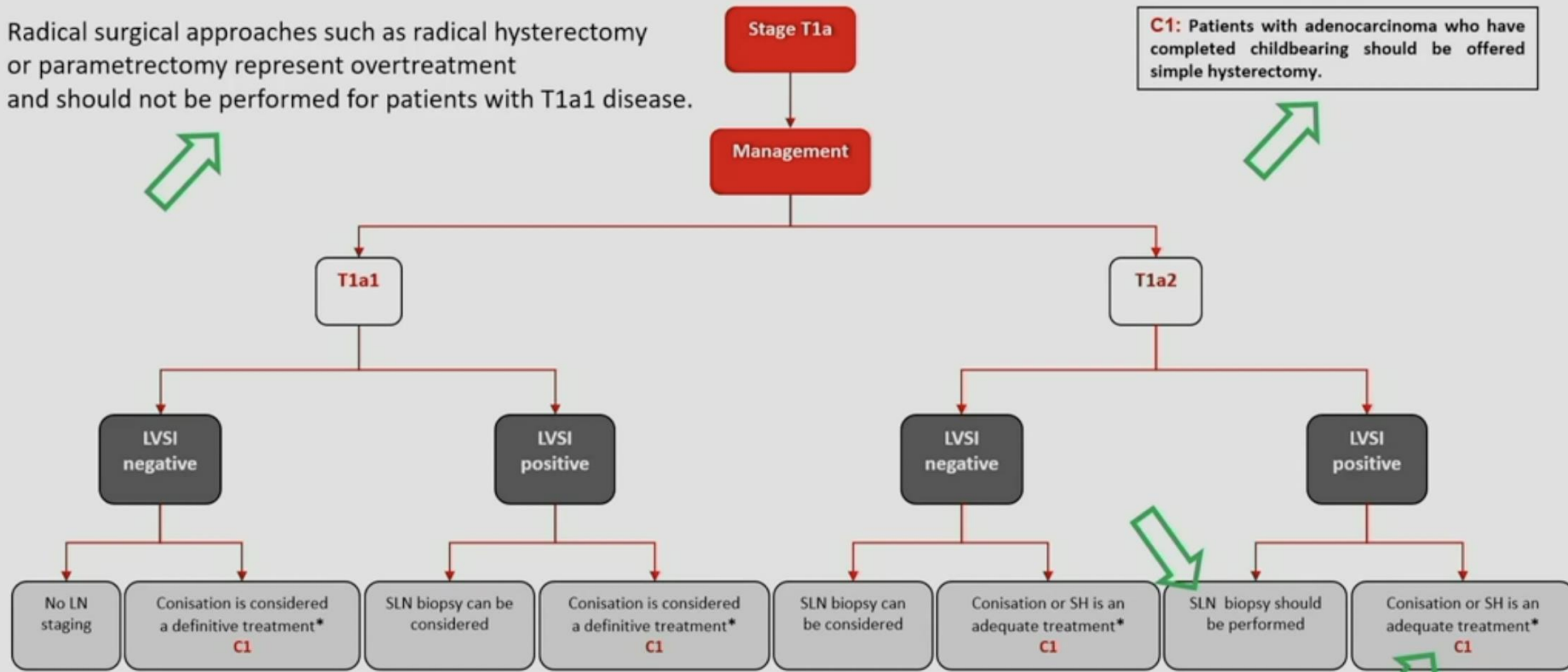
Luis Chiva<sup>1</sup>, Vanna Zanagnolo<sup>2</sup>, Denis Querleu<sup>3</sup>, Nerea Martin-Calvo<sup>4</sup>, Juan Arévalo-Serrano<sup>5</sup>, Mihai Emil Căpîlna<sup>6</sup>, Anna Fagotti<sup>7</sup>, Ali Kucukmetin<sup>8</sup>, Constantijne Mom<sup>9</sup>, Galina Chakalova<sup>10</sup>, Shamistan Aliyev<sup>11</sup>, Mario Malzoni<sup>12</sup>, Fabrice Narducci<sup>13</sup>, Octavio Arencibia<sup>14</sup>, Francesco Raspagliesi<sup>15</sup>, Tayfun Toptas<sup>16</sup>, David Cibula<sup>17</sup>, Dilyara Kaidarova<sup>18</sup>, Mehmet Mutlu Meydanli<sup>19</sup>, Mariana Tavares<sup>20</sup>, Dmytro Golub<sup>21</sup>, Anna Myriam Perrone<sup>22</sup>, Robert Poka<sup>23</sup>, Dimitrios Tsolakidis<sup>24</sup>, Goran Vujic<sup>25</sup>, Marcin A Jedryka<sup>26</sup>, Petra L M Zusterzeel<sup>27</sup>, Jogchum Jan Beltman<sup>28</sup>, Frederic Goffin<sup>29</sup>, Dimitrios Haidopoulos<sup>30</sup>, Herman Haller<sup>31</sup>, Robert Jach<sup>32</sup>, Iryna Yezhova<sup>33</sup>, Igor Berlev<sup>34</sup>, Margarida Bernardino<sup>35</sup>, Rasiyah Bharathan<sup>36</sup>, Maximilian Lanner<sup>37</sup>, Minna M Maenpaa<sup>38</sup>, Vladyslav Sukhin<sup>39</sup>, Jean-Guillaume Feron<sup>40</sup>, Robert Fruscio<sup>41,42</sup>, Kersti Kukk<sup>43</sup>, Jordi Ponce<sup>44</sup>, Jose Angel Minguez<sup>45</sup>, Daniel Vázquez-Vicente<sup>45</sup>, Teresa Castellanos<sup>45</sup>, Enrique Chacon<sup>46</sup>, Juan Luis Alcazar<sup>47</sup>, et al., On behalf of the SUCCOR study Group



**Figure 4** (A) Protective maneuver for the closure of the vagina over the tumor at the time of colpotomy, either at the beginning or at the end of the laparoscopic procedure to avoid the spillage of the cervical tumor. Courtesy of Dr. Aureli Torne and Dr. Jaume Pahisa. Clinic Hospital Barcelona Spain. (B) Hazard ratios and 95% confidence intervals for the risk of relapse by type of intervention in patients that underwent minimally invasive surgery (protective vaginal closure vs no protective vaginal closure) compared with patients with open radical hysterectomy adjusted using inverse probability weighting by propensity scores.

Radical surgical approaches such as radical hysterectomy or parametrectomy represent overtreatment and should not be performed for patients with T1a1 disease.

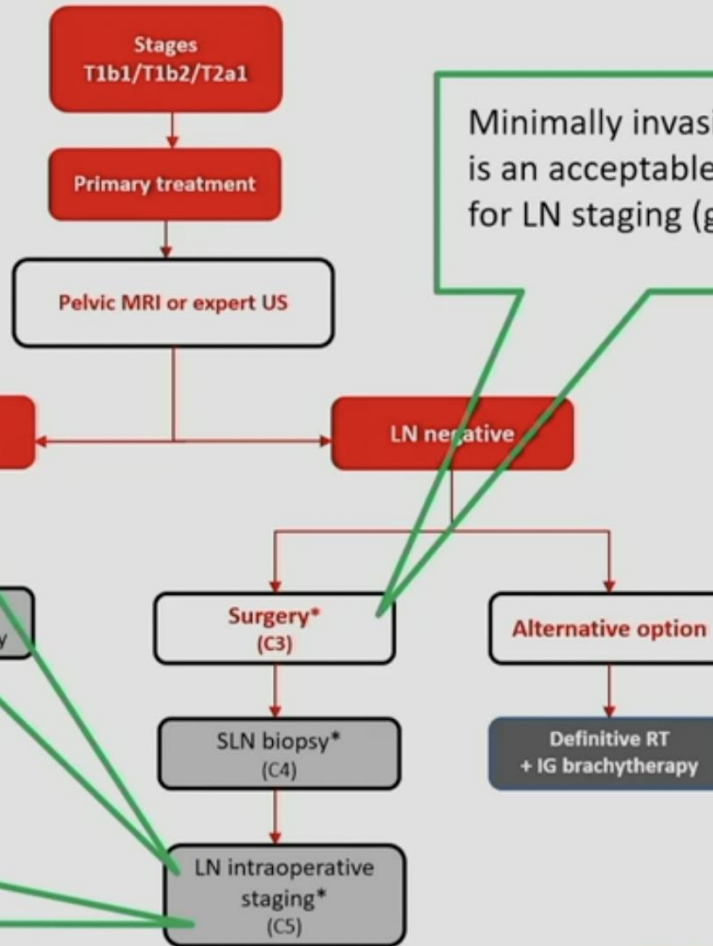
**C1:** Patients with adenocarcinoma who have completed childbearing should be offered simple hysterectomy.



- Stage T1a - Management -



Minimally invasive approach may be considered only in low risk tumours (<2cm and free margins after conisation), in high-volume centers experienced in performing radical hysterectomy with minimally invasive surgery, which meet the ESGO quality criteria for surgery, if patient agrees after comprehensive discussion about current evidence (grade C).



Minimally invasive surgery is an acceptable approach for LN staging (grade B).

Laparotomy is the standard approach for all procedures which include radical parametrectomy (grade A).

- Stages T1b1/T2a1 - Primary treatment -

# Traitement Chirurgical Exclusif – Recommandation CNGOF

- FIGO IA1 et IA2 : Hystérectomie non élargie aux paramètres
- FIGO IB1 à bas risque (Emboles – et <10mm invasion) :  
Hystérectomie élargie aux paramètres (option non élargie)
- FIGO IB1 non à bas risque (Emboles+ et/ou > ou= 10mm invasion), IB2 : Hystérectomie élargie aux paramètres
- Si chirurgie → Laparotomie recommandée afin de ne pas altérer la survie

# Les indications de CLAO

- Stade IB3-IIIB (localement avancé N- pelvien) → Non recommandé
- Stade IIIC1 (N+ pelvien) → CLAO recommandé (stratégie thérapeutique), mais le bénéfice pronostique n'est pas démontré.
  - Essai PAROLA
- Stade IIIC2 (N+ aortique à la TEP/TDM) → Non Recommandé

# Radio-chimiothérapie concomittante

- IB1, IB2 et IIA1 → RCC + curiethérapie si éléments suggérant une indication d'irradiation
- IB3, IIA2 et IIB → Pas de chirurgie, RCC + curiethérapie

# Take Home Message

- FIGO IA1 à FIGO IB2 → Conisation première ( Sélection des patientes à bas risque)
- Laparotomie est la voie d'abord recommandée afin de ne pas altérer la survie
- FIGO IA1 et IA2 :
  - Si emboles + → Evaluation ganglionnaire première
  - Hystérectomie non élargie aux paramètres par voie mini invasive possible
- FIGO IB1 à bas risque (Emboles – et <10mm invasion) :
  - Hystérectomie élargie aux paramètres (option non élargie, attente SHAPE),
  - Si < 2cm en exérèse complète à la conisation → voie mini invasive possible
- FIGO IB1 non à bas risque (Emboles+ et/ou > ou= 10mm invasion), IB2 :
  - Hystérectomie élargie aux paramètres