Poster (C24)
Cervical Cancer

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Treatment patterns and surgical outcome of stage IA1 cervical carcinoma

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Objective: To evaluate treatment patterns and surgical outcome of stage IA1 cervical cancer.

Methods: Patients with stage IA1 cervical cancer diagnosed between January 2001 and June 2018 at Chiang Mai University Hospital were retrospectively reviewed. The analysis included treatment patterns, surgical types, and clinicopathologic variables, i.e., nodal metastasis, parametrial involvement, positive surgical margins, deep stromal invasion, lymph-vascular space invasion, adjuvant treatment, and 5-year disease-free survival and 5-year overall survival. All pathologic slides were reviewed by gynecologic pathologists. Kruskal-Wallis test and Fisher's exact test, Kaplan-Meier method, and log-rank test were used for statistical analysis.

Results: One-hundred eighty-five patients were included in this study. Simple hysterectomy was the major treatment (57.3%) followed by modified radical hysterectomy and radical hysterectomy (27.6% and 9.7% respectively). Conization and radiation were chosen in few cases. At the median follow-up time of 40.8 months, the 5-year disease-free survival rate was 99.1% and the 5-year overall survival rate was 95.0%. Pelvic lymph node dissection was done in 62 cases (33.7%), but only one (0.54%) had pelvic lymph node metastasis.

Conclusion: Surgical and survival outcomes of women with stage IA1cervical cancer are excellent. These could be effectively treated by conservative treatment (simple hysterectomy and conization). Lymph node metastasis is rare in this stage, therefore, the lymphadenectomy could be omitted.

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Objective: Cervical cancer screening has been implemented nationwide since 1982 in Japan and managed by 1,737 local governments (LGs). In order to improve the level of quality assurance (QA), the Ministry of Health, Labour and Welfare (MHLW) released a guide in 2007 which contains QA instructions and implementation procedures. The aim of this study is to introduce the indicators for the QA structure in the cervical cancer screenings.

Methods: The MHLW and National Cancer Center (NCC) play roles in formulating the screening program's QA. We obtained cancer screening indicators from the NCC's website and MHLW's portal site which pertained to the QA structure.

Results: The guide described 2 main indicators for QA: one is a compliance rate using checklists which listed 50 structural criteria for conducting screening, and the other is a process indicator which is detailed screening results. NCC surveys compliance rate in each LG and publishes it as quality control indicators on their website. Regarding process indicators, all LGs submit annual screening results including the number of women who underwent screening, screen negative, referral, and detection to diagnose not only the cervical cancer but also cervical intraepithelial neoplasia (CIN) 3, CIN2, and CIN1 to the MHLW and they published detailed screening results by age group and screening histories.

Conclusion: The cancer screening programs established QA structures based upon compliance rates and process indicators, however comprehensive evaluation strategies need to be formulated for evaluating the screening activities in order to detect problematic issues and to improve QA.

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Active clinical trials of cervical cancer committee in KGOG

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Quality assurance for the cervical cancer screening program in Japan

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