JOURNAL OF CLINICAL ONCOLOGY

CORRESPONDENCE

Management and Care of Women With Invasive Cervical Cancer: ASCO Resource-Stratified Clinical Practice Guideline

TO THE EDITOR: *Journal of Global Oncology* recently published the ASCO resource-stratified guideline on caring for women with invasive cervical cancer.[1] Cervical cancer primarily affects women in low- and middle-income countries, where > 84% of incident cervical cancers and related death occurs. Cervical cancer is the fourth highest cause of cancer-related death in women. Mortality varies 18-fold among different regions of the world,[2] with the highest incidence in sub-Saharan Africa, South East Asia, Western Pacific Asia, and India. In these regions, efforts are in place to provide human papillomavirus vaccination and cervical cancer screening. The treatment and management of women with cervical cancer will become more feasible and crucial with diagnosis at earlier disease stages. Most available guidelines address women and clinicians in high-resource settings and are often not appropriate where one or more treatment modalities are lacking or limited.[3] Multidisciplinary treatment of women with cervical cancer is standard in high-resource settings. Women with early cervical cancer are treated with radical surgery or radiation, and concurrent chemoradiation or chemotherapy with biologic agents can achieve optimal outcomes for women with advanced cervical cancer.

In 2014, ASCO convened an Expert Panel to review the existing literature and guidelines on the treatment and management of cervical cancer in all resource settings. Guidelines identified included those from Canadian Cancer Care Ontario,[4,5] the European Society of Medical Oncology,[6] the Japan Society of Gynecologic Oncology,[7] the US National Comprehensive Cancer Network (NCCN),[8] and WHO.[9] Formal expert consensus was used when published evidence from low-resource settings was lacking.[10] ASCO adapted the four-resource tier approach developed by the Breast Health Global Initiative and adapted by Disease Control Priorities 3.[12,13] Approximately 1 year after we began working, in March 2015, the NCCN published resource-stratified guidelines on cervical cancer.[8,14-16] Although the ASCO Expert Panel found the NCCN guidelines helpful, it felt that several areas related to surgical and radiation management for women in lower-resource settings could benefit from further clarification and attention. The ASCO guideline provides recommendations for clinicians whose patients encounter large barriers to care and who cannot refer their patients to higher-resource settings for surgery and radiation therapy. Some options offered in the basic setting may be considered suboptimal in enhanced/maximal settings. Practitioners should offer treatments recommended for enhanced/maximal settings whenever possible or should refer patients to centers with these options.

A majority of patients in basic settings do not have access to surgeons trained to perform radical surgeries or to radiation treatment of a curative or palliative intent. In addition, low-resource countries/regions face great challenges in acquiring routine supplies of chemotherapy and radiation equipment, and in having access to personnel for women with locally advanced disease. In women with early-stage disease, basic/extrafascial hysterectomy or its modifications, or neoadjuvant chemotherapy followed by surgery, is recommended. The Panel based this conclusion on weak evidence but offered recommendations, rather than not offering these women any opportunities for disease control and survival. For women in the basic setting who have advanced disease, neoadjuvant chemotherapy followed by extrafascial surgery when feasible becomes the only viable option. In cases in which surgeons can perform radical surgery, but where there is a general lack of radiation machines, they may use shorter radiation fractionation schemes with curative intent. The Panel also addressed the settings in which brachytherapy is not available, where clinicians may perform extrafascial hysterectomy, or its modification, if there is limited residual tumor on the cervix. Using bony landmarks for treatment planning in settings in which simulators are not available is also suggested. The guideline also reviews palliative care, largely adapted from WHO's cervical cancer guideline palliative care chapter.[9]

ASCO recognizes that enormous gaps and disparities in access exist, especially in radiation therapy. More than 30 countries, most in sub-Saharan Africa, do not have radiotherapy machines (International Atomic Energy Agency).[17] Some authors call the disease

Table 1. Groups Working on Radiation Therapy Supply and Education in Basic/Limited-Resource Settings

American Society for Radiation Oncologists Association of Residents in Radiation Oncology
ASCO
Global Task Force on Radiotherapy for Cancer Control
International Atomic Energy Agency
Health Volunteers Overseas
International Gynecologic Cancer Society
Society for Gynecologic Oncology
Union for International Cancer Control

Table 2. Talking Points for Clinicians To Highlight With Policymakers in Basic/Limited-Resource Settings

Provide statistics on the number of new cases of cervical cancer per year per functioning radiation therapy machine
Provide statistics on the percent of all patients receiving radiotherapy who have cervical cancer
Emphasize the role of women as economic drivers
Highlight that when there is a lack of sufficient radiation therapy supplies, patients who have the means to travel outside of settings/countries to obtain therapy face individual and family stresses and clinicians lose opportunities to treat patients

burden and the lack of treatment "desperate" or a "crisis."[18] These experts and other groups have called attention to the lack of radiation equipment and trained personnel,[17,19-21] and other groups have highlighted the lack of access to surgery.[22] ASCO endorses these groups' efforts to address these issues and encourages their members to participate in international advocacy (Tables 1 and 2). Although the Expert Panel recognizes the potential of primary and secondary prevention, wider application in basic/limited settings may take decades. Therefore, the Panel encourages policymakers and other leaders to recognize the mortality, morbidity, loss of working-age women, and other opportunity costs to families and societies from invasive disease. Cervical cancer is a major public health problem requiring priority attention and funding commensurate with other common problems (eg, with water and infectious diseases) found in low-resource settings.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at www.jco.org.

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DOI: 10.1200/JCO.2016.68.3789; published online ahead of print at www.jco.org on July 5, 2016.

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No relationship to disclose

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No relationship to disclose

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No relationship to disclose

Jonathan S. Berek
Consulting or Advisory Role: Atara Biotherapeutics
Research Funding: Tesaro (Inst)