



Gynae Cancers

Vaginal

- Usually present with bleeding
- Spread is local and by lymphatics
- Treatment is usually radiotherapy
- Prognosis is poor (50% 5 year survival)

Cervical

Presentation

- Main cause is HPV (16, 18, 31, 33, 45)
- Risk factors: prolonged pill use, high parity, many sexual partners, early first sex, HIV, other STIs, smoking

Screening

- Aim to detect pre-invasive disease
- Screening smears every 3 years from 25 to 50, then if clear every 5 years to 65
- Screening: a one off smear results gives 20% reduction in cancer risk, every 5 years gives 85%, every 3 years gives 91%
- Smear are blind checked independently by two people, if there are any discrepancies the smear is checked again

Cervical Intraepithelial Neoplasia

Pre cancerous stage

- CIN1: mild cell changes
 - Colposcopy or repeat smear in 6 months
 - Return to normal screening after 3 normal 6 monthly smears
- CIN2: moderate cell changes
- CIN3: severe cell changes

Management of CIN2 & CIN3

- Removal of affected cells
- Laser ablation, cold coagulation, and cryotherapy treat just the part of the cervix that contains abnormal cells
- LLETZ (large loop excision of the transformation zone), cone biopsy and hysterectomy remove the whole area of the transformation zone - the area containing all the cells that could become precancerous or develop into cervical cancer

Invasive disease

Pathology

- Most are squamous cancers

Diagnosis

- Overt carcinoma is rarely detected on smear
- Non menstrual bleeding is classic symptoms

Management

- Depends on staging of tumour
- Hysterectomy +/- radiotherapy
- Chemotherapy in advanced disease / palliative management

Uterine / Endometrial

Presentation

- Risk factors: obesity, oestrogen therapy, family Hx (breast / ovarian / colon cancer), nulliparity, tamoxifen, pelvic irradiation, polycystic ovaries
- Most commonly occurs between 50 & 64 years
- Post menopausal bleeding - initially occasionally, then becoming heavier and more frequent

Diagnosis

- Examination may be normal
- Investigate with ultrasound
- If suspicious ultrasound / history hysteroscopy & biopsy

Pathology

- Most tumours start in the fundus and spread slowly
- May metastasize to pelvic lymph nodes, vagina or ovaries
- Staging
 - 1: in situ
 - 2: reaches cervical os
 - 3: spread beyond uterus but with pelvis
 - 4: spread beyond pelvis
- Most tumours are adenocarcinomas

Management

- Stage 1 & 2: total hysterectomy + bilateral salpingo-oophorectomy +/- radiotherapy
- If advanced disease consider radiotherapy / high dose progestogens which shrink the tumour
- Recurrent disease usually presents in the first 2 - 3 years; common sites: pelvis, lung, bone, vagina, liver

Ovarian

Presentation

- Varied and often late presentation - hence high mortality rate
- Asymptomatic; Swollen abdomen; Pressure effects (e.g. on bladder)
- Torsion (severe pain, potential for intermittent pain if tumour twists and untwists)
- Endocrine or metastatic effects
- Haemorrhage; Rupture +/- peritonism; Ascites

Risk factors

- If 2 close relatives affected lifetime risk is 40%
- Increased risk: if BRCA gene, those with many ovulations (late menopause, nulliparity), current HRT
- Reduced risk: combined OCP, breastfeeding, hysterectomy

Diagnosis

- Ultrasound can confirm presence of a mass
- Blood test Ca125: 80% sensitive but poor specificity (also raised in PID and endometriosis)

Pathology

- Majority are epithelial in origin, although hormone producing tumours are common
- Staging
 - 1: only ovaries (a = one ovary, b = two ovaries, c = with ascites)
 - 2: outside ovaries but within pelvis
 - 3: spread to abdomen
 - 4: distant mets

Management

- Most present at stage 3 or 4 (15% 5 year survival)
- Surgical tumour removal + 6 months chemo

Vulva

Presentation

- Vulva itching / soreness
- Obvious change in colour
- Noticeable lump

Higher risk groups

- Lichen Sclerosus
- HPV infection

Management

- Local excision
- Chemoradiation if extensive
- Good 5 year survival if no nodal involvement