| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
| IA1, LVSI negative, FS | 1A1 (negative margins): cone biopsy\(^1\) (with scalpel) Repeat cone biopsy or extrafascial hysterectomy for positive margins | 1A1 (negative margins): cone biopsy Repeat cone biopsy or extrafascial hysterectomy for positive margins | 1A1 (negative margins): cone biopsy | 1A1 (negative margins): cone biopsy Repeat cone biopsy, or extrafascial hysterectomy for positive margins. |
| | Type of recommendation: evidence-based Evidence: high Recommendation: strong | Type of recommendation: evidence-based Evidence: high Recommendation: strong | Type of recommendation: evidence-based Evidence: high Recommendation: strong | Type of recommendation: evidence-based Evidence: high Recommendation: strong |
| IA1, LVSI positive, FS | Cone biopsy in selected cases, if follow-up possible | Cone biopsy | Cone biopsy plus PLND (see Discussion regarding current evidence on FS sparing for women desiring fertility preservation) | Cone biopsy plus PLND |
| | Type of recommendation: consensus-based Evidence: intermediate Recommendation: weak | Type of recommendation: consensus-based Evidence: intermediate Recommendation: weak | Type of recommendation: evidence and consensus-based Evidence: high Recommendation: strong | Type of recommendation: evidence and consensus-based Evidence: high Recommendation: strong |
| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
|                 |         |       | OR radical trachelectomy plus pelvic LND | OR radical trachelectomy plus PLND (may offer ± SLN) |
| IA1, non-FS (no LVSI) | Type of recommendation: evidence and consensus-based | Evidence: intermediate | Recommendation: moderate | Type of recommendation: evidence and consensus-based | Evidence: intermediate | Recommendation: moderate |
| Cone biopsy (if follow-up possible) OR extrafascial hysterectomy,² then observe after initial cone biopsy, repeat cone, or extrafascial hysterectomy if margins are positive | Type of recommendation: evidence and consensus-based | Evidence: high | Recommendation: strong | |
| Cone biopsy (if follow-up possible); observe (after cone biopsy)³ OR extrafascial hysterectomy OR modified radical hysterectomy plus PLND OR if positive margins repeat conization⁴ | Type of recommendation: evidence and consensus-based | Evidence: high | Recommendation: strong | |
| Cone biopsy³ OR extrafascial hysterectomy² (extrafascial hysterectomy OR modified radical hysterectomy plus pelvic LND OR if positive margins repeat conization⁴) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong | Cone biopsy³ OR extrafascial hysterectomy² (extrafascial hysterectomy OR modified radical hysterectomy plus pelvic LN sampling if positive margins [may offer ± SLN] OR repeat conization⁴) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |
| Stage IA1 (with LVSI) and stage IA2: modified radical hysterectomy (when positive margins on repeat cone) plus PLND ± PANB (pelvic irradiation plus brachytherapy [with LVSI] if patient is not eligible for surgery) | Type of recommendation: evidence-based | Evidence: intermediate | Recommendation: moderate | Stage IA1 (with LVSI) and stage IA2: modified radical hysterectomy plus pelvic LND ± para-aortic (may offer ± SLN OR pelvic irradiation plus brachytherapy [if patient is not eligible for surgery]) | Type of recommendation: evidence-based | Evidence: intermediate | Recommendation: moderate |
| IA1, non-FS (with LVSI) | As above | Type of recommendation: consensus-based | Evidence: low | Recommendation: weak | |
| Stage IA1 (with LVSI) and stage IA2: modified radical hysterectomy | Type of recommendation: consensus-based | Evidence: low | Recommendation: weak | |
| Stage IA1 (with LVSI) and stage IA2: modified radical hysterectomy (when positive margins on repeat cone) plus PLND ± PANB (pelvic irradiation plus brachytherapy [with LVSI] if patient is not eligible for surgery) | Type of recommendation: evidence-based | Evidence: intermediate | Recommendation: moderate | |
### Management and Care of Women With Invasive Cervical Cancer: American Society of Clinical Oncology Resource-Stratified Clinical Practice Guideline

| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
| IA2 FS          |         | Cone biopsy (if follow-up possible) | Cone biopsy (if follow-up possible) | Cone biopsy plus PLND ± para-aortic LN sampling<sup>3</sup> | Cone biopsy plus pelvic LND ± para-aortic LN sampling<sup>3</sup> |
|                 |         | Type of recommendation: consensus-based Evidence: low Recommendation: weak | Cone biopsy (if follow-up possible) | Type of recommendation: evidence-based Evidence: low Recommendation: weak | Type of recommendation: evidence-based Evidence: low Recommendation: weak |
|                 |         |       |         | Radial tracheectomy plus PLND | Radial tracheectomy plus PLND |
|                 |         |       |         | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate |
| IA2, non-FS     |         | Cone biopsy (if follow-up possible) or extrafascial hysterectomy (non-FS) | Cone biopsy plus PLND ± para-aortic LN sampling<sup>3</sup> | Cone biopsy plus PLND ± para-aortic LN sampling<sup>3</sup> | See above |
|                 |         | Type of recommendation: evidence and consensus-based Evidence: low Recommendation: weak | Type of recommendation: evidence-based Evidence: low Recommendation: weak | Type of recommendation: evidence-based Evidence: low Recommendation: weak | |
|                 |         | Extrafascial hysterectomy | Modified radical hysterectomy plus PLND ± para-aortic LN sampling<sup>4</sup> | Modified radical hysterectomy plus PLND ± para-aortic LN sampling<sup>4</sup> | |
|                 |         | Type of recommendation: evidence-based Evidence: low Recommendation: weak | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate | |
|                 |         |       | Modified radical hysterectomy plus PLND ± para-aortic LN sampling<sup>4</sup> | Modified radical hysterectomy plus PLND ± para-aortic LN sampling<sup>4</sup> | OR pelvic RT and brachytherapy |
|                 |         |       | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate |
|                 |         |       | OR pelvic RT and brachytherapy | OR pelvic RT and brachytherapy |
| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|----------------|---------|-------|---------|----------|---------|
| IB1, FS        | No recommendation | No recommendation | Radical trachelectomy plus PLND (if adding trachelectomy > 2 cm) Adjuvant therapy may be needed for patients with tumors > 2 cm with risk factors | Radical trachelectomy plus pelvic LN sampling; may offer SLN | Type of recommendation: evidence-based Evidence: intermediate Recommendation: moderate |
| IB1, Non-FS    | Extrafascial hysterectomy Type of recommendation: consensus-based Evidence: insufficient Recommendation: weak | Radical hysterectomy plus PLND or radical hysterectomy (see Note) with adjuvant RT or RT with concurrent low-dose chemotherapy (concurrent chemoRT), if needed | Radical hysterectomy plus pelvic LND Type of recommendation: evidence-based Evidence: high Recommendation: strong | Radical hysterectomy plus PLND; may offer SLN Type of recommendation: evidence-based Evidence: high (SLN option, low) Recommendation: strong (weak) |
| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
| NACT if available, then extrafascial hysterecomy | ChemoRT or RT followed by extrafascial or radical hysterectomy (see Note) ± PLND ± PANB<sup>5</sup> If no RT is available but chemotherapy is available, NACT may be used to shrink the tumor to make it removable by surgery (extrafascial or modified radical hysterectomy [see Note] ± PLND ± PANB<sup>5</sup>) If the patient’s tumor does not shrink and is not resectable with negative margins, palliative measures, including best supportive care, ± chemotherapy should be offered | Pelvic RT plus brachytherapy plus concurrent low-dose platinum-based chemotherapy | Pelvic RT plus brachytherapy plus concurrent low-dose platinum-based chemotherapy |
| Type of recommendation: consensus-based Evidence: insufficient Recommendation: weak | Type of recommendation: evidence-based Evidence: low Recommendation: weak | Type of recommendation: evidence-based Evidence: high Recommendation: strong | Type of recommendation: evidence-based Evidence: high Recommendation: strong |

Note: NACT, neoadjuvant chemotherapy; RT, radiotherapy; PLND, pelvic lymph node dissection; PANB<sup>5</sup>, pelvic, abdominal, and nodal bundle.
### MANAGEMENT AND CARE OF WOMEN WITH INVASIVE CERVICAL CANCER:
#### AMERICAN SOCIETY OF CLINICAL ONCOLOGY RESOURCE-STRATIFIED CLINICAL PRACTICE GUIDELINE

| Type of Disease | Setting                                      |
|-----------------|----------------------------------------------|
|                 | Basic                                        | Limited                                      | Enhanced                                      | Maximal                                      |
| Note            | Wherever radical hysterectomy with concurrent chemoRT listed as a surgical option above, extrafascial hysterectomy is recommended if there is residual disease after RT or chemoRT with a boost of 68 Gy or initial tumor > 6 cm. Radical hysterectomy may be used following RT or chemoRT to a dose of 50 Gy |
| IB2 and IIA2    | If chemotherapy is available, use NACT followed by extrafascial hysterectomy; if chemotherapy is not available, extrafascial hysterectomy (modification as deemed necessary) may be performed if the surgical capacity is present |
|                 | If chemotherapy is available, NACT followed by radical hysterectomy (see Note) plus PLND ± para-aortic LN sampling may be an option⁴,⁶ |
|                 | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy |

Type of recommendation: consensus-based
Evidence: low
Recommendation: weak

Type of recommendation: evidence-based
Evidence: intermediate
Recommendation: moderate

Type of recommendation: evidence-based
Evidence: high
Recommendation: strong

Type of recommendation: evidence-based
Evidence: high
Recommendation: strong
| Type of Disease | Setting | | | |
|---|---|---|---|---|
| | Basic | Limited | Enhanced | Maximal |
| If EBRT is available, but not brachytherapy, then chemoRT followed by extrafascial hysterectomy or RT (if chemotherapy not available) followed by extrafascial hysterectomy (see Note) | | | |
| Type of recommendation: consensus-based Evidence: low Recommendation: weak | | | |
| OR if no EBRT is available, then brachytherapy and concurrent low-dose platinum-based chemotherapy followed by radical hysterectomy (see Note) | | | |
| When brachytherapy is not available, extrafascial or radical hysterectomy is recommended only when there is persistent central pelvic disease and selective lymphadenectomy or LN biopsy for suspicious lesions | | | |
| Type of recommendation: evidence and consensus-based Evidence: low/intermediate Recommendation: weak/moderate | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy plus adjuvant hysterectomy; adjuvant hysterectomy is not recommended except if evidence of presence of residual disease | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy plus adjuvant hysterectomy; adjuvant hysterectomy is not recommended except if evidence of presence of residual disease | |
| | Type of recommendation: evidence-based Evidence: intermediate Recommendation: weak | Type of recommendation: evidence-based Evidence: intermediate Recommendation: weak | |
| Type of Disease | Basic | Limited | Enhanced | Maximal |
|----------------|-------|---------|----------|---------|
| **Radical hysterectomy plus PLND ± para-aortic LN sampling** | | | | Radical hysterectomy plus pelvic LND ± para-aortic LN sampling and adjuvant RT or chemoRT if needed (plus RT ± concurrent low-dose platinum-based chemotherapy after hysterectomy if risk factors)³ |
| Type of recommendation: evidence-based | | | | Type of recommendation: evidence-based and consensus-based |
| Evidence: low | | | | Evidence: low |
| Recommendation: weak | | | | Recommendation: weak |

³ Type of recommendation: evidence and consensus-based
| Type of Disease | Setting | | | |
|---|---|---|---|---|
| | Basic | Limited | Enhanced | Maximal |
| Note | With risk factors on pathology specimen: adjuvant chemotherapy after hysterecomy | Adjuvant RT (intermediate risk) or with concurrent low-dose platinum-based chemotherapy (high risk) in a referral center | With risk factors on pathology specimen: adjuvant RT ± concurrent low-dose platinum-based chemotherapy after hysterecomy | With risk factors on pathology specimen: adjuvant RT ± concurrent low-dose platinum-based chemotherapy after hysterecomy |
| | Type of recommendation: evidence and consensus-based | Evidence: insufficient | Recommendation: weak | Type of recommendation: evidence-based | Evidence: intermediate | Recommendation: moderate |

IIA1  
See IB1  
See IB1  
See IB1  
See IB1

IIA2  
See IB2  
See IB2  
See IB2  
See IB2
| Type of Disease | Setting | Type of recommendation | Evidence | Recommendation |
|----------------|---------|------------------------|----------|----------------|
| IIB and IIIA   | Basic   | ChemoRT or RT followed by extrafascial or modified hysterectomy ± PLND ± PANB | insufficient | weak |
|                | Limited | NACT followed by extrafascial hysterectomy (modification as deemed necessary) | consensus-based | weak |
|                | Enhanced| Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy | low/intermediate | weak/moderate |
|                | Maximal | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy | insufficient | strong |
|                |         | Adjacent hysterectomy is an option only if residual disease after chemoRT |          | strong |
|                |         | Extrafascial or modified hysterectomy plus pelvic LND ± para-aortic LN sampling ± adjuvant therapy |          | weak |
|                |         | Extrafascial hysterectomy when chemotherapy is not consistently available | consensus-based | weak |
| Palliative care| Basic   | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy | evidence-based | strong |
|                | Limited | Adjacent hysterectomy is an option only if residual disease after chemoRT |          | strong |
|                | Enhanced| Extrafascial or modified hysterectomy plus pelvic LND ± para-aortic LN sampling ± adjuvant therapy |          | weak |
|                | Maximal | Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy |          | strong |
|                |         | Adjacent hysterectomy is an option only if residual disease after chemoRT |          | strong |
|                |         | Extrafascial hysterectomy when chemotherapy is not consistently available | consensus-based | weak |
|                |         | Extrafascial hysterectomy when chemotherapy is not consistently available | insufficient | weak |
|                |         | Extrafascial or modified hysterectomy plus pelvic LND ± para-aortic LN sampling ± adjuvant therapy |          | weak |
|                |         | Extrafascial or modified hysterectomy plus pelvic LND ± para-aortic LN sampling ± adjuvant therapy |          | weak |
|                |         | Extrafascial or modified hysterectomy plus pelvic LND ± para-aortic LN sampling ± adjuvant therapy |          | weak |
| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
| IIIB to IVA     | Palliative care | ChemoRT or RT\(^6\) followed by extrafascial or radical hysterectomy (see Note) ± PLND\(^7\) ± PANB | Pelvic RT plus brachytherapy plus concurrent low-dose platinum-based chemotherapy (in some cases extended-field RT) AND/OR palliative care | Pelvic RT plus brachytherapy plus concurrent low-dose platinum-based chemotherapy (in some cases extended-field RT) AND/OR palliative care |
|                 | Type of recommendation: evidence-based | Evidence: intermediate | Type of recommendation: strong | Evidence: high |
|                 | Evidence: insufficient | Recommendation: weak/moderate | Recommendation: strong |
| NACT followed by extrafascial hysterectomy | RT ± concurrent low-dose platinum-based chemotherapy (may offer systemic adjuvant chemotherapy) | RT + brachytherapy ± concurrent low-dose platinum-based chemotherapy (may offer systemic adjuvant chemotherapy) | RT + brachytherapy ± concurrent low-dose platinum-based chemotherapy (may offer systemic adjuvant chemotherapy) |
|                 | Type of recommendation: evidence-based | Evidence: intermediate | Type of recommendation: evidence-based | Evidence: intermediate |
|                 | Evidence: insufficient | Recommendation: weak | Evidence: low/intermediate | Recommendation: weak |
| Note            | Wherever radical hysterectomy with concurrent chemoRT listed as a surgical option above, extrafascial hysterectomy is preferred if there is residual disease or initial tumor > 6 cm | | | |
|                 | Type of recommendation: consensus-based | Evidence: intermediate | Evidence: intermediate | Evidence: high |
|                 | Evidence: insufficient | Recommendation: weak | Recommendation: weak | Recommendation: strong |
| Type of Disease | Setting | Basic | Limited | Enhanced | Maximal |
|-----------------|---------|-------|---------|----------|---------|
| IVB             |         |       |         |          |         |
| Palliative care and chemotherapy (if available) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Palliative care and/or chemotherapy ± individualized RT (palliative care may include palliative RT) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Chemotherapy ± individualized RT AND/OR palliative care | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Chemotherapy ± bevacizumab ± individualized RT AND/OR palliative care | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Recurrent       |         |       |         |          |         |
| Palliative care | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Depending on previous RT and either “no prior RT or failure outside of previously treated field”* (CERV-11) then may offer tumor-directed RT plus platinum-based chemotherapy |       |       |          |          |         |
| Depending on previous RT and central v noncentral disease: |       |       |          |          |         |
| Central disease: chemoRT or RT ± brachytherapy if no prior RT | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| If central and prior RT: exenteration Noncentral: chemotherapy, tumor-directed RT, and palliative care | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Prior RT plus central disease: pelvic exenteration OR radical hysterectomy OR brachytherapy (latter two “in carefully selected patients with small (< 2 cm) lesions”** (CERV-11)) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| Prior RT plus central disease: pelvic exenteration ± intraoperative RT OR radical hysterectomy OR brachytherapy (latter two “in carefully selected patients with small (< 2 cm) lesions” ** (CERV-11)) | Type of recommendation: evidence-based | Evidence: high | Recommendation: strong |       |         |
| AND/OR central disease: chemotherapy | Type of recommendation: consensus-based | Evidence: insufficient | Recommendation: weak |       |         |
| NOTE. this is best managed with exenteration (type of surgery that is not |       |       |          |          |         |
### MANAGEMENT AND CARE OF WOMEN WITH INVASIVE CERVICAL CANCER:
#### AMERICAN SOCIETY OF CLINICAL ONCOLOGY RESOURCE-STRATIFIED CLINICAL PRACTICE GUIDELINE

| Type of Disease | Setting | Maximal |
|-----------------|---------|---------|
| feasible to perform in low-resource setting | | Prior RT plus noncentral disease: tumor-directed RT ± chemotherapy OR resection with intraoperative RT for close or positive margins OR clinical trial OR chemotherapy plus bevacizumab AND/OR palliative care |
| Prior RT plus noncentral disease: chemotherapy or best palliative care | Prior RT plus noncentral disease: tumor-directed RT ± chemotherapy or best palliative care | NOTE. Before palliative care alone, try options such as RT boost, salvage surgery, or chemotherapy |
| Type of recommendation: evidence-based | Type of recommendation: evidence-based | Type of recommendation: evidence-based |
| Evidence: high | Evidence: high | Evidence: high |
| Recommendation: strong | Recommendation: strong | Recommendation: strong |

**NOTE.** Bold indicates addition of a recommended action over a previous resource level (eg, in limited setting, a bold action is one that was not recommended in basic).

Additional recommendations regarding settings with limited radiotherapy resources are provided in the main article.

Abbreviations: chemoRT, chemotherapy plus radiotherapy; EBRT, external-beam radiation therapy; FS, fertility sparing; LN, lymph node; LND, lymph node dissection; LVSII, lymphovascular space invasion; NACT, neoadjuvant chemotherapy; PANB, para-aortic node biopsy; PLND, pelvic lymph node dissection; RT, radiotherapy.

1. This option in basic level only if follow-up is available; 2. For negative margins or operable tumor or positive margins for dysplasia or carcinoma; 3. For negative margins or inoperable tumor; 4. Margins for dysplasia or carcinoma; 5. Selective lymphadenectomy or LN biopsy for suspicious lesions; 6. Recommended in setting where chemotherapy is not consistently available; 7. When brachytherapy is not available, extrafascial or radical hysterectomy is recommended only when there is persistent central pelvic disease and selective lymphadenectomy or LN biopsy for suspicious lesions

**References**

* Koh WJ, Greer BE, Abu-Rustum NR, et al: NCCN Guidelines Version 2.2015: Cervical Cancer Preliminary Resource Stratification—Limited Level. Fort Washington, PA, National Comprehensive Cancer Network, 2015

**Koh WJ, Greer, B.E., Abu-Rustum, NR, et. al.: NCCN guidelines version 2.2015: Cervical cancer preliminary resource stratification: Maximal level, National Comprehensive Cancer Network, Fort Washington, PA, 2015