Effects of Treatment of Uterine Cervical Carcinoma Monitored by Magnetic Resonance Imaging - Sarajevo Experience

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ABSTRACT

Goal: The goal of this study was the determination of the effects in treatment of early stage (≤IIB) and locally advanced stages (≥IIB) of uterine cervical carcinoma by using MRI. Material and Methods: The study was a prospective, comparative, analytical, and observational and included 74 patients with cervical cancer (PH confirmed). All 74 patients have initially gone through the pre-therapeutic MRI to determine the tumour FIGO stage. At a renewal of the initial MRI findings, patients were divided into two study groups: group A and group B. Group A consisted from 39 patients with early-stage cervical carcinoma (≤IIB) and group B comprised from 35 patients with locally advanced stage (≥IIB). Posttherapeutic MRI control, were performed in both group (A and B). Further MRI examinations were set for the patients from both groups. Results: An analysis of treatment outcomes in group A showed that most patients had no local recurrence or residuum disease in 89.7%, while local recurrence was observed in only 10.3% cases. An analysis of treatment outcomes in group B showed that most patients had complete regression after local chemoradiotherapy in 68.8%, while 25.7% of patients had local progression of the disease, while the 5.7% cases recorded partial local tumour regression(p<0.05).

It has been shown that a complete local regression was more frequent in the case of squamous cell carcinoma in 74.2% vs 25% in adenocarcinoma cases. Also local and partial regression was observed more frequently in the case of squamous cell carcinoma in 6.5% compared to 0% in adenocarcinoma, while progression was more common in adenocarcinoma at 75% compared to 19.4% for squamous cell (p<0.05). MRI results showed positive outcome of treatment group A and B comprised from 35 patients with locally advanced stage (≥IIB).

Conclusion: The results obtained from our studies show that early stage cervical cancer (<IIB) shows more complete regression after local chemoradiotherapy in 68.8% and local recurrence was observed in only 10.3% cases. An analysis of treatment outcomes in group B showed that most patients had no local recurrence or residuum disease in 89.7%, while local recurrence was observed in only 10.3% cases. An analysis of treatment outcomes in group B showed that most patients had complete regression after local chemoradiotherapy in 68.8%, while 25.7% of patients had local progression of the disease, while the 5.7% cases recorded partial local tumour regression(p<0.05).

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Keywords: cervical cancer, MRI, FIGO stage, surgical treatment, oncology treatment.

1. INTRODUCTION

Invasive cervical cancer is the fourth most common malignancy of women in the world and it holds a fourth place of death caused by cancer in women (1). It develops from precursor lesions, dysplasia, which may be cervical intraepithelial neoplasia (CIN) or adenocarcinoma in situ. The diagnosis of invasive cervical cancer is set using any of the following procedures: history and physical examination, gynaecological speculum and recto-vaginal palpation examination, the cervix cytology (Pap smear), HPV typing, colposcopy, biopsy, endocervical curettage. Regular gynaecological examinations and Pap smear screening test can greatly reduce the incidence rate of cervical cancer. Staging of the tumour can be evaluated using: ultrasound (US), magnetic resonance (MR), computer tomography (CT), positron emission tomography (PET) and bone scintigraphy. Determining the correct tumour stage is an important step in the treatment process, because it directly affects the choice of therapy and prognosis. Retrospective studies have shown that the disease is most often repeated within the first 2 years (2). As a result, most of the guide suggests routine monitoring of patients every 3-4 months during the first two years, after which the inspections are required every 6 months.

It is known that magnetic resonance...
is a “state of the art” method to estimate FIGO stage, treatment planning, monitoring after therapeutic treatment and monitoring survival (3, 4, 5). MRI is the method of choice in the evaluation of cervical cancer because it shows better results when determining the local extent of the tumour compared with physical examination and other imaging techniques (6, 7). Also, MRI is sovereign in determining the tumour response to treatment after chemoradiotherapy cycle, and in determining the after-effects on normal tissue (8, 9). The superiority of MRI is proven in comparison to all other techniques (6, 7). Also, MRI is sovereign in determining the tumour response to treatment after chemoradiotherapy cycle, and in determining the after-effects on normal tissue (8, 9).

2. GOALS

The goal of the study focused at determination of the effects of treatment of early stage (<IIB) and locally advanced stages (≥IIB) of uterine cervical carcinoma using magnetic resonance imaging.

3. MATERIALS AND METHODS

The study was a prospective, comparative, analytical, and observational and was made in the Clinical centre University of Sarajevo (KCUS) during 2013 through the year 2016. The study included 74 patients with cervical cancer, which were diagnosed using PH received from biopsy material. All patients (n = 74) have initially gone through the pre-therapeutic MRI to determine the tumour FIGO stage. The selection was made for the therapeutic treatment of patients. At a renewal of the initial MRI findings, patients were divided into two study groups, group A and group B. Group A consisted of 39 patients with early-stage cervical carcinoma (<IIB) who were candidates for surgical treatment. Group B is comprised of 35 patients with locally advanced stage of cervical cancer of the uterus (≥IIB), which were not candidate for surgical treatment. Their FIGO stage demanded a chemoradiation therapy treatment.

After appropriate therapeutic treatment, all patients in both groups underwent through a second MRI control, in order to assess therapeutic effects. Further MR1 examinations were set for the patients from both groups, and as per the oncological protocol were defined to be undertaken every four months, during the next three years.

Positive outcome of treatment in the group A is considered the tumour remission, while a negative treatment outcome was defined through a presence of recurrence or residuum.

Positive outcome of treatment in group B was considered a complete regression after radiochemotherapy, a negative outcome was defined as a partial regression or progression.

Outcomes of both groups were compared with the following parameters: patients age, FIGO stage of cancer, tumour size, PH tumour findings, the degree of differentiation of the tumour, the type of therapeutic treatment. The patients were examined by MRI apparatus Siemens (Germany) of 1.5T and GE (USA) of 1.5T. Gel was applied to vagina using T2 bright contrast medium in order to reach dilatation and better resolution of detail. The patients were given intravenous contrast medium based on gadolinium (Gadovist).

4. RESULTS

In our total sample (groups A and B), mostly consisted of six decades, in 37.8% of cases, while the average age of patients was 56.6 ± 12.3 years. There was no statistically significant difference (p > 0.05) in the average age among the group A of 58.4 ± 10.98 and group B of 54.4 ± 13.4. Table1 Looking at the entire sample (group A and B) we can observe that more squamous carcinoma type were present with n = 61 (82.4%) cases, in comparison to adenocarcinoma of the present n = 13 (17.6%) cases (p < 0.05). This proportion is retained in both study groups without statistically significant difference (p > 0.05). Squamous cell cancer of the group was present in 76.9%
of A, the group B of 88.6%, and adenocarcinoma of the group A of 23%, the group B of 11.4%.

Comparison of representation of squamous cell in comparison to adenocarcinoma its pointing to statistically significant difference in relation to the expected distribution both in the total sample ($\chi^2 = 31.135$, $p = 0.000$) and in certain groups, group A ($\chi^2 = 11.308$, $p = 0.001$) and group B ($\chi^2 = 20.829$, $p = 0.000$). Viewing grade shows that in the total sample (groups A and B) was the most represented G2 with $n = 41$ (55.4%) cases, followed by G3 with $n = 27$ (36.5%) cases, and at least G1 $n = 6$ (8.1%) cases. This relationship is maintained and in between the two groups with no statistically significant differences ($p> 0.05$). In group A represented by G2 of 56.4%; G3 33.3% and 10.3% of G1. In group B represented by 54.3% of G2 stage, G3 of 40%, and the G1 stage in 5.7% patients. Average length of tumours in group B was 53.9 ± 13.3 mm, with a minimum value of 10 mm, and the highest 76 mm, with a slightly greater length in the tumour and the stage IIIB was 56.6 ± 15.2 mm (40–76 mm) according to the stage IIIB tumours with an average length of 53, 5 ± 13.2 mm (10–70 mm) with no statistically significant difference ($p> 0.05$). An analysis of treatment outcomes in group A showed that most patients had no local recurrence or residuum disease $n = 35$ (89.7%), while local recurrence was observed in only $n = 4$ (10.3%) cases.

Statistical analysis by chi-square test shows that there is a statistical discrepancy in statistical significance of the expected distribution in favour of representation of patients without recurrence ($p < 0.05$). An analysis of treatment outcomes in group B showed that most patients had complete regression after local chemoradiotherapy $n = 24$ (68.8%), while $n = 9$ (25.7%) patients had local progression of the disease, while the un = 2 (5.7%) cases recorded partial local tumour regression (Figure 1).

Figure 4. Distribution of results of treatment – the degree of differentiation of tumours within the group B

Statistical analysis by chi-square test shows that there is a statistical discrepancy in statistical significance of the expected distribution for the benefit of complete regressions ($p < 0.05$). It has been shown that a complete local regression was more frequent in the case of squamous cell carcinoma in 74.2% compared to 25% in adenocarcinoma cases. Also local and partial regression was observed more frequently in the case of squamous cell carcinoma in 6.5% compared to 0% in adenocarcinoma, while progression was more common in adenocarcinoma at 75% compared to 19.4% for squamous cell (Figure 2).

These differences are statistically significant ($p < 0.05$). An analysis of treatment outcomes in relation to the age of patients in the group were not proven to be statistically significant. Analysis of treatment outcome in respect to the average size of the tumour, demonstrates the highest value of 55.9 ± 18.9 mm in the case of the progression, over 53.9 ± 11 mm in the case of total regression, and to 42.5 ± 14.8 mm in the case of partial regression, no statistically significant differences ($p> 0.05$). Analysing the outcome of group B, compared to the G stage, complete regression was observed in 1 patient (50%) in the group G1, 12 (63.2%) patients in group G2 and 11 (78.6%) patients in the group with the G3, with no statistically significant difference ($p> 0.05$). Progression occurred in 1 patient (50%) in the group G1, 5 (26.3%) patients in the group G 2 and the n = 3 (21.4%) patients in the group G 3, no statistically significant difference ($p > 0.05$). Partly regression was observed only in the group with the G2 and in 2 patients, which amounts to 10.5% of the cases with the PC grade (Figure 3).

Comparing the MRI results positive outcome of treatment group A and B in our sample, showed a statistically significant difference ($p < 0.05$) in favour of group A (89.7%) compared to group B (68.8%) (Figure 4).
5. DISCUSSION

It is imperative to make the proper MRI FIGO selection of patients with cervical cancer in order to receive appropriate therapeutic treatment.

Infiltration parametric (IIB) is the main diagnostic marker, because patients with lower FIGO stage, without infiltration parametric should be successfully operated, with no signs of recurrence of the tumour resection margin. (Figure 5, 6). For negative women with early-stage cervical cancer (<IIB), MRI helps determine the suitability of surgical treatment compared to primary chemo radiation treatment. (10, 11). Several studies, using preoperative MRI examination showed that in patients with early-stage cervical cancer MRI has a 94% precision and 95% negative predictive value for determining invasion parametric in the time of diagnosis. Multplan T2 sequences at MRI plays an important role in making a selection for therapeutic treatments among patients (12, 13, 14). Surgical treatment and radiation therapy are equally effective in the early stages of the disease, although for tumours of small volume (15). Younger patients may benefit from surgery for ovarian preservation and avoidance of vaginal atrophy and stenosis. Surgical treatment is indicated for most patients with stage IB and IIA cervical cancer. The classic surgical approach involves Wertheim-Meigs operation. It includes a total abdominal hysterectomy, resection of the upper third of the vagina, and excision parametria paravaginal saketutrine tissues including ligament and pelvic dissection paraaortic lymph nodes (16). Concomitant radiooncological treatment of cervical cancer varies depending on the stage of the disease, radiation dose and schedule of administration of Cisplatin and radiation, but shows significant benefit in survival when combined approach to therapy. Five randomized trials (GOG-85, RTOG-9001, GOG-120, GOG-123 and SWOG -8797) showed an overall survival advantage for Cisplatin therapy given concurrently with radiation therapy, and one study shows that this mode of therapy has no benefit (17, 18, 19). The risk of death from cervical cancer has declined from 30% to 50% when using chemoradiation in the total sample of our study (<IIB and ≥IIB). Mostly consisted of six decades, in 37.8% of cases, and when the average age of patients was 56.6 ± 12.3 years, with no significant differences between early and advanced stages. A similar survey of French population states that top the incidence was between 40 and 49 years of age, with a mean age of 52 ± 16.4 years (20). The total sample was significantly more common squamous (82.4%) compared to adenocarcinoma no statistically significant differences between early and advanced stages. Dominated the G2 was in 55.4%, G3 in 36.5% and G1 in 8.1% of cases, with no significant difference. The average length of tumor was 53.9 ± 13, 3 mm, with a minimum value of 10 and maximum of 76 mm. Elmarjany Research shows that the median size of tumors in their patients was 48 ± 16 mm from the domination of squamous cell with 86.2% (21).

The results indicate that there is no statistically significant difference in length compared to the tumours in advanced stages of the stages of cervical cancer, although it was slightly higher in stage IIB and was 56.6 ± 15.2 mm (40-76 mm) as compared to stage IIIb with an average length of tumours from 53.5 ± 13.2 mm (10-70 mm).

When it comes to the early stages of cervical cancer (<IIB) in our study, there was a statistically and significantly more patients with the absence of tumours after treatment in the OP 89.7%, while the relapse was recorded only in 10.3% of cases. A survey conducted in Serbia showed that relapse after surgical treatment with radical hysterectomy occurred in 12.5% of patients (22).

In advanced stages of cervical cancer (≥IIB), after radio/chemo treatments in our study, a complete tumour was achieved regression in 68.8%, indicating a statistically significant difference with respect to progression (25.7%) and partial regression (5.7%). Study Naghi and his associates is showing nearly identical results for the same period of monitoring (23). Our studies, as well as Zhang and associates from China showed statistically significant better response to radio/chemo therapy from squamocellular tumours of the cervix of 74% compared to 25% of adenocarcinomas, with statistically no significant difference in the tumour size (24).

After radio/chemo therapy we had complete regression of 50.0% in the group with G1, over 63.2% in the group with G2 to 78.6% in the group with the G3, but no statistically significant difference. In a similar study, conducted by Heller and his associates in Croatia, the statistically significant difference has not been proven in radio sensitivity between poorly and well-differentiated tumours (25). There were no statistically significant differences between the patient’s age and tumour successfully treated through radio/chemo therapy. Our results show that the complete regression was more frequent in stage IIB (80%) compared to stage IIIb (66.7%). West and his associates haven’t reached statistically significant differences in results when it comes to a comparison of success in radio/chemo therapy. Our results show that this mode of therapy has no benefit (17, 18, 19). These results suggest that in patients with advanced tumour stage (≥IIB), its height tumour stage, tumour grade, tumour length and age of the patient are not independent factors to the success of treatment and different influence on the individual therapeutic result radio/chemo therapy. In contrast, PH type of cervical cancer significantly affects the therapeutic response. Squamous cell type compared to adenocarcinoma shows better treatment outcome and prognosis. Comparison of our results in a three-year study, a total sample of n = 74 patients showed that significantly better outcome of treatment in terms of the absence of tumours in the early stages of 89.7% (<IIB) in relation to the locally advanced cervical carcinoma from 68, 8% (≥IIB).

6. CONCLUSION

The results obtained from our studies show that early stage cervical cancer (<IIB) shows a better outcome of treatment of advanced stages (≥IIB). In the treatment of advanced stages (≥IIB), concomitant radio chemotherapy shows significant results in terms of complete tumour regression, especially in squamous cell type of cervical cancer.

• Author’s contribution: Amela Sofić: substantial contribution to conception and design, acquisition of data, final approval of the version to be published. Azra Rasic, Dzenana Begic and Anja Tomic: collection of data, substantial contribution to acquisition
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