CERVICAL CANCER

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Abstract: Endometrial cancer is a malignant tumor originating from the epithelium (cell layer) of the uterine body. A uterine tumor is one of the most common malignant neoplasms in women. Uterine cancer affects women, mainly aged 50 to 65 years, less common among women younger than 50 years.

Keywords: infertility, obesity, hyperglycemia, diabetes mellitus, uterine cancer.

There are two main types of endometrial cancer (RE). Hormone-dependent uterine cancer is more common in women aged 45 to 50 years who had a history of polycystic ovary syndrome, infertility, obesity, hyperglycemia, diabetes mellitus, uterine bleeding. Many precancerous conditions play a significant role in the development of uterine cancer. These are scars remaining after birth trauma, ulcers, erosion, leukoplakia, epithelial overgrowth (polyps, warts), inflammatory processes (endometritis and endocervicitis). In the treatment of endometrial cancer, depending on the prevalence of the process, we use all types of cancer therapy – radiotherapy, removal of uterine tumors, hysterectomy (removal of the uterus), endometrial resection, supravaginal amputation of the uterus, chemotherapy, hormone therapy of uterine tumors. Uterine Cancer Surgery In 80%, cancer of the uterine body is diagnosed at 1-2 stages, and the tumor of the uterus can be cured with the help of surgical methods alone or a combination of surgical methods and radiation therapy. Surgical treatment consists of hysterectomy (removal of the uterus); ovaries (ovariectomy) and fallopian tubes are also often removed, i.e. appendages are removed, since these organs are usually affected with any spread of a cancerous tumor. Due to the fact that ovarian removal for women who have not reached menopause may be associated with possible emotional problems characteristic of menopause, we necessarily provide psychological and emotional support, as well as counseling to all

women. Radiation therapy for uterine cancer In common stages, radiation therapy is used in addition to surgical treatment with the second stage or as monotherapy.

For remote therapy, we use VARIAN linear accelerators. Individual planning, the presence of collimators that allow you to create radiation fields according to the shape of the tumor, significantly reduces the risk of side effects of radiation. According to the indications, it is possible to use a combination of remote and intracavitary radiotherapy (brachytherapy). The use of high-dose brachytherapy allows the maximum dose to be brought to the tumor in the shortest period of time, which significantly improves the effectiveness.

The main symptom of endometrial cancer is uterine bleeding (spotting of varying intensity), in rare cases – pain. In young women of reproductive age, the symptoms of the disease are manifested by a violation of menstrual functions – abundant menstrual or intermenstrual bleeding. Pain indicates the prevalence of the process. It may be associated with the compression of nerve trunks by the infiltrate formed or with the fact that the contents of the uterine cavity stretch its walls. Symptoms of uterine cancer: copious vaginal discharge with mucus impurities; intense spotting; pain in the lower abdomen.

Cervical cancer is usually a squamous cell carcinoma, less often an adenocarcinoma. The cause of most types of cervical cancer is human papillomavirus infection. Cervical neoplasia is often asymptomatic; the first symptoms of cervical cancer are usually irregular, often it can be postcoital bleeding. Diagnosis includes a cervical Pap test and a biopsy. If possible, the clinical stage of the disease is determined in combination with the results of visualization and pathological examination. At an early stage of the disease, treatment usually includes surgical resection or radiation therapy in combination with chemotherapy in case of local spread of the disease. If the cancer gives extensive metastases, chemotherapy is often used as the only method.

Cervical cancer in the early stages may be asymptomatic. When symptoms appear, they usually include irregular vaginal bleeding, which can be postcoital, or sometimes spontaneously occur between menstruation. Larger tumors are more likely to manifest

spontaneous bleeding, and can also cause discharge with an unpleasant odor or pelvic pain. With a more extensive spread of cancer, obstruction of the urinary tract may occur, back pain may appear, swelling of the lower extremities due to venous or lymphatic obstruction.

A gynecological examination can reveal an exophytic necrotic tumor of the cervix; however, most types of cervical cancer cannot be seen without magnification.

The staging of cervical cancer has undergone significant changes in 2018. The previous FIGO 2009 staging system for determining the stage allowed only a clinical examination, a cervical biopsy and several additional tests. The FIGO 2018 staging system allows, if possible, to perform cross-sectional imaging (for example, ultrasound, CT, MRI, positron emission tomography [PET], PET-CT, MRI-PET) and obtain the results of surgical research methods to supplement clinical data at all stages. The results of imaging or pathohistological studies are not mandatory, since they may not be available in low- and middle-income countries where cervical cancer is more common.

Other changes to the 2018 staging system include the following. The horizontal spread of the tumor is no longer considered part of stages IA1 and IA2.Stage I is divided into 3 subgroups depending on the size of the tumor (IB1 < 2 cm, IB2 from 2 to < 4 cm, and IB3 ≥ 4 cm) instead of 2 subgroups (stages IB1 and IB2, which used only 4 cm as the boundary value).

The condition of the lymph nodes is currently part of the staging system. Positive pelvic lymph nodes currently belong to stage IIIC1, and positive paraaortic lymph nodes belong to stage IIIC2. Micro metastases in lymph nodes are considered positive; although these isolated tumor cells do not change the stage to III, they must be documented. If the lymph nodes are classified as positive using imaging methods, r is added to the stage (for example, IIIC1r, IIIC2r); if they are classified as positive by pathology results, add p (IIIC1p, IIIC2p [2, 3, 4]).

If stage > IA2, as a rule, CT or MRI of the abdominal cavity and pelvis are performed to more accurately determine the size of the tumor, damage to parametrism, vaginal disorders and nodular metastases. PET with CT (PET/CT) is often used to check for spread beyond the cervix. If it is impossible to perform PET/CT, MRI or CT for the

clinical staging of the disease, cystoscopy, sigmoidoscopy, chest X-ray and intravenous urography can be used.

If visual diagnostic methods suggest a significant increase in pelvic or para-aortic lymph nodes (> 2 cm), diagnostic surgery is sometimes prescribed, usually with retroperitoneal access. Its sole purpose is to remove enlarged lymph nodes so that the use of radiation therapy is more targeted and effective.

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