

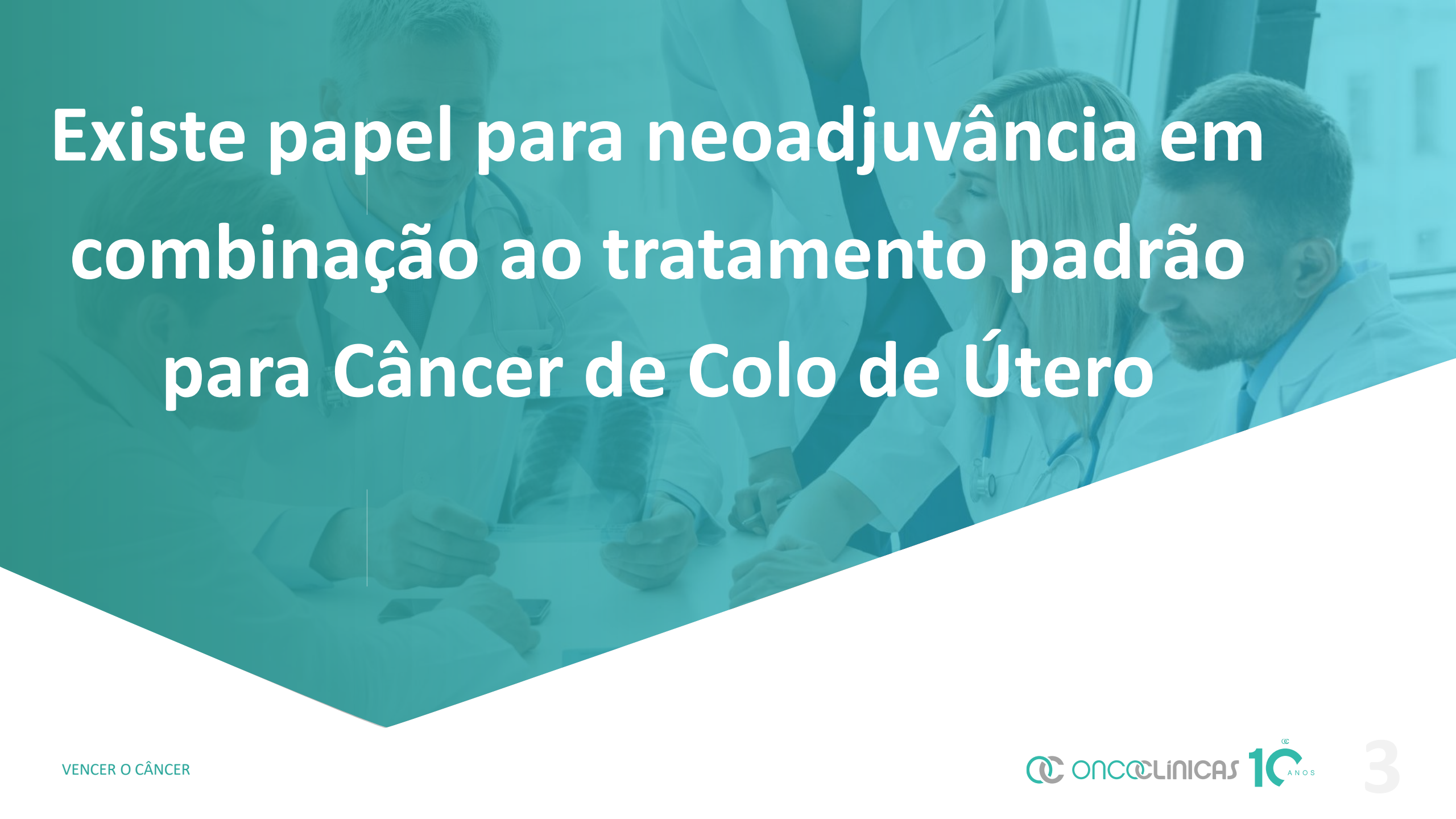
The background is a solid teal color. In the upper half, there are faint, semi-transparent icons: a human silhouette with internal organs, a brain scan, and a medical report card. The report card has the following text: "MEDICAL REPORT", "12/08/1988", "02 43 080", "586 39 403", "253 684 01", and "99 RP_809". In the lower half, there is a faint, semi-transparent image of a doctor in a white coat with a stethoscope around their neck.

@ ONCO@CLINICAS 10 ANOS

Sessão Clínica Ginecológica Câncer de Colo de Útero

Diocésio Andrade

Diretor Técnico – InORP Grupo Oncoclínicas

A photograph of several medical professionals in white coats and stethoscopes, gathered around a table in a clinical setting, looking at documents and discussing. The image is overlaid with a semi-transparent teal filter.

Existe papel para neoadjuvância em combinação ao tratamento padrão para Câncer de Colo de Útero

De acordo com a resolução do Conselho Federal de Medicina nº 1595/2000 e Resolução da Diretoria Colegiada da ANVISA nº 96/2008, eu declaro que:

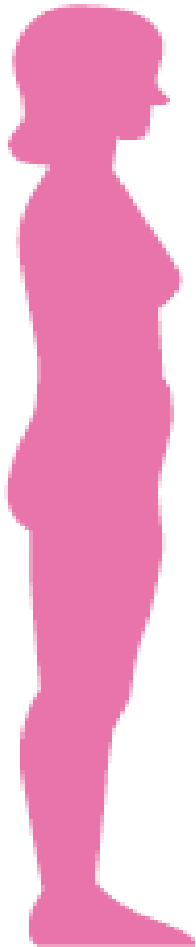
- *Pesquisa Clínica – Como investigador: Roche, Bristol-Myers Squibb*
- *Apresentações científicas – Como palestrante: Novartis, Bayer, MSD, Sanofi*
- *Atividades de Consultoria – Como membro de Advisory Boards: MSD*

Declaro não ter ações em bolsa de valores das empresas supracitadas.


Meus pré-requisitos para participar destas atividades são o intercâmbio científico, a autonomia do pensamento científico, independência de opinião e liberdade de expressão.

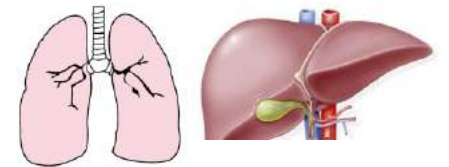
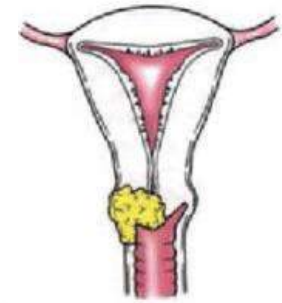
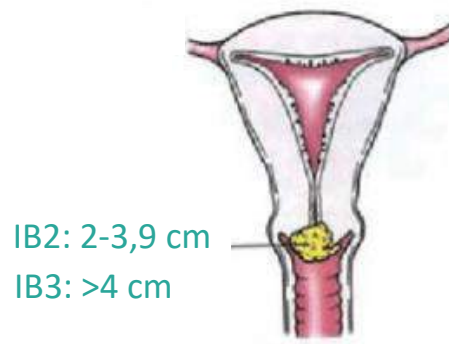
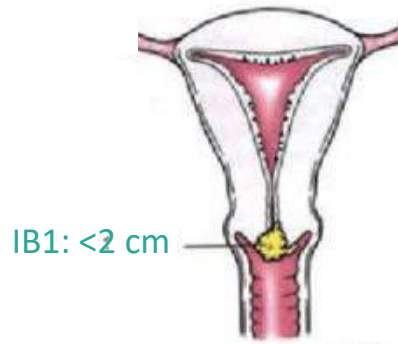
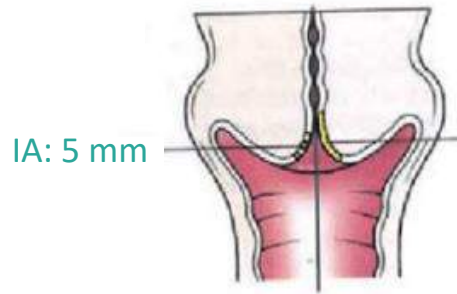
- ✓ **Epidemiologia.**
- ✓ **Estadiamento FIGO 2018 e tratamentos padrões**
- ✓ **QT neoadjuvante**
 - ✓ **Associada à Preservação de Fertilidade**
 - ✓ **Associada à Cirurgia ou à Radioterapia**
 - ✓ **Associada à Radioquimioterapia**
 - ✓ **Países subdesenvolvidos**
- ✓ **Conclusões**

Females



Breast	276,480	30%
Lung & bronchus	112,520	12%
Colon & rectum	69,650	8%
Uterine corpus	65,620	7%
Thyroid	40,170	4%
Melanoma of the skin	40,160	4%
Non-Hodgkin lymphoma	34,860	4%
Kidney & renal pelvis	28,230	3%
Pancreas	27,200	3%
Leukemia	25,060	3%
All Sites	912,930	100%

	Localização Primária	Casos	%
Mulheres 	Mama feminina	66.280	29,7%
	Cólon e reto	20.470	9,2%
	Colo do útero	16.590	7,4%
	Traqueia, brônquio e pulmão	12.440	5,6%
	Glândula tireoide	11.950	5,4%
	Estômago	7.870	3,5%
	Ovário	6.650	3,0%
	Corpo do útero	6.540	2,9%
	Linfoma não Hodgkin	5.450	2,4%
	Sistema nervoso central	5.220	2,3%



Estádio I – limitado ao útero

IA – diagnosticado pela microscopia (invasão estromal < 5 mm)

IA1 – invasão estromal ≤ 3 mm.

IA2 – invasão estromal > 3 mm e < 5 mm

IB – lesão clínica confinada ao colo; lesão microscópica > IA

IB1 – carcinoma invasivo ≥ 5 mm e < 2 cm na maior dimensão

IB2 – lesão invasiva ≥ 2 cm e < 4 cm na maior dimensão

IB3 - lesão ≥ 4 cm na maior dimensão

TRATAMENTO PADRÃO: CIRURGIA

- ✓ Conização ou traquelectomia
- ✓ Histerectomia total
- ✓ Histerectomia radical
- ✓ Pesquisa de linfonodo sentinela
- ✓ Linfadenectomia pélvica bilateral
- ✓ Tratamento adjuvante na dependência de fatores de risco
- ✓ EC IB3/IIA – transição entre cirurgia e QT + Rxt

Estádio II – invasão além do útero (sem parede pélvica ou terço inferior vagina)

- ✓ IIA – acometimento 2/3 superiores da vagina sem comprometimento paramétrios
 - ✓ IIA1 – carcinoma invasivo < 4 cm na maior dimensão
 - ✓ IIA2 – carcinoma invasivo ≥ 4 cm na maior dimensão
- ✓ IIB – invasão óbvia dos paramétrios sem acometimento de parede pélvica.

TRATAMENTO PADRÃO: QT + Rxt externa + Braquiterapia

- ✓ Cisplatina 40 mg/m²/semana x6
- ✓ Rxt externa 50,4 Gy → Braquiterapia: 30-35 Gy

Opção:

- ✓ Cisplatina 40 mg/m²/semana + Gemcitabina 125 mg/m²/semana x6
- ✓ Rxt externa 50,4 Gy → Braquiterapia: 30-35 Gy
- ✓ 2 ciclos Cisplatina 50 mg/m² D1 + Gemcitabina 1000 mg/m² D1-D8
- ✓ EC IVA – transição entre QT + Rxt e tratamento paliativo

Estádio III – invasão da parede pélvica e/ou terço inferior da vagina e/ou hidronefrose

- ✓ IIIA – terço inferior da vagina sem extensão para parede pélvica
- ✓ IIIB – extensão até parede pélvica e/ou hidronefrose e/ou insuficiência renal
- ✓ IIIC – metástase para linfonodos pélvicos e/ou para-aórticos
 - ✓ IIIC1 – metástases em linfonodos pélvicos apenas
 - ✓ IIIC2 – acometimento de linfonodos para-aórticos

TRATAMENTO PADRÃO: QT + Rxt externa + Braquiterapia

- ✓ Cisplatina 40 mg/m²/semana x6
- ✓ Rxt externa 50,4 Gy → Braquiterapia: 30-35 Gy

Opção:

- ✓ Cisplatina 40 mg/m²/semana + Gemcitabina 125 mg/m²/semana x6
- ✓ Rxt externa 50,4 Gy → Braquiterapia: 30-35 Gy
- ✓ 2 ciclos Cisplatina 50 mg/m² D1 + Gemcitabina 1000 mg/m² D1-D8
- ✓ EC IVA – transição entre QT + Rxt e tratamento paliativo

Estádio IV – acometimento além da pelve verdadeira ou invasão da mucosa da bexiga ou reto

IVA – invasão de órgãos adjacentes

IVB – doença à distância

TRATAMENTO PADRÃO: QT paliativa

- ✓ Paclitaxel 175 mg/m² + Cisplatina 50 mg/m² + Bevacizumabe 15 mg/Kg
- ✓ Paclitaxel 175 mg/m² + Topotecan 0,75 mg/m² D1-D3 + Bevacizumabe 15 mg/Kg
- ✓ Paclitaxel 175 mg/m² + Cisplatina 50 mg/m²
- ✓ Paclitaxel 175 mg/m² + Cisplatina 70 mg/m² + Ifosfamida 1,5 g/m²
- ✓ Cisplatina 50 mg/m² + Gemcitabina 1000 mg/m²
- ✓ Paclitaxel 175 mg/m² + Carboplatina AUC 5 (Ins. Renal)

- ✓ Avaliação de sensibilidade à quimioterapia¹
- ✓ Redução do comprometimento de estruturas adjacentes²
- ✓ Tratamento de doença microscópica²
- ✓ Diminuição do volume tumoral com melhora da ação da radioterapia (fração hipóxica)³
- ✓ Nos países subdesenvolvidos, antes do planejamento da radioterapia⁴

1. Napolitano U., et al. *Eur J Gynaecol Oncol* 2003;24(1):51-9.
2. González-Martín A., et al. *Gynecol Oncol* 2008;110(3 Suppl 2):S36-40.
3. Movva S., et al. *Cancer* 2009;115(14):3166-80.
4. Candelaria M., et al. *World J Surg Oncol* 2006;4:77-87.

- ✓ **Tratamento para preservação da fertilidade**
- ✓ **Quimioterapia neoadjuvante antes da cirurgia**
- ✓ **Quimioterapia neoadjuvante antes da radioterapia**
- ✓ **Quimioterapia neoadjuvante antes da radioquimioterapia**

IB1 e IB2
Paciente jovem com desejo
de manter fertilidade



Traquelectomia

IB2, IB3
IIA, IIB
IIIA, IIIB, IIIC



Tratamento

IB1 e IB2

**Paciente jovem com desejo
de manter fertilidade**



Traquelectomia

Neoadjuvant chemotherapy and conservative surgery for stage IB1 cervical cancer[☆]

- ✓ 51 pacientes; ≤ 40 anos; tumor ≤ 3 cm
- ✓ QT neoadjuvante
 - ✓ 3 ciclos de Cisplatina 75 mg/m²; Paclitaxel 175 mg/m²; Ifosfamida 5 g/m² (Epirrubicina 80 mg/m²).
- ✓ Cirurgia
 - ✓ Traquelectomia + linfadenectomia pélvica
 - ✓ Se congelação + → histerectomia total
- ✓ 30 pacientes não aceitaram tratamento conservador
- ✓ 21 pacientes incluídas (12 adenocarcinoma)

RESPOSTA PATOLÓGICA	PACIENTES (%)
COMPLETA	5 (24)
Carcinoma <i>in situ</i> residual	3 (14)
Tumor residual de 1-3 mm	9 (43)
Tumor residual > 3 mm	4 (19)

- ✓ 4 inelegíveis para tratamento conservador; 1 recusa (HTA)
- ✓ 9 pacientes tentaram engravidar
- ✓ 6 pacientes ficaram grávidas: 10 gravidezes
- ✓ 1 aborto no primeiro trimestre
- ✓ 8 gravidezes a termo

Oncological and pregnancy outcomes after high-dose density neoadjuvant chemotherapy and fertility-sparing surgery in cervical cancer

- ✓ 28 pacientes; ≤ 35 anos; sem critérios para cirurgia de preservação da fertilidade (tumor > 2 cm e infiltrando > metade do estroma)
- ✓ QT neoadjuvante dose-densa
 - ✓ Cisplatina/Ifosfamida para CEC (15 pacientes)
 - ✓ Cisplatina/Doxorrubicina para adeno (13 pacientes)
- ✓ Cirurgia
 - ✓ Traquelectomia + linfadenectomia pélvica
 - ✓ Se congelação + ou linfonodo + → histerectomia total

RESPOSTA PATOLÓGICA	PACIENTES (%)
COMPLETA	6 (21,4)
Doença microscópica	11 (39,3)
Doença macroscópica	11 (39,3)

- ✓ 10 mulheres sem preservação da fertilidade
- ✓ 4 mulheres após preservação da fertilidade com recidiva
- ✓ 2 óbitos devido a doença
- ✓ 10 pacientes ficaram grávidas; 8 pacientes tiveram os bebês
- ✓ 6 gravidezes a termo; 4 pré-maturos
- ✓ 3 abortos (2 no segundo trimestre; 1 no primeiro trimestre)

IB1 e IB2
Paciente jovem com desejo
de manter fertilidade



Traquelectomia

IB2, IB3
IIA, IIB
IIIA, IIIB, IIIC



Tratamento

QT neoadjuvante – Cenários

**IB2, IB3
IIA, IIB
IIIA, IIIB, IIIC**

**QT
Neo**

Tratamento

QT neoadjuvante → Tratamento local
versus
Tratamento local

- ✓ 18 trials; 2074 pacientes
- ✓ Alto nível de heterogeneidade estatística
- ✓ Separação dos trials em grupos para análises
 - ✓ Intervalo entre os ciclos de QT
 - ✓ Dose intensidade da QT

Trial grouping	Number of trials	Number of events/patients	HR (95%CI, P value)	Heterogeneity P value	5-year OS (%)
Interval of chemotherapy (days)					
>14	11	639/1214	1.25(1.07-1.46), 0.005	0.238	↓ 8
≤14	6	417/812	0.76(0.62-0.92), 0.005	0.193	↑ 7
Neoadjuvant cisplatin dose intensity (mg/m ²)					
<25	7	413/845	1.35(1.11-1.64), 0.002	0.746	↓ 11%
≥25	11	671/1229	0.91(0.78-1.05), 0.200	0.001	↑ 3%

QT neoadjuvante → Cirurgia
versus
Radioterapia

✓ 5 trials; 872 pacientes

Analysis 2.1. Comparison 2 Treatment comparison 2

Review: Neoadjuvant chemotherapy for locally advanced cervix cancer

Comparison: 2 Treatment comparison 2

Outcome: 1 Survival

Study or subgroup



Heterogeneity: Chi² = 9.18, df = 4 (P = 0.06); I² = 56%
 Test for overall effect: Z = 4.13 (P = 0.000036)
 Test for subgroup differences: Not applicable

Favors NACT-S Favours RT

0.1 0.2 0.5 1 2 5 10
 Favours treatment Favours control

Neoadjuvant chemotherapy plus surgery versus surgery for cervical cancer (Review)

Review

Efficacy of neoadjuvant chemotherapy in patients with FIGO stage IB1 to IIA cervical cancer: An international collaborative meta-analysis

Neo-adjuvant chemotherapy plus surgery versus surgery alone for cervical cancer: Meta-analysis of randomized controlled trials

Neoadjuvant and Adjuvant Chemotherapy of Cervical Cancer

ORIGINAL RESEARCH

Open Access Full Text Article

Neoadjuvant chemotherapy with radical surgery vs radical surgery alone for cervical cancer: a systematic review and meta-analysis



Trabalhos antigos

Heterogeneidade de pacientes

Heterogeneidade de métodos de imagem

Heterogeneidade do tratamento

Quimioterápicos obsoletos



Promove downstaging

Reduz necessidade de RDT adjuvante

Pode reduzir risco de micrometástase

Possível benefício em DFS e OS

QT neoadjuvante – Cenários



**Braço controle
subótimo**

**Comparação com RDT
concomitante a QT?**

QT neoadjuvante → Cirurgia
versus
QuimioRadioterapia

ASES / Study Confirms Chemoradiation is Best Treatment for Locally Advanced Cervical Cancer

ESMO 2017 Press Release: Study Confirms Chemoradiation is Best Treatment for Locally Advanced Cervical Cancer



Date: 10 Sep 2017

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ORIGINAL REPORT

Neoadjuvant Chemotherapy Followed by Radical Surgery Versus Concomitant Chemotherapy and Radiotherapy in Patients With Stage IB2, IIA, or IIB Squamous Cervical Cancer: A Randomized Controlled Trial

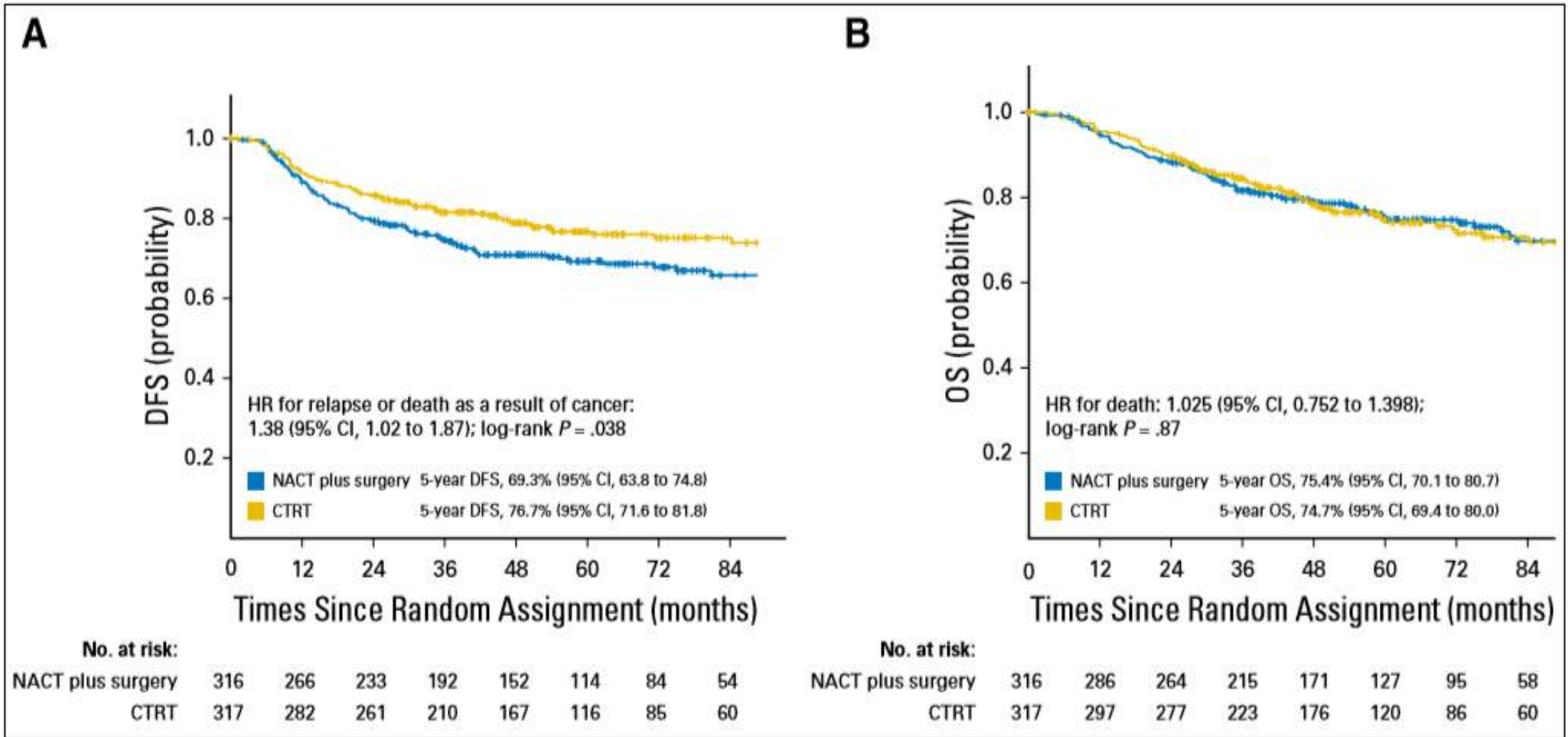
Sudeep Gupta, Amita Maheshwari, Pallavi Parab, Umesh Mahantshetty, Rohini Hawaldar, Supriya Sastri (Chopra), Rajendra Kerkar, Reena Engineer, Hemant Tongaonkar, Jaya Ghosh, Seema Gulia, Neha Kumar, T. Surappa Shylasree, Renuka Gawade, Yogesh Kembhavi, Madhuri Gaikar, Santosh Menon, Meenakshi Thakur, Shyam Shrivastava, and Rajendra Badwe

Table 1. Baseline Patients Characteristics

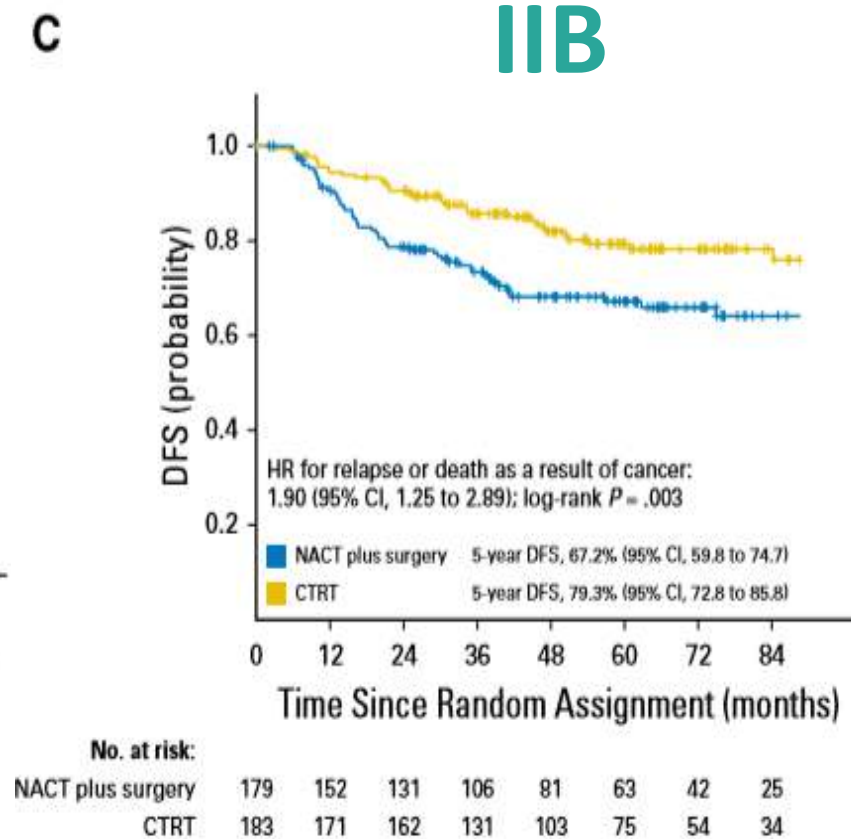
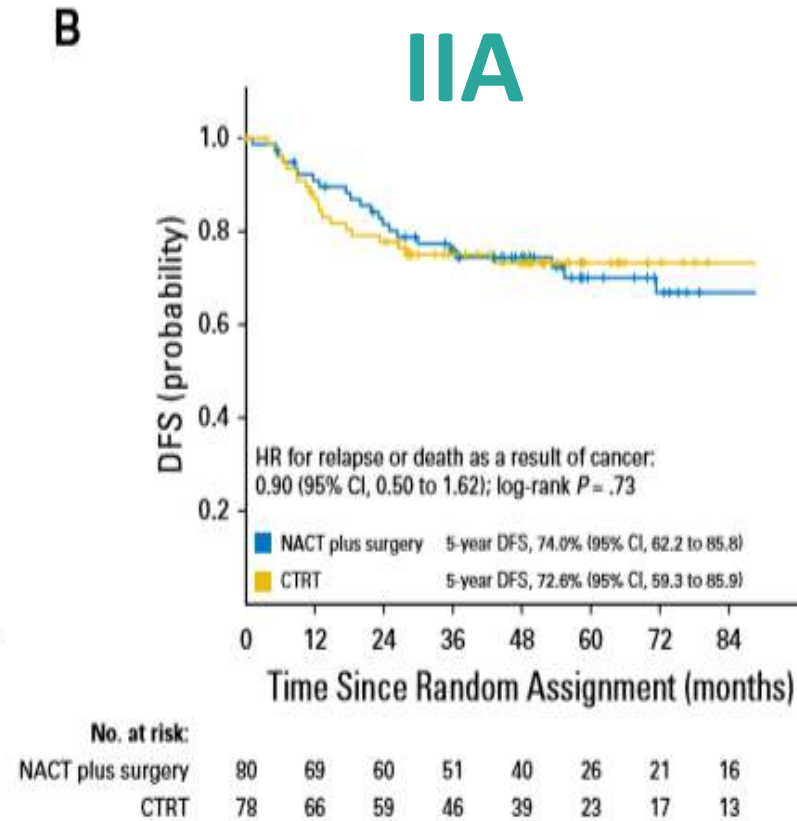
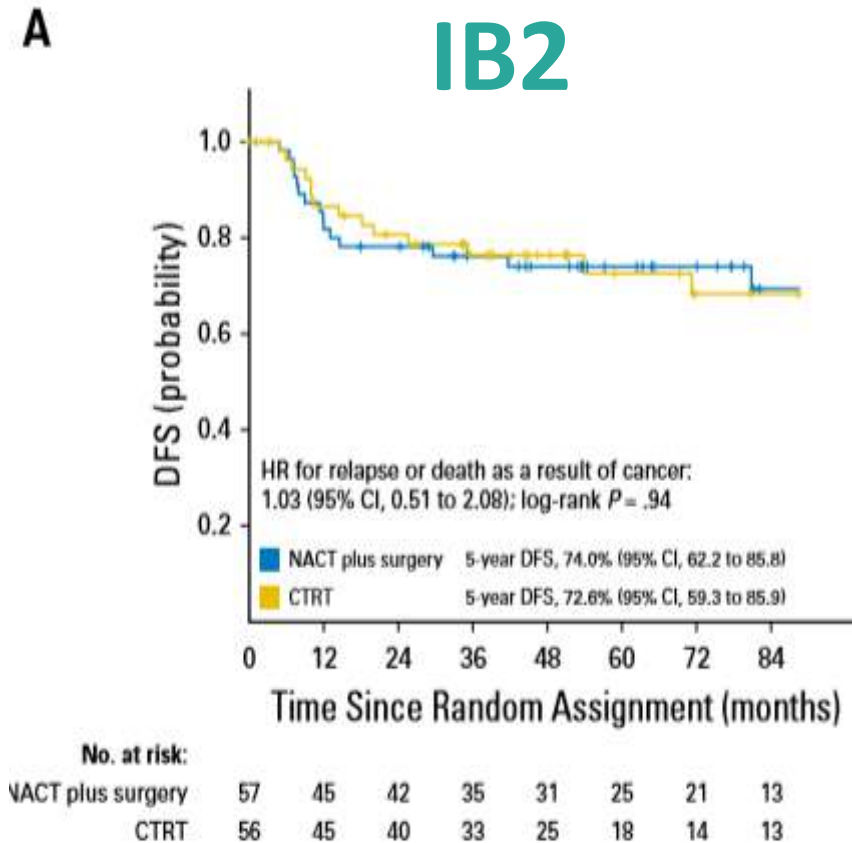
Characteristic	NACT Plus Surgery (n = 316)	CTRT (n = 317)
Median age, years (range)	50 (27-65)	48 (26-65)
Median hemoglobin, g/dL (range)	11.5 (7.6-15.6)	11.5 (7.4-15.5)
Median body mass index, kg/m ² (range)	22.6 (12.8-44.2)	22.5 (14.5-38.4)
Comorbidities		
Yes	67 (21.2)	61 (19.2)
No	249 (78.8)	256 (80.8)
Eastern Cooperative Oncology Group performance status		
0	290 (91.8)	293 (92.4)
1	26 (8.2)	24 (7.6)
FIGO stage		
IB2	57 (18.0)	56 (17.7)
IIA	80 (25.3)	78 (24.6)
IIB	179 (56.7)	183 (57.7)
Radiologic pelvic lymph node status		
Positive	46 (14.6)	45 (14.2)
Negative	270 (85.4)	272 (85.8)

NOTE. Data presented as No. (%) unless otherwise indicated.
 Abbreviations: CTRT, concomitant chemotherapy and radiotherapy; FIGO, International Federation of Gynecology and Obstetrics; NACT, neoadjuvant chemotherapy.

QT neoadjuvante – Cenários



DFS



QT neoadjuvante → QuimioRadioterapia
versus
QuimioRadioterapia

Neoadjuvant Chemotherapy Followed by Chemoradiation in Cervical Carcinoma

A Review

Carla Rameri Alexandre Silva de Azevedo, MD,† Luiz Claudio Santos Thuler, PhD,‡¶
Maria Julia Goncalves de Mello, PhD,*§ and Carlos Gil Ferreira, PhD¶#*

QT neo + (RDT + QT) x RDT + QT

7 estudos
323 pacientes

EC IB2 - IV

2 estudos publicados
5 resumos de congressos

Platina + paclitaxel +/-
capecitabina

4 estudos fase II
3 estudos observacionais

RDT pélvica 50.4 Gy + BQT

TABLE 1. Characteristics of neoadjuvant studies

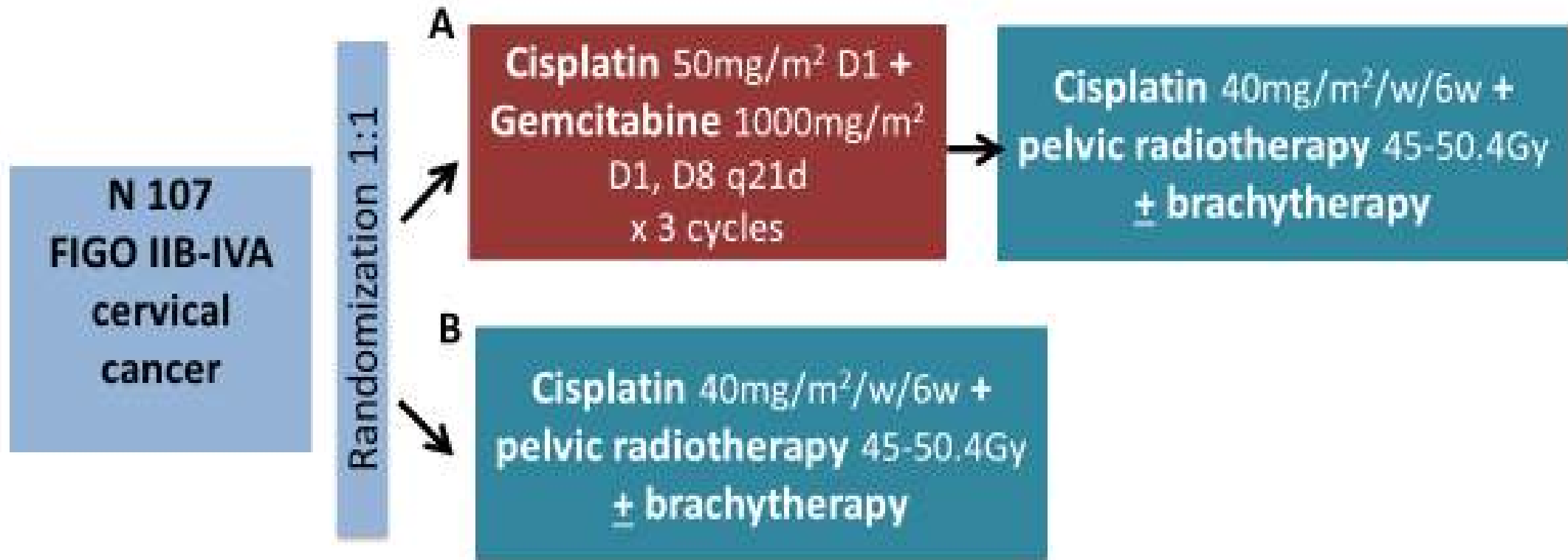
Author	Year	Design	n	Eligibility	Treatment	Staging (%)	RR	Survival
McCormack et al ¹¹	2013	Phase 2	46	Ib2-IVa	Weekly carboplatin and paclitaxel ×6 followed by CRT (cisplatin + 50.4 Gy + brachytherapy)	Ib2 (11), IIb (50), IIIa (4), IIIb (28), IVa (7)	NACT = 70%, CRT = 85%	3 y, DFS = 68%, OS = 67%
Singh et al ¹²	2013	Phase 2	28	IIb-IVa	Weekly carboplatin and paclitaxel ×6 followed by CRT (cisplatin + 50.4 Gy + brachytherapy)	IIb (17.8), IIIb (71.4), IVa (10.7)	NACT = 67.8%, CRT = 85.7%	1 y, DFS = 78%, OS = NR
Rodriguez-Riao et al ¹³	2013	Phase 2	57	Ib2-IVa	Cisplatin, paclitaxel and capecitabine followed by CRT	Ib2 (10.2), IIa (2.0), IIb (42.9), IIIb (40.8), IVa (4.1)	100% (c) 48.9% (p)	NR
Paulson et al ¹⁵	2012	Retrospective observational study	49	II-III	3 weekly carboplatin and paclitaxel followed by CRT (with cisplatin)	IIb (81.9), IIIb (10.3), IVa (10.8)	57.2%	2 y, DFS = 65%, OS = 93%
Graham et al ^{16†}	2012	Retrospective observational study	63	Ib2-IVa	Cisplatin and paclitaxel followed by CRT	I (4.8), II (41.9), III (32.2), IV (21)	>90%	2 y, DFS = 50%, OS = 60%
Nagai et al ¹⁴	2012	Phase 2	22	Patients with common iliac and/or para-aortic node enlargement	Cisplatin and paclitaxel ×2 followed by CRT (with paclitaxel and cisplatin)	NR	90.9%	22 mo, DFS = 68%, OS = 81%
Reed et al ^{17†}	2010	Retrospective observational study	58*	>IIb	Cisplatin and paclitaxel followed by CRT	NR	92%	NR

Phase II trial of neoadjuvant chemotherapy followed by chemoradiation in locally advanced cervical cancer☆

Carla Rameri Alexandre Silva de Azevedo ^{a,b,*}, Luiz Cláudio Santos Thuler ^{c,d}, Maria Júlia Gonçalves de Mello ^{a,e}, Jurema Telles de Oliveira Lima ^a, Ana Luiza Fassizoli da Fonte ^a, Diógenes Fernando Santos Fontão ^a, Vandrê Cabral Gomes Carneiro ^a, Tien Man Cabral Chang ^a, Carlos Gil Ferreira ^f

- ✓ EC IB2-IVa
- ✓ 50 pacientes
 - ✓ QT neo (Cisplatina 35 mg/m² + Gemcitabina 1000 mg/m² D1-D8 (2 ciclos))
 - ✓ Seguindo QT (Cisplatina 40 mg/m²) + Rxt (5040 cGy) → Braquiterapia
- ✓ RR: 81%
- ✓ PFS: 73,4% (1 ano); 53,9% (3 anos)
- ✓ OS: 93,9% (1 ano); 71,3% (3 anos)

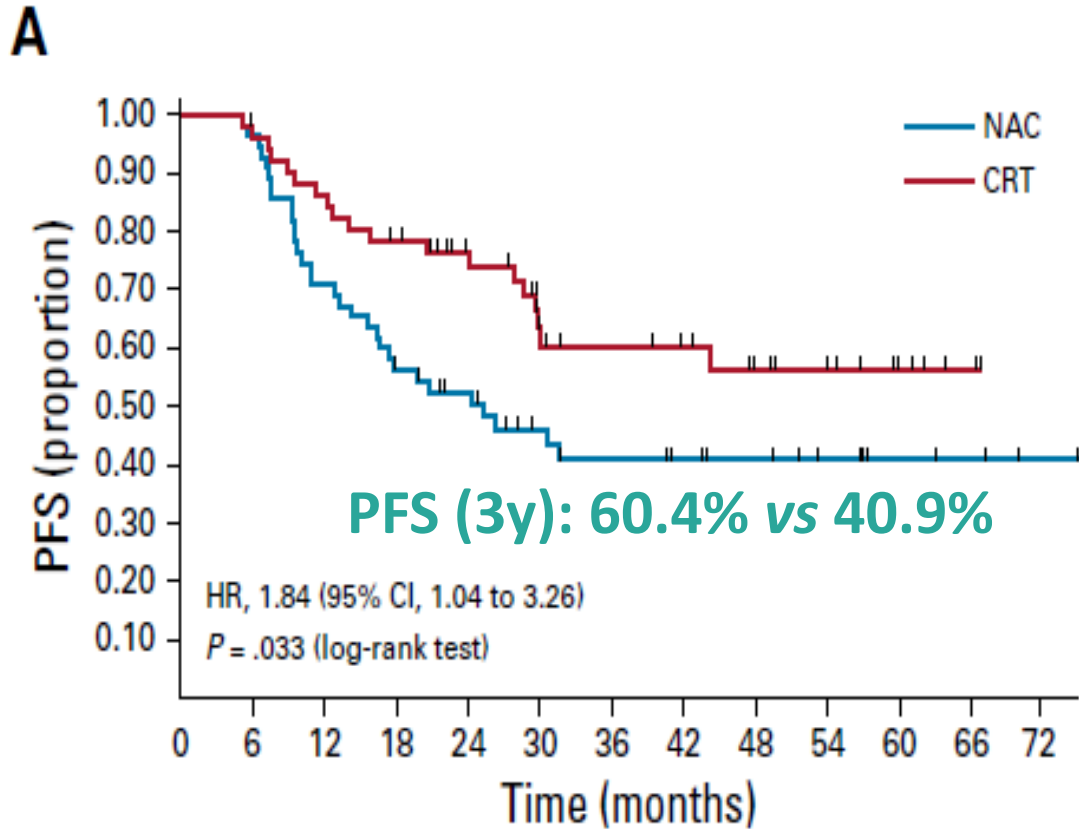
Methods



QT neoadjuvante – Cenários

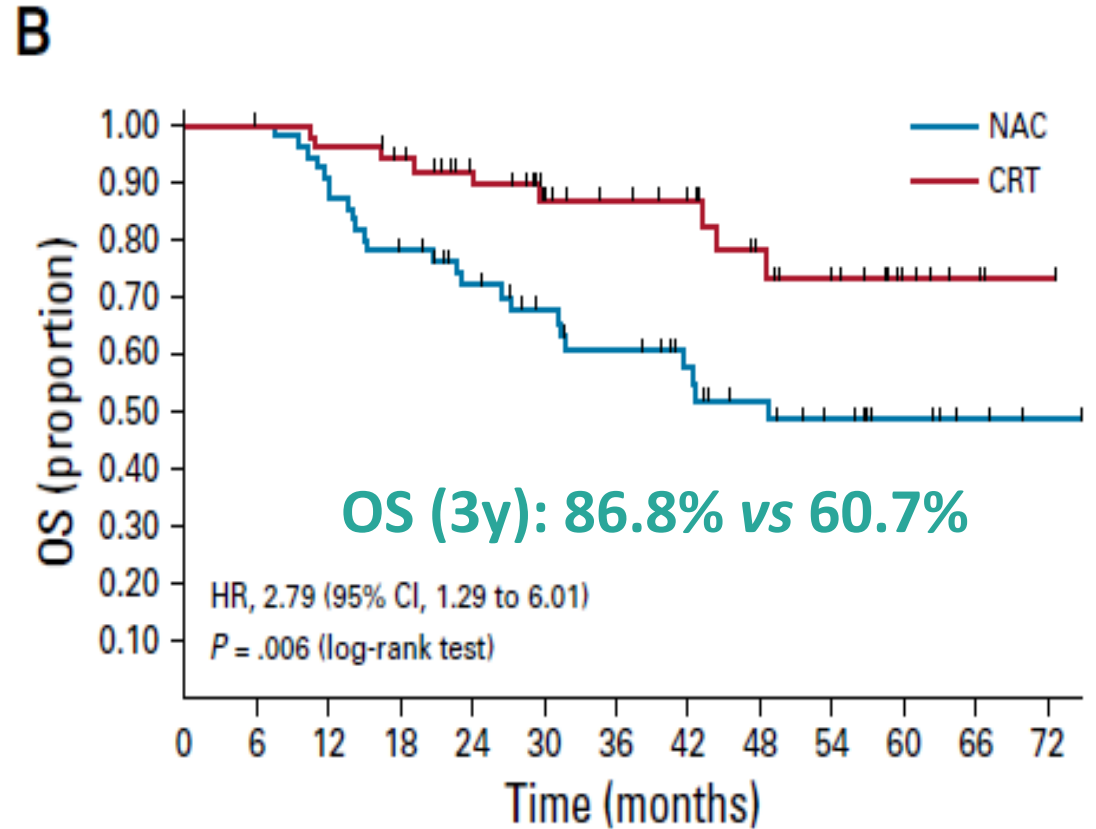
Characteristic	No. of Patients (%)		P
	NAC (n = 55)	CRT (n = 52)	
Age, years			.224*
Median	48	45	
Range	22-69	20-67	
ECOG PS			.769†
0	25 (45.5)	25 (48.0)	
1	30 (54.5)	26 (50.0)	
2	0 (0)	1 (1.9)	
Histology			.654†
Squamous cell carcinoma	48 (87.2)	46 (88.4)	
Adenocarcinoma	7 (12.7)	5 (9.6)	
Undifferentiated carcinoma	—	1 (1.9)	
Stage‡			.745†
IIB	24 (43.6)	22 (42.3)	
IIIA	0 (0)	1 (1.9)	
IIIB	26 (47.2)	22 (42.3)	
IVA	5 (9.0)	7 (13.4)	
Lymph node§			.557†
Positive	23 (41.8)	22 (42.3)	
Negative	32 (58.2)	30 (57.6)	
Hb level before CRT			.471*
Median	11.4	11.9	
IQR	10.7-12.3	10.6-13.1	

QT neoadjuvante – Cenários



No. at risk:

NAC	55	53	39	30	25	18	15	13	11	8	4	3	1
CRT	52	50	44	39	32	21	18	16	12	9	5	2	0



No. at risk:

NAC	55	55	49	42	35	29	25	20	15	11	6	3	1
CRT	52	51	49	46	39	29	26	22	16	12	6	3	1

QT neoadjuvante Países subdesenvolvidos

QT neoadjuvante – Cenários



Type of Disease	Setting			
	Basic	Limited	Enhanced	Maximal
IB2 and IIA2	<p>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</p> <p>Type of recommendation: consensus based Evidence: low Recommendation: weak</p>	<p>If chemotherapy is available, NACT followed by radical hysterectomy (see Note) plus PLND ± para-aortic LN sampling may be an option§ </p> <p>Type of recommendation: evidence Evidence: intermediate Recommendation: moderate</p> <p>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)</p> <p>Type of recommendation: consensus based</p>	<p>Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy</p> <p>Type of recommendation: evidence based Evidence: high Recommendation: strong</p> <p>Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy plus adjuvant hysterectomy; adjuvant hysterectomy is not recommended except if evidence of residual disease</p> <p>Type of recommendation: evidence based</p>	<p>Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy</p> <p>Type of recommendation: evidence based Evidence: high Recommendation: strong</p> <p>Pelvic RT plus concurrent low-dose platinum-based chemotherapy plus brachytherapy plus adjuvant hysterectomy; adjuvant hysterectomy is not recommended except if evidence of residual disease</p> <p>Type of recommendation: evidence based</p>

Basic and Limited Settings

nectomy is adequate. For women with larger tumors or advanced-stage cervical cancer, the Expert Panel recommends neoadjuvant chemotherapy (NACT) whenever chemotherapy is available, for the purpose of shrinking the tumor before performing hysterectomy. The specific chemotherapy agents may be carboplatin, cisplatin, or paclitaxel plus carboplatin. There are two randomized phase III trials (EORTC [European Organisation for Research and Treatment of Cancer] 55994 and ClinicalTrials.gov identifier NCT00193739) comparing NACT followed by surgery with chemoradiotherapy in these patients. The EORTC 55994 trial was recently closed for accrual, whereas the NCT00193739 trial is ongoing (more information is provided in Future Directions). Extrafascial hysterectomy may be used for patients with stage IB2 or IIA2 to IIIA disease after NACT.

Selected ongoing trials of NACT:

- EORTC 55994 (Randomized Phase III Study of Neoadjuvant Chemotherapy Followed by Surgery vs. Concomitant Radiotherapy and Chemotherapy in FIGO Stage Ib2, IIa > 4 cm, IIb Cervical Cancer) trial (ClinicalTrials.gov identifier NCT00039338)
- NACTcervix (Prospective Randomized Trial of Neoadjuvant Chemotherapy and Surgery Versus Concurrent Chemoradiation Therapy in Patients With Stage IB2-IIIB Squamous Carcinoma of the Uterine Cervix) trial (ClinicalTrials.gov identifier NCT00193739)
- SYSGO002 (Neoadjuvant Chemotherapy and Radical Surgery Versus Concurrent Chemoradiation in FIGO Stage IIB Cervical Cancer) trial (ClinicalTrials.gov identifier NCT02595554)

Results from neoadjuvant chemotherapy followed by surgery compared to chemoradiation for stage Ib2-IIb cervical cancer, EORTC 55994. Kenter G., et al. ASCO 2019;abstr 5503.

5-year OS was 72% in arm 1 (NACTS) and 76% in arm 2 (CCRT)
(HR 0.87, 95%CI: 0.65-0.15, p=0.332).

NACTcervix (Prospective Randomized Trial of Neoadjuvant Chemotherapy and Surgery Versus Concurrent Chemoradiation Therapy in Patients With Stage IB2-IIB Squamous Carcinoma of the Uterine Cervix) trial.

Gupta S., et al. J Clin Oncol 2018;36:1548-55.

5-year DFS was 69.3% (NACTS) and 76.7% (CCRT)
(HR 1.38, 95%CI: 1.02-1.87, p=0.038).

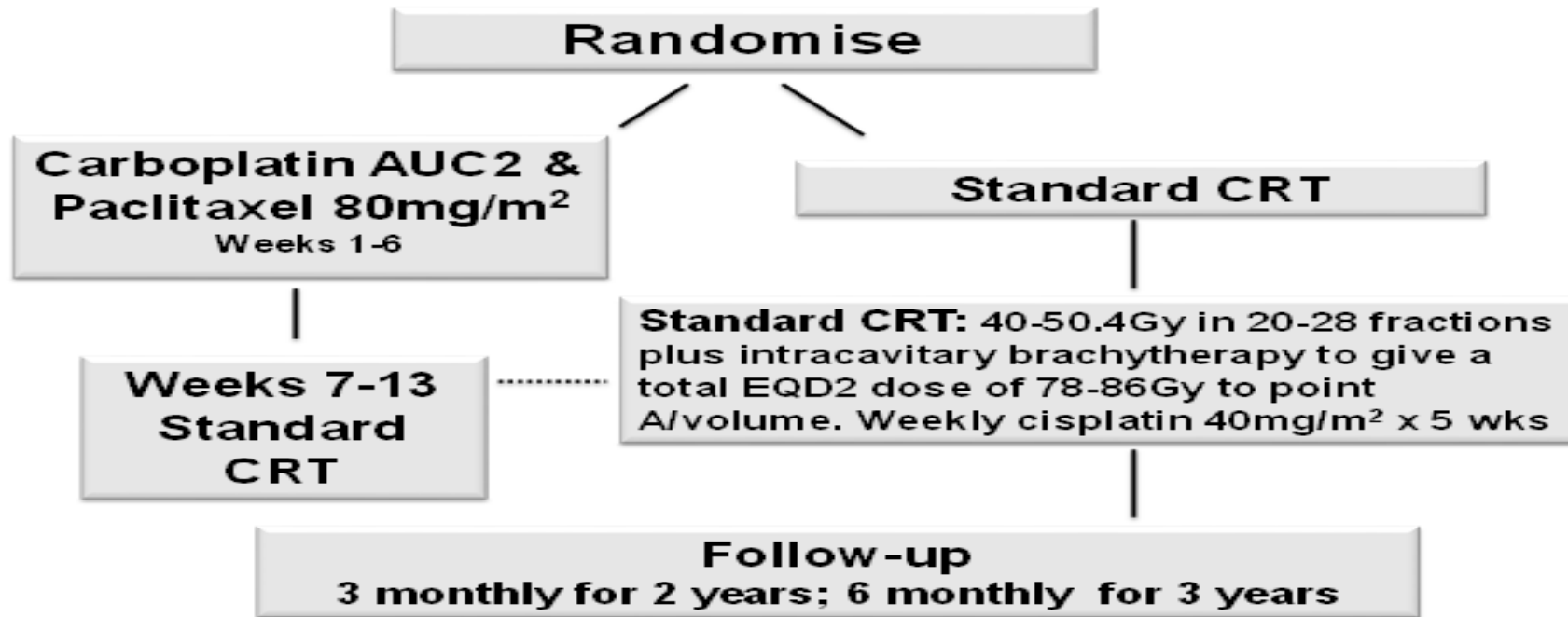
5-year OS was 75.4% (NACTS) and 74.7% (CCRT)
(HR 1.025, 95%CI: 0.75-1.40, p=0.87).

Neoadjuvant chemotherapy followed by radical surgery versus concurrent chemoradiotherapy in patients with FIGO stage IIB cervical cancer: the CSEM 006 study.

Tu H., et al. Int J Gynecol Cancer 2020 Jun 9;ijgc-2020-001357 .

- ✓ Estádios IB2 à IVA
- ✓ Recrutamento entre 2012-2016 (ainda recrutando)

Induction Chemotherapy in Locally Advanced Cervical Cancer



Primary Endpoint: OS
Secondary Endpoints: PFS; AE; HQL

- ✓ Radioquimioterapia é o tratamento padrão para estádios IB2 à IVA.
- ✓ Estudo fase 3 demonstrou ganho em DFS favorável ao tratamento de CCRT quando comparado à NACT → S.
- ✓ Estudo fase 2 demonstrou ganho em DFS e OS favorável ao tratamento de CCRT quando comparado à NACT → CCRT.
- ✓ Meta-análise demonstrou benefício de NACT → S tendo braço controle R isolada.
- ✓ Possível benefício no cenário de pacientes que pretendem gestar após diagnóstico de câncer colo de uterino (EC IB1 e IB2 – experimental).

OBRIGADO