6.1 Presentation and diagnosis of cervical cancer

Occasionally, a patient who attends a pre-cancer screening clinic will be noted to have a visible abnormality on her cervix. If a trained provider and necessary equipment and supplies are available at the clinic, a biopsy can be taken and sent to the laboratory for diagnosis. If this is not feasible, the patient will be referred to a secondary-level facility for biopsy and diagnosis (see Practice Sheet 5.9 on biopsy and endocervical curettage).

Biopsy and ECC

More often, a woman will present to her primary care provider with abnormal symptoms suspicious for cervical cancer. If the primary care provider is trained and has the needed equipment and supplies she may take a biopsy, but in most cases she will refer the patient to the secondary care hospital to be examined by a gynaecologist who will take the biopsy and send it to the laboratory for histopathological examination. If positive results are returned, the patient will be referred to a tertiary care hospital to see a specialist for further testing and treatment.[1]

[1] Please also refer to WHO's 2014 publication *Implementation tools: package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings,* available at: http://www.who.int/nmh/ncd-tools/en/

Unfortunately, many women may remain asymptomatic until the disease is advanced, especially women who are not currently sexually active.

Presenting symptoms of invasive cervical cancer by level of severity (early and advanced) are listed in Table 6.1 (see also section 6.3, including Table 6.2 and Figure 6.1, for more information on the FIGO staging system).

Table 6.1: Symptoms of invasive cervical cancer

Early	• vaginal discharge, sometimes foul-smelling • irregular bleeding (of any pattern) in women of reproductive age • postcoital spotting or bleeding in women of any age, even young women • postmenopausal spotting or bleeding • in the case of abnormal perimenopausal bleeding, cervical cancer should always be considered, particularly if the bleeding fails to respond to appropriate treatment
Advanced	• urinary frequency and urgency • backache • lower abdominal pain • severe back pain • weight loss • decreased urine output (from obstruction of the ureters, or renal failure) • leakage of urine or faeces through the vagina (due to fistulae) • swelling of the lower limbs • breathlessness (due to anaemia or, rarely, lung metastases or effusion)

For more information on managing a patient who has symptoms that may be due to cervical cancer, see Practice Sheet 6.1.

Symptoms: maybe due to cancer

6.2 The role of the health-care provider

6.2.1 Provider roles at the primary and secondary levels

When a patient experiences any of the abnormal symptoms listed in Table 6.1, she may first discuss her situation with a community health worker or traditional healer. She may be given a remedy and, if symptoms continue, she will likely be advised to consult her primary care provider, often a nurse.

a. When a woman presents at the primary- or secondary-level facility with abnormal symptoms

If a provider at a **primary-level facility** is trained and has all the essential equipment and supplies, she may perform a pelvic examination and take a biopsy of any abnormality noted on the cervix. If the result of the biopsy is invasive cervical cancer, the primary care provider will probably refer the patient directly to the tertiary care hospital for further tests and management. However, many primary care centres

do not have the necessary equipment or lack a trained provider to perform a pelvic examination. Therefore, most often a woman presenting with symptoms will be informed that she needs to see a gynaecologist at the closest secondary-level facility without delay. In rare cases, a patient may present at a primary care centre with severe vaginal haemorrhaging; these patients will probably be sent directly to a tertiary-level facility for evaluation and treatment.

At the secondary-level hospital, the provider who manages patients with abnormal symptoms is advised to first establish or reinforce a trusting relationship and rapport with the patient. The provider will take a full history and perform a thorough examination to determine if there are any cervical lesions and note the presence of any indurations, swellings and other abnormalities in the cervix and the surrounding tissues and organs (see Practice Sheet 5.2).

Pelvic exam

If appropriate for the patient, pregnancy and HIV tests will also be done before taking a biopsy of a cervical lesion at the secondary care facility. If both tests are negative and an experienced provider and needed equipment are available, a biopsy will be taken and sent to the laboratory for histopathological examination. If, on the other hand, the woman is pregnant and/or is living with HIV, it is advisable to send her to the tertiary-level hospital to have the biopsy taken and, depending on results, have her treatment planned.

The histopathology of the biopsy specimen will confirm or rule out the diagnosis of cervical cancer, which is an essential step before more extensive examinations are done. If the biopsy is positive for cancer, the patient will again be referred, this time from the secondary- to the tertiary-level facility for further tests and investigations and determination of the most appropriate available treatment (see section 6.2.2 on the roles of tertiary-level providers).

Providers should keep in mind that the biopsy results may also identify a few other possible diagnoses for women with similar symptoms (this process is called differential diagnosis). Other possibilities include infectious diseases, such as herpes, which can change the appearance of the cervix and be confused with early cervical cancers, or metastatic cancer from other sites, including from the lining of the uterus (i.e. uterine or endometrial cancer).

b. When a woman is diagnosed with cervical cancer at the primary- or secondary-level facility

When a definitive diagnosis of cervical cancer is reported, the provider who performed the biopsy needs to gently explain the diagnosis to the woman, allowing

time for her to reflect and understand the seriousness of her disease and ask questions. If she is not already at a tertiary care hospital, she will be referred to the closest specialist hospital, where cancer specialists and sophisticated equipment are available to provide treatment. See Practice Sheets 6.2 and 6.3 for further advice on communicating with patients at this stage.

Counselling: Cancer diagnosis

What will happen at the hospital

c. When a woman is discharged from hospital after treatment

An additional role for primary and secondary care providers is to provide care and support to women who have been discharged from the hospital either because treatment was successful and she can begin her recovery, or because treatment was not effective and she is returning home for palliative care. The primary and secondary care providers, if possible, will maintain communication with the tertiary-level specialists and conduct prescribed periodic follow-up examinations, identify and manage side-effects and complications secondary to the disease and/or treatment, and, if needed and possible, refer the patient back to the treatment facility.

If the patient is receiving palliative care, the primary and secondary care providers are her main medical support, in consultation with the specialists at the tertiary care facility and, if desired, with traditional medicine providers. This medical support may include maintaining the patient free of pain and treating many of the common problems developed by patients who have been treated for cancer.

d. Other important roles

Primary- and secondary-level providers also have other important collaborative roles as members of the cervical cancer team. These may include:

- educating and training communities;
- training community health workers, including to dispense medicines for pain-relief (if this is permitted by the national regulations);
- training staff who have recently joined the care team;
- instructing the patient's close family and friends on how to provide special care to prevent serious symptoms and treat these if they occur;
- establishing links between the patient and her family and faith-based or other assistance agencies that may provide broad nonmedical support, including donations of funds, food and nonmedical supplies;
- aiding the patient and her family as much as possible during the terminal stages of disease;
- doing home visits during severe or terminal phases of the disease, if feasible.