

# CLINICAL ASPECTS OF DIAGNOSIS OF CERVIX CANCER

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The clinical aspects are manifold. We can say that the clinical aspects only give the diagnosis the importance it deserves. And it is especially the early diagnosis which claims the most interest. Early diagnosis is in many tumors a pious desire, we may only mention stomach or intestinal cancer. The cancer of the cervix uteri makes an exception. An early diagnosis in this case can be made and is therefore of the greatest clinical interest. We can make an early diagnosis of cervical cancer if we examine the patient properly. But even nowadays it happens that a patient comes to the doctor complaining about irregular bleedings and he, without examining her, writes a prescription on ergot and nothing more is done. In this way even a well developed cancer may escape the diagnosis. It happens furthermore that there is done a bimanual examination, but a beginning invasive cancer is not detected because no exposure of the cervix is done by spatulas. In both cases a chance is missed for the patient. If such things happen—and they do happen—then we may not be surprised when some doctors say, that more important than all the modern methods of early detection of cervical cancer is a good training of the practitioners and gynecologists in the routine methods and is the strengthening of a sense of responsibility. Well, years ago—not too many—we were very satisfied, when we detected by the conventional methods the cervical cancer in its stage I and we called it an early diagnosis. But we noticed at that time that the results of our therapy in such early cases were not too good. We had about a 60% five years cure. There were two reasons for this rather poor result. First, the patients had in some cases no symptoms and therefore did not come to the doctor and second, we had no means to detect a cancer which we would call nowadays a preclinical cancer.

To the first point: our slogan was in the former times: visit immediately the doctor when you have unusual discharge, hemorrhage or contact bleeding. And we were happy when they did so. Now we ask the woman to visit the doctor regularly without having any symptoms. What a difference for our diagnosis! We detect cancers where we could hardly believe that they did not make any symptoms, I mean definite tumors, ulcers and craters. But we know how different the sensibility of patients is.

To the second point: These pretendedly symptomless but well developed cancers are relatively rare and therefore not so important. The actual justification and the importance of the periodical examination in "healthy" women dates from the time, when new methods gave us the possibility to diagnose a cancer without a palpable or visual finding. There are four

tests which brought us the progress: Schiller's Jodinetest, Colposcopy, Cytology and Colpomicroscopy. About Colposcopy and Colpomicroscopy you will hear from the next speaker. We mentioned the tests in chronological order. If we do it corresponding to the exactitude of their findings, I would—after my personal experience in all the four methods range them: Cytology, Colpomicroscopy, Colposcopy, Schiller's test. We will not discuss the advantages and disadvantages of the single methods. We will only discuss what they all together mean for our clinical work and what new views they give us for the therapy.

The new methods allow us to make the diagnosis of a cancer which can not be seen with the naked eye, or of a lesion which can at least not be recognized as a cancer. That means that we can detect cancers which are much smaller as up to this time. Of course even a minimal cancer, if invasive, is an invasive one and is to be treated in the same way as any invasive cancer which is restricted to the cervix but is substituting the whole tissue of it. Both will have the classification stage I, nowadays one would make the difference of stage I a and I b, which after my opinion is not necessary. For the therapy I b and I a means the same. The real border line runs between invasive and preinvasive. The differentiation between a and b is entirely opposite to the original international classification which is based *only* on *clinical* findings. How can the gynecologist after clinical examination say whether this invasive tumor in the cervix is as big as a millet-corn or a pea or a hazlenut? In a breast tumor we can make such a differentiation because we can palpate it. This is a clinical examination. In Gynecology only the pathologist can do it but then it is too late to alter our decisions about therapy. Some people say that the most minimal degree of invasion can be treated like a preinvasive cancer. I can not agree with that. If this minimal infiltration forms some smooth buds then it may be assigned to the preinvasive form. But if this minimal infiltration is fingerlike in loose strands then it must be considered as a real infiltration and be treated as such one. A few years ago we were too of the opinion to treat these cases like preinvasive ones. But we were set right. In two cases we saw a recurrence with metastases which we could not stop any more. This experience showed us where the borderline is to be drawn.

The greatest importance have the above mentioned new methods in cases where the naked eye can not see anything at all and only by these methods an invisible cancer can be made detectable. If a cancer is detected by one of these auxiliary methods it does not mean that it must be a preinvasive one. There

might be nothing to be seen on the exocervix but there is an invasive lesion in the endocervix. These endocervical cancers are the field of the Cytology because they can be diagnosed with no other method, supposed a proper technique of taking the smear. Here we have to state a peculiarity of the cytology. We mentioned above the 4 qualified methods of an early detection. Among them the Cytology has a special position. Schiller's test, Colposcopy and Colpomicroscopy are practiced by gynecologists or by other men who are experts in these special methods. The smear is taken by every practitioner in many parts of the world even by the patients themselves. They are not trained and are not aware of all the difficulties the cytologist is to meet with if the smear is not taken properly. It may be too thick, it may be taken from a wrong place. This is the handicap which owes only to the cytology. Nevertheless Cytology is the method which has the greatest accuracy. We may ask therefore, why use other methods if there is one which is superior?

If—let us say roughly—the exactness in Cytology is 90%, in Colpomicroscopy 80% and in Colposcopy 70%, it would at the first sight be ridiculous to use the latter ones. That it is an advantage to use the other ones too is based on the fact that the positive results in the different methods are not identic but overlapping. It means that by using all the three methods the final accuracy would be about 98% instead of 90%. We were right to use the Cytology *only* if it would give us a 100% exactness. It is of course an other thin whether it is worth while to use three methods for these few percents of a better result. But this is an other question, a question of time, of money and certainly of ones consciousness of medical responsibility. Needless to say before this audience that all these mentioned methods are screening methods. They need the confirmation by the histologist. The results we get following our diagnostic procedures mentioned show the following tables.

We were talking up till now on the early diagnosis and were neglecting the diagnosis of the so to say grown up cancer. We did it, because I think the early diagnosis deserves the greatest interest. Why? The first reason everybody knows. It is the fact that we can cure a preinvasive lesion with nearly 100%. That is important enough. The second reason is, I think, quite as important. Women with a preinvasive cancer are—as many statistics showed— younger as such ones with a well developed cancer. For them it is of great importance not to undergo a mutilating operation as the radical ones are or any irradiation. But besides the diagnosis of the very beginning cancer the correct diagnosis of the well developed one has its great practical importance. It is in case of a clinical obvious cancer very important whether it belongs to group I, II, III or IV. It is paradox but true that the grouping of these evident cancers is much more difficult than the diagnosis of a preclinical, of an preinvasive cancer. If we find a suspicious lesion or

a positive smear or other screening method we do a conisation and we know exactly where we are. For the clinical diagnosis we have only our fingers (even the speculum does not help) to get out the stage of the lesion. And these fingers, as important as they are, are sometimes treacherous. I remember a gynecological congress in Vienna, where Amreich, a man known to everybody who is concerned with cervical cancer, invited three professors, heads of big gynecological clinics, to examine a few cases of cervix cancer and to put down the supposed stage separately on a paper. It was astonishing how different the opinions were. What are the pitfalls? 1) we find a lesion on the cervix, the parametria are soft. Nevertheless there are already cancer cells in the lymphatics of the parametrium or few strands of cancer in the connective tissue. The clinical diagnosis was wrong. 2) The proximal part of the parametrium is infiltrated, but smooth. We think it is only inflammatory from the ulcerated cervix. Histology shows that the infiltration is cancerous. Just the opposite is possible too. 3) we think that an infiltration we find and judge as a cancer does not reach the pelvic wall and therefore the case would be operable. On the specimen we find cancerous tissue on the cut end of the parametrium. The operation was not radical. Three possibilities of a wrong staging as they may occur and dont occur so rarely. Things are not so bad if whatever the diagnosis was, the whole cancerous tissue is removed by the operation. But they are bad, if we were not radical. We do not only miss the desired effect but we damaged the patient. Any not radical operation is a stimulus for the cancer growth. The choice of our therapy depends on our diagnosis. If this is wrong the therapy will often be not adequate. That means we fail in our endeavour to do the best for the patient. To make a good diagnosis gives the doctor of course a great satisfaction. Many colleagues are very proud of it and the therapy has no interest for them. The patient on the contrary is not so much interested in the diagnosis but most interested in the therapy. She wants to get well, whatever the diagnosis may be. And that must be at the end our main idea too.

How will the proper diagnosis influence the therapy? We may state that we have up till now only two ways of an efficient therapy that is Operation and Irradiation. The Chemotherapy has not yet proved its value in this form of cancer. Operate or irradiate matters only for those who operate. The limits of operability are very different with different authors. In the principle we can say that an operation has only a sense if we can remove the whole cancer radically, nowadays may be including the lymphnodes (although the value of the latter is not yet proved statistically). We saw above how difficult and even sometimes impossible it is to find a proper staging. I therefore think that borderline cases have to be irradiated. The enthusiasm for a technically interesting operation does not give us the authorization to operate. In stage IV rises the question of the exentera-

tion. We get good results in many cases with irradiation where others exenterate. We do it there fore only in radioresistant cancers and in cases where the bladder or the rectum is involved. We never do a wet colostomy. Whether we can expect a person to have a wet colostomy done depends on the mentality of the patient in the respective country. After our experience cases appropriate for a total exenteration are relatively rare because in a number of them we find paraaortic glands or fixed glands to the iliac external vessels which make the operation impossible.

What does the diagnosis *preinvasive* cancer mean for the choice of therapy? Unnecessary to say that the diagnosis can only be made by the microscopical slide. *Not* unnecessary to say that even nowadays one can read the preinvasive cancer turned out to be invasive after the specimen had been examined. What a nonsense! The histological diagnosis can *only* be made after the examination of the *whole* lesion. Therefore punch biopsies are insufficient. The only way to get a right diagnosis in a suspicious lesion is the conisation. Only in cases where it is very likely that the lesion is invasive a punch biopsy is allowed. If this shows invasion it is alright, if not, a conisation must follow. But this specimen has to be step-sectioned (at least 100 for each cervix), otherwise one is not sure of the diagnosis. Just in these cases the proper diagnosis is of the utmost importance for the choice of the following intervention. With the punch biopsy the diagnosis might be: preinvasive. Simple hysterectomy is performed. Microscopical examination of the specimen: invasive growth. The operation was therefore insufficient. A good irradiation is impossible too because there is no uterus any more as carrier for the radium. Such things can never happen if primarily a conisation is performed. If then an invasive tumor is found radical operation or irradiation will follow. Punch biopsy is only reliable if it shows an invasive cancer. If there is only a preinvasive lesion it depends upon whether the brims of the conus outside and inside are free from cancerous epithelium or not. If they are free nothing more has to be done. If the atypic epithelium reaches the brim simple hysterectomy and no more has to follow because one never finds an invasive cancer higher up in the uterus. Relatively often on the other hand one can not see any cancerous lesion any more on the specimen. Therefore the idea of some gynecologists may be right who say, that in such cases a following cytological control is sufficient. The clinical aspects of a proper diagnosis are just

in these preinvasive cancers of an enormous importance. Not only because, as we indicated above, the chance for the healing would be about 100% but too because we preserve the function of the genitalia at least as far as the menstrual cycle is concerned, sometimes even the fertility is not altered. That is I think something worth while.

#### SUMMARY

The clinical aspects only give the diagnosis the importance it deserves. The fate of the patient depends on the correct and we may add the early diagnosis. In the well developed cancers the diagnosis states whether a patient can be operated or has to be irradiated. In the earlier cases the proper diagnosis does not only give a better prognosis but also enables us to cure the patient with a minimal operation, which preserves at least the menstrual cycle, if not the fertility. The possibility of early diagnosis was given to us by the detection of the many special methods as Schiller's Jodine test, Papanicolaou's Cytology, Colposcopy and Colpomicroscopy. These methods enable us to find the cancer of the cervix in its preinvasive stage which means that we can cure it at a nearly 100% rate. We can say that progress in the diagnosis is at least of the same importance as the one in therapy.

#### SUMARIO

El aspecto clínico solamente da el diagnóstico y la importancia que merece. El destino del paciente depende de lo correcto y de lo a tiempo que se haga el diagnóstico. En los cánceres desarrollados el diagnóstico afirma, si el paciente puede ser operado o radiado. En los casos tempranos el diagnóstico adecuado no solamente da un mejor pronóstico si no, pero también nos ayuda a curar al paciente con una operación mínima, que conserva cuando menos el ciclo menstrual, aunque no la fertilidad. La posibilidad de diagnóstico, nos fue dada por el descubrimiento de varios métodos especiales como: la prueba de yodo de Schiller, la citología con técnica de Papanicolaou, la colposcopia y la colpomicroscopia. Estos métodos nos ayudan a encontrar el cáncer del cervix en su etapa inicial, esto significa que podemos curarlo con una proporción aproximada del 100%. Podemos decir que el progreso en el diagnóstico es por lo menos de la misma importancia que el de la terapia.