Results of surgical treatment of carcinoma of the cervix

Richard K. Green
University of Nebraska Medical Center

Follow this and additional works at: https://digitalcommons.unmc.edu/mdtheses

Part of the Medical Education Commons

Recommended Citation
Green, Richard K., "Results of surgical treatment of carcinoma of the cervix" (1964). MD Theses. 18.
https://digitalcommons.unmc.edu/mdtheses/18

This Thesis is brought to you for free and open access by the Special Collections at DigitalCommons@UNMC. It has been accepted for inclusion in MD Theses by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.
RESULTS OF SURGICAL TREATMENT OF CARCINOMA OF THE CERVIX

Richard Kenny Green

Submitted in Partial Fulfillment for the Degree of Doctor of Medicine
College of Medicine, University of Nebraska
February 1, 1964
Omaha, Nebraska
TABLE OF CONTENTS

I. Introduction ........................................ 1

II. History ................................................ 3

III. Materials ............................................. 6
    (a) Distribution by Stages of the Disease .......... 6
    (b) Distribution by Ages. ............................. 7
    (c) Parity of Patients ................................ 7
    (d) Blood Type Distributions. ......................... 8
    (e) Initial Symptoms. ................................ 9

IV. General Aspects of Surgery of Cervix Neoplasms .. 14
    (a) Carcinoma in Situ .................................. 14
    (b) Invasive Carcinoma ................................ 16
        (1) Cervical Lymphatic System ...................... 17
        (2) Wertheim Hysterectomy .......................... 19
        (3) Radical Vaginal Hysterectomy ................. 20
        (4) Pelvic Lymphadenectomy ........................ 20
        (5) Exenteration ................................... 21

V. Results of Surgical Treatment of Carcinoma of the Cervix. 23

VI. Discussion ........................................... 33

VII. Summary ............................................. 42

VIII. Conclusions ......................................... 43

IX. Bibliography
INTRODUCTION

Squamous cell carcinoma of the cervix is a significant cause of death in our female population. The contributions of George N. Papanicolaou have resulted in massive reduction in the number of deaths from this disease by increasing the number of cases discovered in a completely curable stage.\textsuperscript{20} It must be remembered that invasive carcinoma of the cervix still exists and that being a killer it demands adequate treatment however radical this may be. This disease ranks second in frequency only to carcinoma of the breast among malignant neoplasms of American women. It is far and away the greatest killer among gynecologic patients; for this reason the gynecologist is obligated to be aware of all methods of diagnosis, and the most efficacious methods of treatment.\textsuperscript{14}

Over the years, large numbers of patients have been treated for this disease by a variety of methods. The results obtained are valuable, not only from the points of view of the individual patients, but also as sources of data for statistical analysis. The compiled statistics are valuable in that they will offer a guide to the most successful methods of attack.

The purpose of this report is to gain an impression of what
modern surgery alone can do in treating carcinoma of the cervix.
There is a definite paucity of papers dealing with this subject at the present time. On the other hand, the results of radiation therapy alone are fairly well known. One result of the lack of reports dealing with purely surgical methods of attack is that in the teaching of medical students over the last three decades, it has been stated that radiation is the primary method of choice. This categorical statement seems justified only by tradition since surgical results have been published so infrequently.
One thing that must be remembered is that modern surgery is not to be disregarded in the attack upon carcinoma of the cervix. It is a highly effective method of treatment and its possibilities have not yet been extensively explored. It is important that a "baseline" be established to show what modern surgical treatment alone can do. This report is an attempt to establish such a baseline.
During the early 1800's, a number of investigators attempted to treat cancer of the cervix with various methods of local excision but their obvious lack of understanding of the metastatic features of malignant disease resulted in the overall failure of their efforts.

In the 1870's, a somewhat more realistic approach to the problem was taken by Freund of Strassburg who advocated total abdominal hysterectomy, but his immediate mortality was somewhere in the range of 72%. Other surgeons tried to amputate the cervix vaginally and then remove the rest of the uterus abdominally, or to do the entire hysterectomy by the vaginal route. All these methods, of course, were doomed to failure since none of these physicians were aware of the lymphatic extension of the disease.

In 1890, Pawlik introduced the concept of dissection of parametrial tissues and in 1908, Schauta modified Schuscharidt's radical vaginal operation. In 1900, Wertheim advocated a radical abdominal hysterectomy with removal of parametrial tissues, regional lymph nodes, and the upper half of the vagina. His method found wide acceptance and modifications of it are the mainstay of surgical treatment today.
After the discovery of x-rays by Roentgen in 1895, a number of investigators began to irradiate patients with carcinoma of the cervix in an attempt to effect a cure. With the primitive means of generating, controlling, and measuring the radiation, very few cures were accomplished and many complications occurred.

The Curies discovered radium in 1898 and this new agent began to be explored as regards its anti-neoplastic properties. This application for radium was suggested, strangely enough, by Alexander Graham Bell. Between 1910 and 1920, radium was widely and successfully employed to the virtual exclusion of x-ray, but around 1930, combinations of x-ray and radium began to be used with some degree of success.

During the time of this widespread usage of irradiation therapy in carcinoma of the cervix, the radical surgical attack, with its 15-30% operative mortality, had largely fallen into disrepute. By 1937, even the strongest advocates of surgery had come to the conclusion that radium offered the best chance of cure with the least chance of unpleasant sequellae.

It was the almost universal belief at that time that if the disease had spread to the lymph nodes of the lateral pelvic wall, these metastases could not be eradicated by the currently existing methods of irradiation, and those thoughts seemed to be substantiated.
by statistics. With this in mind a few daring investigators began to suggest that surgical lymphadenectomy after irradiation of the primary tumor might be in order. The most prominent of these pioneers were Leveuf in France and Taussig in St. Louis. The real stimulus for the return of surgical treatment of carcinoma of the cervix, however, was J. V. Meigs' report in 1944 of a series of cases in stages I and II treated by radical hysterectomy and pelvic node dissection. Further interest was aroused in 1947 by Brunschwig's report of his experience with pelvic exenteration in women with far advanced disease.27 The surgical attack was coming back, but the surgical gynecologists and the radiotherapists still stood largely in their separate camps.14
MATERIALS

In this report, we are primarily interested in results of treatment of carcinoma of the cervix at the University of Nebraska Hospital, although we will compare these results with those obtained at other centers.

Between January 1, 1958, and October 1, 1963, there was a total of 99 patients treated for carcinoma of the cervix at the University of Nebraska Hospital. Table I shows the number and per-centange of patients presenting with each stage of the disease.

<table>
<thead>
<tr>
<th>Stage</th>
<th># of Patients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>38</td>
<td>38.4</td>
</tr>
<tr>
<td>I</td>
<td>25</td>
<td>25.2</td>
</tr>
<tr>
<td>II</td>
<td>17</td>
<td>17.2</td>
</tr>
<tr>
<td>III</td>
<td>14</td>
<td>14.1</td>
</tr>
<tr>
<td>IV</td>
<td>5</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Table I-Distribution by Clinical Stage of Patients with Squamous Cell Carcinoma of the Cervix. 1958-1963

There was a total of 88 white patients and 11 Negroes. They were taken from the whole state of Nebraska, although the largest per-centange was from the Omaha area.
The average age of the patients was 46.4. Table 2 shows the distribution of patient ages by clinical stage of the disease.

<table>
<thead>
<tr>
<th>Stage</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80---</th>
<th>Average Age at Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>11</td>
<td>15</td>
<td>8</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>35.8</td>
</tr>
<tr>
<td>I</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>45.4</td>
</tr>
<tr>
<td>II</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>54.1</td>
</tr>
<tr>
<td>III</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>62.4</td>
</tr>
<tr>
<td>IV</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>61.8</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>29</td>
<td>21</td>
<td>11</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>46.4</td>
</tr>
</tbody>
</table>

Table 2—Distribution of Ages at Time of Diagnosis of Patients with Carcinoma of the Cervix. By Stage of Disease. 1958-1963.

These figures compare nicely with the average age of 47 found in a group of patients studied by Campos. They also fit the observation of Dodds that the older patients tend to have the more advanced stages of the disease.

It is interesting to note that the vast majority of the patients in the study group are parous. Taking the whole group into consideration, there was a total of 406 full-term pregnancies in 98 mothers, or an average of 4.1 full-term pregnancies per patient. The parity of one patient is unknown. Many of the patients had premature deliveries. Considering the group as a
whole, there were 28 premature deliveries in 98 women. This is an average of 0.28 prematures per patient. In the entire group of patients, there were a number of miscarriages. In the 98 patients whose parity is known, there were 76 miscarriages, or an average of 0.78 miscarriages per patient.

These figures are broken down for each stage of the disease and are presented in Table 2.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Mean # Full Term Pregnancies per Patient</th>
<th>Mean # Prematures per Patient</th>
<th>Mean # Miscarriages per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4.1</td>
<td>0.50</td>
<td>1.02</td>
</tr>
<tr>
<td>I</td>
<td>3.8</td>
<td>0.20</td>
<td>0.52</td>
</tr>
<tr>
<td>II</td>
<td>4.6</td>
<td>0.19</td>
<td>0.93</td>
</tr>
<tr>
<td>III</td>
<td>3.6</td>
<td>0.07</td>
<td>0.43</td>
</tr>
<tr>
<td>IV</td>
<td>2.8</td>
<td>0.28</td>
<td>0.78</td>
</tr>
<tr>
<td>All Stages</td>
<td>4.1</td>
<td>0.28</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Table 2-Mean Number of Full Term Pregnancies, Prematures, and Miscarriages per Patient.

These data do not seem to fit any logical pattern and tend only to substantiate the observation of Rotkin29 that the majority of cervix cancer patients are parous.

Seventy-two of the 99 patients had their blood typed. The
results of this blood typing can be seen in Table 4.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Group A</th>
<th>Group B</th>
<th>Group AB</th>
<th>Group O</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>I</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>II</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>III</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>IV</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>1</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Percent</td>
<td>50%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>47.2%</td>
</tr>
</tbody>
</table>

Table 4—Distribution of Blood Types in Patients.

It is interesting to note the variability in initial symptomatology observed by the patients. We can see by examining this factor in the various clinical stages of the disease that there is a marked difference in initial symptoms between the stages.

Stage 0. In the 38 patients in Stage 0, it is noted that 33 carcinomas-in-situ were discovered by way of routine Papanicolaou smears followed by cervical conization. These 33 patients (86.9% of Stage 0) had absolutely no signs or symptoms of their cancers and the disease was discovered by routine smear.

These asymptomatic patients waited varying lengths of time
after they knew they had suspicious Pap smears before submitting themselves to therapeutic measures. Time from suspicious Pap smear to definitive treatment ranged from one week to four years, with a mean waiting period of six months.

Four patients (10.5%) were directed to the Gynecology Clinic because of vaginal bleeding of varying degrees. One of these patients was bleeding from uterine fibroids and the cancer was discovered by routine Pap smear. Another patient complained of excessive bleeding and her cancer was likewise discovered by routine Pap smear. The other two patients complained of occasional foul bloody discharge and inter-menstrual spotting respectively, and their neoplasms were also discovered by routine Papanicolaou smear. These patients had been bleeding from three to twelve weeks before they came to the clinic. These patients all submitted to treatment within a week after they were found to have suspicious Pap smears.

One patient (2.6%) was found to have an unsuspected Stage 0 cancer at routine pathological examination of a cervical polyp which she had removed. She submitted to treatment while still in the hospital recovering from her polypectomy.

**Stage I.** Thirteen of the 25 Stage I patients (52%) were asymptomatic and were found to have carcinoma of the cervix by way
of routine Papanicolaou smears followed by cervical conization and definitive treatment.

Ten Stage I patients (40%) had some form of vaginal bleeding as initial symptomatology. The time span from initial symptoms to treatment ranged from 2 weeks to 13 months. One patient had post-coital bleeding for 6-7 years before consulting her physician.

One patient (4%) complained only of a foul discharge (associated with pelvic inflammatory disease) of long standing. Her neoplasm was detected by way of a Papanicolaou smear followed by a cervical conization 2 months later.

One patient (4%) was found to have Stage I carcinoma of the cervix on pathological examination of her uterus following a hysterectomy. This elderly lady had worn a Cellhorn pessary for uterine prolapse for 15 years, and had never once removed it.

Stage II. Twelve of the 17 patients with Stage II cancer (70.6%) had vaginal bleeding as their initial symptom. The time interval from the onset of symptoms to treatment in these patients ranged from 2 weeks to 13 months, with a mean time interval of 3.6 months.

The initial symptoms of three of the Stage II (17.6%) patients are unknown.
Two of the Stage II patients (11.8%) were found to have cervical neoplasms by way of routine Papanicolaou smear followed by cervical conization. One patient was treated 10 months after the first suspicious smear. The other Pap-to-treatment time interval is not known.

**Stage III.** Bleeding vaginally was the initial symptom in 6 of the 14 patients in Stage III (42.9%). The time from first symptom to treatment ranged from 3 months to 12 years. Excluding the patient with the 12 year bleeding history, average time from symptom to treatment was 7.4 months.

Vaginal discharge was the initial symptom in 3 patients (21.4%). Two of these patients later developed vaginal bleeding. The symptom-to-treatment time ranged from 2 weeks to 19 months, averaging 10.3 months.

One patient of the Stage III group (7.1%) had right lower quadrant pain as her first symptom. It lasted three months, and later progressed to vaginal bleeding.

One patient (7.1%) had her disease diagnosed two years previously at another institution, and the initial symptoms of three Stage III patients (21.4%) are not known.

**Stage IV.** Four of the five Stage IV patients (80%) had
vaginal bleeding of some type as initial symptoms. Time from symptoms to treatment ranged from 4 months to 16 years. The initial symptoms of one patient are unknown.

Data regarding the initial symptoms are summarized in Table 5.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Routine Pap &amp; Cone</th>
<th>Vaginal Bleeding</th>
<th>Incidental Findings after Unrelated Surgery</th>
<th>Vaginal Discharge</th>
<th>Not Known</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>86.9%</td>
<td>10.5%</td>
<td>2.6%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I</td>
<td>52.0%</td>
<td>40.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>II</td>
<td>11.8%</td>
<td>70.6%</td>
<td>-</td>
<td>-</td>
<td>17.6%</td>
<td>-</td>
</tr>
<tr>
<td>III</td>
<td>-</td>
<td>42.9%</td>
<td>-</td>
<td>21.4%</td>
<td>28.5%</td>
<td>7.1%</td>
</tr>
<tr>
<td>IV</td>
<td>-</td>
<td>30.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Table 5—Initial Symptoms of Patients, by Stage of Disease.
GENERAL ASPECTS OF SURGERY OF CERVIX NEOPLASMS

Carcinoma in situ-(Stage 0)

After it has been proven by cervical conization or other biopsy procedure that a carcinoma is present and that there is no invasion of the neoplasm beneath the basement membrane, then Stage 0 carcinoma is said to exist. There is little necessity to do radical surgery on patients with carcinoma in situ because, by definition, there has been no invasion and the lymphatics are not involved. It is currently felt that once the presence of Stage 0 cancer is proven, the physician must be guided by the age, parity, and wishes of the patient.\textsuperscript{19} For example, a patient in her 20's with three children should probably have a hysterectomy, but if the patient is under 30 and desires more children, definitive therapy can be delayed if the patient is followed closely by cervical smears. If at any time, however, a positive smear is seen and the presence of carcinoma is confirmed by repeat conization, this conservative management must end, and hysterectomy be carried out at once.\textsuperscript{1, 36, 13}

It is now agreed by most authorities that definitive treatment for carcinoma in situ of the cervix is total abdominal hysterectomy with removal of at least a 3 cm vaginal cuff. It is not necessary to remove the ovaries since there has been no
trouble with recurrence in these organs.\textsuperscript{1, 19, 36}

Some investigators feel that a more conservative treatment for Stage 0 carcinoma is in order. According to Bret, et al, Stage 0 carcinoma is, "only a pattern in the definition of irregular dysplasias," and some 15-20\% of these cannot later be traced after biopsies, cautery, topical antibiotics, and trauma of childbirth.\textsuperscript{5} Boyd and his group reviewed the records of 71 patients with Stage 0 carcinoma of the cervix who did not have hysterectomy. All these patients had only cervical conization as primary treatment. Of these, 80.2\% are alive with negative cytology and 8.3\% are alive with abnormal cytology. Hysterectomy was performed after conization in 3.2\%, and 8.3\% died of unrelated causes.\textsuperscript{4} Bickenbach feels that conization is adequate temporary management of Stage 0 cancer in patients who want children. Conization was the only means of therapy in 74\% of his patients, and there have been no recurrences in 1-5 years. He stresses that follow-up smears must be taken regularly.\textsuperscript{2} Hillemans and Kottmeier feel that conization will not increase the incidence of later invasions because bleeding carries cells out of the wound and because forming granulation tissue is hostile to neoplastic cells.\textsuperscript{18}

If the patient is in such poor general physical condition
that surgery is contraindicated, it is perfectly acceptable to use radiation therapy as definitive treatment. Radiation is felt to be almost 100% effective.\textsuperscript{1,19,21,36}

**Invasive carcinoma**

When the neoplastic growth has invaded beneath the cervical basement membrane, invasive carcinoma is said to be present. This condition requires more radical treatment than non-invasive carcinoma, since the lymph nodes are potentially involved.

The surgical approach to invasive cancer has many advantages. First of all, surgery permits exploration of the pelvis under direct vision, thereby enabling the physician to more accurately evaluate the extent of the disease. In addition to this, the surgical attack removes the cervix, uterus, and node bearing areas and it is well known that a recurrence cannot take place in extirpated areas.\textsuperscript{30,35}

It is now felt by many that surgery can be used as adequate primary treatment in Stage I.\textsuperscript{26,30,35} It may also be used in combination with radiation in Stages I through IV. There are, however, many radiotherapists who feel that surgery is not indicated except in situations where radiation has been shown to fail, or in cases where infection or pelvic abnormalities preclude the use of radiation.\textsuperscript{3,19}
Cervical Lymphatic System. In order to understand the various surgical procedures used in treating invasive carcinoma of the uterine cervix, and the degree of success of each of these procedures, it is necessary to be familiar with the lymphatics that drain the cervix since it is by way of the lymphatics that metastases occur. It is on a firm knowledge of the anatomy of the lymphatic drainage that modern cancer surgery is based.

The lymphatics which drain the cervix converge in the same area of the isthmus to form the so-called paracervical plexus, and from here individual lymph channels follow the course of the uterine vessels. There are three main channels. The major drainage is the anterior, preureteric, or external iliac route. As the name implies, this drainage follows the uterine artery and extends laterally, anterior to the ureter, to the hypogastric, obturator, external iliac and sacral nodes. The posterior, retroureteric, or internal iliac drainage follows the uterine vein posteriorly to terminate in the hypogastric nodes. The sacral drainage passes within the uterosacral folds to terminate in nodes near the sacral promontory or in the lateral sacral nodes.

As regards the lymph nodes themselves, they are variable in size from 4 mm to 1.5 cm and are embedded in fat and areolar tissue. Even though they vary in size and number, they tend to appear in
distinct groups which can be classified.

I. THE PRIMARY GROUP

A. Parametrial Nodes. This is a constant group of small nodes which occur along the lymphatic channels as they cross the parametrium.

B. Paracervical or Ureteral Node. This node is found at the junction of the uterine artery and ureter. It may be absent or may be found with other nodes.

C. Obturator Nodes. These nodes are found in the obturator fossa near the obturator vessels and nerve. There may be a few nodes or one large node, the so-called Leveuf's node.

D. Hypogastric Nodes. These nodes are found along the hypogastric vein near its junction with the external iliac. This group usually consists of a few small nodes.

E. External Iliac Nodes. These nodes which consist of six to eight large nodes, are found in the sulcus between the external iliac vessels but may occasionally be found medial to the vein.

II. THE SECONDARY GROUP

A. Sacral Nodes. These are found along the concavity and promontory of the sacrum.
B. **Common Iliac Group.** This group of four to six nodes lies along the course of the common iliac vessels just below the bifurcation of the aorta.

C. **Inguinal Group.** This group, including the deep and superficial femoral lymph nodes, is made up of large nodes.

D. **Periaortic or Aortic Nodes.** These run along the aorta and vena cava from the bifurcation to the diaphragm.

**Wertheim Hysterectomy.** This operation, more properly called a radical hysterectomy with bilateral pelvic lymph node dissection, is the most widely used surgical procedure against invasive carcinoma of the cervix. According to Meigs,

"This type of surgical approach should be confined to Stage I, most Stage II, and especially early Stage III cases... The more advanced the disease, the more likelihood of extension and of positive nodes, and the less likelihood of cure." 26

The technique is based on a surgical concept for treating malignant disease that is entirely different from the approach to benign conditions. That concept is that the operation must begin at the most lateral point of potential spread and work toward the primary; whereas, operations for benign disease begin at the lesion and work laterally only as necessary. This, of
course, is to prevent iatrogenic metastases, if possible. It is necessary to do a wide excision, removing uterus, adnexa, and all areolar tissue and lymph nodes in the common iliac, hypogastric, external iliac, and obturator regions. A wide vaginal cuff is taken to guard against local metastases. The ureters are dissected free from the bifurcation of the aorta to the bladder entrance. The bladder is mobilized from the vagina so that the block of lymphatic tissue which runs from lateral pelvic wall to the paracervical and paravaginal areas may be removed. The vesical nerve supply will be damaged by this maneuver and bladder atony will occur for some time in an adequate operation.\textsuperscript{14}

**Schauta Hysterectomy. (Radical Vaginal Hysterectomy).** This operation, a radical vaginal hysterectomy, supposedly has the advantage of less operative hazard than the abdominal approach, and there are fewer ureteral injuries. Also, the primary mortality is supposedly lower and there are fewer post operative fistulae.\textsuperscript{25} However, this operation has not gained favor in the United States because the pelvic lymph nodes cannot be removed by this approach.\textsuperscript{26}

**Pelvic Lymphadenectomy.** This procedure, which has not found wide acceptance in this country, consists of bilateral pelvic lymph node dissection without the removal of the primary lesion. In 1952, Kimbrough treated a small series of patients with lymphadenectomy followed by full radiation to the cervix.
His Stage I patients had 20.3% incidence of positive nodes, and his Stage II patients had a 34.8% incidence. After 5 years, 87% of Stage I patients and 62% of Stage II patients were alive without recurrence. Gray found that preoperative radiation reduced the number of positive nodes to the extent that operative lymphadenectomy should not be necessary.

Exenteration. These operations were originally meant to be only palliative and were used to relieve the patient from necrotic fistulae, pelvic sepsis, and the possibility of sudden massive hemorrhage. They were originally done by Brunschwig in 1947. At the present time, however, they are known to be curative in a small number of cases.

These radical operations are an attempt to salvage patients with Stage III or IV carcinomas of the cervix who would otherwise have no hope of recovery. In the total exenteration, all pelvic organs including the vagina, bladder, uterus, adnexa, and rectum are removed. A colostomy is done, as well as some means for urinary drainage. The anterior exenteration is done when the bladder is involved but the rectum is free. The posterior exenteration is done when the bladder is free but the rectum is involved. The initial mortality rate is 20-30%, but it must be remembered that patients selected for exenteration would
ordinarily live only 1-2 years without the operation. The survival rates are about 20% at best\textsuperscript{37} and complications are extremely frequent, but the proponents of exenteration feel that since these figures are comparable to those in lung and stomach cancer, the operations should continue to be done when indicated.
RESULTS OF SURGICAL TREATMENT OF CARCINOMA OF THE CERVIX

Stage 0. In Stage 0, there was a total of 38 patients treated between January 1, 1958 and October 1, 1963. The average age of these patients was 35.8 years. All of these patients except one were treated by surgical means. One patient (2.6%) was treated by irradiation because she had severe heart disease which was considered a contraindication to surgery.

Total abdominal hysterectomy was the treatment in 26 of the 38 patients (68.4%). Six patients (15.8%) were treated with total abdominal hysterectomy with bilateral salpingoophorectomy, and two patients (5.3%) were treated by total abdominal hysterectomy with unilateral salpingoophorectomy. Three patients (7.9%) were treated with only cervical conization. These methods of treatment are summarized by years in Table 6.

<table>
<thead>
<tr>
<th>Year</th>
<th># Patients</th>
<th>TAH</th>
<th>TAH with BSO</th>
<th>TAH with USO</th>
<th>Cervical Cone</th>
<th>Rad.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1958</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>1959</td>
<td>7</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1960</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1961</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>1962</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>1963</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 6—Methods of Treatment of Stage 0 Carcinoma of the Cervix.
In the 26 total abdominal hysterectomies which were done, operative time ranged from 1-3½ hours, with a mean operative time of 2.6 hours. No blood was required in 15 patients, but 11 patients had transfusions of from one to three units.

In the six total abdominal hysterectomies with bilateral salpingoophorectomies, operative time ranged from two to three hours, with a mean operative time of 2.6 hours. Only one patient required a unit of blood.

In the two total abdominal hysterectomies with unilateral salpingoophorectomies, the operative time was two hours. Neither of the patients required blood transfusions.

**Complications.** In the 37 patients who were surgically treated for carcinoma in situ (Stage 0) carcinoma of the cervix, seven (18.9%) had postoperative complications. These were infectious in nature, for the most part, and are listed below.

1. Infected hematoma of vaginal cuff (1 case)
2. Intraabdominal abscess (1 case)
3. Wound infection (3 cases)
4. Cystitis (2 cases)

All complications occurred in patients who had hysterectomies, while none occurred in patients who were treated by cervical conization only.
Results. Of the 37 patients treated surgically, all are alive today. In no case has there been any evidence of recurrence. The one irradiated patient is also alive and free of recurrence.

Stage I. In Stage I, there was a total of 25 patients treated between January 1, 1958 and October 1, 1963. The average age of these patients was 45.4 years. Thirteen of these patients (52.0%) were treated by surgical means alone. Of these, ten had Wertheim hysterectomies, two had simple total abdominal hysterectomies, and one a vaginal hysterectomy with anterior and posterior repair of uterine prolapse. Three patients (12.0%) were treated with a combined program of radiation and surgery. Of these, one had radiation and an anterior exenteration, one had a simple total abdominal hysterectomy and radiation, and one had a Wertheim hysterectomy and radiation. Nine patients (36.0%) were treated with radiation alone. These methods of treatment are shown in tabular form in Table 7.

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
<th>Wertheim</th>
<th>TAH</th>
<th>Vaginal Hysterectomy</th>
<th>Radiation &amp; Surgery</th>
<th>Radiation Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1958</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>1959</td>
<td>9</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>1960</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1961</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 7-Methods of Treatment, Stage I Carcinoma of Cervix, 1958-1963.
In the 11 Wertheim hysterectomies which were done, operative time ranged from 2½ to 5½ hours, with a mean operative time of 3.8 hours. All patients required blood transfusions, ranging in amounts from one to four units. The average amount of transfused blood per patient was 2.5 units.

In the three total abdominal hysterectomies, operative time ranged from 1½ to 3½ hours, with a mean operative time of 2.3 hours. Only one patient required a unit of blood.

The vaginal hysterectomy with repair of a uterine prolapse took 2 hours. No blood was required.

The anterior exenteration with sigmoid ureterostomy took 5½ hours.

Complications. In the 11 Wertheim hysterectomies which were done in Stage I, there were three complications (27.2%). These are listed below.

1. Postoperative infection leading to adhesions, finally resulting in bowel obstruction.
2. Postoperative cystitis.
3. Postoperative pyelitis and hydronephrosis.

The vaginal hysterectomy with repair of uterine prolapse was complicated by breakdown of the vaginal cuff and infection.
There were no complications in the three total abdominal hysterectomies or in the anterior exenteration.

Hence, there was a total of four operative complications in the 16 surgically treated patients, or an incidence of 25%.

Results. Ten patients were treated by Wertheim hysterectomy alone, and all of these patients are alive today with no evidence of recurrence. One patient who was operated upon in 1958 has survived 56 months. The most recently treated patient has survived 33 months. This results in a 2 year survival rate of 100%.

Two patients were treated by total abdominal hysterectomy only. Both of these patients are alive today, but the patient treated in 1961 is currently being treated for recurrence of the neoplasm after 28 months. The two year survival rate is 100%.

The one patient whose Stage I cancer was detected as an incidental finding after hysterectomy for other reasons is alive today, 45 months post operatively. This is a 2 year survival rate of 100%.

Two of the three patients who were treated with radiation and surgery are dead of cancer of the cervix. These are the patient who had a simple hysterectomy plus radiation, and an anterior exenteration plus radiation. The patient who had a Wertheim
hysterectomy with radiation is alive and free from recurrence after 34 months. The two year survival rate is 33 1/3%.

Of the patients (9) who were treated with radiation alone, one is dead (after 2 months) of her tumor. Another died of a myocardial infarction, but at the time of her death, she was 30 months post-treatment, and free of carcinoma. The two year survival rate is 88.9%. The above results for Stage I are shown in Table 8.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th># Patients</th>
<th>Alive &amp; Well after 2 yr.</th>
<th>2 yr. Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wertheim hysterectomy only</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>TAH alone</td>
<td>2</td>
<td>2*</td>
<td>100%</td>
</tr>
<tr>
<td>Vaginal hysterectomy only</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Radiation &amp; surgery</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Radiation only</td>
<td>9</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>Totals</td>
<td>25</td>
<td>22</td>
<td>88%</td>
</tr>
</tbody>
</table>

*Recurrence after 28 mo. in one patient.

Table 8—Survival of Patients Treated for Stage I Carcinoma of the Cervix, 1958-1963.

Stage II. In Stage II, a total of 17 patients was seen between January 1, 1958 and October 1, 1963. The average age of
these patients was 54.1 years. None of these patients were treated by surgery alone. Two patients (11.8%) were treated with a combination of radiation and surgery. One of these had radiation and an anterior exenteration which lasted 8 hours, and the other had radiation and a Wertheim hysterectomy. Fourteen of the patients (82.4%) received radiation therapy alone, and one patient (5.8%) refused any therapy and was lost to follow-up in 1961.

Results. The two patients who were managed with radiation and surgery combined are both alive at this time. The patient who had radiation and an exenteration is alive after 48 months, but recently developed pulmonary metastases, presumably from the cervical tumor. The patient who had a Wertheim hysterectomy is alive at 24 months, but has just had recurrence of the disease in her pelvis.

Of the 14 patients treated with radiation alone, seven (50.0%) are now dead of the carcinoma. Seven others are alive and free of the disease at post-treatment time spans ranging from 6 to 48 months.

The one patient who refused treatment was lost to follow-up in 1961.
These results are shown on Table 2.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th># PATIENTS</th>
<th>LIVING</th>
<th>DEAD</th>
<th>% SURVIVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation &amp; exenteration</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Radiation &amp; Wertheim</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Radiation alone</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>50%</td>
</tr>
<tr>
<td>Totals</td>
<td>16</td>
<td>7</td>
<td>7</td>
<td>56.25%</td>
</tr>
</tbody>
</table>

Table 2—Results of Treatment in Stage II.

Stage III. In Stage III, there was a total of 14 patients treated between January 1, 1958 and October 1, 1963. All of these patients were treated by radiological means. Of these 14 patients, 13 (92.8%) are dead. These deaths occurred from two to 40 months after treatment, with an average survival time of 15 months. The one surviving patient is now alive 42 months after treatment.

Stage IV. In Stage IV, there was a total of 5 patients treated between January 1, 1958 and October 1, 1963. The average age of these patients was 61.8 years. Two patients (40%) refused therapy. One patient (20%) was treated with an anterior exenteration alone. One (20%) had an exenteration and radiation. Another (20%) was treated with radiation only. These methods of treatment are shown in Table 10.
The anterior exenteration in 1960 took seven hours. The patient required 23 pints of blood. Complications in this case included a wound infection and a rectoperineal fistula.

The exenteration with sigmoid colostomy took five hours to perform and the patient required five units of blood.

Results. The two patients who refused therapy are both dead at two weeks and four months after treatment was offered.

The patient treated with anterior exenteration alone is living 35 months after surgery.

The patient treated with radiation and exenteration with sigmoid colostomy died 17 months after treatment, and the patient treated with radiation only died 14 months after treatment. These results are summarized in Table 11.
<table>
<thead>
<tr>
<th>MANAGEMENT</th>
<th># PATIENTS</th>
<th>LIVING</th>
<th>DEAD</th>
<th>% SURVIVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refused therapy</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Anterior exenteration</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Radiation &amp; exenteration</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation only</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>20%</td>
</tr>
</tbody>
</table>

Table 11—Two year Survivals in Stage IV Carcinoma of the Cervix.
DISCUSSION

Stage 0. In our study, there were 37 patients treated surgically for carcinoma in situ of the cervix. All of these are now alive and there has been no recurrence in any case. This 100% survival rate is excellent compared to the results of other centers.

At the Mayo Clinic, there were 1,290 patients treated for carcinoma in situ between 1932 and 1960. In this group there was one operative death, and there were three deaths from recurrent carcinoma in the vagina.36 This gives a survival rate (excluding 37 patients who have died of unrelated causes) of 99.8%. Surgical procedures done in this group of patients included total abdominal hysterectomies and definitive conizations. In a smaller group of Stage 0 patients done at Rochester, 12 patients were subjected to Wertheim hysterectomies with a five year survival rate of 100%. There were no recurrences in this group.

At the University of Oklahoma, somewhat more unfortunate results were obtained. In this study of 74 patients with Stage 0 cancer, there were six recurrences of the neoplasm in the vagina after total abdominal hysterectomy. This is attributed in part to lack of removal of an adequate vaginal cuff.
In our series of surgical patients, there were a number of complications attributed to surgery. In the 34 total abdominal hysterectomies done in Stage 0, there were 7 complications. They were, for the most part, minor. There were three wound infections, two cases of cystitis, one intra-abdominal abscess, and one infected vaginal cuff.

**Invasive Carcinoma.** Table 12 shows results of purely surgical therapy. Table 12, included only for reference, shows results of pure radiation therapy, and will not be discussed since this report is intended to discuss surgical results only.

<table>
<thead>
<tr>
<th>STAGE</th>
<th># SURGICAL PATIENTS</th>
<th>L &amp; W AFTER 2 YEARS</th>
<th>2 YEAR SURVIVAL RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>13</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td>II</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>III</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IV</td>
<td>14</td>
<td>14</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table 12-Survival of Surgically Treated Patients.**

<table>
<thead>
<tr>
<th>STAGE</th>
<th># IRRADIATED PATIENTS</th>
<th>L &amp; W AFTER 2 YEARS</th>
<th>2 YEAR SURVIVAL RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>9</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>II</td>
<td>14</td>
<td>7</td>
<td>50.0%</td>
</tr>
<tr>
<td>III</td>
<td>14</td>
<td>5</td>
<td>35.7%</td>
</tr>
<tr>
<td>IV</td>
<td>1</td>
<td>0</td>
<td>00.0%</td>
</tr>
<tr>
<td>Totals</td>
<td>38</td>
<td>20</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

**Table 12-Survival in Radiation Program.**
At first glance, it seems that our 2-year survival rate of 100% in patients treated only by surgical means is remarkably good. Our elation must be tempered by the fact that we are comparing this survival rate to an exceedingly small group of combined therapy and radiation patients, and that our surgical group itself is small. Even though this is true, the good results are encouraging and warrant continued investigation in purely surgical treatment.

In reviewing the literature regarding the survival of surgical patients, the results of several investigators were studied. The operative procedure used most frequently was the radical abdominal hysterectomy with bilateral pelvic lymphadenectomy (Wertheim hysterectomy). The best results were obtained in a group in Japan reviewed by Magara.24 In Stage I, the five year survival rate in his 28 patients was 100%. In Stage II, it was 74.1% and in Stage III it was 47.2%. The poorest results in the Wertheim hysterectomies were obtained by Blakley3 whose 5-year survival rate in Stage I was 66.1%. In Stage II it was 48.9% and in Stage III it was 20%. These results, along with those of other investigators are shown in Table 14.
INVESTIGATOR    STAGE I    STAGE II    STAGE III    STAGE IV

Blaikly\textsuperscript{3}  66.1\%  48.9\%  20.0\%  - - -
Carter\textsuperscript{9}   81.5\%  57.3\%  50.0\%  00.0\%
Green\textsuperscript{17}  85.5\%  57.3\%  10.0\%  - - -
Magara\textsuperscript{24}  100\%  74.1\%  47.2\%  - - -
Welch\textsuperscript{25}   89.2\%  74.3\%  60.0\%  00.0\%
TOTAL            86.4\%  63.7\%  45.9\%  00.0\%

Table 14-Results of Several Investigators of Radical Hysterectomy with Lymphadenectomy in Various Stages of Cancer of the Cervix.

Kimbrough\textsuperscript{22} summarized the results of four other investigators who used Wertheim hysterectomies in Stages I and II. These results are roughly comparable to the totals in Table 14, and are shown in Table 15.

INVESTIGATOR    STAGE I    STAGE II

Kelso           85.9\%  71.1\%
Rauscher and Spurny  87.4\%  58.0\%
Phillip         86.0\%  53.8\%
Meigs           81.8\%  61.8\%

Table 15-Five Year Survival Rates, Wertheim Hysterectomies.

Brunschwig\textsuperscript{16} published results in 1958 of his 269 Wertheim
procedures, giving an overall 5 year survival rate for all stages of 58%. Combining this with the results shown in Table 14, we find that there was a total of 1,335 patients treated by Wertheim hysterectomy and 959 were alive at the end of 5 years. This is a survival rate of 71.8%. This survival rate is deceivingly high because it is biased with regard to the number of patients in Stages I and II.

McCall25 treated 116 patients in all stages with the Schauta-Amreich radical vaginal hysterectomy and found that 108 (98%) survived five years. Brunschwig6 found that 17 (68%) of his 25 patients treated with radical vaginal hysterectomy survived five or more years. Combining the data of these two investigators of the radical vaginal operation, we find that of 141 patients in all stages, 125 (88.6%) survived five years or more.

With regard to the pelvic exenteration procedures for far advanced carcinoma of the cervix, the results of two investigators were studied. In 1957, Schmitz31 published results of various procedures which included results of 34 exenterations. Of the 34 patients, eight (23.5%) survived five or more years. Between 1947 and 1957, Brunschwig did 552 exenterations and found that 116 or 21.0% survived five years or more.37 These results are combined and presented in Table 16.
INVESTIGATOR  # PATIENTS  # SURVIVORS  5 YEAR SURVIVAL RATE
Schmitz31  34  8  23.5%
Brunschiwig37  552  116  21.0%
TOTALS  586  124  21.2%

Table 16- Results of Pelvic Exenteration Procedures.

In our study at the University of Nebraska, six patients were treated with a combined radiation-surgery program. The results of this management are seen on Table 17.

<table>
<thead>
<tr>
<th>STAGE</th>
<th># CASES</th>
<th># 2 YR. SURVIVALS</th>
<th>2 YR. SURVIVAL RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>II</td>
<td>2</td>
<td>2*</td>
<td>100%</td>
</tr>
<tr>
<td>III</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IV</td>
<td>1</td>
<td>0</td>
<td>00.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>3</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

*Now recurring in both patients.

Table 17-Survival in Combined Therapy Program

Several investigators studied the effects of pre-operative radiation on five year survival rates. Blaikly3 found that a combination of radiation and surgery produced identical five year cure rates to either method alone in Stage I. Brunschiwig6 concluded in 1958 that preoperative radiation was of no value, although his later statistics showed that this was not true.
Sweeney\textsuperscript{32} did Wertheim hysterectomies on previously irradiated patients and got a five year survival rate in all stages of 68.6%. In 1961, Brunschwig\textsuperscript{7} published a report on survivals of 404 patients without pre-operative radiation and 110 patients who were irradiated prior to surgery. He found that pre-operative radiation contributed to the survival rate. This was also the conclusion of Welch\textsuperscript{35} who studied 153 non-irradiated surgical patients and 144 irradiated ones. The results of these two investigators are tabulated and combined in Table 18.

<table>
<thead>
<tr>
<th>INVESTIGATOR</th>
<th>STAGE I NO RAD</th>
<th>STAGE I RAD</th>
<th>STAGE II NO RAD</th>
<th>STAGE II RAD</th>
<th>STAGE III NO RAD</th>
<th>STAGE III RAD</th>
<th>STAGE IV NO RAD</th>
<th>STAGE IV RAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunschwig\textsuperscript{7}</td>
<td>76%</td>
<td>84%</td>
<td>52%</td>
<td>53%</td>
<td>27%</td>
<td>20%</td>
<td>15%</td>
<td>27%</td>
</tr>
<tr>
<td>Welch\textsuperscript{35}</td>
<td>88%</td>
<td>91%</td>
<td>80%</td>
<td>72%</td>
<td>50%</td>
<td>67%</td>
<td>-</td>
<td>00%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>81%</td>
<td>88%</td>
<td>56%</td>
<td>64%</td>
<td>31%</td>
<td>45%</td>
<td>15%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Table 18—Five Year Survival Rates in Surgical Patients with and without Pre-operative Radiation.

All of our Stage I patients who were operated upon had pelvic lymph nodes which were free of metastases, as proved by pathologic examination. Other investigators have found a higher percentage of positive nodes. Green\textsuperscript{17}, Carter\textsuperscript{9}, and Brunschwig\textsuperscript{6} have found that 14\% of their Stage I patients have positive nodes. Riva\textsuperscript{24} and Kimbrough\textsuperscript{22} have a 19\% incidence of positive nodes in Stage I. It has been shown that the presence of pelvic lymph node metastases...
markedly affects the five year survival rate. For example, Green\textsuperscript{17} found that his five year survival rate in Stage I surgical patients with negative nodes was 89\%, but in those with positive nodes it was only 44\%. Brunschwig\textsuperscript{6} found that 82\% of his Stage I patients with negative nodes survived five years, while only 61\% of those with positive nodes did. Cosbie's\textsuperscript{10} results were 75\% and 22\% respectively. Our 100\% survival rate is no doubt a result of the absence of node metastases.

In our series of surgical cases, there were no operative mortalities. In comparing this to the operative deaths of others, we find that McCall\textsuperscript{25} had an 0.36\% immediate mortality in radical vaginal operations. Riva's\textsuperscript{28} Stage I operative mortality rate was 0.8\% for Wertheim hysterectomies. Brunschwig\textsuperscript{7} found an operative mortality of 0.7\% for all operations exclusive of exenterations. The immediate death rate for his exenterations was 11\%.

In the 11 Wertheim hysterectomies done here in Stage I, there were three complications (27.2\%). One patient had post-operative cystitis, another developed pyelitis and hydronephrosis, and another developed adhesions which finally resulted in bowel obstruction. There were no fistulae. In Stage IV, there were two exenteration procedures done. In one of these, there was a wound
infection and a rectoperineal fistula.

Our low incidence of major complications compares favorably with the findings of other investigators. Most found that their major complications were fistulae. In 447 Wertheim hysterectomies, Brunschwig\(^7\) had a 9% incidence of ureterovaginal fistulae and a 7% incidence of vesicovaginal fistulae. These findings are similar to those of Green.\(^1\) Green found that his 11% incidence of all fistulae was reduced to 5.6% by prolonged post-operative bladder drainage. Schmitz\(^3\) had an 11% incidence of complications (including fistulae, infection, and evisceration) in 24 Wertheim hysterectomies on patients who had had no pre-operative radiation. His incidence of complications in patients who had pre-operative radiation was 30%. Schmitz also had an incidence of 17.1% fistulae in 35 exenterations. Decker, in an interesting paper on sexual function after surgical treatment of carcinoma of the cervix found that sexual function was diminished or abolished in 18.8% of his 37 patients, but was increased or remained unchanged in the remainder.\(^1\)
SUMMARY

In this report, we have attempted to discuss the results which can be expected in the surgical treatment of carcinoma of the cervix.

The study group was a group of 99 patients treated by various means at the University of Nebraska Hospital between January 1, 1958 and October 1, 1963. Patient distribution by stage of carcinoma, age, blood group, and parity was presented. Initial symptoms and delay between the onset of symptoms and the patient's seeing a doctor were discussed.

The general aspects of surgery of carcinoma of the cervix were presented, and the indications and various procedures were discussed. These included the Wertheim radical hysterectomy, the Schaunta radical vaginal hysterectomy, pelvic lymphadenectomy, and the exenteration operations.

Results of surgical treatment at the University of Nebraska Hospital were tabulated and discussed, and complications were mentioned. A short literature review showing results of other investigators was also included.
CONCLUSIONS

It is apparent from the results of our study and from the results of others that the most widely accepted method of treatment for carcinoma in situ of the cervix is a total abdominal hysterectomy with removal of a wide vaginal cuff. Our two year survival rate, recurrence free, was 100%. From the results of other investigators we can see that the expected five year survival rate is virtually 100%. If the patient is pregnant, or wishes to become pregnant, it is acceptable to treat her by conization and adequate follow-up.

The advantages of surgery in the treatment of invasive cervical carcinoma are basically twofold. First, surgery allows direct exploration so that the extent of the disease can be seen. Second, the cervix, uterus, and node-bearing areas can be removed, precluding recurrences in these areas.

In our Stage I patients there were ten Wertheim hysterectomies, two total abdominal hysterectomies, and one vaginal hysterectomy. The two year survival rate is 100%. Complications after the Wertheim procedure included adhesions,(1); cystitis,(1); and hydronephrosis,(1). The Stage I surgical cases were obviously early invasions as shown by the fact that there were no positive
lymph nodes in any case. In Stage II, there were no patients treated by surgery alone, but two were treated with radiation and surgery, and they both have survived at least two years. No surgery was performed on Stage III patients. In Stage IV, one patient had an anterior exenteration and is alive after two years. Another had an exenteration and radiation and is dead.

The Wertheim hysterectomy, or radical hysterectomy with bilateral pelvic lymphadenectomy is the most widely used operation in the attack against invasive carcinoma of the cervix. After reviewing the literature, we find that we can expect a five year survival of about 86% in Stage I, 64% in Stage II, 46% in Stage III, and 0% in Stage IV. If there are pelvic nodal metastases, we can expect our survival rates to be halved. The Wertheim procedure carries with it an operative mortality of 0.8% and a 16% incidence of fistulae.

The pelvic exenteration procedures for far advanced carcinoma of the cervix may be expected to provide a five-year survival rate of approximately 20%.

It has been shown that modern surgery is not to be disregarded in the attack upon carcinoma of the cervix. It is a highly effective method of treatment which deserves further study.
BIBLIOGRAPHY


37. Gynecological Cancer Symposium, New York University Medical Center, November 14, 15, and 16, 1963, Unpublished Data.