Western Cape Government

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TYGERBERG HOSPITAL
Obstetrics and Gynaecology
Tel: 021 938 4638

Work-up for a suspected cervical carcinoma

- The incidence of cervical cancer cases in South Africa is 44.4/100 000.
- It is the second leading cause of female cancer in South Africa, the leading cause of cancer for females 15-44 and the most common cause of female cancer deaths in SA.
- The primary cause of cervical cancer is persistent infection with high-risk Human Papillomavirus (HPV), particularly types 16, 18, and 45.
- A patient with a cervical lesion must have an urgent biopsy which must be sent for histology. Cervical cytology / HPV testing is an inappropriate investigation for these patients.
- Once cervical cancer is confirmed, staging investigations are performed and the patients referred with an oncology booklet for discussion at the MDT

SIGNS AND SYMPTOMS OF CERVICAL CANCER

- Abnormal vaginal bleeding between periods.
- Continuous vaginal discharge.
- Menstrual periods becoming heavier and lasting longer.
- Vaginal bleeding or pain during sexual intercourse.
- Increased urinary frequency.
- Vaginal bleeding after menopause.

STAGING INVESTIGATIONS

IF A PATIENT HAS A CERVICAL LESION, she should have a BIOPSY

Cytology reporting *Squamous cell carcinoma* or *Suggestive of squamous cell carcinoma* still needs histology before referral. She should not be referred to colposcopy clinic, rather examined at her nearest hospital.

- STABLE PATIENTS SHOULD BE MANAGED AT A DISTRICT/REGIONAL HOSPITAL FOR INITIAL WORK-UP AND STAGING.
- PATIENTS WITH COMPLICATIONS: Ongoing, active bleeding, systemic sepsis, renal failure etc. should be transferred URGENTLY to Tygerberg Hospital (call the registrar on call for gynaecology).

The aim is to do the work up fast, efficiently, and as far as possible AS AN OUT-PATIENT.

- On presentation: Do cervical biopsy (organize it with Anatomical Pathologist on call to be done urgently). Provide your cell phone number on request form so that the Histology lab can contact you with the result.
- Check result, confirm cancer diagnosis and inform patient of result, then arrange investigations.
- FBC – look for anaemia & sepsis
- U&E and creatinine – exclude renal failure
- ALP, GGT, ALT, AST – to detect liver metastases
- Urine for MCS and give treatment if infection.
- HIV test with consent – contact HIV counsellor to do counselling and rapid test. Take CD4 count if patient is positive. Patient must be informed of the result and be referred for initiation of Anti-retrovirals if not already initiated. If already known with HIV, ensure a recent CD4 count and viral load and that the patient is compliant on treatment.
- RPR for Syphilis and treat if positive.
- Chest X-ray & report specifically ask to assess for lung metastases.
- Abdominal Ultrasound. Request radiographer to report on: liver metastases, pelvic or para-aortic lymph nodes, ascites and hydronephrosis.
- Do a catheter specimen dipsticks. If erythrocytes are absent, document this on the oncology booklet. If erythrocytes are present, document and book a cystoscopy (021 9386360) at Tygerberg Hospital. Write a referral for cystoscopy and take the consent. Write the cystoscopy date on the consent form and Oncology Book. Book the Gynaecology-oncology staging appointment on the same day.
- The Oncology Book should be COMPLETED at the referring hospital with all results. Phone 021 9384428 and book a Wednesday Gynae-oncology staging appointment or contact the registrar via the VULA app.
- In the case of abnormal clinical findings, complex pathology or special investigations that are abnormal, please phone and discuss the patient with the gynae-oncology registrar (021 9384428) or contact the registrar via the VULA app.

- If the patient has advanced cancer (stage II and above) please refer to the social worker to start the process of arranging a temporary disability grant.

INITIAL TREATMENT

1) Analgesia: Paracetamol & IMI morphine if in severe pain. Can convert IMI to oral mist morphine: 20mg/5ml. Give 2.5mls P.O. 4 hourly. The dose can be increased if pain not controlled.
2) Treat anaemia with iron and folate and transfuse if necessary. DO NOT transfuse patients when they have renal failure without discussing with an oncologist first. Hb should be > 10g/dL.
3) Bleeding from the tumour is often due to infection. If there is active bleeding, give Tranexamic acid (Cyclokapron) 500mg – 1g 8 hourly as well as antibiotics (e.g. co-amoxiclav).
4) Anticoagulation should be avoided in patients who are bleeding. Encourage mobilization for thrombus prevention.

Signed: Dr JL Butt

AUTHORISED BY	Haynes van der Merwe, GS Gebhardt
COMPILED BY	J Butt
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Abbreviation	Meaning
ALP	Alkaline Phosphatase
ALT	Alanine Aminotransferase
AST	Aspartate Aminotransferase
CA	Cancer
CD4	Cluster of Differentiation 4 (T-lymphocyte count)
FBC	Full Blood Count
GGT	Gamma-Glutamyl Transferase

Abbreviation	Meaning
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IMI	Intramuscular Injection
MDT	Multidisciplinary Team
MCS	Microscopy, Culture and Sensitivity
P.O.	Per os (oral administration)
RPR	Rapid Plasma Reagin (syphilis test)
U&E	Urea and Electrolytes
US	Ultrasound