



Understanding Cervical Cancer

A guide for people with cancer,
their families and friends

Cancer
information

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13 11 20



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The illustration on page 7 has been adapted from *An abnormal Pap smear result – what this means for you* (National Cervical Screening Program, 2006). Used by permission of the Australian Government.

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Note to reader

Always consult your doctor about matters that affect your health. This booklet is intended as a general introduction to the topic and should not be seen as a substitute for medical, legal or financial advice. You should obtain independent advice relevant to your specific situation from appropriate professionals and you may wish to discuss issues raised in this book with them. All care is taken to ensure that the information in this booklet is accurate at the time of publication. Please note that information on cancer, including the diagnosis, treatment and prevention of cancer, is constantly being updated and revised by medical professionals and the research community. Cancer Council Australia and its members exclude all liability for any injury, loss or damage incurred by use of or reliance on the information provided in this booklet.

Cancer Council

Cancer Council is Australia's peak non-government cancer control organisation. Through the eight state and territory Cancer Councils, we provide a broad range of programs and services to help improve the quality of life of people living with cancer, their families and friends. Cancer Councils also invest heavily in research and prevention. To make a donation and help us beat cancer, visit cancer.org.au or call your local Cancer Council.



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About this booklet

This booklet has been prepared to help you understand more about cervical cancer. The information in this booklet is relevant for anyone with a cervix. It is common to feel shocked and upset when told you have cervical cancer. We hope this booklet will help you, your family and friends understand how cervical cancer is diagnosed and treated.

We cannot give advice about the best treatment for you. You need to discuss this with your doctors. However, this information may answer some of your questions and help you think about what to ask your treatment team (see page 63 for a question checklist).

This booklet does not need to be read from cover to cover – just read the parts that are useful to you. Some medical terms that may be unfamiliar are explained in the glossary (see page 64). We also include information about support services. You may like to pass this booklet to your family and friends for their information.

How this booklet was developed

This information was developed with help from a range of health professionals and women affected by cervical cancer. It is based on Australian and international clinical practice guidelines for cervical cancer.¹⁻²

If you or your family have any questions, call Cancer Council **13 11 20**. We can send you more information and connect you with support services in your area. You can also visit your local Cancer Council website (see back cover).



**Cancer
Council
13 11 20**

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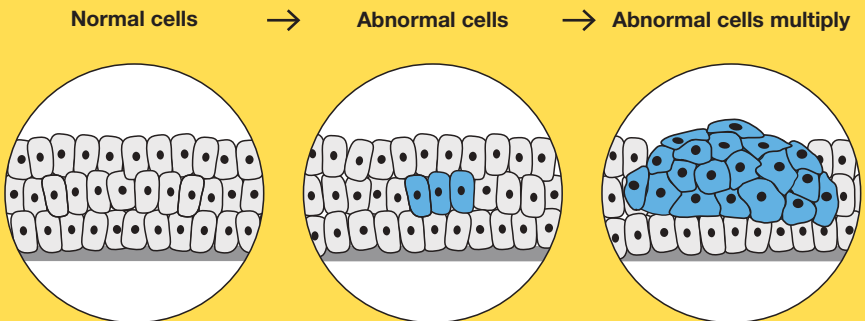
What is cancer?

Cancer is a disease of the cells. Cells are the body's basic building blocks – they make up tissues and organs. The body constantly makes new cells to help us grow, replace worn-out tissue and heal injuries.

Normally, cells multiply and die in an orderly way, so that each new cell replaces one lost. Sometimes, however, cells become abnormal and keep growing. In solid cancers, such as cervical cancer, the abnormal cells form a mass or lump called a tumour. In some cancers, such as leukaemia, the abnormal cells build up in the blood.

Not all tumours are cancer. Benign tumours tend to grow slowly and usually don't move into other parts of the body or turn into

How cancer starts

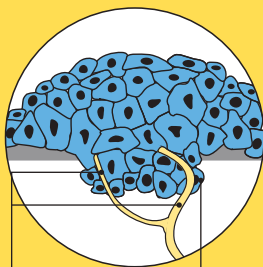


cancer. Cancerous tumours, also known as malignant tumours, have the potential to spread. They may invade nearby tissue, destroying normal cells. The cancer cells can break away and travel through the bloodstream or lymph vessels to other parts of the body.

The cancer that first develops is called the primary cancer. It is considered localised cancer if it has not spread to other parts of the body. If the primary cancer cells grow and form another tumour at a new site, it is called a secondary cancer or metastasis. A metastasis keeps the name of the original cancer. For example, cervical cancer that has spread to the lungs is called metastatic cervical cancer, even though the main symptoms may be coming from the lungs.

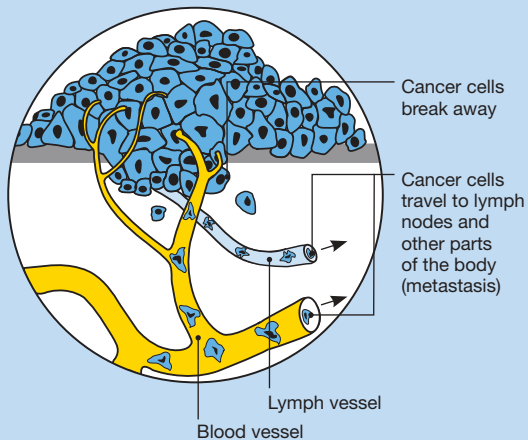
How cancer spreads

→ Malignant cancer



Grows own
blood vessels
(angiogenesis)

Invades
surrounding
tissue



Cancer cells
break away

Cancer cells
travel to lymph
nodes and
other parts of
the body
(metastasis)

Lymph vessel

Blood vessel



The cervix

The cervix is part of the female reproductive system, which also includes the fallopian tubes, uterus (womb), ovaries, vagina (birth canal) and vulva (external genitals).

Also called the neck of the uterus, the cervix connects the uterus to the vagina. The cervix:

- produces moisture to lubricate the vagina, which keeps the vagina healthy
- opens to let menstrual blood pass from the uterus into the vagina
- produces mucus that helps sperm travel up the uterus and fallopian tubes to fertilise an egg that has been released from the ovary
- holds a developing baby in the uterus during pregnancy by remaining closed, then widens to let a baby be born through the vagina.

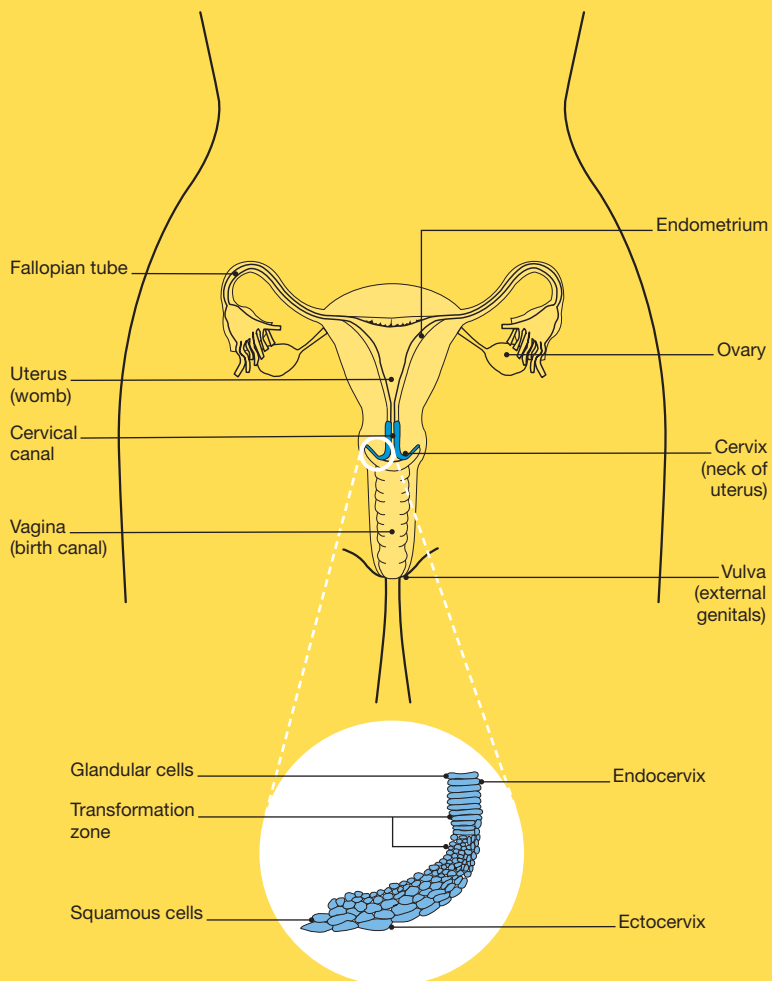
The cervix has an outer surface that opens into the vagina (ectocervix) and an inner surface that lines the cervical canal (endocervix). These two surfaces are covered by two types of cells:

Squamous cells – flat, thin cells that cover the outer surface of the cervix (ectocervix). Cancer of the squamous cells is called squamous cell carcinoma (see page 8).

Glandular cells – column-shaped cells that cover the inner surface of the cervix (cervical canal or endocervix). Cancer of the glandular cells is called adenocarcinoma (see page 8).

The area where the squamous cells and glandular cells meet is known as the transformation zone. This is where most cervical cancers start.

The female reproductive system





Key questions

Q: What is cervical cancer?

A: Cervical cancer begins when abnormal cells in the lining of the cervix grow uncontrollably.

Cancer most commonly starts in the area of the cervix called the transformation zone (see pages 6–7), but it may spread to tissues around the cervix, such as the vagina, or to other parts of the body, such as the lymph nodes, lungs or liver.

Q: What types are there?

A: There are two main types of cervical cancer, which are named after the cells they start in:

Squamous cell carcinoma (SCC) – the most common type, starts in the squamous cells of the cervix. It accounts for about 7 out of 10 cases (70%).

Adenocarcinoma – a less common type (about 25% of cases), starts in the glandular cells of the cervix. Adenocarcinoma is more difficult to diagnose because it occurs higher up in the cervix and the abnormal glandular cells are harder to find.

A small number of cervical cancers feature both squamous cells and glandular cells. These cancers are known as adenosquamous carcinomas or mixed carcinomas.

Other rarer types of cancer that can start in the cervix include small cell carcinoma and cervical sarcoma.

Q: How common is cervical cancer?

A: About 850 women in Australia are diagnosed with cervical cancer every year. Cervical cancer is most commonly diagnosed in women over 30, but it can occur at any age. About one in 195 women will develop cervical cancer before the age of 75.³

The incidence of cervical cancer in Australia has decreased significantly since a national screening program was introduced in the 1990s (see page 15) and a national HPV vaccination program was introduced in 2007 (see page 12).

Q: What are the symptoms?

A: In its early stages, cervical cancer usually has no symptoms. The only way to know if there are abnormal cells in the cervix that may develop into cervical cancer is to have a cervical screening test (see pages 15–16). If symptoms occur, they usually include:

- vaginal bleeding between periods, after menopause, or during or after sexual intercourse
- pelvic pain
- pain during sexual intercourse
- an unusual vaginal discharge
- heavier periods or periods that last longer than usual.

Although these symptoms can also be caused by other conditions or medicines, it is very important to rule out cervical cancer. See your general practitioner (GP) if you are worried or the symptoms are ongoing. This is important for anyone with a cervix, whether straight, lesbian, gay, bisexual, transgender or intersex.

What are precancerous cervical cell changes?

Sometimes the squamous cells and glandular cells in the cervix start to change. They no longer appear normal when they are examined under a microscope.

These early cervical cell changes may be precancerous. This means there is an area of abnormal tissue (a lesion) that is not cancer, but may lead to cancer. Only some women with precancerous changes of the cervix will develop cervical cancer.

Precancerous cervical cell changes are caused by certain types of the human papillomavirus (HPV). These cervical cell changes don't have symptoms but can be found during a routine cervical screening test (see pages 15–16).

There are two main types of cervical cell changes:

Abnormal squamous cells – These are called squamous intraepithelial lesions (SIL). They can be classified as either low grade (LSIL) or high grade (HSIL).

SIL used to be called cervical intraepithelial neoplasia (CIN), which was graded according to how deep the abnormal cells were within the surface of the cervix:

- LSIL, previously graded as CIN 1, usually disappear without treatment.
- HSIL, previously graded as CIN 2 or 3, are precancerous. High-grade abnormalities have the potential to develop into early cervical cancer over 10–15 years if they are not found and treated. They can often be treated without affecting fertility.

Abnormal glandular cells – These are called adenocarcinoma in situ. They will need treatment to reduce the chance they develop into adenocarcinoma. Anyone with abnormal glandular cells in the cervix should be referred to a gynaecologist for a colposcopy.

Treating precancerous cervical cell changes will prevent them developing into cervical cancer. See pages 18–20 for more information.

Q: What are the causes?

A: Almost all cases of cervical cancer are caused by an infection called human papillomavirus (HPV). There are also other known risk factors (see pages 12–13).

Infection with HPV – HPV is the name for a group of viruses. It is a common infection that affects the surface of different areas of the body, such as the cervix, vagina and skin.

There are more than 100 different types of HPV, including over 40 types that affect the genitals. Genital HPV is usually spread via the skin during sexual contact. About four out of five people will become infected with at least one type of genital HPV at some time in their lives. Some other types of HPV cause common warts on the hands and feet.

Most people will not know they have HPV as it is usually harmless and doesn't cause symptoms. In most people, the virus is cleared quickly by the immune system and no treatment is needed. In some women, the infection doesn't go away and they have an increased risk of developing changes in the cervix. These changes usually develop slowly over many years.

Approximately 15 types of genital HPV cause cervical cancer. Screening tests are used to detect most of these types of HPV or the precancerous cell changes caused by the virus. See pages 15–16 for more information on screening tests. There is also a vaccine that protects people from some types of HPV (see next page).

National HPV vaccination program

The HPV vaccine used in Australia protects against nine strains of HPV known to cause around 90% of cervical cancers.

People who are already sexually active may still benefit from the HPV vaccine. Ask your GP for more information.

The vaccine also offers some protection against other less common cancers associated with HPV, including vaginal, vulvar, anal and oropharyngeal cancers.

The HPV vaccine does not treat precancerous cell changes or cervical cancer.

As part of the national HPV vaccination program, the vaccine is free for girls and boys aged 12–13. (The vaccine helps to protect males against penile, anal and oropharyngeal cancers.)

If you've been vaccinated, you will still need regular screening tests as the HPV vaccine does not provide protection against all types of HPV.

For more information, visit hpvaccine.org.au.

Q: What are the risk factors?

A: Smoking and passive smoking – Chemicals in tobacco can damage the cells of the cervix, making cancer more likely to develop in women with HPV.

Long-term use of oral contraceptive (the pill) – Research has shown that women who have taken the pill for five years or more are at increased risk of developing cervical cancer. The reason for this is not clear. However, the risk is small and the pill can also help protect against other types of cancer, such as uterine and ovarian cancers. Talk to your doctor if you are concerned.

Having a weakened immune system – The immune system helps rid the body of HPV. Women with a weakened immune system have an increased risk of developing cervical cancer and need to have more frequent cervical screening tests. This includes women with the human immunodeficiency virus (HIV) and women who take medicines that lower their immunity. Ask your doctor if this applies to you and how often you should have a screening test.

Exposure to diethylstilbestrol (DES) – This is a synthetic (artificial) form of the female hormone oestrogen. DES was prescribed to pregnant women from the 1940s to the early 1970s to prevent miscarriage. Studies have shown that the daughters of women who took DES have a small but increased risk of developing a rare type of cervical adenocarcinoma.

Q: Which health professionals will I see?

A: Your GP will arrange the first tests to assess your symptoms. If these tests do not rule out cancer, you will usually be referred to a specialist, such as a gynaecologist or gynaecological oncologist. The specialist will arrange further tests.

If cervical cancer is diagnosed, the specialist will consider treatment options. Often these will be discussed with other health professionals at what is known as a multidisciplinary team (MDT) meeting. During and after treatment, you will see a range of health professionals who specialise in different aspects of your care (see table on the next page).

Health professionals you may see

gynaecologist*	specialises in diseases of the female reproductive system; may diagnose cervical cancer and then refer you to a gynaecological oncologist
gynaecological oncologist*	diagnoses and performs surgery for cancers of the female reproductive system (gynaecological cancers), such as cervical cancer
radiation oncologist*	treats cancer by prescribing and overseeing a course of radiation therapy
medical oncologist*	treats cancer with drug therapies such as targeted therapy, chemotherapy and immunotherapy
radiologist*	analyses x-rays and scans; an interventional radiologist may also perform a biopsy under ultrasound or CT, and deliver some treatments
cancer care coordinator	coordinates your care, liaises with MDT members, and supports you and your family throughout treatment; may be a clinical nurse consultant (CNC) or clinical nurse specialist (CNS)
nurse	administers drugs and provides care, information and support throughout treatment
dietitian	recommends an eating plan to follow during treatment and recovery
social worker, psychologist	link you to support services; help with emotional and practical problems associated with cancer and treatment
women's health physiotherapist	treats physical problems associated with treatment for gynaecological cancers, such as bladder and bowel issues, sexual issues and pelvic pain

**Specialist doctor*



Diagnosis

You may have tests for cervical cancer because you have symptoms or because your cervical screening test results (see next page) suggest that you have a higher risk of developing cervical cancer.

Some tests allow your doctor to see the tissue in your cervix and surrounding areas more clearly. Other tests tell the doctor about your general health and whether the cancer has spread. You probably won't need to have all the tests described in this chapter.

Screening test for cervical cancer

Cervical screening is the process of looking for cancer or precancerous changes in women who don't have any symptoms. The cervical screening test detects cancer-causing types of HPV in a sample of cells taken from the cervix.

The National Cervical Screening Program recommends that women aged 25–74 have a cervical screening test two years after their last Pap test, and then once every five years. Whether you identify as straight, lesbian, gay, bisexual, transgender or intersex, if you have a cervix you should have regular cervical screening tests.

During both the old Pap test and the new cervical screening test the doctor gently inserts an instrument called a speculum into the vagina to get a clear view of the cervix. The doctor uses a brush or spatula to remove some cells from the surface of the cervix. This can feel slightly uncomfortable, but it usually takes only a minute or two. The sample is placed into liquid in a small container and sent to a laboratory to check for HPV.

If HPV is found, a specialist doctor called a pathologist will do an additional test on the sample to check for cell abnormalities. This is called liquid-based cytology (LBC).

The results of the cervical screening test are used to predict your level of risk for significant cervical changes. If the results show:

- a higher risk – your GP will refer you to a specialist (gynaecologist) for colposcopy (see below)
- an intermediate risk – you will be monitored by having a follow-up test (usually for HPV) in 12 months and more frequent screening tests in the future
- a low risk – you will be due for your next cervical screening test in five years.

A small number of women are diagnosed with cervical cancer because of an abnormal cervical screening test. For more information about screening tests, call Cancer Council 13 11 20 or visit cervicalscreening.org.au.

Colposcopy and biopsy

If the cervical screening test results show that you have a higher risk of significant cervical changes, you will usually be referred for a colposcopy. A colposcopy lets your doctor look closely at the cervix to see where any abnormal or changed cells are and what they look like.

The colposcope is a magnifying instrument that has a light and looks like a pair of binoculars on a large stand. It is placed near your vulva but does not enter your body.

A colposcopy usually takes 10–15 minutes. You will be advised not to have sex or put anything in your vagina (e.g. tampons) for 24 hours before the procedure.

You will lie on your back in an examination chair with your knees up and apart. The doctor will use a speculum to spread the walls of your vagina apart, and then apply a vinegar-like liquid or iodine to your cervix and vagina. This makes it easier to see abnormal cells through the colposcope. You may feel a mild stinging or burning sensation, and you may have a brown discharge from the vagina afterwards.

If the doctor sees any suspicious-looking areas, they will usually take a tissue sample (biopsy) from the surface of the cervix for examination. You may feel uncomfortable for a short time while the tissue sample is taken. You will be able to go home once the colposcopy and biopsy are done. The doctor will send the tissue sample to a laboratory, and a pathologist will examine the cells under a microscope to see if they are cancerous. The results are usually available in about a week.

Side effects of a colposcopy with biopsy – After the procedure it is common to experience cramping that feels similar to menstrual pain. Pain is usually short-lived and you can take mild pain medicines such as paracetamol or non-steroidal anti-inflammatory drugs. You may also have some light bleeding or other vaginal discharge for a few hours.

To allow the cervix to heal and to reduce the risk of infection, your doctor will probably advise you not to have sexual intercourse or use tampons for 2–3 days after a biopsy.

Treating precancerous abnormalities

If any of the tests show precancerous cell changes, you may have one of the following treatments to prevent you developing cervical cancer.

Large loop excision of the transformation zone (LLETZ)

Also called loop electrosurgical excision procedure (LEEP), this is the most common way of removing cervical tissue to treat precancerous changes of the cervix. The abnormal tissue is removed using a thin wire loop that is heated electrically. The doctor aims to remove all the abnormal cells from the surface of the cervix.

A LLETZ or LEEP is done under local anaesthetic in your doctor's office or under general anaesthetic in hospital. It takes about 10–20 minutes. The tissue sample is sent to a laboratory for examination under a microscope. Results are usually available within a week.

Side effects of a LLETZ or LEEP – After a LLETZ or LEEP, you may have some vaginal bleeding and cramping. This will usually ease in a few days, but you may notice some spotting for 3–4 weeks. If the bleeding lasts longer than 3–4 weeks, becomes heavy or smells bad, see your doctor. To allow your cervix to heal and to prevent infection, you should not have sexual intercourse or use tampons for 4–6 weeks after the procedure.

After a LLETZ or LEEP you can still become pregnant, however you may have a slightly higher risk of having the baby prematurely. Talk to your doctor before the procedure if you are concerned.

Cone biopsy

This procedure is similar to a LLETZ. It is used when the abnormal cells are found in the cervical canal, when early-stage cancer is suspected, or for older women needing a larger excision. In some cases, it is also used to treat very small, early-stage cancers, particularly for young women who would like to have children in the future (see page 30).

The cone biopsy is usually done as day surgery in hospital under general anaesthetic. A surgical knife (scalpel) is used to remove a cone-shaped piece of tissue from the cervix. The tissue is examined to make sure that all the abnormal cells have been removed. Results are usually available within a week.

Side effects of a cone biopsy – You may have some light bleeding or cramping for a few days after the cone biopsy. Avoid doing any heavy lifting for a few weeks, as the bleeding could become heavier or start again. If the bleeding lasts longer than 3–4 weeks, becomes heavy or has a bad smell, see your doctor. Some women notice a dark brown discharge for a few weeks, but this will ease.

To allow your cervix time to heal and to prevent infection, you should not have sexual intercourse or use tampons for 4–6 weeks after the procedure.

A cone biopsy may weaken the cervix. You can still become pregnant after a cone biopsy, but you may be at a higher risk of having a miscarriage or having the baby prematurely. If you would like to become pregnant in the future, talk to your doctor before the procedure.

Laser surgery

This procedure uses a laser beam instead of a knife to remove the abnormal cells or pieces of tissue for further study.

A laser beam is a strong, hot beam of light. The laser beam is pointed at the cervix through the vagina. The procedure is done under local anaesthetic. Laser surgery takes about 10–15 minutes, and you can go home as soon as the treatment is over.

Laser surgery works just as well as LLETZ and may be a better option if the precancerous cells extend from the cervix into the vagina or if the lesion on the cervix is very large.

Side effects of laser surgery – These are similar to those of LLETZ. Most women are able to return to normal activity 2–3 days after having laser surgery, but will need to avoid sexual intercourse for 4–6 weeks.

Further tests

If any of the tests or procedures described on pages 16–20 show that you have cervical cancer, you may need further tests to find out whether the cancer has spread to other parts of your body. This is called staging (see page 24). You may have one or more of the tests described on the following pages.

Blood test

You may have a blood test to check your general health, and how well your kidneys and liver are working.



Before having scans, tell the doctor if you have any allergies or have had a reaction to contrast during previous scans. You should also let them know if you have diabetes or kidney disease or are pregnant.

Imaging scans

You may have one or more of the following imaging scans to find out if the cancer has spread to lymph nodes in the pelvis or abdomen or to other organs in the body.

CT scan – A CT (computerised tomography) scan uses x-rays to take pictures of the inside of your body and then compiles them into a detailed, three-dimensional picture.

Before the scan, you may be given a drink or an injection of a dye (called contrast) into one of your veins. The contrast may make you feel hot all over for a few minutes. You may also be asked to insert a tampon into your vagina. The dye and the tampon make the pictures clearer and easier to read.

During the scan, you will need to lie still on a table that moves in and out of the CT scanner, which is large and round like a doughnut. The scan is painless and takes 5–10 minutes.

MRI scan – An MRI (magnetic resonance imaging) scan uses a powerful magnet and radio waves to build up detailed cross-sectional pictures of the inside of your body. Let your medical team know if you have a pacemaker or any other metal implant as some may affect how an MRI works.

During the scan, you will lie on a treatment table that slides into a large metal cylinder that is open at both ends. The noisy, narrow machine can make some people feel anxious or claustrophobic. If you think you may become distressed, mention it to your medical team before the scan. You may be given medicine to help you relax, and you will usually be offered headphones or earplugs. Most MRI scans take 30–90 minutes.

PET scan – Before a PET (positron emission tomography) scan, you will be injected with a glucose (sugar) solution containing some radioactive material. You will be asked to lie still for 30–60 minutes while the solution spreads throughout your body.

Cancer cells show up brighter on the scan because they absorb more of the glucose solution than normal cells do. It may take a few hours to prepare for a PET scan, but the scan itself usually takes about 30 minutes.

PET-CT scan – A PET scan combined with a CT scan is a specialised test available at many major metropolitan hospitals. It produces a three-dimensional colour image. The CT helps pinpoint the location of any abnormalities revealed by the PET scan.

Examination under anaesthetic

Another way to check whether the cancer has spread is for the doctor to examine your cervix, vagina, uterus, bladder and rectum. This is done in hospital under general anaesthetic. If the doctor sees any abnormal areas of tissue during the procedure, they will take a biopsy (see pages 16–17) and send the sample to a laboratory for examination.

Pelvic examination – The doctor will put a speculum into your vagina and spread the walls of the vagina apart so they can check your cervix and vagina for cancer.

Uterus – The cervix will be dilated (gently opened) and some of the cells in the lining of the uterus (endometrium) will be removed and sent to a laboratory for examination under a microscope. This is called a dilation and curettage (D&C).

Bladder – A thin tube with a lens and a light called a cystoscope will be inserted into your urethra (the tube that drains urine from the bladder to the outside of the body) to examine your bladder.

Rectum – The doctor will use a gloved finger to feel for any abnormal growths inside your rectum. To examine your rectum more closely, the doctor may insert an instrument called a sigmoidoscope, which is a tube with an attached camera.

You will most likely be able to go home from hospital on the same day after one of these examinations under anaesthetic. You may have some light bleeding and cramping for a few days afterwards. Your doctor will talk to you about the side effects you may experience.



For more information about the most common tests used to diagnose cancer – from blood tests and biopsies to CT, MRI and PET scans – listen to our “Tests and Cancer” podcast episode at cancercouncil.com.au/podcasts.

Staging cervical cancer

The tests described on pages 16–23 help the doctors decide how far the cancer has spread. This is called staging. Knowing the stage of the cancer helps your health care team recommend the best treatment for you.

In Australia, cervical cancer is usually staged using the International Federation of Gynecology and Obstetrics (FIGO) staging system. This is also often used for other cancers of the female reproductive organs. FIGO divides cervical cancer into four stages. Each stage is further divided into several sub-stages.

Stages of cervical cancer

stage I	Cancer is found only in the tissue of the cervix.	early or localised cancer
stage II	Cancer has spread outside the cervix to the upper two-thirds of the vagina or other tissue next to the cervix.	locally advanced cancer
stage III	Cancer has spread to the lower third of the vagina and/or the tissue on the side of the pelvis (pelvic wall). The cancer may also have spread to lymph nodes in the pelvis or abdomen, or caused a kidney to stop working.	locally advanced cancer
stage IV	Cancer has spread to the bladder or rectum (stage IVA) or beyond the pelvis to the lungs, liver or bones (stage IVB).	metastatic or advanced cancer

Prognosis

Prognosis means the expected outcome of a disease. You may wish to discuss your prognosis and treatment options with your doctor, but it is not possible for anyone to predict the exact course of the disease. Instead your doctor can give you an idea about the general prognosis for people with the same type and stage of cancer.

To work out your prognosis, your doctor will consider:

- your test results
- the type of cervical cancer
- the size of the cancer and how far it has grown into other tissue
- whether the cancer has spread to the lymph nodes
- other factors such as your age, fitness and overall health.

In general, the earlier cervical cancer is diagnosed and treated, the better the outcome. Most early-stage cervical cancers have a good prognosis with high survival rates. If cancer is found after it has spread to other parts of the body (referred to as an advanced stage), the prognosis is worse and there is a higher chance of the cancer coming back after treatment (recurrence).



Key points about diagnosing cervical cancer

Cervical screening test

A cervical screening test checks for HPV, the virus that causes almost all cervical cancers. If HPV is detected, a pathologist will look for cell changes. HPV usually goes away on its own, but if your cervical screening test shows you are at higher risk of precancerous cell changes, you will usually have further tests.

Precancerous cell changes

Precancerous cell changes can be checked and treated in several ways including large loop excision of the transformation zone (LLETZ)/ loop electrosurgical excision procedure (LEEP), cone biopsy or laser surgery.

Follow-up tests

- If you are at higher risk of significant cervical abnormalities, the first test is a colposcopy to look for cell changes in the cervix and vagina.
- Your doctor may take a tissue sample (biopsy) from the cervix to see whether any cell changes are precancerous or cancerous.
- You may have further tests or imaging scans to find out whether the cancer has spread to other parts of the body.

Staging and prognosis

The stage shows how far the cancer has spread through the body. Early cervical cancer is stage I. Locally advanced cervical cancer is stage II or III. Advanced (metastatic) cervical cancer is stage IV. If cervical cancer is diagnosed early, it can usually be treated successfully.



Making treatment decisions

Sometimes it is difficult to decide on the type of treatment to have. You may feel that everything is happening too fast, or you might be anxious to get started. Check with your specialist how soon treatment should begin, as it may not affect the success of the treatment to wait a short time. Ask them to explain the options, and take as much time as you can before making a decision.

Know your options – Understanding the disease, the available treatments, possible side effects and any extra costs can help you weigh up the options and make a well-informed decision. Check if the specialist is part of a multidisciplinary team (see page 13) and if the treatment centre is the most appropriate one for you – you may be able to have treatment closer to home, or it might be worth travelling to a centre that specialises in a particular treatment.

Record the details – When your doctor first tells you that you have cancer, you may not remember everything you are told. Taking notes or recording the discussion can help. It is a good idea to have a family member or friend go with you to appointments to join in the discussion, write notes or simply listen.

Ask questions – If you are confused or want to check anything, it is important to ask your specialist questions. Try to prepare a list before appointments (see page 63 for suggestions). If you have a lot of questions, you could talk to a cancer care coordinator or nurse.

Consider a second opinion – You may want to get a second opinion from another specialist to confirm or clarify your specialist's recommendations or reassure you that you have explored all options.

Specialists are used to people doing this. Your GP or specialist can refer you to another specialist and send your initial results to that person. You can get a second opinion even if you have started treatment or still want to be treated by your first doctor. You might decide you would prefer to be treated by the second specialist.

It's your decision – Adults have the right to accept or refuse any treatment that they are offered. For example, some people with advanced cancer choose treatment that has significant side effects even if it gives only a small benefit for a short period of time. Others decide to focus their treatment on quality of life. You may want to discuss your decision with the treatment team, GP, family and friends.

- See our *Cancer Care and Your Rights* booklet and listen to our “Making Treatment Decisions” podcast episode.

Should I join a clinical trial?

Your doctor or nurse may suggest you take part in a clinical trial.

Doctors run clinical trials to test new or modified treatments and ways of diagnosing disease to see if they are better than current methods. For example, if you join a randomised trial for a new treatment, you will be chosen at random to receive either the best existing treatment or the modified new treatment. Over the years, trials have improved treatments

and led to better outcomes for people diagnosed with cancer.


You may find it helpful to talk to your specialist, clinical trials nurse or GP, or to get a second opinion. If you decide to take part in a clinical trial, you can withdraw at any time. For more information, visit australiancancertrials.gov.au.

- See our *Understanding Clinical Trials and Research* booklet.

Treatment

The most common treatment for cervical cancer is surgery and/or a combination of radiation therapy and chemotherapy (chemoradiation). When cervical cancer has spread beyond the cervix, targeted therapy may also be used.

Your medical team will recommend treatment based on the results of your tests; the location of the cancer and whether it has spread; your age and general health; and whether you would like to have children in the future.

 If becoming a parent is important to you, talk to your doctor before starting treatment and ask for a referral to a fertility specialist. For more information about fertility options, see page 51.

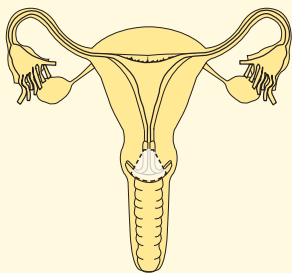
Surgery

For some women, surgery may be the only treatment needed. Surgery is usually recommended for women who have a tumour that is in the cervix only. The type of surgery you have will depend on how far within the cervix the cancer has spread. Your surgeon will talk to you about the most appropriate surgery for you, as well as the risks and any possible complications (in both the short and long term).

The main type of surgery is called a hysterectomy, which is done under general anaesthetic. A hysterectomy is an operation to remove the uterus (womb) and cervix. The surgeon may also remove other organs of the reproductive system (see pages 30–31) or the lymph glands on the side wall of the pelvis (see page 33).

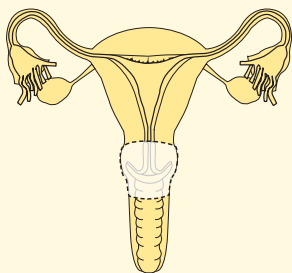
Types of surgery

Depending on how far the cancer has spread and your age, you may have one or more of the procedures listed below.



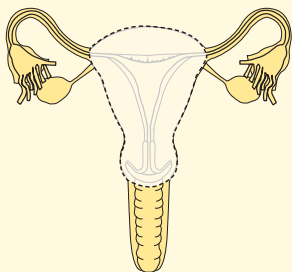
Cone biopsy

Removes a cone of tissue around the cancer, including a margin of healthy tissue. This is used to treat very early cervical cancers, particularly for young women who would like to have children. See page 19 for more information.



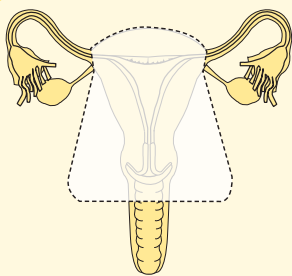
Trachelectomy

Removes part or all of the cervix, along with the upper part of the vagina. The uterus, fallopian tubes and ovaries are left in place. This is not a common procedure, but it may be used in young women with early-stage cancer who would like to have children.



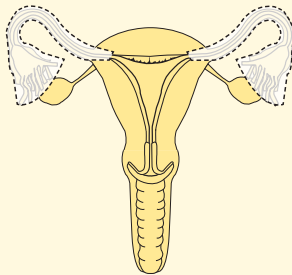
Total hysterectomy

Removes the uterus and cervix. Can be suitable for early cervical cancers. The fallopian tubes are also commonly removed (see *Bilateral salpingectomy*, opposite). Some premenopausal women are able to keep their ovaries.



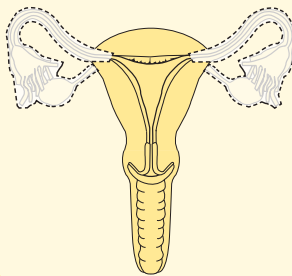
Radical hysterectomy

Removes the uterus, cervix, and soft tissue around the cervix and top of the vagina. This is the standard operation for most cervical cancers treated with surgery. The fallopian tubes are also commonly removed (see below). Some premenopausal women are able to keep their ovaries.



Bilateral salpingectomy

Removes both fallopian tubes. This is commonly recommended for women having a hysterectomy performed through the abdomen (open surgery). Your doctor will talk to you about the risks and benefits of removing the fallopian tubes.



Bilateral salpingo-oophorectomy

Removes both fallopian tubes and ovaries. This is considered when your doctor is concerned that the cancer may have spread to the ovaries, or for women approaching the menopause or of menopausal age.

How the surgery is done

The surgery will be performed under a general anaesthetic. The hysterectomy can be done in two different ways.

Open surgery (laparotomy) – The surgery is performed through the abdomen. A cut is usually made from the pubic area to the bellybutton. Sometimes the cut is made along the pubic line instead. The uterus and other organs are then removed. Research has shown that open surgery is the better option for most cervical cancers.

Keyhole surgery (laparoscopy or robotic surgery) – These methods use thin cameras and instruments that are inserted through small cuts into the abdomen. The uterus and other organs are removed through the vagina. Laparoscopic surgery may be used for small, early-stage tumours.

Treatment of lymph nodes

Cancer cells can spread from the cervix to the lymph nodes in the pelvis. You may have one of the following procedures:

Sentinel lymph node biopsy – This test helps to identify the lymph node that the cancer is most likely to spread to first (the sentinel lymph node). While you are under anaesthetic, your doctor will inject a dye into the cervix. The dye will flow to the sentinel lymph node, and the surgeon will remove it for testing. If it contains cancer cells, the remaining nodes in the area may be removed in a procedure called a lymphadenectomy. Alternatively, your doctors may decide you need other treatments such as chemoradiation (see page 37). A sentinel lymph node biopsy can help the doctor avoid removing more lymph

nodes than necessary and minimise side effects such as lymphoedema (see page 49). This procedure may be used for some women with early cervical cancer and is only available in some treatment centres. Research into its role in treating cervical cancer is ongoing.

Lymphadenectomy (lymph node dissection) – The surgeon will remove an area of lymph nodes from the pelvic and/or abdominal areas to see if the cancer has spread beyond the cervix. If cancer is found in the lymph nodes, your doctor may recommend you have additional treatment, such as radiation therapy (see pages 37–41).

What to expect after surgery

When you wake up from surgery, you will be in a recovery room near the operating theatre. Once you are fully conscious, you will be taken to your bed on the hospital ward.

Tubes and drips – You may have an intravenous (IV) drip to give you fluid and medicine, a tube in your abdomen to drain fluid from the operation site, and a small plastic tube (catheter) in your bladder to drain urine. These tubes will be removed before you go home.

After the catheter is removed from your bladder, the nurses will perform a test to check that your bladder is emptying properly. This is done by measuring the amount of urine you pass each time you go to the toilet, then using an ultrasound scan to check that your bladder is empty. It is a quick, painless test that is done on the hospital ward.

Pain and discomfort – After a major operation it is common to feel some pain. You will be given pain medicine as a tablet, through a

drip (intravenously) or through a catheter inserted in the spaces in the spine (epidural). If you still have pain, let your doctor or nurse know so they can change your medicine to one that provides more relief.

Moving your legs – While you are in bed, you may have to wear compression stockings or “calf compressors” around your lower legs. These help the blood in your legs circulate and prevent blood clots forming in the deep veins of the legs or pelvis (deep vein thrombosis). You will be encouraged to walk around as soon as you can.

Recovery – You will spend 3–5 days in hospital after a hysterectomy. The recovery time depends on the type of surgery and your fitness. You will be able to go home when the medical team is satisfied with your recovery and the results of your bladder function tests.

Side effects of surgery

After surgery for cervical cancer, you may experience some of the following side effects. For more information, see the *Managing side effects* chapter, pages 46–54 .

Problems with bladder or bowel function – If some of the nerves to the bladder were removed during the hysterectomy, you may feel that you’re not able to empty your bladder completely, or that you’re emptying your bladder or bowel too slowly. These problems improve with time. Some women experience accidental leakage of urine after surgery. This is called urinary incontinence.

Lymphoedema – Sometimes the removal of lymph nodes in the pelvis can stop or slow the natural flow of lymphatic fluid. This may

cause lymphoedema, which is excess fluid in the legs. Symptoms of lymphoedema may appear immediately or years after surgery.

Menopause – If your ovaries are removed and you have not been through menopause, removal will cause sudden menopause. After menopause you will not be able to become pregnant.

Impact on sexuality – The physical and emotional changes you experience after surgery may affect how you feel about sex, but surgery doesn't change the ability to have sex or feel pleasure.

Internal scar tissue (adhesions) – Tissues in the pelvis may stick together. Sometimes adhesions to the bowel or bladder may cause abdominal pain or discomfort. Rarely, adhesions may need to be treated with surgery.



Anne's story

After the operation, I had radiation therapy daily for six weeks. The treatment made me feel very tired and also affected my bowels and bladder.

But for me, the hardest part of cancer and treatment is the ongoing emotional side of it. The physicality of having treatment is one thing, but the emotional roller-coaster was the worst part.

My doctors have told me to be vigilant about everything abnormal, such as any vaginal bleeding or pain. Even many years later, there is a lot of uncertainty.

Sometimes I panic when I feel unwell and rush to my doctor for reassurance. Mostly now, it feels like it was a bad dream, and I focus on living my life to the full.

Taking care of yourself at home

Your recovery time after a hysterectomy will depend on the type of surgery you had, your age and general health. Most women say they feel better within six weeks.



Rest

Take things easy for the first few weeks and only do what is comfortable. Ask family or friends to help you with chores so you can rest as much as you need to.

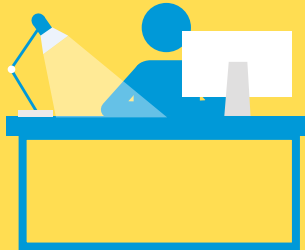


Exercise

Walk regularly if your doctors say it is okay to do so. Gentle exercise can help speed up recovery. Speak to your doctor about when it is suitable to start more vigorous exercise.

Work

Depending on the nature of your work, you will probably need 6 weeks leave from work.



Diet

Drink plenty of water and eat lots of fresh vegetables and fruit to avoid becoming constipated.

Sex

You'll need to avoid sexual intercourse for at least 6 weeks to give the vaginal wound time to heal properly.



Bathing

Take showers instead of baths and avoid swimming for 4–6 weeks after surgery.

Lifting

Avoid heavy lifting for about a month, although this will depend on the type of surgery you had.

Radiation therapy

Also called radiotherapy, radiation therapy uses x-rays to kill or damage cancer cells. The radiation is targeted at the parts of the body with cancer or areas the cancer cells might have spread to. Treatment is carefully planned to do as little harm as possible to healthy tissues.

You may have radiation therapy on its own as the main treatment for cervical cancer, or you may have it after surgery to help get rid of any remaining cancer cells. Women with cervical cancer that has spread to the tissues or lymph nodes surrounding the cervix will usually have radiation therapy in combination with chemotherapy (chemoradiation) to reduce the chance of the cancer coming back.

There are two main ways of delivering radiation therapy: externally or internally. Most women who have radiation therapy for cervical cancer will have both types.

Chemoradiation

When radiation therapy is combined with chemotherapy, it is known as chemoradiation. The chemotherapy drugs make the cancer cells more sensitive to radiation therapy.

If you have chemoradiation, you will usually receive chemotherapy once a week a few hours before the radiation therapy appointment.

Side effects of chemoradiation include fatigue; diarrhoea; needing to pass urine more often or in a hurry; cystitis; dry and itchy skin in the treatment area; nausea; and low blood counts. Low numbers of blood cells may cause anaemia, infections or bleeding problems. Talk to your treatment team about ways to manage the side effects of chemoradiation.

External beam radiation therapy

In external beam radiation therapy, a machine precisely directs radiation beams from outside the body to the cervix, lymph nodes and other organs that need treatment. The initial planning session will include a CT scan to work out where to direct the radiation beams, and may take up to 45 minutes. The actual treatment takes only a few minutes each time.

You will probably have external radiation therapy as daily treatments, Monday to Friday, over 4–6 weeks as an outpatient. You will lie on a table under the radiation therapy machine. Before the machine is turned on, the radiation therapist will leave the room, but they will be able to talk to you through an intercom and they will watch you on a screen while you have treatment. The treatment itself is painless.

Internal radiation therapy

Internal radiation therapy is known as brachytherapy. It is a way of delivering radiation therapy from inside your body directly to the tumour, while reducing the amount of radiation delivered to nearby organs such as the bowel and bladder. The main type of internal radiation therapy used for cervical cancer is high-dose-rate (HDR) brachytherapy. With HDR, bigger doses are given in a few treatments.

During treatment – You will probably have 3–4 sessions over 2–4 weeks. You will be given a general or spinal anaesthetic at each brachytherapy session.

Applicators are used to deliver the radiation source to the cancer. They are available in different sizes and your radiation oncologist

will examine you to choose a suitable applicator for your situation. The applicator is placed into the cervix under the guidance of an ultrasound to make sure it is in the right place.

To hold the applicator in place, you may have gauze padding put into your vagina, and a stitch or two in the area between the vulva and the anus (perineum). You will also have a small tube (catheter) inserted to empty your bladder of urine during treatment.

You will have a CT or MRI scan to check the position of the applicator. This scan helps your doctor deliver the brachytherapy to the correct area. Once your doctor has completed the treatment plan, the radiation source will be placed into the applicator for 10–20 minutes. If you have a general anaesthetic, this will happen while you are asleep.

If you've had surgery to remove the cervix and uterus (hysterectomy), your doctor may want to deliver some extra radiation to the top of the vagina. An applicator will be placed into your vagina. You will not need to have a general anaesthetic or gauze padding.

After treatment – The applicator is taken out after the radiation dose is delivered. If several sessions are needed, the applicator will be reinserted each time.

External beam radiation therapy and HDR brachytherapy will not make you radioactive. It is safe for you to be with both adults and children after your treatment sessions.



Side effects of radiation therapy

The side effects you experience will vary depending on the dose of radiation and the length of the treatment. Many will be short-term side effects that occur during treatment or within a few weeks of finishing.

Short-term side effects

fatigue

(see also page 48)

Your body uses a lot of energy dealing with the effects of radiation on healthy cells. Tiredness usually builds up slowly during the course of the treatment, particularly near the end. It may last for some time after treatment ends.

bladder and bowel problems

(see also pages 46–47)

You may pass urine more often or with more urgency, or with a burning sensation. Try to drink plenty of water to make your urine less concentrated. Bowel motions may be more frequent, urgent or loose (diarrhoea), or you may pass more wind than normal. Less commonly, there may be some blood in the stools. Your treatment team will prescribe medicines to reduce these side effects.

skin redness, soreness and swelling

Radiation therapy may make the skin in the treatment area dry and itchy. Occasionally, your skin may look red and peel, like sunburn. The treatment team will recommend creams to use to make you more comfortable.

hair loss

If radiation therapy is aimed at your pelvic area, you may lose your pubic hair. This hair may grow back after the treatment ends, but it will usually be thinner. The radiation therapy will not cause you to lose hair from your head or other parts of your body.

vaginal discharge

Radiation therapy may cause or increase vaginal discharge. Let your treatment team know if it smells bad or has blood in it. Do not wash inside the vagina with douches as this may cause infection.

Side effects can take several weeks to get better, though some may continue longer. Some side effects from radiation therapy may not show up until many months or years after treatment. These are called late effects.

Long-term or late effects

lymphoedema (see also page 49)

Radiation can scar the lymph nodes and vessels and stop them draining lymph fluid properly from the legs. This may lead to swelling of the legs. This can occur months or years after radiation therapy.

bladder and bowel problems (see also pages 46–47)

Bladder and bowel changes can also be late effects, appearing months or years after radiation therapy finishes. You may pass urine more often or need to go in a hurry. The movement of waste through the large bowel can become faster, meaning you need to go to the toilet more urgently and more often. It is important to let your doctor know if you have any bleeding or if you have pain in the abdomen and cannot open your bowels.

narrowing of the vagina (see also pages 52–53)

The vagina may become drier, shorter and narrower (vaginal stenosis), which may make sex and follow-up pelvic examinations uncomfortable or difficult. Your treatment team will suggest strategies to prevent this.

menopause (see also pages 49–50)

If your ovaries have not been removed, radiation therapy can stop the ovaries producing hormones, which leads to early menopause. Your periods will stop, you will no longer be able to become pregnant and you may have menopausal symptoms.

pelvic fracture

In rare cases, radiation therapy to the pelvic area can weaken the bones and cause a fracture. Pelvic fractures are the most common. This may not occur for 2–4 years after treatment.

Chemotherapy

Chemotherapy uses drugs to kill cancer cells or slow their growth while causing the least possible damage to healthy cells. Chemotherapy may be given if the cervical cancer is advanced or returns after treatment, and may be combined with radiation therapy.

The drugs are usually given through a vein (intravenously) and most women have treatment as an outpatient. The number of chemotherapy sessions you have depends on the type of cervical cancer and any other treatments you may be having. If you have chemotherapy without radiation therapy, you are likely to have six sessions, scheduled every 3–4 weeks over several months.

Side effects of chemotherapy

The side effects of chemotherapy vary according to the drugs given, how often you have treatment, your general health and fitness, and whether you have chemotherapy alone, or as part of chemoradiation. You may experience nausea or vomiting, feel tired, or lose some hair from your body or head. Chemotherapy can also cause temporary or permanent menopause (see pages 49–50).

Chemotherapy may reduce the number of blood cells in your body. Depending on the type of blood cells affected, you may feel very tired and be more prone to infections. If your temperature rises to 38°C or above, seek urgent medical attention. You will have regular blood tests during treatment to monitor the levels of blood cells.

Most side effects are temporary, and your treatment team can help you to prevent or reduce them.

Targeted therapy

Targeted therapy drugs affect specific molecules within cells to block cell growth. They are used to treat some women with cervical cancer that has spread to other parts of the body or has come back and cannot be treated by surgery or radiation therapy.

Cancers develop their own blood vessels to help them grow. This process is called angiogenesis. Some targeted therapy drugs known as angiogenesis inhibitors are designed to stop this process.

Bevacizumab is an angiogenesis inhibitor that can be used to treat advanced cervical cancer. It is given with chemotherapy every three weeks through a drip into a vein (infusion). The total number of infusions you receive will depend on how you respond to treatment.

Side effects of targeted therapy

The most common side effects experienced by women taking bevacizumab include high blood pressure, feeling tired and loss of appetite. Less common side effects include bleeding and wound healing problems.

► Listen to our “New Cancer Treatments” podcast episode.



For more information on treatments and managing side effects, read Cancer Council's *Understanding Surgery*, *Understanding Chemotherapy* and *Understanding Radiation Therapy* booklets, or our *Understanding Targeted Therapy* fact sheet. Call **13 11 20** for free copies or find them on your local Cancer Council website (see back cover).

Palliative treatment

Palliative treatment helps to improve people's quality of life by managing the symptoms of cancer without trying to cure the disease.

Many people think that palliative treatment is for people at the end of their life, but it may be beneficial for people at any stage of advanced cervical cancer. It is about living as long as possible in the most satisfying way you can.

As well as slowing the spread of cancer, palliative treatment can relieve any pain and help manage other symptoms. Treatment may include radiation therapy, chemotherapy, targeted therapy or other medicines such as hormone treatment.

Palliative treatment is one aspect of palliative care, in which a team of health professionals aim to meet your physical, emotional, practical and spiritual needs. The team also provides support to families and carers.

▶ See our *Understanding Palliative Care* and *Living with Advanced Cancer* booklets.



Key points about treating cervical cancer

Surgery

- Surgery may be used to remove early cervical cancer. The type of surgery you have will depend on how far the cancer has spread.
- Some women with early-stage cervical cancer who still want to have children may have a cone biopsy or a trachelectomy to remove the cervix and some surrounding tissue.
- Operations include a hysterectomy to remove the cervix and uterus, and a bilateral salpingo-oophorectomy to remove the ovaries and fallopian tubes.
- Sometimes the lymph nodes in the pelvic region are removed (a lymphadenectomy).

Radiation therapy and chemotherapy

- Radiation therapy may be used on its own as the main treatment for cervical cancer, or you may have it after surgery to help get rid of any remaining cancer cells.
- Radiation therapy is often used with chemotherapy (chemoradiation) to treat more advanced cervical cancer.

Targeted therapy

Targeted therapy may be used for advanced cancer. The most commonly used targeted therapy drug for cervical cancer that has spread is bevacizumab.

Treatment side effects

All treatments can cause side effects, such as pain, skin problems or diarrhoea. If having children is important to you, talk to your doctor before starting treatment.



Managing side effects

It will take some time to recover from treatment for cervical cancer. You may find the cancer affects you physically and emotionally. Some women experience many side effects, while others don't experience any. Side effects may last from several weeks to a few months or, less commonly, many years or permanently. Fortunately, there are ways to reduce or manage the discomfort that side effects cause.

Bladder problems

Bladder control may change after surgery or radiation therapy. Some women find they need to pass urine more often or in a hurry. Others may experience involuntary loss of urine when they cough, sneeze, laugh, strain or lift. This is called urinary incontinence.

Strengthening the muscles needed for urinary control can help manage urinary incontinence. You can find a guide to exercising the pelvic floor muscles in our *Exercise for People Living with Cancer* booklet. Using continence pads can help you manage any leakage and prevent any loss of dignity. A continence nurse or physiotherapist can develop a bladder training program – ask your doctor for a referral, or contact the National Continence Helpline on 1800 33 00 66 or at continence.org.au.



The blood vessels in the bowel and bladder can become more fragile after radiation therapy. This can cause blood to appear in urine or stools, even months or years after treatment. Let your doctor know if this occurs so you can be given the appropriate treatment.

Bowel changes

After surgery or radiation therapy, some women notice changes in their bowel habits. You may experience constipation or diarrhoea, or feel pain in your abdomen from trapped wind.

If radiation therapy has damaged the lining of the rectum, it can cause inflammation and swelling known as radiation proctitis. This can cause a range of symptoms including blood in bowel motions; frequent passing of loose, watery stools (diarrhoea); the need to empty the bowels urgently; and loss of control over the bowels (faecal incontinence). The risk of developing radiation proctitis is low, but you may develop some of these symptoms for other reasons. Talk to your treatment team if you develop any of these symptoms. If you have ongoing bowel problems, they may refer you to a gastroenterologist.



Tips for managing bowel changes

- Drink peppermint or chamomile tea to reduce abdominal or wind pain.
- Drink plenty of liquids (except alcohol and caffeinated drinks) to replace fluids lost through diarrhoea or to help soften stools if you are constipated.
- See a women's health physiotherapist for information about exercises to strengthen your pelvic floor and anal sphincter. These exercises can help you control your bowels.
- Limit spicy and greasy foods, as these can make diarrhoea and constipation worse.
- Talk to your doctor or a dietitian about dietary changes, or to ask about suitable medicines. They may suggest you take a soluble fibre supplement to help avoid constipation, diarrhoea and loss of bowel control.

Fatigue

Many women who are treated for cervical cancer find that tiredness is a major issue, particularly if they have both radiation therapy and chemotherapy. The tiredness may continue for several months, or even a year or two, after treatment has finished.

Feeling tired is not only a side effect of the treatment itself. Travelling to hospitals and clinics for treatment can be exhausting. If you work during your treatment or if you have a family to care for, this can make you feel especially tired.

It may be frustrating if other people don't understand how you're feeling. See pages 60–61 for information about support services.

- ▶ See our *Fatigue and Cancer* fact sheet and *Living Well After Cancer* booklet.



Tips for managing fatigue

- Plan to do things at the time of day when you feel less tired. Keep a journal to track your “good times”.
- Talk with your family and friends about how you're feeling and discuss things they can help you with, e.g. housework and shopping.
- Do some light exercise, such as walking or stretching, to help increase your energy levels. Ask your doctor if these activities are suitable for you.
- Limit daytime naps to 30 minutes so they don't make it hard to sleep at night.
- Don't expect to be able to instantly do everything you used to do. Your body is still recovering and it will take time for your energy levels to return.

Lymphoedema

After surgery or radiation therapy to the pelvic area, some women may find that one or both legs become swollen. This is known as lymphoedema. Lymphoedema may appear during treatment or months or years later.

It is important to avoid pressure, injury or infection to the lower limbs, and to manage lymphoedema symptoms as soon as possible. Mild lymphoedema is usually managed with exercise, skin care and a compression stocking or sleeve. A physiotherapist trained in lymphoedema management will be able to give you further advice.

To find a practitioner who specialises in the management of lymphoedema, visit the Australasian Lymphology Association's website at lymphoedema.org.au and click on "Find a Practitioner".

► See our *Understanding Lymphoedema* fact sheet.

Menopause

If your ovaries have been damaged by radiation therapy or chemotherapy, or they've been surgically removed, your body will no longer produce the hormones oestrogen and progesterone. When these hormones are no longer made, women stop having periods. This is called menopause. For most women, menopause is a natural and gradual process that starts between the ages of 45 and 55.

Symptoms of menopause can include hot flushes, mood swings, trouble sleeping (insomnia), tiredness and vaginal dryness. You may also have a decreased interest in sex (low libido, see page 52).

Menopause may cause other changes in the body. For example, over time, your bones may become weak and brittle, and break more easily. This is called osteoporosis. Your cholesterol levels may rise, which can increase your risk of heart disease.

The symptoms of sudden menopause are usually more severe than a natural menopause, because the body hasn't had time to get used to a gradual decrease in the levels of oestrogen and progesterone. Oestrogen-alone hormone replacement therapy (HRT) has been shown to be an effective treatment for menopausal symptoms and to help prevent osteoporosis. For more information about dealing with the symptoms of menopause and whether HRT is right for you, talk to your doctor or ask for a referral to a specialist menopause clinic.



Tips for managing symptoms of menopause

- Talk to your doctor about having a bone density test or taking medicines to prevent osteoporosis.
- Regular exercise will help keep your bones strong. Osteoporosis Australia has more information – visit osteoporosis.org.au or call **1800 242 141**.
- Ask your doctor to check your cholesterol levels. If they are high, regular exercise and a balanced diet may help them improve. If not, talk to your doctor about cholesterol-lowering drugs.
- Your doctor can suggest dietary changes and suitable exercises.
- If you smoke, talk to your doctor about quitting or call the Quitline on **13 7848**.
- Try meditation and relaxation techniques to help reduce stress and lessen symptoms.

Fertility issues

Surgery or radiation therapy for cervical cancer may mean you are unable to conceive children. Before treatment starts, ask your doctor or a fertility specialist about what options are available to you.

Many women experience a sense of loss when they learn that their reproductive organs will be removed or will no longer function. You may feel extremely upset if you are no longer able to have children, and may worry about the impact of this on your relationship or future relationships. Even if your family is complete or you were not planning to have children, you may feel some distress. If you have a partner, talk to them about your feelings. Speaking to a counsellor or gynaecological oncology nurse may also help.

Ways to preserve fertility

- If you have not already been through menopause, ask about ways to preserve your fertility. One option may be to store eggs or embryos for use in the future.
 - Having a trachelectomy, where only the cervix is removed, is an option for some women (see page 30). It will still be possible to become pregnant after this procedure, but you will be at higher risk of having a miscarriage and having the baby prematurely. Your doctor can discuss these risks with you.
 - If you require radiation therapy but your ovaries do not need to be treated, one or both of the ovaries may be surgically moved higher in the abdomen and out of the field of radiation. This is called ovarian transposition or relocation (oophoropexy), and it may help the ovaries keep working properly.
- See our *Fertility and Cancer* booklet.

Impact on sexuality and intimacy

Having cervical cancer can affect your sexuality in physical and emotional ways. The impact of these changes depends on many factors, such as your treatment and its side effects, whether you have a partner, and your overall self-confidence.

Low libido – A lack of interest in sex or loss of desire is common because of the experience of having cancer and the side effects of treatment. If you do not feel like having sexual intercourse, or if you find it uncomfortable, let your partner know. It normally takes some time for sex to be comfortable again. You can also explore other ways to be intimate, such as massage and cuddling. See the table opposite for some ways to manage sexual changes.

Vaginal changes – The main side effect of treatment for cervical cancer will be to the vagina. If the ovaries have been affected by surgery or radiation therapy, they will no longer produce oestrogen. This will cause your vagina to become very dry and it may not expand easily during sexual intercourse.

Radiation therapy to the pelvic area can also cause vaginal tissue to lose its elasticity and shrink, narrowing the vagina (vaginal stenosis). These side effects can make sexual penetration difficult or painful, and you may have to explore different ways to orgasm or climax. See the table opposite for ways to keep your vagina open and more elastic. If you need more support resuming sexual activity, ask your doctor for a referral to a sexual therapist or psychologist.

- See our *Sexuality, Intimacy and Cancer* booklet and listen to our “Sex and Cancer” podcast episode.



Coping with impact on sexuality

Sexual changes

- Give yourself time to get used to any physical changes.
- Talk to your doctor about ways to manage side effects that change your sex life. This may include using hormone creams and vaginal moisturisers to help with vaginal discomfort and dryness.
- Hormone creams are available on prescription, while vaginal moisturisers are available over the counter from pharmacies.
- Discuss changes to your libido with your partner so they understand how you're feeling and don't feel rejected.
- Consider touching, hugging and kissing. This is a chance to feel close to your partner without expectations of sexual penetration.
- Explore other ways to climax, such as caressing the breasts, inner thighs, feet or buttocks.
- Use water- or silicone-based vaginal lubricants without perfumes, oils or glycerines.

Changes to the vagina

- Your doctor may suggest you use a vaginal dilator to help keep the walls of the vagina open and supple.
- Dilators are tube-shaped devices made from plastic or silicone that are designed to gently stretch the vagina. They come in different sizes – it is important to seek advice from a health professional about the correct size for you.
- Make sure any soreness or inflammation has settled before you start using a dilator. This is usually 2–6 weeks after your last session of radiation therapy.
- Used with lubricant, the dilator is inserted into the vagina for short periods of time.
- Using a dilator can be challenging. Your doctor or a physiotherapist can provide practical advice on their use.
- Having regular gentle sexual intercourse can also help widen the vagina. Use a lubricant to prevent discomfort caused by vaginal dryness.



Key points about managing side effects

Common side effects

Some women experience few side effects from treatment, while others have many. Common side effects include bladder and bowel problems, fatigue, lymphoedema, menopause, sexual changes and infertility.

Managing side effects

Talk to your treatment team about any symptoms or side effects you have. They may be able to suggest ways to reduce or manage any discomfort.

Bladder and bowel changes

- Bladder and bowel control may change after treatment.
- A continence nurse, physiotherapist or dietitian can help you manage any changes.

Menopause and fertility

- Treatment may cause menopause. This means your periods stop and you will not be able to become pregnant.
- If you are concerned about your fertility, discuss the options with your medical team before treatment starts.

Sexuality

- Cancer and its treatment may affect sexuality in physical and emotional ways.
- A sexual therapist or psychologist may be able to help you find new strategies for expressing intimacy and enjoying sex.
- A women's health physiotherapist can help you with pelvic floor relaxation and using vaginal dilators.



Looking after yourself

Cancer can cause physical and emotional strain, so it's important to look after your wellbeing. Cancer Council has free booklets and programs to help you during and after treatment. Call 13 11 20 to find out more, or visit your local Cancer Council website (see back cover).

Eating well – Healthy food can help you cope with treatment and side effects. A dietitian can explain how to manage any special dietary needs or eating problems and choose the best foods for your situation.

➤ See our *Nutrition and Cancer* booklet.

Staying active – Physical activity can reduce tiredness, improve circulation and lift mood. The right exercise for you depends on what you are used to, how you feel, and your doctor's advice.

➤ See our *Exercise for People Living with Cancer* booklet.

Complementary therapies – Complementary therapies are designed to be used alongside conventional medical treatments. Therapies such as massage, relaxation, acupuncture and reiki can increase your sense of control, decrease stress and anxiety, and improve your mood. Let your doctor know about any therapies you are using or thinking about trying, as some may not be safe or evidence-based.

➤ See our *Understanding Complementary Therapies* booklet.



Alternative therapies are therapies used instead of conventional medical treatments. These are unlikely to be scientifically tested and may prevent successful treatment of the cancer. Cancer Council does not recommend the use of alternative therapies as a cancer treatment.

Work and money – Cancer can change your financial situation, especially if you have extra medical expenses or need to stop working. Getting professional financial advice and talking to your employer can give you peace of mind. You can also check with a social worker or Cancer Council whether any financial assistance is available to you.

- See our *Cancer and Your Finances* and *Cancer, Work & You* booklets.

Relationships – Having cancer can affect your relationships with family, friends and colleagues in different ways. Cancer is stressful, tiring and upsetting, and this may strain relationships. It may also result in positive changes to your values, priorities or outlook on life. Give yourself time to adjust to what's happening, and do the same for those around you. It may help to discuss your feelings with each other.

- See our *Emotions and Cancer* booklet, and see pages 52–53 for information about sexuality after treatment.

Contraception and fertility – If you can have sex, you may need to use certain types of contraception to protect your partner or avoid pregnancy for a time. Your doctor will explain what precautions to take. They will also tell you if treatment will affect your fertility permanently or temporarily. If having children is important to you, discuss the options with your doctor before starting treatment.

- See page 51 and our *Fertility and Cancer* booklet.

Body image – Changes to your body can affect the way you feel about yourself (your self-esteem) and make you feel self-conscious. You may feel less confident about who you are and what you can do. Try to see yourself as a whole person (body, mind and personality), instead of focusing on the parts that have changed.



Life after treatment

For most women, the cancer experience doesn't end on the last day of treatment. Life after cancer treatment can present its own challenges. You may have mixed feelings when treatment ends, and worry that every ache and pain means the cancer is coming back.

Some women say that they feel pressure to return to “normal life”. It is important to allow yourself time to adjust to the physical and emotional changes, and establish a new daily routine at your own pace. Your family and friends may also need time to adjust.

Cancer Council 13 11 20 can help you connect with other women who have had cancer, and provide you with information about the emotional and practical aspects of living well after cancer.

► See our *Living Well After Cancer* booklet.

Dealing with feelings of sadness

If you have continued feelings of sadness, have trouble getting up in the morning or have lost motivation to do things that previously gave you pleasure, you may be experiencing depression.

This is quite common among people who have had cancer.

Talk to your GP, as counselling or medicine – even for a short time – may help. Some people can get a

Medicare rebate for sessions with a psychologist. Ask your doctor if you are eligible. Cancer Council may also run a counselling program in your area.

For information about coping with depression and anxiety, call Beyond Blue on **1300 22 4636** or visit beyondblue.org.au. For 24-hour crisis support, call Lifeline **13 11 14** or visit lifeline.org.au.

Follow-up appointments

After treatment ends, you will have regular appointments to monitor your health, manage any long-term side effects and check that the cancer hasn't come back or spread.

At these appointments, you will usually have a pelvic examination, and you may have a follow-up HPV test or liquid-based cytology (LBC) test, blood tests, x-rays, a CT scan or PET scan. You will also be able to discuss how you're feeling and mention any concerns you may have. Your doctor will discuss your follow-up schedule with you.

When a follow-up appointment or test is approaching, many people find that they think more about the cancer and may feel anxious. Talk to your treatment team or call Cancer Council 13 11 20 if you are finding it hard to manage this anxiety.

For the first few years, you will probably have a check-up every 3–6 months. Check-ups will become less frequent if you have no further problems. Let your doctor know immediately if you have any symptoms or health problems between follow-up appointments.

What if cervical cancer returns?

For some women cervical cancer does come back after treatment, which is known as a recurrence. It is important to have regular check-ups so that if cancer does come back, it can be found early. If cervical cancer returns, you will usually be offered treatment with chemotherapy, radiation therapy or surgery. If you had radiation therapy the first time you had treatment, you may not be able to have further radiation therapy.



Caring for someone with cancer

You may be reading this booklet because you are caring for someone with cancer. What this means for you will vary depending on the situation. Being a carer can bring a sense of satisfaction, but it can also be challenging and stressful.

It is important to look after your own physical and emotional wellbeing. Give yourself some time out and share your concerns with somebody neutral such as a counsellor or your doctor, or try calling Cancer Council 13 11 20. There is a wide range of support available to help you with both the practical and emotional aspects of your caring role.

Support services – Support services such as Meals on Wheels, home help or visiting nurses can help you in your caring role. You can find local services, as well as information and resources, through the Carer Gateway. Call 1800 422 737 or visit carergateway.gov.au.

Support groups and programs – Many cancer support groups and cancer education programs are open to carers as well as to people with cancer. Support groups and programs offer the chance to share experiences and ways of coping.

Carers Associations – Carers Australia works with the Carers Associations in each state and territory to provide information and services to carers. Call 1800 242 636 or visit carersaustralia.com.au.

Cancer Council – You can call Cancer Council 13 11 20 or visit your local Cancer Council website to find out more about carers' services.

➤ See our *Caring for Someone with Cancer* booklet.



Seeking support

A cancer diagnosis can affect every aspect of your life. You will probably experience a range of emotions – fear, sadness, anxiety, anger and frustration are all common reactions. Cancer also often creates practical and financial issues.

There are many sources of support and information to help you, your family and carers navigate all stages of the cancer experience, including:

- information about cancer and its treatment
- access to benefits and programs to ease the financial impact of cancer treatment
- home care services, such as Meals on Wheels, visiting nurses and home help
- aids and appliances
- support groups and programs
- counselling services.

The availability of services may vary depending on where you live, and some services will be free but others might have a cost.

To find good sources of support and information, you can talk to the social worker or nurse at your hospital or treatment centre, or get in touch with Cancer Council 13 11 20.



If your GP refers you to an allied health practitioner such as a dietitian, physiotherapist or lymphoedema practitioner, you may be eligible for a Medicare rebate. Talk to your GP about developing a Chronic Disease Management Plan.

Support from Cancer Council

Cancer Council offers a range of services to support people affected by cancer, their families and friends. Services may vary depending on where you live.

Cancer Council 13 11 20

Trained professionals will answer any questions you have about your situation and link you to services in your area (see inside back cover).



Information resources

Cancer Council produces booklets and fact sheets on over 25 types of cancer, as well as treatments, emotional and practical issues, and recovery. Call **13 11 20** or visit your local Cancer Council website (see back cover).

Practical help

Your local Cancer Council can help you find services or offer guidance to manage the practical impact of a cancer diagnosis. This may include access to transport and accommodation services.



Legal and financial support

If you need advice on legal or financial issues, we can refer you to qualified professionals. These services are free for people who can't afford to pay. Financial assistance may also be available. Call Cancer Council **13 11 20** to ask if you are eligible.

Peer support services

You might find it helpful to share your thoughts and experiences with other people affected by cancer. Cancer Council can link you with individuals or support groups by phone, in person, or online. Call **13 11 20** or visit cancercouncil.com.au/OC.



Useful websites

You can find many useful resources online, but not all websites are reliable. These websites are good sources of support and information.

Australian

Cancer Council Australia	cancer.org.au
Cancer Australia	canceraustralia.gov.au
Cancer Council Online Community	cancercouncil.com.au/OC
Cervical Screening	cervicalscreening.org.au
<i>The Thing About Cancer</i> podcast	cancercouncil.com.au/podcasts
Australasian Lymphology Association	lymphoedema.org.au
Australian Cervical Cancer Foundation	accf.org.au
Australia New Zealand Gynaecological Oncology Group	anzgog.org.au
Australian Physiotherapy Association	australian.physio
Carer Gateway	carergateway.gov.au
Carers Australia	carersaustralia.com.au
Continence Foundation of Australia	continence.org.au
Department of Health	health.gov.au
Healthdirect Australia	healthdirect.gov.au

International

American Cancer Society	cancer.org
Cancer Research UK	cancerresearchuk.org
HysterSisters: Woman-to-Woman Hysterectomy Support	hystersisters.com
International Gynecologic Cancer Society	igcs.org



Question checklist

Asking your doctor questions will help you make an informed choice. You may want to include some of the questions below in your own list.

Diagnosis

- What type of cervical cancer do I have?
- Has the cancer spread? If so, where has it spread? How fast is it growing?
- Are the latest tests and treatments for this cancer available in this hospital?
- Will a multidisciplinary team be involved in my care?
- Are there clinical guidelines for this type of cancer?

Treatment

- What treatment do you recommend? What is the aim of the treatment?
- Are there other treatment choices for me? If not, why not?
- If I don't have the treatment, what should I expect?
- How long do I have to make a decision?
- I'm thinking of getting a second opinion. Can you recommend anyone?
- How long will treatment take? Will I have to stay in hospital?
- Are there any out-of-pocket expenses not covered by Medicare or my private health cover? Can the cost be reduced if I can't afford it?
- How will we know if the treatment is working?
- Are there any clinical trials or research studies I could join?

Side effects

- What are the risks and possible side effects of each treatment?
- Are the side effects immediate, temporary or long-lasting?
- Will I have a lot of pain? What will be done about this?
- Can I work, drive and do my normal activities while having treatment?
- Will the treatment affect my sex life?
- Will the treatment affect my ability to have children? What options do I have to preserve my fertility?
- Should I change my diet or physical activity during or after treatment?

After treatment

- How often will I need check-ups after treatment? Who should I go to?
- If the cancer returns, how will I know? What treatments could I have?



Glossary

abdomen

The part of the body between the chest and hips. The lower part of the abdomen (pelvic cavity) contains the uterus and other female reproductive organs.

adenocarcinoma

A cancer that starts in the glandular cells of the body, such as those found in the inner surface of the cervix.

adenosquamous carcinoma

A rare type of cervical cancer that features both squamous cells and glandular cells. Also called mixed carcinoma.

biopsy

The removal of a sample of tissue from the body for examination under a microscope to help diagnose a disease.

brachytherapy

A type of internal radiation therapy in which radioactive material is placed into or near the tumour.

cervical screening test

A test that checks cells taken from the cervix for HPV. Replaced the Pap test.

cervix

The lower part of the uterus that connects the uterus to the vagina. Also called the neck of the uterus.

chemoradiation (chemoradiotherapy)

Combined chemotherapy and radiation therapy treatment.

chemotherapy

A cancer treatment that uses drugs to kill cancer cells or slow their growth.

colposcopy

Examination of the cervix, vulva and vagina from outside the body with a colposcope (a magnifying instrument).

cone biopsy

The removal of a cone-shaped piece of the cervix for examination under a microscope.

CT scan

Computerised tomography scan. This scan uses x-rays to create cross-sectional pictures of the body.

cystitis

Inflammation of the bladder lining and urinary tract.

ectocervix

The outer surface of the part of the cervix that opens into the vagina.

endocervix

The inner surface of the cervix. Also called the cervical canal.

fallopian tubes

The two thin tubes that extend from the ovaries to the uterus. The tubes carry sperm to the egg and a fertilised egg from the ovaries to the uterus.

glandular cell

A type of cell found in the inner surface of the cervix (endocervix).

grade

A score that describes how similar cancer cells look to normal cells and how quickly they may grow.

hormones

Chemicals that send information between cells in the body. Some hormones control growth, others control reproduction.

HPV test

A test that can detect human papillomavirus (HPV).

human papillomavirus (HPV)

A group of viruses that can cause infection in the skin surface of different body areas, including the genital area. HPV is a risk factor for cervical cancer.

hysterectomy

The surgical removal of the uterus.

laparoscopy

Surgery done through small cuts in the abdomen using a viewing instrument called a laparoscope. Also called keyhole surgery.

laparotomy

A type of open surgery in which a long cut is made in the abdomen to examine and remove internal organs.

large loop excision of the transformation zone (LLETZ)

A procedure to remove cervical tissue for examination and to treat some precancerous changes of the cervix. Also called loop electrosurgical excision procedure (LEEP).

laser surgery

The use of a laser beam to remove tissue and treat some precancerous changes of the cervix.

lesion

An area of abnormal tissue.

liquid-based cytology (LBC) test

A test that looks for cervical cell abnormalities if the cervical screening test finds HPV.

loop electrosurgical excision procedure (LEEP)

See large loop excision of the transformation zone (LLETZ).

lymphadenectomy

Removal of the lymph nodes from a part

of the body. Also called a lymph node dissection.

lymphatic system

A network of tissues, capillaries, ducts, vessels and nodes that removes excess fluid from tissues, absorbs fatty acids, transports fat, and produces immune cells.

lymph nodes

Small, bean-shaped structures found in groups throughout the body. They help protect the body against disease and infection. Also called lymph glands.

lymphoedema

Swelling caused by a build-up of lymph fluid. This happens when lymph vessels or nodes can't drain properly because they have been removed or damaged.

malignant

Cancerous. Malignant cells can spread (metastasis) and eventually cause death if they cannot be treated.

menopause

When a woman stops having periods (menstruating). This can happen naturally, from treatment, or because the ovaries have been removed.

metastasis (plural: metastases)

A cancer that has spread from a primary cancer in another part of the body. Also called secondary cancer.

MRI scan

Magnetic resonance imaging scan. A scan that uses magnetic fields and radio waves to take detailed, cross-sectional pictures of the body.

oestrogen

A female sex hormone produced mainly by the ovaries.

oophoropexy

See ovarian transposition.

osteoporosis

Thinning and weakening of the bones that can lead to bone pain and fractures.

ovarian transposition or relocation

The surgical relocation of one or both ovaries from the pelvis into the abdomen. This procedure is used to protect the ovaries from radiation therapy. Also called oophoropexy.

ovary

A female reproductive organ that contains eggs (ova). It produces the hormones oestrogen and progesterone.

palliative treatment

Medical treatment for people with advanced cancer to help them manage pain and other physical and emotional symptoms of cancer.

Pap test

A test that can detect changes in cervical cells. Replaced by the cervical screening test.

pelvic sidewall

A structure of bone and tissue on the side of the pelvis.

pelvis

The lower part of the trunk of the body: roughly, the area that extends from hip to hip and waist to groin.

PET scan

Positron emission tomography scan. A scan in which a person is injected with a small amount of radioactive glucose solution to find cancerous areas.

precancerous

A term used to describe a condition that may or is likely to become cancer.

progesterone

A female sex hormone made by the ovaries that prepares the lining of the uterus (endometrium) for pregnancy.

radiation therapy

The use of targeted radiation to kill or damage cancer cells so they cannot grow, multiply or spread. The radiation is usually in the form of x-ray beams. Also called radiotherapy.

radical hysterectomy

An operation that removes the uterus, cervix, and soft tissue around the cervix and top of the vagina.

recurrence

The return of a disease after a period of improvement (remission).

screening

An organised program to identify disease in people before any symptoms appear.

speculum

An instrument used to hold the vagina open during an internal examination to see the vagina and cervix more clearly.

squamous cell

A type of cell found in the outer surface of the cervix (ectocervix).

squamous cell carcinoma (SCC)

A cancer that starts in the squamous cells of the body, such as those found in the outer surface of the cervix.

squamous intraepithelial lesion (SIL)

Abnormal growth of squamous cells on the surface of the cervix. Changes may be low grade (LSIL) or high grade (HSIL).

staging

Performing tests to determine how far a cancer has spread.

targeted therapy

Drugs that attack specific particles (molecules) within cells that allow cancer to grow and spread.

testosterone

The major male sex hormone produced by the testicles. A small amount is also made in the ovaries and helps increase sexual desire in women.

total hysterectomy

The surgical removal of the uterus and cervix.

trachelectomy

The surgical removal of the cervix and some surrounding tissue.

transformation zone

The area in the cervix where the squamous and glandular cells meet.

tumour

A new or abnormal growth of tissue on or in the body. A tumour may be benign (not cancer) or malignant (cancer).

ultrasound

A scan that uses soundwaves to create a picture of part of the body.

urethra

The tube that carries urine from the bladder to the outside of the body.

uterus

A hollow muscular organ in a woman's lower abdomen in which a baby grows during pregnancy. Also called the womb.

vagina

A muscular canal about 7–10 cm long that extends from the entrance of the uterus to the vulva.

vaginal dilator

A cylinder-shaped device that is inserted into the vagina to keep the walls of the vagina open and supple.

vaginal stenosis

Narrowing of the vagina.

vulva

The external sexual organs (genitals) of a woman.

womb

See uterus.

Can't find a word here?

For more cancer-related words, visit:

- cancercouncil.com.au/words
- cancervic.org.au/glossary
- cancersa.org.au/glossary

References

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2. Cancer Council Australia Cervical Cancer Screening Guidelines Working Party, *National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding*, Cancer Council Australia, Sydney, 2017.
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How you can help

At Cancer Council, we're dedicated to improving cancer control. As well as funding millions of dollars in cancer research every year, we advocate for the highest quality care for cancer patients and their families. We create cancer-smart communities by educating people about cancer, its prevention and early detection. We offer a range of practical and support services for people and families affected by cancer. All these programs would not be possible without community support, great and small.

Join a Cancer Council event: Join one of our community fundraising events such as Daffodil Day, Australia's Biggest Morning Tea, Relay For Life, Girls' Night In and other Pink events, or hold your own fundraiser or become a volunteer.

Make a donation: Any gift, large or small, makes a meaningful contribution to our work in supporting people with cancer and their families now and in the future.

Buy Cancer Council sun protection products: Every purchase helps you prevent cancer and contribute financially to our goals.

Help us speak out for a cancer-smart community: We are a leading advocate for cancer prevention and improved patient services. You can help us speak out on important cancer issues and help us improve cancer awareness by living and promoting a cancer-smart lifestyle.

Join a research study: Cancer Council funds and carries out research investigating the causes, management, outcomes and impacts of different cancers. You may be able to join a study.

To find out more about how you, your family and friends can help, please call your local Cancer Council.



Cancer Council

13 11 20

Being diagnosed with cancer can be overwhelming. At Cancer Council, we understand it isn't just about the treatment or prognosis. Having cancer affects the way you live, work and think. It can also affect our most important relationships.

When disruption and change happen in our lives, talking to someone who understands can make a big difference. Cancer Council has been providing information and support to people affected by cancer for over 50 years.

Calling 13 11 20 gives you access to trustworthy information that is relevant to you. Our cancer nurses are available to answer your questions and link you to services in your area, such as transport, accommodation and home help. We can also help with other matters, such as legal and financial advice.

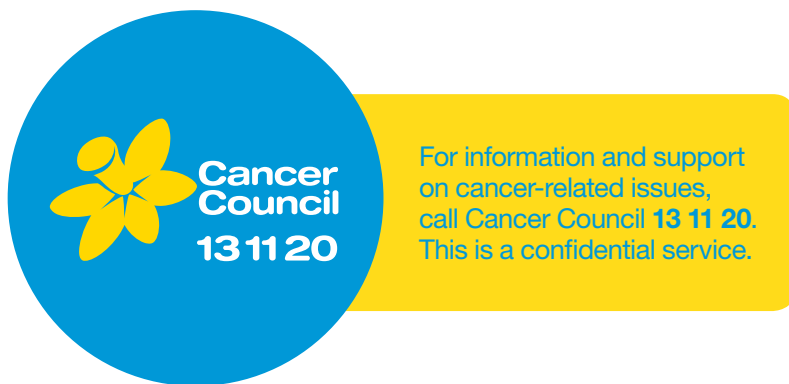
If you are finding it hard to navigate through the health care system, or just need someone to listen to your immediate concerns, call 13 11 20 and find out how we can support you, your family and friends.

Cancer Council services and programs vary in each area.
13 11 20 is charged at a local call rate throughout Australia (except from mobiles).



If you need information in a language other than English, an interpreting service is available. Call 13 14 50.

If you are deaf, or have a hearing or speech impairment, you can contact us through the National Relay Service. www.relayservice.gov.au



Visit your local Cancer Council website

Cancer Council ACT
actcancer.org

Cancer Council NSW
cancercouncil.com.au

Cancer Council NT
nt.cancer.org.au

Cancer Council Queensland
cancerqld.org.au

Cancer Council SA
cancersa.org.au

Cancer Council Tasmania
cancertas.org.au

Cancer Council Victoria
cancervic.org.au

Cancer Council WA
cancerwa.asn.au

Cancer Council Australia
cancer.org.au

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 To support Cancer Council, call your local Cancer Council or visit your local website.*