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https://reachmd.com/programs/cme/Applications-in-Multidisciplinary-Care-for-Cervical-Cancer/39297/

Released: 10/31/2025
Valid until: 10/31/2026
Time needed to complete: 1h 04m

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Applications in Multidisciplinary Care for Cervical Cancer

Announcer:
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Dr. Slomovitz:
Hi, this is Dr. Brian Slomovitz, and this is CE on ReachMD. Here with me today, as always, Michelle Flint and Casey Cosgrove.

Michelle, you prepared a case today, one of the cases we've seen in clinic, to summarize with one of our new patients with cervical cancer. Take it away.

NP Michelle Flint:
Yes, so this is a case review for cervical cancer. It was a 62-year-old postmenopausal female admitted to the hospital for symptomatic anemia with postmenopausal bleeding. She reported vaginal spotting for about a year that transitioned into heavy bleeding and clots. Prior to her hospitalization, she hadn't seen a gynecologist or a doctor, for that matter, in greater than 10 years. Her past medical history included type 2 diabetes, anemia, family history with a mother of uterine cancer, brother with lung cancer.

We got imaging on her in the hospital. Pelvic ultrasound showed an irregular, 5-cm hypervascular mass arising from the lower uterine segment and cervix. There was a PET scan that showed hypermetabolic activity in the left external iliac lymphadenopathy with no extra-pelvic disease, and also a pelvic MRI which showed a solid uterine cervical mass, worrisome for cervical carcinoma. It included left external iliac chain lymph nodes as well.

So we saw her, and then for physical exam, there was a 4- to 6-cm cervical mass with bilateral parametrial involvement. A biopsy was taken.

Dr. Slomovitz:
Oh wow. Tough, tough, tough case. Before we go on, you mentioned she hadn't had a Pap smear in 10 years. Fifty percent of cases of cervical cancer are in women who don't have Paps over the last 5 years.

But back to the case. Great presentation.

Casey, you're sending out the slides. You're working with pathology. What are you looking for to help determine what do you need to do for your next steps?

Dr. Cosgrove:
Yeah, certainly for cervical cancer, which we're anticipating here, we're looking to see whether or not it's squamous or adenocarcinoma, and we're looking to see whether or not they have PD-L1 positivity, which might help guide our decision-making for adding in immunotherapy.

For this individual, you might also consider ordering things like next-generation sequencing to look for tumor mutational burden or some targetable mutations, as well as potentially even HER2 immunohistochemistry to kind of have all the options available for future therapeutic conversations.

Dr. Slomovitz:
Great. So it's really the PD-L1 we're looking for, and 91% of the time it's going to be positive.

The field has changed with the results of what we'll call KEYNOTE-A18. The inclusion, I should say, of pembrolizumab with chemo-sensitizing radiation for this patient population.

Michelle, can you tell us a little bit about the prep for the patient? How much different is it for the patients who are just going to get five doses of chemo-sensitizing chemo versus what it is now—prolonged immunotherapy?

NP Michelle Flint:
So the addition of the pembrolizumab into their chemo RT is an extra step. The chemotherapy cis-RT is a very intensive process for the patient. So receiving those five cycles of pembrolizumab during that time is an extra step, but they tolerate it well. It's not much of a toxicity for them.

Then they continue on 15 cycles of pembrolizumab maintenance, and they're coming into clinic and receiving IO only. They typically have great quality of life at that point.

Dr. Slomovitz:
The key here – and we always want to talk to patients about why we're doing what we're doing. And I don't always talk about numbers, but for this, I do. The progression-free survival benefit, statistically beneficial, 28% reduction in risk of recurrence, 27% reduction in overall survival. So a lot of times, these are younger patients who don't understand what it means to do the best we can upfront to help them live longer. Twenty-seven percent decreased risk in death due to disease in those patients receiving pembrolizumab.

Michelle, how did the patient do, quickly, as we finish up here?

NP Michelle Flint:
So on biopsy, the pathology came back with poorly differentiated squamous cell carcinoma of the cervix, IHC positive for P40 and P16, supporting the diagnosis of an HPV-associated squamous cell carcinoma. The PD-L1 testing had CPS of 50, so pembrolizumab was a great benefit for her.

Dr. Slomovitz:
So let me guess, she responded.

NP Michelle Flint:
Very well. She actually completed the entire course. So she's now off maintenance and surveillance. She had no side effects from the pembrolizumab at all, and she was on for 15 cycles every 6 weeks, maintenance.

Dr. Slomovitz:
What a great way, a great story, to end this session. Michelle, Casey, it's been great. Thank you very much for that.

Announcer:
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