

Histopathology: Carcinoma Cervix- Invasive moderately differentiated Squamous cell carcinoma (non keratinizing type).

Statistical analysis: statistical analysis was done using "R" software. The survival was analysed by Kaplan Meiers curve.

Table 1: Patient's characteristics Stage Distribution

Stage	No	%
IIB	4	26.7
IIIA	2	13.3
IIIB	9	60
Total	15	100

Table 2: Bladder toxicity Cystitis Distribution

Grade	No	%
0	9	60
1	2	13.3
2	4	26.7
Total	15	100

Table 3: Rectal toxicity Proctitis Distribution

Grade	No	%
0	5	33.3
1	2	13.3
2	6	40
4	2	13.3
Total	15	100

Table 4: Dose statistics Summary Statistics Death VS Alive

Variable	Mean	SD	Mean	SD	P-value	Mean	SD
IN_Point_A	30	0	30	0	1	30	0
IN_TBD	16	3.7	18	1.5	0.1743	16.9	3.2
IN_TRD	13.9	2.1	14.3	2.9	0.7365	14.1	2.4
R_Dose	27.4	2	28	2	0.6078	27.7	2
R_TBD	19.4	2.1	18.7	1.2	0.4346	19.1	1.8
R_TRD	15.6	2	17.5	2.8	0.1403	16.3	2.5

Table 5: Response evaluation Response Status

Response	No	%
Alive	9	60
Death	6	40
Total	15	100

4. Results

Out of the 15 patients, 9 patients are alive, 7 patients have complete response, 6 deaths were due to progressive disease. Maximal survival of 26 months was seen in 1 patient. The median average survival after ISBT is 13 months. The complication rates are 40% (GrI-II Cystitis) and 53.3%(GrI-II Proctitis) and 2 patients had Gr IV Proctitis.

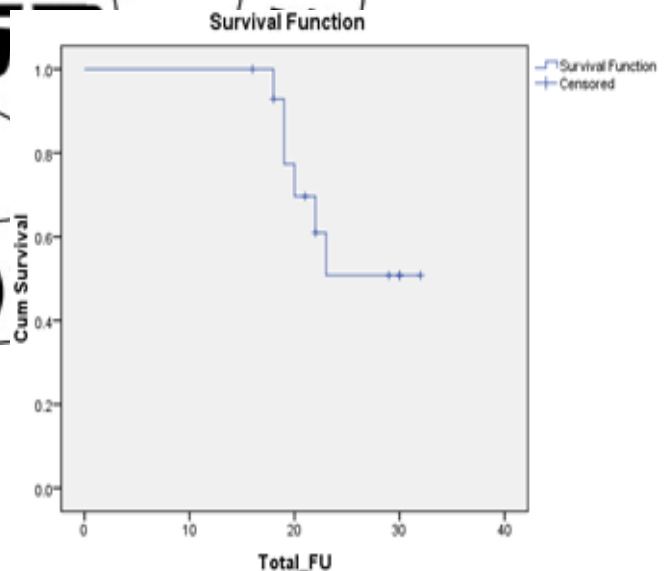


Figure 1: Overall survival before Reirradiation.

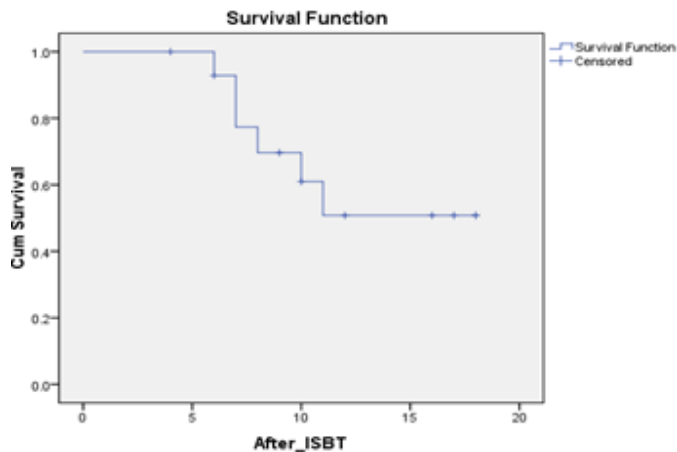


Figure 2: Survival post ISBT.

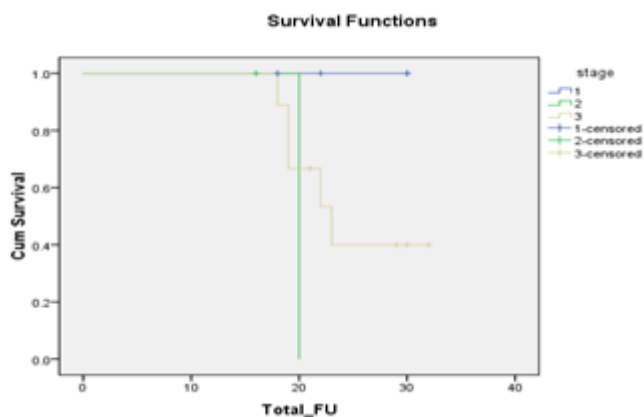


Figure 3: Overall survival, Stage grouped after Re-irradiation.

5. Conclusion

There was no significant differences between the stages, it may be due to less number of cases or events. In Patients with Recurrent Cervical cancer who have received prior chemoradiation and having good performance status and who are not suitable for Pelvic Exenteration, Re-irradiation can be considered by Interstitial Brachytherapy. The total bladder and rectal doses received prior to the treatment is very important before considering Re-irradiation. Future goals of therapy are to increase efficacy of treatment options while decreasing toxicity.

6. Discussion

Treatment decisions should be based on the performance status of the patient, the site of recurrence, the extent of metastatic disease and prior treatment. The prognosis is better for patients with a disease-free interval greater than 6 months, recurrent tumor size <3 cm in diameter and having no pelvic side wall fixation.

With the advent of Image guided Brachytherapy, higher doses of radiation can be delivered to the tumor and increase the likelihood of local control for patients with small volume central recurrences. The bladder and rectal toxicity can be reduced, giving good Quality of life to patients who have very limited options of treatment.

Patients with large volume central or pelvic side wall recurrences have very poor prognosis and efforts should be made to detect pelvic recurrences at the earliest to enhance the chance for long-term survival. A number of chemotherapeutic agents (e.g. Paclitaxel, Vinorelbine, Irinotecan, and Gemcitabine)⁽⁵⁾ have been combined with Cisplatin in phase II studies in patients with either locally advanced and/or recurrent cervical cancer^(6,7).

Future trials are necessary, not only to compare combinations of existing chemotherapeutic agents but also to incorporate biological agents (monoclonal antibodies or other molecules) in order to improve the treatment results of advanced, persistent or recurrent cancer cervix.

The coordinated efforts of a team of professionals is required to cater to the needs of the patient, to tackle particular problems faced by the individual and decide the goals of treatment. The team should include Radiation Oncologists, Gynecologic Oncologists, Medical Oncologists, Palliative care Physicians, Nursing staff, Psychologists, Stomatherapists and a specialized pain management team.

7. Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

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