



Minimally invasive surgery in the management of early stage cervical cancer after the publication of SHAPE trial

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We commend Plante et al for the recently published randomized, multicentre, non-inferiority SHAPE (Simple Versus Radical Hysterectomy in Women with Low-Risk Cervical Cancer) trial comparing radical and simple hysterectomy in the management of early stage cervical cancer. The study reported similar pelvic recurrence rates at 3 years (2.17% and 2.52% for radical and simple hysterectomy, respectively) with a median follow-up of 4.5 years.¹ The surgical approach in this trial (laparoscopic, robotic, or open) was left to the discretion of the surgeon,² with minimally invasive surgery performed in 71.2% of radical and 83.1% of simple hysterectomies.

Pelvic recurrence rates at 3 years were similar between minimally invasive surgery and open surgery groups, respectively, in both the radical (2.9% vs 3.0%) and simple (3.2% vs 3.5%) hysterectomy arms. However, as women were not randomized to different treatments, and the trial was not powered to investigate minimally invasive surgery versus open surgery, the results from SHAPE cannot be generalized. Of interest, considering only the women with tumors ≤2 cm who underwent open radical hysterectomy, we found a higher recurrence rate in the SHAPE trial (3.0% at 3 years) compared with the LACC (Minimally Invasive Versus Abdominal Radical Hysterectomy for Cervical Cancer) trial (0.6% at 4.5 years).³

Unexpectedly, in the SHAPE trial, the rate of involved margins was similar between the radical and simple hysterectomy arms (2.7% vs 2.4%). A previous retrospective study of 125 patients with tumors ≤2 cm of any grade, without lymph vascular space invasion, undergoing radical hysterectomy, failed to report any case of parametrial involvement.⁴ In contrast, the SHAPE trial reports a parametrial involvement rate of 1.8% in the radical hysterectomy arm, of which 12.5% of patients demonstrated lymphovascular space invasion.

In the simple hysterectomy group, the involvement of the parametrium was not assessed. The rate of cancer-related deaths was 1.1% (four patients) in the simple and 0.3% (one patient) in the radical hysterectomy arms. This difference could be related to undiagnosed parametrial involvement, regardless of the site of recurrence, as

the consequence is the inadvertent omission of adjuvant treatment.

We conclude that there is no randomized controlled evidence powered to inform decisions regarding the best surgical approach in patients with low risk cervical cancer, with tumors ≤2 cm in size. Concerns raised by the LACC trial regarding reduced survival in patients undergoing minimally invasive surgery, although the trial was not powered to assess oncological outcomes for tumors ≤2 cm, have led the international oncology community to see open surgery as the gold standard in the management of early stage cervical cancer. The publication of the SHAPE trial does not support a return to minimally invasive surgery.

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