EDITORIAL

Cervical Cancer: Neoadjuvant chemotherapy as a Pre-surgical intervention

Cervical cancer continues to impose a substantial health burden worldwide, particularly in low- and middle-income countries such as Bangladesh, where late presentation and limited screening coverage remain significant challenges. Patients with bulky stage IB2–IIA2 disease represent a complex subgroup in which primary radical surgery often results in high rates of adverse pathological features, frequently necessitating adjuvant radiotherapy or chemo-radiation. The cumulative morbidity associated with multimodal therapy underscores the need for carefully evaluated treatment sequencing strategies.

Cervical cancer is among the most common cancers in women and the fourth leading cause of cancer-related death in females. The rationales for the use of NACT are several. Tumor size reduction may facilitate subsequent local therapy, whether radiotherapy or surgery. This reduction can transform inoperable tumors into radically resectable ones. NACT has also been suggested to increase radiosensitivity and decrease the hypoxic cell fraction. Moreover, NACT treats the micrometastatic disease, preventing a significant proportion of relapses.[1]

It is with great interest that we present this original article entitled "Neoadjuvant Chemotherapy Prior to Radical Hysterectomy versus Radical Surgery Alone for Stage IB2–IIA2 Bulky Cervical Cancer: A Comparative Study." This study addresses a clinically important and ongoing debate in the management of bulky early-stage cervical cancer—whether neoadjuvant chemotherapy (NAC) can meaningfully enhance surgical outcomes without compromising oncologic safety.

In this retrospective comparative analysis conducted at Bangladesh Medical University, the authors have provided valuable regional data examining the impact of paclitaxel–platinum–based NAC prior to radical hysterectomy. Their findings demonstrate improved intraoperative parameters—specifically reduced operative time and significantly lower estimated blood loss—among patients receiving NAC, suggesting enhanced surgical feasibility in bulky tumors. Importantly, these improvements were achieved without significant differences in lymphovascular space invasion compared with primary surgery.

Although the study does not establish definitive survival benefit, it contributes meaningful evidence supporting a selective role for NAC in appropriately chosen patients. The observation that tumor grade may correlate with chemotherapy response further highlights the importance of tumor biology in guiding individualized treatment approaches. Such findings are especially relevant as gynecologic oncology increasingly moves toward precision-based strategies.

We commend the authors for addressing a question of direct clinical relevance to practicing oncologic surgeons and multidisciplinary teams. The study also underscores the necessity of prospective randomized trials with long-term follow-up to clarify oncologic endpoints and refine patient selection criteria.

The Journal of Holy Family Medical College remains committed to publishing scientifically rigorous research that reflects both global evidence and local clinical realities. We believe this article will stimulate thoughtful discussion and encourage further research into optimizing treatment pathways for women with bulky early-stage cervical cancer.

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References:

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