20as Jornadas HITOS ONCOLÓGICOS: LO MEJOR DE 2025
MADRID 19 - 20 NOVIEMBRE 2025
20 ANIVERSARIO

Actualización terapéutica del cáncer de cérvix

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DISCLOSURE SLIDE

Employment: Hosp. Univ. 12 de Octubre

Consultant or Advisory Role: Abbvie, MSD, Lilly, GSK, Clovis, Astra-Zeneca, Roche, Novartis, Pfizer.

Research Funding: Tesaro-GSK

Speaking: Abbvie, MSD, Lilly, Roche, Astra-Zeneca, Novartis, Pfizer, GSK, Pharma&

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- Introduction.
- Immunotherapy cervical cancer.
  - R/M CC.
  - LACC.
- Novel treatment ADCs.
  - Tistotumab Vedotin.
  - T-Dxd.
- Conclusions.

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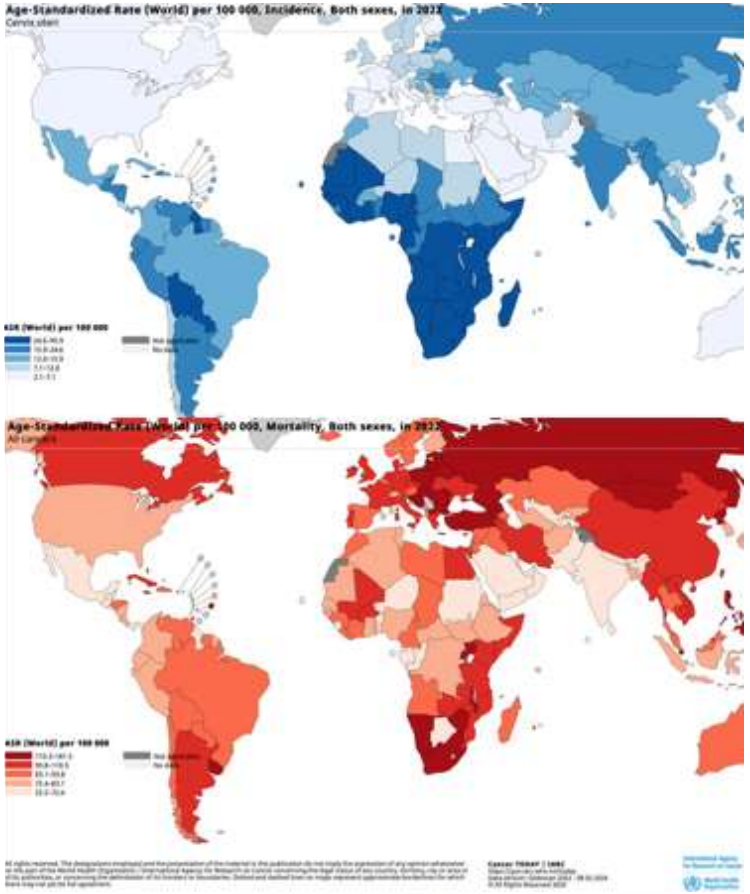
INTRODUCTION

GLOBOCAN 2022: Incidence 662 301

GLOBOCAN 2022: Mortality 348 874

Additional treatment options beyond the current standard of care **ARE NEEDED** to improve prognosis



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R/M CC

After progresion of platinum based therapy.

Design	N	ORR (%)	PFS (months)	OS (months)
Topotecan	45	12.5	2.1	6.6
Vinorelbine	44	13.7	NS	NS
Pemetrexed	29	15	3.1	7.4
Docetaxel	27	8.7	3.8	7.0
Gemcitabine	22	4.5	2.1	6.5
Bevacizumab	46	10.9	3.4	7.29
Pembrolizumab	98	14,3% (PDL1+ 17%, PDL1- 0%)	2.1 (PDL1+ 22.1)	9.4 (PDL1+ 11)

Yu et al. Am J Hematol Oncol. 2015
Chung. JCO. 2019

Cemiplimab in recurrent cervical cancer: Final analysis of overall survival in the phase III EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 trial

Oaknin A et al, 2024

Objective

- To report the final survival analysis from the phase III randomized EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 trial

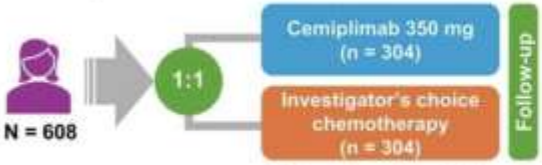
Key takeaways

- Cemiplimab significantly improved OS compared with chemotherapy, regardless of PD-L1 status
- No new safety signals were identified compared to previously published data

Conclusion

- Cemiplimab maintains survival benefit compared with chemotherapy in recurrent cervical cancer after progression on first-line platinum therapy, regardless of PD-L1 expression

Trial design



Adult patients with recurrent and/or persistent cervical cancer

Treatment every 3 weeks for ≤96 weeks or until disease progression or unacceptable toxicity

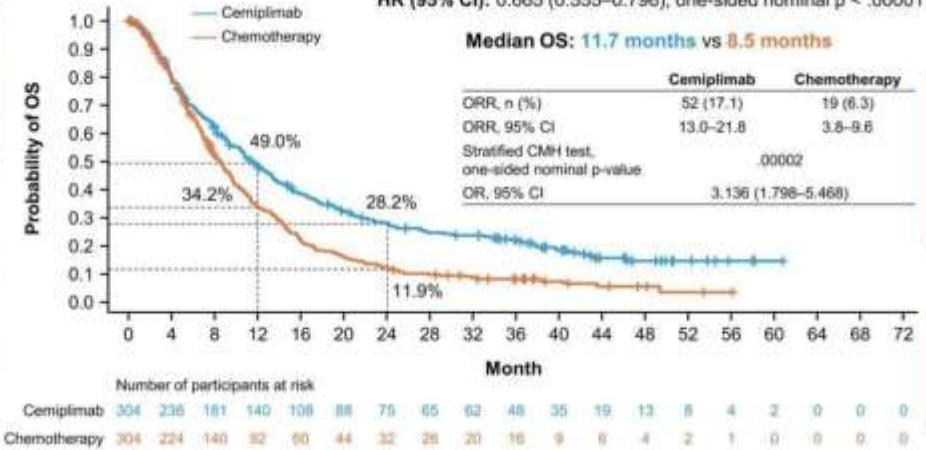
Primary endpoint: OS

Secondary endpoints: ORR and safety

Exploratory analysis: OS by PD-L1 status

Abbreviations: AE, adverse event; CI, confidence interval; CMH, Cochran–Mantel–Haenszel; HR, hazard ratio; OR, odds ratio; ORR, objective response rate; OS, overall survival; PD-L1, programmed cell death-ligand 1.

Results



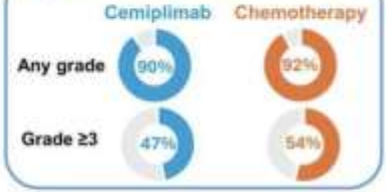
HR (95% CI): 0.665 (0.555–0.796); one-sided nominal p < .00001

Median OS: 11.7 months vs 8.5 months

	Cemiplimab	Chemotherapy
ORR, n (%)	52 (17.1)	19 (6.3)
ORR, 95% CI	13.0–21.8	3.8–9.6
Stratified CMH test, one-sided nominal p-value	.00002	
OR, 95% CI	3.136 (1.798–5.468)	

Median follow-up time: 47.3 months

Safety (AEs)



Median OS by PD-L1

Cemiplimab (PD-L1≥1%): **13.9 months**
Cemiplimab (PD-L1<1%): **8.2 months**
Chemotherapy (PD-L1≥1%): **9.3 months**
Chemotherapy (PD-L1<1%): **6.7 months**

Tewary KS at al. N Engl J Med 2022
Oakni. A et al. Eur J Cancer. 2025 Feb.

R/M CC

Cemiplimab … lysis of overall survival in the phase III EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 trial

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…emiplimab significantly improved OS compared with …emotherapy, regardless of PD-L1 status
…o new safety signals were identified compared to previously …ublished data

Conclusion

- Cemiplimab maintains survival benefit compared with chemotherapy in recurrent cervical cancer after progression on first-line platinum therapy, regardless of PD-L1 expression

Trial design

N = 608

1:1

Cemiplimab 350 mg (n = 304)

Investigator's choice chemotherapy (n = 304)

Follow-up

Adult patients with recurrent and/or persistent cervical cancer

Treatment every 3 weeks for ≤96 weeks or until disease progression or unacceptable toxicity

Primary endpoint: OS

Secondary endpoints: ORR and safety

Exploratory analysis: OS by PD-L1 status

Abbreviations: AE, adverse event; CI, confidence interval; CMH, Cochran-Mantel-Haenszel; HR, hazard ratio; OR, odds ratio; ORR, objective response rate; OS, overall survival; PD-L1, programmed cell death-ligand 1.

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…months vs 8.5 months

	Cemiplimab	Chemotherapy
	52 (17.1)	19 (6.3)
	13.0-21.8	3.8-9.6

…0002

Safety (AEs)

Cemiplimab Chemotherapy

Any grade 96% 92%

94%

PD-L1

13.9 months

8.2 months

9.3 months

6.7 months

Probability of OS

1.0 0.9 0.8 0.7 0.6 0.5 0.4 0.3 0.2 0.1 0.0

11.9%

0 4 8 12 16 20 24 28 32 36 40 44 48 5…

Month

Number of participants at risk

Cemiplimab 304 …

Chemotherapy 304 …

agencia española de medicamentos y productos sanitarios

GOBIERNO DE ESPAÑA MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

Tewary KS at al. N Engl J Med 2022
Oakni. A et al. Eur J Cancer. 2025 Feb.

HITOS

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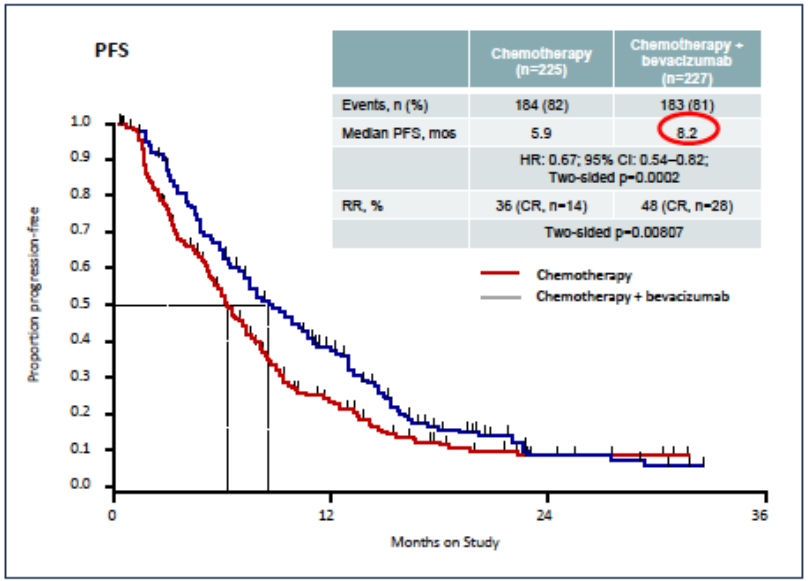
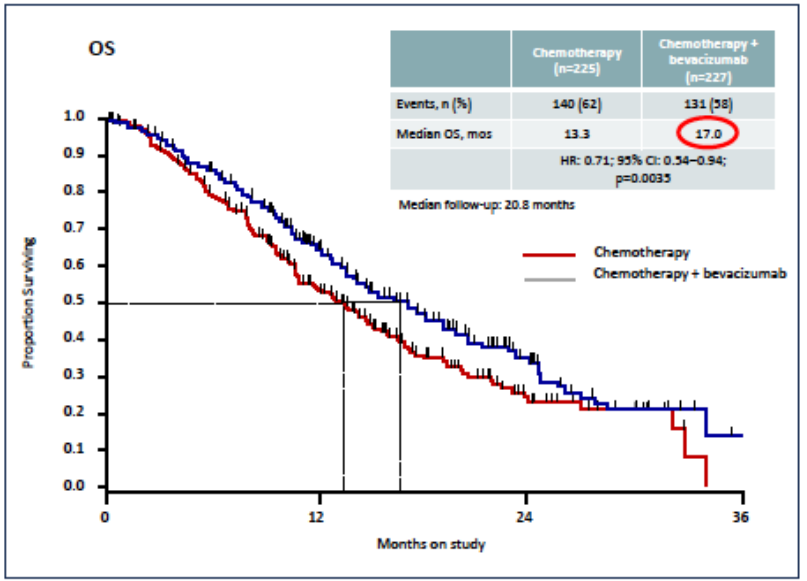
GOG 240: chemo vs chemo + bev

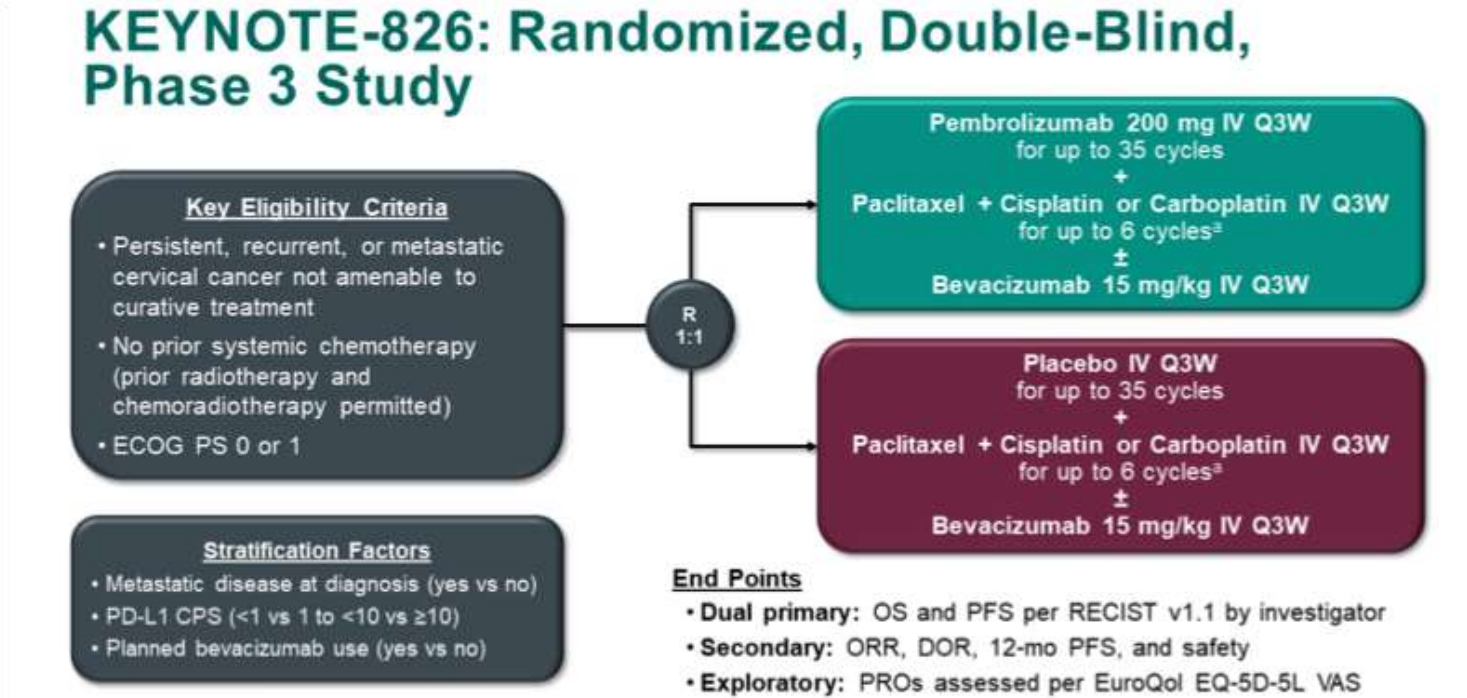
PFS and OS





Tewari KS et al. Presented at the American Society for Clinical Oncology (ASCO) 2013, 31 May–4 June 3. Abstract 3.

KEYNOTE-826



[a]Paclitaxel: 175 mg/m². Cisplatin: cisplatin 50 mg/m². Carboplatin: AUC 5 mg/mL/min. The 6-cycle limit was introduced with protocol amendment 2, although participants with ongoing clinical benefit who were tolerating chemotherapy could continue beyond 6 cycles after sponsor consultation.
CPS, combined positive score (number of PD-L1–staining cells [tumor cells, lymphocytes, macrophages] divided by the total number of viable tumor cells, multiplied by 100); PROs, patient-reported outcomes; VAS, visual analog scale. KEYNOTE-826 ClinicalTrials.gov identifier, NCT03635567.

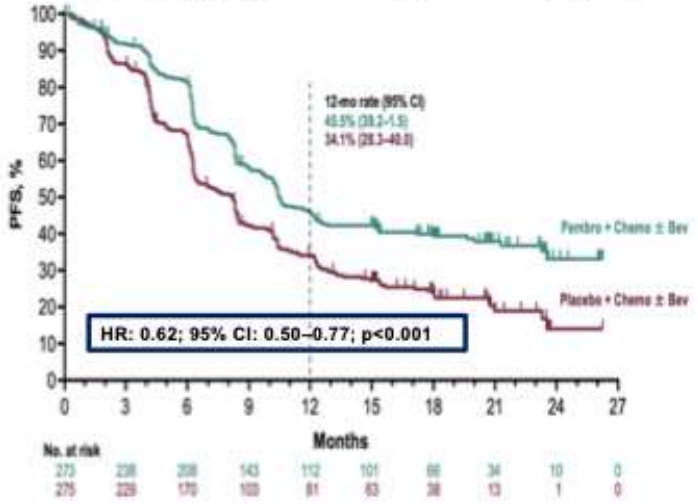
Colombo N. et al; N Engl J Med. 2021 Sep 18

KEYNOTE-826

KEYNOTE-826: Dual Primary Endpoints (PD-L1 CPS ≥1 population)

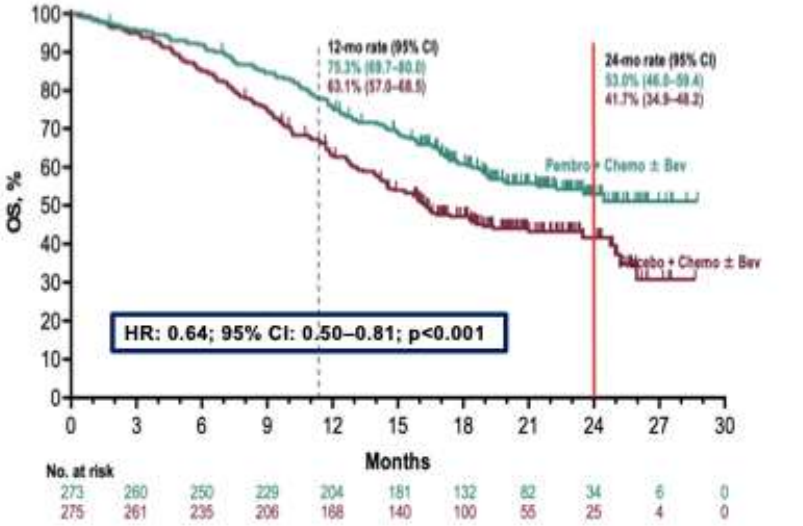
PFS

	Pts w/Event	Median, mo (95% CI)
Pembro + Chemo ± Bev	57.5%	10.4 (9.7-12.3)
Pbo + Chemo ± Bev	72%	8.2 (6.3-8.5)



OS

	Pts w/Event	Median, mo (95% CI)
Pembro + Chemo ± Bev	43.2%	NR (19.8-NR))
Pbo + Chemo ± Bev	56.0%	16.3 (14.5-19.4)



KEYNOTE-826

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Colombo N. et al; N Engl J Med. 2021 Sep 18

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PEMBROLIZUMAB, en combinación con quimioterapia con o sin bevacizumab, está indicado para el tratamiento del cáncer de cuello uterino persistente, recurrente o metastásico en mujeres adultas cuyos tumores expresen PD-L1 con una CPS ≥ 1.

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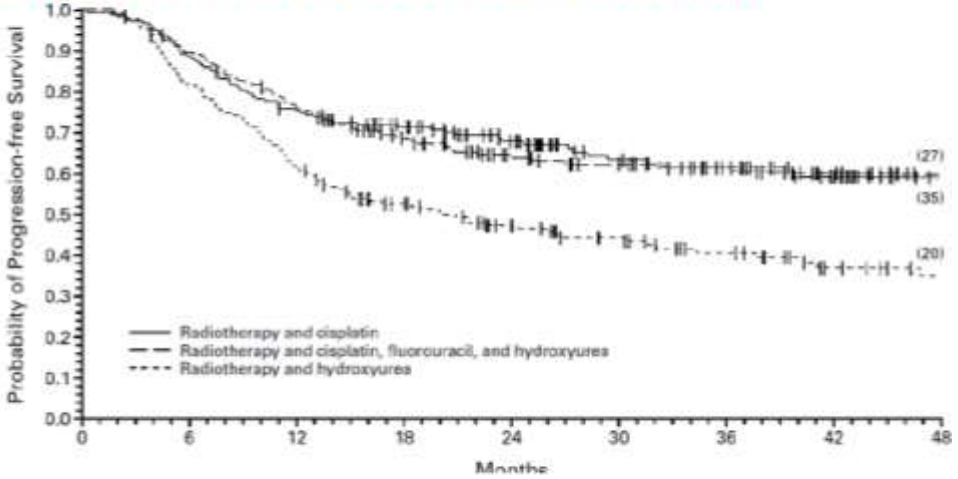
LACC

1999 NCI alert: Meta-analysis 18 RCT's

GOG 120 Established the Standard of Care in 1999: Cisplatin Plus RT in Locallv Advanced Cervical Cancer

- N = 526 women
- Median duration of follow-up was 35 months
- Both Groups that received cisplatin had a higher rate of progression- free survival and overall survival
- At 2 years 67% alive and progression-free with cisplatin compared to 46% with hydroxyurea



The New England Journal of Medicine

CONCURRENT CISPLATIN-BASED RADIOTHERAPY AND CHEMOTHERAPY FOR LOCALLY ADVANCED CERVICAL CANCER

Peter G. Rose, M.D., Bhagwan N. Bundy, Ph.D., Edwin B. Watkins, M.D., J. Tate Thigpen, M.D., Guenther Deppe, M.D., Mitchell A. Maiman, M.D., Daniel L. Clarke-Pearson, M.D., and Sam Insalaco, M.D.

Rose PG et al. Concurrent cisplatin-based radiotherapy and chemotherapy for locally advanced cervical cancer. NEJM 340(15):1144, 1999

Meta-analysis collaboration JCO 2008

INTRODUCTION

"Californication"

Dreamcast Console

Baby one more time

LACC

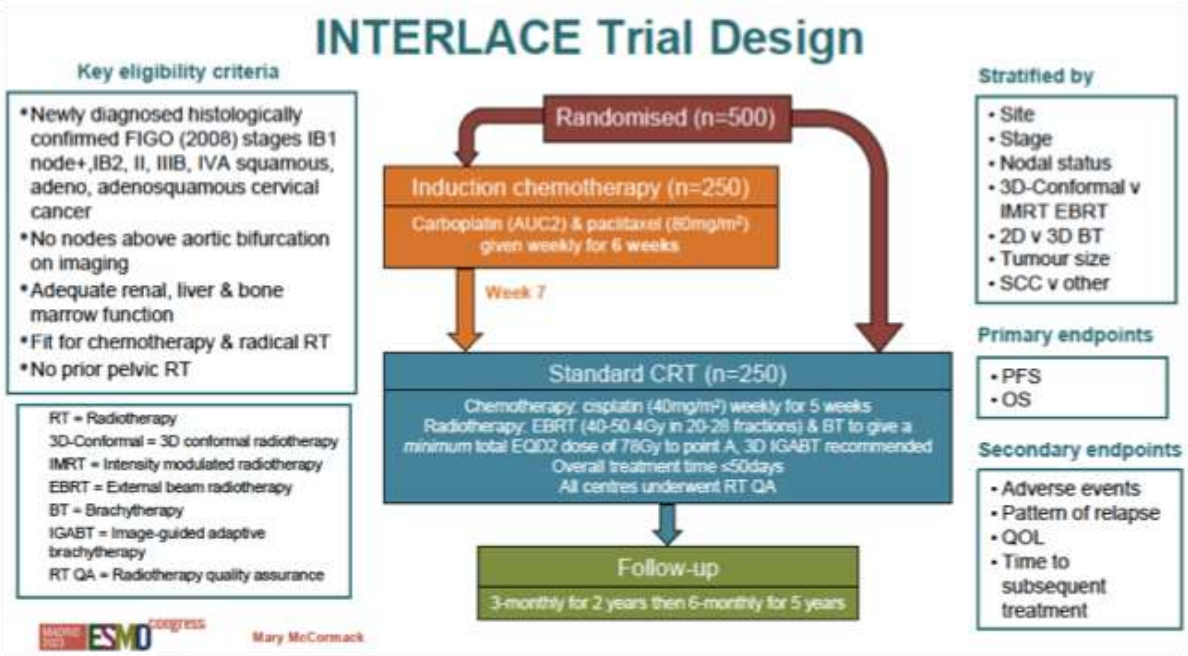
A randomised phase III trial of induction chemotherapy followed by chemoradiation compared with chemoradiation alone in locally advanced cervical cancer

The GCIG INTERLACE trial

STATISTICAL DESIGN:

- PFS: HR 0.65 (132-168 events for 70-80% power)
- OS: HR 0.65-0.70 (70-84% power)

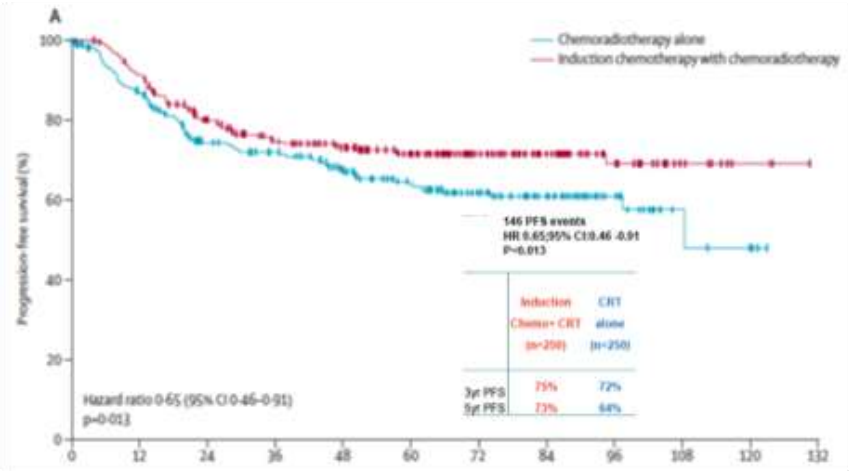
Hierarchical sequential testing approach

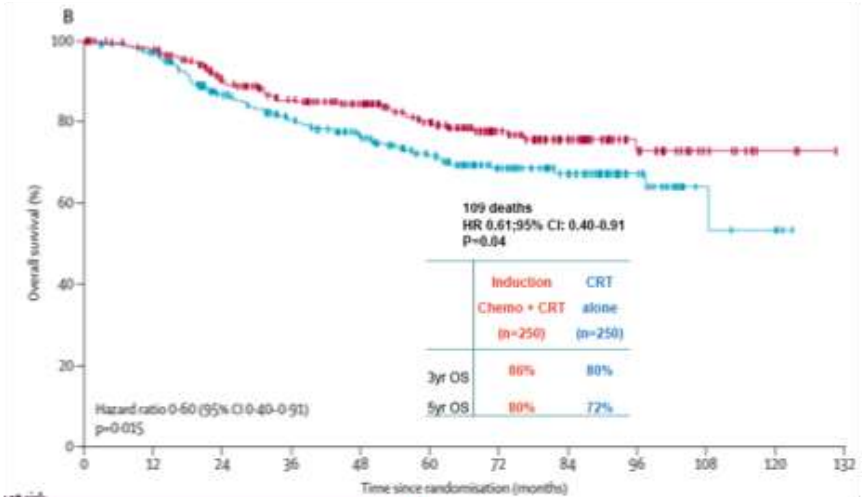


McCormack M. Lancet. 2024

LACC

mFUP 67m





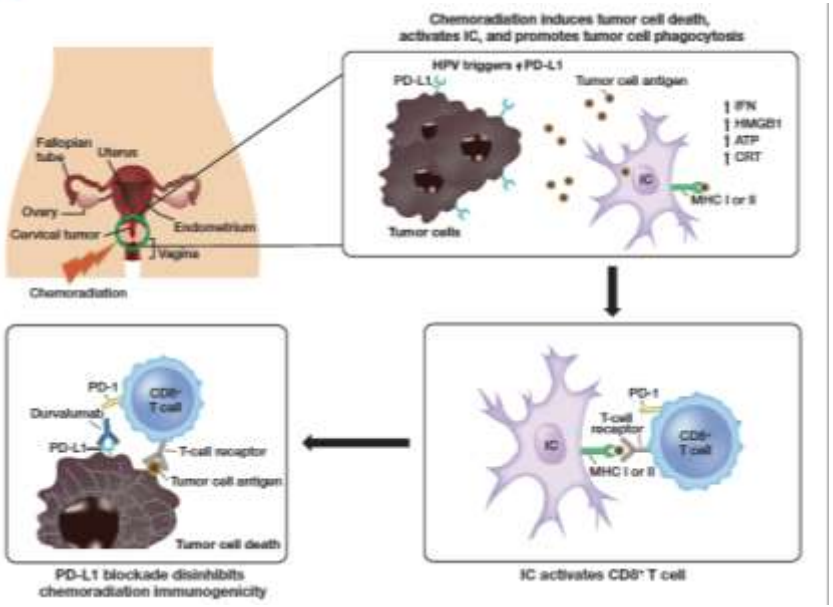
Patterns of Relapse

	CRT alone (n=250)	Induction Chemo + CRT (n=250)
	No. of patients (%)	
Local/pelvic	21 (8)	28 (10)
Local/pelvic & distant	20 (8)	14 (6)
Distant	30 (12)	18 (8)
Total local/pelvic relapses	41 (16)	42 (16)
Total distant relapses	50 (20)	32 (12)

McCormack M. Lancet, 2024

LACC

PRECLINICAL RATIONALE (IO + CCRT)



- Local tumor releases **tumor neoantigens**, which are taken up by antigen presenting cells (APCs).
- Release of damage-associated molecular patterns (**DAMPs**) and pro-inflammatory cytokines that leads to maturation and activation of dendritic cells.
- The **APCs** then migrate to lymph nodes to present the **tumor neoantigens to cytotoxic (CD8+) T-cells**.
- **Activated T-cells** induce immunogenic tumor cell death by acting on primary irradiated tumor as well as distant metastatic sites.

LACC

ENGOT-cx11/ GOG-3047/KEYNOTE-A18

Key Eligibility Criteria

- FIGO 2014 stage IB2-IIB (node-positive disease) or FIGO 2014 stage III-IVA (either node-positive or node-negative disease)
- RECIST 1.1 measurable or non-measurable disease
- Treatment naïve

R
1:1
N = 1060

Cisplatin 40 mg/m² QW for 5 cycles[a] + EBRT followed by brachytherapy
+
Pembrolizumab 200 mg Q3W for 5 cycles

Pembrolizumab 400 mg Q6W for 15 cycles

Cisplatin 40 mg/m² QW for 5 cycles[a] + EBRT followed by brachytherapy
+
Placebo Q3W for 5 cycles

Placebo Q6W for 15 cycles

Stratification Factors

- Planned EBRT type (IMRT or VMAT vs non-IMRT or non-VMAT)
- Stage at screening (stage IB2-IIB N+ vs III-IVA)
- Planned total radiotherapy dose (<70 Gy vs ≥70 Gy [EQD2])

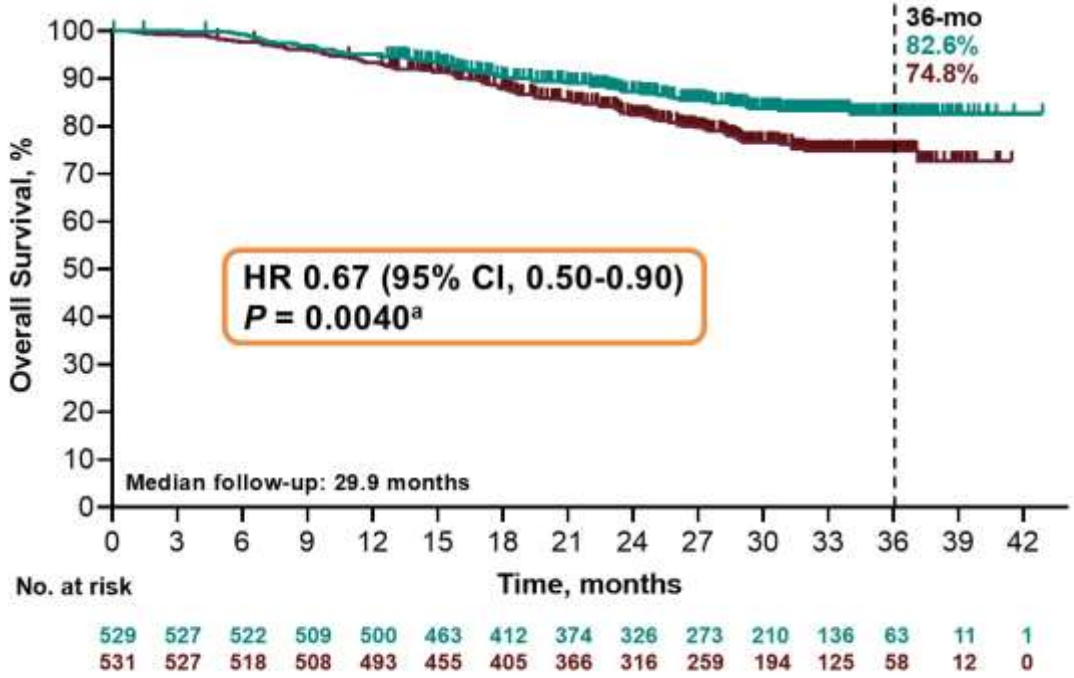
End Points:

- Primary: PFS (per RECIST v1.1) by investigator or histopathologic confirmation and OS.
- Secondary: 24-month PFS, 36-month OS, ORR, patient-reported HRQoL, and safety

Loruso D, Lancet, 2024

ENGOT-cx11/ GOG-3047/KEYNOTE-A18

Primary Endpoint: Overall Survival at Interim Analysis 2



	Pts w/ Event	Pts Censored
Pembro Arm	14.2%	85.8%
Placebo Arm	20.5%	79.5%

[a]With 184 of the 240 deaths expected at the final analysis (76.7% information fraction), the observed $P = 0.0040$ (1-sided) crossed the prespecified nominal boundary of 0.01026 (1-sided) at this planned second interim analysis.

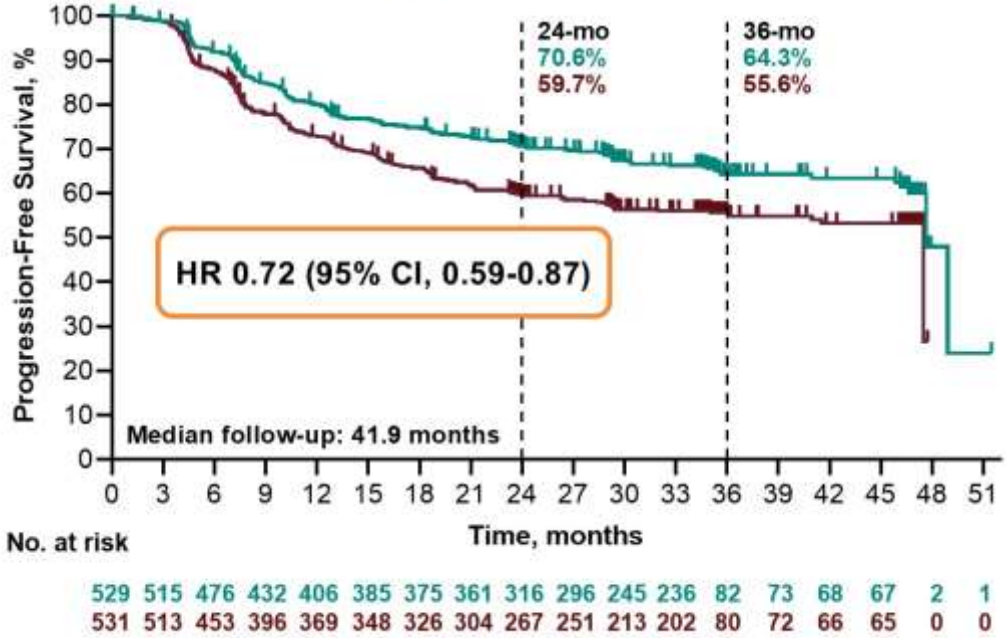
Data cutoff date: January 8, 2024.

1. Duska et al. Presented at ASCO 2025.

LACC

ENGOT-cx11/ GOG-3047/KEYNOTE-A18

Descriptive Progression-Free Survival at Final Analysis



	Pts w/ Event	Pts Censored
Pembro Arm	33.5%	66.5%
Placebo Arm	42.4%	57.6%

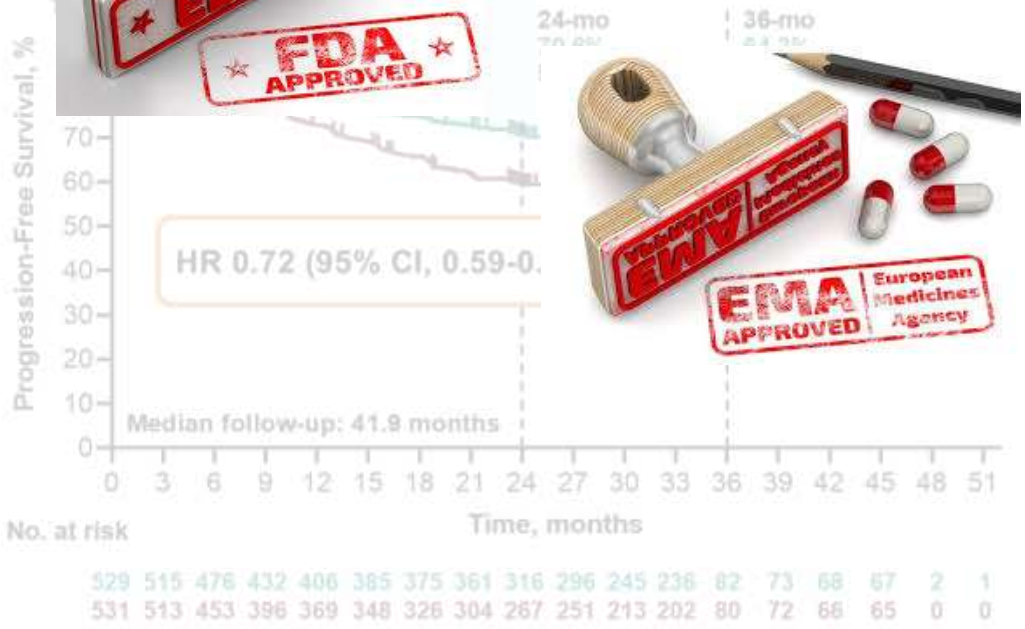
Response assessed per RECIST v1.1 by investigator review or histopathologic confirmation. Data cutoff date: January 7, 2025.

1. Duska et al. Presented at ASCO 2025.

LACC

ENGOT-cx11/ GOG-3047/KEYNOTE-A18

De sion-Free Survival at Final Analysis



	Pts w/ Event	Pts Censored
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PEMBROLIZUMAB, en combinación con quimiorradioterapia (radioterapia de haz externo seguida de braquiterapia), está indicado para el tratamiento del cáncer de cuello uterino localmente avanzado en estadio III - IVA según la estadificación FIGO 2014, en mujeres adultas que no han recibido tratamiento definitivo previo.

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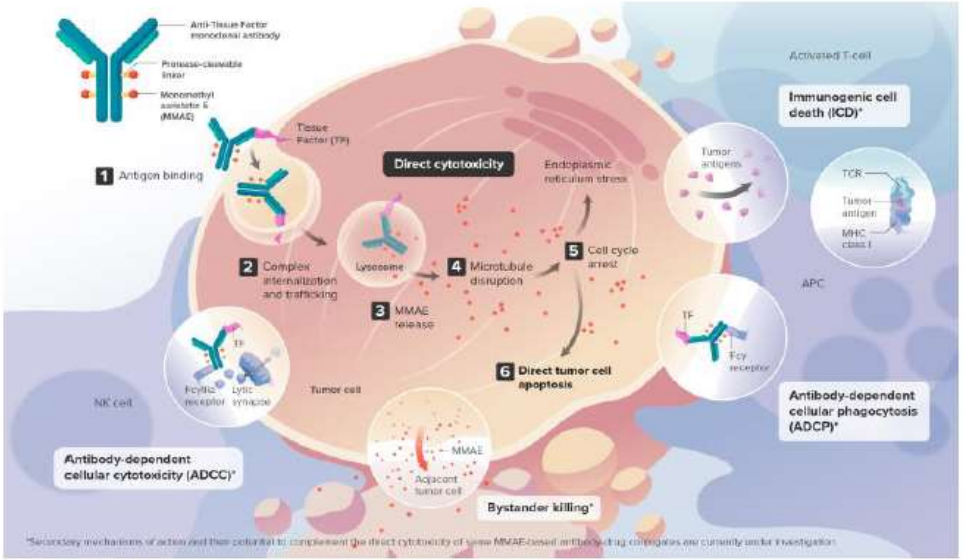
innovaTV301/ENGOT

Proposed MOA of Tisotumab Vedotin

- Tisotumab vedotin is an investigational antibody-drug conjugate directed to tissue factor (TF) and covalently linked to the microtubule-disrupting agent MMAE via a protease-cleavable linker[1,2]
- TF is highly prevalent in cervical cancer and other solid tumors and is associated with cancer pathophysiology and poor prognosis[3-5]
  - TF is co-opted by tumor cells to promote tumor growth, angiogenesis, and metastasis[6]
  - In normal physiology, TF's primary role is to initiate the coagulation cascade after vascular injury[6]
- Tisotumab vedotin has multiple anti-tumor effects[1,2,7]

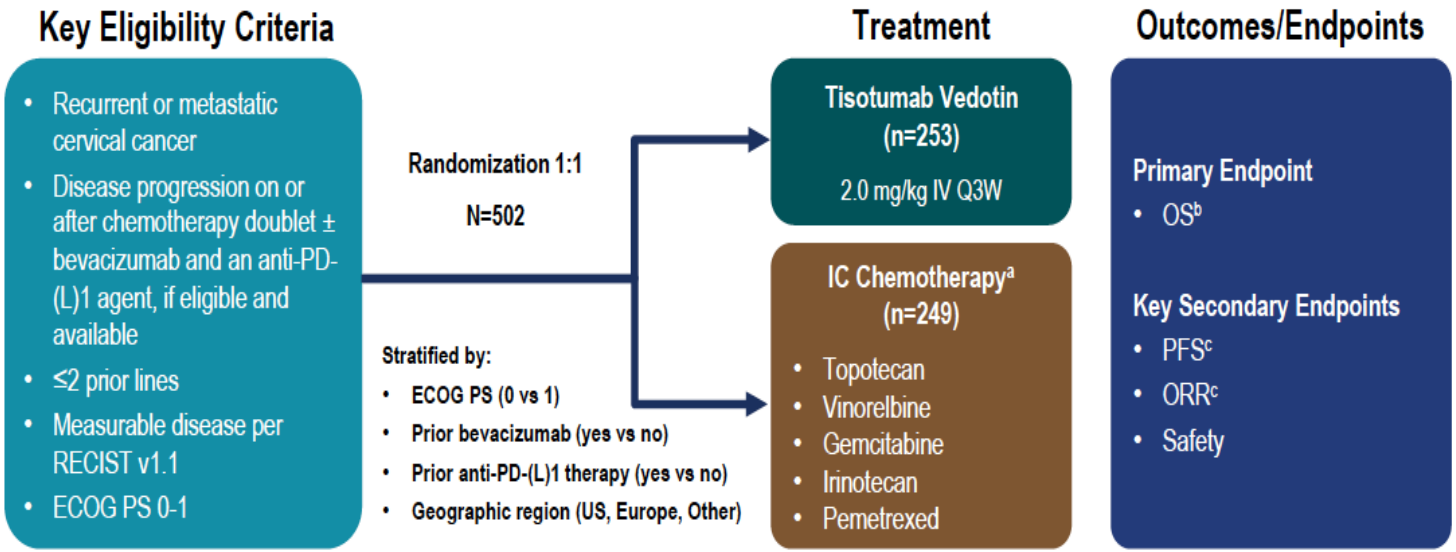


Tisotumab vedotin is an investigational agent, and its safety and efficacy have not been established.

1. Breij EC et al. *Cancer Res.* 2014;74(4):1214-1226. 2. De Goeij BE et al. *Mol Cancer Ther.* 2015;14(5):1130-1140. 3. Pan L et al. *Mol Med Rep.* 2019;19:2077-2086. 4. Cocco E et al. *BMC Cancer.* 2011;11:263. 5. Zhao X et al. *Exp Ther Med.* 2018;16:4075-4081. 6. Forster Y et al. *Clin Chim Acta.* 2006;364:12-21 7. Alley SC et al. American Association for Cancer Research Annual Meeting; March 29 – April 3, 2019; Atlanta, GA, USA; Abstract #221.
ADCC, antibody-dependent cellular cytotoxicity; ADCP, antibody-dependent cellular phagocytosis; MMAE, monomethyl auristatin E; MOA, mechanism of action; TF, tissue factor.

innovaTV301/ENGOT

innovaTV 301: A Randomized, Open-Label, Phase 3 Trial



- Data presented herein are a planned interim analysis

IC, investigator's choice
End of treatment visit occurred 30 days after the last dose of treatment. Survival follow-up occurred every 60 days after the last dose of treatment.
[a]Chemotherapy regimens were given at the following doses: topotecan: 1 or 1.25 mg/m² IV on Days 1 to 5, every 21 days; vinorelbine: 30 mg/m² IV on Days 1 and 8, every 21 days; gemcitabine: 1000 mg/m² IV on Days 1 and 8, every 21 days; irinotecan: 100 or 125 mg/m² IV weekly for 28 days, every 42 days; pemetrexed: 500 mg/m² on Day 1, every 21 days; [b]OS was defined as the time from the date of randomization to the date of death due to any cause; [c]Assessed by investigator.

Vergote I et col 2024 Jul 4;391(1):44-55. doi: 10.1056/NEJMoa2313811. PMID: 38959480.

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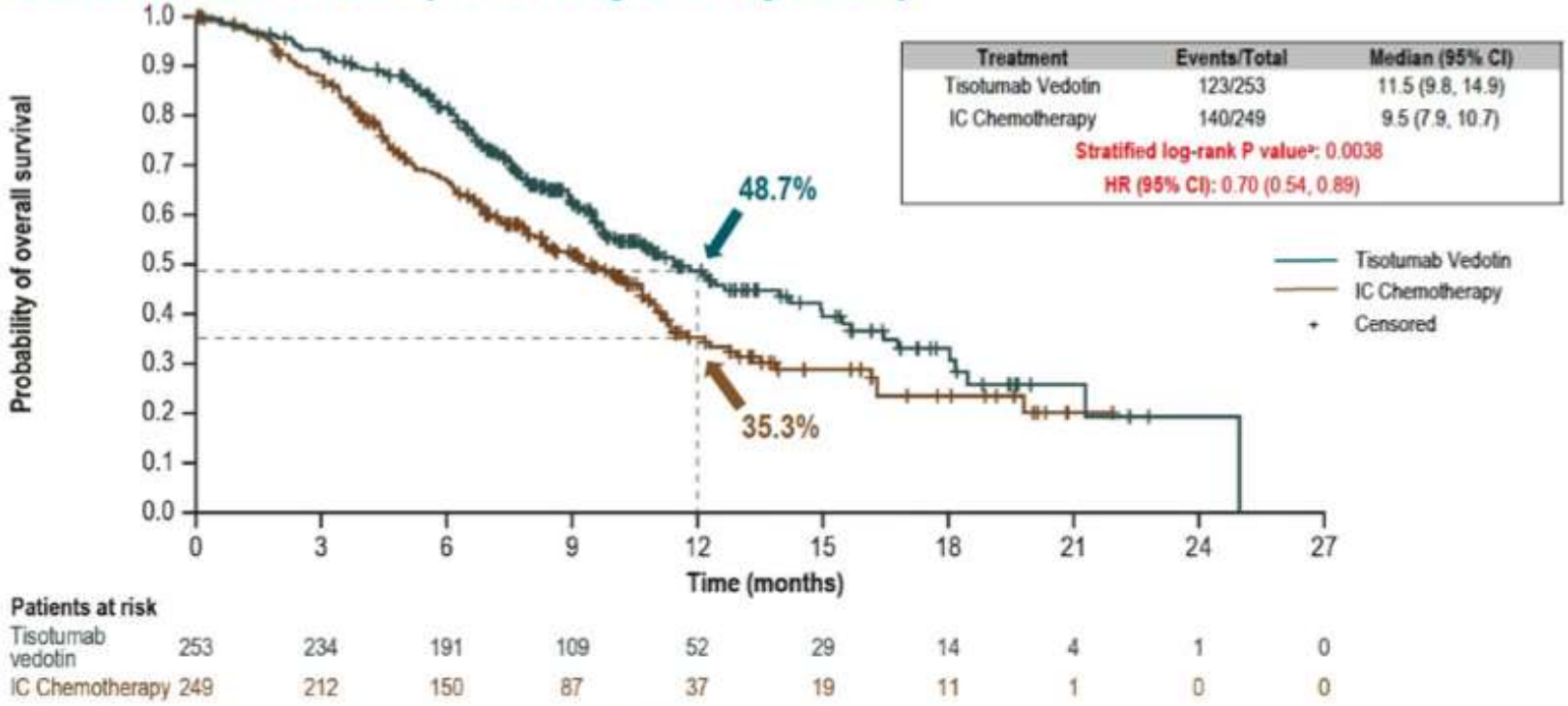
Overall Survival (Primary Endpoint)



Treatment	Events/Total	Median (95% CI)
Tisotumab Vedotin	123/253	11.5 (9.8, 14.9)
IC Chemotherapy	140/249	9.5 (7.9, 10.7)

Stratified log-rank P value[a]: 0.0038

HR (95% CI): 0.70 (0.54, 0.89)

[a]The threshold for statistical significance is 0.0226 (2-sided), based on the actual number of OS events at interim analysis.

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Vergote I et col 2024 Jul 4;391(1):44-55. doi: 10.1056/NEJMoa2313811. PMID: 38959480.

HITOS

CEMIPLIMAB en monoterapia está indicado para el tratamiento de pacientes adultas con cáncer de cuello uterino metastásico o recurrente cuya enfermedad ha progresado durante o después de quimioterapia basada en platino

PEMBROLIZUMAB, en combinación con quimioterapia con o sin bevacizumab, está indicado para el tratamiento del cáncer de cuello uterino persistente, recurrente o metastásico en mujeres adultas cuyos tumores expresen PD-L1 con una CPS ≥ 1.

PEMBROLIZUMAB, en combinación con quimiorradioterapia (radioterapia de haz externo seguida de braquiterapia), está indicado para el tratamiento del cáncer de cuello uterino localmente avanzado en estadio III - IVA según la estadificación FIGO 2014, en mujeres adultas que no han recibido tratamiento definitivo previo.

HITOS

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TISOTUMAB V en monoterapia está indicado para el tratamiento de pacientes adultas con cáncer de cuello uterino recurrente o metastásico con progresión de la enfermedad durante o después del tratamiento sistémico.

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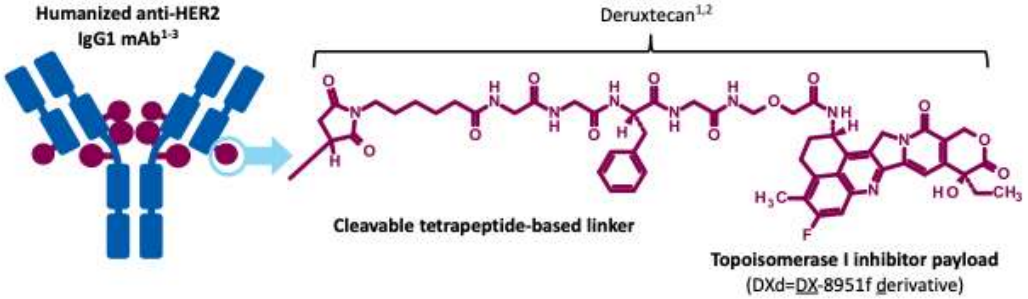
DESTINY-PanTumor02

Trastuzumab Deruxtecan (T-DXd) was Designed with 7 Key Attributes

T-DXd is an ADC with 3 components:

1. A humanized anti-HER2 IgG1 mAb with the same amino acid sequence as trastuzumab
2. A topoisomerase I inhibitor payload, an exatecan derivative
3. A tetrapeptide-based cleavable linker



7 Key Attributes[a,1–5]
Payload mechanism of action: topoisomerase I inhibitor
High potency of payload
High drug-to-antibody ratio ≈8
Payload with short systemic half-life
Stable linker payload
Tumor-selective cleavable linker
Bystander antitumor effect

ADC, antibody-drug conjugate; HER2, human epidermal growth factor receptor 2; IgG1, immunoglobulin G1; mAb, monoclonal antibody.
[a]The clinical relevance of these features is under investigation.

1. Nakada T, et al. *Chem Pharm Bull*. 2019;67:173-185. 2. Ogitani Y, et al. *Clin Cancer Res*. 2016;22:5097-5108. 3. Trail PA et al. *Pharmacol Ther*. 2018;181:126-142. 4. Okamoto H, et al. *Xenobiotica*. 2020;50(10):1242-1250. 5. Nagai Y, et al. *Xenobiotica*. 2019;49(9):1086-1096.

DESTINY-PanTumor02: a Phase 2 study of T-DXd for HER2-expressing solid tumors

An open-label, multicenter study (NCT04482309)

Key eligibility criteria

- Advanced solid tumors not eligible for curative therapy
- 2L+ patient population
- HER2 expression (IHC 3+ or 2+)
  - Local test or central test by HercepTest if local test not feasible (ASCO/CAP gastric cancer scoring[1])[a]
- Prior HER2-targeting therapy allowed
- ECOG/WHO PS 0–1

Baseline characteristics

- 267 patients received treatment; 202 (75.7%) based on local HER2 testing
  - 111 (41.6%) patients were IHC 3+ based on HER2 test (local or central) at enrollment, primary efficacy analysis (all patients)
  - **75 (28.1%) patients were IHC 3+ on central testing**, sensitivity analysis on efficacy endpoints (subgroup analyses)
- Median age was 62 years (23–85) and [redacted]

T-DXd
5.4 mg/kg Q3W

40 per cohort[b]

- Endometrial cancer
- Cervical cancer
- Ovarian cancer
- Bladder cancer
- Other tumors[c]
- Biliary tract cancer
- Pancreatic cancer

Primary endpoint

- Confirmed ORR (investigator)

Secondary endpoints

- DOR, DCR, PFS, OS
- Safety

Exploratory analysis

- Subgroup analyses by HER2 status

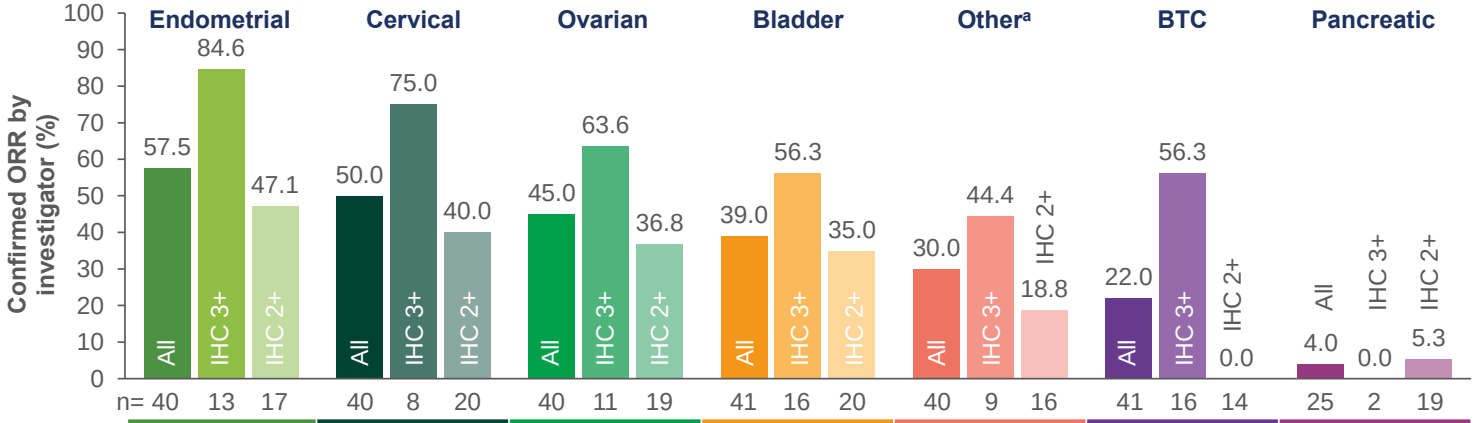
Primary analysis
data cutoff: Jun 8, 2023
Median follow up: 12.75 mo

[a]Patients were eligible for either test. All patients were centrally confirmed; [b]planned recruitment, cohorts with no objective responses in the first 15 patients were to be closed; [c]patients with tumors that express HER2, excluding tumors in the tumor-specific cohorts, and breast cancer, non-small cell lung cancer, gastric cancer, and colorectal cancer

2L, second-line; ASCO, American Society of Clinical Oncology; CAP, College of American Pathologists; DCR, disease control rate; DOR, duration of response; ECOG, Eastern Cooperative Oncology Group; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PS, performance status; Q3W, every 3 weeks; T-DXd, trastuzumab deruxtecan; WHO, World Health Organization

1. Hofmann M, et al. *Histopathology*. 2008;52:797–805

Objective response and duration of response

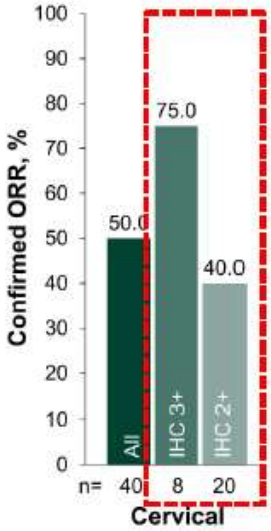


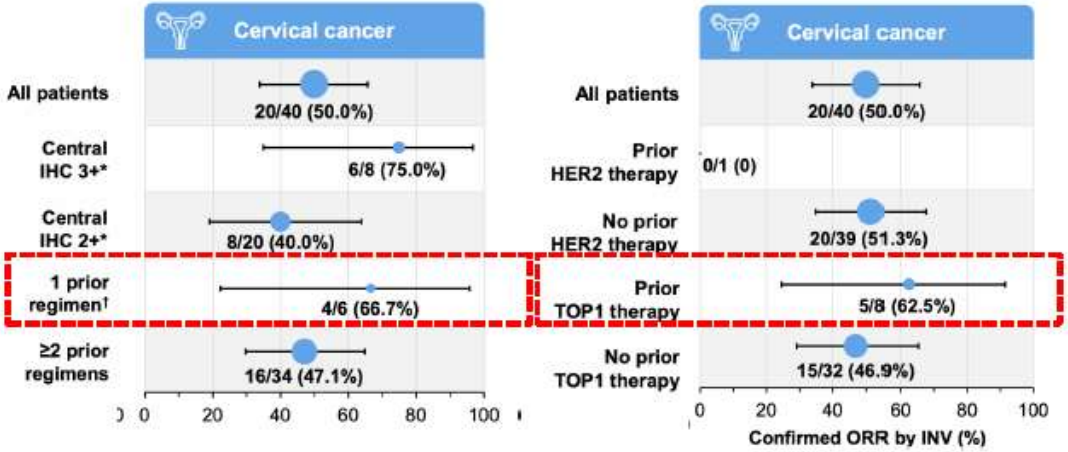
Median DOR, months (95% CI)[b]	NR (9.9, NR)	14.2 (4.1, NR)	11.3 (4.1, 22.1)	8.7 (4.3, 11.8)	22.1 (4.1, NR)	8.6 (2.1, NR)	5.7 (NR, NR)

	All patients (N=267)	IHC 3+ (n=75)	IHC 2+ (n=125)
ORR, % (95% CI)	37.1 (31.3, 43.2)	61.3 (49.4, 72.4)	27.2 (19.6, 35.9)
Median DOR, months (95% CI)[b]	11.3 (9.6, 17.8)	22.1 (9.6, NR)	9.8 (4.3, 12.6)

DXd; all patients (n=267; including 67 patients with IHC 1+ [n=25], IHC 0 [n=30], or unknown IHC status [n=12] by central testing) and patients with centrally confirmed HER2 IHC 3+ (n=75) or IHC 2+ (n=125) status. DXd; all patients (n=99; including 19 patients with IHC 1+ [n=6], IHC 0 [n=9], or unknown IHC status [n=4] by central testing) and patients with centrally confirmed HER2 IHC 3+ (n=46) or IHC 2+ (n=34) status. [a]Responses [b]includes patients with a confirmed objective response only

Objective response and duration of response

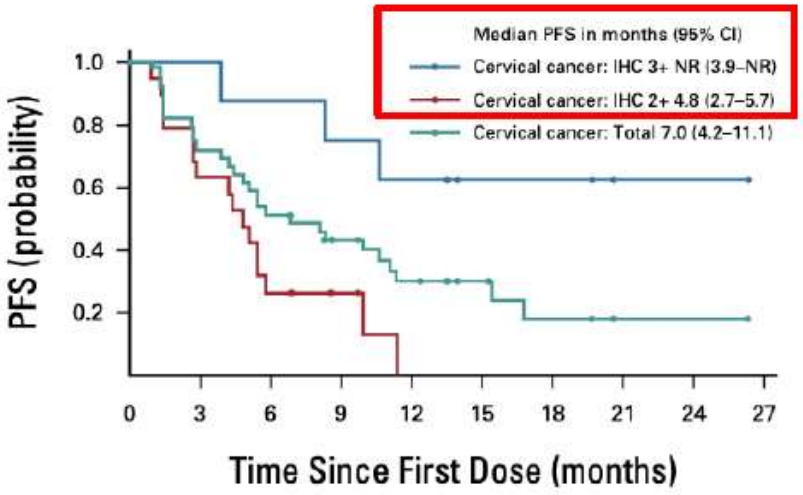


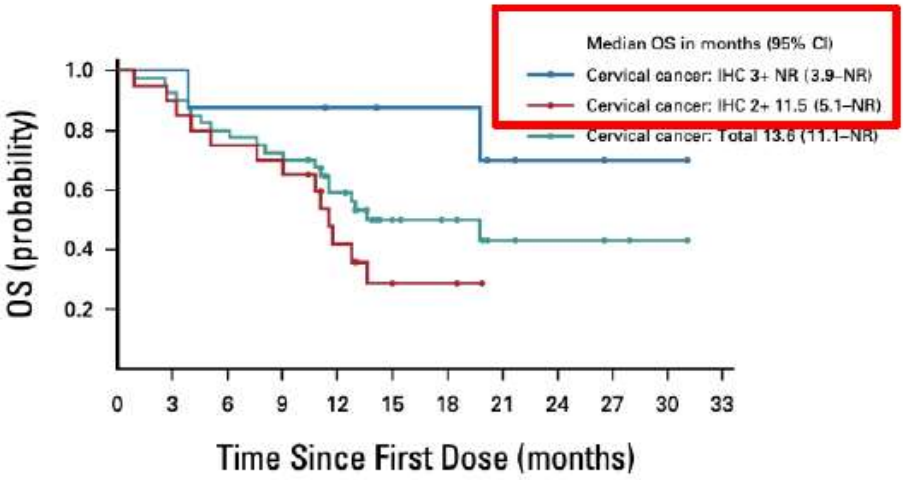


Mediana DOR: **5.5 meses (IHQ 2+), NR (IHQ 3+)**

Meric-Bernstam F et al, JCO 2024; Makker V et al, SGO 2024

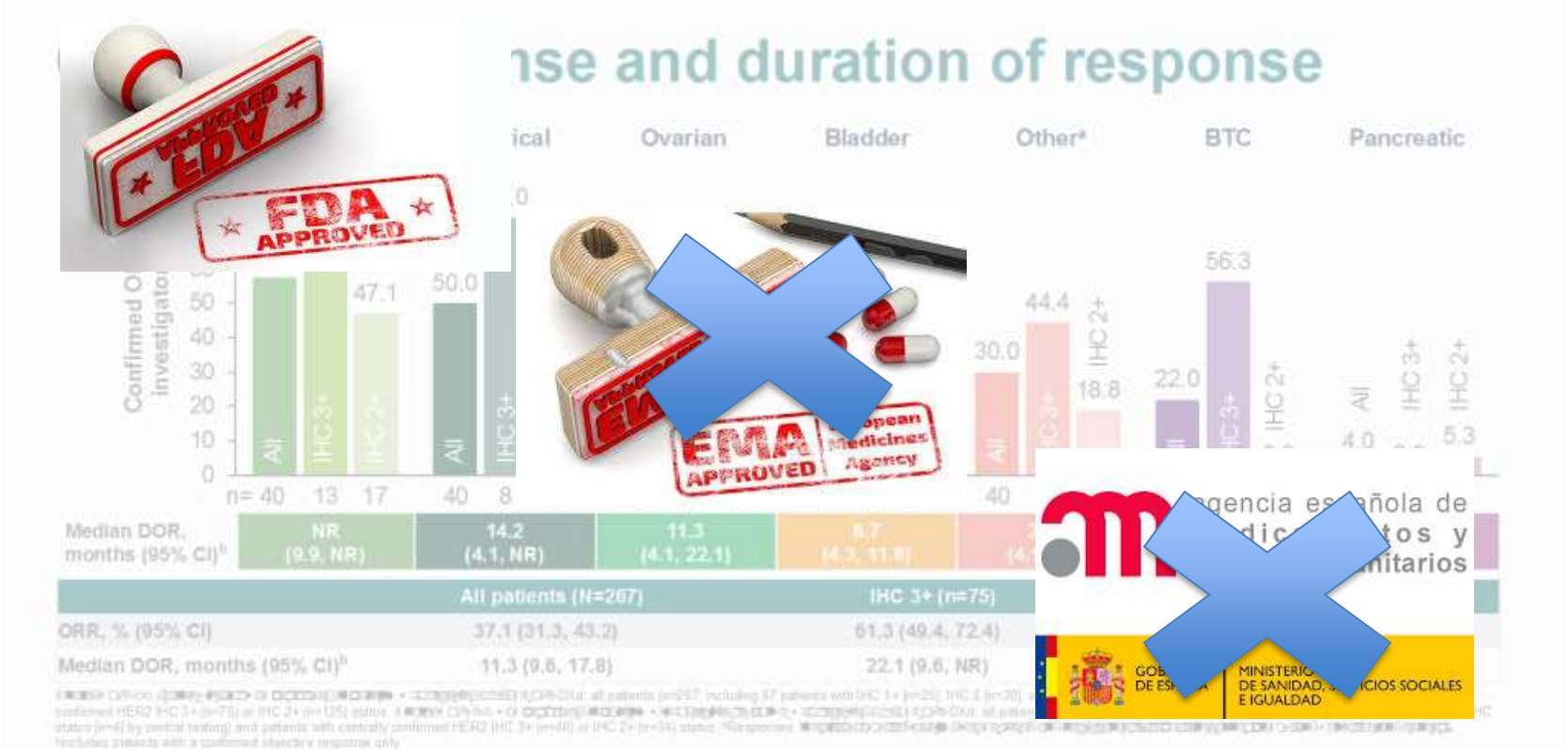
DESTINY-PanTumor02: a Phase 2 study of T-DXd for HER2-expressing solid tumors





Meric-Bernstam F et al, JCO 2024; Makker V et al, SGO 2024

ADCs


nse and duration of response
ical
Ovarian
Bladder
Other*
BTC
Pancreatic
FDA APPROVED
EMA APPROVED
European Medicines Agency
Confirmed O investigato
All
IHC 3+
IHC 2+
47.1
50.0
30.0
44.4
18.8
22.0
56.3
n= 40 13 17 40 8
40
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HITOS

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TISOTUMAB V en monoterapia está indicado para el tratamiento de pacientes adultas con cáncer de cuello uterino recurrente o metastásico con progresión de la enfermedad durante o después del tratamiento sistémico.

HITOS

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TISOTUMAB V en monoterapia está indicado para el tratamiento de pacientes adultas con cáncer de cuello uterino recurrente o metastásico con progresión de la enfermedad durante o después del tratamiento sistémico.

TRASTUZUMAB DERUXTECAN en monoterapia estuviera indicado para el tratamiento de pacientes adultas con cáncer de cuello uterino recurrente o metastásico HER2 3+……..

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CONCLUSIONS

☆ **H1. Immunotherapy has become a central pillar across all cervical cancer settings.** Pembrolizumab and cemiplimab are now foundational treatments in both recurrent/metastatic disease.

☆ **H2. Locally advanced cervical cancer is undergoing its biggest therapeutic shift in 20 years.** CCRT + Pembrolizumab as the new standard for LACC.

☆ **H3. Antibody–drug conjugates (ADCs) have opened a new, effective therapeutic avenue.** Tisotumab vedotin and the emerging role of trastuzumab deruxtecan (in HER2 3+ disease).

☆ **H4. Cervical cancer management is becoming truly biomarker-driven**. PD-L1?, HER2, and potentially other targets (TF, TROP2).

☆ **H5. The immediate future lies in integrating therapies: chemotherapy + IO + ADCs.** Cervical cancer care is now multimodal and biologically guided.