# Eviti Imaging: Cervical Cancer

**Version: 1.0**

**Effective Date: 1/1/2026**

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## Please note the following:



For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Please refer to the CMS website at http://www.cms.gov for additional information.

For Medicaid members/enrollees, circumstances when state Medicaid coverage provisions conflict with the coverage provisions within this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

# Cervical Cance Imaging

## Discussion

This imaging guideline provides a standardized framework for the use of diagnostic and surveillance imaging in the management of common adult malignancies, specifically cervical cancer. The goal is to ensure timely, evidence-based imaging that supports accurate staging, treatment planning, response assessment, and post-treatment surveillance.

### Guiding Principles

- Follow evidence-based practices from major guidelines (e.g., NCCN, ESMO, ACR Appropriateness Criteria)
- Ensure imaging aligns with the clinical context and stage of disease
- Minimization of unnecessary radiation exposure
- Promote timely and cost-effective imaging utilization
- Incorporate multidisciplinary collaboration in imaging decisions

## Imaging Guidelines

This guideline applies to the following patients:

1. At least 18 years of age with confirmed or suspected diagnoses of cervical cancer; AND
2. All phases of oncologic care, including one of the following:
   a) Initial staging
   b) Treatment response evaluation
   c) Post-treatment surveillance
   d) Detection of recurrence or progression; AND
3. All imaging modalities used in oncology care, including but not limited to the following:
   a) Computed Tomography (CT) (neck, chest, abdomen, pelvis, neck, or site-specific)
   b) Magnetic Resonance Imaging (MRI) (including site-specific protocols such as pelvis MRI, brain MRI, liver MRI)
   c) Fluorodeoxyglucose Positron Emission Tomography/CT (FDG-PET/CT)
   d) PET/MRI
   e) Somatostatin Receptor PET/CT (SSTR-PET/CT)
   f) Nuclear Medicine (e.g., bone scan, PSMA PET)
   g) Single Photon Emission Computed Tomography/CT (SPECT/CT) (e.g., octreotide SPECT/CT for neuroendocrine tumors)

**Notes:**

1. The concurrent utilization of multiple advanced imaging modalities—such as PET/CT and MRI—is not routinely warranted and should be considered only when each modality is expected to provide distinct and clinically relevant information that will directly impact patient management. The selection of the most appropriate imaging study should be individualized, taking into account tumor type, clinical presentation, prior imaging, and other patient-specific factors. Imaging requests will be evaluated on a case-by-case basis to ensure clinical necessity, appropriateness, and the potential to influence therapeutic decision-making.

2. When PET imaging is clinically indicated, the appropriate radiotracer should be selected based on tumor type and clinical scenario.

## Cervical Cancer Imaging

Imaging in cervical cancer is essential for accurate staging, treatment planning, and post-therapy surveillance. The choice of modality depends on clinical stage, symptomatology, and treatment intent.
Cross-sectional imaging is critical for assessing tumor extent, nodal involvement, and distant metastases. MRI provides superior pelvic soft tissue delineation, while PET/CT is valuable for evaluating nodal and distant disease, particularly in locally advanced cases.

| Cervical Cancer Recommendations | | | |
|---|---|---|---|
| **Clinical Scenario** | **Recommended Modality** | **Frequency/Timing** | **Purpose/Notes** |
| **Initial Diagnosis and Stage IB1 and Higher** | MRI pelvis | Once at diagnosis | Preferred for local staging—defines tumor size, parametrial, and vaginal extension |
| | CT chest/abdomen/pelvis<br><br>or<br><br>PET/CT | Once at diagnosis<br><br>Once at diagnosis (Stage IB1 or higher) | Evaluate lymph nodes and distant metastases (lung, liver, para-aortic)<br><br>Recommended for detection of nodal/distant metastases; may replace CT for systemic staging PET/CT (preferred) |
| | MRI brain (if small cell neuroendocrine) | Once at diagnosis | |
| **Treatment Monitoring Locally Advanced, Recurrent, and Stage IV** | CT chest/abdomen/pelvis | Every 2-3 months | NCCN does not specifically note a duration for imaging interval although imaging should be primarily symptom-driven |
| | FDG-PET/CT | Every 2-3 months | PET CT when clinically indicated due to inconclusive |

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| | | | findings on conventional imaging |
| | MRI pelvis | Every 2-3 months | |
| **Surveillance/Post Treatment Evaluation After Fertility-Sparing Surgery** | MRI pelvis | At 6 months then annually for 2-3 years | Assesses tumor size and stromal invasion; essential for radical trachelectomy consideration |
| **Surveillance/Post Treatment Evaluation Stages IB3-IV** | FDG-PET/CT | At 3–6 months post-therapy | PET preferred. If PET finding indeterminate then repeat at 3 months |
| | CT pelvis/abdomen ± chest | At 3–6 months post-therapy | May also consider imaging in patents with high risk features or required radiation or chemoradiation |
| | MRI pelvis | At 3–6 months post-therapy | |
| **Suspected Recurrence or Progression** | FDG-PET/CT | As clinically indicated | Most sensitive for detecting recurrent/metastatic disease. Guides biopsy or therapy |
| | CT pelvis/abdomen ± chest | As clinically indicated | |
| | MRI pelvis | As clinically indicated | Evaluate local recurrence, especially in previously irradiated pelvis |

**Notes:**

1. PET/CT is preferred over CT for advanced disease (≥IB3 or node-positive).
2. MRI with and without contrast is the gold standard for local assessment of cervical tumor and parametrial invasion.
3. Imaging is not routinely recommended for surveillance unless clinically indicated.
4. Recurrence patterns often include pelvic sidewall, para-aortic nodes, lungs, and liver—use imaging tailored to suspected sites.
5. For fertility-sparing management, MRI ensures accurate measurement of tumor <2 cm and absence of parametrial invasion.[1]

## Revision and Review History

| No. | Description | Date |
|---|---|---|
| 1 | Original Effective Date: | 1/1/2026 |
| 2 | Policy Annual Review Dates: | |
| 3 | Department Owner: | Medical Affairs |
| 4 | NH Advisory Committee Approval Dates: | |
| 5 | Revision Changes: | |

## References

[1] National Comprehensive Cancer Network Guidelines: Cervical Cancer. https://www.nccn.org/professionals/physician_gls/pdf/cervical.pdf. Accessed December 15, 2025.