Provisional Pathological Staging Pre-MDTM (Core and Non-core)

FIGO staging is defined as a core item while TNM can also be used (non-core item- see below). A new FIGO staging system for cervical cancer was introduced in 2018. The main changes from the prior 2009 system are:-

1 The horizontal dimension of 7 mm is no longer considered in defining the upper boundary of a stage IA carcinoma.

2 Stage IB has been subdivided into IB1, IB2 and IB3 based on maximum tumour size.

3 Nodal status is included; the presence of nodal involvement upstages a tumour to stage IIIC, with IIIC1 indicating pelvic and IIIC2 indicating para-aortic nodal involvement. As discussed, the revised FIGO classification is now more closely aligned with the TNM classification.

4 Prior FIGO staging systems were based mainly on clinical examination but the 2018 staging system allows imaging and pathology findings to be taken into account to supplement clinical staging with respect to tumour size and extent in all stages. The notation of r (imaging) or p (pathology) should indicate the parameters that are used to allocate the case to stage IIIC; for example, if imaging indicates pelvic lymph node metastasis, the stage would be stage IIIC1r, and if confirmed by pathologic findings, it would be stage IIIC1p.

Table 1: 2009 and 2018 FIGO staging of carcinoma of the cervix uteri. Differences in the two staging systems are highlighted in red text.

FIGO staging of carcinoma of the cervix uteri		
	2009	**2018**
Stage I	Carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded).	The carcinoma is strictly confined to the cervix uteri (extension to the corpus should be disregarded)
IA	Invasive cancer identified only by microscopy, with deepest invasion ≤5mm and largest extension ≤7mm.	Invasive carcinoma that can be diagnosed only by microscopy, with maximum depth of invasion <5 mm[a]
IA1	Measured stromal invasion ≤3.0 mm in depth and extension ≤ 7 mm.	Measured stromal invasion <3 mm in depth
IA2	Measured stromal invasion >3 mm and <5 mm with an extension ≤7 mm	Measured stromal invasion ≥3 mm and <5 mm in depth
IB	Clinically visible lesions limited to the cervix uteri or preclinical lesions greater than stage IA.	Invasive carcinoma with measured deepest invasion ≥5 mm (greater than stage IA), lesion limited to the cervix uteri[b]
IB1	Clinically visible lesions ≤4 cm in greatest diameter	Invasive carcinoma ≥5 mm depth of stromal invasion and <2 cm in greatest dimension
IB2	Clinically visible lesions >4 cm in greatest diameter	Invasive carcinoma ≥2 cm and <4 cm in greatest dimension
IB3		Invasive carcinoma ≥4 cm in greatest dimension
Stage II	Cervical carcinoma extends beyond the uterus, but not to the pelvic wall or to the lower third of the vagina	The carcinoma invades beyond the uterus, but has not extended onto the lower third of the vagina or to the pelvic wall
IIA	Without parametrial invasion	Involvement limited to the upper two-thirds of the vagina without parametrial involvement
IIA1	Clinically visible lesion ≤4.0 cm in greatest diameter	Invasive carcinoma <4 cm in greatest dimension
IIA2	Clinically visible lesion >4 cm in greatest dimension.	Invasive carcinoma ≥4 cm in greatest dimension
IIB	With obvious parametrial invasion	With parametrial involvement but not up to the pelvic wall
Stage III	The tumour extends to the pelvic wall and/or involves lower third of the vagina and/or causes hydronephrosis or non-functioning kidney. On rectal examination, there is no cancer–	The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or non-functioning kidney and/or involves pelvic and/or paraaortic lymph nodes[c]

	free space between the tumour and the pelvic wall	
IIIA	No extension to the pelvic wall but involvement of the lower third of vagina	Carcinoma involves the lower third of the vagina, with no extension to the pelvic wall
IIIB	Extension on to pelvic wall and/or hydronephrosis or non-functioning kidney	Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney (unless known to be due to another cause)
IIIC		Involvement of pelvic and/or paraaortic lymph nodes, irrespective of tumour size and extent (with r and p notations)[c]
IIIC1		Pelvic lymph node metastasis only
IIIC2		Paraaortic lymph node metastasis
Stage IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous oedema, as such, does not permit a case to be allotted to stage IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to stage IV
IVA	Spread of growth to adjacent organs	Spread of the growth to adjacent organs
IVB	Spread to distant organs	Spread to distant organs
Notes		
		[a] Imaging and pathology can be used, when available, to supplement clinical findings with respect to tumour size and extent, in all stages. [b] The involvement of vascular/lymphatic spaces does not change the staging. The lateral extent of the lesion is no longer considered. [c] Adding notation of r (imaging) and p (pathology) to indicate the findings that are used to allocate the case to stage IIIC. For example, if imaging indicates pelvic lymph node metastasis, the stage allocation would be stage IIIC1r and, if confirmed by pathological findings, it would be Stage IIIc1p. The type of imaging modality or pathology technique used should always be documented. When in doubt, the lower staging should be assigned.

There are several difficulties inherent in the staging of carcinoma of the uterine cervix[1]: (i) there are difficulties in obtaining precise tumour measurements in low-stage disease (FIGO IA and IB); this has been discussed in **NOTE 7 - TUMOUR DIMENSION**. (ii) clinical staging, as previously recommended by FIGO may under or overestimate true anatomical extent of disease as it does not include information obtained from post-surgical pathology specimens or radiological/surgical techniques which may not be universally available. Reliance on clinical staging tends to occur in underdeveloped or under-resourced countries where surgical facilities and ancillary investigations (such as radiology and pathology) may be limited. As discussed, the 2018 FIGO staging systems allows incorporation of imaging and pathology findings. A provisional FIGO stage should be provided on the pathology report but the definitive stage is assigned at the tumour board/ MDTM.

As stated, FIGO staging is defined as a core item while TNM is non-core. However, in many areas of the world, TNM staging UICC or American Joint Committee on Cancer (AJCC) versions) is used or even mandated in clinical and pathological practice. For example, in the United States, use of the AJCC system is required for College of Surgeons Cancer Center accreditation, National Comprehensive Cancer Network (NCCN) Clinical decision guidelines implementation and for the College of American Pathologists (CAP) accreditation.

References

1 Bhatla N, Berek JS, Cuello Fredes M, Denny LA, Grenman S, Karunaratne K, Kehoe ST, Konishi I, Olawaiye AB, Prat J, Sankaranarayanan R, Brierley J, Mutch D, Querleu D, Cibula D, Quinn M, Botha H, Sigurd L, Rice L, Ryu HS, Ngan H, Maenpaa J, Andrijono A, Purwoto G, Maheshwari A, Bafna UD, Plante M and Natarajan J (2019). Revised FIGO staging for carcinoma of the cervix uteri. *Int J Gynaecol Obstet* 145(1):129-135.