History of the Cancer Staging System

Since the 1930s, gynaecologic oncologists around the world have strived towards a common language to facilitate making diagnoses and planning treatment for their patients. The aim was, and still is, to reach a uniform as well as a unified terminology to provide appropriate prognosis to the patients, and to enhance the exchange of information among health professionals. The International Federation of Gynecology and Obstetrics (FIGO) was the first organization to develop its own classification and staging system, making it the first cancer staging system ever developed.

The first rules for classification and staging of malignant tumors of the female genital tract were developed by the Radiological Sub-Commission of the Cancer Commission of the Health Organization of the League of Nations. In 1928, the Radiological Sub-Commission assigned the task of producing uniform statistical information on the results of radiotherapeutic treatment methods for uterine cervical cancer to Professor J. Heyman (the Radiumhemmet, Stockholm, Sweden), Dr A. Lacassagne (Radium Institute of the University of Paris, France), and Professor F. Voltz (Munich, Germany). The group of experts stressed the absolute necessity of a uniform method to describe the extent of the disease. This led to an international classification system for grouping cervical cancer patients based on clinical examination and on the anatomic extent of the disease. This staging classification was designed to mimic the natural history of the disease, i.e., the different stages representing the progressive growth of the tumor. Such recommendations were adopted by the Sub-Commission and published in 1929. They became known as the League of Nations Classification for Cervical Cancer (1, 2).

In 1949 Professor Heyman produced the following recommendations (3): The definition of the different stage groups should be as simple and precise as possible (4); the rules for allocating cases to their appropriate stages should be easily interpreted so that they could be applied in a uniform way by the examining clinicians (5); each stage should be differentiated from the other by characteristics easily recognized on clinical examination, even by a less experienced examiner (6); and the system of stage grouping should be sufficiently complete to include every possible type of cancer case. In 1950 an Editorial Committee met in New York at the International Gynecological Congress and Fourth American Congress of Obstetrics and Gynecology and agreed upon several modifications to the classification adopted by the Health Organization of the League of Nations. The group of experts recommended that the new classification should be called “The International Classification of the Stages of Carcinoma of the Uterine Cervix”.

In 1954, the International Union Against Cancer (UICC) appointed a committee with the task of establishing the rules for classification and clinical staging of malignant tumors and the presentation of therapeutic results. A tumor-node-metastasis (TNM) classification for cervical cancer was proposed by this Committee in 1966, taking the experience gained by the FIGO stage grouping into great consideration.

In 1959, the American Joint Committee for Cancer Staging and End Results Reporting (today known as the American Joint Committee on Cancer, AJCC) was organized with the aim of developing a system of clinical staging of cancer by site acceptable to the US medical profession. In 1976, the AJCC accepted the FIGO stage grouping for gynecological cancers (7).

Evolution of the FIGO Staging System

Over the past 70 years, the system for gynecologic cancer staging has gradually been modified to adapt to the significant scientific changes in medical research and practice, particularly in the field of oncology, which has shown explosive growth (8). Over the last 30 years, all changes to the FIGO classification and staging have been extensively discussed by the FIGO Committee on Gynecologic Oncology and put forward in agreement with and approved by the UICC TNM Committee, the AJCC, and the World Health Organization. Over the years the UICC, AJCC, and FIGO have modified their staging systems for gynecological cancers so that all 3 systems are virtually identical (4). Currently, an agreement between the 3 bodies ensures comparability of staging classifications for gynecologic malignancies and their representatives meet annually. The interaction among these bodies has led to the creation of uniform information shared within the scientific community (9). Further and joint efforts are constantly being made to unify the FIGO and TNM classifications.

In the light of the recent significant scientific breakthroughs, the scientific community - with the support of FIGO as well as other international scientific societies and agencies – felt that the time had come to revise the staging of some gynaecologic cancers. Over the past 3 years, the FIGO Committee on
Gynecologic Oncology (Sergio Pecorelli, Italy, Chairperson; Lynette Denny, South Africa, Co-Chairperson; Hextan Ngan, People’s Republic of China, Past Chairperson; Neville F. Hacker, Australia, member; Adriana Bermudez, Argentina, member; David Mutch, United States, member) has devoted much time and attention to reviewing proposals concerning the classification and staging for the carcinoma of the vulva, cervix uteri, and corpus uteri, lately revised in 1988, 1994, and 1988, respectively.

In the final phase of the revision process, the FIGO Committee on Gynecologic Oncology invited international scientific societies and agencies specializing in research and treatment of female malignancies to take part. Representatives of the International Gynecologic Cancer Society (IGCS), the Gynecologic Cancer Inter Group (GCIG), the American Society of Gynecologic Oncologists (SGO), and the AJCC (American Joint Commission on Cancer), together with the International Gynecologic Cancer Society (IGCS), the American Society of the International Gynecologic Cancer Society (IGCS), the Gynecologic Oncology Group (GOG), and the AJCC (American Joint Commission on Cancer), together with the International Society of Gynecological Pathologists (ISGyP), agreed to collaborate, and formed the Enlarged Committee (Scott McMeekin, United States, AJCC; Edgar Petru, Austria, GCIG; Jaime Prat, Spain, ISGyP; Adriana Bermudez, Argentina, IGCS; David Mutch, United States, SGO) (10).

The FIGO Classification and Staging for Uterine Sarcomas

According to the FIGO Committee on Gynecologic Oncology, the old classification and staging for corpus uteri cancer was no longer applicable to both endometrial cancer and uterine sarcomas, as more knowledge on these malignancies had been acquired. Therefore, they deserved their own staging despite their relative rarity. Uterine sarcomas, i.e. leiomyosarcomas, endometrial stromal sarcomas (ESS), adenosarcomas, and carcinosarcomas are a heterogeneous group of malignancies both from the pathological and clinical points of view, and also very different from endometrial cancer.

The process of producing a new staging for uterine sarcomas began more than 2 years ago when the FIGO Committee asked the International Society of Gynecologic Pathologists (ISGyP) to draft an ad hoc classification and staging for these rare tumours. Detailed discussions led to the first ISGyP draft. The ensuing document was circulated and discussed among the members of the Enlarged Committee.

The consensus document with the updated staging for vulvar, cervical, and endometrial cancer together with the new staging for uterine sarcomas was presented at the TNM UICC Core Group meeting in Geneva in May 2008, where it was approved by both UICC and AJCC with only minor changes. In early September 2008, the new staging for vulvar, cervical, endometrial cancers, and uterine sarcomas were submitted to the FIGO Executive Board, for a final stamp of approval from its members (11).

Latest Changes to the FIGO Staging System

**Vulva:** Vulvar cancer has undergone major changes following the worldwide debate based on stromal invasion and tumour size, as well as lymph nodal involvement. For a more thorough analysis of the latest changes to vulvar cancer staging refer to the article Revised FIGO staging for carcinoma of the vulva by Hacker NF published in the International Journal of Gynecology and Obstetrics (Volume 105, Issue 2, May, p. 105-106).

**Cervix:** Since cervical cancer was first staged in 1929, 7 further revisions have been made so far to cervical cancer staging, the most recent being in 1994. Almost all of these changes were relevant to Stage I cervical cancer. Although this staging has already been thoroughly revised in the past, the debate is still open in the scientific community regarding different aspects, the most important of which is whether this disease should be clinically or surgically staged. The reason why cervical cancer will remain clinically staged is mainly due to epidemiological reasons rather than scientific rationale. For a more thorough analysis of the latest changes to cervical cancer staging refer to the article Revised FIGO staging for carcinoma of the cervix by Pecorelli S, Zigliani L, Odicino F published in the International Journal of Gynecology and Obstetrics (Volume 105, Issue 2, May, p. 107-108).

**Corpus Uteri/Endometrium:** In 1988 a revolutionary step was taken by the FIGO Committee on Gynecologic Oncology whereby staging was changed from clinical to surgical. Based as usual on solid and mature data, surgical staging dramatically changed the management of and therefore the therapeutic approach to corpus uteri cancer. Twenty years later, minor though significant changes were made. They are basically linked to the data provided by the FIGO Annual Report on the Results of Treatment in Gynecological Cancer (Volume 27 due to be published by the end of 2009) and confirmed by other publications. All these data better define the clinically relevant risk strata. For more thorough analyses of the latest changes to endometrial cancer staging refer to the articles Revised FIGO staging for carcinoma of the endometrium by Creasman WT, and New surgical staging of endometrial cancer: 20 years later by Mariani A, Dowdy SC, Podratz KC published in the International Journal of Gynecology and Obstetrics (Volume 105, Issue 2, May, p. 109-111).

**Uterine Sarcomas:** Three new classifications have been developed and approved: a) staging for leiomyosarcomas and endometrial stromal sarcomas (ESS), b) staging for adenosarcomas, and c) staging for carcinosarcomas (formerly MMMT). The first two stagings are completely new, while carcinosarcomas are staged according to the new classification of endometrial carcinoma. For a more thorough analysis of the staging for uterine sarcomas refer to the article FIGO staging for uterine sarcomas by Prat J published in the International Journal of Gynecology and Obstetrics (Volume 105, Issue 3, April, p. 177-178).

Tables 1-8 provide the current and updated FIGO staging of the carcinomas of the vulva, vagina, cervix uteri, endometrium, Fallopian tube, ovary, of uterine sarcomas, and of gestational trophoblastic neoplasia.
History of the FIGO Staging System and Current Update

**Table 1. Staging of vulvar cancer (2008)**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Tumor confined to the vulva</td>
</tr>
<tr>
<td>IA</td>
<td>Lesions ≤2 cm in size, confined to the vulva or perineum and with stromal invasion ≤1.0 mm, no nodal metastasis</td>
</tr>
<tr>
<td>IB</td>
<td>Lesions &gt;2 cm in size or with stromal invasion &gt;1.0 mm, confined to the vulva or perineum, with negative nodes</td>
</tr>
<tr>
<td>II</td>
<td>Tumor of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with negative nodes</td>
</tr>
<tr>
<td>IIA</td>
<td>Tumor of any size with or without extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with positive inguino-femoral lymph nodes</td>
</tr>
<tr>
<td>IIB</td>
<td>Tumor of any size with or without extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with positive para-inguinal nodes</td>
</tr>
<tr>
<td>IIC</td>
<td>With positive nodes with extracapsular spread</td>
</tr>
<tr>
<td>IV</td>
<td>Tumor invades another regional (2/3 upper urethra, 2/3 upper vagina), or distant structures</td>
</tr>
<tr>
<td>IVA</td>
<td>Tumor invades any of the following: (i) upper urethra and/or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed to pelvic bone, or (ii) fixed or ulcerated inguino-femoral lymph nodes</td>
</tr>
<tr>
<td>IVB</td>
<td>Any distant metastasis including pelvic lymph nodes</td>
</tr>
</tbody>
</table>

*The depth of invasion is defined as the measurement of the tumor from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.*

**Table 2. Staging of vaginal cancer**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The carcinoma is limited to the vaginal wall</td>
</tr>
<tr>
<td>II</td>
<td>The carcinoma has involved the subvaginal tissue but has not extended to the pelvic wall</td>
</tr>
<tr>
<td>III</td>
<td>The carcinoma has extended to the pelvic wall</td>
</tr>
<tr>
<td>IV</td>
<td>The carcinoma has extended beyond the true pelvis or has involved the mucosa of the bladder or rectum; bulbus edema as such does not permit a case to be allotted to Stage IV</td>
</tr>
<tr>
<td>IVA</td>
<td>Tumor invades bladder and/or rectal mucosa and/or direct extension beyond the true pelvis</td>
</tr>
<tr>
<td>IVB</td>
<td>Spread to distant organs</td>
</tr>
</tbody>
</table>

**Table 3. Staging of vulvar cancer (2008)**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded)</td>
</tr>
<tr>
<td>IA</td>
<td>Invasive carcinoma which can be diagnosed only by microscopy, with deepest invasion ≤5 mm and largest extension ≤7 mm</td>
</tr>
<tr>
<td>IA1</td>
<td>Measured stromal invasion of ≤3.0 mm in depth and horizontal extension of ≤7.0 mm</td>
</tr>
<tr>
<td>IA2</td>
<td>Measured stromal invasion of &gt;3.0 mm and not &gt;5.0 mm with an extension of not &gt;7.0 mm</td>
</tr>
<tr>
<td>IB</td>
<td>Clinically visible lesions limited to the cervix uteri or pre-clinical cancers greater than stage IA</td>
</tr>
<tr>
<td>IB1</td>
<td>Clinically visible lesion ≤4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>IB2</td>
<td>Clinically visible lesion &gt;4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>II</td>
<td>Cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina</td>
</tr>
<tr>
<td>IIA</td>
<td>Without parametral invasion</td>
</tr>
<tr>
<td>IIA1</td>
<td>Clinically visible lesion ≤4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>IIA2</td>
<td>Clinically visible lesion &gt;4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>IIB</td>
<td>With obvious parametral invasion</td>
</tr>
<tr>
<td>III</td>
<td>The tumor extends to the pelvic wall and/or involves lower third of the vagina and/or causes hydrenphrosis or non-functioning kidney **</td>
</tr>
<tr>
<td>IIIA</td>
<td>Tumor involves lower third of the vagina, with no extension to the pelvic wall</td>
</tr>
<tr>
<td>IIIB</td>
<td>Extension to the pelvic wall and/or hydrenphrosis or non-functioning kidney</td>
</tr>
<tr>
<td>IV</td>
<td>The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bulbus edema, as such, does not permit a case to be allotted to Stage IV</td>
</tr>
<tr>
<td>IVA</td>
<td>Spread of the growth to adjacent organs</td>
</tr>
<tr>
<td>IVB</td>
<td>Spread to distant organs</td>
</tr>
</tbody>
</table>

*All macroscopically visible lesions - even with superficial invasion - are allotted to stage IB carcinomas. Invasion is limited to a measured stromal invasion with a maximal depth of 5.00 mm and a horizontal extension of not >7.00 mm. Depth of invasion should not be >5.00 mm taken from the base of the epithelium of the original tissue - superficial or glandular. The depth of invasion should always be reported in mm, even in those cases with “early (minimal) stromal invasion” (~1 mm). The involvement of vascular/lymphatic spaces should not change the stage allotment. **On rectal examination, there is no cancer-free space between the tumor and the pelvic wall. All cases with hydrenphrosis or non-functioning kidney are included, unless they are known to be due to another cause.*

Conclusions

It is inevitable that changes will occur as more data and information emerge regarding molecular markers and mechanisms, as will a more precise understanding of the actual genetic factors and aberrations involved in cancer etiology and pathogenesis (12). An increasing awareness of prognostic scoring systems and the incentive to adopt etiology and pathogenesis (12). An increasing awareness of actual genetic factors and aberrations involved in cancer mechanisms, as will a more precise understanding of the information emerge regarding molecular markers and aberrations involved in cancer mechanisms.

Future efforts should focus on major issues such as the possibility of including also residual tumor in the classifications, since it is known that, in several neoplasia, the residual tumor status is one of the strongest outcome predictors after treatment; the possible inclusion of new concepts regarding tumor spread such as the detection of isolated tumor cells in regional lymph nodes, blood, bone marrow, or biopsies; and the classification of findings in sentinel node biopsies (14).

Despite the shortcomings a cancer staging inevitably has, FIGO together with AJCC and UICC is committed to providing better guidance to physicians involved in the field of gynaecological oncology in low- as well as high-resource settings. As scientists responsible for maintaining, modifying, and proposing changes to the existing cancer staging, we shoulder an enormous responsibility to make the appropriate changes timely, wisely, and based on sound scientific data.

The FIGO Committee on Gynecologic Oncology is therefore certain that the new classification and staging for uterine sarcomas together with the amendments to the
Future Directions

In the next few years the FIGO Committee on Gynecologic Oncology will concentrate its efforts on the improvement of the current staging system for Ovarian and fallopian tube cancers. In order to accomplish this task, the Committee will focus on the epidemiological, clinical, pathological, and molecular data of the diseases. The aim is also to make classifications a more user-friendly system that can be easily applied also in less fortunate countries.

**Table 4.** Staging of endometrial cancer (2008)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I*</td>
<td>Tumor confined to the corpus uteri</td>
</tr>
<tr>
<td>IA*</td>
<td>No or less than half myometrial invasion</td>
</tr>
<tr>
<td>IB*</td>
<td>Invasion equal to or more than half of the myometrium</td>
</tr>
<tr>
<td>Stage II*</td>
<td>Tumor invades cervical stroma, but does not extend beyond the uterus**</td>
</tr>
<tr>
<td>Stage III*</td>
<td>Local and/or regional spread of the tumor</td>
</tr>
<tr>
<td>IIIA*</td>
<td>Tumor invades the serosa of the corpus uteri and/or adnexae#</td>
</tr>
<tr>
<td>IIB*</td>
<td>Vaginal and/or parametrial involvement#</td>
</tr>
<tr>
<td>IIC*</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes#</td>
</tr>
<tr>
<td>IIIC1*</td>
<td>Positive pelvic nodes</td>
</tr>
<tr>
<td>IIIC2*</td>
<td>Positive para-aortic lymph nodes with or without positive pelvic lymph nodes</td>
</tr>
<tr>
<td>Stage IV*</td>
<td>Tumor invades bladder and/or bowel mucosa, and/or distant metastases</td>
</tr>
<tr>
<td>IVA*</td>
<td>Tumor invasion of bladder and/or bowel mucosa</td>
</tr>
<tr>
<td>IVB*</td>
<td>Distant metastases, including intra-abdominal metastases and/or inguinal lymph nodes</td>
</tr>
</tbody>
</table>

*Either G1, G2, or G3. **Endocervical glandular involvement only should be considered as Stage I and no longer as Stage II. #Positive cytology has to be reported separately without changing the stage.

staging for vulvar, cervical, and endometrial cancers will serve as a springboard for future discussion and improvements.

**Table 5.** Staging of cancer of the Fallopian tube (1991)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>Carcinoma in situ (limited to tubal mucosa)</td>
</tr>
<tr>
<td>Stage I</td>
<td>Growth limited to the Fallopian tubes</td>
</tr>
<tr>
<td>IA</td>
<td>Growth is limited to one tube, with extension into the submucosa and/or muscularis, but not penetrating the serosal surface; no ascites</td>
</tr>
<tr>
<td>IB</td>
<td>Growth is limited to both tubes, with extension into the submucosa and/or muscularis, but not penetrating the serosal surface; no ascites</td>
</tr>
<tr>
<td>IC</td>
<td>Tumor either Stage IA or IB, but with tumor extension through or onto the tubal serosa, or with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage II</td>
<td>Growth involving one or both Fallopian tubes with pelvic extension</td>
</tr>
<tr>
<td>IIA</td>
<td>Extension of tumor to the uterus and/or ovaries</td>
</tr>
<tr>
<td>IIB</td>
<td>Extension to other pelvic tissues</td>
</tr>
<tr>
<td>IIC</td>
<td>Tumor either Stage IIA or IIB and with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage III</td>
<td>Growth involving one or both Fallopian tubes with distant metastases</td>
</tr>
<tr>
<td>IIA</td>
<td>Extension and/or metastases to the uterus and/or tubes</td>
</tr>
<tr>
<td>IIB</td>
<td>Extension to other pelvic tissues</td>
</tr>
<tr>
<td>IIC</td>
<td>Tumor either Stage IIA or IIB, but with tumor on surface of one or both ovaries, or with capsule(s) ruptured, or with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Growth involving one or both ovaries with pelvic extension</td>
</tr>
<tr>
<td>IIA</td>
<td>Extension and/or metastases to the uterus and/or tubes</td>
</tr>
<tr>
<td>IIB</td>
<td>Extension to other pelvic tissues</td>
</tr>
<tr>
<td>IIC</td>
<td>Tumor either Stage IIA or IIB, but with tumor on surface of one or both ovaries, or with capsule(s) ruptured, or with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage V</td>
<td>Growth involving one or both ovaries with distant metastases</td>
</tr>
<tr>
<td>IIA</td>
<td>Tumor grossly limited to the true pelvis, but with histologically proven malignant extension to small bowel or omentum</td>
</tr>
<tr>
<td>IIB</td>
<td>Tumor of one or both ovaries with histologically confirmed metastases, peritoneal metastases of abdominal peritoneal surfaces, none exceeding 2 cm in diameter; nodes are negative</td>
</tr>
<tr>
<td>IIC</td>
<td>Peritoneal metastasis beyond the pelvis &gt;2 cm in diameter and/or positive regional lymph nodes</td>
</tr>
</tbody>
</table>

*In order to evaluate the impact on prognosis of the different criteria for allotting cases to Stage IC or IIC, it would be of value to know if rupture of the capsule was spontaneous, or caused by the surgeon; and if the source of malignant cells detected was peritoneal washings, or ascites.

**Table 6.** Staging of cancer of the ovary (1988)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Growth limited to the ovaries</td>
</tr>
<tr>
<td>IA</td>
<td>Growth limited to one ovary; no ascites present containing malignant cells. No tumor on the external surface; capsule intact</td>
</tr>
<tr>
<td>IB</td>
<td>Growth limited to both ovaries; no ascites present containing malignant cells. No tumor on the external surfaces; capsules intact</td>
</tr>
<tr>
<td>IC*</td>
<td>Tumor either Stage IA or IB, but with tumor on surface of one or both ovaries, or with capsule ruptured, or with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage II</td>
<td>Growth involving one or both ovaries with pelvic extension</td>
</tr>
<tr>
<td>IIA</td>
<td>Extension of tumor to the uterus and/or ovaries</td>
</tr>
<tr>
<td>IIB</td>
<td>Extension to other pelvic tissues</td>
</tr>
<tr>
<td>IC*</td>
<td>Tumor either Stage IIA or IIB, but with tumor on surface of one or both ovaries, or with capsule(s) ruptured, or with ascites present containing malignant cells, or with positive peritoneal washings</td>
</tr>
<tr>
<td>Stage III</td>
<td>Growth involving one or both ovaries with distant metastases and/or inguinal lymph nodes</td>
</tr>
<tr>
<td>IIA</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIB</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIC</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Growth involving one or both ovaries with distant metastases</td>
</tr>
<tr>
<td>IIA</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIB</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIC</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>Stage V</td>
<td>Growth involving one or both ovaries with distant metastases</td>
</tr>
<tr>
<td>IIA</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIB</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>IIC</td>
<td>Metastases to pelvic and/or para-aortic lymph nodes</td>
</tr>
</tbody>
</table>

Parenchymal liver metastases equals Stage IV

Parenchymal liver metastases equals Stage IV
Table 7. Staging of GTN (2000) (15)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Disease confined to the uterus</td>
</tr>
<tr>
<td>Stage II</td>
<td>GTN extends outside of the uterus, but is limited to the genital structures (adnexa, vagina, broad ligament)</td>
</tr>
<tr>
<td>Stage III</td>
<td>GTN extends to the lungs, with or without known genital tract involvement</td>
</tr>
<tr>
<td>Stage IV</td>
<td>All other metastatic sites</td>
</tr>
</tbody>
</table>

Modified WHO Prognostic Scoring System as adapted by FIGO

<table>
<thead>
<tr>
<th>Scores</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&lt;40</td>
<td>≥40</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Antecedent pregnancy</td>
<td>mole</td>
<td>abortion</td>
<td>term</td>
<td></td>
</tr>
<tr>
<td>Interval months from index pregnancy</td>
<td>&lt;4</td>
<td>4-6</td>
<td>7-12</td>
<td>&gt;12</td>
</tr>
<tr>
<td>Pretreatment serum hCG (IU/l)</td>
<td>&lt;103</td>
<td>103-104</td>
<td>104-105</td>
<td>&gt;105</td>
</tr>
<tr>
<td>Largest tumor size (including uterus)</td>
<td>&lt;3</td>
<td>3-4 cm</td>
<td>&gt;5</td>
<td>-</td>
</tr>
<tr>
<td>Site of metastases</td>
<td>lung</td>
<td>spleen, kidney</td>
<td>gastro-intestinal</td>
<td>liver, brain</td>
</tr>
<tr>
<td>Number of metastases</td>
<td>-</td>
<td>1-4</td>
<td>5-8</td>
<td>&gt;8</td>
</tr>
</tbody>
</table>

To stage and allot a risk factor score, a patient’s diagnosis is allocated to a stage as represented by a Roman numeral I, II, III, and IV. This is then separated by a colon from the sum of all the actual risk factor scores expressed in Arabic numerals, e.g. Stage II:4, Stage IV:9. This stage and score will be allotted for each patient.

Table 8. Staging of uterine sarcomas (2008)

Staging for uterine sarcomas (leiomyosarcomas, endometrial stromal sarcomas, adenosarcomas, and carcinosarcomas).

1. Leiomyosarcomas and endometrial stromal sarcomas (ESS)*

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Tumor limited to uterus</td>
</tr>
<tr>
<td>IA</td>
<td>≤5 cm</td>
</tr>
<tr>
<td>IB</td>
<td>&gt;5 cm</td>
</tr>
<tr>
<td>Stage II</td>
<td>Tumor extends beyond the uterus, within the pelvis</td>
</tr>
<tr>
<td>IIA</td>
<td>Adnexal involvement</td>
</tr>
<tr>
<td>IIB</td>
<td>Involvement of other pelvic tissues</td>
</tr>
<tr>
<td>Stage III</td>
<td>Tumor invades abdominal tissues (not just protruding into the abdomen).</td>
</tr>
<tr>
<td>IIA</td>
<td>One site</td>
</tr>
<tr>
<td>IIB</td>
<td>&gt; one site</td>
</tr>
<tr>
<td>IIC</td>
<td>Metastasis to pelvic and/or para-aortic lymph nodes</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Tumor invades and/or rectum</td>
</tr>
<tr>
<td>IVA</td>
<td>Distant metastasis</td>
</tr>
</tbody>
</table>

Note: Simultaneous endometrial stromal sarcomas of the uterine corpus and ovary/pelvis in association with ovarian/pelvic endometriosis should be classified as independent primary tumors.

2. Adenosarcomas

| Stage I | Tumor limited to uterus |
| IA | Tumor limited to endometrium/endocervix with no myometrial invasion |
| IB | Less than or equal to half myometrial invasion |
| IC | More than half myometrial invasion |
| Stage II | Tumor extends beyond the uterus, within the pelvis |
| IIA | Adnexal involvement |
| IIB | Involvement of other pelvic tissues |
| Stage III | Tumor invades abdominal tissues (not just protruding into the abdomen). |
| IIA | One site |
| IIB | > one site |
| IIC | Metastasis to pelvic and/or para-aortic lymph nodes |
| Stage IV | Tumor invades bladder and/or rectum |
| IVA | Distant metastasis |

3. Carcinosarcomas

Carcinosarcomas should be staged as carcinomas of the endometrium.

The FIGO Committee on Gynecologic Oncology will also review the current literature on vulvar, endometrial, and cervical cancer, as well as on uterine sarcomas in order to monitor the appropriateness of the proposed staging classifications.

References