FIGO Staging for Cervical Cancer

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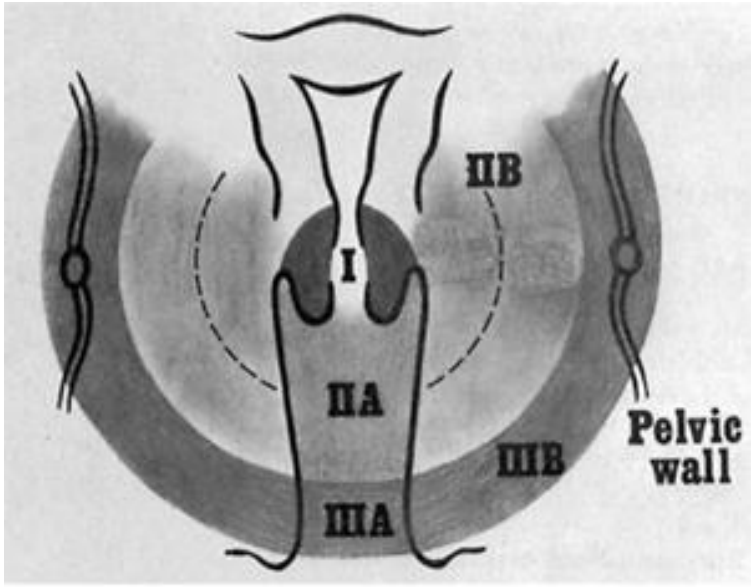
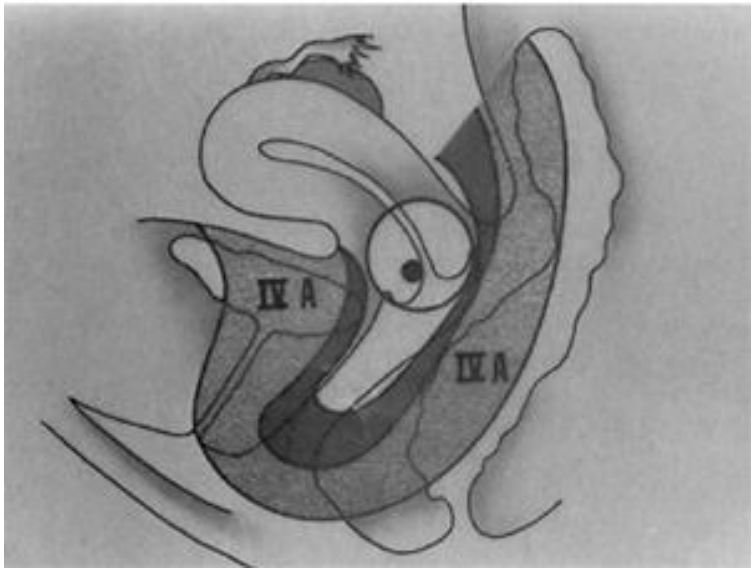
Investigations for Staging

- Examination under Anesthesia + Cystoscopy
- CXR
- IVU
- Labs: CBC, LFT, KFT
- Optional: CT if available will replace IVU for renal changes and will also detect Lymphadenopathy.
- Optional: MRI to detect Parametrial Involvement.
- Optional: PET CT to detect Metastases

Overview of Staging

- Stage I – Confined to Cervix *(extension to the corpus should be disregarded)*
- Stage II – Extends beyond Cervix to Upper 2/3rd of Vagina or Parametrium, but not to lower 1/3rd of vagina or Pelvic wall
- Stage III – Involves lower 1/3rd of vagina or pelvic wall/causes hydronephrosis
- Stage IV – Bladder/Rectum/Beyond true pelvis or Metastatic.





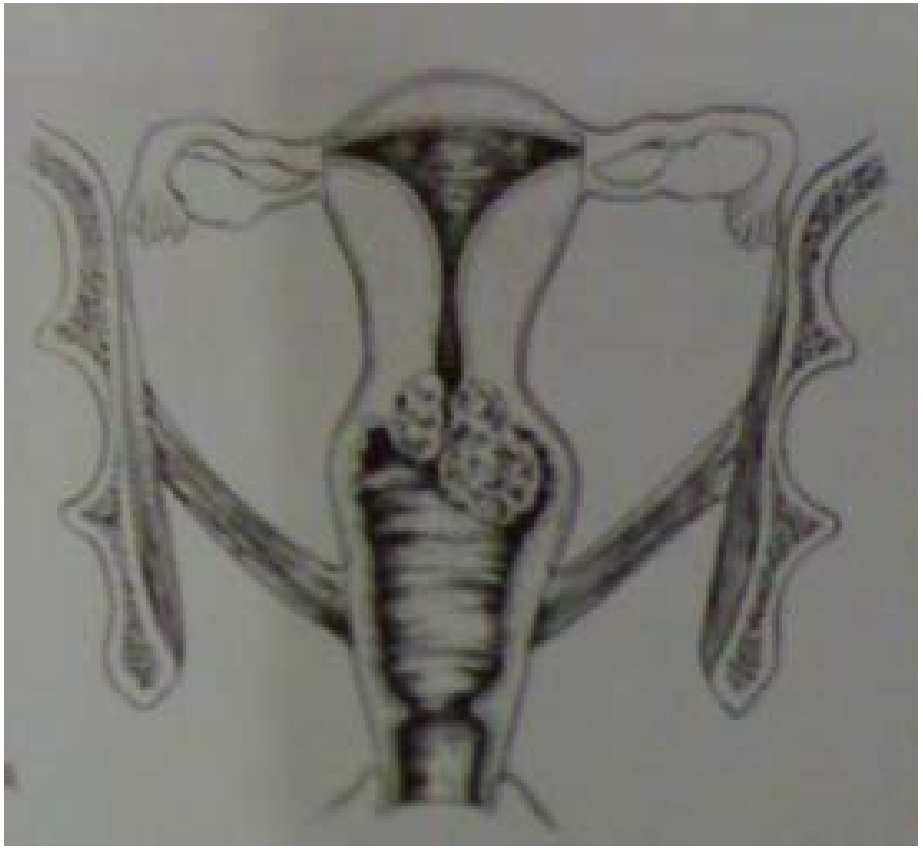
- Parametrium: Condensation of fascia extending from lateral wall of cervix to pelvic wall.
- Lateral pelvic wall is comprised of the iliac bone.
- Initially in IIIB no free space between tumor and pelvic wall. Later Hydrouretronephrosis.
- M.C. cause of death in Ca Cervix is Renal Failure.

- Stage IA diagnosis is usually reached after a suspicious PAP smear which is followed up with a Colposcopy directed biopsy and a Conization.
- Pathologists usually require a Cone to make a certain stage IA diagnosis.

Staging of Carcinoma of the Cervix (FIGO, 1995)

Stage I: Cervical carcinoma confined to the cervix

- IA : invasive carcinoma diagnosed only microscopically (*All gross lesions even with superficial invasion are stage IB)*
  - IA1 – measured stromal invasion maximum 3 mm deep and maximum width of 7 mm
  - IA2 - measured stromal invasion with depth 3 – 5 mm and maximum width of 7 mm
- IB: Clinical lesions confined to cervix or preclinical lesions > stage IA
  - IB1 - Clinical lesion ≤ 4 cm in size
  - IB2 - Clinical lesion > 4 cm in size



Stage I B

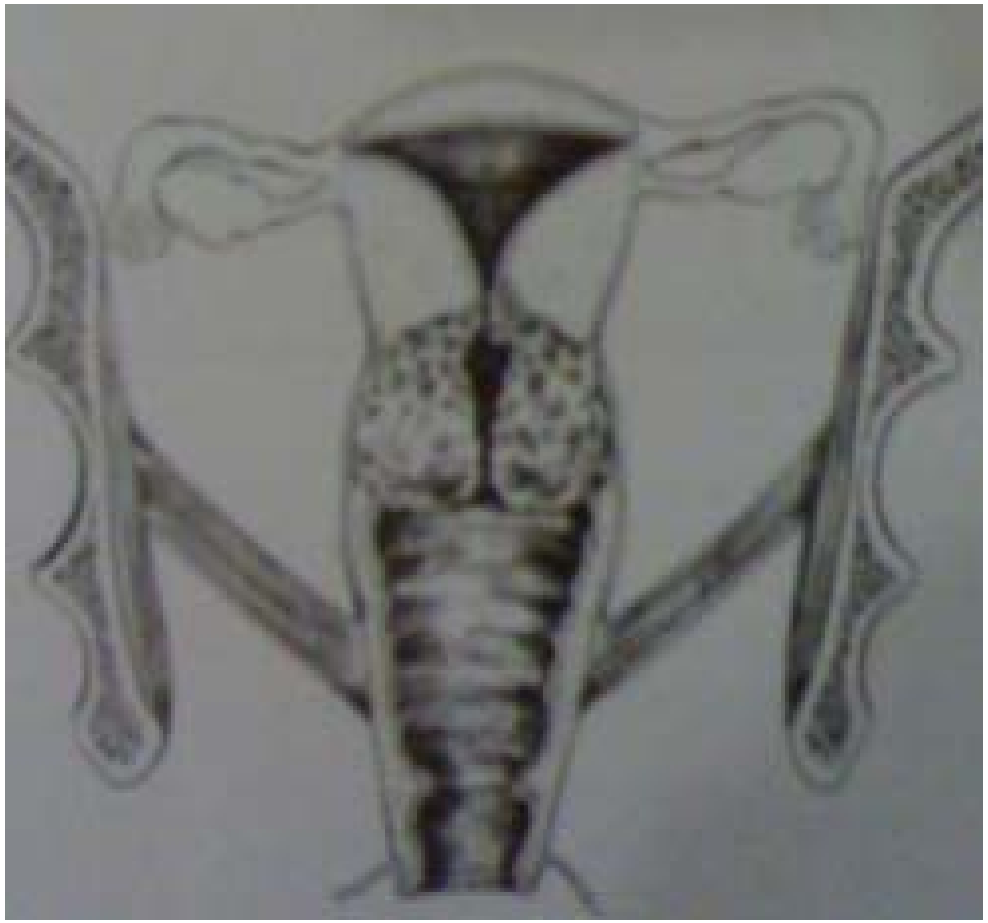
Tumour confined to cervix(exophytic)

Staging (contd)

Stage II: Cervical carcinoma extends/invades beyond the cervix but not to the pelvic wall or the lower third of the vagina

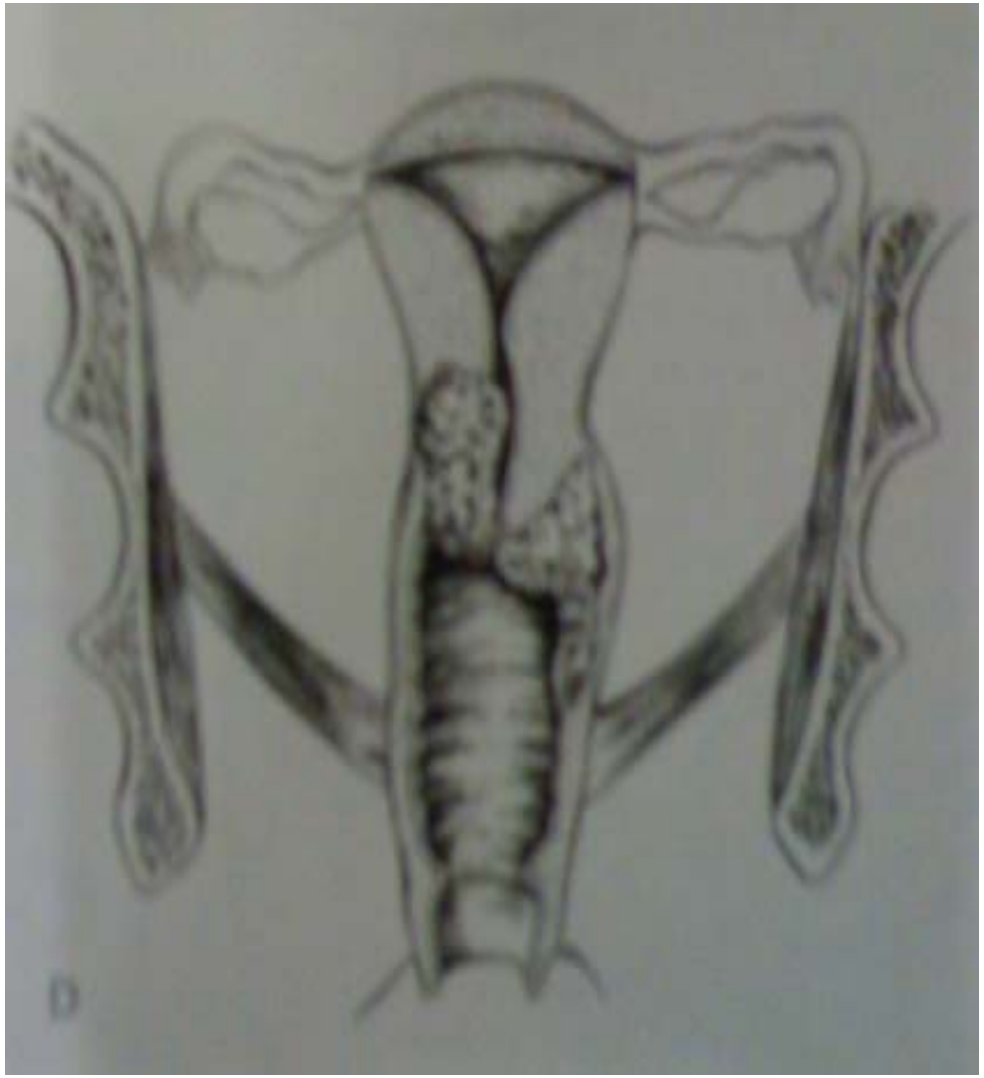
- IIA – no obvious parametrial involvement
  - IIA1 – tumour size < 4 cm*
  - IIA2 – tumour size > 4 cm
- IIB – obvious parametrial invasion

[* FIGO modification 2010]



Stage IIA

Bulky stage II A disease with involvement of vaginal fornix



Stage II A

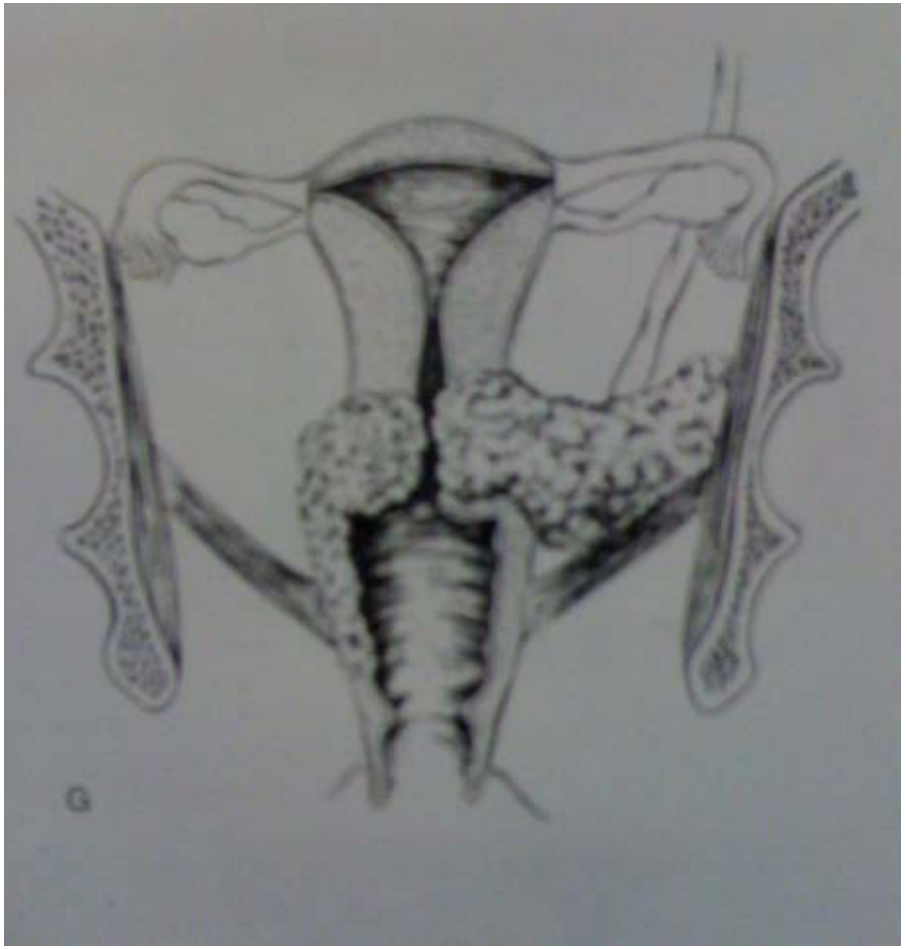
Carcinoma extends into the upper vagina or fornix

Stage IIB

Carcinoma extends into the parametrium but does not extend upto the lateral pelvic wall

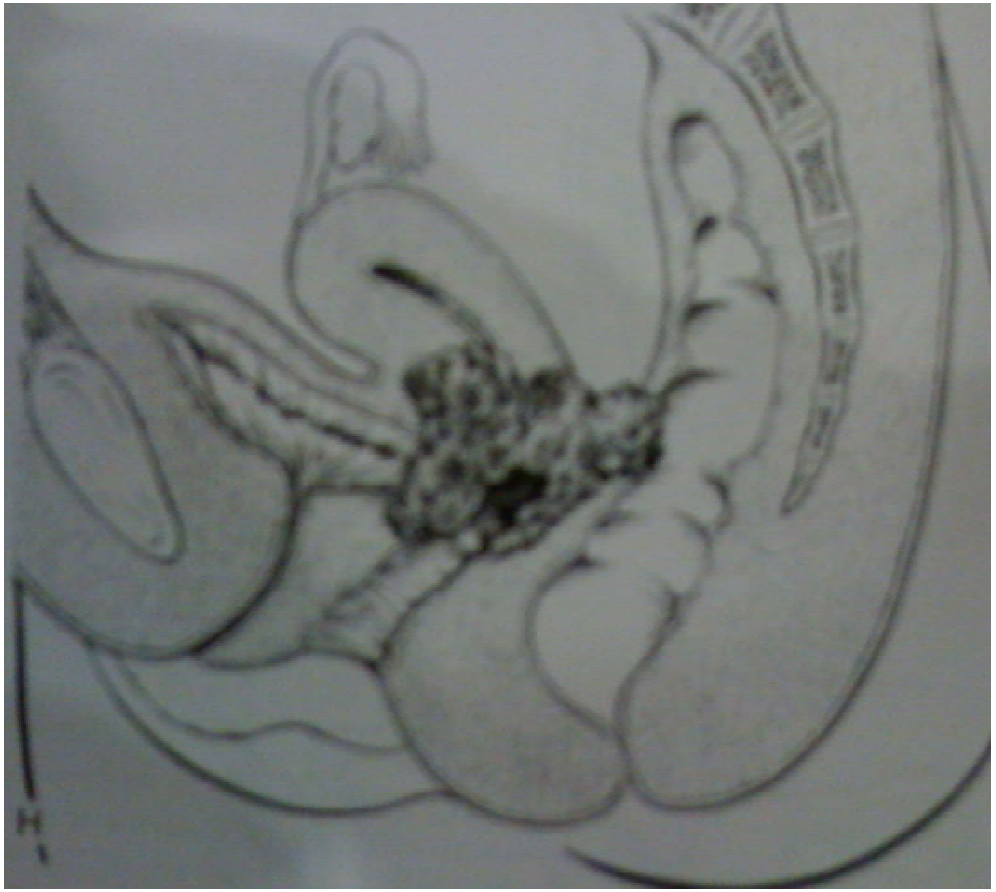
Staging (contd)

- Stage III: Involves lower 1/3rd of vagina or pelvic wall/causes hydronephrosis
  - III A – tumour involves the lower third of vagina. No extension to the pelvic wall
  - III B – tumour extends the lateral pelvic wall or causes hydronephrosis
- Stage IV: carcinoma extends beyond true pelvis or has clinically involved the mucosa of bladder or rectum or is metastatic *(bullous edema should be excluded)*
  - IVA – spread of the growth to adjacent organs
  - IV B – spread to distant organs



Stage III B

Parametrium is infiltrated and carcinoma extends upto the pelvic wall



Stage IV A

Bladder base and

rectum is involved

Why FIGO?

- Advantages:
  - Purely clinical staging with minimal investigations. Useful for developing countries where cervical cancer rates are higher.
  - Accurately predicts outcomes(except in case of Nodal Metastases, which FIGO staging cannot assess if we ignore the optional investigations)
- Disadvantages
  - Ignores Nodal Metastases
  - Ignores early spread in parametrium which might be clinically undetectable
  - Puts a higher clinical stage(IIB) below a lower clinical stage(IIIA) [If we apply the dictum of 'spread beyond the primary site holds a worse prognosis']

Thank you