Critical analysis of the FIGO 2018 cervical cancer staging

To the Editor,

Cancer staging is a process that changes with technological development leading to improvements in diagnosis, prognosis, and treatment. Therefore, the International Federation of Gynecology and Obstetrics (FIGO) updated the classification of cervical cancer staging in 2018. The main changes in the FIGO 2018 system occurred in stages IA, IB, and IIIC, as well as the inclusion of any imaging modality or pathological findings to allocate the stage (1). However, some conditions still need adjustments to differentiate each stage of the system.

Only the depth of invasion is now considered as the cut-off for stage IA, assigning stage IA as stroma invasion less than 5.0 mm, and further subdivided into stage IA1 and IA2 at a cutoff of 3.0 mm (1). The change at this stage was about the lateral extent of the lesion, which is no longer considered. After removing the lateral extent criterion, there is a concern with different cases being analyzed in the same way. It is also unclear whether clinically visible cases with stromal infiltration up to 3 mm would be IA1 or IB stage.

Tumor size has been recognized as a prognostic factor in stage IB for a long time, with larger tumor sizes displaying higher rates of nodal involvement, and decreased survival rates (2). At this stage, FIGO 2018 has included three substages, rather than two.

In terms of stage IIIB, Katanyoo (3) demonstrated that patients with a lower third vaginal invasion associated with parametrial involvement have poorer survival outcomes than patients at the same stage without a lower third of vaginal invasion. More studies are needed to verify these findings. However, if the finding of vaginal invasion in IIIB has worse prognosis, our suggestion is that stage IIIB should be subdivided into stage IIIB1, with involvement of only the parametrium, and IIIB2, with involvement of the lower third of the vagina and parametrium.

In FIGO 2018, any patient with positive lymph nodes automatically gets upstaged to stage IIIC (1). Ayhan et al. (2) suggested an increase in the number of sub-stages. This classification might be more prognostic than the current 2018 FIGO staging system, as more patients would be allocated to each sub-stage (2). We suggest that lymph node involvement accompany each stage without modifying the original stage instead of grouping them in stage IIIC.

Radiotherapy may be of limited value for patients with cervical adenocarcinoma and may not represent the best treatment, being an important prognostic factor for local failure (4). Different prognoses and treatment needs within the same stage would require some differentiation, as in endometrial cancer, where the serous papillary type is considered high-grade endometrial carcinoma (FIGO grade 3) (5).

An optimal staging system should assign cases to prognostic categories, define the anatomical extent of disease, refer patients for individualized treatments, and compare patients and their outcomes between centers (1,2). These observations on staging, considering new discriminations, could contribute to better understanding and planning through better prognostic accuracy for cervical cancer, reflecting differences in survival and guiding treatment.

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