

FIGO has revised the staging of carcinoma of the vulva

Introduction

Cancers are staged to allow for standardised terminology, appropriate prognosis, and worldwide communication. Therapeutic guidelines often flow from staging data. FIGO (International Federation of Gynecology and Obstetrics) has provided a staging system since 1958. More recently, International Union Against Cancer and the American Joint Commission on Cancer have also generated staging systems. As staging is based on research data and progressive science, the staging systems need to be revised frequently.¹

As far as carcinoma of the vulva is concerned, the staging needed revision as the previous (even revised) staging systems did not make use of all the available data on depth of invasion, details of nodal involvement and surgical findings.

Vulvar cancer is uncommonly found in general practice, but commonly seen in gynaecologic oncology units. The epidemiological problems of advanced age, late referral, advanced tumours on diagnosis and frequent co-incident HIV infection are still present in many cases. Clinicians should be aware of new developments in the staging and management of this disease. The new FIGO staging is given below.

Discussion

The most marked change in the new system is the extensive use of surgical data to stage a patient. This includes size, site and details of lymph node involvement. What has been retained is the concept of depth of invasion, and the poor prognostic features of extensive disease and pelvic node involvement. In its 1988 recommendations, the FIGO Committee for Oncology adopted the surgical staging model as the most appropriate for patients with carcinoma of the vulva. This was done in recognition of the fact that the most important prognostic factor for carcinoma of the vulva is the status of the lymph nodes. Even large tumours have an excellent prognosis if the lymph node status is negative.² In the previous staging, this led to the prognosis of patients with Stage I and Stage II disease being similar. In this sense, the staging system had to be improved in order to have a more accurate prediction of outcome. In terms of the new staging system, nodal negativity remains a feature of Stage I and Stage II, with the difference between the two stages now being the localisation of the tumour: confined to the vulva in Stage I and involvement of the adjacent structures in Stage II.

FIGO staging of carcinoma of the vulva¹

Stage I Tumour confined to the vulva

IA: Lesions ≤ 2 cm in size, confined to the vulva or perineum, and with stromal invasion ≤ 1 mm; no nodal metastases. (Depth of invasion is defined as the measurement of the tumour from the epithelial-stromal junction of the adjacent, most superficial dermal papilla to the deepest point of invasion.)

IB: Lesions > 2 cm in size or with stromal invasion > 1 mm, confined to the vulva or perineum, with negative nodes.

Stage II Tumour of any size, with extension to the adjacent perineal structures (lower 1/3 of urethra, lower 1/3 of vagina, anus), with negative nodes.

Stage III Tumour of any size, with or without extension to the adjacent perineal structures (lower 1/3 of urethra, lower 1/3 of vagina, anus), with positive inguino-femoral lymph nodes.

IIIA: (i) with one lymph node metastasis (≥ 5 mm), or
(ii) one or two lymph node metastases (< 5 mm)

IIIB: (i) with two or more lymph node metastases (≥ 5 mm), or
(ii) three or more lymph node metastases (< 5 mm)

IIIC: With positive nodes with extracapsular spread

Stage IV Tumour invades other regional (upper 2/3 of urethra, upper 2/3 of vagina) or distant structures.

IVA: Tumour invades any of the following:

- (i) upper urethral and/or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed to pelvic bone, or
- (ii) fixed or ulcerated inguino-femoral lymph nodes

IV B: Any distant metastases, including pelvic lymph nodes

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The most important direct implication of using the new staging system is that no woman can be adequately staged in the absence of a standardised operation preceding the staging. Inadequate staging will have an immediate impact on the accuracy of the total treatment plan. This will include decision making regarding subsequent therapeutic modalities, and also in relation to setting a prognosis.

It is furthermore of great importance that units treating patients with carcinoma of the vulva follow the staging criteria meticulously, as these should be audited for usefulness in clinical practice.

Gerhard Lindeque

University of Pretoria

E-mail: gerhard.lindeque@up.ac.za

References

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