

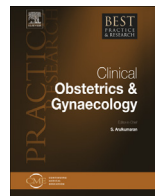


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Staging for vulvar cancer



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Vulvar cancer has been staged by the International Federation of Gynaecology and Obstetrics (FIGO) since 1969, and the original staging system was based on clinical findings only. This system provided a very good spread of prognostic groupings. Because vulvar cancer is virtually always treated surgically, the status of the lymph nodes is the most important prognostic factor and this can only be determined with certainty by histological examination of resected lymph nodes, FIGO introduced a surgical staging system in 1988. This was modified in 1994 to include a category of microinvasive vulvar cancer (stage IA), because such patients have virtually no risk of lymph node metastases. This system did not give a reasonably even spread of prognostic groupings. In addition, patients with stage III disease were shown to be a heterogeneous group prognostically, and the number of positive nodes and the morphology of those nodes were not taken into account. A new surgical staging system for vulvar cancer was introduced by FIGO in 2009. Initial retrospective analyses have suggested that this new staging system has overcome the major deficiencies in the 1994 system.

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Staging is used to describe the extent of an individual's cancer. Four basic stages are described, and these are assigned by dividing the extent of the disease into four categories, based on increasingly poor prognostic features. Ideally, the 5-year survival for the four stages should be reasonably evenly distributed between 0% and 100%.

For an individual patient with vulvar cancer, an accurate knowledge of the extent of her disease is critical for optimal management, and for determining the prognosis. Staging is also important beyond the individual patient, because it allows patients to be placed in reasonably homogeneous groups, so that results can be compared between treatment centres internationally. It also facilitates entry of reasonably homogeneous groups of patients on to clinical trials.

The most widely used staging system for vulvar cancer is the one defined by the International Federation of Gynaecology and Obstetrics (FIGO) [1], but vulvar cancer may also be staged according to the TNM classification, which is used by both the American Joint Commission on Cancer (AJCC) and the Union for International Cancer Control (UICC) [2]. There was close collaboration between FIGO, AJCC and UICC in developing the 2009 staging system for vulvar cancer.

Earlier FIGO staging systems for vulvar cancer

The first FIGO staging system for vulvar cancer was introduced in 1969. The system was based on a clinical evaluation of the primary tumour and regional lymph nodes, and a limited search for distant metastases [3]. Basically, patients with stage I disease had a primary tumour confined to the vulva ≤ 2 cm in diameter, with no suspicious groin nodes; patients with stage II disease had a tumour confined to the vulva > 2 cm in diameter with no suspicious groin nodes; patients with stage III disease had a tumour that had spread to the urethra, distal vagina or anus, or clinically suspicious groin nodes; and patients with stage IV disease had infiltration of the bladder, rectum or proximal urethral mucosa, fixation to bone or distant metastases.

This clinical staging was easy to apply, and it gave a reasonable distribution of prognostic groups, the 5-year survivals being 90.4%, 77.1%, 51.3% and 18% for patients with stages I, II, III and IV, respectively [3]. This prognostic distribution reflected the fact that the status of the lymph nodes is the single most important prognostic factor in vulvar cancer [4,5], and the incidence of lymph node metastases increased with each stage, with 10.7% for patients with stage I disease, 26.2% for stage II, 64.2% for stage III and 88.9% for stage IV [3].

Both microscopic and macroscopic metastases may be present in lymph nodes that are not palpable, and suspicious nodes may be enlarged because of inflammatory changes only. Clinical evaluation of lymph nodes is therefore inaccurate in approximately 20–30% of cases [6,7]. Because vulvar cancer is virtually always treated surgically and the true status of the lymph nodes can only be determined histologically, FIGO introduced a surgical staging system for the disease in 1988.

The 1988 FIGO surgical staging system was modified in 1994, with the subdivision of stage I into IA and IB. Stage IA was a lesion up to 2 cm in diameter, with stromal invasion not greater than 1 mm. Such patients have virtually no risk of lymph node metastases [3], so they can be treated by radical local excision alone. The 1994 FIGO staging is shown in Table 1.

In 1991, the Gynecological Oncology Group (GOG) reported a retrospective analysis of 588 patients with vulvar cancer available from their database [8]. This analysis highlighted a number of problems with the new surgical staging system.

The first problem was that the new system did not give a reasonably even spread of prognostic groupings. The GOG study demonstrated that when the tumour had negative lymph nodes, even primary lesions with up to 8-cm diameter had an excellent prognosis [8]. An analysis of 121 cases of stages I and II squamous cell carcinoma of the vulva managed at the Royal Hospital for Women in Sydney from 1987 to 2005 showed no difference in recurrence rates, time to recurrence or survival between patients with 1988 FIGO stages I or II disease. The 5-year actuarial survival for patients with stage I disease was 97%, compared to 95% for patients with stage II ($p = 0.83$) [9].

A second problem was that patients with stage III disease were a heterogeneous group prognostically, with survivals ranging from 100% to 34% [8]. For example, the GOG study reported six patients with tumours ≤ 2 cm in diameter with negative nodes, but with involvement of the distal vagina and/or

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