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SPECIAL ARTICLE

History of the FIGO cancer staging system

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Abstract

The main objectives of any good staging system – essential to an evidence-based approach to cancer – are: to aid the clinician in planning treatment; to provide indication of prognosis; to assist the physician in evaluating the results of treatment; to facilitate the exchange of information between treatment centers, thus disseminating knowledge; and to contribute to continuing investigations into human malignancies. A good staging system must have 3 basic characteristics: it must be valid, reliable, and practical. The first staging system for gynecological cancers appeared around the turn of the 20th century and applied to the carcinoma of the cervix uteri—the most common cancer affecting women in high income countries at that time. The classification and staging of the other gynecological malignancies was not put forward until the 1950s. Over the years, these staging classifications – with the exception of cervical cancer and gestational trophoblastic neoplasia – have shifted from a clinical to a surgical–pathological basis. This paper reviews the history of the International Federation of Gynecology and Obstetrics (FIGO) cancer staging system, how it was developed, and why.

1. Introduction

Cancer staging is one of the fundamental activities in oncology and is of pivotal importance to the modern management of cancer patients. It is structured to represent a major prognostic factor in predicting patients' outcome and lending order to the complex dynamic behavior of a cancer [1].

To optimally manage any malignant disease, certain factors must be taken into consideration: the site of origin of the disease, its biology, and the extent of the disease at the time of presentation, i.e., the stage of the tumor [2]. Tumor classification is generally conceived so that the clinical and/or pathological spread is stratified into 4 stages: Stage I refers to a tumor strictly confined to the organ of origin, hence of relatively small size; Stage II describes disease that has extended locally beyond the site of origin to involve adjacent organs or structures; Stage III represents more extensive involvement, i.e., wide infiltration reaching neighboring organs; and Stage IV represents clearly distant metastatic

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disease [3]. These 4 basic stages are then classified into substages, as a reflection of specific clinical, pathological, or biological prognostic factors within a given stage [4].

One of the major purposes of cancer staging, agreed upon internationally, is to offer a classification of a cancer's extent in order to provide a method of conveying one's clinical experience to others for the comparison of treatment methods without ambiguity.

To achieve this objective, staging systems should be evidence-based and user-friendly [5]. They should also be based on and updated according to the latest available knowledge, thus implying that cancer staging systems should be responsive and adaptive to scientific development [1,6]. However, the contrary also applies in that knowledge and developments in the field of oncology inevitably benefit from staging, which helps produce new data on similar groups of patients as well as to facilitate clinical research [7].

Over the years, all staging systems for gynecological malignancies – with the exception of cervical cancer and gestational trophoblastic neoplasia – have shifted from a clinical to a surgical–pathological basis [8,9].

In addition, it should be remembered that staging was not proposed as a means for determining therapy, and certainly in many situations it has been used to guide therapy by individual investigators, although a certain modality might not be agreeable to all [9].

2. History of the staging system

2.1. The early years

The rules for classification and staging of malignant tumors of the female genital tract adopted by the International Federation of Gynecology and Obstetrics (FIGO) originated in the work carried out 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 exploring the possibility 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) [10,11]. This group of experts recommended that the task could only be accomplished if various institutions could produce statistical information collected in a consistent manner for analysis and evaluation. They also stressed the absolute necessity of a uniform method to describe the extent of the disease [12,2]. 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 – adopted by the Sub-Commission with minor modifications – were published in 1929 and became known as the League of Nations Classification for Cervical Cancer [13]. Although the recommendations for collecting and analyzing materials were subsequently adopted in several countries, their acceptance and widespread use did not immediately occur.

In 1934 the Health Organization held a conference in Zurich, attended by former members of the Sub-Commission and other international experts, to discuss what further action might be pursued to facilitate wider endorsement and adoption of these principles. This conference recommended that a publication in the form of a medical report should be issued annually by the Health Organization analyzing the results of treatment with radiotherapy in cervical cancer patients, estimated after an observation of 5 or more years. The recommendations of the Zurich conference were adopted by the Health Committee in 1935 and subsequently an Advisory Committee, chaired by Professor Heyman, was appointed to carry out this task. The first 3 volumes appeared in 1937, 1938, and 1939 with the title "Annual Report" and were published by the Health Organization of the League of Nations, which also bore the financial responsibility. These volumes contained only the results of cervical cancer patients treated with radiotherapy, but indicated the hope that future reports would be expanded to include material relating to cases of carcinoma of the corpus uteri and of the vagina [14]. The main objective of the Annual Report was to provide the greatest possible comparability between therapeutic statistics in order to ensure reliable evaluation of the different treatment methods employed [15].

In 1938, in an attempt to promote more uniform grouping of cases, to minimize variation, and to secure comparabilities and statistics for the Annual Report, Heyman and M Strandquist (Radiumhemmet) published the first "Atlas on Cervical Cancer Staging," a pocket-sized booklet with definitions, staging diagrams, and with descriptive text in English, French, and German [15].

The second Annual Report, published in 1938, contained changes to the wording and definitions for the various stages of cervical cancer and, as such, represented the first recorded changes made to the cervical cancer staging system.

In 1949 Heyman outlined the following requirements needed to provide acceptable tumor classifications: (1) the definition of the different stage groups should be as simple and precise as possible; (2) 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; (3) each stage should be differentiated from the other by characteristics easily recognized on clinical examination, even by a less experienced examiner; and (4) the system of stage grouping should be sufficiently complete to include every possible type of cancer case [15,16]. Further changes were made in 1950 when the Editorial Committee met in New York (with 9 American representatives) at the International Gynecological Congress and Fourth American Congress of Obstetrics and Gynecology. This joint group agreed on several modifications to the classification adopted by the Health Organization of the League of Nations. It recommended that the new classification should be called "The International Classification of the Stages of Carcinoma of the Uterine Cervix" and that all organizations concerned with this problem should be approached to consider its adoption.

Since then, 7 changes have been made to the staging system for cervical cancer, with the most recent in 1994. Almost all of these changes were relevant to Stage I cervical cancer [17].

With the outbreak of World War II work on the Annual Report came to a standstill until 1945, when Heyman established the Editorial Office at the Radiumhemmet in Stockholm, Sweden.

Table 1 Carcinoma of the vulva: FIGO nomenclature

Stage 0	Carcinoma *in situ*, intraepithelial neoplasia Grade III
Stage I	Lesions ⩽2 cm in size, confined to the vulva or perineum, no nodal metastasis
Ia	Lesions ⩽2 cm in size, confined to the vulva or perineum and with stromal invasion ⩽1.0 mm [a], no nodal metastasis
Ib	Lesions ⩽2 cm in size, confined to the vulva or perineum and with stromal invasion >1.0 mm [a], no nodal metastasis
Stage II	Tumor confined to the vulva and/or perineum; > 2 cm in greatest dimension, no nodal metastasis
Stage III	Tumor of any size with adjacent spread of the lower urethra and/or the vagina, or the anus, and/or unilateral regional lymph node metastasis
Stage IV	
IVa	Tumor invades any of the following: upper urethra, bladder mucosa, rectal mucosa, pelvic bone, and/or bilateral regional node metastases
lVb	Any distant metastasis including pelvic lymph nodes

[a] 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.

Reprinted from: Beller U, Quinn MA, Benedet JL, Creasman WT, Ngan HYS, Maisonneuve P, et al. Carcinoma of the vulva. Int J Gynecol Obstet 2006;95(Suppl 1):S7.

In 1953 Volume 8 of the Annual Report presented, for the first time, the results of treatment on the carcinoma of the corpus uteri. Volume 13, published in 1964, contained the first data on vaginal cancer. Subsequently, similar statistics on ovarian and vulvar cancer were first published in Volume 15 (1973) and Volume 17 (1979), respectively. Since its inception, the Annual Report has been inevitably entwined with the development and changes of gynecological cancer classification and staging.

2.2. The FIGO years

In 1958 FIGO became the official patron of the Annual Report. Volume 12, issued in 1961, became the first report published under its auspices. However, the collection and publication of the report's data continued to be primarily dependent on generous financial support from a variety of international cancer organizations and institutions, particularly the Radiumhemmet — where the Editorial Office was located until 1994. In that year Professor Folke Pettersson (the third Editor of the Annual Report) retired and the FIGO Executive Board appointed Professor Sergio Pecorelli as the new Editor. The Editorial Office was then transferred to the European Institute of Oncology in Milan, Italy.

Table 2 Carcinoma of the vagina: FIGO nomenclature

Stage 0	Carcinoma *in situ*, intraepithelial neoplasia Grade III
Stage I	The carcinoma is limited to the vaginal wall
Stage II	The carcinoma has involved the subvaginal tissue but has not extended to the pelvic wall
Stage III	The carcinoma has extended to the pelvic wall
Stage IV	The carcinoma has extended beyond the true pelvis or has involved the mucosa of the bladder or rectum; bullous edema as such does not permit a case to be allotted to Stage IV
IVa	Tumor invades bladder and/or rectal mucosa and/or direct extension beyond the true pelvis
lVb	Spread to distant organs

Reprinted from: Beller U, Benedet JL, Creasman WT, Ngan HYS, Quinn MA, Maisonneuve P, et al. Carcinoma of the vagina. Int J Gynecol Obstet 2006;95(Suppl 1):S29.

Table 3 Carcinoma of the cervix uteri: FIGO nomenclature (Montreal, 1994)

Stage 0	Carcinoma *in situ*, cervical intraepithelial neoplasis Grade III.
Stage I	The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded).
Ia	Invasive carcinoma which can be diagnosed only by microscopy. 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 5.0 mm and a horizontal extension of not >7.00 mm. Depth of invasion should not be >5.0 mm taken from the base of the epithelium of the original tissue should not change the stage allotment.
Ia1	Measured stromal invasion of not >3.0 mm in depth and extension of not >7.0 mm.
Ia2	Measured stromal invasion of >3.0 mm and not >5.0 mm with an extension of not >7.0 mm.
Ib	Clinically visible lesions limited to the cervix uteri or preclinical cancers greater than Stage Ia
Ib1	Clinically visible lesions not >4.0 cm.
Ib2	Clinically visible lesions >4.0 cm.
Stage II	Cervical carcinoma invades beyond uterus, but not to the pelvic wall or to the lower third of vagina
IIa	No obvious parametrial involvement.
IIb	Obvious parametrial involvement.
Stage III	The carcinoma has extended to the pelvic wall. On rectal examination, there is no cancer-free space between the tumor and the pelvic wall. The tumor involves the lower third of the vagina. All cases with hydronephrosis or nonfunctioning kidney are included, unless they are known to be due to other cause.
IIIa	Tumor involves lower third of the vagina, with no extension to the pelvic wall.
IIIb	Extension to the pelvic wall and/or hydronephrosis or nonfunctioning kidney.
Stage IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to Stage IV.
IVa	Spread of the growth to adjacent organs.
IVb	Spread to distant organs.

Reprinted from: Quinn MA, Benedet JL, Odicino F, Maisonneuve P, Beller U, Creasman WT, et al. Carcinoma of the cervix uteri. Int J Gynecol Obstet 2006;95(Suppl 1):S43.

Table 4 Carcinoma of the corpus uteri: surgical staging classification (FIGO nomenclature, Rio de Janeiro, 1988)

Stage Ia [a]	Tumor limited to the endometrium
Stage Ib [a]	Invasion to less than half of the myometrium
Stage Ic [a]	Invasion equal to or more than half of the myometrium
Stage IIa [a]	Endocervical glandular involvement only
Stage IIb [a]	Cervical stromal invasion
Stage IIIa [a]	Tumor invades the serosa of the corpus uteri and/or adnexae and/or positive cytological findings
Stage IIIb [a]	Vaginal metastases
Stage IIIc [a]	Metastases to pelvic and/or para-aortic lymph nodes
Stage IVa [a]	Tumor invasion of bladder and/or bowel mucosa
Stage lVb [a]	Distant metastases, including intra-abdominal metastasis and/or inguinal lymph nodes

[a] Either G1, G2 or 03. See section on Rules for classification.
Reprinted from: Creasman WT, Odicino F, Maisonneuve P, Quinn MA, Beller U, Benedet JL, et al. Carcinoma of the corpus uteri. Int J Gynecol Obstet 2006;95(Suppl 1):S105.

The first 3 volumes were published annually. Subsequent volumes were issued at irregular intervals, although an attempt was made to publish the report annually between 1951 and 1955. Since 1973 the "Annual Report on the Results of Treatment in Gynecological Cancer" has been published every 3 years to coincide with the FIGO World Congress. It is published under the supervision of the FIGO Committee on Gynecologic Oncology, which deals with all questions concerning rules for classification and stage grouping, thus promoting and periodically revising cancer staging [12].

From the initial group of 6 institutions contributing to the Annual Report (the Center for Tumors at the University of Brussels, Belgium; Liverpool Radium Institute, UK; London Marie Curie Hospital, UK; the Radium Centre for Carcinoma of the Uterus, London, UK; the Institute of Radium at the University of Paris, France; and the Radiumhemmet, Sweden), the number of contributing institutions and centers has been constantly growing. By Volume 26, published in October 2006, there were 108 centers with a total of 34,414 cases for the descriptive analysis [18].

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 carcinoma of the cervix uteri was proposed by this Committee in 1966, which took into great consideration the experience gained by the FIGO stage grouping.

In the United States the American Joint Committee for Cancer Staging and End Results Reporting (today known as the American Joint Committee on Cancer, AJCC) was organized in 1959 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 [19].

Over the past 70 years the system for gynecologic cancer staging has gradually been modified to cope with the explosive growth in medical research and practice, particularly in the field of oncology [20]. Over the last 30 years all changes to the FIGO classification and staging system 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. Tables 1–7 provide the current FIGO staging classifications published in the Twenty-sixth Volume of the FIGO Annual Report [21]. Over the years the UICC, AJCC, and FIGO have modified their

Table 5 Carcinoma of the Fallopian tube: FIGO nomenclature (Singapore, 1991)

Stage 0	Carcinoma *in situ* (limited to tubal mucosa)
Stage I	Growth limited to the Fallopian tubes
Ia	Growth is limited to one tube, with extension into the submucosa and/or muscularis, but not penetrating the serosal surface; no ascites
Ib	Growth is limited to both tubes, with extension into the submucosa and/or muscularis, but not penetrating the serosal surface; no ascites
Ic	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
Stage II	Growth involving one or both Fallopian tubes with pelvic extension
IIa	Extension and/or metastasis to the uterus and/or ovaries
IIb	Extension to other pelvic tissues
IIc	Tumor either Stage IIa or IIb and with ascites present containing malignant cells or with positive peritoneal washings
Stage III	Tumor involves one or both Fallopian tubes, with peritoneal implants outside the pelvis and/or positive retroperitoneal or inguinal nodes. Superficial liver metastasis equals Stage III. Tumor appears limited to the true pelvis, but with histologically-proven malignant extension to the small bowel or omentum
IIIa	Tumor is grossly limited to the true pelvis, with negative nodes, but with histologically-confirmed microscopic seeding of abdominal peritoneal surfaces
IIIb	Tumor involving one or both tubes, with histologically-confirmed implants of abdominal peritoneal surfaces, none exceeding >2 cm in diameter. Lymph nodes are negative
IIIc	Abdominal implants >2 cm in diameter and/or positive retroperitoneal or inguinal nodes
Stage IV	Growth involving one or both Fallopian tubes with distant metastases. If pleural effusion is present, there must be positive cytology to be Stage IV. Parenchymal liver metastases equals Stage IV

Reprinted from: Heintz APM, Odicino F, Maisonneuve P, Quinn MA, Benedet JL, Creasman WT, et al. Carcinoma of the fallopian tube. Int J Gynecol Obstet 2006;95(Suppl 1):S145.

Table 6 Carcinoma of the ovary: FIGO nomenclature (Rio de Janeiro 1988)

Stage I	Growth limited to the ovaries
Ia	Growth limited to one ovary: no ascites present containing malignant cells. No tumor on the external surface; capsule intact
Ib	Growth limited to both ovaries: no ascites present containing malignant cells. No tumor on the external surfaces; capsules intact
Ic [a]	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
Stage II	Growth involving one or both ovaries with pelvic extension
IIa	Extension and/or metastases to the uterus and/or tubes
IIb	Extension to other pelvic tissues
IIc [a]	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
Stage III	Tumor involving one or both ovaries with histologically-confirmed peritoneal implants outside the pelvis and/or positive retroperitoneal or inguinal nodes. Superficial liver metastases equals Stage III. Tumor is limited to the true pelvis, but with histologically-proven malignant extension to small bowel or omentum
IIIa	Tumor grossly limited to the true pelvis, with negative nodes, but with histologically-confirmed microscopic seeding of abdominal peritoneal surfaces, or histologic proven extension to small bowel or mesentery
IIIb	Tumor of one or both ovaries with histologically-confirmed implants, peritoneal metastasis of abdominal peritoneal surfaces, none exceeding 2 cm in diameter: nodes are negative
IIIc	Peritoneal metastasis beyond the pelvis >2 cm in diameter and/or positive retroperitoneal or inguinal nodes
Stage IV	Growth involving one or both ovaries with distant metastases. If pleural effusion is present, there must be positive cytology to allot a case to Stage IV. Parenchymal liver metastasis equals Stage IV

[a] 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 peritoneal washings, or ascites.

Reprinted from: Heintz APM, Odicino F, Maisonneuve P, Quinn MA, Benedet JL, Creasman WT, et al. Carcinoma of the ovary. Int J Gynecol Obstet 2006;95(Suppl 1):S163.

staging systems for gynecological cancers so that all 3 systems are virtually identical [2]. 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 [22], thereby promoting continuous uniformity between all bodies. Further and joint efforts are constantly made to unify the FIGO and TNM classifications. Future efforts should focus on major issues such as the possible inclusion of residual tumor into classifications since we know that, in several neoplasias, the residual tumor status is one of the strongest outcome predictors after treatment; the possible inclusion in classifications 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 [23].

3. Conclusion

A good staging system must have 3 basic characteristics: it must be valid, reliable, and practical. A valid staging system should make suggestions on the setting up of patients' groups experiencing similar outcomes and must reflect the full range of possible clinical manifestations for each type of cancer. In order to retain its validity, the staging system must be flexible and adaptable to significant scientific changes. A reliable staging system should ensure that identical cases are always assigned to the same stage category. It should not be ambiguous and must respond to the necessary changes when

Table 7 GTN: FIGO staging and classification (Washington, 2000)

FIGO anatomical staging	
Stage I	Disease confined to the uterus
Stage II	GTN extends outside of the uterus, but is limited to the genital structures (adnexa, vagina, broad ligament)
Stage III	GTN extends to the lungs, with or without known genital tract involvement
Stage IV	All other metastatic sites

Modified WHO prognostic scoring system as adapted by FIGO				
Scores	0	1	2	4
Age	<44	≥40	–	–
Antecedent pregnancy	Mole	Abortion	Term	–
Interval months from index pregnancy	<4	4–6	7–12	>12
Pretreatment serum hCG (IU/l)	$<10^3$	10^3–10^4	10^4–10^5	$>10^5$
Largest tumor size (including uterus)	<3	3–4 cm	≥5 cm	–
Site of metastases	Lung	Spleen, kidney	Gastro-intestinal	Liver, brain
Number of metastases	–	1–4	5–8	>8
Previous failed chemotherapy	–	–	Single drug	2 or more drugs

Reprinted from: Ngan HYS, Odicino F, Maisonneuve P, Creasman WT, Beller U, Quinn MA, et al. Gestational trophoblastic neoplasia. Int J Gynecol Obstet 2006;95(Suppl 1):S193.

sufficient data and information are obtained to warrant them. A practical staging system must be user-friendly and suitable for use in different clinical environments. It should not require specific diagnostic procedures that are unavailable to most practitioners world-wide, or extraordinary expertise.

It is inevitable that changes will, of necessity, 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 [24]. An increasing awareness of prognostic scoring systems and the incentive to adopt them is already evident and will play a major role in future classification systems [25]. As scientists responsible for maintaining, modifying, and proposing changes to the existing staging systems, we indeed feel we shoulder an enormous responsibility to make the appropriate changes timely, wisely, and based on sound scientific data.

Websites for further information

FIGO: www.figo.org
Global Call to Stop Cervical Cancer: www.cervicalcanceraction.org/home/home.php
International Union Against Cancer: www.uicc.org
American Joint Committee on Cancer: www.cancerstaging.org/
National Cancer Institute: www.cancer.gov/
American Cancer Society: www.cancer.org
European Society of Gynaecological Oncology (ESGO): www.esgo.org
Society of Gynecologic Oncologists (SGO): www.sgo.org
International Gynecologic Cancer Society (IGCS): www.igcs.org
International Society of Gynecological Pathologists (ISGYP): www.isgyp.com

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