



AJCC Cervix Uteri Version 9 Cancer Staging System

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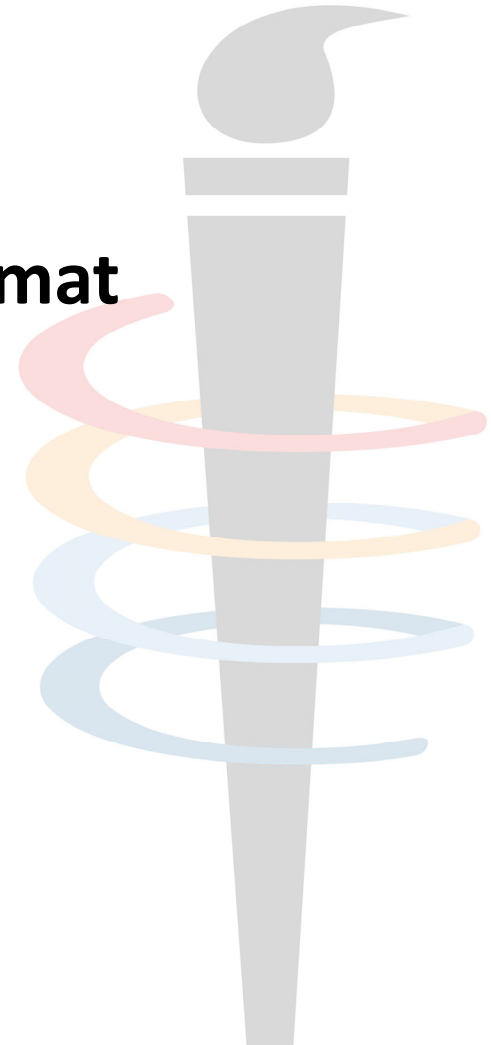
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AJCC

American Joint Committee on Cancer
American College of Surgeons

Version 9 Cervical Cancer Protocol Format



Protocol Format

- **AJCC updated to protocol format**
 - *Same information* as previous AJCC chapters which has 3 key components:
 1. *Staging report format* which is key information for managing physician to document
 2. *Explanatory notes* which provide guidance
 3. *Supplemental* information
- **Why change?**
 - Easier for users to *find what they need ... just when they need it*
 - Users wanted a synoptic styled report format
 - Synoptic reports are proven to *increase accurate and complete* documentation

Diving deeper into the key components

1. Staging report format

- Provides all of the key information
- Includes new items
 - Modalities used for staging
 - Clinical staging and workup
 - Pathological staging and workup

2. Explanatory notes

- Provide the **same details** found in previous AJCC chapters
- Includes **images** for primary site, nodal map, and T N M categories

3. Supplemental information includes general staging rules

NEW Features – Clinical Staging and Workup Table

DIAGNOSTIC WORKUP	DESCRIPTION	SPECIFIC CONTRIBUTION TO TNM CATEGORY
Clinical exam		
Colposcopy	Size, local spread	T1a-T1b
Biopsy	Microscopic confirmation	T1a-T4
Endocervical curettage	Microscopic confirmation	T1a-T1b
Conization, cone biopsy Loop electrosurgical excision procedure (LEEP)	Microscopic confirmation	T1a1 - may be treatment
Inspection and palpation	Visible and palpable lesions	T1b-T4
Exam under anesthesia (EUA) Cystoscopy Proctoscopy	Size, spread to vagina, parametrium, or pelvic wall Bladder or rectum mucosa involvement	T1b-T4
Imaging		
CT	Chest/abdomen/pelvis for T1b-T4	T1b-T4, N0-2; T1a not seen on imaging
PET/CT (whole body)	Base of neck to mid-thigh	T1b-T4, N0-2, M0-1
MRI	Pelvis – define extent of local disease	T1b-T3b, N0-1; T1a not seen on imaging
US	Pelvis – define extent of local disease	T1b-T3b, N0-1; T1a not seen on imaging
Intravenous urography (IVP)	Hydronephrosis	T3b
X-ray lungs, skeleton	Pulmonary metastasis	M1 distant metastasis
Labs		
p16	Immunohistochemistry (IHC), microscopy	Histopathological classification

Contains following elements

- Common diagnostic workup
- Description of the evaluation
- How each workup contributes to TNM category for staging

The workup list is made up of workup options, **not** required workup

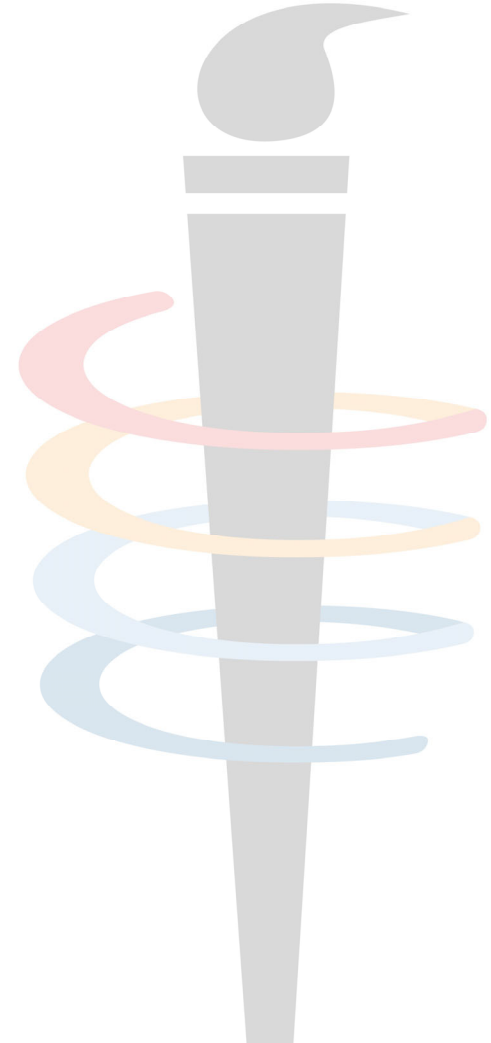
NEW Features – Pathological Staging and Workup

CATEGORY	SPECIMEN	PATHOLOGIST	MANAGING PHYSICIAN (Stage Documented by Cancer Registry)
General Information		<ul style="list-style-type: none"> Assignment of pTNM categories are based on surgical resection specimen, as well as intraoperative findings, biopsy procedures and clinical evaluation up to the point of definitive surgical treatment, if available All other surgical procedure specimens use cTNM. For example, biopsy of a positive regional lymph node without surgical resection of the primary carcinoma is classified as cN1 	<ul style="list-style-type: none"> Assignment of pTNM categories for the patient requires use of information from all biopsy procedures performed during the clinical evaluation up to and including definitive surgical treatment Requires information from clinical assessment or imaging studies or interoperative findings to assign pTNM categories (may not change pTNM, but must be considered)
pTX		Not for use by pathologist; assigned only by managing physician	May assign if unable to determine pT category after surgical resection
pT0		No tumor found in specimen and never identified on diagnostic biopsies	No tumor found in specimen and never identified on diagnostic biopsies
pT1	Conization specimen, trachelectomy, simple or radical hysterectomy	Pathologic information from surgical specimen(s) only	Pathology Report(s)
pT1a			
pT1a1			
pT1a2			
pT1b			
pT1b1			
pT1b2			
pT1b3	If unable to determine greatest dimension from microscopic examination of surgical specimen(s), may use clinical or imaging measurement, if available	Pathology Reports +/- appropriate imaging studies, interoperative findings and clinical evaluation	
pT2			Simple or radical hysterectomy
pT2a			
pT2a1			
pT2a2			
pT2b			

- Emphasizes the role of the pathologist in assessing resection **specimen**
- Emphasizes the role of the managing physician in assigning TNM categories and stage to the **patient**

Key Changes in Cervix Uteri Staging

- ❖ All types of imaging allowed
- ❖ Designation of HPV association status
- ❖ T category changes
- ❖ N category changes
- ❖ M category assessment changes



Imaging

- **All** imaging modalities allowed for staging, including
 - CT
 - MRI
 - PET or PET/CT or PET/MRI
 - US - recommended worldwide
 - Roentgenography of lungs and skeleton – recommended worldwide
- The above imaging modalities are allowed for all staging classifications
 - Clinical
 - Pathological
 - Posttherapy Clinical and Posttherapy Pathological

HPV-association Status

Required documentation: whether cancer is HPV-associated or HPV-independent

- AJCC Version 9 histology list includes both types of histologies
- HPV-independent cervical cancers generally have poorer prognosis
- p16 IHC overexpression is a good surrogate for HPV-association
- P16 IHC is a data item for registrars to collect

T Category and N Category

T Category

- T1a: horizontal spread removed
- T1b subcategories: dimensions changed, new T1b3

N Category

- N1: pelvic nodes only
N1mi micromets, N1a macromets
- N2: para-aortic nodal with/without pelvic nodal involvement
N2mi micromets, N2a macromets

AJCC Prognostic Stage Groups

- Nodal status *now* plays role in stage groups
 - 8th edition every stage group included Any N
 - Positive nodes had no effect on stage groups

- N1 for TX-T3 M0 is stage IIIC1

TX, T0, T1-3	N1	M0	IIIC1
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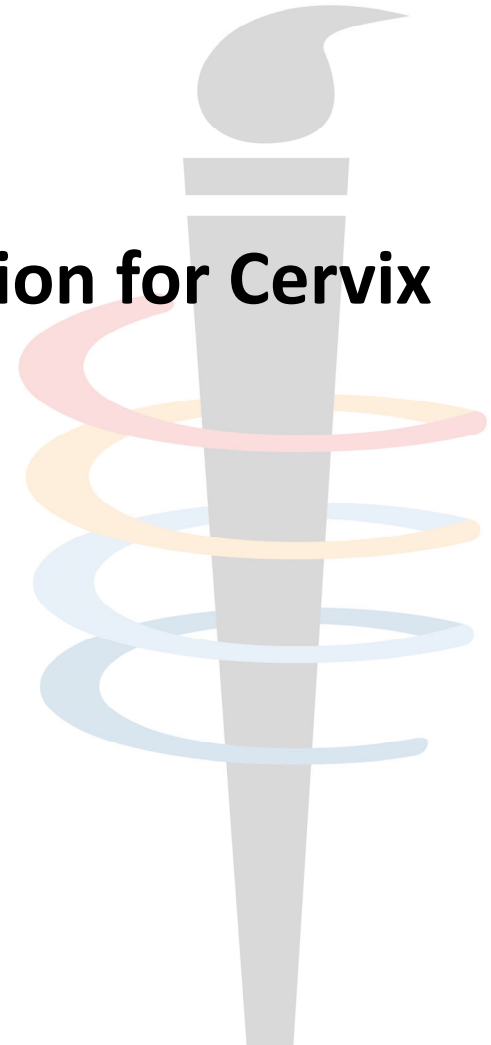
- N2 for TX-T3 M0 is stage IIIC2

TX, T0, T1-3	N2	M0	IIIC2
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- Any N is now only used with stage groups IVA and IVB

T4	Any N	M0	IVA
Any T	Any N	M1	IVB

Key Staging Information by classification for Cervix Uteri carcinoma



Clinical Classification

- Imaging by **all** modalities incorporated into clinical staging
 - Includes CT, MRI, PET

- Lymph node status
 - Assessed by imaging or surgical means (FNA, bx, sentinel node)
 - Use appropriate N category suffix (f) or (sn)
 - Isolated tumor cells (ITCs) are *not* considered nodal mets

Pathological Classification

- pT category
 - Cancer not visible and confined to cervix:
 - Cervical excision (cold knife conization or loop electrosurgical excision procedure [LEEP])
Cervical bx and endocervical curettage are not sufficient for pathological classification
 - All other cancers suitable for excision:
 - simple or radical hysterectomy, radical trachelectomy
- pN category
 - At least 1 node with cancer involvement is required
 - Use appropriate N category suffix (f) or (sn)
 - Isolated tumor cells (ITCs) are *not* considered nodal mets, N0(i+)
 - Nodal information is collected by registrars in site-specific data items
- Perineural invasion in parametrium qualifies as pT2b

Factors Important for Clinical Care

- Tumor size
 - Size may be based on clinical examination, radiographic, or pathologic
 - In descending order of priority: pathologic > radiographic > clinical exam
- Lymph node mets
 - Micro & macro-metastases will be important for future data analysis
 - Micro is N1mi, N2mi
 - Macro is N1a, N2a
- p16
 - p16 IHC overexpression is a good surrogate of HPV-association
 - HPV-associated tumors have a more favorable prognosis than HPV-independent tumors

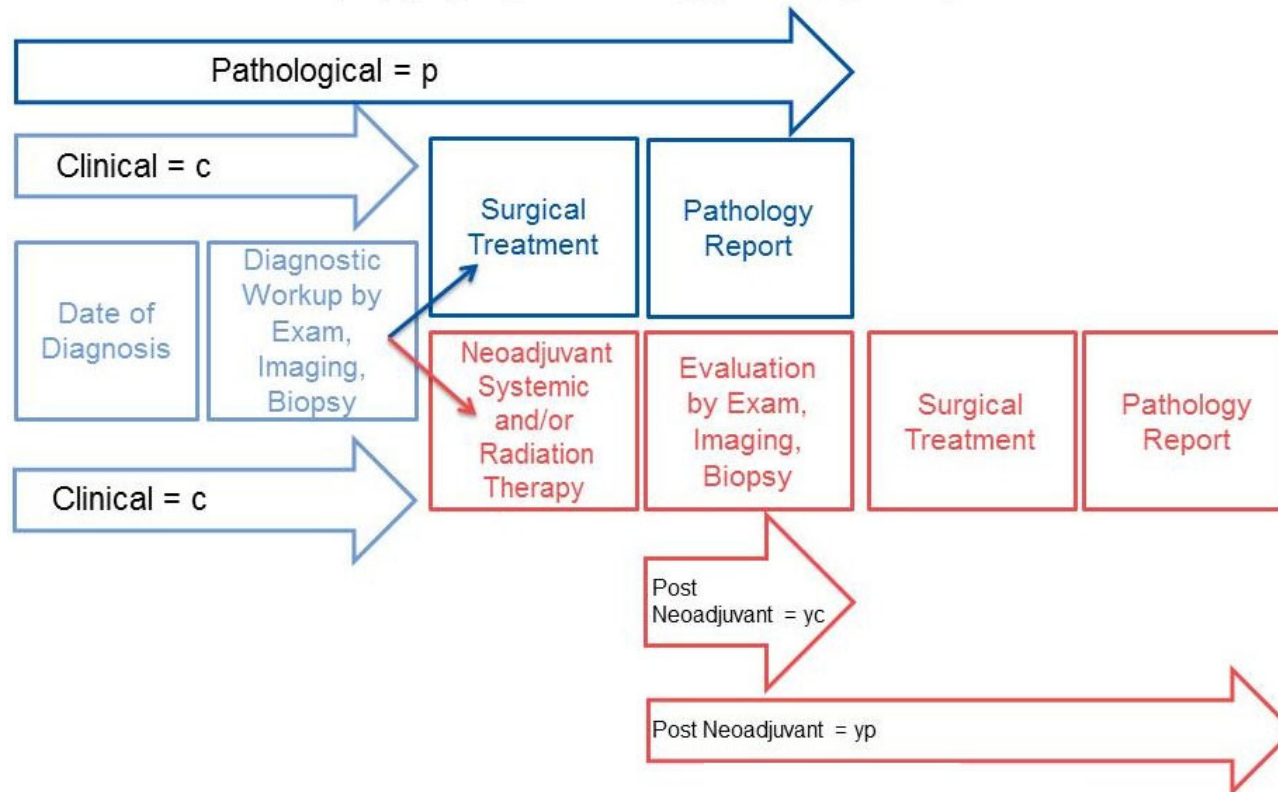
Grading

- Grading is encouraged for squamous and usual type adenocarcinoma
- Grading is G1, G2, G3
 - Squamous cell carcinoma grading is the degree of differentiation
 - Adenocarcinoma grading incorporates architecture and nuclear features
- Special cases
 - Endometrioid uses the same grading system as endometrioid of uterine corpus
 - Aggressive subtypes are not graded
 - These include clear cell cancer, carcinosarcoma, neuroendocrine cancer
 - Rare subtypes of adenocarcinoma like adenoid basal cell carcinoma are GX

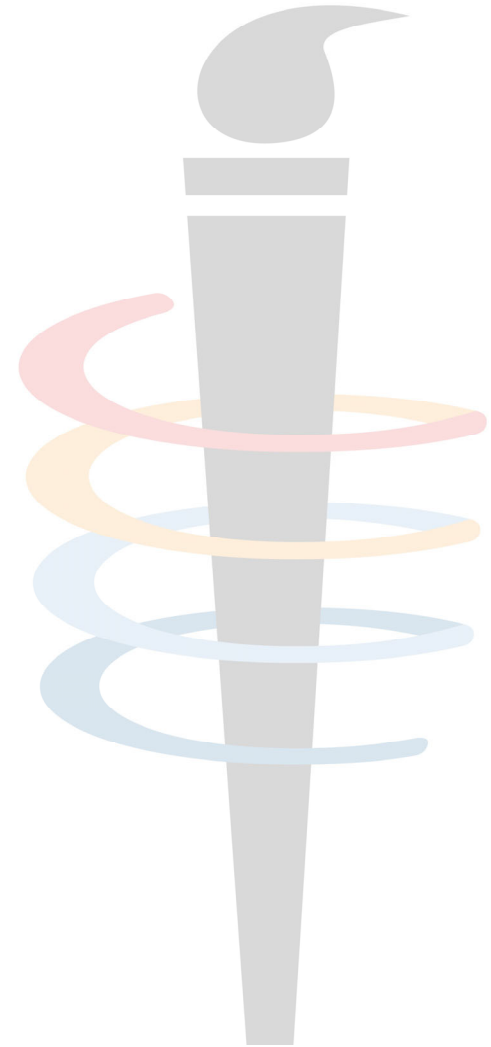
Timing is Everything

AJCC Stage Classifications

Defining Time Frame and Criteria



Access to Version 9 Protocol



Access to Version 9 Cervix Uteri Protocol

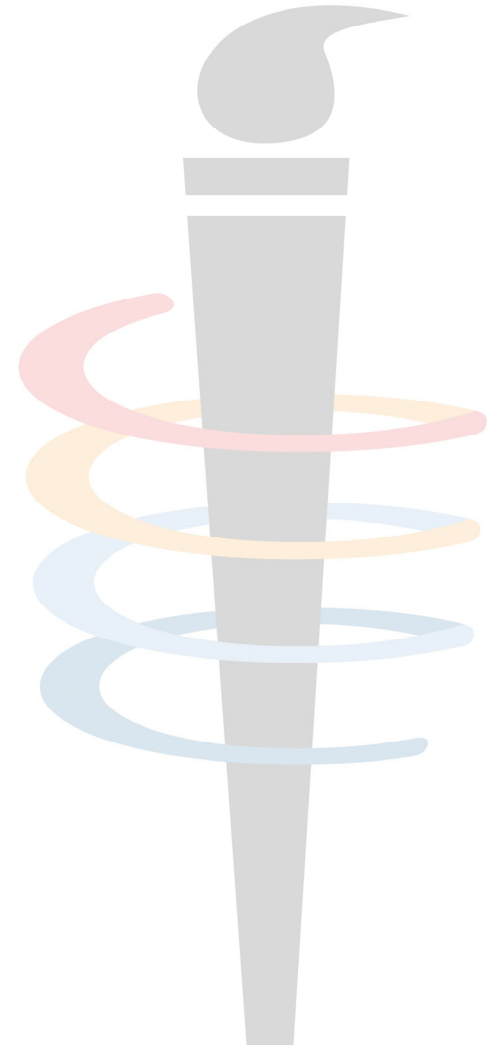
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 - Purchaser emails links for users to download AJCC ebook
- Institutional access vendors
 - Multiple vendors who supply ebooks to hospital libraries
 - EHR companies may include content in their software, staging tables or complete protocol

FAQ

- AJCC has FAQ document on website
 - Covers most common questions
 - Provides information and options for institutional purchases
- Additional questions should be directed to ajcc@facs.org

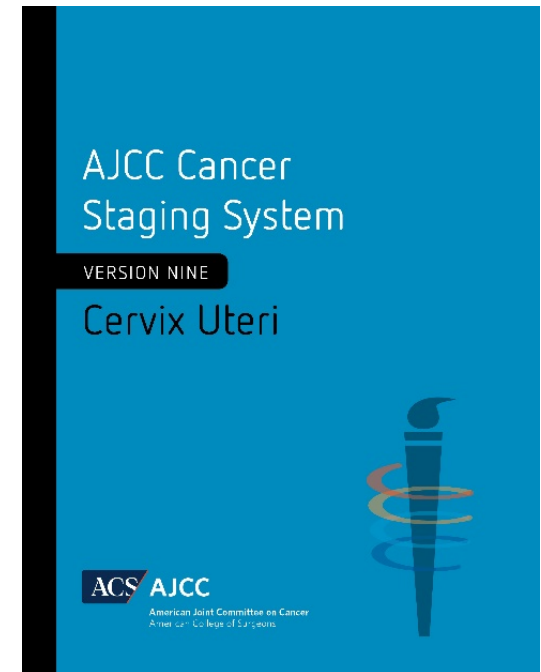
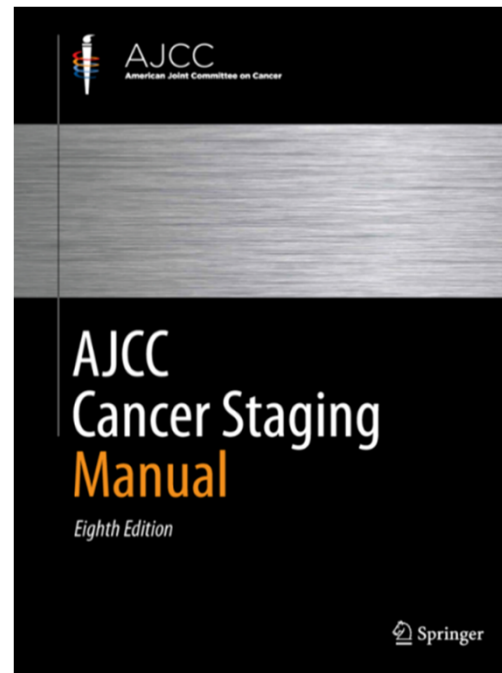


Information and Questions on AJCC Staging



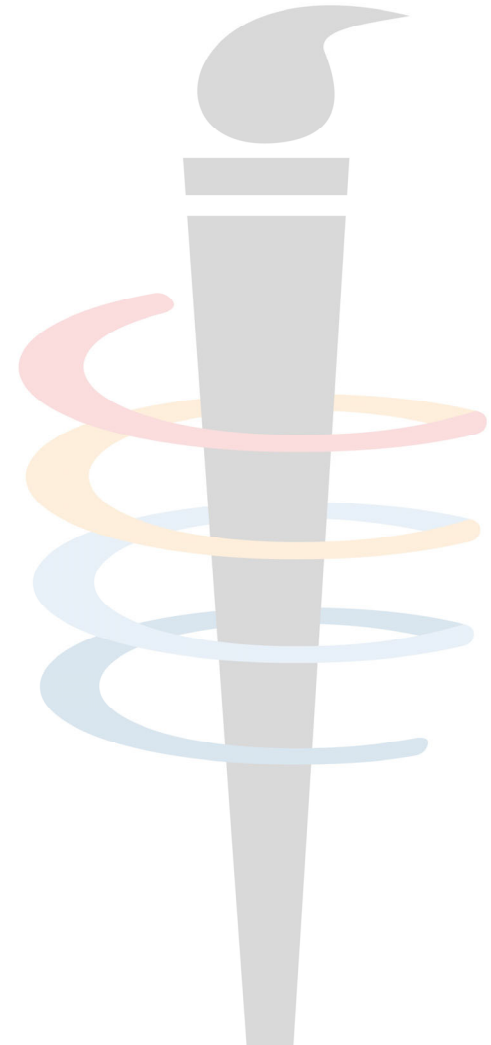
AJCC Web Site

- <https://cancerstaging.org>
- <https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/>
- General information
 - Overview
 - Version 9
 - Cancer Staging Systems
 - AJCC 8th edition Chapter 1: Principles of Cancer Staging
 - Cancer Staging Education
 - FAQ & Resources





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Thank You

