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## ► To cite this version:

Lobna Ouldamer, Martin Koskas, Xavier Carcopino. Evaluating the clinical impact of the 2023 FIGO staging for endometrial cancer: Complexities and considerations. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 2023, 291, pp.59-60. 10.1016/j.ejogrb.2023.10.008 . hal-04271254

**HAL Id: hal-04271254**

**<https://hal.science/hal-04271254v1>**

Submitted on 5 Apr 2024

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# Evaluating the clinical impact of the 2023 FIGO staging for endometrial cancer: Complexities and considerations

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Dear colleagues,

We wish to direct your attention to the recent update of the FIGO staging for endometrial cancer, as elucidated by the works of Berek et al. [1]. This revised framework introduces several noteworthy alterations to the preceding FIGO staging paradigm. It is of paramount importance for us to undertake a rigorous examination of these modifications to fully apprehend their ramifications for both clinical practice and research. With the introduction of precise histopathological criteria, one should consider that the novel classification is far more complex, bringing the question of its reproducibility in clinical routine practice.

We have to highlight that distinguishing between older IA stage with and without relevant myometrial invasion has implications for conservative treatment options (which are not validated in cases of myometrial infiltration), it is crucial to consider the almost negligible likelihood of lymph node involvement in the absence of myometrial infiltration.

Furthermore, with the integration of tumor grade and biomolecular classification data, the treatment approach aligns more closely with the choice of adjuvant therapy.

Lastly, the importance of incorporating lymphovascular space invasion (LVSI) into the treatment strategy has gained recognition, a cause for which advocates have campaigned for nearly a decade [2].

Despite all these improvements, all these modifications bring major complexity to the updated classification thus jeopardizing its applicability and use in routine practice.

For Stage I: Although the updated classification preserves the notion of confining the ailment to the uterine corpus and ovary, it introduces subclassifications depending on histological type and depth of myometrial invasion. Worth mentioning is the division of Stage IA into three

distinct subgroups (IA1, IA2, IA3), defined by the extent of myometrial invasion and the presence of LVSI. The increased number of subgroups within Stage IA is very likely to complicate communication among clinicians, pathologists, and researchers, thus jeopardizing the genuine interpretation and application of the staging criteria. Furthermore, the use of histological types and degree of invasion as classification criteria for stage I could be challenging due to the inherent variability in assessment of invasion extent and of histological interpretation, especially in mixed cases. This variability could result in differences of opinion among observers and consequently influence treatment decisions. Finally, due to its complexity, the differentiation between low-grade endometrioid carcinomas affecting both the uterus and ovary (Stage IA3) and endometrial carcinoma extensively involving the ovary except when meeting stage IA3 criteria (Stage IIIA1) could lead to classification errors.

For Stage II: The second stage remains centered on cervical stromal invasion with varying levels of lymphovascular space involvement and histological presentation. Surprisingly, in omitting extra cervical extension, the 2023 classification could potentially lead to an underestimation of the prognosis in such scenarios. Finally, the accentuation of the updated classification on the histological type, without direct consideration of tumor behavior, may curtail its precision. Histology alone may not always correlate with clinical behavior.

Stage III still addresses the local and regional dissemination of the tumor, encompassing the uterine serosa, adnexa, vagina, parametria, and lymph nodes. But it now introduces categories for micrometastasis and macrometastasis in pelvic and *para*-aortic lymph nodes. Nonetheless, the precise detection of micrometastases necessitates scrupulous

histopathological methodologies, thereby raising queries about their routine clinical applicability.

Stage IV now encompasses involvement of bladder and intestinal mucosa, abdominal peritoneal metastasis, and distant spread. Although we acknowledge the involvement of pelvic organs is paramount, the classification could benefit from enhanced clarity regarding the scope and consequences of such involvements. Additionally, while precisising distant metastases to diverse sites, the heterogeneity in management and prognosis among these sites might warrant further elucidation.

In conclusion, although the new FIGO staging classification for endometrial cancer introduces significant improvements, it is important to acknowledge its limitations and potential challenges. The complexity arising from the augmented number of subgroups, especially in stage I, the systematic use of histological types without considering the current molecular classification, and the intricate lymph node substage classifications requires thorough validation and careful evaluation of their impact on clinical decision-making and research. As dedicated practitioners and researchers in gynecologic oncology, it is our duty to

continually assess and refine staging systems to ensure the optimal care of patients and the advancement of our field.

#### **Declaration of Competing Interest**

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

#### **References**

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