

Gynecologic Cancer InterGroup Cervix Cancer Research Network



Early Cervical Cancer: Hennie Botha

- 30year old, nulligravida
- Screening cytology HSIL
- Colposcopic directed biopsy CIN II
- LLETZ performed

The specimen consists of two LLETZ fragments pinned to a sponge. The LLETZ fragments measure 35 x 12 x 3mm and 30 x 10 x 2mm.

MICROSCOPY:

Sections of the completely embedded cervix tissue confirm focal microinvasive squamous cell carcinoma in one block. This is moderately differentiated keratinising squamous cell carcinoma with the following features:-

- Depth of invasion: 1.6mm
- Horizontal extent: 2mm

Distance from the excision margins:-

- Ectocervix: 1.8mm
- Endocervix: 4.5mm
- Deep : 2mm

Lymphovascular invasion is present.

Adjacent CIN III (HSIL) is present in the same block, and extends to the endocervix margin.

CIN II (HSIL) with extension into endocervical crypts is present in two blocks, with extension into the endocervical crypts. This lesion extends to the cauterised deep excision margin.

Background human papilloma virus (HPV) change (LSIL) is present in two blocks; this is excised.

Adequacy of specimen:

- Total number of blocks: 18
- Ectocervix component: Present in 12 blocks
- Transformation zone component: Present in 6 blocks
- Endocervix component: Present in 11 blocks

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Options:

- a) Radical hysterectomy with PLND
- b) Cold Knife Cone
- c) SNL
- d) LLETZ (with "top-hat"?)
- e) Careful follow-up with cytology
- f) PLND (laparoscopic?) followed by conisation

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DIAGNOSIS:

(A) LEFT ILIAC AND OBTURATOR LYMPH NODES:

- ELEVEN LYMPH NODES PRESENT.
- NO EVIDENCE OF METASTATIC CARCINOMA.

(B) RIGHT ILIAC AND OBTURATOR LYMPH NODES:

- THIRTEEN LYMPH NODES PRESENT.
- NO EVIDENCE OF METASTATIC CARCINOMA.

Sections of the cervical LLETZ and top hat sample show no residual lesion. The surgical bed is identified with adjacent epithelial repair. No HPV features are present and there is no CIN, glandular dysplasia or residual invasive malignancy.

TABLE 1 FIGO staging of cancer of the cervix uteri (2018).

Stage	Description
I	The carcinoma is strictly confined to the cervix (extension to the uterine corpus should be disregarded)
IA	Invasive carcinoma that can be diagnosed only by microscopy, with maximum depth of invasion <5 mm ^a
IA1	Measured stromal invasion <3 mm in depth
IA2	Measured stromal invasion ≥3 mm and <5 mm in depth
IB	Invasive carcinoma with measured deepest invasion ≥5 mm (greater than Stage IA), lesion limited to the cervix uteri ^b
IB1	Invasive carcinoma ≥5 mm depth of stromal invasion, and <2 cm in greatest dimension
IB2	Invasive carcinoma ≥2 cm and <4 cm in greatest dimension
IB3	Invasive carcinoma ≥4 cm in greatest dimension
II	The carcinoma invades beyond the uterus, but has not extended onto the lower third of the vagina or to the pelvic wall
IIA	Involvement limited to the upper two-thirds of the vagina without parametrial involvement
IIA1	Invasive carcinoma <4 cm in greatest dimension
IIA2	Invasive carcinoma ≥4 cm in greatest dimension
IIB	With parametrial involvement but not up to the pelvic wall
III	The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or nonfunctioning kidney and/or involves pelvic and/or para-aortic lymph nodes ^c
IIIA	The carcinoma involves the lower third of the vagina, with no extension to the pelvic wall
IIIB	Extension to the pelvic wall and/or hydronephrosis or nonfunctioning kidney (unless known to be due to another cause)
IIIC	Involvement of pelvic and/or para-aortic lymph nodes, irrespective of tumor size and extent (with r and p notations) ^c
IIIC1	Pelvic lymph node metastasis only
IIIC2	Para-aortic lymph node metastasis
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 to adjacent pelvic organs
IVB	Spread to distant organs

When in doubt, the lower staging should be assigned.

^aImaging and pathology can be used, where available, to supplement clinical findings with respect to tumor size and extent, in all stages.

^bThe involvement of vascular/lymphatic spaces does not change the staging. The lateral extent of the lesion is no longer considered.

^cAdding notation of r (imaging) and p (pathology) to indicate the findings that are used to allocate the case to Stage IIIC. Example: If imaging indicates pelvic lymph node metastasis, the stage allocation would be Stage IIIC1r, and if confirmed by pathologic findings, it would be Stage IIIC1p. The type of imaging modality or pathology technique used should always be documented.

Source: Bhatla et al.¹⁷

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New FIGO: What is different?

- Stage IA1 < 3.0 mm deep
- Stage IA2 3.0 - 5.0 mm deep

- Stage IB1 > 5.0 mm < 2 cm
- Stage IB2 2 cm - 4 cm
- Stage IB3 > 4 cm

- Stage IIIC for positive lymph nodes: notation of r (imaging) and p (pathology)
 - Stage IIIC1 Pelvic lymph node metastasis only
 - Stage IIIC2 Para-aortic lymph node metastasis

Example:

- Stage IIIC1r (Pelvic node mets on Imaging)
- Stage IIIC1p (Pelvic node mets on Pathology)