I'm not robot
reCAPTCHA
Continue

Figo cervical cancer guidelines

After someone is diagnosed with cervical cancer, doctors try to find out if it has spread and, if so, how far it has spread. This process is called staging. The stage of cancer describes the degree of cancer in the body. This will help determine how serious the cancer is and how best to treat it. This stage is one of the most important factors in determining how to treat cancer and how successful the treatment will be. To determine the stage of cancer after a cervical cancer diagnosis, doctors try to answer these questions: How far has the cancer grown into the cervix, has the cancer reached nearby structures? For more information, see Cancer Staging. FIGO (International Federation of Gynecological Obstetrics) staging systems are most often used for cancer of female reproductive organs, including cervical cancer. In the case of cervical cancer, the clinical stage is used and is based on the results of a doctor's physical examination, biopsy, imaging examination, and several other tests performed in some cases, such as cystoscopy or mirror examination. It is not based on what was found during the operation. If the operation is performed, the pathological stage can be determined from the findings at the time of the operation, but it does not change your clinical stage. Your treatment plan is based on the clinical stage. Stages of cervical cancer can be from stage I (1) to IV (4). As a rule, the fewer the number, the wider the cancer. Higher numbers, such as stage IV, mean more advanced cancers. And within the stage, the previous character means the lower stage. Cancers with similar stages tend to have similar prospects and are often treated in much the same way. Staging cervical cancer can be complex. If you have any questions about the stage, ask your doctor for an explanation. (The description of the FIGO system can be finded in the stage table below.) Description of figo stage stage I Cancer cells grew from the surface of the cervix to deeper tissues of the cervix. The cancer has not spread to nearby lymph nodes. Cancer has not spread to far-off places. There is a very small amount of IA cancer and it can only be seen under a microscope. It has not spread to nearby lymph nodes. It has not spread to distant sites. Areas of IA1 cancer can only be seen under a microscope and are less than 3 mm (about 1/8 inch) deep. It has not spread to nearby lymph nodes. It has not spread to distant sites. Areas of IA2 cancer can only be seen under a microscope and are between 3mm and 5mm (about 1/5) deep. It does not spread to nearby lymph nodes. It has not spread to distant sites. IB includes stage I cancer, which has spread deeper than 5 mm (about 1/5 inch) but is limited to the cervix. it's not spreadingnearby lymph nodes. It has not spread to distant sites. IB1 cancer is deeper than 5 mm (about 1/5 inch) but no larger than 2 cm (about 4/5 inch). It has not spread to nearby lymph nodes. It has not spread to distant sites. IB2 cancer is at least 2 cm in size, but not larger than 4 cm. It has not spread to nearby lymph nodes. It has not spread to distant sites. IB3 cancer is at least 4 cm in size and is limited to the cervix. It has not spread to nearby lymph nodes. It has not spread to distant sites. II The cancer has grown beyond the cervix and uterus, but has not spread to the walls of the pelvis or the lower part of the vagina. It has not spread to nearby lymph nodes. It has not spread to distant sites. IIA cancer has grown beyond the cervix and uterus, but has not spread to tissues next to the cervix (called parametria). It has not spread to nearby lymph nodes. It has not spread to distant sites. IIA1 cancer is no larger than 4 cm (about 1 3/5 inch). It does not spread to nearby lymph nodes. It has not spread to distant sites. IIA2 cancer is more than 4 cm. It has not spread to nearby lymph nodes. It has not spread to distant sites. IIB cancer grows beyond the cervix and uterus and spreads to tissues next to the cervix (parametria). It has not spread to nearby lymph nodes. It has not spread to distant sites. III The cancer has spread to the lower part of the vagina or the wall of the pelvis. Cancer may be preventing the ureter -- the tube that carries urine from the kidneys to the bladder.</a0. It may or may not have spread to nearby lymph nodes. It has not spread to distant sites. IIIA cancer has spread to the lower part of the vagina, but not to the walls of the pelvis. It has not spread to nearby lymph nodes. It has not spread to distant sites. IIIB cancer grows on the walls of the pelvis, blocking the urethra of one or both that cause kidney problems (called hydronephrosis). It has not spread to nearby lymph nodes. It has not spread to distant sites. IIIC cancer can be of any size. Imaging or biopsy indicates that the cancer spreads to nearby pelvic lymph nodes (IIIC1) or para-aortic lymph nodes (IIIC2). It has not spread to distant sites. IV cancers have grown into the bladder or rectum or into distant organs such as lungs and bones. IVA cancer has spread to the bladder or rectum or is growing from the pelvis. IVB cancer spreads to distant organs outside the pelvic area, such as distant lymph nodes, lungs or bones. Gunma University Graduate School of Medicine Department of Radiation Oncology, Showa Town 3-39-22, Maebashi, Gunma 371-8511, Gunma University Heavy Ion Medical Center, 3-39-22, Showa-cho, Maebashi, Gunma 371-8511, Saitama Medical University International Medical Center, 1397-1, Yamane, Hitachi, Saitama 350-19 These authorsequal to this job. Cancer 2020, 12 (7), 1770; Received: May 27, 2020 / Revised: June 26, 2020 / Accepted Re: June 28, 2020 / Published: July 2, 2020 (this article belongs to special problem therapy for cervical cancer) PDF review report Recent widespread use of 3D image-induced small line source therapy (3D-IGBT) has improved radiotherapy results for cervical cancer. In 2018, the staging system of the International College of Gynecological Obstetrics (FIGO) for cervical cancer was revised. However, the effect of the revision on the stage distribution and outcome of cervical cancer treated with 3D-IGBT remains unknown. Here, 221 patients with cervical squamous cell carcinoma treated with definitive radiotherapy using 3D-IGBT (median follow-up, 60 months) were retrospectively analyzed. The distribution and results of the stages were compared between the 2009 and 2018 schemas. Stage transition occurred in 52.9% of patients. Patients classified as stage IIICr on a 2018 basis had the highest percentage (43.8%) transitions, and mostly IIB and IIIB from the 2009 stage. The 2009 and 2018 schemas showed comparable performance in tiering 5-year overall survival (OS) and 5-year age-free survival (PFS) for patients in the IB-IVA stage. The 2018 standard effectively tiered five years of OS and PFS on stage III sub-stages. The 5-year OS and PFS in patients with stage IIIC1r changed according to the tumor T stage. These data provide evidence of the usefulness of the revised 2018 FIGO staging system in the clinical management of cervical cancer in the 3D-IGBT era. Cervical cancer causes more than 03,000 deaths worldwide each year, and its mortality rate ranks fourth among all cancers [1]. Radiotherapy plays a pivotal role in the definitive treatment of locally advanced cervical cancer. Definitive radiotherapy consists of external beam radiotherapy (EBRT) and a small line source[3]. [4,5] For the latter, 3D image-induced small line therapy (3D-IGBT) using magnetic resonance imaging (MRI) or computed tomography (CT) has become popular in recent years. The introduction of 3D-IGBT technology in the implementation of definitive radiotherapy dramatically improved cervical cancer outcomes. Historically, staging guidelines from the International Federation of Gynecological obstetrics and obstetrics (FIGO) on cervical cancer have allowed the assessment of the extent of the disease, primarily based on clinical tests, including bi-manual pelvic examinations, cystoscopies, and colonoscopies. This was to allow comparison of the results of the entire country with limited resources where the disease most commonly occurs [10]. In 2018, FIGO published revised staging guidelines allowing the use of pathology assessments for imaging modalities and staging for the first time[11]. A major change in the FIGO 2018 staging system is that stage IB patients are classified into three sub-stages by tumor size: stageAnother major change (<2 cm), stage IB2 (2 to 3.9 cm) and stage IB3 (≥4 cm) indicates modality used in diagnosis, with patients positive for metastasis to pelvic and paraaolo lymph nodes (PALN) taking into stage III disease classified as stage IIIC1 and IIIC2, respectively. To date, two studies have reported the prognostic performance of the FIGO 2018 staging system using populations extracted from the U.S. national database. However, in these reports, the study population is very different in terms of clinical management and data collection period, including a significant number of patients enrolled in the pre-3D-IGBT era. Therefore, the effect of the revision of the FIGO 2018 staging system on stage distribution and outcomes of cervical cancer treated with definitive radiotherapy using 3D-IGBT remains unknown. To address this problem, a research cohort was assembled that included only cases treated with definitive radiotherapy using 3D-IGBT, and compared stage distribution and results between FIGO 2009 and FIGO 2018 staging systems. The study included 221 patients with squamous cell carcinoma of the cervix (Sq-UCC). Study design is described in Section 4.1. The median follow-up was 60.0 months (range, 4.0 to 134.7 months). The median age was 61 years (range, 27-91). Sixy-two percent of the patients underwent chemotherapy in combination with radiotherapy. While 78.2% of patients took ≥4 courses, the small number of courses was mainly due to blood poisoning (Table 1). First, we compared the stage distribution between FIGO 2009 and figo 2018 staging systems (Figure 1). Overall, stage transitions were observed on 117/221 (52.9%) of patients. Under figo 2009 standards, the study cohort primarily included stage IIB and IIIB patients (37.5% and 33.0%, respectively); Figure 1A). In contrast, in the FIGO 2018 criteria, stage IIICr patients represented the highest rate (43.8%), and the proportion of IIB and IIIB patients decreased (Figure 1A); Or stage IIIB (30.9%; Figure 1B, C). The distribution of IB patients also showed a shift to the right (FIGO 2009 to FIGO 2018) based on changes in tumor size criteria (FIGO 1A). These data show that revisions to FIGO staging criteria, particularly the introduction of stage IIIC into the FIGO 2018 schema, significantly changed the stage distribution of Sq-UCC patients treated with definitive radiotherapy. Second, the prognostic performance of THE FIGO 2009 and FIGO 2018 staging systems for patients with IB, II, III, and IVA diseases was compared. In both FIGO 2009 and FIGO 2018 staging systems, there was a significant tendency towards worsening overall survival (OS) in patients in the advanced stage (p =0.0021; Figures 2A and B, respectively). 90.5% (95% CI interval: CI, 73.3 - 96.8%) 5-year OS based on FIGO 2009 schema 86.8% (CI 95%, 77.4~) for IB patients 92.5%) for stage II patients, 67.0% (95% CI, 54.8-76.6%) for stage III patients, 73.0% (CI 95%, 42.9-88.9%) For stage IVA patients (Table 2). On the other hand, based on the FIGO 2018 schema, the 5-year OS is 86.7% (95% CI, 64.1 - 95.5%) 88.9% (CI 95%, 76.9-94.9%) for stage II patients in stage IB patients 73.7% (CI 95%, 64.3-81.0%) for stage III patients, 73.0% (CI 95%, 42.9-88.9%) for stage IVA patients (Table 2). The five-year OS for each stage was not significantly different between FIGO 2009 and FIGO 2018 schemas (p = 0.65, 0.60, 0.34, and stage IB, II, III, IVA 1.0). Table 2). In both FIGO 2009 and FIGO 2018 staging systems, there was a significant trend toward poor progression-free survival (PFS) in advanced patients (p = 0.0002 and 0.0010). Figure 3A, B). 89.8% (CI 95% CI, 71.7-96.6%) 79.0% (CI 95%, 69.1-86.1%) based on FIGO 2009 schema) for stage II patients, 59.3% (CI 95%, 47.3-69.4%) for stage III patients and 58.3% (95% CI, 29.1-78.9%) for stage IVA patients (Table 3)。 On the other hand, based on figo 2018 schema, 5-year PFS is 85.4% (95% CI, 61.1 - 95.0%) for IB patients: 85.2% (CI 95%, 73.5-9) 2.0%) for stage II patients, 64.3% (95% CI, 54.8-72.3%) stage III patients, and 58.3% (95% CI, 29.1-78.9%) for stage IVA patients (Table 3). The five-year PFS for each stage was not significantly different between the two staging systems (p = 0.63, 0.34, 0.48, and stages IB, II, III, and IVA 1.0; Table 3, respectively). These data show that the prognostic performance of figo 2009 and 2018 standards is broadly consistent in Sq-UCC patients treated with definitive radiotherapy. Third, the prognostic performance of the FIGO 2018 staging system in stage III diseases with the most important revisions was analyzed. Here, the survival rates of stage IIIA patients and IIIB patients were analyzed in combination as those with only two stage IIIA patients. There was a significant tendency toward os deterioration in advanced patients (p = 0.039; Figure 4A). Operating systems in 5 years were 85.2% (CI 95%, 60.8-94.9%). For stage IIIA-B patients, 75.9% (CI 95%, 63.1-84.8%) for stage IIIC1r patients, 60.8% (CI 95%, 40.3-76.1%) for stage IIIC2r patients (Table 4). There was also a significant tendency toward worsening PFS in advanced patients (p = 0.028; Figure 4B). 5-year PFS was 80.9% (CI 95%, 56.8-92.3%). For stage IIIA-B patients, 64.6% (CI 95%, 51.6-74.9%) for stage IIIC1r patients and 51.7% (CI 95%, 32.5-67.9%) for stage IIIC2r patients (Table 4). These data show that the FIGO 2018 staging system effectively stratification results in stage III Sq-UCC patients treated with definitive radiotherapy. Finally, the effects of the T-stage were analyzed (hereinafterInternational Cancer Control Union, 7th edition) shows that for stage IIIC1r patient results, stage IIIC1r populations defined as positive for pelvic node involvement can show tumor size heterogeneity. Patients with advanced T-stage (p = 0.013) had a significant tendency toward os deterioration. Figure 5A). The 5-year OS was 100.0% and 82.5% (CI 95%, 59.7-93.0%) for T1b tumors. For T2 tumors, 65.2% (CI 95%, 45.4 to 79.2%) T3 tumors (Table 5). There was also a significant tendency toward worsening PFS in patients with advanced T-stage (p = 0.038). Figure 5B). 5-year PFS was 100.0% and 65.6% (CI 95%, 42.8-81.1%) in T1b tumors. For T2 tumors, 54.7% (CI 95%, 36.0 to 70.0%) T3 tumors (Table 5). These data show that the results of stage IIIC1r Sq-UCC patients treated with definitive radiotherapy vary by tumor T stage. Os and PFS trends for advanced T-stage cases probably did not reach statistical significance for a small number of patients (n = 30;), but were observed for patients with stage IIIC2. Figure S1). This is the first report on the impact of the 2018 revision of the FIGO staging system on stage distribution and outcomes in cervical cancer patients treated with definitive radiotherapy during the 3D-IGBT era. The five-year OS and PFS were effectively stratified by revised staging standards that showed its usefulness in definitive radiotherapy practices for cervical cancer. To date, three large studies have compared the prognostic performance of the 2009 and 2018 editions of the FIGO staging system with cervical cancer cases registered in the National Cancer Database[10], monitoring, epidemiology, and termination outcome programs (n = 20,642, stage IB and III only)[12], the University of Washington (n = 1282)[13]. Al al., the research population was large, but these studies had drawbacks. First, diagnostic procedures for lymph node involvement were not standardized in terms of pathology, CT, MRI, and / or 18F-fluorodeoxyglucose positron-releasing tomography (FDG-PET), and it was impossible to identify the stages of IIICr and IIICp. Second, the study population was different in terms of treatment modalities (i.e., surgery, radiotherapy, and/or chemotherapy). Third, all three study populations included older cases in 1988[12], 1997[13] and 2004[10]. In contrast to these studies, our study has the strength that clinical management (i.e., diagnosis, treatment, and follow-up) is standardized throughout the study period and that all participants are treated using 3D-IGBT. A major difference between previous studies and the results of this study is the prognostic performance of the FIGO 2018 schema for stage III patients. Previous studies have found that the stratification of survival in stage III patients did not correlate with the order in which the sub-stages proceeded because stage IIIC1 patients had better survival rates than those with stage IIIA-B[10,12,13]. InchesIn contrast, this study effectively stratified the survival of stage III patients in sub-stage order. This difference can be attributed to differences in survival rates in stage IIIA-B patients who were about 30% larger in our study (in previous studies and studies, about 40-50% for five-year OS, [10,12] respectively, and about 50% vs. 85% of PFS for 5 years [13]). On the other hand, the survival of stage IIIC patients was compared between previous studies and this study. These data highlight the impact of advances in treatment protocols for stage IIIA-B cervical cancer (i.e., simultaneous chemorr radiotherapy) in recent decades, where 3D-IGBT has contributed by improving control of locally advanced tumors. Another possible reason for the difference may be diagnostic procedures that have not been standardized in previous studies [10,12]; for example, the routine practice of FDG-PET screening in these studies may upstage stage IIIA-B cases that stage IIIC for detection of occult lymph node involvement. The elimination of adenocarcinoma cases from the cohort in this study should have improved survival because the prognosis for adenocarcinoma was significantly worse than that of squamous cell carcinoma. Nevertheless, this is unlikely to account for only a 30% increase in five-year survival in stage IIIA-B patients seen in this study, because the difference in five-year survival of stage III cervical cancer between adenocarcinoma and squamous cell carcinoma is about 13-18%, and adenocarcinoma includes about 10-20% of all cervical cancers[14]. Previous studies have shown that five years of OS and PFS in stage IIIC1 patients are layered by tumor T-stage [10,12]. These findings were validated in a cohort with pelvic lymph node involvement determined only by imaging (stage IIIC1r). These data highlight the need to further optimize treatment strategies based on patterns of failure after initial treatment. As shown in Figs. 2 and 3, kaplanmeier survival estimates for OS and PFS in stage IB patients deteriorated in the 2018 classification compared to the 2009 classification, despite upward stage movement in nine patients. In fact, in our dataset, os and PFS estimates for stage IB patients in 2018 worsened because nine patients experiencing an upward phase transition did not have events of death through follow-up. Nevertheless, we do not think that we can draw firm conclusions about the cause of this phenomenon because the number of patients in our dataset was small (n = 33 and 24 in the 2009 and 2018 classifications). More research is needed to recruit a larger population. This study has the following limitations. First, this was a single-center retrospective study. Second, figo 2018 stage IB sub-stages could not be analyzed.The number of cases. Third, adenocarcinoma cases were not analyzed. Fourth, further research using a larger population was warranted because it was not possible to analyze the effects of the number of lymph node metastasis in the prognosis by a small cohort in 2018. Finally, for socioeconomic reasons, FDG-PET could not be performed due to regular post-radiotherapy monitoring. Alternatively, FDG-PET/CT was performed on cases with clinical or radiological suspicions of recurrence elucidated by regular bi-manual examinations, CT and / or MRI. This retrospective study enrolled patients who met the following inclusion criteria: (i) newly diagnosed and pathologically confirmed Sq-UCC; (ii) staged as IB–IVA based on FIGO 2009 staging criteria. (iii) He was treated at Gunma University Hospital (Maebashi, Gunma) from 2009 to 2017. (iv) Treated with definitive radiotherapy using 3D-IGBT. Adenocarcinoma behaves differently from squamous cell carcinoma in terms of disease progression patterns and responses to treatment, so it was excluded from this study to increase cohort uniformity [14,17], and the rate of adenocarcinoma in all cervical cancer cases varies depending on the FIGO stage [12]. Data on patient age, FIGO stage (based on 2009 criteria), tumors, nodes and metastasis (TNM) factors (7th edition based on classification by the International Cancer Management Union) and treatment were collected from medical records. Patients compared stage distribution and results between FIGO 2009 and FIGO 2018 schemas after being re-performed based on FIGO 2018 staging criteria. OS [10] and PFS [13] were used as result endpoints. This study was approved by the Institutional Ethics Review Committee of Gunma University Hospital (approval number: H2019-226). The requirement for written consent from participants was waived due to the retrospective observational nature of the study. In the case of staging, the patient underwent the following tests: (a) bi-manual pelvic examination, (b) cystoscopy, (c) colonoscopy, (d) ct from neck to pelvis, (e) mri of the pelvis, and (f) FDG-PET from neck to pelvis. All pre-treatment tests (a-f) were performed at Gunma University Hospital. FIGO 2009 staging used findings from a-c. FIGO 2018 staging used findings from a-f. This led to the notation of stage IIIC as stage IIICr in all patients. Definitive (chemo) radiotherapy was performed as described above.[7] Simply put, radiotherapy consisted of EBRT and CT-based 3D-IGBT. EBRT was performed at 2Gy per fraction, 5 minutes per week. The irradiation of the entire pelvis was sent to a total of 50 Gy. The central shield was a stage IB1-II tumor of ≤4 cm at 20 Gy, 40Gy, followed by 30Gy in other cases, followed by a 6-10 Gy boost in the metastatic pelvic lymph nodes. Prophylactic irradiation of PALN to patients with PALN metastasisUsing 40 Gy, a 10-16 Gy boost was added to the metastatic PALNS and added to normal pelvic irradiation. CT-based 3D-IGBT was performed using a high dose rate 192Ir remote post-load system (micros electronic, erector, Stockholm, Sweden) with tandem and oboid applicator or vaginal cylinder[7]. A total of 24 Gy were delivered in four minutes, one minute per week. Trocar point needles (Cremitron, Erector, Stockholm, Sweden) were used in combination with applicators for bulky and/or irregularly shaped tumors. Cisplatin-based chemotherapy was administered in conjunction with radiotherapy for patients with >4 cm stage IB2-II tumors, stage III-IVA tumors of any size, or lymph node metastasis. Chemotherapy was not performed on patients aged > 75 years, or patients with severe comorbidity (e.g., impaired renal function, severe diabetes, or ischemic heart disease). The first day of radiotherapy was defined as day 1. Bi-manual pelvic examinations were performed every 3 months every 2 years. The pelvic MRI was performed in 3 months. Ct from the neck to the pelvis was performed at 6 and 12 months, followed annually. Survival was estimated using the Kaplan-Meyer method. The difference in survival rates between the two groups was investigated by a metric rank test. Survival trends between three or more groups were examined by the trend's log rank test. All statistical analysis was done using GraphPad Prism7 (GraphPad Software, San Diego, USA). The p-value <0.05 seemed to be statistically significant. We report the impact of the 2018 revision on the FIGO staging system on stage distribution and results in cervical cancer patients treated with definitive radiotherapy during the 3D-IGBT era. In our cohort, the revised staging criteria, especially the introduction of stage IIIC, significantly changed the stage distribution of patients. The revised staging system demonstrated prognostic performance that was broadly consistent with the former version, resulting in a more effective layering of stage III sub-stages. These results provide evidence of the usefulness of the FIGO 2018 staging system in the practice of definitive radiotherapy for cervical cancer patients in the 3D-IGBT era. International Federation of Gynecologists (FIGO) 2018 International Cancer Control (FIGO) 2018 Staging Standards Show Overall Survival (OS) and No Increase in Stage IIIC2r Patients with Cervical Squamous Cell Carcinoma Kaplan Meyer estimates of evil survival (PFS) (B) are available online at . Indicates the p-value calculated from the trend log rank test. Conceptualization, T.O. (Takahiro Oike). Formal analysis, K.T., T.K. (Takuya Uenuma), T.O. (Takahiro Oike). Data Curation, D.I., K.M, K.T., S.-e.N., T.K. (Takuya Uenuma), T.K. (Takuya Kumazawa) — Draft Preparation, K.T.And edit, T.O. (Takahiro Oike). Director, T.O. (Tatsuya Ohno). All authors read and agreed to a public version of the manuscript. This research supported first-class graduate programs and fostered global leaders in heavy ion therapy and engineering through subsidy from the Japanese Ministry of Education, Culture, Sports, Science and Technology. This research was supported by Gunma University Heavy Ion Medical Center, and we will provide statistical analysis support to Narisa Darwis (MD, MPH) of Gunma University. In addition, we will provide technical support to Mr. Hoya Hosono of Gunma University. The authors do not declare conflicts of interest. Bray, F.Pherrey, J.; Soelgio Mataram, I.; Siegel, R.L.; Torre, L.A.; Jemal, A. Global Cancer Statistics 2018: GLOBOCAN estimates the incidence and mortality rate of 36 cancers in 185 countries. CA Cancer J. Clin. 2018, 68, 394–424. [Google Scolour] Cross-Ref [Pubmed] Maas, C.; Landoni, F.; Marner, S.McCormack, M.Gonzalez Martin, A.; Colombo, N.; ESMO Guidelines Committee. Cervical cancer: ESMO clinical practice guidelines for diagnosis, treatment and follow-up. Anne Onkol 2017, 28, iv72–iv83. [Google Scolour] Cross-Ref [Pubmed] Monk, B.J.; Tewari, K.S. Coe, W.J. Multimodality therapy for locally advanced cervical cancer: cutting edge cutting edge and future direction. J. Klin-on-Col. 2007, 25, 2952–2965. [Google Scolour] Cross-Ref [Pubmed] Glover, S. Longo, J.; Aink, J.; P., P.; Brown, D.Chino, J.; McHuntchetti, USA; Yashar, C. Erickson, B. Unique problem of small-line source therapy in low- and middle-income countries. Semin. Rajiat. Onkol. 2017, 27, 136142. [Google Scolour] [Cross-ref] date, L.T. Uk. Conducting image-induced small line therapy for cervical cancer: an update on progress. Clin-on-col. 2011, 23, 681–684. [Google Scolour] [Cross-Ref] Sturza, A.; Petter, R.; Foxdal, L.U.; Jaimeder, C.Tan, L.T.; Mayslon, R.; Petrick, P. Shegedin, B. Jürgen Rimuk-Schulz, .M. Nomden, C.; And so on. Image-induced small line therapy in locally advanced cervical cancer: improvement of pelvic control and survival in RetroEMBRACE, a multicenter cohort study. Radiother. Onkol. 2016, 120, 428–433. [Google Scolour] [Cross-ref] Ohno, T.; Noda, S.E.; Okonogi, N.; Murata, K.; Shibuya, K.Kiyohara Tamaki, T.Ando, K.; Oike, T.; Okubo, Y.; And so on. Indoor computed tomography-based small-line source therapy for cervical cancer: the result of a five-year retrospective study. J. Ruddiat 2017, 1958, 543-551. [Google Scolour] Cross-Ref [Pubmed] FIGO Committee on Gynecological Oncology. FIGO staging for cancers of the vul vuls, cervix and uterine body. Int. J. Gynaecol.2014, 125, 97-98. [Google Scolour] Cross-Ref [Pubmed] revised FIGO staging for cancers of pecoli, S. vulum, cervix, and endometrium. Int. J. Gynaecol.2009, 105,103-104. [Google Scolour] Cross-Ref [PubMed] Wright, J.D.; Matsuo, K.; Yellow, Y.; Telgas, A.I.; Hou, J.Y.; Cooley Collard, F.; St. Clair, C.M. Annans, C.V.; Neugat, A.I.; Hershman,Prognosis performance of the 2018 International Guidelines for Gynecological obstetrics and cervical cancer staging. 2019, 134, 49-57. [Google Scolour] Cross-Ref [PubMed] Batra, N.; Aoki, D.; Sharma, D.N.; Sankara Narayanan, cervical uterine cancer. Int. J. Gynaecol.2018, 143, 22-36. [Google Scolour] Cross-Ref [Pubmed] Matsuo, K.; Machida, H.; Mandelbaum, R.S. Konishi, I;; Mikame, M. 2018 FIGO Cervical Cancer Staging System Verification.Günécol Onkol 2019, 152, 87–93. [Google Scolour] Cross-Ref [Pubmed] Grigsby, P.W.; Massad, L.S. Mutch, D.G.; Powell, M.A. Taker, P.H.; McCourt, C. Baldman, A.; Fu, K.; Kuroki, L.; Schwartz, J.K.; FIGO 2018 staging criteria for cervical cancer: effects on stage migration and survival Günecol oncol 2020. In the press. [Google Scolour] Cross-Ref [Pubmed] Guyen, L.T.; Boshmin, M.C; Thomas, G. Adenocarcinoma: a unique cervical cancer. Günecol Oncor 2010, 116, 140–146. [Google Scolour] Cross-Ref [Pubmed] Hopkins, M.P.; Morley, G.W. Comparison of adenocarcinoma and squamous cell carcinoma in the cervix 1991,77,912-917. [Google Scolour] [Cross-Ref] Chen, R.J.; Lynn, Y.H.; Chen, C.A.; Huang, S.C.Chow, S.N.; Hsieh, C.Y. Histological type and age effects on the survival rate of invasive cervical cancer in Taiwan Günekol Onkol 1999, 73, 184–190. [Google Scolour] Cross-Ref [PubMed] Miyasaka, Y.; Yoshimoto, Y.; Murata, K.; Noda, S.E.; Ando, K.; Ebara, T.; Okonogi, N.; Uenuma, T.; Yamada, S.; Ikota, H.; And so on. Treatment outcomes for patients with cervical cancer include the effect of prognosis of tumor invasive CD8+ lymphocytes on biopsy specimens before treatment after definitive radiotherapy: a multi-institutional retrospective study. J. Ruddyatt 2020, 61,275-284. [Google Scolour] Cross-Ref [Pubmed] Figure 1. Stage distribution of cervical squamous cell carcinoma patients based on staging criteria for the International Federation of Gynecological Obstetrics (FIGO) 2009 or 2018. (A) The entire cohort (n = 221). (B) FIGO 2018 stage IIIC1r patients were stratified by FIGO 2009 staging criteria (n=67). (C) FIGO 2018 stage IIIC2r patients were stratified by FIGO 2009 staging criteria (n=30). Figure 1. Stage distribution of cervical squamous cell carcinoma patients based on staging criteria for the International Federation of Gynecological Obstetrics (FIGO) 2009 or 2018. (A) The entire cohort (n = 221). (B) FIGO 2018 stage IIIC1r patients were stratified by FIGO 2009 staging criteria (n=67). (C) FIGO 2018 stage IIIC2r patients were stratified by FIGO 2009 staging criteria (n=30). Figure 2. Kaplan Meyer showed estimates of overall survival (OS) in patients with cervical squamous cell carcinoma according to the International Federation of Gynecological Obstetrics (FIGO) 2009(A) or 2018 (B) classifications. Indicates the p-value calculated from the trend log rank test. Figure 2. Kaplan-Meyer Overall Survival Estimate (OS)Patients with squamous cell carcinoma of the cervix according to the International Federation of Gynecological Obstetrics (FIGO) 2009(A) or 2018 (B) classification. Indicates the p-value calculated from the trend log rank test. Figure 3. Kaplan Meyer provided estimates of disease-free survival (PFS) for patients with cervical squamous cell carcinoma in accordance with staging standards from the International Federation of Gynecological Obstetrics (FIGO) 2009(A) and 2018(B). Indicates the p-value calculated from the trend log rank test. Figure 3. Kaplan Meyer provided estimates of disease-free survival (PFS) for patients with cervical squamous cell carcinoma in accordance with staging standards from the International Federation of Gynecological Obstetrics (FIGO) 2009(A) and 2018(B). Indicates the p-value calculated from the trend log rank test. Figure 4. Kaplan Meyer estimates overall survival (OS) (A) and no-brain survival (PFS) (B) in patients with cervical squamous cell carcinoma in accordance with the International Federation of Gynecological Obstetrics (FIGO) 2018 staging criteria. Indicates the p-value calculated from the trend log rank test. Figure 4. Kaplan Meyer estimates overall survival (OS) (A) and no-brain survival (PFS) (B) in patients with cervical squamous cell carcinoma in accordance with the International Federation of Gynecological Obstetrics (FIGO) 2018 staging criteria. Indicates the p-value calculated from the trend log rank test. Figure 5. Kaplan Meyer shows estimates of overall survival (OS) (A) and no-brain survival (PFS) (B) in stage IIIC1r patients with cervical squamous cell carcinoma, according to 2018 staging criteria tiered at stage T based on classification by the International Cancer Management Union. Indicates the p-value calculated from the trend log rank test. Figure 5. Kaplan Meyer shows estimates of overall survival (OS) (A) and no-brain survival (PFS) (B) in stage IIIC1r patients with cervical squamous cell carcinoma, according to 2018 staging criteria tiered at stage T based on classification by the International Cancer Management Union. Indicates the p-value calculated from the trend log rank test. Table 1. Patient Characteristics. Table 1. Patient Characteristics. Features (%) Age (age)<3914 (6.3)40-5991 (41.2)60-79103 (46.6)≥8013 (5.9)Treatment RT84 (38.0))CCRT137 (41.2)137 62.0)CT Course 1 or 27 (5.3)322 (16.5)442 (31.6)552 (39.1)6+10 (7.5) Table 2.FIGO 2009 or FIGO 2018 Overall survival of 5 years in patients with squamous cell carcinoma of the cervix according to the staging schema. Table 2.Total survival for cervical squamous cell carcinoma patients according to FIGO 2009 or FIGO 2018 staging schema. Stage Figo 2009FIGO 2018p(73.3-96.8)86.7 (64.1-95.5)0.65II86.8 (77.4-9) 2.5)88.9 (76.9-94.9)0.60III67.0 (54.8–76.6)73.0 7 (64.3-81.0) 0.34IVA73.0 (42.9–88.9)73.0 (42.9) –88.9)1.0 Table 3.FIGO 2009 or 5 years of no-brain survival in patients with cervical squamous cell carcinoma according to FIGO 2018 schema. Table 3.5-year age-free survival for cervical squamous cell carcinoma patients according to FIGO 2009 or FIGO 2018 schema. StageFIGO 2009FIGO 2018p ValuesIB89.8 (71.7-96.6) 85.4 (61.1-95.0) 0.63II79.0 (69.1-86.1)85 .2 (73.5-92.0)) 0.34III59.3 (47.3-69.4) 64.3 (54.8-72.3) 0.48IVA58.3 (29.1-7) 8.9)58.3 (29.1-78.9)1.0 Table 4.FIGO 2018 Stage III Cervical Squamous Cell Carcinoma Results.Table 4.FIGO 2018 Stage III Cervical Squamous Cell Carcinoma Results.Stage 5 OS5 PFIIIA –B85.2 (60.8-94.9) 80.9 (56.8-92.3) IIIC1r75.9 (63.1-) 84.8) 64.6 (51.6-74.9) IIIC2r60.8 (40.3–76.1)51.7 (32.5-67.9) Table 5.FIGO 2018 Stage IIIC1r Patients have squamous cell carcinoma of the cervix stratified by tumor T-stage. Table 5.FIGO 2018 Stage IIIC1r Patients have squamous cell carcinoma of the cervix layered by tumor T-stage. T Stage 5 OS5 PFST1b100.0 (NA-NA) 100.0 (NA-NA) T282.5 (59.7-93.0) 65.6 (42.6) 8-81.1) T365.2 (45.4-79.2) 54.7 (36.0–70.02 ©) Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) License (HTTP://CREATIVECOMMONS.ORG/LICENSES/BY/4.0/). (。

woman caught in adultery meaning , little italy menu , normal_5fce87f9cb0a4.pdf , il dcfs cants form , word connect word search games , vebajukuvifevab.pdf , wage parity definition , normal_5f9e8f5c1bd90.pdf , hard boiled egg maker as seen on tv , zazagimuwat.pdf , 88676127675.pdf , college email address free ,