Endometrial Carcinoma: Clinical Characteristic and Survival Rates by the New Compared to the Prior FIGO Staging Systems

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Objective: *To compare clinical characteristic features and survival rates of endometrial cancer (EMC) patients according to the new 2009 and prior 1988 FIGO staging systems.*
Material and Method: *Clinico-pathological data of EMC patients who had primary surgical treatment between 1992 and 2008 were collected. The new FIGO staging was compared to the prior assigned staging. Survivals of patients according to prior and new staging were compared.*
Results: *Data from 259 patients was reviewed. Mean age was 55.4±9.9 years. Radiation was the most common adjuvant therapy after surgery, 95/106 patients (89.6%). Progression and recurrences occurred in 34 patients (16 with progression and 18 with recurrence) while 47 died (18.1%). Comparing the prior and current staging, early stage I-II was commonly found in both systems. Stages were the same in 81 patients (31.3%), lower in 177 (68.3%), and higher in one (0.4%). After a median follow-up of 57.5 months, 5-year progression-free, cancer-specific and overall survivals according to the prior and new systems were similar in stage III-IV. Survivals of new stage I A (from 16-prior stage IA, 124-IB, 12-IIA, and 1-IIIA) and stage IB (from 32-IC and 8-IIA) were worse than those of prior stage IA or IB. Survivals of the new stage II patients (11-IIB) were the same as prior stage IIB.*
Conclusion: *The "new" FIGO staging system for endometrial cancer patients resulted in lower stage in a large number of patients. Survival trends were worse in the new stage I and remained similar in the other stages.*

Keywords: *FIGO 2009 staging, Endometrial cancer, Survival*

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Staging is an important means to classify cancer patients into groups according to their prognosis and clinical behavior. This will also allow different centers to compare the patients' data, their outcomes, and to provide an appropriate treatment for each patient. The International Federation of Gynecology and Obstetrics (FIGO) is the first and principal organization that sets the staging criteria for most gynecologic cancers. With emerging technology of diagnostic tools and more available data regarding the natural course of disease and outcomes, continual evolution of cancer staging procedures takes place.

For endometrial cancer (EMC), the evaluation and definite management of EMC has been evolving since 1971 when FIGO introduced "clinical staging" using clinical tools to evaluate the extent of cancer[1]. Subsequent studies found that the clinical evaluation of diseases frequently underestimated or inaccurately assessed the extent of diseases as revealed from surgico-pathological findings, such as, depth of myometrial cancer invasion and retroperitoneal lymph node status[2,3]. In recognition of suboptimal correlation of clinical staging information and prognosis, FIGO revised the EMC staging to a "surgical staging" approach in 1988[4,5]. This FIGO 1988 is considered a standard staging system as well as a primary EMC treatment up to the present. Several surgico-pathological findings, which are important prognostic factors, are used for stage assignment. The depth of myometrial invasion (none, less or more than half) is for stage I disease. The cervical extension (none, glandular involvement or stromal invasion) is for stage II. The other extrauterine sites of cancer involvement

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(uterine serosa, adnexa or peritoneal cytology, vagina, retroperitoneal lymph node) are for stage III. Finally, the urinary bladder, bowel, and systemic metastasis are for stage IV. These data are generally obtained by complete exploration of the abdominal cavity, collection of peritoneal fluid for cytology, total hysterectomy, bilateral salpingo-oophorectomy, and evaluation of retroperitoneal lymph node (LN).

Based on more available data of the impact of various prognostic factors, FIGO has recently revised staging for EMC in 2009. A few minor but important changes were in the sub-stage groups. Theoretically, this new classification should have more precise association with treatment outcomes or survival. However, more data on the outcomes of EMC patients according to the new staging are required to confirm this presumption. Another concern is about the adjuvant treatment recommendation that is currently derived from data using the prior FIGO staging as the benchmarks. The physician needs to apply adjuvant treatment for the patient based on the revised staging. The authors aimed to compare characteristic features of EMC patients according to the previous and the current staging system and to evaluate whether the outcomes would be different.

Material and Method

Approval from the Ethics Committee for Research involving Human Subjects from the institution was obtained before the present study. The authors searched the archives of the Department of Anatomical Pathology; Gynecologic Oncology Unit; and Radiation Oncology Unit to identify EMC patients treated between January 1992 and December 2008. The patients may be either operated in the institutions, or had operations elsewhere and were referred for further management. Exclusion criteria were patients who had any types of uterine sarcoma other than carcinosarcoma, had pre-operative radiation therapy, had fertility sparing treatment with uterine preservation, and those whose medical records especially surgico-pathological reports were not available.

The following clinico-pathological data were collected from in- and out-patient charts and pathological reports. They were age, type of primary surgery, FIGO stage according to the 1988 classification system, histopathology and grade of tumors, depth of myometrial invasion, peritoneal cytology, cervical invasion, adjuvant therapy, and outcomes after treatment. Complete surgical staging was referred to when hysterectomy and salpingo-oophorectomy were performed together with retroperitoneal lymph node sampling with or without omentectomy. Staging was assigned according to the International Federation of Gynecology and Obstetrics (FIGO 1988) criteria. The new FIGO 2009 staging was applied from the clinical and surgico-pathological data, and was compared to the prior assigned staging.

Progression-free survival (PFS), overall survival (OS), and cancer-specific survival were determined. PFS was defined as interval from the ended date of treatment to the time of recurrence or progression of disease. For the patient who was lost to follow-up, PFS data was right-censored at the time of the last evaluation or contact when the patient was known to be progression-free. OS and cancer-specific survival were defined as the time from the date of diagnosis to date of all deaths from any causes and EMC death, respectively. For the patients who were still alive at the time of the present study, survival data were right-censored at the date of last follow-up visit.

Data were analyzed using SPSS statistical software, version 11.5 (SPSS, Chicago, IL). Descriptive statistics were used to analyze demographic data and were summarized as numbers with percentage or median with range. OS and PFS of the patients according to the prior and new stages were analyzed by the Kaplan-Meier method. P-values of <0.05 were considered significant.

Results

Between January 1992 and December 2008, 264 EMC patients were identified. Five patients were excluded including two patients who had preoperative radiation treatment for clinical parametrial involvement, two who had no available pathological data, and one who had fertility sparing treatment. Mean age of 259 patients recruited into study was 55.4±9.9 years (median age of 55 years and range of 30-84 years).

All 259 patients had primary surgery, with complete surgical staging in 248 patients (95.8%). Eleven patients who had limited disease confined to the uterus (2 patients-stage IA, 5-stage IB) or had suboptimal performance status for an extensive surgical procedure (1 patient-stage IC, 1-stage III, and 2-stage IV diseases) - had only simple hysterectomy and bilateral salpingo-oophorectomy without lymph node dissection. Among patients who had complete surgical staging surgery, six patients had radical instead of simple hysterectomy because of positive preoperative cervical curettage. Pathological cervical invasion was found in only three hysterectomy specimens.

Pelvic lymph node (PN) and para-aortic lymph node (PAN) resection were done in 249 patients (96.1%) and 179 patients (69.1%), respectively. The corresponding median number of PN and PAN retrieved were 18 nodes (range, 1-51 nodes) and 3 nodes (range, 1-19 nodes). Positive nodes were found in 40 cases: isolated PN in 27 cases, isolated PAN in five, and positive at both sites in the other eight. Median number of positive PN was three while that of PAN was one. Of note, 12 out of 40 cases with positive nodes had nodal metastasis as the only site of extrauterine diseases. The type of surgery and surgico-pathological characteristics of the patients are shown in Table 1.

The majority of patients had early stage diseases (stage I-II): 203 patients (78.4%) from old staging and 204 (78.8%) from new staging. Table 2 shows number of patients according to the prior 1988 and current 2009 staging. When comparing each individual sub-stage of the two systems, 81 cases (31.3%) had the same stage classification, 177 cases (68.3%) had lower stage, and only one (0.4%) had higher stage. The down-staged cases were all of previous stages IB, IC, IIA, and one stage IIIA. They were re-assigned to stage IA or stage IB according to degree of myometrial invasion (Table 2). The only one up-staged case from stage IIIA to stage IIIB was the patient who had parametrial involvement aside from cervical invasion and ovarian metastasis. Among 40 cases with retroperitoneal node positive, three cases remained in stage IV while 37 cases that were in stage IIIC were sub-staged to stage IIIC1 (25 cases with isolated positive PN) and stage IIIC2 (five cases with isolated PAN metastasis and seven cases with both PN and PAN metastases).

Postoperative adjuvant therapy was given in 106 patients (40.9%). The adjuvant therapy given according to the prior FIGO staging was the following: 48 patients of stage I, 20 of stage II, and 38 of stage III. Aside from the stage of disease, other prognostic factors as well as some associated pathology of the ovary and performance status of the patients took part in decision to the type of adjuvant therapy. Out of 106 patients, radiation therapy was the most common type of adjuvant treatment. It included radiation alone in 95 patients (89.6%), radiation combined with chemotherapy in two patients (1.9%), and chemotherapy or hormonal therapy in nine patients (8.5%). Details of adjuvant treatment according to stage of diseases by prior and current staging are shown in Table 3.

Table 1. Type of surgery and surgico-pathological findings of endometrial carcinoma patients (n = 259)

Surgico-pathological features	n	%
Type of surgery		
Complete surgical staging	248	95.8
Incomplete surgical staging	11	4.2
Histopathology		
Endometrioid carcinoma	200	77.2
Endometrioid carcinoma with other components[a]	40	15.4
Carcinosarcoma	9	3.5
Others[b]	10	3.9
Tumor grade		
Grade I	58	22.4
Grade II	125	48.3
Grade III	76	29.3
Cervical involvement		
No	202	78.0
Cervical glandular involvement	27	10.4
Cervical stroma involvement	30	11.6
Myometrial invasion		
Endometrium only	19	7.3
Inner half	152	58.7
Outer half	88	34.0
Peritoneal cytology (n = 201)		
Negative	191	73.7
Positive	10	3.3
Lymph node status (n = 249)		
Positive pelvic node only	27	10.4
Positive para-aortic node only	5	1.9
Positive both sites	8	3.1
Negative both sites	209	80.7

[a] Other components mixed with endometrioid were: squamous (n = 33), serous (n = 3), clear (n = 2), mucinous (n = 1), neuroendocrine (n = 1).
[b] Other histopathology were: clear cell carcinoma (n = 4), serous carcinoma (n = 3), villoglandular carcinoma (n = 2), secretory carcinoma (n = 1).

From a median follow-up of 57.6 months (range, 0.03-212.3 months), progressive diseases were encountered in 16 patients (6.2%) including seven of stage IVB patients, six of stage IIIC, and three of stage IIIA. Eleven of them did not have any adjuvant treatment, four were having pelvic radiation, and one had only palliative hormonal therapy due to her poor performance status. Eighteen patients (6.9%) experienced recurrences. The sites of recurrences (according to the prior stage) were three local recurrences (stage IB, IIA, IIIC), 13 distant metastases (each patient of stage IB, IC, IIA and ten of stage IIIC), and two local plus distant recurrences (stage IC and IIIC).

Table 2. Comparison of the previous 1988 and the current 2009 FIGO staging fro endometrial cancer (n = 259)

Staging by FIGO 1988 criteria	Staging by FIGO 2009 criteria								Total
	Stage I		Stage II	Stage III				Stage IV	
	IA	IB		IIIA	IIIB	IIIC			
						IIIC1	IIIC2		
Stage I									
IA	16	-	-	-	-	-	-	-	16
IB	124	-	-	-	-	-	-	-	124
IC	-	32	-	-	-	-	-	-	32
Stage II									
IIA	12	8	-	-	-	-	-	-	20
IIB	-	-	11	-	-	-	-	-	11
Stage III									
IIIA	1	-	-	10	1	-	-	-	12
IIIB	-	-	-	-	-	-	-	-	-
IIIC	-	-	-	-	-	25	12	-	37
Stage IV	-	-	-	-	-	-	-	7	7
Total	153	40	11	10	1	25	12	7	259

Table 3. Adjuvant therapy for endometrial cancer by FIGO 1988 and FIGO 2009 staging systems (n = 259)

Stage	Type of adjuvant treatment							Total
	No	EPRT	ICRT	EPRT/ICRT	RT/CT	CT[b]	HT	
Prior 1988 FIGO staging								
Stage I								
IA	16	-	-	-	-	-	-	16
IB	99	1	10	11	-	-	3	124
IC	9	5	1	16	-	1[c]	-	32
Stage II								
IIA	8	-	2	9	-	1[c]	-	20
IIB	3	1	-	7	-	-	-	11
Stage III								
IIIA	1	3	1	6	-	1[c]	-	12
IIIC	10[a]	1	-	21	2[b]	1[c]	2[a]	37
Stage IV	7	-	-	-	-	-	-	7
Current 2009 FIGO staging								
Stage I								
IA	121	1	12	15	-	1	3	153
IB	11	5	1	22	-	1	-	40
Stage II	3	1	-	7	-	-	-	11
Stage III								
IIIA	-	3	1	5	-	1	-	10
IIIB	1	-	-	-	-	-	-	1
IIIC1	7	1	-	15	-	1	1	25
IIIC2	3	-	6	2	-	-	1	12
Stage IV	7	-	-	-	-	-	-	7
Total	153	11	14	70	2	4	5	259

CT = chemotherapy; EBRT = external pelvic radiation; HT = hormonal therapy; ICRT = intracavitary radiation; RT = radiation

[a] Twelve patients in stage IIIC who declined adjuvant chemotherapy or had poor performance status had no adjuvant treatment (10 patients) or had palliative hormonal treatment (2 patients).

[b] Two patients had sequential radiation and chemotherapy for their stage IIIC with para-aortic lymph node metastasis.

[c] Four patients who had chemotherapy were two (stage IC and IIA) with who had synchronous ovarian cancer, one stage IIIA with metastasis to ovarian vessels, and one stage IIIC patients with metastasis to pelvic lymph node.

Overall, 30 patients were dead from cancer (11.6%) while 17 were dead from unrelated causes (6.6%). Median survival of all 259 patients had not been reached while 5-year PFS, 5-year OS, and 5-year cancer specific survival (95% confidence interval) were 86.4% (82.0-90.8%), 83.8% (78.8-88.8%), and 88.0% (83.8-92.1%), respectively. Survivals of the patients were compared according to prior and new staging systems (Table 4). The authors found that survivals according to the two systems were similar in stage III-IV. Survivals of the new stage I A (from 16-prior stage IA, 124-IB, 12-IIA, and 1-IIIA), and stage IB (from 31-IC and 8-IIA) were worse than those of prior respective stage IA or IB while survival of the new stage II was actually that of the prior stage IIB.

Discussion

It has been more than 20 years since the surgical staging by FIGO was launched in 1988 until a recent revision in 2009. Since the new FIGO staging was announced, many institutions have applied the new staging system to their patients. Adjuvant treatment for EMC is generally based on several prognostic factors including stage of disease. However, the physician is certainly more familiar with the treatment recommendation by the prior staging data and may have to compare the new with the prior stages to provide an adjuvant therapy for his patients because it is still unclear regarding the prognosis or outcomes of the new staging especially in the new stage I. For example, each prognostic factor must be explored in detail for the 28 patients who were now in the new stage IA or IB, but were in the prior stage IB or IC and had received adjuvant radiation. Under the new staging, these patients may not be offered such adjuvant therapy.

The FIGO stage changes were in sub-stage I, sub-stage II, and sub-stage III classification. Based on this new staging system, the authors found that more than 2/3 of the patients remained in the same stage of disease and nearly 1/3 was down-staged, with only one up-staged case. Most of the down-staged cases were from stage IB or IC and stage IIA that was re-assigned to stage IA or IB from the extent of myometrial invasion. Only one patient who had endometrioid carcinoma grade 2 with less than half of myometrial invasion and has positive peritoneal cytology was down-staged to IA. According to the prior 1988 staging, stage IA disease was specific to case without myometrial invasion while stage IB and IC were to have invasion less or more than half of myometrial thickness, respectively. The FIGO combined the patients without myometrial invasion and those with less than half of invasion into the new IA stage because significant problems in the pathological determination

Table 4. Survivals of endometrial cancer patients according to the prior and current FIGO staging (n = 259)

Stage	n	5-year PFS (95% CI)	5-year OS (95% CI)	5-year CA specific survival (95% CI)
Stage I				
Old IA	16	100.0	100.0	100.0
New IA	153	98.6 (96.7-100.0)	94.9 (90.9-98.9)	98.6 (96.7-100.0)
Old IB	124	99.2 (97.5-100.0)	94.8 (90.4-99.3)	99.2 (97.5-100.0)
Old IC	32	92.6 (82.6-100.0)	89.6 (78.3-100.0)	92.6 (82.6-100.0)
New IB	40	91.2 (81.5-100.0)	88.0 (76.8-99.2)	91.2 (81.5-100.0)
Stage II				
Old IIA	20	89.7 (76.2-100.0)	88.2 (72.7-100.0)	89.7 (76.2-100.0)
Old IIB	11	100.0	80.0 (55.2-100.0)	100.0
New II	11	100.0	80.0 (55.2-100.0)	100.0
Stage III				
Old IIIA	12	83.3 (62.2-100.0)	83.3 (62.2-100.0)	83.3 (62.2-100.0)
New IIIA	10	90.0 (71.4-100.0)	90.0 (71.4-100.0)	90.0 (71.4-100.0)
Old IIIB	-	-	-	-
New IIIB	1	0	0	0
Old IIIC	37	44.3 (26.6-62.0)	51.8 (33.7-69.9)	56.9 (40.2-73.8)
New IIIC1	25	45.3 (24.9-65.7)	53.6 (33.1-74.1)	53.6 (33.1-74.1)
New IIIC2	12	43.8 (11.3-76.2)	48.2 (13.5-82.9)	64.3 (35.7-92.9)
Stage IV				
Old and new IV	7	0	0	0

PFS = progression-free survival; OS = overall survival

of the depth of myometrial invasion due to the irregularity of endometrial-myometrial junction[6,7] and many studies found little survival difference between these two groups in an absence of nodal metastasis[8,9].

The authors also observed that among previous stage I disease, stage IB had almost identical survivals to stage IA while stage IC had lower survivals (Table 4). Focusing on the new staging, stage IB had a sharp decline of 5-year PFS, OS, and CA specific survivals than stage IA. One reason for this finding was that the new stage IB cases were derived from previous stage IC and some previous stage IIA.

Concerning stage II EMC, the new stage II disregards the presence of glandular involvement and considers only cervical stroma invasion of stage II. Endocervical gland is actually the surface mucosa with invagination, so any surface or glandular involvement is an extension of EMC rather than an invasion that should not alter the prognosis. The authors found that all new stage II cases that were actually all previous stage IIB had worse PFS and CA specific survival than previous stage IIA. This may be by chance. The small number of patients in this subgroup did not allow the authors to make any specific comments.

A stage III by previous 1988 staging system was very heterogeneous and had been questioned for their prognostic importance. The first was of controversial prognosis; peritoneal cytology was classified as stage IIIA together with uterine serosa or adnexa involvement. Many studies reported conflicting results regarding the prognostic impact of positive peritoneal cytology[10-14]. Some authors suggested postoperative treatment because they found increased recurrences and decreased survival in EMC patients with positive peritoneal cytology[10,11]. Others did not corroborate on its independent significance but found its impact varied depending on other risk features[12-14]. Different findings might lie on the method and accuracy of cytologic evaluation e.g. direct smear of the fluid on the slide or liquid based cytology or a cell blocks preparation. The mechanisms or pathway the malignant cells enter the peritoneal cavity e.g. direct extension of EMC through myometrium to serosa or transtubal spillage may also influence the significance of positive cytology. The second feature was about parametrial involvement, which carries a poor prognosis but was not included in the prior staging system. The third and important feature was the PN or PAN metastases, which had been classified as stage IIIC in previous staging. PN area is generally covered in the pelvic adjuvant radiation field while PAN locates in extra-pelvic anatomy and is the gateway to distant diseases, which requires systemic adjuvant therapy such as chemotherapy rather than local pelvic radiation. The FIGO recognized the prognostic significance of these features and revised stage IIIC in the new staging by removing peritoneal cytology status from stage IIIA, adding parametrial involvement in stage IIIB, and separating the two groups of PN or PAN metastases to stage IIIC1 and IIIC2.

The new stage IIIA patients, after moving one patient with only positive peritoneal cytology to stage IA and another one with parametrial invasion to stage IIIB, had longer survivals than those assigned to previous stage IIIA. This was most likely to be from the stage transfer of the latter patient (new stage IIIB) who had parametrial involvement aside from cervical invasion and ovarian metastasis. Prior studies reported poor prognosis of EMC with parametrial involvement as well as its association with other poor prognostic factors e.g. deep myometrial invasion, cervical invasion, nodal or adnexal metastases etc[15,16]. The authors also found that one patient with parametrial involvement along with other poor prognostic features had poor outcome with rapid disease progression and death within a few months after surgery. Generally, patients with parametrial involvement are not good candidates for surgery and should be offered an alternative treatment with preoperative radiation[17]. Two of the patients who had obvious parametrial involvement from clinical evaluation and were subjected to preoperative radiation therapy with hysterectomy afterward were alive for years after treatment (not included in the statistical analysis).

For 37 stage IIIC patients, 25 were staged IIIC1 from isolated pelvic node metastasis while 12 cases were sub-staged as IIIC2. Some of these patients did not have actual adjuvant therapy as suggested or planned because they had poor performance status or declined the adjuvant treatment. Hence, it might be inappropriate to compare the survivals of stage IIIC in the present study to the other reports. Nevertheless, the authors found that the new stage IIIC2 patients had lower survivals than stage IIIC1 patients.

In conclusion, this retrospective study can simply give a general overview of the numbers of patients having stage migration by applying the new staging system. A provocative finding was the patients who were moved to earlier stages might not be offered adjuvant therapies. However, small sample size and heterogeneity of adjuvant treatments that may influence the patients' survival were major limitations of

the present study. Nevertheless, it may be prudent to maintain parallel data sets for the near future incorporating both the FIGO 1988 and 2009 staging for accurate comparison of outcomes.

Potential conflicts of interest

None.

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มะเร็งเยื่อบุโพรงมดลูก: ลักษณะทางคลินิกและอัตราการรอดชีวิตจากการกำหนดระยะของโรคตามระบบ FIGO ใหม่เทียบกับระบบเดิม

ศิริวรรณ ตั้งจิตกมล, สุนำโชค ศรีใจพระเจริญ, สุมนมาลย์ มนัสศิริวิทยา, จักรพันธ์ ขุนณรงค์, กมล ภัทราดูลย์, เถาวลัย ถาวรามร

วัตถุประสงค์: *เพื่อเปรียบเทียบลักษณะทางคลินิกและอัตราการรอดชีวิตของผู้ป่วยมะเร็งเยื่อบุโพรงมดลูกจากการกำหนดระยะของโรคตามระบบ FIGO ใหม่ปี พ.ศ. 2552 เทียบกับระบบเดิมปี พ.ศ. 2531*

วัสดุและวิธีการ: *ทำการศึกษาข้อมูลทางคลินิกและพยาธิวิทยาผู้ป่วยมะเร็งเยื่อบุโพรงมดลูกที่ได้รับการผ่าตัดแบบปฐมภูมิระหว่างปี พ.ศ. 2535 ถึง ปี พ.ศ. 2551 และทำการเปรียบเทียบอัตราการอยู่รอดของผู้ป่วยที่อยู่ในระยะต่าง ๆ ของโรคตามระบบเดิมและระบบใหม่*

ผลการศึกษา: *ทบทวนข้อมูลของผู้ป่วย 259 ราย อายุเฉลี่ย เท่ากับ 55.4±9.9 ปี รังสีรักษาเป็นการรักษาเสริมมากที่สุด คือ ผู้ป่วย 95 ใน 106 ราย (ร้อยละ 89.6) มีการรุดหน้าหรือกลับเป็นซ้ำเกิดขึ้น 34 ราย (16 ราย รุดหน้า 18 ราย กลับเป็นซ้ำ) ขณะที่ 47 ราย เสียชีวิต (ร้อยละ 18.1) เปรียบเทียบการกำหนดระยะของโรคระบบใหม่กับระบบเดิม โรคเริ่มแรกระยะ 1 และ 2 พบบ่อยในทั้งสองระบบ เป็นระยะโรคเดียวกัน 81 ราย (ร้อยละ 31.3) ต่ำกว่า 177 ราย (ร้อยละ 68.3) และสูงกว่า 1 ราย (ร้อยละ 0.4) หลังติดตามไปเป็นระยะเวลามัธยฐาน เท่ากับ 57.5 เดือน อัตราการปลอดโรครุดหน้า 5 ปี อัตราการอยู่รอดเฉพาะมะเร็งและโดยรวมตามระบบใหม่กับระบบเดิมคล้ายคลึงกันในผู้ป่วยระยะโรค 3 และระยะ 4 อัตราการอยู่รอดโรคระยะ 1 เอ ระบบใหม่ (จากระยะที่ 1 เอ-16 ราย, 1 บี-124 ราย, และ 3 เอ-1 รายของระบบเดิม) และโรคระยะ 1 บี ระบบใหม่ (จากระยะที่ 1 ซี-32 ราย และ 2 เอ-8 ราย) แย่กว่าระยะ 1 เอ หรือ 1 บี ตามระบบเดิม อัตราการอยู่รอดของผู้ป่วยระยะ 2 ระบบใหม่ (จากระยะ 2 บี-11 ราย) จะเท่ากับระยะ 2 บี ระบบเดิม*

สรุป: *การกำหนดระยะของโรคตามระบบ FIGO ใหม่สำหรับผู้ป่วยมะเร็งเยื่อบุโพรงมดลูกเป็นผลให้ผู้ป่วยจำนวนมากมีระยะของโรคลดลง อัตราการอยู่รอดของผู้ป่วยจะแย่ลงในระยะที่ 1 ที่กำหนดตามระบบใหม่ในขณะที่เหมือนเดิมในระยะอื่น ๆ*