The International Federation for Cancer Prevention and Colposcopy

Clarifications for the 2026 IFCPC Nomenclature draft
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Introduction

The following text accompanies the draft table of the IFCPC Colposcopy Nomenclature. Its purpose is to highlight and clarify the major changes from the previous nomenclature, based on the deliberations of the Nomenclature Committee.

Further discussion of your comments will take place, and may influence the final nomenclature proposal, which will be voted upon at the upcoming IFCPC World Congress in Versailles, France, June 4-6, 2026.

Please do not use, cite, or publish this text or the accompanying tables prior to final acceptance, in order to avoid circulation of multiple versions of the nomenclature.

1. Colposcopic Nomenclature of Lugol's Iodine Staining

The wording of *"Lugol's Iodine Staining"* and its role and interpretation in the IFCPC Colposcopic Nomenclature have been thoroughly discussed by the members of the Nomenclature Committee.

Historically, the test was introduced by Walter Schiller in the early 20th century and was incorporated into early colposcopic terminology in 1954. Lugol's staining has since been included in various IFCPC classifications.

Early colposcopy classifications regarded the iodine test as a secondary adjunct without specific categorization. It was first acknowledged as an *"uncharacteristic iodine-negative area"* in 1946 and later included under *"abnormal colposcopic findings"* in the first international IFCPC terminology in 1975. In the second and third IFCPC terminologies (1990 and 2002*), "partial iodine uptake*" was introduced as an indicator of minor abnormalities. However, in the 2011 IFCPC Nomenclature, the term *"iodine-negative"* was replaced by *"non-stained"*, reflecting the underlying pathophysiological phenomenon. Lugol's iodine staining was categorized as a nonspecific abnormal

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colposcopic finding rather than a major or minor abnormal finding, due to concerns about its poor diagnostic performance.

A proposal to reconsider the weight given to Lugol's iodine staining in the IFCPC Nomenclature was raised and discussed. A literature review conducted by the Nomenclature Committee confirmed that the test continues to demonstrate low positive predictive value of non-stained areas (in some studies, under 10%). Therefore, Lugol's iodine non-staining remains classified as a nonspecific abnormal colposcopic finding. Nonetheless, it was acknowledged that the test can highlight areas of interest, particularly within the transformation zone and identifying vaginal lesions. The wording "Lugol's iodine staining" was preferred over "Schiller's test" and other variants.

To address these considerations, it was decided to:

- Continue recommending the use of Lugol's iodine staining as an adjunct to colposcopy, in the IFCPC publication that will accompany the nomenclature.
- Revise its interpretation in the Nomenclature as follows:
    - **Normal colposcopic findings**: Add *"Lugol's iodine brown staining"* (replacing the 2011 term *"Lesion staining by Lugol's solution (Schiller's test): nonstained"*).
    - **Abnormal colposcopic findings – Grade 2 (Major):** Add *"A concurrence of a Lugol's iodine non-stained area with any other Grade 2 (Major) lesion."*
    - **Abnormal colposcopic findings – nonspecific**: Change the entry to *"Lugol's iodine non-stained inside transformation zone"* (replacing the 2011 term *"Lesion staining by Lugol's solution (Schiller's test): stained"*).

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2. Colposcopic Nomenclature of Glandular Abnormalities

The usefulness and terminology for the colposcopic evaluation of glandular diseases in the IFCPC Colposcopic Nomenclature have been thoroughly discussed by the members of the Nomenclature Committee, following an updated review of the literature.

All previous IFCPC nomenclatures primarily focused on squamous lesions and did not include terminology for glandular abnormalities. The main reason is that, unlike high-grade squamous lesions— which typically produce distinct acetowhite changes or vascular patterns on the ectocervix—adenocarcinoma in situ (AIS) may present with subtle or completely occult changes beneath an intact epithelium. AIS lesions are frequently located partly or entirely within the endocervical canal and crypts, making complete visualization during colposcopy challenging.

Even with expert colposcopic evaluation, up to half of patients with glandular lesions may have no visible abnormal findings. One study reported that colposcopic examination detected less than 10% of biopsy-proven endocervical lesions in their cohort (sensitivity 9.8%), whereas cervical cytology detected approximately 66%. Similarly, Italian guidelines note that AIS "has no colposcopic features that can differentiate it from other cervical lesions,".

Adenocarcinomas account for an estimated 20–25% of cervical cancers. The lack of formal colposcopic descriptors for AIS or early glandular neoplasia has contributed to inconsistent recognition and reporting.

Therefore, the Committee decided to accept the proposal to incorporate the colposcopic nomenclature of glandular lesions into the IFCPC Nomenclature, while acknowledging the inherent limitations of colposcopy in detecting adenocarcinoma in situ and early invasive glandular disease.

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3. Transformation Zone Types

Post-treatment transformation zone:
In addition to the three established transformation zone types, which develop as a result of physiological metaplasia, transformation zones following cervical treatment by excision or destruction typically exhibit more pronounced features of metaplasia.

The Committee did not support the introduction of a separate, specific “post-treatment transformation zone” or "neo-transformation zone" category, but decided to add in the IFCPC Nomenclature publication, a notification of this conditiony

Abnormal colposcopic findings – Grade 1 (minor):
Minor changes may occasionally be observed in association with physiological processes such as metaplasia, and may also be present in cases with normal histology, low-grade lesions, or high-grade lesions.

The Committee did not support the elimination of the “Grade 1 (minor)” category from abnormal colposcopic findings, as the patterns described under this grade are real, distinct, and consistently recognized in colposcopic practice.

4. Cervical Excision Types

The 2011 IFCPC Colposcopic Nomenclature was the first IFCPC Nomenclature to include descriptions of excision types. Although these excision types are not strictly part of the colposcopic nomenclature, the 2011 Committee took the opportunity to publish them alongside the comprehensive nomenclature of the cervix, vagina, and vulva. To underscore that they are not an integral part of the nomenclature, they were presented in an addendum table.

The excision typeswere defined as follows:

- **Type 1 excision**: Resection of a completely ectocervical or type 1 transformation zone.
- **Type 2 excision**: Resection of a type 2 transformation zone, including a small amount of endocervical epithelium visible with a colposcope.

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- **Type 3 excision:** Resection of a type 3 transformation zone, removing a greater volume and length of tissue than type 1 or type 2 excisions, and including a significant amount of endocervical epithelium. Type 3 excision may be used to treat glandular disease, microinvasive carcinoma, or in women with previous treatment.

In the present revision, the 2026 Nomenclature Committee has decided to modify the description of type 3 excision. The indication “for microinvasive carcinoma” has been replaced with “for suspicion of cervical carcinoma.” This reflects the clinical reality that treatment planning often occurs when invasion is suspected, before final histopathological confirmation is available. The definitive treatment decision—whether to proceed beyond type 3 excision or not—will depend on the histopathological findings, particularly the extent of invasion and the presence or absence of lymph-vascular space invasion.
The committee decided to add a note of caution to the description of type 3 excision, as follows: *In women wishing to preserve fertility, special caution should be taken to avoid excessive resection of endocervical tissue, as this may weaken the cervix.*"

- In addition, **a type 4 excision** (cylinderectomy) has been introduced into the Addendum Nomenclature Table. This procedure involves removal of the endocervix and is intended for cases of endocervical glandular neoplasia or recurrence following a previous type 3 excision. It should be performed parallel to the endocervical canal in order to adequately remove the deep glands located within the cervical stroma.

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