Materials and Methods

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A data management software running on standard personal computer has been especially designed for the data collection of the Twenty-fifth volume of the *FIGO Annual Report.* This allowed participating centers to gather their data following the format and coding rules established by the FIGO Editorial Board. Thereafter, data were sent on electronic media to the data center, where a series of quality control checks were performed. For the centers which did not use the FIGO software conversions were made in order to ensure data compatibility.

Further procedures allowed identification and elimination of duplicated records while specific rules were adopted before data analysis. Although some center provided data for a wider time period, only patients diagnosed in 1995–98 and treated in 1996–98 were included in this *Report.* Only patients for whom either the date of diagnosis or that of the first treatment (for those patients who lacked the date of diagnosis) was provided were entered in the final database. Patients with missing or incorrect date of birth or follow-up were excluded from the analysis.

For each of the sites included in this volume, comprehensive descriptive statistics and frequency tables are given.

Since some of the contributors do not have the possibility to follow-up actively all their patients, the proportion of patients lost at follow-up might be quite important in some centers. In order to reduce the resulting bias, we decided to exclude from the survival analysis data for all the centers in which more than 40% of the patients were lost at follow-up three years after diagnosis or treatment.

The probability of surviving different lengths of time is provided by overall and stratified Kaplan–Meier survival curves. Survival tables reported under each curve provide the overall survival at 1, 2, 3, 4 and 5 years for each of the considered strata. In addition, country-adjusted hazards ratios (the risk of dying compared with the reference group, which is generally the first group or the group with the highest number of patients) are expressed with their 95% confidence intervals (CI). CI is expressed as a range of values that we can be confident includes the true value. It is expected that the 95% CI does not include the true hazards ratios 5% of the time.

As data were obtained from selected centers, it was not possible to get adequate background mortality data necessary for the calculation of relative survival.

For patients who had a partial or complete response to treatment, the relapse-free survival was calculated as the time between diagnosis or treatment and the date of first relapse or death of the patient. Patients still alive and free of disease at the end of the follow-up period were censored.

Finally, for each tumor site, a multivariate Cox proportional regression analysis was performed. Proportional hazards regression models are used to investigate how several variables influence overall survival simultaneously. This analysis is presented in a table format stratified by FIGO stage for each tumor site. Different independent variables with the relevant strata were taken into consideration according to the main prognostic factors reported in literature. Data are presented as hazards ratios with the relevant CI compared with the reference group for each of the considered strata.

Data for 30898 patients submitted by 93 centers were included in this report (Table 1).

Table 1
Number of patients included for the descriptive analysis, the overall survival analysis and the relapse-free survival analysis by tumor site

Site	Descriptive analysis	Overall survival	Relapse-free survival
Carcinoma of the Vulva	1,127	848	398
Carcinoma of the Vagina	289	235	83
Carcinoma of the Cervix Uteri	13,982	10,525	6,873
Carcinoma of the Corpus Uteri	8,790	7,496	4,490
Carcinoma of the Fallopian Tube	115	103	50
Carcinoma of the Ovary	5,694	5,105	2,645
Gestational Trophoblastic Diseases	901	658	409
Total	30,898	24,970	14,948

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