Esophagus
C15.0-C15.5, C15.8-C15.9

C15.0 Cervical esophagus
C15.1 Thoracic esophagus
C15.2 Abdominal esophagus
C15.3 Upper third of esophagus
C15.4 Middle third of esophagus
C15.5 Lower third of esophagus
C15.8 Overlapping lesion of esophagus
C15.9 Esophagus, NOS

The cardia/EGJ, and the proximal 5cm of the fundus and body of the stomach (C16.0-C16.2) have been moved from the Stomach chapter and added to Esophagus effective with AJCC TNM 7th Edition. A new schema EG Junction was created in CSv2 to accommodate this change. Tumors arising at the EGJ, or arising in the stomach within 5 cm of the EGJ and crossing the EGJ are staged using the schema for EG Junction. All other cancers with a midpoint in the stomach lying more than 5 cm distal to the EGJ, or those within 5 cm of the EGJ but not extending into the EGJ or esophagus, are staged using the stomach schema.

Anatomic Limits of Esophagus:

Cervical Esophagus (C15.0): From the lower border of the cricoid cartilage to the thoracic inlet (suprasternal notch), about 18 cm from the incisors.

Intrathoracic (including abdominal esophagus) (C15.1 - C15.5): Upper thoracic portion (C15.3): From the thoracic inlet to the level of the tracheal bifurcation (18-24 cm). Mid-thoracic portion (C15.4): From the tracheal bifurcation midway to the gastroesophageal (GE) junction (24-32 cm).

Lower thoracic portion (C15.5: From midway between the tracheal bifurcation and the gastroesophageal junction to the GE junction, including the abdominal esophagus (C15.2) between 32-40 cm.

Effective with AJCC TNM 7th Edition, there are separate stage groupings for squamous cell carcinoma and adenocarcinoma. Since squamous cell carcinoma typically has a poorer prognosis than adenocarcinoma, a tumor of mixed histopathologic type or a type that is not otherwise specified should be classified as squamous cell carcinoma.

Effective with AJCC TNM 7th Edition, histologic grade is required for stage grouping.

CS Tumor Size	CS Site-Specific Factor 1 Clinical Assessment of Regional Lymph Nodes	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2 Specific Location of Tumor	Histology Inclusion Table AJCC 7th ed.
CS Tumor Size/Ext Eval	CS Site-Specific Factor 3 Number of Regional Lymph Nodes with Extracapsular tumor	Histology Exclusion Table AJCC 6th ed.
CS Lymph Nodes	CS Site-Specific Factor 4 Distance to proximal edge of tumor from incisors	AJCC TNM 7 Stage
CS Lymph Nodes Eval	CS Site-Specific Factor 5 Distance to distal edge of tumor from incisors	AJCC TNM 6 Stage
Reg LN Pos	CS Site-Specific Factor 6	Summary Stage
Reg LN Exam	CS Site-Specific Factor 7	AJCC TNM 7 Stage
CS Mets at DX	CS Site-Specific Factor 8	Squamous
CS Mets Eval	CS Site-Specific Factor 9	AJCC TNM 7 Stage
	CS Site-Specific Factor 10	Adenocarcinoma
	CS Site-Specific Factor 11	Lymph Nodes Clinical Evaluation 7th Table
	CS Site-Specific Factor 12	Lymph Nodes Pathologic Evaluation 7th Table Also
	CS Site-Specific Factor 13	Used When CS Reg Nodes
	CS Site-Specific Factor 14	Eval is Not Coded
	CS Site-Specific Factor 15	Lymph Nodes Mets at DX
	CS Site-Specific Factor 16	Table AJCC 6
	CS Site-Specific Factor 17	Histologies Stage Table
	CS Site-Specific Factor 18	
	CS Site-Specific Factor 19	
	CS Site-Specific Factor 20	
	CS Site-Specific Factor 21	
	CS Site-Specific Factor 22	
	CS Site-Specific Factor 23	
	CS Site-Specific Factor 24	
	CS Site-Specific Factor 25	

Esophagus

CS Tumor Size (Revised: 08/28/2009)

Note: For esophagus, this field is used for size of tumor/length of involved esophagus.

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"

Code	Description
998	Circumferential
999	Unknown; size not stated Not documented in patient record

Esophagus

CS Extension (Revised: 01/26/2010)

Note 1: Ignore intraluminal extension to adjacent segment(s) of esophagus or to cardia of stomach and code depth of invasion or extra-esophageal spread as indicated.

Note 2: T4 has been subclassified into T4a and T4b in the 7th Edition.

Note 3: For this site, AJCC defines Tis as High grade dysplasia, in which they Include "all non-invasive neoplastic epithelium that was previously called carcinoma in situ. Cancers stated to be non-invasive or in situ are classified as Tis." High grade dysplasia is generally not reportable in cancer registries, but if a registry does collect it, code 000 should be used.

Code	Description	TNM 7	TNM 6	SS77	SS2000
000	In situ; non-invasive; intraepithelial; high grade dysplasia	Tis	Tis	IS	IS
100	Invasive tumor confined to mucosa, NOS (including intramucosal, NOS)	T1a	T1	L	L
110	Invades lamina propria	T1a	T1	L	L
120	Invades muscularis mucosae	T1a	T1	L	L
160	Invades submucosa	T1b	T1	L	L
170	Stated as T1 [NOS]	T1NOS	T1	L	L
200	Muscularis propria invaded	T2	T2	L	L
210	Stated as T2 [NOS]	T2	T2	L	L
300	Localized, NOS	T1NOS	T1	L	L
400	Adventitia and/or soft tissue invaded Esophagus is described as "FIXED"	T3	T3	RE	RE
450	Stated as T3 [NOS]	T3	T3	RE	RE

Code	Description	TNM 7	TNM 6	SS77	SS2000
600	OBSOLETE DATA RETAINED V0200 T4 subclassified in AJCC 7th Edition; See Codes 610-820 Tumor invades adjacent structures Cervical esophagus: Blood vessel(s): Carotid artery Jugular vein Subclavian artery Thyroid gland Intrathoracic, upper or mid-portion, esophagus: Blood vessel(s), major: Aorta Azygos vein Pulmonary artery/vein Vena cava Carina Diaphragm Main stem bronchus Trachea Intrathoracic, lower portion (abdominal), esophagus: Blood vessel(s): Aorta Gastric artery/vein Vena cava Diaphragm, not fixed, or NOS Stomach, cardia (via serosa)	ERROR	T4	RE	RE
610	Tumor invades adjacent structures Cervical esophagus: Hypopharynx Jugular vein Larynx Thyroid gland Intrathoracic, upper or mid-portion, esophagus: Blood vessel(s), major: Azygos vein Diaphragm Intrathoracic, lower portion (abdominal), esophagus: Blood vessel(s): Gastric artery/vein Diaphragm, not fixed, or NOS Stomach, cardia (via serosa) Intrathoracic esophagus: Pleura	T4a	T4	RE	RE

Code	Description	TNM 7	TNM 6	SS77	SS2000
650	OBSOLETE DATA RETAINED V0200 T4 subclassified in AJCC 7th Edition; See Codes 610-820 Cervical esophagus: Carina Cervical vertebra(e) Hypopharynx Larynx Trachea Intrathoracic esophagus: Lung via bronchus Mediastinal structure(s), NOS Pleura Rib(s) Thoracic vertebra(e)	ERROR	T4	RE	RE
660	Thoracic/middle esophagus: Pericardium	T4a	T4	RE	D
680	Cervical/upper esophagus: Pleura Abdominal/lower esophagus: Diaphragm fixed	T4a	T4	D	D
700	Stated as T4 [NOS]	T4NOS	T4	RE	RE
710	Stated as T4a [NOS]	T4a	T4	RE	RE

Code	Description	TNM 7	TNM 6	SS77	SS2000
730	Tumor invades adjacent structures Cervical esophagus: Blood vessel(s): Carotid artery Subclavian artery Carina Cervical vertebra(e) Trachea Intrathoracic, upper or mid-portion, esophagus: Blood vessel(s), major: Aorta Pulmonary artery/vein Vena cava Carina Main stem bronchus Trachea Intrathoracic, lower portion (abdominal), esophagus: Blood vessel(s): Aorta Vena cava Intrathoracic esophagus: Adjacent Rib(s) Bronchus Mediastinal structure(s), NOS Thoracic vertebra(e)	T4b	T4	RE	RE
750	Cervical/upper esophagus: Lung Main stem bronchus	T4b	T4	D	D
780	OBSOLETE DATA RETAINED V0200 T4 subclassified in AJCC 7th Edition; See Code 660 Thoracic/middle esophagus: Pericardium	ERROR	T4	RE	D
800	OBSOLETE DATA RETAINED V0200 T4 subclassified in AJCC 7th Edition; See Codes 730 and 750 Further contiguous extension: Cervical/upper esophagus: Lung Main stem bronchus Pleura Abdominal/lower esophagus: Diaphragm fixed	ERROR	T4	D	D
810	Further contiguous extension Stated as T4b [NOS]	T4b	T4	D	D
820	Tumor Invades adjacent structures listed in codes 610,660,or 680, but stated as unresectable	T4b	T4	D	D

Code	Description	TNM 7	TNM 6	SS77	SS2000
950	No evidence of primary tumor	T0	T0	U	U
999	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	TX	U	U

Esophagus

CS Tumor Size/Ext Eval (Revised: 08/10/2009)

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used.	c
2	Meets criteria for AJCC pathologic staging: No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Either criteria meets AJCC pathologic staging: Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed AND Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. No surgical resection done. Evaluation based on positive biopsy of highest T classification.	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6).	c
6	Meets criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy AND tumor size/extension based on pathologic evidence, because pathologic evidence at surgery is more extensive than clinical evidence before treatment.	yp

Code	Description	Staging Basis
8	Meets criteria for autopsy (a) staging: Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Esophagus

CS Lymph Nodes (Revised: 12/06/2009)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: In 7th Edition, regional lymph nodes for any part of esophagus fall in the range from periesophageal/cervical to celiac region.
Note 3: Lymph nodes from the supraclavicular region down to the celiac region previously considered to be distant are now regional.
Note 4: Lymph node stations/groups are listed in parentheses when applicable. See page 107 of the AJCC TNM 7th Ed. for an illustration.

Code	Description	TNM 7	TNM 6	SS77	SS2000
000	None; no regional lymph node involvement	N0	N0	NONE	NONE

Code	Description	TNM 7	TNM 6	SS77	SS2000
100	Regional lymph nodes (including contralateral or bilateral) For all subsites: Peri-/paraesophageal (8L, 8M) Cervical esophagus only: Cervical, NOS Anterior deep cervical (laterolateral) (recurrent laryngeal) Internal jugular, NOS: Deep cervical, NOS: Upper, NOS: Jugulodigastric (subdigastric) Intrathoracic esophagus, upper or middle, only: Internal jugular, NOS: Deep cervical, NOS: Lower, NOS: Jugulo-omohyoid (supraomohyoid) Middle Upper cervical, NOS: Jugulodigastric (subdigastric) Intrabronchial: Carinal (tracheobronchial) (10R, 10L) (tracheal bifurcation) Hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Peritracheal Left gastric (superior gastric) (17): Cardiac (cardial) Lesser curvature Perigastric, NOS Posterior mediastinal (tracheoesophageal) Intrathoracic esophagus, lower (abdominal) only: Left gastric (superior gastric) (17): Cardiac (cardial) Lesser curvature Perigastric, NOS Posterior mediastinal (3P) (tracheoesophageal)	^	N1	RN	RN
200	Cervical Esophagus only: Scalene (inferior deep cervical) (1) Supraclavicular (transverse cervical) (1)	^	N1	D	RN
220	Intrathoracic, upper thoracic or middle, only: Superior mediastinal	^	N1	D	RN
250	Upper thoracic esophagus only: Cervical lymph nodes Lower thoracic (abdominal) esophagus only: Celiac lymph nodes (20)	^	*	D	D

Code	Description	TNM 7	TNM 6	SS77	SS2000
260	Cervical esophagus only: Common hepatic (regional) (18) Diaphragmatic (15) Pulmonary ligament (9) Splenic (19) Intrathoracic esophagus, upper or middle, only: Common hepatic (18) (regional) Diaphragmatic (15) Splenic (19) Lower thoracic (abdominal) esophagus only: Aortopulmonary (5) Pulmonary ligament (9)	^	*	D	D
300	All esophagus subsites: Anterior mediastinal (6) Mediastinal, NOS Cervical esophagus only: Aortopulmonary (5) Paratracheal (2R,2L, 4R, 4L) Posterior mediastinal (3P) Superior mediastinal Intrathoracic esophagus,upper or middle, only: Aortopulmonary (5) Pulmonary ligament (9) Intrathoracic esophagus, lower (abdominal) only: Common hepatic (18) Diaphragmatic (15) Paratracheal (2R,2L, 4R,4L) Splenic (19) Superior mediastinal	^	N1	RN	RN
500	Regional lymph node(s), NOS	^	N1	RN	RN
600	Stated as clinical N2 (clinical assessment; no lymph nodes removed)	N2	N1	RN	RN
610	Stated as pathologic N2; no information on which nodes were involved	N2	N1	RN	RN
700	Stated as clinical N3a (clinical assessment; no lymph nodes removed)	N3	N1	RN	RN
710	Stated pathologically as N3a; no information on which nodes were involved	N3	N1	RN	RN
800	Lymph nodes, NOS; Stated as N1	^	N1	RN	RN
999	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	NX	U	U

^ For codes 100-500 and 800, the N category is assigned based on the number of positive lymph nodes. ^ For codes 100-500 and 800 ONLY: when CS Regional Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation 7th Edition Table, using Reg LN Pos and CS Site-Specific Factor 1; when CS

Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation 7th Edition Table using Reg LN Pos.
* For codes 250 and 260 the N and M categories for AJCC 6th Edition are assigned based on the coding of this field and CS Mets at DX as shown in the Lymph Nodes Mets at DX Table AJCC 6

Esophagus

CS Lymph Nodes Eval (Revised: 10/26/2009)

Note 1: This field is used primarily to derive the staging basis for the N category in the TNM system. It records how the code for the item "CS Lymph Nodes" was determined based on the diagnostic methods employed and their intent.

Note 2:

In the 7th edition of the AJCC manual, the clinical and pathologic classification rules for the N category were changed to reflect current medical practice. The N is designated as clinical or pathologic based on the intent (workup versus treatment) matching with the assessment of the T classification. When the intent is workup, the staging basis is clinical, and when the intent is treatment, the staging basis is pathologic.

A. Microscopic assessment including biopsy of regional nodes or sentinel nodes if being performed as part of the workup to choose the treatment plan, is therefore part of the clinical staging. When it is part of the workup, the T category is clinical, and there has not been a resection of the primary site adequate for pathologic T classification (which would be part of the treatment).

B. Microscopic assessment of regional nodes if being performed as part of the treatment is therefore part of the pathologic staging. When it is part of the treatment, the T category is pathologic, and there has been a resection of the primary site adequate for pathologic T classification (all part of the treatment).

Note 3: Microscopic assessment of the highest N category is always pathologic (code 3).
Note 4: If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.
Note 5: Only codes 5 and 6 are used if the node assessment is performed after neoadjuvant therapy.

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No regional lymph nodes removed for examination. Evidence based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria: No regional lymph nodes removed for examination. Evidence based on endoscopic examination, or other invasive techniques including surgical observation, without biopsy. No autopsy evidence used. OR Fine needle aspiration, incisional core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup, WITHOUT removal of the primary site adequate for pathologic T classification (treatment).	c
2	Meets criteria for AJCC pathologic staging: No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p

Code	Description	Staging Basis
3	Meets criteria for AJCC pathologic staging based on at least one of the following criteria: Any microscopic assessment of regional nodes (including FNA, incisional core needle bx, excisional bx, sentinel node bx or node resection), WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category. OR Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6).	c
6	Meets criteria for AJCC y-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on pathologic evidence, because the pathologic evidence at surgery is more extensive than clinical evidence before treatment.	yp
8	Meets criteria for AJCC autopsy (a) staging: Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Esophagus

Reg LN Pos (Revised: 12/10/2009)

Note: Record this field even if there has been preoperative treatment.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Esophagus
Reg LN Exam (Revised: 03/02/2009)

Code	Description
00	No nodes examined
01-89	1 - 89 nodes examined (code exact number of regional lymph nodes examined)
90	90 or more nodes examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed
96	Regional lymph node removal documented as sampling and number of nodes unknown/not stated
97	Regional lymph node removal documented as dissection and number of nodes unknown/not stated
98	Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but number unknown
99	Unknown if nodes were examined; not applicable or negative Not documented in patient record

Esophagus
CS Mets at DX (Revised: 01/07/2010)

Note 1: Lymph nodes from the supraclavicular region down to the celiac region previously considered to be distant are now regional.

Note 2: Lymph node stations/groups are listed in parentheses when applicable. See page 107 of the AJCC TNM 7th Ed. for an illustration.

Code	Description	TNM 7	TNM 6	SS77	SS2000
00	No; none	M0	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	M1NOS	D	D
11	OBSOLETE DATA RETAINED V0200 Considered regional in AJCC 7th Edition See CS Lymph Nodes code 250 Upper thoracic esophagus only: Cervical lymph nodes M1 Lower thoracic (abdominal) esophagus only: Celiac lymph nodes (20) M1	ERROR	M1a	D	D

Code	Description	TNM 7	TNM 6	SS77	SS2000
12	OBSOLETE DATA REVIEWED AND CHANGED V0200 The specified lymph nodes in code 12 were considered distant in AJCC 6th Edition and are considered regional in AJCC 7th Edition EXCEPT for common hepatic and splenic lymph nodes which are still considered distant and are included in code 15. See CS Lymph Nodes code 260 for lymph nodes other than common hepatic and splenic Specified distant lymph node(s), other than code 11, including: Cervical esophagus only: Common hepatic (18) Diaphragmatic (15) Pulmonary ligament (9) Splenic (19) Intrathoracic esophagus, upper or middle, only: Common hepatic (18) Diaphragmatic (15) Splenic (19) Lower thoracic (abdominal) esophagus only: Aortopulmonary (5) Pulmonary ligament (9)	ERROR	ERROR	ERROR	ERROR
15	Common hepatic (18) Splenic (19)	M1	M1NOS	D	D
40	Distant metastases except distant lymph node(s) (codes 10 or 15) Carcinomatosis	M1	M1b	D	D
50	40 + any of 10 to 15 Distant lymph node(s) plus other distant metastases	M1	M1b	D	D
60	Distant metastasis, NOS Stated as M1 [NOS]	M1	M1b	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

Esophagus

CS Mets Eval (Revised: 08/10/2009)

Note: This item reflects the validity of the classification of the item CS Mets at DX only according to the diagnostic methods employed.

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastatic tissue performed or pathologic examination was negative.	c
1	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastatic tissue performed or pathologic examination was negative.	c
2	Meets criteria for AJCC pathologic staging of distant metastasis: No pathologic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Meets criteria for AJCC pathologic staging of distant metastasis: Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation OR specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed OR specimen from metastatic site microscopically positive prior to neoadjuvant treatment.	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.	c
6	Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence.	yp
8	Meets criteria for AJCC autopsy (a) staging of distant metastasis: Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Esophagus

CS Site-Specific Factor 1 Clinical Assessment of Regional Lymph Nodes (Revised: 12/31/2009)

Note: In the rare instance that the number of clinically positive nodes is stated but a clinical N category is not stated, code 1-2 nodes as 100 (N1), 3-6 nodes as 200 (N2), and 7 or more nodes as 300 (N3).

Code	Description
000	Nodes not clinically evident
100	Clinically N1
200	Clinically N2
300	Clinically N3
400	Clinically positive regional nodes, NOS
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
999	Unknown if nodes are clinically evident

Esophagus

CS Site-Specific Factor 2 Specific Location of Tumor (Revised: 12/30/2009)

Code	Description
010	Cervical
020	Upper Thoracic
030	Middle Thoracic
040	Abdominal
050	Lower Thoracic
070	Upper third
080	Middle third
090	Lower third
100	Overlapping lesion of the Esophagus
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site

Code	Description
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
999	Unknown; Esophagus, NOS

Esophagus
CS Site-Specific Factor 3 Number of Regional Lymph Nodes with Extracapsular tumor
(Revised: 12/30/2009)

Note: Record the information from the Pathology report. If there is no Pathology report or it is unavailable, record code 999.

Code	Description
000	All nodes examined negative.
001-089	1 - 89 nodes (code exact number of nodes with extracapsular tumor)
097	Positive nodes - not stated if extracapsular tumor present
098	No nodes examined
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
999	Unknown if nodes are positive; unknown if extracapsular tumor present; Not documented in patient record

Esophagus
CS Site-Specific Factor 4 Distance to proximal edge of tumor from incisors (Revised: 12/30/2009)

Note: The distance to the proximal edge of tumor from the incisors is the distance from the gross tumor edge to the esophageal transection line. Record the information from the Pathology report. If there is no Pathology report or it is unavailable, record code 999.

Code	Description
000	Proximal edge of tumor involved
001-050	1-50 Centimeters (code exact distance to proximal edge in centimeters)
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site

Code	Description
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
990	Distance to proximal edge not stated
999	Unknown Not documented in patient record

Esophagus
CS Site-Specific Factor 5 Distance to distal edge of tumor from incisors (Revised: 12/30/2009)

Note: Record the information from the Pathology report. If there is no Pathology report or it is unavailable, record code 999.

Code	Description
000	Distal edge of tumor involved
001-060	1-60 Centimeters (code exact distance to proximal edge in centimeters)
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
990	Distance to distal edge not stated
999	Unknown Not documented in patient record

Esophagus
CS Site-Specific Factor 6 (Revised: 06/30/2008)

Code	Description
888	OBSOLETE DATA CONVERTED V0200 See code 988 Not applicable for this site
988	Not applicable for this schema

Esophagus
CS Site-Specific Factor 7 (Revised: 06/30/2008)

Code	Description
988	Not applicable for this schema