Summary Stage 2000

Introduction and General Rules

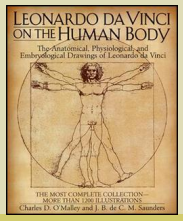
1

FCDS ANNUAL CONFERENCE

ST. PETERSBURG, FLORIDA

STEVEN PEACE, CTR

JULY 30, 2015



Objectives

2

Provide an Overview and Introduction to SEER Summary Stage 2000 concepts; review the format, content, and general instructions for how to use of the SEER Summary Stage 2000 manual; discuss advances in understanding of cancer as a disease process, cancer staging, treatment, imaging and new technologies that have occurred since the release of SEER Summary Stage 2000 that affect staging, but have not yet been incorporated into the SEER Summary Stage 2000 Manual, and discuss future updates and new directions for Summary Stage for 2016.

- ✓ Better understand the **why** of SEER Summary Stage
- ✓ Better understand the **how** of SEER Summary Stage
- ✓ Better understand the **need for a SS2016 Update**
- ✓ **Instruct registrars on correct use of SS2000 Manual**

To Download an electronic (PDF) copy of the SEER Summary Stage 2000 Manual go to http://www.seer.cancer.gov/tools/ssm

SEER Summary Staging Manual – 2000

Summary staging is the most basic way of categorizing how far a cancer has spread from its point of origin. Summary staging has also been called General Staging, California Staging, and SEER Staging. The 2000 version of Summary Stage applies to every anatomic site, including the lymphomas and leukemias. Summary staging uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

The manual provided here contains the codes and coding instructions for the summary stage field for cases diagnosed January 1, 2001 and forward. The North American Association of Central Cancer Registries has developed Guidelines for Implementation of SEER Summary Stage 2000.

The chapters of this manual are provided below as individual files and as a single PDF. The errata and updates have been incorporated into the complete manual and the individual PDF files.

Updates and Errata

- Updates to Manual and Files (12/2012) [105 KB]
- Errata (8/20/2002) [30 KB]
- Errata (6/14/2001) [21 KB]

Manual Sections

- Introduction to Summary Staging [52KB]
- Head and Neck [403 KB]
- Digestive System [769 KB]
- Respiratory Tract and Thorax [371 KB]
- Musculoskeletal System [173 KB]
- Breast and Female Genital System [274 KB]
- Male Genital System [195 KB]
- Urinary System [322 KB]
- Eye [108 KB]
- Brain and Central Nervous System [391 KB]
- Endocrine System [41 KB]
- Other Sites [90 KB – updated 12/2012]
- Appendices and Index [108 KB]

Complete SEER Summary Staging Manual – 2000 [3.5 MB – updated 12/2012]

Organization, Content, and Use Instructions

Outline

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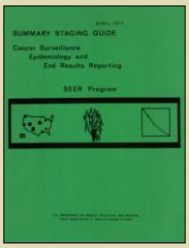
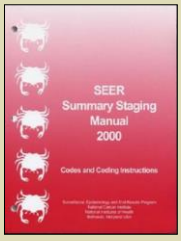
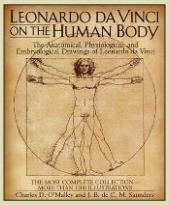
- (Re) Introduction to Summary Stage 2000
- Why Summary Stage? Scope? Limitations?
- Where do I locate "Stage" Information?
- Efforts to Synchronize Staging Systems
- Derived Versus Direct-Coded Stage
- Summary Stage 2000 Manual
- Summary Stage Instructions
- Summary Stage Guidelines
- PDF Manual Navigation
- Future Course
- Q&A







Vitruvian Man by Leonardo da Vinci

Introduction

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Image Source: www.commlawblog.com

Introduction

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- Why do we have Cancer Staging System(s)? What Purpose?
  - **Standardized Method(s) to Classify *"Extent of Disease"***
    (e.g. how far the tumor has spread from the body organ or site of origin – based on anatomy – also known as "Anatomic Staging").
  - Provide standard means to communicate disease characteristics
  - Provide metrics to ensure physicians adequately assess extent of cancer and use of this information to guide treatment planning
  - Provide standard indicators to assess prognosis for patients
  - Allow for easy identification of "high risk" patients and groups
  - Provide long-term stable, standard and meaningful measure to compare trends in stage at first diagnosis/presentation - over time
  - Provide standard metrics to allow programs to assess impact of public health interventions like cancer screening programs.

Introduction

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- Summary Staging is the most basic way of categorizing how far a cancer has spread from its point of origin to other parts of body.
- Summary Stage provides a standardized measure of anatomic extent of disease for cancer surveillance programs with longitudinal stability for population-based cancer registries.
- Summary Stage applies to every anatomic site - includes staging criteria for lymphoid and myeloid neoplasms and for pediatrics.
- Summary Stage **allows use of all information available** in the medical record; it is a *combination of* the most precise ***clinical and pathologic*** documentation of *extent of disease*.

SEER Summary Staging Manual - 2000: Codes and Coding Instructions NIH Pub. No. 01-4969, Bethesda, MD, 2001

Why Summary Stage

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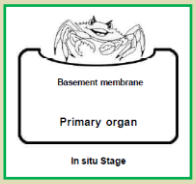
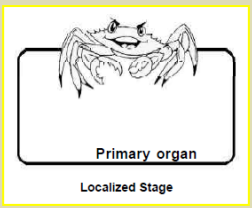
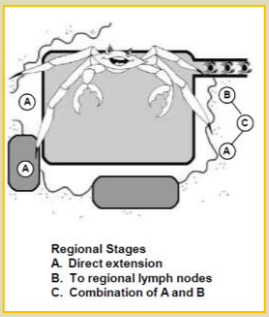
- ✓ Basis of Summary Stage has not changed since the 1950s.
- ✓ Basic Concepts of in-situ, local, regional, and distant stage and definitions are "frozen in time" to allow assessment of long-term trends without edition-to-edition variation that confounds trend analysis using multiple editions as in TNM.
- ✓ Summary Stage applies to every anatomic site, including lymphoid and myeloid neoplasms (lymphoma and leukemia).
- ✓ Summary Stage also can be applied to pediatric cancers.

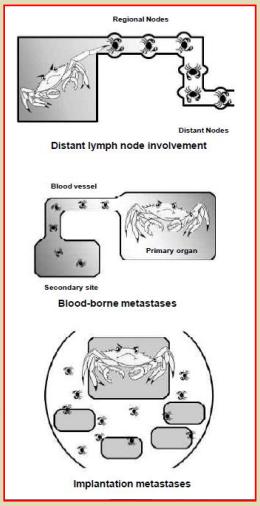
Why Summary Stage





Purpose of Staging
Biochemical Tumor Markers
Molecular Tumor Markers
Genetic Mutations/Variations
Risk Stratification





Source: SEER Summary Staging Manual 2000

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Scope of Summary Stage 2000

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- Basic Understanding of How Cancer Spreads Has Not Changed
  - Benign Neoplasm
  - Borderline Malignant Neoplasm
  - Non-Invasive or In-Situ Neoplasm
  - Invasive Neoplasm
    - Local Invasion
    - Loco-Regional Extension
    - Lymphatic System Spread
    - Blood Circulatory System Spread
    - Intracavitary Metastatic Seeding of Tumor

Registrars already know how to apply anatomic staging principles.

You have been locating and coding anatomic stage information in fine detail for Collaborative Stage. You just need to learn how to use and follow the SS Manual Instructions and Guidelines.

- Scientific and Technological Progress and the rapid pace of new discovery has forced standardized anatomy-based cancer staging concepts beyond the scope/intent of the original methodology.

Limitations

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- Based on tumor, node, metastasis concept for staging cancer
- Does not incorporate last 15 years of discovery in medicine
  - Cause
  - Histology
  - Proteomics
  - Clinical Factors
  - Immunophenotype
  - Biochemical Markers
  - Stage of Differentiation
  - Other Prognostic Factors
  - Molecular Tumor Markers
  - Genotype/Genomic Variants
  - Historically Non-Invasive Cancers Had Limited Impact
  - Cancer Screening Factors have changed expected stage at dx
  - Treatment Approach has changed immensely based on other factors
  - Differentiate finer levels of primary tumor extension and nodal involvement
  - More learned to locate and assess sentinel nodes and Lymph Vascular Invasion

Not Designed to Accommodate New Markers or Disease Characteristics that effect Treatment Options such as Neo-Adjuvant Therapies, Risk-Based Treatment Options or capturing Multiple Stages of Disease (i.e. clinical, surgical, neoadjuvant, recurrence, re-staging, etc.)

Limitations

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- SS2000 not up-to-date with WHO Classification of Diseases
  - Not all ICD-O-3 histology codes in use are included in SS2000
  - Instructions to point registrar to correct schema for "new" codes
  - No new *chapters* will be added until "*SS2016*" or later publication
- Backward Comparison Cross-Walks Lose Specificity Over Time
  - SS2000 to SS1977
  - AJCC TNM *ed. to AJCC TNM *ed.
  - Collaborative Stage to SS1977
  - Collaborative Stage to SS2000
  - Collaborative Stage to AJCC TNM 6th ed. (clin/path)
  - Collaborative Stage to AJCC TNM 7th ed. (clin/path)
  - Any Stage Directly Coded Compared to Computer-Derived
  - Any Old Staging System Compared to Any New Staging System

Limitations

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TNM and CS have evolved to meet current needs for anatomic staging with refinement of anatomic staging concepts, details, and the addition of new key factors (SSFs) for some cancers. Summary Stage is not and will never be 100% consistent with what is known today about fine details of anatomic staging + "SSFs".

System limitations and inconsistencies with current staging criteria are well known and are documented. Registrars do not need to debate, challenge or point out where these discrepancies exist. We are not asking you to test the system or to assess the value of SS2000 criteria or the staging system…but rather to use it "as is".

We are working to update staging resources, manuals and instructions based on original core anatomic staging concepts, but with refined, enhanced, corrected, or clarified criteria PLUS the addition of SSF-like data items to code strategic "SSFs".

Manual Instruction and Revision will be a higher priority than Manual Corrections.

Where do I find "Stage" Info?

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- Use Available/Complete Diagnostic Workup
- Priority Order – Pathological, Surgical, Clinical
- Clinicians will not document the Summary Stage
- You are looking for the same information as CS or TNM
- What is "early stage" and/or "late stage" and can I code this?
- Don't forget to DOCUMENT Positive and Negative Test Results!!!

Admission Note(s)	Diagnostic Imaging Report(s)	Treatment Records
History and Physical	Reports from Scopes and Scans	Specialty Lab Test/Markers
Discharge Summary	Operative Report(s)	Cancer Conference Notes
Consultation Report(s)	Pathology Report(s)	Physician Progress Note(s)
Cancer Screening Report(s)	Nuclear Medicine Report(s)	Expert Review/2nd Opinion

SS2000 / AJCC TNM / CS

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Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ, intraepithelial, noninvasive	Tis	Tis	IS	IS
050	(Adeno)carcinoma, noninvasive, in a polyp or adenoma	Tis	Tis	IS	IS
100	Invasive tumor confined to mucosa, NOS, including intramucosal, NOS	Tis	Tis	L	L
110	Invades lamina propria, including lamina propria in the stalk of a polyp	Tis	Tis	L	L
120	Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp	Tis	Tis	L	L
130	Confined to head of polyp, NOS	T1	T1	L	L
140	Confined to stalk of polyp, NOS	T1	T1	L	L
150	Invasive tumor in polyp, NOS	T1	T1	L	L
160	Invades submucosa (superficial invasion), including submucosa in the head or stalk of a polyp	T1	T1	L	L
170	Stated as T1 with no other information on extension	T1	T1	L	L
200	Muscularis propria invaded Stated as T2 with no other information on extension	T2	T2	L	L

In Situ = 0

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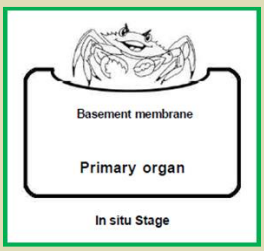
- No potential to metastasize
- No invasion of the basement membrane
- In Situ Stage can only determined by a pathologist
- No evidence of invasion, extension, or nodal involvement
- No lymph-vascular invasion
- No foci of invasion
- No micro-invasion

- Caution with breast cases
- Caution with bladder cases
- Caution with cancer in polyps
- Caution with high grade dysplasia



Localized = 1

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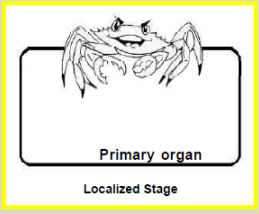
- Cancer has some potential to metastasize
- Cancer must be confined to the organ of origin
  1. Rule out in situ – is there any invasion?
  2. Rule out distant – are there any distant metastasis?
  3. Rule out regional – is there any nodal involvement?
  4. Rule out regional – is there any extension through the wall of the organ of origin, into adjacent tissue or regional organ(s)?

- Caution with hollow organs
- Caution with adjacent organs
- Know layers of the wall of organ
- Understand that LVI is not regional



Regional = 3, 4, or 5

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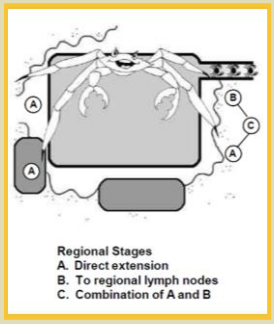
- Neoplasm has greater potential to metastasize via direct extension
- Neoplasm demonstrated it can metastasize via regional lymphatics
- **…or both…**

- Caution with anatomy
- Caution with micro-anatomy
- Caution with regional lymphatics
- Caution with micro-lymphatic disease
- Caution with greater lymphatics drainage
- Caution with insufficient workup to stage
- Caution with clinically positive nodes



Distant = 7

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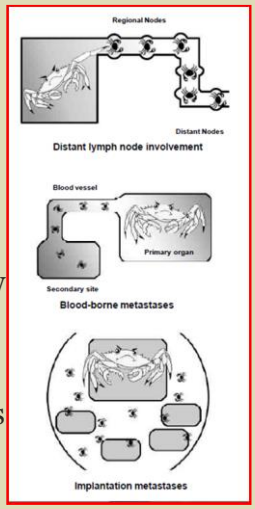
- Neoplasm demonstrating metastatic potential
  - Can be clinically diagnosed metastasis
  - Can be biopsy-proven metastasis

- Direct extension – very large tumor
- Lymphatics – distant lymph nodes
- Blood – blood-born – lung/liver/bone marrow
- Pleural Cavity Seeding – pleural effusion
- Peritoneal Cavity Seeding – malignant ascites
- Peritoneal Cavity Seeding – implantation mets

- Caution – may not have complete workup



Unknown Stage = 9

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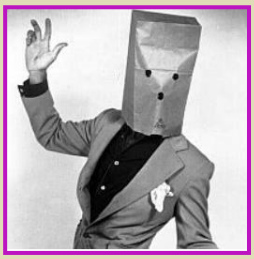
- Insufficient information available to stage the case
- No physician statement about extent of disease
- No documentation of TNM or other stage

- Incomplete Workup due to comorbidity
- Incomplete Workup due to refusal
- Incomplete Workup due to death



- Caution – when you have enough information in the chart to determine the case is not in situ and not distant but somewhere in-between…you should be able to stage the case – regardless.

Murray Langston as "The Unknown Comic" from The Gong Show

Downstage Principle

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The Downstage Principle has been applied to all registry staging including; Summary Stage, AJCC TNM and Collaborative Stage

- AJCC TNM Downstage: "When there is doubt concerning the T, N, or M classification to which a particular case should be assigned, then the lower (less advanced) category should be assigned."
- Collaborative Stage Downstage: "The general rules of CS say to assign the highest applicable code. This is not a contradiction of the TNM downstaging principle. The TNM downstaging principle had already been applied during the development of the CS code structure. The downstaging rule was not applied to stage group."

Benign/Borderline Brain and CNS Tumors

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= 8

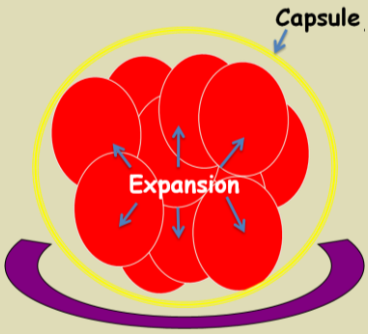

Image Source: wordpress.com

Derived vs. Direct-Coded

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- 1/1/2016 Collaborative Stage Data Collection No Longer Supported
- Direct Coding by Registrars is highly accurate and reproducible.
- Direct Coding of Summary Stage and TNM (clinical and pathologic) will introduce new interpretation error as schema not as exact as CS
- Must select the correct schema to make the correct assignment.
- Direct-Coded Summary Stage for all NPCR Registries 1/1/2016.
- SEER developing "derived SS2016" based on TNM or other factors

Requirements – Direct Coding

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- **CDC/NPCR:** Starting with 2015 diagnoses, NPCR will require all state registries to collect directly coded SS2000 from all facilities. In 2016, all facilities must submit AJCC and SS to their state registries (in NPCR states). NPCR will provide additional information regarding possible exceptions for registries who may limit stage to directly coded SS2000.
- **NCI/SEER:** All cases diagnosed in 2016 and after are expected to be staged using directly assigned AJCC stage. Both pathologic and clinical TNM will be collected when available. A consolidated "best stage" will be derived from the two staging results as has been done previously.
- **CoC:** All cases with defined AJCC T, N, M and/or Stage Group will continue to be directly coded using those definitions, both clinically and pathologically. CS coding will remain in effect with no changes in rules for all cases diagnosed through December 31, 2015.

Requirements – Direct Coding

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- Summary Stage should include *all information available through completion of surgery(s)* in the 1st course of treatment *or within 4 months of diagnosis in absence of disease progression*, whichever is *longer*.
- Disease progression *is defined as further direct extension, regional node involvement, or distant metastasis known to have developed after the diagnosis was established.*
- The rules for each staging scheme (chapter) must be reviewed and followed for each site/histology. Refer to the SS2000 Manual for a list of sites or histologies for which each staging scheme applies. Updates pending.
- Micro-Invasion *implies invasion through the basement membrane (an anatomic landmark), indicating the tumor behavior is invasive (/3) not in-situ (/2). Micro-invasion is not the same as Lymph Vascular Invasion.*

Summary Stage 2000 Manual

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TABLE OF CONTENTS

NOTE: The site-specific schemes in this manual are in ICD-O-3 order, with a few exceptions. If a site or subsite is not found in the table of contents or index, determine the ICD-O-3 code and locate the site sequentially.

Summary Stage 2000 Manual

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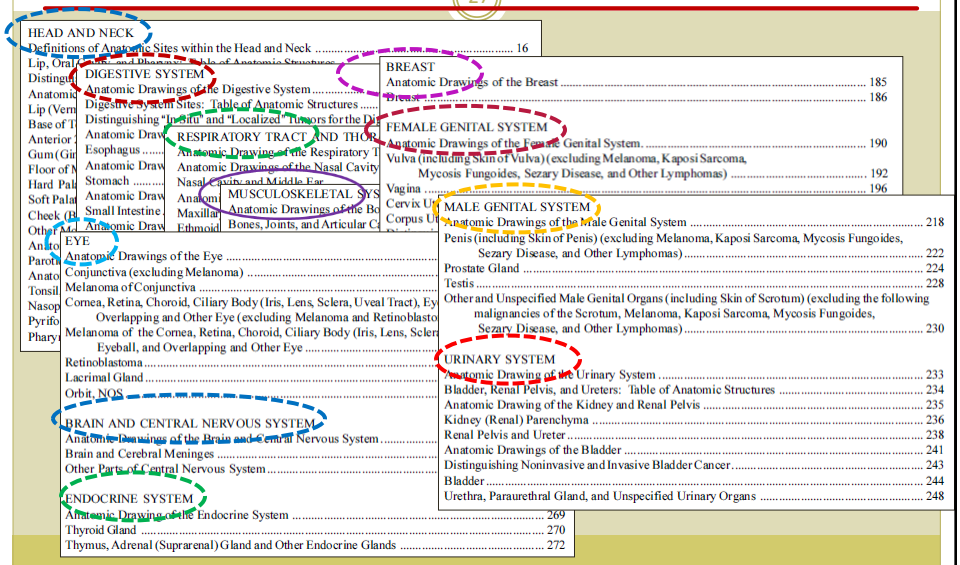

Summary Stage 2000 Manual

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4 Basic Questions

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1. Where did the cancer start (primary site)?
2. Where did the cancer go (how far did it spread)?
3. How did the cancer get to the other organ or structure?
4. What is the Summary Stage and Code for this cancer?

- Will add in Site Specific Factors but not for SS2000.

Using the Manual

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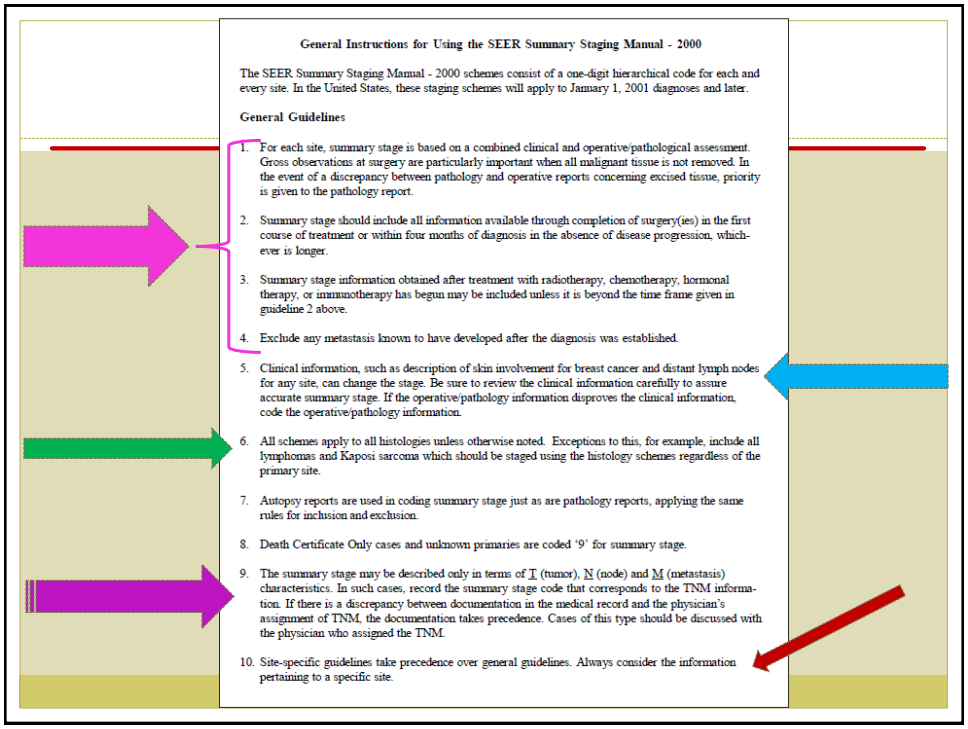
1. Open or Search the SEER Summary Staging Manual 2000 to identify the staging scheme that includes the ICD-O-3 primary site (topography) and/or histology code identified earlier.
2. Staging schemes for all primary sites are in ICD-O-3 code order with the exception of those that are based on histology.
3. Review the staging scheme looking for the names of the structures and organs that were reported as involved.
4. If more than one structure or organ is involved, select the highest category that includes an involved structure.



General Instructions for Using the SEER Summary Staging Manual - 2000

The SEER Summary Staging Manual - 2000 schemes consist of a one-digit hierarchical code for each and every site. In the United States, these staging schemes will apply to January 1, 2001 diagnoses and later.

General Guidelines

1. For each site, summary stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.
2. Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.
3. Summary stage information obtained after treatment with radiotherapy, chemotherapy, hormonal therapy, or immunotherapy has begun may be included unless it is beyond the time frame given in guideline 2 above.
4. Exclude any metastasis known to have developed after the diagnosis was established.
5. Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the stage. Be sure to review the clinical information carefully to assure accurate summary stage. If the operative/pathology information disproves the clinical information, code the operative/pathology information.
6. All schemes apply to all histologies unless otherwise noted. Exceptions to this, for example, include all lymphomas and Kaposi sarcoma which should be staged using the histology schemes regardless of the primary site.
7. Autopsy reports are used in coding summary stage just as are pathology reports, applying the same rules for inclusion and exclusion.
8. Death Certificate Only cases and unknown primaries are coded '9' for summary stage.
9. The summary stage may be described only in terms of T (tumor), N (node) and M (metastasis) characteristics. In such cases, record the summary stage code that corresponds to the TNM information. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.
10. Site-specific guidelines take precedence over general guidelines. Always consider the information pertaining to a specific site.

Guidelines

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Three summary stage groups can be ruled out quickly: in situ, distant, and localized

FIRST

In situ

1. Rule out in situ stage disease. Carcinomas and melanomas are the only types of cancer that can be classified as in situ. Only carcinomas have a basement membrane. Sarcomas are never described as in situ. A pathologist must examine the primary organ and state that the tumor is in situ. If the cancer is anything except a carcinoma or melanoma, it cannot be in situ.
2. If there is any evidence of invasion (or extension to), nodal involvement or metastatic spread, the case is not in situ even if the pathology report so states. This is a common error in staging cervical cancer where the path report states that the cancer is "in situ with microinvasion"—such a case would be staged as localized.

Guidelines

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Three summary stage groups can be ruled out quickly: in situ, distant, and localized

SECOND

Distant

3. Rule out distant disease. If metastases can be documented, there is no need to spend a great deal of time identifying local or regional spread. If distant metastases are recorded on x-ray or needle biopsy, the stage is already determined and the patient does not need to undergo a lot of other tests.
4. Hematopoietic diseases, such as leukemia and multiple myeloma, are considered disseminated or distant at time of diagnosis.
5. Rule out distant spread by reading the operative report for comments about seeding, implants, liver nodules, or other indications of metastases. Read diagnostic reports for references to distant disease.
6. If nodes, organs, or adjacent tissues are not specifically mentioned in the description of the various categories, attempt to cross-reference the term you have with those outlined. If there is no match, assume the site in question represents distant disease.

Guidelines

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Three summary stage groups can be ruled out quickly: in situ, distant, and localized

THIRD

Localized

7. Rule out that the cancer is "confined to the organ of origin." In order for a lesion to be classified as localized, it must not extend beyond the outer limits of the organ and there must be no evidence of metastases anywhere else.
8. Terms such as "blood vessel invasion" or "perineural lymphatic invasion" do not necessarily indicate that the cancer has spread beyond the primary organ. If tumor at the primary site has invaded lymph or blood vessels, there is the potential for malignant cells to be transported throughout the body. Step 1 (invasion), has occurred, but not necessarily steps 2 (transport of cancer cells) and 3 (growth at the secondary site). The case may still be localized.
9. Vascular invasion within the primary is not a determining factor in changing the stage unless there is definite evidence of tumor at distant sites.

Guidelines

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Three summary stage groups can be ruled out quickly: in situ, distant, and localized

FINAL (if needed)

Regional

10. If in situ, local and distant categories have been ruled out, the stage is regional.
11. For carcinomas, if there are lymph nodes involved with the tumor, the stage is at least regional.
12. For tissues, structures, and lymph nodes, assume ipsilateral unless stated to be contralateral or bilateral.

Unknown if Extension or Metastasis

13. If there is not enough information in the record to categorize a case, it must be recorded as unstageable.

Colon Example

The Colon Scheme is within the Digestive System Chapter

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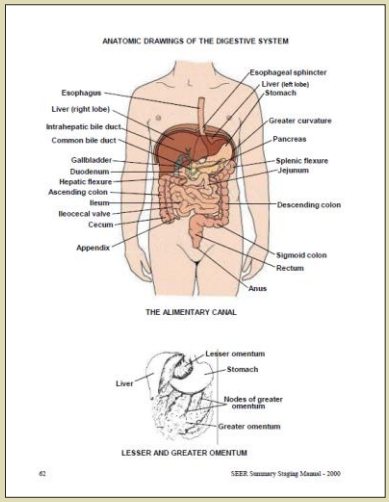

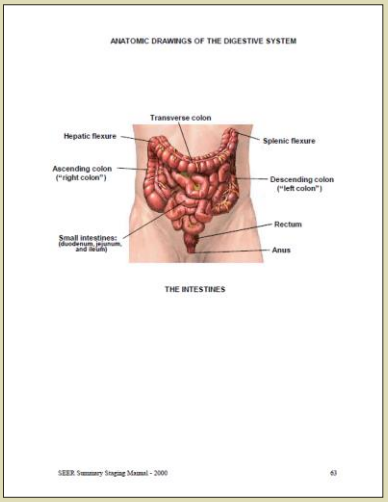

Colon Example

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DIGESTIVE SYSTEM SITES
TABLE OF ANATOMIC STRUCTURES

PRIMARY SITE	MUCOSA			SUB-MUCOSA	MUSCU-LARIS	SUB-SEROSAL TISSUES	SEROSA	OUTSIDE THE SEROSA[1]
	Epi-thelium	BASEMENT MEMBRANE	Lamina Propria / Muscu-laris					
Esophagus (C15.)	Yes	B	Yes Yes	Yes	Yes	See note 4.	No	See note 4.
Stomach (C16.)	Yes	A	Yes Yes	Yes	Yes	No	Yes	Greater and lesser omentum
Sm Intestine (C17.)	Yes	S	Yes Yes	Yes	Yes	No	Yes	Mesentery of small intestine
Colon (C18._)	Yes	E	Yes Yes	Yes	Yes		Yes	
.0 Cecum	Yes	N	Yes Yes	Yes	Yes	Yes	Yes	
.1 Appendix	Yes	T	Yes Yes	Yes	Yes	Yes	Yes	
.2 Ascending	Yes	M	Yes Yes	Yes	Yes	No	See note 5.	Mesenteric or pericolic fat
.3 Hepatic flex.	Yes	E	Yes Yes	Yes	Yes	Yes	Yes	
.4 Transverse	Yes	M	Yes Yes	Yes	Yes	Yes	Yes	
.5 Splenic flex.	Yes	B	Yes Yes	Yes	Yes	Yes	Yes	
.6 Descending	Yes	R	Yes Yes	Yes	Yes	No	See note 5.	
.7 Sigmoid	Yes	A	Yes Yes	Yes	Yes	Yes	Yes	
.8 Overlapping	Yes	N	Yes Yes	Yes	Yes		Yes	
.9 Colon, NOS	Yes	E	Yes Yes	Yes	Yes			
Rectosigmoid (C19.9)	Yes		Yes Yes	Yes	Yes	Yes	Yes	Mesenteric or pericolic/ perirectal fat
Rectum (C20.9)	Yes		Yes Yes	Yes	Yes	No	No	See note 6.

DISTINGUISHING "IN SITU" AND "LOCALIZED" TUMORS FOR THE DIGESTIVE SYSTEM

Careful attention must be given to the use of the term "confined to mucosa" for the esophagus, stomach, small intestine, colon and rectum.

Historically, carcinomas described as "confined to mucosa" have been coded as localized. In order to provide greater specificity and to rule out the possibility of classifying noninvasive tumors in this category, abstractors should determine:

1) if the tumor is confined to the epithelium, in which case it is in situ, **OR**

2) if the tumor has penetrated the basement membrane to invade the lamina propria, in which case it is localized and is coded to invasion of the lamina propria.

The mucosa of the digestive tract consists of:

The EPITHELIAL LAYER borders on the lumen. It contains no blood vessels or lymphatics.

The BASEMENT MEMBRANE, a sheet of extracellular material, functions as a filtration barrier and a boundary involved in generating and maintaining tissue structure.

The LAMINA PROPRIA, composed of areolar connective tissue, contains blood vessels, nerves, and, in some regions, glands. Once tumor has broken through the basement membrane into the lamina propria, it can spread by way of the lymphatics and blood vessels to other parts of the body.

The MUSCULARIS MUCOSAE is a thin layer of smooth muscle fibers. It is found in the wall of the digestive tract from the esophagus to the anal canal.

The SUBMUCOSA is a thick layer of either dense or areolar connective tissue. It contains blood vessels, lymphatic vessels, nerves, and, in some regions, glands.

The MUSCULARIS PROPRIA is a double layer of muscle tissue in most of the digestive tract. It supports the wall of the organ.

The SEROSA, the outermost layer covering most of the digestive tract, is a single layer of squamous epithelial cells, part of the visceral peritoneum. Just inside the serosa (mesothelium), and sometimes considered part of the serosa, is a layer of connective tissue called the subserosa. The serosa and subserosa are present only in the peritonealized portions of the digestive tract. For the esophagus and in the rectum below the peritoneal reflection, there is no serosa. For the esophagus, the connective tissue of surrounding structures merges with the connective tissue of the esophagus and is called ADVENTITIA.

Colon Example

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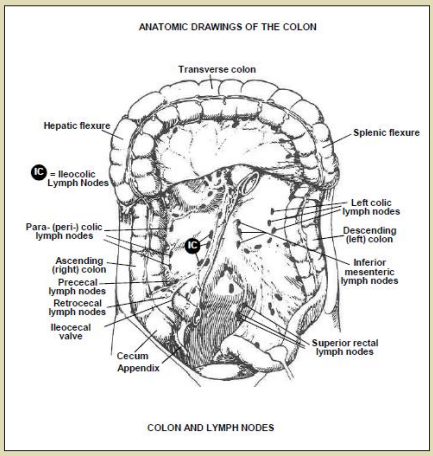
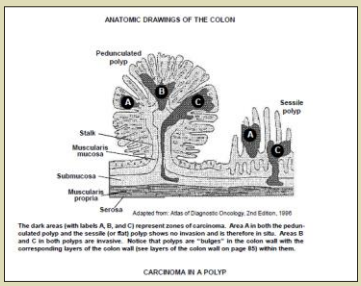
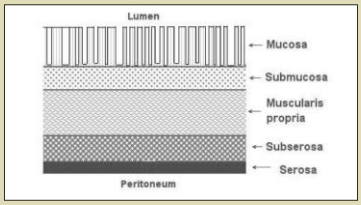


COLON AND LYMPH NODES



CARCINOMA IN A POLYP



Colon Example

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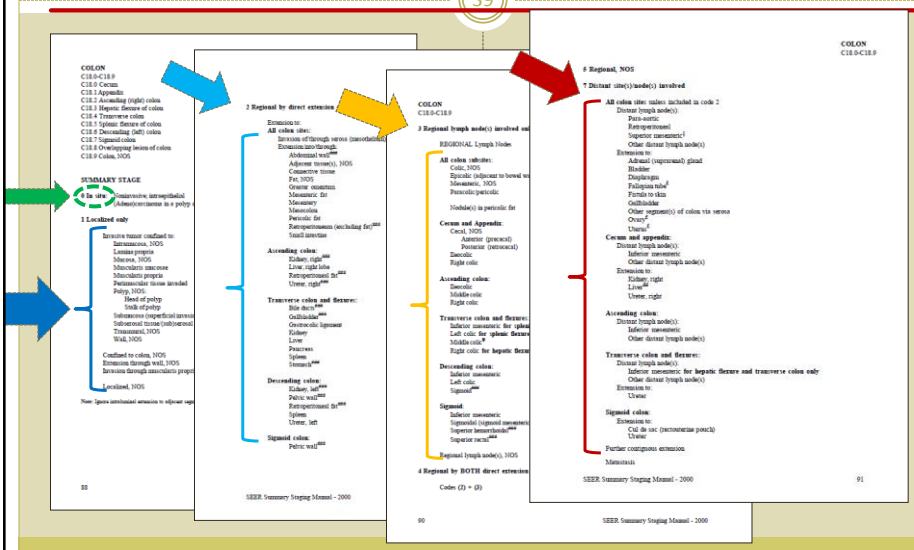

Navigation Demo

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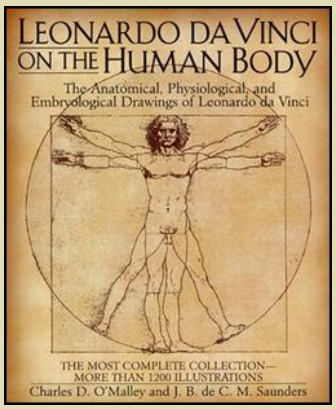

Future Vision

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Future Vision

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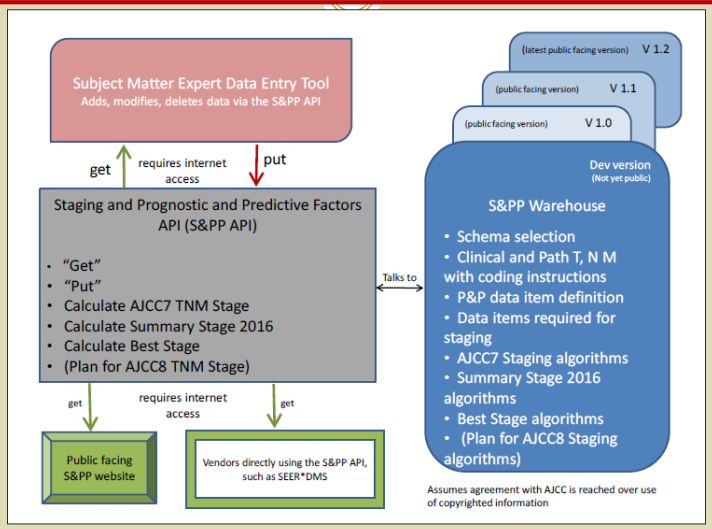

Future Vision

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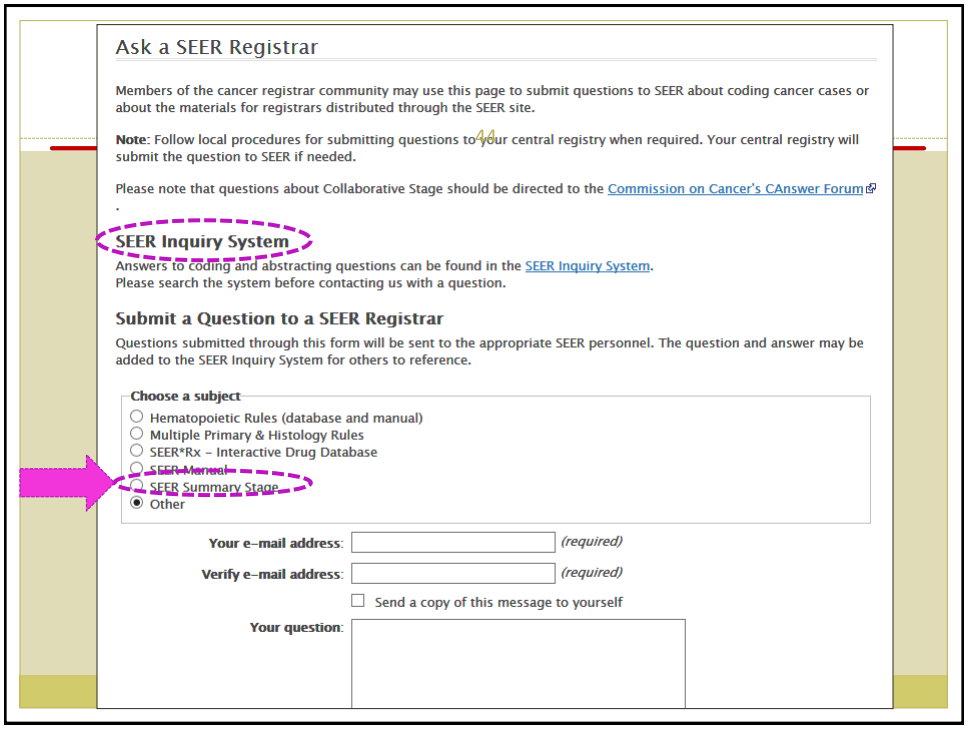
Development of Summary Stage 2016

Purpose: To develop and test a system that will permit staging over time consistent with the change to TNM staging. The intent is to create a system that will allow post hoc recoding for the analysis of time trends since 1988 (and possibly further back). NCI SEER is currently thinking that without CS we will not be able to continue to collect older staging systems. We are therefore investigating the idea of a new summary stage that will be based on TNM and will not require a separate stage collection, but can be calculated by the software from the data elements. It is



Questions

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Ask a SEER Registrar – Subject: Summary Stage
http://seer.cancer.gov/registrars/contact.html