Indiana Department of Health

MONTHLY WEBINAR: ABSTRACTING ESOPHAGUS AND STOMACH CANCERS

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AGENCY PRIORITIES

1. Improve Maternal and Infant Health Outcomes

2. Prevent Chronic Disease

3. Strengthen Data Quality and Transparency

About the presenter

Kelsi Fryauf-Perkins



The Indiana Department of Health (IDOH) has contracted with Registry Partners Incorporated (RPI) to fill the role of educational coordinator for the State of Indiana. RPI and IDOH have a longstanding relationship and collaborated to bring in RPI's Kelsi Fryauf-Perkins as educational coordinator for IDOH.

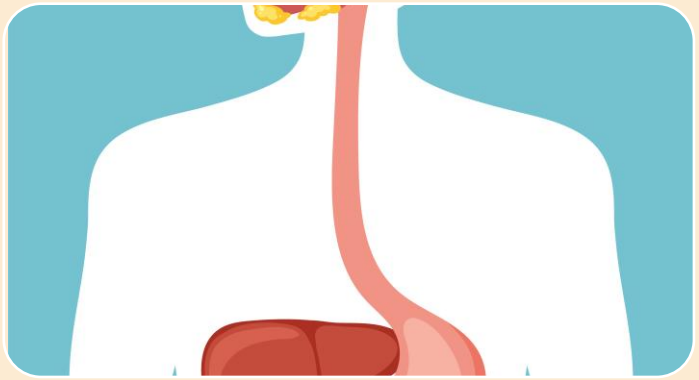
Kelsi holds a Bachelor of Science degree in Human Anatomy and Physiology and brings over a decade of experience in the cancer registry field. Kelsi began her career at the Iowa Central Cancer Registry, where she served as an Analyst from 2015 to 2020. Driven by a passion for continuous learning and growth she transitioned to hospital-accredited programs and joined Registry Partners in April 2020, where she is currently serves as Director, Quality and Education Programs, Oncology Services. In her current role, Kelsi serves as a subject matter expert in data abstraction, overseeing quality control processes and contributes to education program curricula. Kelsi is also working with the Indiana Central Registry to assist in the processes of quality control, case consolidation and maintenance of the policy and procedure manual. She has worked with all types of facilities across the US, from Hawaii to Massachusetts, and has experience with a variety of cancer registry software and electronic medical records.

Kelsi lives in West Branch, Iowa with her husband and two children.

Objectives

- Review anatomy and physiology of the esophagus, stomach and regional structures
- Identify how anatomy correlates to staging principles
- Assign primary site and histology
- Discuss schema discriminators and SEER Summary Stage
- Assign SSDIs
- Review Treatment
- Case Scenarios

Anatomy of Esophagus and Stomach



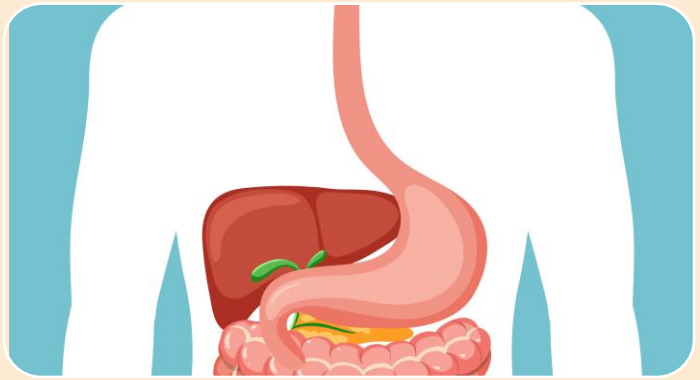
Esophagus

Muscular tube from hypopharynx to stomach about 10 in/ 25 cm long.

Posterior to trachea and heart and passes through mediastinum and hiatus

No serosal layer

Two sub site descriptions which are not equivalent



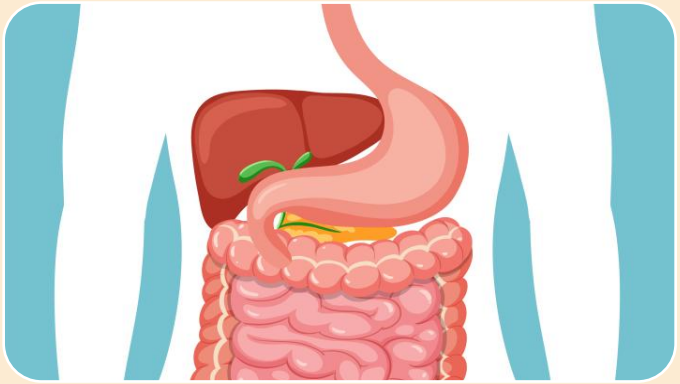
Stomach

Muscular organ located on the left side of the upper abdomen just below the diaphragm

Hollow and J-shaped and most dilated part of the digestive system

Lies between the cardiac and pyloric orifices

The pylorus of the stomach connects the opening of the duodenum



Regional Structures

Surrounding esophageal tissue is adventitia overlying the subserosal fat

Esophageal regional structures and LNs depend on tumor location

Stomach is suspended by lesser omentum and attaches to regional structures by greater omentum

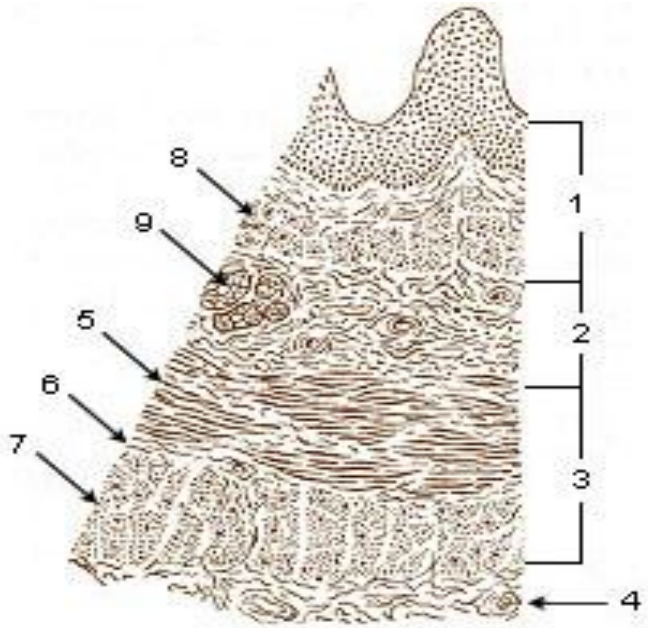
Hepatic, celiac artery and gastric nodes are regional for stomach

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Source: SEER Anatomy Training

Image Source

Anatomy of Esophagus and Stomach



Layers of Esophagus

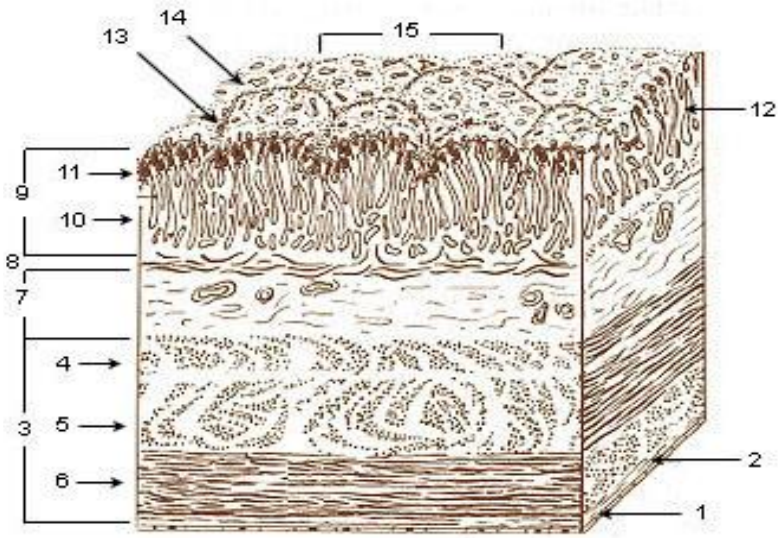
Mucosa*

Submucosa

Muscularis

Adventitia

*Mucosa NOS = /3



Layers of Stomach

Gastric Surface

Mucosa

Submucosa

Smooth Muscle (3 layers)

Muscularis

Serosa

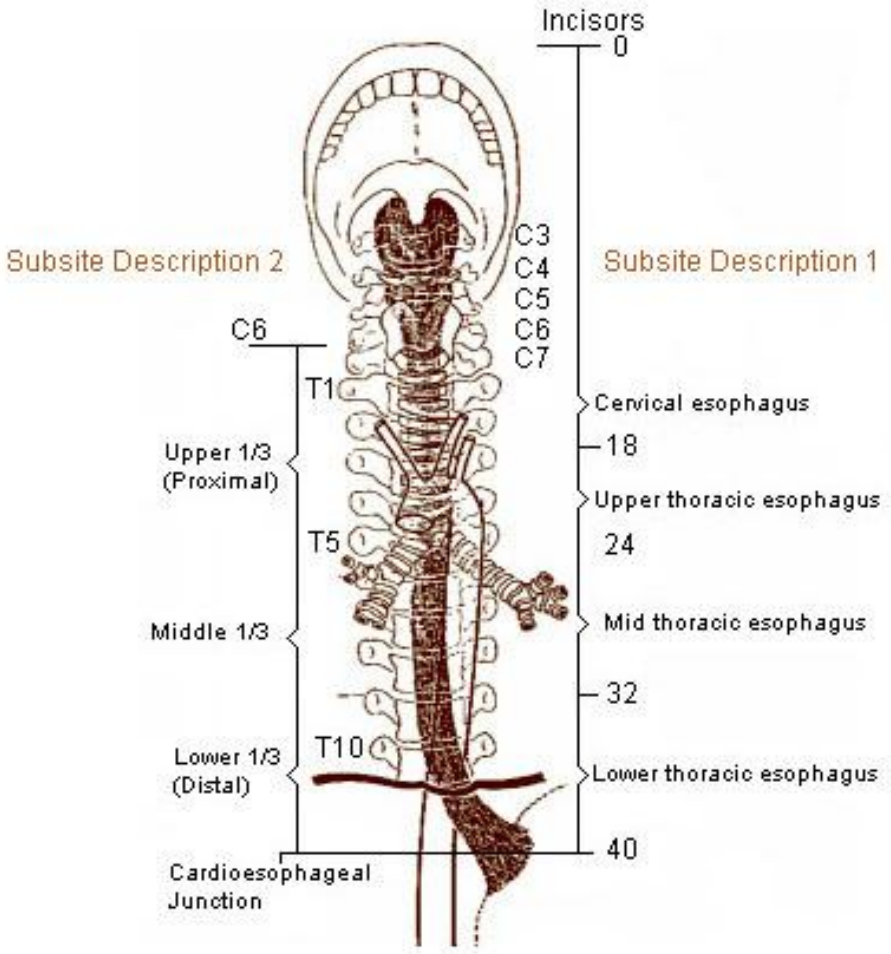
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Source: SEER Anatomy Training

Image Source

Anatomy and Primary Site

Subsite 2	Primary Site	Primary Site	Subsite 1
Upper third Proximal third • *15-24 cm*	C15.3	C15.0	Cervical Esophagus • *15-19 cm*
Middle third • *25-29 cm*	C15.4	C15.1	Thoracic Esophagus • *20-39 cm*
Lower third Distal • *30-39 cm*	C15.5	C15.2	Abdominal Esophagus • *40-45 cm*
GE Junction • *40-45 cm*	C16.0		



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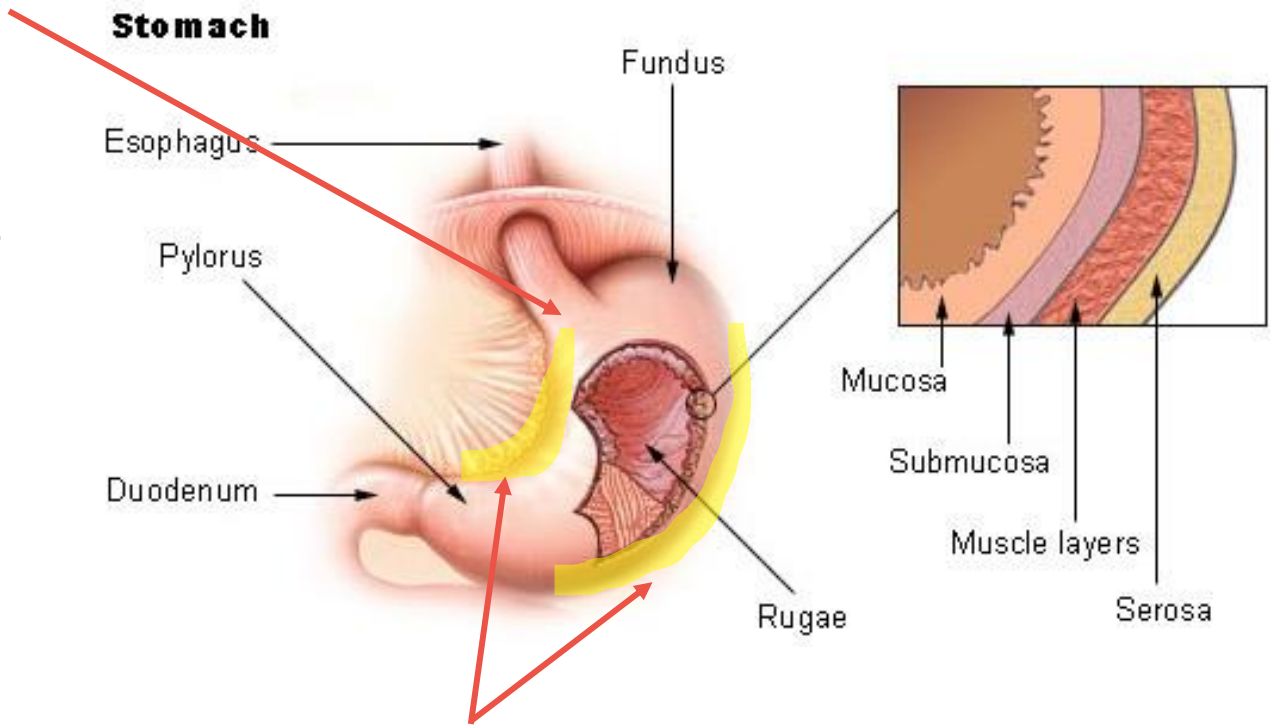
Source: SEER Anatomy Training and https://training.seer.cancer.gov/ugi/anatomy/esophagus.html

Anatomy and Primary Site

Four main regions:

- Cardia (C16.0)→ Esophagus connects to stomach
  - Gastroesophageal (GE) junction
- Fundus (C16.1)→ Above and to the left of cardia
- Body (C16.2)→ Below fundus
- Pylorus (C16.4) → Connects stomach to duodenum (small intestine)

Pyloric antrum, gastric antrum C16.3



Lesser (C16.5) and Greater Curvatures (C16.6)

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Source: SEER Anatomy Training

Image Source

Schema Discriminators

Schema Discriminator 1

Criteria met when Primary Site = c16.0

- Used to assign AJCC ID
- Tumors with midpoint (epicenter) in GE junction staged as Esophagus
- Tumors with midpoint (epicenter) in cardia/stomach staged as Stomach

Schema Discriminator 2

Criteria met when histology = 8020/3

- Used to determine AJCC Stage Group table use
- Undifferentiated carcinoma with squamous component staged in Squamous Cell Carcinoma table
- Undifferentiated carcinoma with glandular component staged in Adenocarcinoma table

When criteria is not met, schema discriminators are blank

Source: Solid Tumor Rules 2026.1

Test Your Knowledge

Assign the primary site and schema discriminator 1 for the following scenarios:

1. EGD with finding of mucosal esophageal mass at 24-29 cm. CT shows mass like thickening at middle esophagus.
   - Primary Site: C15.3 Schema Discriminator 1: Blank
2. Fungating mass at GE junction, circumferential on the gastric side, suspicious for gastric malignancy. No invl of esophagus.
   - Primary Site: C16.0 Schema Discriminator 1: 1
3. Endoscopy shows ulcerative lesion measuring 2.3 cm at the fundus extending to cardia. On resection, tumor measures 3.5 cm adjacent to cardia at the fundus
   - Primary Site: C16.1 Schema Discriminator 1: Blank

Source: SEER Anatomy Training and https://training.seer.cancer.gov/ugi/anatomy/esophagus.html

Rationale

- Use all information available in the medical record
- Code where the site originated, even if it extends to adjacent subsite
- Code the last digit to 8 when a single tumor overlaps two subsites and point of origin cannot be determined
  - i.e. Cervicothoracic esophagus NOS = C15.8.
- Do not record primary site based on Schema Discriminator or SSDI coding of tumor epicenter

Tumors that involve the esophagogastric junction with their tumor epicenter **>2 cm** into the proximal stomach are staged as stomach

DO NOT CHANGE PRIMARY SITE FOR STAGING PURPOSES

Source: SEER Manual 2026 and NAACCR Webinar 2025

Esophageal Cancer Signs and Symptoms

- Trouble Swallowing (Dysphagia)
- Chest pain Heartburn
- Weight loss
- Voice Hoarseness
- Chronic cough
- Vomiting after eating
- Fatigue
- Bone pain from metastatic disease
- Blood in vomit
- Black/tarry stool

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Source: American Cancer Society

Stomach Cancer Signs and Symptoms

- Poor appetite
- Unintentional weight loss
- Abdominal pain
- Early satiation
- Heartburn or indigestion
- Nausea and vomiting (with or without blood)
- Abdominal swelling or fluid build-up
- Blood in stool (black/tarry)
- Fatigue or weakness (anemia)
- Jaundice

Indiana Department of Health

Source: American Cancer Society

Workup

Medical History and PE

Upper Endoscopy

- Flexible scope with camera to help diagnose and biopsies may be taken
- May also be called Esophagogastroduodenoscopy (EGD)

Endoscopic Ultrasound (EUS)

- Performed during the endoscopy to evaluate nearby structures
- Often provides tumor size and depth of invasion information!

Imaging

- CT/MRI/PET
- Barium Swallow to show abnormal areas if patient has dysphagia

Lab Testing

- CBC
- HER2
- MMR and MSI
- PD-L1

Referral to Gastroenterology or GI

Source: American Cancer Society

Esophagus Histology

Specific or NOS Term, Code, and Synonym(s)	Subtype(s) and Variant(s)
Adenocarcinoma NOS **8140** • Adenocarcinoma in situ (/2)	
Adenoid cystic carcinoma **8200**	
Adenosquamous carcinoma **8560**	
Gastrointestinal stromal tumor **8936*** • GANT • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal sarcoma • GIST • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Mixed neuroendocrine-non-endocrine neoplasm **8154** (/3)** • MiNEN	*See Solid Tumor Rules 2026.1 for full list*

Esophagus Histology

Specific or NOS Term, Code, and Synonym(s)	Subtype(s) and Variant(s)
Mucoepidermoid carcinoma **8430**	
Mucosal melanoma **8720** (/3)	
Neuroendocrine carcinoma **8246** (/3)	Large cell neuroendocrine carcinoma **8013** (/3) Small cell neuroendocrine carcinoma **8041** (/3)
Neuroendocrine tumor **8240** (/3) • NET • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249** (/3) • Neuroendocrine tumor, grade 3
Squamous cell carcinoma **8070** • Squamous carcinoma • Squamous cell carcinoma, usual type • Squamous cell carcinoma in situ (/2)	Basaloid squamous cell carcinoma **8083** Squamous cell carcinoma, spindle cell **8074** • Squamous cell carcinoma, sarcomatoid Verrucous squamous cell carcinoma **8051**
Undifferentiated carcinoma **8020 (/3)**	*See Solid Tumor Rules 2026.1 for full list*

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Source: Solid Tumor Rules 2026.1

Solid Tumor Rules Notes

Important!

Reportable Tis Neoplasms [2022+]

- Intraepithelial neoplasia (dysplasia), high grade (8148/2)*
  - *Esophageal intraepithelial neoplasm, high grade is reportable and assigned as 8142/2 per rules H4/H26
- High-grade dysplasia in an adenomatous polyp (8210/2)
- High-grade intestinal type adenoma (8144/2)

Coding notes for Stomach:

- When both the Lauren Classification and Classification of Tumours histologies are stated, code the Classification of Tumours diagnosis.
  - Exception: If the Classification of Tumours diagnosis is adenocarcinoma NOS and the Lauren Classification indicates a more specific type, code the specific histology.
- When multiple subtype/variants of adenocarcinoma are identified, code adenocarcinoma, mixed subtypes 8255.

Stomach Histology

Specific or NOS Term, Code, and Synonym(s)	Subtype(s) and Variant(s)
Adenocarcinoma NOS **8140** • Adenocarcinoma of fundic gland type • Paneth cell carcinoma* • Adenocarcinoma in situ (/2)	Adenocarcinoma, diffuse type **8145** (/3) Adenocarcinoma, intestinal type **8144** (/3) • Intestinal type adenoma, high grade (/2) Hepatoid adenocarcinoma **8576** Medullary carcinoma with lymphoid stroma **8512** Micropapillary carcinoma **8265** Mucinous adenocarcinoma **8480*** Mucoepidermoid carcinoma **8430** Papillary adenocarcinoma **8260** Parietal cell carcinoma **8214** Signet ring cell carcinoma **8490**** • Poorly cohesive carcinoma Tubular adenocarcinoma **8211**
Adenomatous polyp, high grade **8210** (/2) • Adenocarcinoma in situ in adenomatous polyp • Adenomatous polyp, high grade dysplasia	
Adenosquamous carcinoma **8560**	*See Solid Tumor Rules 2026.1 for full list*

Stomach Histology

Specific or NOS Term, Code, and Synonym(s)	Subtype(s) and Variant(s)
Gastrointestinal stromal tumor **8936***** • GANT • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal sarcoma • GIST • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Glandular intraepithelial neoplasia, high grade **8148** (/2) • Glandular intraepithelial neoplasia, grade III	
Mixed adenoneuroendocrine carcinoma **8244** (/3) • Combined carcinoid and adenocarcinoma • Composite carcinoid • MANEC • Mixed carcinoid and adenocarcinoma	
Mixed neuroendocrine-non-endocrine neoplasm **8154** (/3)**** • MiNEN	*See Solid Tumor Rules 2026.1 for full list*

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Source: Solid Tumor Rules 2026.1

Stomach Histology

Specific or NOS Term, Code, and Synonym(s)	Subtype(s) and Variant(s)
Neuroendocrine carcinoma **8246** (/3) • NEC	Large cell neuroendocrine carcinoma **8013** (/3) Small cell neuroendocrine carcinoma **8041** (/3)
Neuroendocrine tumor **8240** (/3) • Carcinoid • Neuroendocrine tumor, grade 1 • Well-differentiated endocrine tumor	Enterochromaffin-like cell tumor **8242** (/3) Neuroendocrine tumor, EC-cell, serotonin-producing **8241** (/3) Neuroendocrine tumor, gastrin-producing **8153** (/3) • Gastrinoma Neuroendocrine tumor, grade 2 **8249** (/3) • Neuroendocrine tumor, grade 3
Serrated dysplasia, high grade **8213** (/2)	
Squamous cell carcinoma **8070**	
Undifferentiated carcinoma **8020 (/3)**	Carcinoma with osteoclast-like giant cells **8035** (/3) Large cell carcinoma with rhabdoid phenotype **8014** (/3) Pleomorphic carcinoma **8022** (/3) Sarcomatoid carcinoma **8033** (/3)

See Solid Tumor Rules 2026.1 for full list

Test Your Knowledge

1. Which table should be used in Solid Tumor Rules to assign histology of the following sites?
   A. Esophagus 5 B. Stomach 6

2. Path report shows esophageal intraepithelial neoplasm, high-grade arising in Barrett's esophagus.
   - Histology: 8148/2

3. Is High-grade squamous dysplasia reportable?
   - Yes or No: Yes
   - Histology: 8077/2

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Source: Solid Tumor Rules 2026.1

Grade Coding

Grade Manual v3.3
Both Esophagus Schemas (with GE Junction) d
- ❑ Grade Table 03

Stomach
- ❑ Grade Table 04

Applies for both 2018+ cases
- Clinical (c)
- Pathological (p)
- Post therapy clinical (yc)
- Post therapy pathological (yp)

Code	Grade Description
1	Well-differentiated
2	Moderately-differentiated
3	Poorly Differentiated *Includes undifferentiated and anaplastic*
9	Unknown grade or cannot be assessed

Grade Coding

Clinical Grade:

A. Must be completed
B. Code from clinical timeframe (before start of treatment)
C. Grade 3 includes undifferentiated and anaplastic histologies

Pathologic Grade:

A. Must be completed
B. Code from clinical and surgical timeframe (code 9 if neoadjuvant treatment administered)
C. Grade 3 includes undifferentiated and anaplastic histologies

Post-therapy Clinical Grade:

A. May leave blank if not applicable
B. Applicable if biopsy of primary site AFTER neoadjuvant treatment and BEFORE definitive surgical resection

Post-therapy Pathological Grade:

A. May leave blank if not applicable
B. Applicable if neoadjuvant treatment followed by definitive resection

Source: Grade Manual v3.3

SEER Summary Stage

- **Digestive and Hepatobiliary Systems: Esophagus**
  - C160 + Schema Discriminator code 2
  - Other Chapters
    - GIST
    - Kaposi Sarcoma
    - Mycosis Fungoides
    - Soft Tissue
- **Digestive and Hepatobiliary Systems: Stomach**
  - C160 + Schema Discriminator codes 0, 3, and 9
  - Other Chapters
    - GIST
    - Kaposi Sarcoma
    - Mycosis Fungoides
    - Soft Tissue

SEER Summary Stage

Esophagus

Important Notes	
Note 3: GE Junction	• Cancers involving the EGJ that have their epicenter within proximal 2 cm of cardia are to be staged as esophageal cancer
Note 4: High grade dysplasia	• Non-invasive carcinomas in the esophagus formerly called in situ are now called high grade dysplasia • High grade dysplasia and severe dysplasia are generally not reportable in cancer registries • Code 0 if your registry collects these tumors

SEER Summary Stage

Esophagus	
0- In situ, noninvasive, high-grade dysplasia	• (Adeno)carcinoma, noninvasive, in a polyp

1- Localized	• Confined to esophagus, NOS
	• Extension through wall, NOS
	• Invasion of
	  ○ Intramucosa, NOS
	  ○ Lamina propria
	  ○ Mucosa (NOS) or Muscularis mucosae
	  ○ Muscularis (NOS) or Muscularis propria
	  ○ Submucosa (superficial invasion)
	• Perimuscular tissue invaded
	• Subserosal tissue/(sub)serosal fat invaded

See SEER Summary Manual for full list

SEER Summary Stage

Esophagus	

2- Regional by direct extension only	• **All sites**
	  ○ Adjacent structure(s), NOS
	  ○ Adventitia and/or soft tissue invaded
	  ○ Perigastric fat
	  ○ Peritoneum, NOS
	  ○ Serosa (invasion of/or through)
	  ○ Tunica serosa
	  ○ Vertebral body
	  ○ Visceral peritoneum (including perforation)
	• **Cervical Esophagus**
	  ○ Blood vessel(s) such as carotid artery or subclavian artery
	  ○ Carina
	  ○ Larynx
	  ○ Thyroid
	  ○ Trachea
	• **Upper/mid thoracic esophagus**
	  ○ Major blood vessel(s) such as gastric/pulmonary arteries or veins or vena cava
	  ○ Carina
	  ○ Stomach via serosa
	  ○ Trachea

Site dependent	*See SEER Summary Manual for full list*

SEER Summary Stage

Esophagus	

2- Regional by direct extension only cont'd
 	
Site dependent
	• **Lower thoracic/abdominal esophagus**
	  ○ Blood vessel(s)- Vena cava
	• **Thoracic esophagus (all portions)**
	  ○ Adjacent rib(s)
	  ○ Lung via bronchus
	  ○ Mediastinal structure(s), NOS
	  ○ Thoracic vertebra(e)
	• **Esophagus GE Junction**
	  ○ Liver
	  ○ Pancreas
	  ○ Small intestine (duodenum [via serosa], ileum, jejunum)
	  ○ Spleen
	  ○ Transverse colon (including flexures)

3- Regional lymph nodes only
 	
Site dependent
	• **All subsites**
	  • Nodule(s) in perigastric fat
	  • Peri-/paraesophageal (8L, 8M) (excluding GE junction)
	  • Regional lymph node(s), NOS
	  • Lymph node(s), NOS
	
	See SEER Summary Manual for full list

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Source: SEER Summary Manual v3.4

SEER Summary Stage

Esophagus	

3- Regional lymph nodes only
 	
Site dependent
	• **Cervical esophagus only**
	  ○ Cervical, NOS
	  ○ Scalene (inferior deep cervical)
	• **Thoracic esophagus, upper or middle, only**
	  ○ Internal jugular, NOS
	  ○ Intrabronchial
	  ○ Carinal (tracheobronchial) (10R, 10L) (tracheal bifurcation)
	  ○ Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
	  ○ Left gastric (superior gastric), Lesser curvature
	  ○ Perigastric, NOS
	  ○ Peritracheal
	  ○ Posterior mediastinal (tracheoesophageal)
	  ○ Superior mediastinal

See SEER Summary Manual for full list

Esophagus	

3- Regional lymph nodes only
 	
Site dependent
	• **Thoracic esophagus, lower (abdominal) only**
	  ○ Left gastric (superior gastric)/ Perigastric NOS
	  ○ Posterior mediastinal (3P) (tracheoesophageal)
	• **Esophagus GE Junction**
	  ○ Celiac (20)
	  ○ Hepatic (excluding gastrohepatic and hepatoduodenal)
	  ○ Left gastric (superior gastric), NOS
	  ○ Pancreaticosplenic (pancreaticolineal) Peripancreatic
	  ○ Right gastric (inferior gastric), NOS
	  ○ Splenic (lienal), NOS
	  ○ Gastroepiploic (gastro-omental), left
	  ○ Splenic hilar

Draining is intramural and longitudinal and majority of nodal regions are within the submucosa but also present in the lamina propria

SEER Summary Stage

Esophagus	
4- Regional by BOTH direct ext and LN	• **Codes (2)+ (3)**

7- Distant
 	
Site dependent
	Distant site(s) including further contiguous extension
	• **All sites**
	  ○ Airway
	  ○ Stated as unresectable, NOS
	  ○ Vertebral body
	• **Abdomen/lower esophagus**
	  ○ Diaphragm fixed
	• **Cervical/upper esophagus**
	  • Lung, Pleura and Main Stem Bronchus
	• **Thoracic/middle esophagus**
	  • Pericardium
	• **Esophagus GE Junction**
	  • Abdominal wall
	  ○ Adrenal (suprarenal) gland and Kidney
	  ○ Pulmonary ligament
	  ○ Retroperitoneum
	  ○ Trachea
	Distant lymph node(s), NOS
	• **All subsites**
	  ○ Anterior mediastinal and mediastinal NOS
	  ○ Subcarinal (tracheal carina) and Supraclavicular (transverse cervical)
	See SEER Summary Manual for full list

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Source: SEER Summary Manual v3.4

SEER Summary Stage

Esophagus

7- Distant
 	
Site dependent
	Distant lymph node(s), NOS
	• **Cervical esophagus**
	  ○ Aortopulmonary
	  ○ Posterior mediastinal; Superior mediastinal
	• **Thoracic esophagus, upper or middle, only**
	  ○ Aortopulmonary
	  ○ Cervical
	• **Lower thoracic (abdominal) esophagus**
	  ○ Aortopulmonary
	  ○ Celiac
	  ○ Paratracheal (2R, 2L, 4R, 4L)
	  ○ Superior mediastinal
	• **Esophagus GE Junction**
	  ○ Hepatoduodenal; portahepatis
	  ○ Mesenteric, NOS; Inferior mesenteric; Superior mesenteric
	  ○ Paraesophageal, NOS; Periesophageal, NOS
	  ○ Anterior mediastinal
	  • Retropancreatic; Retroperitoneal
	Distant metastasis, NOS
	• Carcinomatosis
	• Distant metastasis WITH or WITHOUT distant lymph node(s)

See SEER Summary Manual for full list

SEER Summary Stage

- **Stomach**

Important Notes	
Note 3: Esophagogastric Junction (EGJ)	• Cancers involving the EGJ and epicenter is >2cm into proximal stomach (i.e., >2cm distal to the EGJ) are classified using the stomach chapter. • Cardia cancers that do not invade the EGJ should be classified based on the stomach cancer chapters for summary stage.

SEER Summary Stage

Stomach	
0- In situ, noninvasive, high-grade dysplasia	• (Adeno)carcinoma, noninvasive, in a polyp

1- Localized	• Confined to the stomach, NOS
	• Extension through wall, NOS
	• Implants within stomach
	• Intraluminal spread to esophagus or duodenum
	• Invasion of the:
	  ○ Intramucosa, NOS
	  ○ Lamina propria
	  ○ Mucosa, NOS; Muscularis mucosae
	  ○ Muscularis, NOS; Muscularis propria
	  ○ Submucosa (superficial, NOS)
	• Linitis plastica (diffuse involvement of the entire stomach wall)
	• Perimuscular tissue invaded
	• Polyp (head, stalk, NOS)
	• Subserosal tissue/ fat
	See SEER Summary Manual for full list

SEER Summary Stage

Stomach	
2- Regional by direct extension only	• Adjacent (connective) tissue, NOS • Colon/mesocolon (including transverse and flexures) • Diaphragm • Duodenum (via serosa) • Esophagus (via serosa) • Gastric Artery • Ileum • Jejunum • Ligaments- Gastrocolic, Gastrohepatic, Gastrosplenic • Liver • Mesothelium • Omentum (greater, lesser, NOS) • Pancreas • Perigastric fat • Serosa • Small intestine NOS • Spleen • Tunica serosa • Visceral periotoneum

See SEER Summary Manual for full list

SEER Summary Stage

Stomach	
3- Regional lymph nodes only	• Celiac Artery • Common hepatic artery • Hepatic, NOS • Left gastric (superior gastric) NOS • Pancreaticosplenic • Perigastric, NOS • Peripancreatic • Pyloric, NOS • Right Gastric (inferior gastric, NOS) • Splenic (lineal), NOS • Nodule(s) in perigastric fat • Regional LNs NOS
4- Regional by BOTH direct ext and LN	• **Codes (2)+ (3)**
7- Distant	**Distant site(s) including further contiguous extension** • Abdominal wall • Adrenal (suprarenal) gland; Kidney • Aorta; Celiac axis • Retroperitoneum *See SEER Summary Manual for full list*

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Source: SEER Summary Manual v3.4

SEER Summary Stage

Stomach	
7- Distant	**Distant lymph node(s), NOS** • Hepatoduodenal • Intra-abdominal • Mesenteric • Middle colic • Pancreaticoduodenal (excludes greater curvature subsite) • Paraaortic • Porta hepatic • Distant Metastasis • Carcinomatosis • Krukenberg tumor (mets to ovary(ies) • Malignant peritoneal cytology **Distant metastasis, NOS** • Carcinomatosis • Distant metastasis WITH or WITHOUT distant lymph node(s) • Krukenberg tumor (mets to ovary(ies) • Malignant peritoneal cytology *See SEER Summary Manual for full list*

SSDI Coding

Esophagus and Stomach

SSDI: HER2 Overall Summary (1/1/2021+)

- Code the highest value from the primary tumor. Physician statement may be used
- HER2 testing is part of the NCCN guidelines (Gastric Cancer)
- Performed if patients mets are suspected or documented
- HER2 monoclonal antibodies may be added to chemotherapy for patients with HER2 positive disease.
- Herceptin Immunotherapy treatment increases survival

Codes	Description
0	HER2 negative; equivocal
1	HER2 positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indermediate) HER2 not assessed or unknown if assessed

Source: SSDI Manual v3.3 and NCCN Guidelines

SSDI Coding

Esophagus Squamous Cell

SSDI: Esophagus and EGJ Tumor Epicenter

- Position of epicenter (i.e. midpoint) of tumor in the esophagus.
- Required for Squamous Cell Carcinoma only
- Example: Lesion was from 15-21 cm = 6 cm lesion with epicenter at 18 cm
- Required for pathologic staging only, not for primary site
- Note 3: Priority Statements
  - Clinician or pathologist statement take priority over any individual results or measurements.

Codes	Description
0	U: Upper (Cervical/Proximal to lower border or azygos vein)
1	M: Middler (Lower border azygos vein to lower border of inferior pulm vein
2	L: Lower (Lower border of inferior pulm vein to stomach, including GE junction)
9	X: Esophagus NOS Specific location of epicenter not documented, not assessed or unknown Primary Site is c15.9

If no statement of epicenter is provided these measurements may be used:

- 15-24 cm from incisors= Upper
- 25-29 cm from incisors= Middle
- 30-40/45 cm from incisors= Lower

Esophageal Surgery

Esophagus	
A100 • A110 • A120 • A130 • A140	Local tumor destruction NOS • Photodynamic therapy (PDT) • Electrocautery; fulguration (includes use of hot forceps) • Cryosurgery • Laser No specimen sent to pathology from surgical events

A200
• A260
• A270
  ○ A210
  ○ A220
  ○ A230
  ○ A240
  ○ A250
	Local tumor excision NOS
	• Polypectomy
	• Excisional biopsy
	• Any combination of A200 or A260-270 WITH
	  ○ PDT
	  ○ Electrocautery
	  ○ Cryosurgery
	  ○ Laser ablation
	  ○ Laser excision

A300	Partial esophagectomy
A400	Total esophagectomy NOS

Esophagus	
A500 • A510 • A520 • A530 • A540 • A550	Esophagectomy NOS WITH laryngectomy and/or gastrectomy • WITH laryngectomy • WITH gastrectomy NOS • Partial gastrectomy • Total gastrectomy • A510 WITH any of A520-A540
A800	Esophagectomy NOS

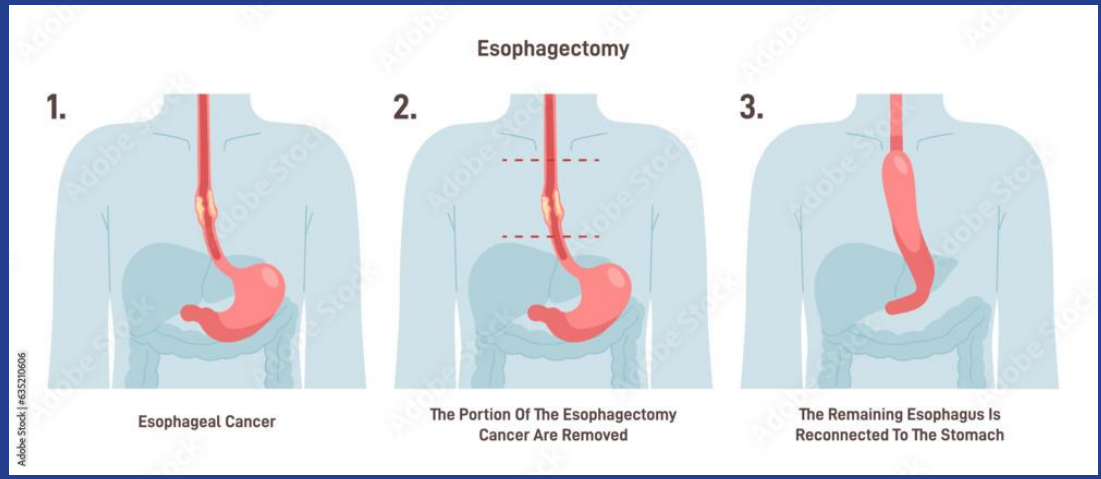


Image source

Indiana Department of Health

Source: STORE Manual 2026 Appendix A and NCCN Guidelines

Gastric Surgery

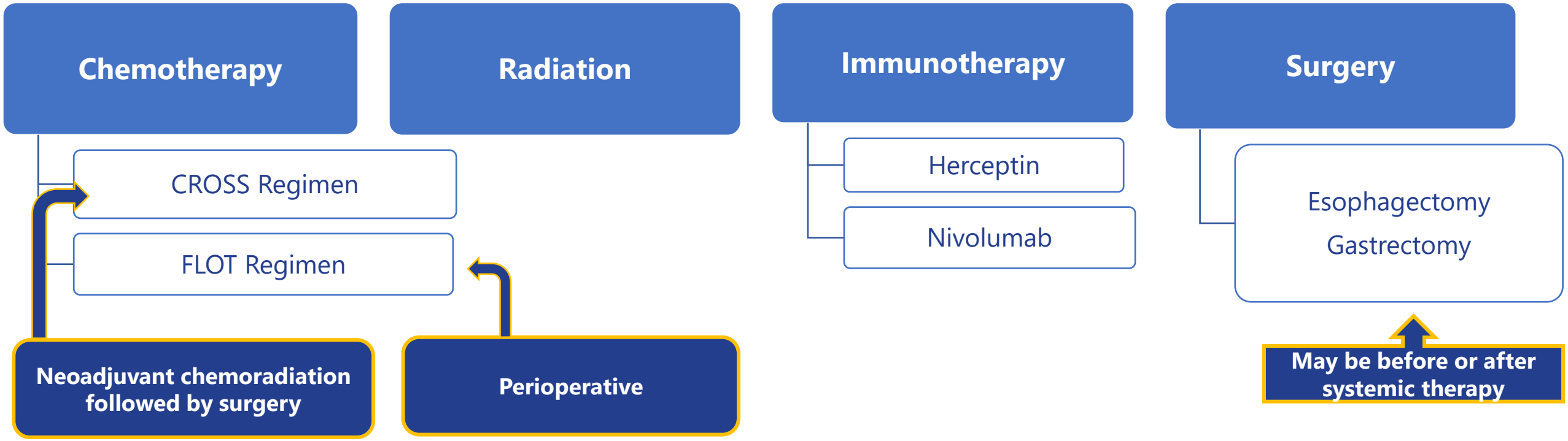
Stomach	
A100 • A110 • A120 • A130 • A140	Local tumor destruction NOS • Photodynamic therapy (PDT) • Electrocautery; fulguration (includes use of hot forceps) • Cryosurgery • Laser No specimen sent to pathology from surgical events

A200
• A260
• A270
  ○ A210
  ○ A220
  ○ A230
  ○ A240
  ○ A250
	Local tumor excision NOS
	• Polypectomy
	• Excisional biopsy
	• Any combination of A200 or A260-270 WITH
	  ○ PDT
	  ○ Electrocautery
	  ○ Cryosurgery
	  ○ Laser ablation
	  ○ Laser excision

A300 • A310 • A320 • A330	Gastrectomy NOS • Antrectomy, lower (less than 40% of stomach) • Lower (distal) gastrectomy (partial, subtotal, hemi-) • Upper (proximal) gastrectomy (partial, subtotal, hemi-) *A300 includes sleeve resection, Billroth I/II*

Stomach	
A400 • A410 • A420	Near-total or total gastrectomy NOS • Near-total gastrectomy • Total gastrectomy *A total gastrectomy may follow previous partial resection*
A500 • A510 • A520	Gastrectomy NOS WITH removal of a portion of esophagus • Partial or subtotal gastrectomy • Near total or total gastrectomy *Gastrectomy when only portions of esophagus are included*
A600 • A610 • A620 • A620 • A630	Gastrectomy with resection in continuity of other organs NOS • Partial or subtotal gastrectomy, in continuity with resection of other organs • Near total or total gastrectomy, in continuity • Radical gastrectomy, in continuity *Gastrectomy with organs other than esophagus*
A800	Gastrectomy NOS

Treatment



Source: NCCN Guidelines

Coding tips

Tumor Size Summary

- Use size from resection (if no neoadjuvant treatment)
- If no resection code clinical size

Endoscopic ultrasound (EUS) staging

- Ultrasound "u" (*i.e.. ucT3*)
- Staging by ultrasonographer, not managing physician
- Managing physician compiles all clinical findings to assign stage

Coding tips

Endoscopic ultrasound (EUS) staging

- Ultrasound “u” (*i.e.. ucT3*)
- Staging by ultrasonographer, not managing physician
- Managing physician compiles all clinical findings to assign stage

Case Scenario

History & Physical Text	60 yr old single Asian male presents with abdominal pain, localized around belly. Pt observed and underwent EGD showing gastric mass
X-rays/Scans Text	10/15/25 ABC Hospital, CT C/A/P: Markedly thickened irregular distal gastric body & gastric antrum w/mesenteric haziness & hypoattenuation to areas of distal gastric body & antrum to pylorus suspicious for primary gastric neoplasm. Gastric ulcer/perforated gastric ulcer less likely. Perigastric adenopathy suspicious for metastases, 1-2 nodes measuring up to 1.5cm. 11/8/25 Imaging Center, PET/CT: Irregular circumferential mass 1cm in gastric antrum w/proximal gastric dilatation consistent w/partially obstructing distal gastric ca. Mild soft tissue infiltration surrounding mesenteric fat but no discrete enlarged or fdg avid mesenteric LNs.
Scopes Text	10/07/25 ABC Hosp, Dr. John Smith, EGD: Large 3cm obstructing friable ulcerated gastric mass in antrum w/ gastric outlet obstruction suggestive of gastric malignancy. Margins well-defined, partially involving incisura. Mass appears to involve the perigastric fat. Biopsy obtained. 02/25/2026 ABC Hospital, Dr. John Smith, EGD: Complete response to treatment.
Lab Text	None
Operative Text	10/07/2025 ABC Hospital, Dr. John Smith, Biopsy of gastric antrum mass. 03/02/26 ABC Hospital, Dr. John Smith, Distal gastrectomy and RLN Dissection: Less than 40% of stomach removed in location of previous tumor.

Case Scenario

Pathology Text	10/07/2025 ABC Hospital, S25-1234 Biopsy of gastric antrum mass: Well differentiated Adenoca, intestinal type. 03/02/26 ABC Hospital, S26-3456 Distal gastrectomy: No residual tumor. RLN dissection: 10/13 positive for mets. Staged by pathologist, ypT0 ypN3a
Surgery Text	10/07/2025 ABC Hospital, Dr. John Smith, Biopsy of gastric antrum mass. 03/02/26 ABC Hospital, Dr. John Smith, Distal gastrectomy and RLN Dissection: Less than 40%
Chemotherapy Text	10/27/25 – 02/15/26 Oncology Center, Dr. Jane Doe, FLOT (5-FU, Oxaliplatin, Docetaxel). 5/13/26 Oncology Center, Dr. Jane Doe, Adjuvant Xeloda/oxaliplatin
Remarks Text	10/20/2025 Surg Onc- Intestinal Type Gastric Adenoca with possible involvement of mesenteric vein, recommend neoadjuvant chemo to shrink tumor. Pt referred to Med Onc. 10/22/2026 Med Onc-Probable T3 N1 stage 3 gastric cancer with involvement of the perigastric fat with perigastric RLN involvement. 11/10/2021 Med Onc- continue current chemo regimen, clear response to treatment. 03/30/2022 Med Onc-after healed from surgery continue adjuvant Xeloda and Oxaliplatin, maintenance.

Case Scenario

Data Field	Answer	Rationale
Primary Site Code	C163	Gastric Antrum on pre-treatment EGD and imaging. The primary is not stated by the Managing Physicians.
Histology Code/Behavior	8144/3	Bx results “Adenocarcinoma, Intestinal Type” only histology identified.
Laterality	0	Stomach is not a paired site
Date of Diagnosis	10/7/2026	Date of diagnosis based on imaging. 4/1 CT stated to be consistent with ovarian cancer
Diagnostic Procedure Code	00	No biopsy was performed
Clinical Grade	1	Biopsy of primary tumor during clinical timeframe was well differentiated
Pathological Grade	9	Path grade is 9 due to the neoadjuvant therapy
Post-therapy Path Grade	9	No residual on resection after neoadjuvant therapy must be 9 per the grade manual

Case Scenario

Data Field	Answer	Rationale
SEER Summary Stage	4- Reg by Direct Ext + RLN	Clinically and pathologically, this was regional by direct extension-2 & RLN involvement -3 by "stating perigastric fat with perigastric RLN involvement." It was never localized or metastatic. SEER uses all information available to stage. Use code 4 when a combo of 2+3 is identified.
Tumor Size Summary	030	Only size mentioned prior to treatment was 3cm mass on EGD
SSDI: HER2 Overall Summary	9	HER2 was not performed
Surgery Code	A310	Distal gastrectomy and operative findings stated less than 40% of the stomach was removed.
Chemo	03	Multiple agents
Systemic Surgical Sequence	4	Systemic treatment was given before and after surgery

Conclusion

- Reviewed anatomy and physiology of the esophagus, stomach and regional structures
- Identified how anatomy correlates to staging principles
- Assigned primary site and histology
- Discussed schema discriminators and SEER Summary Stage
- Assigned SSDIs
- Reviewed Treatment
- Case Scenarios

Thank you!

Return to FLccSC to take the quick five-question quiz and earn your 1 category A CE!



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4. SEER*RSA v3.3 Database: https://staging.seer.cancer.gov/eod_public/list/3.3/
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6. SSDI Manual v3.3, Ruhl J, Hofferkamp J, et al. (December 2025). Site-Specific Data Item (SSDI) Manual. NAACCR, Springfield, IL 62704-4194
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8. SEER Appendix C: Site Specific Coding Manual, https://seer.cancer.gov/manuals/2026/appendixc.html.
9. SEER Summary Staging Manual, version 3.4. Ruhl JL, Callaghan C, Schussler N, Adams, S (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2026
10. NCCN Guidelines:

Abbreviations

Abd: Abdomen

AJCC: American Joint Commission on Cancer

Bil: Bilateral

Bx: Biopsy

C/A/P: Chest, abdomen and pelvis

C/O: Complaint of/complains of

CT: Computed Tomography

C/W: Consistent with

EGD - Esophagogastricduodenoscopy

EGJ - Espophagogastric junction

EUS - Endoscopic ultrasound

HG: High grade

Invl: Involved/involving

LAD: Lymphadenopathy

LG: Low grade

LN(s): Lymph Node(s)

LT: Left

Med Onc: Medical Oncologist

Mets: Metastasis

MRI: Magnetic Resonance Imaging

Neg: Negative

Abbreviations

NOS: Not otherwise specified

Onc: Oncology/Oncologist

Op: Operative

Path: Pathology

PET: Positron Emission Tomography

PMHX: Patient medical history

Pos: Positive

Preop: Pre-operative

PreTx: Pretreatment

RT: Right

SEER: Surveillance, Epidemiology, and End Results Program

SSDI: Site Specific Data Item

Unk: Unknown

US: Ultrasound

Yr: Year

Questions?

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