Esophagus Cancer Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Esophageal Cancer Be Found Early?
- Signs and Symptoms of Esophageal Cancer
- Tests for Esophageal Cancer
- Understanding Your Pathology Report

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- Esophageal Cancer Stages
- Survival Rates for Esophageal Cancer by Stage

Questions to Ask About Esophagus Cancer

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- What Should You Ask Your Doctor About Esophageal Cancer?

Can Esophageal Cancer Be Found Early?
Screening is the process of looking for cancer or pre-cancer in people who have no symptoms of the disease. In the United States, screening the general public for esophageal cancer is not recommended by any professional organization at this time. This is because no screening test has been shown to lower the risk of dying from esophageal cancer in people who are at average risk.

However, people who have a high risk of esophageal cancer, such as those with Barrett’s esophagus, are often followed closely to look for early cancers and pre-cancers.

Testing people at high risk

Many experts recommend that people with a high risk of esophageal cancer, such as those with Barrett’s esophagus, have upper endoscopy regularly. For this test, the doctor looks at the inside of the esophagus through a flexible lighted tube called an endoscope. (see Tests for Esophageal Cancer.) The doctor may remove small samples of tissue (biopsies) from the area with Barrett’s so that they can be checked for dysplasia (pre-cancer cells) or cancer cells.

Doctors aren’t certain how often the test should be repeated, but most recommend testing more often if areas of dysplasia are found. This testing is repeated even more often if there is high-grade dysplasia (the cells appear very abnormal).

If the area of Barrett’s is large and/or there is high-grade dysplasia, treatment of the abnormal area might be advised because of the high risk that an adenocarcinoma is either already present (but was not found) or will develop within a few years. Treatment options for high-grade dysplasia might include surgery to remove part of the esophagus with the abnormal area, endoscopic mucosal resection (EMR), photodynamic therapy (PDT), or radiofrequency ablation (RFA). See Endoscopic Treatments for Esophageal Cancer. The outlook for these patients is relatively good after treatment.

Careful monitoring and treatment (if needed) may help prevent some esophageal cancers from developing. It may also detect some cancers early, when they are more likely to be treated successfully.

- References

Posner MC, Minsky B, Ilson DH. Chapter 45 - Cancer of the esophagus. In: DeVita VT,
Cancers of the esophagus are usually found because of the symptoms they cause. Diagnosis in people without symptoms is rare and usually accidental (because of tests done for other medical problems). Unfortunately, most esophageal cancers do not cause symptoms until they have reached an advanced stage, when they are harder to treat.

### Trouble swallowing

The most common symptom of esophageal cancer is a problem swallowing, with a feeling like the food is stuck in the throat or chest, or even choking on food. The medical term for trouble swallowing is *dysphagia*. This is often mild when it starts, and then gets worse over time as the opening inside the esophagus gets smaller.

When swallowing becomes harder, people often change their diet and eating habits without realizing it. They take smaller bites and chew their food more carefully and slowly. As the cancer grows larger, the problem can get worse. People then might start eating softer foods that can pass through the esophagus more easily. They might avoid bread and meat, since these foods typically get stuck. The swallowing problem may even get bad enough that some people stop eating solid food completely and switch to
a liquid diet. If the cancer keeps growing, at some point even liquids might be hard to swallow.

To help pass food through the esophagus, the body makes more saliva. This causes some people to complain of bringing up lots of thick mucus or saliva.

**Chest pain**

Sometimes, people have pain or discomfort in the middle part of their chest. Some people get a feeling of pressure or burning in the chest. These symptoms are more often caused by problems other than cancer, such as heartburn, so they are rarely seen as a signal that a person might have cancer.

Swallowing may become painful if the cancer is large enough to limit the passage of food through the esophagus. Pain may be felt a few seconds after swallowing, as food or liquid reaches the tumor and has trouble getting past it.

**Weight loss**

About half of people with esophageal cancer lose weight (without trying to). This happens because their swallowing problems keep them from eating enough to maintain their weight. Other factors include a decreased appetite and an increase in metabolism from the cancer.

**Other symptoms**

Other possible symptoms of cancer of the esophagus can include:

- Hoarseness
- Chronic cough
- Vomiting
- Hiccups
- Bone pain
- Bleeding into the esophagus. This blood then passes through the digestive tract, which may turn the stool black. Over time, this blood loss can lead to anemia (low red blood cell levels), which can make a person feel tired.

Having one or more of the symptoms above does not mean you have esophageal cancer. In fact, many of these symptoms are more likely to be caused by other conditions. Still, if you have any of these symptoms, especially trouble swallowing, it’s
important to have them checked by a doctor so that the cause can be found and treated, if needed.

- References


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**Tests for Esophageal Cancer**

Esophagus cancers are usually found because of signs or symptoms a person is having. If esophagus cancer is suspected, exams and tests will be needed to confirm the diagnosis. If cancer is found, further tests will be done to help determine the extent (stage) of the cancer.

**Medical history and physical exam**

If you have symptoms that might be caused by esophageal cancer, the doctor will ask about your medical history to check for possible risk factors and to learn more about your symptoms.

Your doctor will also examine you to look for possible signs of esophageal cancer and other health problems. He or she will probably pay special attention to your neck and chest areas.

If the results of the exam are abnormal, your doctor will probably order tests to help find the problem. You may also be referred to a gastroenterologist (a doctor specializing in digestive system diseases) for further tests and treatment.
Imaging tests to look for esophagus cancer

*Imaging tests* use x-rays, magnetic fields, sound waves, or radioactive substances to create pictures of the inside of your body. Imaging tests might be done for many reasons, such as:

- To help find a suspicious area that might be cancer
- To learn if and how far cancer has spread
- To help determine if the treatment is working
- To look for possible signs of cancer coming back after treatment

**Barium swallow**

In this test, a thick, chalky liquid called *barium* is swallowed to coat the walls of the esophagus. When x-rays are then taken, the barium clearly outlines the esophagus. This test can be done by itself, or as a part of a series of x-rays that includes the stomach and part of the intestine, called an *upper gastrointestinal (GI) series*. A barium swallow test can show any abnormal areas in the normally smooth surface of the inner lining of the esophagus, but it can't be used to determine how far a cancer may have spread outside of the esophagus.

This is sometimes the first test done to see what is causing a problem with swallowing. Even small, early cancers can often be seen using this test. Early cancers can look like small round bumps or flat, raised areas (called *plaques*), while advanced cancers look like large irregular areas and can cause narrowing of the inside of the esophagus.

This test can also be used to diagnose one of the more serious complications of esophageal cancer called a *tracheo-esophageal fistula*. This occurs when the tumor destroys the tissue between the esophagus and the trachea(windpipe) and creates a hole connecting them. Anything that is swallowed can then pass from the esophagus into the windpipe and lungs. This can lead to frequent coughing, gagging, or even pneumonia. This problem can be helped with surgery or an endoscopy procedure.

**Computed tomography (CT or CAT) scan**

A *CT scan* uses x-rays to produce detailed cross-sectional images of your body. This test can help tell if esophageal cancer has spread to nearby organs and lymph nodes (bean-sized collections of immune cells to which cancers often spread first) or to distant parts of the body.
Before the test, you may be asked to drink 1 to 2 pints of a liquid called oral contrast. This helps outline the esophagus and intestines. If you are having any trouble swallowing, you need to tell your doctor before the scan.

**Magnetic resonance imaging (MRI) scan**

Like CT scans, MRI scans provide detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets instead of x-rays. A contrast material called gadolinium may be injected into a vein before the scan to see details better. MRI can be used to look at abnormal areas in the brain and spinal cord that might be due to cancer spread.

**Positron emission tomography (PET) scan**

PET scans usually use a form of radioactive sugar (known as fluorodeoxyglucose or FDG) that is injected into the blood. Normal cells use different amounts of the sugar, depending on how fast they are growing. Cancer cells, which grow quickly, are more likely to absorb larger amounts of the radioactive sugar than normal cells. These areas of radioactivity can be seen on a PET scan using a special camera.

The picture from a PET scan is not as detailed as a CT or MRI scan, but it provides helpful information about whether abnormal areas seen on these other tests are likely to be cancer or not.

If you have already been diagnosed with cancer, your doctor may use this test to see if the cancer has spread to lymph nodes or other parts of the body. A PET scan can also be useful if your doctor thinks the cancer may have spread but doesn’t know where.

**PET/CT scan:** Some machines can do both a PET and CT scan at the same time. This lets the doctor compare areas of higher radioactivity on the PET scan with the more detailed picture of that area on the CT scan.

**Endoscopy**

An endoscope is a flexible, narrow tube with a tiny video camera and light on the end that is used to look inside the body. Tests that use endoscopes can help diagnose esophageal cancer or determine the extent of its spread.

**Upper endoscopy**
This is an important test for diagnosing esophageal cancer. During an upper endoscopy, you are sedated (made sleepy) and then the doctor passes an endoscope down your throat and into the esophagus and stomach. The camera is connected to a monitor, which lets the doctor see any abnormal areas in the wall of the esophagus clearly.

The doctor can use special instruments through the scope to remove (biopsy) samples from any abnormal areas. These samples are sent to the lab to see if they contain cancer.

If the esophageal cancer is blocking the opening (called the lumen) of the esophagus, certain instruments can be used to help enlarge the opening to help food and liquid pass.

Upper endoscopy can give the doctor important information about the size and spread of the tumor, which can be used to help determine if the tumor can be removed with surgery.

**Endoscopic ultrasound**

This test is usually done at the same time as the upper endoscopy. For an endoscopic ultrasound, a probe that gives off sound waves is at the end of an endoscope. This allows the probe to get very close to tumors in the esophagus. This test is very useful in determining the size of an esophageal cancer and how far it has grown into nearby areas. It can also help show if nearby lymph nodes might be affected by the cancer. If enlarged lymph nodes are seen on the ultrasound, the doctor can pass a thin, hollow needle through the endoscope to get biopsy samples of them. This helps the doctor decide if the tumor can be removed with surgery.

**Bronchoscopy**

This exam may be done for cancer in the upper part of the esophagus to see if it has spread to the windpipe (trachea) or the tubes leading from the windpipe into the lungs (bronchi).

**Thoracoscopy and laparoscopy**

These exams let the doctor see lymph nodes and other organs near the esophagus inside the chest (by thoracoscopy) or the abdomen (by laparoscopy) through a hollow lighted tube.
These procedures are done in an operating room while you are under general anesthesia (in a deep sleep). A small incision (cut) is made in the side of the chest wall (for thoracoscopy) or the abdomen (for laparoscopy). Sometimes more than one cut is made. The doctor then inserts a thin, lighted tube with a small video camera on the end through the incision to view the space around the esophagus. The surgeon can pass thin tools into the space to remove lymph nodes and biopsy samples to see if the cancer has spread. This information is often important in deciding whether a person is likely to benefit from surgery.

**Lab tests of biopsy samples**

Usually if a suspected esophageal cancer is found on endoscopy or an imaging test, it is biopsied. In a biopsy, the doctor removes a small piece of tissue with a special instrument passed through the scope. See [Testing Biopsy and Cytology Specimens for Cancer](#) to learn more about the types of biopsies, how the tissue is used in the lab to diagnose cancer, and what the results may show.

**HER2 testing:** If esophageal cancer is found but is too advanced for surgery, your biopsy samples may be tested for the HER2 gene or protein. Some people with esophageal cancer have too much of the HER2 protein on the surface of their cancer cells, which helps the cells grow. A drug that targets the HER2 protein called trastuzumab (Herceptin®) may help treat these cancers when used along with chemotherapy. Only cancers that have too much of the HER2 gene or protein are likely to be affected by this drug, which is why doctors may test tumor samples for it. (See [Targeted Therapy for Esophageal Cancer](#).)

**Blood tests**

Your doctor might order certain blood tests to help determine if you have esophageal cancer.

**Complete blood count (CBC):** This test measures the different types of cells in your blood. It can show if you have anemia (too few red blood cells). Some people with esophageal cancer become anemic because the tumor has been bleeding.

**Liver enzymes:** You may also have a blood test to check your liver function, because esophageal cancer can spread to the liver.

- References
Kleinberg L, Kelly R, Yang S, Wang JS, Forastiere AA. Chapter 74 – Cancer of the
Esophageal Cancer Stages

After someone is diagnosed with esophageal cancer, doctors will try to figure out whether it has spread, and if so, how far. This process is called staging. The stage of a cancer describes the extent of the cancer in the body. It helps determine how serious the cancer is and how best to treat it. The stage is one of the most important factors in deciding how to treat the cancer and determining how successful treatment might be.

To determine the cancer’s stage after an esophageal cancer diagnosis, doctors try to answer these questions:

- How far has the cancer grown into the wall of the esophagus?
- Has the cancer reached nearby structures?
- Has the cancer spread to the nearby lymph nodes or to distant organs?

The stage of esophageal cancer is based on the results of physical exams, biopsies, and imaging tests (CT or MRI scan, x-rays, PET scan, etc.), which are described in Tests for Esophageal Cancer, as well as the results of surgery.
Understanding your esophageal cancer stage

After looking at your test results, your doctor will tell you the stage of your cancer. The staging system most often used for esophageal cancer is the American Joint Committee on Cancer (AJCC) TNM system. The TNM system is based on 3 key pieces of information:

- How far the main (primary) tumor (T) has grown into the wall of the esophagus and whether it has grown into nearby areas.
- If the cancer has spread to nearby (regional) lymph nodes (N). Lymph nodes are small bean-shaped collections of immune system cells to which cancers often spread first.
- If the cancer has spread (metastasized) to other organs of the body (M).

Numbers or letters after T, N, and M provide more details about each of these factors. Higher numbers mean the cancer is more advanced. Once a person’s T, N, and M categories have been determined, usually after surgery, this information is combined in a process called stage grouping to assign an overall stage.

The earliest stage cancers are called stage 0 (carcinoma in situ), and then range from stages I (1) through IV (4). Some of the stages have sub-stages with the letters A, B, and C.

As a rule, the lower the number, the less the cancer has spread. A higher number, such as stage IV, means a more advanced cancer. And within a stage, an earlier letter means a lower stage. Cancers with similar stages tend to have a similar outlook and are often treated in much the same way.

The staging system in the table below uses the pathologic stage. It is based on the results of physical exam, biopsy, imaging tests, and the results of surgery. This is likely to be more accurate than clinical staging, which only considers the tests done before surgery.

Esophageal cancer staging can be complex. If you have any questions about your stage, please ask your doctor to explain it to you in a way you understand.

T categories

This describes how deeply the cancer has grown into the wall of the esophagus or into nearby structures. Most esophageal cancers start in the innermost lining of the esophagus (the epithelium) and then grow into deeper layers over time. (See What Is
Esophagus Cancer? for a description of the layers of the esophagus wall.)
**Tx:** The primary tumor can’t be assessed.

**T0:** There is no evidence of a primary tumor.

**Tis:** The cancer is only in the epithelium (the top layer of cells lining the inside of the esophagus). It has not started growing into the deeper layers. This stage is also known as *high-grade dysplasia*.

**T1a:** The cancer is growing into the lamina propria or muscularis mucosa (the tissue under the epithelium).

**T1b:** The cancer has grown through the other layers and into the submucosa.

**T2:** The cancer is growing into the thick muscle layer (muscularis propria).

**T3:** The cancer is growing into the outer layer of the esophagus (the adventitia).

**T4a:** The cancer is growing into the pleura (the thin layer of tissue covering the lungs), the pericardium (the thin sac surrounding the heart), or the diaphragm (the muscle below the lungs that separates the chest from the abdomen).

**T4b:** The cancer has grown into the trachea (windpipe), the aorta (the large blood vessel coming from the heart), the spine, or other crucial structures.

**N categories**

**Nx:** No description of lymph node involvement possible because of incomplete information.

**N0:** The cancer has not spread to nearby lymph nodes.

**N1:** The cancer has spread to 1 or 2 nearby lymph nodes.

**N2:** The cancer has spread to 3 to 6 nearby lymph nodes.

**N3:** The cancer has spread to 7 or more nearby lymph nodes.

**M categories**

**M0:** The cancer has not spread (metastasized) to distant organs or lymph nodes.
M1: The cancer has spread to distant lymph nodes and/or other organs. (Common sites of spread include the liver and lungs.)

Grade

Another factor that can affect your treatment and your outlook is the grade of your cancer. The grade describes how closely the cancer looks like normal tissue when seen under a microscope.

The scale used for grading esophagus cancers is from 1 to 4.

Gx: The grade cannot be assessed (treated in stage grouping as G1).

Grade 1 (G1: well differentiated) means the cancer cells look more like normal esophagus tissue.

Grade 4 (G4: undifferentiated) means the cancer cells look very abnormal.

Grades 2 and 3 (G2: moderately differentiated and G3: poorly differentiated) fall somewhere in between.

The grade is often simplified as either low grade (G1 or G2) or high grade (G3 or G4).

Low-grade cancers tend to grow and spread more slowly than high-grade cancers. Most of the time, the outlook is better for low-grade cancers than it is for high-grade cancers of the same stage.

Location

Some stages of early squamous cell carcinoma also take into account where the tumor is in the esophagus. The location is assigned as either upper, middle, or lower based on where the upper edge of the tumor is.

Stage grouping

Once the T, N, M, and G categories have been assigned, this information is combined into an overall stage of 0, I, II, III, or IV. This process is called stage grouping. Some stages are further subdivided into A, B, or C. The stages identify cancers that have a similar prognosis (outlook). Patients with lower stage numbers tend to have a better prognosis.
The stage groupings for squamous cell carcinoma and adenocarcinoma are different. Cancers that have features of both squamous cell and adenocarcinoma are staged as squamous cell carcinomas.

**Squamous cell carcinoma stages**

**Stage 0: Tis, N0, M0, Gx or G1; any location:** This is the earliest stage of esophageal cancer. It is also called *high-grade dysplasia*. The cancer cells are found only in the epithelium (the layer of cells lining the esophagus). The cancer has not grown into the connective tissue beneath these cells (Tis). The cancer has not spread to nearby lymph nodes (N0) or other organs (M0). The tumor is well differentiated (G1) or grade information is not available (Gx), and it can be anywhere along the esophagus.

**Stage IA: T1, N0, M0, Gx or G1; any location:** The cancer has grown from the epithelium into the layers below, such as the lamina propria, muscularis mucosa, or submucosa, but it has not grown any deeper (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). The tumor is well differentiated (G1) or grade information is not available (Gx). It can be anywhere along the esophagus.

**Stage IB: Either of the following:**

- **T1, N0, M0, G2 or G3; any location:** The cancer has grown from the epithelium into the layers below, such as the lamina propria, muscularis mucosa, or submucosa, but it has not grown any deeper (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is moderately (G2) or poorly differentiated (G3). The tumor can be anywhere in the esophagus.

- **T2 or T3, N0, M0, Gx or G1; location lower:** The cancer has grown into the muscle layer called the *muscularis propria* (T2). It may also have grown through the muscle layer into the adventitia, the connective tissue covering the outside of the esophagus (T3). The cancer has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is well differentiated (G1) or grade information is not available (Gx). Its highest point is in the lower part of the esophagus.

**Stage IIA: Either of the following:**

- **T2 or T3, N0, M0, Gx or G1; location upper or middle:** The cancer has grown into the muscle layer called the *muscularis propria* (T2). It may also have grown through the muscle layer into the adventitia, the connective tissue covering the outside of the esophagus (T3). The cancer has not spread to nearby lymph nodes (N0) or to distant sites (M0). The cancer is in the upper or middle part of the esophagus.
esophagus and is well differentiated (G1) or grade information is not available (Gx).

**T2 or T3, N0, M0, G2 or G3; location lower:** The cancer has grown into the muscle layer called the *muscularis propria* (T2). It may also have grown through the muscle layer into the adventitia, the connective tissue covering the outside of the esophagus (T3). The cancer has not spread to lymph nodes (N0) or to distant sites (M0). The cancer is in the lower part of the esophagus and is moderately (G2) or poorly differentiated (G3).

**Stage IIIB:** Either of the following:

**T2 or T3, N0, M0, G2 or G3; location upper or middle:** The cancer has grown into the muscle layer called the *muscularis propria* (T2). It may also have grown through the muscle layer into the adventitia, the connective tissue covering the outside of the esophagus (T3). The cancer has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is in the upper or middle part of the esophagus and is moderately (G2) or poorly differentiated (G3).

**T1 or T2, N1, M0, any G; any location:** The cancer has grown into the layers below the epithelium, such as the lamina propria, muscularis mucosa, or submucosa (T1). It may also have grown into the muscularis propria (T2). It has not grown through to the outer layer of tissue covering the esophagus. It has spread to 1 or 2 lymph nodes near the esophagus (N1) but has not spread to lymph nodes further away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

**Stage IIIA:** Any of the following:

**T1 or T2, N2, M0, any G; any location:** The cancer has grown into the layers below the epithelium, such as the lamina propria, muscularis mucosa, or submucosa (T1). It may also have grown into the muscularis propria (T2). It has not grown through to the outer layer of tissue covering the esophagus. It has spread to 3 to 6 lymph nodes near the esophagus (N2) but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

**T3, N1, M0, any G; any location:** The cancer has grown through the wall of the esophagus to its outer layer, the adventitia (T3). It has spread to 1 or 2 lymph nodes near the esophagus (N1), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.
**T4a, N0, M0, any G; any location:** The cancer has grown all the way through the esophagus and into nearby organs or tissues (T4a) but still can be removed with surgery. It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

**Stage IIIB: T3, N2, M0, any G; any location:** The cancer has grown through the wall of the esophagus to its outer layer, the adventitia (T3). It has spread to 3 to 6 lymph nodes near the esophagus (N2), but has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

**Stage IIIC:** Any of the following:

- **T4a, N1 or N2, M0, any G; any location:** The cancer has grown all the way through the esophagus and into nearby organs or tissues (T4a) but still can be removed with surgery. It has spread to 1 to 6 lymph nodes near the esophagus (N1 or N2), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

- **T4b, any N, M0, any G; any location:** The cancer cannot be removed with surgery because it has grown into the trachea (windpipe), the aorta (the large blood vessel coming from the heart), the spine, or other important structures (T4b). It may or may not have spread to nearby lymph nodes (any N), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G) and can be anywhere along the esophagus.

- **Any T, N3, M0, any G; any location:** The cancer has spread to 7 or more nearby lymph nodes (N3), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade and can be anywhere along the esophagus.

**Stage IV: Any T, any N, M1, any G; any location:** The cancer has spread to distant lymph nodes or other sites (M1). It can be any grade (G) and can be anywhere along the esophagus.

**Adenocarcinoma stages**

The location of the cancer along the esophagus does not affect the stage of adenocarcinomas.
Stage 0: Tis, N0, M0, Gx or G1: This is the earliest stage of esophageal cancer. It is also called high-grade dysplasia. The cancer cells are found only in the epithelium (the layer of cells lining of the esophagus). The cancer has not grown into the connective tissue beneath these cells (Tis). The cancer has not spread to nearby lymph nodes (N0) or other organs (M0). It is well differentiated (G1) or grade information is not available (Gx).

Stage IA: T1, N0, M0, Gx, G1, or G2: The cancer has grown from the epithelium into the layers below, such as the lamina propria, muscularis mucosa, or submucosa, but it has not grown any deeper (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is well (G1) or moderately differentiated (G2), or grade information is not available (Gx).

Stage IB: Either of the following:

- T1, N0, M0, G3: The cancer has grown from the epithelium into the layers below, such as the lamina propria, muscularis mucosa, or submucosa, but it has not grown any deeper (T1). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is poorly differentiated (G3).

- T2, N0, M0, Gx, G1, or G2: The cancer has grown into the muscle layer called the muscularis propria (T2). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is well (G1) or moderately differentiated (G2), or grade information is not available (Gx).

Stage IIA: T2, N0, M0, G3: The cancer has grown into the muscle layer called the muscularis propria (T2). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It is poorly differentiated (G3).

Stage IIB: Either of the following:

- T3, N0, M0, any G: The cancer has grown through the wall of the esophagus to its outer layer, the adventitia (T3). It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It can be any grade.

- T1 or T2, N1, M0, any G: The cancer has grown into the layers below the epithelium, such as the lamina propria, muscularis mucosa, or submucosa (T1). It may also have grown into the muscularis propria (T2). It has not grown through to the outer layer of tissue covering the esophagus. It has spread to 1 or 2 lymph nodes near the esophagus (N1), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade.
Stage IIIA: Any of the following:

**T1 or T2, N2, M0, any G:** The cancer has grown into the layers below the epithelium, such as the lamina propria, muscularis mucosa, or submucosa (T1). It may also have grown into the muscularis propria (T2). It has not grown through to the outer layer of tissue covering the esophagus. It has spread to 3 to 6 lymph nodes near the esophagus (N2) but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

**T3, N1, M0, any G:** The cancer has grown through the wall of the esophagus to its outer layer, the adventitia (T3). It has spread to 1 or 2 lymph nodes near the esophagus (N1), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

**T4a, N0, M0, any G:** The cancer has grown all the way through the esophagus and into nearby organs or tissues (T4a) but still can be removed. It has not spread to nearby lymph nodes (N0) or to distant sites (M0). It can be any grade (G).

Stage IIIB: T3, N2, M0, any G: The cancer has grown through the wall of the esophagus to its outer layer, the adventitia (T3). It has spread to 3 to 6 lymph nodes near the esophagus (N2), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

Stage IIIC: Any of the following:

**T4a, N1 or N2, M0, any G:** The cancer has grown all the way through the esophagus and into nearby organs or tissues (T4a) but still can be removed with surgery. It has spread to 1 to 6 lymph nodes near the esophagus (N1 or N2), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

**T4b, any N, M0, any G:** The cancer cannot be removed with surgery because it has grown into the trachea (windpipe), the aorta (the large blood vessel coming from the heart), the spine, or other important structures (T4b). It may or may not have spread to nearby lymph nodes (any N), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

**Any T, N3, M0, any G:** The cancer has spread to 7 or more nearby lymph nodes (N3), but it has not spread to lymph nodes farther away from the esophagus or to distant sites (M0). It can be any grade (G).

Stage IV: Any T, any N, M1, any G: The cancer has spread to distant lymph
nodes or other sites (M1). It can be any grade (G).

Resectable versus unresectable cancer

The AJCC staging system provides a detailed summary of how far an esophagus cancer has spread. But for treatment purposes, doctors are often more concerned about whether the cancer can be removed completely with surgery (resected). If, based on where the cancer is located and how far it has spread, it could be removed completely by surgery, it is considered potentially resectable. If the cancer has spread too far to be removed completely, it is considered unresectable.

As a general rule, all stage 0, I, and II esophageal cancers are potentially resectable. Most stage III cancers are potentially resectable also, even when they have spread to nearby lymph nodes, as long as the cancer has not grown into the trachea (windpipe), the aorta (the large blood vessel coming from the heart), the spine, or other nearby important structures. Unfortunately, many people whose cancer is potentially resectable may not be able to have surgery to remove their cancers because they aren't healthy enough.

Cancers that have grown into nearby structures or that have spread to distant lymph nodes or to other organs are considered unresectable, so treatments other than surgery are usually the best option.

- References


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Survival Rates for Esophageal Cancer by Stage

Survival rates tell you what portion of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can’t tell you how long you will live, but they may help give you a better understanding about how likely it is that your treatment will be successful. Some people will want to know the survival rates for their cancer type and stage, and some people won’t. If you don’t want to know, you don’t have to.

What is a 5-year survival rate?

Statistics on the outlook for a certain type and stage of cancer are often given as 5-year survival rates, but many people live longer than 5 years. The 5-year survival rate is the percentage of people who live at least 5 years after being diagnosed with cancer. For example, a 5-year survival rate of 90% means that an estimated 90 out of 100 people who have that cancer are still alive 5 years after being diagnosed. Keep in mind, however, that many of these people live much longer than 5 years after diagnosis.

Relative survival rates are a more accurate way to estimate the effect of cancer on survival. These rates compare people with colorectal cancer to people in the overall population. For example, if the 5-year relative survival rate for a specific type and stage of cancer is 90%, it means that people who have that cancer are, on average, about 90% as likely as people who don’t have that cancer to live for at least 5 years after being diagnosed.

But remember, the 5-year relative survival rates are estimates – your outlook can vary based on many factors specific to you.

Cancer survival rates don’t tell the whole story

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can’t predict what will happen in any particular person’s case. There are a number of limitations to remember:

- The numbers below are among the most current available. But to get 5-year survival rates, doctors must look at people who were treated at least 5 years ago.
As treatments are improving over time, people who are now being diagnosed with esophageal cancer may have a better outlook than these statistics show.

- These statistics are based on the stage of the cancer when it was first diagnosed. They do not apply to cancers that later come back or spread, for example.
- The outlook for people with esophageal cancer varies by the stage (extent) of the cancer – in general, the survival rates are better for people with earlier stage cancers. But many other factors can affect a person’s outlook, such as age and overall health, and how well the cancer responds to treatment. The outlook for each person is specific to his or her circumstances.

Your doctor can tell you how these numbers may apply to you, as he or she is familiar with your situation.

The numbers below come from the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) database, looking at people diagnosed with esophageal cancer between 2007 and 2013. The SEER database doesn’t divide survival rates by AJCC TNM stage. Instead, it divides cancers into 3 larger, summary stages:

- **Localized** means that the cancer is only growing in the esophagus. It includes AJCC stage I and some stage II tumors (such as those that are T1, T2, or T3, N0, M0). Stage 0 cancers are not included in these statistics.
- **Regional** means that the cancer has spread to nearby lymph nodes or tissues. This includes T4 tumors and cancers with lymph node spread (N1, N2, or N3).
- **Distant** means that the cancer has spread to organs or lymph nodes away from the tumor, and includes all M1 (stage IV) cancers.

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-Year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized</td>
<td>43%</td>
</tr>
<tr>
<td>Regional</td>
<td>23%</td>
</tr>
<tr>
<td>Distant</td>
<td>5%</td>
</tr>
</tbody>
</table>

These survival rates for esophageal cancer do not separate squamous cell carcinomas from adenocarcinomas, although people with adenocarcinomas are generally thought to have a slightly better prognosis (outlook) overall.

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can’t predict what will happen with any specific person. Knowing the type and the stage of a person’s cancer is important in estimating their outlook. But many other factors are also important, such as the treatment received, how well the cancer responds to treatment, and a person’s overall health. Even when taking these other factors into account, survival rates are at best rough estimates. Your doctor
can tell you how well these numbers may apply to you, as he or she knows your situation best.

- **References**
  


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**What Should You Ask Your Doctor About Esophageal Cancer?**

It’s important for you to have honest, open discussions with your cancer care team. They want to answer all your questions, so that you can make informed treatment and life decisions. For instance, consider these questions:

**When you’re told you have esophageal cancer**

- Where is the cancer located?
Has the cancer spread beyond where it started?

- What is the cancer’s stage (extent), and what does that mean?
- Will I need other tests before we can decide on treatment?
- Do I need to see any other doctors or health professionals?
- If I’m concerned about the costs and insurance coverage for my diagnosis and treatment, who can help me?

When deciding on a treatment plan

- What are my treatment options?
- What do you recommend and why?
- How much experience do you have treating this type of cancer?
- Should I get a second opinion? How do I do that? Can you recommend someone?
- What would the goal of the treatment be?
- How quickly do we need to decide on treatment? What should I do to be ready for treatment?
- How long will treatment last? What will it be like? Where will it be done?
- What risks or side effects are there to the treatments you suggest? Are there things I can do to reduce these side effects?
- How might treatment affect my daily activities? Can I still work full time?
- What are the chances the cancer will recur (come back) with these treatment plans?
- What will we do if the treatment doesn’t work or if the cancer recurs?
- What if I have trouble getting to and from my treatments because of transportation problems?

During treatment

Once treatment begins, you’ll need to know what to expect and what to look for. Not all of these questions may apply to you, but asking the ones that do may be helpful.

- How will we know if the treatment is working?
- Is there anything I can do to help manage side effects?
- What symptoms or side effects should I tell you about right away?
- How can I reach you on nights, holidays, or weekends?
- Do I need to change what I eat during treatment?
- Are there any limits on what I can do?
- Can I exercise during treatment? If so, what kind of exercise should I do, and how
Can you suggest a mental health professional I can see if I start to feel overwhelmed, depressed, or distressed?
What if I need some social support during treatment because my family lives far away?

After treatment

- Do I need a special diet after treatment?
- Are there any limits on what I can do?
- What other symptoms should I watch for?
- What kind of exercise should I do now?
- What type of follow-up will I need after treatment?
- How often will I need to have follow-up exams and imaging tests?
- Will I need any blood tests?
- How will we know if the cancer has come back? What should I watch for?

Along with these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times so you can plan your work or activity schedule. You might also want to ask about clinical trials for which you may qualify.

Keep in mind that doctors are not the only ones who can provide you with information. Other health care professionals, such as nurses and social workers, may have the answers to some of your questions. You can find more information about communicating with your health care team in The Doctor-Patient Relationship.

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