

Principles of Cancer Staging - 2026

American Joint Committee on Cancer





American Joint Committee on Cancer (AJCC)

Cancer program of the American College of Surgeons

Member Organizations

- [American Association of Pathologists' Assistants](#)
- [American Cancer Society](#)
- [American College of Physicians](#)
- [American College of Radiology](#)
- [American College of Surgeons](#)
- [American Head and Neck Society](#)
- [American Society for Radiation Oncology](#)
- [American Society of Clinical Oncology](#)
- [American Society of Colon and Rectal Surgeons](#)
- [American Urological Association](#)
- [Canadian Partnership Against Cancer](#)
- [Centers for Disease Control and Prevention](#)
- [College of American Pathologists](#)
- [International Collaboration on Cancer Reporting](#)
- [National Cancer Database](#)
- [National Cancer Institute](#)
- [National Cancer Registrars Association](#)
- [National Comprehensive Cancer Network](#)
- [North American Association of Central Cancer Registries](#)
- [Society of Gynecologic Oncology](#)
- [Society of Surgical Oncology](#)
- [Society of Urologic Oncology](#)



AJCC Mission

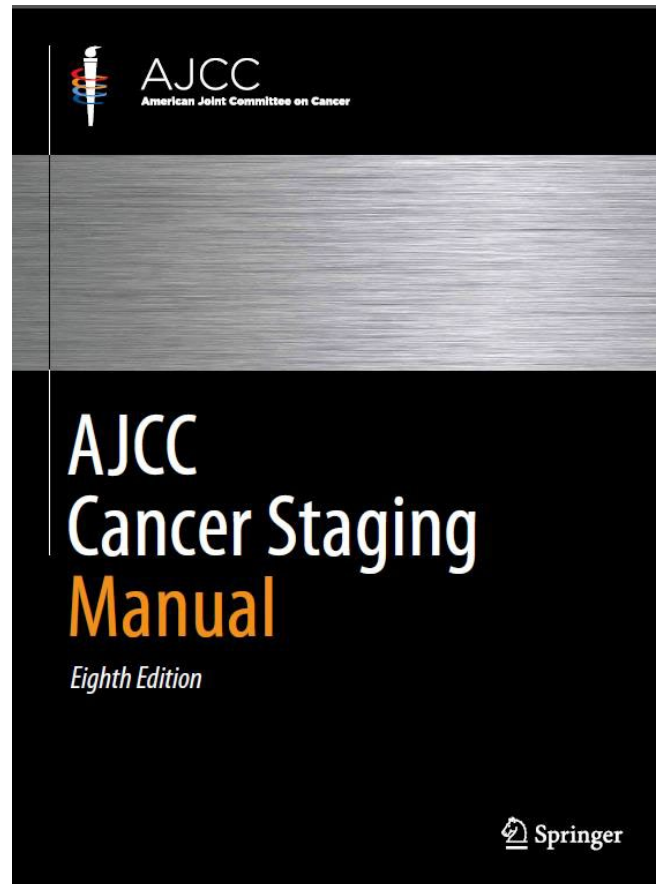
The American Joint Committee on Cancer (AJCC) provides worldwide leadership in the development, promotion and maintenance of evidence-based systems for the classification and management of cancer in collaboration with multidisciplinary organizations dedicated to cancer surveillance and to improving care.

- Cancer Staging Manuals
 - Periodic publications to provide single source of truth
 - Describe location, extent, severity, and prognosis of cancers
- Last full-print publication, AJCC Cancer Staging Manual, 8th Ed
 - Implemented for patient care on Jan.1, 2018:
 - 18 parts with 83 chapters
 - Produced by over 450 national and international **volunteer** cancer experts
 - Effort led by expert panel Chairs and Vice-Chairs

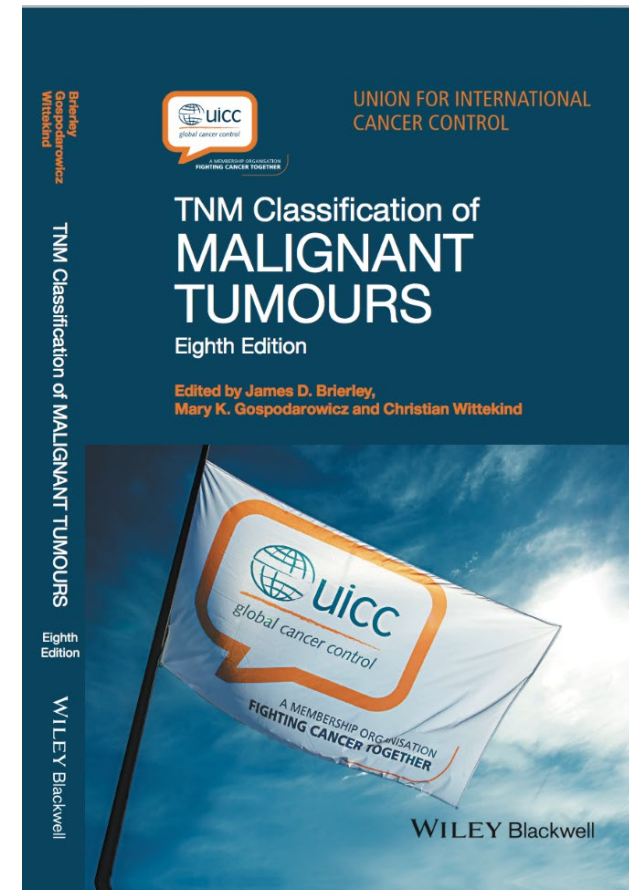


Publications 2016

AJCC: Cancer Staging Manual



UICC: TNM Classification System





Uses of Cancer Staging

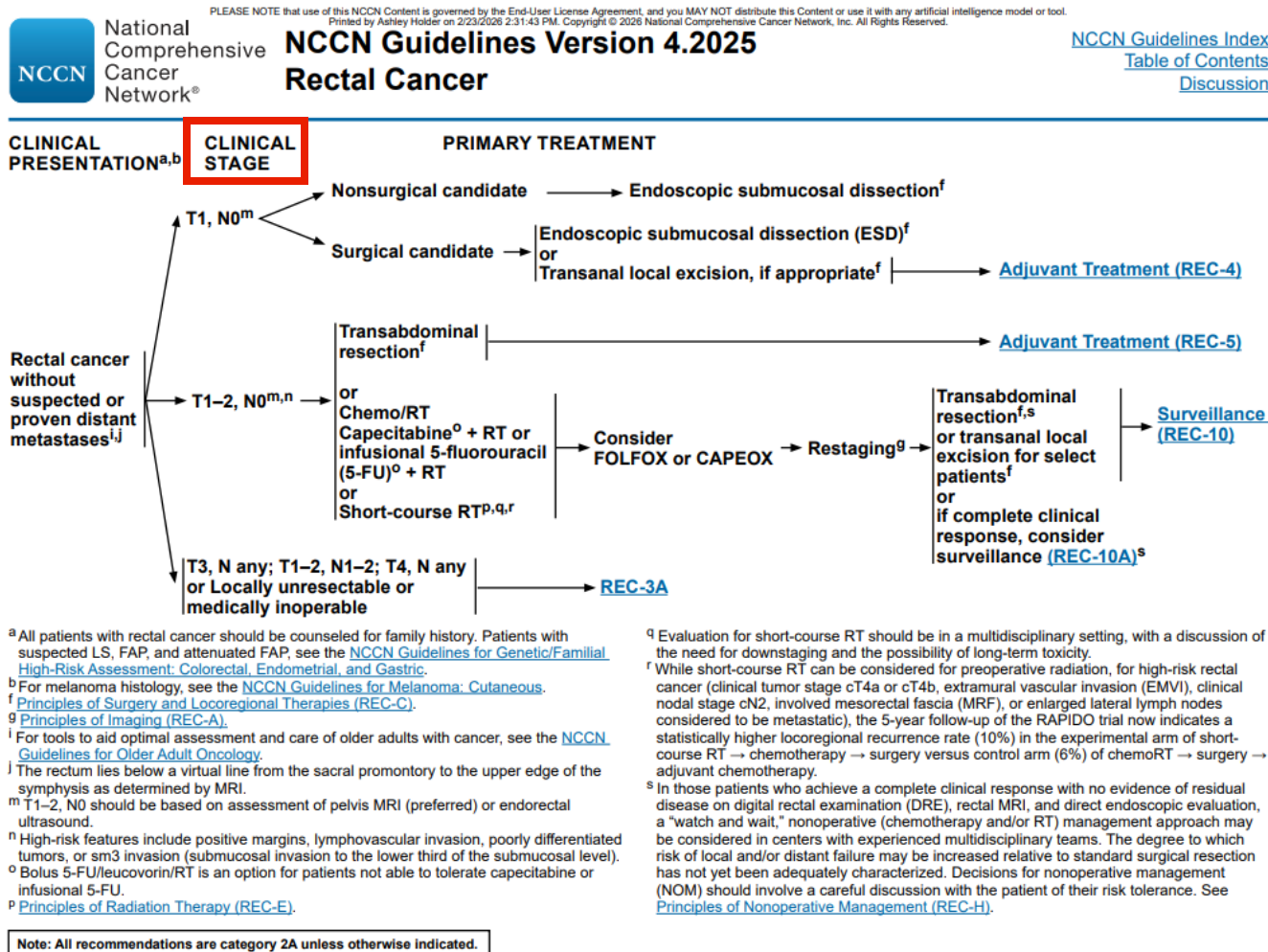
- Facilitate exchange and comparison of information
 - Between providers and treatment centers
 - Both nationally and internationally
- Determine prognosis
- Guide treatment recommendations
- Facilitate clinical research
 - Evaluate results of treatments and clinical trials
- Provide longitudinal cancer surveillance statistics: Center Disease Control – National Program of Cancer Registries (CDC-NPCR) and National Cancer Institute – Surveillance, Epidemiology and End Results (NCI - SEER)
- Measure early detection efforts and impact of screening



Factors Determining Prognosis after Cancer Diagnosis

- Primary tumor characteristics:
 - Location
 - Clinicopathologic factors
 - Local, regional, and distant extent (**burden of disease**)
- Patient (**host**) characteristics:
 - Age
 - Co-morbidities
 - Lifestyle factors (smoking, ethanol use)
 - Nutritional status
 - Immunocompetency
 - Psychosocial factors
 - Genetic factors
- **Environment:**
 - Access to quality healthcare
 - Social determinants of health
 - Exposure to carcinogenic chemicals/pollutants and/or radiation
- Integration of host and environmental factors is complex
 - NOT currently used in staging systems, with rare exception

Stage is used in Treatment Decision Making



- Stage at diagnosis is essential for treatment planning
- NCCN guidelines for the management of rectal cancer:
 - Primary treatment recommendations differ by stage

REC-3

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®), Version 4.2025



Stage is Important in Patient Education



About Cancer ▾ Cancer Types ▾ Research ▾ Grants & Training ▾ News & Events ▾ About NCI ▾

[Home](#) > [Cancer Types](#) > [Colorectal Cancer](#) > [Patient](#) > Rectal Cancer Treatment (PDQ®)–Patient Version

Colorectal Cancer

Patient

Colon Cancer Treatment

Rectal Cancer Treatment

Childhood Colorectal Cancer

Colorectal Cancer Prevention

Colorectal Cancer Screening

Health Professional >

Research Advances >

Rectal Cancer Treatment (PDQ®)–Patient Version

[Go to Health Professional Version](#) ➔

ON THIS PAGE

- [General Information About Rectal Cancer](#)
- [Stages of Rectal Cancer](#)
- [Treatment Option Overview](#)
- [Treatment of Stage 0 \(carcinoma in situ\)](#)
- [Treatment of Stage I Rectal Cancer](#)
- [Treatment of Stages II and III Rectal Cancer](#)
- [Treatment of Stage IV and Recurrent Rectal Cancer](#)
- [To Learn More About Rectal Cancer](#)
- [About This PDQ Summary](#)



- Patients encouraged to ask stage of their cancer if they have not been told

- Allows patients to identify stage-specific information about their cancer and treatment options



Staging in Population Health

If stage is known, as well as incidence, data can be used for:

Cancer Screening

- Assess the need and effectiveness of screening
 - After introduction of an effective screening program, would expect change in distribution with fewer stage IV and more stage I cancers

Treatment guideline concordance

- If treatment is known, can assess if treatment given is concordant with guidelines utilizing stage

Resource Planning

- Different resources needed for stage at presentation
- More advanced stage → greater need for systemic therapy and palliative care facilities

Comparisons of survival by stage

- Survival by stage can be compared between countries



Cancer Staging Essentials

To effectively care for any patient with cancer, it is essential to consider three factors:

- Site/organ of origin of the cancer
 - e.g. lung, prostate, breast
- Histological and biologic characteristics
 - if lung cancer: non small cell (NSCLC) or small cell cancer?
 - if prostate cancer: tumor grade?
 - if breast cancer: grade, hormone receptor status, HER2 overexpression?
- Extent of the cancer - **TNM Classification**

General Rules of TNM

- T** Size and extent of primary **tumor**
- N** Absence or presence and extent of regional lymph **node** metastasis; non-nodal regional metastasis
- M** Absence or presence and extent of distant **metastasis**



INTRODUCTION TO STAGE

General Rules - Primary Tumor - T Category

- **TX** Primary tumor cannot be assessed
- **T0** No evidence of primary tumor
- **Tis** Carcinoma in situ
- **T1-T4** Increasing size and/or local extent

T is a category. There is no T “stage”*

*take-home message



INTRODUCTION TO STAGE

General Rules - Regional Nodes - N Category

- **NX** Cannot be assessed (not examined)
- **N0** No regional lymph node metastasis
- **N1-N3** Increasing involvement of regional lymph nodes.
 - May include non-nodal in-transit disease in melanoma or tumor deposits (TDs) in colon carcinoma
 - Distant nodal involvement is considered in M, not N, category

N is a category. There is no N “stage”



INTRODUCTION TO STAGE

General Rules - Metastasis - M Category

- **M0** No distant metastasis
 - Clinical assessment of metastasis can be based on exam alone. No imaging studies are required to assign M0
 - **cM0** No clinical evidence of metastases by examination or imaging for distant disease
- **M1** Distant metastases
 - cM1 is used where physical examination or imaging studies show distant disease. Biopsy confirmation is required for pM1
- **cMX** is not valid category and should never be used*
- **pM0** is not valid category and should never be used*

*take-home message

Stage Group

- T, N, and M categories combine to yield stage groups:
- **Stage 0** – in situ cancer
- **Stage I** – invasive tumor confined to primary site without evidence of regional lymph node involvement
- **Stages II, III** – invasive tumor that may be due to regional extension with involvement of regional lymph nodes
- **Stage IV** – Greatest tumor involvement or distant metastasis



Who is Responsible for Cancer Staging?

- Staging requires the collaborative effort of many professionals, including the managing physician, pathologist, radiologist, oncology data specialists (ODS/cancer registrars) and others
- While the pathologist and the radiologist provide important information, **stage is defined ultimately by the managing physician*** from the synthesis of all available information, some of which the other physicians may not have

*take-home: Chap 1, 8th Ed AJCC
Cancer Staging Manual



Staging Classifications – Time Points of Staging

- **Clinical**

- cTNM Stage applies to the initial presentation ONLY
- Prefix “c” is used– cT, cN, cM or pM
- All information from history, physical examination and imaging
- Whatever is available – advanced imaging NOT required

- **Pathological**

- Includes clinical information + surgeon’s operative findings
- AND results of surgery (if surgery initial treatment): prefix “p” - pT, pN, cM or pM

- **Post-therapy (post-neoadjuvant) – denoted by prefix “y”**

- Includes clinical or pathologic information after completion of initial systemic or radiation therapy. If no surgery follows, then ycT, ycN is used. If surgery follows neoadjuvant treatment, ypT, ypN is used.



Use of the Electronic Health Record (EHR) for Staging

Staging Tools in the EHR—Benefits:

- Provide structured fields within the EHR to capture and document discrete elements of tumor staging
 - Help submit staging data to the National Cancer Database (NCDB) and national cancer registries aligned with AJCC TNM Staging System
 - By capturing staging data, clinicians can develop more personalized and effective treatment plans
 - Aid oncology data specialists (ODS) in capturing the correct stage for patient abstracts
 - In Epic, staging found under Problem list. *
- *take-home



Clinical Stage (cTNM)

Clinical stage is based on patient history, physical examination, imaging, and any procedure performed before initiation of treatment, e.g. endoscopy.

- No specific imaging required to assign a clinical stage
- Imaging study information may be used for clinical staging
- Biopsy information on regional lymph nodes and/or other sites of metastatic disease may be included in clinical classification



Case Example - Rectal Carcinoma

- 65 y/o man presents with rectal bleeding
- Exam reveals a rectal mass
- Biopsy confirms adenocarcinoma
- Pelvic MRI performed



Case Example

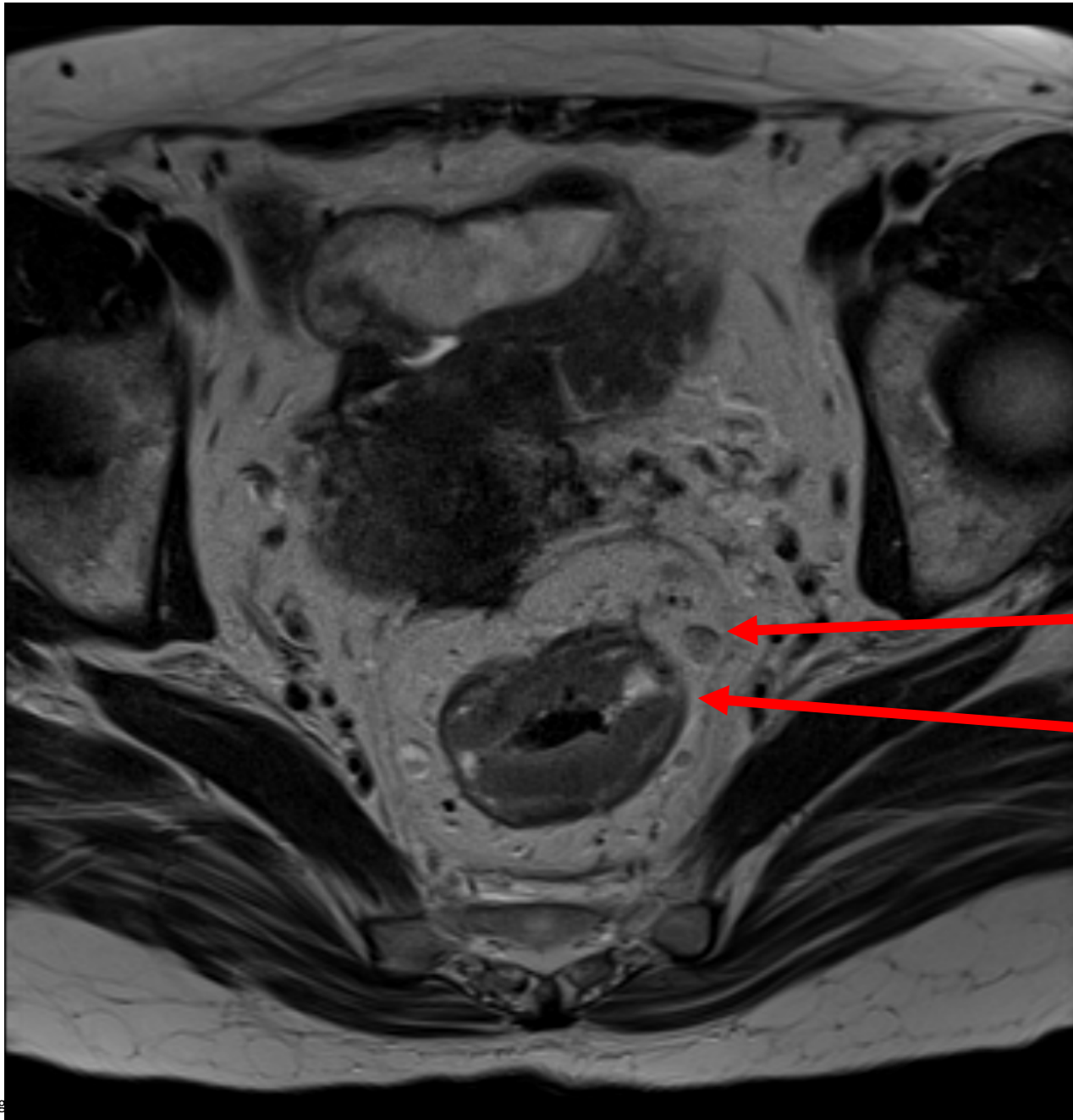


Image of MRI

cT3N1

Rectal cancer

Abnormal perirectal
lymph Node

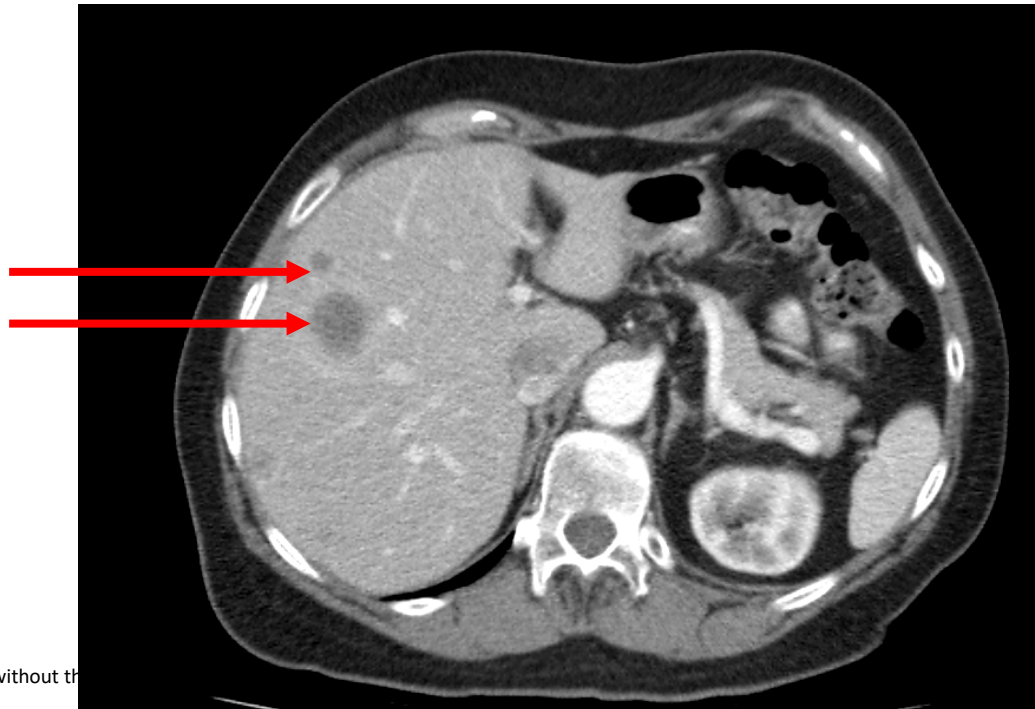
T3 Rectal Cancer as it invades
through muscularis propria



Case Example - Further Imaging Studies for Clinical Staging

- CT C/A/P reveals multiple liver metastases
- Needle biopsy positive for metastatic rectal CA
- cM1a (metastasis to one site or organ without peritoneal metastasis)

Liver metastases





Therefore, the Stage Group is:

AJCC Cancer Staging Manual, 8th Ed

When T is...	And N is...	And M is...	Then the stage group is...
Tis	N0, NX	M0	0
T1 , T2	N0	M0	I
T3	N0	M0	IIA
T4a	N0	M0	IIB
T4b	N0	M0	IIC
any T	N1-N2	M0	III
T1 –T2	N1/N1c	M0	IIIA
T1	N2a	M0	IIIA
T3–T4a	N1/N1c	M0	IIIB
T2–T3	N2a	M0	IIIB
T1–T2	N2b	M0	IIIB
T4a	N2a	M0	IIIC
T3–T4a	N2b	M0	IIIC
T4b	N1-N2	M0	IIIC
Any T	Any N	M1	IV
Any T	Any N	M1a	IVA
Any T	Any N	M1b	IVB
Any T	Any N	M1c	IVC

- T3N1aM1a
- Stage IVA



Summary: Distant Metastasis Found on Initial Workup

- Clinical TNM: T3 N1a M1a, Stage IVA
- Clinical staging was not complete until imaging was performed
- Clinical stage used for prognosis and to direct treatment
- Treatment recommendations (at least initially) will be systemic therapy
- There is no pathological stage since no surgery is performed



Staging for Newly Diagnosed Solid Tumors Without Distant Metastases

- Primary tumor
- Regional nodes
- No evidence of distant metastasis

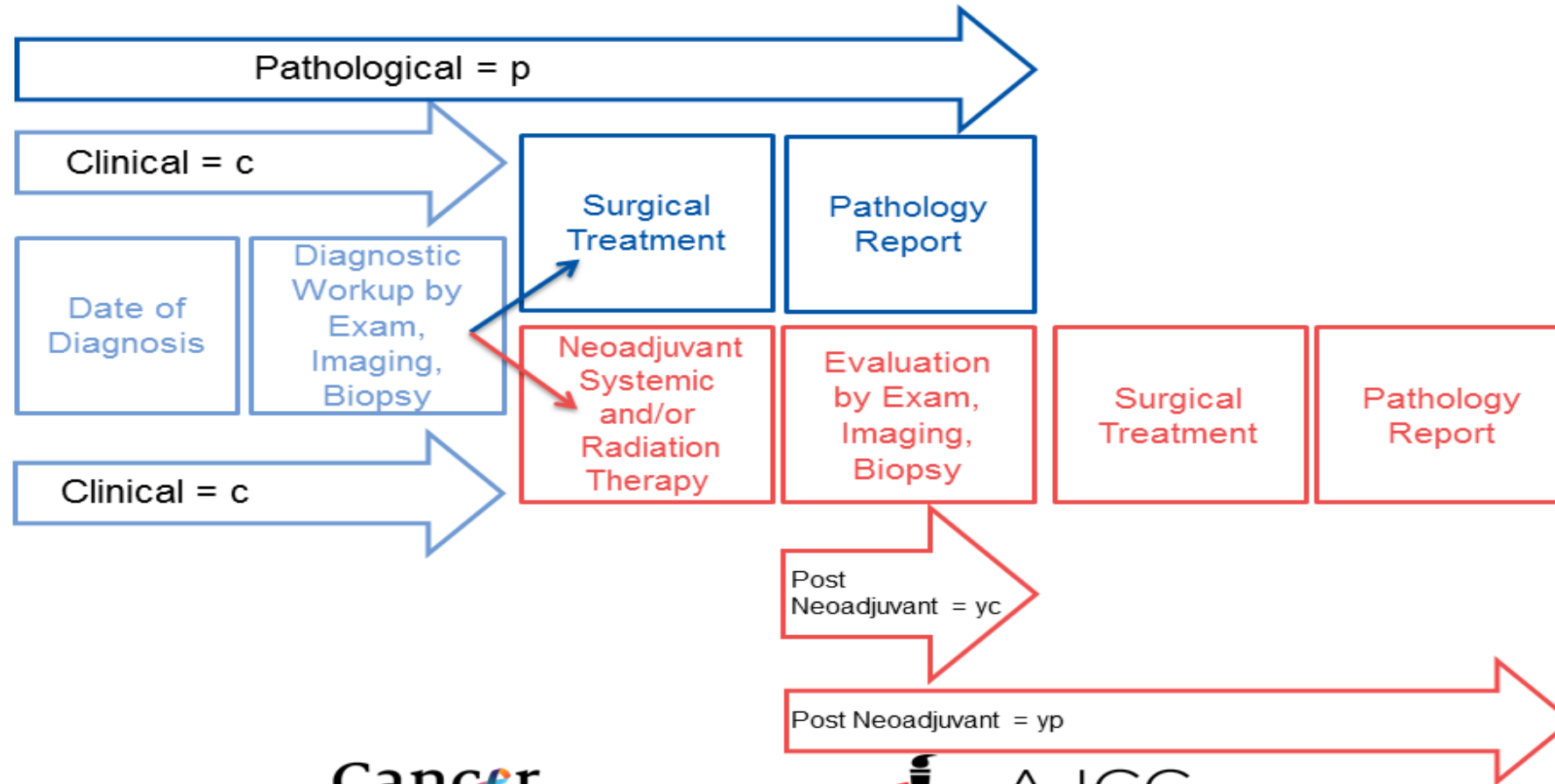
Planned Treatment with Curative Intent



Understanding Stage Classifications

AJCC Stage Classifications

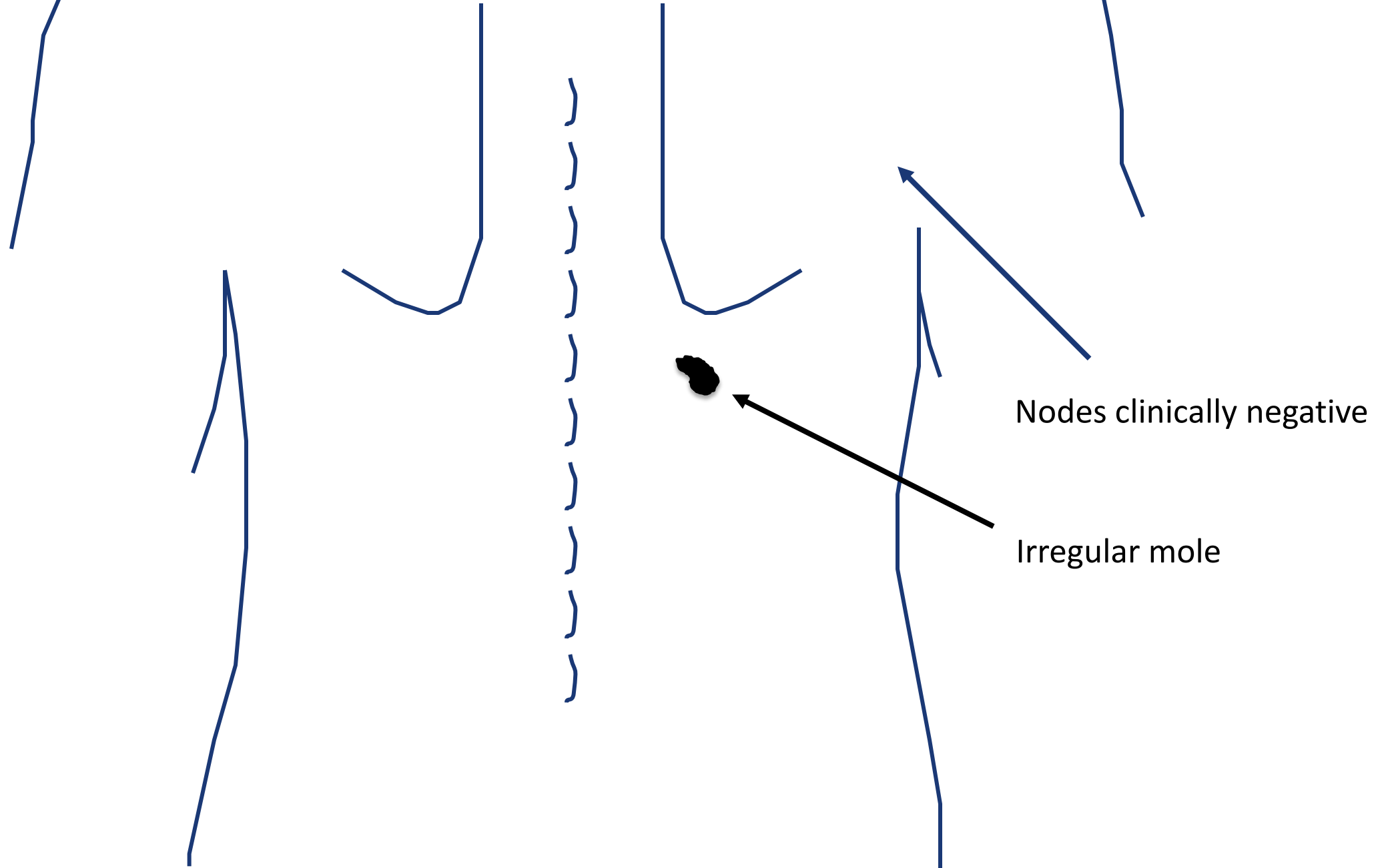
Defining Time Frame and Criteria



Staging After Initial Treatment with Curative Intent for localized Disease



Case Example: 45 y/o man with itchy mole on right back





1.8 X 0.8 cm



College of American Pathology Reporting Template - Melanoma

- A) Skin, right back, punch biopsy:**
1. Approximate Breslow thickness: **at least 1.5 mm.**
 2. Clark's Level: IV.
 3. Ulceration: **present**
 4. Mitotic rate: 3/mm².
 5. Lymphocapillary invasion: None identified.
 6. Satellitosis: None identified.
 7. Perineural invasion: None identified.
 8. Lymphocytic infiltrate: Not brisk
 9. Regression: None identified.
 10. Margins: Peripheral margins positive for melanoma.
 11. Melanoma in situ: Present.
 12. Biopsy site identified.

Features in **red** are used for T category



Clinical Stage after Biopsy

- At least cT2b (1-2 mm with ulceration)
- cN0 - regional nodes normal to palpation
- cM0 – no symptoms suggestive of distant metastasis

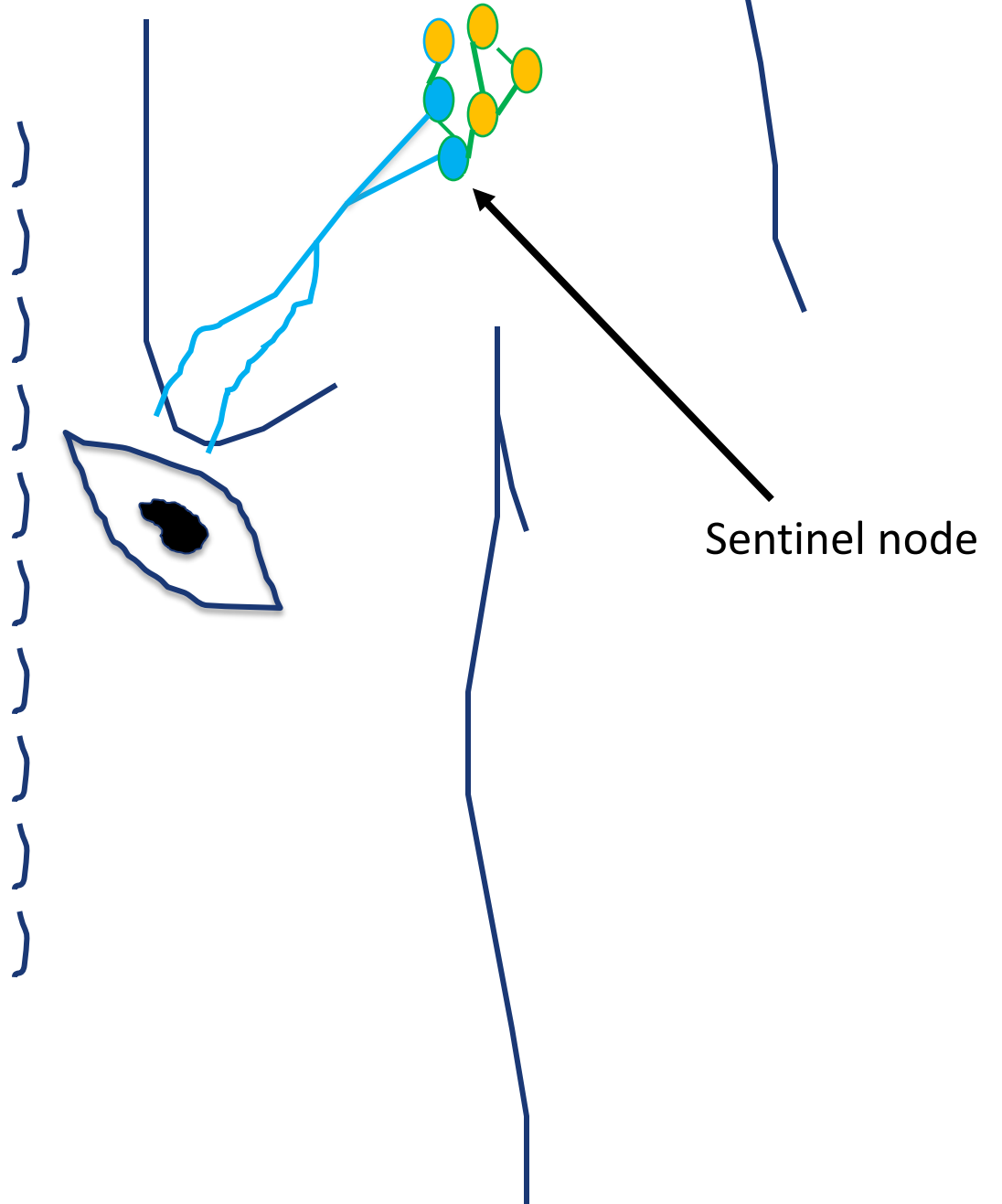
Stage group: At least IIA

Amin M, et al: AJCC Cancer Staging Manual, 8th Ed, 2016



Melanoma Right Back

Treatment:
Wide local excision
w/ 1 cm margins
+ sentinel node biopsy





Surgical Pathology

- Superficial spreading melanoma
- Thickness: 1.8 mm thick
- Margins widely free
- 1 of 2 sentinel nodes positive for melanoma
 - Largest nodal deposit – 1 mm
 - No extranodal extension



Pathological Stage after Surgery

- pT2b (1-2 mm with ulceration)
- pN1a (sn*) – one positive node
- cM0 – no symptoms suggestive of distant metastasis + staging CT
C/A/P negative

Stage group: IIIB

*node(s) found positive only on sentinel node biopsy are designated **sn**

Amin M, et al: AJCC Cancer Staging Manual, 8th Ed, 2016



Pathological Stage (pTNM)

Pathological Stage is applicable after surgery is performed and before initiation of adjuvant radiation or systemic therapy, if administered.

pTNM is composed of information from:

- Clinical staging from diagnostic workup
- Operative findings
- Pathology review of resected surgical specimens



Role of Pathology in Cancer Staging

- Pathology is critical for clinical and pathological cancer staging
- Pathology can only evaluate and report on specimens that are submitted:
 - Often occurs at different time points
 - Biopsies and/or resected specimens
- Report often includes most accurate pT and pN staging information:
 - **pM1 can be based on a positive biopsy or excision of a distant site**
 - **There is no pMX or pM0 designation***

*take-home



Additional Pathology Studies Used for Staging

- Additional tissue assays are currently required for some tumor types
 - e.g. HER2 status, estrogen and progesterone receptor status in breast cancer
 - Many more will potentially be required for other tumors in future
- Serological and circulating tumor cell assays (CTCs) and cell-free circulating tumor DNA (ctDNA) are becoming important for identification of cancer recurrence
 - May soon be integrated into cancer staging



Rules of Cancer Staging – Prognostic Stage Group

- Assigning stage group includes:
 - T category
 - N category
 - M category
 - Non anatomic factors
- **Non-anatomic factors** are used to assign a **Prognostic Stage Group** for some disease sites
- Prognostic Stage group is required when available



Non-anatomic factors

- Measurements/assays generally available in upper resource settings
- Often not available in lower and middle resource settings
- Therefore, must maintain anatomic staging for universal application
- Prognostic staging includes non-anatomic factors
 - Better inform prognosis and treatment
 - Examples: estrogen/progesterone receptors, microsatellite instability, etc.



Evolution to Prognostic Staging: Breast Cancer

- AJCC 8th Edition Breast Staging incorporates key prognostic factors into primary staging
 - Anatomic stage groups still maintained
 - Clinical and pathological Stage
 - When biomarkers cannot be assessed
- “Prognostic Stage” - stage recorded in US cancer registries
- Requires:
 - T, N, and M
 - Grade; HER2; Estrogen Receptor; Progesterone Receptor
 - Genomic profiles (OncotypeDx™) as appropriate

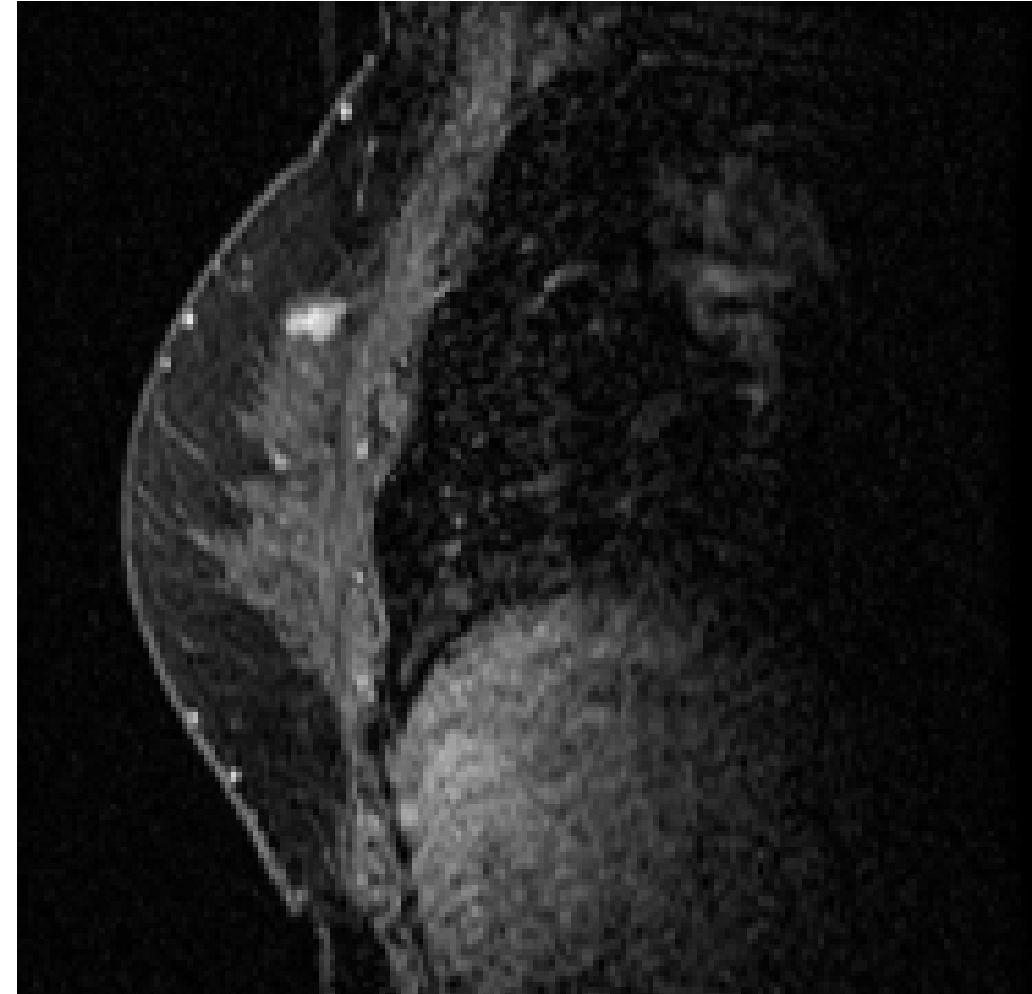


Case Example - Limitations of Anatomic Breast Cancer Staging

Diagnostic mammography 2.5 cm mass

Similar Clinical presentations - 2 pts:

- **42F** w/ 2.5 cm breast mass, clinically node negative
- **75F** w/ 2.5 cm breast mass, clinically node negative





Case Example - Post-Biopsy Clinical Prognostic Factors

Change Stage

- Diagnostic core biopsy pathology:

42F w/ 2.5
cm breast
mass,
clinically
node
negative

- Core needle biopsy = Grade III IDC*, ER-, PR-, HER2- (triple negative)
- Clinical prognostic Stage IIB

75F w/ 2.5
cm breast
mass,
clinically
node
negative

- Core needle biopsy = Grade I tubular IDC*, ER+ PR+, HER2- (HR positive)
- Clinical prognostic Stage IB

*IDC = infiltrating ductal carcinoma



Both Patients have Surgery as First Course of Treatment

- Both patients undergo partial mastectomy and sentinel lymph node biopsy
- Pathology: 2.5 cm IDC, negative margins, 0/3 sentinel nodes (negative)
- Final stage:
 - 42F: pT2 pN0 (sn)* cM0, pathological prognostic Stage IIA
 - 75F: pT2 pN0 (sn)* cM0, pathological prognostic Stage IA

*sn = sentinel node



Case Example – Unknown Primary Tumor



38M palpable right inguinal node - core needle biopsy showing metastatic melanoma

Clinical stage?

Work up?





38M palpable right inguinal node core needle biopsy = metastatic melanoma

Clinical stage:
T0 (unknown primary) N1 M0
(PET/CT only shows right inguinal node)
= Stage III





How to Record the Stage

- Stage after diagnosis and workup (clinical) and after treatment (pathological) is recorded in the chart and **remains unchanged**

Use of other classifications:

- After neoadjuvant therapy – ycTNM or ypTNM:
 - yc if no subsequent surgery performed.
 - yp if surgery performed after neoadjuvant treatment
- Recurrence after a disease-free interval following treatment with curative intent:
 - A recurrent staging system is under development through an AJCC Recurrence Staging Workgroup



Staging After Neoadjuvant Treatment

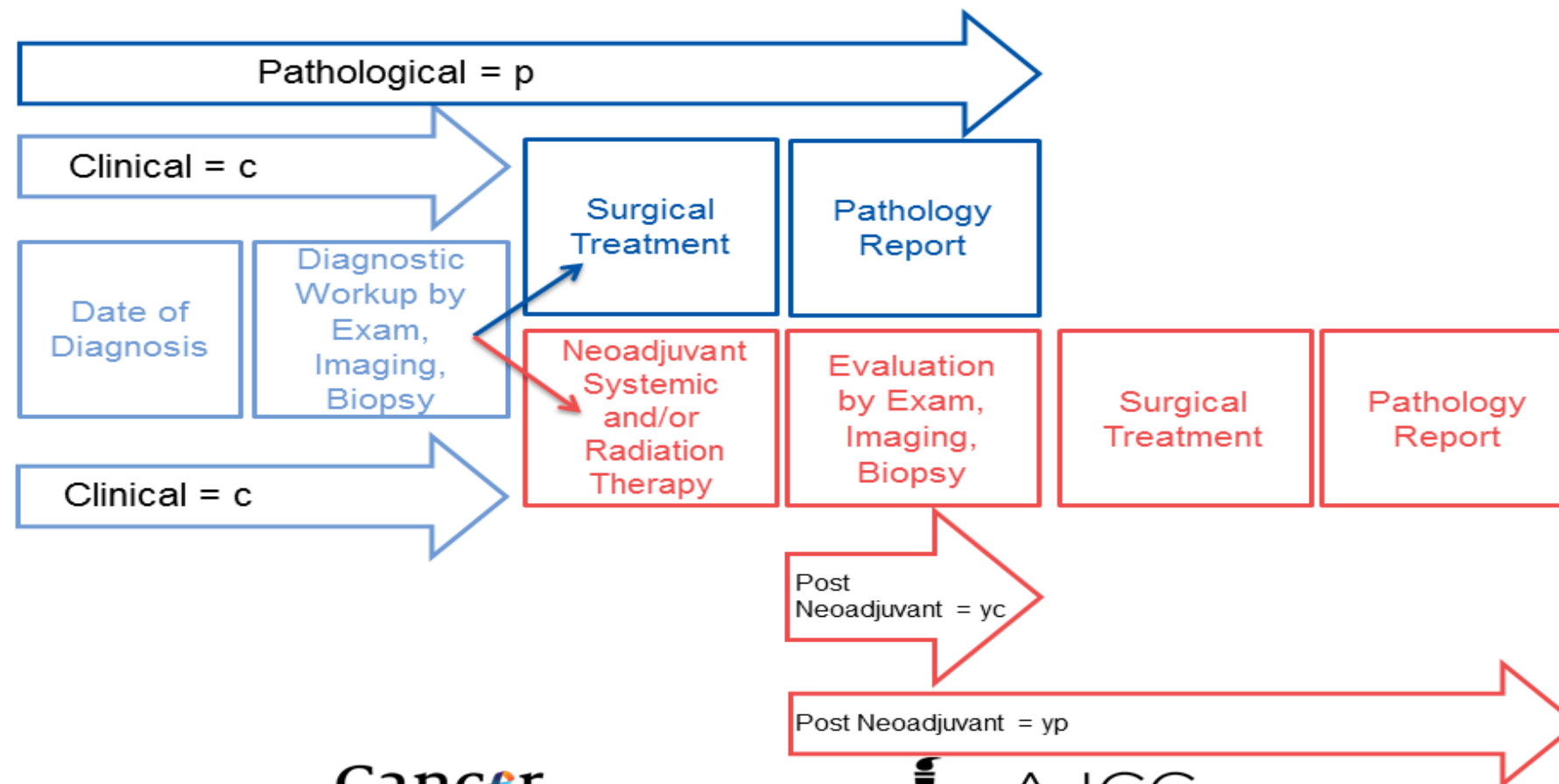




Neoadjuvant Classification and Staging

AJCC Stage Classifications

Defining Time Frame and Criteria





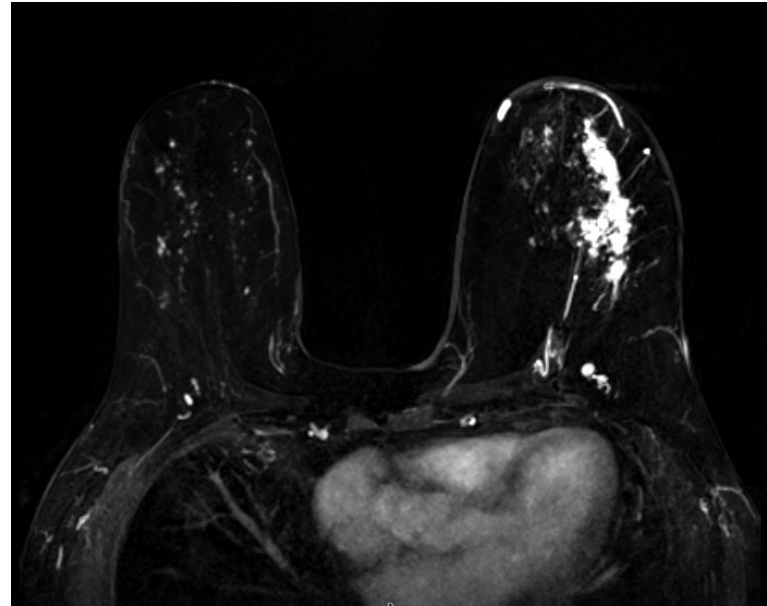
Case Example – 61F with High Grade, Hormone Receptor-Negative Breast Carcinoma

- 61-year-old woman presents with left breast mass and palpable non-matted left axillary lymphadenopathy
- Diagnostic bilateral mammogram and US demonstrated:
 - a 3.8cm mass in the left lower outer quadrant (LOQ) with associated calcifications
 - a 6.3cm focal asymmetry and associated calcifications in the left upper outer quadrant (UOQ)
 - abnormal level I left axillary lymph nodes by US
- Left US-guided biopsies (UOQ, LOQ, axillary node): Invasive ductal carcinoma, Grade 3 (ER-/PR-/HER2+) and associated ductal carcinoma in situ
- Staging PET-CT chest and abdomen/pelvis negative for distant metastasis
- Clinical stage: cT3N1M0 (clinical prognostic **Stage IIIA**)

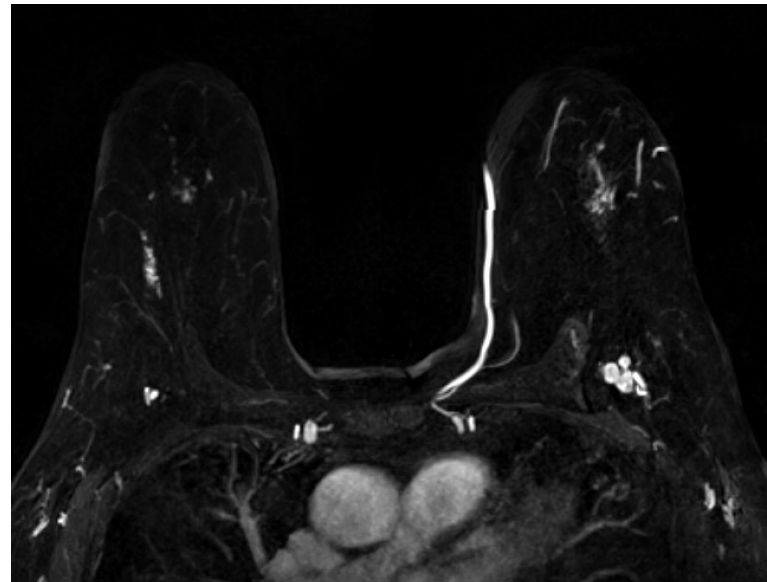


BREAST MRI

cT3 cN1 cM0
Breast cancer



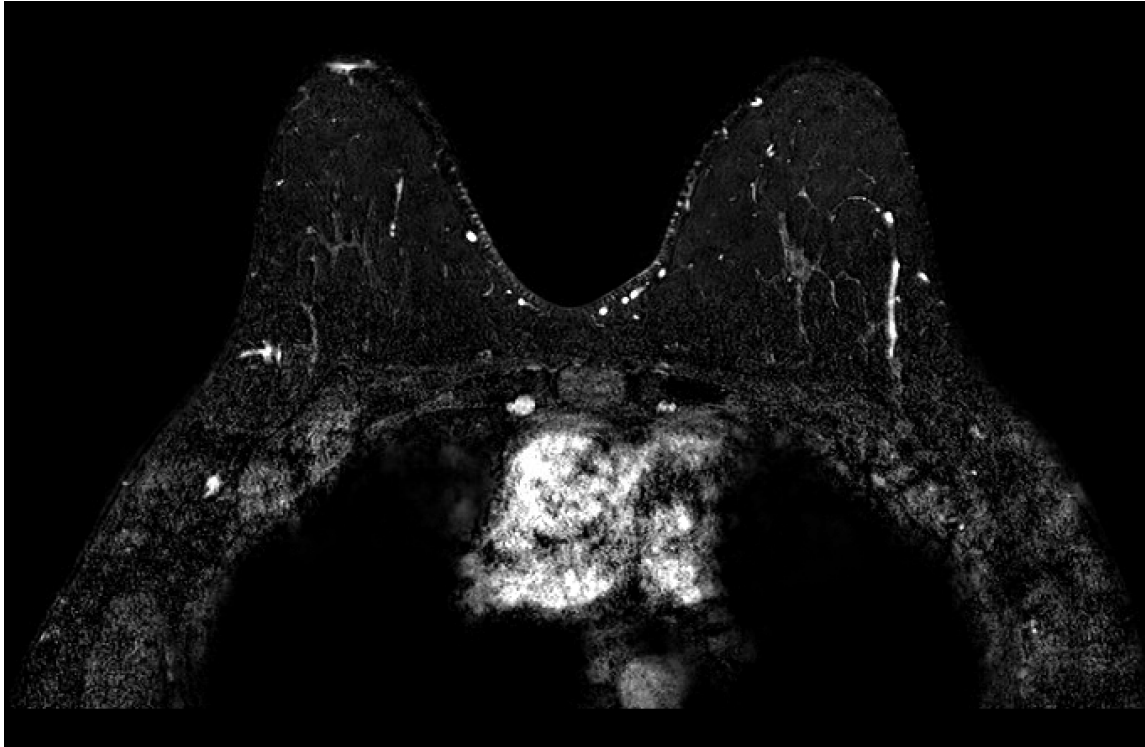
← **T3 breast cancer:
>5 cm contiguous disease**



← **Abnormal axillary
lymph node**



Case Example - Initial Course of Treatment - Chemotherapy



- Localization clip placed into axillary node prior to start of chemo
- MRI post chemo shows no evident breast mass or abnormal axillary node(s): ycT0N0
- Surgery (skin-sparing mastectomy and seed-localized targeted axillary sentinel node dissection) is performed.
- Pathology reveals no residual tumor involving the breast or three axillary sentinel lymph nodes (including the clipped node)



Case Example - Final Post-Neoadjuvant Staging

Post-neoadjuvant treatment:

Pathological complete response (pCR) in breast and axilla

- ypT0
- ypN0
- cM0 (remains clinical M0)

- * There was insufficient follow up data for analysis of survival at the time of the 8th Ed. publication, therefore, there is no Stage Group for breast cancer patients after neoadjuvant treatment in the AJCC 8th Ed. Cancer Staging Manual
- * AJCC Version 9 Breast Cancer Staging System (coming in 2027) does include sufficient survival data for analysis and will publish ypTNM Stage Groups after neoadjuvant treatment



Complete Pathological Response after Neoadjuvant Therapy – ypT0 ypN0 cM0

- The cM0 category doesn't change after neoadjuvant treatment
- ypT0 ypN0 cM0 is **NOT** Stage 0*. There is no Stage group for a complete pathological response.*
- Complete pathological response to neoadjuvant therapy (ypT0 and ypN0) is still used clinically for prognosis, further therapy, and follow up

*take-home



Neoadjuvant Therapy for Post-therapy Staging

- Neoadjuvant therapy eligible for post-therapy yc and yp staging should meet **national treatment guidelines** to be considered course of **treatment**
- Systemic therapy (chemo/hormone/immunotherapy) must
 - Be provided by **dosage and time frame**
 - Providing drug in any dosage for any length of time does **not** make it treatment
- Short course of tamoxifen **not** treatment
 - Given to see if cells react to drug as surrogate of tumor response
 - Can be predictive to plan for standard 5-10 years as adjuvant treatment after surgery
- Drugs given for unconventional reasons prior to surgery
 - Physician experts and national treatment guidelines make it clear:
 - These drugs **not** given to treat cancer and
 - Do **not** provide treatment to patient



Neoadjuvant Therapy with No Surgery

- Significant issue causing incomplete data analysis
 - 20% estimated neoadjuvant treatment is not followed by *surgery* across all disease sites
 - 90% of patients with anal carcinoma are treated with neoadjuvant chemoradiation and do *not* have surgery
- Neoadjuvant therapy gaining in popularity, some examples
 - Head & Neck
 - Esophagus/Stomach
 - Rectum
 - Neuroendocrine
 - Soft tissue sarcoma
 - Melanoma
 - Breast
 - GYN sites
 - Adrenal

This trend reinforces the importance in collecting yc clinical response after neoadjuvant therapy

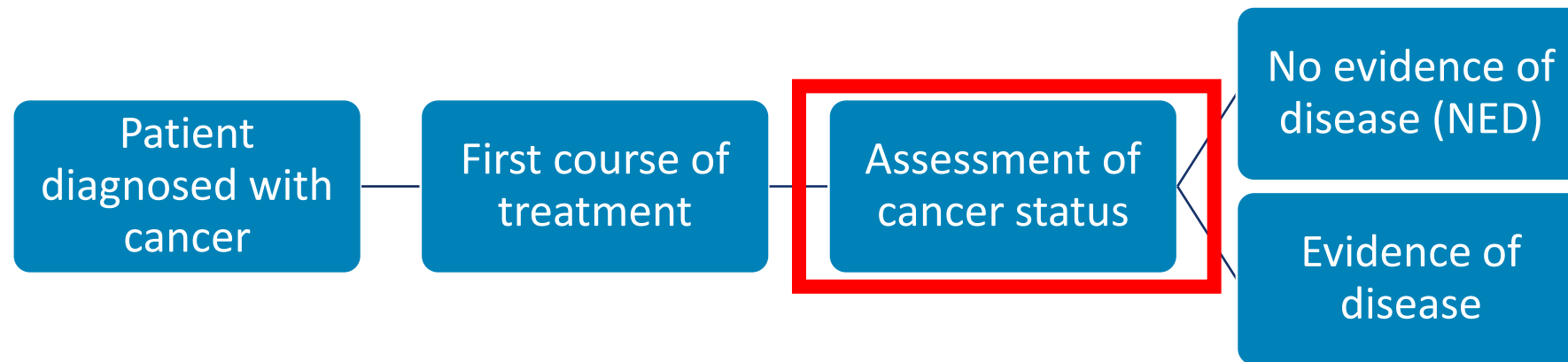


Staging Cancer Recurrence – An Ongoing Exploration





Patient Journey to First Cancer Status Evaluation





Case Example - 65M with Recurrent Cancer

Clinical Stage III rectal CA, NED after chemoradiation and resection with curative intent, downstaged to ypT0 ypN0 cM0; There is no Stage group after complete pathological response



- **Five years later** has pelvic pain. MRI reveals sacral mass.
- Biopsy consistent with rectal carcinoma recurrence

Sacral mass



Case Example - What is the Current Stage?

- This is NOT a new Stage IV cancer*
- The best description is a distant (bony) recurrence of a previous ypT0 ypN0 cM0 rectal carcinoma
- The treatment recommendations will likely be same/similar for a patient with newly diagnosed (de novo) Stage IV disease

*take-home



Staging Cancer Recurrence (rTNM)

- Identification and characterization of cancer recurrence is vital:
 - 1. For clinical care to give prognostic information to providers, to direct treatment recommendations for patients, and stratify eligibility for entry into clinical trials
 - 2. To help the cancer surveillance community track long-term outcomes to guide federal healthcare resource allocation
- Although recurrent or retreatment rTNM is described in Chapter 1 of the AJCC 8th Ed Cancer Staging Manual, it is currently NOT in use
- AJCC Cancer Recurrence Staging Workgroup was formed in 2025 to address these challenges



Overview of Challenges to Refine Cancer Recurrence Staging (rTNM) – Domains of Work

- Definitions of terms
 - recurrence, progression, no evidence of disease (NED), treatment with curative intent, residual or persistent disease
- What is needed to assess cancer status?
 - Timing
 - Measurement of recurrence –clinical evaluation, imaging, diagnostic testing
 - Disease agnostic or specific?
- Harmonization of registry rules with clinical practice
- Documentation in health record
 - There is no requirement to document recurrence. Synoptic documentation is preferable but not standardized.
 - Cancer care follow up may be decentralized and not captured by ODS



Basic disease status at follow up – Lack of Documentation

- There is no mandate for long-term patient follow up and no standardization of documentation in the EHR.
- Setting of follow up may be outpatient clinics where recurrence may not be captured by ODS.
- Basic disease status is crucial to identify recurrence:
 - NED (no evidence of disease), AWD (alive with disease), Status unknown
- Who is responsible for documentation? **The managing physician is responsible to document recurrence***

*take-home

Evolution of Cancer Staging





Evolution of Cancer Staging

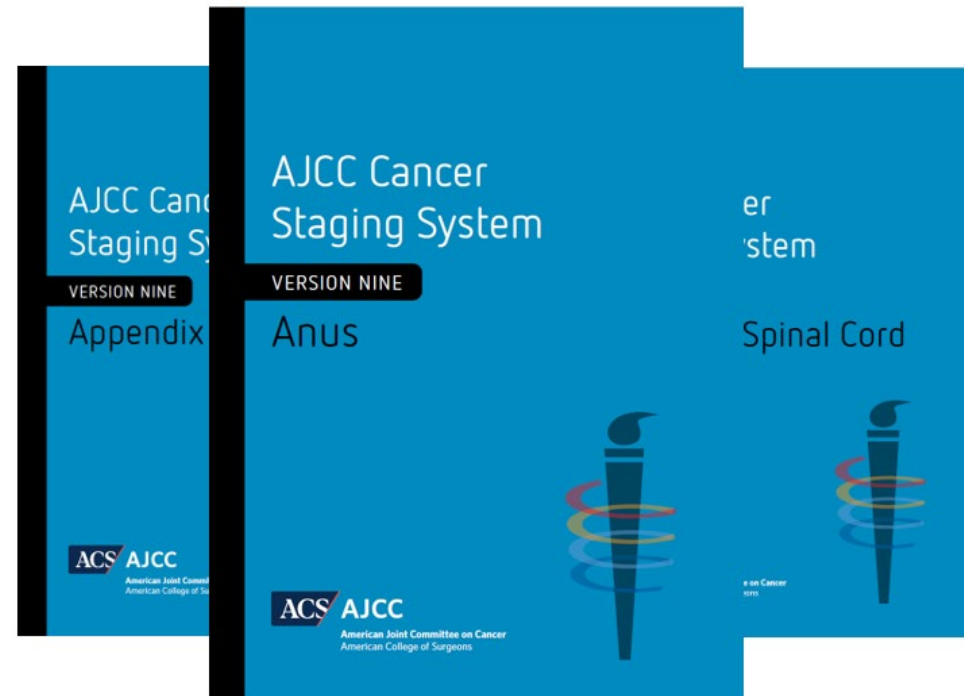
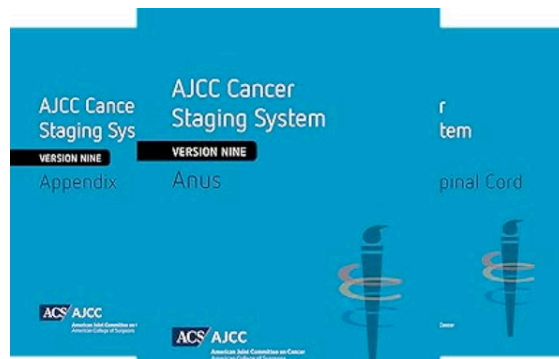
- Cancer Staging **Manual** → rebranded as Cancer Staging **System**
- Goal → Continue to ensure cancer staging is current, evidence-based, and meets needs of clinical care and surveillance communities

8 th Edition	Version 9
Hardcopy book	Leverages Content Management infrastructure to support multiple products
Chapters	Protocols for each disease site (Cervix released in 2020)
Published every 5-7 years	AJCC will release 1-5 protocols each year
Entire manual (all chapters) published simultaneously	Protocols published disease site by disease site based on needs of clinical care & surveillance communities and in coordination with WHO Blue Book update cycle
Print manual → “static”	Electronic platform facilitates rapid integration of updated staging information into EHR and cancer registry software as well as other products



Version 9 Cancer Staging

- 2021 – present
- Digital and paper options
- Changes/Updates are published immediately when approved





AJCC Version 9 Protocols

NEW – Effective January 1, 2026

- Salivary Glands
- Oropharynx (HPV-Associated)

Currently Available

- Nasopharynx
- Lung
- Thymus
- Diffuse Pleural Mesothelioma
- Appendix
- Anus
- Vulva
- Cervix
- Neuroendocrine Tumors – Stomach
- Neuroendocrine Tumors – Duodenum/Ampulla
- Neuroendocrine Tumors – Jejunum/Ileum
- Neuroendocrine Tumors – Appendix
- Neuroendocrine Tumors – Colon/Rectum
- Neuroendocrine Tumors – Pancreas
- Brain and Spinal Cord



Discover AJCC Staging Online

With Version 9 updates

New website provides access to the entire AJCC Cancer Staging System, with all the latest Version 9 updates available to individual users for just \$49.99 per year.



facs.org/ajcconline



given_name

/ AJCC Staging Online

Explore our content

How can we help you?



General Information on
Cancer Staging

Head and Neck

Upper Gastrointestinal
Tract

How can we help you?



given_name

General Information on
Cancer Staging

Head and Neck

Upper Gastrointestinal
Tract

Lower Gastrointestinal
Tract

Hepatobiliary System

Neuroendocrine Tumors

Thorax

Bone

Soft Tissue Sarcoma

Skin

Breast

Female Reproductive
Organs

Male Genital Organs

Urinary Tract

Ophthalmic Sites

Central Nervous System

Endocrine System

Hematologic Malignancies

Chapter 1 Principles of
Cancer Staging is **FREE**

BREAST

CONTENTS

▼ Breast

Breast Staging - Quick Reference

Protocol for Cancer Staging
Documentation: Breast

Staging Report Format

Explanatory Notes

Supplemental Information

Version: 2024 V8

Breast Staging - Quick Reference

*Definition of Primary Tumor (T) (Note T)

T Category	T Criteria
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis (DCIS)*	Ductal carcinoma in situ
Tis (Paget)	Paget disease of the nipple NOT associated with invasive carcinoma and/or carcinoma in situ (DCIS) in the underlying breast parenchyma. Carcinomas in the breast parenchyma associated with Paget disease are categorized based on the size and characteristics of the parenchymal disease, although the presence of Paget disease should still be noted.

ON THIS PAGE

Breast Staging - Quick
Reference

*Definition of Primary
Tumor (T) (Note T)

*Definition of Regional
Lymph Node (N) Clinical N
(cN) (Note N)

*Definition of Regional
Lymph Node (N)