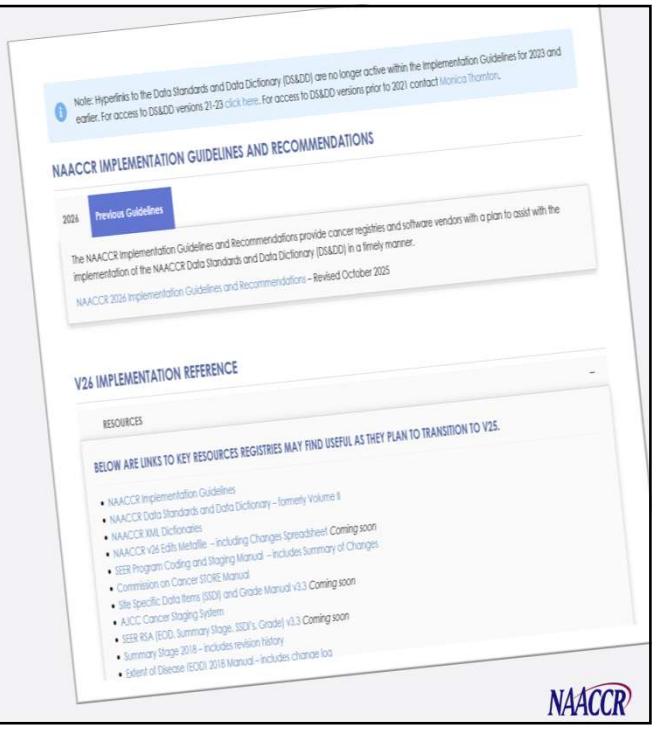
V26 Updates

Solid Tumor Rules, SSDIs, CPC and More



1

Agenda

- Implementation Guidelines
  - Jim Hofferkamp
    - NAACCR
- SSDI Updates
  - Jennifer Ruhl
    - NCI SEER
- Hematopoietic Updates
  - Jennifer Ruhl
    - NCI SEER
- Solid Tumor Rules
  - Denise Harrison
    - Independent
- Cancer PathCHART
  - Alison VanDyke
    - NCI SEER

Thank you for your years of service and countless contributions!

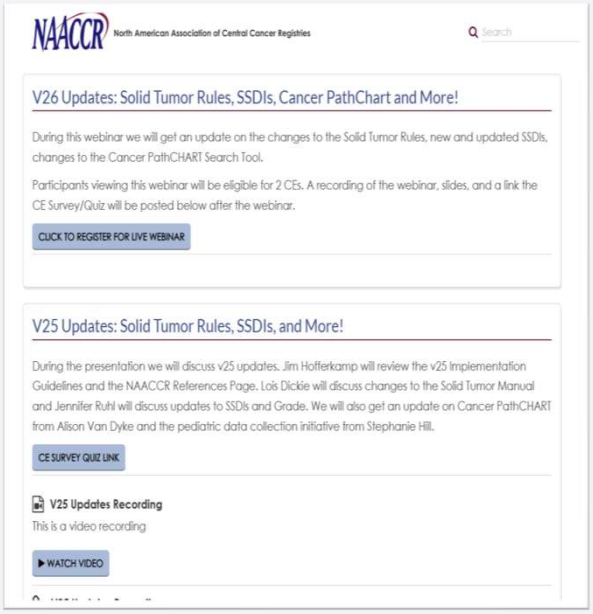
- Lori Havener
  - NAACCR
- Lois Dickie
  - NCI SEER

NAACCR

2

Housekeeping

- Please submit all questions concerning the webinar content through the Q&A panel.
- The following will be posted to the NAACCR Education and Training Page
  - Recording of session
  - Slides
  - Link to CE Survey/Quiz
  - This session is eligible for 2 category A CE's



NAACCR

3

2026 Implementation Guidelines

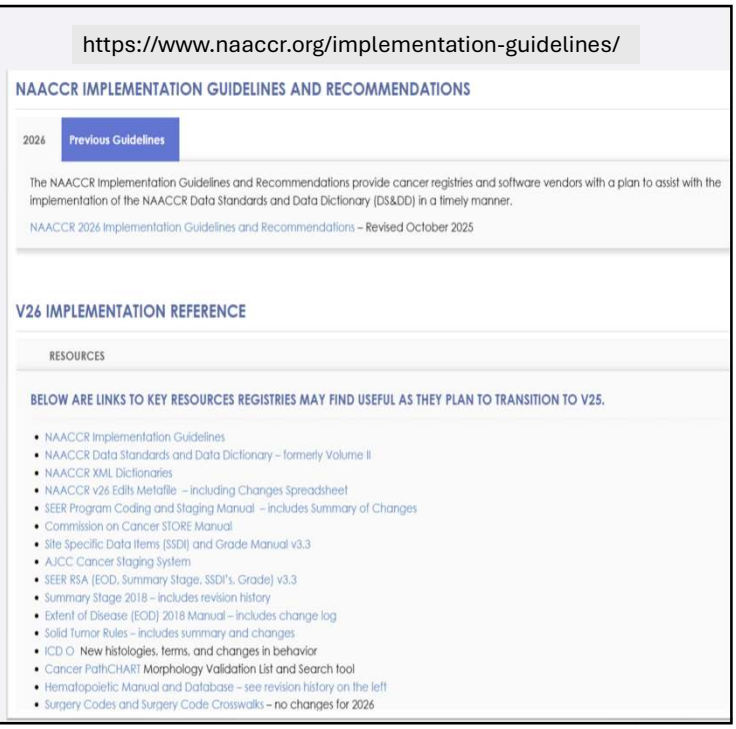
Jim Hofferkamp, ODS
Program Manager of Education and Training
NAACCR Staff Support for the Implementation Guidelines

NAACCR

4

NAACCR 2026 Implementation Guidelines

- V26 Implementation Reference
- 2026 Implementation Guidelines



5

SSDI Updates

Jennifer Ruhl, ODS
Co-Chair of the SSDI WG

NAACCR

6

Changes to SSDI Manual Development

The SSDI manual is now automatically generated from the SEER*API.

- This means that a WORD version of the SSDI manual will no longer be maintained
- This also means that there will be no discrepancies between the online version of the SSDIs and the PDF version of the SSDI manual

- For 2027 updates, plan is to implement the Grade and PDCS manuals the same way
  - It is very cumbersome maintaining online and WORD versions of the manuals, not to mention the chance of them getting out of sync

NAACCR

7

Schema Name Changes

Current Names	Revised names
• Oropharynx HPV-Mediated	• Oropharynx HPV-Associated
• Oropharynx (p16-)	• Oropharynx HPV-Independent

These name changes have been applied back to 2018. All references in the AJCC DLL, SEER API (which includes SSDIs, Grade, EOD) have been updated to reflect the new terminology
Note: Summary Stage chapter has not changed (Oropharynx)

NAACCR

8

Version 9 Changes

- **Major Salivary Glands, Version 9**
  - New Grade Table (#28) (Effective for cases diagnosed 1/1/26+)
  - Previously A-D, 9
  - Now L, M, H, 9
- **Oropharynx HPV-Associated, Version 9**

NAACCR

9

Breast: Residual Cancer Burden (2026+)

- Registrar is to record the "score" directly from the synoptic pathology report
  - If the score is not on the synoptic pathology report, code X.999
  - If there is no neoadjuvant therapy, or no surgical resection after neoadjuvant therapy, code X.777
- Registrar is NOT to try and calculate the score

0.000-9.999	0.000 – 9.999 score
X.777	Patient had no neoadjuvant therapy, but surgical resection done Patient had neoadjuvant therapy, but no surgical resection
X.888	Not applicable: information not collected for this case (If this item is required by your standard setter, use of code X.8 will result in an edit error).
X.999	Post neoadjuvant surgery completed and RCB burden not documented in CAP Protocol or synoptic pathology report
<BLANK>	Must be blank if diagnosis year is before 2026

10

Breast: Residual Cancer Burden Class (2026+)

- Registrar is to record the "class" directly from the synoptic pathology report
  - If the class is not on the synoptic pathology report, code 9
  - If there is no neoadjuvant therapy, or no surgical resection after neoadjuvant therapy, code 7
- Registrar is NOT to try and calculate the class

Code	Description
0	RCB-0 (pCR)
1	RCB-I
2	RCB-II
3	RCB-III
7	Patient had no neoadjuvant therapy, but surgical resection done Patient had neoadjuvant therapy, but no surgical resection
8	Not applicable: information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Post neoadjuvant surgery completed and RCB class not documented in CAP Protocol or synoptic pathology report
<BLANK>	Must be blank if diagnosis year is before 2026

NAACCR

11

Lung: Spread Through Air Spaces (STAS) (2026+)

- Registrar is to record the STAS directly from the synoptic pathology report
  - If the STAS is not on the synoptic pathology report, code 9
  - If there is no surgical resection, code 9

Code	Description
0	Not identified
1	Present
8	Not applicable: information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error).
9	No surgical resection done Surgical resection done and STAS not documented in the CAP Protocol or synoptic pathology report STAS not assessed or unknown if assessed or cannot be determined
<BLANK>	Must be blank if diagnosis year is before 2026

NAACCR

12

General Instructions

Section: Rules for Recording Laboratory Values

Follow the below guidelines for recording laboratory value

- All laboratory values must be done no earlier than approximately three months before diagnosis

Note: Rules for recording PSA have changed in Version 3.3 of the SSDI manual. This rule no longer applies to PSA. Please review the specific rules in the PSA SSDI (Prostate Schema)

NAACCR

13

Prostate: PSA (New Note 3)

Note 3: PSA criteria

- Diagnostic biopsy done
  - Record the last PSA lab value done prior to AND within 3 months of the diagnostic biopsy
- No diagnostic biopsy done (or unknown if diagnostic biopsy done)
  - Record the last PSA lab value done within 3 months of the date of diagnosis or additional confirmatory testing when no diagnostic biopsy is done or unknown if diagnostic biopsy done

NAACCR

14

Prostate: PSA (New Note 3)

Note: This is a change in the rules for Version 3.3 of the SSDI manual from the PSA had to be within 3 months and prior to the date of diagnosis AND within 3 months of the diagnostic biopsy

This change can be applied for cases diagnosed 2018+. There is no recommendation or expectation that registrars will review older cases.

Prostate: PSA clarification and proposed changes - CAnswer Forum

NAACCR

15

Prostate: Cores examined/positive

Note 4: If there is a targeted biopsy or a region of interest (ROI) biopsy done, count as 1 core positive/1 core examined.

- When doing a targeted or ROI biopsy, the region being biopsied is suspected of cancer (usually based on an MRI).
- Since the area is targeted, there will be many more cores removed. To record all these cores would be inflating the numbers.

NAACCR

16

Head and Neck SSDIs

- The SSDI WG would like to take the opportunity to give a shout out to Aleisha Williams from AJCC
- Aleisha worked tirelessly for several months discussing the Head and Neck SSDIs with both physicians and the SSDI WG

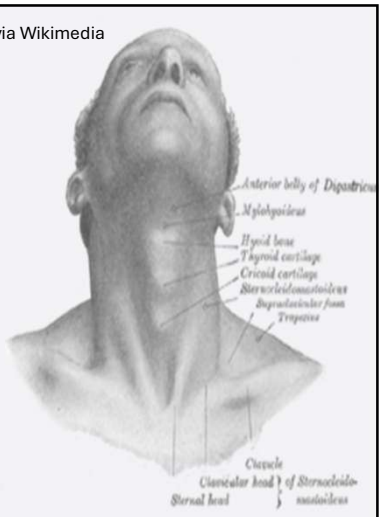
NAACCR

17

Head and Neck: ENE

- New terms associated with ENE
  - cENE for clinical ENE
  - iENE for imaging detected ENE
  - pENE for pathological ENE

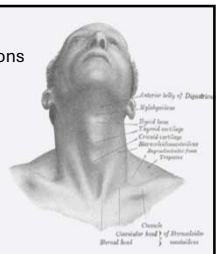
Henry Vandyke Carter, Public domain, via Wikimedia Commons



NAACCR

18

Henry Vandyke Carter, Public domain, via Wikimedia Commons



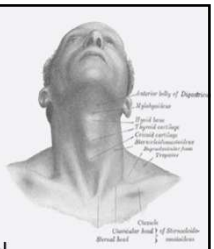
Head and Neck: Clinical ENE (Note 2 update)

- The assessment for ENE may **include imaging and/or physical examination**.
  - Biopsy of the regional lymph node or surrounding tissue can be used to confirm the presence of metastatic carcinoma and thus verify the clinical assessment, but cannot be used in isolation to determine ENE during clinical staging
- Fixed nodes and/or frank skin involvement are indications of cENE
- Matted nodes are indications of iENE
- iENE is identified exclusively on imaging
- ENE during clinical staging is considered present when cENE and/or iENE are present

NAACCR

19

Henry Vandyke Carter, Public domain, via Wikimedia Commons



Head and Neck: Clinical ENE

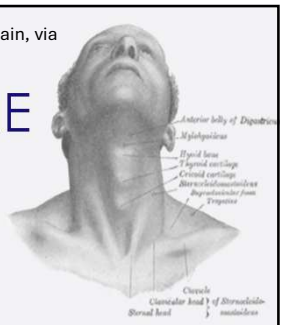
Coding Guidelines

- **Code 0** when lymph nodes are determined to be **clinically positive** and there is **no clinical evidence of ENE** based on physical examination.
- **Code 1** when there is **definitive (unquestionable) evidence of ENE** as determined by physical examination and/or imaging
- **Code 2** when there is **definitive (unquestionable) evidence of ENE** as determined by physical examination and/or imaging **and** nodal involvement is microscopically confirmed by biopsy
- **Code 4** when there is **definitive (unquestionable) evidence of ENE**, but the means of identification is not known

NAACCR

20

Henry Vandyke Carter, Public domain, via Wikimedia Commons



Head and Neck: Pathological ENE

- No major changes
- Microscopic ENE changed to Minor ENE

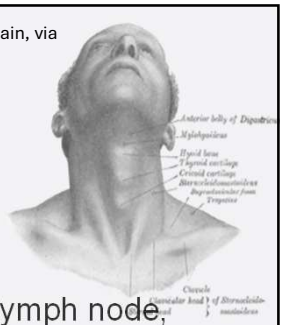
Note 4: Minor and Major ENE

- Minor ENE is defined as ≤ 2 mm
- Major ENE is defined as > 2 mm
  - Matted lymph nodes and soft tissue metastases are considered major ENE

NAACCR

21

Henry Vandyke Carter, Public domain, via Wikimedia Commons



Head and Neck: LN size

Note 2: Criteria for coding LN size

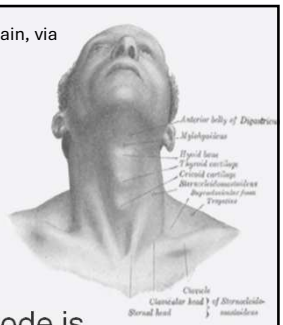
- The metric is the size of the largest tumor deposit in the lymph node, not the size of the overall lymph node that is involved.
- For larger nodes however, the size of the deposit becomes essentially the size of the overall lymph node as the nodes become almost entirely overtaken with tumor.
- Code the size of the largest deposit if pathology reports separately list the size of a deposit and the size of the overall lymph node that the deposit is involving.

NAACCR

22

Head and Neck: LN Size

Henry Vandyke Carter, Public domain, via Wikimedia Commons



Note 3: Clinical vs Pathological size

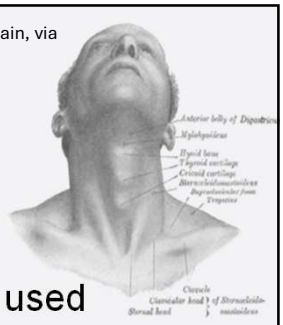
- Code the **clinical node size** when the largest involved node is not examined pathologically.
- Code the **pathological node size** when the largest involved node (or same level) is examined clinically and pathologically, even if the pathological size is smaller.
- Code the **size of the largest deposit** when the pathology report separately lists the size of a deposit and the size of the overall lymph node that the deposit is involving.

NAACCR

23

Head and Neck: p16

Henry Vandyke Carter, Public domain, via Wikimedia Commons



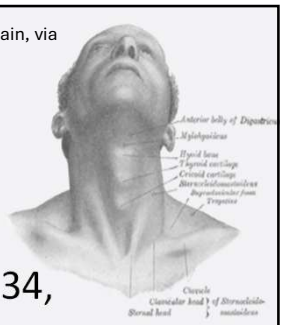
- Major overhaul of this SSDI
- There are now several ways that a result can be used
  - Other tests that can be used in addition to p16 or when p16 is not available
    - High-risk HPV RNA ISH
    - High-risk HPV DNA ISH
  - High-risk HPV DNA PCR can be used in conjunction with p16, but it cannot be used on its own

NAACCR

24

Head and Neck: p16

Henry Vandyke Carter, Public domain, via Wikimedia Commons



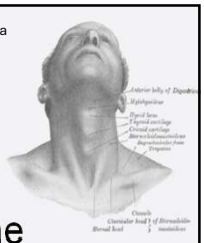
High-risk HPV types include: 16, 18, 26, 31, 33, 34, 35, 39, 45, 51, 52, 53, 56, 58, 59, 66, 68, 70, 73, and 82

Low-risk (cannot be used to determine HPV status)
HPV types include: 6, 11, 42, 43, and 44

25

Head and Neck: p16

Henry Vandyke Carter, Public domain, via Wikimedia Commons

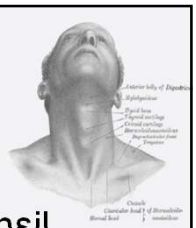


- The following can be coded as positive when this is the ONLY information available
  - Stated as “HPV-associated” or “High-risk HPV”
- The following can be coded as negative when this is the ONLY information available
  - Stated as HPV-Independent
- If the only information available is HPV positive, code unknown

26

Head and Neck

Henry Vandyke Carter, Public domain, via Wikimedia Commons



- Schema Discriminator 1: Nasopharynx/Pharyngeal Tonsil
- This SSDI is no longer effective for cases diagnosed 1/1/25
  - Nasopharynx, 8th edition schema (2018-2024): Still required
  - Nasopharynx, Version 9 schema (2025+): Not applicable
  - Oropharynx HPV-Associated, 8th edition schema (2018-2025): Required for cases diagnosed 2018-2024
  - Oropharynx HPV-Associated, Version 9: Not applicable
  - Oropharynx HPV-Independent, 8th edition (2018+): Required for cases diagnosed 2018-2024

NAACCR

27

Melanoma Skin: Clinical Margin Width

- This SSDI only applies to primary sites C440-C449

See case_identification_guidelines_standard_5_5.pdf (facs.org)

-This reference was provided by CoC



Jhofferkamp, CC BY-SA 4.0 <https://creativecommons.org/licenses/by-sa/4.0>, via Wikimedia Commons

NAACCR

28

Lung: PD-L1

Patrick J. Lynch, CC BY-SA 2.5 <https://creativecommons.org/licenses/by-sa/2.5>, via Wikimedia Commons



Question: How is the SSDI PD-L1 for lung to be coded when the PD-L1 test result is the "Combined Positive Score" (CPS) instead of the "Tumor Proportion Score" (TPS)?

- We have received confirmation that both CPS and TPS can be recorded in this data item
- Changes to the coding instructions for this SSDI are under development (will be part of 2026 updates)
- Code definitions (which indicate only TPS) cannot be changed until the 2027 updates

NAACCR

29

Hematopoietic Manual and Database

Jennifer Ruhl, ODS

Administrator of the Hematopoietic Manual and Database

NAACCR

30

Heme Major Update

- WHO Blue Book 5th edition Hematolymphoid Tumors published and implemented in Heme DB
- Evidence that some registrars are not following the rules correctly, nor understand them
- Evidence of general confusion about Heme
- Evidence that instructions/rules are being interpreted differently than what was intended
- It was time (last major update 2014)

NAACCR

31

WHO 5th edition: Hematolymphoid tumors

- 5th edition double the size as 4th edition
  - 2 volumes now instead of one
  - *Reminder: Registrars do not need to have access to the WHO Blue Books to abstract!*
- 100's of new terms added
- Definitions updated/changed
- Lineage tables restructured
- **No new ICD-O-3 codes!**

NAACCR

32

Hematopoietic Database

- New terms added to database
- Immunophenotyping and genetics updated
  - Only most common are listed
- Abstractor notes updated
- Definitions updated

NAACCR

33

Hematopoietic Manual

- No new rules or modules, no deleted rules or modules
- Overhaul of structure (content not changed)
- Overhaul of several sections
- New section: Introducing Hematopoietic neoplasms
- New section: Coding Mets at Dx fields

NAACCR

34

First Course Treatment

- Added information about induction, consolidation/intensification and maintenance
- Updated coding instructions include:
  - When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. **First course of therapy ends when the treatment plan is completed or remission is achieved, no matter how long it takes to complete the plan**

NAACCR

35

Chronic/Acute

- Overhaul of this section
- Screen shots from database included, along with an explanation of how they are used
- Examples included, including one where the registrar interpreted the rules incorrectly
  - Question and answer included are verbatim
  - Excellent teaching question

NAACCR

36

Chronic/Acute Rules

- **Initial Clinical Workup**
- Several of the M rules now refer to "initial clinical workup." This is the timeframe of when patients are first diagnosed. The initial clinical workup may include blood work, imaging, biopsies (including bone marrow), and genetic testing. In some situations, treatment may be started before the full workup is completed.
- This is replacing "21 days" and "simultaneously" in the M8-M13 rules

NAACCR

37

Mets at Dx fields: New section

- Registrars struggle with primary site because they don't recognize the common metastatic sites, which incidentally, are also the most common metastatic sites for solid tumors (except bone marrow)
- When trying to determine primary site, if any of the common metastatic sites are involved [bone, brain (CNS), liver, lung, distant lymph nodes (except for C77 primaries), and other (bone marrow)], **set those aside and work with the remaining sites/lymph nodes that are involved**

NAACCR

38

Histology and Ambiguous Terminology

- The following terms are now "definitive diagnoses" **for coding histology ONLY.**
  - Compatible with
  - Comparable with
  - Consistent with
  - Most likely
  - Probable
  - Typical (of)
- **DO NOT APPLY THIS TO REPORTABILITY OR STAGE, HISTOLOGY ONLY**

NAACCR

39

Histology Coding Instructions

- **Registrars are NOT to update the histology based on genetics or immunophenotyping without a pathologist's/physician's statement.**
  - Pathologist's/physician statement can be found in the final diagnosis, synoptic report, or in the comments section
  - Registrars have been picking positive genetics out from pathology reports and trying to figure out which code to use, sometimes listing 4-5 different codes (especially for Acute Myeloid Leukemia) based on the genetics
  - This is not how a histology is determined and why registrars are not to assign a more specific histology based on genetics or immunophenotyping **UNLESS** the pathologist/managing physician documents it

NAACCR

40

Additional information

- Presentation done for the SEER Workshop will be available for anyone starting in early March.
- If you want to get CE credits, you will need to pay a fee.
- Watching the whole presentation is highly recommended, only had time for a few highlights today

- https://www.cancerregistryeducation.org/seer

NAACCR

41



Questions?

NAACCR

42

Solid Tumor Rules

Denise Harrison, ODS

Member of the Solid Tumor Rule Reformatting Group

NAACCR

43

General Instructions – Annual Updates

- The Solid Tumor Rules are revised annually to reflect new terminology, ICD-O codes, and other changes needed to keep in step with current clinical practice. **The most recent update to the Solid Tumor Rules should be used as soon as it is released.**
- Rules and other information from previous updates convey to every annual update. **Previous versions are archived and should not be used**.

NAACCR

44

General Instructions – Diagnosis Years

Table 1. Solid Tumor Rules Site-groups by Diagnosis Year

Site-group	Solid Tumor Rules	MP/H Rules
Head and Neck*	2018-Current	2007-2017
Colon**	2018-Current	2007-2017
Lung	2018-Current	2007-2017
Breast	2018-Current	2007-2017
Kidney	2018-Current	2007-2017
Urinary Sites	2018-Current	2007-2017
Non-Malignant CNS*	2018-Current	2007-2017
Malignant CNS and Peripheral Nerves *	2018-Current	2007-2017
Cutaneous Melanoma	2021-Current	2007-2020
Other Sites	2023-Current	2007-2022*, **

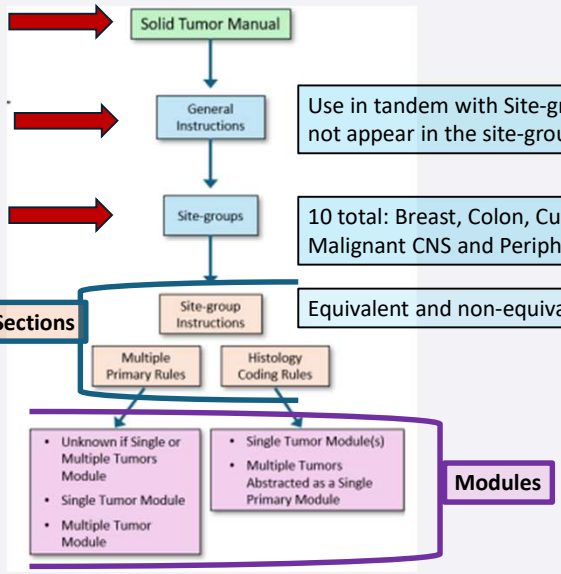
Example: A patient presents with a newly diagnosed invasive lobular carcinoma (8520/3) of the breast in 2025. The patient has a history of ductal carcinoma in situ (8500/2) diagnosed in 2017. Apply the rules that are in effect at the time the most recent tumor was diagnosed to determine if the invasive lobular carcinoma is a subsequent primary

*Peripheral nerves were moved from the MP/H Other Sites to the Solid Tumor Head and Neck, Non-Malignant CNS, and Malignant CNS site-groups beginning with cases diagnosed 2018. Paraganglioma histologies 8680/3, 8690/3, 8692/3, and 9693/3 for primary sites C479, C754 and C755 ONLY are in Head and Neck (Table 9) for cases diagnosed 1/1/2019 forward.
*Trachea was moved from MP/H Other Sites to Solid Tumor Head and Neck beginning with cases diagnosed 2018.
**Rectosigmoid and rectum were moved from MP/H Other Sites to Solid Tumor Colon beginning with cases diagnosed 2018.

NAACCR

45

Structure of the 2026 Update of the Solid Tumor Manual



Use in tandem with Site-group rules and instructions - contain information that may not appear in the site-groups.

10 total: Breast, Colon, Cutaneous Melanoma, Head and Neck, Kidney, Lung, Malignant CNS and Peripheral Nerves, Non-Malignant CNS, Other Sites, and Urinary

Equivalent and non-equivalent terms, various tables, illustrations

NAACCR

46

Metastasis and the Solid Tumor Rules

2025 General Instructions > Multiple Primary Rules Do NOT Apply to Tumors Described as Metastasis

- Each Multiple Primary Rule section begins with a note that reads, "These rules are NOT used for tumor(s) described as metastases." **This means that a tumor in a metastatic site is not counted when deciding which module to use in the Multiple Primary Rules (Unknown if Single or Multiple Tumors, Single Tumor or Multiple Tumors).**
- **This statement was REMOVED from the General Instructions and added to each site-group in the *Multiple Primary Rules* section**

NAACCR

47

Metastasis and the Solid Tumor Rules

Site Groups > Multiple Primary Rules Section

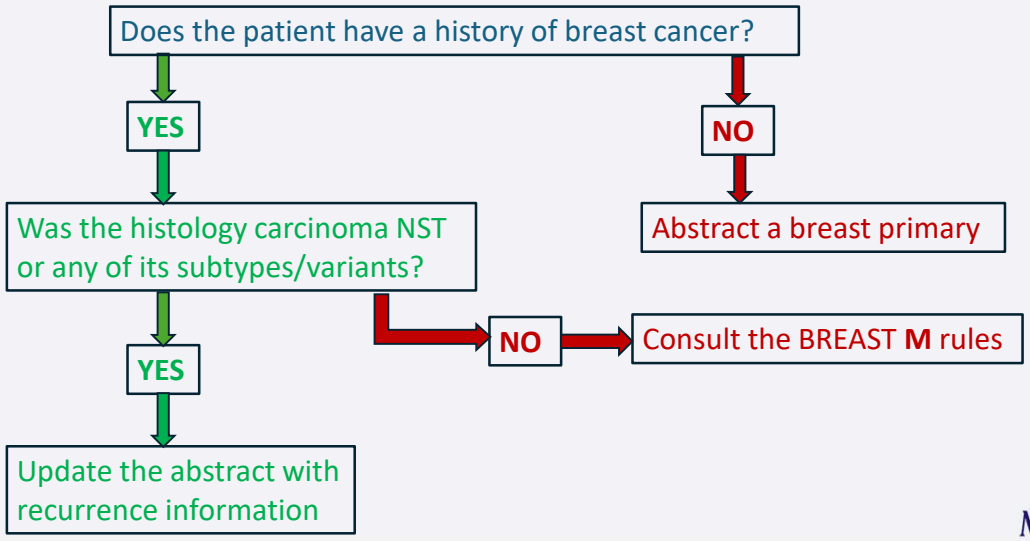
- **2025 Update**: These rules are not used for tumors described as metastasis. Metastatic tumors include but are not limited to: (followed by a list of common metastatic sites)
- **2026**: **Metastatic tumors are not included when determining how many tumors are present**. Metastatic tumors include but are not limited to: (followed by a list of common metastatic sites)

NAACCR

48

Example

Bx of a nodule in the **Lt lung** reveals **carcinoma NST** consistent w/ **breast** origin



NAACCR

49

Ambiguous Terminology Updates

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

No changes to the rules that apply to coding histology described by **ambiguous terminology.**

50

Note 1: Table __ below includes terms previously included in the table of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype.

Note 2: The terms in Table __ were removed from the list of ambiguous terms and added to a list of definitive terminology based on the recommendation of a panel of pathologists and subject matter experts. A **definitive** term does not require clinical verification of the subtype or variant.

Examples added to **General Instructions** to help with ambiguous terminology.

NAACCR

50

Important Reminder



These different lists should be applied **only** for the purpose(s) for which they were **intended** (casefinding, reportability, involvement, or histology). Do not mix and match.

Lists of Ambiguous/Definitive Terms	
STORE	Ambiguous Terms That Constitute a **Diagnosis**
SPCSM	Ambiguous Terms for **Reportability**
Heme Manual	Ambiguous Terms for **Reportability** and **Casefinding**
STM	List of Ambiguous Terminology [for coding **histology]**
STM	List of Definitive Terminology [for coding **histology]**
SS 2018	Ambiguous Terminology [for determining **involvement]**
EOD	Ambiguous Terminology [for determining **involvement]**

NAACCR

51

Example 1

- 7/14/25 Colonoscopy. IMP: **Likely malignant** partially obstructing tumor in the rectum.
- 7/31/25 Repeat colonoscopy w/ bx: **adenocarcinoma**

- **Question:** Do I make the date of dx 7/14/25 based on the new ambiguous term "likely" from the STR?
- **Answer**: **NO**. The lists of ambiguous and definitive terms in the STM are to be used **ONLY** for assigning **histology**, **NOT** for reportability or any other purpose
- If you try to use the STR terms for reportability, it could push the dx date back and impact timeliness measures

NAACCR

52

Order of Operations (Solid Tumors)

1. Determine whether the case is reportable. If the diagnosis is based on an ambiguous term, compare that term to the list of ambiguous terms that constitute a diagnosis in
   - STORE and/or
   - SPCSM
2. Once the case is deemed to be reportable, assign the histology using the **STM**
   - If the histologic term is described by an ambiguous term, use the instructions, list of ambiguous/definitive terms, and H rules to arrive at the histology

NAACCR

53

Example 2

- 7/14/25 Colonoscopy. IMP: **Suspicious for malignant** partially obstructing tumor in the rectum.
- 7/31/25 Colonoscopy w/ bx: Adenocarcinoma ***likely*** mucinous carcinoma

1. Is it **reportable** on 7/14/25? **YES**. **Suspicious for** (a reportable term) is an ambiguous term that constitutes a dx per STORE and SPCSM
2. What is the **histology**? **Adenocarcinoma** – ***likely*** is an ambiguous term in the STM; since the more specific histology is not confirmed by the managing physician or the treatment plan, code the NOS

NAACCR

54

Histology After Neoadjuvant Therapy

- ***Through 2025:*** If the initial diagnosis is based on FNA, smears, cytology OR from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of the primary **site** which identifies a different or specific histology, code the histology from the primary **site**.

- ***2026:*** If the initial diagnosis is based on FNA, smears, or cytology **from the primary site OR histology** from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary **tumor** which identifies a different or specific histology, code the histology from the **resected primary tumor**.

NAACCR

55

Pre-2026 Format of Histology Tables

Header row shaded in gray

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Mucinous carcinoma 8480 *Note 1:* This is a diagnosis that is **EXACTLY** "mucinous carcinoma," "mucinous duct carcinoma," "mucinous DCIS" OR "greater than 90% mucinous." **See Histology Rules.** *Note 2:* Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.	Colloid carcinoma Mucinous adenocarcinoma Mucoid carcinoma	
Mucoepidermoid carcinoma 8430		
Neuroendocrine carcinoma NOS 8246/3	Poorly differentiated neuroendocrine carcinoma	Carcinoma with neuroendocrine differentiation **8574/3** Large cell neuroendocrine carcinoma/large cell carcinoma **8013/3** Small cell neuroendocrine carcinoma/small cell carcinoma **8041/3**

3 Columns

Notes in Column 1

Synonyms of Column 1 terms listed in Column 2

Synonyms of Column 3 terms separated by "/"

NAACCR

56

2026 Update Format of Histology Tables

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Papillary carcinoma 8503 • Invasive ductal papillary carcinoma (/3) • Invasive papillary carcinoma (/3) • Papillary carcinoma of breast, NOS (/3) • Intraductal papillary carcinoma (/2) • Intraductal papillary carcinoma with DCIS (/2) • Intraductal papilloma with ductal carcinoma in situ (/2) • Papillary carcinoma non-invasive (/2) • Papillary ductal carcinoma in situ (/2)	Encapsulated papillary carcinoma with invasive carcinoma, NST 8504 (/3) • Encapsulated papillary carcinoma with invasion (/3) • Encapsulated papillary carcinoma with invasive duct carcinoma (/3) • Encapsulated papillary carcinoma, NOS (/2) • Intracystic papillary carcinoma (/2) • Non-infiltrating papillary carcinoma (/2) Micropapillary carcinoma 8507 Tall cell carcinoma with reverse polarity 8509 (/3) • Solid papillary carcinoma with invasion (/3) • Solid papillary carcinoma in situ (/2)
Phyllodes tumor, malignant 9020 (/3) • Cystosarcoma phyllodes, malignant • Periductal stromal tumor, low grade	
Polymorphous carcinoma 8525	

‣ **Header row** shaded in color ‣ **Thick boxes** around table rows ‣ Alternating **row shading**

2 Columns Synonyms moved to Column 1 & bulleted under preferred term

Bulleted lists grouped by behavior and alphabetized Invasive first followed by white space, then non-invasive

Behavior codes separated from histology w/ parentheses

NAACCR

57

2026 Update Format of Histology Tables

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mucinous carcinoma 8480 [7] [8] • Colloid carcinoma • Mucinous adenocarcinoma • Mucoid carcinoma	
Mucinous cystadenocarcinoma 8470 • Mucinous cystic neoplasm with associated invasive carcinoma (/3)	
Mucoepidermoid carcinoma 8430	
Neuroendocrine carcinoma NOS 8246 (/3)	Carcinoma with neuroendocrine differentiation **8574 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma **(/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1 **(/3)**	Neuroendocrine tumor, grade 2 **8249 (/3)**

[7] The term mucinous carcinoma applies when the diagnosis is EXACTLY "mucinous carcinoma," "mucinous duct carcinoma," "mucinous DCIS" OR "greater than 90% mucinous." See Histology Rules.
[8] Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.

Notes previously in Column 1 converted to hyperlinked footnotes

NAACCR

58

2026 Update Format of Histology Tables

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Angiosarcoma 9120 (/3) • Epithelioid angiosarcoma (/3) • Hemangiosarcoma (/3) • Post radiation angiosarcoma of breast (/3) • Lymphangiosarcoma 9170 (/3) • Malignant hemangioendothelioma 9130 (/3) Liposarcoma 8850 (/3) Leiomyosarcoma 8890 (/3) Osteosarcoma 9180 (/3) Rhabdomyosarcoma 8900 (/3) • Alveolar type 8920 (/3) • Embryonal type 8910 (/3) • Pleomorphic 8901 (/3)

- Both synonyms **and** subtypes/variants of NOS terms in Column 2 are bulleted
- Histology for synonyms is the **SAME** as the term under which they are indented – no histology code listed
- Histology for subtype/variants is DIFFERENT than that of the NOS under which they are indented – histology code listed next to term

59

Common M Rules Related to Tables: Specific Histologies, NOS/ NST, and Subtypes/Variants

1

Abstract **multiple primaries** when separate/non-contiguous (S/N-C) tumors are on **different rows** in **Table** _ in the Equivalent Terms and Definitions.

2

Abstract **multiple primaries** when S/N-C tumors are two or more **different subtypes/variants** in Column 2 (formerly column 3) of **Table** _ in the Equivalent Terms and Definitions.

3

Abstract a **single primary** when **synchronous**, S/N-C tumors are on the **same row** in **Table** _ in the Equivalent Terms and Definitions.

- Breast, Kidney, & Lung – also has to be same laterality
- CNS tumors do not have to be synchronous or same laterality

60

MP when S/N-C tumors are **different subtypes** in Column 2 (same NOS or different NOS)

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200 • ACC (rare)	
Chondrosarcoma 9220 (/3) • Chondrosarcoma grade 2/3 • Chondrosarcoma NOS	Chondrosarcoma, grade 1 **9222 (/3)** [1] Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)**
Liposarcoma 8850 (/3)	Liposarcoma, well differentiated **8851 (/3)**
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma
Neuroendocrine tumor NOS 8240 (/3) • Carcinoid • Neuroendocrine tumor grade 1	Neuroendocrine tumor grade 2 **8249 (/3)** • Atypical carcinoid • Neuroendocrine tumor grade 3 [2]

Same NOS

Different NOS

61

MP when S/N-C tumors are on **different** rows of **any** column

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200 • ACC (rare)	
Chondrosarcoma 9220 (/3) • Chondrosarcoma grade 2/3 • Chondrosarcoma NOS	Chondrosarcoma, grade 1 **9222 (/3)** [1] Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)**
Liposarcoma 8850 (/3)	Liposarcoma, well differentiated **8851 (/3)**
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma
Neuroendocrine tumor NOS 8240 (/3) • Carcinoid • Neuroendocrine tumor grade 1	Neuroendocrine tumor grade 2 **8249 (/3)** • Atypical carcinoid • Neuroendocrine tumor grade 3 [2]

62

SP when *SYNCHRONOUS S/N-C tumors (normally in **same** primary site w/ same laterality) are on the **same** row - 1

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200 • ACC (rare)	
Chondrosarcoma 9220 (/3) • Chondrosarcoma grade 2/3 • Chondrosarcoma NOS	Chondrosarcoma, grade 1 **9222 (/3)** [1] Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)**
Liposarcoma 8850 (/3)	Liposarcoma, well differentiated **8851 (/3)**
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma
Neuroendocrine tumor NOS 8240 (/3) • Carcinoid • Neuroendocrine tumor grade 1	Neuroendocrine tumor grade 2 **8249 (/3)** • Atypical carcinoid • Neuroendocrine tumor grade 3 [2]

* Tumors do NOT have to be synchronous in either of the CNS site-groups

63

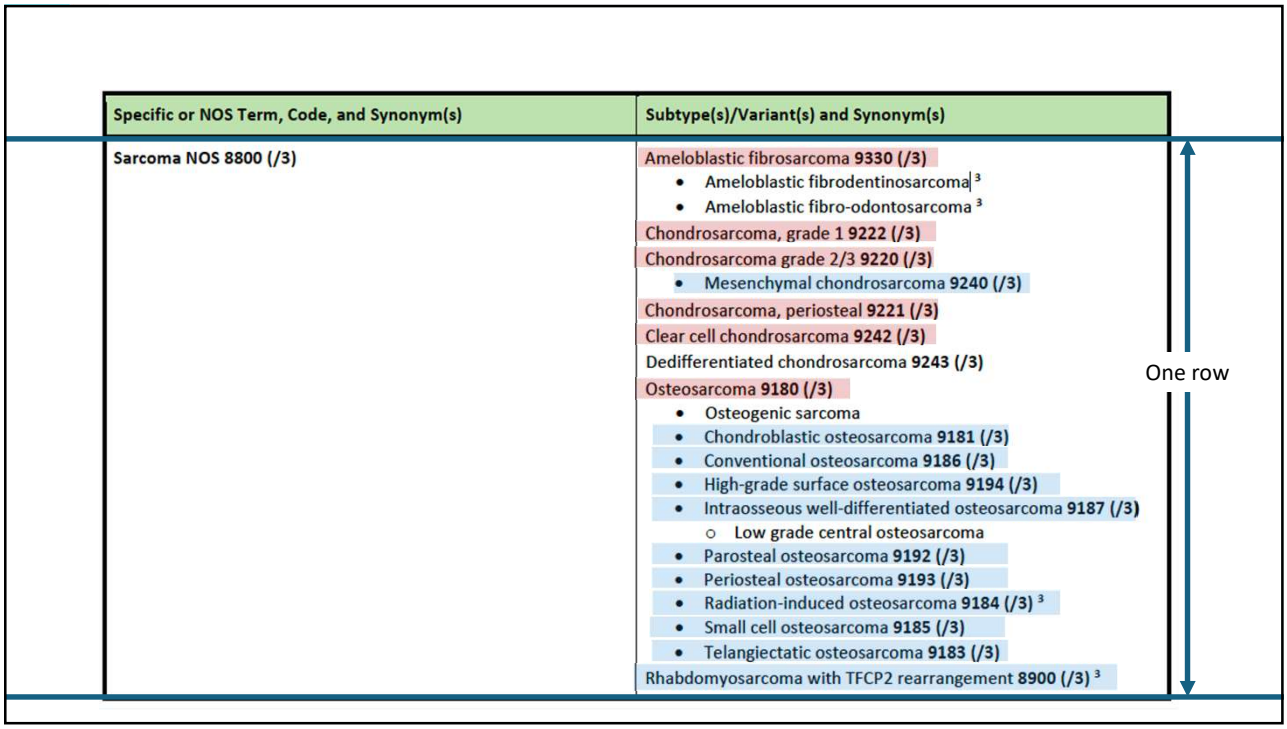
SP when **synchronous**, S/N-C tumors (normally in **same** primary site w/ same laterality) are on the **same** row - 2

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Ameloblastic fibrosarcoma **9330 (/3)** • Ameloblastic fibrodentinosarcoma [3] • Ameloblastic fibro-odontosarcoma [3] Chondrosarcoma, grade 1 **9222 (/3)** Chondrosarcoma grade 2/3 **9220 (/3)** • Mesenchymal chondrosarcoma **9240 (/3)** Chondrosarcoma, periosteal **9221 (/3)** Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)** Osteosarcoma **9180 (/3)** • Osteogenic sarcoma • Chondroblastic osteosarcoma **9181 (/3)** • Conventional osteosarcoma **9186 (/3)** • High-grade surface osteosarcoma **9194 (/3)** • Intraosseous well-differentiated osteosarcoma **9187 (/3)** ○ Low grade central osteosarcoma • Parosteal osteosarcoma **9192 (/3)** • Periosteal osteosarcoma **9193 (/3)** • Radiation-induced osteosarcoma **9184 (/3)** [3] • Small cell osteosarcoma **9185 (/3)** • Telangiectatic osteosarcoma **9183 (/3)** Rhabdomyosarcoma with TFCP2 rearrangement **8900 (/3)** [3]

Different subtype/variants of the same NOS in column 1 **reside** on the same row, but do NOT meet the **definition** of the same row!

One row

64



65

Definition of the Same Row

The separate, non-contiguous tumors are:

1. The **same** histology
   a. A NOS in Column 1 and an indented synonym (also in Column 1) **OR**
   b. A NOS in Column 2 and an indented synonym (also in Column 2) **OR**
   c. Different indented synonyms of the **same** NOS (Column 1 or Column 2)
2. A NOS in Column 1 and a SINGLE subtype/variant of that NOS in Column 2 **OR**
3. A NOS in Column 2 and a SINGLE subtype/variant of that NOS in Column 2

Different subtypes/variants listed in the same row in column 2 do **not** meet the definition of being on the same row

66

Other Updates

- Most of the changes were made to the histology tables
  - Formatting, new/deleted/updated rows, synonyms, and subtypes/variants, and footnotes
- Breast rule **M10** Abstract a single primary when there are multiple, separate/non-contiguous tumors of **carcinoma NST**/**duct** and **lobular**
  - Deleted (now any time there is duct in one tumor and lobular in another, they are separate primaries)
- Refer to the change log for a comprehensive list of all updates

NAACCR

67

Cancer PathCHART

Alison VanDyke

Co-Chair of the Cancer PathCHART Core Management Team

NAACCR

68

Cancer
Pathology
Coding
Histology
And
Registration
Terminology

69

CPC Site-Morphology Combination Validity Status

Table 1: Validity Status, NAACCR Edits, and Coding in Registry Software		
Validity Status	**Edits Errors**	**Coding in Cancer Registry Database**
Valid	Will not generate edit errors	Can be coded
Unlikely	Will generate an edit error	Requires manual override or correction to site and/or morphology to be coded
Impossible	Will generate an edit error	Cannot be coded

70

Sites Reviewed by Implementation Year

Implementation Year	Organ System Reviewed
2024	Breast Bone & Soft Tissue Digestive Female Genital Male Genital Urinary
2025	CNS Male Genital Soft Tissue Respiratory Thorax Urinary
2026	Head & Neck
2027+	Skin Eye & Orbit (+) Endocrine

71

2024 & 2025 CPC updates released 10/1/25

Needed improvements identified through questions submitted using real world cases (AASR & SINQ)

In Depth Review

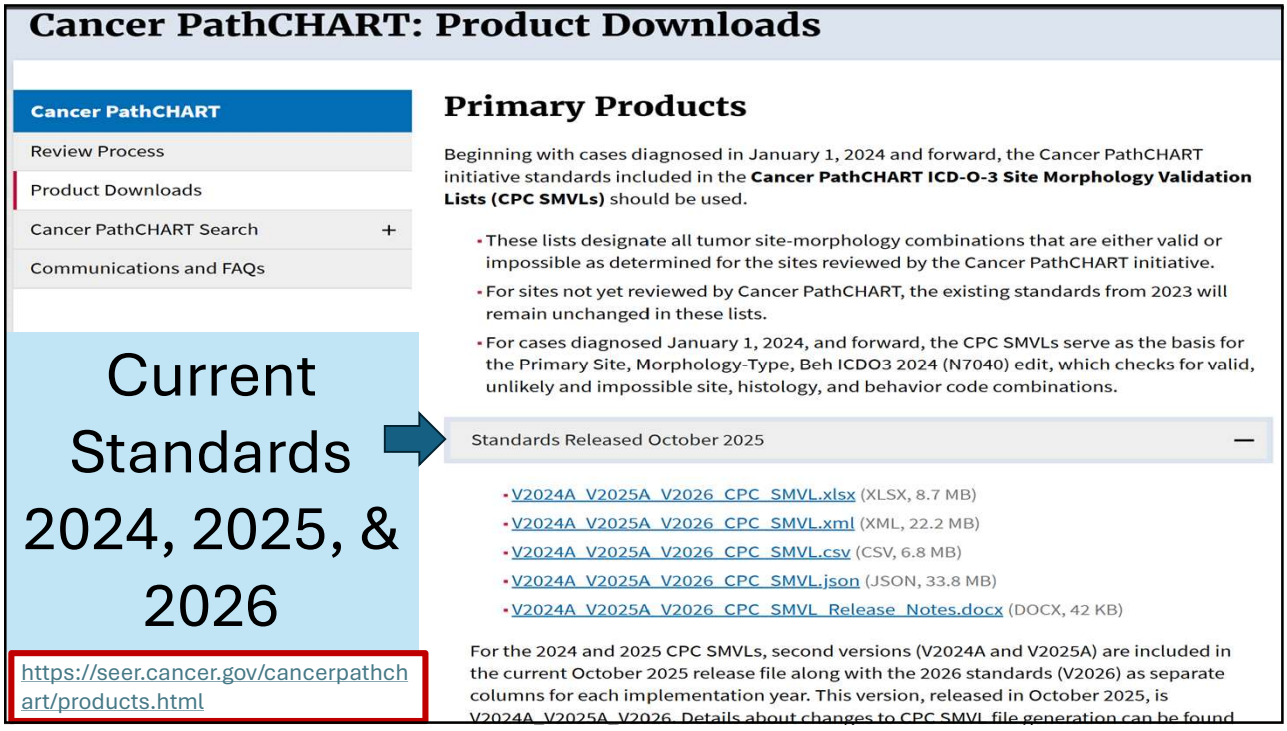
- Pediatric WHO vs. existing standards from organ system review
- Germ cell tumor standards across an organ system
- Conflicting standards for NOS and overlapping sites

72

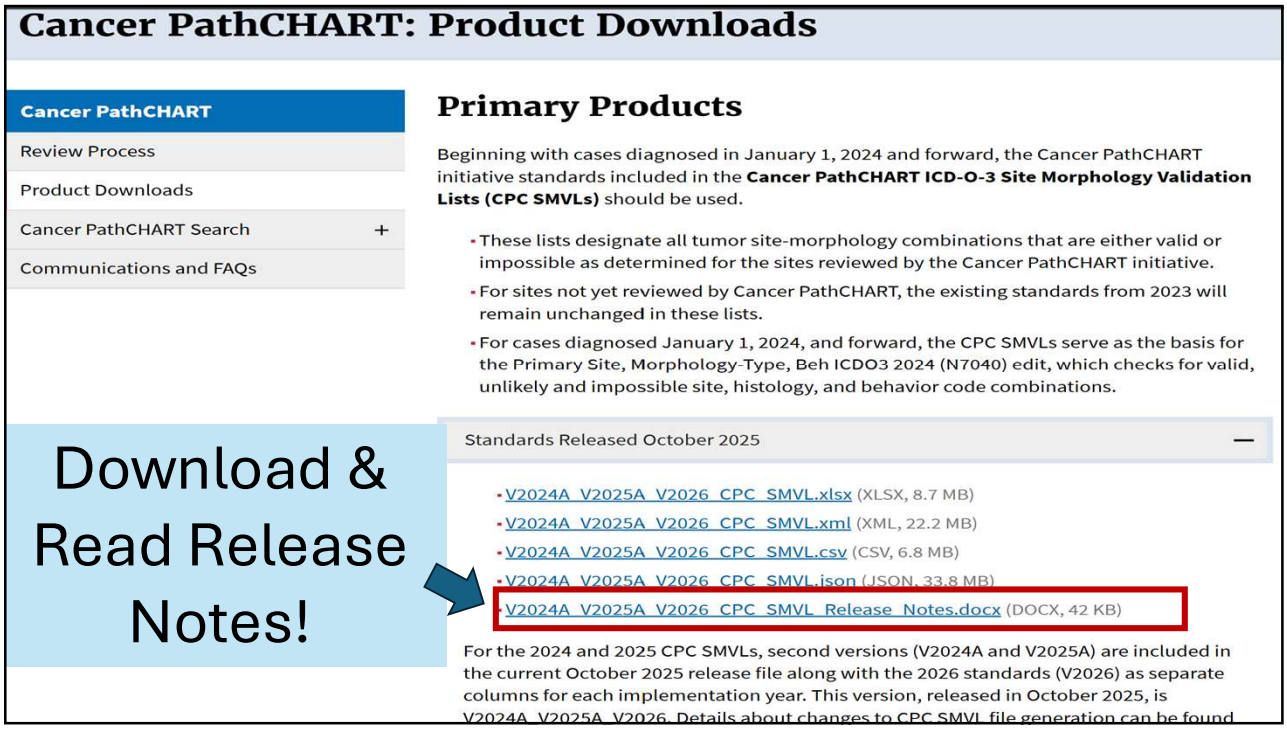
Solved conflicts between N7040 & other site-morphology edits

- N0446 Primary Site, Morphology-Imposs ICDO3 (SEER IF38)
- N4911 Histologic Type ICDO3, Primary Site, Date of Diagnosis (NAACCR)
- N2021 Primary Site, Heme Morph, DateDX, NoOverride (SEER)
- N2022 Primary Site, Heme Morph, DateDX, Override (SEER)

73



74



75

Newly impossible morphologies with recommendation(s) by pathologists for 2024

2015–2019 USCS Count	Site	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
3,486	Endometrium	8460/3 (Low grade serous carcinoma)	Code to 8441/3 (Serous carcinoma, NOS)
2,998	Liver	8160/3 (Cholangiocarcinoma)	Code to IHBD C22.1
2,373	Liver	8140/3 (Adenocarcinoma, NOS)	Code to IHBD C22.1
2,167	Prostate	8550/3 (Acinar cell carcinoma)	Code to 8140/3 (Acinar adenocarcinoma of prostate)
1,224	Breast	8510/3 (Medullary carcinoma, NOS)	Code to 8500/3 if there is no additional characterization Not being used anymore
402	Breast	8032/3 (Spindle cell carcinoma, NOS)	Code to 8575/3 (Metaplastic carcinoma)

76

Newly impossible morphologies in kidney parenchyma with recommendation(s) by pathologists for 2025

2015–2019 USCS Count	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
3,851	8255/3 (Adenocarcinoma with mixed subtypes)	Code the subtype variant Otherwise, code to 8312/3 (Renal cell carcinoma, NOS)
1,390	8120/3 (Transitional cell carcinoma, NOS)	Code to C65.9 (Renal Pelvis)
603	8130/3 (Papillary transitional cell carcinoma)	Code to C65.9 (Renal Pelvis)
88	8270/3 (Chromophobe carcinoma)	Code to 8317/3 (Renal cell carcinoma, chromophobe type)
65	8032/3 (Spindle cell carcinoma, NOS)	Code to 8033/3 (Sarcomatoid carcinoma)
14	8980/3 (Carcinosarcoma, NOS)	Code to 8033/3 (Sarcomatoid carcinoma)



77

Newly impossible morphologies in lung and bronchus with recommendation(s) by pathologists for 2025

2001–2019 USCS Count	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
Adenocarcinomas		
26,634	8550/3 (Acinar cell carcinoma)	Code to 8551/3 (Acinar adenocarcinoma of lung)
1,945	8323/3 (Mixed cell adenocarcinoma)	Use more specific diagnosis. Consider site miscoding.
6,124	8252/3 (Bronchioloalveolar carcinoma, non-mucinous)	Code to 8140/3 (Adenocarcinoma, NOS)
4,121	8490/3 (Signet ring cell carcinoma)	Code to 8140/3 (Adenocarcinoma, NOS)
1,074	8050/3 (Papillary carcinoma, NOS)	Code to 8140/3 (Adenocarcinoma, NOS)



78

Newly impossible morphologies in lung and bronchus with recommendation(s) by pathologists for 2025

2001–2019 USCS Count	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
Small Cell Lung Carcinoma		
12,547	8042/3 (Oat cell carcinoma)	Code to 8041/3 (Small cell carcinoma)
538	8043/3 (Small cell carcinoma, fusiform cell)	Code to 8041/3 (Small cell carcinoma)
Pleomorphic Carcinoma		
2,226	8074/3 (Squamous cell carcinoma, spindle cell)	Code to 8022/3 (Pleomorphic carcinoma)
864	8021/3 (Carcinoma, anaplastic, NOS)	Code to 8022/3 (Pleomorphic carcinoma)

79

Newly impossible morphologies in parotid gland with recommendation(s) by pathologists for 2026

2003 to 2022 USCS Count	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
675	8940/3 (Mixed tumor, malignant NOS)	Code to 8941/3 (Carcinoma ex pleomorphic adenoma)
217	8022/3 (Pleomorphic carcinoma)	Code to 8033/3 (Sarcomatoid salivary duct carcinoma) **or** 8070/3 (Squamous cell carcinoma, NOS)
122	8010/2 (Carcinoma in situ, NOS)	Code to 8941/2 (Intracapsular carcinoma ex pleomorphic adenoma)
74	8255/3 (Adenocarcinoma with mixed subtypes)	Code to 8140/3 (Adenocarcinoma, NOS)

80

Newly impossible morphologies with V2024A and recommendation(s) by pathologists

Year Changed	Site	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
2024	Female genital tract, NOS	8461/3 (High grade serous carcinoma)	If endometrium, code to 8441/3 (Serous carcinoma, NOS)
	Overlapping lesion of male genital organs	8542/3 (Paget disease, extramammary)	Valid only in the penis
	EHBD	8180/3 (Combined HCC & cholangiocarcinoma)	8180/3 only valid in C22.1 (intrahepatic bile ducts) Review site and histology. If histology is 8180/3, site of origin is Intrahepatic Bile Duct (C22.1). If site is C240, C248, or C249, assign a different histology code.
	Overlapping biliary tract,		
	Biliary tract, NOS		

81

Newly impossible morphologies with V2025A with recommendation(s) by pathologists

Year Changed	Site	Code (Term)	Cancer PathCHART Pathologist Consensus Recommendations
2025	Bladder dome	8440/3 (Cystadenocarcinoma, NOS)	Only valid in urachus (C67.7). Reconsider primary site.
	Bladder, NOS	8440/3 (Cystadenocarcinoma, NOS)	



82

Planned May V2026A Release

- 26A CPC SMVL to be incorporated into V26A NAACCR Edits Metafile scheduled to be released in May 2026
- **Correction** to Squamous cell carcinoma, non-keratinizing type in the
  - Lung & bronchus (2025)
  - Head & neck sites (2026)
- Changing 8070/3 from Impossible to Unlikely for C71.0 to C71.6 (brain sites)
- Changing 9509/1 from Impossible to Unlikely for C71.5 (CNS ventricles)
- Release of pathologists' recommendations

83

CPC*Search Updates Underway

Current Version

•Only contained 2024 validity standards

•Since then, V2024A released in October 2025

Updated Version

•Separate tabs by year latest standards (2024 to 2026)

•One column for terms in bulleted list

•Flag if combination is in Pediatric WHO

•Year last reviewed

•Adding consensus comments field for May V2026A release

84



85



86



87