



V26 Updates

Mid-Year Update





Agenda

- Implementation Guidelines
 - Jim Hofferkamp
 - NAACCR
- SSDI Updates
 - Jennifer Ruhl
 - NCI SEER
- Solid Tumor Rules 2026.1
 - Suzanne Adams
 - NCI SEER
- CPC Search Tool
 - Jim Hofferkamp
 - NAACCR
- Questions
 - We will answer as many questions as we can today during the live session.
 - Questions we are not comfortable answering live, will go into the Q&A and will be posted with the recording.
 - We may need you to submit the question to a standard setter.
 - If you do, we ask that you send us the response!



- <https://education.naaccr.org/updates-implementation>

During the presentation we will discuss v25 updates. Jim Hofferkamp will review the v25 Implementation



- 

North American Association of Central Cancer Registries

 search

V26 Updates: Solid Tumor Rules, SSDIs, Cancer PathChart and More!

During this webinar we will get an update on the changes to the Solid Tumor Rules, new and updated SSDIs, changes to the Cancer PathChart Search Tool.

Participants viewing this webinar will be eligible for 2 CEs. A recording of the webinar, slides, and a link to the CE Survey/Quiz will be posted below after the webinar.

CE SURVEY/QUIZ LINK

 V26 Updates: Solid Tumor Rules, SSDIs, CPC and More! Slides_UPDATED 1.15.26

DOWNLOAD

 V26 Updates Webinar Recording

WATCH VIDEO

 V26 Updates Streaming Link

LINK

 V26 Updates Q&A COMING SOON!

DOWNLOAD



2026 Implementation Guidelines

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

NAACCR

NAACCR 2026 Implementation Guidelines

- The v26 Implementation Guidelines have been moved to the Previous Guidelines Tab

https://www.naaccr.org/implementation-guidelines/

NAACCR IMPLEMENTATION GUIDELINES AND RECOMMENDATIONS

2027

Previous Guidelines

NAACCR IMPLEMENTATION GUIDELINES AND RECOMMENDATIONS

2027

Previous Guidelines

NAACCR 2026 Implementation Guidelines and Recommendations – Revised October 2025

NAACCR 2025 Implementation Guidelines and Recommendations – revised January 2025

NAACCR 2024 Implementation Guidelines and Recommendations – revised October 2023

NAACCR 2023 Implementation Guidelines and Recommendations – January 2023

NAACCR 2022 Implementation Guidelines and Recommendations – revised June 2022

NAACCR 2021 Implementation Guidelines and Recommendations – revised February 2021

NAACCR 2021 Implementation Guidelines and Recommendations – revised October 2020

• AJCC Cancer Staging System

• SEER RSA (EOD, Summary Stage, SSDe, Grade) v3.4 – Coming soon

• Summary Stage 2018 – Includes revision history – Coming soon

• Extent of Disease (EOD) 2018 Manual – Includes change log – Coming soon

• Solid Tumor Rules – Includes summary and changes – Coming soon

• ICD O New histologies, terms, and changes in behavior

Questions?



SSDI Updates

Jennifer Ruhl

NCI

Co-Chair SSDI WG





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



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
- *Any questions regarding this SSDI are to be posted in the AJCC CAnswer Forum*

NAACCR



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
- *Any questions regarding this SSDI are to be posted in the AJCC CAnswer Forum*

NAACCR



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
- *Any questions regarding this SSDI are to be posted in the AJCC CAnswer Forum*

NAACCR



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



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





Prostate: Cores examined/positive

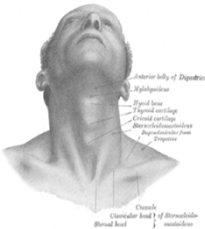
Note 4: If there is a targeted biopsy or a region of interest (ROI) biopsy done, count as 1 core positive/1 core examined.

- 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.



Head and Neck: Clinical ENE (cENE) (Note 2 update)

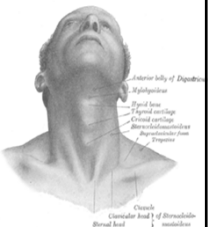
Henry Vandyke Carter, Public domain, via Wikimedia Commons



- 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



Henry Vandyke Carter, Public domain, via Wikimedia Commons



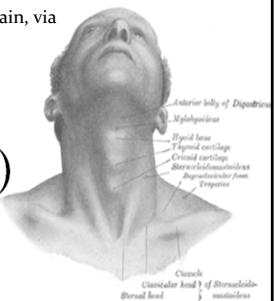
Head and Neck: Clinical ENE (cENE)

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

Henry Vandyke Carter, Public domain, via Wikimedia Commons



Head and Neck: Pathological ENE (pENE)

- No major changes
- Microscopic ENE changed to Minor ENE

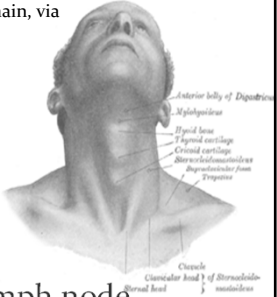
Note 4: Minor and Major ENE

- 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

Henry Vandyke Carter, Public domain, via Wikimedia Commons

Head and Neck: LN size



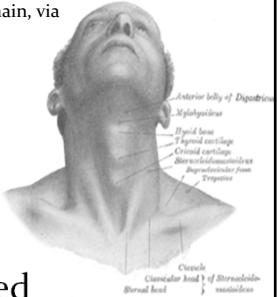
Note 2: Criteria for coding LN size

- 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

Henry Vandyke Carter, Public domain, via Wikimedia Commons

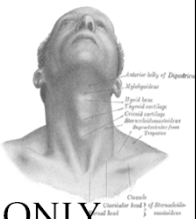
Head and Neck: p16



- 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

Henry Vandyke Carter, Public domain,
via Wikimedia Commons



Head and Neck: p16

- 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

NAACCR

Melanoma Skin: Clinical Margin Width

- This SSDI only applies to primary sites C440-C449

See [case identification guidelines standard 5.5.pdf \(facs.org\)](#)

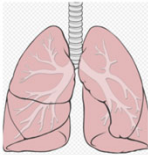
-This reference was provided by CoC



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

NAACCR

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



Lung: PD-L1

- Changes to PD-L1 were implemented for the 2026 updates **HOWEVER**
- Additional changes will occur for the 2027 updates
- We are going to a negative/positive/unknown selection
- All data previously collected will be converted during your 2027 software updates
- For now:
 - IF PD-L1 is negative, code XXX.2
 - IF PD-L1 is positive (any value 0.1-100.0), code XXX.4



Questions?



Thank You!

NAACCR

Solid Tumor Rules 2026.1 Update
and Common Questions

Suzanne Adams, BS, ODS-C

Surveillance, Epidemiology, and End Results Program

Aligned Histology Tables with Cancer PathCHART (CPC)



- Histologies were deleted
 - Example: “Medullary carcinoma” deleted from Breast table
- Behavior codes added or removed
 - Example: Added "(/3)" to 8310 and 8380 in Urinary table
- Terms added, removed, or updated
 - Example: “Low-grade” added to preferred term for nasopharyngeal papillary adenocarcinoma 8260 in Head and Neck Table 2

Surveillance, Epidemiology, and End Results Program

Deleted Inaccurate Notes

Deleted inaccurate note from LUNG H4 and H13:

When the histology is carcinoma in situ NOS, code histology to 8010/3. Cancer PathCHART has determined that carcinoma in situ 8010/2 is biologically impossible and will not pass edits.

Deleted inaccurate footnote from Other Sites Table 2:

Code 8255 does not apply to GYN primaries. Continue through the table to determine correct mixed histology code for GYN neoplasms

8010/2 is **unlikely** for lung, not impossible!

8255 is **valid** for gyn sites!

Surveillance, Epidemiology, and End Results Program

Lung: Adenocarcinoma with Mixed Subtypes 8255/3



• Added “including <> pattern” to the terminology for 8255 in the combination code table

Lung Site-group Instructions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Diagnosis must be a single tumor which meets one of the following two criteria: 1. <u>At least two</u> of the below subtypes/variants of adenocarcinoma ⁶ <u>AND percentages of each type are unknown/not stated OR they are equal percentages</u> • Acinar adenocarcinoma (including acinar pattern) • Clear cell adenocarcinoma • Lepidic adenocarcinoma ⁷ (including lepidic (growth) pattern) • Micropapillary adenocarcinoma (including micropapillary pattern) • Papillary adenocarcinoma (including papillary pattern) • Solid adenocarcinoma (including solid pattern) • Well-differentiated fetal adenocarcinoma 2. A combination of histologies <u>not listed on previous rows</u> of this table.	Adenocarcinoma with mixed subtypes 8255 (/3) ^{8 9 10} 2026.1 Update

Surveillance, Epidemiology, and End Results Program

Lung: Coding Adenocarcinoma Histologic Patterns



Tips

1. If only one histologic type is used

2. If the histologic type is “histologic type not specified”

Example

1. Adenocarcinoma

2. Histologic type not specified

3. Adenocarcinoma, non-mucinous

4. Adenocarcinoma, mucinous

5. Adenocarcinoma, non-mucinous, minimally invasive

6. Adenocarcinoma, mucinous, minimally invasive

Histologic Type (Note [C](#))

___ Adenocarcinoma in situ (AIS), non-mucinous

___ Adenocarcinoma in situ (AIS), mucinous

___ Minimally invasive adenocarcinoma, non-mucinous

___ Minimally invasive adenocarcinoma, mucinous

___ Invasive lepidic adenocarcinoma

___ Invasive acinar adenocarcinoma

___ Invasive papillary adenocarcinoma

___ Invasive micropapillary adenocarcinoma

___ Invasive solid adenocarcinoma

Histologic Patterns (may include percentages in 5% increments totaling 100%) (applicable to non-mucinous adenocarcinomas only) (select all that apply)

___ Not applicable

___ Acinar: _____

___ Papillary: _____

___ Lepidic: _____

___ Solid: _____

___ Micropapillary: _____

Surveillance, Epidemiology, and End Results Program

Prostate: Ductal Adenocarcinoma Coding Requirement



2026 Update:

Table 3: Prostate Histologies

Coding notes for acinar adenocarcinoma subtype/variants:

- Ductal adenocarcinoma 8500/3: In order to code ductal adenocarcinoma 8500/3, a radical prostatectomy must be performed, and the ductal component must comprise >50% of the tumor. In prostate biopsies, the term “adenocarcinoma of prostate with ductal features” should be coded 8140/3.

Coding change: If “ductal adenocarcinoma” or “ductal carcinoma” is stated with no other histologies present, 8500/3 should be coded even if no percentage is provided.

2026.1 Update:

Table 3: Prostate Histologies

Coding notes for acinar adenocarcinoma subtype/variants:

- In order to code ductal adenocarcinoma 8500/3:
 - a radical prostatectomy must be performed AND
 - the histologic diagnosis must be either:
 - Ductal adenocarcinoma or ductal carcinoma with no other histologies present (% ductal not needed) OR
 - There is a mix of ductal and another histology (usually acinar) and the ductal component comprises >50% of the tumor

Surveillance, Epidemiology, and End Results Program

Prostate: Ductal Adenocarcinoma Coding Requirement



Corresponding change made to Rules H11 and H24

2026 Update:

Rule H24

Code 8140 (adenocarcinoma NOS) for prostate primaries when the diagnosis is:

- Acinar adenocarcinoma/carcinoma OR
- Adenocarcinoma OR
- Adenocarcinoma with ductal features OR
- Atrophic adenocarcinoma OR
- Ductal adenocarcinoma when the percentage of duct is not stated or is less than 50 percent of the tumor OR

2026.1 Update:

Rule H24

Code 8140 (adenocarcinoma NOS) for prostate primaries when the diagnosis is:

- Acinar adenocarcinoma/carcinoma OR
- Adenocarcinoma OR
- Adenocarcinoma with ductal features OR
- Atrophic adenocarcinoma OR
- Ductal adenocarcinoma mixed with acinar adenocarcinoma NOS when the percentage of duct is not stated OR is less than 50 percent of the tumors OR

FYI: Requirement for radical prostatectomy remains unchanged!

Surveillance, Epidemiology, and End Results Program

GIST Synonyms Added



Specific or NOS Term, Code, and Synonym(s)
Gastrointestinal stromal tumor 8936 (/3) ¹ - GANT - Gastrointestinal pacemaker cell tumor - Gastrointestinal stromal sarcoma - Gastrointestinal stromal tumor - GIST, behavior not stated (2021+) - GIST, benign (2021+) - GIST, borderline (2021+) 2026.1 Update - GIST NOS (2021+) - GIST, malignant - Succinate dehydrogenase-deficient gastrointestinal stromal tumor

- This is **not** a change
- Intended to help the registrar determine reportability for GIST by year
- All GIST are reportable as malignant for 2021+ cases

Surveillance, Epidemiology, and End Results Program

Paraganglioma Reportability



After receiving expert guidance, paraganglioma reportability was revised in the 2026.1 Update:

All paragangliomas are reportable, even those stated to be benign.

2026 Update:

Cases diagnosed 1/1/2021 forward:

The term “malignant” is no longer required to assign malignant (/3) behavior. Paragangliomas diagnosed 1/1/2021 or after are malignant unless otherwise stated by the pathologist.

2026.1 Update:

Cases diagnosed 1/1/2021 forward:

All paragangliomas diagnosed 1/1/2021 and forward are reportable as malignant even when stated to be benign.

Surveillance, Epidemiology, and End Results Program

Cavernoma



Non-malignant CNS Table 5:

- **Cavernoma** used to be a synonym of Hemangioma. This was incorrect!
- It is now a synonym of **cavernous hemangioma** 9121/0.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Hemangioma 9120 (/0) • Cavernoma • Cavernous angioma 2026 Update	Cavernous hemangioma 9121 (/0) Venous hemangioma 9122 (/0)
Hemangioma 9120 (/0) • Cavernous angioma	Cavernous hemangioma 9121 (/0) • Cavernoma Venous hemangioma 9122 (/0) 2026.1 Update

Surveillance, Epidemiology, and End Results Program

Common question (Breast)



Scenario: Separate, non-contiguous tumors within 5 years

- Tumor #1: ductal (8500)
- Tumor #2: mixed ductal and lobular (8522)

Question: Are these multiple primaries?

Answer: Yes. Per the current rules (2026.1 update), these tumors are multiple primaries per Rule M13. An additional, separate lobular tumor would be a third primary.

Separate mixed and non-mixed tumors for all sites is on our list for content review.

Surveillance, Epidemiology, and End Results Program

How to code...



- Invasive **mucinous** adenocarcinoma, with patterns or predominant pattern? (**lung**)
 - Code as invasive mucinous carcinoma. Only non-mucinous carcinoma can be coded according to predominant pattern.

Wait for it...

Surveillance, Epidemiology, and End Results Program

Common question (All site-groups)



Question: In situ diagnosis, followed by mets, no new primary found. Abstract a new primary?

Examples:

- DCIS, followed by a clinically disease-free interval. LN Mets (ductal) found 3 years later, no new breast tumor identified.
- Melanoma in situ of right jaw, neg margins. Metastatic melanoma found in submandibular LN one year later, no skin lesions seen.

Answer: Do **not** abstract a new primary if no new primary has been identified in the interim. Update the behavior code of the original tumor.

See the SEER Manual, Changing Information on the Abstract section, #3, Example 3

Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when **no new primary has been diagnosed in the interim.**

Surveillance, Epidemiology, and End Results Program

Ask a SEER Registrar



Please submit your questions to Ask a SEER Registrar

- Always include dx year, primary site, histology (if known) when submitting a case
- Choose the correct subject
 - Select “SEER Manual” for **reportability** questions
- SEER does not answer questions about:
 - SSDIs; Grade for 2018+ cases; surgery codes; AJCC Stage; Class of Case, and more. Post in CAnswer forum.
- **DE-IDENTIFY!** This includes **physician names** and **facility names**

Question volume is high and staffing is low; we also commonly discuss your questions during upcoming meetings or consult expert pathologists.

We thank you for your patience!

Surveillance, Epidemiology, and End Results Program

Solid Tumor Rules Registrar Working Group



- Suzanne Adams
- Denise Harrison
- Jim Hofferkamp
- Annelie Landgren (Project Manager)
- Ruth Li
- Maricarmen Traverso-Ortiz (**Lead**)
- Alison Van Dyke

Surveillance, Epidemiology, and End Results Program

Thank You

Surveillance, Epidemiology, and End Results Program

■ NAACCR 2026 Mid Year Update

Cancer PathCHART
May 2026 Release

Gonçalo Forjaz, DVM, MSc, ODS-C
Presented by: Jim Hofferkamp

Surveillance, Epidemiology, and End Results Program



Cancer

Pathology

Coding

Histology

And

Registration

Terminology

- One source of truth for tumor site-morphology combination standards
- Reducing differences between stakeholders
- Decreased implementation timeline
- Improved data quality



Surveillance, Epidemiology, and End Results Program

Validity Standards



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

Important Reminder

Unlikely combinations can be entered with a manual override if site-morphology combination confirmed.

Updated Standards Released May 1, 2026!

- V2024**B**_V2025**B**_V2026**A** CPC SMVL
- Change files
- Release notes
- Aligns with NAACCR Edits Metafile V26A & current CPC*Search content
- <https://seer.cancer.gov/cancerpathchart/products.html>



Surveillance, Epidemiology, and End Results Program

Changes to 2024 Diagnosis Year Standards



Site Group	Histology	Was	Now
Pancreas	Enterochromaffin cell carcinoid (8241/3) AKA Serotonin-producing tumor	Unlikely	Valid
Pancreas	Pituitary carcinoma, NOS (8272/3) AKA Gonadotropin (GH)-producing tumor	Impossible	Valid
Myometrium	Sex cord-gonadal stromal tumor (8590/3) AKA Uterine tumor resembling ovarian sex cord tumor, malignant	Impossible	Unlikely
Penis	Clear cell sarcoma (9044/3) AKA Clear cell sarcoma of soft tissue	Impossible	Unlikely

46

Changes to 2025 Diagnosis Year Standards				
Site Group	Histology	Was	Now	
Mediastinal Space	Ependymoma, NOS (9391/3)	Impossible	Unlikely	
Thymus	Mixed neuroendocrine-non-neuroendocrine neoplasm (MiNEN) (8154/3) <i>AKA: Combined thymic squamous cell carcinoma and carcinoid/neuroendocrine tumor</i>	Impossible	Unlikely	
Lung	Mixed neuroendocrine-non-neuroendocrine neoplasm (MiNEN) (8154/3)	Impossible	Unlikely	
Surveillance, Epidemiology, and End Results Program				

Changes to 2026 Diagnosis Year Standards



Site Group	Histology	Was	Now
Branchial Cleft	Squamous Cell Carcinoma, Non-keratinizing (8072/3)	Impossible	Unlikely
Gingiva			Unlikely
Larynx & Hypopharynx			Valid
Lip			Unlikely
Middle Ear			Unlikely
Oral Cavity & Mobile Tongue			Valid

Surveillance, Epidemiology, and End Results Program

**Submit questions to
Ask a SEER Registrar and
select “Cancer PathCHART (CPC)”
as subject**

**[https://seer.cancer.gov/registrars/
contact.html](https://seer.cancer.gov/registrars/contact.html)**

Surveillance, Epidemiology, and End Results Program



**NATIONAL
CANCER
INSTITUTE**

www.cancer.gov

www.cancer.gov/espanol

Questions?



Thank You!

