2026 Solid Tumor Rules: Updates for Cancer Registrars

Key Changes, Practical Impact, and Coding Implications

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Objectives

- **Review** major 2026 Solid Tumor Rules (STR) revisions.
- **Understand** structural and coding changes.
- **Discuss** impact on abstracting and histology coding.
- **Identify** workflow and education implications.

What's New in 2026: High-Level Changes

- Use the most recent Solid Tumor Rules as soon as released; applicable to 2018+ cases unless a later effective year is noted.
- Manual restructured for clarity: streamlined general instructions and reworked histology tables (3 columns → 2 columns; notes moved to footnotes).
- Updated list of ambiguous terms usable for histology determination.
- Breast rules M10 and H28 deleted.
- CNS section now links to the most current CAP Protocol for WHO grades (Table 1 replaced).

Implementation and Applicability

- Apply the 2026 update immediately for abstraction and QC workflows.
- Check “Diagnosis Years for Which the Solid Tumor Rules Should Be Used” in General Instructions (p. 7 of the 2026 PDF).

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*, **

General Instructions – What to Look For

- Reorganized sections. Histology table format has been simplified moving from 3 columns to 2 columns.
- Ambiguous terms list has been updated and can affect when to code a more specific histology.
- Check for footnotes which provide clarifications that were previously embedded in the tables.

Reorganized Sections with Footnotes Example (Solid Tumor Rules p. 208 of 2026 pdf)

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

Table 3: Specific Histologies, NOS, and Subtype/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Minimally invasive adenocarcinoma NOS **(/3)** • Invasive non-mucinous adenocarcinoma **(/3)**	Acinar adenocarcinoma **(for lung only) 8551** • Adenocarcinoma, acinar predominant **(for lung only)** Adenoid cystic **8200** • Adenocystic carcinoma Colloid adenocarcinoma **8480** Enteric adenocarcinoma **8144** • Pulmonary intestinal type adenocarcinoma Fetal adenocarcinoma **8333** Lepidic adenocarcinoma **8250 (/3)** • Adenocarcinoma, lepidic predominant **(/3)** • Non-mucinous adenocarcinoma preinvasive **(/2)** • Non-mucinous adenocarcinoma in situ **(/2)** Micropapillary adenocarcinoma **8265** • Adenocarcinoma micropapillary predominant Mixed invasive mucinous and non-mucinous adenocarcinoma **8254** Mucinous adenocarcinoma **8253 (/3)** • Mucinous adenocarcinoma, in situ **(/2)** • Mucinous adenocarcinoma, preinvasive **(/2)** Mucinous adenocarcinoma, minimally invasive **8257 (/3)** [1] Non-mucinous adenocarcinoma, minimally invasive **8256 (/3)** [2] Papillary adenocarcinoma **8260** • Adenocarcinoma, papillary predominant Solid adenocarcinoma **8230** • Adenocarcinoma, solid predominant

[1] "Mucinous adenocarcinoma, microinvasive" is a non-preferred term. It should be coded to 8257.
[2] "Non-mucinous adenocarcinoma, microinvasive" is a non-preferred term. It should be coded to 8256.

How to use Ambiguous Terms to Code Histology (Solid Tumor Rules p. 15 of 2026 pdf)

Note: *The following instructions apply to coding histology. These instructions should not be used when determining reportability or when assigning stage.*

1. Within each site-group, the Coding Histology section will contain instructions for using ambiguous terms to assign a more specific histology. The table below includes the ambiguous terms for which the histology coding instructions apply.

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

2. The table below includes terms previously included in the list of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype/variant.
   The terms in the table below were re-classified as definitive terminology based on the recommendation of a panel of pathologists and subject matter experts.

   IMPORTANT: This change applies to any diagnosis year covered by the Solid Tumor Rules. Previously abstracted cases do not need to be reviewed or updated.

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

Important Reminder

Different lists are used for different purposes for which they were intended.

Ambiguous Terms/Definitive Terms	
STORE	Ambiguous terms constitute a diagnosis
SPCSM	Ambiguous terms for reportability
Heme Manual	Ambiguous terms for reportability and case-finding
STM	Ambiguous terms and definitive terms used for coding histology
SS 2018 & EOD	Ambiguous terms for determining involvement

Breast-specific rule changes

- Breast M10 deleted: The prior breast rule labeled M10 has been removed; remaining M rules are renumbered.
- Breast H28 deleted: Histology rule H28 for breast has been deleted; histology section is now governed by the revised tables and remaining H rules.
- Key “single primary” M rule removed (duct vs lobular): The rule that said “Abstract a single primary when there are multiple tumors of carcinoma NST/duct and lobular” has been deleted. This is a major conceptual change.
- New multiple primary guidance via Table 3 (M13): New/updated rule (now M13) instructs to abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 3, regardless of timing (synchronous or metachronous). This directly affects cases like separate ductal and lobular carcinomas.

Breast Example Using 2026 STR:

Question: How many primaries and which Breast Solid Tumor Rules (STR) M Rule applies when a patient has synchronous, separate/non-contiguous breast tumors which are a ductal carcinoma and a separate lobular carcinoma?

Answer: Accession two primaries when patient has separate ductal and lobular tumors. Rule M13 applies according to the 2026 update.

Applying the rules: Breast Example

- 1/9/24 Pt has right breast IDC treated with lumpectomy, RT, HT. NED after treatment.
- 1/9/26 Pt has new non-contiguous right breast cancer, core Bx shows ILC.
- Is this a new primary or a recurrence?

Applying the rules: Breast Example (pgs. 49-53 of 2026 pdf)

Rule M1 Abstract a single primary when it is not possible to determine if there is a single tumor or multiple tumors.

Rule M2 Abstract a single primary when the diagnosis is inflammatory carcinoma in:

- Multiple quadrants of same breast OR
- Bilateral breasts

Rule M3 Abstract a single primary when there is a single tumor.

Rule M4 Abstract multiple primaries when there are separate, non-contiguous tumors in sites with ICD-O site codes that differ at the second (CXxx) and/or third characters (CxXx).

Rule M5 Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than five years after the original diagnosis or last recurrence.

Rule M6 Abstract a single primary when there is inflammatory carcinoma in:

- Multiple quadrants of same breast OR
- Bilateral breasts

Rule M7 Abstract multiple primaries when there is bilateral breast cancer (both right and left breast).

Rule M8 Abstract a single primary when the diagnosis is Paget disease with synchronous underlying in situ or invasive carcinoma NST (duct/ductal) or subtypes of duct.

Rule M9 Abstract multiple primaries when the diagnosis is Paget disease with underlying tumor which is NOT duct.

Rule M10 Abstract a single primary when a ductal carcinoma occurs after a combination code in the same breast.

Rule M11 Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 2 of Table 3 in the Site-group Instructions. Timing is irrelevant.

Rule M12 Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 3 in the Site group Instructions.

Rule M13 Abstract multiple primaries when separate/non-contiguous tumors are:

- On different rows in Table 3 in the Site-group Instructions
- A combination code in Table 2 and a code from Table 3 .

Applying the rules: Breast Example (pgs. 36-39 of 2026 pdf)

Carcinoma NST 8500 • Carcinoma NOS • Carcinoma of no special type • Carcinoma NST with choriocarcinomatous features • Carcinoma NST with cribriform features • Carcinoma NST with melanotic features • Carcinoma NST with neuroendocrine features • Carcinoma/Carcinoma NST with signet ring cell differentiation • Ductal carcinoma	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma **8201 (/3)** • Ductal carcinoma, cribriform type **(/3)** • Cribriform carcinoma in situ **(/2)** Pleomorphic carcinoma **8022 (/3)** Solid carcinoma **8230 (/3)** [2] • Solid adenocarcinoma **(/3)** • Ductal carcinoma in situ, solid type **(/2)** • Intraductal carcinoma, solid type **(/2)**
Lobular carcinoma 8520 • Alveolar lobular carcinoma • Classic lobular carcinoma • Lobular carcinoma with cribriform features • Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants of lobular carcinoma) • Solid lobular carcinoma • Tubulolobular carcinoma • Invasive lobular carcinoma, alveolar type/variant **(/3)** • Invasive lobular carcinoma, solid type **(/3)** • Invasive pleomorphic lobular carcinoma **(/3)** • Florid lobular carcinoma **(/2)** • Intraductal papilloma with lobular carcinoma in situ **(/2)** • Lobular carcinoma in situ **(/2)**	Pleomorphic lobular carcinoma in situ **8519 (/2)**

We stop at Rule M13. Ductal Carcinoma (8500) is on a different row than Lobular Carcinoma (8520) in Table 3.

Answer: new primary, accession a new case.

Applying the rules: Lung Example

Patient has RUL lobectomy, pathology revealed 2 separate tumors. Tumor 1 is a 2.1cm acinar predominant adenocarcinoma. Tumor 2 is a 0.9cm lepidic predominant adenocarcinoma.

Is this a single primary or multiple primaries?

Applying the rules: Lung Example (pgs. 220-222 of 2026 pdf)

Rule M1 Abstract a single primary when it is not possible to determine if there is a single tumor or multiple tumors.

Rule M2 Abstract a single primary when there is a single tumor.

Rule M3 Abstract multiple primaries when there are separate, non-contiguous tumors in sites with ICD-O site codes that differ at the second CXxx and/or third character CxXx.

Rule M4 Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than three years after the original diagnosis or last recurrence.

Rule M5 Abstract multiple primaries when there is:

- At least one tumor with:
  - o neuroendocrine carcinoma or subtype/variant of neuroendocrine carcinoma OR
  - o neuroendocrine tumor or subtype/variant of neuroendocrine tumor
- AND there is another tumor with non-small cell carcinoma subtypes/variant

Rule M6 Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 2, Table 3 in the Site-group Instructions. Timing is irrelevant.

Applying the rules: Lung Example (pg. 208 of 2026 pdf)

- Acinar Adenocarcinoma (8551) and Lepidic Adenocarcinoma (8250) are two subtypes/variants of Adenocarcinoma, NOS.
- According to rule M6 Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 2, Table 3 in the Site-group Instructions. Timing is irrelevant.
- Accession 2 primaries.

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Applying the rules: Histology Table Lookup

- Pathology Report: Left breast ductal carcinoma with lobular features.
- Use the 2026 Breast Histology Rules to determine the correct histology code.
- See pg 37 of 2026 pdf.
- Ductal carcinoma with lobular features is coded to 8500.

Specific or NOS Term, Code, and Synonym(s)
Carcinoma NST 8500 (continued) • Ductal carcinoma NST (no special type) • Ductal carcinoma with apocrine features • Ductal carcinoma with apocrine metaplasia • Ductal carcinoma with lobular features • Ductal carcinoma with micropapillary features • Ductal carcinoma with mucin production • Duct/ductal carcinoma with neuroendocrine features • Ductal carcinoma with squamous metaplasia • Mammary carcinoma/cancer • Infiltrating ductal carcinoma **(/3)** • Invasive carcinoma with medullary features **(/3)** • Invasive carcinoma with micropapillary features **(/3)** • Invasive carcinoma with neuroendocrine features **(/3)** • Invasive carcinoma not otherwise specified (Invasive carcinoma NOS) **(/3)** • Invasive carcinoma NST with metaplastic features **(/3)** • Invasive carcinoma NST with medullary features **(/3)** • Invasive carcinoma, with signet-ring cell features **(/3)** • Invasive carcinoma of no special type (NST) **(/3)** • Invasive carcinoma with clear cell (glycogen rich) features **(/3)** • Invasive carcinoma, NST **(/3)** • Invasive carcinoma, type cannot be determined **(/3)** • Invasive ductal with medullary features **(/3)** • Invasive mammary carcinoma **(/3)**

Applying the rules: Histology Table Lookup

- Pathology Report: Left breast duct and lobular carcinoma in a single tumor.
- Use the 2026 Breast Histology Rules to determine the correct histology code.
- See pg. 32 of 2026 pdf.
- Duct and lobular carcinoma is coded to 8522.
- Ensure you review footnote about the use of 8522.
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Table 2: Histology Combination Codes

Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **8500 OR** any subtype/variant of carcinoma NST (see Table 3) **AND** LCIS/lobular carcinoma (**8520**) **OR** pleomorphic lobular carcinoma in situ **8519/2**	Duct and lobular **8522** [1] [2] • Invasive duct and in situ lobular **(/3)** [3] • DCIS and invasive lobular **(/3)** • Invasive duct and invasive lobular **(/3)** • Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") **(/3)** [4] • DCIS and LCIS **(/2)** [3]
DCIS/duct carcinoma/carcinoma NST **OR** any ONE subtype/variant of carcinoma NST (see Table 3) **AND** [5] **Any** histology in **Table 3 with exception** of • Lobular carcinoma **8520** and pleomorphic lobular carcinoma in situ **8519 (/2)** • Paget disease **8540**	Invasive carcinoma NST/duct mixed with other types of invasive carcinoma **8523 (/3)** DCIS mixed with other in situ carcinoma **8500 (/2)** [6]

[1] 8522 is used when:
- Duct and lobular carcinoma are present in a single tumor **OR**
- All tumors in the same breast are mixed duct and lobular

[2] **Do not** use when the diagnosis is carcinoma NST/duct carcinoma with lobular **differentiation.**
[3] Includes pleomorphic LCIS
[4] CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") to indicate both duct and lobular are present. This is an exception to the instruction that features are not coded.
[5] Both histologies **must have** the **same behavior** code.
[6] Prior to 2018, DCIS and other in situ was coded 8523/2.

Applying the rules: Ambiguous Terminology Scenario

- Lung Primary, pathology report reads: LLL nodule, morphology suggestive of squamous cell carcinoma.
- Can you code squamous cell carcinoma (8070/3) using the term "suggestive of"?
- Reference pg. 229 of pdf.
- "Suggestive of" is an acceptable term.
- Because the term is allowed and fits the criteria, you may assign the code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

   B. There is a **NOS histology and a more specific** (subtype/variant) described by ambiguous terminology
      - Specific histology is clinically confirmed by a physician (attending, surgeon, oncologist, etc.) **OR**
      - Patient is receiving treatment based on the specific histology described by ambiguous term

   If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the Ambiguous Terminology section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 24: List of Ambiguous Terminology

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

CNS Rules – WHO Grade Table Change

- “WHO Grades for Select CNS Neoplasms” table removed; replaced by a link to the current CAP CNS Protocol to maintain currency with WHO updates.
- Action: Use CAP link for grade references; continue to use Solid Tumor Rules for MP/H as usual. Linked on page 244 of the pdf.

Use your notepad to document rationale

- Record rationale when applying updated ambiguous terms or when histology selection hinges on footnotes.
- Cross-reference page/footnote numbers in your abstract text for audit trail.
- Document rule number and date it was applied.

Tips, Pitfalls, and Edits

- Tip: Always consult the latest PDF; do not rely on memory of table positions—format shifted in 2026. seer.cancer.gov
- Pitfall: Coding “features/differentiation” without a specific ICD-O code—confirm before assigning. training.seer.cancer.gov
- Escalation: If a histology term isn’t in tables or ICD-O updates, submit to Ask A SEER Registrar. seer.cancer.gov

Test your knowledge

Resources and Links

Appendix C: Site-Specific Coding Modules - 2025 SEER Program Coding and Staging Manual

Solid Tumor Rules

SEER Inquiry System - Search

Key Takeaways

Use the 2026 Solid Tumor Rules immediately.

Breast M10/H28 removed, recheck your pathways.

CNS grade is now located in CAP link, can be accessed via hyperlink in STR.

Updated ambiguous terms can change histology codes.


Q&A and
Feedback