

## Gynecologic Pathology Grossing Guidelines

**Specimen Type:** SALPINGECTOMY (neoplastic resection)

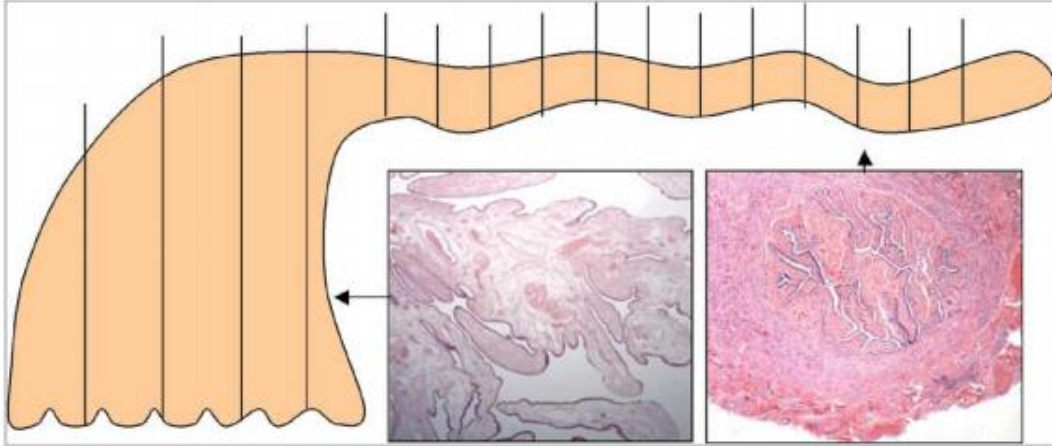
### **Gross Template:**

Labeled with the patient's name (\*\*\*), medical record number (\*\*\*), designated "\*\*\*\*", and received [*fresh/in formalin*] is a [*disrupted/intact*] salpingectomy measuring \*\*\* cm in length x \*\*\* cm in diameter. Fimbriae are [*present/absent*]. The external surface of the fallopian tube is remarkable for [*color, texture, adhesions, paratubal cysts*]. The specimen is sectioned to reveal [*describe lesion-location, focality, color, circumscription, extension (transmural, % of lumen involved, layers of wall involved)*]. The remaining mucosa is [*describe cut surface*]. No additional lesions or masses are identified. Representative sections are submitted [*describe cassette submission*].

**Cassette Submission:** 8-10 cassettes

- Representative sections of tumor, if present, including one of grossly involved mucosa and one of uninvolved mucosa.
- Representative sections of any cystic lesions.
- In a case of primary adenocarcinoma of the fallopian tube, if the tube is intact, submit section representing deepest invasion in/through wall.
- Submit the surgical margin in a separately designated cassette.
- **Take gross photographs**
- For **suspected or confirmed high-grade serous carcinoma, BRCA +, or history of breast cancer**, in which no lesion is grossly identified, submit entire fallopian tube and ovary using SEE-FIM protocol, see sectioning diagram below:
  - **Amputate and longitudinally section the infundibulum and fimbrial segment (distal 2 cm) to allow maximal exposure of the tubal plicae.**
  - **The isthmus and ampulla are cut transversely at 0.2-0.3 cm intervals.**
  - **In the gross description, mention in the summary of section that the fallopian tube has been submitted in its entirety using the SEE-FIM protocol.**

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**Figure 1. Protocol for Sectioning and Extensively Examining the Fimbriated End (SEE-FIM) of the Fallopian Tube.** This protocol entails amputation and longitudinal sectioning of the infundibulum and fimbrial segment (distal 2 cm) to allow maximal exposure of the tubal plicae. The isthmus and ampulla are cut transversely at 2- to 3-mm intervals. From Crum et al.<sup>10</sup> Copyright © 2007 Lippincott Williams & Wilkins. Reproduced with permission.