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.
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. Copyright © 2007 Lippincott Williams & Wilkins. Reproduced with permission.