

GASTROINTESTINAL PATHOLOGY GROSSING GUIDELINES

Specimen Type: LAR (LOW ANTERIOR RESECTION)

Procedure:

1. Measure length and range of diameter or circumference. Measure the bowel and anus separately.
2. Describe external surface, noting color, granularity, adhesions, fistula, discontinuous tumor deposits, areas of retraction/puckering, induration, stricture, or perforation.
3. Note any enlarged lymph nodes and thrombosed vessels or other vascular abnormalities.
4. Open the bowel longitudinally along the anterior surface, while trying to avoid cutting through the tumor.
5. Measure any areas of luminal narrowing or dilation (location, length, diameter or circumference, wall thickness), noting relation to tumor.
6. Describe tumor, noting size, shape, color, consistency, appearance of cut surface, % of circumference of the bowel wall involved by the tumor, depth of invasion through bowel wall, and distance from margins of resection (radial/circumferential margin, mesenteric margin, closest proximal or distal margin).
 - a. If resection includes mesorectum, gross evaluation of the intactness of mesorectum must be included. For rectum, the location of the tumor must also be oriented: anterior, posterior, right lateral, left lateral.
 - b. If a rectal tumor is close to distal margin, the distance of tumor to the distal margin should be measured when specimen is stretched. This is usually done during intraoperative gross consultation when specimen is fresh.
 - c. If the tumor is in a retroperitoneal portion of the bowel (e.g. rectum), radial/retroperitoneal margin must be inked and one or more sections must be obtained (a shave margin, if tumor is far from the radial margin; and perpendicular sections showing the relationship of the tumor to the inked radial margin, if tumor is close to the radial margin).
 - d. If the tumor is in a peritonealized portion of the bowel (e.g. sigmoid colon), then the serosal surface over the tumor needs to be inked. If tumor grossly puckers the serosa, one or more perpendicular sections must be taken to show the relationship of the tumor to the inked serosal surface).
 - e. Mesenteric margin is evaluated grossly for tumor involvement for segments with mesentery (transverse and sigmoid colon). The distance of tumor to the mesenteric margin should be described.
7. Describe the appearance of uninvolved mucosa.
8. Describe the size, appearance and location of any additional lesions such as polyps.
9. After submitting all sections that are needed to demonstrate the relationship of the tumor (or tumor bed) to the pericolic fat and serosa, **dissect the remaining pericolic and mesenteric adipose tissue off of the colonic segment**, slice it at 2-3 mm intervals, and thoroughly palpate the tissues to identify all lymph nodes and possible lymph nodes. Note range of size and appearance of cut surface of lymph nodes.

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Gross Template:

MMODAL COMMAND: INSERT L A R

It consists of an [*intact/disrupted****] low anterior resection. [*Indicate orientation if provided****] The specimen measures [***] cm in length and ranges from [*smallest to largest*] cm in open circumference. The attached fibroadipose tissue extends up to [***] cm from the bowel wall.

The serosal surface is [*pink-tan and smooth, unremarkable/ remarkable for describe, if applicable****]. The mucosa of the [*describe location-sigmoid, rectosigmoid junction, rectum****] is remarkable for a [*describe lesion: size (___ x ___ x ___ cm), shape (e.g. polypoid, ulcerated, fungating), color, consistency (e.g. soft, firm, friable)****]. The lesion involves [***]% of the circumference of the bowel. [*describe obstruction or strictures caused by lesion****] The lesion is located [***] cm [*proximal/distal/ or is located at the anterior peritoneal reflection/ADJUST SENTENCE AS NEEDED FOR EACH CASE****] to the anterior peritoneal reflection. Sectioning of the lesion reveals a [*describe color, consistency/white-tan and firm****] cut surface. The lesion [*is grossly superficial, extends into the bowel wall, extends through the bowel wall into the fibroadipose tissue (for GISTs or serosa-based lesions indicate layers of bowel wall involved and any associated mucosal ulceration)****] The lesion measures [***] cm from the proximal margin, [***] cm from the distal margin, [***] cm from the [*radial/mesenteric****] margin. [*Please ask for margin determination if needed****] [*and *** cm from the serosal surface (if located above the level of peritoneal reflection)*]

The remainder of the bowel serosa is [*tan, smooth, glistening, and unremarkable or describe any additional lesions****]. The remainder of the bowel mucosa is [*tan, glistening, folded, and unremarkable or describe any additional lesions****]. The bowel wall thickness ranges from [*smallest to largest****] cm. After removing the pericolic/perirectal adipose tissue, it is thoroughly examined for lymph nodes. [*State number****] lymph nodes and possible lymph nodes are identified, ranging from [*smallest to largest****] cm in greatest dimension.

All identified lymph nodes are entirely submitted. [*The lesion/mass is entirely submitted (if applicable, otherwise skip to next sentence)****] Gross photographs are taken. Representative sections of the remaining specimen are submitted.

INK KEY:

Black Mesenteric/radial margin overlying lesion
Blue Serosa overlying lesion

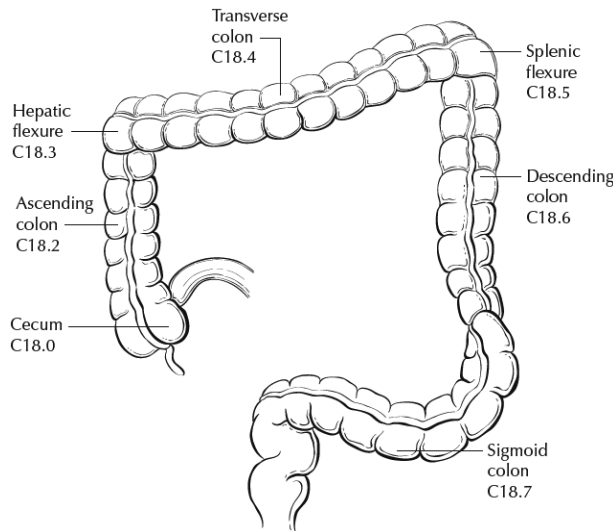
[*insert cassette summary****]

Cassette Submission: 15-20 cassettes

- Proximal resection margin, shave (perpendicular if close to tumor)
- Distal resection margin, shave (perpendicular if close to tumor)
- Mesenteric/radial resection margin (perpendicular section with nearest approach to tumor), or a shave if tumor is far away
- One cassette per 1 cm of tumor (OR at least 5 sections of tumor OR if small enough, entirely submit)
 - o Show maximum depth of invasion
 - o Show nearest approach to serosal surface

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- Show relationship to unremarkable mucosa
- Show relationship to any contiguous or adherent organs
- If the resection is for a large adenomatous polyp with no gross invasion - entirely submit
- Sampling any additional pathology in the gross description (ulcers, polyps, etc.)
- Representative sections of unremarkable colon/rectum in one cassette
- Dissect remaining pericolonic and mesenteric adipose tissue and thoroughly dissect fat to look for all possible lymph nodes. Submit all lymph nodes identified (at least 12 lymph nodes are suggested for colorectal carcinoma)
- **Note:** If no tumor is grossly identified and instead an area of ulceration or scar is present (which is often the case for rectal carcinomas status post neoadjuvant therapy), then the entire ulcer or scar area needs to be submitted.



Anatomic Subsites of the Colon and Rectum

Site	Relationship to Peritoneum	Dimensions (approximate)
Cecum	Entirely covered by peritoneum	6 x 9 cm
Ascending colon	Retroperitoneal; posterior surface lacks peritoneal covering; lateral and anterior surfaces covered by visceral peritoneum (serosa)	15-20 cm long
Transverse colon	Intraperitoneal; has mesentery	Variable
Descending colon	Retroperitoneal; posterior surface lacks peritoneal covering; lateral and anterior surfaces covered by visceral peritoneum (serosa)	10-15 cm long
Sigmoid colon	Intraperitoneal; has mesentery	Variable
Rectum	Upper third covered by peritoneum on anterior and lateral surfaces; middle third covered by peritoneum	12 cm long

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Site	Relationship to Peritoneum	Dimensions (approximate)
	only on anterior surface; lower third has no peritoneal covering	

