Rectum, Tumor

(4.14 Rectum_Tumor); Created November 8th, 2018 by Maria Rabina; Last updated December 4th, 2021 by JKD

SAMPLE DICTATION

(Labeled: ___, ___; ___) Received ___ is a __ cm long by __ cm in diameter segment of rectum (and sigmoid) with a __ cm wide mesorectum. The mesorectal envelope is (complete/nearly complete/incomplete) [*see notes below*].

Major pathologic finding(s): The mucosa shows a __ x __x __ cm (exophytic/endophytic/ulcerated) mass (that is entirely above/below/that straddles) the anterior peritoneal reflection on the (anterior/posterior/right lateral/left lateral wall). The mass comes to within __ cm from the proximal margin and __ cm from the distal margin. The mass extends to a depth of __ cm, involves the __ (extent of invasion), and is __ cm from the closest radial margin. The mass involves __ % of the circumference of the bowel. There (is/is no) gross tumor perforation.

Other findings: The background colonic mucosa shows appropriate folds without additional focal lesions or discoloration (describe additional lesions if identified). Multiple lymph node candidates are present within the pericolonic adipose tissue ranging from __ to __ cm in greatest dimension.

Specimen Handling: Ink key: ___ = radial margin. (RS / TE, ___ caps)

SUGGESTED SAMPLING

1-5: Tumor, full thickness with depth of invasion (contiguous sections for large tumors)
6: Proximal margin, perpendicular
7: Distal margin, perpendicular
8: Radial/mesenteric margin, perpendicular
9: Uninvolved mucosa
>9: Lymph node candidates [*15 or more are required for assessment of nodal status - pN*]

STAGING CRITERIA (AJCC 8TH EDITION)

- Depth of invasion and/or infiltration of adjacent structures (other organs or other segments of the colorectum) is the primary criteria for pT staging.
- pN status is determined by number of positive lymph nodes (<3 vs. 4 or more) or non-nodal tumor deposits within lymph node drainage
- pM status is determined by presence of metastatic disease *or non-regional lymph node metastases;* pM0 is not assigned by pathologists, as the entire clinical picture is often not known to pathologists.

ADDITIONAL CONSIDERATIONS

- Abdominoperineal resections (APR) include the perianal skin and anus. For this resection, include the distance of the mass from the dentate/pectinate line on the gross description. Ink the anal skin margin differently from the radial margin and sample the closest anal margin perpendicularly.
- In cases for carcinomas with status post neoadjuvant therapy and no tumor is grossly identified, sample the entire ulcer or scar. Post-neoadjuvant cases often have very small lymph nodes
- Posteriorly, the peritoneal reflection is located higher and most of the posterior rectum does not have a serosal covering.
- For all rectal carcinomas, **take four photographs of the mesorectum** (anterior, posterior, and lateral - both sides), label appropriately with orientation, and save to LIS. This is an accreditation requirement.

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- **TOTAL MESORECTAL EXCISION (TME):** For rectal carcinomas, resection of the entirety of the mesorectum and associated fat pad greatly reduces local recurrence rates. Thus, completeness of the mesorectum should be documented. https://sites.ualberta.ca/~rmclean/tme.htm
    - Complete (Quirke grade 3) TME: Smooth intact mesorectum, no deep (> 5 mm) defects in mesorectum, mesorectal fat pad is bulky distally, smooth circumferential radial margin (CRM); no coning of specimen
    - Nearly complete (Quirke grade 2) TME: Moderate bulk in distal aspect of specimen, moderate irregularity of mesorectum with defects > 5 mm deep; moderate coning; no exposure of muscularis propria seen
    - Incomplete (Quirke grade 1) TME: Little bulk in distal mesorectum, prominent coning of specimen, exposure of muscularis propria, circumferential radial margin is shaggy and irregular