GYN grossing

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Major specimens types

- Cervical excision - cone/ LEEP
- Hysterectomy – benign
- Hysterectomy, BSO – endometrial cancer/hyperplasia
- Hysterectomy – cervical cancer
- Hysterectomy, BSO – ovarian cancer
- BSO -BRCA mutation (or personal history of breast cancer)
- Hysterectomy for Lynch syndrome
- Vulvar resections – simple excision
- Vulvar resection – radical vulvectomy
- Myomectomy
- Products of conception

Before starting to cut

- Check clinical history
  - why this specimen was taken
  - why this organ needed to come out
- If it does not make sense – check with an attending
- All unusual cases – show to an attending
- If not all named organs present– show to an attending
- All vulvectomy specimens (more than a simple ellipse excision) – show to an attending
- Malignant cases – review tumor staging before you start cutting

Cervical excision

- Indications
  - HSIL
  - Cervical cancer
- LEEP
- Cold knife cone

Need to evaluate margins

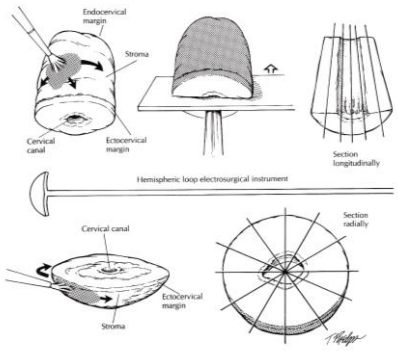
No more than 3 pieces in one cassette (or less, if cervix is large)

Cervical excision

- Fix the specimen before cutting
- Orientation – ectocervix/endocervix
- Differential inking
  - Endocervical margin – blue
  - Ectocervical/deep margin – black
- LEEP in multiple fragments – ink cauterized surfaces (one color – black)

Cervical excision

- Differential inking
  - Endocervical margin – blue
  - Ectocervical/deep margin – black



Cervical excision

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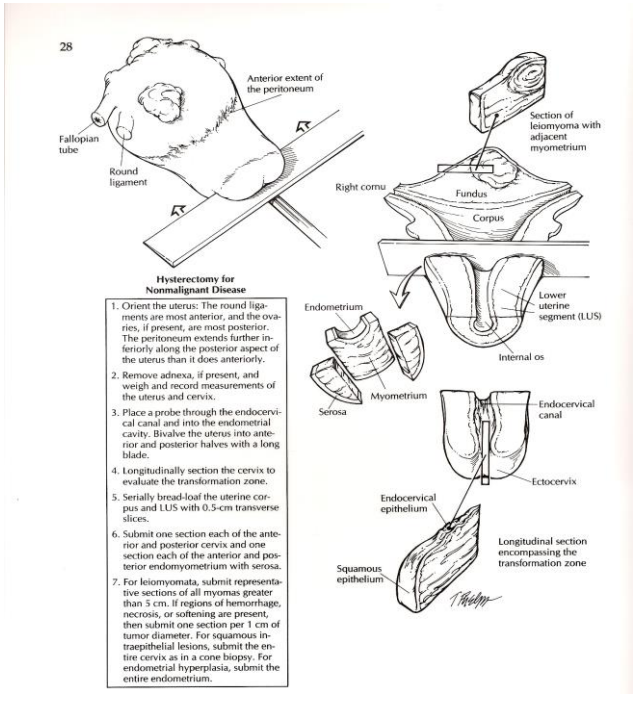
Hysterectomy

- Measure
  - Cervix to fundus
  - Cornu to cornu
  - Anterior to posterior
  - Cervix – length; diameter
  - Cervical os – diameter
  - Ovaries A x B x C
  - Fallopian tubes, length; diameter, mention if fimbria are present
- Describe uterine serosa



Uterus – standard sections
Benign – prolapse, etc.

- Cervix – 6:00; 12:00
- Lower uterine segment – anterior; posterior
- Endomyometrium – anterior; posterior (full thickness)

+ If additional findings are present

Polyps

Endometrial polyps – submit entirely

Include junction with underlying myometrium

Hysterectomy – benign, leiomyomas

- Count nodules, more than 5 – multiple
- Describe nodules location – subserosal, submucosal, intramural
- Measure nodules, if multiple – give range
- Sampling – "normal" looking leiomyoma, no hemorrhage or necrosis

- 2.0 cm or less, no need to sample, if larger nodules present
- 2.0 – 4.0 cm – one section per nodule
- 5.0 cm or larger – one section per 2 cm of greatest dimensions

Eg. – 10.0 cm leiomyoma – 5 sections (3 cassettes)

Hysterectomy – benign, leiomyomas

Eg. – 10.0 cm leiomyoma – 5 sections (3 cassettes)

- No more than 2 sections per cassette ,
  - multiple small pieces are not helpful
- If areas of necrosis or hemorrhage are present
  - sample interface with viable tissue
  - Sections of entirely necrotic tissue from the middle are not helpful
- If calcified
  - try to shave non-calcified tissue from the periphery
  - try to avoid submitting for decal
- In the summary of sections
  - refer to nodules by size
  - so we could go back to a specific nodule, if we have to

Hysterectomy – history of complex endometrial hyperplasia or carcinoma No grossly identifiable endometrial lesion

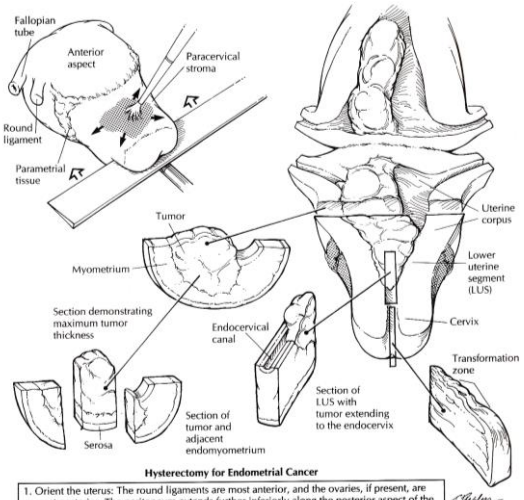
- Submit <u>entire</u> endometrium

  2 sections full thickness – anterior + posterior

  Remainder – partial = ½ thickness

Hysterectomy – endometrial carcinoma

- After opening the uterus
  - measure endometrial tumor
  - if both anterior and posterior walls are involved measure them <u>separately</u>
- Section endomyometrium
  - measure myometrial thickness
  - if there is gross myoinvasion – describe and measure the depth
- If there is no myoinvasion grossly
  - submit 2-3 full thickness sections
  - remainder of tumor to myometrium junction in partial thickness



Hysterectomy for Endometrial Cancer

1. Orient the uterus: The round ligaments are most anterior, and the ovaries, if present, are most posterior. The peritoneum extends further inferiorly along the posterior aspect of the uterus than it does anteriorly.
2. Weigh and measure the uterus and cervix. Ink the paracervical and parametrial soft tissue margins.
3. Place a probe in the endocervical and endometrial canal. Bivalve the uterus into anterior and posterior halves with a long blade.
4. Longitudinally section the cervix, extending the incision upward through the LUS. Serially bread-loaf the uterine corpus with 0.5-cm transverse slices.
5. Describe the size, appearance, and location of the tumor.
6. Submit sections of tumor to demonstrate the maximum tumor thickness, anterior and posterior LUS sections, uninvolved endometrium, and anterior and posterior cervix. If the adnexa are present, submit sections of the ovary and fallopian tube with adjacent soft tissue.

Hysterectomy – endometrial carcinoma

- Large polypoid endometrial mass
  - closely examine the stalk, if no myoinvasion, submit entire stalk
- If there is suspicion of serosal involvement
  - ink serosa and submit section
- Preop biopsy – serous carcinoma
  - submit entire fallopian tube in addition to the ovary

Ovary - what do we need to stage?

Ovary

- Describe - intact/ruptured/fragmented
- Describe surface - smooth/irregular/adherent tissue
  - If any surface irregularities present – ink and submit sections
- Solid/ cystic
- Multicystic/ unilocular cyst
- Open cyst – describe inner lining (smooth/ excrescencies)

Ovary

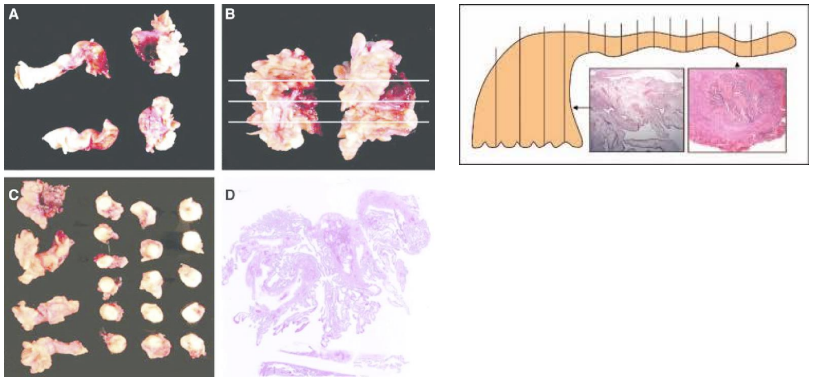
- Sampling
  - benign ovary (TAHBSO for fibroids)
    – 1 section
  - endometrial cancer/ normal size ovaries
    – submit entirely
  - malignant or borderline tumor
    – 1 section per cm of greatest dimensions
      - 1-2 sections per cassette, if solid
      - several sections per cassette, if cystic
  - may need to submit more depending on histology

Benign ovaries and fallopian tube – standard sections

- Fallopian tube
  - – fimbria bisected and submitted <u>in all cases</u>
  - + 2 cross-sections of tube
- Ovary – bisected along the long access – ½ submitted

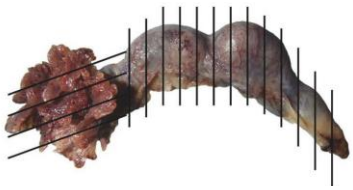
- If either ovaries or fallopian tube are named on the requision, but not identified grossly
  - show specimen to attending and/or submit entire adnexal soft tissue

BSO- prophylactic/ risk-reducing salpingo-oophorectomy BRCA, personal history of breast ca



BSO- prophylactic/ risk-reducing salpingo-oophorectomy
BRCA, personal history of breast ca

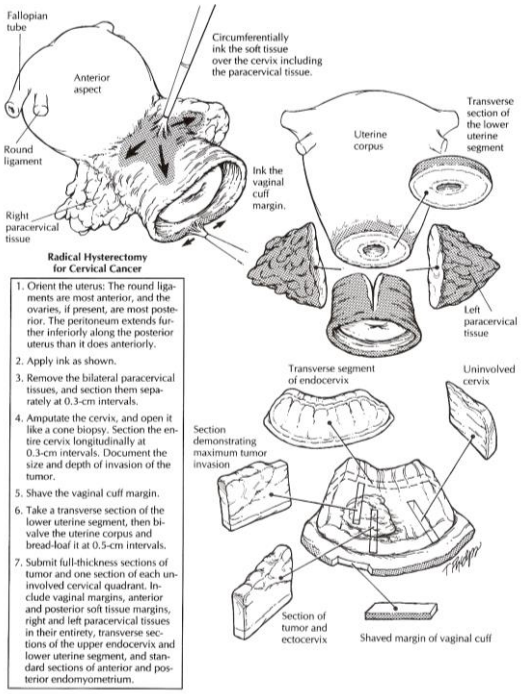
- Submit entire adnexa
- Ovary – section perpendicular to the long axis
- Section fallopian tube per protocol
  - amputate fimbria – section
  - section tubular portion
  - in hysterectomy – submit intramural FT



Radical Hysterectomy – show to an attending

- Cervical cancer
- Occasionally endometrial cancer with suspected cervical involvement

- Identify
  - vaginal cuff – submit entirely
    show relationship to the tumor, if you can
  - parametria – submit entirely



Hysterectomy for cervical cancer

- No grossly visible lesion/tumor

  - submit entire cervix – include ecto- and deep margins

- Grossly visible tumor – measure

  - submit representative sections

    relationship to margins and vaginal cuff

Vulva

- Needs to be fixed stretched and pinned down
- Check orientation, per surgeon or anatomic landmarks
- Check operative note to help with orientation
- Measure specimen
- Describe lesions
- Measure distance from the lesion to margins
- Do NOT put too many pieces in one cassette
  no more than 3 small pieces

Vulva

- Ink margins with two color (right/left; medial/lateral)
- Submit tips in two separate cassettes
- Serial consecutive sections (entirely or rep sections)

Products of conception

- If no obvious villous tissue or fetal parts identified
  Submit entirely if it fits into 5-6 blocks
- If you don’t see products when you are previewing
  Check with the attending - consider going back and submitting the rest