Required Elements for Standardized Synoptic Reporting: MRI Local Excision Procedure Assessment (Standard 5.4)

Clinical Information:

Procedure Date: [ ]

Procedure Type: [Endoscopic polypectomy/TAE/TAMIS/TEMS/ESD/EMR/NA]

Procedure Location: [___cm from anal verge/NA]

Tattoo placed: [Y/N]

Endo-clip in place? [Y/N]

Procedure Histology: [HGD or invasive cancer only intramucosal (TIS)/invasive cancer involves SM (T1) +/- positive margin/LVI or incomplete polypectomy/NA]

Technique: Multiplanar, multisequence imaging of the pelvis.

Magnet strength: [ ]

IV gadolinium contrast: [ ]

Comparison: [ ]

Rectal Wall:

EXCISION SITE/MUCOSAL ABNORMALITY:

MRI-T2W:

☐ No Focal abnormality seen

☐ Focal abnormality as follows

☐ Scar present

☐ Scar and possible residual tumor (mass-like or polypoid intermediate signal intensity or mucin signal intensity in wall)

☐ Residual tumor/mass

☐ Equivocal finding between residual tumor and post-procedural change

DWI: (with associated low ADC) – restricted diffusion and low ADC in tumor or tumor bed

☐ Present

☐ Absent

☐ Artifact/equivocal

Distance of the inferior margin of treated tumor/area to the anal verge: [ ] cm

Distance of inferior margin to the top of the sphincter complex/anorectal junction: [ ] cm

Craniocaudal length: [ ] cm (comment on any change since prior)

Maximal wall thickness: [ ] cm (comment on any change since prior)

Lymph Nodes:

Mesorectal/superior rectal lymph nodes and/or tumor deposits:

☐ N0 (no visible lymph node or probably reactive)

☐ N + (Meet Dutch Criteria* see below) American College of Surgeons | 2026 Standards | Optimal Resources for Rectal Cancer Care | 77

☐ Nx (unable to tell reactive vs. malignant nodes)

1. Sensitivity of 51 (85%) of 60 (95% CI: 74%, 92%) and a specificity of 216 (97%) of 221 (95% CI: 95%, 99% (Brown G, Richards CJ, Bourne MW, Newcombe RG, Radcliffe AG, Dallimore NS, Williams GT. Morphologic predictors of lymph node status in rectal cancer with use of high-spatial-resolution MR imaging with histopathologic comparison. Radiology. 2003 May;227(2):371-7. doi: 10.1148/radiol.2272011747. PMID: 12732695.)

2. Presence of a spiculated border and an indistinct border shows sensitivities of 45 and 36%, and specificities of 100 and 100%, respectively. Presence of a mottled heterogeneic pattern shows a sensitivity of 50%, a specificity of 95%. The presence of these three features were strongly correlated with LN positivity ($P < 0.001$, respectively). (Kim JH, Beets GL, Kim MJ, Kessels AG, Beets-Tan RG. High-resolution MR imaging for nodal staging in rectal cancer: are there any criteria in addition to the size? Eur J Radiol. 2004 Oct;52(1):78-83. doi: 10.1016/j.ejrad.2003.12.005. PMID: 15380850.)

Extra-mesorectal lymph nodes: any suspicious?

☐ No

☐ Yes

Extramural Vascular Invasion (EMVI): ☐ No/☐ Yes

Tumor Deposit: ☐ No/☐ Yes

Other: [free text: bones, peritoneal mets, other incidental findings]

Impression:

☐ Rectal Wall

*No visualized rectal wall abnormality

* Scar-only is visualized

*Residual soft tissue at excision site

☐ Worrisome for residual tumor

☐ Equivocal for tumor

☐ Likely post-procedural change

☐ Lymph Nodes

☐ N0 (no visible lymph node or probably reactive)

☐ N + (Meet Dutch Criteria*)

☐ Nx (unable to tell reactive vs. malignant nodes)

Suspicious Extra-mesorectal lymph nodes: ☐No ☐Yes (provide location)

***Dutch Baseline Lymph Node Criteria**

☐ N0 (no visible lymph nodes/deposits)

☐ N+ (short axis >= 9 mm)

☐ N+ (short axis 5-9 mm AND at least 2 of the following criteria: round shape/irregular border contour/heterogeneous signal intensity)

☐ N+ (short axis < 5 mm AND round shape AND irregular border contour AND heterogeneous signal intensity)

☐ Nx (all other cases)