Trainee Identification:_____ Date: __ __/__ __/__ __ __ __

Program: _____ Evaluator Identification: _____

Global Assessment LAR

Instructions: Please read each action highlighted in grey. Evaluate the performance of each action according to the 1-5 scale listed below the stated action. Then write the corresponding score in the column labeled "score.

E	Exposure	Score
E1	**Demonstrates knowledge of optimum skin incision/portal/access** **1** Does not extend an incision when struggling for access **2** **3** Makes an incision clearly too small or too large **4** **5** Verbally states or marks with a pen the anatomical landmarks prior to making the incision. Extends incision if necessary for exposure.	
E2	**Achieves an adequate exposure through purposeful dissection in correct tissue planes and identifies all structures correctly** **1** Describes the structure encountered in the dissection in the wrong location. Rough blind palpation of abdominal contents causing damage **2** **3** Tries to maintain the standard approach despite the fact that access is proving difficult. Forgets to examine some of the abdominal contents **4** **5** Is able to give a running commentary to the trainer of the structures encountered. Makes a cautious entry through peritoneum. Systematic inspection of contents of abdomen	
E-T	**Total Score for Exposure**	
LAR-IT	**LAR Intraoperative Technique**	**Score**
LAR-IT1	**Mobilizes sigmoid/left colon with regard to correct planes; the superior rectal artery and inferior mesenteric vessels are identified, leaving intact the pre-aortic nerves and superior hypogastric plexus** **1** Fails to mobilize colon safely and fails to identify adjacent structures correctly **2** **3** Mobilizes deliberately, but slowly. **4** **5** Mobilizes colon safely. Identifies adjacent structures carefully. Careful and accurate idetntification	
LAR-IT2	**Ureters are identified bilaterally** **1** Fails to identify ureters correctly **2** **3** Mobilizes fairly well, but does not identify the left ureter prior to clamping	

	and tying the IMA pedicle. **4** **5** Ureters identified correctly	
LAR-IT3	**Mobilizes the rectum by sharp, anatomic dissection;** **1** Fails to establish oncologically sound and safe vascular resection margins causes injury to sidewall and pre-sacral vessels, nerves, and ureters **2** **3** Mobilizes by sharp dissection, and causes disruption of less than 20% of the fascia propria envelope. **4** **5** Establishes oncologically sound and safe vascular resection margins: preserves an intact mesorectal fascial envelope and intact endopelvic fascia; avoids injury to sidewall and pre-sacral vessels, nerves, and ureters	
LAR-IT4	**Dissects the rectum in appropriate anterior plane.** **1** Makes proctotomy in anterior rectal wall **2** **3** Anatomic planes reasonably well identified, but frequently obscured by intermittent bleeding. **4** **5** Male: identifies prostate/seminal vesicles; makes decisions about anterior plane of dissection with regard to Denonvillers's fascia and location of cancer Female: identifies vagina	
LAR-IT5	**Decides on "TME or subtotal mesorectal excision with regard to tumor location: if subtotal, divides across mesorectum without coning, at least 2 cm beyond cancer; if TME, dissects circumferentially to pelvic floor** **1** Fails to adequately obtain a distal margin, cuts across tumor. **2** **3** Is able to decide on TME vs partial TME based on tumor location, but specimen has mild coning, fascia propria 10-20%defects, or distance on partial mesorectum inadequate. **4** **5** Able to quickly and accurately decide on TME vs partial TME. For TME, no coning, intact fascia propria, with obvious clearance of lesion. For partial TME, at least 2 cm distal to the tumor on the mucosa and the mesorectum	
LAR-IT6	**Divides inferior mesenteric artery at its origin; divides inferior mesenteric vein at inferior border of pancreas; incises bare area of left colon mesentery** **1** Ligates branches of IMA within mesentery. **2** **3** Ligates the IMA l midway. **4**	

	5 High ligation of the IMA/IMV bare area of colonic mesentery recognized and incised.	
LAR-IT7	**Divides the bowel with regard to minimizing spillage\contamination** **1** Resects bowel causing spillage and contamination **2** **3** Minimal spillage/contamination **4** **5** Makes safe resection without bleeding or spillage	
LAR-IT8	**If the double staple technique is used: applies the transverse stapler across the rectum ensuring that the other tissue (e.g. vagina) is not trapped** **1** Failure to clearly delineate proximate tissue that may be trapped in the stapler (vagina/seminal vesicles). Stapled tissue thick/substantial mesentery trapped posteriorly in staple line. **2** **3** Transverse stapler clear of other tissues, but clearance between staple line and vagina/vesicles small. **4** **5** Other tissues well clear of TA device, rectal mesentery cleared posteriorly, at least 1 cm of clearance on the staple line between adjacent structures	
LAR-IT9	**Checks specimen for satisfactory margin of clearance, quality of mesorectal dissection** **1** Sends specimen off without consideration of margins, quality of fascia propria or inclusion of pathology if appropriate). **2** **3** Checks distal margin, but no others. **4** **5** Checks specimen for satisfactory margin of clearance, quality of mesorectal dissection.	
LAR-IT10	**Mobilizes descending colon and splenic flexure in the correct plane with regard to avoiding splenic, gastric or colonic injury;** **1** Fails to mobilize the splenic flexure **2** **3** Incomplete mobilization but tension-free mesentery **4** **5** Complete flexure mobilization of splenic flexure	
LAR-IT11	**If the double staple technique is used: selects correct EEA stapler size; applies purse string suture correctly; passes cartridge atraumatically per anus and brings trocar through or adjacent to rectal staple line; couples the anvil and cartridge atraumatically per anus and bring trocar through or adjacent to rectal staple line; couples the anvil and cartridge with correct orientation of the colon and ensures no tissue trapping as anvil and**	

	cartridge are approximated; checks correct firing zone of instrument before firing **1** Purse string incomplete/with gaps; trocar introduced far from the staple line; indifferent colonic orientation; no consideration of potential tissue trapping. **2** **3** Purse string appears intact, but fails to inspect, struggling with trocar introduction, minimal clearance of adjacent tissue/bladder/vagina **4** **5** Careful purse string technique whether with an automatic device or hand sewn; trocar introduced adjacent to/or through the staple line, careful/deliberate closing of the device; no tissue trapping	
LAR-IT12	**Establishes a tension-free, well-vascularized, intact anastomosis, with correct orientation of the colon (i.e. no twist in the mesentery)** **1** Anastomosis created with tension and/or twists in the mesentery **2** **3** Some tension, appears well-vascularized. **4** **5** Intact anastomosis is tension-free, well-vascularized with an adequate lumen	
LAR-IT13	**If the double staple technique is used: inspects the tissue donuts and sends these specimens for pathological examination** **1** No donut inspection. No pathologic follow up. **2** **3** **4** **5** Carefully inspects the donuts, gives feedback on degree of integrity; sends as a path specimen.	
LAR-IT 14	**Test the anastomosis with air insufflation and saline filled pelvis** **1** Fails to test the anastomosis. **2** **3** Tests the anastomosis via proctoscopy, incomplete inflation of the proximal colon. **4** **5** Tests the anastomosis via proctoscopy, makes sure there is adequate insufflation with no leak.	
LAR-IT15	**Establishes diverting stoma at appropriate site, with adequate aperture, hemostasis correct orientation of afferent/efferent limbs, minimal tension; preop marking if appropriate.** **1** No preop marking, no consideration to anatomy when siting stoma, inadequate aperature size/width. **2** **3** No preop marking; consideration of anatomy done; some mobilization to relieve tension.	

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	4 **5** Preop marking and counseling; placement of ostomy in marked spot; mobilization to create minimal tension/ correct orientation of limbs of ostomy.	
LAR-IT-T	**Total Score for LAR Intraoperative Technique**	
C	**Closure**	**Score**
C1	**Completes a sound wound repair where appropriate** **1** Ties very tight sutures, clearly strangulating soft tissue **2** **3** Leaves too large a gap between sutures so that sutures are not properly opposed **4** **5** Closes each layer without tension	
C2	**Protects the wound with dressings, splints and drains where appropriate** **1** Walks away from the operating table without briefing the assistant or the nurse about required dressing. **2** **3** Fails to specify required dressing **4** **5** Personally supervises the application of the wound dressing	
C-T	**Total score for closure**	

	Exposure	LAR Intra-op Technique	Closure
Total			

GLOBAL RATING SCALE OF OPERATIVE PERFORMANCE

Domain of Surgical Performance	Notes	UNSAT	GEN SURG	BRD CR SURG	COMP CR SURG	CR Surg
Respect for Tissue	Appropriate handling of tissue, minimizes tissue damage through appropriate use of instruments and appropriate force	☑	☑	☑	☑	☑

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Time and Motion	Efficient and economic movement	☑	☑	☑	☑	☑
Instrument Handling	Competent use of instruments, fluid movements without stiffness or awkwardness	☑	☑	☑	☑	☑
Knowledge of Instruments	Familiar with names and uses of instrument required for this procedure, does not ask for wrong instrument or use incorrect names when asking for instruments	☑	☑	☑	☑	☑
Flow of Operation	Demonstrates forward planning; course of operation demonstrated through effortless flow from one move to the next	☑	☑	☑	☑	☑
Use of Assistant (if applicable)	Strategically used assistants to the best advantage at all times	☑	☑	☑	☑	☑
Knowledge of Specific Procedure	Demonstrated familiarity with all steps of the operation /procedure	☑	☑	☑	☑	☑
Quality of Final Product		☑	☑	☑	☑	☑
Based on the **OVERALL** performance, the candidate's current competence	**Unsatisfactory** – Below the level of a general surgeon. **Gen SURG** – Could function as a general surgeon. Basic competence in technical skills. **BRD CR SURG**– Borderline CR surgeon. **COMP CR SURG –** Competent as an independent CR surgeon. More advanced competence in technical skills. **CR SURG**– Could practice without supervision as a colorectal surgeon. Could function as an independent practitioner. Professionally sophisticated. At an exemplary level would also imply the person is competent enough to act as a resource to other health care professionals.	☑	☑	☑	☑	☑

Comments