

TUMORAL OESOPHAGECTOMY

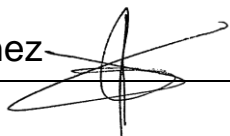
1. An oesophago-gastrectomy specimen is received, consisting of an oesophagus measuring XXX cm and a partial gastrectomy specimen measuring XXX cm // following neoadjuvant therapy.
2. Externally, no remarkable features are identified // a defect / retraction measuring XXX cm is identified // a superficial lesion measuring XXX cm is identified, located X cm from the closest margin.
3. The oesophageal radial margin is inked.
4. On opening, a lesion measuring XXX cm is identified at X cm from the gastro-oesophageal junction, located X cm from the proximal / oesophageal margin and X cm from the distal / gastric margin.
5. The lesion shows a polypoid / exophytic / ulcerative / ulceroinfiltrative / diffuse infiltrative morphology, with a brownish / whitish appearance, occluding X% of the lumen / etc.
6. On sectioning / serial slicing, the lesion is located X cm from the oesophageal radial margin and appears to infiltrate the muscular layer / adipose tissue / adventitia / appears confined to the mucosa.
7. The remaining oesophageal / gastric mucosa shows no remarkable features // shows erythematous and salmon-coloured mucosa measuring X cm in diameter, suggestive of Barrett oesophagus // shows a lesion located at X, demonstrating X features and situated X cm from the surgical margins.
8. On palpation, X nodular formations are identified within the paraoesophageal tissue / greater curvature / lesser curvature, the largest measuring X cm.
9. Representative sections are submitted as follows:

1st Example (Post-neoadjuvant oesophagectomy: longitudinal sectioning)

- A1 and A2: proximal (oesophageal) surgical margin.
- A3 and A4: one complete oesophageal section.
- A5 and A6: second complete oesophageal section.
- A7 and A8: third complete oesophageal section.
- A9 and A10: fourth complete oesophageal section.
- A11: section to assess the gastro-oesophageal junction.
- A12: gastric margin / lesion in relation to gastric margin.
- A13 – A15: 3 paraoesophageal nodular formations.
- A16 – A17: 4 nodular formations from the lesser curvature.
- A18 – A19: 4 nodular formations from the greater curvature.

2nd Example (Post-neoadjuvant oesophagectomy: longitudinal sectioning)

- A1 and A2: proximal (oesophageal) surgical margin.
- A3 to A5: one longitudinal oesophageal section from proximal to distal.
- A6 to A8: transverse sections of the lateral margin from proximal to distal.
- A9 to A11: transverse sections from proximal to distal.
- A12: gastric margin / lesion in relation to gastric margin.
- A13 – A15: 3 paraoesophageal nodular formations.
- A16 – A17: 4 nodular formations from the lesser curvature.
- A18 – A19: 4 nodular formations from the greater curvature.

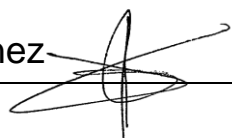


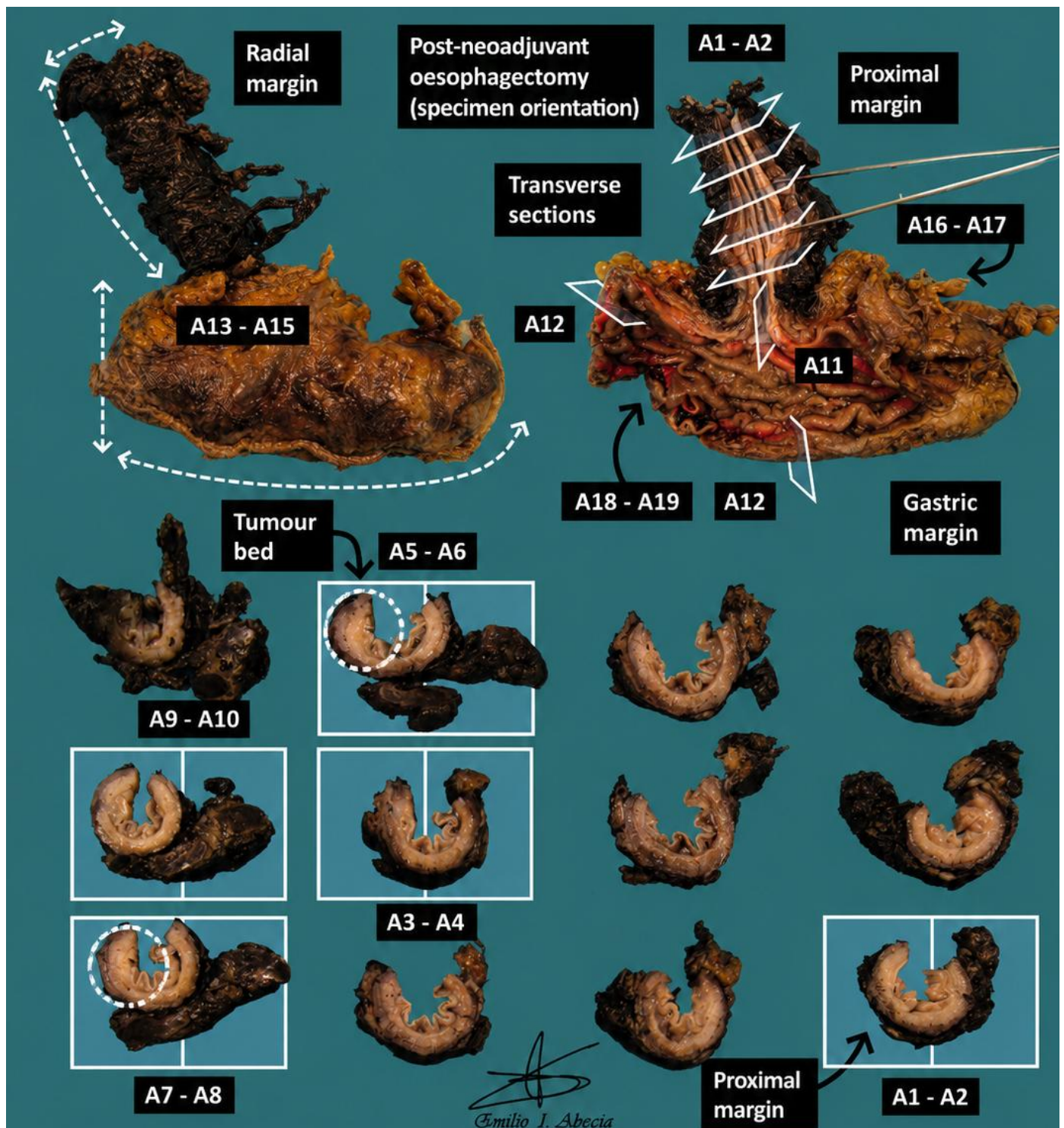
3rd Example (Barrett oesophagus resection with high-grade dysplasia)

- A1 and A2: proximal (oesophageal) surgical margin.
- A3 to A5: one longitudinal oesophageal section from proximal to distal.
- A6 to A8: transverse sections of the lateral margin from proximal to distal.
- A9 to A11: transverse sections from proximal to distal.
- A12: gastric margin / lesion in relation to gastric margin.
- A13 – A15: 3 paraoesophageal nodular formations.
- A16: 2 nodular formations from the lesser curvature.
- A17: 3 nodular formations from the greater curvature.

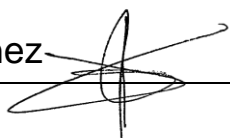
TO CONSIDER

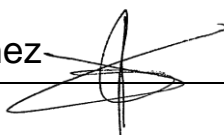
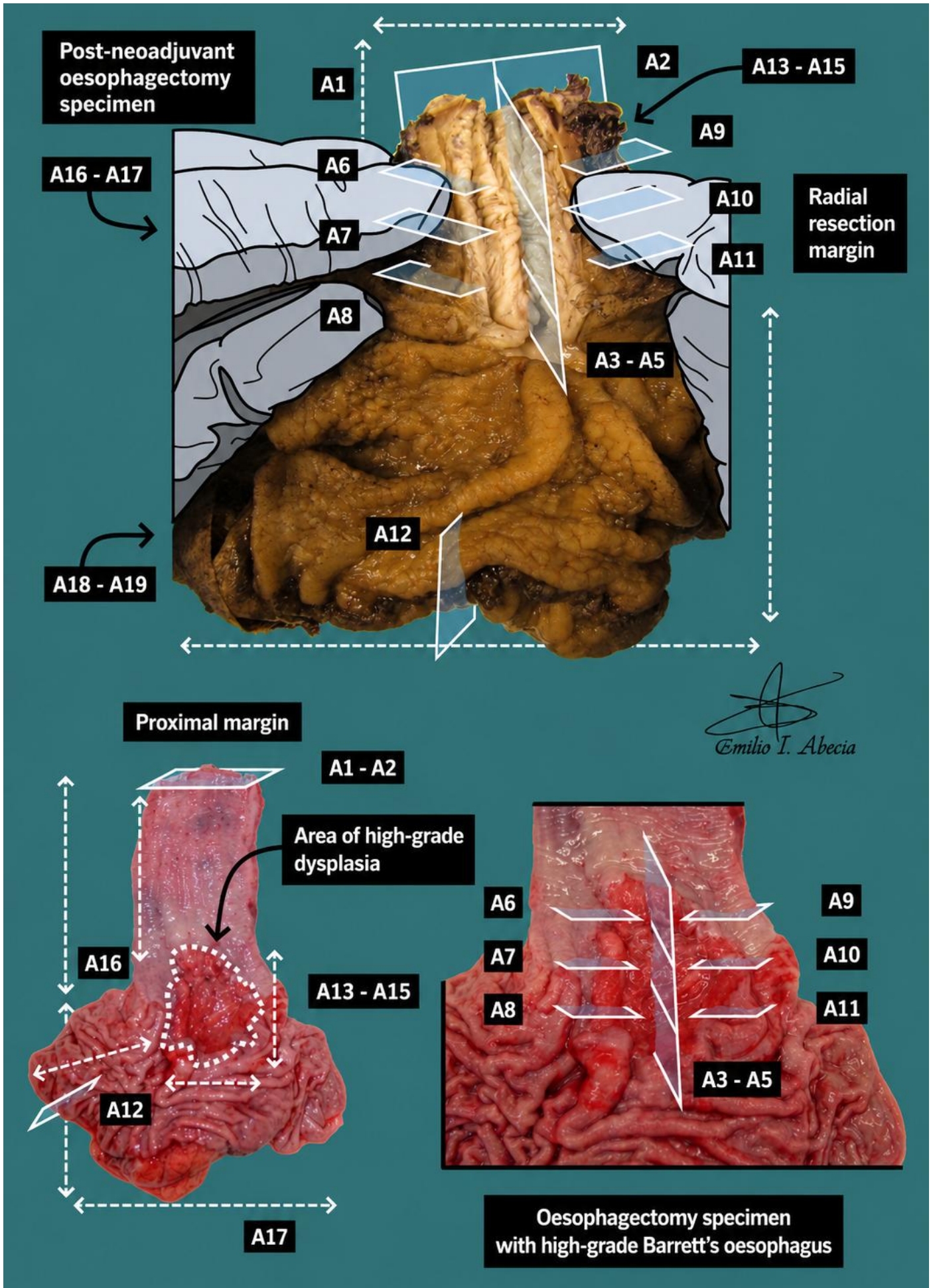
- Tumoural oesophageal resections are commonly received together with proximal gastrectomy specimens. These most frequently correspond to adenocarcinomas or squamous cell carcinomas; less commonly, neuroendocrine tumours or gastrointestinal stromal tumours (GISTs).
- Review the clinical history to confirm tumour location, multifocality, and whether neoadjuvant therapy has been administered (the lesion may show regressive changes, fibrosis, muscular hyperplasia, erosions, and lymph nodes may be difficult to identify).
- Measure and describe the specimen. If perforations / bowel adhesions are identified, this should be documented (macroscopic pT4 stage).
- Ink the oesophageal adventitial surface and open the specimen longitudinally, avoiding transection of the tumour whenever possible. If the specimen includes stomach, open it along the greater curvature.
- Identify and describe the lesion. It is important to document the distance to the radial margin (oesophageal adventitia) and whether the tumour involves the gastro-oesophageal junction / where its epicentre is located (distal oesophagus, gastro-oesophageal junction, or below the junction). If the epicentre is located >2 cm distal to the junction, the specimen should be staged according to the gastric TNM classification.
- Submit representative sections:
 - If the lesion is very close to one of the margins, consider inking or submitting this margin longitudinally (in relation to the lesion) rather than transversely.
 - At least one section of tumour per centimetre of greatest dimension. It is crucial to sample the area showing the deepest wall infiltration (the images demonstrate two approaches for sampling the tumour area).
 - If neoadjuvant therapy has been administered and no residual tumour is grossly identified, entirely submit all indurated / ulcerated areas (tumour bed with regressive changes).
 - Include at least one section of non-neoplastic mucosa to assess for concomitant pathology. Barrett oesophagus should be suspected if adenocarcinoma has been previously diagnosed. Attempt to measure and sample any salmon-coloured mucosal areas.
- When submitting identified lymph nodes, their anatomical origin should be specified (greater curvature, lesser curvature, paraoesophageal, etc.). If fewer than 12 clearly identifiable nodular formations are isolated, it may be useful to submit representative sections of adipose tissue from the peritumoral region.





1. Orientate the specimen and identify anatomical components (oesophagus + stomach)
2. Describe the external surface
3. Ink the radial (circumferential) oesophageal margin
4. Open the oesophagus longitudinally / serially section transversely; identify and measure the lesion, including distance to margins and to the oesophagogastric junction
5. Describe the lesion morphologically
6. Section the lesion and report depth of macroscopic invasion and distance to radial margin
7. Describe any incidental (non-neoplastic) findings in the remainder of the specimen
8. Palpate the peri-oesophageal and perigastric adipose tissue for nodal tissue
9. Include representative sections





BIBLIOGRAPHY

- *Carcinoma Of The Oesophagus*. Structured Pathology reporting of Cancer-Protocols. Recuperado el 13 de Mayo de 2024: <https://www.rcpa.edu.au/Library/Practising-Pathology/Structured-Pathology-Reporting-of-Cancer/Cancer-Protocols/Gastrointestinal/Protocol-Oesophagus.aspx>
- *Esophagogastrectomy*. Gross Manual. UCLA Health. Recuperado el 13 de Mayo de 2024: <https://www.uclahealth.org/sites/default/files/documents/01/esophagogastrectomy-13123.pdf?f=6e7ac687>
- Cipriani N., Rose S. (2019). *Esophagus (neoplastic)*. Gross Pathology Manual (University of Chicago). Recuperado el 13 de Mayo de 2024: <https://voices.uchicago.edu/grosspathology/gi-liver/esophagus-neoplastic/>
- Burgart L. J., Chopp W. V., MD; Jain D. (2022). *Esophagus* (v4.2.0.1). College of American Pathologists (CAP). Recuperado el 13 de Mayo de 2024: https://documents.cap.org/protocols/Esophagus_4.2.0.1.REL_CAPCP.pdf?_gl=1*1lax37z*_ga*MTc4Nzk0MDczNC4xNzE0NDczNzAy*_ga_97ZFJSQQ0X*MTcxNDQ3MzcxwMi4xLjEuMTcxNDQ3NDExMy4wLjAuMA
- WHO Classification of Tumours Editorial Board (2019). *Digestive system tumours* (5th ed., vol. 1). International Agency for Research on Cancer. <https://publications.iarc.fr/Book-And-Report-Series/Who-Classification-Of-Tumours/Digestive-System-Tumours-2019>
- Lemos, M. B., & Okoye, E. (2019). *Atlas of Surgical Pathology Grossing*. Springer Nature Switzerland AG. <https://link.springer.com/book/10.1007/978-3-030-20839-4>
- Susan C. Lester, French, C. A., & Curtis, S. G. (2010). *Manual of Surgical Pathology: Expert Consult* (ed. 3). Elsevier. <https://www.sciencedirect.com/book/9780323065160/manual-of-surgical-pathology>
- Shameem Shariff. (2019). *Fundamentals of Surgical Pathology* (ed.2). Jaypee Brothers Medical Publishers. <https://www.jaypeedigital.com/book/9789388958967>
- Westra, W. H., Ralph H. Hruban, Timothy H. Phelps, & Christina Iacon. (2003). *Surgical Pathology Dissection: An Illustrated Guide* (ed.2). Springer. <https://link.springer.com/book/10.1007/b97473>

DISCLAIMER

The image and text are provided for illustrative purposes only. The tissue sections submitted and the description provided will depend on the individual specimen characteristics, the clinical diagnostic suspicion, the experience of the dissector, and the institutional guidelines of the laboratory.

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