TUMOURAL COLON RESECTION (HEMICOLECTOMY / SIGMOIDECTOMY)

1. A right / left hemicolectomy specimen is received, consisting of XXX cm of ileum, XXX cm of colon, and an appendix measuring XXX cm / a sigmoidectomy specimen measuring XXX cm / a colon resection specimen measuring XXX cm, without specification of laterality.
2. Externally, no remarkable features are identified // an area of tattooing / induration / a defect measuring XXX cm in length is identified, located X cm from the closest surgical margin (proximal / distal) and X cm from the mesenteric margin.
3. On opening, an exophytic / flat / ulceroinfiltrative / polypoid lesion measuring XXX cm is identified, located X cm from the proximal margin and X cm from the distal margin, partially / completely / X% obstructing the lumen.
4. On sectioning, the lesion appears to infiltrate the muscularis propria / adipose tissue / serosa // appears confined to the mucosa.
5. The caecal appendix shows no remarkable features on serial sectioning. In addition, X polypoid / diverticular lesions are identified, ranging from X to X cm, located X cm from the X margin.
6. On palpation, X nodular formations are identified, the largest measuring X cm // following extensive dissection, no definite nodular formations are identified.
7. Representative sections are submitted as follows:

1st Example (Right hemicolectomy with ascending colon adenocarcinoma):

- A1: proximal surgical margin.
- A2: distal surgical margin.
- A3: sections from the appendix.
- A4: polypoid lesion.
- A5 – A6: one longitudinal section of the lesion.
- A7 – A10: transverse sections of the lesion.
- A11: largest nodular formation, bisected.
- A12 – A13: one bisected nodular formation per block.
- A14 – A17: four nodular formations per block.

2nd Example (Right hemicolectomy with caecal adenocarcinoma):

- A1: proximal surgical margin.
- A2: distal surgical margin.
- A3: sections from the appendix.
- A4: polypoid lesion.
- A5 – A6: one longitudinal section of the lesion.
- A7 – A10: transverse sections of the lesion.
- A11: largest nodular formation, bisected.
- A12 – A17: three nodular formations per block.

3rd Example (Sigmoidectomy with two adenocarcinomas):

- A1: closest surgical margin, submitted perpendicularly.
- A2: distal surgical margin.
- A3 – A7: sections from the first lesion.
- A8 – A12: sections from the second lesion.
- A13 – A16: four nodular formations from the region of the first lesion.
- A17 – A20: four nodular formations from the region of the second lesion.

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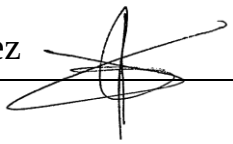

TO CONSIDER

– Neoplastic colon resections, generally already diagnosed on previous endoscopic biopsies. Occasionally, these may represent emergency procedures in patients with intestinal obstruction secondary to a tumoural aetiology.
– Measure and describe the external surface of the specimen.
– The presence of perforation or adherence between bowel loops should be documented, as this corresponds macroscopically to pT4 stage disease.
– Open the specimen along the antimesenteric border, avoiding sectioning through the neoplasm.
– Measure and describe the lesion, including the distance to the surgical margins.
– In specimens with a mesenteric margin (sigmoid and transverse colon), indicate the distance from the tumour to this margin. Some pathologists report this as the radial / circumferential margin.
– Submit representative sections:

- Include at least one section of the lesion per centimetre of greatest dimension. Selection of the area showing deepest invasion is of critical importance for accurate pathological staging.
- If no gross lesion is identified or the specimen is received following subtotal endoscopic resection (unresectable polyp), palpate carefully to identify areas of induration. Submit these areas entirely or the area adjacent to the endoscopic tattoo.
- If the lesion is located very close to one of the surgical margins, consider submitting this end longitudinally rather than transversely, in order to demonstrate the relationship between the lesion and the margin within the same block.

– It is recommended to identify a minimum of 12–14 lymph nodes / nodular formations. The peritumoural region provides the highest yield for lymph node retrieval. If no definite nodular formations are identified or the yield is insufficient, submission of representative sections of adipose tissue, particularly from the peritumoural area, may be useful.
– If more than one neoplastic lesion is identified, lymph nodes should be designated according to loco-regional distribution (see Figure III).
– Inspect the remaining mucosa for additional lesions or concomitant pathology.

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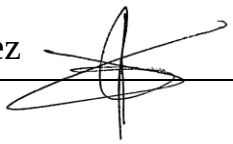

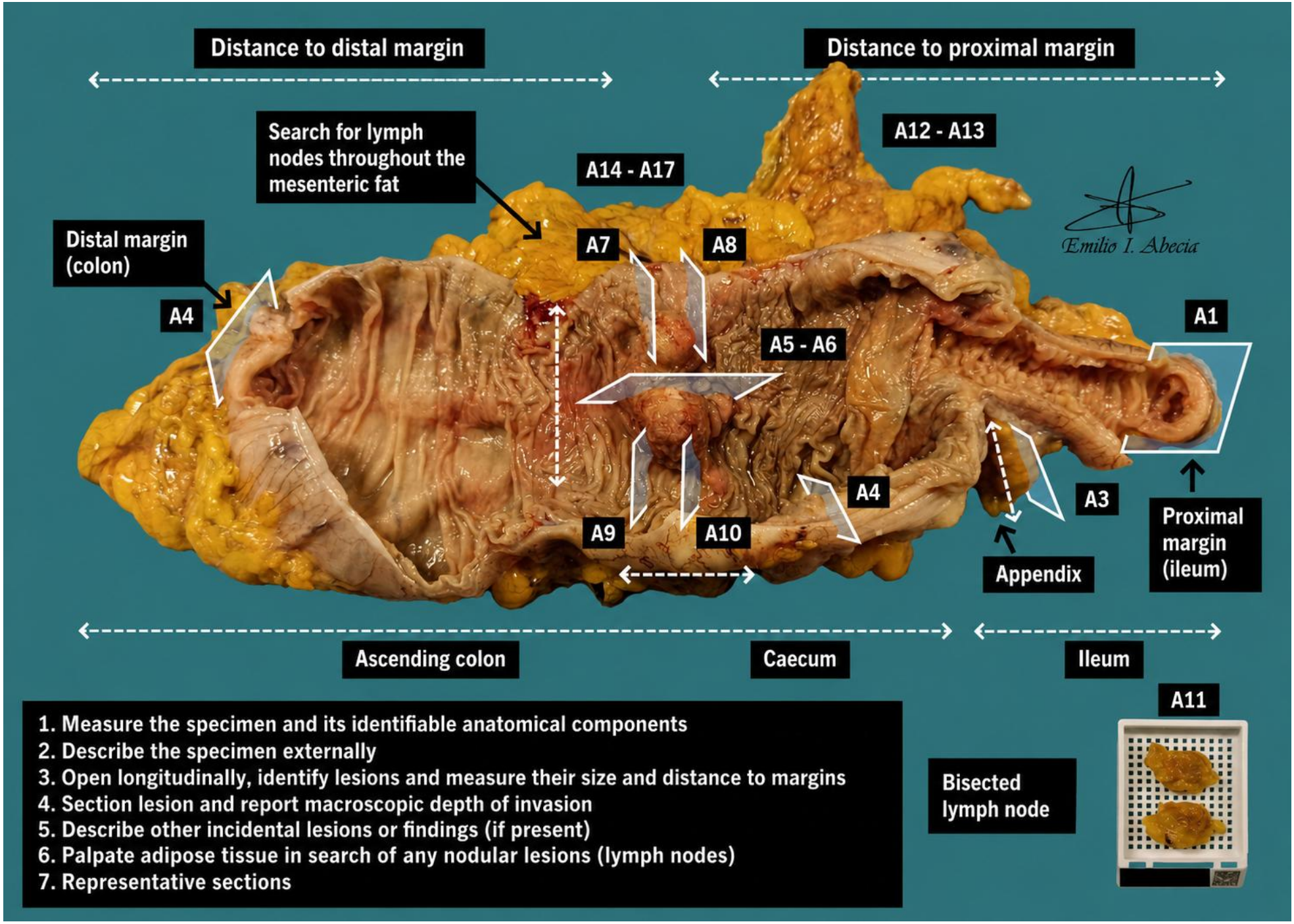

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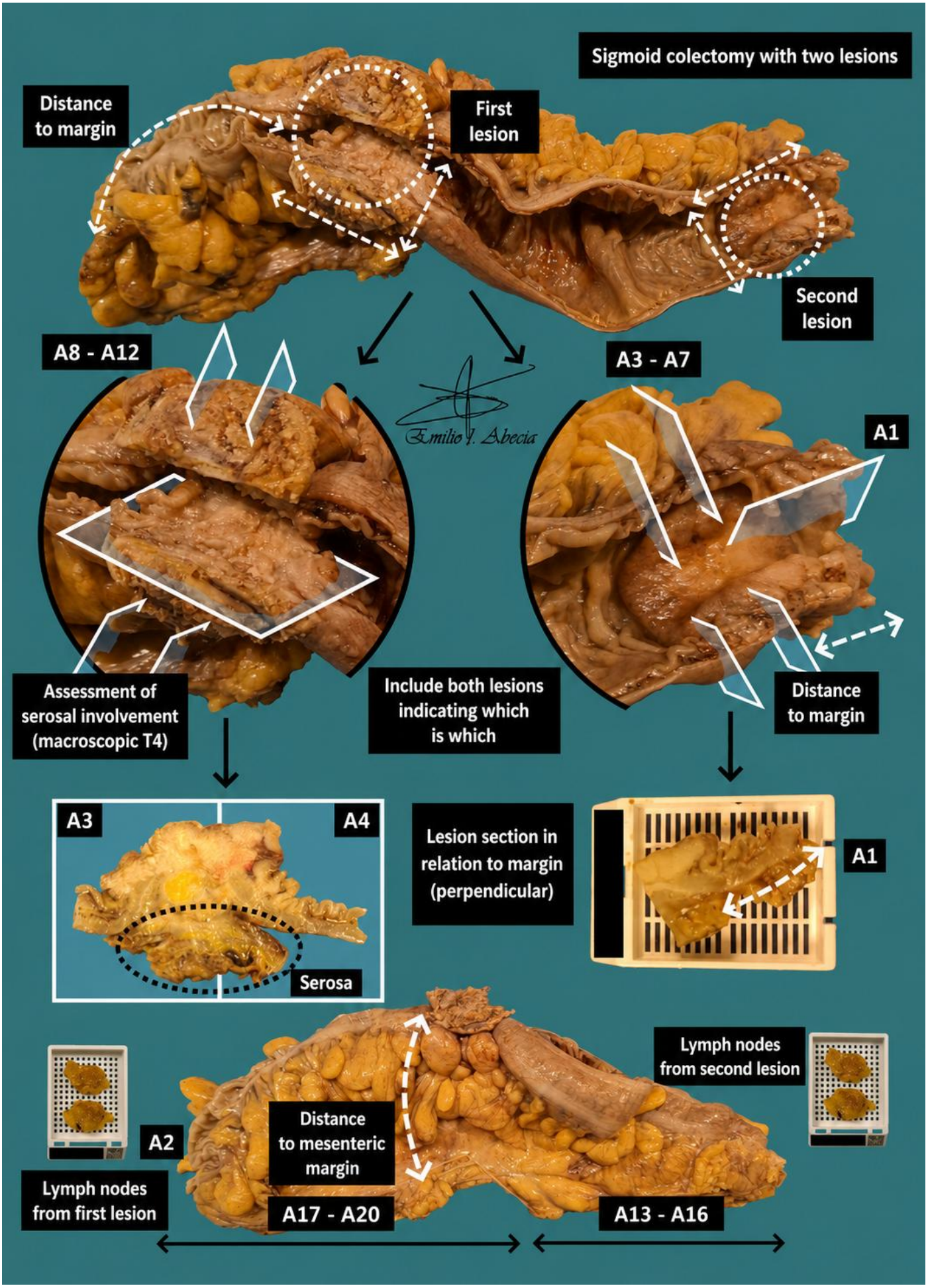

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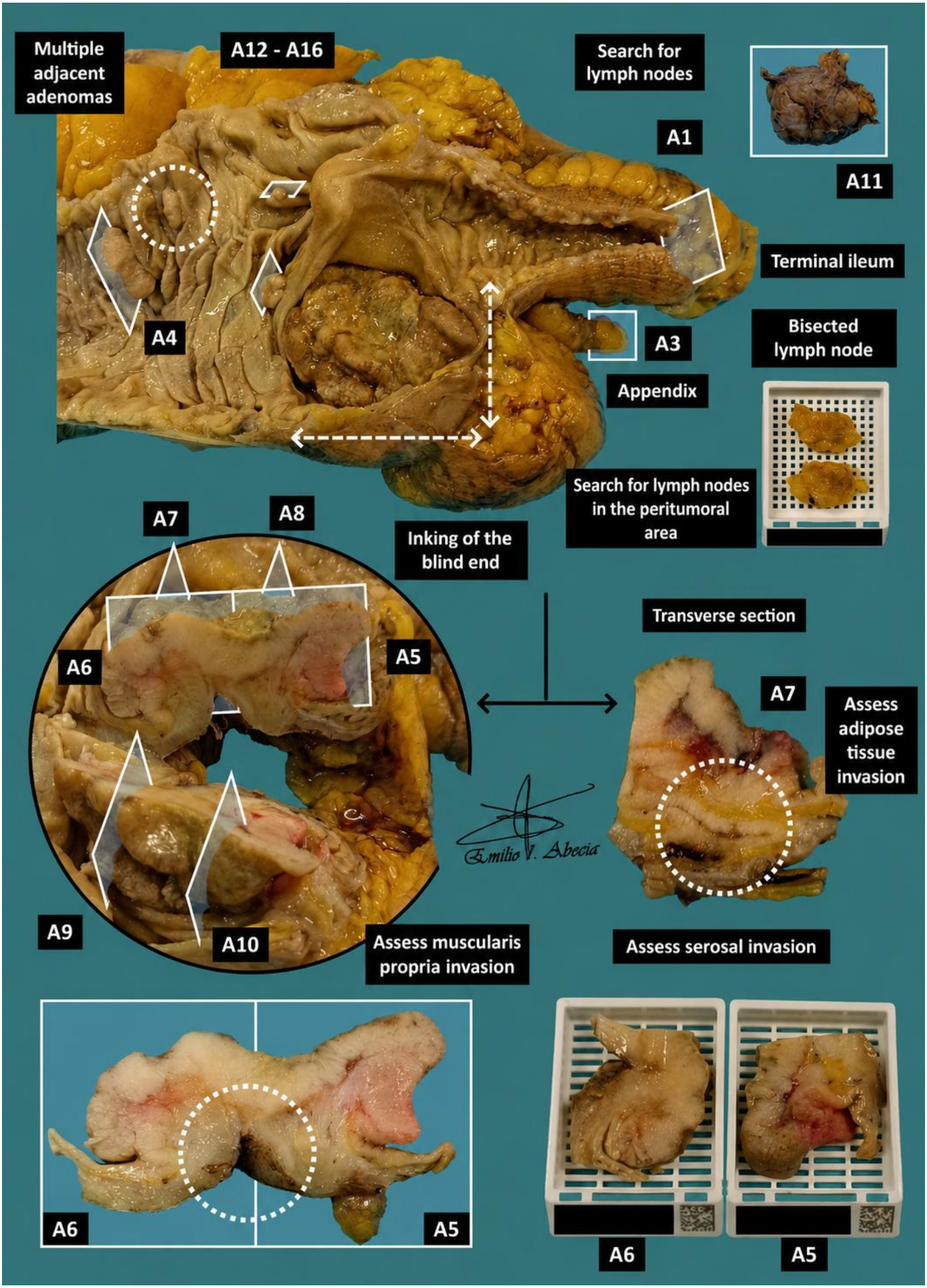

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DISCLAIMER

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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