FAMILIAL ADENOMATOUS POLYPOSIS (FAP / AFAP)

1. A right / left hemicolectomy specimen is received, composed of XXX cm of ileum, XXX cm of colon, and an appendix measuring XXX cm / a sigmoidectomy measuring XXX cm / a colon resection measuring XXX cm, without specified 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 nearest surgical margin (proximal / distal) and X cm from the mesenteric margin.
3. On opening, X / innumerable polypoid lesions are identified, ranging from X to X cm in diameter, located X and X cm from the surgical margins. Among them, there are X lesions measuring XXX cm with an exophytic / flat / ulcero-infiltrative / polypoid morphology, located X cm from the proximal margin and X cm from the distal margin.
4. On sectioning, the dominant lesions appear to infiltrate the muscularis propria / adipose tissue / serosa // appear confined to the mucosa.
5. On palpation, X nodular formations are identified, the largest measuring X cm // despite extensive search, no definite nodular formations are identified.
6. Representative sections are submitted as follows:

1st Example (Familial adenomatous polyposis - FAP):
• A1: proximal surgical margin.
• A2: distal surgical margin.
• A3 - A5: sections from the appendix.
• A6 - A9:
• A10 - A22: one bisected nodular formation per block.
• A23 - A25: four nodular formations per block.

2nd Example (Attenuated familial adenomatous polyposis - AFAP):
• A1: proximal surgical margin.
• A2: distal surgical margin.
• A3 - A11: sections from the appendix.
• A12 - A15: three nodular formations per block.

TO CONSIDER

– Colonic resections performed with prophylactic or therapeutic intent in patients with hereditary syndromes and familial clustering associated with the development of numerous colonic polyps.
– Clinical history should be reviewed to identify prior radiological or endoscopic investigations, as well as any available genetic diagnosis.
– Measure, externally describe, and open the specimen along the antimesenteric border.
– Attempt to enumerate lesions whenever possible, identifying those with greater size / induration that may have undergone neoplastic transformation.
– Submit representative sections:
- Include both surgical margins (proximal and distal). If lesions are close to the margins, consider longitudinal sampling.
- Include the largest lesions / those suspicious for neoplastic transformation.
- Include sections from secondary lesions, optimising block utilisation where possible (some specimens may contain >100 polyps).

– Isolate lymph nodes, aiming to identify at least 12–14 lymph nodes / nodular formations. If definite or sufficient nodular formations are not identified, submission of representative sections of adipose tissue may be helpful.

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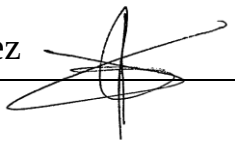

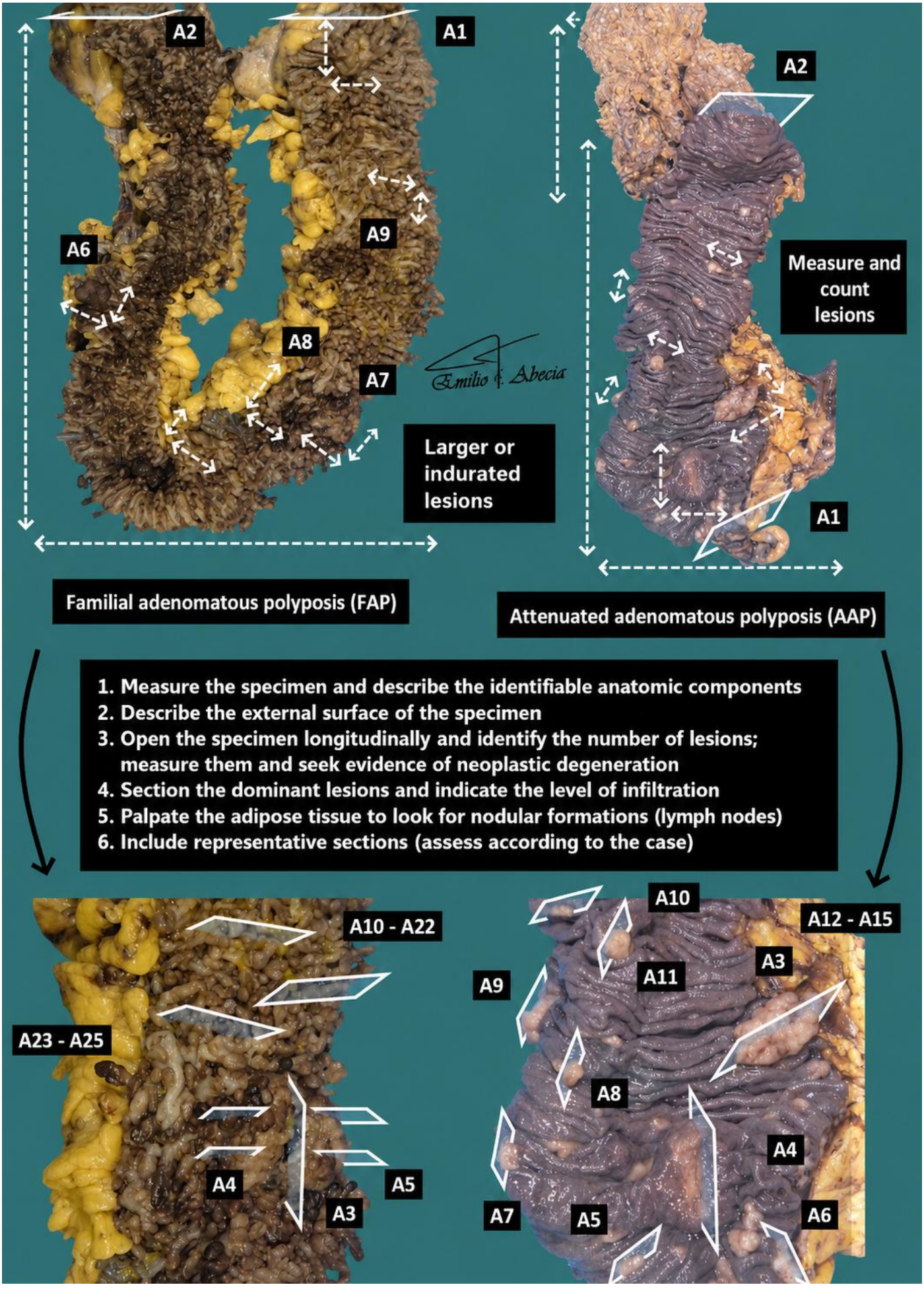

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DISCLAIMER

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.

This document has been translated from the original Spanish version using AI-based tools. The text may contain typographical errors or inaccurate translations.

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