RADICAL PAROTIDECTOMY

1. A specimen consisting of a skin ellipse / parotidectomy specimen measuring XXX cm, with an en bloc / separately submitted functional neck dissection measuring XXX cm, is received // oriented with X marking the X margin // without orientation provided.
2. Externally, a cutaneous / subcutaneous lesion measuring XXX cm is identified, located X cm from the X margin. The lesion is flat / exophytic / nodular, with an indurated consistency / ulcerated centre / crusted surface.
3. The surgical margins are inked.
4. On sectioning, the lesion measures X cm in thickness and is located X cm from the deep margin. The lesion is encapsulated / non-encapsulated, with a homogeneous / heterogeneous cut surface, well / poorly defined borders, and a brownish / whitish coloration.
5. The remaining parotid parenchyma appears yellowish / brownish, without other remarkable features // with an atrophic / lobulated / fibrotic appearance // an intraparotid lymph node measuring X cm is identified // one / several calculi measuring X cm in diameter are identified.
6. A submandibular gland measuring XXX cm / vascular structure measuring XXX cm / muscular fragment measuring XXX cm is identified // the specimen is received fragmented, measuring XXX cm in aggregate.
7. On sectioning, the submandibular gland shows yellowish parenchyma without remarkable features // shows fatty degeneration / a lesion measuring X cm with X appearance is identified.
8. On inspection and palpation, X nodular formations are identified in the upper third / level X, the largest measuring X cm. In the middle third / level X, X nodular formations are identified, the largest measuring X cm. In the lower third / level X, X nodular formations are identified, the largest measuring X cm.
9. On bisection, no remarkable features are identified // an X nodular formation from the X third / level shows a whitish focus measuring X cm, with macroscopic intranodal / extranodal involvement suggestive of malignancy.
10. Representative sections are submitted as follows:
    - A1: vascular margin.
    - A2: section of submandibular gland.
    - A3 – A6: central section of the lesion.
    - A7 – A10: second complete section of the lesion.
    - A11 – A12: lateral margin.
    - A13 – A14: contralateral margin.
    - A15 – A17: three nodular formations per block from the upper third.
    - A18 – A20: three nodular formations per block from the middle third.
    - A21 – A23: three nodular formations per block from the lower third.

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TO CONSIDER

– Radical neck resections including different anatomical structures (skin paddle, salivary gland, neck dissection specimen, etc.). This template is an example of complex head and neck specimens containing multiple structures requiring assessment.
– Measure and spatially orient the specimen using surgical references and anatomical landmarks.
– Identify and describe lesions; ink the surgical resection surface margins (at least two colours are recommended for margin designation).
– Serially section the specimen; document lesion location, distance to surgical margins, and infiltration of anatomical structures.
– Describe the cut surface of the lesion.
– Examine the parenchyma for lymph nodes (intraparotid lymph nodes), calculi, or salivary duct abnormalities.
– Attempt to identify anatomical regions within the neck dissection specimen; if not possible or if fragmented, isolate nodular formations (lymph nodes) by thirds or collectively. Note that the submandibular gland corresponds to level I (anteroposterior), the sternocleidomastoid muscle represents the superficial margin, and the internal jugular vein represents the deep margin.
– Submit representative sections:

- Sample all spatial surgical margins.
- As a rule, submit at least one section per centimetre of the greatest dimension of the lesion, preferably demonstrating its relationship to anatomical structures or resection margins.
- Include at least one section of salivary gland parenchyma uninvolved by neoplasia, to assess for concomitant pathology.
- Attempt to isolate approximately 20 lymph nodes from the specimen. Submit all palpable or visible nodular formations, and indicate whether sectioning reveals foci suggestive of metastasis (record size and describe findings).
- Large lymph nodes may require submission in multiple blocks; however, if grossly metastatic “de visu”, complete submission is unnecessary (1–2 sections demonstrating regional invasion are sufficient).

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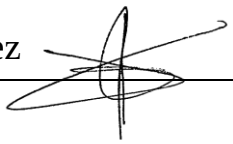
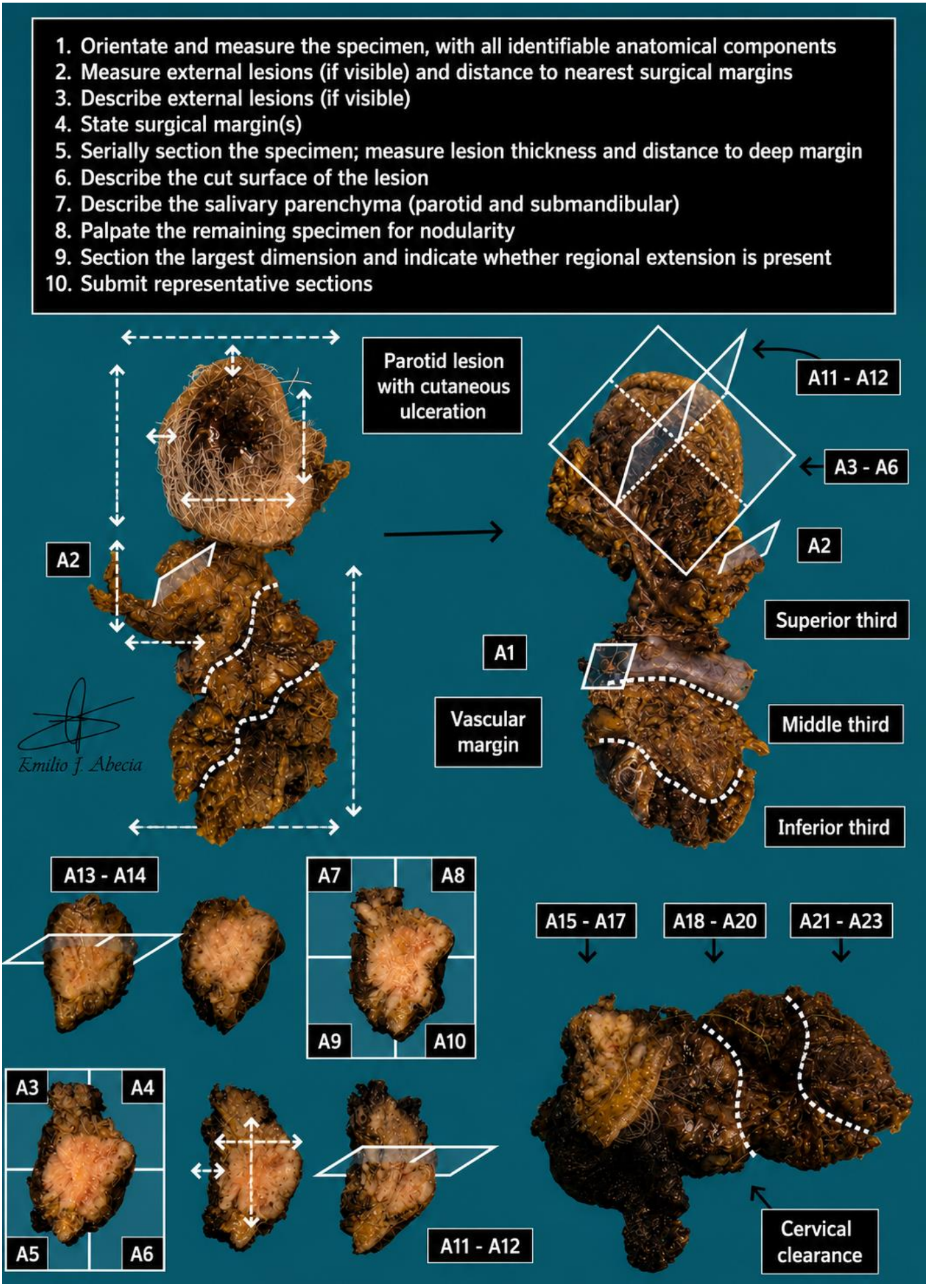


1. Orientate and measure the specimen, with all identifiable anatomical components
2. Measure external lesions (if visible) and distance to nearest surgical margins
3. Describe external lesions (if visible)
4. State surgical margin(s)
5. Serially section the specimen; measure lesion thickness and distance to deep margin
6. Describe the cut surface of the lesion
7. Describe the salivary parenchyma (parotid and submandibular)
8. Palpate the remaining specimen for nodularity
9. Section the largest dimension and indicate whether regional extension is present
10. Submit representative sections



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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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