TUMOURAL GASTRECTOMY

1. A partial / total gastrectomy measuring XXX cm is received // accompanied by omentum / duodenum / etc. measuring XXX cm // following neoadjuvant therapy.
2. Externally, no remarkable features are identified // a serosal defect measuring XXX cm is identified / a superficial lesion / induration measuring X cm is identified, located at X.
3. On opening, no remarkable features are identified // a lesion measuring XXX cm is identified, located in the upper / middle / lower third / antrum / incisura / body / fundus, on the anterior / posterior wall, and X cm from the proximal / distal / radial margin.
4. The lesion shows a polypoid / exophytic / ulcerative / ulceroinfiltrative / diffuse infiltrative morphology, with a brownish / whitish appearance, occluding X% of the lumen / etc.
5. On sectioning, the lesion infiltrates the muscularis propria / serosa / is confined to the mucosa, and shows a X cut surface.
6. The remaining gastric mucosa is unremarkable // shows X features.
7. On serial sectioning and inspection, no remarkable features are identified in the omentum // one / several implants measuring X cm in diameter are identified. On sectioning, these show X features.
8. On palpation, X nodular formations are identified along the greater curvature / lesser curvature / paraduodenal area / paraoesophageal area, the largest measuring X cm in diameter.
9. Representative sections are submitted as follows:

1st Example (Gastrectomy for "Diffuse" Adenocarcinoma)

- A1: distal surgical margin.
- A2: proximal surgical margin.
- A3 and A4: longitudinal sections of the lesion (fundus).
- A5 - A7: transverse sections of the lesion (body).
- A8: representative section from the lower third (antrum).
- A9: representative section from the middle third.
- A10: representative section from the upper third.
- A11 and A12: representative sections of omentum.
- A13 - A16: 3 nodular formations per block from the greater curvature.
- A17 - A20: 3 nodular formations per block from the lesser curvature.

2nd Example (Gastrectomy for GIST)

- A1: distal surgical margin.
- A2: proximal surgical margin.
- A3 - A6: one section per lesion slice.
- A7 - A8: sections of the lesion in relation to the serosa.
- A9: representative section from the upper third (fundus).
- A10: representative section from the middle third (body).
- A11: representative section from the lower third (antrum).
- A12 - A14: representative sections of omentum.
- A15 - A17: 4 nodular formations per block from the greater curvature.
- A18 - A20: 4 nodular formations per block from the lesser curvature.

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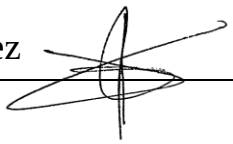


3rd Example (Gastrectomy for "Intestinal" Adenocarcinoma)

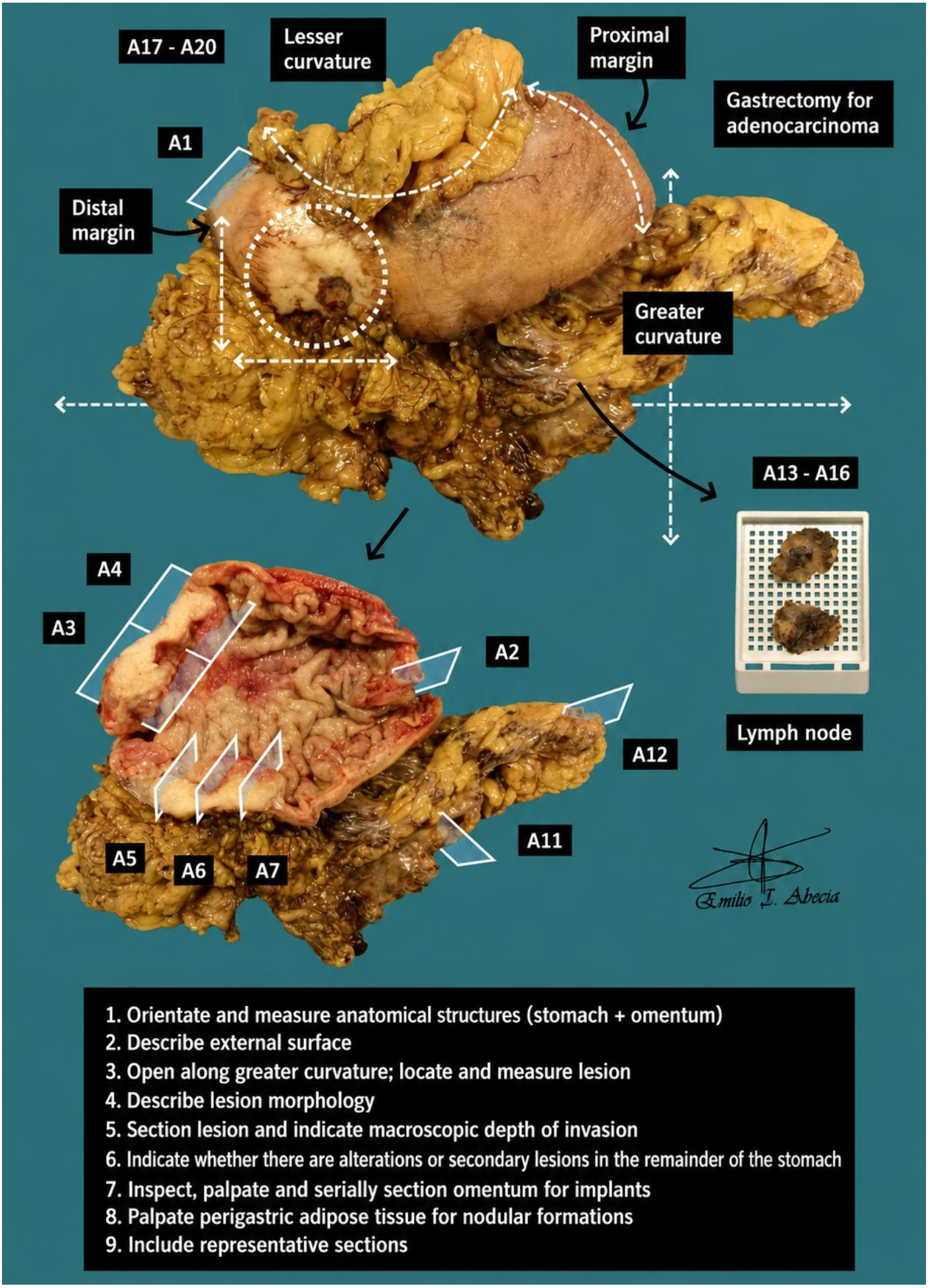
- A1: distal surgical margin.
- A2: proximal surgical margin.
- A3 - A5: longitudinal sections of the lesion.
- A6: representative section from the upper third (fundus).
- A7: representative section from the middle third (body).
- A8: representative section from the lower third (antrum).
- A9 and A10: representative sections of omentum.
- A11 - A13: 4 nodular formations per block from the greater curvature.
- A14 - A16: 4 nodular formations per block from the lesser curvature.

POINTS TO CONSIDER

– Tumoural gastrectomies may be total or partial (distal or proximal half), depending on the surgical procedure. These are most commonly performed for adenocarcinomas, neuroendocrine tumours, or gastrointestinal stromal tumours (GIST).
– Review the clinical history to confirm lesion location, multifocality, and whether the specimen has received neoadjuvant therapy (the lesion may show regressive changes, fibrosis, muscular hypertrophy, erosions, and lymph nodes may be difficult to identify).
– Open the stomach along the greater curvature unless the tumour is located in that region (in which case open along the lesser curvature to avoid disrupting the lesion).
– Measure and describe the specimen. If perforations or bowel loop adhesions are identified, this should be documented (macroscopic pT4 stage).
– Some authors recommend inking the serosal surface underlying the tumour area.
– Open the specimen; measure and describe the lesion. If the tumour involves the gastro-oesophageal junction, this should be specifically documented, as tumours with an epicentre <2 cm from the junction should be staged according to the oesophageal TNM protocol.
– Submit representative sections:

- If the lesion is very close to one of the margins, consider inking or sampling that margin perpendicularly (in relation to the lesion) rather than transversely.
- Submit at least one section of tumour per centimetre of greatest dimension. It is crucial to represent the area of deepest wall invasion.
- If neoadjuvant therapy has been administered and no residual tumour is identified, entirely submit all indurated / ulcerated areas (tumour bed with regressive changes).
- Submit sections of uninvolved gastric wall to assess for possible concomitant pathology.

– When submitting identified lymph nodes, their anatomical origin should be specified (greater curvature, lesser curvature, paraoesophageal, paraduodenal, etc.). If fewer than 12 clearly identifiable nodular formations are isolated, it may be useful to submit representative sections of adipose tissue from the peritumoural area.
– If lymphoma is suspected, fresh tissue should be collected for flow cytometry according to institutional protocol.



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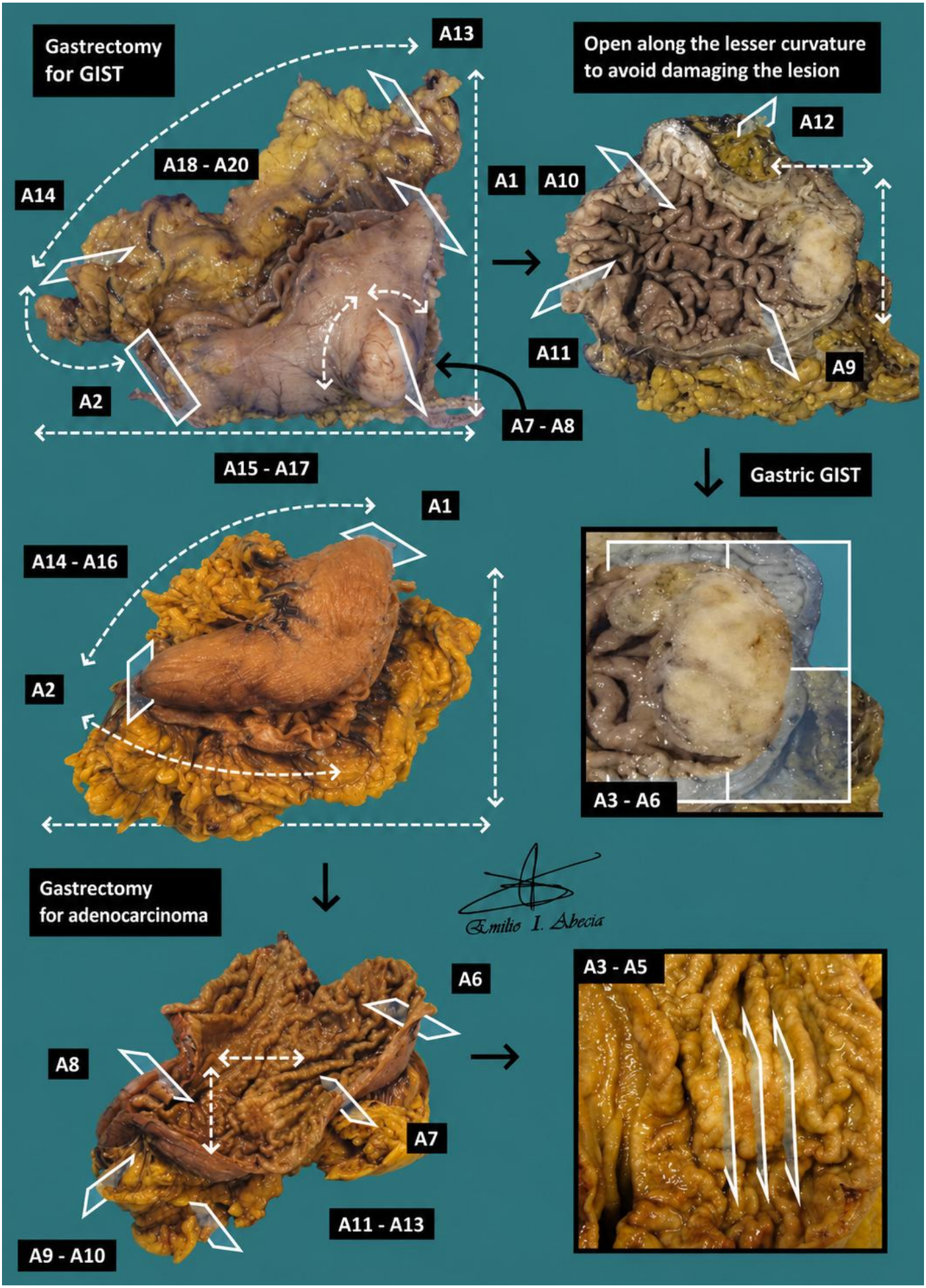

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BIBLIOGRAPHY

- The Royal College of Pathologisy of Australasia*. Gastric Cancer*. 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-gastric-cancer.aspx
- Cipriani N., Rose S. (2019). *Stomach (Neoplastic).* Gross Pathology Manual (University of Chicago). Recuperado el 13 de Mayo de 2024: https://voices.uchicago.edu/grosspathology/gi-liver/stomach-neoplastic/
- *Partial Gastrectomy (Gastrointestinal)*. Gross Manual. UCLA Health. Recuperado el 13 de Mayo de 2024: https://www.uclahealth.org/sites/default/files/documents/b3/gastrectomy-partial-2123.pdf?f=75b24705
- *Total Gastrectomy (Gastrointestinal)*. Gross Manual. UCLA Health. Recuperado el 13 de Mayo de 2024: https://www.uclahealth.org/sites/default/files/documents/36/gastrectomy-total-2123.pdf?f=9de535a2
- Burgart L. J., Chopp W. V., MD; Jain D. (2023). ***Stomach*** (v4.4.0.0). College of American Pathologists (CAP). Recuperado el 13 de Mayo de 2024: https://documents.cap.org/documents/Stomach_4.4.0.0.REL_CAPCP.pdf?_gl=1*1xeaez*_ga*MTc4Nzk0MDczNC4xNzE0NDczNzAy*_ga_97ZFJSQQ0X*MTcxNDQ3MzcwMi4xLjEuMTcxNDQ3NDExMy4wLjAuMA
- Fanburg-Smith J.C, Bellizzi A.M., Bridge J.A., Murugan P., Laurini J.A., Miettinen M. (2022). *GIST, Resection* (v4.3.0.0). College of American Pathologists (CAP). Recuperado el 13 de Mayo de 2024: https://documents.cap.org/protocols/Stomach.GIST_4.3.0.0.REL_CAPCP.pdf?_gl=1*reqi1t*_ga*MTc4Nzk0MDczNC4xNzE0NDczNzAy*_ga_97ZFJSQQ0X*MTcxNDQ3MzcwMi4xLjEuMTcxNDQ3NDExMy4wLjAuMA
- Jain D., Chopp W.V., Graham R.P. (December 2023). *Stomach NET* (v5.0.0.0). College of American Pathologists (CAP). Recuperado el 13 de Mayo de 2024: https://documents.cap.org/protocols/Stomach.NET_5.0.0.0.REL_CAPCP.pdf?_gl=1*1bdfdcl*_ga*MTc4Nzk0MDczNC4xNzE0NDczNzAy*_ga_97ZFJSQQ0X*MTcxNDQ3MzcwMi4xLjEuMTcxNDQ3NDExMy4wLjAuMA
- 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). Elservier. 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 Iacson. (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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