

PULMONARY SEGMENTECTOMY FOR TUMOUR

1. A lung wedge resection designated as right / left upper / middle / lower lobe is received, measuring XXX cm.
2. Externally, the pleural surface is violaceous / anthracotic / intact, without other remarkable features // a pleural retraction / surface disruption / external lesion measuring X cm in diameter is identified, located X cm from the staple line.
3. A XX cm staple line is removed and the surgical margin is inked.
4. On sectioning, a lesion measuring XXX cm is identified, located X cm from the inked margin and X cm from the pleural surface.
5. The lesion is homogeneous / heterogeneous, with a nodular / multilobulated morphology, well / poorly defined borders, and brown / whitish coloration, with central cavitation / foci of necrosis and haemorrhage involving X % of the total lesion volume.
6. The remaining parenchyma shows no remarkable features / shows an anthracotic / emphysematous / "honeycomb" / fibrotic appearance // bullous lesions ranging from X to X cm are identified.
7. Representative sections are submitted as follows:

1st Example (pulmonary micronodule):

- A1 – A2: Entire submission of the lesion.
- A3: Section of uninvolved lung parenchyma.

2nd Example (pulmonary nodule):

- A1 – A4: Subtotal submission of the lesion.
- A5: Section of uninvolved lung parenchyma.
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POINTS TO CONSIDER

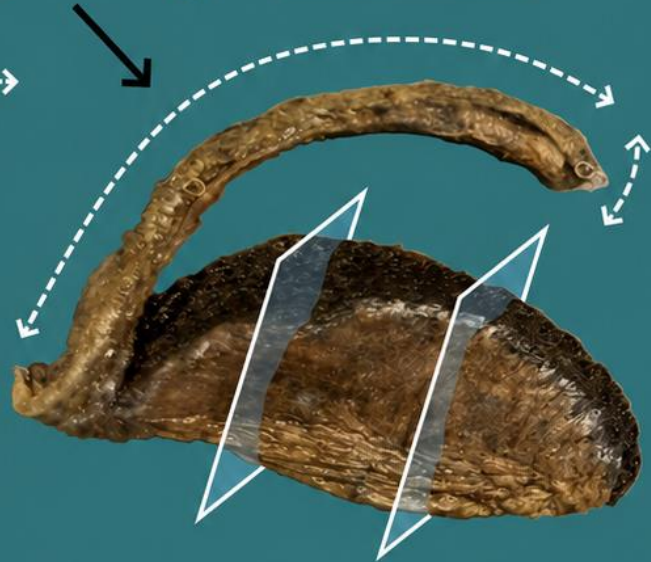
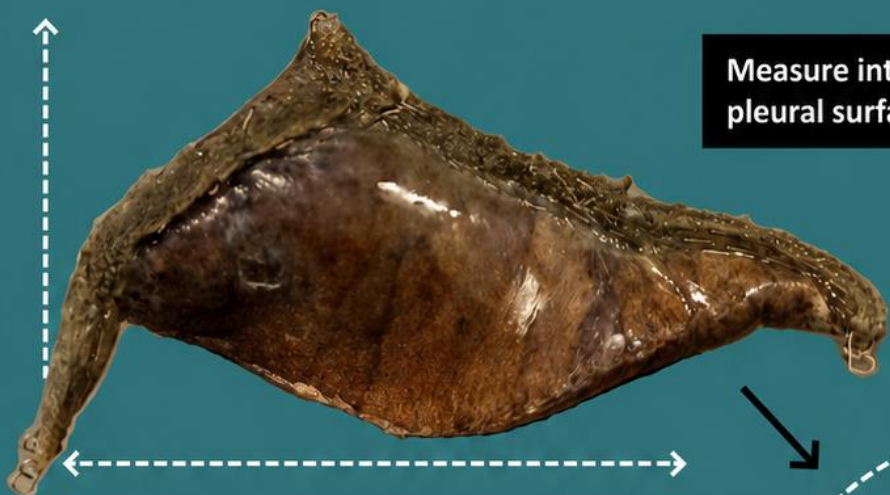
- Segmental pulmonary resections performed for peripheral lesions amenable to elective treatment.
- Review the clinical history to document the type of lesion (primary tumour vs metastasis), underlying pulmonary disease, and imaging findings.
- Measure the specimen and describe the external pleural surface.
- These specimens are frequently received with a stapled margin; when removing the staple line, care should be taken not to disrupt the lesion, thereby avoiding grossing artefacts and/or specimen contamination.
- Measure the thickness of the suture line once removed and ink the margin. Some specialists recommend inking the pleural surface with a different colour.
- Serially section the specimen; identify and measure the lesion, including the distance to the surgical margin and pleural surface.
- Submit representative sections:
 - Consider entire / subtotal submission of the lesion, including a full-face section showing the maximum diameter and additional sections demonstrating the relationship to the pulmonary surgical margin and pleural surface.
 - If no lesion is identified, submit the entire specimen.
 - Include a section of non-neoplastic lung parenchyma to assess for possible concomitant pathology.



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Measure intact pleural surface

Remove suture margin

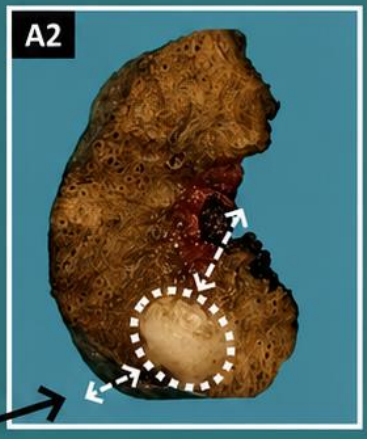


1. Measure the specimen
2. Describe the external surface, identifying any possible lesions
3. Remove the suture line and keep the margin
4. Serially slice the specimen; measure the lesion and the distance to the nearest pulmonary parenchymal margin
5. Describe the morphology of the lesion
6. Describe the pulmonary parenchymal margin
7. Take representative sections of the specimen

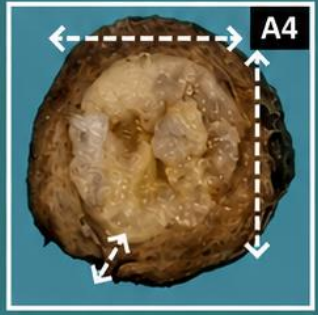
First example



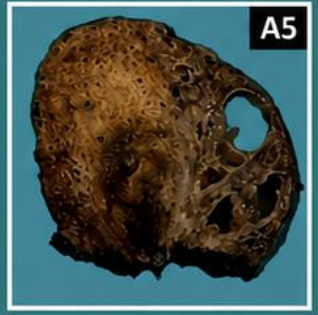
Distance to pleura



Second example



Distancia to pulmonary surgical margin



Section of pulmonary parenchyma without tumour

BIBLIOGRAPHY

- WHO Classification of Tumours Editorial Board (2021). *Thoracic Tumours* (5th ed., vol. 5). International Agency for Research on Cancer. <https://publications.iarc.fr/Book-And-Report-Series/Who-Classification-Of-Tumours/Thoracic-Tumours-2021>
- Cipriani N., Rose S. (2019). *Lung Wedge Biopsy (Thorax & Peritoneum)*. Gross Pathology Manual (University Of Chicago). Recuperado el 13 de Mayo de 2024: <https://voices.uchicago.edu/grosspathology/thoracic/lung-wedge-biopsy/>
- *Wedge Resection (Pulmonary)*. Gross Manual. UCLA Health. Recuperado el 13 de Mayo de 2024: <https://www.uclahealth.org/sites/default/files/documents/Wedge%20Resection%2010.06.20.pdf>
- Schneider F., Butnor K.J., Beasley M.B., Dacic S. (2022). *Lung, Resection* (v4.3.0.1). College of American Pathologists (CAP). Recuperado el 13 de Mayo de 2024: https://documents.cap.org/protocols/Lung_4.3.0.1.REL_CAPCP.pdf?_gl=1*1av0k6b*_ga*MTc4Nzk0MDczNC4xNzE0NDczNzAy*_ga_97ZFJSQQ0X*MTcxNDQ3MzcxwMi4xLjEuMTcxNDQ3NDExMy4wLjAuMA
- 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 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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