

TUMOUR ORCHIDECTOMY

1. A right / left inguinal orchidectomy specimen is received, weighing X g and consisting of a testis measuring XXX cm and a spermatic cord measuring XXX cm.
2. Externally, no remarkable features are identified // a superficial lesion measuring X cm is identified, located X cm from the spermatic cord margin.
3. The external surface of the specimen is inked.
4. On sectioning, a single / multiple lesion(s) measuring XXX cm is identified, located X cm from the spermatic cord margin and X cm from the tunica albuginea / vaginalis margin.
5. The lesion is confined to the testicular parenchyma // infiltrates the tunica albuginea / vaginalis / rete testis / epididymis / hilar adipose tissue / spermatic cord and represents approximately X% of the testicular volume. It shows a heterogeneous / homogeneous appearance, with well / poorly defined borders, X coloration, and haemorrhagic / necrotic areas representing X% of the total tumour volume.
6. The remaining parenchyma measures XXX cm and shows no abnormalities // shows an atrophic / nodular / fibrotic appearance, etc.
7. Representative sections are submitted as follows:

1st Example (Orchidectomy for seminoma)

- A1: Spermatic cord margin.
- A2: Representative sections of spermatic cord.
- A3–A5: Entire section of the lesion.
- A6: Tumour in relation to surgical margin / tunica albuginea / tunica vaginalis.
- A7: Section of epididymis.
- A8: Section of rete testis / hilar adipose tissue.
- A9: Testicular parenchyma without neoplastic lesions.

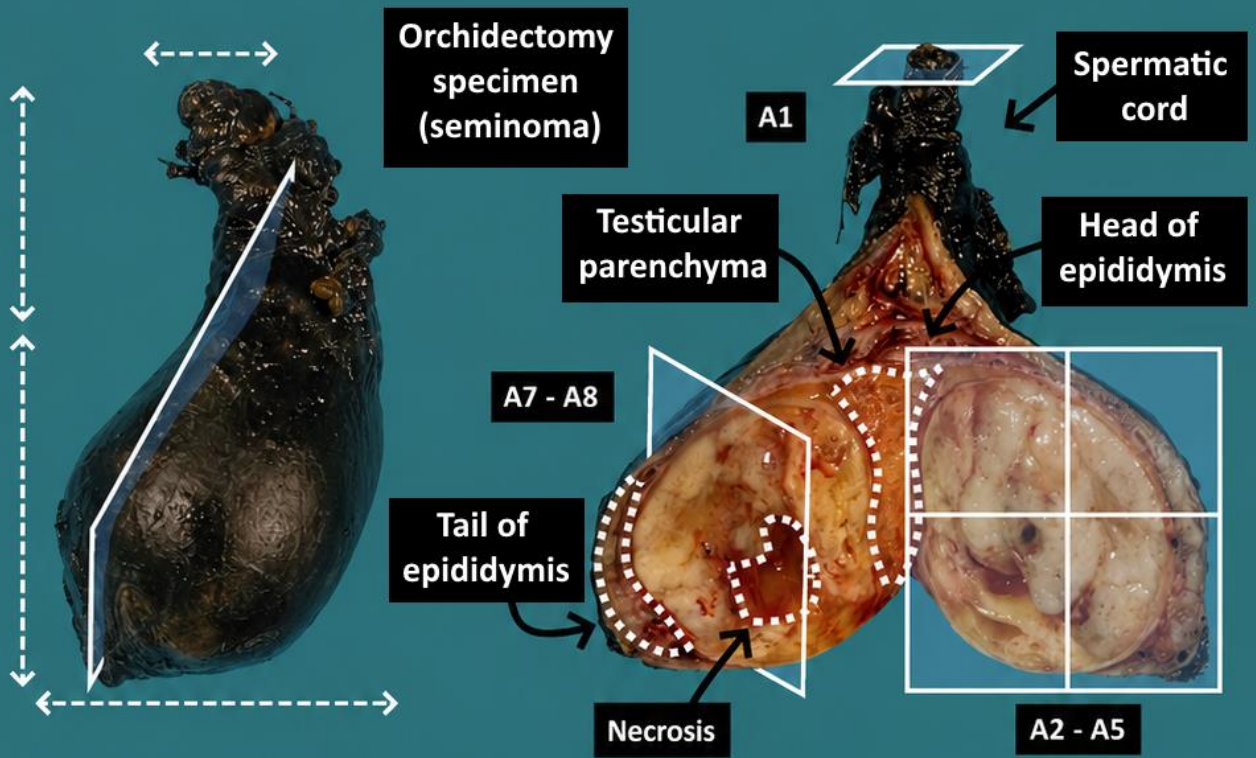
2nd Example (Orchidectomy for rhabdomyosarcoma)

- A1: Spermatic cord margin.
- A2–A7: Entire section of the lesion.
- A8–A9: Sections of the lesion in relation to margin / tunica albuginea / tunica vaginalis.
- A10: Testicular parenchyma without neoplastic lesions.
- A11: Lesion in relation to epididymis / rete testis / hilar adipose tissue.

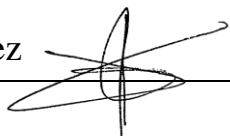
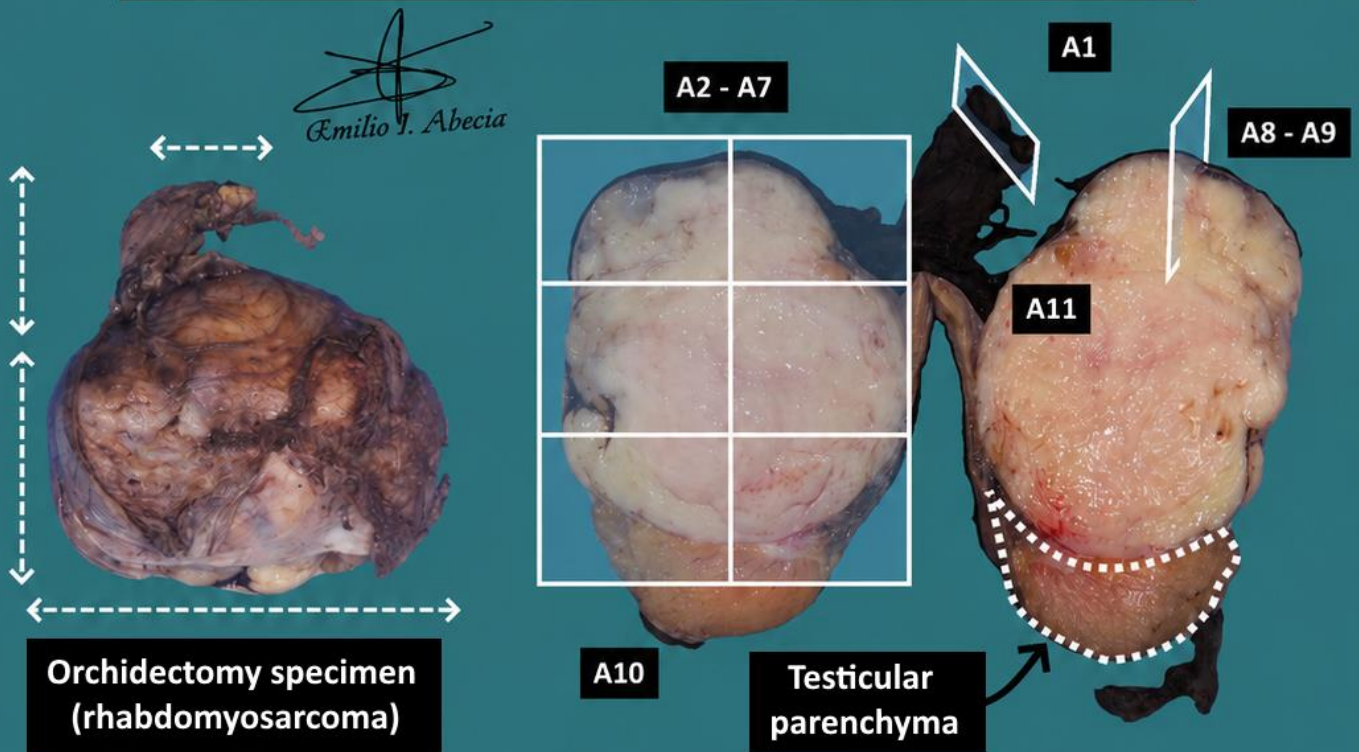
TO CONSIDER

- Testicular resections for tumour pathology. A total orchidectomy specimen consists of testis + epididymis + spermatic cord; otherwise, it should be regarded as a partial orchidectomy.
- Review of the clinical history and imaging studies is recommended in order to assess the diagnostic suspicion, multifocality, involvement of adjacent structures, etc.
- Measure, weigh, orientate, and describe the external surface of the specimen.
- It is recommended that the spermatic cord margin be submitted prior to serial sectioning of the specimen, as contamination may occur if the tumour is highly friable.
- Ink the external surface and section the testis and spermatic cord longitudinally. Subsequently, perform the remaining sections in parallel or perpendicular planes.
- Identify, measure, and describe the cut surface of the lesion, as well as the appearance of the testicular parenchyma and other structures.
- Submit representative sections:
 - Include the spermatic cord margin.
 - Include at least one section per centimetre of the greatest dimension of the lesion. Adequately represent spatial margins, relationship to non-neoplastic parenchyma, and relationship to adjacent anatomical structures.
 - Include a couple of sections of uninvolved parenchyma (testis, epididymis, etc.).





1. Weigh, orient and measure the specimen, including anatomical structures
2. Describe the external surface
3. Describe the surgical margin
4. Section, locate and measure the lesion, including infiltration of structures
5. Describe the cut surface of the lesion
6. Identify any secondary lesions or parenchymal alterations present
7. Include 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.

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