

HEMITHYROIDECTOMY

1. A left / right hemithyroidectomy specimen is received, weighing X g and consisting of the left / right lobe measuring XXX cm and an isthmus measuring XXX cm.
2. Externally, no remarkable features are identified // the specimen shows a multinodular / nodular / irregular appearance, with a smooth / disrupted surface / with attached fragments of skeletal muscle tissue.
3. The external margin is inked in X colour and the isthmic margin in X colour.
4. On sectioning, the parenchyma is tan-brown without other remarkable features // the right / left lobe shows a dominant nodule measuring XXX cm, encapsulated / non-encapsulated, located X cm from the inked margin // the cut surface shows lesions ranging from X to X cm, displaying X characteristics and located respectively X cm from the closest margin.
5. The lesions show a solid / cystic cut surface, with a homogeneous / heterogeneous / colloid / haemorrhagic / calcified / brownish appearance, etc.
6. Representative sections are submitted as follows:

1st Example (Hemithyroidectomy for oncocytic cell carcinoma):

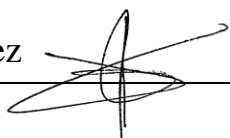
- A1: superior margin, perpendicular (“cross-section”).
- A2: inferior margin, perpendicular (“cross-section”).
- A3 - A6: complete submission of first lesion.
- A7 - A10: complete submission of second lesion.

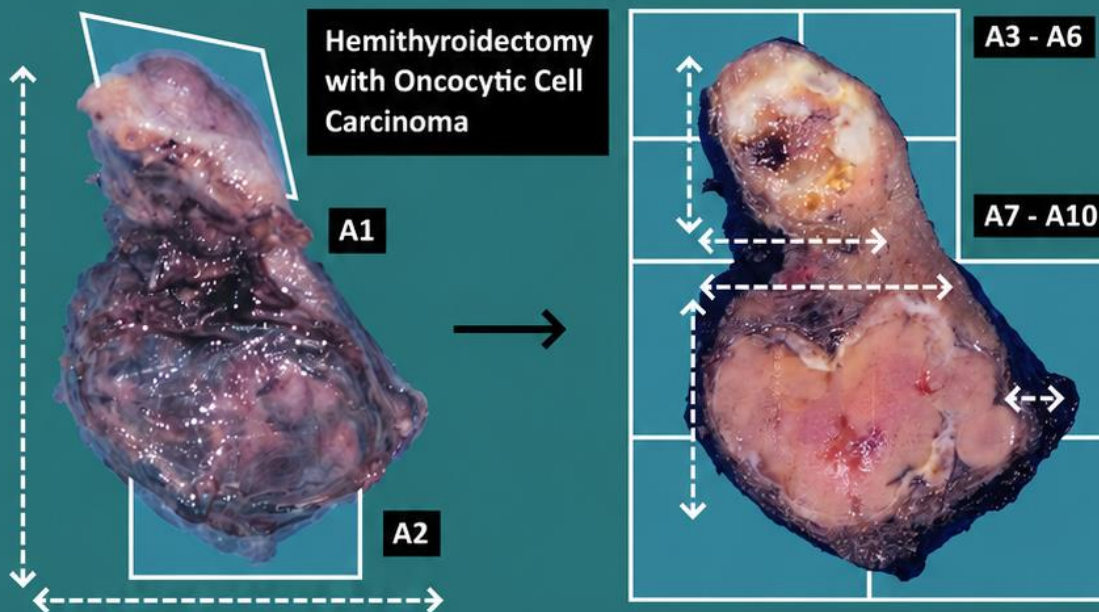
2nd Example (Hemithyroidectomy with papillary carcinoma):

- A1: superior margin, perpendicular (“cross-section”).
- A2: inferior margin, perpendicular (“cross-section”).
- A3 - A5: transverse sections of the lesion.

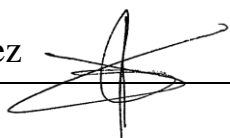
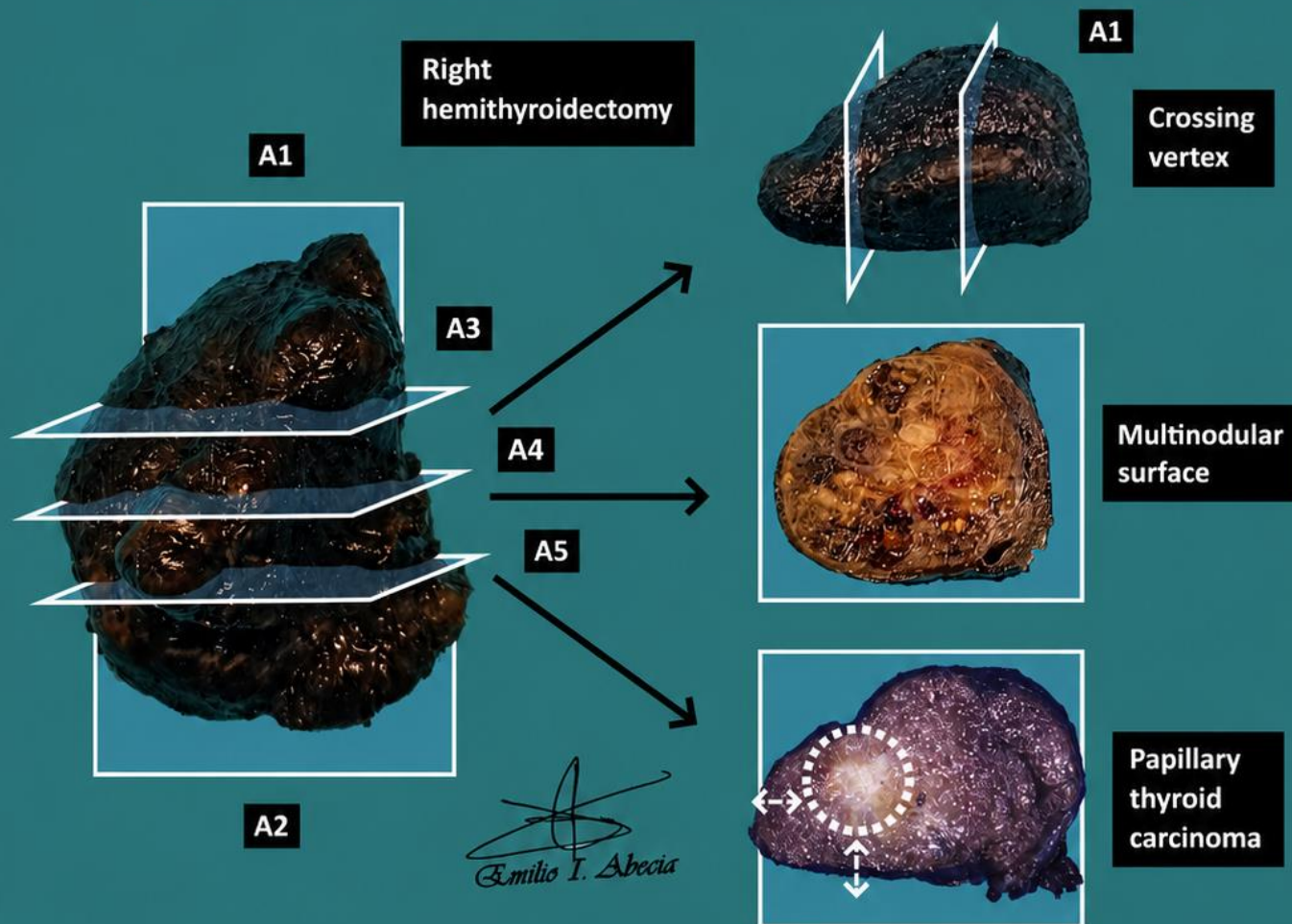
TO CONSIDER

- Hemithyroidectomies (right or left lobe ± isthmus) are usually performed for localised benign lesions (follicular adenomas) or malignant lesions (follicular, papillary, medullary, or anaplastic carcinoma).
- Due to the implications for gross dissection, it is recommended to review the clinical history and imaging studies to determine lesion location, multifocality, and the presumptive diagnosis (often cytological).
- Weigh, measure, orient, and describe the external surface of the specimen.
- Ink and serially section transversely. It is recommended to ink the surgical margin of the isthmus (in contact with the contralateral thyroid lobe) in a different colour from the peripheral surgical margin (in contact with surrounding soft tissues).
- Identify the lesion, record its dimensions, and measure the distance to the surgical margins.
- Describe the cut surface of the lesion.
- Submit representative sections:
 - If lesions are identified, submit at least one section per centimetre of the greatest dimension of the lesion, including representation of its relationship to all surgical margins.
 - If multiple well-defined lesions are present, measure the distance to margins and submit those with the largest size and/or most suspicious malignant features.
 - If a capsule is present, it should be entirely submitted in relation to the resection margins. Complete submission of the lesion itself is not required (see image).
 - If the patient is diagnosed with MEN syndrome, consideration should be given to complete submission of the specimen. If a previously known medullary carcinoma is present, sections from the upper and lower poles should be submitted to assess for “C-cell” hyperplasia.





1. Weigh, orient and measure the specimen
2. Describe the external surface of the specimen
3. Ink one surface
4. Serially section, localise and measure any cystic or solid lesions identified
5. Describe the cut surface of the lesions
6. 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.

