HOW THE PATHOLOGIST WORKS-UP A RESECTED TUMOR SPECIMEN?

„THINK BEFORE YOU INK“

-use the ink *exclusively* with resected specimen and resection plaines in amputations, NOT with biopsies or curettages.

-the pathologist must personally examine the complete (specifically the un-cut! Surgeons shall not open themselves!), preferably fresh specimen.

-orient the specimen according to the imaging, the suture orientation and/pr the remarks by the surgeon.

-all resection plaines (usually 6) are judged by the pathologist both visually and manually:
- -is there tumor at the resection plain?
- -if yes, where exactly?
- → take foto *before* you cut, and immediately *after* cutting, to document the area of interest
- -do you palpate tumor at the resection margin?
- -are the fascias over the tumor moveable and intact?

-cut the specimen open in the predetermined plain (topography, other parameters) under preservation oft he landmarks / suture marks.

-measure all distances from the tumor to the resection margin in all 6 plains.

-critical areas (specifically when unexpected for surgeon) must be photographed and/or noted with a drawing/scheme, Mind you: better to often than let something unclear!

-place the ink ONLY where infiltrative growth and/or where tumor cannot easily be distinguished from scar etc, DIRECTLY onto the area of interest after pre-defined removal of tumor tissue from the area of interest.

-mind you: specific biologies (myxofibrosarcoma, DFSP, epithelioid sarcoma etc → known from preceding biopsy) and specific situations (preceding radiation, re-resections after whoops surgery) require a change to the „mamma-technique“.

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