

GROSS SPECIMENS

@pathology practicals



1. LIPOMA

- Specimen shows cut section of a soft tissue mass measuring 15 X 10 cms.
- Cut surface grey yellow, greasy lobulated mass.
- Benign tumour of fat, most common soft tissue tumor of adulthood.

LIPOMA

1. WELL ENCAPSULATED MASS OF MATURE ADIPOCYTES.
2. USUALLY ARISES IN THE SUBCUTIS OF THE PROXIMAL EXTREMITIES AND TRUNK.
3. SOFT, WELL-CIRCUMSCRIBED
4. CUT SURFACE - SOFT, PALE, YELLOW, HOMOGENOUS, MATURE APPEARING ADIPOSE TISSUE.
5. TYPICALLY NO AREAS OF HEMORRHAGE OR NECROSIS.



A462 Wet gangrene

2. WET GANGRENE

- Above ankle amputated specimen shows edematous foot (marked area) with altered colour and peeling of epidermis,
- It can occur due to Infection and liquefaction of dry gangrenous tissue by saprophytic bacteria.
- It's a type of liquefactive necrosis.

WET GANGRENE

1. DEVELOPS RAPIDLY DUE TO VENOUS OCCLUSION.
LESS COMMONLY DEVELOPS DUE TO ARTERIAL OCCLUSION.
2. THE AFFECTED PART IS SOFT, SWOLLEN, PUTRID AND DARK.
3. MORE COMMON IN BOWEL.
4. PUTREFACTION IS MARKED DUE TO STUFFING OF ORGAN WITH BLOOD.
5. THERE IS NO CLEAR LINE OF DEMARCACTION.

3. DRY GANGRENE



- Specimen of an amputated hand shows dry, shrivelled appearance with autoamputation of the index finger.
- Line of demarcation is the characteristic feature of dry gangrene(its not clearly visible in the specimen).
- It's a type of coagulative necrosis.

DRY GANGRENE

1. BEGINS IN THE DISTAL PART OF A LIMB DUE TO ISCHEMIA (ARTERIAL OCCLUSION)
2. THE AFFECTED PART IS DRY, SHRUNKEN AND DARK BLACK
3. THE GANGRENE SPREADS SLOWLY UPWARDS UNTIL IT REACHES A POINT WHERE BLOOD SUPPLY IS ADEQUATE TO KEEP THE TISSUE Viable.
4. A LINE OF SEPARATION IS FORMED BETWEEN THE GANGRENOUS PART AND THE Viable PART.
5. THE LINE OF SEPARATION USUALLY BRINGS ABOUT COMPLETE SEPARATION WITH EVENTUAL FALLING OFF OF THE GANGRENOUS TISSUE IF IT IS NOT REMOVED SURGICALLY.



4. MELANOMA FOOT

- Above ankle amputated specimen shows nodular growth from the sole of the foot.
- Cut section is solid with black to brown discoloration.
- But 40% cases are amelanotic.

MELANOMA

1. MOST MELANOMAS PRESENT AS ASYMMETRICAL, IRREGULARLY PIGMENTED LESIONS WITH ILL-DEFINED BORDERS.
2. GENERALLY MEASURE MORE THAN 4mm IN DIAMETER.
3. 4 TYPES - (i) SUPERFICIAL SPREADING
(ii) LENTIGO MALIGNA
(iii) ACRAL LENTIGENOUS
(iv) NODULAR
4. MELANOMAS SHOW STRIKING VARIATIONS IN COLOR, APPEARING IN SHADES OF BLACK, BROWN, RED, DARK BLUE AND GRAY.
5. ON OCCASION, ZONES OF WHITE OR FLESH-COLORED HYPOPIGMENTATION ALSO APPEAR (DUE TO FOCAL REGRESSION OF TUMOR)
6. THE BORDERS ARE IRREGULAR AND OFTEN NOTCHED.



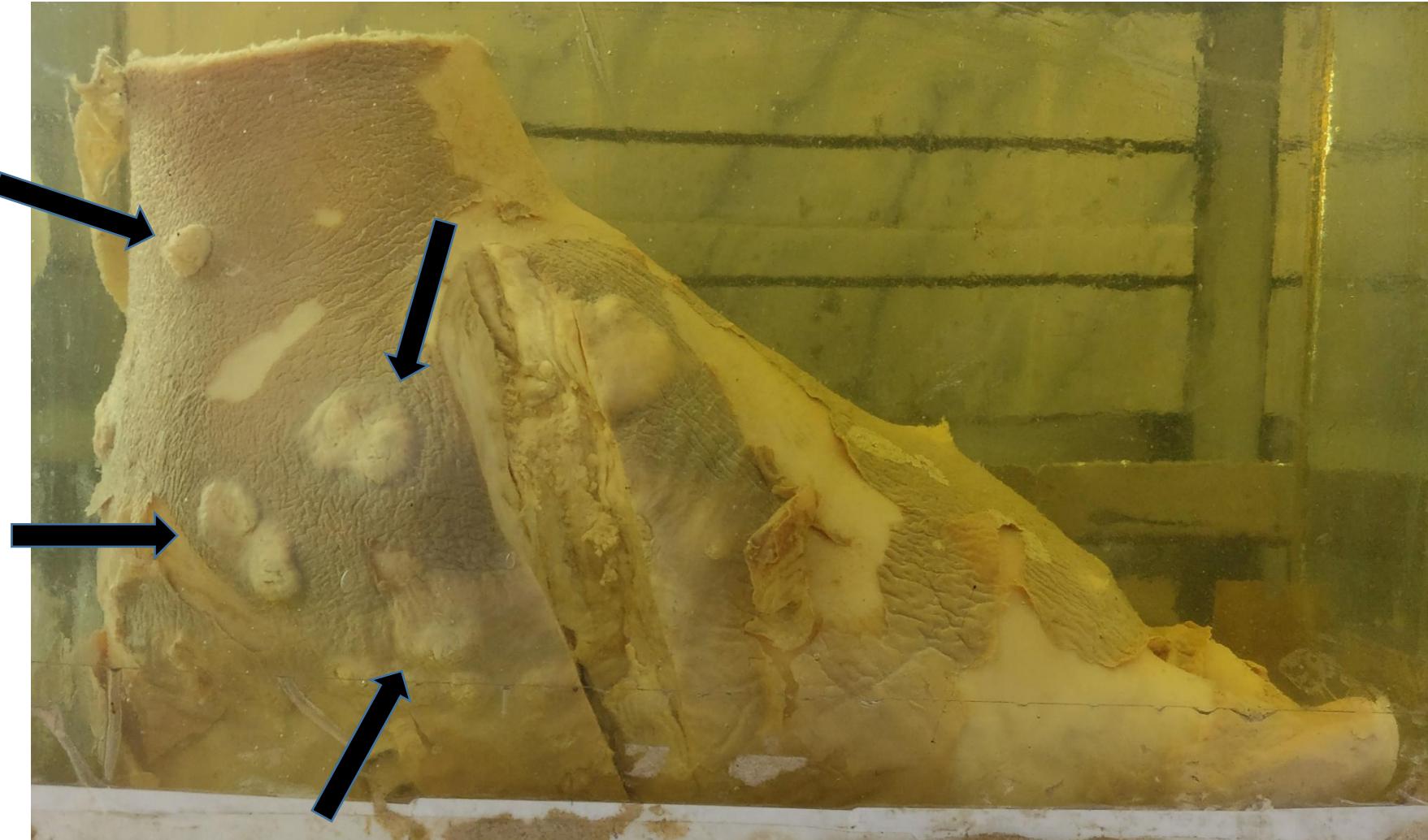
5. INFARCTION OF SPLEEN

- Cut section of spleen showing Wedge shaped grayish-white infarct involving capsule.
- Infarcts heal as large, depressed scars.

[INFARCTION SPLEEN]

1. INFARCTS ARE OF WEDGE SHAPE; WITH THE OCCLUDED VESSEL AT THE APEX AND THE PERIPHERY OF THE ORGAN FORMS BASE.
2. IN SPLEEN INFARCTS ARE MOSTLY → WHITE INFARCTS
[WHITE INFARCT → OCCUR WITH ARTERIAL OCCLUSIONS IN SOLID ORGANS WITH END-ARTERIAL CIRCULATION]
3. FRESH INFARCTS ARE POORLY DEFINED AND SLIGHTLY HEMORRHAGIC.
4. WITH PASSAGE OF TIME, INFARCTS BECOME PROGRESSIVELY PALER AND MORE SHARPLY DEFINED.

6. MYCETOMA FOOT



MYCETOMA

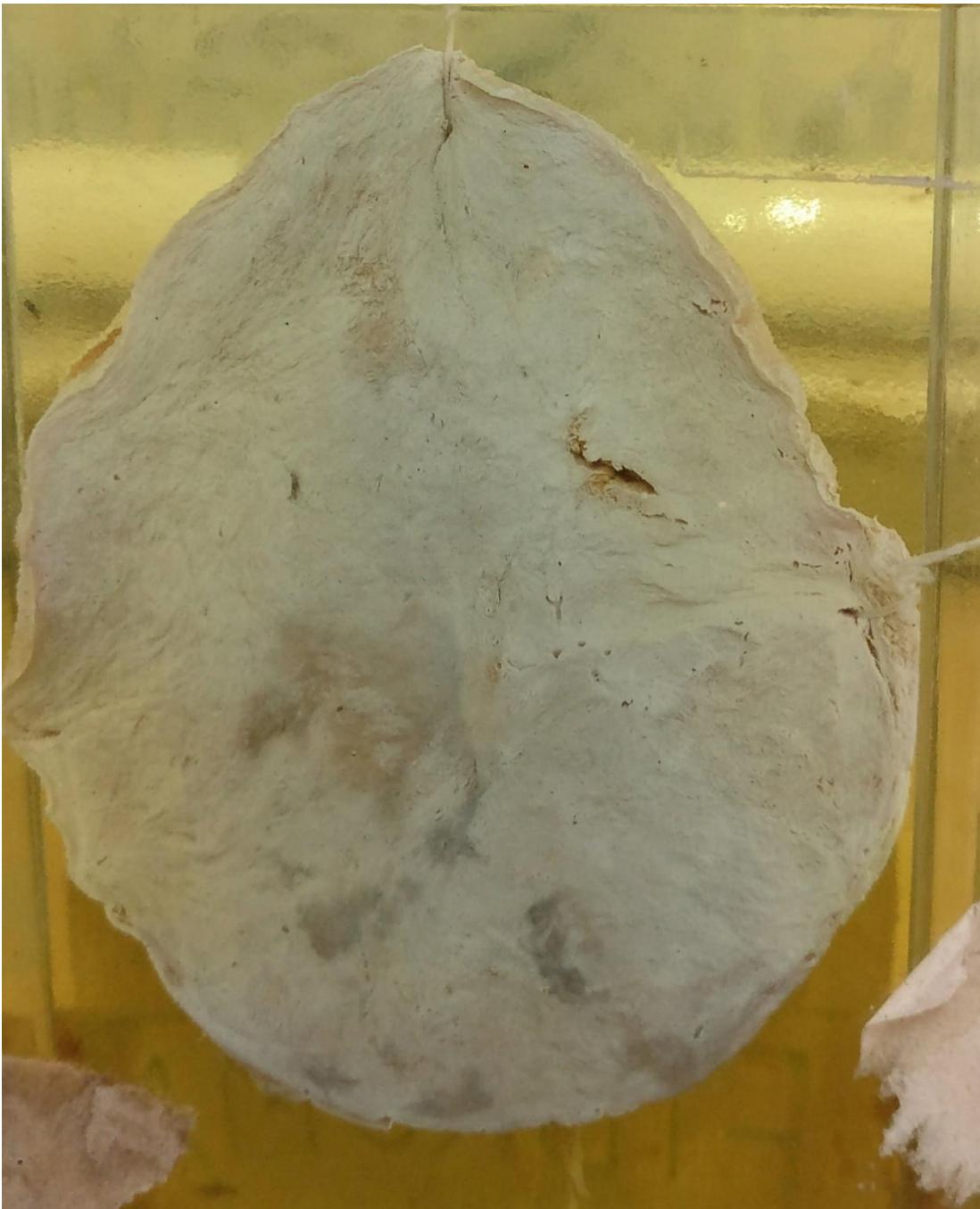
1. CHRONIC GRANULOMATOUS, PROGRESSIVE INFLAMMATORY DISEASE THAT INVOLVES THE SUBCUTANEOUS TISSUE AFTER A TRAUMATIC INOCULATION OF THE CAUSATIVE ORGANISM.
2. CLASSIFIED AS EUMYCETOMA (TRUE FUNGI) AND ACTINOMYCETOMA (BY HIGHER BACTERIA - ACTINOMYCETES)
3. CHARACTERISED BY THE FORMATION OF GRAINS CONTAINING AGGREGATES OF THE CAUSATIVE ORGANISMS THAT MAY BE DISCHARGED ON TO THE SKIN SURFACE THROUGH MULTIPLE SINUSES.
4. USUALLY PRESENTS AS A SLOWLY PROGRESSIVE PAINLESS SWELLING AT THE SITE OF PREVIOUS TRAUMA IT MAY SPREAD TO DEEP STRUCTURES RESULTING IN DESTRUCTION OF BONE, DEFORMITY AND LOSS OF FUNCTION.

DESCRIPTION

- Specimen of amputated foot showing multiple nodular lesions with sinus openings, each nodule measuring around 1cm in diameter. Skin appears eroded at the lesions.
- Foot appears to be swollen&/ oedematous indicating some inflammatory changes

Viva Q?

- Causative organisms?
- How to diagnose?
- Differential diagnosis?
- Granules and their colours?



7. FIBROMA OF OVARY

- Cut section of ovary(probably) which is enlarged in size & spherical in shape.
- Encapsulated and glistening mass with slightly lobulated surface.
- Solid grey white homogenous in cut section.

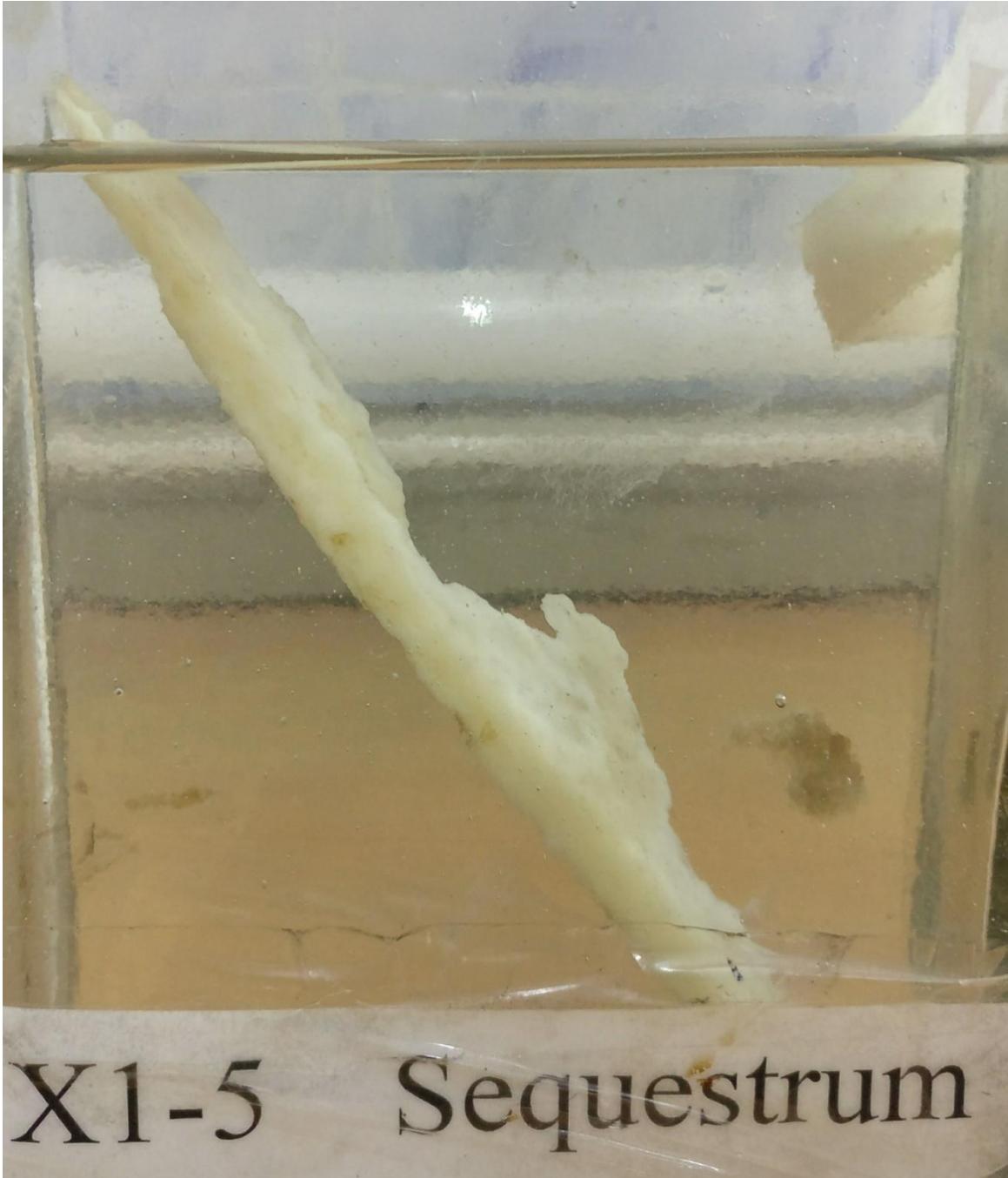
FIBROMA:

GROSS: 1> GREY WHITE
2> FIRM IN CONSISTANCY

CUT SURFACE: 1> SOLID
2> GREY TO GOLDEN BROWN COLOR

CELL OF ORIGIN: FIBROBLAST

- Other sites of fibroma
- Ovarian tumors classification



X1-5 Sequestrum

SEQUESTRUM

Specimen of thin gray white
necrotic bony fragment

SEQUESTRUM

→ SPECIMEN OF FRAGMENT OF BONE

1) IS THE NECROTIC BONE THAT IS EMBEDDED IN THE
INFECTED GRANULATION TISSUE

2) BONE THAT HAS BECOME SEPARATED DURING THE
PROCESS OF NECROSIS FROM SURROUNDING NORMAL BONE

3) SEEN IN CHRONIC OSTEOMYELITIS.



A347 Hydatid cyst
x1-6 LIVER

HYDATID CYST OF LIVER

Single unilocular cyst with fibrous wall

HYDATID CYST

- CAUSED BY ECHINOCOCCUS GRANULOSUS.
- DURATION \propto SIZE OF CYST (Approx >10cms)
- CYST ① OUTER - PERICYST - DENSE FIBROVASCULAR TISSUE - "HOST ORIGIN"
② ECTOCYST / - AVASCULAR LAMINATED MEMBRANE
③ INNER - ENDOCYST / GERMINAL LAYER - BROOD CAPSULE
- "HYDATID SAND" - DEGENERATED SCOLICES SEDIMENT IN THE HYDATID FLUID.



FATTY LIVER

Specimen of liver which is enlarged.
Surface is smooth and greasy showing yellowish discolouration.

FATTY LIVER

- ALSO KNOWN AS STEATOSIS
- ABNORMAL ACCUMULATIONS OF TRIGLICERIDES WITHIN PARENCHYMAL CELLS.
- SEEN IN LIVER - MOST COMMON (MAJOR ORGAN FOR FAT METABOLISM);
HEART, MUSCLE AND KIDNEY
- CAUSES :
 - 1) ALCOHOL ABUSE
 - 2) TOXINS
 - 3) PROTEIN MALNUTRITION
 - 4) DIABETES
 - 5) OBESITY
 - 6) ANOXIA
- LIPID ACCUMULATES AS SMALL DROPLETS → COALESCE INTO LARGE DROPLETS
→ DISTEND THE HEPATOCYTE AND PUSH THE NUCLEUS ASIDE
- GROSS: LARGE → 4-6kg; SOFT YELLOW GREASY.



SQUAMOUS CELL CARCINOMA

Specimen of amputated right hand showing fungating mass on the palmar aspect. Surface shows an ulcer(arrow).

SQUAMOUS CELL CARCINOMA

→ CAUSE : UV LIGHT EXPOSURE → DNA DAMAGE
→ SECOND MOST COMMON TUMOUR ARISING ON SUN-EXPOSED SITES
IN ELDERLY.

GROSS : "CAULIFLOWER LIKE"
FUNGATING / ULCERO PROLIFERATIVE GROWTH



CVC LIVER

CVC LIVER (SOLID ORGAN)

⇒ CHRONIC VENOUS CONGESTION OF (CVC) IS MAINLY
DUE TO RIGHT HEART FAILURE (OR) IVC (OR) HEPATIC
VEIN OBSTRUCTION

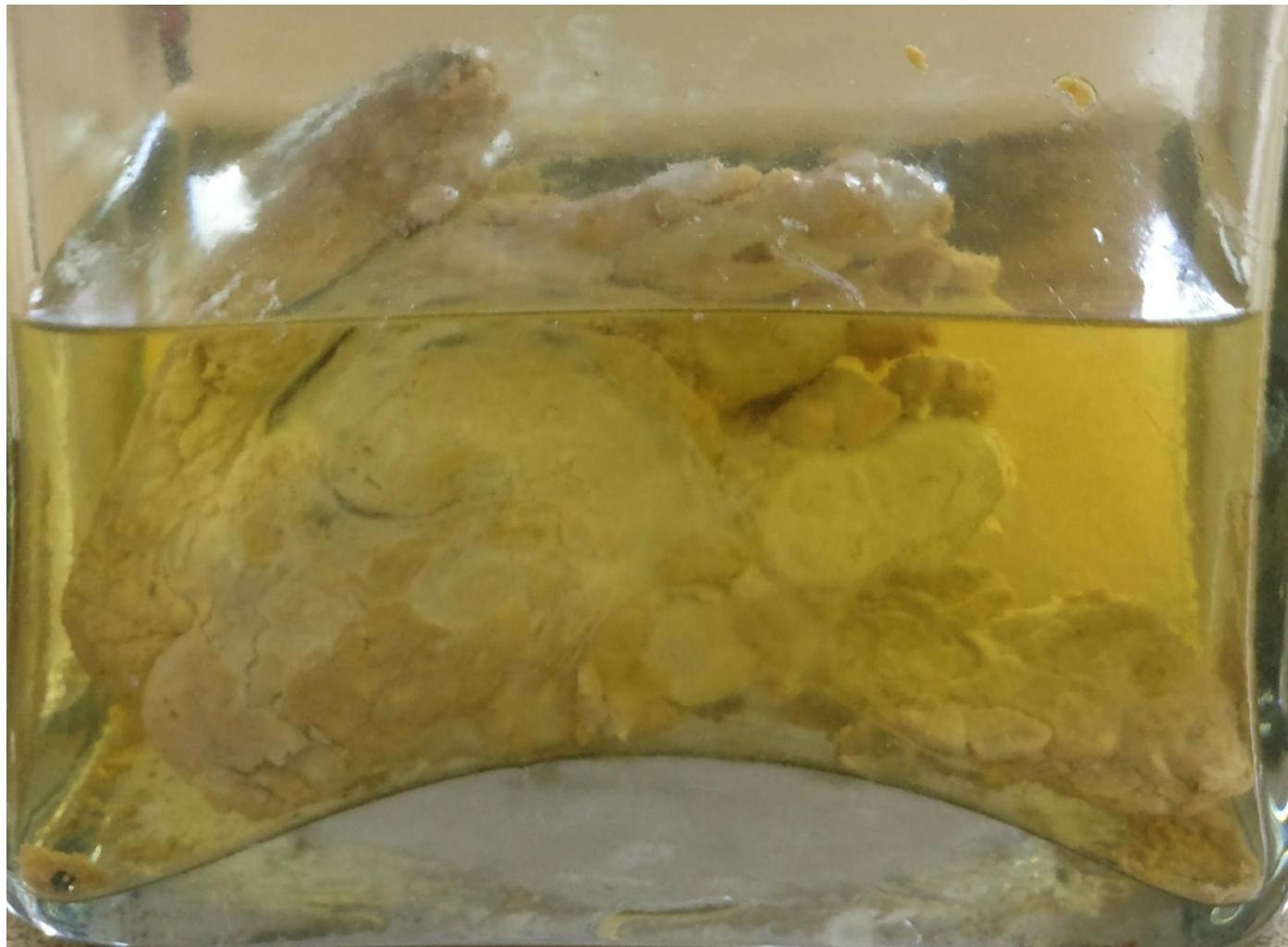
⇒ GROSSLY

AY LIVER IS ENLARGED AND CAPSULE IS TENSE

BY CUT SECTION: SHOW RED AND YELLOW MOTTLED

APPEARANCE → NUTMEG LIVER

TB LYMPH NODE

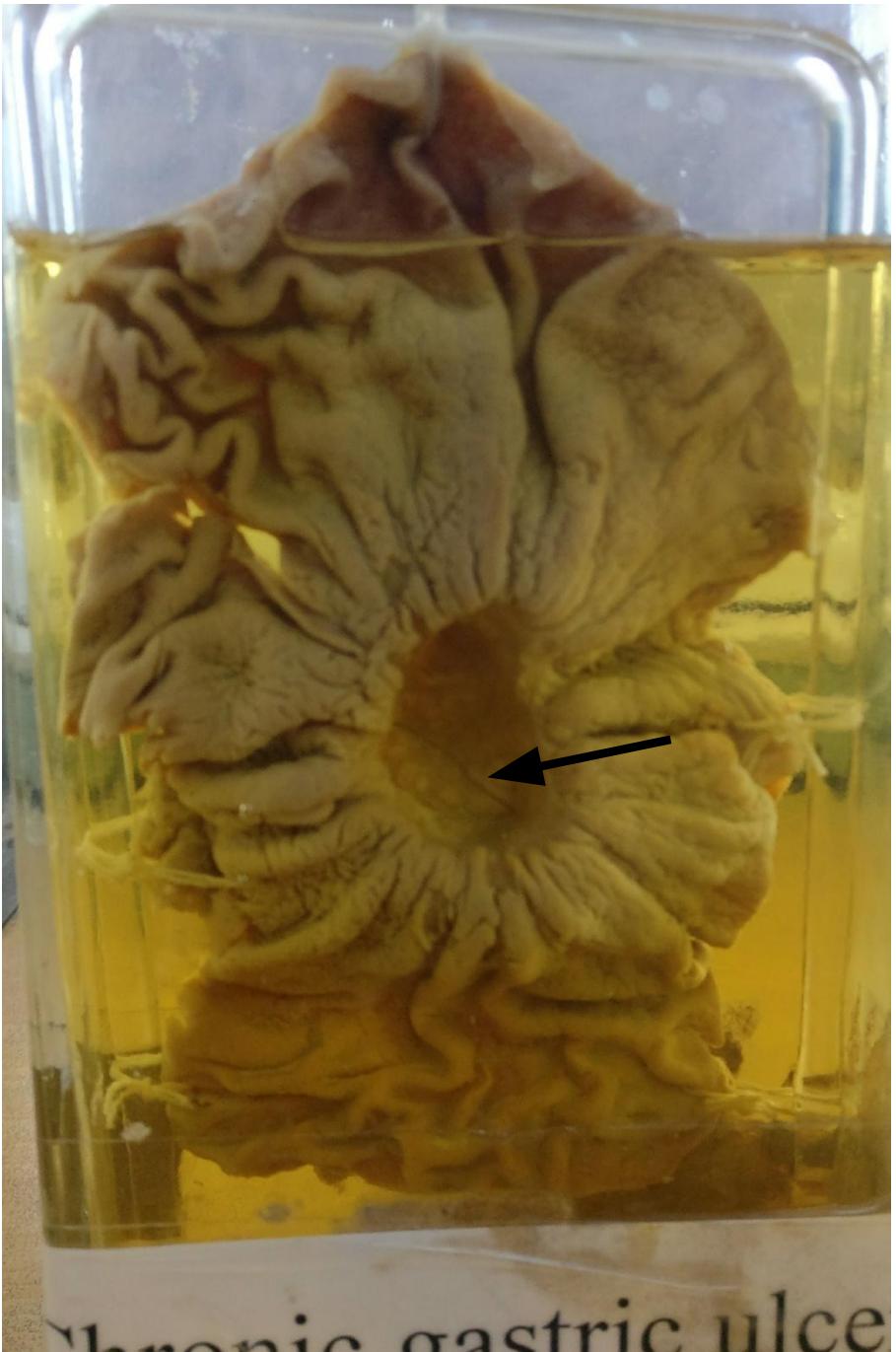


Specimen of multiple matted lymph nodes of varying sizes. Cut section shows yellow caseating necrosis.

TB LYMPH NODE:

- MOST COMMONLY INVOLVES CERVICAL LYMPH NODES.
- INITIALLY: ^① ENLARGED LYMPHNODES ARE FIRM AND DISCRETE → ^② PROGRESS TO MATTING OF LYMPH NODES → [DUE TO PERI ADENITIS]
- ^③ COLLAR STUD ABSCESS → SINUS TRACT FORMATION.

Q. What is scrofula.
Q. Most freq presentation of extrapulmonary TB?



CHRONIC GASTRIC ULCER

Specimen of partial gastrectomy showing ulceration which is oval and sharply punched out. Base of ulcer is smooth and has fibrinoid debri(arrow) which indicates active nature.

CHRONIC GASTRIC ULCER

→ CHRONIC MUCOSAL ULCERATION AFFECTING STOMACH LINING.
→ MC SITE: JUNCTION OF BODY & ANTRUM / GASTRIC ANTRUM

- RISK FACTORS:
- 1) H. PYLORI INFECTION
 - 2) CIGARETTE USE
 - 3) NSAIDS / DRUGS
 - 4) COPD
 - 5) ALCOHOLIC CIRRHOsis (DUODENAL PUD)
 - 6) ENDOCRINE CELL HYPERPLASIA
 - 7) ZES
 - 8) PSYCHOLOGICAL STRESS
 - 9) VIRAL INFECTIONS

GROSS: ROUND-OVAL, PUNCHED OUT DEFECT.
* BASE IS SMOOTH & CLEAN → PEPTIC DIGESTION OF EXUDATE
* HEMORRHAGE & FIBRIN DEPOSITION - ON GASTRIC SEROSA.

COMPLICATION: PERFORATION

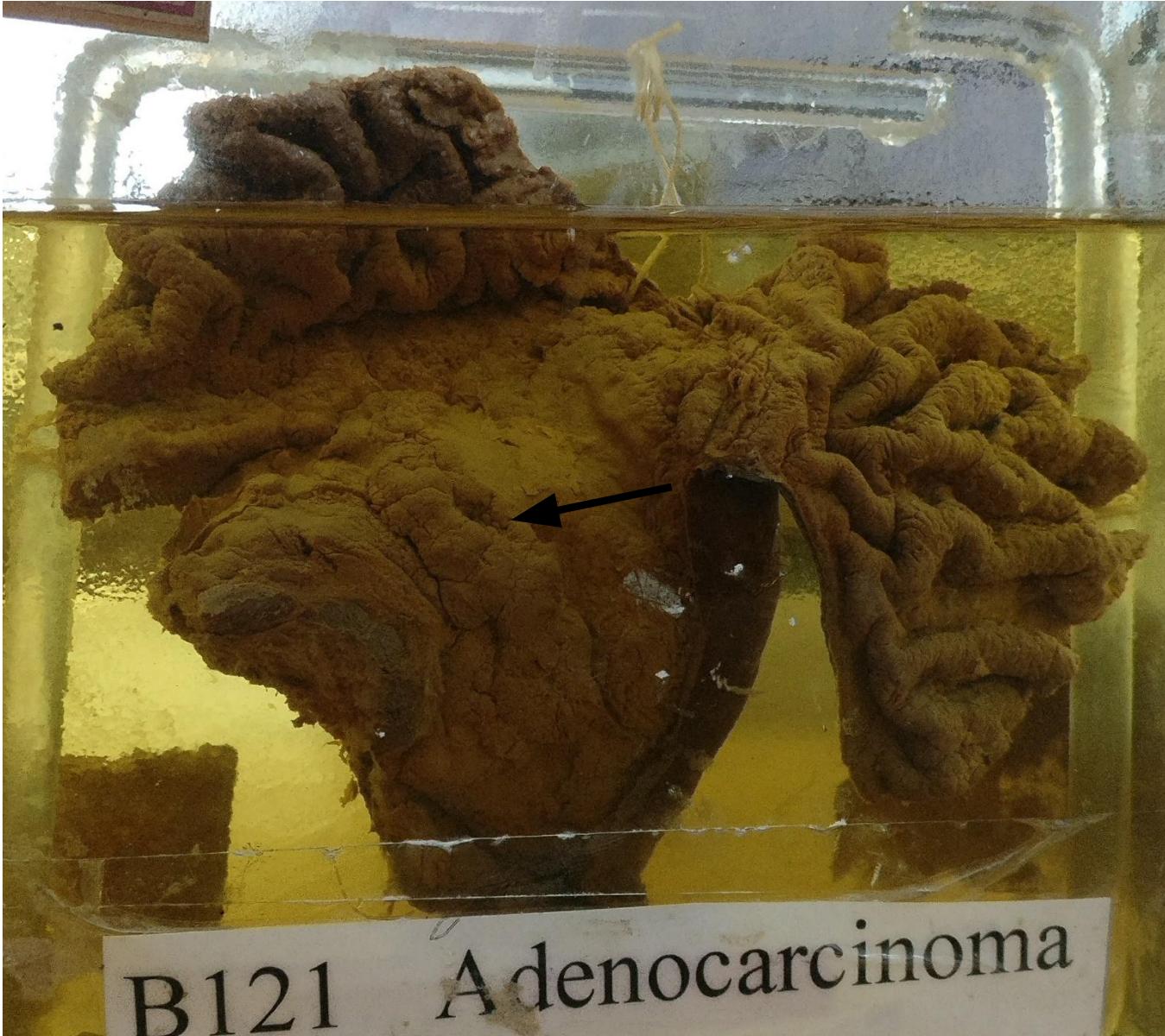
Clean base indicates inactive ulcer.

Q. Layers of peptic ulcer in histology

ADENOCARCINOMA STOMACH

Specimen of partial gastrectomy showing proliferating mass with a central ulceration which is oval with heaped up margins. Note the loss of rugae surrounding the ulcer..

B121 Adenocarcinoma



ADENOCARCINOMA STOMACH

→ >90% OF ALL GASTRIC CANCERS

→ SITE : GASTRIC ANTRUM / LESSER CURVATURE ➤ GREATER CURVATURE

→ 2 FORMS — 1) INTESTINAL TYPE — BULKY MASSES
2) DIFFUSE TYPE — INFILTRATES DIFFUSELY, THICKENS

GROSS : INTESTINAL TYPE — EXOPHYtic MASS / ULCERATED TUMOR
— ELEVATED MASS ↗ HEAPED UP BORDERS & CENTRAL
ULCERATION

DIFFUSE TYPE — GASTRIC WALL DIFFUSELY THICKENED &
RUGAL FOLDS ARE PARTIALLY LOST ⇒ LEATHER BOTTLE APP
↓
UNITIS PLASTICA

TB INTESTINE

Specimen of resected part of
large intestine showing ???



TB INTESTINE

- SPECIMEN OF FORMALIN FIXED CUT OPENED INTESTINE
- ILEUM MOST COMMONLY INVOLVED
- GRANULOMATOUS INFLAMMATION THAT CAN LEAD TO
 - ULCERATION OF THE OVERLYING MUCOSA
- ULCER → STRICTURE FORMATION
- a) CIRCULAR
 - b) ENTIRE CIRCUMFERENCE IS INVOLVED
 - c) LEADING TO STRICTURE FORMATION
 - d) INTESTINAL OBSTRUCTION



TYPHOID ULCER

Specimen of resected part of ileum showing oval shaped ulcer oriented along the long axis of the intestine.

- a/c enteric fever- salmonella enterica.
- These bacteria attack M cells in small bowel and then engulfed by macrophages.
- They can disseminate via lymphatic and blood vessels.

Q. What happens to payers patches???

Q. What are typhoid nodules???

ACUTE APPENDICITIS

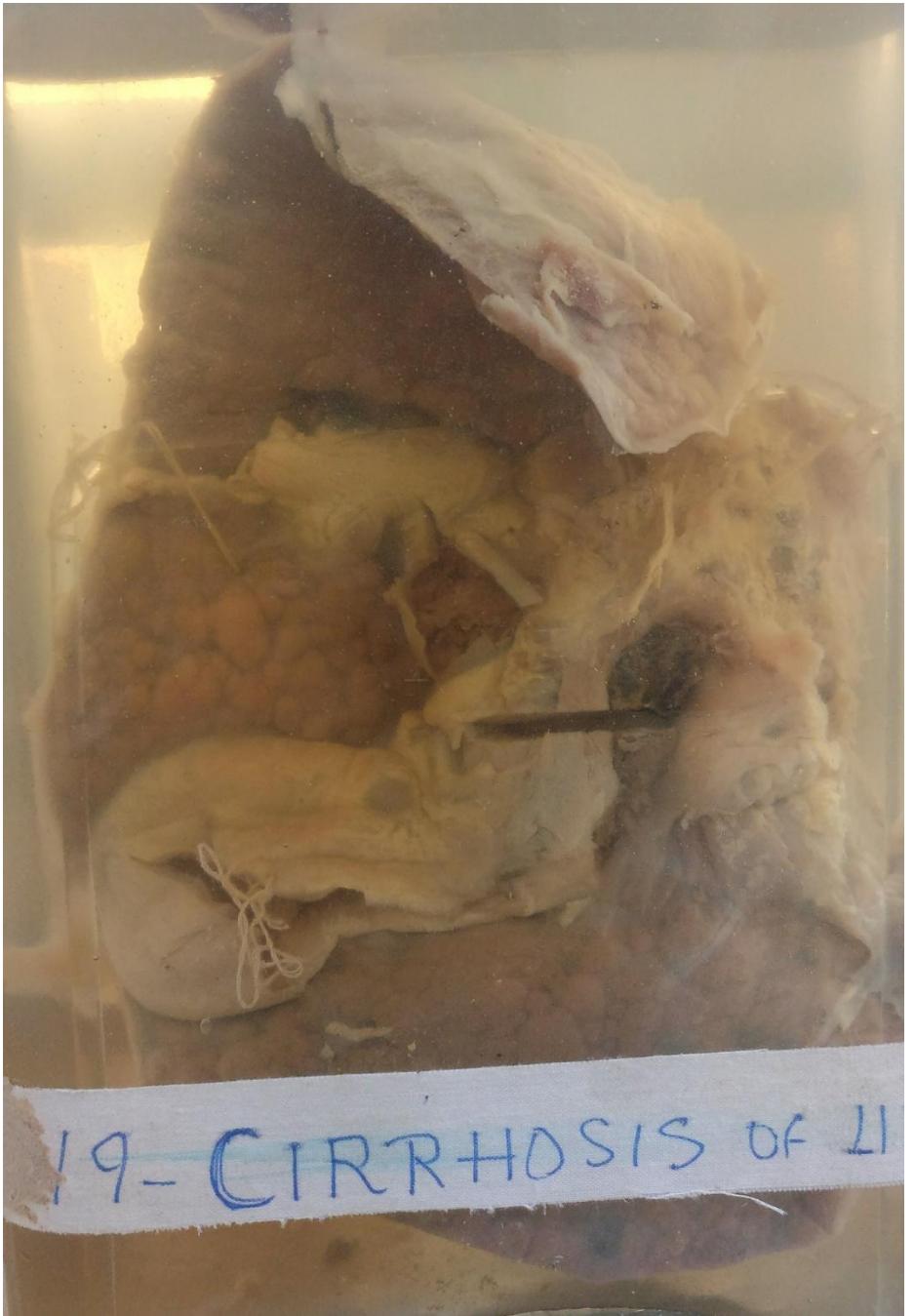
Specimen of appendectomy showing dull erythematous serosa indicating congestion.

-14 Appendicitis

ACUTE APPENDICITIS

- APPENDIX IS A NORMAL TRUE DIVERTICULUM OF THE CECUM,
TUBULAR STRUCTURE
 - CAUSE: 50-80% → OVERT LUMINAL OBSTRUCTION — FECOLITH, TUMOR,
MASS OF WORMS.
- GROSS: SEROSA — CONGESTED
NORMAL GLISTENING SEROSA ⇒ DULL, GRANULAR,
ERYTHEMATOUS SURFACE
- COMPLICATION : 1) ABSCESS
2) PERFORATION

Q. The diagnostic histological feature of acute appendicitis???



CIRRHOSIS OF LIVER

Specimen of liver which is shrunken with surface showing multiple nodules of varying sizes.

CIRRHOSIS OF LIVER

→ COMPOSED OF REGENERATING PARENCHYMAL NODULES, SURROUNDED BY DENSE BANDS OF SCAR TISSUE.

→ 2 TYPES ↗ MICRO NODULAR < 3mm
 MACRO NODULAR > 3mm

GROSS: SURFACE IRREGULAR SHOWING REGENERATIVE NODULES OF VARYING SIZE.

CAUSES: ALCOHOL
HEPATITIS B, C



MITRAL STENOSIS

.65
1-15

Mitral stenosis

2) AMOEBOIC LIVER ABSCESS

- ✓ CAUSATIVE AGENT: ENTAMOEBA HISTOLYTICA
- ✓ PARASITE OCCURS IN 2 FORMS: TROPHOZOIT AND CYSTIC FORM

GROSS:

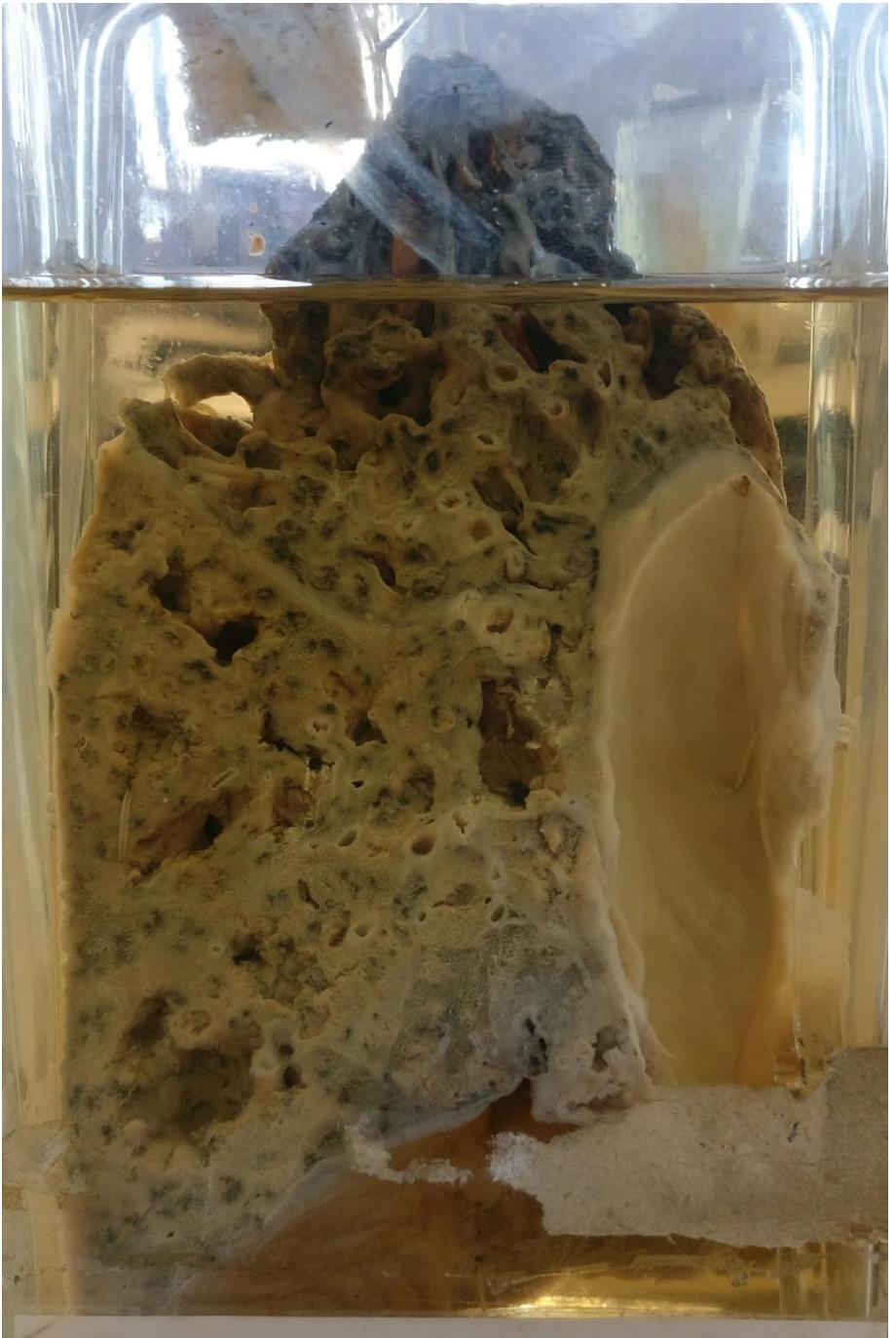
- 1) SINGLE
- 2) RIGHT LOBE OF LIVER
- 3) CENTRE PART OF ABSCESS CONTAINS NECROTIC AREA FILLED WITH REDDISH BROWN THICK PUS WHICH RESEMBLES ANCHOVY (OR) CHOCOLATE SAUCE



ATHEROSCLEROSIS

ATHEROSCLEROSIS:

- SPECIMEN OF CUT OPENED AORTA
- IT IS A DISEASE OF LARGE AND MEDIUM SIZED ARTERIES
CHARACTERIZE BY ① ENDOTHELIAL DYSFUNCTIONS
 - ② VASCULAR INFLAMMATION
 - ③ ATHEROMA FORMATION
- ATHEROMA ALSO CALLED ATHEROMATOUS PLAQUE
THAT PROTRUDE INTO VASCULAR LUMEN



TB LUNG

TB LUNG

SPECIMEN OF LUNG CUT SECTION

PRIMARY TUBERCULOSIS:

- 1) MOST COMMONLY INVOLVES UPPER PART OF LOWER LOBE OR
LOWER PART OF UPPER LOBE NEAR PLEURA
- 2) GHON FOCUS: 1 - 1.5 CM AREA OF GREY WHITE INFLAMMATION
WITH CONGALIDATION.
- 3) GHON COMPLEX: GHON FOCUS + NODAL INVOLVEMENT
- 4) RANKE COMPLEX: GHON COMPLEX + RADIOLAGICALLY DETECTABLE
CALCIFICATION

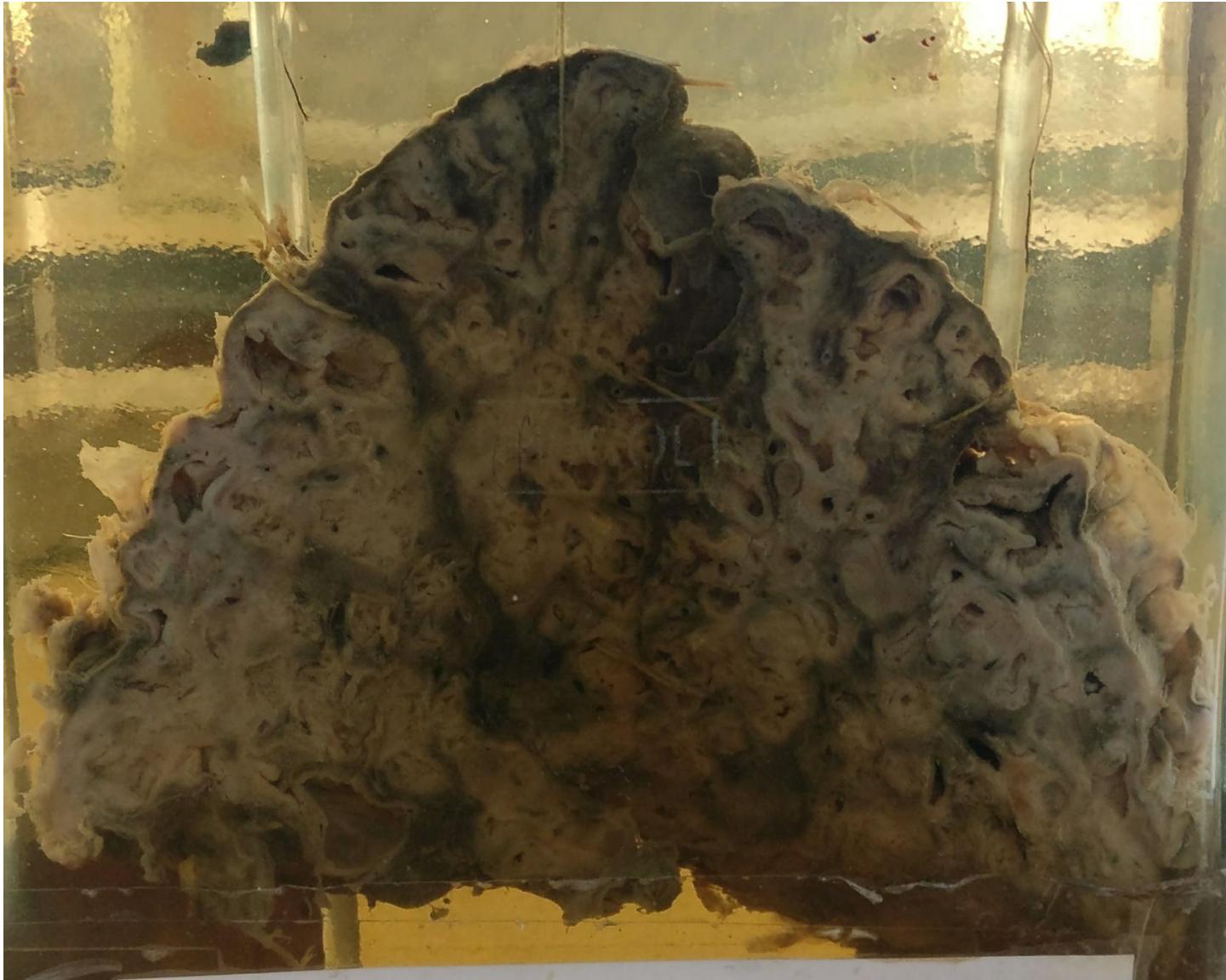
SECONDARY TB:

- ▷ MOST COMMONLY INVOLVES APICAL LOBE
- 2) FOCI OF CONSOLIDATION < 2 CM.
 - SHARPLY CIRCUMSCRIBED, FIRM.
 - GREY WHITE TO GREY YELLOW
 - HAVING CENTRAL CASEATION AND PERIPHERAL FIBROSIS
- 3) CAVITATION

PROGRESSIVE PRIMINARY TB:

- 4) THE APICAL LESION EXPANDS INTO ADJACENT LUNG
- ERODES INTO BRONCHI AND VESSELS
- 5) CAVITY FORMATION

BRONCHIECTASIS



BRONCHIECTASIS

- 1) FORMALIN FIXED SPECIMEN OF LUNG WITH BRONCHOS
→ CUT SECTION SHOWS → MARKEDLY DILATED PERIPHERAL
BRONCHI FILLED WITH MUCO PURULENT SECRETIONS.
- 2) USUALLY AFFECTS THE LOWER LOBES.

CAUSES:

- 1) STAPHYLO COCCI
- 2) STREPTO COCCI
- 3) PNEUMO COCCI
- 4) H. INFLUENZAE

BRONCHOGENIC CARCINOMA



BRONCHIOGENIC CARCINOMA TRACHEA, BRONCHI

1> FORMALIN FIXED SPECIMEN OF LUNG^x SHOWING A
GREY WHITE LESION (TUMOR) THAT INFILTRATES THE
LUNG PARENCHYMA.

2> IT BEGINS AS A SMALL MUCOSAL LESION → GROWS
INTRA LUMINAL MASS → INVADES BRONCHIAL WALL →
FINALLY INVADES LUNG PARENCHYMA →

CLASSIFICATION:

1> ADENO CARCINOMA (38%)

2> SMALL CELL CARCINOMA (14%)

2> SQUAMOUS CELL CARCINOMA (25%)

4> LARGE CELL CARCINOMA (3%)

5> OTHERS.



POLYCYSTIC KIDNEY

POLY CYSTIC KIDNEY DISEASE

FORMALIN FIXED CUT SECTION OF KIDNEY WITH HILUM.
• → (30x15x8 CM)
SHOWING : 1) KIDNEY IS ENLARGED, BOSSELATED
2) CUT SECTION SHOWING MULTIPLE CYSTS
OF VARYING SIZES LARGEST ME: 6x6 CM.

→ TWO TYPES

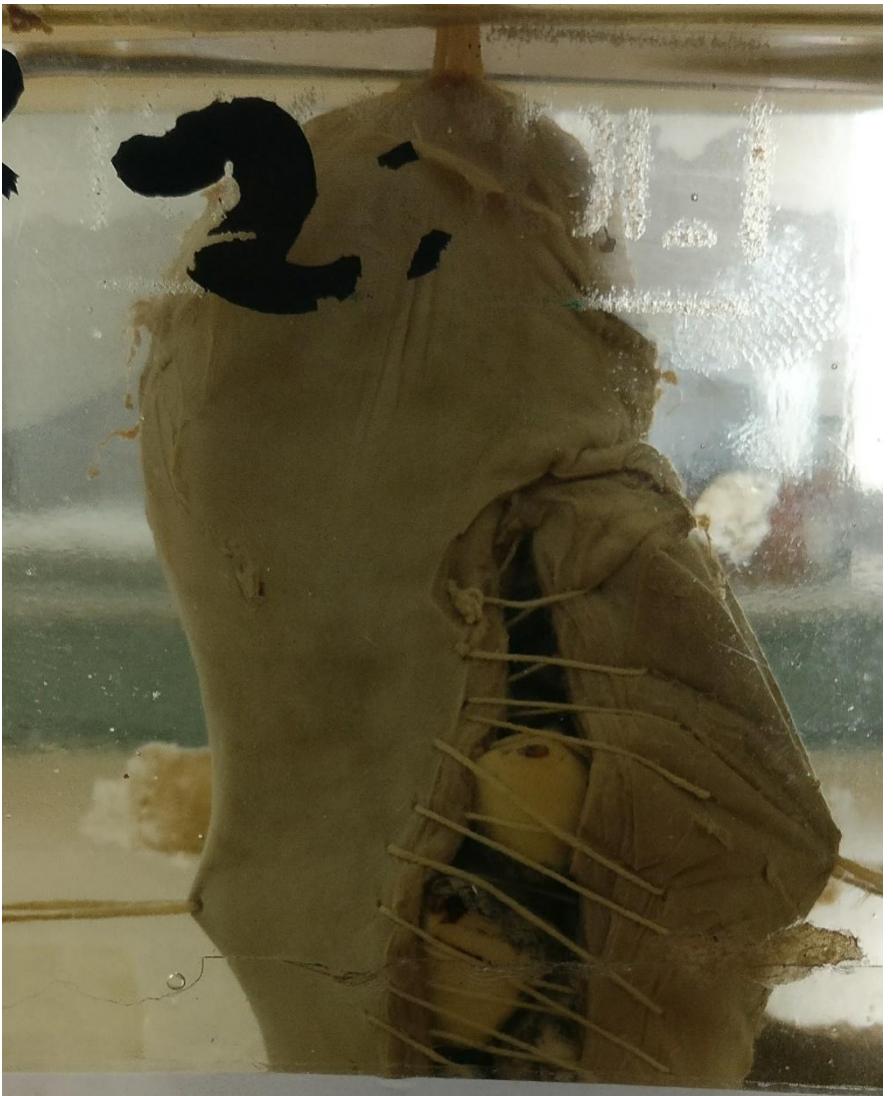
- ① ADULT POLYCYSTIC KIDNEY: AUTOSOMAL DOMINANT
AUTOSOMAL
- ② CHILDHOOD POLYCYSTIC KIDNEY DISEASE: RECESSIVE.



HORSE SHOE KIDNEY

HORSE SHOE KIDNEY

- TWO BEAN SHAPED STRUCTURES FUSING AT THE LOWER POLE; BLADDER \supset URETERS
- MOST COMMON TYPE OF RENAL FUSION ANOMALY.
- IT CONSISTS OF TWO DISTINCT FUNCTIONING KIDNEYS ON EACH SIDE OF THE MIDLINE, CONNECTED AT THE LOWER POLES BY AN IsthMUS OF FUNCTIONING RENAL PARENCHYMA OR FIBROUS TISSUE THAT CROSSES MIDLINE OF BODY
- SPECIMEN SHOWS - EACH KIDNEY m/s $7\text{cm} \times 4\text{cms}$.
LOWER POLES \Rightarrow HORSE-SHOE SHAPE
BLADDER - m/s $11 \times 7\text{cms}$
URETERS - m/s 12cms .
- * UPPER POLE FUSION - 10% ; LOWER POLE - 90%.



es in the

CHOLELITHIASIS

STONES IN GALL BLADDER

- SPECIMEN - PEAR SHAPED ORGAN ABOUT 7-8 CMS LONG AND 3 CMS WIDTH AT WIDEST PART.
- IT HAS 3 PARTS:
 - 1) NECK - CONSTRICTED PART
 - 2) BODY - ATTACHED TO NECK
 - 3) FUNDUS - ROUND PART AT ONE END
- GALL BLADDER IS ALREADY CUT OPEN SHOWING MULTIPLE DARK (YELLOW) STONES.
- TYPES OF GALL STONES:
 - 1) PURE CHOLESTEROL ⇒ PALE YELLOW,
ROUND - OVAL ; FINELY GRANULAR & HARD EXTERNAL SURFACE
 - 2) PIGMENT ⇒ BLACK → FRIABLE, SPICULATED & MOULDED
BROWN → LAMINATED, SOFT ; SOAP LIKE / GREASY CONSISTENCY
 - 3) MIXED

NEPHROLITHIASIS



Stones in the kidney

STONES IN KIDNEY

→ SPECIMEN — KIDNEY m/s 10x5cm.

EXTERNAL SURFACE — IRREGULAR

C/S → LOSS OF CORTICOMEDULLARY DIFFERENTIATION

DILATED PELVICALYCEAL SYSTEM.

MULTIPLE & IN SMOOTH ROUND STONES IN THE
DILATED CALYCES m/s ABOUT 1cm IN DIAMETER

→ TYPES : 1) CALCIUM OXALATE & PHOSPHATE (70%)

2) TRIPLE PHOSPHATE (5-10%) — PROTEUS / UREA SPLITTING
BACTERIA

3) URIC ACID STONES (5-10%)

4) CYSTINE STONES (1-2%)

5) OTHERS



X2-9 Renal cell carcinoma

RENAL CELL CARCINOMA

RENAL CELL CARCINOMA

SPECIMEN — C/S OF KIDNEY TO MASS M/S 7X5cms.

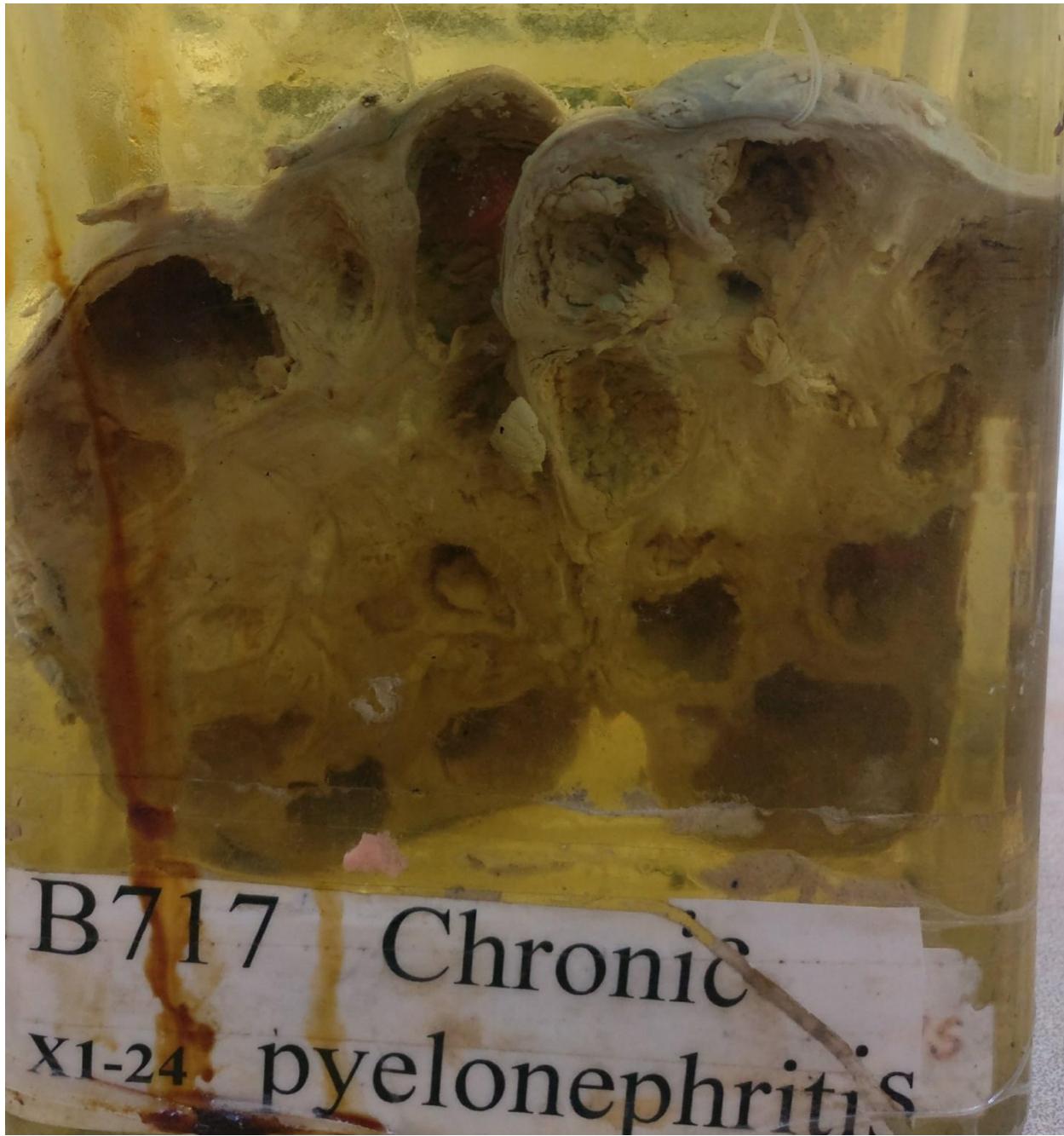
— TUMOR TISSUE INVOLVING ENTIRE KIDNEY M/S 6X5cms.

— AREAS OF NECROSIS & HEMORRHAGE SEEN

— DISTORTION OF PELVIS & CALYCES OF KIDNEY.

→ MOSTLY AFFECT POLES OF KIDNEY

→ MOST COMMON TYPE CLEAR CELL CARCINOMA ⇒ SOLITARY,
UNILATERAL.



CHRONIC PYELONEPHRITIS

B717 Chronic
x1-24. pyelonephritis

CHRONIC PYELONEPHRITIS

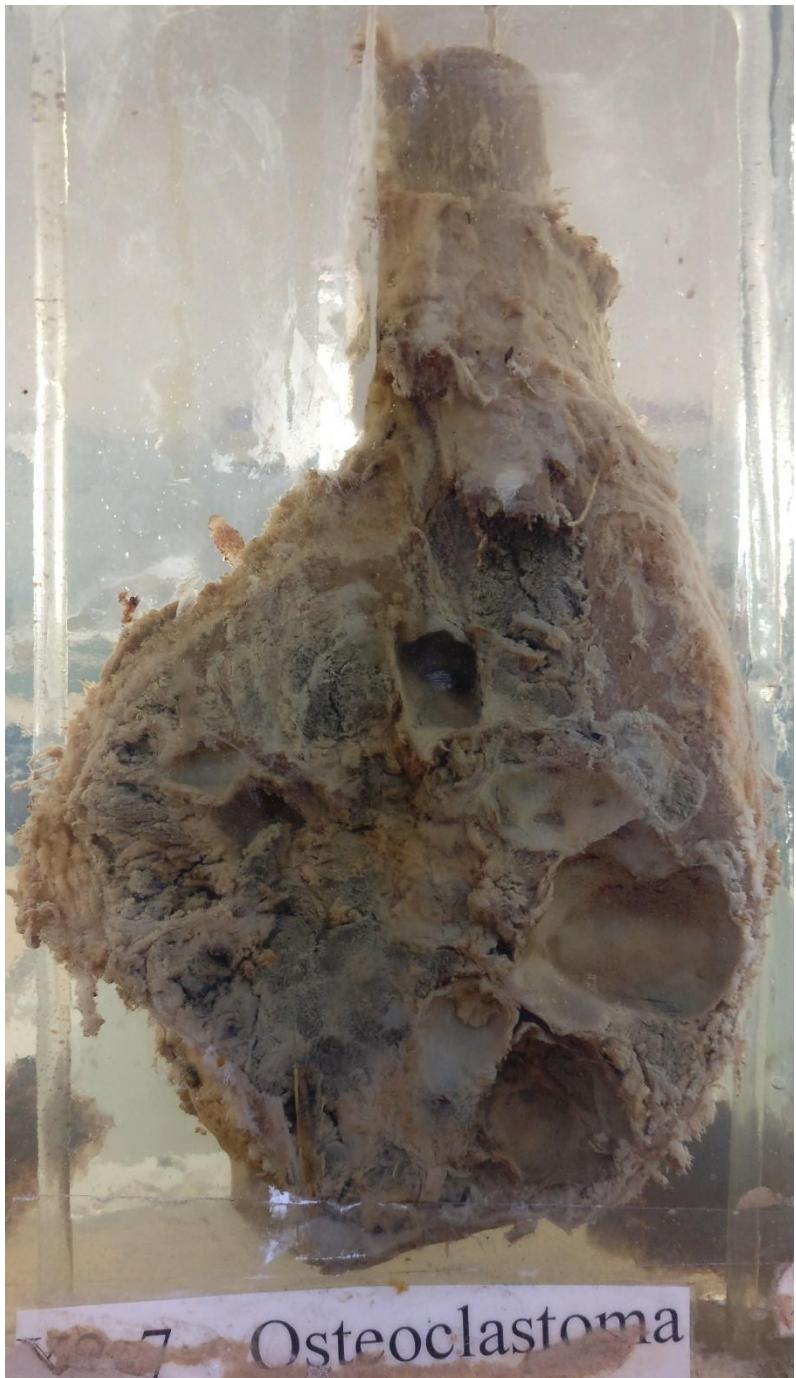
SPECIMEN — KIDNEY m/s 11x7cms

EXT. SURFACE — IRREGULAR, THICKENED &

CUT SECTION — THINNED OUT CORTEX

DILATED & BLUNTING OF CALYCES

PAPILLAE APP~~E~~R BLUNTED



OSTEOCLASTOMA

OSTEOCLASTOMA

SPECIMEN — LOWER END OF FEMUR m/s 16x8x3cms WITH THE
ATTACHED MUSCLES.

— MASS TO ONE END m/s 8x7x3cms.

CUT SECTION — HEMORRHAGIC AREAS WITH MULTIPLE CYSTS.
LARGER CYST m/s 2.5x2cms.

OSTEOSARCOMA

X2-8 Osteosarcoma

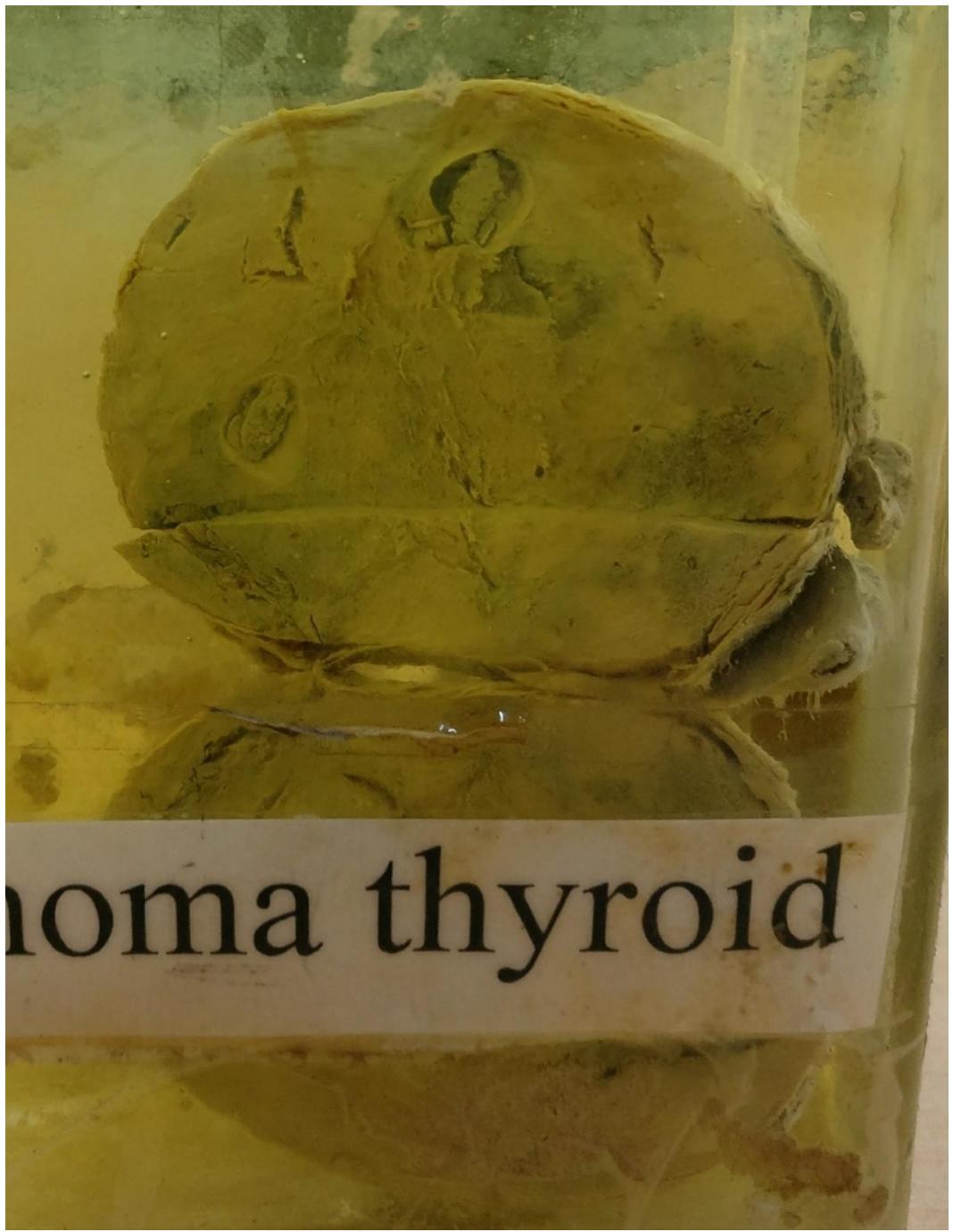
OSTEOSARCOMA

SPECIMEN \Rightarrow LOWER END OF FEMUR & THE MASS m/s 8x10x2 cms.

- NODULAR MASS PRESENT ON EITHER SIDE OF BONE
m/s 8x4 cms & 5x3 cms.

CUT SECTION - HOMOGENOUS GREY WHITE AREA

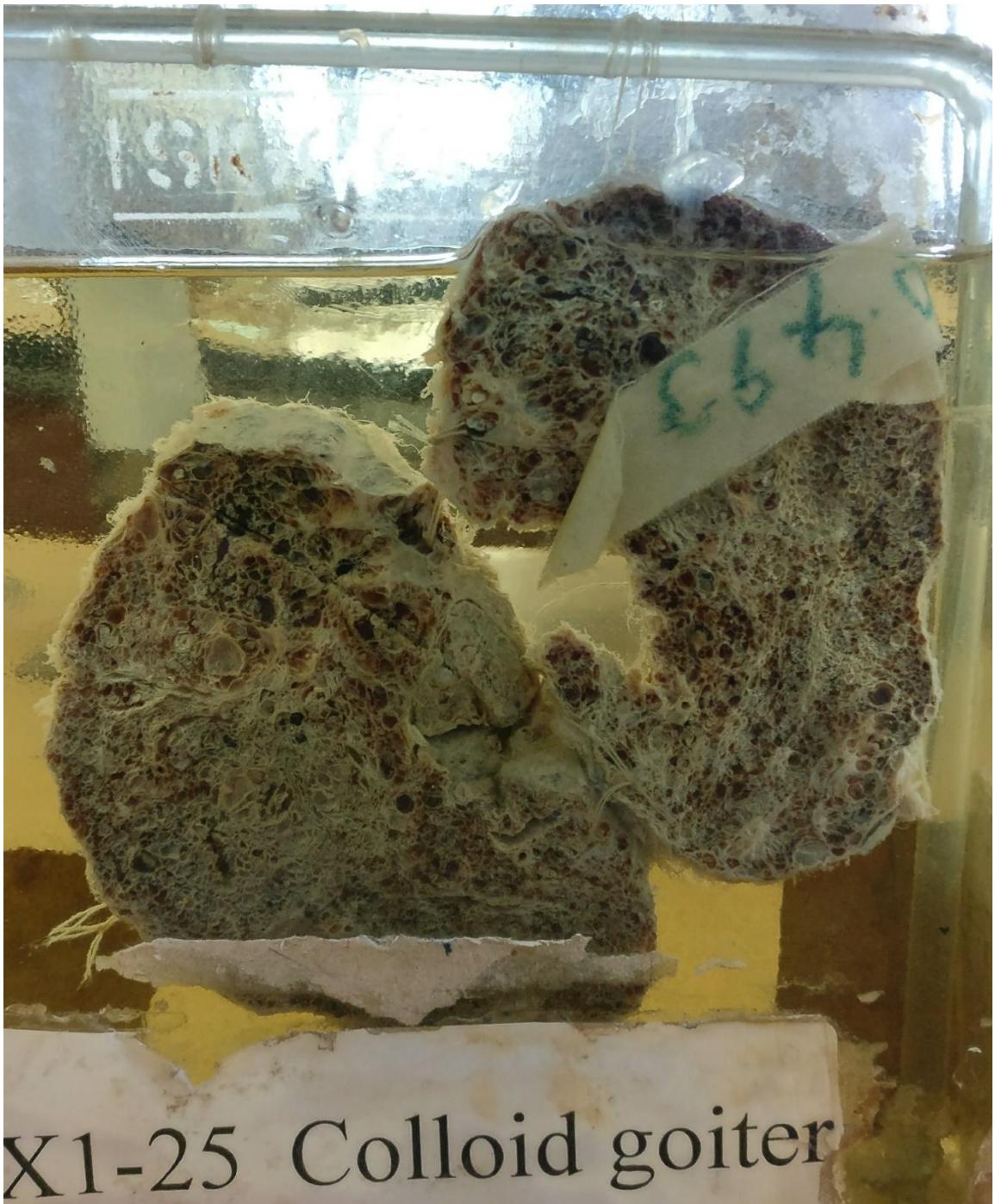
\rightarrow BULKY TUMOR ; GRITTY , GREY-WHITE .



ADENOMA THYROID

ADENOMA THYROID

1. SOLITARY, ENCAPSULATED GRAY-WHITE LESION WITH FOCAL
CYSTIC AREAS OF NECROSIS AND ADJACENT RESIDED COMP.
THYROID PARENCHYMA } - PROBABLY ADENOMA THYROID
2. ADENOMA THYROID - TYPICALLY DISCRETE, SOLITARY MASS
ARISING FROM FOLLICULAR EPITHELIUM.
3. DEMARCATED FROM THE SURROUNDING THYROID PARENCHYMA
BY WELL DEFINED INTACT CAPSULE.
THEY COMPRESS THE SURROUNDING ADJACENT THYROID.
4. AVERAGE SIZE - 3CM IN DIAMETER (SOME ARE >10 CM)
5. AREAS OF HEMORRHAGE, FIBROSIS, CALCIFICATION & CYSTIC
CHANGE ARE COMMON.



COLLOID GOITER

X1-25 Colloid goiter

COLLOID GOITER

1. ~~SOLITARY~~ DIFFUSELY AND SYMMETRICALLY ENLARGED LESION WITH CUT SECTION SHOWING BROWN, TRANSLUCENT CYSTIC SPACES - PROBABLY COLLOID GOITER.
2. SIMPLE GOITER CAUSES ENLARGEMENT THE ENTIRE GLAND WITHOUT PRODUCING NODULARITY.
3. BECAUSE THE ENLARGED FOLLICLES ARE FILLED WITH COLLOID, THE TERM COLLOID GOITER IS APPLIED.
4. THYROID GLAND IS DIFFUSELY AND SYMMETRICALLY ENLARGED - MODERATE INCREASE (RARELY EXCEEDS 150 gm)
5. CUT SECTION - BROWN, SOMEWHAT GLASSY AND TRANSLUCENT.



SEMINOMA

SEMINOMA

BULKY GRAY WHITE MASS WITH SOLID, HOMOGENOUS LOBULATED CUT SURFACE
WITH COMPRESSED TESTIS WITH ATTACHED CORD - SEMINOMA

1. MOST COMMON TYPE OF GERM CELL TUMOR INVOLVING TESTIS
2. COMPRIMES 50% OF GERM CELL TUMORS
3. PEAK AGE INCIDENCE - THIRD DECADE
4. IDENTICAL TUMOR IN OVARY - DYSGERMINOMA
5. PRODUCE BULKY MASS (SOMETIMES 10 TIMES THE SIZE OF NORMAL TESTIS)
6. CUT SECTION - SOLID, HOMOGENOUS, GRAY WHITE/LIGHT YELLOW
LOBULATED CUT SURFACE.
7. USUALLY DEVOID OF HEMORRHAGE OR NECROSIS.

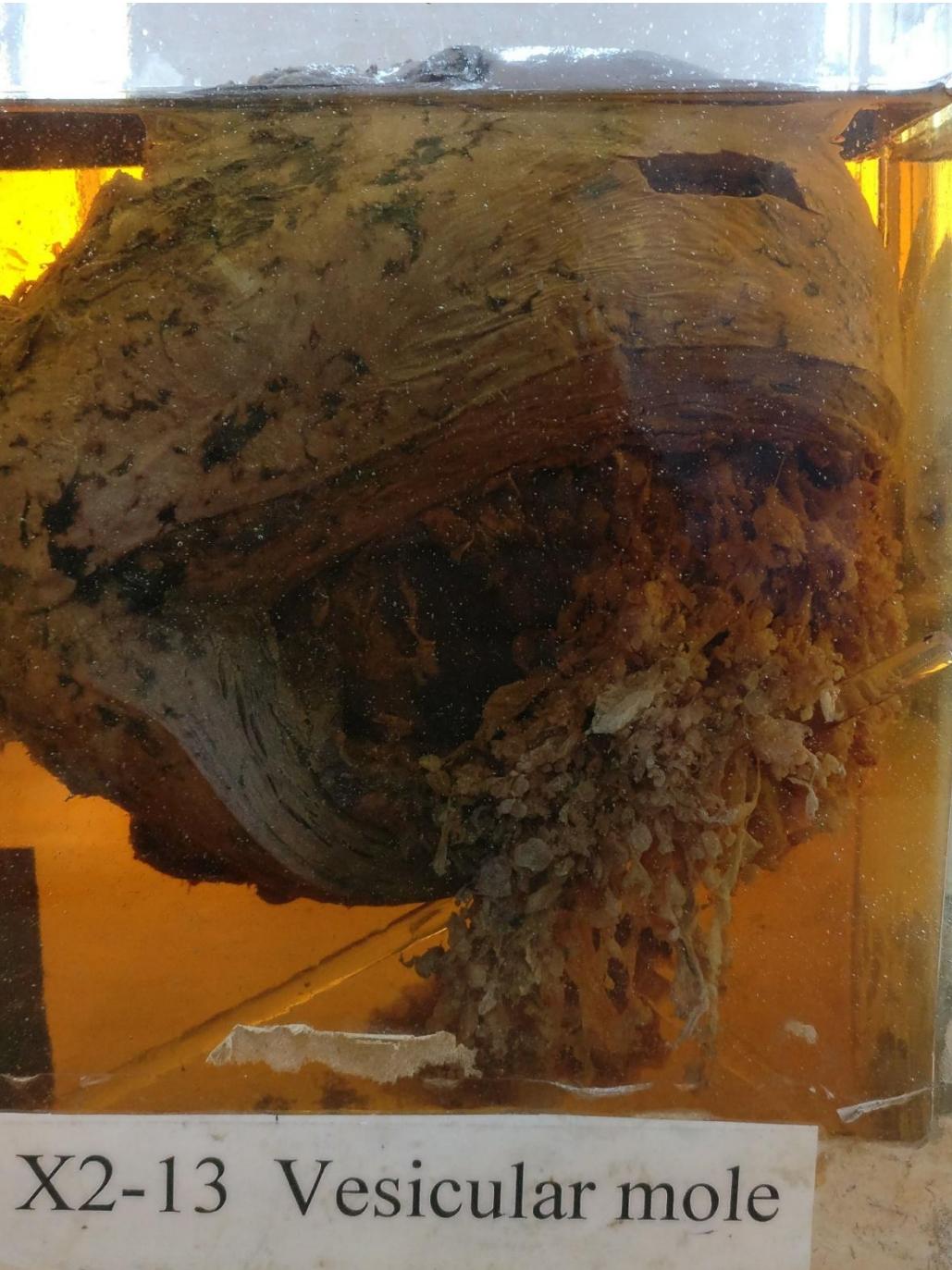


TERATOMA

B371 Teratoma
x2-12

TERATOMA SPECIMEN OF CUT OPEN TESTICULUM
MASS WITH INTACT TUNICA VAGINALIS AND
HETEROGENOUS CORD MUSCLE TINY 10X6cm

1. LARGE, GRAY WHITE MASS WITH MULTIPLE CYSTIC SPACES --
AND INTERSPERSED CHALKY WHITE AREAS (GALCIFICATION)
WITH ATTACHED CORD - PROBABLY TERATOMA
2. TERATOMA REFERS TO TUMORS HAVING VARIOUS CELLULAR
OR ORGANOID COMPONENTS REMINISCENT OF THE NORMAL
DERIVATIVES OF MORE THAN 1 GERM LAYER.
3. MAY OCCUR AT ANY AGE → INFANCY TO ADULT LIFE.
4. PURE FORMS COMMON IN INFANTS AND CHILDREN.
5. IN ADULTS - PURE FORMS ARE RARE. MIXED GERM
CELL TUMORS ARE COMMON.



VESICULAR MOLE

X2-13 Vesicular mole

VESICULAR MOLE

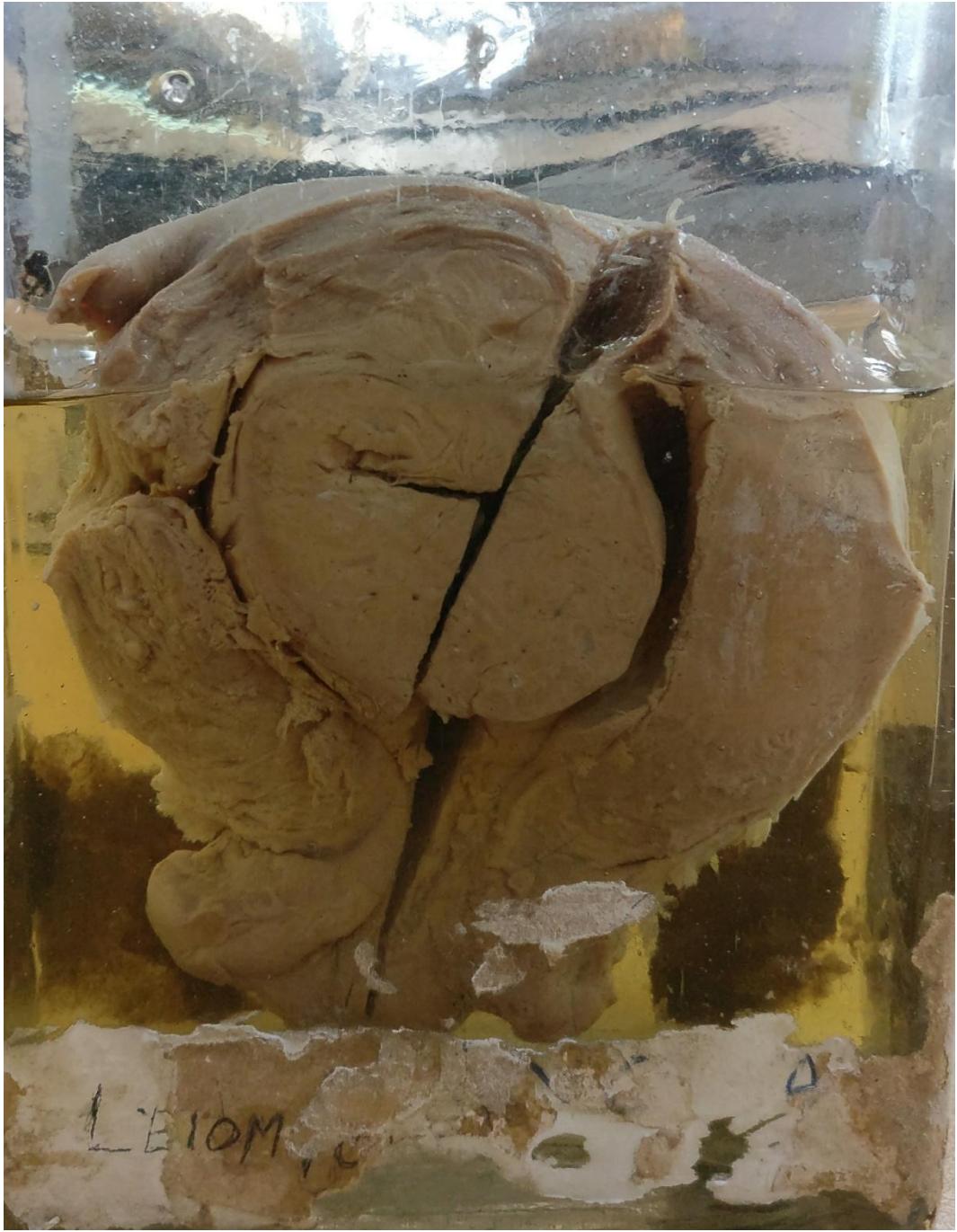
1. THIS IS CUT OPEN HYSTERECTOMY SPECIMEN WITH CUT SECTION SHOWING MASS OF GRAPE LIKE VESICLES - PROBABLY VESICULAR MOLE
2. CHARACTERISED BY HYDROPIC SWELLING OF THE MAJDRITY OF VILLI. (ENLARGED, EDEMATOUS VILLI)
3. SWOLLEN VILLI MAY RANGE FROM FEW mm TO 3cm IN DIAMETER (AVERAGE ABOUT 1.5cm)
4. CLASSIC APPEARANCE OF HYDROPIC VILLI - DELICATE, FRIABLE MASS OF THIN WALLED, TRANSLUCENT, CYSTIC GRAPE LIKE STRUCTURES.
5. ASSOCIATED WITH INCREASED RISK OF PERSISTENT TROPHOBLASTIC DISEASE .



DERMOID CYST

DERMOID CYST

1. THIS IS HYSTEROSALPINGO-OOPHORECTOMY SPECIMEN WITH CYSTIC MASS ATTACHED TO OVARY.
2. CYSTIC MASS SHOWING UNILOCULATED CAVITY FILLED WITH HAIR; ARISING FROM THE WALL AND PROJECTING INTO THE CAVITY IS A PROTRUBERANCE (ROKITANSKY/DERMOID PROTRUBERANCE) FROM WHICH TEETH & BONE ARE ARISING.
3. SO THIS IS MOSTLY MATURE CYSTIC TERATOMA/DERMOID CYST.
4. THE TUMOR COMPOSED OF WELL DIFFERENTIATED DERIVATIVES OF 3 GERM LAYERS - ECTO, MESO & ENDODERM WITH ECTODERMAL ELEMENTS PREDOMINATING.
5. COMPRISSES 20% OF ALL OVARIAN NEOPLASMS.
6. VARIES IN SIZE FROM VERY SMALL (0.5cm) - LARGE (up to 40cm) BUT >90% ARE <15cm.



LEIOMYOMA

LEIOMYOMA

1. THIS IS HYSTERECTOMY SPECIMEN WITH LUMEN FILLED SHARPLY CIRCUMSCRIBED, ROUND, FIRM , GRAY-WHITE MASS WITH CUT SECTION OF WHORLED APPEARANCE - PROBABLY LEIOMYOMA .
BY ~~WHTH~~
2. LEIOMYOMA - BENIGN SMOOTH MUSCLE NEOPLASM, THAT MAY OCCUR SINGLY, BUT MORE OFTEN ARE MULTIPLE .
3. CAN OCCUR - WITHIN THE MYOMETRIUM (INTRA MURAL)
- JUST BENEATH THE ENDOMETRIUM (SUB MUCOSAL)
- BENEATH THE SEROSA (SUB SEROSAL)