

HISTORY

Pneumonectomy.

Left pneumonectomy. Left lung cancer. Left lower lobe crossing fissure into lingula.

MACROSCOPIC

Four specimens received.

The specimen is labelled "left lung" and comprises a left lung, 240 x 170 x 40 mm in the fresh state. A 30 mm length of bronchus protrudes from the hilum. There is an area of induration and puckering on the lateral aspect of the pleura of the lower lobe. There is also an area of induration and puckering in the interlobar fissure. A further area of induration is present posterolaterally on the upper lobe. A number of emphysematous bullae are present at the apex and in the anterior margin of the upper lobe. Serial parallel slicing through the lung parenchyma reveals a tumour mass approximately 65 mm in greatest diameter abutting the pleura of the lateral aspect of the lower lobe. This tumour has a fleshy, grey, somewhat mucoid, cut surface. Posteriorly it merges with adjacent lung parenchyma and its full extent is difficult to appreciate macroscopically. At its upper aspect, in the region of previously noted puckering in the interlobar fissure, tumour appears to cross into the upper lobe. There is extensive greyish-white consolidation extending from this point anteriorly into the lingula. It is unclear whether this represents tumour or infective consolidation. Beneath the area of puckering noted on the posterolateral aspect of the upper lobe, there is a separate area of parenchymal consolidation and possible fibrosis. The remainder of the upper lobe parenchyma appears emphysematous. In the lower segments of the lower lobe there is no evidence of emphysema and there is very little anthracosis. However, on the medial aspect, towards the diaphragmatic surface of the lung, there is an area of plaque-like pleural thickening approximately 10 mm in diameter and 2-3 mm in depth. [1A, bronchial resection margin and peribronchial lymph nodes; 1B, peribronchial lymph nodes; 1C-1E, tumour and overlying lateral pleura; 1F, tumour within interlobar fissure; 1G, lingular consolidation; 1H, subpleural consolidation and fibrosis in posterolateral aspect of upper lobe; 1I, representative upper lobe parenchyma; 1J, plaque-like pleural lesion from medial aspect of lower lobe].

2: The specimen is labelled "aortopulmonary window" and consists of three irregular reddish-brown pieces of fatty tissue which measure in aggregate 10 x 10 x 2 mm. [BIT, 2A].

3: The specimen is labelled "inferior pulmonary ligament" and consists of an ovoid-shaped piece of greyish-black tissue, 12 x 7 x 5 mm, which has a smooth outer surface and is covered in a small amount of fat. [Bisected and BIT, 3A].

4: The specimen is labelled "lymph node" and consists of two irregular nodular pieces of tissue which have a slate-grey appearance. The larger piece measures 18 x 5 x 4 mm and the smaller piece measures 15 x 4 x 2 mm. [Each portion of tissue is BIT, 4A].

MICROSCOPIC

1: Sections show that the majority of the tumour comprises well-differentiated papillary adenocarcinoma. Focally there is stromal invasion by moderately differentiated adenocarcinoma with a more usual acinar architecture. Tumour abuts but does not invade the lateral pleura. However, at its superior aspect it does cross the interlobar fissure into the upper lobe (1F), and there is extensive contiguous infiltration of the lingula (1G). The abnormal area in the posterolateral aspect of the upper lobe (1H) is an entirely separate deposit of histologically identical papillary adenocarcinoma with adjacent fibroelastotic scarring and emphysema. This presumably represents a metastasis, although a synchronous primary tumour cannot be excluded. Definite vascular or lymphatic invasion is not identified in any of the sections, and none of the peribronchial lymph nodes contains metastatic adenocarcinoma. The plaque-like pleural lesion on the medial aspect of the lower lobe appears to represent artefactual diathermy injury.

2-4: Sections of each of the separately submitted lymph nodes show no evidence of metastatic adenocarcinoma.

SUMMARY

Left pneumonectomy:

Papillary adenocarcinoma of left lower lobe, 65 mm in diameter, crossing interlobar fissure into left upper lobe.

Separate focus of adenocarcinoma in left upper lobe.

No vascular or lymphatic invasion found.

No lymph node metastases.

Pathological stage T2 N0 ?M1.



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cc:

