Skin cut-up

Dictation:

Ellipse/disc of skin,
Length:.....mm
Breadth:.....mm
Depth:.....mm
Maximum diameter of lesion: .....mm or not discernible

THEN describe lesion eg Ulcerated, pigmented,

IF PIGMENTED/SUSPECTED MELANOMA:
Nodule: Absent or present (if present then size – Breadth.....mm, depth.....mm)
Border of lesion: Regular or irregular
Pigmentation of lesion: Uniform or Variable

Ink ALL excisions

If SUTURE then dictate – Suture at tip or long axis
DICTATE which colour is which margin (try and use the same colour each time).
BLOCK CODES – ALWAYS STATE which are tips, and if orientated which tip is in which cassette.

STATE if ALL TAKEN/SAMPLED/TIPS REMAIN

CUT UP Protocol

Primary excisions

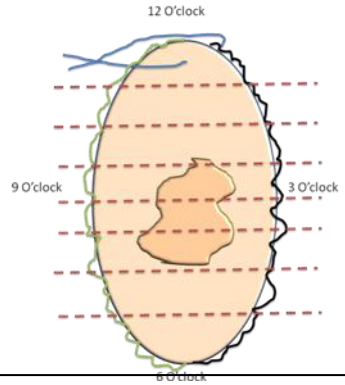
If less than 15mm in maximum dimension then TAKE ALL specimen in TRANSVERSE SECTIONS

If more than 15mm then sample lesion in TS (be generous if no lesion is seen) and **take tips ONLY if lesion is not visible.**

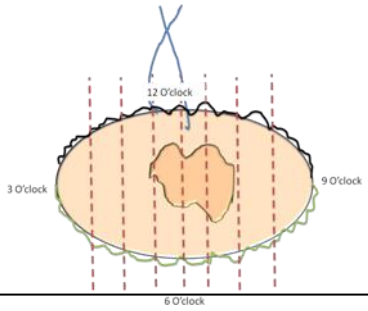
If orientated & suture at tip then designate 12 O'clock, ink 3 O'clock one colour and 9 O'clock another. If tips need to be taken then place cut in one tip and dictate which and put both in one cassette.

If suture on long axis – designate this 12 O'clock – ink 12 O'clock margin one colour and 6 O'clock another. If tips need to be taken then put 3 and 9 O'clock tips in one cassette cutting one tip and dictating which. **If tips are not required still cut one** and dictate which just in case need to embed later.

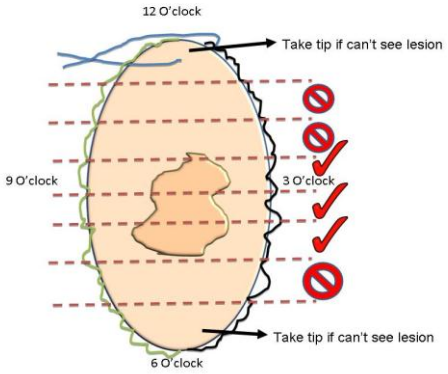
Suture at tip



Suture at long axis

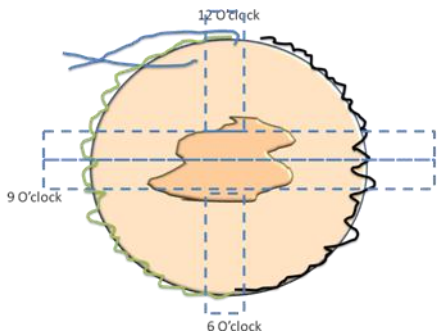


If more than 15mm long then don't take perilesional skin, just sample lesion. If no lesion is identifiable then take tips.



If DISC of skin >20mm or large specimen then CRUCIATES of margins can be better than shaving the tips in transverse sections. You can place 12 O'clock and one transverse in one cassette and 6 O'clock and another transverse in another to save blocks, but dictate which block contains which cruciate.

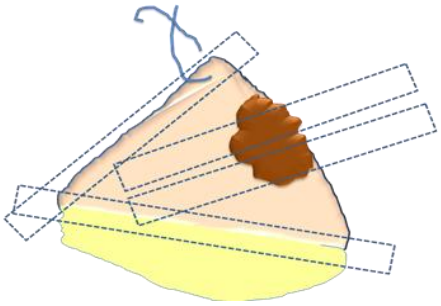
Discs of skin >20mm can be cruciated,



Cutting a tip, make sure the epidermis is cut nearly all the way to the tip

Wedge excisions (normally ears)

These need to be described as wedge excisions, and measured. Ink in one colour even if orientated, take a 2mm sliver from one margin and place in a cassette and a 2mm sliver from the other margin and place in another cassette – dictating which margin is in which cassette. Then cut lesion transversely.



Wedge excision of ear, take margins first then transverse sections of lesion.

WIDE LOCAL EXCISIONS FOR MELANOMA

If original lesion was completely excised then take 2 TS through scar.

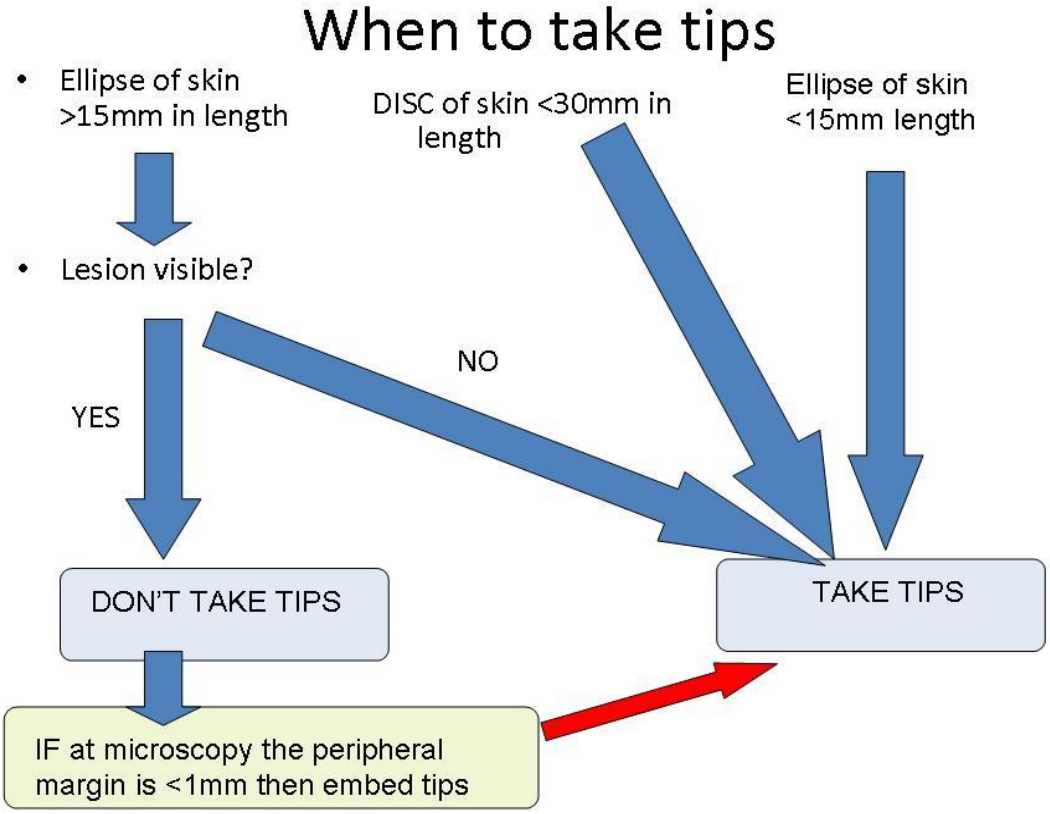
If original lesion was not completely excised then take whole of scar – tips not required (can take these later if required)

If nothing on computer then take 2 TS through scar but state in macro – "No previous specimen details available – presumed previous complete excision – minimal sampling performed"

If LENTIGO MALIGNA – previously – then sample more extensively.

RE-EXCISIONS eg for SCC/BCC

Deal with these in same way as for primary excisions ie <15mm take all, >15mm then take tips and sample central area (often only a scar to see).



Reference: Adamczyk L, Simpkin A, Oxley J. What is the point of tips? J Clin Pathol. 2014 Jan;67(1):40-4.
http://jcp.bmj.com/content/early/2013/08/12/jclinpath-2013-201802