SOFT TISSUE SARCOMA

CLINICAL CASE PRESENTATION

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INCA INSTITUTO NACIONAL DE CÂNCER

FONDAZIONE IRCCS ISTITUTO NAZIONALE DEI TUMORI

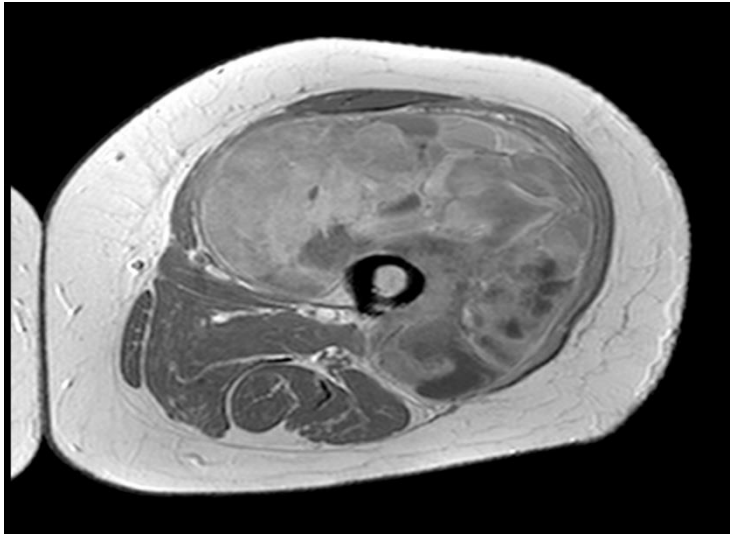
DISCLOSURES

Nothing to declare

Female, 54 years-old

ECOG PS 0

November 2014: evidence of left thigh soft tissue mass, 22 cm



ECOG PS, Eastern Cooperative Oncology Group performance status; STS, soft tissue sarcoma

Q1. Which one would be your first approach to do the diagnosis in this case?

1- Tru-cut biopsy

2- Fine needle aspiration

3- Open biopsy

4- Excisional biopsy

5- Surgery

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ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

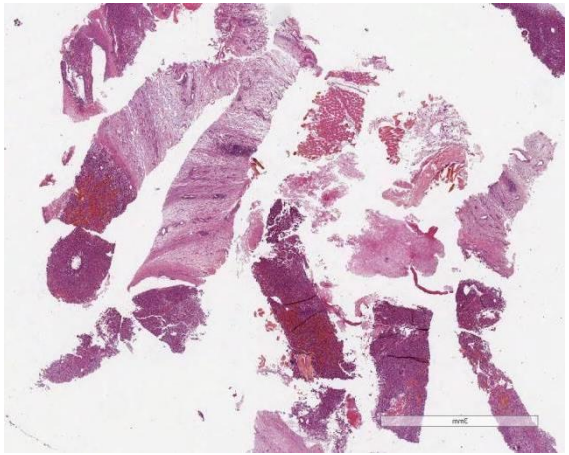
Annals of Oncology 0 (Supplement 0): iv1–iv17, 2018
doi:10.1093/annonc/mdy096

CLINICAL PRACTICE GUIDELINES

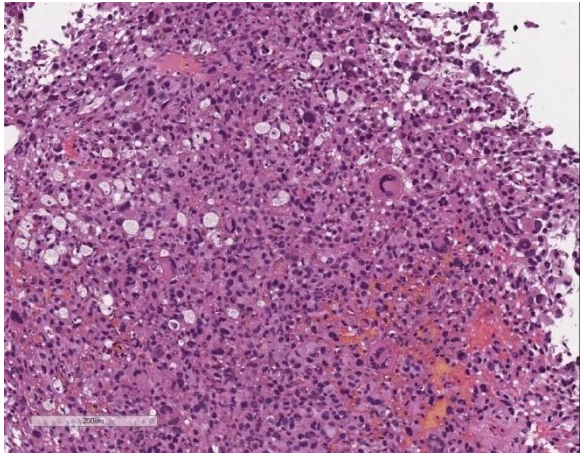
Soft tissue and visceral sarcomas: ESMO–EURACAN Clinical Practice Guidelines for diagnosis, treatment and follow-up†

Following appropriate imaging assessment, the standard approach to diagnosis consists of multiple core needle biopsies, possibly by using ≥14–16 G needles. However, an excisional biopsy may be the most practical option for < 3 cm superficial lesions. An open biopsy may be another option in selected cases, as decided within reference centres. An immediate evaluation of tissue viability may be considered to ensure that the biopsy is adequate at the time it is carried out. However, a frozen-section technique for immediate diagnosis is not encouraged, because it does not allow a complete diagnosis, particularly when neoadjuvant (preoperative) treatment is planned. Fine needle aspiration is used only in some institutions that have developed specific expertise on this procedure and is not recommended outside these centres. A biopsy may underestimate the tumour malig-

Core biopsy: High-grade pleomorphic sarcoma



CT scan: no evidence of distant metastases



CT, computed tomography

High grade pleomorphic sarcoma, 22 cm, deeply located

Q2. Which is the risk of distant recurrence?

1- < 10%

2- 10-50%

3- 50-90%

4- 100%

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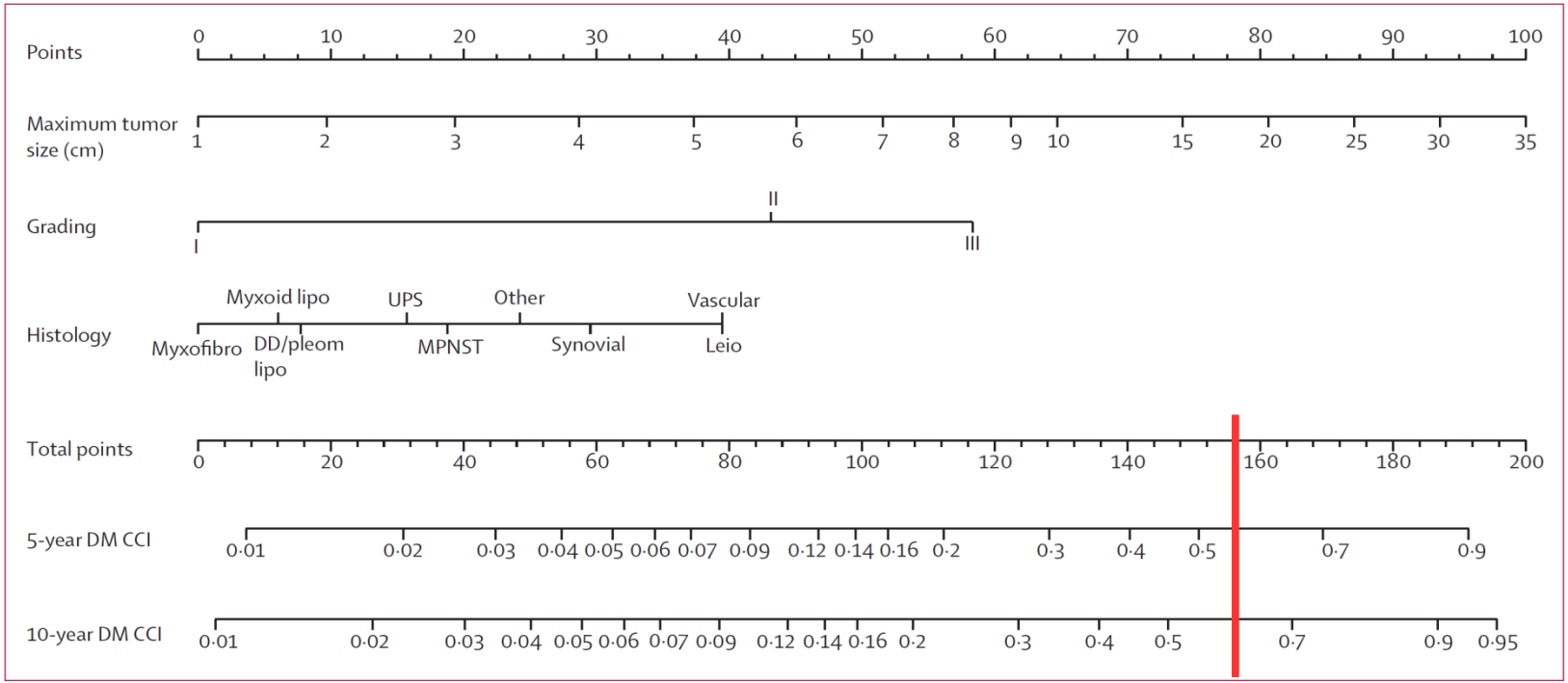
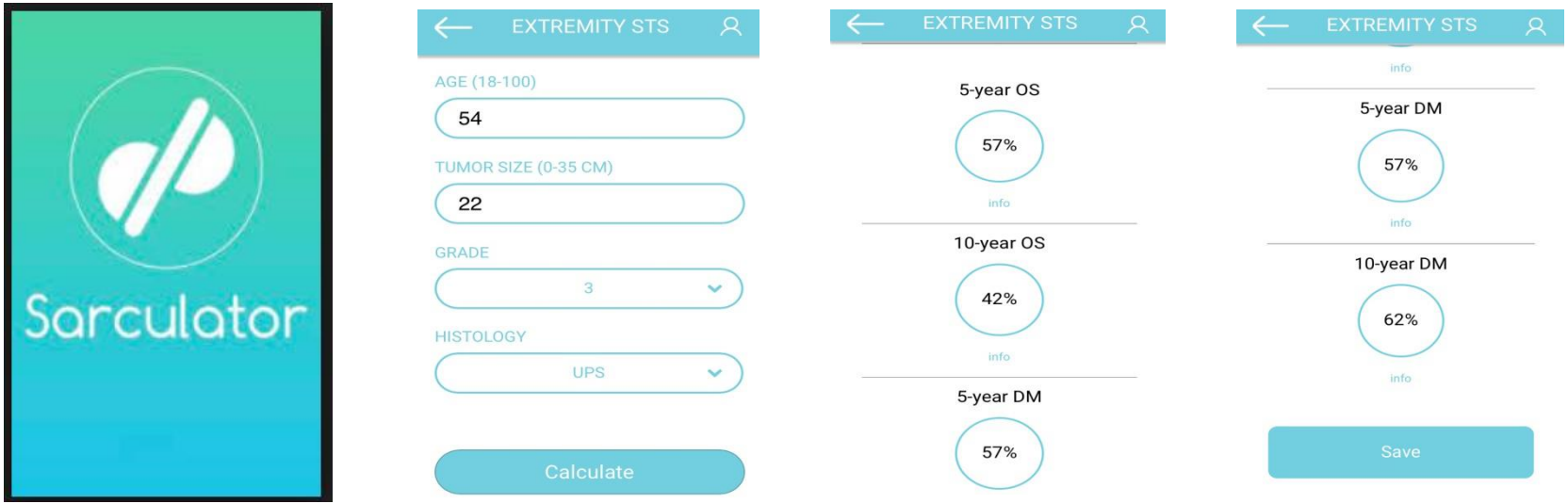


Figure 3: **Distant metastases nomogram**

Callegaro D et al. Lancet Oncol 2016



Callegaro D et al. Lancet Oncol 2016

DM, distant metastases; OS, overall survival; UPS, undifferentiated pleomorphic sarcoma

Q3. How would you treat?

1- Surgery alone

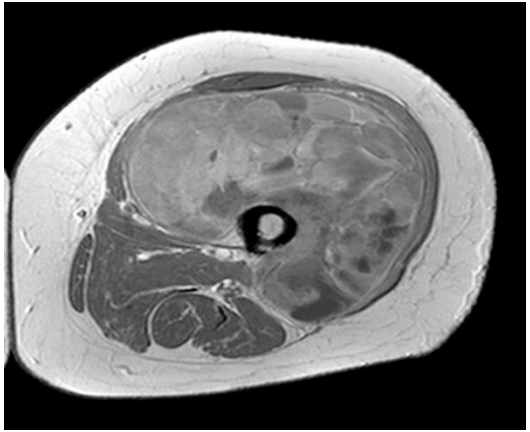
2- Surgery → RT

3- Surgery → Chemo/RT

4- Chemo → Surgery → RT

5- Chemo/RT → Surgery

*Resection feasible



Chemo, chemotherapy; RT, radiotherapy

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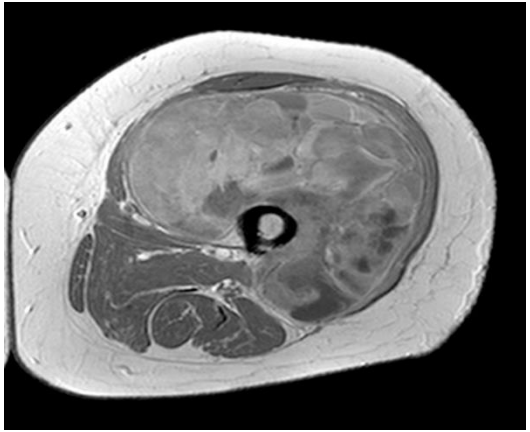

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Management of local/locoregional disease (see Figures 1 and 2)

Surgery is the standard treatment of all patients with an adult type, localised STS. It must be carried out by a surgeon specifically trained in the treatment of this disease. The standard surgical procedure is a wide excision with negative margins (no tumour at the margin, R0). This implies removing the tumour

The typical wide excision is followed by radiotherapy (RT) as the standard treatment of high-grade (G2–3), deep, >5 cm lesions [II, B] [11–13]. RT is not given in the case of a currently

RT, radiotherapy

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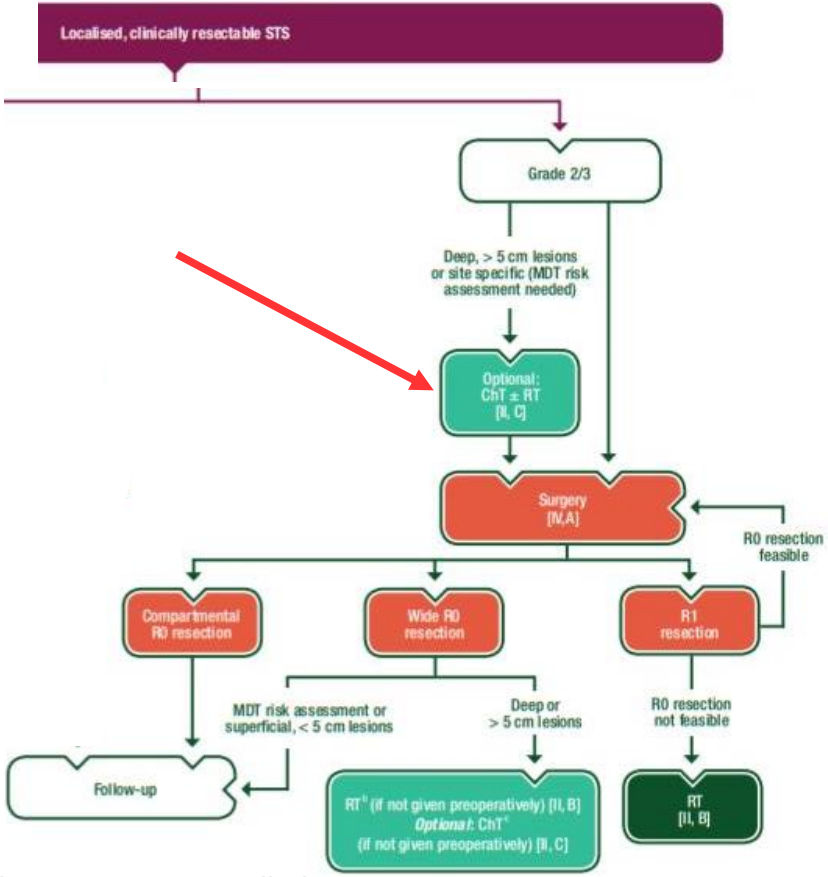
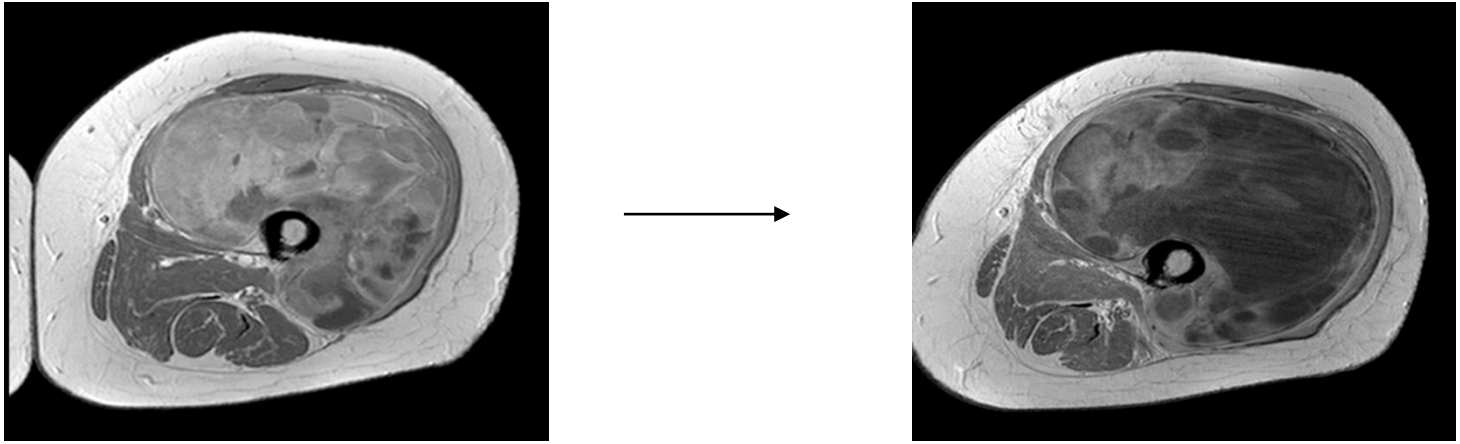


ChT, chemotherapy; MDT, multidisciplinary team; RT, radiotherapy

3 cycles of epirubicin/ifosfamide (120 mg/m^2 + 9 g/m^2 21 days) + RT (50 Gy):



RT, radiotherapy

Q4. What would you do next?

1- Surgery

2- Chemo

3- Isolated limb perfusion

4- Surgery → Radiotherapy

5- Chemo → Surgery

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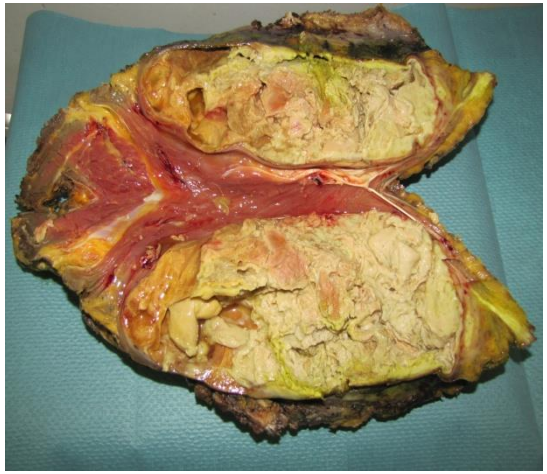
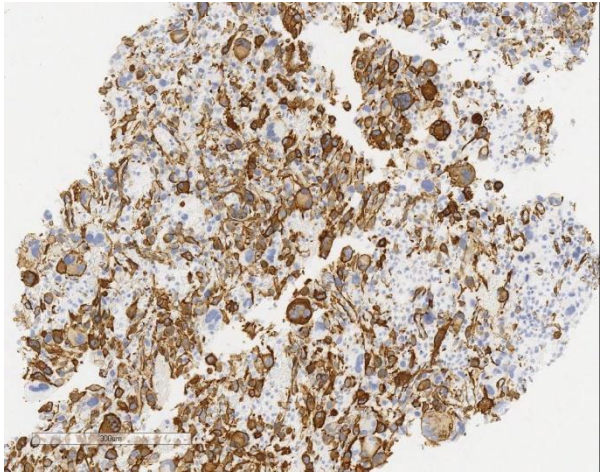
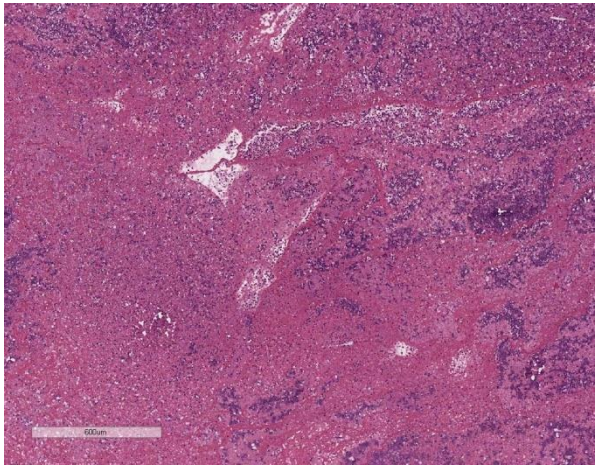
Surgery after six weeks:







Q5. What would you do next?

1- Follow up

2- Adjuvant chemotherapy

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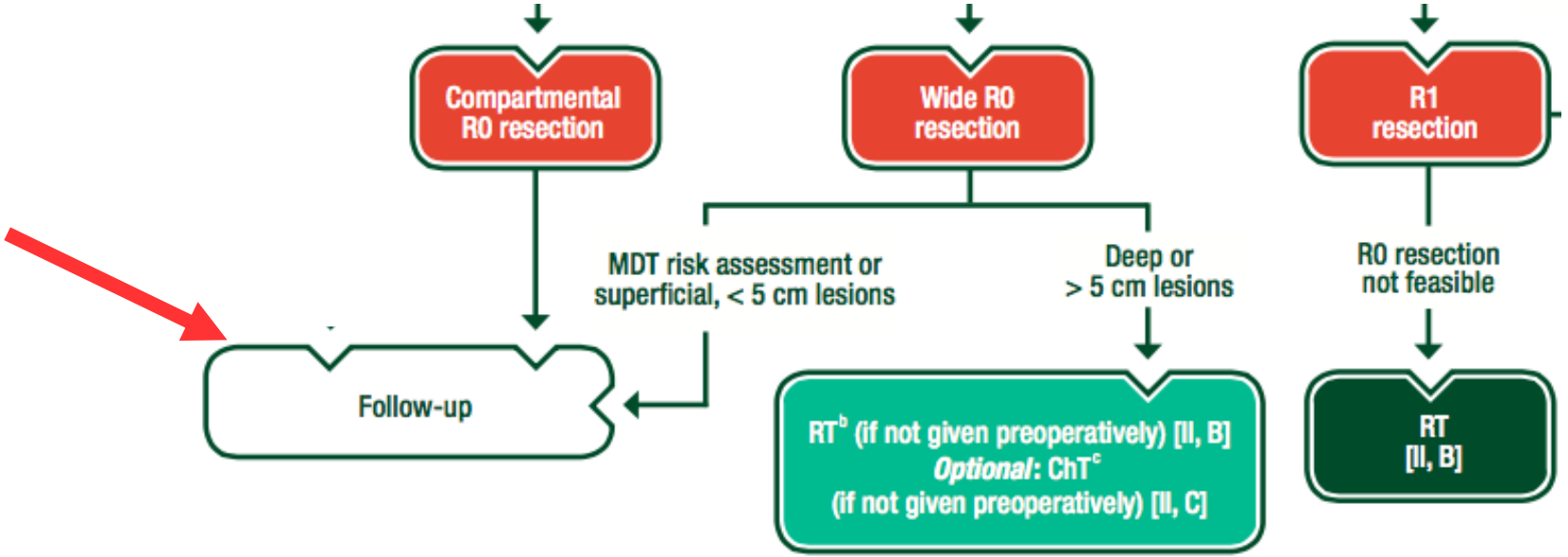

esmo.org

ChT, chemotherapy; MDT, multidisciplinary team; RT, radiotherapy

Follow up:

After 3 years → no evidence of disease

Thank you!

Obrigada!

Grazie!