SOFT TISSUE SARCOMA

CLINICAL CASE PRESENTATION

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

1- Tru-cut biopsy
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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
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%
High grade pleomorphic sarcoma, 22 cm, deeply located

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Figure 3: Distant metastases nomogram

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
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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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 [11, 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/m² + 9 g/m² 21 days) + RT (50 Gy):
Q4. What would you do next?

1- Surgery
2- Chemo
3- Isolated limb perfusion
4- Surgery → Radiotherapy
5- Chemo → Surgery
Q4. What would you do next?

1- Surgery
2- Chemo
3- Isolated limb perfusion
4- Surgery → Radiotherapy
5- Chemo → Surgery
Surgery after six weeks:
Q5. What would you do next?

1- Follow up

2- Adjuvant chemotherapy
Q5. What would you do next?

1- Follow up

2- Adjuvant chemotherapy
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- **Compartamental RO resection**
  - MDT risk assessment or superficial, < 5 cm lesions
  - Follow-up

- **Wide RO resection**
  - Deep or > 5 cm lesions
  - RT\(^{b}\) (if not given preoperatively) [II, B]
  - Optional: ChT\(^{c}\)
  - (if not given preoperatively) [II, C]

- **R1 resection**
  - RO resection not feasible
  - RT [II, B]

ChT, chemotherapy; MDT, multidisciplinary team; RT, radiotherapy
Follow up:

After 3 years → no evidence of disease
Thank you!

Obrigada!

Grazie!