Sarcoma Update

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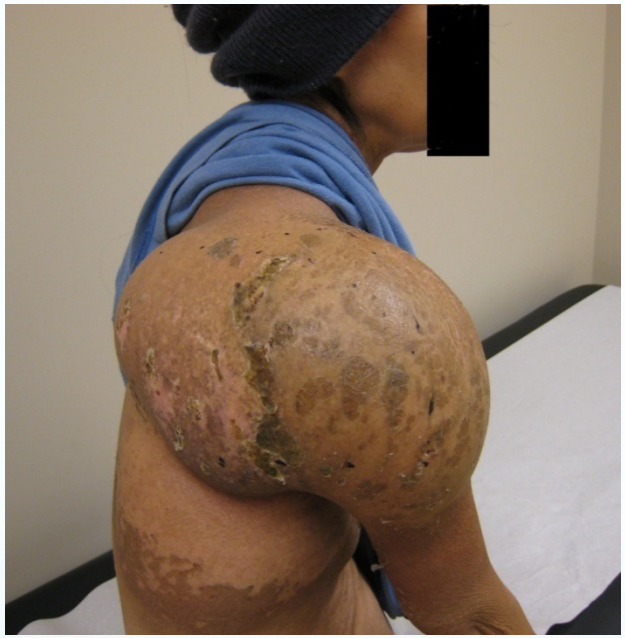
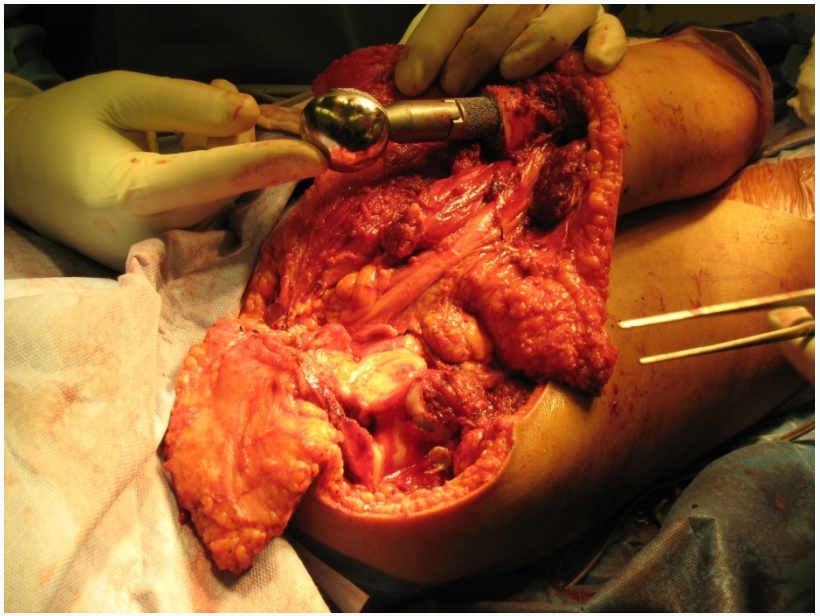
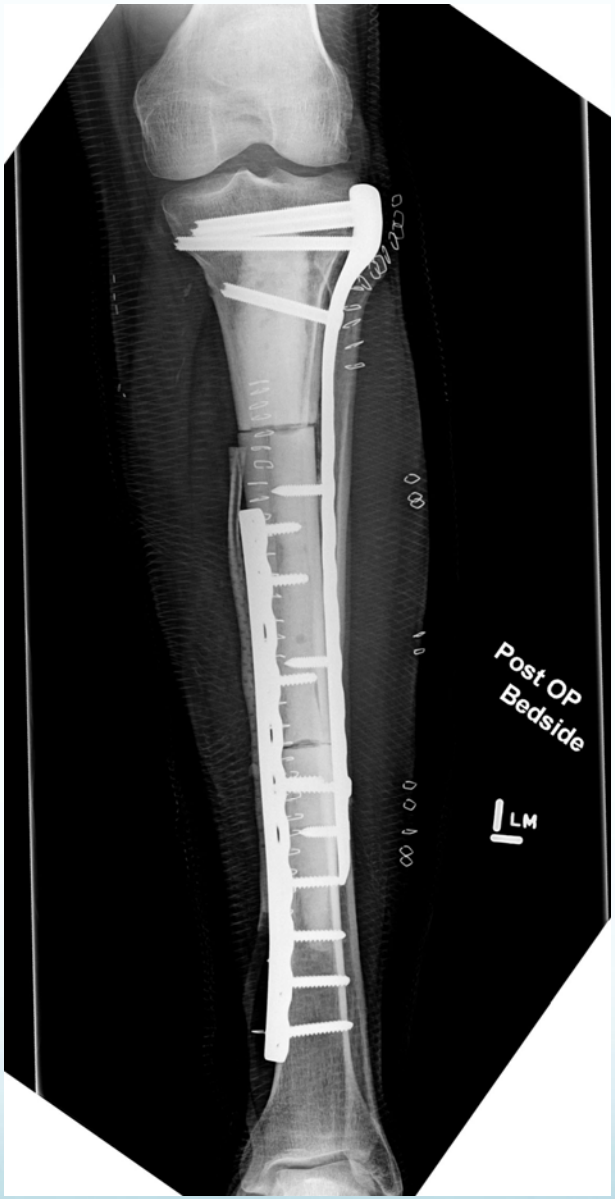
Introduction

- Extremity Sarcoma Service
- Myself and Bas Masri
- 200 Sarcomas per year
- Monday clinic every week
- Multidisciplinary service



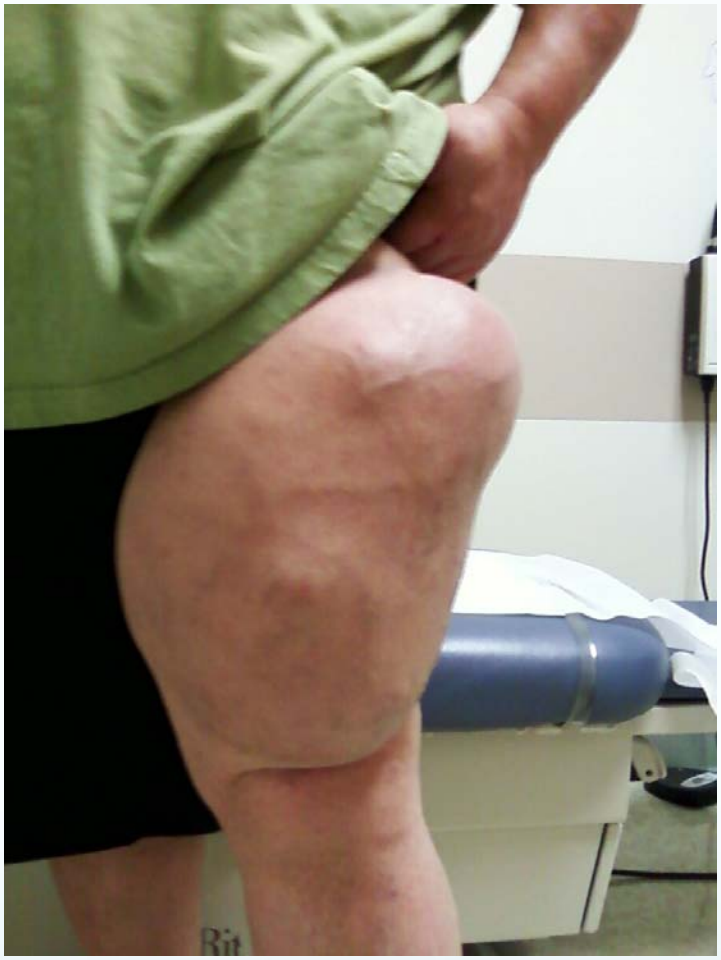



Post OP
Bedside
LM

Problem

- Significant % of patients
  - Delay in diagnosis
  - Inappropriate surgery
  - Compromises Limb Salvage
  - Requires more RT/Chemo/Amputations

- BUT – huge overlap between benign and malignant



Presentation

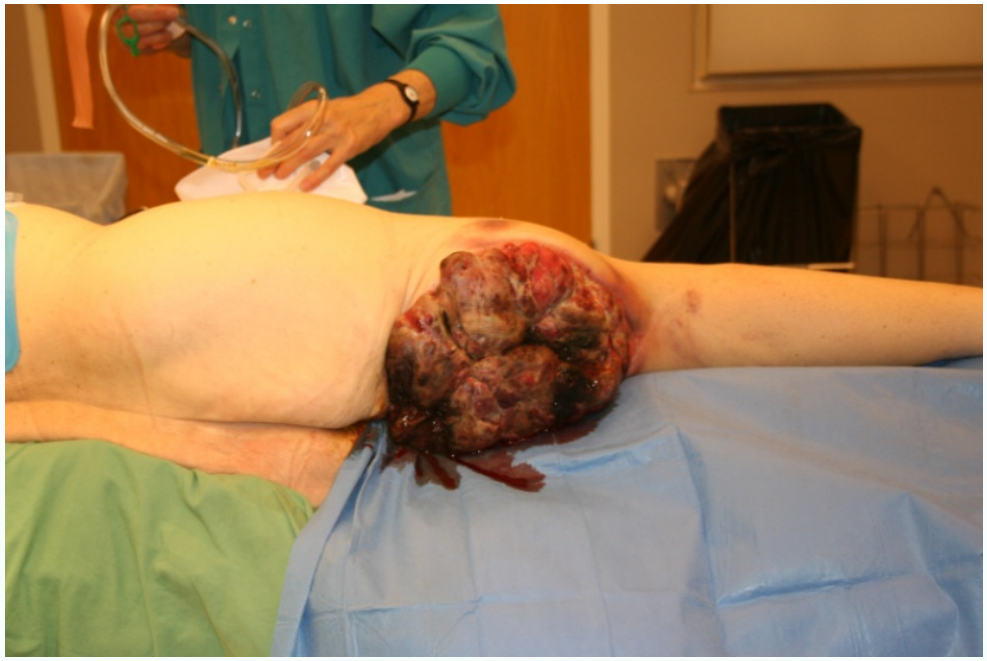
- Present as
  - Mass
  - 8mm up to 50cm or more
  - Painless or painful
  - Grow slowly or quickly
  - Soft or firm or hard

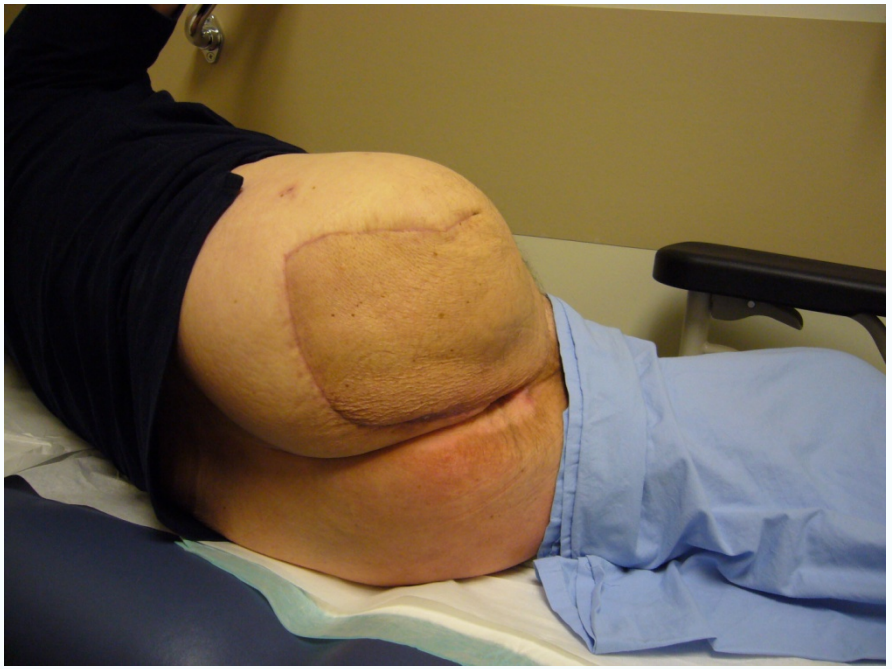
Presentation

- Suspicious if:
  - >5cm
  - Growing
  - Deep to the fascia
- Look for systemic conditions
  - NF
  - Family History Li Fraumeni

Presentation

- Tips
  - Ganglions get bigger and smaller, Sarcomas don't
  - Spontaneous Hematomas Don't Happen
    - Mythical Creatures
    - Have to have trauma/coagulopathy/etc
    - Large sarcomas can be completely necrotic





Workup

- Clinical Examination
- Ultrasound
  - Very non-specific
  - Guide you to size and depth
  - Monitor over time

Workup

- USS = “Sarcoma cannot be excluded”
  - Radiologists can be wusses at times
  - Correlate with clinical suspicion
    - If high – go to MRI or refer
    - If low – repeat test in 8 weeks
      excise it if <5cm

Workup

- MRI
  - Gold standard
  - Expensive/access issues
  - Gives you
    - Is it a lipoma or not
      - Definitive in superficial lesions
      - Could still be a WDLS if deep and large
    - Anatomy for surgical planning
    - Extent of infiltration

Workup

- MRI Guidelines
  - All lesions >5 cm
  - All deep lesions
  - All rapidly growing lesions

(I do MRI for everything – my pre-test probability is >70%)

Workup

- MRI ?before referral
  - If you can – do it!
  - But don’t delay by > a week or two

Biopsy

Having the Correct Diagnosis Never Impedes Management

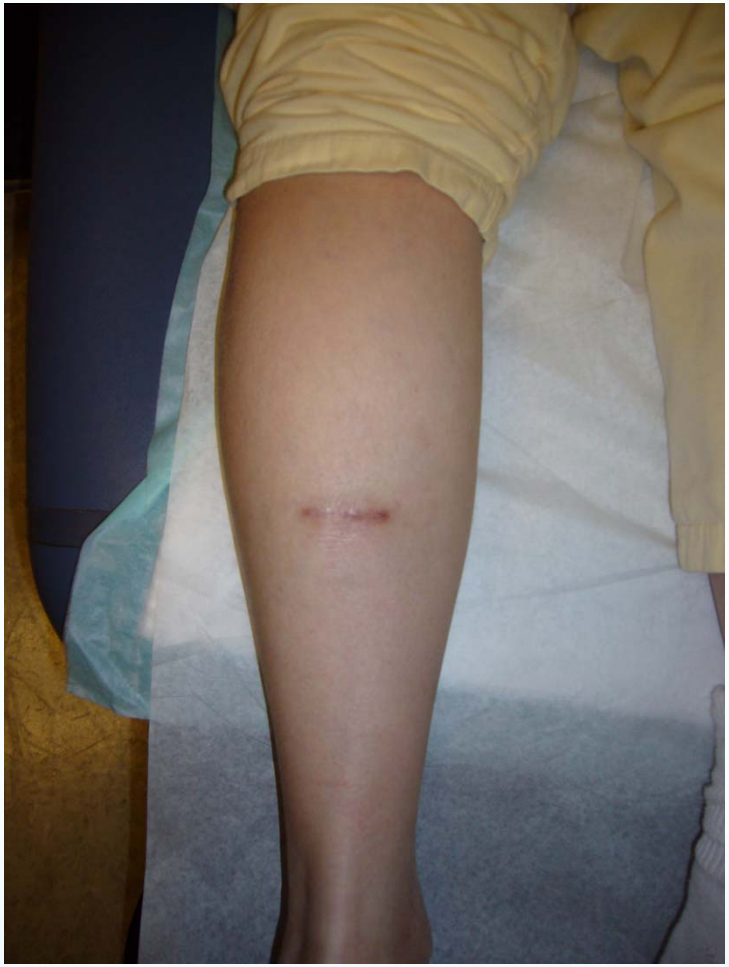
(Clarkson's First Law)

Biopsy

- Tract Contamination
  - Very transplantable
  - Compromise Limb Salvage
  - Superficial Lesions:
    - In line with the mid-point of the lesion
    - Enter distally, fire up proximally
  - Deep Lesions:
    - We prefer to do these – not obvious
    - Go through the EDGE of a muscle

Biopsy

- FNA
  - 50% accuracy. So toss a coin instead
- Core Biopsy
  - Requires experienced pathologist
  - 98% accuracy
  - Make sure leave a scar
- Open Biopsy
  - If needs an open biopsy – refer it.



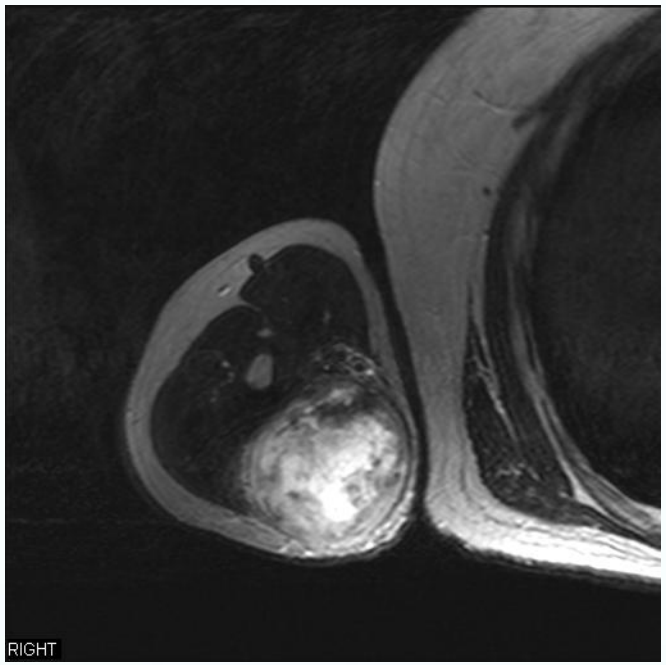
Straight to Excision

- Safe When
  - Small (<5cm)
  - Slow growing/stable
  - Superficial
  - Longitudinal Incision

Straight to Excision

- If follow guidelines
  - Will still get occasional sarcomas
  - BUT
    - Easy to re-excise
    - Small superficial lesions = >95% cure rate

Some Cases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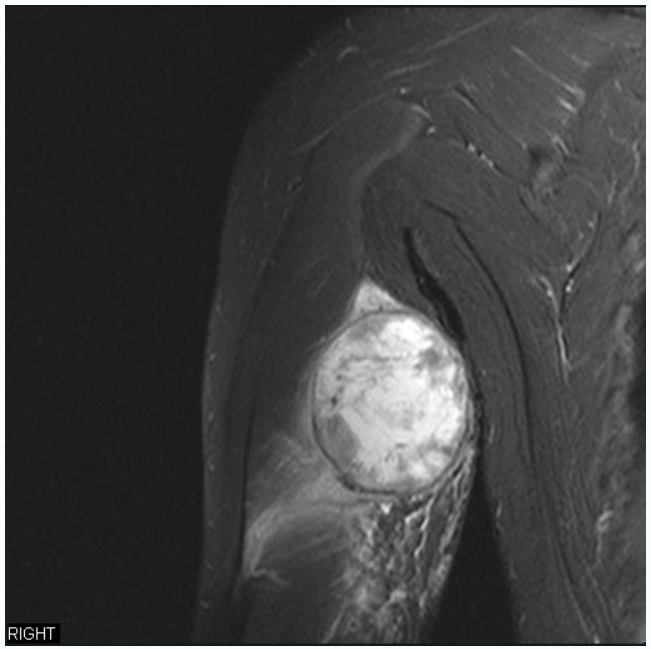
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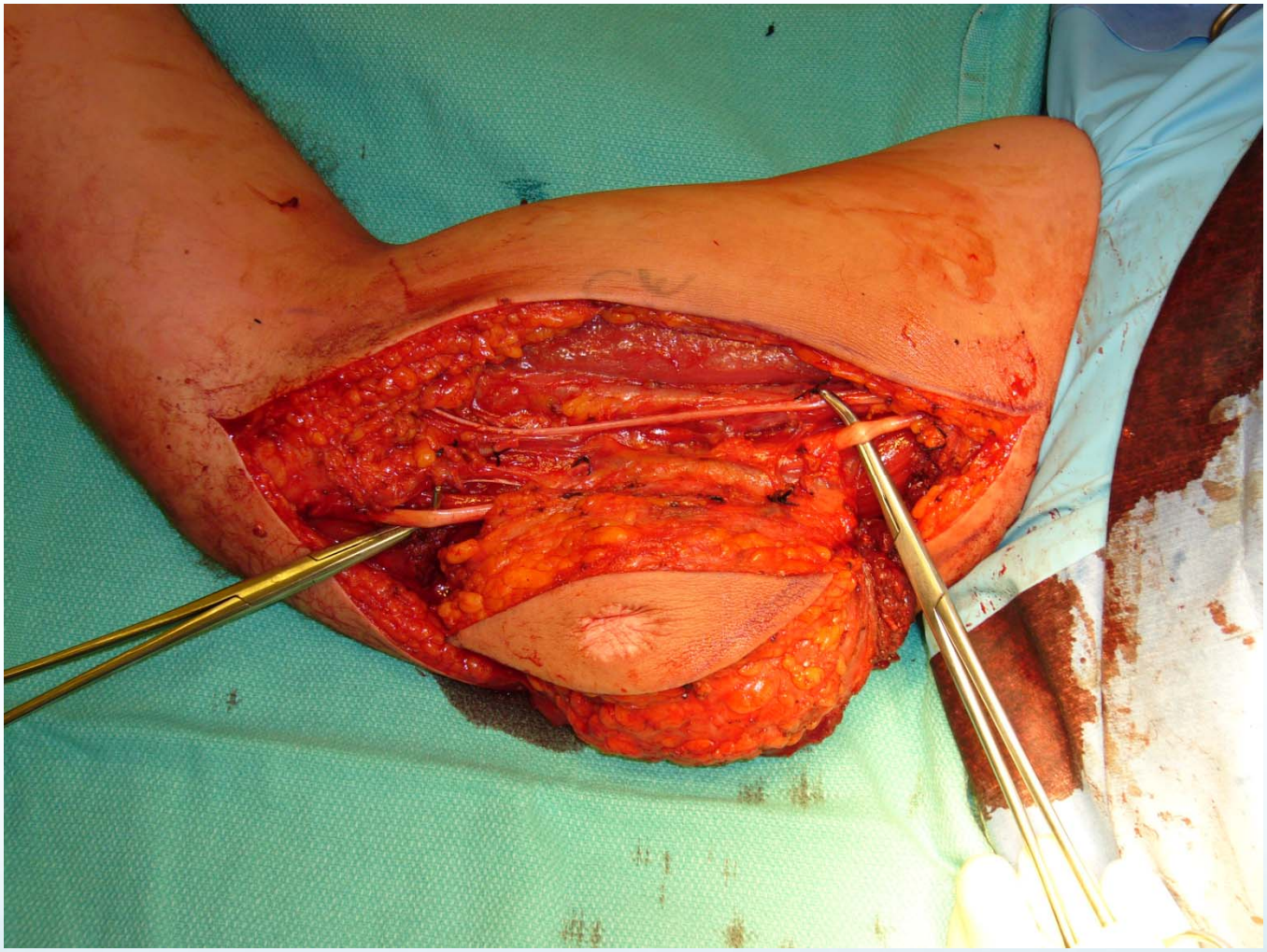

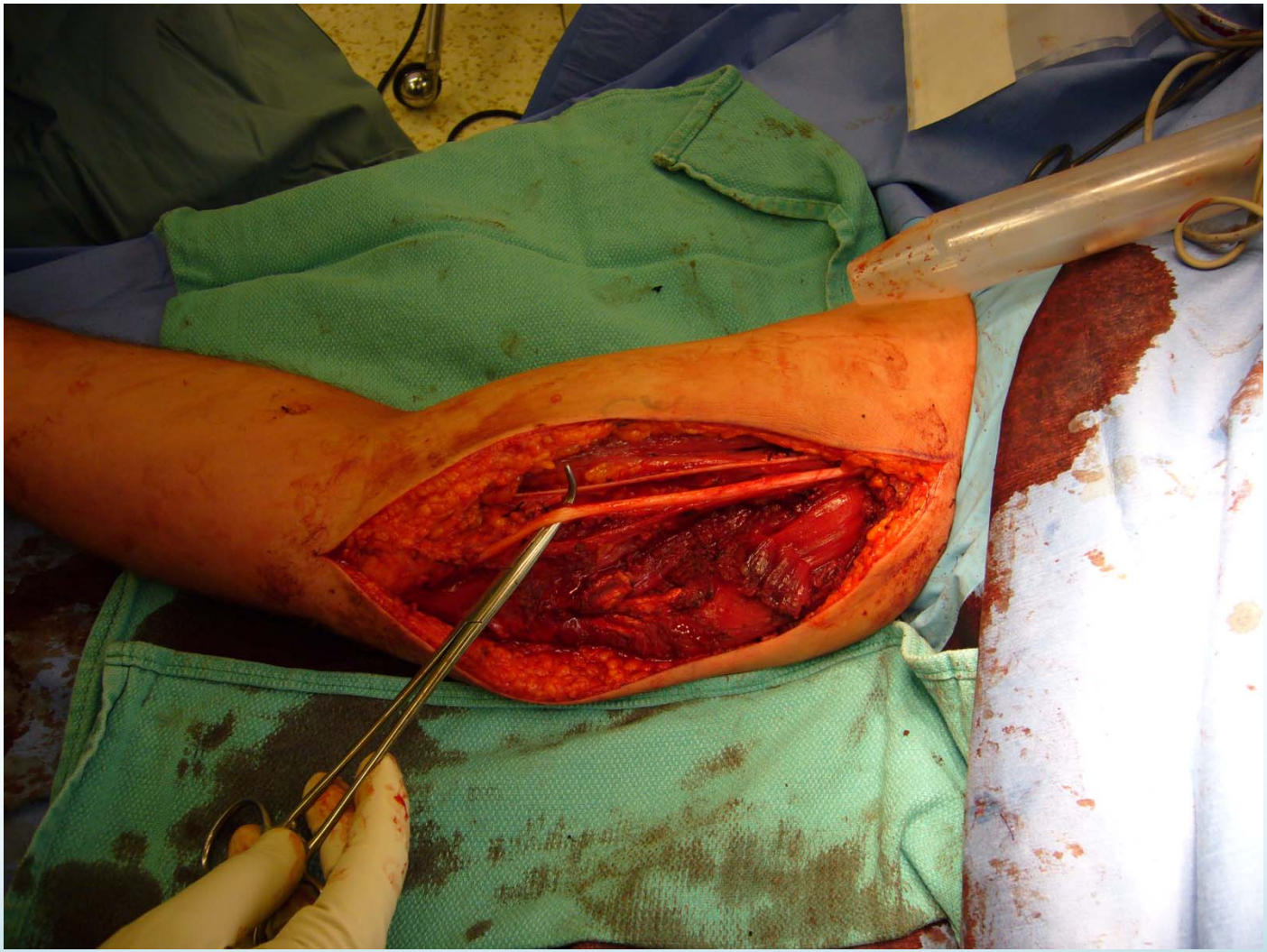

Summary

- Deep/Large/Growing = Bad
- Excise if <5cm/superficial/stable
- MRI for suspicious lesions

- We are happy to review cases