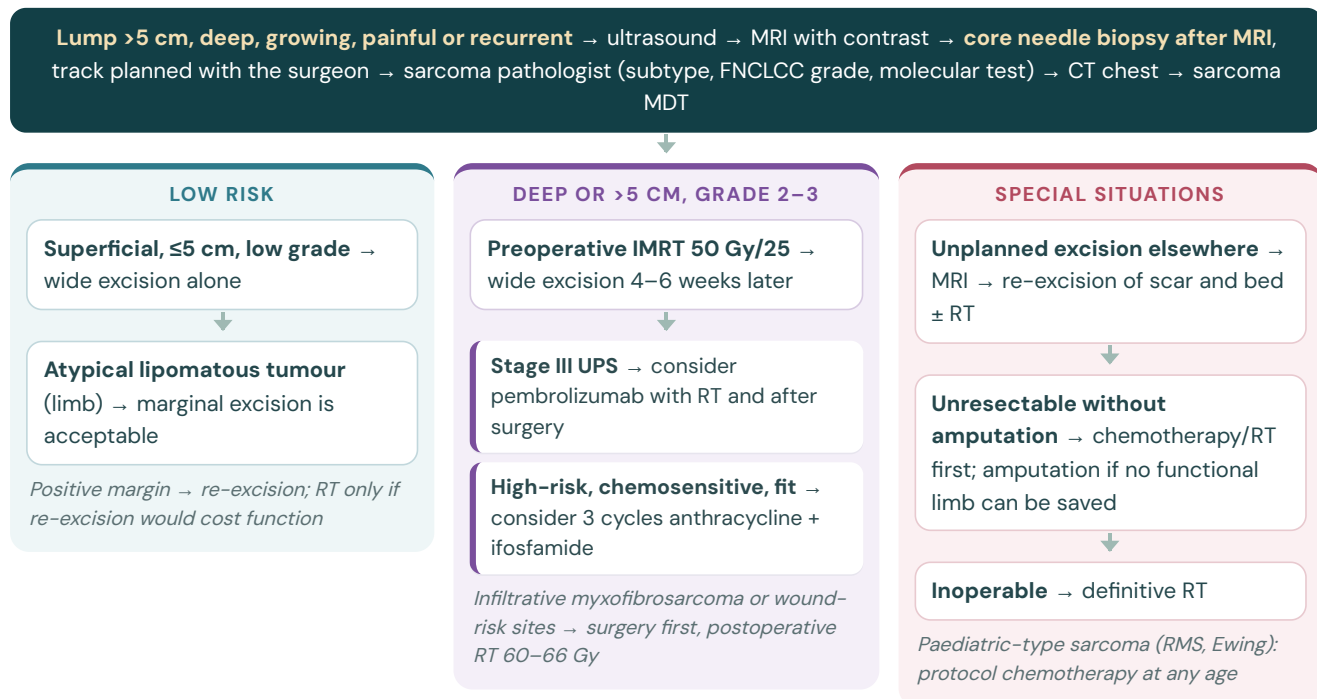


Sarcoma: Soft tissue mass of the limb or trunk

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MD, DM · Senior Medical Oncologist & Hemato-Oncologist



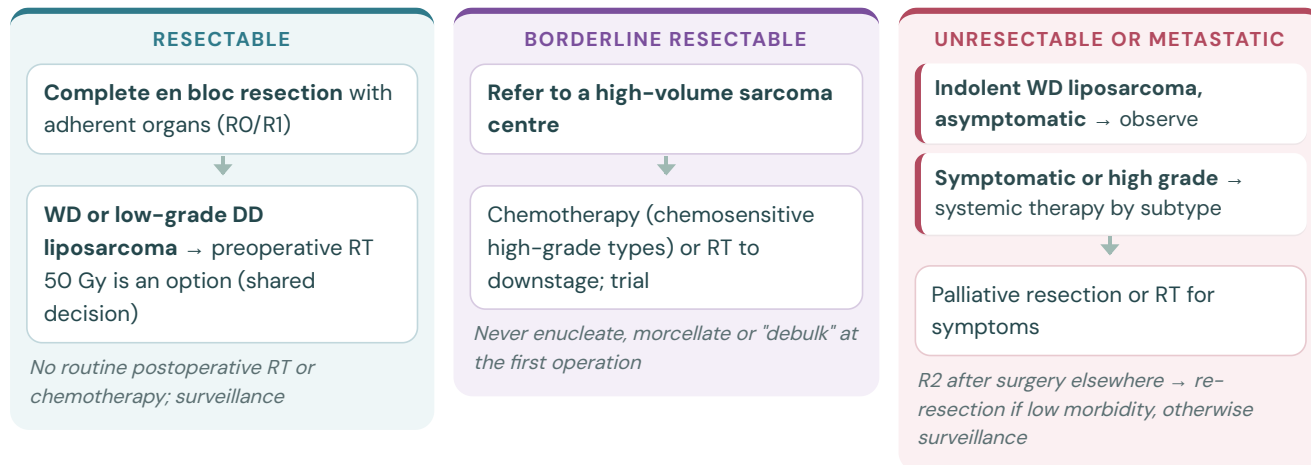
All patients: no excision before imaging · no FNAC-only diagnosis · plan flaps up front · physiotherapy and lymphoedema care · fertility counselling before chemotherapy · follow-up by stage (Figure in section O8).

Sarcoma: Retroperitoneal mass

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Retroperitoneal mass: CT chest–abdomen–pelvis · testicular examination, AFP, β -hCG, LDH if germ cell or lymphoma possible · **is it extravisceral and unifocal?** → sarcoma likely → percutaneous posterior core biopsy (unless classic WD liposarcoma for upfront surgery) → reference–centre MDT



Scan for life in liposarcoma (late local relapse; dedifferentiation can appear years later) · chest and liver imaging in leiomyosarcoma · check renal function before nephrectomy.

Sarcoma: Metastatic soft tissue sarcoma

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Metastatic STS: confirm subtype (expert pathology, molecular test, NTRK if relevant) · count and site of metastases · performance status · goals of care · trial?

OLIGOMETASTATIC

Lung only, few nodules, long interval, primary controlled → metastasectomy (VATS) or SBRT

Short interval or uncertain tempo → rescan in 6–8 weeks or chemotherapy first

No routine adjuvant chemotherapy after metastasectomy

NEEDS SYSTEMIC THERAPY

Most types → doxorubicin (± ifosfamide if response needed)

LMS → doxorubicin + trabectedin / dacarbazine

Angiosarcoma → weekly paclitaxel

PEComa → mTOR · NTRK → TRK inhibitor

Second line by subtype: gem-docetaxel, trabectedin, eribulin (liposarcoma), pazopanib (not adipocytic), immunotherapy (UPS)

INDOLENT OR FRAIL

Asymptomatic, slow → observe with scans

Frail → single agent (doxorubicin, or oral options) or best supportive care

Palliative RT for pain, bleeding or cord compression

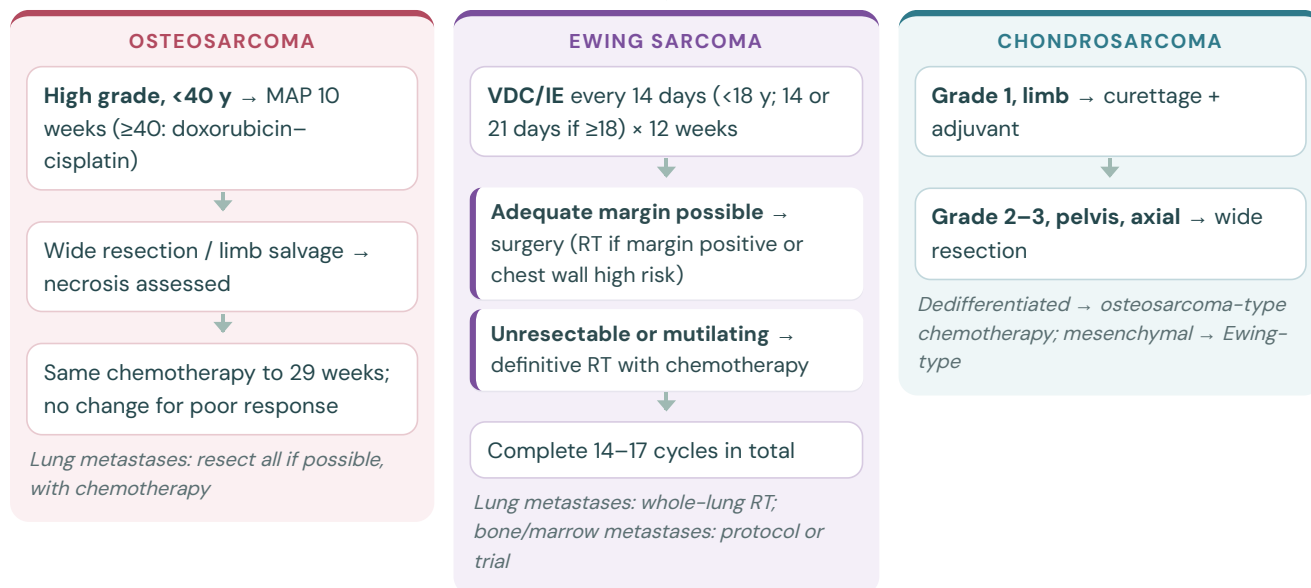
All patients: cumulative anthracycline dose and echo · fertility · VTE awareness · early palliative care · trial referral at every progression.

Sarcoma: Suspected bone sarcoma

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Persistent bone pain, swelling or aggressive X-ray → MRI whole bone · CT chest · PET-CT or bone scan → **biopsy at the treating centre** (core, track excisable) → histology + molecular (EWSR1) + culture if infection possible



All patients: no curettage of a suspected sarcoma as "infection" · fertility preservation · audiometry and echo · TP53 testing if young with family cancers · rehabilitation and school or work support.

Sarcoma: Follow-up and survivorship plan

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Before any cut

- MRI before biopsy for any deep or >5 cm lump
- Core needle biopsy along the future incision
- No excision of a "lipoma" without imaging
- Expert pathology and a molecular test
- CT chest for every sarcoma

Red flags to report

- New lump in or near the scar
- Cough, breathlessness or chest pain
- New bone pain, especially at night
- Fever or bleeding during chemotherapy
- Wound breakdown after preoperative RT

Do not forget

- Sperm banking or ovarian protection before chemotherapy
- Echo and lifetime anthracycline dose
- Audiometry and kidney tests after cisplatin/ifosfamide
- Physiotherapy and prosthesis care
- TP53, NF1, RB1 genetics when the history fits