

## **Management Summary**

### Primary Care Management

1. Soft Tissue Tumours
  - a. Detection
    - i. Can be any size, anywhere
    - ii. Be suspicious if >5cm, growing, and/or deep to the fascia
  - b. Investigation
    - i. MRI is the 'best', but expensive and not always necessary
    - ii. Ultrasound useful for locating or following a non-suspicious lesion
    - iii. Biopsy
      1. Core needle, not FNA
      2. Interpretation requires subspecialist pathology
  - c. Excision
    - i. Superficial, stable, or small lesions can be safely excised by generalists
      1. Use longitudinal incisions when possible
      2. Even if it is a sarcoma, re-resection is usually feasible
    - ii. If in doubt, biopsy first or consider referral
  - d. Referral
    - i. Multidisciplinary teams will review cases of suspected sarcoma prior to a pathologic diagnosis being made
2. Bone Tumours
  - a. Unexplained bone or joint pain for >6 weeks deserves an X-Ray!
  - b. Especially if <25 or >50 years of age
  - c. Plain X-Ray is the gold standard
  - d. Multidisciplinary teams will review any lesion suspicious on X-Ray

### Specialist Care Management

1. Multidisciplinary Teams
  - a. Patients have better outcomes for survival and function
  - b. Team members should have subspecialist expertise and training
  - c. Wide range of experts required to manage these tumours
  - d. Structured manner with conference review, etc.
2. Broad Treatment Principles
  - a. Benign Bone Tumours
    - i. Incidental lesions can be watched
    - ii. Aggressive lesions are usually treated surgically
  - b. Malignant Bone Tumours
    - i. Wide Resection Surgery, Chemotherapy and Radiation
    - ii. Treatment modality selection depends on tumour type and situation
  - c. Benign Soft Tissue Tumours
    - i. Often managed by non-specialists
    - ii. Some, e.g. fibromatosis, are complex
  - d. Malignant Soft Tissue Tumours
    - i. Wide Resection Surgery and Radiotherapy commonly used
    - ii. Chemotherapy remains controversial