London and South East Sarcoma Network
Shared Care Pathway for Soft Tissue Sarcomas Presenting to Site Specialised MDTs
Lung /chest wall sarcomas incl. pulmonary metastatectomy

Background

Sarcomas that arise in the lung *de novo* are extremely rare; however those arising in the chest wall are more common and may arise in bone or soft tissue. This guidance is to provide direction for the management of patients with lung/chest wall sarcomas that may present to the lung MDT, orthopaedic services or via primary or secondary care services. The guidance refers to the care of patients in the London and South East Sarcoma Network and therefore recognises that specialist services for soft tissue sarcomas are provided by the Sarcoma Unit at The Royal Marsden Hospital and the London Sarcoma Service provided through joint working of UCLH and RNOH. All bone sarcomas are managed by the London Sarcoma Service (see www.lsesn.nhs.uk and SAG Constitution for referral pathway for bone sarcomas).

The rarity of lung/chest wall sarcomas and the potential complexity of this surgery requires close co-operation between the sarcoma and referring MDT's. The first aim of this pathway is to ensure timely discussion between referring MDTs, the sarcoma MDT and the specialist sarcoma thoracic surgical service based at The Royal Brompton Hospital (RBH). A weekly video-conferenced MDM to discuss all sarcoma patients potentially requiring thoracic surgery takes place between clinicians from UCLH, RMH and RBH. All planned surgery will be performed by the RBH specialist sarcoma thoracic surgeons. All suspected primary bone sarcomas of the chest wall should be referred to the diagnostic service at RNOH (see www.lsesn.nhs.uk and SAG Constitution for pathway) and then discussed at the sarcoma thoracic MDT attended by members of the LSS sarcoma MDT for management to be decided.

Surgery alone may be performed in primary bone sarcomas where there is no known benefit for other modalities such as chondrosarcoma or small low grade soft tissue sarcomas in accordance with STS guidelines. In other cases combined modality treatment is indicated. Ewing's sarcomas and osteosarcomas arising from the chest wall/rib are well recognised and require close co-operation with the sarcoma MDT to ensure optimal combined modality therapy and appropriate timing of surgery.

Patients who may require pulmonary metastatectomy will be discussed at the sarcoma thoracic MDM and surgery undertaken at RBH. Palliative pleurodeses may be discussed at this meeting but may be undertaken with local thoracic surgical services if appropriate.

Principals

This guidance is being developed in accordance with the relevant measures in the Manual for Cancer Services: Sarcoma Measures and Manual for Cancer: Lung Measures. They are also written in accordance with the LSESN referral guidelines (see www.lsesn.nhs.uk) and the LSESN Patient Management Policy.

1) Referral

All lung/chest wall sarcoma patients presenting to a local lung MDT or secondary care should be referred to the sarcoma MDT nominated in the local network lung cancer operational policy. It is recommended that all suspected chest wall or lung sarcomas are referred through sarcoma diagnostic pathways (see www.lsesn.nhs.uk and SAG Constitution for pathways)

2) Review by Sarcoma MDT

a) Pathology

All sarcomas arising in the lung/ chest wall will have pathology review undertaken by the nominated specialist sarcoma pathology service (for details see MDT operational policies).

b) Management

Management of all new soft tissue sarcomas will be discussed with the sarcoma MDT. Early referral from the time of suspicion or biopsy is recommended. All new bone sarcomas will be referred at time of suspicion to the London Sarcoma Service for the diagnostic pathway and discussed at the sarcoma MDT. Discussion at the sarcoma thoracic MDT should then follow and referral to the RBH made in accordance with below.

3) Site of Definitive Treatment

Surgical excision should be performed at the designated sarcoma thoracic surgery centre (Royal Brompton Hospital). Discussion and close co-operation between the sarcoma and cardio-thoracic MDTs will take place to determine the appropriate timing for definitive excision.

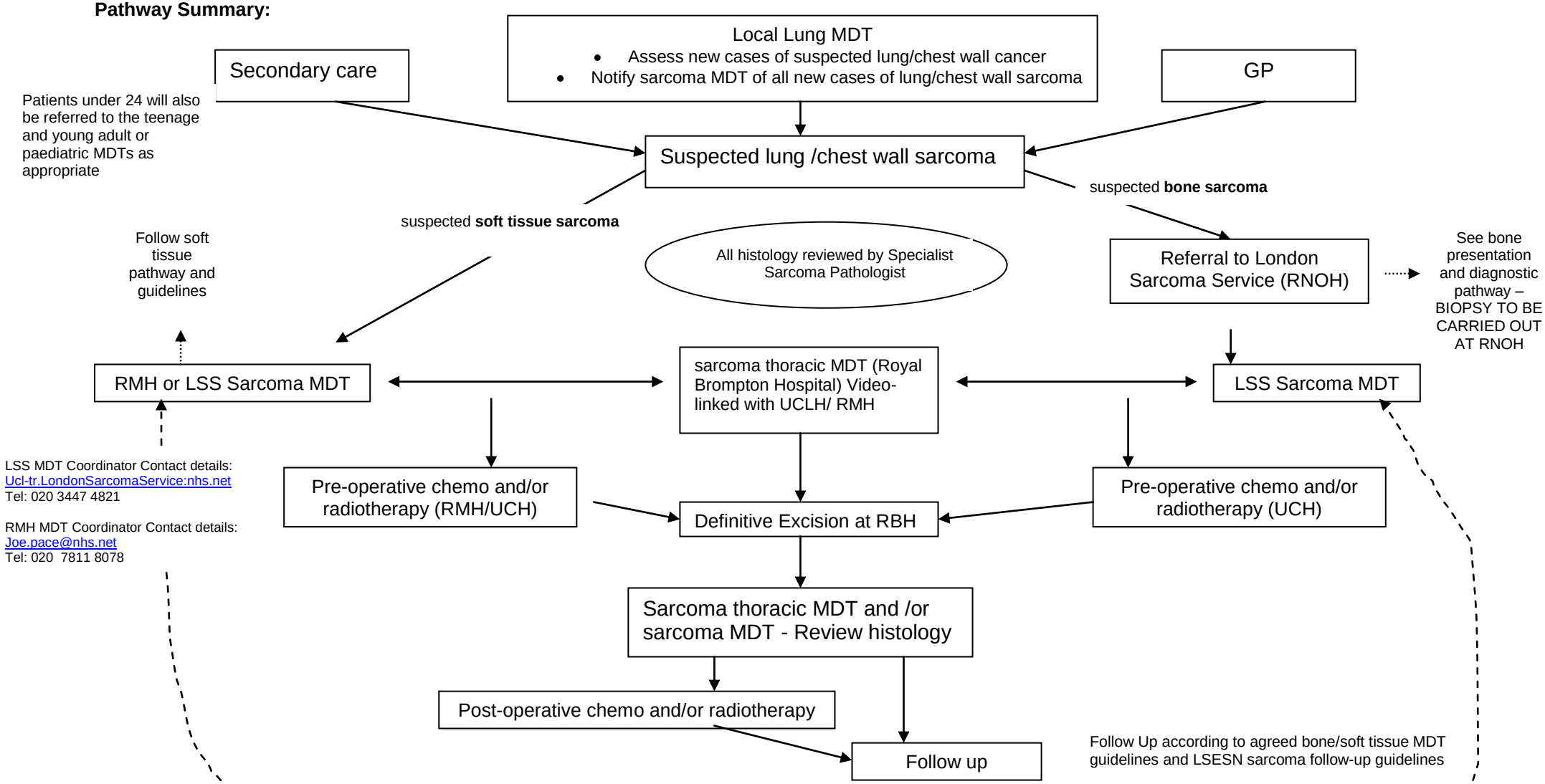
Chemotherapy and radiotherapy will be undertaken by designated practitioners as agreed by the SAG.

4) Recurrence

All recurrent lung/chest wall sarcomas will be discussed and reviewed by the sarcoma MDT.

	Role and Responsibility	
	Lung MDT/Clinic	**Sarcoma MDT/Clinic**
Presentation		Refer suspected sarcomas for diagnosis. Refer all chest wall bone sarcomas to RNOH for biopsy.
Diagnosis	Assess and diagnosis of primary lung tumours if no suspicion of sarcoma. Onward referral of tumours with biopsies indicating sarcoma	Review pathology of all new cases of lung/chest wall sarcoma Clinical review of all new cases
Treatment	Palliative pleurodesis	Need for neo /-adjuvant chemotherapy and/or radiotherapy. All chemotherapy All radiotherapy Excision when agreed by thoracic and sarcoma MDT's at designated sarcoma thoracic centre (Royal Brompton Hospital). Definitive excision of all lung/chest wall sarcomas; re-excision of all incompletely excised or recurrent sarcomas
Follow up		Initial post-operative assessment at Royal Brompton Hospital Patients to be followed up by sarcoma MDT/clinic .Follow up in accordance with sarcoma follow up guidelines of all patients treated by the sarcoma MDT

Pathway Summary:



Recurrence