NHS
London and South-East
Sarcoma Network

DOCUMENT CONTROL SUMMARY

Title of Document	LSESN Pathway for Gynaecological Sarcomas
Aims	To agree the pathway for patients presenting with suspected or confirmed gynaecological sarcomas within the London and South-East Sarcoma Network
Issued by	London and South-East Sarcoma Network (LSESN) Sarcoma Advisory Group (SAG)
Circulation To	LSESN SAG: • Core members • Trust Sarcoma Leads • Designated Practitioners • Cancer Alliances for distribution to Gynae-Onc MDTs within the LSESN
Author/s	LSESN Oncologists
Date of Version	August 2023
Version Number	2
Approved By	LSESN SAG
Approval Date	13/10/2023 (SAG Meeting)
Outstanding Items	none
Date of Review	October 2025
Storage Pathway	https://www.lsesn.nhs.uk/sarcoma.html

LSESN Pathway for Gynaecological Sarcomas

Introduction

This guidance is to provide direction for the management of patients with sarcomas that may present through gynaecological cancer services and to define the relationship that should exist with the specialist sarcoma MDT. This 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.

Sarcomas arising in the gynaecological tract are rare and comprise <1% of all gynaecological malignancies. The majority are uterine in origin but may also arise in the cervix, ovary, fallopian tube, vagina and vulva. The most common histopathological subtype is leiomyosarcoma (40% approximately), others include endometrial stromal tumours (10%), undifferentiated endometrial sarcoma and rhabdomyosarcoma.

Carcinosarcomas are outside the scope of these guidelines as they should be treated as epithelial malignancies. Adenosarcomas with a dominant sarcomatous component fall within these guidelines.

Multidisciplinary management is key and although surgery is the most common treatment modality, discussion in a specialist sarcoma MDT regarding the role of adjuvant therapies and appropriate treatment choices in the metastatic setting are essential.

Due to the rarity of these tumours, close co-operation between the sarcoma and gynaecological MDTs is crucial in ensuring good outcomes for this diverse group of patients.

Key messages

All sarcoma patients presenting to a local Gynaecology MDT should be referred to the sarcoma MDT nominated in the local network Gynaecological cancer operational policy.

Treatment of gynaecological sarcomas will only be undertaken by core members of the sarcoma MDT or by designated practitioners (designation by the LSESN Sarcoma Advisory Group).

Discussion between MDTs will take place to determine the appropriate hospital for definitive excision. Initial surgical treatment, usually total abdominal hysterectomy +/- bilateral salpingoophorectomy, may be undertaken by the local gynaecological oncology team. There is no role for routine bilateral lymph node dissection. Morcellation or similar procedures are strongly discouraged because of the evidence of increasing the risk of local recurrence and metastatic disease[1].

Decisions around complex surgery and second operations and where they should take place should be made after collaboration between the sarcoma and gynaecology MDTs . Special consideration should be taken when surgery is part of a multimodality treatment plan.

[1] https://www.fda.gov/medical-devices/surgery-devices/laparoscopic-power-morcellators
https://www.rcog.org.uk/media/2j3cjksd/consent-advice-no-13-morcellation-myomectormy-hysterectomy-1.pdf

Chemotherapy and radiotherapy to be undertaken by sarcoma centre or designated practitioners agreed by the SAG. Multimodality treatments are most likely to be delivered at the sarcoma centre.

All recurrent gynaecological sarcomas will be discussed and reviewed by the sarcoma MDT, in order to establish a management plan.

Principles, consistent with the national sarcoma service specification

- All people with a suspected or confirmed diagnosis of sarcoma must be referred to a Specialist Sarcoma Centre
- The principal role of a Sarcoma MDT is to determine a care plan for all people with bone and soft tissue sarcoma and to be responsible for its delivery either by members based at the Specialist Sarcoma Centre or by designated practitioners working at Local Sarcoma Units or by Children/Teenage and Young Adult Principal Treatment Centres following care pathways agreed by the Sarcoma Advisory group
- Pathology for all sarcomas must be reviewed by a Specialist Sarcoma Pathologist for diagnostic confirmation and undertaking any appropriate molecular analysis and genomic testing
- When biopsy or resection is undertaken, tissue should be frozen for whole genome sequencing where possible
- Sarcoma services must be structured and managed to reduce the number of unplanned excisions
- All resections of sarcomas are undertaken by surgeons who are core or designated members of the Sarcoma MDT. Surgery for gynaecological sarcomas must only be carried out by designated practitioners in centres defined by the Sarcoma Advisory Group

Additional background evidence supporting specialist care

- Presentation to a specialised sarcoma multidisciplinary tumour board is independently correlated with reduction in the risk of relapse[2]
- Surgery in a sarcoma reference centre has been reported to be associated with improved local recurrence free survival, event free survival and overall survival[3]

[2] Ann Oncol 2017;28(11):2852-2859
[3] Ann Oncol 2019;30:1143-1153

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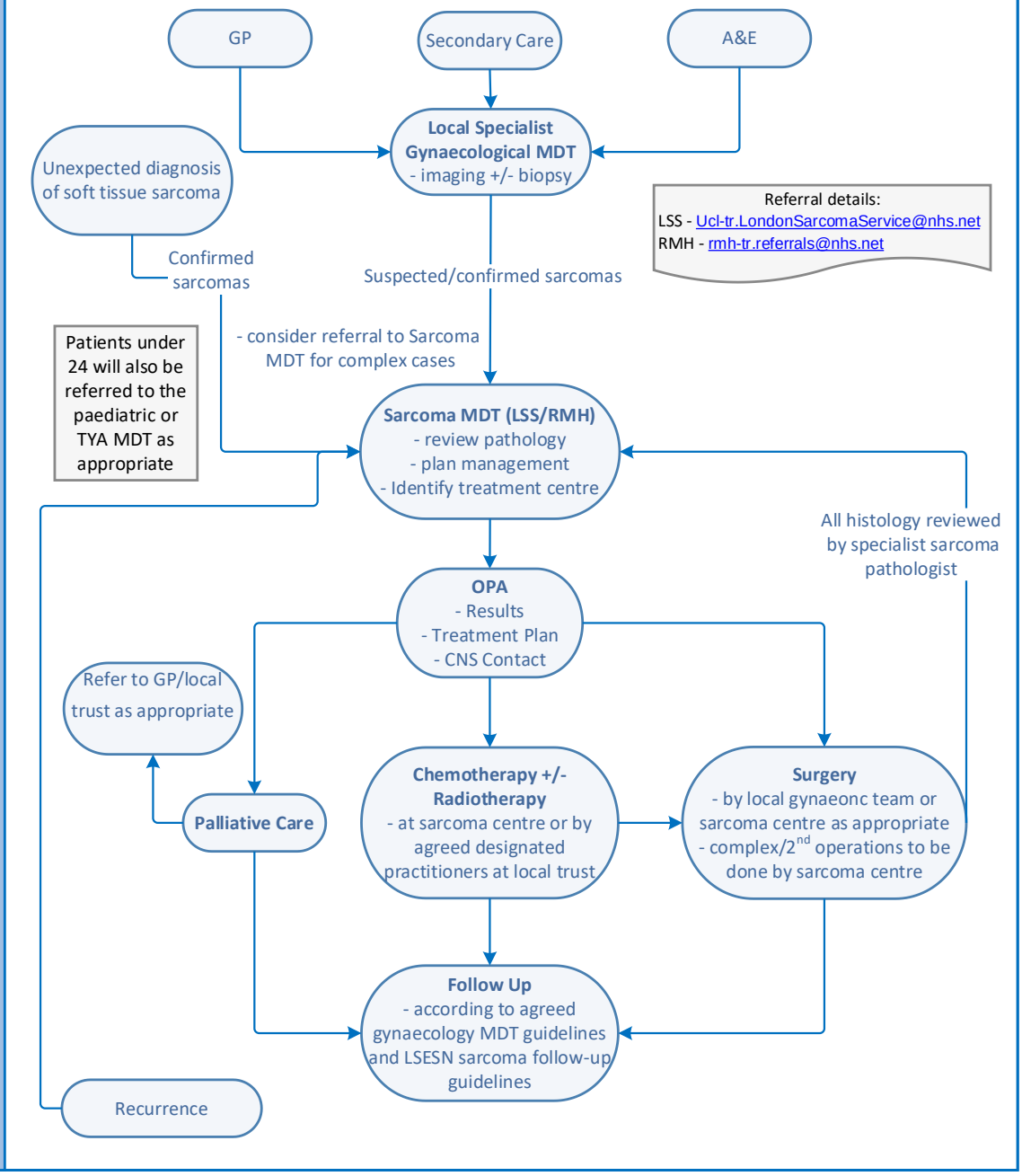

Directory of Contacts

UCLH

To discuss the referral please contact:

Sarcoma Medical Oncologist (via PA)	020 3447 9346
Gynae-Onc Surgeon – Nicola MacDonald (via PA)	020 3447 8636
24/7 on call sarcoma consultant (via switchboard)	020 3456 7890

To refer a patient please email the referral form to uclh.tr.sarcomareferrals@nhs.net

RMH

To discuss the referral please contact:

Sarcoma Medical Oncologist (via PA)	0207 808 2200
Lead Gynae-Onc Surgeon – Desmond Barton (via PA)	0207 808 2623
24/7 on call sarcoma consultant (via switchboard)	0207 352 8171

To refer a patient please email rmh-tr.referrals@nhs.net

Designated Practitioners

(see Appendix 2 of Sarcoma Service Specification 170122S)

A list of Designated Practitioners and their contact details can be found on the LSESN website https://www.lsesn.nhs.uk/guidelines.html