London and South East Sarcoma Network
Shared Care Pathway for Soft Tissue Sarcomas Presenting to Site Specialised MDTs
Head and Neck sarcomas

Background

This guidance is to provide direction for the management of patients with sarcomas that may present through Head and Neck 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. All bone sarcomas are managed by the London Sarcoma Service.

The local control rate for intermediate and high grade soft tissue sarcoma of the head and neck is markedly inferior to that of sarcoma of the limbs. This is largely related to the extent and nature of the excisions possible. The surgical factors associated with higher control rate in the limb are (i) primary, en bloc, rather than piecemeal, resection and (ii) resection with negative margins. These goals are difficult to achieve in the head and neck. Furthermore, although post operative radiotherapy reduces the local relapse rate, this still remains high when surgical margins are positive. For surgery to be sufficient local treatment alone, margins must be wide. Where radiotherapy is used with surgery the width of the margin is less important provided that the margins are negative.

The first aim of this pathway is to ensure early discussion with a specialist head and neck sarcoma MDT so that the chances of the first surgical intervention resulting in negative margins are maximised. Where possible the surgery should be en bloc. Surgery alone may be sufficient when sarcomas are small (2 cm or less) and can be excised en bloc with a wide margin (minimum 0.5 cm of uninvolved tissue or across an intact fascial plane). In all other cases combined modality treatment with surgery and radiotherapy is indicated. For high grade sarcomas, adjuvant chemotherapy will also be considered in all cases. The sequence has usually been surgery followed by radiotherapy but increasingly pre-operative radiotherapy +/- chemotherapy may be preferred. The major rationale for neoadjuvant chemotherapy is that in overview studies of adjuvant chemotherapy in STS as a whole, use of chemotherapy is associated with a reduction in local recurrence. While this may be insignificant in sarcomas of the limb, where the local relapse rate is 10-15% with surgery and radiotherapy, the impact of chemotherapy may be greater where the expected local relapse rate is of the order of 25-50%. Therefore, for patients without contraindications to both chemotherapy and pre–operative radiotherapy (where it will not significantly compromise long term morbidity) both modalities are considered before surgery.

The rarity of head and neck sarcomas, their clinical diversity, the poor outcomes referred to above and the important differences compared with squamous carcinomas of the head and neck argue for close co-operation between head and neck and sarcoma MDTs and for centralisation of care. Where patients are receiving combined modality treatment, especially with pre-operative chemotherapy and/or radiotherapy, receiving all treatments at a single institution has many advantages for patients and treating teams. Regular multidisciplinary clinical review when patients are on treatment and co-ordination between surgeon and oncologist is essential.

Principals

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

1) Notification

All sarcoma patients presenting to a specialist Head and Neck MDT should be notified to the sarcoma MDT nominated in the local network Head and Neck cancer operational policy.

2) Review by Sarcoma MDT

a) Pathology

All sarcomas arising in the head and neck 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 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 UCLH Sarcoma Unit.

3) Site of Definitive Treatment

Discussion between MDT's will take place to determine the appropriate hospital for definitive excision. In general, primary surgical excision at the sarcoma centre is preferred. All patients undergoing pre-operative chemotherapy or radiotherapy will be managed at the sarcoma centre.

All craniofacial bone sarcomas will be managed at UCLH.

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

4) Recurrence

All recurrent head and neck sarcomas will be discussed and reviewed by the sarcoma MDT.

	Role and Responsibility	
	Specialist Head and Neck MDT/Clinic	**Sarcoma MDT/Clinic**
Presentation	Assess new cases of suspected head and neck cancer Notify Sarcoma MDT of all new cases of head and neck sarcoma	
Diagnosis	Refer all cases of head and neck sarcoma for pathology review. Refer all new cases of head and neck sarcoma for review by sarcoma MDT	Review pathology of all new cases of head and neck sarcoma Clinical review of all new cases
Treatment	Excision when agreed by head and neck and sarcoma MDT's	Consider definitive excision of all head and neck sarcomas; need for adjuvant chemotherapy and/or radiotherapy; re-excision of all incompletely excised or recurrent

		sarcomas. All radical chemotherapy and radical radiotherapy except agreed by sarcoma and head and neck MDT's that individual factors determine otherwise
Follow up	Follow up according to agreed guidelines of selected patients agreed by MDT's	Follow up in accordance with sarcoma follow up guidelines of all patients treated by the sarcoma MDT

Pathway Summary: