

SOFT TISSUE SARCOMAS POST R1 / R2 RESECTIONS (WHOOOPS! LESIONS)

1 Facts

- outcome following unplanned excisions is poorer than following planned oncological surgery
- microscopic tumor is found in some 50% of re-excisions
- presence of microscopic tumor in re-excised specimen is associated with poorer outcome due to metastasis
- assessing residual macro-/microscopic disease after whoops surgery on MRI as well as review of pathology is mandatory before re-excision.
- initial grade, size, scar orientation/positioning, contamination of compartments, and tumor biology play important roles to plan re-excision.
- all whoops material has to be re-assessed by a reference sarcoma pathologist.

Treatment strategy has to be individualized and orchestrated
at the interdisciplinary Sarcoma Board !

>> Assessment by sarcoma surgeon regarding re-excision, i.e. salvage surgery, as very next step is crucial because only complete removal of surgical tumor bed is able to render the patient disease free.

>> Assessment by radiation oncologist regarding combined therapy and radiation therapy (RT) sequence (pre salvage surgery, post salvage surgery, definitive RT, palliative RT, no RT) is crucial

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2 Salvage therapy

2.1 Salvage Surgery (re-operation/2nd surgery)

- First question: re-excision possible?
- general rule: re-surgery is the treatment of choice

2.1.1 Salvage surgery (re-operation/2nd surgery) possible: individualized procedure, in most cases in combination with preoperative RT

2.1.2 Reasons not to perform salvage surgery in curative intent

- no metastases:
 - patient refuses amputation
 - amputation does not render R0 situation
 - reconstruction of soft tissue defects and/or vessels and/or neural structures is not possible or not meaningful (ie tibial trifurcation) because of functional consequences and potential rehab
- with metastases:
 - no local surgery cures a patient, therefore, amputation is used very prohibitively

2.2 Radiation Therapy (RT)

2.2.1 RT with curative intent:

→ In combination with salvage surgery (=2nd surgery) as defined above: preoperatively (or postoperatively)

→ Local definitive RT in selected cases if surgery is not indicated/not possible (as defined above) → has to be assessed by a radiation oncologist ('reasonable tumor volumes/reasonable planning target volumes (PTVs)/acceptable expected late effects' ?)

2.2.2 RT with palliative intent:

→ Symptomatic primary or metastases, if no curative RT nor curative salvage surgery possible