Shared Care Pathway for Soft Tissue Sarcomas Presenting to Site Specialised MDTs

Head and Neck sarcomas – Version 1

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.

The West Midlands sarcoma services are provided by Royal Orthopaedic Hospital Birmingham and University Hospital Birmingham working in close collaboration. Services for Bone and Soft Tissue Sarcomas of limb and external Trust are provided by the Royal Hospital Birmingham all other Soft Tissue sarcomas are provided by the Soft Tissue Sarcoma Service at University Hospitals Birmingham.

NB. The Royal Orthopaedic Hospital has designated the University Hospitals Birmingham Specialist Head and Neck MDT as the nominated team to undertake all surgical resection.

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 has been 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 West Midlands SAG referral guidelines (see www.birminghamcancer.nhs.uk).

1) Notification

All sarcoma patients presenting to a specialist Head and Neck MDT should be notified to the Specialist Bone or Soft Tissue Sarcoma MDT nominated by the local Cancer Network and recorded in the local Head and Neck cancer MDT operational policy.

2) Review by Specialist 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) Treatment Planning

All new bone and soft tissue sarcomas sarcomas arising in the head and neck will be discussed with the respective bone or soft tissue 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 ROH Sarcoma MDT all new soft tissue sarcomas will be referred to University Hospital Birmingham Sarcoma MDT.

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 nominated surgical centre (University Hospital Birmingham) 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 UHBFT.

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.

5) Follow up

Follow up arrangements will be discussed and agreed between the local Head & Neck MDT and the SSTMDT. This will include details of frequency, purpose and location of follow up.

6) Summary of roles and responsibilities

	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

7) Referral to Palliative Care

Palliative care services will be made available to all patients as deemed appropriate by the MDT.

8) Patient Information and Counselling

All patients, and with their consent, their partners, will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the Breast MDT at all times.

Access to psychological support will be available if required. All patients should be offered an holistic needs assessment and onward referral as required.

9) Clinical Trials

Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@westmidlands.nhs.uk

Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

Staging data for 70% of all cancers (90% of stageable cancers) should be collected electronically and transferred to the West Midlands Cancer Intelligence Unit (WMCIU).

All Trusts

a. The Trust should send electronic extracts from their histopathology system regularly to the WMCIU
b. The Trust should send imaging extracts for cancer patients electronically to the WMCIU regularly, or establish remote access for the WMCIU to their radiology information system and / or data warehouse

c. Data extracts should be sent in line with the cancer registry dataset / cancer outcomes and services dataset guidance

For cancers **diagnosed clinically** or those that have not had surgery

a. Clinical stage is recorded on the MDT database
b. Staging extracts for all patients are sent to the WMCIU within 6 months of diagnosis

For those with **invasive cancer who have had surgery**

a. MDTs record the full cancer registry dataset onto their MDT database at the time of discussion at the MDT meeting.
b. Staging extracts for all patients are sent to the WMCIU within 6 months of diagnosis

11) Performance Status

All patients should have their performance status recorded onto the MDT database at the MDT. This should be done using the WHO classification which will ensure it is in line with the cancer outcomes and services dataset guidance

12) References

1. 2012 London and South East Sarcoma Network – referral guidelines for sarcoma http://www.lsesn.nhs.uk/files/lsesn-referral-guidelines.pdf

2. National Cancer Peer Review Programme, Manual for Cancer Services: Sarcoma Measures National Cancer Action Team, Part of the National Cancer Programme Version 1.1 http://www.dh.gov.uk/health/2011/08/sarcoma-measures

3. The Manual for Improving Outcomes for People with Sarcoma (2006) www.nice.org.uk/csg**sarcoma**

Pathway Summary: