Shared Care Pathway for Soft Tissue Sarcomas Presenting to Site Specialised MDTs
Lung /chest wall sarcomas incl. pulmonary metastatectomy – Version 2

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.

Specialist services for bone and soft tissue sarcomas are provided by The Royal Orthopaedic Hospital Birmingham and University Hospital Birmingham. All bone sarcomas and soft tissue sarcomas arising from chest wall are managed by the Royal Orthopaedic Hospital. All other Soft tissues are managed by University Hospitals Birmingham.

Heart of England FT is designated by both Specialist Sarcoma MDTs as the surgical centre for all surgical resections for sarcomas of lung or chest wall.

The rarity of lung/chest wall sarcomas and the potential complexity of this surgery requires close co-operation between the Specialist Sarcoma MDT 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 Heart of England FT.

A weekly MDT to discuss all sarcoma patients potentially requiring thoracic surgery takes place between clinicians from ROH, UHBFT and HEFT. All planned surgery will be performed at HEFT by the specialist sarcoma thoracic surgeons. All suspected primary bone sarcomas of the chest wall should be referred to the diagnostic service at ROH who will then coordinate the case discussion with the sarcoma thoracic MDT attended by members of the HEFT 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 HEFT. Palliative pleurodeses may be discussed at this meeting but may be undertaken with local thoracic surgical services if appropriate.

Principals

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

1) Referral

All lung/chest wall sarcoma patients presenting to a local lung MDT or secondary care should be referred to the Specialist (bone/soft tissue) Sarcoma MDT nominated by the local Cancer Network and recorded in the lung cancer MDT operational policy. Within the West Midlands all chest sarcomas should be referred to ROH

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) Treatment planning

All cheat sarcomas will be referred at time of suspicion to the Royal Orthopaedic Hospital 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 surgical centre at HEFT made in accordance with below.

3) Site of Definitive Treatment

Surgical excision should be performed at the designated sarcoma thoracic surgery centre (Heart of England FT). 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.

5) Follow up

Follow up arrangements will be discussed and agreed between the local Lung 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	
	Lung MDT/Clinic	**Sarcoma MDT/Clinic**
Presentation		Refer suspected sarcomas for diagnosis. Refer all chest wall bone sarcomas to ROH 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 Definitive excision of all lung/chest wall sarcomas; re-excision of all incompletely excised or recurrent sarcomas
Follow up		Initial post-operative assessment at HEFT 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

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 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.

10) Staging

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

Pathway Summary: