

Resource for Management Options of Sarcoma During COVID-19

DATE: March 30, 2020



SSO supports the need for treatment decisions to be made on a case-by-case basis. The surgeon's knowledge and understanding of the biology of each cancer, alternative treatment options, and the institution's policies at the time the patient will be scheduled for surgery all need to be taken into consideration.

The information below is based on the opinions of individuals who are experts within the field of sarcoma and are members of the Society's Sarcoma Disease Site Work Group.

Sarcoma

1. A primary soft tissue sarcoma without metastatic disease on staging that needs surgery will be prioritized for the OR.
 - a. Resection of newly diagnosed truncal/extremity atypical lipomatous tumor (ALT), classic dermatofibrosarcoma protuberans without fibrosarcomatous degeneration, and desmoid can be deferred for 3 months or more.
 - b. Resection of other low-grade sarcomas with known indolent behavior (e.g., retroperitoneal well-differentiated liposarcoma) and low metastatic risk (e.g., myxoid liposarcoma, low grade-fibromyxoid tumor) can be deferred for short intervals depending on available resources and absence of symptoms.
 - c. Consider deferral of re-excision for R1 margins in extremity/truncal lesions if OR resources are limited and there is no evidence of residual disease on imaging.
2. If there is an indication for radiation therapy, plan to do it preoperatively. This can be administered in a lower risk outpatient setting and will push out the timing of surgery for about 3-4 months. In addition, consider the use of preoperative radiation therapy as a bridge therapy to postpone surgery when appropriate, even if the treatment is not standard, but there is evidence that it won't harm (i.e. preoperative radiation therapy in retroperitoneal liposarcoma).
3. Use of neoadjuvant chemotherapy for high grade sarcomas at any site or for recurrent disease can be considered if it can be safely delivered in an outpatient setting as a means of deferring surgical intervention.
4. Use of neoadjuvant Imatinib in localized GIST as a bridge therapy can be considered even if a formal indication for neoadjuvant therapy does not exist, provided the mutation is sensitive.

5. Active observation protocols or low-toxicity systemic options can be considered for patients with recurrent disease. Surgery for recurrent disease can be offered to patients who:

- a. are likely to have relatively high chances of obtaining long-term disease control in the context of complete gross resection (e.g., long disease-free interval, solitary site of recurrence)
- b. require immediate palliation (e.g., due to bleeding, obstruction)
- c. do not have indolent histologies (e.g., well-differentiated liposarcoma in the retroperitoneum or classic solitary fibrous tumor) that can be managed with active observation.