Breast Sarcoma, Clinical Stage I-II[1]

Note: Consider Clinical Trials as treatment options for eligible patients.

INITIAL EVALUATION

- History and physical (H&P)
- CBC with differential, CMP, LDH, PT, and PTT
- Imaging, breast-specific
  - Mammography (women ≥ 30 years old)
  - Ultrasound
  - MRI breast bilateral with and without contrast[2]
- Imaging, metastatic
  - CT chest/abdomen/pelvis
- Pre-treatment core needle biopsy
- Lifestyle risk assessment[3]

A

Is patient a candidate for surgical resection?

Yes

- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[4]
- Surgical resection with attempt towards 2 cm gross margins
- Consider Plastic and Reconstructive Surgery consult for chest wall coverage and future reconstruction[5]
- Consider preoperative radiation therapy (RT) in patients known to be at increased risk of local recurrence[6]
- Consider the role of neoadjuvant chemotherapy for high risk histology

TREATMENT

Does the patient have grossly positive margins?

Yes

Is the patient able to be re-resected?

Yes

- Re-excision. Total mastectomy typically required for T2+ tumors[7].
- Consider postoperative RT if preoperative RT was not given in patients that are at increased risk for local recurrence[8]

No

Postoperative RT in patients at increased risk of local recurrence[8]

No

Final pathology shows high grade or large size or primary angiosarcoma?

Yes

Discuss at multidisciplinary tumor board the role for adjuvant systemic therapy

No

No

- Discuss GCC with patient or if clinically indicated, with Patient Representative[4]
- Multidisciplinary discussion for management recommendations and consideration for radiation therapy with or without chemotherapy

SURVEILLANCE

- H&P:
  - Every 3 months for 2 years, then
  - Every 4 months for 2 years, then
  - Every 6 months for 1 year, then
  - Annually
- Nodal evaluation for those who had nodal disease both on exam and imaging
- CBC with differential, CMP and LDH at every visit
- Chest x-ray with H&P as above

CMP = comprehensive metabolic panel

[1] Clinical stage I-II: Patients with low grade tumors ≤ 5 cm

[2] MRI breast can be helpful when lesions are mammographically or sonographically occult and in patients with dense breast tissue

[3] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[4] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

[5] Immediate reconstruction is generally not preferred in patients who are intended for post-operative radiation

[6] Potential scenarios include: high risk histology or concern for ability to achieve negative surgical margins

[7] Routine lymph node assessment not indicated

[8] Re-irradiation in patients receiving prior radiation or radiation in patients with secondary radiation-associated sarcoma is generally not recommended but should be discussed in a multidisciplinary setting

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Breast Sarcoma, Clinical Stage III[1]

Note: Consider Clinical Trials as treatment options for eligible patients.

INITIAL EVALUATION

- History and physical (H&P)
- CBC with differential, CMP, LDH, PT, and PTT
- Imaging, breast-specific
  - Mammography (women ≥ 30 years old)
  - Ultrasound
  - MRI breast bilateral with and without contrast[2]
- Imaging, metastatic
  - CT chest/abdomen/pelvis
- If suspicion for axillary involvement (CT, exam):
  - Axillary ultrasound and fine needle aspiration for suspicious nodes
- Pre-treatment core needle biopsy
- Lifestyle risk assessment[3]
- Multidisciplinary tumor board discussion

TREATMENT

- Discuss GCC with patient or if clinically indicated, with Patient Representative[4]
- Chemotherapy regimens based on patient factors and histologic subtype

Progression to inoperable or metastasis?

- Yes → Second line chemotherapy **or** clinical trial
  - Consider palliative local therapy
- No → See Diamond A on Page 1

Response and good performance status?

- Yes → Evaluate for local therapy with or without treatment of metastatic disease
- No → Third line chemotherapy **or**
  - Clinical trial **or**
  - Supportive care

SURVEILLANCE

- H&P:
  - Every 3 months for 2 years, then
  - Every 4 months for 2 years, then
  - Every 6 months for 1 year, then
  - Annually
- Nodal evaluation for those who had nodal disease both on exam and imaging
- CBC with differential, CMP and LDH every visit
- Chest x-ray with H&P as above

[1] Clinical stage III: Patients with intermediate or high-grade tumors > 5 cm. For clinical management of soft-tissue sarcoma, see Adult Soft-Tissue Sarcoma for Clinical Stage III Extremity/Superficial Trunk algorithm

[2] MRI breast can be helpful when lesions are mammographically or sonographically occult and in patients with dense breast tissue

[3] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[4] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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