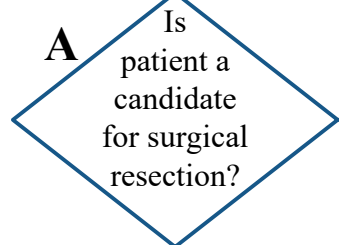


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Note: Consider Clinical Trials as treatment options for eligible patients.

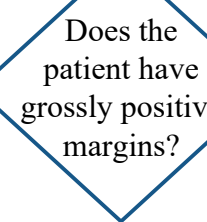
INITIAL EVALUATION

- 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 contrast²
- Imaging, metastatic
 - CT chest/abdomen/pelvis
- Pre-treatment core needle biopsy
- Lifestyle risk assessment³

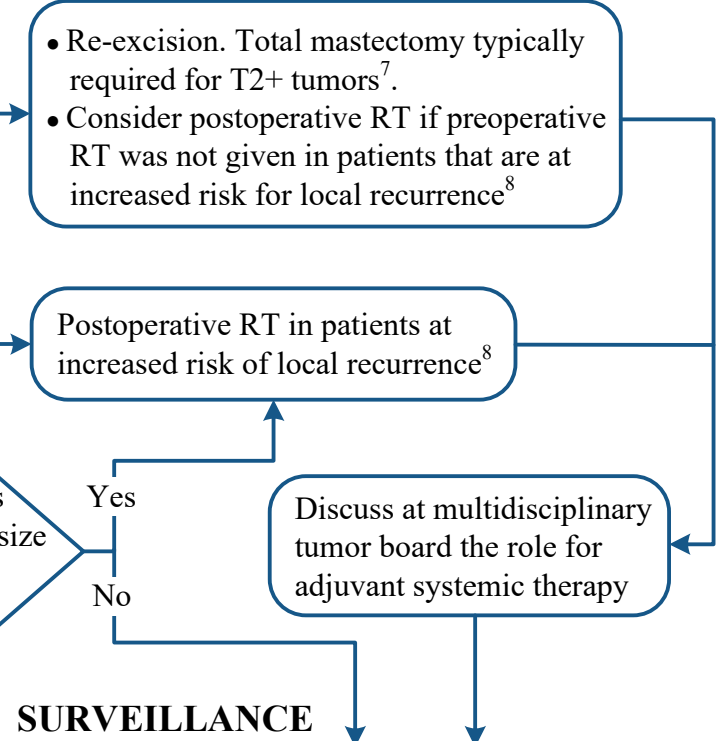


- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative⁴
- Surgical resection with attempt towards 2 cm gross margins
- Consider Plastic and Reconstructive Surgery consult for chest wall coverage and future reconstruction⁵
- Consider preoperative radiation therapy (RT) in patients known to be at increased risk of local recurrence⁶
- Consider the role of neoadjuvant chemotherapy for high risk histology

TREATMENT



- Discuss GCC with patient or if clinically indicated, with Patient Representative⁴
- 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

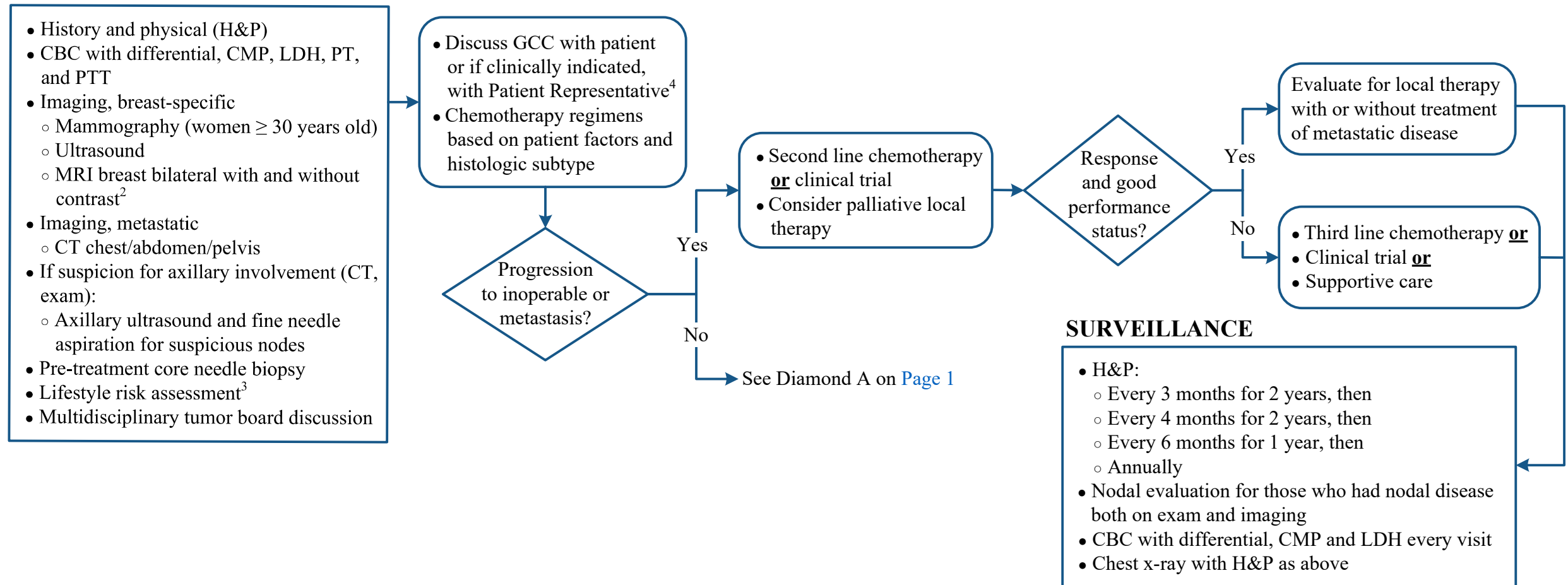
⁸ Re-irradiation in patients receiving prior radiation or radiation in patients with secondary radiation-associated sarcoma is generally not recommended but should be discussed in a multidisciplinary setting

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

INITIAL EVALUATION

TREATMENT



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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SUGGESTED READINGS

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DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Breast Sarcoma Center providers at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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