Breast Sarcoma, Clinical Stage I-II

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

TREATMENT

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

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

Note: Consider Clinical Trials as treatment options for eligible patients.
Breast Sarcoma, Clinical Stage III

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

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
- Mammaryography (women ≤30 years old)
- Ultrasound
- MRI breast bilateral with and without contrast

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
- Multidisciplinary tumor board discussion

TREATMENT

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

Second line chemotherapy or clinical trial
- Consider palliative local therapy

Response and good performance status?

Yes
- Third line chemotherapy or clinical trial
- Supportive care

No
- Evaluate for local therapy with or without treatment of metastatic disease

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

Yes
- See Diamond A on Page 1

No

Progression to inoperable or metastasis?

Yes

No

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).

Copyright 2023 The University of Texas MD Anderson Cancer Center

Approved by The Executive Committee of Medical Staff 05/16/2023
SUGGESTED READINGS


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


Breast Sarcoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

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:

Core Development Team Lead
Kelly Hunt, MD (Breast Surgical Oncology)

Workgroup Members
Jaime Anderson, PharmD (Clinical Pharmacy)
Dejka Araujo, MD (Sarcoma Medical Oncology)
Andrew Bishop, MD (Radiation Oncology)
Ahsan Farooqi, MD (Radiation Oncology)
Wendy Garcia, BS
Megha Kapoor, MD (Breast Imaging)
Heather Lillemoe, MD (Breast Surgical Oncology)
Bryce Olenczak, MD (Plastic Surgery)
Miral Patel, MD (Breast Imaging)
Christina Roland, MD (Surgical Oncology)
Hannah Warr, MSN, RN, CPHON
Wendong Yu, MD (Pathology)

*Clinical Effectiveness Development Team