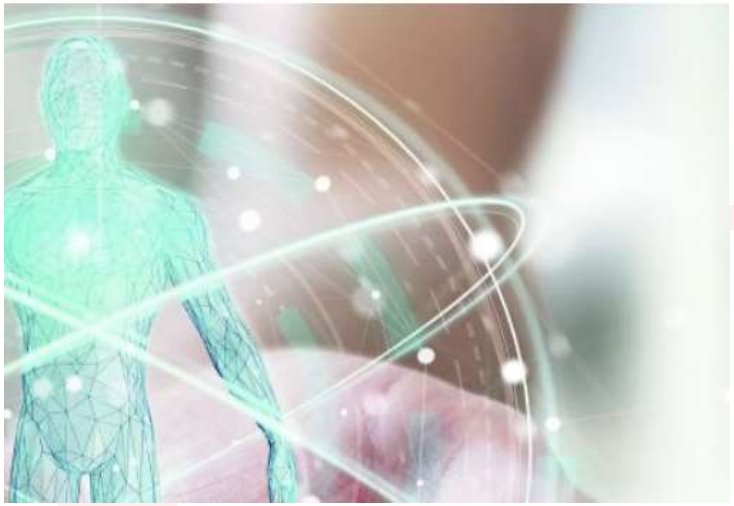
FACHVERANSTALTUNGEN, WINTERTHURER ÄRZTEFORTBILDUNG



Donnerstag
28
November 2024
16:00 - 18:00 Uhr

WEBINAR UND VOR ORT

Weichteilknoten – wann ist Vorsicht geboten?

Weichteilknoten sind häufige Befunde, die sowohl bei Ärztinnen und Ärzten als auch bei Patientinnen und Patienten Unsicherheit auslösen können. Die möglichen Ursachen bilden ein breites Spektrum – von harmlosen Veränderungen bis hin zu ernsthaften Erkrankungen. Dieses Symposium richtet sich an medizinische Fachkräfte, um ein besseres Verständnis für den Umgang mit Weichteilknoten und deren Diagnostik zu schaffen.

Ziel dieser Veranstaltung ist es, Ihnen fundiertes Wissen zu dieser Thematik zu vermitteln. So können Sie frühzeitig erkennen, wann eine weitere Abklärung oder Behandlung erforderlich ist. Fachvorträge und Diskussionsrunden bieten die Gelegenheit zum Austausch über aktuelle Erkenntnisse und ermöglichen es Ihnen, gezielt Fragen an Expertinnen und Experten zu stellen. Ausserdem werden Sie den hohen Stellenwert der interdisziplinären und überregionalen Zusammenarbeit bei diesem Thema sowie die Versorgungsforschung kennenlernen.

SWISS SARCOMA NETWORK

WEICHTEILKNOTEN
-
GUT ODER BÖSARTIG ?

Bruno Fuchs, MD PhD

Chief Sarcoma Surgery & IPU LUKS / KSW
Health Services & Medical Faculty, University of Lucerne
Chair SwissSarcomaNetwork

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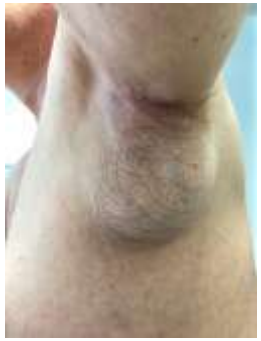
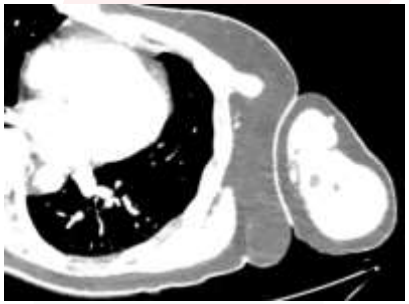
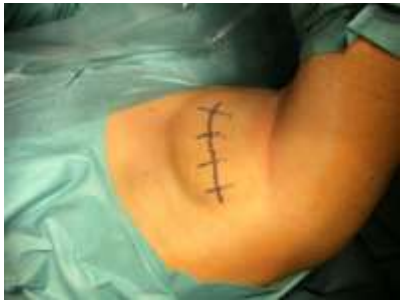
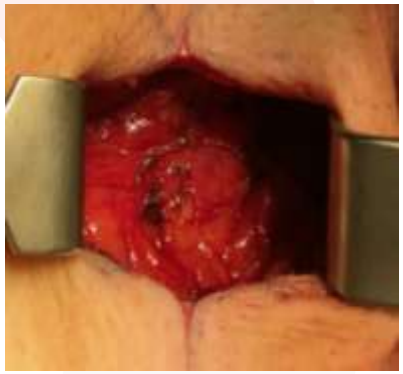
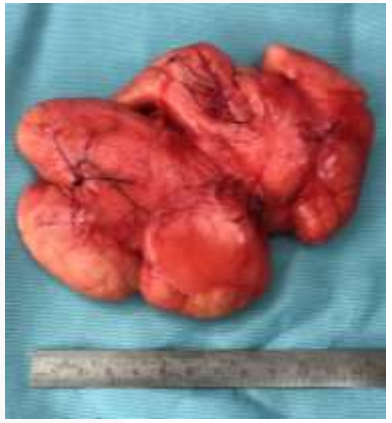
EINFÜHRUNG

Definition von Weichteilknoten

Abnorme Gewebewucherungen im Weichgewebe


„nehmen wir es mal raus und schauen was es ist...“

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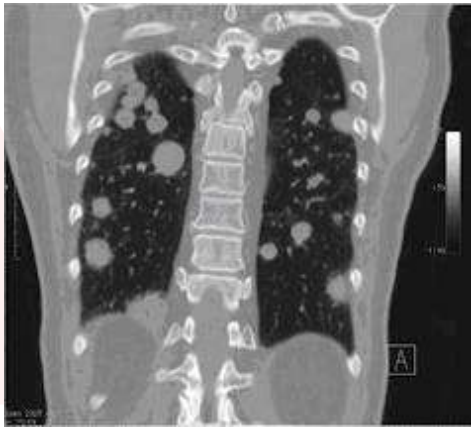
EINFÜHRUNG

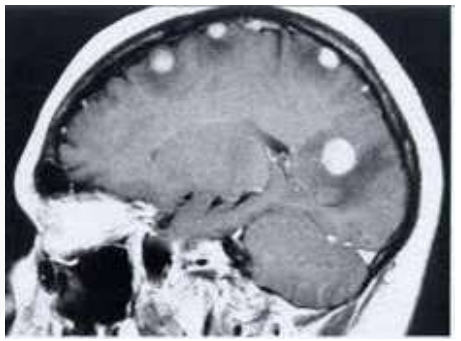
Definition von Weichteilknoten

- **<u>Gutartig</u>**

wächst (bleibt) lokal

→ führt (in der Regel) nicht zum Tod

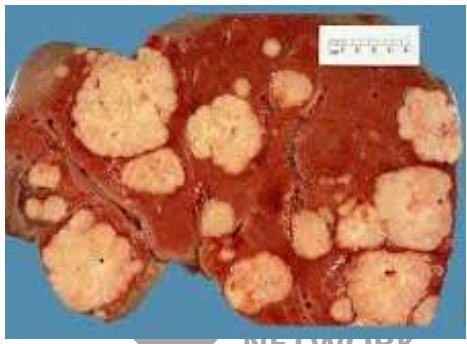




- **<u>Bösartig („Krebs“)</u>**

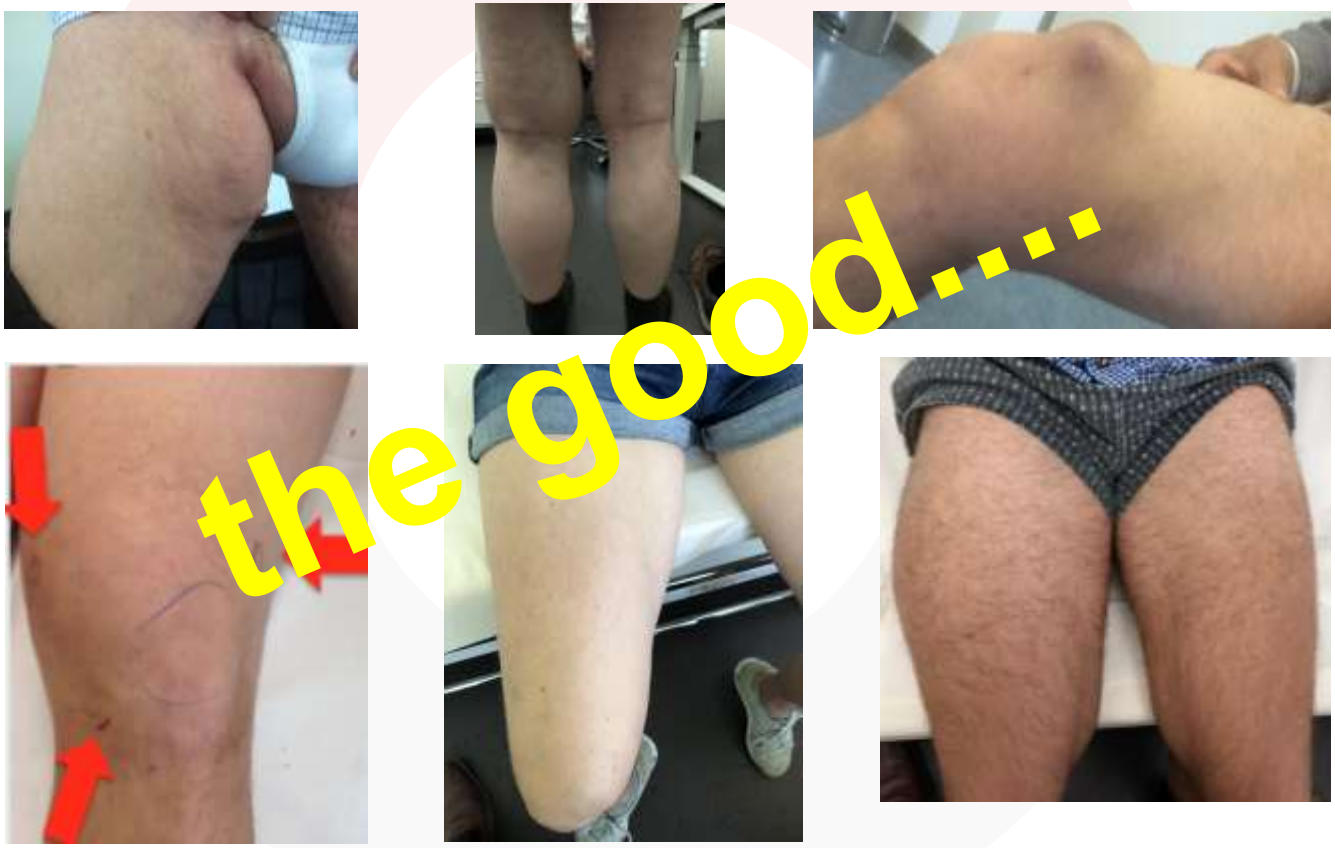
hat das <u>Potential</u>, Ableger (=Metastasen) zu bilden.

→ kann zum Tod führen



EINFÜHRUNG

Definition von Weichteilknoten



SWISS SARCOMA NETWORK

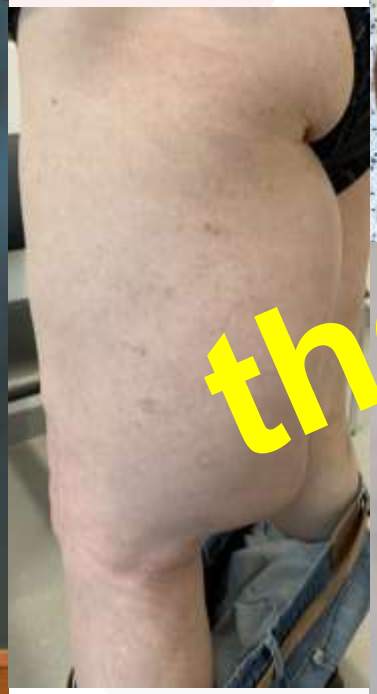
EINFÜHRUNG

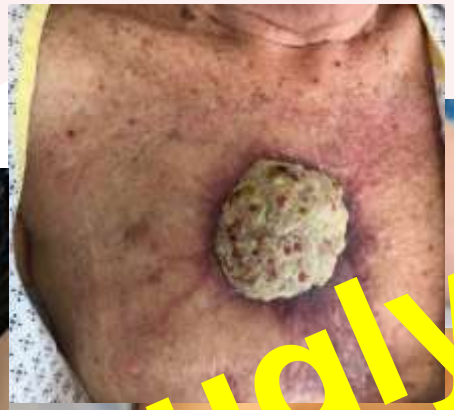
Definition von Weichteilknoten

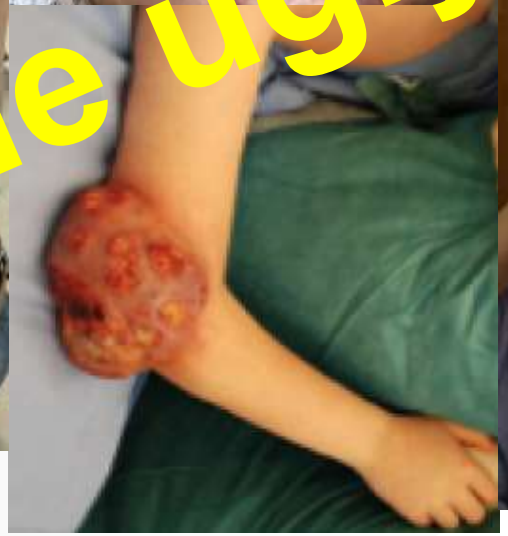
SWISS SARCOMA NETWORK

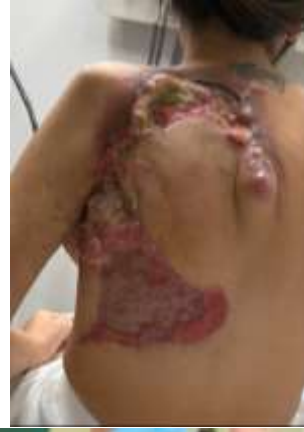
EINFÜHRUNG

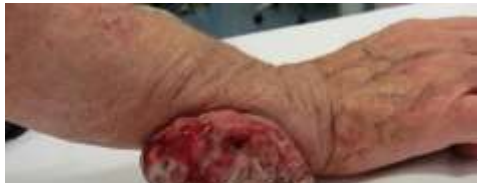
Definition von Weichteilknoten







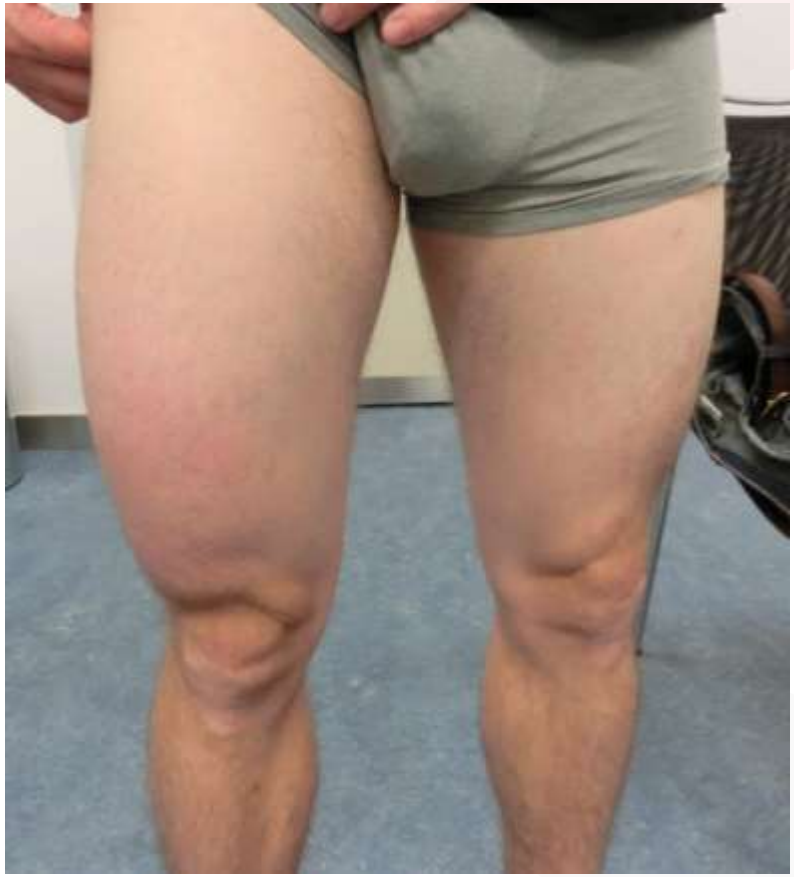


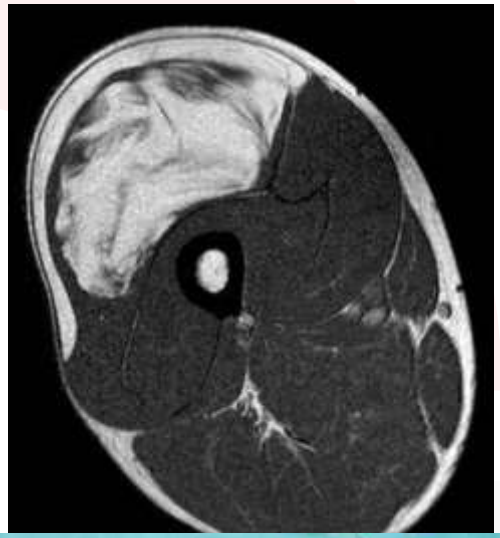


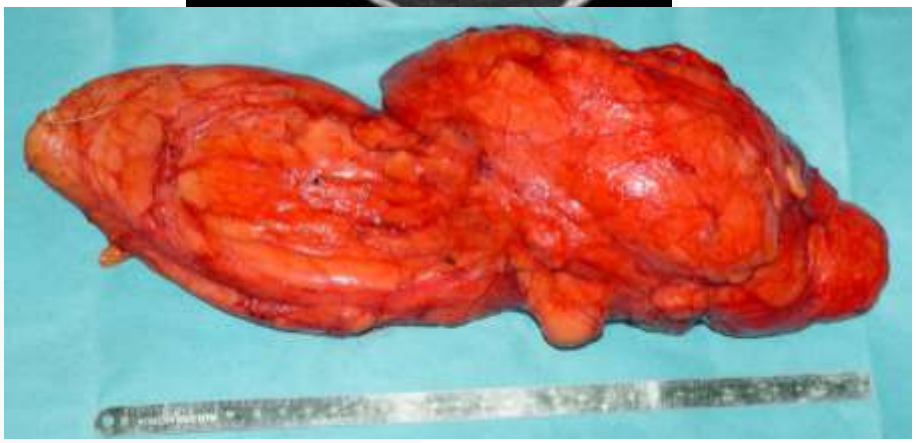
the ugly....

EINFÜHRUNG

Bedeutung der Unterscheidung gut- versus bösartig







→ **Lipom („Fettgeschwulst“)**

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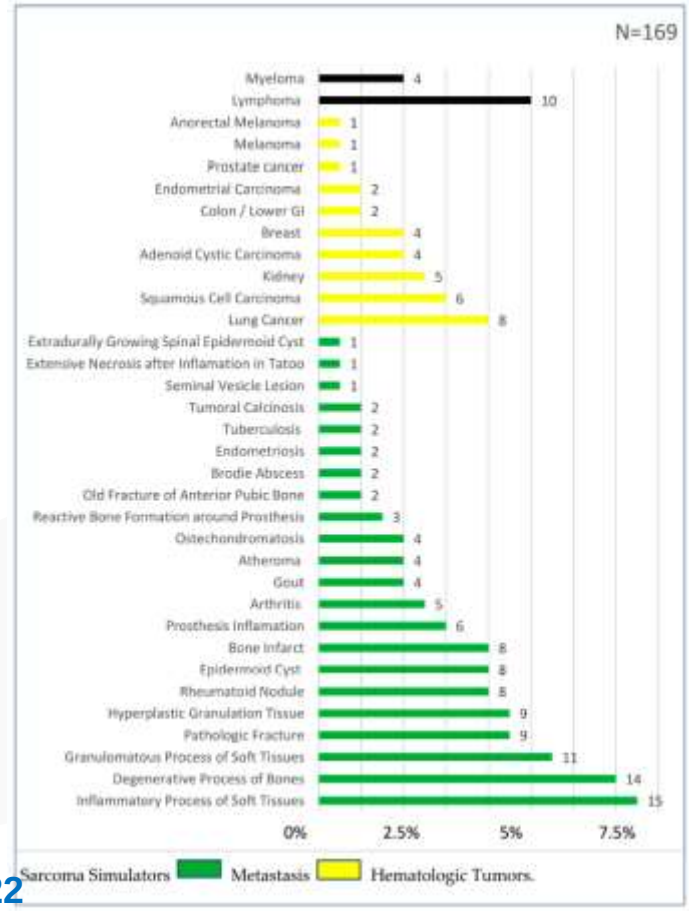
HÄUFIGE GUTARTIGE WEICHTEILTUMOREN

Was häufig ist, ist häufig

Lipome: weiche, bewegliche Fettgewebsknoten; häufig asymptomatisch

Fibrome: Bindegewebsknoten; meist klein und symptomlos

Ganglien: Zystische Strukturen, oft an Handgelenken; können Drucksymptome verursachen



Mosku N et al. *Cancers* 14:1559, 2022

ISS
RCOMA
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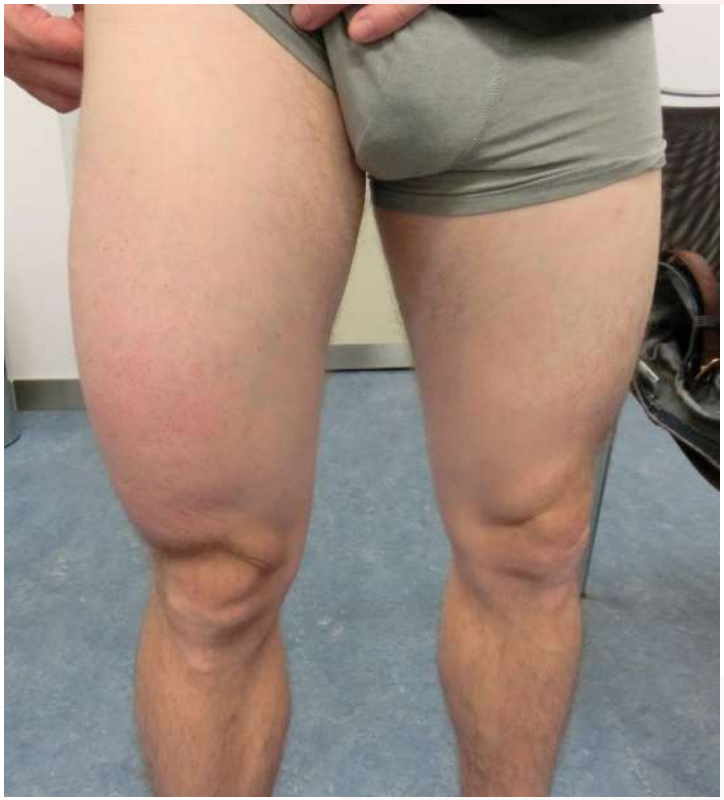
KLINISCHE SYMPTOME

Abgrenzung

Lipome / gutartiges Fettgeschwulst



- ***sind sehr häufig***
- ***sind harmlos***
- ***OP nicht zwingend***

- **ABER:**

sichere Abgrenzung zu Krebs-Läsionen möglich ?

→ ***<u>NEIN, nicht immer</u> !***

Wie kann ich erkennen, wann ich abklären muss?

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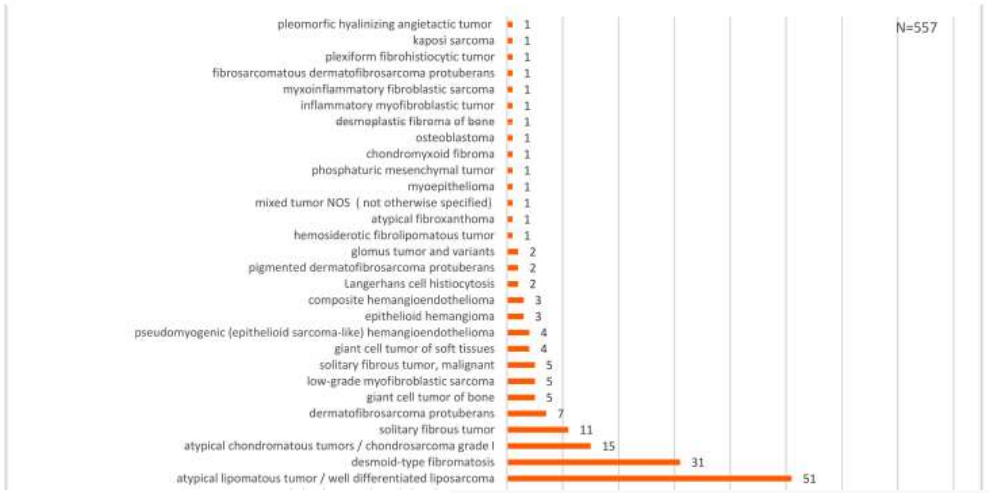
CHARAKTERISTIKA MALIGNER WEICHTEILTUMOREN

Seltene, bösartige Tumoren des Weichtegewebes

Typische Merkmale: **schnelles Wachstum, fest Konsistenz, Fixierung an tieferen Strukturen, mögliche Schmerzhaftigkeit**



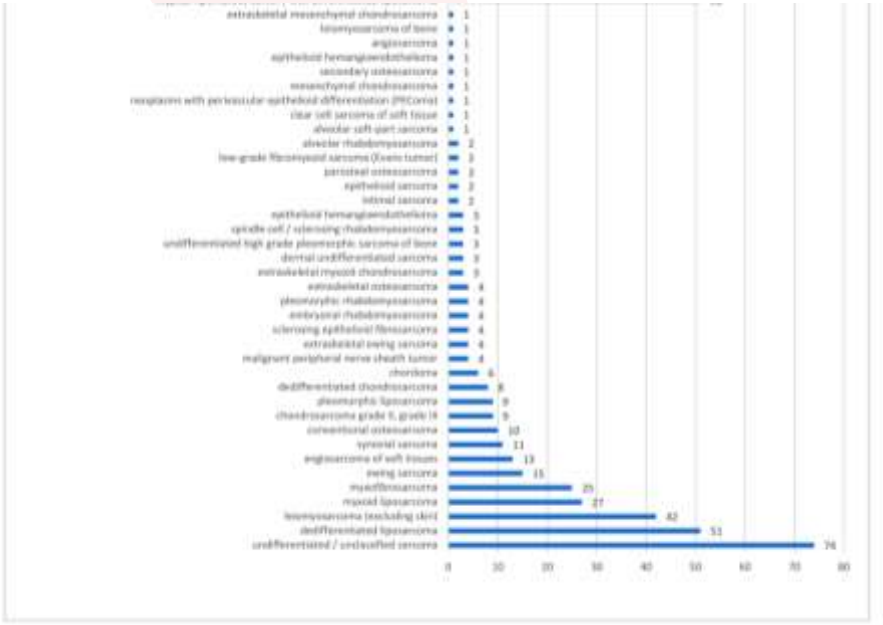


Figure 3. Histological types of sarcoma diagnoses.

Mosku N et al. *Cancers* 14:1559, 2022

SWISS SARCOMA NETWORK

DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Hauptpfeiler

Anamnese: Dauer, Wachstumsgeschwindigkeit, Symptome

Klinische Untersuchung:
Grösse, Konsistenz, Verschiebbarkeit, Schmerzhaftigkeit

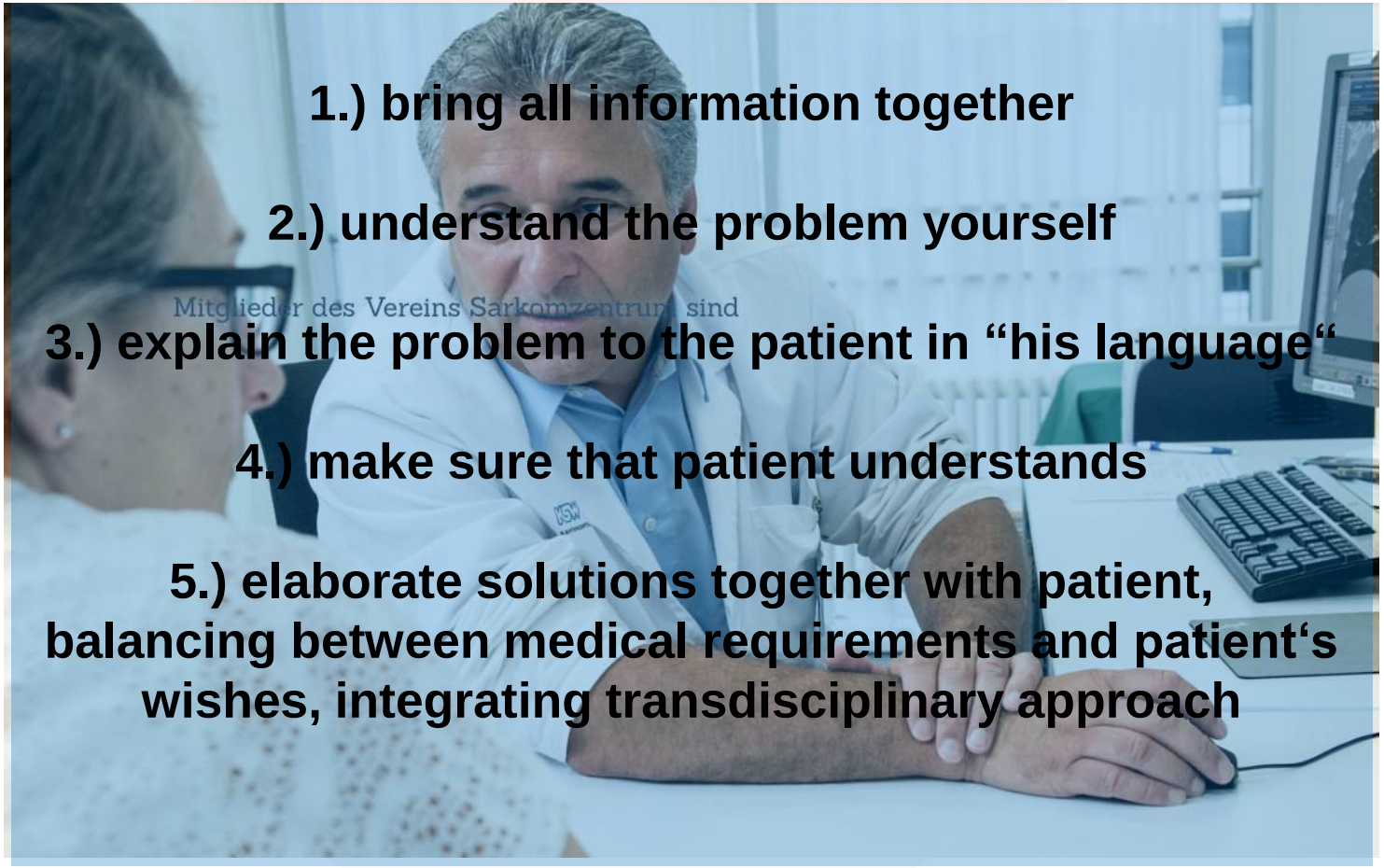
Bildgebung:
bei Verdacht auf Malignität, MRT zur weiteren Abklärung

Biopsie: **indiziert bei unklaren oder suspekten Befunden zur histologischen Diagnosesicherung**

SWISS SARCOMA NETWORK

DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Anamnese



SWISS SARCOMA NETWORK

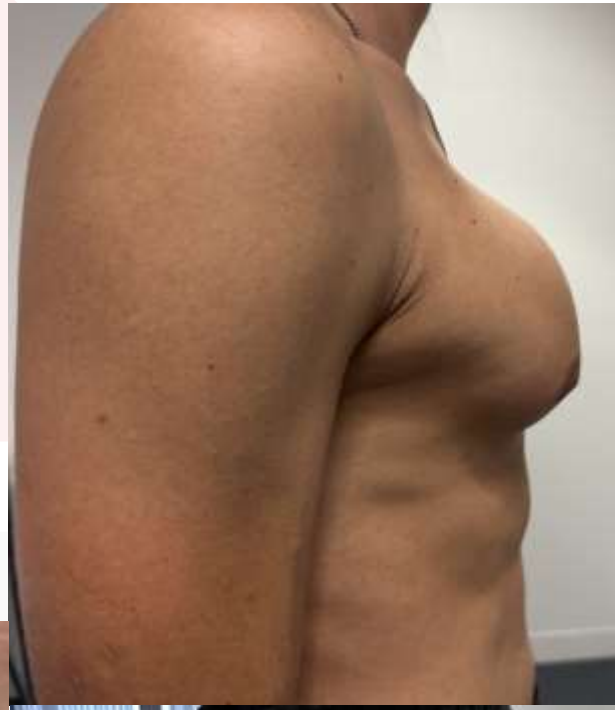
DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

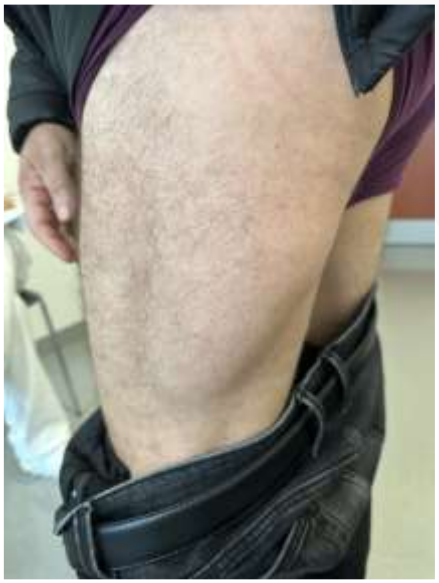
Klinische Untersuchung

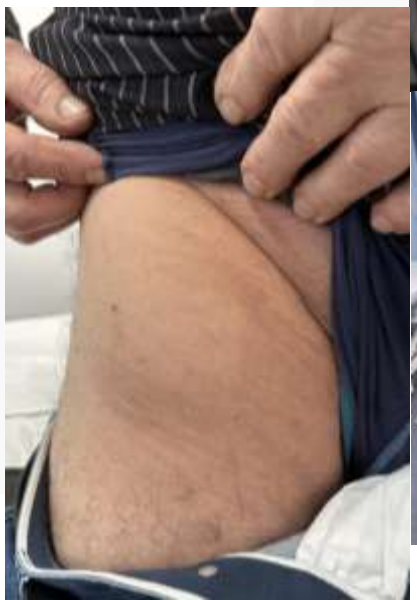
- **Klinische Präsentation**

- Symptome variieren je nach Lage und Größe des Tumors, häufig schmerzlose Schwellung oder Masse.

- Knochensarkome können Schmerzen, Schwellungen und Frakturen verursachen.







DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Anamnese & Untersuchung

cancers

MDPI

Article

Pain Accelerates, Swelling and Sensory Disturbances Delay Diagnosis in Mesenchymal Tumors

Maria Elyes [1], Philip Heesen [2], Georg Schelling[2,3], Beata Bode-Lesniewska[2,3], Gabriele Studer[1,2], and Bruno Fuchs[1,3,4,*], on behalf of the Swiss Sarcoma Network[5]

Table 3. More precise breakdown of symptoms per subgroup.

	BS	STS		BTB	STTB	
	n = 82	Deep and superficial STS n = 356	Deep STS n = 296	Superficial STS n = 60	n = 61	Deep and superficial STTB n = 213	Deep STTB n = 172	Superficial STTB n = 41
rdiovascular								
eeding	0 (0.0%)	5 (1.4%)	2 (0.7%)	3 (5.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
ld foot	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.5%)	1 (0.6%)	0 (0.0%)
ema	0 (0.0%)	3 (0.8%)	3 (1.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
matoma	0 (0.0%)	4 (1.1%)	3 (1.0%)	1 (1.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
moptysis	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
creased resting heart rate	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
al vein markings	1 (1.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
wer leg edema	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
gastrointestinal								
constipation	1 (1.2%)	6 (1.7%)	6 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
decrease in stool frequency	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
diarrhoe	0 (0.0%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
emesis	0 (0.0%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
frequent bowel movements	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
increase in abdominal girth	0 (0.0%)	7 (2.0%)	7 (2.4%)	0 (0.0%)	0 (0.0%)	1 (0.5%)	1 (0.6%)	0 (0.0%)
loss of appetite	0 (0.0%)	5 (1.4%)	5 (1.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
meteorism	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
nausea	2 (2.4%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	1 (0.5%)	1 (0.6%)	0 (0.0%)
stool irregularities	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
urge to defecate	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
general symptoms								
chills	1 (1.2%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
deterioration in general condition	0 (0.0%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
difference in leg circumference	0 (0.0%)	7 (2.0%)	6 (2.0%)	1 (1.7%)	0 (0.0%)	2 (0.9%)	2 (1.2%)	0 (0.0%)
fatigue	0 (0.0%)	8 (2.3%)	8 (2.7%)	0 (0.0%)	0 (0.0%)	3 (1.4%)	3 (1.7%)	0 (0.0%)
fever	1 (1.2%)	4 (1.1%)	4 (1.4%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
growing deformation	1 (1.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
			67				57	
growing swelling	9 (11.0%)	88 (24.7%)	(22.6%)	21 (35.0%)	7 (11.5%)	80 (37.6%)	(33.1%)	23 (33.1%)
imbalance	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
malaise	0 (0.0%)	4 (1.1%)	4 (1.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
night sweats	2 (2.4%)	6 (1.7%)	6 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	65		131		43		68	
pain	(79.3%)	138 (38.8%)	(44.3%)	7 (11.7%)	(70.5%)	78 (36.6%)	(39.5%)	10 (39.5%)
subfebrile temperature	1 (1.2%)	2 (0.6%)	1 (0.3%)	1 (1.7%)	0 (0.0%)	1 (0.5%)	1 (0.6%)	0 (0.0%)
sweating	0 (0.0%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	25		165		21		120	
swelling	(30.5%)	210 (59.0%)	(55.7%)	45 (75.0%)	(34.4%)	160 (75.1%)	(69.8%)	40 (69.8%)
swelling/deep vein thrombosis	0 (0.0%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
swelling; after trauma	1 (1.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
syncope	0 (0.0%)	3 (0.8%)	3 (1.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
weight loss	0 (0.0%)	16 (4.5%)	16 (5.4%)	0 (0.0%)	0 (0.0%)	1 (0.5%)	1 (0.6%)	0 (0.0%)
incidental finding								
incidental finding			42		15		32	
	9 (11.0%)	46 (12.9%)	(14.2%)	4 (6.7%)	(24.6%)	32 (15.0%)	(18.6%)	0 (0.0%)
incidental finding after trauma	3 (3.7%)	2 (0.6%)	2 (0.7%)	0 (0.0%)	8 (13.1%)	3 (1.4%)	3 (1.7%)	0 (0.0%)
incidental finding after trauma; pain	1 (1.2%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	4 (6.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
incidental finding at control of cancerous disease	2 (2.4%)	26 (7.3%)	23 (7.8%)	3 (5.0%)	3 (4.9%)	7 (3.3%)	7 (4.1%)	0 (0.0%)

*** pain reduces PI / DI prompting early consultation**

*** growing swellings, sensory disturbances and integumentary symptoms delay all intervalls**

DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Bildgebung

→radiologische Bildgebung als erster Schritt

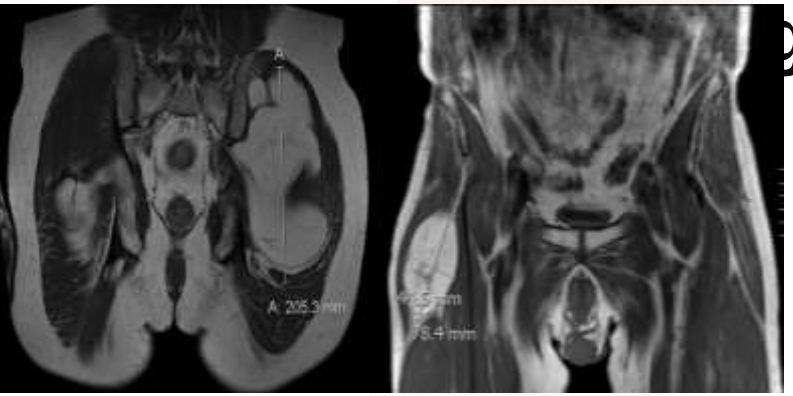
→ Röntgenbild und MRI

SWISS SARCOMA NETWORK

DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

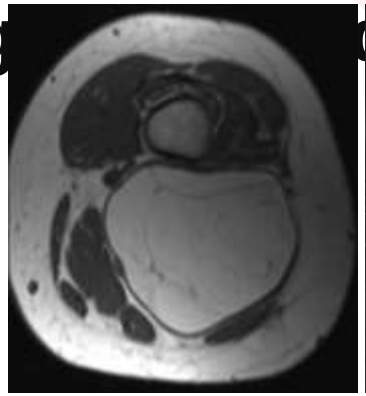
Bildgebung

„klassisches“ Lipom:

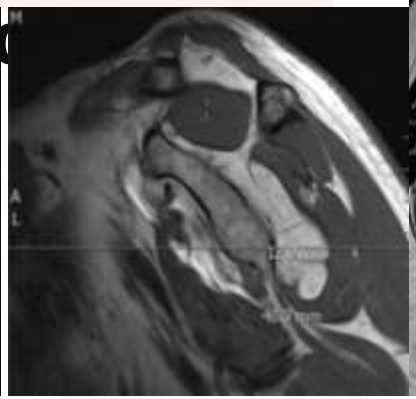


lipoma

lipoma



ALT



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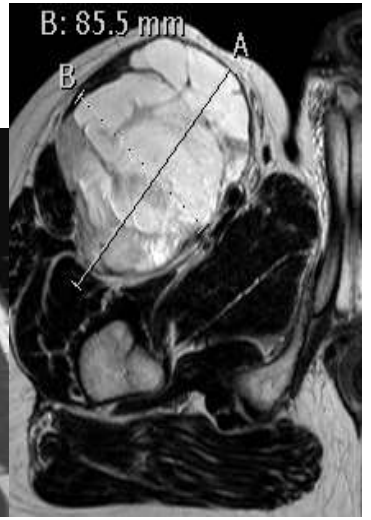


myxoid liposarcoma

Jede tief gelegene Masse ist verdächtig auf Bösartigkeit

Wann immer eine Unsicherheit besteht: Bildgebung!

SWISS SARCOMA NETWORK

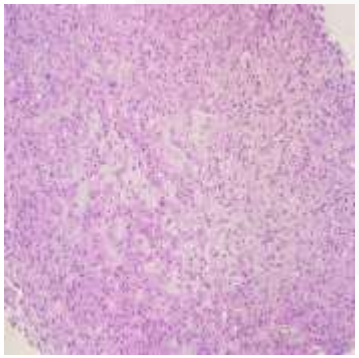
DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

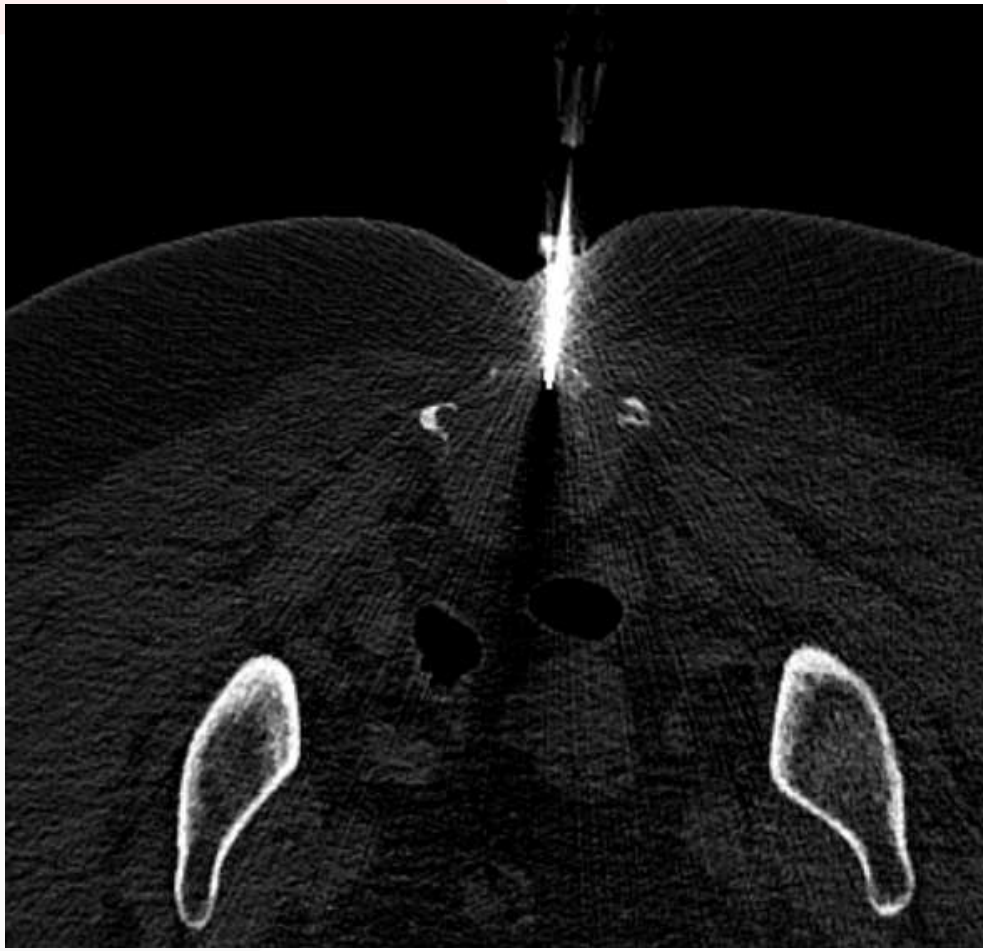
Biopsie

- **Diagnostische Methoden**

- Bildgebung (z.B. MRT, CT, PET) zur Lokalisierung und Größenbestimmung.

- Biopsie zur histologischen Bestätigung der Diagnose.





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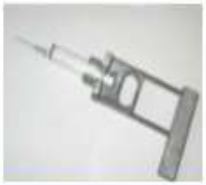
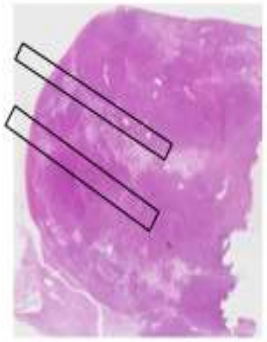
DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

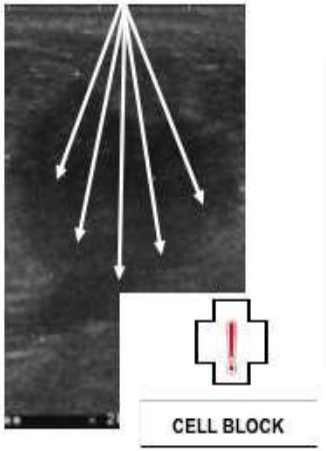
Biopsie

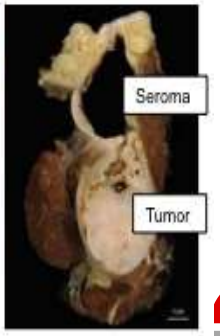
Needle biopsy



Core biopsy	Fine needle biopsy	Open (surgical) biopsy
Needle diameter	Needle diateter	Excisional biopsy (max 3-5 cm mass)
>1mm (18G)	**<1mm** (24G)	Incisional biopsy (>5 cm)
Histology	**Cytology**	**Histology**







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DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Biopsie

Table 2. Types of biopsies performed; n = 950.

	Types of Biopsies	No./% of Cases	No./% of Confirmed Sarcoma
1	Core Biopsy	409/43%	542/57%
2	Fine Needle Aspiration	130/14%	456/48%
3	Incisional Biopsy with suspicion of sarcoma	110/11%	504/53%
4	Excisional Biopsy with suspicion of sarcoma	90/10%	589/62%
5	Incisional Biopsy without suspicion of sarcoma	136/14%	Not Applicable
6	Excisional Biopsy without suspicion of sarcoma	75/8%	Not Applicable

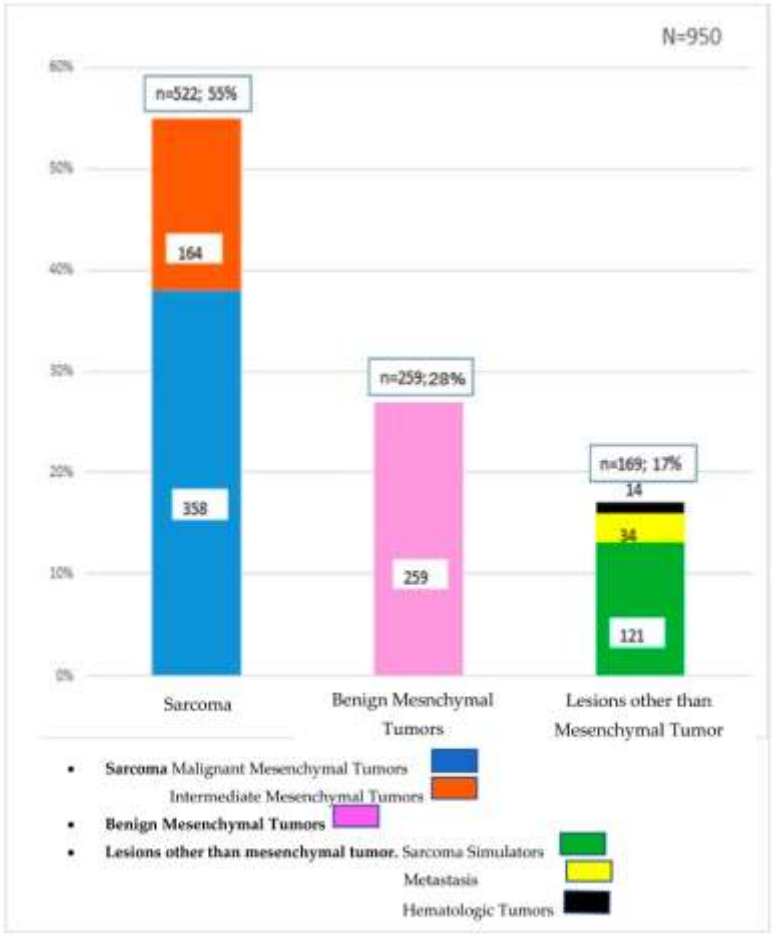

Figure 1. Types of lesions after biopsy.

ratio sarcoma/non-sarcoma: 55%

Mosku N et al. *Cancers* 14:1559, 2022

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DIAGNOSTISCHER ANSATZ BEI WEICHTEILKNOTEN

Anamnese & Untersuchung

LUMPS - CAMPAIGN

L = Larger than a golf ball (42mm)

U = Under the fascia

M = More painful

P = Progressing

S = Should be investigated - refer to regional Sarcoma - MDT MDU

SWISS SARCOMA NETWORK

MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

In Abhängigkeit der Dignität

SWISS SARCOMA NETWORK www.swiss-sarcoma.net

MINIMAL WORKUP REQUIREMENTS

Introduction
Multidisciplinary patient management is absolutely crucial to optimize the therapy success. It is recommended that biopsy and surgery be performed by the same team/person.

When is a mass suspicious for malignancy (sarcoma)?
Soft tissue: - each subfascial mass (situated underneath the fascia)
- any rapidly growing mass > 3cm and/or symptomatic
- each superficial (epifascially located) mass >3-5cm (depending on localization)
- any superficial mass suspicious for sarcoma (except for "classic" lipoma)

Bone: - any aggressively looking lesion on conventional Xray.

What does an initial (local) imaging include to strengthen my suspicion?
- conventional radiographs of local tumor in 2 projections (mandatory for bone, optional for selected soft tissue lesions)
- MRI w/wo IV Gadolinium

When should a biopsy be planned / performed?
- any mass suspicious for sarcoma
- after completion of local imaging
- after presentation at regional Sarcoma Board (or at least contacting it; Addendum 4)

How is the biopsy organized?
- always in consultation with sarcoma surgeon to determine biopsy tract
- core biopsy (CT- or US-guided): whenever possible
- excisional biopsy only when tumor <2cm and superficial; or: after presentation at a sarcoma board
- fine needle biopsy: only recommended with experienced pathologist. Indications: confirmation of local recurrences and metastases or where a core biopsy risks significant morbidity
- incisional biopsy: usually not indicated as first line approach; after tru-cut failure
- histopathological diagnosis of the soft tissue mass has been confirmed/read by Sarcoma Center reference Pathologists (Addendum 5)

What do I do when sarcoma diagnosis is confirmed?
- send patient to regional Sarcoma Center (all bone sarcomas; Addendum 4); or:
- complete staging (see below)
- make sure that patient management strategy is discussed at regional Sarcoma Board

How do I need to complete staging?
- chest CT (PET-CT usually not necessary)
- thoraco-abdominal CT for myxoid liposarcoma

Concluding remarks:
It is imperative that referring/family physician be informed about each therapy step/strategy. If there is any doubt regarding management, please always contact your nearest Sarcoma Center.

www.swiss-sarcoma.net

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MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

Analyse von Zuweisungsintervallen

cancers

MDPI

Article

Enhancing Healthcare for Sarcoma Patients: Lessons from a Diagnostic Pathway Efficiency Analysis

Maria Elyes [1], Philip Heesen [2], Georg Schelling [1], Beata Bode-Lesniewska [3], Gabriela Studer [1] and Bruno Fuchs [1,2,4,*] on behalf of the Swiss Sarcoma Network

Cancers **2023**, *15*, 4892. https://doi.org/10.3390/cancers15194892

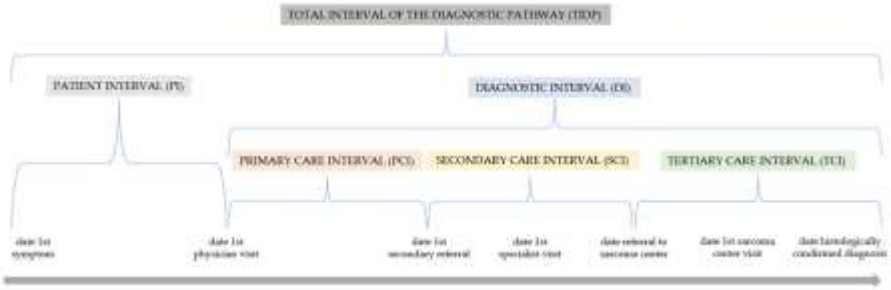


Table 2. Length of patient, diagnostic, primary care, secondary care, tertiary care, and total interval in weeks.

	OVERALL	BONE SARCOMA	SOFT-TISSUE SARCOMA				BENIGN BONE TUMOR		BENIGN SOFT-TISSUE TUMOR			
			Deep and Superficial	Deep		Superficial			Deep and Superficial	Deep		Superficial
	n = 712	n = 82	n = 356	n = 286	p-Value [a]	n = 40	n = 41	p-Value [a]	n = 233	n = 172	p-Value [a]	n = 41
Patient Interval, weeks	60.0 (22.0, 284.0)	7.8 (2.7, 27.5)	0.46	8.9 (2.3, 29.0)	8.3 (2.6, 24.4)	0.05	20.7 (4.2, 130.6)	39.1 (4.3, 52.1)	0.17	21.6 (6.4, 109.6)	39.0 (6.3, 75.1)	0.22	20.9 (9.0, 176.4)
Diagnostic Interval, weeks	46.0 (25.5, 95.5)	7.6 (3.1, 14.2)	0.99	8.7 (3.7, 15.3)	6.9 (3.0, 13.7)	0.22	5.7 (3.4, 9.5)	29.0 (6.0, 79.7)	0.005	6.0 (2.6, 13.4)	6.0 (2.6, 14.6)	0.35	5.6 (3.6, 8.5)
Primary Care Interval, weeks	4.0 (0.1, 18.5)	0.6 (0.1, 6.5)	0.34	0.4 (0.0, 1.4)	0.4 (0.0, 1.3)	0.31	0.0 (0.0, 1.4)	0.5 (0.1, 44.6)	0.50	0.7 (0.0, 3.1)	0.7 (0.0, 4.4)	0.19	0.3 (0.0, 3.0)
Secondary Care Interval, weeks	28.0 (12.0, 57.0)	2.2 (0.9, 6.6)	0.005	4.3 (2.1, 9.3)	3.9 (1.9, 8.1)	0.05	8.1 (4.9, 16.2)	2.6 (1.0, 10.7)	0.47	3.5 (1.6, 7.5)	5.9 (1.7, 30.0)	0.14	2.6 (1.5, 3.8)
Tertiary Care Interval, weeks	14.0 (5.0, 26.3)	2.1 (1.0, 3.7)	0.006	1.3 (-0.0, 3.4)	1.6 (-0.2, 3.6)	0.05	0.9 (-3.3, 3.9)	3.1 (2.0, 8.1)	0.14	2.6 (1.8, 4.1)	2.6 (1.7, 4.0)	0.36	2.7 (1.9, 5.8)
Total Interval, weeks	213.0 (94.0, 762.2)	22.8 (11.0, 36.7)	0.42	25.3 (10.4, 59.4)	20.9 (10.4, 55.3)	0.07	34.8 (12.3, 148.0)	102.5 (40.1, 206.6)	0.22	48.2 (17.7, 193.3)	45.0 (14.7, 170.6)	0.04	28.1 (29.2, 304.4)

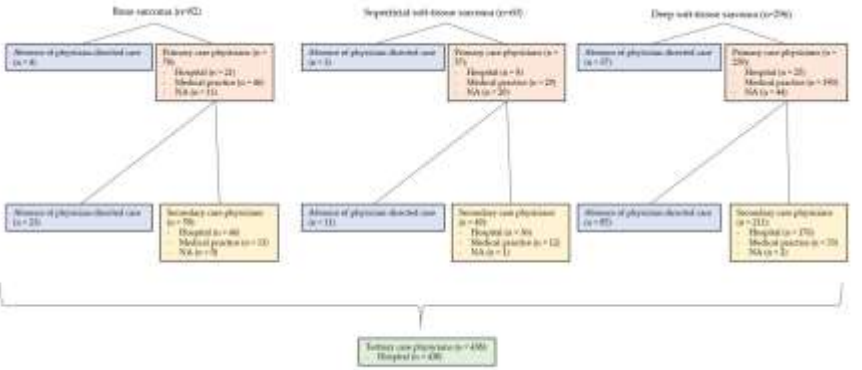


Figure 3. Referral pattern of bone sarcoma, superficial soft-tissue sarcoma, and deep soft-tissue sarcoma.

„Patient-“ and „Secondary Care Interval“ with the greatest potential for optimization

SWISS SARCOMA NETWORK

MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

Ungeplante „whoops-“ Operationen

cancers MDPI

Article

Planned and Unplanned Sarcoma Resections: Comparative Analysis of Local Recurrence, Metastasis, and Mortality

Kim N. Nydegger [1,2], Timothy T. A. F. Obergfell [1,2], Philip Heesen [3], Georg Schelling [1,2], Gabriela Studer [1,2], Beata Bode-Lesniewska [1,2] and Bruno Fuchs [1,2,4,*] the Swiss Sarcoma Network

Cancers **2024**, *16*, 3408. https://doi.org/10.3390/cancers16193408

cancers MDPI

Article

Improving Sarcoma Outcomes: Target Trial Emulation to Compare the Impact of Unplanned and Planned Resections on the Outcome

Timothy T. A. F. Obergfell [1,2], Kim N. Nydegger [1,2], Philip Heesen [3], Georg Schelling [2], Beata Bode-Lesniewska [3], Gabriela Studer [1,2] and Bruno Fuchs [1,2,4,*] on behalf of the SwissSarcomaNetwork

Cancers **2024**, *16*, 2443. https://doi.org/10.3390/cancers16132443

Table 4. Multivariable propensity score weighted Cox regression for LRFS.

Characteristics	HR	95% CI	*p*-Value
UE	7.49	2.88, 19.49	<0.001
Biological Behavior			
Intermediate	—	—	
Malignant	1.75	0.26, 11.67	0.56
Sarcoma classification			
SST	—	—	
DST	1.44	0.50, 4.16	0.50
Bone	1.06	0.24, 4.70	0.93
Bone (versus DST) *	0.74	0.23, 2.37	0.61
Anatomic region			
Appendicular	—	—	
Axial	1.96	0.80, 4.77	0.14
Largest tumor diameter (mm)	1.00	1.00, 1.01	0.03
Grade			
1	—	—	
2	8.03	1.09, 59.04	0.04
3	8.50	1.21, 59.48	0.03
3 (versus 2) *	1.06	0.56, 1.99	0.86

* After releveling, bone was compared to DST, and grade 3 was compared to grade 2.

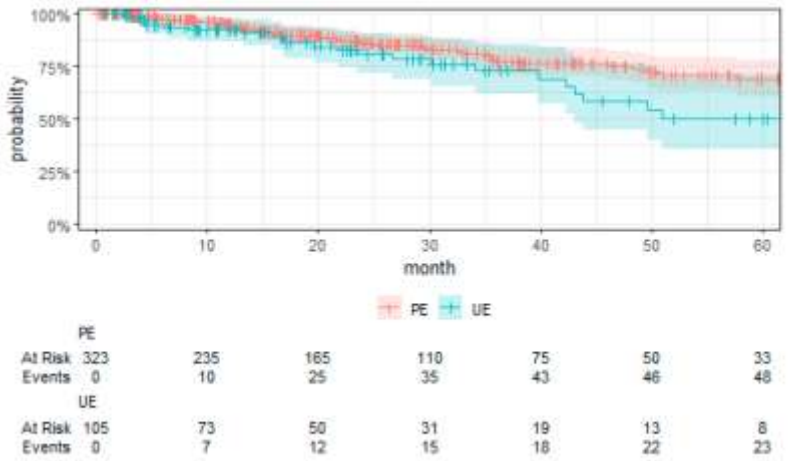


Figure 2. Kaplan–Meier plot of LRFS with the 95% confidence interval.

MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

Direkte Zuweisung

cancers

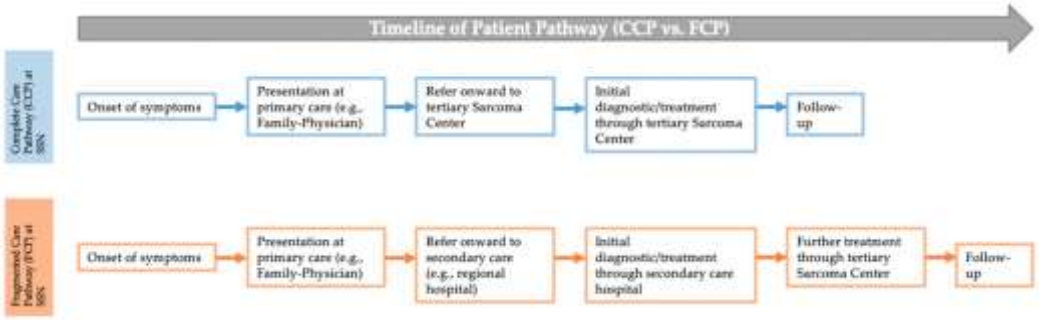
MDPI

Article

Integrated Care in Specialized Networks: Leveraging Early Referrals to Reduce Local Recurrence in Soft Tissue Sarcoma

Markus Schärer [1], Pascale Hüsli [2], Philip Heesen [2], Georg Schelling [3,4], Timothy Obergfell [2], Kim N. Nydegger [4], Gabriela Studer [3,4], Beata Bode-Lesniewska [5] and Bruno Fuchs [1,3,4,*] on behalf of the Swiss Sarcoma Network

Cancers **2024**, *16*, 3616. https://doi.org/10.3390/cancers16213616



Characteristics	Overall (%)	CCP (%)	FCP (%)	*p*-Value
Resection margin	e	d	a	0.001
R0 wide margin/R0	232 (61.1)	199 (85.8/68.2)	33 (14.2/37.5)	0.0001
Positive resection margins (R1 + R2)	148 (38.9)	93 (62.8/31.3)	55 (37.2/61.8)	0.0001
Chemotherapy part of first treatment	42 (10.9)	33 (78.6/11.1)	9 (21.4/10.1)	0.08
Radiotherapy part of first treatment	159 (41.2)	128 (80.5/43.1)	31 (19.5/34.8)	0.9
Whoops resections	96 (24.8)	51 (53.1/17.2)	45 (46.9/50.6)	<0.0001
Local recurrence n, %	68 (17.6)	39 (57.4/13.1)	29 (43.6/32.6)	<0.0001

MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

In Abhängigkeit der Dignität

Gutartige Knoten:

Beobachtung oder chirurgische Entfernung bei Symptomen oder kosmetischen Bedenken

Verdacht auf Malignität:

Frühzeitige Überweisung an spezialisierte Zentren für weitere Diagnostik und Therapieplanung.

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MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

In Abhängigkeit der Dignität

ESMO

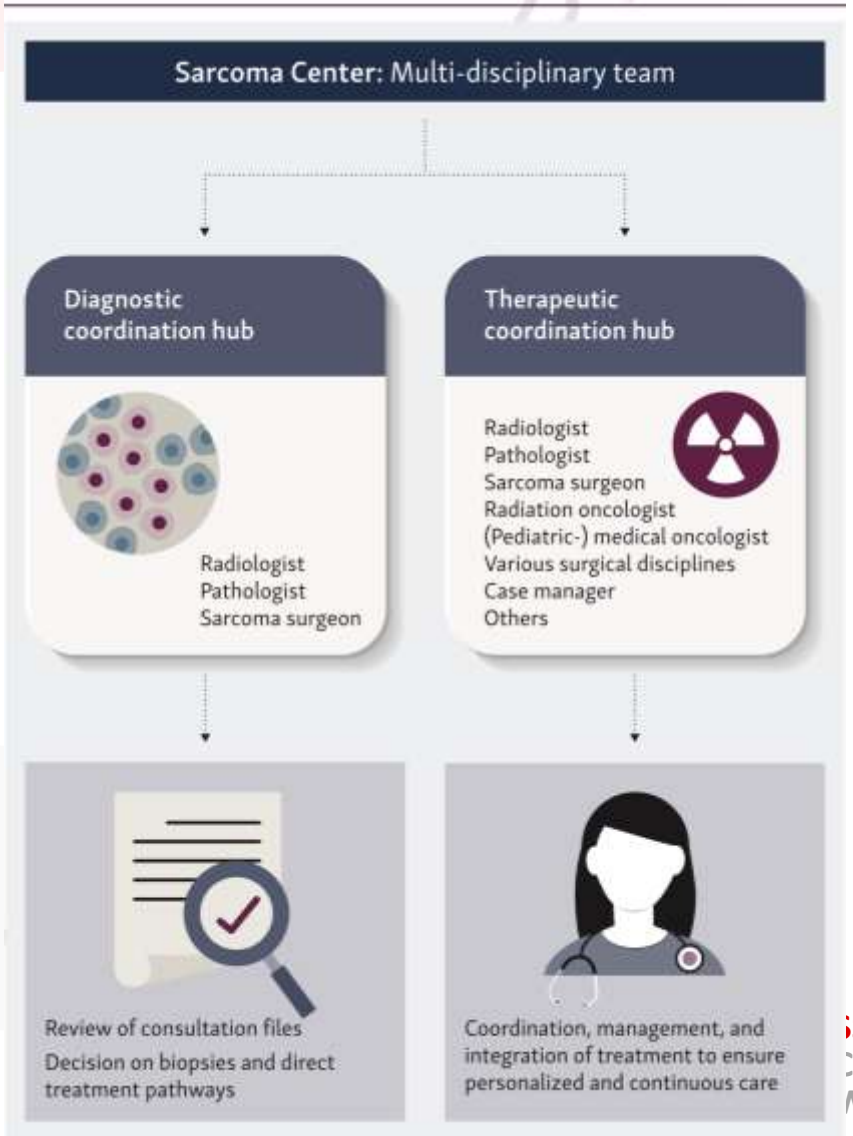
ESMO OPEN

REVIEW

Beyond the sarcoma center: establishing the Sarcoma Hub and Spoke Model network—a Hub and Spoke Model network for global integrated and precision care

B. Fuchs[1,2*] & A. Gronchi[3**]

[1]Sarcoma Center/IPU, Department of Orthopaedics and Trauma, LUKS University Hospital, Lucerne; [2]Faculty of Health Research & Medicine, University of Lucerne, Lucerne, Switzerland; [3]Fondazione IRCCS, Istituto Nazionale die Tumori, Via Giacomo Venezian, Milano, Italy



MANAGEMENT UND ÜBERWEISUNGSKRITERIEN

In Abhängigkeit der Dignität

ESMO OPEN

REVIEW

Beyond the sarcoma center: establishing the Sarcoma Hub and Spoke Model network—a Hub and Spoke Model network for global integrated and precision care

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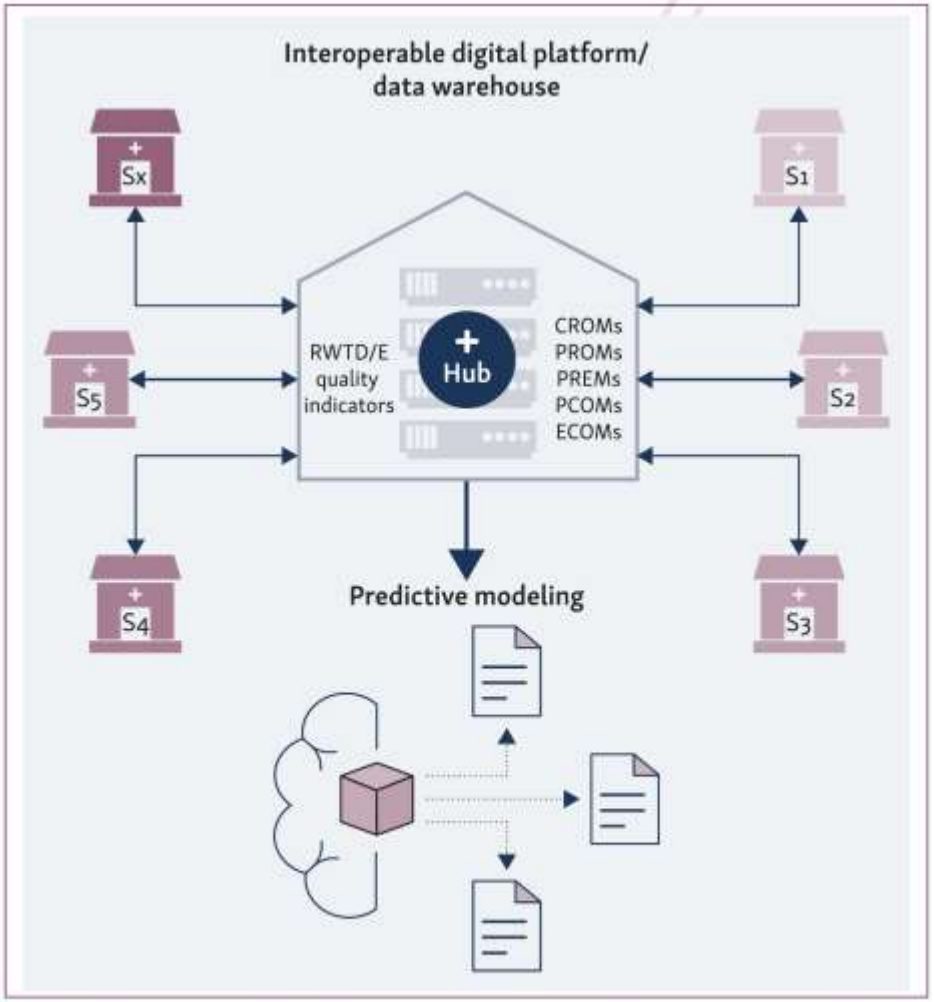

Figure 2. This figure illustrates an interconnected Hub and Spoke Model for sarcoma care, where a central hub coordinates complex case management and predictive modeling, linked to multiple spokes representing regional healthcare centers handling routine diagnostics and treatments. The central interoperable digital platform/data warehouse aggregates and analyzes real-time data from these nodes, integrating clinical-reported outcome measures (CROMs), patient-reported outcome measures (PROMs), patient-reported experience measures (PREMs), economic measures (ECOMs), and patient-centric omics measures (PCOMs) to optimize treatment and resource allocation. This setup facilitates multihub collaboration across geographic locations and continents, enhancing the generation of expansive population data to inform quality metrics and establish global sarcoma care standards.

KONKLUSION

Take home messages

Früherkennung und adäquate Überweisung sind entscheidend für die Prognose

Wichtige Rolle des Hausarztes in der initialen Bewertung und im Management von Weichteilknoten

SWISS SARCOMA NETWORK

THANK YOU

Sarcoma Academy Webinar

YouTube

https://www.youtube.com/@sarcomaacademy

fuchs@sarcoma.surgery

SWISS SARCOMA NETWORK

SARCOMA WORK-UP

cancers

MDPI

Article

Biopsy Ratio of Suspected to Confirmed Sarcoma Diagnosis

Nasian Mosku [1,2], Philip Heesen [2], Gabriela Studer [1,2], Beata Bode [2], Vito Spataro [2], Natalie D. Klass [2], Lars Kern [2], Mario F. Scaglioni [1,2] and Bruno Fuchs [1,2,*]

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2 Swiss Sarcoma Network, 6000 Lucerne, Switzerland; philip.heesen@uzh.ch (P.H.); beata.bode@patho.ch (B.B.); vito.spataro@hin.ch (V.S.); nataliedesiree.klaas@ksgr.ch (N.D.K.); lars.kern@ksw.ch (L.K.)
* Correspondence: fuchs@sarcoma.surgery; Tel.: +41-41-229-50-00

Simple Summary: Determining the biology of mesenchymal tumor, imaging alone is usually not enough, and the final diagnosis is established through tissue analysis If the indication to perform a biopsy is not established frequently enough, an undesired unplanned resection of a sarcoma may result, and conversely, a patient's discomfort as well as costs may increase. In here, using a real-world data registry of quality, we included the absolute number of a consecutive series of patients, to determine the prevalence of biopsies and its related diagnosis, to establish a reference, which may allow for the definition of a quality indicator for the work-up within a multidisciplinary team.

n = 950 biopsies

Table 1. Classification of mesenchymal biopsies.

Suspicion of Sarcoma	Confirmed Sarcoma	Malignant
		Intermediate
	Benign Mesenchymal Tumors	
	Lesions other than Mesenchymal Tumor	Metastasis
		Hematologic Tumors
		Sarcoma Simulators

Mosku N et al. *Cancers* 14:1559, 2022

SWISS SARCOMA NETWORK