

## CHONDROSARCOMA– GUIDELINES

### *Suspicious signs suggestive of a sarcoma:*

- The commonest symptom of a primary bone sarcoma is non mechanical pain
- The presence of pain or a palpable mass arising from any bone should be viewed with suspicion
- The presence of any of the following on the X-ray is suggestive, but not diagnostic of a bone sarcoma:
  - ♦ bone destruction
  - ♦ new bone formation
  - ♦ periosteal swelling
  - ♦ soft tissue swelling

## CHONDROSARCOMA

- One of the most common bone sarcomas of adulthood, characterized by the production of tumor cartilage
- Though commonest in the long bones they also occur in flat bones such as pelvis, rib, and scapula
- Secondary chondrosarcomas can arise in preexisting benign lesions such as osteochondroma and enchondroma
- Rarer subtypes of chondrosarcoma include mesenchymal chondrosarcoma and clear cell chondrosarcoma
- Conventional chondrosarcomas may rarely “dedifferentiate” into a very high-grade tumor with a dismal prognosis so called dedifferentiated chondrosarcoma

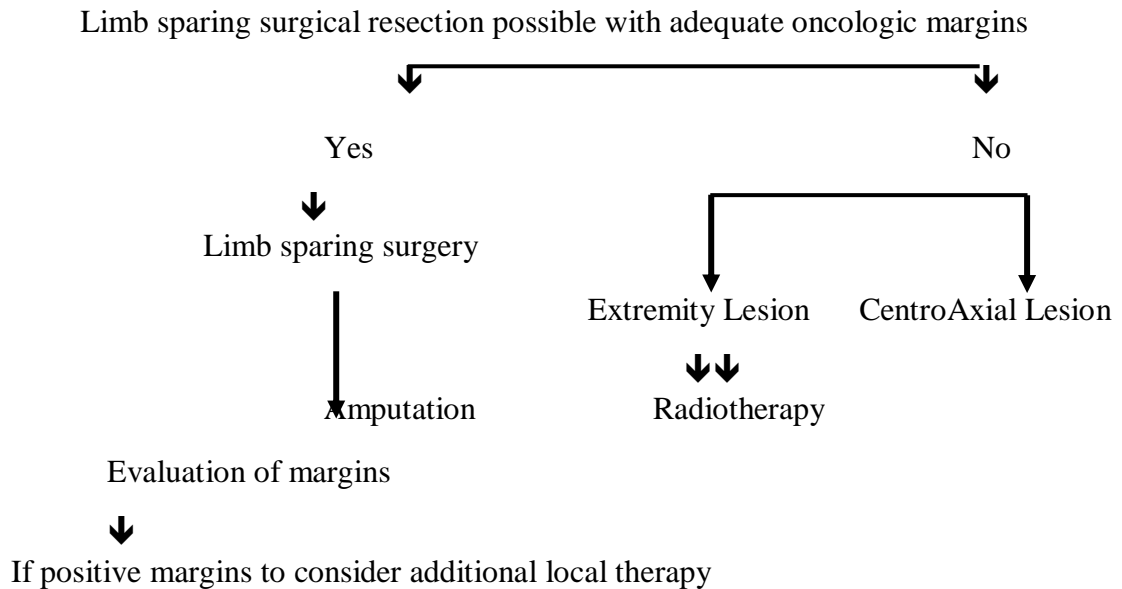
## BIOPSY

- Biopsy diagnosis is mandatory
- Biopsy to be done only after all local imaging is completed
- In most cases a core needle biopsy is adequate (it may need to be image guided depending on anatomical location of lesion)
- Ideally performed at centre which will do definitive management of disease

## STAGING

- Local X Ray
- MRI
- CT scan chest
- Bone scan

## CHONDROSARCOMA



- **Though the benefit is not certain**
  - *dedifferentiated chondrosarcomas may receive multiagent chemotherapy similar to high grade osteosarcoma*
  - *mesenchymal chondrosarcoma may receive multiagent chemotherapy similar to Ewing's sarcoma*
- **It may be feasible to safely treat extremity grade I (low grade) chondrosarcoma with intralesional curettage without increasing the risk for local recurrence or metastatic disease**

### ***Post treatment surveillance:***

- Relapses most often occur to the lungs
- Risk assessment based on tumor grade, tumor size and tumor site may help in choosing the most suitable follow-up policy
- MRI to detect local relapse and CT scan for lung metastases is likely to pick up recurrence earlier but it is yet to be demonstrated that this is beneficial or cost effective compared with clinical assessment of the primary site and regular chest X-rays

- Local examination, chest and local imaging every 3 to 6 months for first 2 years, every 6 months for next 3 years and annually after year 5 is suggested
- Extended surveillance may be necessary to identify and address potential late effects of surgery, radiation and chemotherapy for long term survivors