FRIDAY THE 13TH
RARE SOLID TUMOURS
CANCER EDUCATION DAYS

Resource Package

Friday, June 13, 2025

This package includes resources as well as specific supports pertaining to the care of CNS, Sarcoma, and Melanoma patients. We invite you to explore the various sections of the package to learn more.

Questions and Answers

Thank you for your questions during Cancer Education Day: Rare Solid Tumours event. Below is a summary of the questions asked and answers from the speakers during the event.

Question	Answer
CENTRAL NERVOUS SYSTEM (CNS)	
From stories that you have heard from patients, what are the types of symptoms that would prompt the family physician to want to order advanced imaging? What are they hearing that's really concerning as part of their story with headaches, or something that really tips them off?	For about half of the patients, many have said they ended up in the Emergency Department because they're having seizures and that's what prompts the initial presentation. The others, from a family doctor perspective, is progressive headaches or personality changes that seem out of the ordinary.
What are the barriers to investigating new therapies for GBM? Or have therapies been investigated and proven ineffective?	There are tons of trials that have been done and they've all been sort of lackluster in terms of their results. From at least a systemic perspective, many drugs don't cross the blood brain barrier very well, and also the tumour itself is not very responsive to chemotherapy in general or other approaches. There have been more recent trials of CAR-T to try to control the cancer and prolong survival and some trials have worked in the past year or so in Massachusetts but they were very, very specific and rare subtypes of glioblastoma. This has just been a very resistant tumour to everything we tried in the past many years.
How soon would an MRI be needed? Would a CT scan be performed first?	A CT is a fine first choice because you know you are not going to miss a tumour if someone has a lot of symptoms. The MRI helps later in terms of planning and more understanding of what it looks like. If there is a brain-based tumour (tumour in the CNS), a CT is a reasonable first start. An MRI gets done a lot faster once you have a CT scan showing something is abnormal.

SARCOMA	
When someone presents with a potential mass, is it reasonable to start with just an X-ray and ultrasound because those might be the tools we have in the community that we could get done within a few days?	For bone sarcomas we expect everybody to have an X-ray. Even with a soft tissue sarcoma, there are things you can glean from an X-ray and certainly an ultrasound could be useful in terms of indicating which trajectory this patient is heading down. Most of the time the ultrasound is of uncertain diagnostic benefit (i.e., it will talk about solid or liquid, proximity structures), but to say histologically what is going on is challenging. There have been ultrasounds that report it is a lipoma and then when the MRI is done we see that it's clearly a sarcoma. It's a good initial first step, but it really does not replace an MRI scan when it comes to characterizing these lesions.
Dr. Ferguson is such a valued resource for our region, Is there anything that we can do to make your job easier, whether or not it's a referral or workup for these sarcomas?	Early diagnosis is best. The longer a sarcoma is addressed, it becomes past the point where appropriate treatment can be done (i.e. patients are developing metastatic disease or such locally infiltrative disease that limb salvage might not be possible). Have open communication with the Sarcoma Team, as they are very receptive to calls or emails and will respond right away.
Further to the point of U/S misdiagnosing a sarcoma for a lipoma – do you have any advice for when to go forward with a MRI for U/S identified lipoma?	Physical exam is important. Lipomas have a fairly distinct physical exam character in terms of their softness and mobility. Growth is an important factor; if you see a lesion that is enlarging, then regardless of what the ultrasound says, the patient should have a MRI scan.
I had a case with a suspicious ultrasound but struggled to get a MRI for months afterwards. Should we refer earlier? I had asked our local ortho team to get involved but they deferred to getting the MRI done first.	Express to the DI department the urgency of the situation and put on the requisition "concern of sarcoma". Have the MRI completed prior to biopsy. Communicate with the Sarcoma Team in Windsor. The ortho team has been trained the same way to begin with MRI prior to biopsy as well. Most DI departments in the province will book a patient within 3-4 weeks for an MRI if you indicate that you are concerned about sarcoma. As long as you indicate the urgency of the situation, they are willing to work to ensure things are done expediently.
Is U/S specific enough for differentiating non-reducible inguinal hernia vs sarcoma? Or should we be arranging MRI?	For other things that may be more superficial, like in the area of the groin and so forth, it would be reasonable to get a biopsy to start. The Sarcoma Team is happy to have a discussion in advance to determine if an ultrasound-guided core biopsy vs further advanced imaging prior to the biopsy should be performed.
MELANOMA	
What is the best size punch?	Somewhere between 3-4 mm would be the recommendation. This will give you the most versatility across small lesions and large lesions. Don't be shy to use that punch biopsy to take multiple samples of larger lesions.

If it is a large lesion, is it best to take it on the edge of the lesion to include normal skin, or should we always take the whole biopsy on the lesion?	The normal tissue adjacent is not really important for the diagnosis or pathologist. What is important is that they get a sample of viable tumour. If you see some heme crust on top of that lesion, pick that off before you take the biopsy so that you're not including that in your biopsy. If you see an area of ulceration, it's not necessarily bad to include part of that ulceration or take that as a second biopsy. You want to take a sample of what feels and looks like actual tumour because that's what's going to give the actual tissue diagnosis for the pathologist. If the tissue has a big heme crust on top and you don't take it off and you take a sample in the center of that, by the time the biopsy gets to the bottom, all you're going to have is a layer of heme crust and some ulcerated fibrinous tissue and you're not going to get a diagnosis off of that. Take a sample that includes a bit of ulceration and a bit of solid tissue adjacent and that is going to get a diagnosis.
Nail bed melanoma and how to navigate that process	Clinical history is important in these (i.e., when did it arise? how did this come about? is it progressing over time?) because subungual hematomas are small and exceptionally common; whereas some of the melanomas are really not. If you're seeing a patient that seems fairly low-risk, it is appropriate to take a measurement of the lesion and bring them back in 4-6 weeks to take another measurement. If it's a subungual hematoma, it should be growing out as part of that. Secondly, perform a biopsy if you are still concerned. In Dr. Laschuk's practice, typically he removes the nail and takes the biopsy. You can do the biopsy through the nail; however, the challenge is going to be making sure you get deep enough to actually get a tissue sample and not just getting a hard nail plate sample.
I wonder if using systemic steroids (and other immunosuppressant) might get in the way of tumor control, as we try to treat the targeted therapy adverse events.	Initially we focus on managing the side effect. If you're using them short-term, that's fine. Make sure it's less than four weeks and then try to taper off as quickly as possible. We only reinitiate immunotherapy once you are less than 10 mg of Prednisone. If you need more steroids then it is difficult to resume.
What would you recommend for a family physician that has a patient undergoing active treatment and they start to have some of these side effects? Would you recommend we simply point them to the Cancer Clinic? How would you recommend navigating this?	If based on clinical condition the patient needs steroids, there is no harm in using these short term. For example, for 1-2 weeks you can use Prednisone up to 1 mg per kg of dosing, and then tell them to call the Cancer Centre so we can tell them how to taper it. Make sure it is not an infectious cause if it is respiratory issues.
COMMENT FROM DR. HOOPER REGARDING RADIOLOGY:	If one of your patients has one of the nonspecific side effects of immunotherapy and you are ordering imaging, it is <u>VERY IMPORTANT</u> to indicate that on the requisition so that diagnosis can be suggested.

If we're considering ordering a cortisol level, should we get an ACTH right away or should we do that as follow-up?	You should order them at the same time if you suspect any adrenal or pituitary problems. It is much easier to interpret the two at the same time. Preferably, have this done between 7-8 AM. It doesn't have to be fasting but it has to be a specific time. Always keep in mind, if the patient has received steroids before, you will have a low ACTH and low cortisol; in those cases it is harder to interpret.
CLINICAL TRIALS	
How do patients get started with the Clinical Trials program? Do they have to be referred or can they go on the website themselves?	The patient can go on the website themselves and enter their information. If they have trouble, they can call us and we will gather all of the information and complete the chart ourselves. Physicians here can send the program the name and contact information of the patient, and we will connect with them.
At present, is it only oncology specific or are you going to widen it?	Currently it is oncology specific. There is interest and need for expansion; however, given the workload, it is limited to oncology.

Erie St. Clair Cancer Clinic Webpages

- The cancer clinics below provide exceptional cancer care to residents of Sarnia-Lambton, Chatham-Kent and Windsor-Essex:
  - Bluewater Health Cancer Clinic
  - Chatham-Kent Health Alliance Cancer Clinic
  - Erie Shores HealthCare – Satellite Site
  - Windsor Regional Cancer Centre
    - To refer a patient to the Windsor Regional Cancer Centre, complete the New Patient Referral Form and fax to 519-253-5364.
- My Cancer Journey has been developed by patients, family members, and our care team to guide your patients through the cancer experience. It includes directions to the Windsor Regional Cancer Centre, important phone numbers, what to bring, and community resources in addition to other helpful information.

Central Nervous System Cancer (CNS)

Treatments for Brain and Spinal Cord Tumours:
Treatments for brain and spinal cord tumours | Canadian Cancer Society

Guidelines – Cancer Care Ontario:
Displaying Guidelines | Cancer Care Ontario

Central Nervous System Cancer – Cancer Care Ontario:
Cancer Care Ontario | Cancer Care Ontario

Brain and Central Nervous System Cancer (BC Cancer):
Brain & Central Nervous System Cancer

Brain Tumour Foundation of Canada:
Support Tools - Brain Tumour Foundation of Canada
Signs & Symptoms - Brain Tumour Foundation of Canada

Brain Tumour Types - Brain Tumour Foundation of Canada
Facts About Brain Tumours - Brain Tumour Foundation of Canada

Glioblastoma:
Glioblastoma - Symptoms and causes - Mayo Clinic

Astrocytoma:
Astrocytoma - Symptoms and causes - Mayo Clinic

Oligodendroglioma:
Oligodendroglioma - Symptoms and causes - Mayo Clinic

Sarcoma

Orthopedic Sarcoma Pathway – Suspected Sarcoma Involving Limb – Windsor Regional Hospital:
Sarcoma Pathway w UMC and UHN Form 2023 UPDATED Oct 2024.pdf

Body Sarcoma Pathway – Suspected Soft Tissue Sarcoma Involving Body – Windsor Regional Hospital:
Sarcoma Pathway - Soft Tissue Body 2023 Current.pdf

Soft Tissue Sarcoma Pathway Map – Cancer Care Ontario:

- This pathway map provides an overview of best practices for the management of patients in Ontario during a specific phase of the soft tissue sarcoma continuum.
- This pathway map was developed by a clinical working group using available literature and clinical consensus. The process was facilitated by our Sarcoma Services Program and the Sarcoma Services Steering Committee.
- Soft Tissue Sarcoma Pathway Map | Cancer Care Ontario

Soft Tissue Sarcoma – Canadian Cancer Society:
Soft tissue sarcoma | Canadian Cancer Society

Chondrosarcoma – Canadian Cancer Society:
Treatments for chondrosarcoma | Canadian Cancer Society

Osteosarcoma – Canadian Cancer Society:
Treatments for osteosarcoma | Canadian Cancer Society

Kaposi Sarcoma – Canadian Cancer Society:
Kaposi sarcoma | Canadian Cancer Society

Rhabdomyosarcoma – Canadian Cancer Society:
Rhabdomyosarcoma | Canadian Cancer Society

Angiosarcoma:
Angiosarcoma - Symptoms & causes - Mayo Clinic

Melanoma

Skin Cancer Pathway Map – Cancer Care Ontario:

- This pathway map provides an overview of the best practices for the management of skin cancer patients in Ontario, across all phases of care. Skin cancers covered in this pathway include melanoma, merkel cell, basal cell and squamous cell carcinoma.

Skin Cancer Pathway Map | Cancer Care Ontario

Melanoma Skin Cancer – Canadian Cancer Society:
Melanoma | Canadian Cancer Society

Melanoma Canada:
Melanoma Canada

Melanoma Warning Signs – The Skin Cancer Foundation:
Melanoma Warning Signs and Images

Punch Biopsy:
Punch biopsy | Canadian Cancer Society

Sentinel Lymph Node Biopsy (SLNB):
Sentinel lymph node biopsy (SLNB) | Canadian Cancer Society

Immunotherapy for Melanoma:
Immunotherapy for melanoma skin cancer | Canadian Cancer Society

Targeted Therapy for Melanoma:
Targeted therapy for melanoma skin cancer | Canadian Cancer Society

Endocrine Toxicities of Immunotherapy:
Endocrine Toxicities of Immune Checkpoint Inhibitors - PMC