I am writing on behalf of the Yorkshire and The Humber Sarcoma Advisory Group (SAG) to explain the need for and the nature of changes to the Suspected Soft Tissue Sarcoma Referral Pathway.

NICE CG12 'Referral for suspected soft tissue sarcoma' indicates soft tissue ultrasound (U/S) as first-line, GP initiated, urgent investigation. This is recognised and supported by the British Sarcoma Group and Sarcoma UK, representing both clinician and patient views.

Increasing referral activity across the SAG, combined with a prior decision by PHE to relocate sarcoma services from The Humber catchment to Leeds, means that a more streamlined approach to the triage of suspected sarcomas and the management of benign findings is required.

The Yorkshire and The Humber(Y&H) SAG, in collaboration with the Yorkshire imaging Collaborative (YIC), have developed and agreed the attached guidelines and flow-chart for radiology departments within the Y&H SAG. The key points are as follows:

1. Following referral for U/S, if the U/S findings are concerning, there will be automatic progression of the patient to MRI and, if that is of concern too, to discussion at the Sarcoma Multidisciplinary Team Meeting (MDTM) and possible biopsy. Referral by the GP will not be required. However, it is critical that the GP requesting the U/S includes on the U/S request:
    a. As much clinical information about the suspected sarcoma as possible
        i. Site
        ii. Size
        iii. Depth (superficial or deep)
        iv. Duration and rate of growth
        v. Presence of any associated overlying skin changes and/or local discomfort
    b. Relevant medical history
        i. Prior surgery at the same site
        ii. Existing or prior history of malignancy or connective tissue disease
        iii. Conditions or drugs that may affect the risk of bleeding
2. As there will be no routine contact with the Sarcoma MDT clinical staff until the diagnosis is secured it is essential that the GP requesting the U/S explains to the patient that:
    a. The U/S is being undertaken as the GP feels that the mass may be malignant (as defined within NICE CG12).
    b. The patient may be asked to attend for further tests (MRI, plain film or CT) without contact with a sarcoma MDT clinician.

c. If either the U/S or MRI is suspicious the Sarcoma MDT will contact the patient by telephone to explain that a biopsy is required. Any biopsy procedure will normally be in Leeds.

d. If imaging is normal or reveals a mass that is not felt to be worrisome then the diagnostic process will end with either a radiology report or letter back to the GP. The patient will NOT be contacted by a the local radiology team or sarcoma MDT member.

e. It is sometimes impossible to tell what small (<3cm) abnormalities are on U/S or MRI. The radiology team may recommend interval imaging (with repeat U/S or MRI) if the GP's clinical concerns persist beyond 4 weeks. This will require a repeat contact for re-examination by the GP and a repeat imaging request if felt necessary. This safety-netted approach will be instructed on the radiology report (or within a letter from the Sarcoma MDT). The Primary Care team will need to enact the safety-netting process. The patient will NOT be seen or contacted by a member of the sarcoma MDT. This communication will end the Urgent Suspected Sarcoma episode. A new episode will be reopened if there are worrisome findings on GP review and/or repeat imaging.

f. This information can be found on the Leeds Sarcoma Service MDT website.

3. Benign masses identified on imaging or biopsy (not all lesions are biopsied) will not be excised by the Sarcoma MDT clinicians. Confirmation that a lesion is not malignant (radiologically or on biopsy) will end the Urgent Suspected Sarcoma Pathway. If resection is desired for symptomatic or cosmetic reasons (subject to any cosmetic exclusion criteria being met) the GP will need to refer the patient to an appropriate non-cancer/non-sarcoma service. Any referral will be subject to the 18-week rule).

4. There is no requirement for a GP Suspected Sarcoma Urgent Referral (a '2-week-wait') as the U/S (if abnormal) will trigger internal escalation via the radiology team if the initial imaging request was made to an NHS hospital-based provider. Queries from health-care professionals (but not patients) may be raised via the Sarcoma MDT Office (snr.leedsth-tr@nhs.net).

5. Imaging or biopsy findings concerning for non-sarcoma malignancy will be escalated directly to the appropriate tumour-site-specific cancer MDT. The patient's local hospital Malignancy of Unknown Origin/Carcinoma Unknown Primary (MUO/CUP) MDT administration team will be the contact point until the patient is seen by the site-specific cancer MDT.

It is recognised that a period of transition will be required to allow systems to adapt to these arrangements. The current system of referral will continue to function, as well, until the end of December 2021 when further communications will be released advising that, from 1st April 2022, a fully radiology-based system of escalation will replace GP referrals.

This transition period will also allow local providers to set up internal pathways for non-malignant soft tissues masses, as they feel appropriate to local needs.