NSW HEALTH

Lump on the Head

Oncology Opinion & Advice

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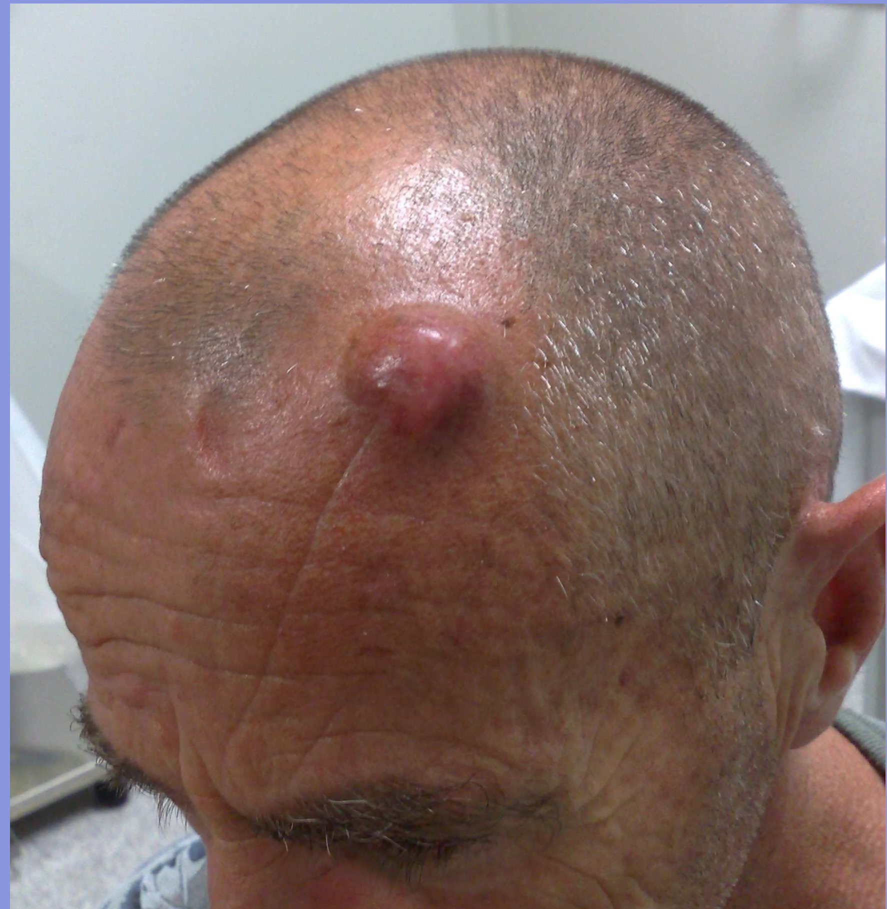
Lump on the Head

- Visible masses are confronting
- You still have to do the assessment!



Lump on the Head

- Visible masses need a description
- Masses arise from something
- Masses grow at a rate
  - Slow ?benign
  - Fast ?inflammatory
  - Medium ?malignant

Lump on the Head

- Carcinoma
  - Skin & appendages
- Sarcoma
  - Muscle, fat, nerve, fibrous tissue, bone, vessels
- Lymphoma
  - Primary, metastasis
  - Unusual lymphoid

Lump on the Head

- Sarcoma
  - Unusual cancer
  - PRIMARY MANAGEMENT
    - **Surgery**
      - Biopsy track
      - Margins
      - Tissue planes
    - **Radiotherapy**
      - Adjuvant if +ve margins, “local resection”
      - Primary if no decent surgery possible
    - **Chemotherapy**
      - No role

University of Wollongong
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Phase 2 : Oncology Topics
Oncology Opinion & Advice: **Lump on the Head**

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Visible masses are confronting and you need to be prepared to not show your shock. Sometimes there is an assault of both vision and olfaction, and belief. Breathing through the nose helps! Visible masses need to be assessed for size, fixation, ulceration, colour, character, as well as speed of growth. And they need to be assessed in clear light without clothes getting in the way.

The diagnostic possibilities for this mass are best determined by understanding the tissues in the area. Moving from the outside there is epidermis, dermis, subcutaneous tissue (containing skeletal and smooth muscle, vessels, nerves, lymphatics, fibrous tissue including periosteum, and bone).

The lesion could be benign or malignant, and history would give some idea of this. Ultrafast (2-3 weeks) or ultraslow (3-4 years) growth points away from malignant. The typical length of growth for a such malignancy would be between 2 and 6 months. Benign lesions in this area could be sebaceous cyst, maybe fibroma, or schwannoma). The malignant lesions fall into three groups -

> the **carcinomas** arising from skin and its appendages – think squamous cell carcinoma (*ulcerated*), basal cell cancer (*pearly edge with telangiectasia and central ulceration*), Merkel cell carcinoma (*rapid purple lump*), melanoma (*pigmented and ulcerated*) sebaceous adenocarcinoma (*rare*);
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> the **sarcomas** arising from dermis, subcutaneous tissues and bone – think rhabdomyosarcoma (*rare*), leiomyosarcoma (*rare*), angiosarcoma (*dark pigmented, rare but characteristic*), neurofibrosarcoma (*rare*), lymphangiosarcoma (*rare*), malignant fibrous histiocytoma (MFH) (*not so rare*), osteosarcoma (*rare*);
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> the **lymphomas** arising from lymphoid tissue – cutaneous lymphoma (*rare*), chloroma (*rare*), myeloma (*rare*), osteolymphoma (*rare*) and histiocytosis X (*rare*).

Conclusion: In this site, my favoured possibilities are Merkel cell carcinoma, angiosarcoma of the H&N, and MFH, although SCC and BCC, even if very atypical, must also be considered because they are so common (*the uncommon presentation of the common is more common than the common presentation of the uncommon!*).

Progress:

The incisional biopsy of this lesion revealed a MFH, and the surgeon asked the oncologist for advice. This is wise, as the management of sarcoma is multidisciplinary and based on several 'best practice' principles.

Firstly, the person doing the biopsy does the surgery, so as to excise the needle track. Implantation metastases are common in sarcoma. While sarcomas are curable by surgery, they are spread by inclement surgical technique, particularly involved margins and bleeding.

The initial surgical decision revolves around complete *en bloc* resection **outside the first layer of uninvolved tissue planes** – to put it in colloquial terms, if you see the cancer during surgery you have stuffed it! For this patient the requirement is for a wide local excision with consideration of resection of outer table of the calvarium. Because this may be difficult here, the oncologist's opinion is sought. The opinion called for wide margins and referral back after surgery.

Reconstruction can be undertaken by a skin graft with or without a scalp slide. Postoperative radiotherapy must be considered in light of the actual operation AND the pathological outcome. A superficial sarcoma of less than 5cm size is curable with adequate surgery and appropriate adjuvant radiotherapy if margins are compromised.