### Localized Sarcomas: Therapeutic Approach

**Extremities and axial**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Additional Standard Options in relation to anatomic barriers nerves, vessels, physical status, age</th>
<th>Options for Selected Patients **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histology and Imaging according to „Minimal Requirements“</td>
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</tbody>
</table>

**Superficial and deep**

- wide resection
- RT*

**Primary, high grade (G2-3)**

**Superficial**

- wide resection
- RT*

**Deep**

- RT* & wide resection
- Postoperative boost when surgical margin questionable
- (neo-)adjuvant chemotherapy

- RT +/- hyperthermia; Protonen; IORT
- ILP

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- this scheme excludes GIST, retroperitoneal sarcomas, uterine sarcomas, head/neck sarcomas, extrasosseous Ewing’s Sarcomas, Rhabdomyosarcomas, and a majority of childhood sarcomas which need preoperative systemic therapy. (adapted according to ESMO, NCCN, GISG, austrian consensus)

- ILP= isolated limb perfusion; IORT = intraoperative RT / Brachytherapie

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*Preoperative or Postoperative Radiotherapy: whenever the surgeon/radiation oncologist at the sarcoma board feel that preoperative RT is mandatory, RT is performed preoperatively. Preoperative RT uses less dose volume and intensity compared to postoperative RT, with equal oncological control but potentially less RT related longterm side effects, probably acceptable wound control rates post surgery (when using IMRT).

**Preferentially conducted/applied in studies/clinical trials**