Transcript:

Interview with Dr. Lee Hartner, Clinical Director of Sarcoma Medical Oncology at Pennsylvania Hospital

Melanie: Welcome to the podcast series from the specialists at Penn Medicine. I'm Melanie Cole. And joining me today is Dr. Lee Hartner. He's the Director of the GI Cancer Risk Evaluation Program and the Clinical Director of Sarcoma Medical Oncology at Pennsylvania Hospital. And he's a Clinical Associate Professor of Medicine at Penn Medicine. And he's here to highlight diagnostic information for sarcomas.

Dr. Hartner, thank you so much for being with us today. As we get into this topic, and it's so interesting, can you provide a little bit of background on your role and an overview of what we'll be speaking about today?

Dr. Lee Hartner: Sure, Melanie. Thank you very much for inviting me to participate. I really do appreciate the opportunity. So I'm a medical oncologist who has been evaluating and treating patients with both bone and soft tissue sarcomas for about the past 20 years. I am one of three medical oncologists who are part of a larger sarcoma group that really spans the whole health system. So while I work at Pennsylvania Hospital, there are others who work at some of the other downtown hospitals. And we function collaboratively as a group in the evaluation and treatment of these difficult diseases.

Today, I'm going to be talking about issues surrounding biopsy. And, in particular, issues surrounding biopsies I want to highlight, I think, some potential issues that can arise from things that are done before we see people and talk about some of the problems that we encounter.

Melanie: Thank you so much for that comprehensive overview, Dr. Hartner. As we know and as you just alluded to, the initial evaluation and management of soft tissue masses can be challenging for many clinicians due to this overlap in the presentation of benign versus malignant tumors. From your perspective, doctor, what factors should community physicians take into account when they're deciding which lumps and bumps to biopsy?

Dr. Lee Hartner: So that's an excellent question. And I think there are a few different considerations here. I will start by saying, as I think the audience knows, sarcomas are rare diseases. Most soft tissue masses that are encountered by practitioners in the community are not going to be sarcomas. They're going to be benign lesions. Having said that, there are a few things that can be looked for just on a clinical physical exam as well as history that can give an idea about whether something is more likely to be benign or, on the other hand, if it's potentially concerning. So location is one. And when I talk about location, I'm specifically talking about masses that are subcutaneous versus those that are in deeper tissues. In general, subcutaneous masses, ones that sit right under the skin, are much less likely to be malignant and are less concerning. Not that they can't be, but they're definitely less likely. Whereas those that seem to be in deeper tissues are more concerning.

The rate of growth is also important. So if somebody is evaluated by their physician for a lump that they feel, if it's seen to be growing relatively rapidly, that's certainly more concerning. If it doesn't really change much over say a few weeks' time, that is of less concern.

Symptoms in particular, pain is another one. A small soft subcutaneous mass, for example, a lipoma, will rarely cause pain and typically is asymptomatic. Whereas if somebody has, you know, a firmer deeper mass that's causing some discomfort, that also is of more concern. And then, that gets to one of the final points, which would be consistency. So how hard or soft is it, is it moveable? What size is it? All those different things are things that can be looked at to try to get a sense as to whether something is more likely to be malignant, say a sarcoma, or benign.

So the other thing I was going to talk about was the decision between biopsy and resection, and maybe that gets to some other topics we might talk about, but we see people who have had these things just biopsied, but also see people where lesions are removed without a biopsy and both of those things, which I'd like to touch on as we continue present their own unique challenges.

Melanie: Well, then let's hit that, Dr. Hartner. Speak to some of those challenges that you and your patients have experienced when certain lumps have been biopsied or

removed before these patients are seen by your team. And I would like you to just touch on adding many tests to the situation. Sometimes a provider might say, "Well, let's do an MRI. Let's do, you know, all of these tests," and it starts this whole cavalcade of testing procedures to see what it is.

Dr. Lee Hartner: Yeah, no, I agree. That can be very problematic. So I think testing is important, but needs to be done, I think, really based on physical exam findings and history. So for masses that are soft, not very big, easily moveable, seem to sit under the skin, honestly, I don't know that any testing needs to be done. I think something like that can just be monitored clinically. And if it grows, then it can be evaluated. Whereas something that is firmer, maybe not as easily moveable, seems to be a bit deeper would require further evaluations. So a mass like that, for example, would require imaging.

I think as far as some of the challenges go with biopsy, some of the issues that we can run into particularly when people are found to have sarcomas, so if a lesion is biopsied and the patient's going to have surgery, then that biopsy tract has to be encompassed in the surgery. So the issues there have to do with the location of the mass that's biopsied, but also the type of biopsy that's done, because sometimes physicians will do excisional biopsies or incisional biopsies, where they actually make a small incision, open up underneath and take a piece of the mass out. And that could be very problematic depending on where the incision is made, how long the incision is, whether the incision is vertical or horizontal, all these things play a significant role and can potentially significantly complicate care down the line.

The other issue just with biopsy is pathology. So, I tell my patients all the time one of the most important people on our team of sarcoma physicians is the pathologist, because sarcoma is not just one disease, sarcoma is over 50 diseases. And making the right diagnosis, getting the grade right, all those things have a lot to do with what we're going to recommend for treatment. So if somebody comes to me on the outside and has a biopsy done, the other thing to do is get it reviewed. And while that often is a relatively straightforward process, it can take time. Sometimes for example, we'll get a few slides and the pathologist won't be happy with the diagnosis, wants to request a block, which takes more time. Then, they have to run tests on that. So it can definitely delay care.

I think as far removing masses without any kind of imaging or evaluation, that's much more problematic. So again, I'll back up a second and say, if a physician is considering removing a mass, unless it is clearly subcutaneous, easily removed and has no real aggressive features, I think it really deserves imaging and we typically recommend a biopsy before we remove anything that could potentially be a sarcoma. So for any of those masses I mentioned before that are on the bigger side, more than say two, three centimeters, if they're firmer, if there's pain associated with them, if they seem to be in deeper tissues, if they're growing, all those, in my opinion, require imaging and really require biopsy before they're removed.

If a sarcoma is removed, in what we call an unplanned excision, meaning patient has surgery, but not for something that is thought to be cancer, then that increases the risk of recurrence. It can mean that they'll need a second surgery, one that could be more difficult for them. And it increases potentially the risk of disease going elsewhere. So, you know, I think those are really very important points. And I can tell you, I definitely see not infrequently people who come with just that history where there'll be a mass that's growing, it's removed, it's a deeper mass in many of these cases, one that I would certainly have evaluated further before surgery, then sometimes things can become quite complicated after that.

Melanie: What great points you just made, Dr. Hartner. Can you expand just a little bit more on the expertise of the pathologists?

Dr. Lee Hartner: Oh, definitely. I'm happy to do that. Like I said before, they're really critical. I could not do what I do without them. And I don't think that's overstating it at all. Because again, these are many different diseases and we treat them very differently. So when a pathologist looks at a biopsy, they are determining the type of sarcoma, but they're also determining the grade. Grade is a determination they make based on what the cells look like under the microscope, how typical or atypical they are, how rapidly they're dividing, whether or not the tumor has a necrosis in it, which often comes as a consequence of rapidly growing tumors.

And knowing the diagnosis, but knowing the grade has a lot to do with what we recommend. So for some sarcomas, we would recommend radiation followed by

surgery. But for others, I might give chemotherapy upfront. And while that doesn't happen often, it does happen. So the diagnosis is really critical because it makes a big difference in what we recommend. And if we have to get tissue from the outside, then get additional tissue, I mean, I've had situations where it can take three or four weeks to get all that testing done and make a diagnosis. And that's a delay in care, which obviously we really try hard to avoid. So, in a perfect world, having the opportunity to get the diagnostic biopsy done here so that we can expeditiously review the tissue, establish a diagnosis, that's ideal, I mean, as much as we can possibly do it.

Melanie: What an informative podcast this was, Dr. Hartner. As we wrap up speak please on how Penn Medicine physicians work with community physicians ensure that continuity of care and ultimately the best outcomes for sarcoma patients.

Dr. Lee Hartner: So we try very hard to work closely with our partners in the community. That's true for Penn hospitals in the community as well as. So for example, if a patient is sent here and if we do a biopsy, make a diagnosis, and if they have their initial treatment here, depending on the circumstances, you know, I try to send people back as much as possible to the physicians that sent them. I think from a medical oncology standpoint there are some people I treat here, but there are many who I send back and I have them treated by a local oncologist and I might just see them from time to time to go over scan results, help to plan next steps in treatment. And I think the same is true as much as possible on the surgery and radiation side. So we do endeavor to try to get people back to the physicians who sent them.

And then I think the other important part of that is we work really hard to get people in for evaluation as soon as possible. So if somebody calls, I often get emails, for example, or phone calls from people in the community saying, you know, "I had this case and this is what's going on" and we'll try to get them in as quickly as possible to expedite that workup, come up with an answer and a diagnosis and certainly figure out the treatment plan and, when appropriate, get them back to the people who sent them.

Melanie: Great information, Dr. Hartner. Thank you so much for joining us and sharing your incredible expertise with us today. To refer your patient to Dr. Hartner at Penn Medicine, please call our 24/7 provider-only line at 877-937-PENN or you can submit

your referral via our secure online referral form by visiting our website at pennmedicine.org/referyourpatient.

That concludes this episode from the specialists at Penn Medicine. Please always remember to subscribe, rate and review this podcast and all the other Penn Medicine podcasts.