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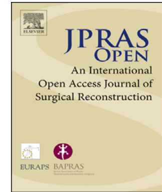

Case Report

Management of longstanding synovial sarcoma of the shoulder region – A case report

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ABSTRACT

Synovial sarcoma comprises approximately 8% of all soft tissue sarcomas. It occurs at all ages and it has a predilection for the extremities of young adults. We report here a patient who had synovial sarcoma over the shoulder joint and waited for six months before seeking any treatment. This patient was managed by a multidisciplinary team and discussed at a Tumour Board Meeting. She had neoadjuvant chemotherapy followed by tumour excision. Subsequently she had radiotherapy. The patient's upper limb was preserved and the function was not affected.

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Introduction

Synovial sarcoma was first described in 1893.[1] It comprises approximately 8% of all soft tissue sarcomas.[2] It occurs at all ages and primary tumours are localised throughout the body, with a predilection for the extremities of young adults.[3] The patients in our community usually seek early medical advice when they notice lumps. This patient was an exception as she waited for six months before seeking any treatment. In this report we present the role of preoperative workup, multidisciplinary team discussion and planning, Tumour Board discussion and neoadjuvant chemotherapy management in order to optimise the outcome and preserve the limb.

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Case report

A 24 years old right hand dominant college student presented to our department with a lesion over the anterior aspect of her right shoulder of 6 months duration. The patient gave a 2 years history of pain over the right shoulder before she noticed the lesion. She had a fine needle aspiration (FNA) done at the referring hospital and it was reported as spindle cell neoplasm in a myxoid background. She was otherwise healthy.

Clinically there was a large firm swelling. The patient had pain that was limiting the movements of the shoulder joint. There were no signs of neurological or vascular impairment.

MRI scan (Figure 1) shows a 7.4 × 5.2 × 8.6 cm intramuscular lesion involving the right pectoralis major and minor muscles and encasing 70% of the axillary neurovascular bundle. CT angiography (Figure 2) shows a heterogeneous mass anterior to the shoulder joint and anterolateral to the clavicle, displacing the axillary artery and vein posteriorly without invasion. Nerve conduction study was normal. Ultrasound guided biopsy confirmed synovial sarcoma. Metastatic workup was negative.

The case was discussed at the Tumour Board Meeting and a consensus decision of surgical excision was agreed. A multidisciplinary team consisting of plastic surgeons, orthopaedic oncology surgeon and vascular surgeon was formed. A planning meeting was conducted. However, initially the patient did not agree with the plan. She sought a second opinion overseas where a trial of chemotherapy was suggested. She returned to us and upon her request neoadjuvant chemotherapy was approved by the Tumour Board and given pre-operatively. A follow up MRI post chemotherapy (Figure 3) showed central necrosis but the tumour did not change in size. However, the patient reported improvement in terms of pain and shoulder function.

After lengthy discussion with the patient and her family, they consented for wide local surgical excision of the tumour with the possible need for sacrificing part of the neurovascular bundle if involved, and reconstruction by vein grafts and nerve grafts which could lead to impairment of the upper limb function. She also consented for limb disarticulation. The tumour was approached through incision as for lower brachial plexus exposure incorporating elliptical excision of the biopsy tract. Intra-operatively, the lesion was found to involve the pectoralis major, pectoralis minor, part of the deltoid,

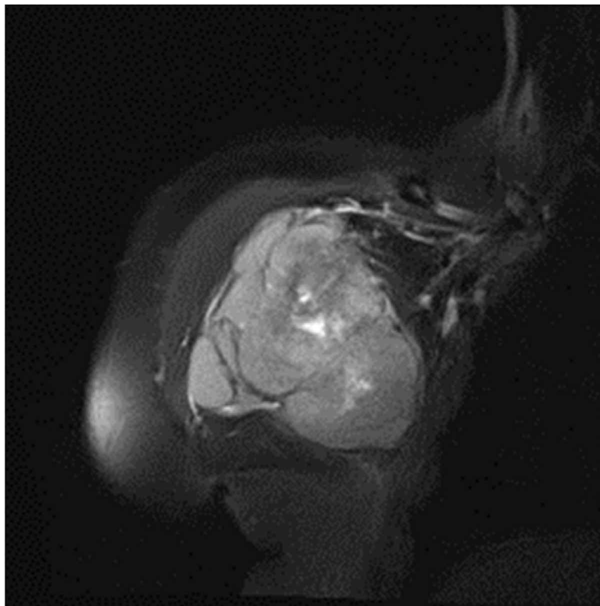

Figure 1. MRI scan showing intramuscular lesion involving right pectoralis major and minor muscles and encasing the axillary neurovascular bundle.

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