TARPSWG SEMIANNUAL MEETING
FRIDAY JULY 17, 2020 (VIRTUAL)

ATTENDEES:

Akira Kawai, Alessandro Gronchi, Anant Desai, Andraz Perhavec, Andrea Porpiglia, Andrew Hayes, Angela Hong, Anne Grandmaison, Barry Feig, Bernd Kasper, Carol Swallow, Carolyn Nessim, Cathy Davidson, Chan Raut, Christina Angeles, Christina Roland, Claire Wunker, Dan Blazer, Dario Callegaro, David Gyorki, David Kirsch, Deanna Ng, Dimitri Tzanis, Dirk Strauss, Dorian García-Ortega, Eisar Al-Sukhni, Elisabetta Pennacchioli, Elizabeth Baldini, Elizabeth Demicco, Emanuela Palmerini, Emily Keung, Eva Wardelmann, Ferdinando Cananzi, Gabrielle van Ramshorst, Gary Mann, Gaya Spolverato, Giovanni Grignani, Hannah Tattersall, Hayden Snow, Jacek Skoczylas, Jason Sicklick, Jeffrey Farma, Jen Dorsey, Jens Jakob, Joal Beane, John Mullinax, Jonathan Greer, Jonathan Trent, Jos van der Hage, Jose Gonzalez, Juan Carlos Marcos Enriquez, Jun Chen, Karla Martin, Ken Cardona, Krisha Howell, Kyo won Lee, Leandro Nikisch, Lore Lapeire, Lorella Rusi, Malcom Squires, Marco Fiore, Mark Fairweather, Marko Novak, Markus Albertsmeier, Martha Quinn, Matthew Spraker, Miranda Lam, Mohammad Alyami, Neha Goel, Nikolaos Memos, Nita Ahuja, Paul Huang, Pedro Martins, Piotr Rutkowski, Raza Sayyed, Rebecca Gladdy, Robert Maki, Roberta Maestro, Sally Burtenshaw, Samuel Aguiar Junior, Samuel Ford, Sav Brar, Sergio Quildrian, Shahbaz Hanif, Shintaro Iwata, Sinziana Dumitra, Stephanie Greco, Teresa Kim, Valerie Grignol, Varun Chowdhry, Wendy Johnston, William Tseng, Wim Ceelen, Winan van Houdt, Yael Babichev, Yen-Lin Chen, Yoon-La Choi, Yukihiro Yokoyama, Yvonne Schrage
Apologize: Sylvie Bonvalot

Welcome and Introduction (A. Gronchi)

-127 attendees registered to attend, largest ever, first meeting in this format
-100 participants signed in

RESAR Update

RESAR Update and Data Sharing Agreement: (M. Fiore)

- Dr. Fiore showed the update for RESAR:
  - 35 centers are actively contributing.
  - As of end of February 2020 we have collected data on 1524 cases since Jan 2017.
  - 15-20 more sites are in the process of joining RESAR
- **ACTION ITEM**: If you would like to be a participating Center, please contact Marco Fiore at marco.fiore@istitutotumori.mi.it

- Dr. Fiore gave an update on the Data Sharing Agreement for RESAR
  - The Main Framework Agreement is done and is now in the process of finalizing signatures with 8 centers. These centers are from Canada, the US, Europe and Australia and therefore cover all of the legalities involved for these various countries. All of these centers have agreed upon this contract through the lawyers at their respective contract offices. These 8 centers were the ones who specifically requested the need for a DTA. This framework agreement is an overarching agreement for all RESAR and non-RESAR projects. In this agreement, Milan is the receiving center and all other centers are the contributing centers. Current centers on the Framework agreement are:
    - Dana Farber
    - Ohio
    - John Hopkins

- Peter MacCallum
- Ottawa Hospital
- Birmingham University
- Leiden University
- Istituto Europeo di Oncologia

- We know there will be other centers that will want to be part of this Framework agreement. To facilitate this, it has been created in this contract that additional sites can be added to this agreement by simply reviewing the contract and signing Appendix 2 (Accession Form)
- For each additional RESAR and non-RESAR project an Appendix 1 (specific to that study) will be added to the Framework agreement. Given the Framework agreement is in place, signing of Appendix 1 will be quick and streamlined in your contracts office which will make collaboration on projects much easier and hopefully quicker.
  - Caveat This is only for projects where Milan is the receiving center and doing the analysis, and so this would not include Retrospective projects where another center is receiving the data and doing the analysis, like in some of our Retrospective projects, but we can maybe create something attached to this agreement in that regard in the future, again in the hopes to streamline DTAs for all projects.
- In order to sign Appendix 1 for a project you need to approve Appendix 2 first.
- Appendix 2 will only need to be signed once by a single institution.
- The Appendix 1 for the Complexity Score is currently being circulated for signature
- Appendix 1 for PelviSarc will also be circulated soon and so on.
- **ACTION ITEMS**: If you are a RESAR Center and need a DTA to share your Data for projects, please contact Marco Fiore (marco.fiore@istitutotumori.mi.it) to start the process to sign Appendix 2 (to be added to the Framework agreement), and Appendix 1 (Complexity Score) if your center id eligible for this study (prospectively enrolled in RESAR between Jan 2017 and Jan 2020)

Introduction to proposed projects (D. Gyorki)

- 3 proposed projects: complexity score project, global patterns of care, difference between anticipated and actual surgical plans

Complexity score project: (M. Fairweather)

- Primary RPS, 30-day post op morbidity of major post op complications (grade 3 or higher), IR procedure, return to OR, ICU care or death. (Excludes 1 and 2 -minor complications)
- Inclusion Criteria: RESAR patients Jan 2017 to July 2020
- Must go back retrospectively to capture date of complication out to 30-days post op. Date of complication was not initially collected in dataset but was recently added. (30-day morbidity main change)

- **ACTION ITEM**: Please let Dr. Fairweather know if you plan on participating in the Complexity Score Project. You can email him at: mfairweather@bwh.harvard.edu

Global patterns of care project: (H. Snow)

Variations in patterns of care for RPS (RT, CT, extent of Sx resection, time to treatment)

- Grouping of patients by institution and histotype to determine frequency of pre-tx variables, surgical variables and neo-adj treatment variables.
- Identify patterns between institutions
- uni and multivariable analyses to be performed between and within institutions.
- Plan is to collect RT dose details where included
    - Question: will there be central pathology or just information about local histology results?
        - Answers:
        - (A. Gronchi): Local histo results should be sufficient for this type of project
        - (C. Swallow): details of the pathology are still not consistent internationally, is an issue especially with LPS.
        - (H. Snow): the patterns are based on the information given for patterns in treatment plan.
- Overall, the group was supportive of this study idea. It is currently under review by the Research Evaluation Committee and they will address these questions. Once approved this study will be open to RESAR centers to opt-in. No additional data points are required to be collected for this study

Difference between anticipated resection and actual surgical resection: (M. Fiore)

- Estimate to have 1300-1400 patients that capture the data required to do this project, including details on radiology staging, anticipated resection, resection and microscopic invasion
- These data points stopped being collected on Jan 31, 2020 but this still leaves a large number of patients that do have this collected information
- No additional data points are required to be collected for this study
- Discussion: (C. Raut) extent of invasion is an interesting question to look at, not always anticipated by surgeons. This may drive 'dose painting' in RT based on patterns of invasion
- Overall the group was supportive of the project

ACTION ITEM: Marco Fiore to submit Proposal to the Research Evaluation Committee

Results of RESAR survey: (D. Gyorki)

- 16 responses from 3 countries.
    - Variability of time spent for entering data for each patient from 20mins to 3 hrs
    - 56% felt there were burdensome datapoints that could be excluded. These were mainly due to lack of standardization thus affecting the ability to capture some of these points

- 44% felt there are data points missing that would be nice to include.: These were mainly patient related factors, periop and pre op factors, QOL, PROs.
- Top 5 research questions? There were many suggestions already able to be done either with maturity of the data, proposing the project or already in progress
- How long should the registry be open for? Ongoing n=7, limited n=3

ACTION ITEMS: D. Gyorki and the RESAR Governance Committee will be taking these suggestions into account when finalizing the Centralized RESAR database to create a final and user friendly data dictionary

Centralized RESAR data: (A.Gronchi)

- Currently data is stored locally but the plan is to centralize the data in Milan
- Each center will still have access to their own data.
- Hopefully to be started in September
- Need to identify someone from IT department to be in charge of transition to the contact person for the softwarehouse.
- Platform will be able to randomize patients and will likely use REDCAP
- Centralized data collection will last at least until STRASS2 is completed
- The Data Sharing Framework agreement should stay applicable for when the RESAR data is centralized with potentially a need for a small amendment and thus the contract is in fact already in place.

ACTION ITEM: When it is time to set up the REDCAP database, Dr. Gronchi to contact Dr. Nessim as she already has the RESAR data dictionary adapted for REDCAP and this can be shared and uploaded with no need to start from Scratch and she can easily add the potential new data points required and remove those that are no longer going to be collected

STRASS2 Update: (W. vanHoudt-A. Gronchi)

- Randomized phase III study in LMS and G2/3 DDLPS with highest metastatic risk-intergroup collaboration with global partners, EORTC is leading group
- Eligibility criteria: histologically proven primary grade 2,3 LMS (>5cm) or grade 3 LPS (or grade 2 with no necrosis on biopsy but clear necrosis on imaging)
- Sub studies: Akynzeo (anti-emetic), Pro-gastrin- voluntary participation from individual
- 50 sites over 14 countries –multiple other collaboration groups identified and in progress
- 2.7M needed from other sources (1M from EORTC, 700K from EORTC cancer, 300K from another EORTC fund). Funding sources being explored currently
- Aim to open Sept 2020 with first site
- Involvement of radiologist important to clarify grade 2 LPS necrosis
- Translational research proposals are welcome
- Question: (R.Gladdy) : In EU tissue collection mandatory but outside is optional? Answer (W.VanHoudt) : Not mandatory but strongly encouraged
- Discussion:
    - (A.Gronchi): Once STRASS2 is started we will need to start thinking about STRASS3. Possible discussion on STRASS3 from R.Haas aiming to develop RT

study. PD1+RT would be a good option for a follow up study (C. Roland). Trabectedin + PD1 study may also be a possibility for futures studies (A.Gronchi), TMB to select patients for immunotherapy (C.Raut), Role of molecular profiling of tumors in treatment algorithms (J. Sicklick), CDK4 inhibitor and ICI for DD LPS (S. Iwata), RT for WD LPS (C.Raut).

ACTION ITEM: To create a separate working group to design different trial ideas. Dr. Roland was keen with this idea and will help create the working group.

Translational research opportunities (R. Gladdy)

- Mission of TARPSWG: current outcomes, evidence based expert consensus, prospective clinical trials all in progress and now need to facilitate translational research
- Current projects:
    - GIST data: Sicklick, Van Houdt, May- predictors of mutational status based on site of disease
    - Angiosacoma project: Raut and Broad Institute- direct to patient study of patients with angiosarcoma at any site. Mutational tumor burden may be associated with response and predict outcomes (high burden in Head and Neck Angiosarcoma)
    - LMS- Gladdy and Schlien –how different are primary and metastatic LMS? Early divergence of primary and metastatic clones, is there evidence that tumor arises decades before detection? Construction of tumor evolution through routine biobanking at expert centers.
- STRASS2 translational research- Wardelmann, Huag, Messiou- collection through STRASS 2, centralized in EU.Virtual biobanking for RPS TARPSWG (recently published)
- Majority of centers biobank (71%), limited germline banking (18%) which may be barrier to translational research
- All welcome to participate in this effort of biobanking, clinical annotation of samples and translational research..

ACTION ITEM: If you are interested in collaborating on Translational Research Projects, please contact Dr. Rebecca Gladdy at Rebecca.gladdy@sinaihealth.ca

SARveillance Trial (SART Trial) (S. Ford)

- Surveillance post retroperitoneal, abdominal and pelvic soft tissue sarcoma resection
- Single center retrospective study done in Birmingham, no impact on OS but did affect DFS as expected based on surveillance patterns
- Study Design planning and meeting took place in Ottawa Jan 2020 with Dana Farber, Milan, Netherlands, Peter Mac, Ottawa, McGill, Marsden and MD Anderson. Patients stratified into low and high intensity surveillance based on high grade/risk vs low grade/risk tumor
- Surveillance imaging through CT Chest abdo pelvis, MRI if CT contraindicated
- 10-year trial: 3 years recruitment and 7 years surveillance
- Number of patients needed to Randomize in low risk group is too high for OS as Primary endpoint but more doable for High grade tumours

- Primary Outcomes for High grade tumours : OS, PROs
- Primary Outcome for Low grade tumours: PROs with secondary outcome of OS
- Discussion:
- (C.Roland) Disparate surveillance strategies interesting, from a practical standpoint it may be a challenge to change the current protocol at each institution in terms of surveillance. Length of time of study also a concern, and cost involved with 10-year study timeline. To remedy this one option could be to randomize by center, where each center does a different arm. This study design has been done before
- (S. Ford) 7 years based on Sarculator timeline for validation, but could potentially shorten to 5 years.
- (D. Callegro): Sarculator can still be used as a substudy in the project
- (C.Nessim): Other ways to save money is to run this as a pragmatic trial

ACTION ITEM: Teleconference to held with all centers involved to continue finalizing study design. If any center is interested in participating in the SART trial please contact Sam Ford at samuel.ford@uhb.nhs.uk

REC (Non-RESAR Projects) Committee Update (C. Nessim)

- Research Evaluation Committee (REC): 8 members, all studies both RESAR and non-RESAR are reviewed by this group prior to invitation to participation

- Summary of process:
    - All RESAR or non-RESAR studies to be sent through REC for review
    - TARPSWG needs to be in the Title of the Manuscript
    - Can only lead max two projects at one time
    - Each study has an ID number to refer to in order to keep track of studies
    - All completed and open studies can be found on the website
- C. Nessim presented all of the publications already accepted, in progress and submitted to date

- Current and Upcoming Studies:
- Two studies open:
    - Intra-abdo desmoid study (C. Nessim and A. Gronchi)
    - Ganglioneuroma study (J. Sicklick)
- Upcoming studies:
    - DFSP (J. Farma)
    - Inguinal-Scrotal Sarcoma (S. Dumitra)
    - Natural History of WD LPS (M. Fairweather)
- Open RESAR studies:
    - Complexity Score (M. Fairweather)
    - Biopsy concordance with surgical pathology (A.Gronchi)
- Upcoming RESAR Studies:
    - Patterns of Care (H. Snow)
    - Anticipated vs Actual Resection (M. Fiore)

New TARPSWG Slides for Oral Presentations (W. VanHoudt)

- Template Powerpoint presentation slides for the group put together by Dr. Van Houdt's research fellow
- Given the many presentations that TARPSWG is doing, we would like these slides to be used
- Many icons and graphics included and template variations
- Can be downloaded from the website and please use freely for content from TARPSWG group (https://tarpswg.org/documents/).

Adjournment (A. Gronchi) and TARPSWG group picture

- The next meeting will be Virtual prior to the Virtual CTOS meeting in November. Details and Agenda to follow.