**Letter to the Editor Regarding - Soft tissue tumor imaging in adults: European Society of Musculoskeletal Radiology‑Guidelines 2023—overview, and primary local imaging: how and where?**

We (Noebauer-H. et al. 2023) thank the authors of “Ultrasonography of Superficial Soft-Tissue Masses: Society of Radiologists in Ultrasound (SRU) Consensus Conference Statement” (Jacobson 2022) for their valuable comment and feel that their recommendations are concordant with ours in almost all respects.

However, the perspectives of the two recommendation papers are different. The SRU guidelines reflect the experience of dedicated musculoskeletal (MSK) ultrasonographers and radiologists dealing with a large amount of benign superficially located lesions in their practice. The ESSR guidelines are derived from our experience at a multidisciplinary MSK tumor board in which we see a relatively large amount of soft tissue “oops lesions” in all age groups where ultrasound (US) was the only available preoperative examination.

We fully agree with the conclusion of the SUR consensus that US is an excellent first-line imaging method in the evaluation of a superficial soft-tissue mass. Many confident diagnoses can indeed be made, particularly by experts in MSK US. However, it must be kept in mind that superficial soft tissue sarcomas (S-STS) represent about one third of all extremity and truncal soft tissue sarcomas (Rydholm 1991, Gustafson 1994). On average, they are smaller (Rydholm 2003), measuring less than 5 cm in about 75% of the patients at the time of initial presentation (Salas 2009), which may cause misdiagnosis. Wide resection is a factor that influences local recurrence free survival (LRFS) and overall survival (OS) in patients with S-STS (Salas 2009). It has been shown that patients with S-STS initially managed outside specialized sarcoma centers undergo more operations, with risk of greater morbidity, and have greater risk of local recurrence (Tan 2018).

We also take note of the specific remarks expressed by the authors of the SUR consensus paper:

1. Superficial thoracic and abdominal wall lesions fall indeed in the first category as indicated in Fig.1. Incidentally detected lesions falling in the first category should also be treated as such. The third starting point, however, refers to deep masses (“thoracic, abdominal and other deep masses”), for which we recommend MRI or CT. The dashed arrows all indicate “consider action”. The dashed black line leads to the box “likely benign” on MRI: apart from the very typical lesions, there are some soft tissue lesions where an initial reliable diagnosis may not be possible even by MRI, such as some vascular malformations, or schwannomas with regressive changes and hemosiderin-containing lesions in joints, among others. Management of these lesions may be difficult, and therefore referring radiologists may consider surveillance or biopsy in a tumor center, or consultation of a tumor center.

2. We agree that that the list of lesions that can be diagnosed by US is much longer than the examples mentioned in our article. To address this, we used the term “include” to express that the list is not limited to these entities.

3. The ESSR recommendations regarding imaging techniques for evaluation of STT are intended for general radiologists without specialized expertise in MSK tumors or specific training or/and experience in advanced techniques. However, detailed elaboration on this was beyond the scope of our consensus paper.

The description of several superficial lesions with a characteristic appearance on US in the SRU consensus statement (Jacobson 2022) is well documented and very useful. The paragraph on other masses with less specific US features is -however- shorter. It should be emphasized that there are many superficially located solid lesions that may not be characterized on ultrasound alone, such as extradigital glomus tumors, or angioleiomyoma, among others. These lesions may be highly vascular and mimic more aggressive lesions. On the other hand, some malignant lesions such as synovial cell sarcoma, melanoma, or metastasis may be detected while still being small, especially in a superficial location. They may present as benign-looking and may be hypovascular on US (Chung 2015).

The SRU consensus statement does not elaborate on the limitations of US and does not provide guidelines when to consult a tumor center.

In summary, we acknowledge that the Consensus Conference Statement of the SRU on ultrasound in superficial soft tissue tumors is very valuable and is complementary to the European Society of Musculoskeletal Radiology Guidelines 2023 on soft tissue tumor imaging in adults. Many superficial soft tissue lesions can be safely diagnosed by ultrasound in the hands of an experienced radiologist. However, the main objective the ESSR Delphi-based consensus guidelines is to provide a safe and all-inclusive imaging algorithm of superficial and deep soft tissue tumors for all radiologists, including less experienced radiologists being non-expert in imaging of soft tissue sarcomas. We emphasize the importance of consulting a tumor center in any case of doubt, as it is of utmost importance to avoid initial diagnostic errors that may be harmful to the patient as they compromise further management and prognosis.

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