

Ideas and principles of action

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When looking back at the first steps of SSG the state of the art in diagnosis and treatment of sarcomas in the 1960s and early 1970s should be recalled. Bone sarcomas were oftenest treated by both oncological and orthopedic departments, whereas soft tissue tumors largely were treated by general surgeons. In each of the Scandinavian countries, there existed one or two local groups interested in sarcoma, but they could not, at the time be called as centers. Therefore experience with treatment was limited in various centers, since patients with these rare sarcomas were taken care of in different hospitals. The prognosis for bone sarcomas was dismal. Even after radiotherapy and amputation, the 10–15-year survival rates for patients with osteosarcoma and Ewing's sarcoma were only about 10–15%.

In the light of these facts, it seemed to be urgently necessary to change the organization of the care of sarcoma patients. New reports suggested that recently developed chemotherapeutic drugs might have better effects. Moreover, limb saving surgery internationally seemed to be tried a little oftener than before, although reconstruction after tumor resection by allografting had been used in Stockholm, Sweden, and Turku, Finland, already in the 1960s. This was the professional and scientific climate when, in the fall of 1979, 30 Scandinavian researchers and clinicians in the field of sarcoma gathered in Oslo to form a cooperative group. Among the leaders were Øyvind Solheim, Oslo, and Thor Alvegård, Lund, who were elected President and Secretary-general, respectively. One might, perhaps, wonder why the group was called Scandinavian. From the strictly formal geographical point of view, Scandinavia comprises a peninsula with Norway and Sweden together with Denmark, to the south. Finland and Iceland are Nordic countries, but it was felt that the joint effort of the five countries internationally could well be regarded as the Scandinavian Sarcoma Group.

The immediate task for this new organization was to strengthen the position existing local groups so that they could develop into national sarcoma centers. This was done by writing careful guidelines concern-

ing the referral of suspected sarcoma patients to these centers. The information was distributed to hospital and district doctors. In particular, it was stressed that the tumor should not be touched, and invasive procedures should only be performed at the sarcoma center. Of course it took a few years until this new approach was accepted. Bone tumors came first, soft-tissue tumors more gradually. But today, with few exceptions, all sarcoma patients are dealt with in a center belonging to the Scandinavian Sarcoma Group.

The next steps were to develop guidelines for handling all kinds of sarcomas. It was immediately realized that a close interdisciplinary collaboration was needed between the various specialists. First, each question was studied separately by subcommittees, representing the fields of radiology, pathology, surgery, chemotherapy and radiotherapy. Then a plenary meeting of the total group took place in which, after a few some adjustments, a protocol for some specific type of sarcoma care was agreed on. Thus uniform diagnostic and treatment programs were created for all five participating countries in the Scandinavian Sarcoma Group. These programs have also become the basis of the Central Register of SSG.

The Scandinavian countries have 24 million inhabitants. Centralized reporting of all sarcoma cases makes it possible to perform population-based studies on all aspects of sarcoma biology. Of course, it is not easy to bring such a multinational register to completion, but the rate of accrual is increasing.

An interesting and unusual feature of the Scandinavian Sarcoma Group is the absence of formal membership. Everybody interested is welcome at the meetings, which are always well attended (by around 130 participants). It was once under consideration to write statutes to formalize the activities of SSG. After rethinking, however, it was found that the present voluntary contributions should not be spoiled by overorganization. However, in one respect rules have been made. They concern the routines for publications based on experience of the SSG group. A Publication Committee supervises the presentations. The idea is that all contributing departments should be represent-

ed by the relevant author(s), whereas material from a single clinic can be used freely by the local group. It must be said that the atmosphere at the SSG meetings, and the collaboration between those in the group, are always enthusiastic and cordial. In later years developments in nuclear medicine and tumor genetics have brought new specialists into our group. It is evident that these new dimensions have increased our knowledge and understanding of tumor biology, which hopefully will have practical use in the treatment of sarcoma. In later years also metastases in skeletal cancer have become an interest of SSG, due to the similarities between oncological and surgical treatment of patients with sarcoma.

During the 20 years that the Scandinavian Sarcoma Group has existed remarkable progress in the treatment of sarcoma has been made. This is also true of

most of the western world and SSG has good relations and exchanges with other musculoskeletal oncological societies such as the Italian Sarcoma Group (ISG), the European MusculoSkeletal Oncology Society (EMSOS), the Connective Tissue Oncology Society (CTOS), the Society for International Oncology Pediatric (SIOP) and the European Organization for Research and Treatment of Cancer (EORTC). What advances in treatment can be foreseen? Will potent chemotherapy make surgery unnecessary? Or, if surgery is performed, will transplantation of whole extremities become a form of reconstruction after amputation? Perhaps these are speculations of a science-fiction type. What has been achieved so far in the Scandinavian Sarcoma Group is presented in the following articles in this publication.