



Treating Osteosarcoma

General treatment information

Great advances have been made in the treatment of osteosarcoma during the past few decades. In the 1960s the only treatment available was amputation, and only a small number of patients survived 2 years or more after diagnosis.

Since that time, doctors have found that chemotherapy given before and after surgery will cure many people with osteosarcoma. It can also allow some people who previously would have needed to have a limb amputated to have limb-sparing surgery instead.

Making treatment decisions

Once osteosarcoma is found and [staged](#), the cancer care team will talk with you about [treatment options](#). It's important to be sure you understand your options. Ask your cancer care team questions. You can find some good questions to ask in the section [What Should You Ask the Doctor About Osteosarcoma?](#)

Because osteosarcoma is rare, only doctors in major cancer centers have a lot of experience treating these cancers.

For children and teens, a team approach is recommended that includes the child's pediatrician as well as children's cancer specialists. Treatment is best done at a children's cancer center. For adults with osteosarcoma, the treatment team typically includes the patient's primary care doctor, as well as specialists at a major cancer center. Doctors on the treatment team might include:

- An orthopedic surgeon (a surgeon who specializes in muscles and bones) who is experienced in treating bone tumors
- A medical or pediatric oncologist (a doctor trained to treat cancer with

chemotherapy and other drugs)

- A radiation oncologist (a doctor trained to treat cancer with radiation therapy)
- A pathologist (a doctor specializing in lab tests to diagnose and classify diseases)
- A physiatrist (a doctor specializing in rehabilitation and physical therapy)

For both adults and children, the team will also include other doctors, physician assistants, nurse practitioners, nurses, psychologists, social workers, rehabilitation specialists, and other health professionals. For more information, see our document [Children Diagnosed With Cancer: Understanding the Health Care System](#).

The types of treatment used for osteosarcomas include:

- [Surgery](#)
- [Chemotherapy](#)
- [Radiation therapy](#) (in certain cases)

Most often, both chemotherapy and surgery are needed.

All of these treatments may have side effects, but many of them can be made less troublesome. Your medical team will help you take care of the side effects and can help you work closely with nutritionists, psychologists, social workers, and other professionals to understand and deal with medical problems, stress, and other issues related to the treatment.

Because many of these issues can be more complex for cancer in children and teens, many people will be involved in your child's overall care. As a parent, taking care of a child with cancer can be a very big job. It's important to remember that you will have a lot of help. It's also important for you to know that the health professionals who treat children with osteosarcoma are using the experience and knowledge gained from many decades of studying the treatment of this disease.

Thinking about taking part in a clinical trial

Clinical trials are carefully controlled research studies that are done to get a closer look at promising new treatments or procedures. Clinical trials are one way to get state-of-the-art cancer treatment. In some cases they may be the only way to get access to newer treatments. They are also the best way for doctors to learn better methods to treat cancer. Still, they are not right for everyone.

If you would like to learn more about clinical trials that might be right for you, start by asking your doctor if your clinic or hospital conducts clinical trials. See [Clinical Trials](#) to learn more.

Considering complementary and alternative methods

You may hear about alternative or complementary methods that your doctor hasn't mentioned to treat your cancer or relieve symptoms. These methods can include vitamins, herbs, and special diets, or other methods such as acupuncture or massage, to name a few.

Complementary methods refer to treatments that are used along with your regular medical care. Alternative treatments are used instead of a doctor's medical treatment. Although some of these methods might be helpful in relieving symptoms or helping you feel better, many have not been proven to work. Some might even be dangerous.

Be sure to talk to your cancer care team about any method you are thinking about using. They can help you learn what is known (or not known) about the method, which can help you make an informed decision. See [Complementary and Alternative Medicine](#) to learn more.

Help getting through cancer treatment

Your cancer care team will be your first source of information and support, but there are other resources for help when you need it. Hospital- or clinic-based support services are an important part of your care. These might include nursing or social work services, financial aid, nutritional advice, rehab, or spiritual help.

The American Cancer Society also [has programs and services](#) – including rides to treatment, lodging, and more – to help you get through treatment. Call our National Cancer Information Center at 1-800-227-2345 and speak with one of our trained specialists.

The next few sections describe the types of treatment used for osteosarcomas. This is followed by a discussion of the [most common treatment approaches based on the extent of the cancer](#).

The treatment information given here is not official policy of the American Cancer Society and is not intended as medical advice to replace the expertise and judgment of your cancer care team. It is intended to help you and your family make informed decisions, together with your doctor. Your doctor may have reasons for suggesting a treatment plan different from these general treatment options. Don't hesitate to ask him or her questions about your treatment options.

Surgery for Osteosarcoma

Surgery is an important part of treatment for virtually all osteosarcomas. It includes:

- The biopsy to diagnose the cancer
- The surgical treatment to remove the tumor(s)

Whenever possible, it's very important that the biopsy and surgical treatment be planned together, and that the same orthopedic surgeon at a cancer center does both the biopsy and the surgery to remove the tumor.

The main goal of surgery is to remove all of the cancer. If even a small number of cancer cells are left behind, they might grow and multiply to make a new tumor. To lower the risk of this happening, surgeons remove the tumor plus some of the normal tissue that surrounds it. This is known as *wide excision*.

A pathologist will look at the removed tissue under a microscope to see if the margins (outer edges) contain cancer cells. If cancer cells are seen at the edges of the tissue, the margins are called *positive*. Positive margins can mean that some cancer was left behind. When no cancer cells are seen at the edges of the tissue, the margins are said to be *negative*, *clean*, or *clear*. A wide excision with clean margins helps limit the risk that the cancer will grow back where it started.

The type of surgery done depends on the location of the tumor. Although all operations to remove osteosarcomas are complex, tumors in the limbs (arms or legs) are generally not as hard to remove as those at the base of the skull, in the spine, or in the pelvis.

Tumors in the arms or legs

Tumors in the arms or legs might be treated with either:

- Limb-salvage (limb-sparing) surgery: removing the cancer and some surrounding normal tissue but leaving the limb basically intact
- Amputation: removing the cancer and all or part of an arm or leg

Limb-salvage surgery: Most patients with tumors in the arms or legs can have limb-sparing surgery, but this depends on where the tumor is, how big it is, and whether it has grown into nearby structures.

Limb-salvage surgery is a very complex operation. The surgeons who do this type of operation must have special skills and experience. The challenge for the surgeon is to

remove the entire tumor while still saving the nearby tendons, nerves, and blood vessels to keep as much of the limb's function and appearance as possible. If the cancer has grown into these structures, they will need to be removed along with the tumor. In such cases, amputation may sometimes be the best option.

The section of bone that is removed along with the osteosarcoma is replaced with a bone graft (piece of bone from another part of the body or from another person) or with an internal prosthesis (a man-made device used to replace part or all of a bone) made of metal and other materials.

Complications of limb-salvage surgery can include infections and grafts or rods that become loose or broken. Limb-salvage surgery patients might need more surgery in the following years, and some might still eventually need an amputation.

Using an internal prosthesis in growing children is especially challenging. In the past, it required occasional operations to replace the prosthesis with a longer one as the child grew. Newer prostheses have become very sophisticated and can often be made longer without any extra surgery. They have tiny devices in them that can lengthen the prosthesis when needed to make room for a child's growth. But even these prostheses may need to be replaced with a stronger adult prosthesis once the child's body stops growing.

It takes about a year, on average, for patients to learn to walk after limb-salvage surgery on a leg. Physical rehabilitation after limb-salvage surgery is more intense than after amputation, but it's extremely important. If the patient doesn't actively take part in the rehabilitation program, the salvaged arm or leg can become useless.

Amputation: For some patients, amputation may be the best option. For example, if the patient has a large tumor that extends into the nerves and/or the blood vessels, it might not be possible to save the limb.

The surgeon decides how much of the arm or leg needs to be amputated based on the results of MRI scans and an examination of removed tissue by the pathologist during the surgery. Surgery is planned so that muscles and the skin will form a cuff around the remaining bone. This cuff will fit into the end of a prosthetic (artificial) limb.

Reconstructive surgery can help some patients who lose a limb to function as well as possible. For example, if the leg must be amputated mid-thigh (including the knee joint), the lower leg and foot can be rotated and attached to the thigh bone, so that the ankle functions as a new knee joint. This surgery is called *rotationplasty*. Of course, the patient would still need a prosthetic limb to extend the leg.

With proper physical therapy, the patient is often able to walk on his/her own 3 to 6 months after leg amputation.

If the osteosarcoma is in the upper arm and amputation is needed, in some cases the part of the arm with the tumor can be removed and the lower arm reattached so that the patient has a functional, but much shorter, arm.

Rehabilitation after surgery: This may be the hardest part of all the treatments, and this discussion cannot describe it completely. Patients and parents should meet with a rehabilitation specialist before surgery to learn about their options and what might be required after surgery.

If a limb is amputated, the patient will need to learn to live with and use a prosthetic limb. This can be particularly hard for growing children if the prosthetic limb needs to be changed to keep up with their growth.

When only the tumor and part of the bone is removed in a limb-sparing operation, the situation can sometimes be even more complicated, especially in growing children. Further operations might be needed in the coming years to replace an internal prosthesis with one more suited to their growing body size.

Both amputation and limb-sparing surgery can have pros and cons. For example, limb-sparing surgery, although often more acceptable than amputation, tends to lead to more complications because of its complexity. Growing children who have limb-sparing surgery are also more likely to need further surgery later.

When researchers have looked at the results of the different surgeries in terms of quality of life, there has been little difference between them. Perhaps the biggest problem has been for teens, who may worry about the social effects of their operation. Emotional issues can be very important, and support and encouragement are needed for all patients. (See [What Happens After Treatment for Osteosarcoma?](#))

Tumors that start in other areas

Pelvic tumors can often be hard to remove completely with surgery. But if the tumor responds well to [chemotherapy](#) first, surgery (sometimes followed by radiation therapy) may get rid of all of the cancer. Pelvic bones can sometimes be reconstructed after surgery, but in some cases pelvic bones and the leg they are attached to might need to be removed.

For a tumor in the lower jaw bone, the entire lower half of the jaw may be removed and

later replaced with bones from other parts of the body. If the surgeon can't remove all of the tumor, radiation therapy may be used as well.

For tumors in areas like the spine or the skull, it may not be possible to remove all of the tumor safely. Cancers in these bones may require a combination of treatments such as chemotherapy, surgery, and [radiation](#).

Surgical treatment of metastases

If the osteosarcoma has spread to other parts of the body, these tumors need to be removed to have a chance at curing the cancer.

If osteosarcoma spreads, most often it is to the lungs. Surgery to remove these metastases must be planned very carefully. Before the operation, the surgeon considers the number of tumors, their location (one lung or both lungs), their size and how they responded to chemotherapy, and the general health of the patient. Since the chest CT scan done before surgery might not show all of the lung tumors, the surgeon will have a treatment plan in case more tumors are found during the operation.

Patients who have tumors in both lungs and respond well to chemotherapy can have surgery on one side of the chest at a time. Removing tumors from both lungs at the same time may be another option.

Some lung metastases may not be able to be removed because they are too big or are too close to important structures in the chest (such as large blood vessels). Patients whose general health is not good (because of poor nutritional status or heart, liver, or kidney problems) might not be able to withstand the stress of anesthesia and surgery to remove metastases.

A small number of osteosarcomas spread to other bones or to other organs like the kidneys, liver, or brain. Whether these tumors can be removed with surgery depends on their size, location, and other factors.

Side effects of surgery

Short-term risks and side effects: Surgery to remove an osteosarcoma is often a long and complex operation. Serious short-term side effects are not common, but they can include reactions to anesthesia, excess bleeding, blood clots, and infections. Pain is common after the operation, and might require strong pain medicines for a while after surgery as the site heals.

Long-term side effects: The long-term side effects of surgery depend mainly on where the tumor is and what type of operation is done. Most osteosarcomas occur in bones of the arms or legs, and some of the long-term issues from surgery on these tumors are described above.

Complications of limb-sparing surgery can include bone grafts or prostheses that might become loose or broken. This is more likely than with surgery done for other reasons because chemotherapy used before and after surgery can increase the risk of infection and affect wound healing. Infections are also a concern in people who have had amputations, especially of part of a leg, because the pressure placed on the skin at the site of the amputation can cause the skin to break down over time.

As mentioned above, physical therapy and rehabilitation is very important for patients who have had surgery for osteosarcoma. Following the recommended rehab program offers the best chance for good long-term limb function. Even with proper rehab, people might still have to adjust to long-term issues such as changes in how they walk or do other tasks, and changes in appearance. Physical, occupational, and other therapies can often help people adjust and cope with these challenges.

For more general information on surgery as a treatment for cancer, see our document [Cancer Surgery](#).

- [References](#)

[See all references for Osteosarcoma](#)

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Chemotherapy for Osteosarcoma

Chemotherapy (chemo) is the use of drugs to treat cancer. The drugs are usually given into a vein or artery and can reach and destroy cancer cells throughout the body.

Chemo is an important part of the treatment for most people with osteosarcoma (although some patients with low-grade osteosarcoma might not need it). Most osteosarcomas don't appear to have spread beyond the main tumor when they are first

found. But in the past, when doctors tried to treat these cancers with surgery alone, they would often come back in other parts of the body, where they would be very hard to control. Giving chemo along with surgery helps lower the risk of these cancers coming back.

Most osteosarcomas are treated with chemo before surgery (known as *neoadjuvant chemotherapy*) for about 10 weeks and then again after surgery (known as *adjuvant chemotherapy*) for up to a year. People with high-grade osteosarcomas that responded well to chemo before surgery usually get the same chemo drugs after surgery. People whose tumors responded poorly usually get different chemo after surgery.

Doctors give chemo in cycles, with each period of treatment followed by a rest period to give the body time to recover. Each cycle typically lasts for a few weeks. The drugs used most often to treat osteosarcoma include:

- Methotrexate (given in high doses along with leucovorin to help prevent side effects)
- Doxorubicin (Adriamycin)
- Cisplatin or carboplatin
- Epirubicin
- Ifosfamide
- Cyclophosphamide
- Etoposide
- Gemcitabine
- Topotecan

Usually, 2 or more drugs are given together. Some common combinations of drugs include:

- High-dose methotrexate, doxorubicin, and cisplatin (sometimes with ifosfamide)
- Doxorubicin and cisplatin
- Ifosfamide and etoposide
- Ifosfamide, cisplatin (or carboplatin), and epirubicin

Many experts recommend that the drugs be given in very high doses when possible. This can affect the bone marrow (where new blood cells are made), which can result in dangerously low white blood cell levels and an increased risk of infections. In these cases, drugs called *growth factors* (such as filgrastim, also known as G-CSF) may be given along with the chemo to help the body make new white blood cells as quickly as possible.

Before starting chemo, the doctor might advise putting a catheter (a thin, soft tube) into

a large vein in the chest. This is sometimes called a *venous access device* (VAD) or *central venous catheter* (CVC). The catheter is inserted surgically while the patient is sedated (sleepy) or under general anesthesia (in a deep sleep). One end of the catheter stays in the vein, while the other end lies just under or outside the skin. This lets the health care team give chemo and other drugs and draw blood samples without having to stick needles into the veins each time. The catheter usually remains in place for several months, and can make having chemo less painful. If such a device is used, the health care team will teach you how to care for it to reduce the risk of problems such as infections.

Side effects of chemotherapy

Chemo drugs attack cells that are dividing quickly, which is why they work against cancer cells. But other cells in the body, such as those in the bone marrow (where new blood cells are made), the lining of the mouth and intestines, and the hair follicles, also divide quickly. These cells are also likely to be affected by chemo, which can lead to side effects.

Children tend to have less severe side effects from chemo than adults and often recover from side effects more quickly. Because of this, doctors can give them higher doses of chemo to try to kill the tumor.

The side effects of chemo depend on the type and dose of drugs given and the length of time they are taken.

General side effects: Many chemo drugs can cause side effects, such as:

- [Nausea and vomiting](#)
- Loss of appetite
- Diarrhea
- Hair loss
- Mouth sores

Because chemo can damage the blood-producing cells of the bone marrow, patients may have low blood cell counts, which can result in:

- Increased chance of [infection](#) (from a shortage of white blood cells)
- Bleeding or bruising after minor cuts or injuries (from a shortage of platelets)
- [Fatigue](#) or shortness of breath (from low red blood cell counts)

Most of these side effects are short-term and tend to go away after treatment is finished. Often there are ways to lessen these side effects. For example, drugs can be given to

help prevent or reduce nausea and vomiting, or to help get blood counts back to normal levels. Be sure to discuss any questions you have about side effects with the cancer care team, and tell them about any side effects so that they can be controlled.

Side effects of certain drugs: Some side effects are specific to certain drugs. Many of these side effects are rare, but they are possible. Before treatment, ask your cancer care team about the possible side effects of the drugs you or your child will be getting.

Ifosfamide and cyclophosphamide can damage the lining of the bladder, which can cause blood in the urine. The chance of this happening can be lowered by giving a drug called *mesna* during chemotherapy, along with plenty of fluids.

Cisplatin and carboplatin may cause nerve damage (called *neuropathy*) leading to numbness, tingling, or pain in the hands and feet. This often goes away or gets better once treatment is stopped, but it may be long lasting in some people. These drugs can sometimes affect hearing, especially of high-pitched sounds. Kidney damage can also occur after treatment. Giving lots of fluid before and after the drug is infused can help prevent this.

Etoposide can also cause nerve damage. It can also increase the risk of later developing a cancer of white blood cells, known as [acute myeloid leukemia](#). Fortunately, this is not common.

High-dose methotrexate can damage the white matter of the brain (called *leukoencephalopathy*) and the liver or kidneys. Before starting high-dose methotrexate, medicines are given to help protect the kidneys. Methotrexate blood levels may be checked to see how much leucovorin (also called *folinic acid*) should be given to help limit any damage to normal tissues.

Doxorubicin (Adriamycin) and epirubicin can cause heart damage over time. This risk goes up as the total amount of the drug that is given goes up, so doctors are careful to limit the total dose. Your (child's) doctor may order a heart function test before and during treatment to see if this drug is affecting the heart. A drug called *dexrazoxane* may be given along with the chemo to help lessen the possible damage.

Some chemo drugs can affect your (child's) ability to have children later in life. Talk to your (or your child's) cancer care team about the risks of infertility with treatment, and ask if there are options for preserving fertility, such as sperm banking.

The doctors and nurses will watch closely for side effects. Don't hesitate to ask your cancer care team any questions about side effects.

For more information on the possible late or long-term side effects of chemo, including infertility and second cancers, see the section [Long-term Effects of Cancer Treatment for Osteosarcoma](#).

Tests to check for side effects of chemotherapy: Before each treatment, your (or your child's) doctor will check lab test results to be sure the liver, kidneys, and bone marrow are working well.

The complete blood count (CBC) includes counts of white blood cells, red blood cells, and blood platelets. Chemo can lower the numbers of these blood cells, so blood counts will be watched closely during and after chemo. The white blood cells and platelets usually reach their lowest point about 2 weeks after chemo is given, though this can occur earlier with high-dose regimens.

Blood chemistry panels measure certain blood chemicals that tell doctors how well the liver and the kidneys are working. Some chemo drugs can damage the kidneys and liver.

An audiogram might be done to check hearing, which can be affected by certain chemo drugs.

If doxorubicin or epirubicin is to be given, tests such as an echocardiogram (an ultrasound of the heart) may be done before and during treatment to check heart function.

For more information on chemotherapy, see the [Chemotherapy](#) section of our website.

- [References](#)

[See all references for Osteosarcoma](#)

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Radiation Therapy for Osteosarcoma

Radiation therapy uses high-energy rays or particles to kill cancer cells. Osteosarcoma

cells are not easily killed by radiation, so radiation therapy doesn't play a major role in treating this disease.

Radiation therapy can be useful in some cases where the tumor can't be removed completely by [surgery](#). For example, osteosarcoma can start in hip bones or in the bones of the face, particularly the jaw. In these situations, often it's not possible to remove all of the cancer. As much as possible is removed, and then radiation is given to try to kill the remaining cancer cells. [Chemotherapy](#) is then often given after the radiation.

Radiation can also be used to help slow tumor growth and control symptoms like pain and swelling if the cancer has come back or surgery is not possible.

External beam radiation therapy

This is the type of radiation therapy most often used to treat osteosarcoma. It focuses high-energy beams on the tumor from a machine outside the body to kill the cancer cells.

Before treatments start, the radiation team takes careful measurements with imaging tests such as MRI scans to determine the correct angles for aiming the radiation beams and the proper dose of radiation.

Most often, radiation treatments are given 5 days a week for several weeks. Each treatment is much like getting an x-ray, although the dose of radiation is much higher. The treatment is not painful. For each session, you (or your child) will lie on a special table while a machine delivers the radiation from precise angles.

Each treatment lasts only a few minutes, although the setup time – getting you (or your child) into place for treatment – usually takes longer. Young children may be given medicine to make them sleep so they will not move during the treatment.

Newer radiation techniques, such as intensity modulated radiation therapy (IMRT) and conformal proton beam therapy, let doctors aim treatment at the tumor more precisely while reducing how much radiation nearby healthy tissues get. This may offer a better chance of increasing the success rate and reducing side effects. Many doctors now recommend using these approaches when they are available. (See [What's New in Osteosarcoma Research and Treatment?](#))

Possible side effects: The side effects of external radiation therapy depend on the dose of radiation and where it is aimed. Short-term problems can include effects on skin

areas that receive radiation, which can range from mild sunburn-like changes and hair loss to more severe skin reactions. Radiation to the abdomen or pelvis can cause [nausea](#), diarrhea, and urinary problems. Talk with your (child's) doctor about the possible side effects because there may be ways to relieve some of them.

In children, radiation therapy can affect the growth of the bones. For example, radiation to the bones in one leg might result in it being much shorter than the other. Radiation to the facial bones may cause uneven growth, which might affect how a child looks. But if a child is fully or almost fully grown, this is less likely to be an issue.

Depending on where the radiation is aimed, it can also damage other organs:

- Radiation to the chest wall or lungs can affect lung and heart function.
- Radiation to the jaw area might affect the salivary glands, which could lead to dry mouth and tooth problems.
- Radiation therapy to the spine or skull might affect the nerves in the spinal cord or brain. This could lead to nerve damage, headaches, and trouble thinking, which usually become most serious 1 or 2 years after treatment. Radiation to the spine might cause numbness or weakness in part of the body.
- Radiation to the pelvis can damage the bladder or intestines, which can lead to problems with urination or bowel movements. It can also damage reproductive organs, which could affect a child's fertility later in life, so doctors do their best to protect these organs by shielding them from the radiation or moving them out of the way whenever possible.

Another major concern with radiation therapy is that it may cause a new cancer to form in the part of the body that was treated with the radiation. The higher the dose of radiation, the more likely this is to occur, but the overall risk is small and should not keep children who need radiation from getting treatment.

To lower the risk of serious long-term effects from radiation, doctors try to use the lowest dose of radiation therapy that is still effective. Still, it's important to continue follow-up visits with your (child's) doctor so that if problems come up they can be found and treated as early as possible.

Radioactive drugs (radiopharmaceuticals)

Bone-seeking radioactive drugs, such as samarium-153, are sometimes used to slow tumor growth and treat symptoms such as pain in people with advanced osteosarcoma. These drugs are injected into a vein and collect in the bones. Once there, the radiation they give off kills the cancer cells.

These drugs are especially helpful when cancer has spread to many bones, since external beam radiation would need to be aimed at each affected bone. In some cases, these drugs are used together with external beam radiation aimed at the most painful bone metastases.

The major side effect of these drugs is a lowering of blood cell counts, which could increase the risk for infections or bleeding, especially if the blood counts are already low.

For more detailed information on radiation therapy, see the [Radiation Therapy](#) section of our website or our document [A Guide to Radiation Therapy](#).

- [References](#)

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Treatment Based on the Extent of the Osteosarcoma

Treatment for osteosarcoma depends on several factors, including the extent, location, and grade of the cancer, and on a person's age and overall health.

Localized, resectable osteosarcoma

These cancers have not been found to have spread to other parts of the body, and all of the visible tumor can be removed (resected) completely by [surgery](#).

High grade: Most osteosarcomas are high grade, meaning they will likely grow and spread quickly if not treated. The usual sequence of treatment for these cancers is as follows:

- Biopsy to establish the diagnosis.

- [Chemotherapy](#), usually for about 10 weeks.
- Surgery to remove the tumor, preferably by the same surgeon who did the biopsy. If cancer is found at the edge of the surgery specimen (meaning some cancer might have been left behind), a second surgery might be done to try to remove any remaining cancer. [Radiation therapy](#) might be given to the area as well.
- More chemo (for up to a year). If the initial chemo killed most of the cancer cells, the same drugs are often given again after surgery. If the initial chemo didn't work well, different drugs might be tried.

Chemotherapy is an important part of treatment for these cancers. Even when imaging tests don't show that the cancer has spread to distant areas, many patients are likely to have very small areas of cancer spread that can't be detected with tests. If chemotherapy isn't given, the cancer is more likely to come back after surgery.

In rare cases, surgery might be the first treatment (before chemo), especially for people who are elderly.

Low grade: A small number of osteosarcomas are low grade, meaning they are likely to grow slowly. Patients with low-grade, resectable osteosarcomas can often be cured with surgery alone (without chemotherapy). However, if the tumor removed by surgery is found to be high grade, chemotherapy might be recommended.

Localized, non-resectable osteosarcoma

These cancers have not been found to have spread to other parts of the body, but they can't be removed (resected) completely by [surgery](#). For example, they may be too large or too close to vital structures in the body to be resected completely.

As with other osteosarcomas, a biopsy is needed first to establish the diagnosis.

[Chemotherapy](#) is usually the first treatment for these cancers. If the tumor shrinks enough to become resectable it will be removed with surgery. This is followed by more chemotherapy for up to a year.

If the tumor is still unresectable after chemotherapy, [radiation therapy](#) can often be used to try to keep the tumor under control and to help relieve symptoms. This may be followed by more chemotherapy.

Metastatic osteosarcoma

These cancers have already been found to have spread to distant parts of the body

when they are diagnosed. Most often they have spread to the lungs. As with other osteosarcomas, a biopsy is needed first to establish the diagnosis.

[Chemotherapy](#) is usually the first treatment for these cancers. If all of the tumors are thought to be resectable after chemotherapy, they are removed with [surgery](#), sometimes in more than one operation. This is followed by more chemo for up to a year.

If some of the tumors remain unresectable after chemo, [radiation therapy](#) can often be used to try to keep them under control and to help relieve symptoms. This may be followed by more chemo.

Because these tumors can be hard to treat, clinical trials of newer treatments may be a good option in many cases.

Recurrent osteosarcoma

Recurrent cancer means that the cancer has come back after treatment. It may come back locally (near where the first tumor was) or in distant organs. Most of the time, if osteosarcoma recurs it will be in the lungs.

If possible, [surgery](#) to remove the tumor(s) is the preferred treatment, as it offers the best chance for long-term survival. If the cancer recurs at the original site on an arm or leg after limb-sparing surgery, amputation of the limb may be recommended.

[Chemotherapy](#) may be used for recurrent cancers as well, although its role in these cases is not clearly defined. If the cancer is not resectable, [radiation therapy](#) may also be used to help keep its growth in check and help relieve symptoms. Because these tumors can be hard to treat, clinical trials of newer treatments may be a good option.

- [References](#)

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