Rhabdomyosarcoma Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Rhabdomyosarcoma Be Found Early?
- Signs and Symptoms of Rhabdomyosarcoma
- How Is Rhabdomyosarcoma Diagnosed?

Stages, Risk Groups, and Outlook (Prognosis)

After a diagnosis of rhabdomyosarcoma, the stage (extent) and risk group of the cancer provide important information about the anticipated response to treatment.

- How Is Rhabdomyosarcoma Staged?
- Survival Rates for Rhabdomyosarcoma by Risk Group

Questions to Ask About Rhabdomyosarcoma

Here are some questions you can ask your cancer care team to help you better understand your child’s diagnosis and treatment options.

- What Should You Ask Your Doctor About Rhabdomyosarcoma?

Can Rhabdomyosarcoma Be Found Early?
At this time, there are no widely recommended screening tests for rhabdomyosarcoma (RMS). (Screening is testing for a disease such as cancer in people who don’t have any symptoms.)

Still, RMS often causes symptoms that allow it to be found before it has spread to other parts of the body. For example, small tumors that start in the muscles behind the eye often make the eye bulge. Tumors in the nasal cavity often cause nasal congestion, nosebleeds, or bloody mucus. When small lumps form near the surface of the body, children or their parents often see or feel them.

Many cases of RMS start in the bladder or other parts of the urinary tract and can cause trouble emptying the bladder or blood in the urine or in diapers. Tumors starting around the testicles in young boys can cause painless swelling that is often noticed early by a parent. In girls with RMS of the vagina, the tumor might cause bleeding or a mucus-like discharge from the vagina.

It can be harder to recognize tumors in the arms, legs, and trunks of older children because they often have pain or bumps from sports or play injuries.

There are many other causes of the symptoms above, and most of them are not serious, but it is important to have them checked by a doctor. This includes having your child’s doctor check out any pain, swelling, or lumps that grow quickly or don’t go away after a week or so.

About 1 in 3 of these cancers is found early enough so that all of the visible cancer can be removed completely by surgery. But even when this happens, very small tumors (which cannot be seen, felt, or detected by imaging tests) could already have spread to other parts of the body, which is why other treatments are needed as well.

Families known to carry inherited conditions that raise the risk of RMS (listed in What Are the Risk Factors for Rhabdomyosarcoma?) or that have several family members with cancer (particularly childhood cancers) should talk with their doctors about the possible need for more frequent checkups. It is not common for RMS to run in families, but close attention to possible early signs of cancer might help find it early, when treatment is most likely to be successful.

- References

See all references for Rhabdomyosarcoma

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Signs and Symptoms of Rhabdomyosarcoma

Rhabdomyosarcoma (RMS) can start nearly anywhere in the body, so there are no symptoms that show up in all cases. The symptoms of RMS depend on where the tumor is, how large it is, and if it has spread to other parts of the body.

- When the tumor is in the neck, chest, back, limbs, or groin (including the testicles), the first sign might be a lump or swelling. Sometimes it can cause pain, redness, or other problems.
- Tumors around the eye can cause the eye to bulge out or the child to appear to be cross-eyed. Vision might be affected as well.
- Tumors in the ear or nasal sinuses can cause an earache, headache, or sinus congestion.
- Tumors in the bladder or prostate can lead to blood in the urine, while a tumor in the vagina can cause vaginal bleeding. These tumors might grow big enough to make it hard or painful to urinate or have bowel movements.
- Tumors in the abdomen or pelvis can cause vomiting, abdominal pain, or constipation.
- RMS rarely develops in the bile ducts (small tubes leading from the liver to the intestines), but when it does it can cause yellowing of the eyes or skin (jaundice).
- If RMS becomes more advanced, it can cause symptoms such as lumps under the skin (often in the neck, under the arm, or in the groin), bone pain, constant cough, weakness, or weight loss.

One or more of these symptoms usually leads parents to bring a child to the doctor. Many of these signs and symptoms are more likely to be caused by something other than RMS. For example, children and teens can have bumps or pain from play or sports injuries. Still, if your child has any of these symptoms and they don’t go away within a week or so, check with your doctor so that the cause can be found and treated, if needed.

- References

See all references for Rhabdomyosarcoma
How Is Rhabdomyosarcoma Diagnosed?

Certain signs and symptoms might suggest that a person has rhabdomyosarcoma (RMS), but tests are needed to find out for sure.

Medical history and physical exam

If your child has symptoms that could be from RMS (or another type of tumor), the doctor will want to get a complete medical history to find out more about the symptoms and how long your child has had them. The doctor will also examine your child to look for possible signs of RMS or other health problems. For example, the doctor might be able to see or feel an abnormal lump or swelling.

If the doctor suspects your child might have RMS (or another type of tumor), tests will be needed to find out. These might include imaging tests, biopsies, and/or lab tests.

Imaging tests

Imaging tests use x-rays, magnetic fields, radioactive substances, or sound waves to create pictures of the inside of the body. Imaging tests can be done for a number of reasons, including:

- To help find out if a suspicious area might be cancer
- To determine the extent of a tumor or learn how far a cancer has spread
- To help determine if treatment is working

People who have or may have RMS will get one or more of these tests.

Plain x-rays
X-rays are sometimes used to look for tumors, but their use is limited mainly to looking at bones because they don’t show much detail in internal organs. A chest x-ray is sometimes done to look for cancer that might have spread to the lungs, although it isn’t needed if a chest CT scan is being done.

**Computed tomography (CT) scan**

The CT scan uses x-rays to make detailed cross-sectional images of parts of the body, including soft tissues such as muscles. Instead of taking one picture, like a regular x-ray, a CT scanner takes many pictures as it rotates around your child while he or she lies on a table. A computer then combines these pictures into images of slices of the part of the body being studied.

This test can often show a tumor in detail, including how large it is and if it has grown into nearby structures. It can also be used to look at nearby lymph nodes, as well as the lungs or other areas of the body where the cancer might have spread.

Before the scan, your child may be asked to drink a contrast solution and/or get an intravenous (IV) injection of a contrast dye that will help better outline abnormal areas. Your child may need an IV line for the contrast dye. The dye can cause some flushing (a feeling of warmth, especially in the face). Some people are allergic and get hives. Rarely, more serious reactions like trouble breathing or low blood pressure can occur. Be sure to tell the doctor if your child has any allergies (especially to iodine or shellfish) or has ever had a reaction to any contrast material used for x-rays.

CT scans take longer than regular x-rays. A CT scanner has been described as a large donut, with a narrow table that slides in and out of the middle opening. Your child will need to lie still on the table while the scan is being done. Younger children may be given medicine to help keep them calm or even asleep during the test.

**Magnetic resonance imaging (MRI) scan**

Like CT scans, MRI scans give detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets to create the images instead of x-rays. A contrast material called gadolinium may be injected into a vein before the scan to help show details better. This contrast material usually does not cause allergic reactions.

This test might be used instead of a CT scan to look at the tumor and the tissues around it. MRI is especially useful if the tumor is in certain parts of the body, such as the head and neck, an arm or leg, or the pelvis. MRI scans can help determine the exact extent of a tumor, because they can show the muscle, fat, and connective tissue around
the tumor in great detail. This is important when planning surgery or radiation therapy. MRI is also very useful if your child's doctor is concerned about possible spread to the spinal cord or brain.

MRI scans take longer than CT scans – often up to an hour. Your child may have to lie on a table that slides inside a narrow tube, which is confining and can be distressing. The test also requires a person to stay still for several minutes at a time. Newer, more open MRI machines, which are less confining, might be an option, but the test still requires staying still for long periods of time. The MRI machine also makes loud buzzing and clicking noises that can be disturbing. Sometimes, younger children are given medicine to help keep them calm or even asleep during the test.

**Bone scan**

A bone scan can help show if a cancer has spread to the bones, and is often part of the workup for anyone with RMS. This test is useful because it provides a picture of the entire skeleton at once.

For this test, a small amount of low-level radioactive material is injected into a vein (IV). The amount of radioactivity used is very low and will pass out of the body within a day or so. Over a couple of hours, the substance settles in abnormal areas of bone throughout the body. Your child then lies on a table for about 30 minutes while a special camera detects the radioactivity and creates a picture of the skeleton. Younger children can be given medicine to help keep them calm or even asleep during the test.

Areas of active bone changes attract the radioactivity and show up as “hot spots” on the scan. These areas may suggest cancer in an area, but other bone diseases can also cause the same pattern, so other tests such as plain x-rays or MRI scans, or even a bone biopsy might be needed.

**Positron emission tomography (PET) scan**

For a PET scan, a radioactive substance (usually a type of sugar related to glucose, known as FDG) is injected into the blood. The amount of radioactivity used is very low and will pass out of the body in a day or so. Because cancer cells in the body are growing quickly, they will absorb large amounts of the sugar.

After about an hour, your child will lie on a table in the PET scanner for about 30 minutes while a special camera creates a picture of areas of radioactivity in the body. The picture is not detailed like a CT or MRI scan, but it provides helpful information about the whole body.
PET scans are not used routinely to help diagnose RMS, but they can sometimes be helpful in finding out if suspicious areas seen on other imaging tests (such as bone scans or CT scans) are tumors. PET scans can also be repeated during treatment to monitor the cancer over time.

Some machines can do a PET and CT scan at the same time (PET/CT scan). This lets the doctor compare areas of higher radioactivity on the PET scan with the more detailed appearance of that area on the CT scan.

**Ultrasound**

Ultrasound uses sound waves and their echoes to make a picture of internal organs or tumors. For this test, a small, microphone-like instrument called a *transducer* is moved around on the skin (which is first lubricated with gel). It gives off sound waves and picks up the echoes as they bounce off the organs. The echoes are converted by a computer into an image on a screen.

Ultrasound can be used to see if tumors in the pelvis (such as prostate or bladder tumors) are growing or shrinking over time. (This test can’t be used to look at tumors in the chest because the ribs block the sound waves.)

This is an easy test to have, and it uses no radiation. Your child simply lies on a table, and a doctor or technician moves the transducer over the part of the body being looked at.

To learn more about these and other imaging tests, see our document Imaging (Radiology) Tests.

**Biopsy**

The results of imaging tests might strongly suggest that someone has RMS, but a biopsy (removing some of the tumor for viewing under a microscope and other lab testing) is the only way to be certain. Usually several different kinds of lab tests are done on the biopsy sample to sort out what kind of tumor it is.

Biopsies can be done in several ways. The approach used depends on where the tumor is, the age of the patient, and the expertise and experience of the doctor doing the biopsy.

**Surgical biopsy**
The most common biopsy approach is to remove a small piece of tumor during surgery while the patient is under general anesthesia (asleep). In some cases, nearby lymph nodes are also removed to see if the tumor has spread to them. The samples are then sent to a lab and tested.

**Needle biopsies**

If for some reason a surgical biopsy can’t be done, a less invasive biopsy using a thin, hollow needle may be done. There are 2 kinds of needle biopsies, each of which has pros and cons.

**Core needle biopsy:** For a core needle biopsy, the doctor inserts a hollow needle into the tumor to withdraw a piece of it (known as a *core sample*). If the tumor is just under the skin, the doctor can guide the needle into the tumor by touch. But if the tumor is deep inside the body, imaging tests such as ultrasound or CT scans might be needed to help guide the needle into place. The removed core sample is then sent to the lab for testing.

The main advantage of a core needle biopsy is that it does not require surgery, so there is no large incision. Depending on where the tumor is, adults and older children might not need general anesthesia (where they are asleep for the biopsy), but some younger children might. On the other hand, the specimen is smaller than with a surgical biopsy, and if the needle isn’t aimed correctly, it might miss the cancer. If the specimen is not a good sample of the tumor, another biopsy will be needed.

**Fine needle aspiration (FNA) biopsy:** For this technique, the doctor uses a very thin, hollow needle attached to a syringe to withdraw (aspirate) a small tumor sample. An FNA biopsy is best suited for tumors that can be reached easily (such as those just under the skin), although it can also be used for tumors deeper in the body.

The downside of FNA is that the sample is very, very small. The pathologist must be experienced with this technique and be able to decide which lab tests will be most helpful on a very small sample. In cancer centers that have the experience to extract the most information from very small amounts of tissue, FNA can be a valuable – though certainly not foolproof – way to diagnose RMS, but it is not usually the preferred biopsy technique.

See [Testing Biopsy and Cytology Specimens for Cancer](#) to learn more about different types of biopsies, how the tissue is used in the lab for disease diagnosis, and what the results can tell you.
Bone marrow aspiration and biopsy

These tests aren’t used to diagnose RMS, but they are often done after the diagnosis to find out if the tumor has spread to the bone marrow (the soft inner parts of certain bones).

The 2 tests are usually done at the same time. The samples are usually taken from the back of both of the pelvic (hip) bones, but in some patients they may be taken from other bones.

These tests might be done during the surgery to treat the main tumor (while the child is still under anesthesia), or they might be done as a separate procedure.

If the bone marrow aspiration is being done as a separate procedure, the child lies on a table (on his or her side or belly). After cleaning the skin over the hip, the doctor numbs the area and the surface of the bone with local anesthetic, which can briefly sting or burn. In most cases, the child is also given other medicines to help them relax or even be asleep during the procedure. A thin, hollow needle is then inserted into the bone, and a syringe is used to suck out a small amount of liquid bone marrow.

A bone marrow biopsy is usually done just after the aspiration. Small pieces of bone and marrow are removed with a slightly larger needle that is pushed down into the bone. Once the biopsy is done, pressure will be applied to the site to help stop any bleeding.

The samples of bone and marrow are sent to the lab, where they are looked at and tested for cancer cells.

Lumbar puncture (spinal tap)

Lumbar puncture is not a common test for RMS, but it might be done for tumors in the head near the covering of the brain (the meninges). This test is used to look for cancer cells in the cerebrospinal fluid (CSF), which is the liquid that bathes the brain and spinal cord.

For this test, the doctor first numbs an area in the lower part of the back near the spine. The doctor may also recommend that the child be given something to make him or her sleep so the spinal tap can be done without difficulty or causing harm. A small, hollow needle is then inserted between the bones of the spine to withdraw some of the fluid, which is then sent to the lab for testing.
Lab tests on the biopsy samples

A doctor called a pathologist looks at the biopsy samples under a microscope to see if they contain cancer cells. If cancer is found, the next step is to figure out if it is RMS. In rare cases, the pathologist can see that the cancer cells have small muscle striations, which confirms that the cancer is RMS. But most often, other lab tests are needed to be sure.

The pathologist might use special stains on the samples to identify the type of tumor. The stains contain special proteins (antibodies) that attach to substances in RMS cells but not to other cancers. The stains produce a distinct color that can be seen under a microscope. This lets the pathologist know that the tumor is a rhabdomyosarcoma.

Sometimes the tumor will also be tested for gene or chromosome changes, such as those discussed in the section Do We Know What Causes Rhabdomyosarcoma?

If a diagnosis of RMS is made, the pathologist will also use these tests to help determine which kind of RMS it is. This is important because it affects how the cancer is treated. For example, alveolar rhabdomyosarcoma (ARMS), which tends to be more aggressive, typically requires more intense treatment than embryonal rhabdomyosarcoma (ERMS).

Blood tests

No blood test can be used to diagnose RMS. But certain blood tests may be helpful once a diagnosis has been made.

A complete blood count (CBC) measures the levels of white blood cells, red blood cells, and platelets in the blood. If the CBC result is abnormal at the time of diagnosis it could mean the cancer has spread to the bone marrow, where these blood cells are made.

Standard blood tests are done often to check a child’s general health both before treatment (especially before surgery) and during treatment (such as chemotherapy) to look for possible problems or side effects. These tests often include a CBC to monitor bone marrow function and blood chemistry tests to measure how well the liver and kidneys are working.

- References
  See all references for Rhabdomyosarcoma
How Is Rhabdomyosarcoma Staged?

Once rhabdomyosarcoma (RMS) has been diagnosed and the type of RMS identified, doctors need to assess, as accurately as possible, how much cancer there is and where it has spread. The answers to these questions are expressed in a standard kind of shorthand known as staging.

The prognosis (outlook) for people with cancer depends, to a large extent, on the cancer’s stage. The stage of a cancer is one of the most important factors in choosing treatment.

Your child’s doctors will use the results of the imaging tests and biopsies (described in How Is Rhabdomyosarcoma Diagnosed?) and the direct examination of the organs during surgery to learn how far the cancer has spread. If there is any doubt about the extent of the cancer, more biopsies may be done on tissues at the edge of the tumor, nearby lymph nodes, and any suspicious lumps in other parts of the body.

To stage RMS, doctors first determine 3 key pieces of information:

- The type of RMS (embryonal or alveolar)
- The TNM stage
- The clinical group

These factors are then used to divide patients into risk groups, which then are used to guide treatment.

RMS is staged differently from most other cancers, and it can be confusing. If you have any questions about the staging or risk groups, ask the doctor or nurse to explain it to you in a way you understand.

The TNM stage

The TNM stage is determined before treatment starts, and is based on 3 key pieces of
information:

- **T**: The characteristics of the main tumor (location and size)
- **N**: Whether the cancer has spread to nearby lymph nodes (bean-sized collections of immune system cells)
- **M**: Whether it has metastasized (spread) to distant parts of the body

These factors are combined to determine an overall stage:

**Stage 1**

The tumor started in a favorable area:

- The orbit (area around the eye)
- The head and neck area, except for parameningeal sites (areas next to the membranes covering the brain, such as the nasal passages and nearby sinuses, middle ear, and the uppermost part of the throat)
- A genital or urinary site, except the bladder or prostate gland
- Bile ducts (tubes leading from the liver to the intestines)

The tumor can be any size. It may have grown into nearby areas and/or spread to nearby lymph nodes, but it has not spread to distant parts of the body.

**Stage 2**

The tumor started in an unfavorable site:

- The bladder or prostate
- An arm or leg
- A parameningeal site (an area next to the membranes covering the brain, such as the nasal passages and nearby sinuses, middle ear, or the uppermost part of the throat)
- Any other part of the body not mentioned in stage 1

The tumor is 5 cm (about 2 inches) or smaller across and there is no evidence that it has spread to nearby lymph nodes or distant parts of the body.

**Stage 3**

The tumor started in an unfavorable site:
• The bladder or prostate
• An arm or leg
• A parameningeal site (an area next to the membranes covering the brain, such as the nasal passages and nearby sinuses, middle ear, or the uppermost part of the throat)
• Any other part of the body not mentioned in stage 1

And one of the following applies:

• The tumor is 5 cm across or smaller but has spread to nearby lymph nodes
• The tumor is larger than 5 cm across and may or may not have spread to nearby lymph nodes

In either case, the cancer has not spread to distant parts of the body.

Stage 4

The tumor can have started anywhere in the body and can be of any size. It has spread to distant parts of the body such as the lungs, liver, bones, or bone marrow.

Clinical group

The clinical group is based on the extent of the disease and how completely it is removed during initial surgery. The groups are defined as follows.

Group I

This group includes children with localized RMS (the cancer has not spread to nearby lymph nodes or to distant sites in the body) that is removed completely by surgery.

About 10% to 15% of RMS patients are in group I.

Group II

This group includes children who have had all of the visible cancer removed by surgery, but cancer cells have been found at the edges (margins) of the removed specimen (meaning that there may have been a small amount of cancer left behind), in the nearby lymph nodes, or in both places. In all cases, as much of the cancer has been removed as possible.
About 20% of RMS patients are in group II.

**Group III**

These children have tumors that could not be removed completely. Some tumor was left behind that could be seen with the naked eye. The cancer may have spread to nearby lymph nodes, but there is no sign that it has spread to distant organs.

About 50% of RMS patients are in group III.

**Group IV**

At the time of diagnosis, these children have evidence of distant cancer spread to places such as the lungs, liver, bones, bone marrow, or to distant muscles or lymph nodes.

About 15% to 20% of RMS patients are in group IV.

**Risk groups**

Using the information about the type of RMS, the TNM stage, and the clinical group, doctors classify patients into 3 risk groups. Information about risk groups helps doctors decide how aggressive treatment should be.

The risk groups are based on what has been learned from previous research on patients’ outcomes. The groups discussed here are based on the most current information, but these may change in the future as safer and more effective treatments are developed.

**Low-risk group**

About 1 in 3 children with RMS falls into the low-risk group. It includes:

- Children with TNM stage 1 *embryonal* rhabdomyosarcomas (ERMS) that fall into clinical groups I, II, or III
- Children with stage 2 or 3 ERMS who are in clinical groups I or II

**Intermediate-risk group**
About half of children of RMS fall into the intermediate-risk group. It includes:

- Children with stage 2 or 3 ERMS who are in clinical group III
- Children with alveolar rhabdomyosarcoma (ARMS) that has not spread to distant parts of the body (stage 1, 2, or 3)

**High-risk group**

This group includes:

- Children with widespread (stage 4) RMS (ERMS or ARMS)
- References

See all references for Rhabdomyosarcoma

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Survival Rates for Rhabdomyosarcoma by Risk Group

Survival rates are often used by doctors as a standard way of discussing a person’s prognosis (outlook). Some people may want to know the survival statistics for those in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you would rather not read about the survival rates, skip to the next section, Treating Rhabdomyosarcoma

When discussing cancer survival statistics, doctors often use a number called the 5-year survival rate. The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Of course, many people live much longer than 5 years (and many are cured).

To get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Improvements in treatment since then might result in a better outlook for patients being diagnosed with rhabdomyosarcoma (RMS) now.
Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can't predict what will happen in any person’s case. For a person with RMS, the risk group is important in estimating their outlook. But many other factors can also affect a person’s outlook, such as their age, the location of the tumor, certain gene changes in the cancer cells, and how well the cancer responds to treatment.

Here are general survival statistics based on risk groups. These numbers come from large clinical trials treating children with RMS in the 1980s and 1990s.

**Low-risk group**

Overall, the 5-year survival rate for children in the low-risk group is over 90%. Most of these children will be cured.

**Intermediate-risk group**

For those in the intermediate-risk group, the 5-year survival rates range from about 60% to about 80%. The rate varies based on tumor location, stage, and the age of the child (children aged 1 to 9 tend to do better than older or younger children).

**High-risk group**

If the cancer has spread widely, the 5-year survival rate is generally around 20% to 40%. Again, it’s important to note that other factors, such as the patient’s age and the site and type of tumor will affect these numbers. For example, children with embryonal rhabdomyosarcoma (ERMS) and limited spread (to only 1 or 2 distant sites) have a higher 5-year survival rate. Also, children 1 to 9 years of age tend to have a better outlook than younger or older patients.

Even when taking risk groups and other factors into account, survival rates are at best rough estimates. Your child’s doctor is your best source of information on this topic, as he or she knows your situation best.

- References
  See all references for Rhabdomyosarcoma

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What Should You Ask Your Doctor About Rhabdomyosarcoma?

It’s important to have honest, open discussions with your cancer care team. They want to answer all of your questions, no matter how minor they might seem. For instance, consider asking these questions:

- What kind of rhabdomyosarcoma does my child have?
- Has the tumor spread beyond where it started?
- Do we need other tests before we can decide on treatment?
- Which risk group does the cancer fall into, and what does that mean?
- How much experience do you have treating this type of cancer?
- Will we need to see other doctors?
- What are our treatment options?
- Are there any clinical trials we might want to consider?
- What do you recommend and why?
- What are the risks and side effects to the suggested treatments?
- Which side effects start shortly after treatment and which ones might develop later on?
- Will treatment affect my child’s ability to grow and develop?
- Could treatment affect my child’s ability to have children later on?
- How soon do we need to start treatment?
- What should we do to be ready for treatment?
- How long will treatment last? What will it be like? Where will it be done?
- How will treatment affect our daily lives (school, work, etc.)?
- Based on what you’ve learned about the cancer, what is the outlook for cure?
- What will we do if the treatment doesn’t work or if the cancer comes back?
- What type of follow-up and rehab will be needed after treatment?

You might have other questions as well. For example, you might want to:

- Ask about getting a second opinion as to the best treatment option.
- Find out if the treatment schedule can be arranged so that your child will miss as little school as possible.
- Ask how to explain what is happening with your child so that other family members
and friends can understand.

- Ask about support groups that might help you benefit from the experience of other families who have been through this.

Also keep in mind that doctors are not the only ones who can provide you with information. Other health care professionals, such as nurses and social workers, may have the answers to some of your questions. You can find out more about speaking with your health care team in our document The Doctor-Patient Relationship.

- **References**

See all references for Rhabdomyosarcoma

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