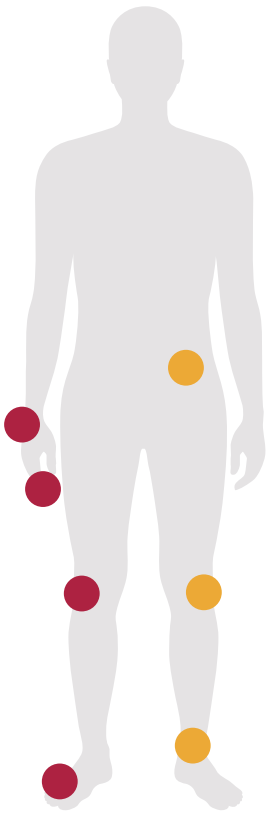
MORE CAN BE DONE TO OPTIMIZE TGCT PATIENT CARE

TGCT (TENOSYNOVIAL GIANT CELL TUMOR) IS A RARE NON-MALIGNANT TUMOR AFFECTING THE JOINTS[1,2]

TGCT is sometimes known as PVNS (pigmented villonodular synovitis)[3]



INCIDENCE:
5–45 PER MILLION PERSON-YEARS
diffuse-type TGCT (D-TGCT) and nodular-type (N-TGCT), respectively*[2]

AGE AT DIAGNOSIS:
35–50 YEARS[3]

COMMON SYMPTOMS:
PAIN, SWELLING, STIFFNESS AND LIMITED RANGE OF MOTION[3]

TWO CLINICALLY DISTINCT SUBGROUPS:

N-TGCT†
- **≈90%** of cases[4]
- Impacts smaller joints[5]
- Well-defined mass[5]
- Does not typically cause pain or joint dysfunction[5]

D-TGCT
- **≈10%** of cases[4]
- Impacts larger joints[5]
- Poorly-defined mass[5]
- More aggressive and destructive[5]

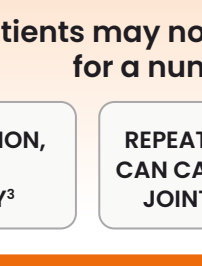
TGCT CAN LEAD TO CONSIDERABLE PHYSICAL AND PSYCHOLOGICAL BURDEN[10-12]

Physical and psychological burden[10,11]

92% REPORTED PAIN‡[10]
(n=457/497)

85% REPORTED LIMITED RANGE OF MOTION‡[10]
(n=423/497)

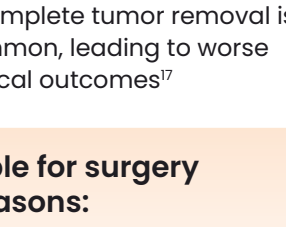
83%
(n=410/497)
REPORTED JOINT STIFFNESS‡[10]



19%
(n=25/135)
PRESENTED WITH AT LEAST MODERATE ANXIETY OR DEPRESSION¶[11]

Disruption to professional and social life[10,12]

63%
(n=187/299)
WERE UNABLE TO PERFORM SPORT ACTIVITIES§[12]



23%
(n=115/497)
CHANGED OCCUPATION OR RETIRED PREMATURELY DUE TO TGCT‡[10]

MEDIAN TIME TO A TGCT DIAGNOSIS IS ≈18 MONTHS[6]

CLINICAL PRESENTATION
Symptoms are generally non-specific[1]

IMAGING
Contrast MRI (gadolinium-enhanced)[3]

SUSPECTED TGCT
BIOPSY
A biopsy may be required for complex cases to confirm diagnosis[3]

CONFIRMED DIAGNOSIS

DELAYED DIAGNOSIS
- **TGCT is a slow, progressive disease** with subtle radiographic changes, making early detection difficult[6,7]
- Patients often visit multiple HCPs before receiving a TGCT diagnosis[1]

MISDIAGNOSIS
- **TGCT can be mistaken for other conditions** (e.g., rheumatoid arthritis)[1,8]

UNTREATED PATIENTS
- **If left untreated, TGCT can become debilitating.** Significant functional impairment is a potential complication[6]

ADVANCED DISEASE
- **Diagnosis delays may result in disease progression,** and further joint destruction[8,9]

SURGERY IS THE STANDARD OF CARE FOR TGCT BUT IS NOT ALWAYS CURATIVE[3]

N-TGCT
- Risk of recurrence: up to **15%**[13–16]
- Typically allows total resection[7]
- Generally, patients report excellent or good clinical results with surgery[7]

D-TGCT
- Risk of recurrence: **72%**[10]
- Incomplete tumor removal is common, leading to worse clinical outcomes[17]

Patients may not be eligible for surgery for a number of reasons:

- TUMOR LOCATION, SIZE AND COMPLEXITY[3]
- REPEATED SURGERY CAN CAUSE FURTHER JOINT DAMAGE[17]
- COMORBIDITIES[18]

Challenges in the management of TGCT

CHEMOTHERAPY
Not indicated for TGCT[3]

RADIOTHERAPY/CRYOTHERAPY
Insufficient data to support the treatment of TGCT[3]

SYSTEMIC THERAPIES
Availability of therapies may differ across countries

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PATIENTS AFFECTED BY TGCT SHOULD BE MANAGED WITHIN EXPERT CENTERS BY A DEDICATED, EXPERIENCED SARCOMA MULTIDISCIPLINARY TREATMENT TEAM[3]

*Incidence rates in The Netherlands (2009–2013).[2] †N-TGCT, also known as localized-type TGCT, is best referred to as nodular TGCT per the International Clinical Consensus.[3] ‡The TGCT Support Registry (launched 2022), collected questionnaire data every six months on patients' experiences. N=497 across 32 countries: diffuse (n=355), localized (n=94) and unknown subtype (n=48). Data cutoff: October 6 2022–December 6 2023.[10] §Outcome from an EU subgroup analysis of TOPP (N=137), a prospective, observational study of patients with D-TGCT. Data was analysed at baseline (12 months prior to entry) and after 12 months of follow-up.[11] ¶Members of the TGCT Facebook group, PVNS is Pants!!, completed a 6-month e-survey. Total: 337 responses from 30 countries (N-TGCT n=72; D-TGCT n=237).[12]

D-TGCT, diffuse-type TGCT; HCP, healthcare professional; MRI, magnetic resonance imaging; N-TGCT, nodular-type TGCT; PVNS, pigmented villonodular synovitis; TGCT, tenosynovial giant cell tumor; TOPP, TGCT Observational Platform Project.

This material is intended for healthcare professionals in Europe only.

References: 1. Berthnal NM, et al. *Orphanet J Rare Dis*. 2021;16(1):191. **2.** Mastboom MJL, et al. *Acta Orthop*. 2017;88(6):688–94. **3.** Stacchiotti S, et al. *Cancer Treat Rev*. 2023:112:102491. **4.** Robert M, et al. *Front Immunol*. 2022:13:820046. **5.** Choi WS, et al. *Cancers (Basel)*. 2024;16(2):402. **6.** Ansel S, et al. J *Med Case Rep*. 2023;17(1):419. **7.** Gouin F, Noailles T. *Orthop Traumatol Surg Res*. 2017;103(1S):S91–S97. **8.** Fecek C, et al. Pigmented Villonodular Synovitis. In: StatPearls. StatPearls Publishing; 2022. **9.** Wu CC, et al. *Ther Radiol Oncol*. 2019;3:17. **10.** Stern S, et al. *Future Oncol*. 2025:1–10. **11.** Lopez-Bastida J, et al. *Orphanet J Rare Dis*. 2021;16(1):294. **12.** Mastboom MJL, et al. *Interact J Med Res*. 2018;7(1):e4. **13.** Ehrenstein V, et al. *J Rheumatol*. 2017;44(10):1476–83. **14.** Palmerini E, et al. *Eur J Cancer*. 2015;51(2):210–7. **15.** Chiari C, et al. *Clin Orthop Relat Res*. 2006;450:172–8. **16.** Siegel M, et al. *PLoS One*. 2021;16(12):e0260795. **17.** Spierenburg G, et al. *J Surg Oncol*. 2022;126(6):1087–1095. **18.** Kolh P, et al. *Eur J Vasc Endovasc Surg*. 2016;51(6):857–66.

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