A Huge Benign Phyllodes Breast Tumor: Case Report

Dr. Trupal Desai*, Dr. Ankur Modi**

*3rd Year Resident Doctor, **Assistant Professor, Department Of General Surgery, CUSMC, Surendranagar, Gujarat

Abstract: Phyllodes tumors are rare fibro-epithelial lesions account for less than 1% of breast neoplasms. Most phyllods are benign but 10% are malignant. Accurate pre-operative pathological diagnosis allows correct surgical planning and avoidance of reoperation. Treatment can be either wide local excision or mastectomy to achieve histologically clear margin. Women aged between 35 and 55 years are commonly involved. Local recurrence occurs in approximately 15% of the patients and is more common after incomplete excision. Approximately 20% of the patients with malignant phyllodes tumors develop distant metastases. The role of chemotherapy, radiotherapy and hormonal manipulation in both the adjuvant and palliative setting remain to be defined. The lungs are the most common metastatic site, followed by the skeleton, heart and the liver. Symptoms of metastatic involvement can arise from as early as a few months to as 12 years after the initial therapy. It is also known as Cystosarcoma Phyllods. [Desai T Natl J Integr Res Med, 2021; 12(5): 83-85]

Key Words: Phyllods, Cystosarcoma, Malignant

Author for correspondence: Dr. Trupal Desai, 3rd Year Resident Doctor, Department Of General Surgery, CUSMC, Surendranagar, Gujarat E-Mail: trupald@gmail.com Mobile: 9662050238

Introduction: A 30 year old Hindu married female residing at near kholadiad, coming from lower social economical class came to surgery opd with complain of lump over left breast with skin and nipple areola complex involvement since last 3 months without any family history of similar complaint. She has complaint of fever since 2 days, low grade fever without chills and rigors without Any Diurnal changes and pain over local site during menstrual cycle. She has no any comorbidity. She was having lactational amenorrhoea since 6 months, and with 2 living child.She was married at 20 years of age.

On clinical examination vital parameters were found like normal temperature with tachycardia(110/min) and blood pressure around 100/64 mm hg with pallor present over lower palpable conjunctiva and without icterus, cyanosis, lymphadenopathy, oedema over foot.

The lump over left breast was around 20*25 cm involving left breast as whole, with smooth consistency, tense and tender on palpation with localised raised temperature with dilated veins and blackening over the some part of skin without muscle and chest involvement.

The lump was non transilluminant, non-fluctuant, non-compressible, non pulsatile, with nipple retracted to same side, without axillary lymph node enlargement. There were no similar signs over opposite side of breast. Laboratory tests were like haemoglobin 11.7 gm%, WBC were 10500/cm,and platelet count was 310000/cm. Her polymorphs were 86%.Her liver function test shows hypoalbuminemia with normal total protein, globulin and alkaline phosphatase. Her weight was around 30kgs.

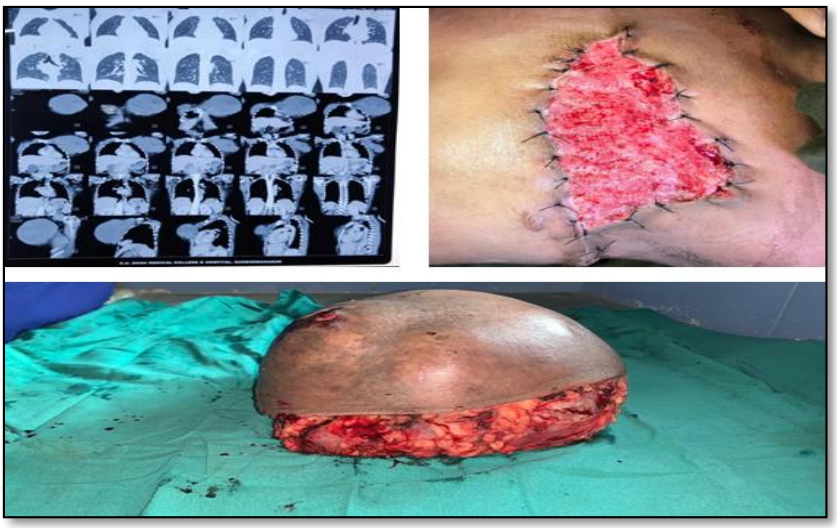
Radiological examination USG left breast was showing 18*12.5 cm mass which was well defined, large, lobulated, with few internal fibrotic strands with internal intact vascularity, and normal underlying muscles.

On mammographic examination both breast shows normal scattered fibro glandular breast parenchyma. On MSCT the left breast shows well defined minimal homogenously enhancing oval shaped soft tissue lesion in left breast with extension posteriorly abutting chest wall muscles and few lymph nodes with preserved fatty hilum in left axilla suggestive of phyllodes tumour.

On True cut biopsy there was proliferation of benign ducts as well as stromal cells with ducts showing increased layer of myoepithelial cells with clear morphology.

Stroma is highly cellular with mitotic index of less than two per ten high power field. At places stroma is compressing the ducts forming intra canalicular pattern with leaf like morphology, with few areas of myxoid degeneration and hyalination suggestive of phyllodes tumour.

Image 1: Preoperative MRI Of Patient And Excised Speciman Of Phyllodes Tumor And Raw Area Over Breast Region Intraop



After all investigation and resuscitation and antibiotic cover patient was taken for left simple mastectomy and the lump was removed with wide local margin and the wound was partially closed with Ethilon 2.0 Round cutting suture in simple intermittent manner. Daily dressing was done of the wound. After post operative day 14,the patient was planned for split thickness skin grafting from her left thigh. Post operative hospital stay was uneventful and graft uptake was 100% on 5th post operative day. Patient was discharged after 1 month of hospital stay from the day of admission. The Histopathological report of the excised specimen showed the findings of phyllods tumor with free margin.

Image 2: Intraoperative Photo After Draping The Area

Image 3: Splithikcness Skin Grafting Over The Ulcer

Discussion: Phyllodes tumours are usually found as an incidental finding during examination of female breast.These tumours are usually well circumscribed and painless with average size of 5 cm. But lesions measuring more than 30 cm have also been reported. It has peak incidence in 25 to 45 years of age. Aetiology of these tumours remains unknown.

The left breast is more commonly involved than right breast. These tumour grows radially and compress the surrounding breast parenchyma, a false capsule is created, through which tumours grows and extends in to healthy tissue. The overlying skin is usually shiny and translucent enough to reveal underlying veins at its initial presentation.

Ultimately tumour can cause ulcer or open wound on the skin. These tumours represent a character of sizeable malignant sarcoma, taking a leaf like appearance on gross examination. In most cases, it mimics fibroadenoma. Its malignant potential is very rare, lungs are the most common metastatic site, followed by the skeleton, heart and liver. The incisional and excisional biopsies are the definitive methods for diagnosing the phyllodes tumour, although core cut biopsy is a reliable investigation for diagnosis.

Complete surgical excision is the treatment of choice. However, particularly in the borderline and malignant phyllodes tumours the extent of excision is controversial as they penetrate in the surrounding healthy tissue. For that reason a wide local excision is done that must include a healthy tissue.

If the tumour size is more than 10 cm then prevalence of local recurrence is four times greater than smaller tumour whereas surgical margin of less than one cm the risk is increased by fivefold and stromal overgrowth increases the probability of local recurrence by seven fold. My patient had all these finding but there was no recurrence after surgery.

Preoperative diagnosis and proper management are crucial in phyllodes tumours because they have tendency to recur and also the malignant potential in some of these tumours.

Conclusion: Phyllodes tumour are rare entity for which early detection on the basis of history like rapid growing mass without axillary lymph node involvement and without skin involvement in young female of ages between 25 to 45 is necessary. Wide local excision or mastectomy should be performed ensuring histological clear margins. Axillary lymph node dissection is not required.

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