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CASE STUDY

A RARE CASE OF RECURRENT PHYLLODES TUMOUR

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ABSTRACT

Phyllodes tumours are rare and account for 0.4% of all breast tumours (Dyer *et al*., 1966). The majority of them tend to be less than 5 cms in size with giant tumours larger than 10 cms being about 20% of these cases. They display a broad range of clinical and pathological behavior and are regarded as falling within the spectrum of fibroepithelial neoplasms. Surgery has been the primary modality of treatment. However the extent of resection and the role of adjuvant radiotherapy and chemotherapy are still controversial. The risk of recurrence is (4.7% - 30%) for benign phyllodes tumour and (30% - 65%) for borderline and malignant phyllodes tumour (Popescu *et al*., 1991). A 46 year old female presented with complaints of lump in the right breast for six months. No other associated symptoms. She had undergone surgery 15 years back for the large right breast lump. On examination a swelling of sized 4x3 cms occupied in the upper outer quardrant of right breast with individual mobility within the breast. All basic investigations were normal. The Preoperative biopsy were phyllodes tumour. Hence we did right excision biopsy of the lump with 1cm clearence which were consistent with benign phyllodes tumour. The post operative periods were uneventful and is on regular follow up. The case is being presented for its rarity.

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INTRODUCTION

Phyllodes tumours are rare and account for 0.4% of all breast tumours (Dyer *et al*., 1966). The majority of them tend to be less than 5 cms in size with giant tumours larger than 10 cms being about 20% of these cases (Dyer *et al*., 1966). They display a broad range of clinical and pathological behavior and are regarded as falling within the spectrum of fibroepithelial neoplasms. Surgery has been the primary modality of treatment. However the extent of resection and the role of adjuvant radiotherapy and chemotherapy are still controversial. The risk of recurrence is (4.7% - 30%) for benign phyllodes tumour and (30% - 65%) for borderline and malignant phyllodes tumour (Popescu *et al*., 1991).

Case Report

A 46 year old female admitted with complaints of lump of right breast for 6 months duration without any associated symptoms. She has three children and having regular menstrual period. There was no comorbid illness. She had undergone surgery for a large right breast lump 15 years back. On local examination of right breast a lump of sized 4x3 cms, occupied in the upper outer quadrant of right breast with healthy scar in the breast. The mobility of the lump was independent from the right breast. No other significant findings noted over the right breast. The left breast was clinically normal. All basic investigations were within normal limits. We proceeded for preop biopsy confirmed as phyllodes tumour. Hence we performed right excision biopsy with 1 cm clearance (Fig 1.1). The post operative periods were uneventful. The excised specimen HPE was consistent with phyllodes tumour . the patient is on regular follow up (Figure 1.2)

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DISCUSSION

Phyllodes tumours are rare fibroepithelial lesions that account for less than 1% of all breast neoplasms (Dyer *et al*., 1966). With the non-operative management of fibroadenomas widely adopted, the importance of phyllodes tumours today lies in the need to differentiate them from other benign breast lesions. All breast lumps should be triple assessed and the diagnosis of a phyllodes tumour considered in women, particularly over the age of 35 years, who present with a rapidly growing "benign" breast lump. Treatment can be by either wide excision or mastectomy provided histologically clear specimen margins are ensured. Nodal metastases are rare and routine axillary dissection is not recommended (Popescu *et al*., 1991).

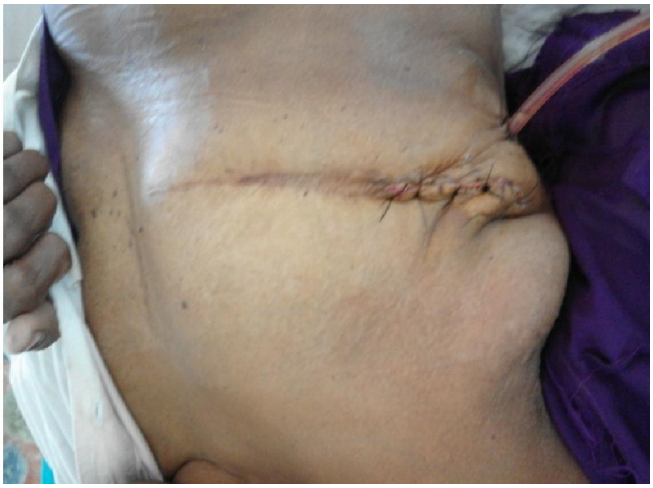

Fig. 1.2. Postoperative image of right excision biopsy of rec. Phyllodes with drain tube

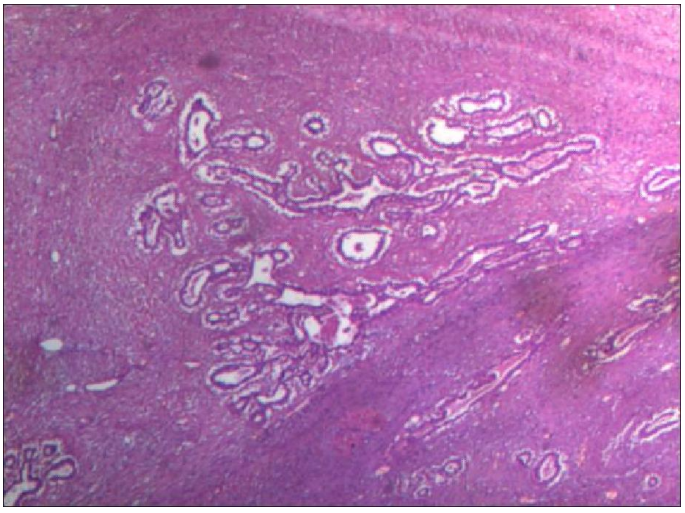

Fig. 1.2. The HPE of right benign phyllodes tumour of breast

Few reliable clinical and histological prognostic factors have been identified. Local recurrence occurs in approximately 15% of patients and is more common after incomplete excision. It can usually be controlled by further surgery. Repeated local recurrence has been reported without the development of distant metastases or reduced survival. Approximately 20% of patients with malignant phyllodes tumours develop distant metastases. Long term survival with distant metastases is rare. Phyllodes tumours are rare fibroepithelial lesions that account for less than 1% of all breast neoplasms. (Dyer *et al*., 1966; Popescu *et al*., 1991; Buchanan *et al*., 1995) First described by Johannes Müller in 1838 (Müller *et al*., 1838) he coined the term cystosarcoma phyllodes; a misleading description as the tumours are rarely cystic and the majority follow a benign clinical course. In total, more than 60 synonyms have been reported (Fiks *et al*., 1982) but today, the World Health Organisation regards phyllodes tumour as the most appropriate nomenclature (World Health Organisation) Displaying a broad range of clinical and pathological behaviour, phyllodes tumours should be regarded as a spectrum of fibroepithelial neoplasms rather than a single disease entity. At one extreme, malignant phyllodes tumours, if inadequately treated, have a propensity for rapid growth and metastatic spread. In contrast, benign phyllodes tumours on clinical, radiological, and cytological examination are often indistinguishable from fibroadenomas and can be cured by local surgery. With the non-operative management of fibroadenomas widely adopted, the importance of phyllodes tumours today lies in the need to differentiate them from other benign breast lesions.

A Medline search of the English literature published since 1975 was performed using the medical subject heading “phyllodes tumour”. Further articles were identified from the reference lists of papers reviewed. In view of the rarity of these tumours, most reported clinicopathological series are small, retrospective in nature, with limited long term follow up. As both phyllodes tumours and fibroadenomas belong to a spectrum of fibroepithelial lesions, accurate cytological diagnosis of phyllodes tumours by fine needle aspiration can be difficult (Chua CL, Thomas A *et al*., 1989). Cytologically, it is often easier to differentiate benign from malignant phyllodes tumours than to separate benign phyllodes tumours from fibroadenomas (Stebbing *et al*., 1995).The presence of cohesive stromal cells (phyllodes fragments), isolated mesenchymal cells, clusters of hyperplastic duct cells, foreign body giant cells, bipolar naked nuclei, and the absence of apocrine metaplasia are highly suggestive of a phyllodes tumour (Umpleby HC, Guyer PB *et al*., 1989). In the correct clinical setting, the presence of both epithelial and stromal elements within the cytological smear supports the diagnosis (Ciatto *et al*., 1992). Epithelial cells may, however, be absent from specimens taken from malignant lesions (Iau *et al*., 2003). The reporting of C3 (possibly benign) or C4 (possibly malignant) cytology from what appears to be a fibroadenoma should raise clinical suspicion of a phyllodes tumour (Oberman *et al*., 1965).With the increased use of core biopsies, preoperative diagnostic accuracy should improve and confusion with breast carcinomas should rarely occur (Amerson *et al*., 1970). The natural history of fibroadenomas has recently been clearly defined. With the negligible increased risk of malignancy and the recognition that 40% of fibroadenomas reduce in size over a two year period, non-operative management has been widely adopted (Adachi *et al*., 1993). With the low prevalence of phyllodes tumours among all benign breast lumps, routine excision of all benign breast lumps cannot be advocated. However, treatment protocols need to be adopted that allow the timely identification of phyllodes tumours. As most phyllodes tumours grow faster than fibroadenomas, histological assessment and possible excision of a benign breast lump should be considered if rapid growth is seen during a period of observation (Nambiar R, Kutty MK *et al*., 1974).

Conclusion

Hence we reported the recurrent benign phyllodes tumour to give the following information. Majority of recurrent phyllodes tumour of breast is because of inadequate surgical excision. So adequate excision with clearance is mandatory in all phyllodes cases. Local recurrence can usually be controlled by further wide excision and mastectomy is not invariably required. We presented this case for its rarity.

Footnotes

Source of Support: Nil

Conflict of Interest: Nil.

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