

Phylloides Tumour- A Case Report

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**Abstract**

*A case of phyllodes tumor of the breast which was diagnosed clinicopathologically and confirmed histopathologically in a 40 year old female presenting with a gradually increasing lump in the right breast is reported.*

**Introduction**

Infrequently, fibroadenomas may grow to very massive proportions, reaching diameter of 10 to 15 cm, the so-called giant fibroadenomas. Some of these large, bulky tumors become lobulated and cystic and on gross section exhibit leaf-like clefts & slits (phyllodes). They have been designated as cystosarcoma phylloides, an unfortunate term since such lesions can be either benign or malignant. They may distort the breast, produce bulges in the skin surface, and even cause pressure necrosis of the overlying skin to appear as an irregular mass. However, even this bizarre clinical behavior does not of necessity imply malignancy. Histologically, these lesions tend to have a more cellular myxoid stroma than do the usual fibroadenomas.

The most ominous change is the appearance of increased stromal cellularity, anaplasia, and high mitotic activity<sup>1</sup>. Malignant transformation is invariably accompanied by rapid increase in size, usually with invasion of adjacent breast tissue by malignant stroma. Malignant lesion may rear but tend to remain as localized lesion for some tissue. However, in tissue, metastasis to distant sites occurs in about 15% of cases. Most writers caution that, in many instances, anaplastic

changes may be found in masses that nonetheless are innocent clinically, and therefore overdiagnosis and overtreatment must be guarded against. Thus the term Phylloides tumour is preferable for these lesions<sup>2</sup>. The degree of histologic benignity or malignancy should be noted, dependent on the cytologic atypia and number of mitoses in stromal cells.

**Case Report**

A 40 year old married female with two children reported to the surgical out patient department of Holy Family Red Crescent Medical College Hospital on 25<sup>th</sup> June, 2001 with the complaints of slowly growing lump in the right breast for the last three years. The lump was painless but caused a dragging sensation in the right breast. She did not give any history of nipple discharge. The patient came from a lower middle class socio economic group and had a regular menstrual history.

On examination, she was slightly anxious, not anemic with average health. Dehydration & edema was absent. Her pulse rate was 80 per minute and regular and BP was 110/75 mm of Hg. Other systemic examination was normal. On local examination, the lump was found to occupy the whole of the right breast. The overlying skin over the breast was free and the lump was not fixed to underlying pectoralis major muscle. The right axillary lymph nodes were not enlarged. There was no change in the right areola or nipple. The lump felt hard in consistency.

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Laboratory investigations showed Hb- 10 gram/dL, WBC- 9000/ cmm. of blood with no significant differential count, ESR was 25 mm. in first hour, FBS was 5.2 mmol/ L. Chest X-ray was normal. As the patient was poor no further costly investigations were done except FNAC of breast which was reported as giant fibro adenoma.

As the whole right breast was involved and the patient has completed her family we decided to perform simple mastectomy of right breast, which was done under general anesthesia. The whole specimen was sent for histopathology. Microscopic examination revealed a tumor composed of epithelial and fibroblastic elements. The epithelial elements were arranged in glandular pattern and some areas composed into cleft like pattern. The stromal fibroblastic elements were cellular and were composed of uniform oval to elongated cells. No evidence of malignancy was seen. Histopathological diagnosis was: Phylloides tumor low grade (benign).

Postoperative recovery was uneventful.

### Discussion

The so-called giant fibroadenomas of the breast can attain massive proportions and some of them may become lobulated and cystic and on gross section exhibit leaf like clefts and slits (Phylloides). Though they have been previously designated as cystosarcoma phylloides which seems to be a misnomer since such lesions can be either benign or malignant. Thus the terms "Phylloides tumor" is more appropriate for

these lesions. The degree of histologic benignity of malignancy should be noted, dependent on the cytological atypia and number of mitosis in stromal cells. The breast Phylloides tumor can be conveniently classified as the following three types: Benign, borderline and malignant. It is important to diagnose and classify the breast phylloides tumor according to the involvement of tumor margin, stromal cellular atypia, mitotic activity, stromal overgrowth and tumor necrosis. There are significant differences of 5 years survival rates, recurrence rates and death rates between the benign, borderline and malignant breast Phylloides tumor. With wide excision the recurrence of the tumor decreased suggesting that broad excision is preferred for the benign phylloides tumor mastectomy is indicated for recurrent borderline and malignant tumors<sup>3</sup>.

### References:

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