Border line Phyllodes Tumor and DCIS of the Breast

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Summary

Phyllodes tumors Represent <1% of all breast tumors and 2% of fibroepithelial neoplasms, the stromal component presents as a proliferation thereof Within the intraductal tissue mammary With an epithelial component That is Characterized by a proliferation of epithelial cells, Which can present in some cases changes of ductal hyperplasia, apocrine metaplasia changes and even squamous, in very rare cases can be changes atypical ductal hyperplasia Observed with, in situ carcinoma and invasive carcinoma. This is why we present a case of borderline phyllodes tumor of the breast associated with a component of ductal carcinoma in situ in a 61-year-old woman, WHO presented a voluminous lesion of the left breast with ulcerated areas in skin progressively growing. Needle biopsy of the lesion palpable tumor benign phyllodes Reported.

Keywords: DIN Carcinoma; Phyllodes

Introduction

The phyllodes tumor was first described as cystosarcoma Phyllodes in 1838 by Johannes year Muller, this tumor appearance of fish meat with 1.2 foliáceo pattern. Macroscopically are neoplasms which may vary between 1 to 20 cm and are observed as unencapsulated multinodular aspect or as a single mass well-defined lesions, are generally bulky firm consistency and may alternate with softened areas or mucoid material hemorrhagic foci 3 Four. Phyllodes tumors are rare tumors and less than 1% of all breast tumors and approximately 2% of fibro epithelial tumors. They are lesions that do not have a predisposition to race on average are observed in women over 40 years’ age, with an average onset of 15 years later compared to the age of onset of fibroadenomas, although it should be considered to be occur at any age, rarely changes may occur to malignancy with atypical ductal hyperplasia, in situ carcinoma and even invasor1,5 carcinoma.

Clinical Case

It is female patient 61 years of age without medical or surgical significant history with V Gestas and V stop and menopause at age 50, that consultation with clinic 3-month history of tumor in the left breast of progressive growth, it is growing rapidly to ulcerated lesion periareolar location external to inferolateral (Figure 1) quadrants.

Figure 1: Patient 61 years left breast tumor ulcerated.

Breast ultrasound reported in left breast tumor greater than 14 cm, heterogeneous behavior with liquid areas and thickening of the skin with loss of continuity of the same level of external lower quadrant. Bilateral mammography, reports asymmetrical breasts with significant increase in size and density in left breast compromising its four quadrants, no calcifications (Figures 2,3) were observed
biopsy was performed with thick needle benign phyllodes tumor reported and planned, in view of the extent of the injury, for a simple total mastectomy. The definitive biopsy describes phyllodes tumor of intermediate grade of malignancy (borderline) with a tumor size of 19 x 11 x 3.5 cm, margins> 4 cm in the surgical specimen, marked hyperplasia with atypia in focal epithelial carcinoma foci component and DCIS low grade, with no evidence of metastases in the lymph nodes removed (Figure 4A). immunohistochemistry in situ component was performed reporting: estrogen receptor positive, progesterone receptor positive, negative and Ki67 Her2Neu 12% (Figure 4B).

**Discussion**

Phyllodes tumor represents the less than 1% of breast tumors and 2% of fibroepithelial tumors. It has a sudden increase up to 30% of cases. It has a tendency to local relapse and in some cases develop metastatic disease when it is classified as malignant. In the microscopic appearance phyllodes tumors it is presented as a fibroepitelial injury which many authors originate from periductal stromal than interlobular, characterized by a pattern of intracanalicular growth projections in sheet form with a histologically heterogenous where the predominant expansion and increasing the cellularity of stromal component near the epithelial component, the latter component can make changes ductal hyperplasia, apocrine changes and even squamous metaplasia, and rarely can occur changes to malignancy with atypical ductal hyperplasia, carcinoma in situ and to invasor1 carcinoma. The current WHO classification of 2012, for phyllodes tumors classifies them as: benign, borderline (borderline) and malignant, according to the following histological parameters [1]. Stromal overgrowth: defined as the absence of epithelial elements in at least one microscopic field of low power and being more pronounced in malignant phyllodes [2]. Mitotic Index: presenting <5 mitoses per field in benign tumors, 5-9 mitosis in tumors bordeline and> 10 mitosis in malignant [3]. the atypia and cellularity in the stromal cells are two more subjective elements may be present and evaluate mild, moderate or marked form according phyllodes tumor types and finally [4]. Tumor margins can be described circumscribing aspect benign or infiltrative lesions in malignas [1,4,5] lesions.

These tumors usually occur as a rapidly growing lesion and are unilateral lesions of hard consistency, alternating with unfixed deep structures remittent areas without compromising skin, although many times the overlying skin may become thinner and even necrotic causing ulcerations, is characteristic for the presence by collateral venous ectasia network of veins of the skin near the tumor. In the presence of an injury such study is imposed as ultrasound imaging, mammography or magnetic resonance imaging and histologic study. In young women, under 35 years, breast ultrasound is usually the first diagnostic tool, confirming a solid nodule, sometimes with heterogeneous areas polilobulado inside. On mammography, Surgery is the mainstay of treatment of breast phyllodes tumor, consisting lumpectomy or mastectomy depending on the size of tumor and breast tumor-related. Haagensen proposed that regardless of histology, removal of healthy tissue margin of 1 cm is a adecuado [6] treatment. Axillary dissection is not contemplated or malignant cases as hematogenous dissemination is basically, but can be felt axillary lymph up to 20%, but the presence of metastatic disease in them is less than
1% [7]. In cases of malignant phyllodes tumors, chemotherapy is not usually very effective results and radiotherapy is controversial results, being recommended in some centers. He phyllodes tumor shows significant variation in tumor size, larger tumors are more likely to be malignant, but evaluation of the biological behavior is based on the histological characteristics above. In our case despite the bulkiness of the lesion and the rate of growth, these factors determined as a phyllodes tumor of intermediate grade.

The appearance of a component of DCIS within a phyllodes tumor is a rare phenomenon and is not known the exact incidence, when it appears be treated both entities with independent oncological criteria for each disorder in our case we believe that the component phyllodes tumor treated with the simple total mastectomy with edges free resection neoplasias and greater margin of 2 cm, with carcinoma component in addition to the surgery site, immunohistochemistry was performed, noting that the lesion has estrogen receptors and progesterone positive, indicating hormone therapy. Currently the patient is 10 months free of recurrence. Have been reported to date 37 cases of phyllodes tumors associated with a component of carcinoma, the average age and size of these cases was 50 years and 7 cm, respectively, in our case the patient age was 61 years and one lesion size 19cm, markedly higher than the average of the reported series. In 32 cases (86%) was a component of carcinoma in situ, similar to the histopathological description of the reported case. Treating our patient was the simple total mastectomy, consistent with the described mainly in the different series. The adjuvant was not described steadily, however the most commonly performed was radiotherapy and hormone therapy (Table 1).

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>HISTOLOGY</th>
<th>AGE</th>
<th>Location</th>
<th>Surgery</th>
<th>adjuvant</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seemayer 1975 [8]</td>
<td>P. Maligno CDIS</td>
<td>27</td>
<td>ipsilateral</td>
<td>MTS</td>
<td>NR</td>
<td>6 cm</td>
</tr>
<tr>
<td>Leong 1980 [9]</td>
<td>Benigno P. CLIS</td>
<td>49</td>
<td>ipsilateral</td>
<td>MPO</td>
<td>NR</td>
<td>6 cm</td>
</tr>
<tr>
<td>Cole-Beuglet 1983 [10]</td>
<td>Benigno P. LCIS DCIS +</td>
<td>55</td>
<td>ipsilateral</td>
<td>MPO</td>
<td>NR</td>
<td>3.5 cm</td>
</tr>
<tr>
<td>Rosa 1989 [16]</td>
<td>P. benign CDIS</td>
<td>77</td>
<td>ipsilateral</td>
<td>MRMM</td>
<td>NR</td>
<td>5 cm</td>
</tr>
<tr>
<td>Schwickerath 1992 [18]</td>
<td>P. malignant DCIS</td>
<td>47</td>
<td>ipsilateral</td>
<td>MRMM</td>
<td>NR</td>
<td>2 cm</td>
</tr>
<tr>
<td>Padmanabhan 1997 [19]</td>
<td>P. malignant DCIS</td>
<td>47</td>
<td>ipsilateral</td>
<td>MRMM</td>
<td>NR</td>
<td>7.5 cm</td>
</tr>
<tr>
<td>Nishimura 1998 [21]</td>
<td>P. maligno CDIS</td>
<td>80</td>
<td>ipsilateral</td>
<td>MPO</td>
<td>NR</td>
<td>10.5 cm</td>
</tr>
<tr>
<td>Villanueva 1999 [22]</td>
<td>P. maligno CLIS</td>
<td>nr</td>
<td>Bilateral</td>
<td>MTS</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Alo 2001 [23]</td>
<td>P. maligno CDIS</td>
<td>39</td>
<td>ipsilateral</td>
<td>MTS</td>
<td>NR</td>
<td>9 cm</td>
</tr>
<tr>
<td>Parfit 2004 [24]</td>
<td>P. benign DCIS + CDI</td>
<td>26</td>
<td>ipsilateral</td>
<td>MPO + DA</td>
<td>Hor + Rt + qt</td>
<td>3.3 cm</td>
</tr>
<tr>
<td>Nomura 2006 [26]</td>
<td>P. malignant DCIS</td>
<td>75</td>
<td>ipsilateral</td>
<td>MTS</td>
<td>NR</td>
<td>3.5 cm</td>
</tr>
<tr>
<td>Yamaguchi 2008 [27]</td>
<td>P. benign CDIS</td>
<td>54</td>
<td>ipsilateral</td>
<td>MTS</td>
<td>NR</td>
<td>15 cm</td>
</tr>
<tr>
<td>Trabelsi 2010 [28]</td>
<td>P. borderline tubular Ca + DCIS</td>
<td>53</td>
<td>ipsilateral</td>
<td>MTS DA</td>
<td>Do not</td>
<td>15 cm</td>
</tr>
<tr>
<td>Yoshimori 2011 [29]</td>
<td>P. benign CDIS</td>
<td>53</td>
<td>ipsilateral</td>
<td>MPO</td>
<td>Rt</td>
<td>3.5 cm</td>
</tr>
</tbody>
</table>
**Conclusion**

We can conclude that, although the association of phyllodes tumor and in situ carcinoma is a rare association, should always be considered in the histopathological reports, since the therapeutic approach and prognosis of this type of patient varies, forcing us to develop new strategies oncologic control.

**References**


