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*Case Report*

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# A Surgical Experience of Poor Prognosis Outcome of Cystosarcomaphylloides Patient in Tripoli Medical Center: A Case Report

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## ABSTRACT

This is a case of fatal malignant cystosarcomaphyllodes in 43 years female is described the patterns of local recurrence and distant spread in this case. A review of the treatment recommendations for cystosarcoma phyllodes revealed is wide local excision with clear margin and mastectomy, and the ineffectiveness of radiotherapy and chemotherapy. Our observations in this case and the information we have obtained from the literature have prompted us to recommend a multidisciplinary approach for malignant cystosarcoma phyllodes.

***Keywords-*** *Cystosarcomaphyllodes; Wide local excision; Radiotherapy; Multidisciplinary team.*

## INTRODUCTION

Phyllodes tumors resemble fibroadenomas, account for 1% of breast malignancies, and usually occur in women from 30 to 70 years old.[1] In a study of 170 patients with phyllodes tumor, the mean age at presentation was 52 years.[2]

Phyllodes tumors often present as discrete, palpable masses, most commonly located in the upper outer quadrant of the breast. Phyllodes tumors usually grow slowly and are often painless. Nipple retraction and bloody nipple discharge may occur when the tumor involves the areolar region.[2-3]

On mammography, phyllodes tumors appear as lobulated, round, or oval masses. They are usually noncalcified and well circumscribed. On sonography, phyllodes tumors are usually well-defined, solid masses with heterogeneous internal echoes, without posterior acoustic attenuation. It is often difficult to differentiate phyllodes tumors from fibroadenomas on sonography or mammography, and it is not possible to distinguish between benign and malignant phyllodes tumors on the basis of sonographic or mammographic findings.[3]

The use of fine-needle aspiration is controversial in the preoperative diagnosis of phyllodes tumors. The accuracy of performing a core biopsy to diagnose phyllodes tumor has not been established. Although the diagnosis of phyllodes tumor may be made with fine-needle aspiration cytology or core biopsy, confidence in correctly diagnosing the lesion is significantly greater with excisional biopsy.[4]

Classification of phyllodes tumors is controversial. In general, phyllodes tumors may be classified as benign, borderline, or malignant; most phyllodes tumors are benign. Approximately 5-25% of phyllodes tumors are described as malignant. Fewer than 20% of the malignant tumors metastasize. When metastatic disease occurs, the metastases usually spread hematogenously to the lungs, pleura, or bone.[5]

Treatment of phyllodes tumor requires complete surgical excision with wide margins. Wide reexcision should be considered when the margins are involved microscopically or when the tumor shows an invasive growth pattern. Mastectomy is often performed for recurrent phyllodes tumor.[6]

## CASE REPORT

49 years female patient presented to the breast clinic in TMC, on 24/11/2013 with history of recurrent rapidly growing mass in the right breast and skin ulceration (Figure 1). She had previous two operations in the same breast since 2008 in the same hospital, both histopathology reported benign phyllodes tumor.

On examination the mass is involved all breast tissue with skin ulceration and a size of about 15×10 cm with palpable right axillary lymph nodes and also had left breast mass which is 3×2 cm.

Extended right mastectomy with lymph nodes sampling and left wide local excision on 02/12/2013. Unfortunately the histopathology reported right malignant sarcoma with inferior margin involved and hyperactive lymph nodes and left fibroadenoma. Post operative staging done CT scan chest and abdomen revealed mass in the left kidney with no other organs involvement.

The case discussed in the MDT and recommended for further surgery. Right wide excision of mastectomy flap with LDF skin cover and left nephrectomy by urologist at the same operation. Histopathology reported



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still involving margins and left renal cell carcinoma as different pathology. The case discussed again in the MDT and decided no benefit from chemotherapy or radiotherapy and only follows up. On 03/04/2014 patient re-admitted with recurrent rapidly growing mass on the site of mastectomy LD Flap (Figures 2 and 3). CT chest and abdomen showed large mass with local invasion to the chest wall and mediastinum (Figure 4). Patient send to Benghazi for palliative radiotherapy to right chest wall, the course started on 17/03/2014 (using 3D-conforme technique 27GY/9F for nine days without response and the tumor size continue to grow rapidly to enormous size. The patient re-admitted to our department for palliative treatment for pain control, finally the patient died in the hospital on 4th May 2014.

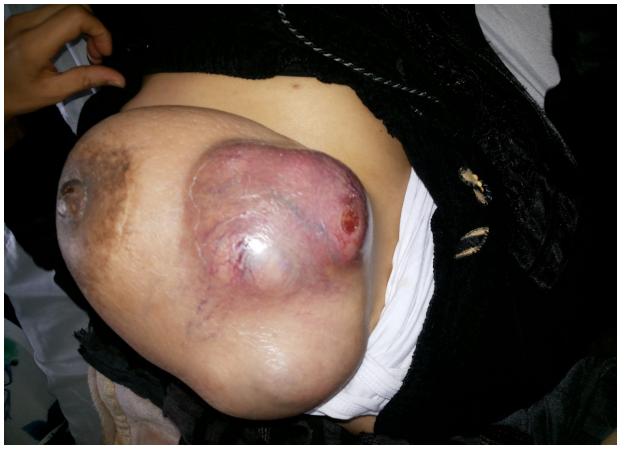

**Figure 1**: Recurrent rapidly growing fungating phyllodes tumor in the right breast of 49 years patient.

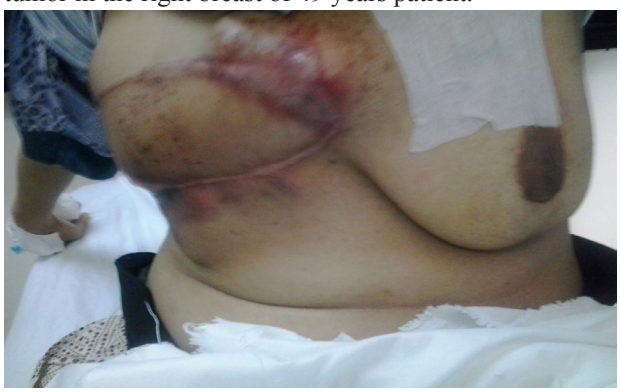

**Figure 2:** Recurrent locally metastasis malignant cystosarcomaphyllodes in the site of post mastectomy LD Flap

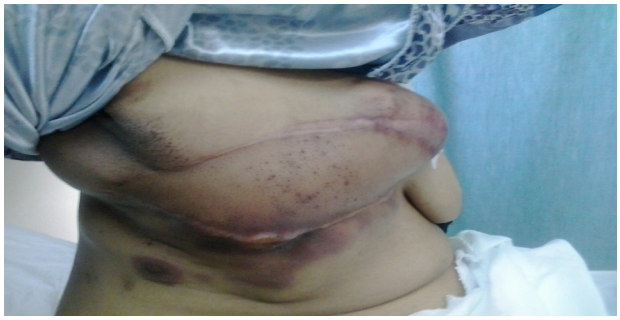

**Figure 3:** Right lateral view showed recurrent malignant cystosarcomaphyllodes in the site of post mastectomy LD Flap.

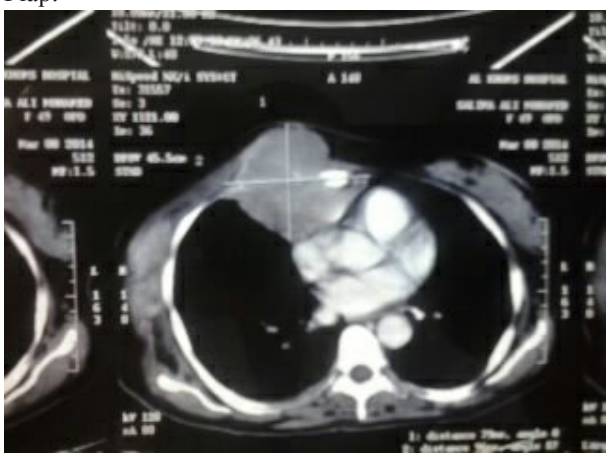

**Figure 4:** CT scan of 49 year patient showed metastasis of malignant phyllodes tumor to the chest wall and mediastinum.

## DISCUSSION

As there is limited data, the percentage of benign versus malignant phyllodes tumors is not well defined. Reports suggest, however, that about 85-90% of phyllodes tumors are benign and that approximately 10-15% are malignant.[7]

Although the benign tumors do not metastasize, they have a tendency to grow aggressively and can recur locally, similar to other sarcomas, the malignant phyllodes tumors metastasize hematogenously.[8]

Perform axillary lymph node dissection only for clinically suspicious nodes.[9] However, virtually all of these nodes are reactive and do not contain malignant cells.

If the tumor-to-breast ratio is sufficiently high to preclude a satisfactory cosmetic result by segmental excision, total mastectomy with or without reconstruction is an alternative. More radical procedures are generally not warranted.[10]

The long-term prognosis is excellent following adequate local excision. However, the possibility for local recurrence following excision always exists; particularly with lesions that display malignant histology.[11,12]

Unfortunately this case was not managed properly at early stage and also had poor follow up, therefore the patient presented after four years with malignant cystosarcomaphyllodes of the breast.

Recurrent malignant cystosarcomaphyllodes tumors seem to be more aggressive than the original tumor, the lungs are the most common metastatic site, followed by skeleton, heart and liver.[13] Most patients with metastases die within 3 years of initial treatment, there is no cures for systemic metastases exist.[14]

## CONCLUSION

Our observations in this case and the information we have obtained from the literature have prompted us to recommend a multidisciplinary approach for benign

and malignant phyllodes tumor, and encourage the subspecialty instead of general surgery to improve the medical service in TMC.

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