MAMMARY SARCOMA - MALIGNANT PHYLLODES TUMOR - CASE REPORT

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ABSTRACT

This article reports a case of a 49-year-old female patient with a large, low-grade malignant phylloid tumor. It is a rare type of breast sarcoma that has presented satisfactory evolution with surgical treatment without the need for chemotherapy.

KEYWORDS: PHYLOID TUMOR, SARCOMA.

INTRODUCTION

Breast sarcomas constitute a histopathologically heterogeneous group, which arise from the connective tissue of the breast. They may develop primarily in the breast or after breast radiotherapy or, still, related to lymphedema of the upper limb/breast, resulting from the treatment of another malignant neoplasia.[1]

The most common type after previous breast therapy is the angiosarcoma.

In the group of sarcomas of the breast we can find the phyllodes tumor. More frequent in patients between 30 and 50 years old, it may or may not be associated with fibroadenomas.[2]

Despite the infrequent presentation in the breast, there are reports of cases of primary lymphomas, melanomas and breast metastases of tumors coming from other organs.

The Phyllodes Tumor, also known as cystossarcoma phyllodes, is rare, more common in black people and benign in 80% of cases. More frequent in patients that are between 30 and 50 years old, and may be associated with fibroadenomas. It presents as a single, encapsulated, bulky, multinodular, lobulated, painless, with rapid growth and fibroelastic consistency.

Histologically they are similar to fibroadenomas, with epithelial and stromal elements, however, hypercellular. They can be classified as benign, borderline or malignant, based on stroma hypercellularity, margin, mitotic index and cell pleomorphism.

The diagnosis is mainly clinical due to the advantageous dimensions typical of the tumor. Ultrasonography shows large tumors, usually with cystic areas inside. Needle biopsy is poorly applicable due to the false negative index, with surgical excision being preferred.

CASE REPORT:

ACMO, 49, menarche at 11, nulliparous, pre-menopausal with regular cycles. She denies smoking and drinking. Denies family history of breast cancer. Lupus carrier. On physical examination: Right breast tumor measuring 15x14 cm (Figure 1). Mobile axillary lymph nodes. Core Biopsy and right mastectomy with sentinel lymph node were performed. Pathological anatomy showed malignant Phyllodes Tumor and free armpits (Figure 2). There was no need for chemo or radiation therapy.

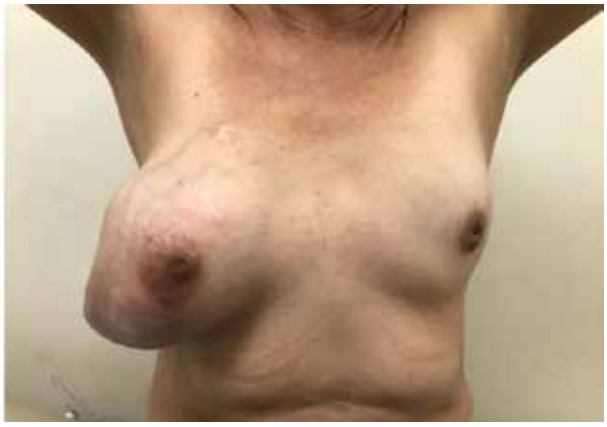

Figure 1. Malignant phyllodes tumor. Large tumor occupying the entire right breast.

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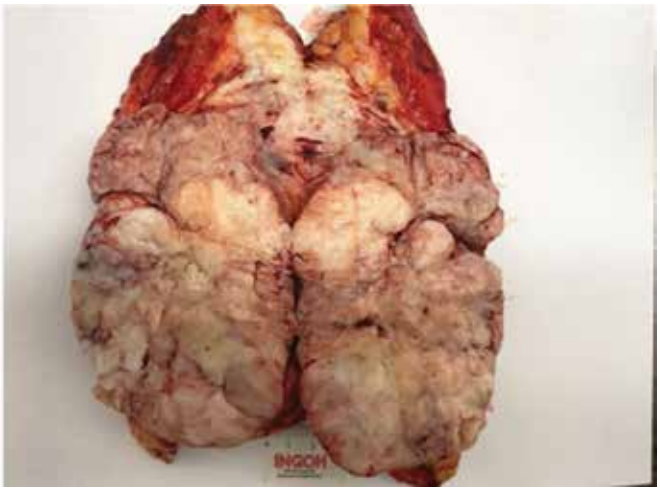

Figure 2. Malignant phyllodes tumor in the right breast. Macroscopic aspect of the lesion.

DISCUSSION

It is a tumor of predominantly clinical diagnosis and eminently surgical treatment. Its subdivisions aim to classify the prognosis and, therefore, the surgical approach to be taken to prevent/minimize recurrences. Post-surgical recurrences occur in 16% to 43% of cases of conservative surgery. Its drainage is hematogenous with low axillary involvement, so there is no need for ganglionic emptying of the axilla. It has low response to radiotherapy. Chemotherapy is rarely indicated and, due to its low positivity of hormone receptors, hormone therapy is also not indicated.[3]

FINAL CONSIDERATIONS

Surgery is the procedure of choice in the treatment of sarcomas, when the intention is curative. Mastectomy is necessary for large tumors and/or that appear in previously irradiated areas.

Adjuvant chemotherapy must be evaluated individually, taking into account the patient's clinical conditions, age, toxicity to previous therapies, comorbidities and, mainly, histological type sensitivity to chemotherapeutic agents.[4]

In the case of metastatic disease, the use of palliative chemotherapy follows the same protocols used for soft tissue sarcomas in general.

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