



A RARE CASE ENTITY: PHYLLOIDES TUMOUR IN AN ADOLSCENT GIRL

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KEYWORDS :

A 16 years old prepubertal female student, resident of Palghar, Maharashtra came to Surgical OPD with complaints of lump in right breast since 6 months, pain over lump since 1 week. The patient gave history that the patient accidentally found the lump while bathing six months back which was initially a mound, gradually increased in size involving half of the breast, initially painless to then painful, intermittent with dragging pain, partly relieved by medication. The patient denied any discharge from nipple or similar complaints in the past or on the other side. The patient also denied similar complaints in family member. The vitals recorded were normal and the patient was examined under broad day light and with proper consent. Local examination revealed a 10 x 8 cm, well-circumscribed, firm and freely mobile lump occupying the entire right breast with dilated veins over the swelling. The nipple were everted and at the same level as the contralateral side. The left breast was normal, and there was no axillary lymphadenopathy.



Clinical Presentation Of The Patient

A thorough workup of the patient revealed Evidence of 10 mm heterogeneously hypochoic lesion noted in right upper medial Large mixed echogenic nodular lesion in right lateral breast region extending to areolar region with hardly any vascularity measuring 8 x7 cm in size in right breast likely to be - - - Giant fibroadenoma. FNAC of the lump revealed sheets and clusters of ductal epithelial cells with overlying occasional myoepithelial cells. The cells were monomorphic in appearance with bland nuclear feature. Background show bare bipolar nuclei and myxoid material. There was no evidence of malignancy seen. A wide local excision of the patient was planned with 0.5cm determined for clear margins. .Excision of the lump revealed a lump of 11 x 6 x 5 cm with irregular margins with weight of 355 gm.

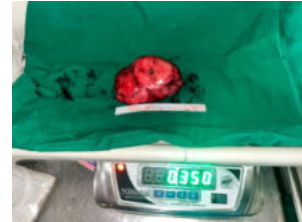


Figure 2 & 3- Lump with breast side-to-side, Weight of the lump.

The entire mass was sent for histopathological examination which revealed it was a benign phyllodes tumor with spindle cell neoplasm margins reaching the inked surface.

The patient was kept for observation for 5 days, the check dressing done on 3rd day.



Figure 4- Post operative wound with scar

The patient was regular for follow up and had no significant post operative complaints.

INTRODUCTION

Breast cancer in males represents a small proportion of all cancers diagnosed. Pure ductal carcinoma in situ (DCIS), a low-grade form of breast cancer, is even more rare in male patients. We present a case of a 47-year-old male patient with a tender breast lump that was noted for 6 months. He was subsequently found to have a low grade, pure micropapillary and cribriform type DCIS with no evidence of invasive disease. Current literature does not provide distinct guidelines regarding management of male breast cancer, and it is currently managed in a similar fashion to female breast cancer.



Male breast cancer is very rare and represents 1% of all cancers diagnosed in the USA [1]. Pure ductal carcinoma in situ (DCIS) in a male is even more rare and represents ~0.1% of all breast cancers [2]. Proposed risk factors for development of DCIS in men is the same as the risks factors for any male breast cancer and includes age, family history, exposure to radiation, conditions causing increased estrogen to androgen ratio (Klinefelter, obesity), and pathological gene mutations (CHEK2, BRCA2 > BRCA1) [3]. Management of male breast cancer stems from understanding of female breast cancer due to a lack of research in men and includes combinations of surgery, radiation and chemotherapy. Imaging for these patients is difficult as gynecomastia is often present and can mask underlying calcifications or carcinoma.

CASE REPORT

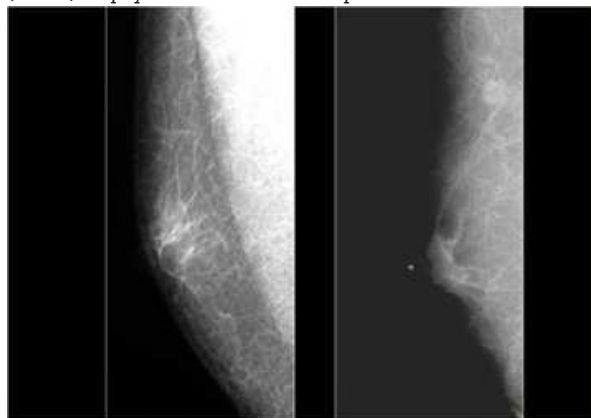
A 81-year-old male with no family history of breast or ovarian cancer presented with a tender mass in the periareolar, left breast. The patient noted the mass 1 year ago, but it had persisted with no improvement in symptoms which were tenderness with application of external pressure with no bloody or cloudy white discharge.

On physical examination, he was an average weight male with asymmetrical breasts. On palpitation, there was an ill-defined, mobile, 4 × 4-cm mass noted around the left nipple. With applied pressure, no discharge fluid was elicited from the left nipple but was tender.

Bilateral mammogram demonstrated mild gynecomastia on the left side with a discrete mass and clusters of microcalcifications.

A follow-up ultrasound around the area of palpable concern did show a prominent duct with irregular contours at the 6:00 position in the left breast.

Excisional biopsy was recommended and a subareolar (trucut) biopsy of the left breast was performed.



The pathology showed pure micropapillary and cribriform type low-grade DCIS with no evidence of invasive disease. Breast specific gamma imaging (BSGI) and genetic testing for BRCA gene mutations were ordered. BRCA testing was negative for both BRCA1 and BRCA2 mutations. The BSGI revealed minimal parenchymal activity in the bilateral breasts. After discussing the diagnosis and treatment options with the patient, he was advised to undergo left sided mastectomy.

Complete excision was performed after the initial biopsy, and comprised removal of a left axillary sentinel lymph node, left sided modified radical mastectomy.

The patient was noted to be doing well 2 months postoperatively and was advised to follow up with medical oncology.

DISCUSSION

DCIS is defined as a group of lesions caused by a proliferation of neoplastic cells within the mammary duct system of the breast. It is differentiated from invasive breast cancer by detection of an intact basement membrane, but it is still associated with a risk for progression to invasive cancer, and thus, should be treated.

The median duration of symptoms for pure DCIS is 2 months, whereas for patients with DCIS and associated invasive carcinoma it is 6 months. Presenting symptoms are similar to female breast cancer. The most common presenting sign is a painless mass, but there may

be breast pain, nipple discharge, or nipple retraction. Given the anatomy of the male breast, the lesions are usually central and slightly eccentric to the nipple, thus nipple involvement is relatively more common.

Screening mammography indicates that calcifications are less frequently associated with male breast cancer as compared to female breast cancer. When present, these calcifications often have a benign or nonspecific appearance. To make matters more challenging, gynecomastia is notorious for masking underlying calcifications and/or carcinoma, even when evaluated in retrospect.

All breast cancer regardless of type is staged the same way in men as in women and follows the TNM staging protocol. Receptor expression for the hormones estrogen and progesterone as well as overexpression of the epidermal growth factor receptor-2 (HER2) is also regularly analyzed and plays a small role in the staging of breast cancers. For the case presented above, the tumor stage would be classified as a stage 0, low grade tumor under the latest guidelines by the American Joint Committee on Cancer. [4]

There are few studies regarding the management guidelines of breast cancer in males. This is likely due to the low incidence of breast cancer in the population. Male breast cancer is currently managed in a similar fashion to female breast cancer. [5] Even so, there are various options for management of such lesions in females. After confirmed biopsy of such a lesion, all management options revolve around surgery which is the primary method required to

remove the lesion from the breast leaving negative margins. For a stage 0 low grade-DCIS, mastectomy (with or without reconstruction) is considered equivalent to breast conserving surgery (lumpectomy) with radiation.[6] All options are offered to patients with discussions about risks and benefits as medical management involves patient satisfaction and cost.

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