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Case Study

PHYLLODES AN UNCOMMON TUMOR OF THE BREAST - A CASE REPORT

Prashanth K[1], Veena P[2]*

[1]Associate Professor, *[2]PG Scholar, Department of Shalyatantra, Sri Dharmasthala Manjunatheshwara College of Ayurveda and Hospital, Kuthpady, Udupi, Karnataka, India.

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ABSTRACT

'Phyllodes' is a Greek word which means leaf- like. Phyllodes tumour, though appears well circumscribed, is characterized by irregular surface projections. These projections if left behind during surgical excision predispose to recurrence. Phyllodes tumour shows a wide spectrum of activity varying from an almost benign condition to a locally aggressive, and sometime metastatic tumour. Although the peak of phyllodes tumor occurs in the age group of 40 to 49 years, they do manifest in younger women. These benign tumours, previously named as serocystic disease of Brodie or cystosarcoma phyllodes. We report a 61 year old female patient presented with a lump on the left breast. Excision was done and histopathology report revealed phyllodes tumour. In this patient, as the tumour size was quite large breast conservation surgery was not an option. Hence, Simple mastectomy was carried out. From Ayurvedic standpoint, this swelling presented with clinical features of *Kaphaja arbuda*. The primary treatment for *Arbuda* is *Chedana karma* (surgical excision) which was followed in this case.

INTRODUCTION

Breast is a modified sweat gland derived from ectoderm, as branching epithelial cords which form lactiferous ducts. About 15-20 lobes develop during puberty, each of which drains into a single lactiferous duct. True secretory alveoli develop during pregnancy and lactation under the influence of oestrogen, progesterone and prolactin[1].

About 1/3rd of the women suffer from breast diseases at least once in their life. Incidence of breast cancer in India is about 25.8 per 1 lakh women with a mortality of 12.7 per 1 lakh women[2]. Benign breast diseases are at least 10 times more common than malignant ones in hospital clinics. Currently malignant to benign ratio is 1:10 as seen in breast clinics[3]. The incidence of benign breast disease is rising from the second decade of life and peaks at fourth to fifth decades. Benign breast disease encapsulates a wide variety of disorders and one among them is Phyllodes tumor of the breast.

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These tumours makes up about 0.3 to 0.5% of the diagnosed case of female breast tumors[4] and have a prevalence of about 2.1 per 10 lakhs cases. Although the peak of phyllodes tumor occurs in the age group of 40 to 49 years, they do manifest in younger women. These benign tumours, previously named as serocystic disease of Brodie or cystosarcoma phyllodes are fibroepithelial lesions present as a large, sometimes massive tumour with an unevenly bosselated surface. Occasionally, ulceration of overlying skin occurs because of pressure necrosis. Despite their size they remain mobile on the chest wall[5].

Histologically, there is a wide variation in their appearance with some of low malignant potential resembling a fibroadenoma and others having a higher mitotic index. The latter may recur locally but, despite the name of cystosrcoma phyllodes, they are rarely cystic and only very rarely develop features of a sarcomatous tumour. These may metastasise via the bloodstream[6].

These tumors show a wide range of activity, varying from almost a benign condition (in 85% of the cases), to locally aggressive ones and sometimes metastatic tumor (in 15% of the cases).

Hence, accurate pre-operative examination and pathological diagnosis allows for precise surgical intervention and thereby avoids reoperation, either by

achieving wider excision of tumor mass or by reducing subsequent tumor recurrence[7-9]. Treatment of phyllodes tumor ranges from extensive local excision to radical mastectomy, depending upon the mitotic index which is provided histopathologically.

Treatment for the benign type is enucleation in young women or wide local excision. Massive tumours, recurrent tumours and those of the malignant type will require mastectomy.

Case Report

A 61-year old female patient visited OPD of Shalyatantra at SDM Ayurveda Hospital, Udupi, with a history of lump in the left breast associated with pain since 1½ years. The lump was small and eventually grew to a considerable size in a span of 6 months to an extent that, there was a significant difference in the size of her breast. She noticed gradual prominence of veins on the affected breast. There was no history of breast trauma, nipple discharge or weightloss. She is K/C/O and HTN (under T AMLOKIND 5 MG 1-0-0) since 10 years. She attained menopause at the age of 50yrs.

Her systemic examination was not significant for any organomegaly or major illness. Examination of the breast revealed gross enlargement of the left breast compared to right. Left breast revealed a bosselated lump with tense glistening skin and prominent subcutaneous veins over it. No Redness, Peau d' orange, Fungation and ulceration on skin over the breast was observed. Nipple areola complex appeared normal without retraction or discharge. Palpation revealed a massive tumour of size 23x12x8.5cm, firm on feel with an unevenly bosselated surface, having a fairly smooth margin. Lump was non-tender with no local rise in temperature. The lump was neither fixed to skin nor fixed to the deeper structures and was confined to breast. No puckering or tethering of the skin was observed during examination. The axillary lymph nodes were not palpable. Right breast revealed no abnormality on examination.

USG breast on 25/2/20 of Left breast revealed an irregular ill-defined solid mass in the retro aerolar area and the upper quadrant with size approximately 6*4 cm without any cystic changes and calcification. Right breast and axilla was normal.

Her pre-operative blood and urine investigations revealed no abnormality. As the tumour size is more than 4cm, breast conservation surgery was not adopted. And simple mastectomy was done under GA.

Patient was positioned in supine with the left arm abducted. Prepping was done with antiseptics followed by draping. The lesion was approached by a transverse elliptical incision as the mass was significantly large. The entire breast including the whole tumour with nipple areola complex along with axillary tail were removed. Bleeders were secured with diathermy and ligatures. A corrugated drain was placed through a stab incision to drain out fluid collection. The subcutaneous layer was approximated by interrupted Vicryl 2-0 sutures. And skin closure was done with interrupted vertical mattress 3-0 Ethylon stitches. Post-operative single unit blood transfusion was done along with IV antibiotics. T. *Kaishora guggulu* 1tid. T.*Gandhaka rasayana* 1tid and *Panchatikta Kashaya* 20ml tid were prescribed as internal medications. Drain was removed after 24 hrs. A subcutaneous collection observed on the 4th day which was found to be a seroma on aspiration. All the sutures were removed on 7th PO day. The excised tumour/ specimen as shown was sent for histopathological study. Biopsy reported as Phyllodes tumor. Patient was periodically followed up for 5 months for any recurrence.

Study Photographs

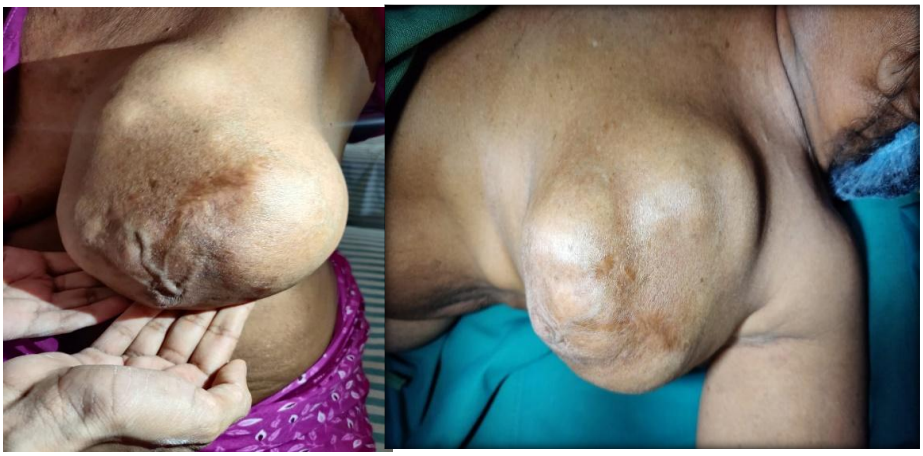

Photo 1 & 2: Before Procedure

Name	[redacted]	IP/OP No	135239
Age/Sex	61Year(s) / Female	Collection Date	10/03/2022 10:38
Sample Id	[redacted] Sample Sl No. S:3698/22	Received On	10/03/2022 12:12
Bill No	OP/21-22/1119294	Reported On	15/03/2022 16:02
Centre	AMRUTH LAB	Location	WALK_IN_LAB

Histopathology

BIOPSY REPORT

Microscopy

Histological diagnosis :
Section shows a biphasic tumor with a well defined pushing border with stromal proliferation with leaf like pattern areas, stromal expansion with stromal overgrowth, diffusely increased cellularity of mild to moderately pleomorphic spindle cells, few showing prominent nucleoli, mitoses 7/10 HPF with atypical mitosis surrounded by myxoid stroma, lymphocytes, necrosis, PASH, few ducts cystically dilated along with epithelial proliferations.
Skin : no involvement
Margins free. Tumor is 1 mm from the 9 o'clock margin however excision appears complete.

Diagnosis

PHYLLODES TUMOUR : BORDERLINE

Verified By KMC242
Professor
MCI Reg. No. : KMC 67118

Certified By: Dr. Manna Valiathan
Professor
MCI Reg. No. : KMC 67118

---------- **End of Report** ----------

1.This report is to be interpreted in the appropriate clinicoradiological context.
2.The specimens will be retained only for 4 weeks after receival.

Photo 3: Histopathology Report

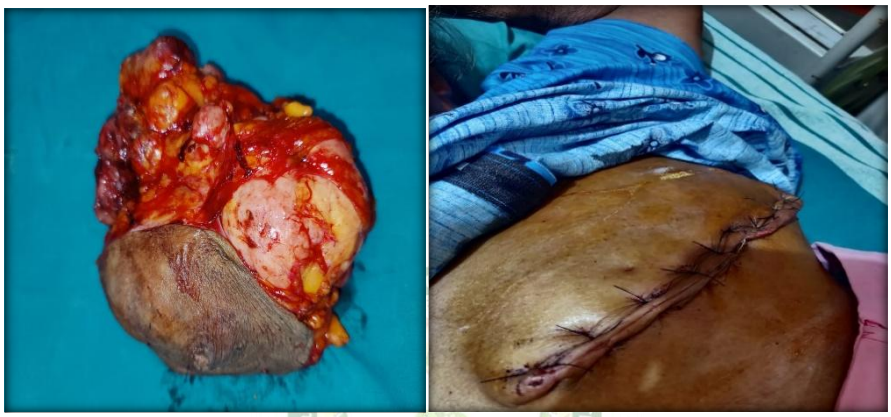

Photo 4: After Procedure

DISCUSSION

Improvements in diagnostic facilities, combined with a greater understanding of the normal cyclical changes within the breast, have reduced the number of benign breast lump excisions. Palpable cysts can be aspirated and many nodular areas can be safely left in situ. A solid, discrete breast lump which is believed to be benign on all assessment criteria may also be left, but some patients and surgeons prefer the excision of such lumps because of the small risk of a missed malignancy. Surgeons who do not have access to reliable mammographic or cytological diagnostic facilities will inevitably have to excise more benign lumps to avoid a missed malignancy.

Phyllodes tumour is usually excised as a suspected fibroadenoma. Phyllodes tumours require adequate wide local excision. Although malignant potential varies, local recurrence and rarely blood borne dissemination may occur. Lymph node metastases are not a feature. Wide local excision, or on rare occasions mastectomy without axillary sampling or clearance, is thus the standard management.

In this patient, as the tumour size was quite large (23x12x8.5cm) breast conservation surgery was not an option. Hence, Simple mastectomy was carried out.

From Ayurvedic standpoint, swelling presented with clinical features like *Vrittam* (globular), *Sthiram* (fixed), *Manda ruja* (mild pain), *Chiravruddhi* (slow continuous growth) and *Apakam* (non-inflammatory), match the description of *Arbuda*, explained in Sushrutha Samhita. Based on the predominance of *Dosa* and *Dushyas* the swelling was diagnosed as *Kaphaja arbuda*. The complications like malignant transformation and metastasis of tumours are explained in Ayurveda as *Adhyarbuda* and *Dvirarbuda* respectively, and are considered incurable (*Asadhya*). The primary treatment for *Arbuda* is *Chedana karma* (surgical excision) which was followed in this case.

CONCLUSION

A female patient presented with a large irregular tumour of the breast which was diagnosed as Phyllodes tumour and treated with simple mastectomy.

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***Address for correspondence**
Dr. Veena P
PG Scholar,
Department of Shalyatantra,
Sri Dharmasthala Manjunatheshwara College of Ayurveda and Hospital,
Kuthpady, Udupi, Karnataka, India.
Email: veenapsugunan@gmail.com
Ph: 9567847184

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