A RARE CASE OF CYSTOSARCOMA PHYLLODES WITH PLEURAL EFFUSION: MASTECTOMY DONE UNDER SURFACE ANAESTHESIA

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ABSTRACT

Cystosarcomaphyllodes or generally known as phyllodes tumour, is a rare breast tumour accounting for less than 1% of all breast neoplasms. Very rarely,malignant transformation with metastatic potential. Phyllodes tumors resemble fibroadenomas, account for 1%of breast malignancies, and usually occur in women from 30 to 70 years old. We report a case of a 44-year-old lady who presented with a painless right breast lump for 3 months duration. The mass was initially 3cm in diameter and firm in consistency. Fine-needle aspiration cytology showed a benign breast lesion. Ultrasonography of breast revealed bilateral pleural effusion. As general anesthesia was deferred due to pleural effusion simple mastectomy was done under surface anesthesia with local application of prilocaine jelly.

Keywords: Cystosarcoma phyllodes; Bilateral pleural effusion; Surface anesthesia

1 .Case Report:

A 44-year-old lady presented to us with a painless right breast lump for 3 months duration. She had no significant family history of breast carcinoma or of any other past medical illnesses. The mass was initially 3cm in diameter (Figure 1) and firm in consistency. Fine-needle aspiration cytology (FNAC) during the first visit to the clinic showed a benign breast lesion. Mammography revealed a benign breast lesion with multiple cysts and necrotic areas and reported as may be Giant Fibroadenoma/Phylloides Tumour.

Ultrasonography of breast revealed Giant fibroadenoma with some sarcomatous changes within with bilateral mild pleural effusion. Right mastectomy was planned under general anaesthesia. As general anaesthesia was deferred due to pleural effusion, simple mastectomy (Figure 3) was done under surface anaesthesia with local application of prilocaine jelly (Figure 2). The postoperative course was uneventful and she was discharged at day 4 postoperatively. Chest X ray postoperatively showed no pleural effusion.

Fig 1: Lump in the right breast, 15*10cms

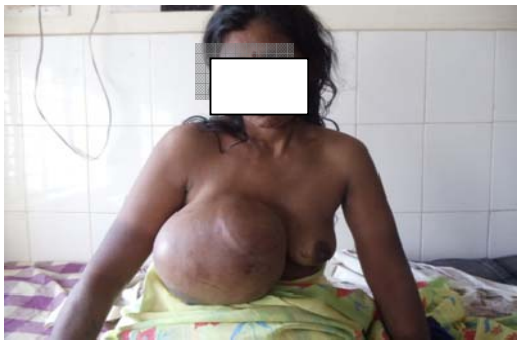


Fig 2: After application of prilocain jelly

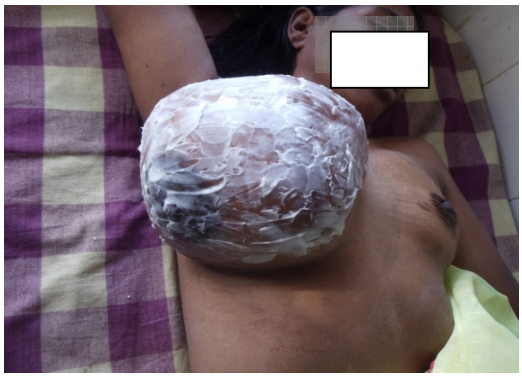


Fig 3 : Dissection under surface anesthesia

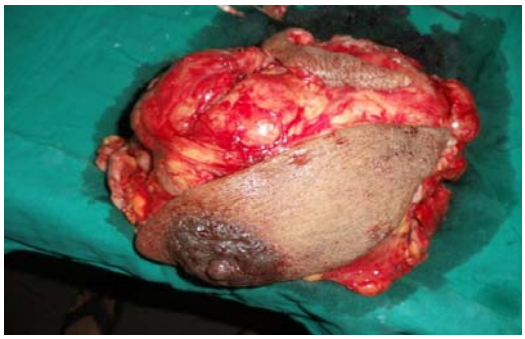


Fig 4: Excised specimen(post mastectomy)

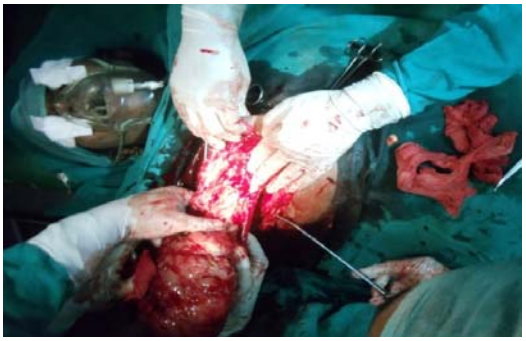
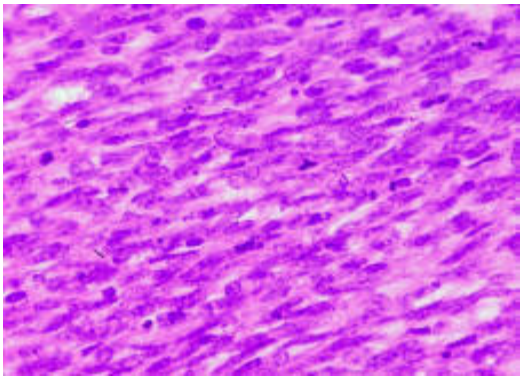


Fig 5:Histopatholgical slide showing phylloids tumour



Stromal cells of a malignant PT showing marked nuclear atypia and frequent mitoses (HE x 400).

2. Discussion:

First described by Johannes Muller in 1838as cystosarcomaphyllodes, phyllodes tumor is a rare fibro epithelial neoplasm. ‘‘Cystosarcomaphylloides’‘, now generally known as phyllodes tumour, is a rare breast tumour accounting for less than 1% of all breast neoplasms. The terminology ‘‘phyllodes tumour’‘given by the World Health Organization (WHO) classifies it into benign, borderline and malignant tumours according to histopathological features. High-grade malignant phyllodes tumour (MPT) is a very rare[2]. Patients presenting with pleural effusion in phyllodes tumour is still rare as it is in this case. The pleural effusion could be an reactionary effusion because of the pressure effect on the chest which could be the reason for respiratory compromise that forced us to go for simple mastectomy under surface anesthesia. Most interesting part was that pleural effusion disappeared after simple mastectomy which goes more in favour of reactionary effusion rather than a malignant effusion., phyllodes tumors may be classifiedas benign, borderline, or malignant; most phyllodes tumors

Classification of phyllodes tumors is controversial. In general are benign. Benign phyllodes tumors characteristically have smooth, non infiltrating borders with hypo cellular stromal components, minimal nuclear atypia, and low mitotic activity. Factors suggesting malignancy includeincreased mitotic activity, pronounced proliferationof stromal components relative to glandular structures, cytologic atypia, and invasive peripheral growth with infiltration into adjacent tissues. Approximately 5–25% of phyllodes tumors are described as malignant. Fewer than 20% of the malignant tumors metastasize. When metastaticdisease occurs, the metastases usually spread hematogenously to the lungs, pleura, or bone [3].

Phyllodestumours are clinically similar to fibroadenomas and they have both mammographic and sonographic characteristics in common. On ultrasound the tumours were lobulated in most of the cases. Heterogeneous internal echoes and intramural cysts are also said to be suggestive of phyllodes tumours[5]. Phyllodes tumour on mammography is described as a sharply defined round or oval mass with lobulation[4].

Difficulties with diagnosis of phyllodes tumour by FNAC have been reported. The cytologist reported phyllodes tumour in only 23% of cases where FNAC was done at the time of diagnosis. In cases where core biopsy was done at the visit where the diagnosis was made, the core biopsy correctly diagnosed 65% of phyllodestumours[4].

Standard therapy includes wide surgical excision with a margin of more than 1 cm even when pathologic features suggest benignity. Mastectomy is necessary only when tumor cannot be removed with adequate clearance[5]. Most of the studies in the literature have found that a positive margin status is the most consistent indicator of local recurrence .Preoperative diagnosis is then important for

good local control. Wide excision should be considered when the margins are involved microscopically[6]. In a recent large series total mastectomy for the malignant and borderline tumors had better results than breast conserving surgery. Adjuvant systemic therapy is of no proven value [7].

Conclusion:

Standard therapy includes wide surgical excision with a margin of more than 1 cm even when pathologic features suggest benignity. Mastectomy is necessary when tumor cannot be removed with adequate clearance or when it involves the entire breast tissue as it was there in our case. High-grade malignant phyllodes tumour is a very rare but aggressive breast malignancy. Patients presenting with pleural effusion in phyllodes tumour is still rare as it is in this case. This rare presentation made us to do simple mastectomy under surface anesthesia which we could complete successfully. We believe this would give a new dimension towards simple mastectomy and anesthesia.

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