Phyllodes tumors are rare accounting to less than 0.3-1% of all breast lesions. They present as painless lumps in the middle aged and elderly patients and are locally aggressive with high recurrence rate. We report a case of a 60-year-old female patient who presented with bilateral, multifocal phyllodes tumors and synchronous invasive ductal carcinoma of the breast. She underwent bilateral mastectomies - (modified radical mastectomy-right and simple mastectomy-left) due to the invasive and multifocal nature. She received adjuvant chemo or radiotherapy and is on regular follow-up until date with no recurrence.

Key Words: Bilateral Phyllodes Tumor, Invasive Tubular Carcinoma, Synchronous Cancer

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Introduction

Phyllodes tumor is an uncommon fibroepithelial tumor of the breast seen in female patients in 45-60 age group, misinterpreted as fibroadenoma clinically. Phyllodes tumor are classified as benign, borderline, and malignant. Malignant transformation is seen in 5-25% of cases. The bilateral occurrence of phyllodes with coexisting invasive carcinoma breast is rare. We report a case of a 60-year-old female patient with bilateral, multiple phyllodes tumor along with invasive tubular carcinoma of the right breast.

CASE REPORT

A 60-year-old patient with asymptomatic multiple lumps in both breasts for 15 years presented to our breast clinic with progressively increasing painful lumps in the right breast and nipple retraction since 6 months. She was para-3, attained menopause at 50 years. No family history of carcinoma breast. On clinical examination, the patient was moderately built and nourished, two palpable lumps of 3 cm x 4 cm and 2 cm x 1 cm size, firm to hard, tender, fixed to breast tissue with nipple retraction was noted in the right breast. Multiple (>7) firm to hard lumps, non-tender, mobile varying from 2 cm to 5 cm were palpable in the left breast. No palpable nodes in both axillae. The Systemic examination was normal. We made a clinical diagnosis of carcinoma right breast (T3, N0, M0) with multiple calcified fibroadenomas in the left breast. Mammogram of bilateral breasts reported as benign multiple calcified lesions in both the breasts with no axillary nodes imaged. Trucut biopsy was suggestive of fibroadenoma or benign lesion. ER/PR and Her2 Neu was negative. Chest X-ray showed multiple calcified lesions in the region of the breast. Ultrasound abdominopelvis was normal. Routine blood investigations, alkaline phosphatase were within normal limits. The bone scan was normal. The patient underwent right breast lumpectomy along with nipple areola complex as the tumor was adherent to it and excision of multiple (>7) lumps in the left breast. Histopathology reported as invasive tubular carcinoma with lateral margin positive for tumor cells in the right lump and phyllodes tumor with multifocality in the left (Figures 2 and 3). We performed a modified radical mastectomy on the right breast and simple mastectomy on the left with uneventful post-operative period and she received the adjuvant chemoradiation. The final histopathology report confirmed invasive ductal carcinoma right breast with all margins free of tumor and negative axillary nodes. For the left breast, multiple benign phyllodes with free margins were confirmed (Figures 4-6). She is on regular follow-up until date with no recurrence.

DISCUSSION

The phyllodes tumors have an incidence rate of 1 in 100,000 with risk of malignancy of 2.1 per one million women. They present as painless, discrete, mobile lumps and are similar to fibroadenoma. Usually, phyllodes tumor is seen after middle age (40-60 years) though the literatures have reported in young girls. It is difficult to differentiate phyllodes from fibroadenoma both by mammogram or ultrasound. They appear as non-specific calcified lesions, with posterior acoustic enhancement (Figure 1). Fine-needle aspiration cytology and core biopsies were inaccurate in our patient who could be due to insufficient sampling as the lump was hard and calcified.
Histopathology of the lumpectomy specimen confirmed it. 
The literatures have reported right breast (62.5%) as the common site of phyllodes tumor and 37.5% in the left, bilateral in 30%, 6-8% in lower inner, 11-25% lower outer, 14-17% in upper inner, 32-36% in upper outer quadrants, and 37% in multiple sites. Malignant transformation of the epithelium in phyllodes tumor is rare this may be due to a coexisting invasive carcinoma. Our patient had a silent disease for 15 years followed by rapid growth associated with pain. About 3-12% of malignant phyllodes tumor metastasize at the time.
of presentation or 12 years later, by hematogenous spread to lungs, bones, brain, liver, and heart. Therefore, thorough metastatic workup is mandatory. Surgically, complete removal of the tumor with adequate margins is the mainstay of the treatment for malignant phyllodes tumor. Wide local excision for small tumors and a simple mastectomy for larger tumors is usually performed. Norris and Taylor suggested mastectomy with low axillary node dissection for palpable nodes, tumor size more than 4 cm, and if biopsy reports infiltrating margins. In view of the bilateral, multifocal and invasive nature of the disease we performed right modified mastectomy and simple mastectomy on left to achieve clear margins with primary closure. Followed by post-operative chemoradiation, she is on regular follow-up until date with no recurrence.

**CONCLUSION**

The coexistence of phyllodes tumor with invasive carcinoma is rare. The presence of both tumors together requires a thorough histopathological examination of the excised specimen along with metastatic workup. Surgical procedures for phyllodes tumor cannot be standardized in unusual cases. It should be focused on adequate removal of a lesion with tumor free margins. Regular follow-up is mandatory.

**End Note**

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**Conflict of Interest**

None Declared

**REFERENCES**