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489 - GIANT MALIGNANT PHYLLODES TUMOR: A RARE CASE REPORT

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Introduction: Phyllodes tumor (PT) of the breast is an infrequent neoplasm, which corresponds to less than 0.5% of the breast tumors. The age group at the greatest risk in women is between 35 and 55 years of age. They are classified as benign (60%–75%), borderline (15%–20%), and malignant (10%–20%). In their less aggressive form, they behave like benign fibroadenomas (FA), however, with a tendency to recur locally after excision without wide margins. In contrast, they may present a metastatic component in its most aggressive form. In general, they are referred to as voluminous tumors, larger than 5 cm, painless, of firm consistency, with a raised or lobulated surface, well defined, movable, and without compromising the skin or deep tissues. They are associated with inflammatory axillary nodes in 17% and metastatic in about 1%. Systemic spread is rare and primarily affects the lungs, bones, liver, and brain. However, the preoperative diagnosis is very difficult, since its clinical presentation, in imaging examinations and in biopsies, is like to FA, requiring surgical excision of the lesion for diagnostic confirmation. Surgical treatment alone is the first therapeutic choice. In smaller tumors, general segmental surgical resection with margins of at least 1 cm is necessary for local control. In very voluminous tumors, total mastectomy or adenomastectomy is performed, without the need for axillary dissection, due to the low probability of lymphatic metastasis. Adjuvant radiotherapy is controversial, with a reduction in the rate of relapses, but without a reduction in mortality. A 67-year-old patient came to the gynecology emergency deparment reporting an ulcerated lesion in the right breast for 3 months, associated with intense right breast tenderness and local fetid secretion. She reported an involuntary weight loss of 6 kg and a progressive increase in the lesion, which at the time of the consultation affected practically the entire breast. She reported active smoking for 40 years. On physical examination, a necrotic-looking tumor was observed, occupying all quadrants of the right breast, with local fetid secretion. She underwent core biopsy, which resulted in a poorly differentiated, high-grade malignant neoplasm in the breast and skin on the right, with breast neoplasia to immunohistochemical marking of prognostic factors: estrogen receptor (ER) negative, progesterone receptor (PR) negative, KI67 positive 50%, and HER2 negative. She underwent right mastectomy with sentinel lymph node biopsy. The anatomopathological conclusion reported histological aspects of a malignant PT of the breast (cystosarcoma phyllodes). The tumor measured 21×15×9.5 cm, with a high-grade epithelioid appearance and necrosis in 60% of the neoplasm, in addition to the ulcerated skin affected by the malignant lesion, with areola and nipple free of invasion. The margins were free and there was no evidence of vascular invasion. In all, 30 mitotic figures were present in 10 CGA in sarcomatous areas. Two sentinel lymph nodes were isolated and were free of neoplasia. Immunohistochemistry was repeated: KI67 is 45%, HER2, ER, and PR are all negative. The patient was referred for outpatient follow-up at Clinical Oncology, which started adjuvant radiotherapy.