

## CASE REPORT

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# Larger than life: A case of a bleeding giant phyllodes tumor in a COVID-19 positive patient

Louie Czelline L De Leon, Orlino C Bisquera Jr, Ray I Sarmiento, Danielle Ramirez

## ABSTRACT

**Introduction:** Phyllodes tumor of the breast, also known as cystosarcoma phyllodes, is a rare fibroepithelial tumor that accounts for about 0.3–1% of all breast tumors. Unlike most breast tumors that start from the ducts and gland, phyllodes tumor originates from the stroma. The classification of phyllodes tumor is less important on assessing the risk of recurrence as compared to the presence of tumor-free margins after surgical treatment.

**Case Report:** A 54-year-old female presented at the emergency room with a large, bleeding, left breast mass. The patient tested positive for COVID-19 and was admitted previously at the isolation ward. After medical management of her current condition, the patient underwent wide excision (total mastectomy), left with en bloc resection of pectoralis major with delayed reconstruction via split thickness skin graft. This case is one of the few reported giant phyllodes tumor in the English literature, measuring 30 cm widest dimension.

**Conclusion:** Malignant phyllodes tumor is a rare form of breast malignancy behaving like a sarcoma. A diagnostic dilemma may be encountered in patients

with such tumors due to the rarity of these cases and the different presentation of the tumor. High suspicion shall be entertained for patients with breast masses which tend to appear like benign lesions but with sudden enlargement. Adequate surgical intervention shall be done ensuring tumor-free margins. Adjuvant therapy for malignant phyllodes tumor is still controversial but shall be entertained according to the patient's actual case needs.

**Keywords:** Bleeding, COVID-19, Giant, Malignant phyllodes tumor

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## INTRODUCTION

Phyllodes tumor of the breast, also known as cystosarcoma phyllodes, is a rare fibroepithelial tumor that accounts for about 0.3–1% of all breast tumors [1]. Unlike most breast tumors that start from the ducts and gland, phyllodes tumor originates from the stroma. World Health Organization (WHO) classified phyllodes tumor to benign, borderline and malignant, though there is no well-defined criteria or clear cut-off for individual histologic parameters. Benign phyllodes tumor is more common with 35–64%, followed by borderline tumors at 7–40%, while malignant tumors are present up to 30% [2].

Fibroadenoma and phyllodes tumors, both benign fibroepithelial tumors, pose a diagnostic challenge among clinicians especially that neither a clinical finding nor radiologic appearance can certainly differentiate the two [3]. Clinically, most fibroadenomas tend to grow slowly while phyllodes tumor usually presents with rapidly growing mass. Some phyllodes tumor present with an indolent activity for many years then afterward grow rapidly. These tumors may present with blue discoloration, dilated skin veins, skin ulcers, and nipple retraction [2].

On gross examination, phyllodes tumor forms a well-circumscribed, firm, protruding, or fungating mass. On cut section, mass shows tan or pink to gray areas with fleshy and mucoid regions. On microscopy, exhibits an enhanced intracanalicular growth pattern with cleft-like spaces lined by epithelial and myoepithelial cells and hypercellular stroma, giving rise to its characteristic “leaf-like pattern” [1].

The classification of phyllodes tumor is less important on assessing the risk of recurrence as compared to the presence of tumor-free margins after surgical treatment. Wide local surgical excision with at least 1 cm gross margin or tumor-free margins is recommended, regardless of the phyllodes tumor classification [4]. While it is established that surgical resection is the cornerstone of managing phyllodes tumor, extent of resection and timing, is not uniform for all cases. In this paper, we present a case of a classic giant phyllodes tumor complicated with bleeding in a patient with concurrent pulmonary infection.

## CASE REPORT

A 54-year-old female presented at the emergency room with a large, bleeding, left breast mass.

The patient is a known case of left breast mass since 2022 when the size of the mass is about a 5-peso coin. No consult was done, any medications were not taken. Until four months prior to admission, the patient noted persistent and rapidly increasing left breast mass with pinpoint bleeding and moist areas, but still no consult was done, any medications were not taken.

Three weeks prior to admission, there was persistence of the mass and intermittent bleeding plus watery discharge. The mass has enlarged up to the size of a newborn’s head. The patient sought consult and she was advised imaging studies and biopsy, which later revealed an atypical stromal tissue suspicious for phyllodes tumor. Then one day prior to admission, the patient noted febrile episodes, difficulty of breathing and persistence of the bleeding left breast mass; hence, the patient was subsequently admitted.

The patient was received with stable vital signs, and with good functional status. On physical examination, there is a violaceous, fungating, friable mass around 35 × 25 × 8 cm (L × W × H), with multiple points of bleeding

at the left breast. No palpable nodes on bilateral axilla, clavicular, and cervical areas noted (Figure 1).

Previous work up few months ago was reviewed revealing an oval, circumscribed, heterogenous complex mass on the left breast, measuring around 10.7 × 6.8 × 6.8 cm at the left breast which is predominantly solid and with microcalcifications (Figure 2). Mammography was done revealing a large, irregular, complex mass occupying the entire left breast. An exophytic component through the lower inner quadrant was noted with diffuse skin thickening (Figure 3). Receiving hemoglobin of the patient is at 8 mg/dL which was subsequently managed with transfusion of blood products. The bleeding mass was also adequately controlled during the admission.

On chest computed tomography (CT) scan, the mass is intimately related posteriorly and cannot be separated from the thickened left pectoralis major muscle. There is a subcentimeter, non-calcified pulmonary nodule in the perifissural region of the anterior segment of the right lower lobe (Figure 4). No liver lesions noted on abdominal CT.

Unfortunately, the patient, on routine screening during admission, tested positive for COVID-19 infection with moderate disease; hence, subsequently admitted at the COVID ward and was advised 21 days of isolation. Adequate control of bleeding and antibiotic therapy was given.

After isolation and optimization, the patient then underwent wide excision (total mastectomy), left with en bloc resection of pectoralis major with delayed reconstruction (Figure 5). Post-mastectomy defect was initially managed with wet to dry dressing with addition of Microdacyn® spray. Initial cultures of the wound bed revealed growth of different species and appropriate antibiotics were given. On the 13th post-operative day, cultures yielded no pathogen growth, and wound bed was noted to have good granulation (Figure 6).



Figure 1: Physical examination. A violaceous, fungating, friable mass ~35 × 25 × 8 cm with multiple points of bleeding on.

On the 19th day post-resection, the patient underwent reconstruction via split thickness skin grafting. Graft site was opened on the 5th day post-reconstruction with note of good uptake around 90%, and the patient was subsequently sent home after few days. Final histopathology of the patient revealed malignant phyllodes tumor, left stage IIIB (T4N0M0 G3) with all margins negative for tumor (Figures 7–9). Tumor size is 30 cm in widest dimension and on microscopy, there is noted marked stromal cellularity and stromal atypia. Stromal overgrowth is as well present and mitotic rate was 24–26 per 10 high-power field (hpf).

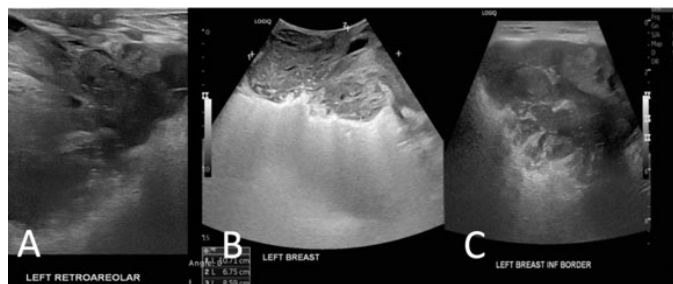


Figure 2: Ultrasound findings reveal a fungating wound, skin, and nipple thickening and retraction on the left breast. (A) Mass almost occupies the entire left breast and extends to the retroareolar region. (B) Oval, circumscribed, heterogenous, complex mass, predominantly solid with macrocalcifications ~10.7 × 6.8 × 8.6 cm. (C) Appears to extend to the pectoralis muscle.

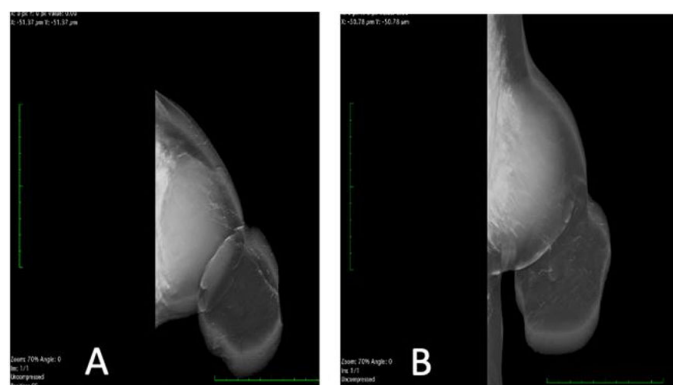


Figure 3: Mammography findings. A large irregular mass completely occupying the left breast with associated exophytic component through the lower inner quadrant and diffuse skin thickening. (A) Craniocaudal view, (B) Medirolateral oblique view.

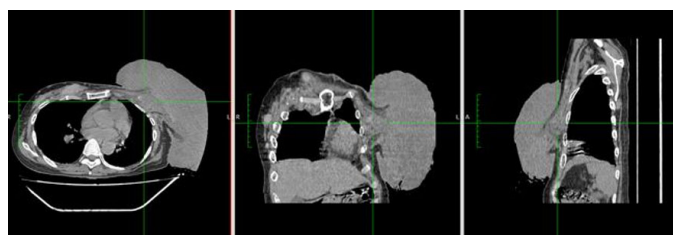


Figure 4: Chest CT scan. Noted a fungating, lobulated, heterogeneously enhancing left breast mass, ~23.1 × 18.9 × 17.5 cm. No normal looking left breast. Mass is intimately related posteriorly, and cannot be separated from the thickened left pectoralis major muscle, likely involved.



Figure 5: Intraoperative findings. 35 × 25 × 8 cm fungating mass with pinpoint bleeding and areas of necrosis. Mass is densely adherent with the pectoralis major muscle. Mass weighs 4 kg. Resultant defect (A) is 13.5 cm × 15.5 cm. (B) Basal surface, (C) Anterior surface of the mass.



Figure 6: Post-mastectomy defect prior to reconstruction. Day 2: Moderate growth of *Pseudomonas aeruginosa*. Day 4: Light to moderate growth of *P. aeruginosa*. Days 6–9: Light growth of *P. aeruginosa*. Day 12: Moderate growth *Acinetobacter* sp. Days 14–16: No growth.



Figure 7: Split thickness skin graft reconstruction with donor site from anterolateral thigh, left.

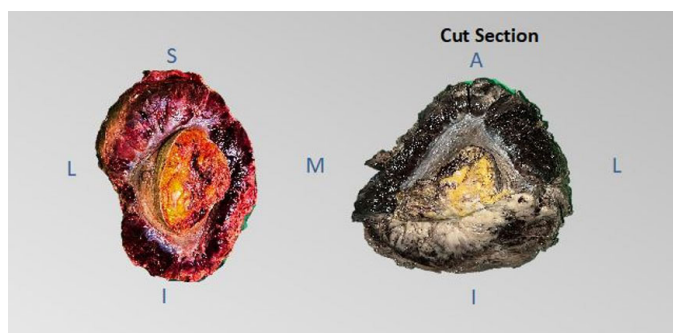


Figure 8: Gross specimen of patient. Tan-white to dark brown, soft to firm irregular mass with areas of cystic changes and necrosis.

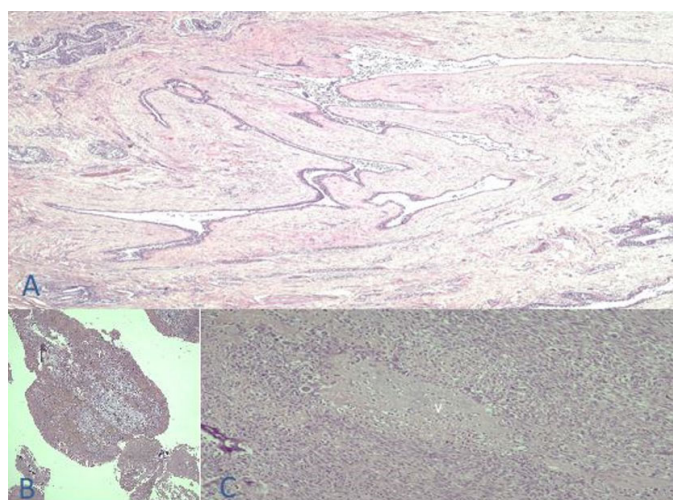


Figure 9: Histopathology report. Breast, Left—Phyllodes tumor, malignant. (A) Leaf-like patterns of the ducts induced by stromal overgrowth. (B) Fibromyxoid stroma with chronic inflammation and hemorrhage. (C) Cartilaginous differentiation from malignant stromal elements (Chondrosarcomatous elements). Tumor size 30 cm in widest dimension. Skin and nipple: Negative for tumor involvement. Stromal cellularity: Marked. Stromal atypia: Marked. Stromal overgrowth: Present. Mitotic rate: 24–26/10 hpf. Histologic tumor border: Infiltrative. All margins negative for tumor (Basal 6 cm, Superior: 5 cm, Inferior: 2 cm, Medial: 3 cm, Lateral: 4 cm).

The patient has initially followed up at the outpatient department (OPD) one week after hospital discharge and no note of necrosis and graft disintegration on the post op site. The patient was then advised for close clinical follow-up at the OPD for monitoring of the post-reconstruction site and monitoring of the disease.

## DISCUSSION

Phyllodes tumor is classified according to several histologic parameters—stromal atypia, stromal cellularity, stromal overgrowth, mitotic count, tumor border, and presence of malignant heterologous elements, based on WHO guidelines (Table 1) [5]. Our patient presents with marked stromal atypia and marked stromal cellularity,

with noted stromal overgrowth and mitotic count of 24–29/10 hpf. In addition, the tumor borders are infiltrative and there is note of chondrosarcomatous elements in the specimen; hence, the patient is classified to have a malignant phyllodes tumor. While it is well-established that the resection margin of phyllodes tumor is more important prognostic factor for recurrence, data also show that risk of recurrence of phyllodes tumor varies among the three classifications, being 18% for malignant phyllodes and 13–14%, 8–10% for borderline and benign phyllodes tumor, respectively [5]. On the other hand, distant metastasis, among cases with tumor-free surgical margins, was found to be associated with high tumor grade, infiltrative border, high mitotic count, pleomorphism, necrosis, and large tumor size [6].

Surgery is the cornerstone of management of phyllodes tumor, and in our case, wide excision with a 1 cm margin entails resection of the entire breast hence total mastectomy was done, including the pectoralis major muscle which on CT was noted to be intimately related and inseparable with the mass. As mentioned, the surgical margin is a more relevant prognostic factor for local recurrence and based on the National Comprehensive Cancer Network (NCCN) for phyllodes tumor, a 1 cm margin is recommended [4, 7]. Phyllodes tumor, unlike breast malignancies of ductal or lobular origin, follows a hematogenous spread instead of lymphatic spread; hence, axillary nodes, in most cases, are not involved. Hence, axillary staging or lymph node dissection is not warranted, even for cases of malignant phyllodes tumor, unless on clinical examination there is an enlarged node that is pathologic upon further examination [7, 8]. Metastasis from phyllodes tumor via the hematogenous spread is most commonly found in the lungs [1, 2].

Malignant phyllodes tumor behaves more similarly to soft tissue sarcoma rather than to other breast cancers; hence, the staging follows that for soft tissue sarcoma of the trunk/body wall and extremity (Table 2). The patient in this case is a stage IIIB (T<sub>4</sub>N<sub>0</sub>M<sub>0</sub> G<sub>3</sub>)—T<sub>4</sub> lesion, the mass being 30 cm, N<sub>0</sub> and M<sub>0</sub>. Histologic grade is G<sub>3</sub> with a score of at least 6—mitotic count of 24–26/hpf, and more than 50% gross necrosis.

Adjuvant therapy for malignant phyllodes tumor is still not well established. Local recurrence and/or tumor positive resection margins entail re-resection with wide margin. Radiation is currently limited to patients with positive tumor resection margins where re-resection is not feasible and to patients in the setting where additional recurrence would create significant morbidity (e.g., chest wall recurrence following mastectomy) [4]. In a study in 2014 regarding the utilization of radiotherapy for malignant phyllodes tumor, it was found that adjuvant radiotherapy significantly reduced the rate of local recurrence but there is no impact on the disease-free survival nor the overall survival after 53 months of median follow-up [10]. Cytotoxic chemotherapy for malignant phyllodes tumor, similarly, does not provide benefit in reduction of recurrence and overall survival. A

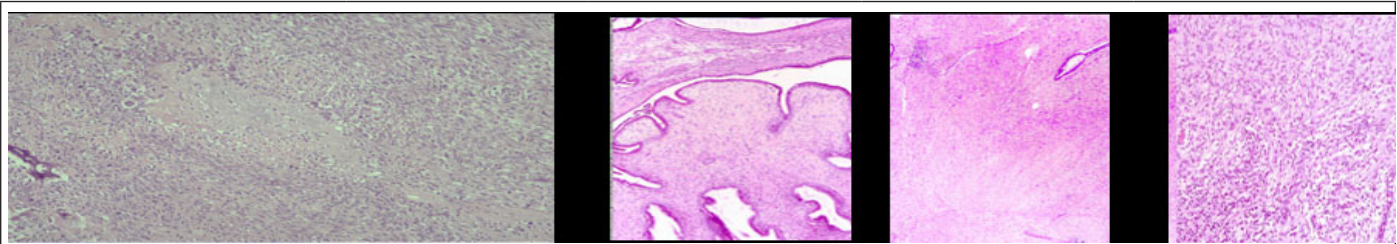
study in 2007 utilizing doxorubicin and dacarbazine in the adjuvant setting showed that chemotherapy did not affect the recurrence-free and the overall survival among patients with malignant phyllodes tumor [11]. However, there has been few case reports published showing that the use of doxorubicin and ifosfamide on patients with recurrent malignant phyllodes or those with lung metastasis help prolong disease-free survival [4, 10].

The patient in the case presented with anemia secondary to tumoral bleeding from phyllodes. Bleeding is one of the most common complications requiring early tumor intervention among patients with giant phyllodes tumor (>10 cm) [12, 13]. In this case, the patient responded with several blood transfusions and doses of antifibrinolytics. On top of this medical complication, the patient was also diagnosed with COVID-19 infection, moderate severity hence surgical intervention has to be delayed. Despite response to medical management, tumoral bleeding needs immediate surgical intervention due to higher risk of rebleeding, and for our patient, tumoral infection also. The recommendation for an

elective procedure for patients with COVID-19 infection is to have the procedure at least seven weeks after the infection [14]. If the benefits of doing the procedure earlier will exceed the risk, then individualized risk assessment and multidisciplinary discussion shall take place. However, it is advised that surgery shall not take place within 10 days of the diagnosis, predominantly because of the risk of infectivity of patients causing risk to surgical pathways, staff, and other patients [14]. Our patient was advised at least three weeks of isolation by the infectious disease and pulmonary counterparts. Afterward the case was presented to a multidisciplinary team, and after discussion, it was agreed upon that the patient will be benefitting from an immediate surgery.

This case is one of the few reported giant phyllodes tumor in English literature, measuring 30 cm widest dimension (Table 3) [13, 15–25]. The patient presents with a bleeding, fungating, necrotic mass at the left breast. No axillary nodes were noted. Due to the intimate relation of the mass to the pectoralis major, the said muscle was also removed en bloc.

Table 1: World Health Organization classification of phyllodes tumor. The patient is classified to have a malignant phyllodes tumor



Patient	Benign	Borderline	Malignant	
Marked	Stromal atypia	Mild	Moderate	Marked
Marked	Stromal cellularity	Mildly increased, can be focal	Moderately increased, can be focal	Markedly and diffusely increased
Present	Stromal overgrowth	Absent	Absent or very focal	Present
24–26/10 hpf	Mitotic count	<5/10 hpf or <2.5/mm <sup>2</sup>	5–9/10 hpf or 2.5– <5/mm <sup>2</sup>	≥ 10/10 hpf or ≥ 5/mm <sup>2</sup>
Infiltrative	Tumor border	Well-defined	Well-defined or focally permeative	Diffusely permeative
Present	Malignant heterologous elements	Absent	Absent	Presence directly upgrades to malignant category

Table 2: AJCC staging system for soft tissue sarcoma of the trunk and extremities (8th ed, 2017) [9]

T	Primary tumor	AJCC anatomic stage/Prognostic groups				
TX	Primary tumor cannot be assessed		T	N	M	G
To	No evidence for primary tumor	Stage IA	T1	No	Mo	G1, GX
T1	Tumor 5 cm or less in greatest dimension	Stage IB	T2	No	Mo	G1, GX
T2	Tumor more than 5 cm and less than or equal to 10 cm in greatest dimension		T3	No	Mo	G1, GX
T3	Tumor more than 10 cm and less than or equal to 15 cm in greatest dimension		T4	No	Mo	G1, GX
T4	Tumor more than 15 cm in greatest dimension	Stage II	T1	No	Mo	G2, G3

T	Primary tumor	AJCC anatomic stage/Prognostic groups				
N	Regional lymph nodes	Stage IIIA	T2	No	Mo	G2, G3
No	No regional lymph node metastasis or unknown lymph node status	Stage IIIB	T3	No	Mo	G2, G3
N1	Regional lymph node metastasis		T4	No	Mo	G1, GX
M	Distant metastasis	Stage IV	Any T	N1	Mo	Any G
Mo	No distant metastasis		Any T	Any N	M1	Any G
M1	Distant metastasis	Histologic grade (G) The FNCLCC grade is determined by three parameters: differentiation, mitotic activity, and extent of necrosis. Each parameter is scored as follows: differentiation (1–3), mitotic activity (1–3), and necrosis (0–2). The scores are added to determine the grade.				
G	Definition of grade FNCLCC histologic grade—See histologic grade (G)	Tumor differentiation				
		1	Sarcomas closely resembling normal adult mesenchymal tissue (e.g., low-grade)			
		2	Sarcomas for which histologic typing is certain (e.g., myxoid/round cell liposarcoma)			
GX	Grade cannot be assessed	3	Embryonal and undifferentiated sarcomas, sarcomas of doubtful type, synovial sarcomas, soft tissue osteosarcoma, Ewing sarcoma/primitive neuroectodermal tumor (PNET) of soft tissue			
G1	Total differentiation, mitotic count and necrosis score of 2 or 3	Mitotic count In the most mitotically active area of the sarcoma, 10 successive high-power fields (hpf; 1 hpf at 400× magnification = 0.1734 mm <sup>2</sup> ) are assessed using a 40× objective				
G2	Total differentiation, mitotic count and necrosis score of 4 or 5	1	0–9 mitoses per 10 hpf			
		2	10–19 mitoses per 10 hpf			
G3	Total differentiation, mitotic count and necrosis score of 6, 7, or 8	3	≥20 mitoses per 10 hpf			
		Tumor necrosis Evaluated on gross examination and validated with histologic sections.				
		1	No necrosis			
		2	<50% tumor necrosis			
		3	≥50% tumor necrosis			

Table 3: Case reports published on giant phyllodes tumor

Author	Year	Size of tumor
Hsu et al.	2007	30 × 25 cm
Tarun et al.	2011	50 × 25.2 cm
Juliana Alves De Suza et al.	2011	14 × 10 cm
Ramesh Sarvanandan et al.	2011	40 × 35 cm
Junaid Nabi et al.	2013	9 × 8 cm
Mohammed A. Sbeih et al.	2015	25 × 20 cm
Tapanutt Likhitmaskul et al.	2015	20 × 20 cm
Dong Xia et al.	2010	47.5 × 37 cm
Rumi Khajotia et al.	2014	24 × 22 cm
Banno A. et al.	2015	30 cm
Islam et al.	2016	50 × 50 cm
Yap et al.	2021	28 cm

## CONCLUSION

Malignant phyllodes tumor is a rare form of breast malignancy behaving like a sarcoma. A diagnostic dilemma may be encountered in patients with such tumors due to the rarity of these cases and the different presentation of the tumor. High suspicion shall be entertained for patients with breast masses which tend to appear like benign lesions but with sudden enlargement. Adequate surgical intervention shall be done ensuring tumor-free margins. Adjuvant therapy for malignant phyllodes tumor is still controversial but shall be entertained according to the patient's actual case needs. COVID-19 infection among patients with malignancy shall be addressed adequately to avoid unnecessary morbidities. We have presented one of the few known and published cases of giant phyllodes tumor measuring 30 cm, who underwent total mastectomy en bloc pectoralis major resection and delayed reconstruction with split thickness skin graft.

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### Author Contributions

Louie Czelline L De Leon – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Interpretation of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

Orlino C Bisquera Jr – Conception of the work, Acquisition of data, Interpretation of data, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

Ray I Sarmiento – Interpretation of data, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

Danielle Ramirez – Conception of the work, Acquisition of data, Analysis of data, Interpretation of data, Drafting the work, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

### Guarantor of Submission

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Written informed consent was obtained from the patient for publication of this article.

### Conflict of Interest

Authors declare no conflict of interest.

### Data Availability

All relevant data are within the paper and its Supporting Information files.

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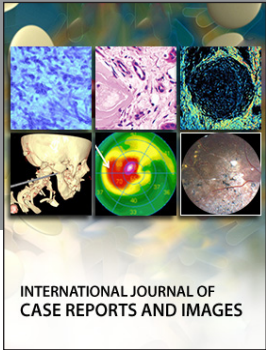
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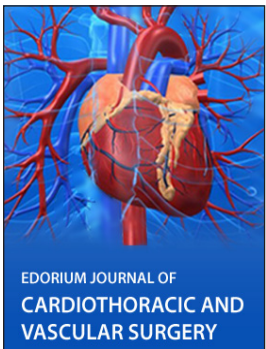
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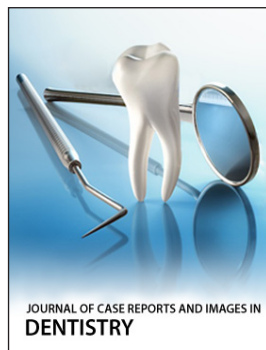
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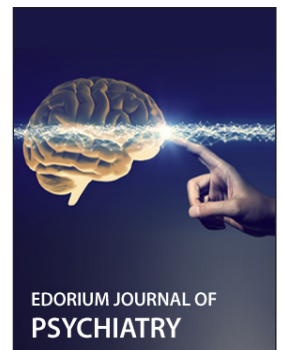
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