Malignant Cystosarcoma Phyllodes with Lymph Node Metastasis
—A Case Report—

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ABSTRACT: A case of malignant cystosarcoma phyllodes with metastasis in the interpectorol lymph node (Rotter's) is presented in this paper. To the author's best knowledge, this is the first case in Japan on this disease, with lymph node metastasis. Although the surgical management of the disease has not yet been standardized, radical or modified radical mastectomy is thought to be the appropriate procedure.

KEY WORDS: cystosarcoma phyllodes, malignant phyllodes tumor, lymph node metastasis

INTRODUCTION

Since Johanners Muller's first report in 18381 on cystosarcoma phyllodes, a number of workers have written about the disease.2,3 It is indeed a rare tumor, the frequency being about 0.5 per cent of all breast tumors. The tumor has shown malignant features in clinical and pathological findings, ranging from 2.5 to 42.5 per cent and remote metastases have occasionally been reported as well. A metastasis from cystosarcoma phyllodes is usually hematogenic, and the tumor rarely metastasizes to the lymph nodes. If it does however, it is almost always the axillary lymph nodes that are involved.

The authors have experienced a case of malignant cystosarcoma phyllodes with metastasis to the interpectorol lymph nodes. The case report is hereby presented with some bibliographical discussion.

A 46-year-old housewife was admitted to the Saga Medical School Hospital in October, 1984 with a preliminary diagnosis of a left breast mass. By chance, the patient had discovered a firm lump in her left breast approximately one month prior to the admission. The mass started as a thumb-sized lump and rapidly increased its size threefold within a month. The skin of the breast showed no edema, redness or dilated veins. Palpation of the breast revealed a firm nodular mass of about 7 cm in diameter, which was not fixed to the skin lining or underlying tissue and was readily moved. No enlargement of the cervical or axillary lymph nodes was observed. Other methods of physical examination revealed no abnormalities. Blood counts and blood chemistry were within normal limits. Mammography and xero-radiography of the left breast made little contribution toward establishing the diagnosis, however ultrasonography revealed a cystic mass with uneven margins, as shown in Fig. 1. A clinical diagnosis of
cystosarcoma phyllodes was thus made.

Excisional biopsy of the left breast mass was done under general anaesthesia, and frozen section examination revealed malignant cystosarcoma phyllodes. In addition, a part of resected specimen was submitted for estrogen receptor examination. Left radical mastectomy was then performed with combined dissection of the regional lymph nodes.

**Gross appearance of the resected tumor**

The resected tumor was greyish white in color with black or reddish sporadic areas and was $12 \times 7 \times 3$ cm in size. Cystic change was present. Papillary parts protruded into a central cystic cavity in which a gelatinous substance was contained, and focal hemorrhage and necrotic areas were observed (Fig. 2).

**Microscopic appearance of the resected tumor and lymph node**

Pleomorphic spindle-shaped tumor cells proliferated with many mitotic interlacing patterns, and bizarre, multinucleated giant tumor cells were intermingled, as shown in Fig. 3. Tubular elements were seen in the sarcomatous tissue such as those tubular patterns which are considered to be part of the epithelial elements of a fibroadenoma which has not turned malignant yet (Fig. 4). Fig. 5 shows chondroid metaplasia in the sarcomatous tissue. The internal surface of the cystic lesion was occupied by the same sarcomatous elements, while fibroadenomatous tissue components made up the rest. Tubular, cylindrical epithels were observed sporadically, and collagenous fibrous tissue proliferated, compressing the epithelial ele-