

Epidemiological, Clinical and Histological Characteristics of Phyllodes Tumors in the Gynecology Department of the Donka National Hospital of the CHU of Conakry (Guinea)

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Abstract

Introduction: The objectives of this study were to determine the frequency of phyllodes tumors of the breast, to describe the epidemiological, clinical and histological characteristics of phyllodes tumors of the breast in the gynecology department of the Donka National Hospital. Methods: This was a retrospective descriptive study lasting 5 years, from January 1, 2018 to December 31, 2022, in the gynecology department of the Donka National Hospital, covering the records of patients whose diagnosis of phyllodes tumors of the breast was confirmed by histology. Results: The frequency of phyllodes breast tumors was 2.7% out of 807 benign and malignant breast pathologies. The epidemiological profile was that of women in the 30 - 39 age bracket (41.0%), nulliparous (50.0%) and genitally active (91%). Breast swelling was the main reason for consultation (81.9%). The left breast was the most affected (54.6%). Tumor size was between 2 - 4 cm in 63.7% of patients and \geq 5 cm in 6 patients (27.2%). The tumor was classified on histology as grade I and grade II with frequencies of 54.6% and 27.2% respectively. Benign phyllodes tumors confirmed by histology were the most numerous (81.8%). Conclusion: Phyllodes tumors of the breast were uncommon in our department. They mainly affect young, nulliparous women. Diagnosis is histological, with a very high frequency of benign tumors.

Keywords

Phyllodes Breast Tumors, Epidemiology, Histology, Conakry-Guinea

1. Introduction

Phyllodes tumors of the breast are uncommon fibro epithelial neoplasms, accounting for 0.3 to 1% of all tumors [1]. They are distributed worldwide, affecting all ages, but with a predominance in women at the height of genital activity between the 3rd and 5th decades, and they affect all races, with a predominance in black women [2]. They occur mainly in young women, with an average age of 40-50 years, i.e. 15 - 20 years later than fibro adenomas [3], and are often described as firm, palpable masses demonstrating rapid growth [4]. The diagnosis of phyllodes tumors of the breast may be evoked clinically and radiologically, but the diagnosis of certainty is anatomopathologically based [5]. Phyllodes tumors are classified as benign, borderline or malignant based on histological features such as cellular atypia, number of mitoses, tumour necrosis, stromal proliferation and tumors margins [6]. Approximately 60-75% of phyllodes tumors are benign [1]. Its malignant forms are high-grade sarcomas, which often have a guarded or poor prognosis [2]. Recurrences are not uncommon, and a relatively small number of patients will develop hematogenous metastases [7]. In Guinea, a study carried out over an 11-year period (2008 - 2018) reported a frequency of 2.7% among breast pathologies and 1.6% among gynecological and breast pathologies, with an average age at tumor onset of 44.5 years [2]. The high frequency of breast pathologies in the department, the delays in diagnosis and treatment on the one hand, and the absence of recent data on the other hand, motivated the carrying out of this study, which could have a significant impact on the management of breast diseases and, more broadly, on the fight against cancers in Guinea. The aim was to describe the epidemiological, clinical and histological characteristics of phyllodes tumors of the breast in the gynecology department of the Donka National Hospital.

2. Materials and Methods

2.1. Type of Study

This was a retrospective descriptive study lasting 5 years, from January 1, 2018 to December 31, 2022, carried out in the gynecology department of the Donka National Hospital, covering the records of patients whose diagnosis of phyllodes tumors of the breast was histologically confirmed.

2.2. Selection Criteria

All correctly completed files, including a histological report confirming the diagnosis of phyllodes breast tumors, were included in the study. Incompletely completed files and those without a histological report were not included in the study.

2.3. Data Collection

We carried out an exhaustive recruitment of all cases meeting the inclusion criteria. The study covered epidemiological (frequency, age, parity, menopausal status), clinical (reasons for consultation and tumor location), para clinical (breast ultrasound) and histological aspects (type of sampling, limited lesion, associated changes, histological grade, tumor behavior, histoprognostic criteria). Data were collected on a pre-established survey form based on a literature review of patient files and histological examination reports of surgical specimens.

2.4. Statistical Analysis

Data analysis was carried out using SPSS version 21 software. We calculated proportions for qualitative variables and mean, standard deviation and extremes for quantitative variables.

2.5. Ethical Considerations

Prior authorization was obtained from the department head, and anonymity and confidentiality were respected.

3. Results

1. Epidemiological characteristics:

Frequency of phyllodes tumors of the breast.



Figure 1. Flow chart.

Of the 807 cases of benign and malignant breast pathologies recorded in the department during the study period, we registered 24 cases of phyllodes tumors, of which we did not include two (2) cases that were poorly completed with incomplete information. Only 22 phyllodes tumor files were included in this study, i.e. a frequency of 2.7% (**Figure 1**).

The average age of patients was 39.1 ± 9.8 years, with extremes of 18 and 77 years. The most frequently encountered age groups were 30 - 39 and 40 - 49 years, with proportions of 41.0% and 31.9% respectively. In our sample, all patients were female. The majority of women with phyllodes tumors were married (90.9%), single (9.1%), uneducated (63.6%) and educated (36.4%). In terms of parity, half the patients diagnosed with phyllodes tumors were nulliparous, with a frequency of 50.0%, followed by primiparous in 27.3% of cases (**Table 1**). The majority of patients were non-menopausal with a frequency of 91% (n = 20). Only two (2) patients were menopausal (9.0%). In the gynecological history, 17 patients had men-

arche before the age of 15 and 5 patients after the age of 15. Breast-feeding was present in 19 patients and not present in 3, with contraception present in 16 and no contraception in 6. Five (5) patients had a history of breast pathology, and 3 had a family history of cancer.

Variables	Numbers $(n = 22)$	Percentages
Age (years)		
< 20	01	4.5
20 - 29	02	9.0
30 - 39	09	41.0
40 - 49	07	31.9
≥ 50	03	13.6
Extremes: 18 and 77 years	Average: 39.1 ± 9.8 years	
Parity		
Nulliparous	11	50.0
Primiparous	06	27.3
Pauciparous	02	9.1
Multipara	03	13.6

Table 1. Distribution of cases by age and parity of patients.

2. Clinical, Para clinical (imaging) and Histological characteristics:

Tumor location	Numbers $(n = 22)$	Percentages
Left breast	12	54.6
Right breast	08	36.3
Both breasts	02	9.1

Table 3. Distribution by ultrasound tumor size.

Size of tumoral	Numbers $(n = 22)$	Percentages
< 2 cm	02	9.1
2 - 4 cm	14	63.7
≥ 5 cm	06	27.2

In our series, 81.9% of patients consulted for breast swelling, and 18.1% for swelling associated with breast pain. On clinical examination, the general condition of the patients was good in 90.9% and poor in 9.1%. The left breast was the most affected in over half the cases (54.6%) (**Table 2**). Breast deformity was absent in 95.5% and present in 4.5%. Tumor size corresponded to ultrasound size. In our sample, 3 patients had axillary adenopathy and 19 patients had none. Tumor size

was between 2 and 4 cm in 63.7% of patients, and \geq 5 cm in six (6) patients (27.2%) (**Table 3**). Hypoechoic solid mass lesions (88.8%) with regular margins were detected in 18 patients, and 18.2% (4) of patients had a lobulated contour with a heterogeneous mass and increased vascularization.

Table 4. Distribution of cases by specimens taken type.

Specimens taken	Numbers $(n = 22)$	Percentages
Mastectomy	02	9.1
Lumpectomy	12	54.6
Microbiopsy	06	27.2
Quadrantectomy	02	9.1

In our series, specimens were taken from surgical specimens in 12 cases of lumpectomy (54.6%), 2 cases each of mastectomy and quadrantectomy (9.1%), and 6 patients had specimens taken by microbiopsy, a frequency of 27.2% (**Table 4**).

Table 5. Distribution of cases by histological findings and tumor diagnosis.

Variables	Numbers	Percentages
Histological findings		
Tumor boundary		
Well limited	17	77.2
Poorly limited	05	22.8
Mitosis		
< 5 mitosis/10GC	15	68.2
5 - 9 mitosis/10GC	06	27.3
\geq 10 mitosis/10GC	01	4.5
Stromal cellularity		
Low	12	54.5
Moderate	07	31.9
Dense	03	13.6
Stromal atypia		
Absent	15	68.1
Moderate	05	22.8
Marked	02	9.1
Stromal hyperproliferation		
Absent	17	77.2
Present	02	9.1
Focal	03	13.6

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Continued		
Malignant heterologous metaplasia		
Absent	18	81.8
Present	04	18.2
Histological type		
Grade I	12	54.6
Grade II	06	27.2
Grade III	04	18.2
Tumor diagnosis		
Benign phyllodes tumor	18	81.8
Malignant phyllodes tumor	04	18.2

Regarding histological findings, the tumor was well limited in the majority of cases (77.2%), and 15 patients in our series had a mitosis of less than five (5) (68.2%). Stromal cellularity was low in more than half the cases (54.5%), moderate in 31.9%, and stromal atypia was absent in 68.1% and moderate in five (5) patients (22.8%). In our study, two (2) patients (9.1%) had stromal hyper proliferation and four (4) patients (18.2%) had malignant heterologous metaplasia. The most frequently encountered histological type was grade I with a proportion of 54.6%, and benign tumors were diagnosed in the majority of cases (81.8%). Malignant tumors were found in four (4) patients (18.2%) (Table 5).

4. Discussion

4.1. Epidemiological Characteristics

Various authors have reported different results in the literature. The number of patients (n = 22) with a frequency of 2.7% and a mean age (39.1 ± 9.8 years) of phyllodes tumors occurrence reported in our study was close to those of Yilmaze et al. [6] in Turkey had collected 26 patients from 2009-2018 with a mean patient age of 35.07 ± 13.95 years (range: 14 - 71) and of the 26 patients, 12 (46.2%) were under 30 years of age and 14 (53.8%) were over 30 years of age. Of these patients diagnosed with a phyllodes tumor, 22 (84.6%) were pre-menopausal and 4 (15.4%) were post-menopausal. Gaétan Mac Grogan [8] in France reported a lower frequency (0.5%) of phyllodes tumors, with an average age of 45. Several studies had reported a total number of patients that was considerably higher than in our study. In China, one study included 192 patients. The median age of patients with phyllodes tumors at diagnosis was 40 years (extremes: 11 - 77 years), and when patients were stratified by age, 63 were under 35 and 129 were 35 or over [9]. In the USA from 1954 to 2005, 352 cases of PT had been identified, and all cases occurred in women, with a median age of 42 years [7]. In Senegal, 196 female patients were registered between 2010 and 2017, with a mean age at onset of the phyllodes tumors of 23.74 years, ranging from 12 to 71 years. 67% of patients were nulliparous, and the majority (183 patients) were genitally active (93.36%), 9 were per pubertal (4.60%) and 4 were menopausal (2.04%) [5]. A low frequency (0.09%) was found in Morocco, with a mean age of 37.3 ± 10.07 years, and 44.4% were nulliparous [10]. The same observation was made in our study concerning parity. The occurrence of phyllodes tumors at an early age was found in a Gabonese and Nigerian study [11] [12]. This tendency towards early onset in sub-Saharan Africa seems to indicate a particularity of the black race [5]. These different frequencies can be explained by the sample size, which varies from one country to another.

4.2. Clinical and Paraclinical Characteristics

The most frequently encountered reason for consultation in our study was identical to that of Diallo *et al.* [2] in Guinea, who reported in their study that swelling was the main reason for consultation (100%). Several authors in the literature have reported the higher frequency of tumor localization in the left breast recorded in our sample, while the size of the tumor found on clinical examination and ultrasound differs from study to study. A case report of a phyllodes sarcoma in a 12year-old girl in Côte d'Ivoire, found on physical examination a tumor localized in the left breast with a large, firm mass measuring 23 cm in long axis, with loss of substance that had carried away the areola-mammary plate. A 2 cm mobile adenopathy was palpated in the homolateral axilla. The right breast and lymph nodes were normal [13]. In another case from Morocco, clinical examination of the breasts revealed a nodule in the upper inner quadrant of the left breast, measuring 5 cm long, firm, painless and mobile in relation to the cutaneous and deep layers, with no inflammatory signs or skin lesions. Mammary ultrasound revealed a hypoechoic nodule measuring 5 cm, with regular contours [14]. However, this size was smaller than that of Kanouni et al. [10], who found a mean tumor size of 13.00 \pm 7.47 cm. In China, studies have reported that phyllodes tumor lesions of the breast are often unilateral, single nodular masses, painless, insidious in onset and slow in progression [15], ranging in size from a few centimeters to a voluminous tumor occupying the entire breast. Tumors sizes of all types vary from 4 to 8 cm in different series, with extremes of 0.8 cm to 40 cm [16]. Yilmaze et al. [6] in Turkey reported that the tumor was more frequently located in the left breast (n = 17) than in the right breast (n = 9). Diagnostic ultrasonography was performed in all patients, and hypoechoic solid mass lesions with regular margins were detected in 18 patients, while 8 patients presented with a lobulated contour with heterogeneous mass appearance and increased vascularization. The mean tumor size at diagnosis was 54.76±29.24 mm (range: 25 - 135).

4.3. Histological Characteristics

The diagnosis of a phyllodes tumor was made on anatomopathological examination of surgical specimens or micro biopsies, which provided tumor characteristics, grade and information on the quality of excision. Phyllodes tumors are classified as benign, borderline and malignant based on histopathological criteria [6], with features such as the number of mitotic cells detected in high-power x10 fields, stromal cellularity, atypia and stromal proliferation, alongside the status of the surgical margin [1]. For histological tumor diagnosis, the majority of samples were taken from surgical specimens; the most frequently encountered histological type was grade 1 (54.6%), and benign tumors (81.8%) were diagnosed in the majority of cases. Gave et al. [5] made the same observation with samples taken from lumpectomy specimens in 163 cases (83.2%), micro biopsies in 30 cases (15.3%) and mastectomies in 3 women (1.5%). Macroscopically, the majority of tumors (71% of cases) were between 2 and 5 cm in size, and over 5 cm in 21.6% of cases. Microscopically, the tumor typically showed an intra-canalicular growth pattern, with leaf-like projections in dilated vascular lumens and a more cellular stroma than in fibro adenoma. The histo-pronostic type was benign in 89% of cases, borderline in 7% and malignant in 4% [5]. In the study by Diallo *et al.* [2], grade I constituted the majority of histological grade found (54.5%), followed by grade II (22.7%). Benign phyllodes tumors constituted the majority of cases observed (77.2%). Phyllodes tumors with a firm consistency were the most common (50%), followed by mixed consistency in 6 cases (27.2%). Tumors without remodeling accounted for 63.63% of cases, followed by cases with associated remodeling (13.6%) [2]. In the literature, benign, borderline and malignant phyllodes tumors were diagnosed in 605 patients in a large case series with frequencies of 72.7%, 18.4% and 8.9% respectively [17]. Another study reported 60%, 20% and 20% benign, borderline and malignant phyllodes tumors [18]. Both borderline and malignant tumors are metastatic, and it has been stated that metastatic tumors have more stromal than epithelial histopathological components [19]. The results reported in our sample on celularity, which was low (54.5%), stromal atypia absent (68.1%) and mitosis less than 5 (68.2%) are different from those of Pengfei Jing et al. [3], who reported that histological examination showed a biphasic tumor, Mesenchymal cells were evident with moderate stromal hypercellularity, marked nuclear atypia and occasional mitosis. Ki67 immunohistochemistry was used to assess the proliferation index, and it showed 20 - 30% positivity. The histological diagnosis was a borderline phyllodes tumor.

5. Conclusion

Phyllodes tumours of the breast are uncommon in our department. They are benign in the majority of cases and are diagnosed in young, nulliparous women at the time of genital activity. Grade I phyllodes tumors were the most frequently diagnosed histological type.

Conflicts of Interest

The authors declare no conflicts of interest.

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Appendix: Data Collection Form

File number: Patient identifier: 1. Patient characteristics Age (in years): $\Box < 20 \Box 20 - 29 \Box 30 - 39 \Box 40 - 49 \Box \ge 50$ Sex: \Box Female \Box Male Place of residence: □ Conakry □ Outside Conakry Level of education:
Unschooled
Primary
Secondary
University Profession: □ Housewife □ Liberal profession □ Pupil/student □ Civil servant Marital status: □ Married □ Single □ Divorced 2. Gynecological-obstetric history Age of first menstrual period (menarche): $\Box < 15$ years $\Box \ge 15$ years Hormonal status: D Non-menopausal D Menopausal Notion of Contraception:
Yes
No If yes which: Notion of maternal breastfeeding: □ Yes □ No History of benign breast pathology: □ Yes □ No Parity: 🗌 Nulliparous 🗌 Primiparous 🗌 Pauciparous 🗌 Multipara 3. Family history of cancer Family history of cancer: □ Yes □ No 4. Clinical characteristics Reasons for consultation: Palpable breast mass: □ Yes □ No Breast pain: □ Yes □ No Skin ulceration: □ Yes □ No Breast discharge; □ Yes □ No Clinical examination General condition: □ Good □ Poor □ Weight □ Height Breast examination: Location of tumor:
Right breast
Left breast
Both breasts Breast deformity: □ Yes □ No Tumor size (cm): $\Box < 2 \Box 2 - 4 \Box \ge 5$ Tumor description: Mammelonal retraction:
Yes
No Mammary discharge:
Yes
No Axillary ADP: □ Yes □ No 5. Paraclinical characteristics Breast ultrasound: Lesion size (cm): $\Box < 2 \Box 2 - 4 \Box \ge 5$ Shape: □ Oval □ Lobulated □ Irregular Contours: □ Well defined □ Poorly defined Internal appearance:
Homogeneous
Heterogeneous Doppler vascularization: □ Yes □ No Pathological examination:

Type of specimen: □ Mastectomy □ Tumorectomy □ Quadrantectomy □ Microbiopsy Macroscopy Measurements: Tumor boundary: □ well limited □ poorly limited Neoplasm characteristics: Weight: Color: Appearance: Consistency: Remodeling: Microscopy Proliferation: 🗆 Fibro epithelial 🗆 Sarcomata's Stroma: Tumor margins: □ Net □ Infiltrated Tumor necrosis: □Present □Absent Stromal cellularity:
Weak
Moderate
Dense Stromal hyper proliferation: □ Absent □ Present □ Focal Cell characteristics: Cellular atypia: 🗆 Absent 🗆 Moderate 🗆 Marked Mitosis: 🗆 Yes 🗆 No Mitosis per field: $\Box < 5$ mitoses/10GC $\Box 5 - 9$ mitoses/10GC $\Box \ge 10$ mitoses/10GC Disproportionate stromal proliferation:
□ Present
□ Absent Heterologous sarcomata's elements:
Yes
No Exeresis limits:
Complete
Incomplete Adjacent mammary parenchyma: Immunohistochemistry:
Found
Not found Presence of vascular invasion: \Box Yes \Box No Malignant heterologous metaplasia:
Absent
Present Histological type:
Grade I
Grade II
Grade II
Grade III Tumor diagnosis:
Benign phyllodes tumor
Borderline phyllodes tumor □ Malignant phyllodes tumor