Phyllodes Tumor

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Clinical suspicion of phyllodes tumor:
- Palpable mass
- Rapid growth
- Imaging with ultrasound suggestive of fibroadenoma except for size (> 2 cm) and/or history of rapid growth

**INITIAL EVALUATION**

- History and physical exam
- Ultrasound
- Diagnostic bilateral mammography for women age ≥ 30 years
- Lifestyle risk assessment
- Core needle biopsy
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative

**Fibroadenoma**
- Close clinical follow-up

**Benign or borderline phyllodes tumor**
- Wide excision without axillary staging
- Review final pathology

**Fibroepithelial lesion or indeterminate pathology**
- Excisional biopsy
- Review final pathology

**Malignant phyllodes**
- See Breast Sarcoma algorithm

**Benign or borderline**
- See Page 2 for Surveillance

**Malignant phyllodes**
- See Breast Sarcoma algorithm

**Borderline phyllodes**
- Fibroadenoma and benign phyllodes tumors (wide excision not needed)

**Malignant phyllodes**
- 6-month follow up ultrasound
  - If no growth, observe
  - If growth, wide excision with follow up as indicated

**Invasive or in situ breast cancer**
- See Breast Cancer - Invasive Stage I-III or Breast Cancer- Ductal Carcinoma in Situ (DCIS) algorithms

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1. See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
2. Fine needle aspiration will not distinguish fibroadenoma from phyllodes tumor in most cases. In general, core needle biopsy is the preferred method for diagnostic biopsy.
3. GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion.
4. There is no high level evidence to support a margin width of at least 10 mm and an ideal margin width remains to be determined. Re-excision may need to be considered in relation to factors such as tumor characteristics, size, and cosmesis. For benign pathology, re-excision of a negative margin is not recommended regardless of margin width. See Suggested Readings for updated information.
5. Obtain molecular sequencing if patient is eligible for clinical trials. For patients with malignant phyllodes tumor or stromal overgrowth on pathology review, referral to a multidisciplinary sarcoma center is appropriate. Refer to Breast Sarcoma algorithm.
6. Recommend review by pathologist experienced in phyllodes tumor and to correlate with imaging findings and physical examination. Core biopsy may not provide definitive evaluation (tumor heterogeneity and inability to assess for infiltrating margins). Cases are discussed at the Multidisciplinary Clinical Management Conference (CMC) for Benign Breast Lesions for management recommendations.
7. Excisional biopsy if recommended at CMC. Excisional biopsy includes complete mass removal, but without the intent of obtaining widely negative surgical margins.
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Note: Consider Clinical Trials as treatment options for eligible patients.

**SURVEILLANCE**

**PATIENT PRESENTATION**

- History and physical exam with age appropriate breast imaging as clinically indicated every 6 months for 2 years, then annually for 5 years

**EVALUATION**

- History and physical exam
- Ultrasound
- Diagnostic bilateral mammography
- Core needle biopsy
- CT chest/abdomen/pelvis with contrast if recurrent malignant phyllodes tumor
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative

No metastatic disease

- Re-excision with histologically negative margins without axillary staging

Metastatic disease

- Metastatic disease management following principles of soft tissue sarcoma (see Adult Soft – Tissue Sarcoma for Clinical Stage III algorithm)

**TREATMENT**

1. Fine needle aspiration will not distinguish fibroadenoma from phyllodes tumor in most cases. In general, core needle biopsy is the preferred method for diagnostic biopsy.

2. GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

3. There is no prospective randomized data supporting the use of radiation treatment with phyllodes tumor. However, in the setting where additional recurrence would create significant morbidity (e.g., chest wall recurrence following salvage mastectomy) radiation therapy may be considered, following the same principles that are applied to the treatment of soft tissue sarcoma. Radiation therapy is considered for malignant phyllodes tumor after wide local excision lesions over 2 cm or after mastectomy for lesions over 5 cm based on the retrospective review of 478 patients analyzed by Pezner, et al., 2008.
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SUGGESTED READINGS


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy. Advance Care Planning (ACP) Conversation Workflow (ATT1925)


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DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Breast Center providers at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Core Development Team Leads
Isabelle Bedrosian, MD (Breast Surgical Oncology)
Ashleigh Guadagnolo, MD, MPH (Radiation Oncology)
Kelly K. Hunt, MD (Breast Surgical Oncology)
Henry M. Kuerer MD, PhD (Breast Surgical Oncology)
Melissa P. Mitchell, MD (Radiation Oncology)
Debu Tripathy, MD (Breast Medical Oncology)

Workgroup Members

Constance Albarracin, MD (Anatomical Pathology)
Dejka M. Araujo, MD (Sarcoma Medical Oncology)
Elsa Arribas, MD (Diag Rad – Breast Imaging)
Banu K. Arun, MD (Breast Medical Oncology)
Robert C. Bast Jr., MD (Translational Research)
Robert S. Benjamín, MD (Sarcoma Medical Oncology)
Therese Bevers, MD (Cancer Prevention)
Daniel J. Booser, MD (Breast Medical Oncology)
Abenaa Brewster, MD (Clinical Cancer Prevention)
Aman U. Buzdar, MD (Clinical Research)
Abigail S. Caudle, MD (Breast Surgical Oncology)
Sarah M. DeSnyder, MD (Breast Surgical Oncology)
Mark J. Dryden, MD (Diag Rad – Breast Imaging)
Olga N. Fleckenstein, BS*
Sharon H. Giordano, MD (Health Svcs Research – Clinical)
Karen Hoffman, MD (Radiation Oncology)
Gabriel N. Hortobagyi, MD (Breast Medical Oncology)
Rosa F. Hwang, MD (Breast Surgical Oncology)
Nuhad K. Ibrahim, MD (Breast Medical Oncology)
Kimberly B. Koenig, MD (Breast Medical Oncology)
Savitri Krishnamurthy, MD (Pathology Admin)
Deanna L. Lane, MD (Diag Rad – Breast Imaging)
Huong Carisa Le-Petross, MD (Diag Rad – Breast Imaging)
Heather Lillemoe, MD (Breast and Sarcoma Surgical Oncology)
Jennifer Litton, MD (Breast Medical Oncology)
Anthony Lucci, MD (Breast Surgical Oncology)
Joseph A. Ludwig, MD (Sarcoma Medical Oncology)
Funda Meric-Bernstam, MD (Invest. Cancer Therapeutics)
Lavinia P. Middleton, MD (Anatomical Pathology)
Tamara Miner Haygood, MD (Diag Rad – Musculoskeletal Imaging)
Shreyas Kumar Patel, MD (Sarcoma Medical Oncology)
George H. Perkins, MD (Radiation Oncology)
Vinod Ravi, MD (Sarcoma Medical Oncology)
Erika Resetkova, MD (Anatomical Pathology)
Merrick J. Ross, MD (Surgical Oncology)
Aysegul A. Sahin, MD (Pathology Admin)
Lumaria Santiago, MD (Diag Rad – Breast Imaging)
Simona F. Shaitelman, MD (Radiation Oncology)
Benjamin Smith, MD (Radiation Oncology)
Eric A. Strom, MD (Radiation Oncology)
W. Fraser Symmans, MD (Anatomical Pathology)
Nina Tamirisa, MD (Breast Surgical Oncology)
Vicente Valero, MD (Breast Medical Oncology)
Mary Lou Warren, DNP, APRN, CNS-CC*
Gary J. Whitman, MD (Diag Rad – Breast Imaging)
Wendy Woodward, MD (Radiation Oncology)
Wei Yang, MD (Diag Rad – Breast Imaging)
Wendong Yu, MD, PhD (Anatomical Pathology)

*Clinical Effectiveness Development Team

Department of Clinical Effectiveness V10
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