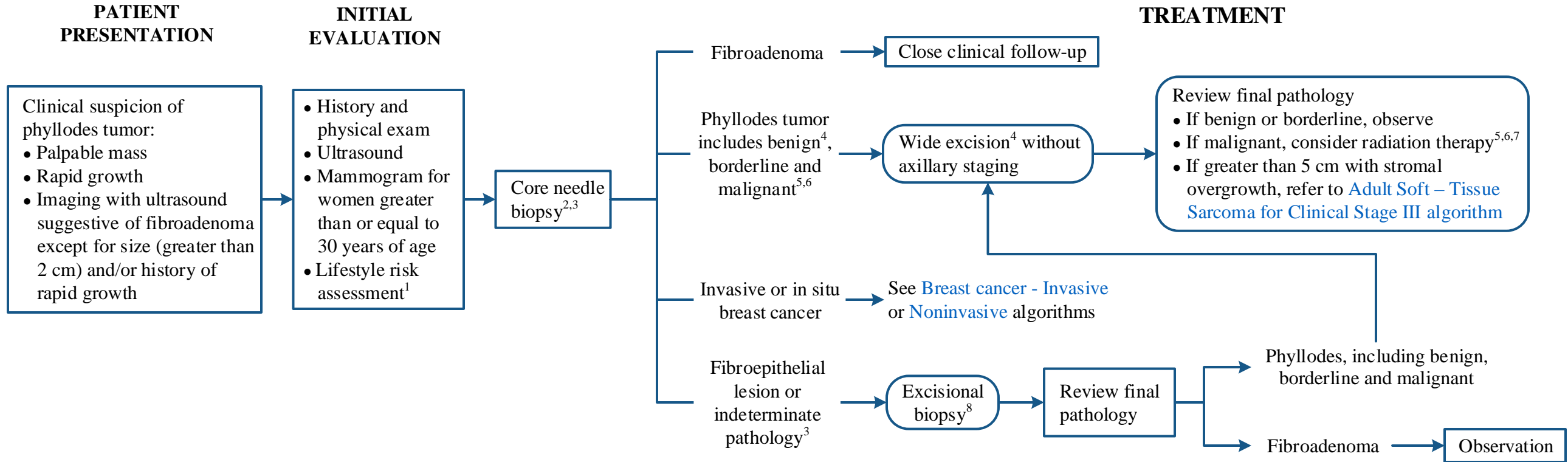


Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

**Note:** Consider Clinical Trials as treatment options for eligible patients.



<sup>1</sup> See [Physical Activity](#), [Nutrition](#), and [Tobacco Cessation](#) algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

<sup>2</sup> Fine needle aspiration will not, and core biopsy may not, distinguish fibroadenoma from phyllodes tumor in most cases (tumor heterogeneity and inability to assess for infiltrating margins may not allow for a definitive evaluation)

<sup>3</sup> It is recommended that the review of the pathology material be performed by a pathologist who is experienced in phyllodes tumor

<sup>4</sup> If initially excised with negative margin, wide local excision not required

<sup>5</sup> Referral to a multidisciplinary sarcoma center for treatment recommendations is appropriate for malignant phyllodes tumor or one with stromal overgrowth

<sup>6</sup> For patients with malignant phyllodes tumor on pathology review, refer to [Adult Soft - Tissue Sarcoma for Clinical Stage III algorithm](#)

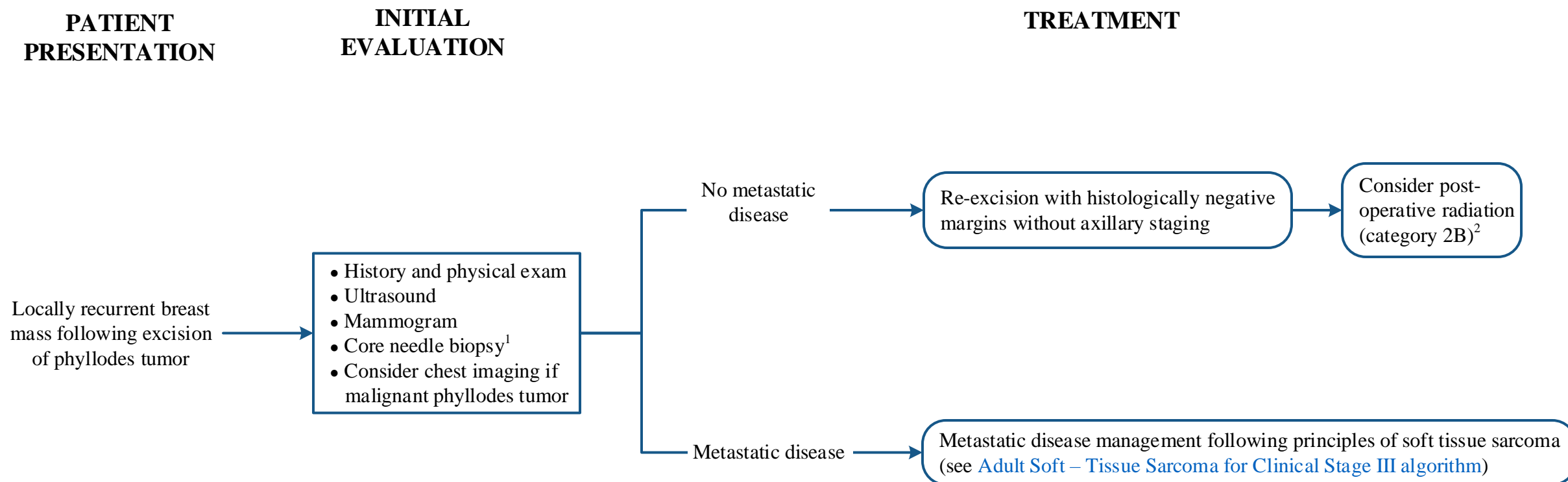
<sup>7</sup> There is no prospective randomized data supporting the use of radiation treatment (XRT) with phyllodes tumor. If the phyllodes tumor of the breast is benign or borderline histology, radiation therapy not routinely recommended after excision. If the tumor has malignant features (*i.e.*, stromal overgrowth, cellular atypia, high number of mitoses) radiation therapy can be considered as follows:

- If mastectomy is performed and margins negative, do not recommend XRT
- If mastectomy was performed and margins were concerning/close, tumor involved the fascia or chest wall, or tumor was very large (greater than 5 centimeters), consider XRT to chest wall
- If partial mastectomy only is performed, consider adjuvant XRT to breast, especially if margins are less than 1 cm

<sup>8</sup> 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.



<sup>1</sup> Pathology should be reviewed to assess for fibroadenoma versus phyllodes (phyllodes benign, borderline and malignant).

<sup>2</sup> 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

- National Comprehensive Cancer Network. (2018). *Breast Cancer* (NCCN Guideline Version 4.2018). Retrieved from [https://www.nccn.org/professionals/physician\\_gls/pdf/breast.pdf](https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf)
- Pezner, R. D., Schultheiss, T. E., & Paz, I. B. (2008). Malignant phyllodes tumor of the breast: Local control rates with surgery alone. *International Journal of Radiation Oncology, Biology, Physics*, 71(3), 710-713. doi: 10.1016/j.ijrobp.2007.10.051

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