

An unusual lesion of the pancreas

Phyllode breast tumors are rare fibroepithelial entities that may become malignant. They represent less than 1% of all primary breast tumors [1]. Management is essentially surgical. The risk of local or metastatic recurrence varies by histological type, but most cases exhibit benign

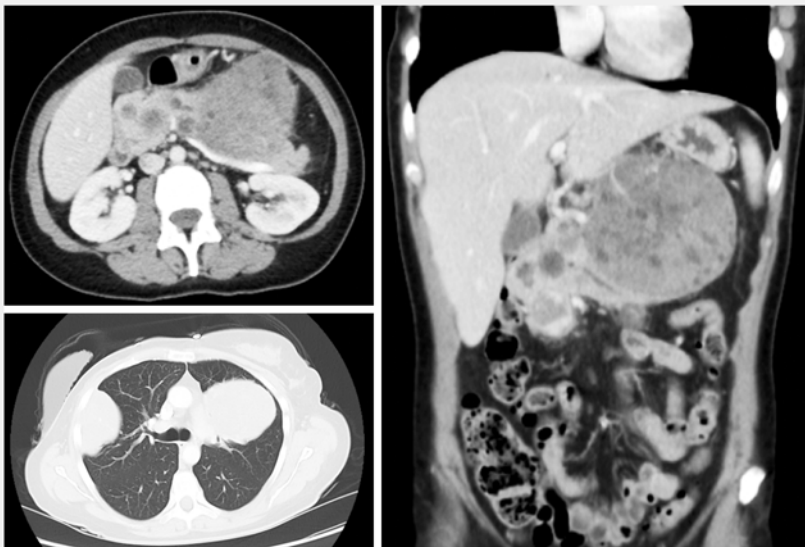
local evolution. The most common metastatic sites are the lungs and bones. No adjuvant treatment (radiotherapy or chemotherapy) is effective. Only five pancreatic metastases have been recorded in the literature, of which only one was diagnosed via endoscopy ultrasound

[2–4]. We present the first video recording of endoscopic ultrasound used to diagnose a pancreatic metastasis of a phyllode tumor (▶ **Video 1**); the diagnosis was histologically confirmed.

We excised a phyllode breast tumor, 30 cm in diameter, from a 47-year-old woman. The tumor was considered benign; we did not schedule any additional treatment or surveillance. Computed tomography was performed 5 years later to explore asthenia and weight loss associated with abdominal pain. We found a large (9 cm diameter) mass in the body of the pancreas (▶ **Fig. 1**), associated with secondary pulmonary masses, suggestive of a primitive pancreatic origin. Endoscopic ultrasonography revealed a large lesion in the body of the pancreas. The tumor was hypoechogenic and heterogeneous in appearance, and featured diffuse millimeter-scale cysts.



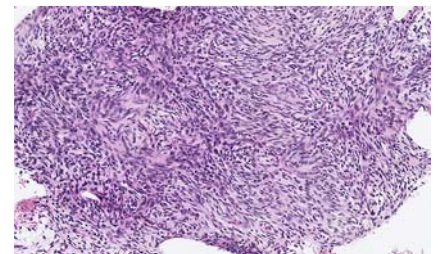
▶ **Video 1** Endoscopic ultrasound with fine-needle aspiration was used to diagnose a pancreatic metastasis of a phyllode tumor.



▶ **Fig. 1** Computed tomography scan showed a mass in the body of the pancreas, which was associated with secondary pulmonary masses, suggestive of a primitive pancreatic origin.



▶ **Fig. 2** Endoscopic ultrasound-guided fine-needle aspiration of a large lesion with diffuse millimeter-scale cysts in the body of the pancreas.



▶ **Fig. 3** Histopathological examination of the pancreatic material. High-power magnification ($\times 20$) showed hypercellular spindle cell proliferation in keeping with the stromal component of phyllode tumors.

Many hypoechogenic lesions were also evident in the head of the pancreas.

We performed endoscopic ultrasound-guided fine-needle aspiration (FNA) using a 19-G needle (► **Fig. 2**). Histology revealed proliferation of densely cellular fusiform cells, the immunohistochemical appearance of which was compatible with a secondary phyllode tumor derived from the tumor removed 5 years earlier (► **Fig. 3**). We scheduled palliative chemotherapy; the patient died a few months later.

Pancreatic metastases of phyllode tumors are very rare, but should be considered in those with a history of such breast tumors. A biopsy with a 19-G FNA needle or a new fine-needle biopsy needle, followed by immunohistochemical analysis, is necessary to confirm a diagnosis.

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Competing interests

None

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