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# Toward a new strategy in desmoid of the breast?

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## Abstract

*Aim*: To report initial results of observation as well as surgery in patients with desmoid tumors (DTs) of the breast, a rare tumor for which data are scarce.

*Patients and methods*: The initial approaches were categorized as either front-line loco-regional treatment [(surgery or radiotherapy group, SRG) n = 20] or initial observation [(no surgery/no radiotherapy group, NSRG) n = 11].

*Results*: A total of 27 women and 4 men were assessed between 1992 and 2013 and included in this study. Patient characteristics were adequately balanced in the 2 groups. Fifteen patients (48.4%) had a past history of breast surgery in the previous 24 months. The median initial DT size on MRI was 50 mm. The median follow-up was 36 months. In the SRG, 8/20 patients (40%) experienced recurrence. The median time to recurrence was 29 months. During the study period, 6 patients in the SRG (30%) received a mastectomy at the time of diagnosis (n = 3) or at relapse (n = 3), 7 patients (35%) received a thoracic wall resection and 8 patients (40%) received radiotherapy at the time of diagnosis (n = 2) or at recurrence (n = 5). In the NSRG, the median tumor size change was −4 mm (range −13 to +20). Three patients changed treatment strategies during the observation period; one received surgery, and 2 were administered anti-hormonal treatment.

*Conclusions*: Loco-regional treatments of breast DTs resulted in undesired disfigurement. Front-line observation yielded encouraging results and could enable the identification of patients who require loco-regional treatment. This strategy needs further evaluation.
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*Keywords:* Treatment; Surgery; Radiotherapy; Desmoid; Aggressive fibromatosis

## Introduction

Desmoid tumor (DT) is a monoclonal proliferative disease that does not metastasize and, unlike sarcomas, does not dedifferentiate into a high-grade malignancy in cases of recurrence.[1] The incidence is 2.4–4.3 new cases per $10^6$ individuals per year, and the breast location represents less than 10% of all cases.[1,2] This equates to an estimated incidence of approximately 20 cases per year in France, which may be an underestimate as patients with small indolent tumors are not seen in referral centers. Surgery has historically been the primary treatment for patients with resectable DTs.[3] Surgical recommendations have traditionally been based on retrospective studies in which surgery was proposed when feasible. Therefore, more conservative treatment approaches were often ignored. Recently, the 2012 Guidelines for soft tissue sarcoma included observation as an option for selected patients with resectable DTs.[4,5] These modifications were made on the basis of recent retrospective analyses that contained a variety of

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tumor locations.[6–11] In these reports, approximately half of the patients remained stable or exhibited spontaneous regression under surveillance, and the vast majority of progressions occurred during the first 3 years after diagnosis.[7] Therefore, adopting a 'wait and see' approach enables the identification of patients who really require treatment. However, it is possible that different specific locations of DT could harbor different characteristics, evolve differently and ultimately require individualized management. Currently, there is no series to confirm that breast DT should evolve as in other sites. The objective of our study was to report initial results of this new conservative management approach and compare these results to surgical results specifically in patients with breast DTs.

## Patients and methods

Data were collected from 31 consecutive patients between 1992 and 2013 with breast DTs who were followed at Institut Gustave Roussy, France. Patients without complete follow-up were excluded from this analysis. The study was approved by the local Institutional Review Board and meets the guidelines of the French law. Diagnoses were confirmed with biopsy results or specimens obtained by a referent pathologist who specializes in soft tissues tumors.

In case of purely mammary gland desmoid, the differential diagnosis with phyllode tumors was based on a specific architecture and the absence of an epithelial component. Before 2010, mutational status of beta-catenin was not performed systematically and was retrospectively examined within a dedicated study published elsewhere.[12] After 2010, the mutational status of beta-catenin has been performed routinely. A common database tracked patient characteristics, including gender, age at diagnosis, initial tumor size, year of diagnosis and treatment outcomes. Family or personal history of sporadic colorectal cancer or sporadic intestinal polyps was recorded. Patients were divided into two groups on the basis of the therapeutic approach employed: patients undergoing front-line loco-regional treatment (surgery or radiotherapy group, SRG) or patients who were initially advised to 'wait and see' or received medical treatment (no surgery/no radiotherapy group, NSRG). Follow-up consisted of contrast-enhanced thoracic and breast magnetic resonance imaging (MRI) at close intervals, including 1 month after the initial evaluation and every 2–3 months thereafter. After 6 months, the patients were followed every 6 months in cases of stable disease. The resection margins in surgically treated patients were classified according to the International Union Against Cancer (UICC) R classification.[13] In the event of treatment change, the date on which the treatment strategy was modified, the reasons for the change (e.g., tumor growth or symptoms in the NSRG, recurrence in the SRG) and the tumor size (at that time) were recorded. At the last follow-up visit, the date, patient status and tumor size were recorded.

The patients' initial characteristics were analyzed as percentages or medians and ranges. For statistical analysis, the Chi-square test was used to compare the distribution of demographic characteristics between groups, whereas the Mann–Whitney test was used for the continuous variables.[14] A change in treatment strategy was defined as a new decision in the event of local recurrence in the SRG and progression/symptoms change in the NSRG. Significant factors associated with changes in treatment strategies for DTs were determined by logistic regression. The results were summarized as odds ratios (OR) and respective 95% confidence intervals (CI). A p-value (two-tailed) of $<0.05$ was considered statistically significant. All analyses were performed using SPSS, version 21 (SPSS Inc., Chicago, IL, USA).

## Results

### *Patient characteristics*

A total of 27 women and 4 men treated between 1992 and 2013 were included in the study (ratio 7/1) (Table 1). The median patient age at the time of initial diagnosis was 46 years (range 17–68). No patient had Gardner syndrome. A family or personal history of sporadic colorectal

Table 1
Demographics and tumor characteristics.

| | Total n = 31 | NSR Group n = 11 (35.5%) | SR Group n = 20 (64.5%) | p-Value |
|---|---|---|---|---|
| Age (median, range) | 46 (17–68) | 50 (24–67) | 41.5 (17–68) | 0.36 |
| Male | 4 (12.9) | 1 (9.1) | 3 (15) | |
| Female | 27 (87.1) | 10 (90.9) | 17 (85) | 0.64 |
| Previous breast surgery (%) | 15 (48.4) | 7 (63.6) | 8 (40) | 0.32 |
| Previous breast cancer (%) | 7 (22.6) | 3 (27.3) | 4 (20) | 0.76 |
| Previous plastic surgery (%) | 6 (19.4) | 4 (36.4) | 2 (11.1) | 0.11 |
| Time between previous surgery and DT (months) (median, range) | 24 (12–156) | 24 (12–156) | 24 (12–60) | 0.46 |
| Initial tumor size (mm) (median, range) | 50 (10–160) | 55 (10–160) | 50 (10–80) | 0.70 |
| Follow-up (months) (median, range) | 36 (3–181) | 23 (3–144) | 60 (9–180) | 0.03 |

SR Group: surgery or radiotherapy group.
NSR Group: non surgery or radiotherapy group.
DT: desmoid tumor.

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