台灣乳房醫學會
TAIWAN BREAST CANCER SOCIETY

2022
乳房手術共識

主編 台灣乳房醫學會

Preface

乳房手術是一項複雜的醫學技術，涉及到許多不同的手術方法和治療選擇。然而，手術的技術和方法卻因醫師專業背景、訓練程度、經驗等因素，存在著差異性，導致手術效果和治療結果的不一致性。

為了提高乳房手術的品質和效果，因此在 2022 年 10 月學會邀請多位專家成立共識會議工作小組，進行共識會議籌備，擬定乳房手術相關重要議題，包含 BCS、SLNB+ALND、Mastectomy、NACT 四大主題。

本會於 2022 年 11 月 27 日，假台北榮民總醫院致德樓舉辦「2022 乳房手術共識會議」，與眾多專家學者們共同討論，會後彙整專家建議，經台灣乳房醫學會第九屆理監事審議通過。期盼透過這份共識的制定和實施，可以進一步提高乳房手術的專業水準，讓病人能夠得到更加安全、有效的治療。同時，我們也希望能夠加強醫療專業人員之間的溝通和協調，提升整體醫療水平，為台灣的乳房疾病治療作出更大的貢獻。

最後，我代表台灣乳房醫學會感謝各位醫療專業人士的參與和支持，期待這份共識的實施能夠為病人和乳房疾病治療帶來更多的福祉和價值。

台灣乳房醫學會 理事長

陳守棟 于 2023 年 3 月

特別感謝以下專家提供寶貴建議（依姓氏筆畫排列、職稱省略概以醫師稱謂）

于家珩、沈陳石銘、杜世興、林金瑤、俞志誠、侯明鋒、洪朝明、施昇良、姚忠瑾、陳訓徹、陳守棟、陳達人、許桓銘、郭玟伶、莊捷翰、陳芳銘、郭文宏、郭耀隆、張金堅、曾令民、黃俊升、張振祥、黃其晟、張耀仁、張宏泰、葉名煒、葉顯堂、葉大成、蔡宜芳、鄭翠芬、謝家明、鍾元強等諸位醫師。

本治療共識僅做為參考，因每人狀況不同，而由各醫師選擇最適當之處置方式，不作為醫療訴訟用。

Agenda

Topic	Speaker		Moderator
Opening	陳守棟 理事長 / 台灣乳房醫學會		
BCS			
Surgery for benign/proliferative lesions	李國鼎 主任 / 成大醫院		張振祥 主任 / 新樓醫院
Breast conserving surgery	沈士哲 醫師 / 長庚醫院		洪朝明 院長 / 義大癌治療醫院
Concurrent breast surgery with radiotherapy	張源清 主任 / 馬偕醫院		許桓銘 醫師 / 三軍總醫院
Panel discussion	張振祥 主任 / 新樓醫院 洪朝明 院長 / 義大癌治療醫院 許桓銘 醫師 / 三軍總醫院 葉名煒 主任 / 中山附醫	沈士哲 醫師 / 長庚醫院 李國鼎 主任 / 成大醫院 張源清 主任 / 馬偕醫院	張金堅 教授 / 臺大醫院 陳訓徹 教授 / 長庚醫院
SLNB+ALND			
Axillary lymph node dissection	周旭桓 醫師 / 長庚醫院		施昇良 主任 / 高醫附醫
Sentinel lymph node biopsy	洪進昇 主任 / 北醫附醫		黃其晟 秘書長 / 台灣乳房醫學會
Panel discussion	施昇良 主任 / 高醫附醫 黃其晟 秘書長 / 台灣乳房醫學會 周旭桓 醫師 / 長庚醫院	洪進昇 主任 / 北醫附醫 郭玟伶 主任 / 長庚醫院 蔡宜芳 醫師 / 台北榮民總醫院	侯明鋒 教授 / 高醫附醫 俞志誠 教授 / 三軍總醫院
Mastectomy			
Mastectomy	蔡青樺 醫師 / 高雄長庚醫院		陳芳銘 副院長 / 高雄市立大同醫院
Nipple sparing mastectomy	曾彥敦 醫師 / 高雄榮民總醫院		葉顯堂 副院長 / 羅東博愛醫院
Endoscopic assisted nipple sparing mastectomy (E-NSM)	賴鴻文 醫師 / 彰化基督教醫院		杜世興 教授 / 北醫附醫
Panel discussion	陳芳銘 副院長 / 高雄市立大同醫院 葉顯堂 副院長 / 羅東博愛醫院 杜世興 教授 / 北醫附醫 姚忠瑾 副部長 / 中山附醫	謝家明 主任 / 台安醫院 蔡青樺 醫師 / 高雄長庚醫院 曾彥敦 醫師 / 高雄榮民總醫院 賴鴻文 醫師 / 彰化基督教醫院	曾令民 部長 / 台北榮民總醫院 陳達人 教授 / 彰化基督教醫院
Robotic-assisted nipple sparing mastectomy	廖國秀 主任 / 三軍總醫院		張耀仁 副院長 / 台北慈濟醫院
Surgery for inflammatory breast cancer	洪志強 主任 / 台中榮民總醫院		于家珩 主任 / 童綜合醫院
(Contralateral) prophylactic mastectomy	劉良智 主任 / 中國附醫		張宏泰 教授 / 馨蕙馨醫療體系
Panel discussion	張耀仁 副院長 / 台北慈濟醫院 于家珩 主任 / 童綜合醫院 張宏泰 教授 / 馨蕙馨醫療體系 鍾元強 院長 / 光田醫院	莊捷翰 醫師 / 高醫附醫 廖國秀 主任 / 三軍總醫院 洪志強 主任 / 台中榮民總醫院 劉良智 主任 / 中國附醫	曾令民 部長 / 台北榮民總醫院 陳達人 教授 / 彰化基督教醫院
NACT			
Axillary clipping	羅　喬 醫師 / 臺大醫院		郭文宏 醫師 / 臺大醫院
Breast clipping	王明暘 醫師 / 臺大醫院		鄭翠芬 主任 / 新光醫院
Panel discussion	郭文宏 醫師 / 臺大醫院 鄭翠芬 主任 / 新光醫院 郭耀隆 教授 / 成大醫院 葉大成 醫療長 / 澄清醫院	林金瑤 主任 / 台中慈濟醫院 羅　喬 醫師 / 臺大醫院 王明暘 醫師 / 臺大醫院	黃俊升 部長 / 臺大醫院 沈陳石銘 教授 / 北醫附醫
Closing	陳守棟 理事長 / 台灣乳房醫學會		

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Strength of the Recommendation and Quality of Evidence

Strength	Recommendation
A	Strong recommendation for use
B	Moderate recommendation for use
C	Marginal recommendation for use
D	Recommendation against use

Quality	Evidence
I	Evidence from at least 1 properly designed randomized, controlled trial
II	Evidence from at least 1 well-designed clinical trial, without randomization; from cohort or case-controlled analytic studies (preferably from > 1 center); from multiple time series; or from dramatic results of uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experience, descriptive case studies

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2. Grading quality of evidence and strength of recommendations in clinical practice guidelines part 3 of 3. The GRADE approach to developing recommendations. Allergy 2011; 66:8
3. Annals of Hematology (2018) 97:1271–1282

The Principle of Voting for Strength of Recommendation

Strength	Recommendation
A	Strong recommendation for use
B	Moderate recommendation for use
C	Marginal recommendation for use
D	Recommendation against use

For the “Strength of Recommendation A and B”, a majority panel vote of at least 85% is required.

For the “Strength of Recommendation C”, a panel vote of at least 50% (but less than 85%) is required.

For recommendations where there is strong panel disagreement regardless of the quality of the evidence, “Strength of Recommendation D” requires a panel vote of at least 25%.

1. NCCN giudelines. Development and Update of Guidelines.

Surgery for benign / proliferative lesions

—— 成大醫院 / 李國鼎 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
Surgical biopsy for B3 lesion			
1.1 B3 lesions should be considered to obtain tissue for pathological diagnosis due to uncertain malignant potential.	II	A	1,2
1.2 Surgical biopsy is not used as the initial biopsy method unless percutaneous needle biopsy is not feasible or available, but it may be required to further investigate discordant or inconclusive results of percutaneous biopsies.	II	A	3
1.3 Review of images and pathology should be undertaken to ensure that the histopathology of a lesion biopsied is concordant with the imaging abnormality.	II	A	4
Surgery for benign/proliferative lesions without atypia			
2.1 For intraductal papilloma, excision is recommended in cases of atypia, a palpable mass lesion, bloody nipple discharge (primarily for symptomatic relief), and/or pathology–imaging discordance.	II	A	5,6
2.2 If a fibroadenoma increases significantly in size or is symptomatic, then excision is mandated to rule out malignant change and confirm the diagnosis.	II	A	7–9
Surgery for benign/proliferative lesions with atypia			
3.1 Following a diagnosis of ADH (atypical ductal hyperplasia) by CNB, the standard of care is to perform an excisional biopsy to exclude the possibility of an associated malignant lesion.	II	A	5,10
3.2 If classic LCIS is diagnosed on an excisional breast biopsy, no further surgery is required. Re–excision is not indicated when classic LCIS is present at the margin.	II	A	11
3.3 Pleomorphic or florid LCIS is identified on an excisional biopsy, evaluation of the surgical margins for the presence of these nonclassic variants of LCIS is required, and re–excision to negative margins is recommended.	II	A	12

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Breast conserving surgery

—— 長庚醫院 / 沈士哲 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
Breast Surgery – Partial Mastectomy			
I. Pre-operative			
I–1. Multidisciplinary team approach (including radiology, radiation oncology, pathology, medical oncology and surgery) is mandatory.	III	A	1
I–1b. Breast MRI is not recommended for routine preoperative assessment.	II	A	12, 13
I–2. Breast conserving surgery is the preferred choice of breast cancer surgery, if not otherwise contraindicated.	II	A	2
I–3. Tissue proof by core needle biopsy or other minimally invasive breast biopsy is required. Excisional biopsy is not suggested.	III	A	
I–4. Breast image study (mammography and ultrasound) is mandatory for preoperative evaluation, and sometimes for intraoperative localization.	III	A	3
I–5. Preoperative localization with dye or other methods for non-palpable lesion by ultrasound or mammography is mandatory.	II	A	4
I–6. Indications for adjuvant radiotherapy should be evaluated and discuss with patient.	I	A	5
I–7. Volume measurement of breast and tumor will help in oncoplastic assessment.	III	B	6
II. Intraoperation			
II–1. For tumor close or adherent to skin, excision of overlying skin is appropriate and for deep-seat tumor, the fascia should be removed.	III	A	7
II–2. After surgery, a negative margin should be achieved.	I	A	17
II–3. After appropriate preoperative evaluation, if excisions carried from the subdermal plane to the pectoral fascia, re-excision for a positive anterior (superficial) or posterior (deep) margin is not routinely required.	II	B	8
II–4. Clipped the resection cavity margin is recommended, especially for complex oncoplastic procedure.	II	B	9
II–5. Intraoperative pathological assessment of margin may help to reduce re-excision rate.	II	B	10
II–6. Specimen mammogram/ultrasound helps to reduce re-excision rate and specimen orientation should be standardized.	II	A	11,14
II–7. Prophylactic antibiotics may be indicated before surgery.	I	B	15,16
III. Postoperative surveillance			
III–1. Post-operative compression dressing should be properly performed to prevent seroma formation.	III	B	
III–2. Evaluation of cosmetic results and quality of life are recommended in postoperative surveillance.	III	B	

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Concurrent breast surgery with radiotherapy

—— 馬偕醫院 / 張源清 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Patients should be counseled that the risk of ipsilateral breast cancer recurrence was higher with IORT (intraoperative radiotherapy)	I	A	1,2, 3,8
2. IORT should be restricted to women with “invasive” cancer considered “suitable” for APBI (accelerated partial–breast irradiation) (age ≥ 50 years, tumor ≤ 2 cm, ER+, margin ≥ 2 mm , N0, no LVI, unifocal disease and no neoadjuvant therapy)(All criteria are met)	II	A	1–3
3. In selective low risk postmenopausal patients with small, strong ER+ node negative breast cancers do not benefit much from RT if they receive endocrine therapy. (>60 years, tumor ≤ 2 cm, ER+, N0, grade 1–2, ki67 < 14%, luminal A)	II	B	5–7
4. APBI include interstitial brachytherapy, 3D/IMRT and applicator brachytherapy excepting IORT.	I	A	3,4

◎ Reference

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Axillary lymph node dissection

—— 長庚醫院 / 周旭桓 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1 Standard technique and indication of axillary lymph node dissection (ALND)			
1–1 Standard ALND includes meticulous dissection in level I and level II to preserve T2 (intercostobrachial) or T3 sensory nerve as possible, and the long thoracic nerve, thoracodorsal nerve, and medial pectoral nerve should be identified and preserved. The total number of the dissected lymph node is at least 10 on average. Level III and Rotter's node would be resected only in grossly palpable nodes or found in the image.	I	A	1–3
1–2 ALND should be performed in clinically palpable lymph node with pathologically proven positive patients if no neoadjuvant treatment is planned. While evaluating the stage of the axillary lymph nodes, clinical physical examination and axillary sonography were recommended.	I	A	1,4
1–3 ALND could be appropriate in patients with locally advanced breast cancer or cN2–3 disease upfront or after neoadjuvant chemotherapy since SLNB in this setting is uncertain.	II	A	1,4
1–4 ALND should be indicated in patients with Inflammatory breast cancer, axillary metastasis from occult primary breast cancer, axillary recurrence with or without local recurrence, and failed SLN mapping.	II	A	3
2 Timing when axillary lymph node dissection can be omitted			
2–1 ALND can be omitted in patients with cT1–2N0 or suspicious ≤ 2 nodes on imaging or confirmed by pathology, planned breast–conserving surgery, post–operation whole breast radiotherapy, and no neoadjuvant treatment while 1–2 positive sentinel lymph nodes are identified or with one or more positive sentinel nodes, all of which were ≤ 2 mm and without extracapsular extension.	I	A	5,6
2–2 In mastectomy patients with cT1–2N0 or suspicious ≤ 2 nodes on imaging or confirmed by pathology and no neoadjuvant treatment, ALND is the standard procedure while 1–2 positive sentinel lymph nodes are identified. Regional nodal irradiation (RNI) is the alternative treatment and should be performed to cover the undissected area or regional node area if ALND is not performed.	I	B	7,8
3 Breast cancer related lymphedema after axillary lymph node dissection			
3–1 Arm lymphedema is a significant complication of axillary surgery, accounting for approximately 20% of patients after ALND. The clear risk factors included BMI, radiotherapy and the extent of axillary surgery.	I	A	9,10

◎ Reference

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Sentinel lymph node biopsy

—— 北醫附醫 / 洪進昇 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Sentinel lymph node biopsy should be considered in patients who have invasive breast cancer or DCIS			
1–1 Patients with early breast cancer, cT1mi–2N0 (clinically non–palpable LN) cancer, should have sentinel lymph node biopsy.	I	A	1–6
1–2 Patients have cT1–2N0 (clinically non–palpable LN) cancer with abnormal axillary imaging and/or ≤ 2 positive lymph node needle biopsy could have sentinel lymph node biopsy.	I	A	4–8
1–3 Patients post neoadjuvant chemotherapy with cN0 (non–palpable LN and image negative) could have sentinel lymph node biopsy.	II	A	9–12
1–4 Patients who have invasive local recurrence post–BCT with a cN0 (non–palpable LN) could consider sentinel lymph node biopsy.	II	A	13
1–5 Pregnant women with breast cancer or DCIS using radio–isotope for sentinel lymph node biopsy is feasible.	II	B	14,15
2. Sentinel lymph node biopsy may be not needed			
2–1 Patients with invasive breast cancer or DCIS but surgical nodal staging will not affect adjuvant therapy recommendations.	II	A	16–20
2–2 Patient with pure DCIS proved after surgical excision will undergo breast–conserving surgery.	II	B	21–23
2–3 Sentinel lymph node biopsy may be not needed in prophylactic mastectomy or primary breast sarcoma or phyllodes tumor.	II	A	24
3. Sentinel lymph node biopsy technique			
3–1 SLNB typically begins with injection of one or two tracers into breast skin or parenchyma either in the vicinity of the tumor or under the areolar plexus.	I	A	25–28
3–2 Tracer agents, including blue dye, ICG and Tc–99, are all feasible for sentinel lymph node biopsy.	II	A	29,30

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Mastectomy

—— 高雄長庚醫院 / 蔡青樺 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
I. Pre-operative			
I-1. Breast image study (mammography and ultrasound) is mandatory for evaluation.	III	A	1-3
I-2. Tissue proof by core needle biopsy or other minimally invasive breast biopsy is required. Excisional biopsy is not suggested.	III	A	4-6
I-3. Multidisciplinary team approach (including radiology, radiation oncology, pathology, medical oncology and surgery) is mandatory.	III	A	7
I-4. Indication: Large tumor-to-breast-size ratio; Multicentric tumor; Insufficient response to neoadjuvant chemotherapy or endocrine therapy ; Persistently positive margins of excision; Inflammatory breast cancer; Extensive malignant/indeterminate microcalcifications; Early pregnancy (first trimester); Local recurrence following BCS/radiotherapy; Contraindication to radiotherapy; History of prior mantle radiotherapy; Patient preference	II	A	
I-5. Shared decision making programs (including reconstruction)	II	A	8

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
II. Intraoperation			
II-1. The skin free margin 1-2 cm and overlying skin and nipple areolar complex are included in the tissue excised.	III	A	
II-2. The excisions carried from the subdermal plane to the pectoral fascia, extended to the anatomic limits of the breast (the sternal border medially, the clavicle superiorly, the latissimus laterally, and the rectus sheath/inframammary fold inferiorly).	II	A	9

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Nipple sparing mastectomy

—— 高雄榮總 / 曾彥敦 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Nipple sparing mastectomy (NSM) is a widely used oncologic and reconstructive option for patients with breast cancer, who are carefully selected by experienced multidisciplinary teams.	II	A	3–5
2. Indications for NSM: early–stage breast cancer, DCIS, risk–reduction procedure, and in some locally advanced breast cancer (ie, with complete clinical response to preoperative chemotherapy and no nipple involvement with cancer).	II	A	1–3
3. Contraindications for NSM: preoperative clinical or radiographic evidence of nipple involvement, including Paget disease, bloody nipple discharge associated with malignancy, inflammatory breast cancer, and/or imaging findings suggesting malignant involvement of the nipple or subareolar tissues. Pathological nipple evaluation should be assessed.	II	A	1–3
4. Patients should be counseled on the risk of delayed healing, nipple necrosis, loss of pigmentation, loss of sensation, loss of projection, and need for subsequent removal of the nipple–areolar complex (NAC).	II	A	3
5. Radiation therapy after NSM should be administered in high risk patients, such as those with tumour size >5 cm, positive lymph nodes in the axilla, or positive tumour margins.	II	A	6

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Endoscopic assisted nipple sparing mastectomy (E-NSM)

—— 彰化基督教醫院 / 賴鴻文 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. In most of the cases, preoperative evaluation, intraoperative nipple margin assessment, indication, contra–indication, and post mastectomy reconstructive options for E–NSM are consistent with those of open NSM. For patients consider for E–NSM, early–stage breast cancer are more suitable candidates due to oncologic safety considerations.	II	A	1–5
2. Patients indicated for E–NSM are preferred to have tumor size of less than 5 cm, and no evidence of skin or chest wall invasion.	II	A	1–5
3. Patients for whom E–NSM are contraindicated included those with apparent nipple areolar complex (NAC) involvement, inflammatory breast cancer, breast cancer with chest wall or skin invasion, or locally advanced breast cancer.	II	A	1–5
4. Axillary Lymph node (ALN) metastases is not a contra–indication for E–NSM. However, multiple ALN metastases (N2 to N3) is associated with higher risk for locoregional recurrence and distant metastasis. Share decision making is recommended for patients with multiple ALN metastases selected for E–NSM. For patients with locally advanced breast cancer (T3, N2/3) should be managed with caution if upfront surgery with E–NSM is considered.	II	B	1–5
5. Patients with severe co–morbid conditions, such as heart disease, renal failure, liver dysfunction, and poor performance status are not good candidates for E–NSM.	II	A	1–5
6. The peri–operative parameters, morbidity and the oncological safety of E–NSM should be carefully monitored per surgeon/center.	II	A	1,3, 4,5
7. E–NSM followed by immediate or delayed breast reconstruction with prothesis or autologous flap is feasible and safe.	II	A	1–11
8. E–NSM needs adequate training, education & auditing.	II	A	5–7
9. From current available evidence, E–NSM is acceptable in oncologic safety for selective early stage breast cancer patients, however, longer follow–up and more data remained needed to confirm its long term oncologic safety.	II	B	8–11

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Robotic-assisted nipple sparing mastectomy

—— 三軍總醫院 / 廖國秀 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. RAM is not approved by US FDA due to limited evidence of cancer recurrence, DFS and OS with RAM.	I	A	1–2
2. SDM and inform consent should be done before RAM, including benefits, risks, and alternatives treatment.	I	A	1–2
3. RAM should be performed by well–experiences qualified breast surgeons, and the oncologic safety should be regularly monitored. RAM is a newly–developing breast surgery, the oncologic evidence has to be accumulated.	II	B	1–3
4. Safety and patient's satisfaction of RAM are same as endoscopic–assisted mastectomy.	II	B	4–8
5. The clinical outcome of robotic–assisted mastectomy (RAM) versus endoscopic–assisted mastectomy is equal, but higher cost in RAM.	II	B	4–8

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Surgery for inflammatory breast cancer

——臺中榮民總醫院 / 洪志強 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Neoadjuvant chemotherapy should be offered for HER2 negative IBC. If Her2 positive IBC, adding on anti–HER2 target therapy is recommended for achieving superior pathologic complete response rate.	I	A	1–3
2. Modified radical mastectomy and radiotherapy are recommended for IBC. If the patient prefers reconstruction, delayed reconstruction six months to one year later after radiotherapy is suggested.	I	A	2, 4–9
3. Axillary lymph node dissection is standard for IBC due to high failure rate of mapping by dual tracer.	II	A	10

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(Contralateral) prophylactic mastectomy

—— 中國附醫 / 劉良智 主任

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Claus Model (including patient history, family history, and genetic testing) is the preferred method for personal risk factor assessment for breast cancer in line with Taiwanese women's assessment.	II	A	2,3
2. For the lifetime breast cancer risk assessment and grading standards for Taiwanese women, ordinary people should set at 8%	II	A	4
3. For the lifetime breast cancer risk assessment and grading standards for Taiwanese women, the high-risk group is defined as ≧ 20%, and BRCA1/2 carriers would also be regarded as high-risk groups.	II	A	5
4. For the life-long breast cancer risk assessment and grading standards for Taiwanese women, middle to high-risk groups set in 8-20%.	II	A	5
5. For healthy women with no family history of breast cancer but confirmed with gBRCA1/2 mutation, bilateral prophylactic mastectomy (regardless of the methods of surgery) is acceptable but discouraged.	II	B	6,7
6. For healthy women with lineal relative relative that has breast cancer or ovarian cancer and confirmed with gBRCA1/2 mutation, bilateral prophylactic mastectomy (regardless of the methods of surgery) is acceptable and encouraged.	II	B	6,7
7. For healthy women, with lineal relative that has breast cancer or ovarian cancer and confirmed without gBRCA1/2 mutation but with other gene mutations (such as PALB2, CHEK2...), bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	6,7
8. For healthy women without gBRCA1/2 and PALB2, CHEK2 mutation but has first-degree-relative that has breast cancer, bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	6,7
9. For healthy women without gene mutation but with medium to high-risk of breast cancer risk assessment, to receive bilateral prophylactic mastectomy if she request, bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	7
10. For a 45-year-old woman with gBRCA1/2 mutated unilateral breast cancer and no family history, bilateral prophylactic mastectomy (regardless of the methods of surgery) is acceptable and encouraged.	II	B	6,8
11. For a 45-year-old woman without gBRCA1/2 mutated unilateral breast cancer and no family history, bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	6,8
12. For a 45-year-old woman with unilateral breast cancer and no family history and gBRCA1/2 mutation but confirmed with other gene mutations (such as PALB2, CHEK2...), bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	6,8
13. For a 45-year-old woman with unilateral breast cancer and confirmed without gene mutation but with medium to high-risk of breast cancer risk assessment, to receive bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	7
14. For a 45-year-old woman with unilateral breast cancer and has first-degree-relative diagnosed with breast cancer or ovarian cancer that has been confirmed with gBRCA1/2 mutation, bilateral prophylactic mastectomy (regardless of the methods of surgery) is acceptable and encouraged.	II	B	6,8

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
15. For a 45–year–old woman with unilateral breast cancer and has first–degree–relative diagnosed with breast cancer or ovarian cancer that has been confirmed without gBRCA1/2 mutation, bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	6,8
16. For a 45–year–old woman with unilateral breast cancer and has first–degree–relative diagnosed with breast cancer or ovarian cancer that has been confirmed without gBRCA1/2 mutation but with other gene mutations (such as PALB2, CHEK2...) , bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	C	6,8
17. For a 45–year–old woman with unilateral breast cancer and has first–degree–relative diagnosed with breast cancer or ovarian cancer that has been confirmed without gBRCA1/2 and other gene mutations (such as PALB2, CHEK2...) but with medium to high–risk of breast cancer risk assessment, to receive bilateral prophylactic mastectomy (regardless of the methods of surgery) is not recommended.	II	B	7
18. Considering the safety and low recurrence rate for unilateral (bilateral) prophylactic mastectomy, nipple areolar sparing mastectomy with reconstruction is the preferred method for the patient.	II	A	9

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Axillary clipping

——臺大醫院 / 羅喬 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Among patients shown to be cN+ prior to NAT, ALND is recommended for residual disease after NAT.	I/II	A	1
2. Among patients shown to be cN+ prior to NAT, when nodes become clinical negative after NAT, SLNB has a false negative rate >10% after NAT. This false negative rate can be improved by marking biopsied nodes to document their removal, using dual tracer (radio-isotope and blue dye), and by removing >= 3 sentinel nodes. ALND is indicated if sentinel lymph nodes/ marked nodes not successfully identified.	II	B	2-7

» cN+: clinical node positive for malignant cells
» NAT: neoadjuvant therapy
» ALND: axillary lymph node dissection
» SLNB: sentinel lymph node biopsy

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Breast clipping

—— 臺大醫院 / 王明暘 醫師

2022 Consensus Statement	Quality of Evidence	Strength of Recommendation	Key Reference
1. Margin status recommendations after BCS for invasive cancers and DCIS treated with NACT is the same as without NACT.	II	A	1–6
2. Resection into new margin is the goal of neoadjuvant therapy. The resection extent should be limited to residual lesions with reasonable safety margin. If no detectable lesion remains, the resection extent may be limited to the tissue in the immediate vicinity of the biopsy site marker.	II	A	1
3. It is recommended to place a clip or tattooing in the primary tumor after biopsy.	III	B	8,9
4. It is recommended to remove all suspicious microcalcifications after neoadjuvant therapy.	III	B	7,10
5. Obtaining an image (mammography and/or ultrasound) for resected specimen is recommended.	III	B	7,10
6. For patients whose negative margin were achieved after breast conserving surgery, but having large amount of tumor or scatter lesions presented in proximity to the margin, the decision for re–excision should be individualized and discussed in a multidisciplinary setting to determine if wider margins are needed.	III	B	11,12

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Note

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