No.	Question	Total votes	Survey results (number of votes, %)				
			A	B	C	D	E
1	A range of 1–10 % of tumour cell nuclei with low ER expression. ER-*low-positive* expression is regarded as a gray zone in which data on the efficacy of hormone therapy are limited.	31	25	5	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**80.65 %**	16,13 %	3,22 %	-	-
	Consensus reached						
2	To minimize the risk of misinterpretation of ER expression, it is recommended to obtain information on preanalytical parameters and on validation of the antibodies used (clones SP1, EP1, 6F11). In case of a borderline result (1–10 %) or clinicomorphological discordance, correlation with Ki-67 and histological grade should be performed; if doubts persist, a repeat assay or referral of the material to a reference laboratory is recommended.	33	30	3	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**90.91 %**	9,09 %	0	-	-
	Consensus reached						
3	A 29-year-old patient with a detected germline pathogenic TP53 mutation (c.817G>A, p.Arg273His). Family history is burdened by sarcoma in the father (at the age of 34 years) and breast cancer (BC) in the grandmother (at the age of 38 years). After breast-conserving surgery (BCS): pT2N1a(sn) G3 (3 + 3 + 3), ER 30 % (3 + 1) = 4 points, PR 0, HER2 3+, Ki-67 45 %, negative resection margins, micrometastasis in one of the three sentinel lymph nodes (LNs). Given the germline TP53 mutation, it is advisable to limit surgery to mastectomy in order to minimize the risk of radiation-induced secondary tumors. Planned CT/PET without strict clinical indications is not recommended. *Note*. In the presence of a germline mutation, the defective p53 protein fails to trigger cell cycle arrest and apoptosis in response to radiation-induced double-strand DNA breaks, which leads to accumulation of mutations and a high risk of secondary tumors (soft tissue/bone sarcomas, breast angiosarcomas).	34	30	3	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**88.24 %**	8,82 %	2,94 %	-	-
	Consensus reached						
4	Before the start of neoadjuvant therapy, metastatic involvement of cN1 has been confirmed (proven by core-needle biopsy of the axillary lymph nodes). To make targeted axillary dissection possible after neoadjuvant therapy, it is recommended to mark the involved node with a clip, I-125 seed or other markers.	34	29	2	3	-	-
	A. Yes B. No C. Abstain from answering	100 %	**85.30 %**	5,88 %	8,82 %	-	-
	Consensus reached						

5	A 75-year-old patient, cT1N0M0, tubular carcinoma, G1 (1 + 2 + 1), ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 3) = 8 points, HER2 0, Ki-67 8 %. Breast-conserving surgery + axillary lymph node dissection has been performed. Adjuvant hormone therapy is not advisable.	25	8	15	2	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	32.00 %	**60.00 %**	8,00 %	-	-
	Consensus reached						
6	Should prophylactic lymphovenous anastomosis be routinely performed in all patients scheduled for axillary lymph node dissection?	36	1	30	5	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	2.78 %	**83.33 %**	13,89 %	-	-
	Consensus reached						
7	Patients with luminal A breast cancer over 60 years of age with stage cT1-2N0M0 (with negative axillary ultrasound and low Ki-67). Is it possible to omit surgical axillary staging during breast-conserving surgery? With mastectomy, this approach requires additional discussion.	34	22	12	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**64.71 %**	35.29 %	0	-	-
	Consensus reached						
8	Intraoperative histological examination (HE) of resection margins is not recommended as a routine procedure in breast-conserving surgery.	30	25	5	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**83.33 %**	16.67 %	0	-	-
	Consensus reached						
9	Intraoperative histological examination of sentinel lymph nodes is not recommended as a routine procedure in previously untreated cN0 patients undergoing breast-conserving surgery or mastectomy.	34	19	14	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**55.88 %**	41.18 %	2.94 %	-	-
	Consensus reached						
10	In patients with cT4N0M0 after neoadjuvant systemic therapy, in the absence of clinical and radiological signs of progression, sentinel lymph node biopsy is recommended.	31	27	4	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**87.10 %**	12.90 %	0	-	-
	Consensus reached						

11	In case of isolated locoregional recurrence after previously completed breast cancer treatment, sentinel lymph node biopsy is recommended if axillary lymphadenectomy has not been performed previously.	33	8	21	4	0	-
	A. Yes, always **B. Yes, but only if axillary lymphadenectomy was not performed** C. No D. Abstain from answering	100 %	24.24 %	**63.64 %**	12.12 %	0	-
	Consensus reached						
12	In patients with invasive lobular breast cancer and metastases detected in two sentinel lymph nodes, axillary lymphadenectomy is recommended.	34	22	8	4	-	-
	A. Yes B. No C. Abstain from answering	100 %	**64.71 %**	23.53 %	11.76 %	-	-
	Consensus reached						
13	In breast cancer patients with stage cT1-3N1M0 who achieved pCR/ypT0N0 after completion of neoadjuvant systemic therapy, complete omission of radiotherapy (RT) after breast-conserving surgery (BCS) is possible.	34	20	11	3	-	-
	A. Yes B. No C. Abstain from answering	100 %	**58.82 %**	32.35 %	8.83 %	-	-
	Consensus reached						
14	In breast cancer patients with cT1-2N0M0 / pT1-2 after breast-conserving surgery with omission of sentinel lymph node biopsy (SLNB), radiotherapy may be limited to partial irradiation of the tumor bed (SOUND, INSEMA trials)	31	20	9	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**64.52 %**	29.03 %	6.45 %	-	-
	Consensus reached						
15	In breast cancer patients with stage pT1-3N1M0 after mastectomy and removal of at least eight axillary lymph nodes, postoperative radiotherapy may be omitted (SUPREMO trial)	33	24	8	1	-	-
	A. Yes (in the absence of adverse prognostic factors) B. No C. Abstain from answering	100 %	**72.73 %**	24.24 %	3.03 %	-	-
	Consensus reached						
16	A 45-year-old patient, BC cT2N0M0 / pT2N1a(sn), ER 0, PR 0, HER2 0. Status after mastectomy with SLNB. Histological examination shows a tumor measuring 3 × 2 × 2 cm, invasive carcinoma of no special type (NST), G2 (3 + 2 + 2). Metastases in two of three lymph nodes. Upon lymphadenectomy the remaining lymph nodes are free of metastases. Adjuvant polychemotherapy (APCT) is planned. Postoperative radiotherapy to the soft tissues of the anterior chest wall and lymphatic drainage areas is not indicated.	33	11	19	3	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	33.33 %	**57.58 %**	9.09 %	-	-
	Consensus reached						

17	A 45-year-old patient. BC with ypT3N1, ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 2) = 7 points, HER2 1+, Ki67 30 %. Status after neoadjuvant chemotherapy (NACT), radical mastectomy with implant-based reconstruction. Histological conclusion: tumor 3 × 3 × 2.5 cm, invasive carcinoma NST, G2 (2 + 2 + 2), metastases in two of 11 lymph nodes. Postoperative radiotherapy to the reconstructed breast and lymphatic drainage areas is indicated in a moderately hypofractionated regimen (2.67 Gy, 15 fractions).	34	26	3	5	-	-
	A. Yes B. No C. Abstain from answering	100 %	**76.47 %**	8.82 %	14.71 %	-	-
	Consensus reached						
18	A 38-year-old patient, BC pTisN0. Status after breast resection, tumor 2.8 × 2.5 × 3 cm, intraductal carcinoma in situ, NG3 with comedonecrosis, ER 0, HER2 1+. Postoperative radiotherapy to the breast is indicated.	33	28	5	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**84.85 %**	15.15 %	0	-	-
	Consensus reached						
19	A 39-year-old patient, BC cT2N0M0 with the tumor located in the central quadrant. After subcutaneous mastectomy with simultaneous implant-based reconstruction, histological conclusion: invasive lobular carcinoma G2 (3 + 2 + 1), lymphovascular invasion detected, ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 2) = 7 points, HER2 1+, Ki-67 25 %. Hormone therapy with aromatase inhibitors (AIs) against the background of ovarian suppression is planned. Radiotherapy to the soft tissues of the anterior chest wall and lymphatic drainage areas is indicated.	33	12	19	2	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	36.36 %	**57.58 %**	6.06 %	-	-
	Consensus reached						
20	A 60-year-old patient. Postmenopause. Breast cancer pT1cN0M0. Luminal tumor subtype. Lymph nodes not involved on ultrasound. Sectoral breast resection performed. R0. Is accelerated partial breast irradiation (APBI) possible?	30	24	3	3	-	-
	A. Yes B. No C. Abstain from answering	100 %	**80.00 %**	10.00 %	10.00 %	-	-
	Consensus reached						
21	Intensification of adjuvant hormone therapy (HT) by adding a CDK4/6 inhibitor is indicated in patients with stage II–III HR+ HER2− breast cancer at greatest concern regarding the likelihood of recurrence in the presence of ≥ 1 risk factor: T4, N2–3, G3.	33	30	3	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**90.91 %**	9.09 %	0	-	-
	Consensus reached						

22	Intensification of adjuvant HT by adding a CDK4/6 inhibitor is indicated in patients with stage II–III HR+ HER2− breast cancer at greatest concern regarding the likelihood of recurrence in the presence of ≥ 2 factors: T3, Ki67 ≥ 30 %, N1, age < 40 years.	33	26	6	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**78.79 %**	18.18 %	3.03 %	-	-
	Consensus reached						
23	A 30-year-old patient, premenopausal. No BRCA1/2 mutations detected. Left breast cancer cT1N1aM0. Complex treatment (radical resection, APCT with the AC-12P regimen, RT). Invasive carcinoma NST G2 (3 + 2 + 2), ER 100 % (5 + 3) = 8 points, PR 30 % (3 + 3) = 6 points, HER2 0, Ki-67 40 %. Metastasis in one of nine axillary lymph nodes. In the adjuvant setting, AI + CDK4/6i + ovarian suppression + zoledronic acid are indicated.	32	25	6	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**78.12 %**	18.75 %	3.13 %	-	-
	Consensus reached						
24	A 40-year-old patient, premenopausal. No BRCA1/2 mutations detected. Left breast cancer cT3N1M0/ ypT2ypN1a: invasive carcinoma NST G3 (3 + 2 + 3), ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 1) = 6 points, HER2 0, Ki-67 50 %. Complex treatment: NACT with the ddAC-12×P regimen, radical mastectomy with implant reconstruction, adjuvant radiotherapy. Residual tumor: cellularity 5 %, RCB index 2.946, class II, ER 0 points, PR 0 points, HER2 0, Ki67 20 %, metastases in two of eight axillary lymph nodes. Is adjuvant capecitabine for 6 months advisable? Followed by AI + CDK4/6i + ovarian suppression + zoledronic acid.	29	9	16	4	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	31.03 %	**55.17 %**	13.80 %	-	-
	Consensus reached						
25	A 48-year-old patient, premenopausal. No BRCA1/2 mutation detected. Right breast cancer cT1N1M0, pT1N2. Invasive carcinoma NST, G2 (2 + 2 + 2), ER 100 % (5 + 3) = 8 points, PR 100 % (5+3) = 8 points, HER2 1+, Ki67 30 %, metastases in five of eight axillary lymph nodes. Complex treatment: radical resection, APCT 4AC-12P, radiotherapy. In the adjuvant setting she receives AI + abemaciclib + ovarian suppression. Is tumor testing for PIK3CA/AKT/PTEN alterations advisable in this patient?	32	23	7	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**71.88 %**	21.88 %	6.24 %	-	-
	Consensus reached						

26	A 40-year-old patient. No BRCA1/2 mutations detected. Left breast cancer cT2N0M0/pT2N1(sn). Breast-conserving surgery with SLNB. Test hormone therapy with tamoxifen for 3 weeks. HE (core biopsy): invasive carcinoma NST G2 (2 + 2 + 2), ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 3) = 8 points, HER2 1+, Ki67 30 %. HE (postoperative): invasive carcinoma NST 25 mm G2 (3 + 2 + 1), ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 3) = 8 points, HER2 1+, Ki67 25 %. Metastases in one of three lymph nodes. Planned in the adjuvant setting: radiotherapy, AI + CDK4/6i + ovarian suppression + zoledronic acid.	32	19	12	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**59.38 %**	37.50 %	3.12 %	-	-
	Consensus reached						
27	Is a test regimen of AI combined with ovarian suppression advisable in premenopausal breast cancer patients?	29	9	20	0	-	-
	A. Yes **B. No** C. Abstain from answering	100 %	31.03 %	**68.97 %**	0	-	-
	Consensus reached						
28	A 33-year-old patient. Left breast cancer cT1cN0M0. HE (core biopsy): invasive carcinoma NST G3 (3 + 3 + 3), ER 0, PR 0, HER2 3+, Ki67 80 %. The first stage of treatment is neoadjuvant chemo-targeted therapy.	31	22	9	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**70.97 %**	29.03 %	0	-	-
	Consensus reached						
29	A 32-year-old patient. Left breast cancer cT2N1M0/ypT1bN0(sn). No BRCA mutation detected. Four cycles of NACT with the AC regimen + pembrolizumab. 12 NACT administrations of weekly TC + four administrations of pembrolizumab once every 21 days. Left mastectomy with SLNB. HE (core biopsy): invasive carcinoma NST G3 (3 + 2 + 3), ER 0, PR 0, HER2 1+, Ki67 80 %. HE (postoperative): invasive carcinoma NST 8 mm, G3 (3 + 3 + 3). Three lymph nodes free of metastases. ypT1bN0(sn). Residual tumor: cellularity 10 %, RCB index 1.280, RCB class I. ER 0, PR 0, HER2 1+, Ki67 70 %. Continue pembrolizumab in the adjuvant setting.	32	16	12	4	-	-
	A. Yes B. No C. Abstain from answering	100 %	**50.00 %**	37.50 %	12.50 %	-	-
	Consensus reached						
30	A 45-year-old patient. No BRCA1/2 mutations detected. Left breast cancer cT2N1M0/ypT0N0(sn). HE (core-needle biopsy): invasive carcinoma NST G3 (3 + 3 + 3), ER 0, PR 0, HER2 1+, Ki67 — 80 %. Four cycles of NACT with the AC regimen + pembrolizumab. 12 NACT administrations with the TC regimen once every seven days + four administrations of pembrolizumab once every 21 days. Left mastectomy with SLNB. RCB class pCR. Continuation of pembrolizumab in the adjuvant setting is not advisable.	29	22	5	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**75.86 %**	17.24 %	6.90 %	-	-
	Consensus reached						

31	A 45-year-old patient. Left breast cancer cT2N2M0/ypT1bN1. A BRCA1 mutation has been detected. HE (core biopsy): invasive carcinoma NST G3 (3 + 2 + 3), ER 0, PR 0, HER2 1+, Ki67 80 %. Four cycles of NACT with the AC regimen + pembrolizumab. 12 weekly NACT administrations with the TC regimen + four administrations of pembrolizumab once every 21 days. Left mastectomy with axillary lymph node dissection. HE (postoperative): residual tumor — invasive carcinoma NST 7 mm G3 (3 + 2 + 3). Cellularity 5 %, RCB index 2.271, RCB class II, ypT1bN1. ER 0, PR 0, HER2 1+, Ki67 75 %. The most optimal tactic is the following:	33	21	1	8	3	-
	A. Adjuvant olaparib for one year B. Adjuvant pembrolizumab for up to nine cycles C. Adjuvant pembrolizumab for up to nine cycles, then olaparib for one year D. Abstain from answering	100 %	**63.64 %**	3.03 %	24.24 %	9,09 %	-
	Consensus reached						
32	In a breast cancer patient with a pathogenic BRCA1/2 gene mutation and a favorable life prognosis, it is advisable to recommend adnexectomy.	31	25	4	2	0	-
	A. Yes, starting at age 40 B. Yes, starting at age 45 C. Yes, starting at age 50 D. Abstain from answering	100 %	**80.65 %**	12.90 %	6.45 %	0	-
	Consensus reached						
33	In a patient with BRCA-associated triple-negative (TN) breast cancer and residual disease (non-pCR) after neoadjuvant chemotherapy, adjuvant olaparib without capecitabine is preferable.	30	21	8	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**70.00 %**	26.67 %	3.33 %	-	-
	Consensus reached						
34	In patients with ER+ HER2− breast cancer and a germline BRCA1/2 mutation meeting the OlympiA criteria (residual disease after (neo)adjuvant chemotherapy with CPS+EG ≥ 3 or ≥ 4 involved lymph nodes), adjuvant olaparib (one year) is preferable, given the improvement in overall survival in this population. *Note*. When the criteria overlap with monarchE/NATALEE, the choice is made in favor of olaparib due to the absence of direct comparison and of a BRCA analysis in the CDK4/6 inhibitor trials).	34	26	7	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**76.47 %**	20.59 %	2.94 %	-	-
	Consensus reached						
35	Before selecting the third line of drug treatment, a biopsy of newly accessible metastatic sites is advisable in order to rule out a change of biological subtype and to identify new targetable mutations.	34	32	2	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**94.12 %**	5.88 %	0	-	-
	Consensus reached						

36	A patient with metastatic breast cancer and one to three oligometastases in the liver and/or lungs has achieved a sustained objective response to systemic therapy (more than six months). In the presence of tumor expression of the ongoing systemic therapy, it is advisable to add a local ablative intervention (radiofrequency ablation/stereotactic radiotherapy) to the residual lesions.	31	27	2	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**87.10 %**	6.45 %	6.45 %	-	-
	Consensus reached						
37	In oligometastatic HER2+ breast cancer with a sustained complete tumor response to systemic therapy lasting more than six months, breast surgery is indicated.	35	28	5	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**80.00 %**	14.29 %	5.71 %	-	-
	Consensus reached						
38	Progression of HER2+ metastatic breast cancer after several lines of anti-HER2 therapy including trastuzumab/pertuzumab/taxanes and T-DM1. The preferred regimen for the next line is trastuzumab deruxtecan.	31	28	1	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**90.32 %**	3.23 %	6.45 %	-	-
	Consensus reached						
39	Progression of HER2+ metastatic breast cancer with active (untreated or progressing after local therapy) brain metastases and visceral metastases. Trastuzumab deruxtecan is considered the preferred systemic option without radiotherapy to the brain metastases. *Note*. Trastuzumab deruxtecan has clinically significant intracranial activity, thereby helping to defer radiotherapy.	31	26	4	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**83.87 %**	12.90 %	3.23 %	-	-
	Consensus reached						
40	In pretreated patients with leptomeningeal involvement in HER2+ breast cancer, trastuzumab deruxtecan is a justified systemic treatment owing to the extremely unfavorable prognosis.	35	30	3	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**85.71 %**	8.57 %	5.72 %	-	-
	Consensus reached						

41	A 79-year-old patient. No BRCA1/2 mutation detected. ECOG 1. Breast cancer cT4N1M1 (liver, bones and mediastinal lymph nodes). ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 3) = 8 points, HER2 1+, Ki67 — 15 %. No visceral crisis. No geriatric asthenia. Not burdened by polymorbidity. Lives in the city with relatives. Which combinatorial partner is the most preferable when prescribing the combination AI + CDK4/6i for unburdened geriatric patients of the older age group?	33	7	10	5	11	-
	A. Ribociclib B. Palbociclib C. Abemaciclib D. Abstain from answering	100 %	21.21 %	30.30 %	15.15 %	33,34 %	-
	No consensus reached						
42	A 52-year-old patient, menopause, complex treatment for left breast cancer cT2N1M0. Invasive lobular carcinoma, G2 (3 + 2 + 1), metastases in two lymph nodes. ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 1) = 6 points, HER2 0, Ki67 10 %. Complex treatment: radical mastectomy with implant reconstruction, adjuvant radiotherapy and hormone therapy with anastrozole. After 1.5 years, on adjuvant HT — disease progression with metastases in the bones, lungs, pleura. On thoracoscopic biopsy of the pleural metastasis: lobular breast carcinoma, ER 100 % (5+3) = 8 points, PR 30 % (3+3) = 6 points, HER2 0, Ki67 20 %. A PIK3CA mutation is detected in the tumor. In the first line, the combination inavolisib + palbociclib + fulvestrant + a bone-modifying agent is indicated.	33	26	7	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**78.79 %**	21.21 %	0	-	-
	Consensus reached						
43	A 53-year-old patient, menopause, complex treatment for left breast cancer cT4N1M0 (invasive carcinoma NST, G2 (3 + 2 + 2), ER 100 % (5 + 3) = 8 points, PR 100 % (5 + 3) = 8 points, HER2 1+, Ki67 30 %, metastases in three axillary lymph nodes), NACT with the 4AC-12P regimen, radical mastectomy, adjuvant RT and HT with AI. After three years, on adjuvant HT — progression with metastases in the liver and bones. On biopsy of the liver metastasis: metastasis of invasive breast carcinoma, ER 100 % (5 + 3) = 8 points, PR 0 points, HER2 1+, Ki67 50 %. No signs of visceral crisis. A pathogenic AKT mutation is detected in the tumor, and a germline BRCA2 mutation in the blood. In the first line, the following is indicated:	32	7	13	7	5	-
	A. CDK4/6i + fulvestrant B. PARPi (olaparib or talazoparib) C. Capivasertib + fulvestrant D. Abstain from answering	100 %	21.88 %	40.62 %	21.88 %	15,62 %	-
	No consensus reached						
44	In a patient with metastatic triple-negative breast cancer (mTNBC) of BRCA-wild type who has achieved a response to platinum-containing first-line therapy, maintenance therapy with capecitabine +/- bevacizumab, rather than active surveillance, is justified.	31	19	7	5	-	-
	A. Yes B. No C. Abstain from answering	100 %	**61.29 %**	22.58 %	16.13 %	-	-
	Consensus reached						

45	In the first line of PD-L1-positive (CPS ≥10) mTNBC, the preferred chemotherapy partner of pembrolizumab is gemcitabine + carboplatin.	30	14	12	4	-	-
	A. Yes B. No C. Abstain from answering	100 %	46.67 %	40.00 %	13.33 %	-	-
	No consensus reached						
46	In patients with visceral metastases of TNBC whose disease has progressed within the first 12 months after completion of neo-/adjuvant chemotherapy and in whom immunotherapy combined with chemotherapy is not indicated or cannot be administered, datopotamab deruxtecan should be considered as first-line therapy.	32	23	5	4	-	-
	A. Yes B. No C. Abstain from answering	100 %	**71.88 %**	15.62 %	12.50 %	-	-
	Consensus reached						
47	In a patient with a germline BRCA mutation who has achieved a response to platinum-containing first-line therapy and has not previously received a PARPi, a switch to maintenance therapy with olaparib is justified.	32	26	6	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**81.25 %**	18.75 %	0	-	-
	Consensus reached						
48	For selecting mTNBC patients for PARPi therapy, extended testing of homologous recombination deficiencies (BRCAness/HRD) is advisable, including germline PALB2 mutations and somatic BRCA1/2 mutations.	32	28	3	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**87.50 %**	9.38 %	3.12 %	-	-
	Consensus reached						
49	A 45-year-old patient. Initially premenopausal (ovarian function suppressed by GnRH agonists), BRCA2-associated breast cancer cT4N2M0. After NACT (ddAC × 4, then TC × 4), a radical mastectomy was performed (ypT3N2, invasive carcinoma, G2 (3 + 2 + 2), ER 100 % (5 + 3) = 8 points, PR 50 % (4 + 1) = 5 points, HER2 0, Ki-67 30 %, metastases in five of nine axillary lymph nodes). Adjuvant radiotherapy was performed. Adjuvant anastrozole + ribociclib (three years), then anastrozole was continued. Four years after the start of adjuvant therapy (while taking anastrozole after completion of the ribociclib course), a locoregional recurrence with liver metastases was detected. No signs of visceral crisis. On biopsy of the recurrence: invasive carcinoma NST, ER 100 % (5+1) = 6 points, PR 30 % (3+3) = 6 points, HER2 0, Ki-67 35 %. A pathogenic PIK3CA mutation is detected in the tumor. Germline BRCA2 mutation confirmed. Which drug therapy regimen is the most optimal in the first line of metastatic disease?	32	5	15	7	5	-
	A. Fulvestrant + switch of CDK4/6i (to another drug of the class) B. Inavolisib + palbociclib + fulvestrant C. PARPi (olaparib or talazoparib) D. Abstain from answering	100 %	15.62 %	46.88 %	21.88 %	15,62 %	-
	No consensus reached						

50	A 45-year-old patient, premenopausal, no BRCA1/2 mutation detected. Right breast cancer cT4N1M1 (bones, mediastinal lymph nodes). Invasive carcinoma NST, G2 (3+2+1), ER 100 % (5 + 3) = 8 points, PR 30 % (3 + 2) = 5 points, HER2 0, Ki67 30 %. No PIK3CA/AKT/PTEN alterations. In the first line, the patient received palbociclib + letrozole + ovarian suppression. After 12 months — progression (growth of pre-existing lesions, lung metastases). No signs of visceral crisis. In the second line, fulvestrant + everolimus + ovarian suppression + bone-modifying agents are indicated.	27	24	2	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**88.89 %**	7.41 %	3.70 %	-	-
	Consensus reached						
51	A 56-year-old patient, menopause, BRCA2-associated left breast cancer cT3N1M1 (bones, liver). Invasive carcinoma NST, G3 (3 + 3 + 2), ER 100 % (5+3) = 8 points, PR 100 % (5 + 1) = 6 points, HER2 0, Ki-67 40 %. No PIK3CA/AKT/PTEN alterations in the tumor. The patient received ribociclib + letrozole. After 18 months — brain metastases (three lesions up to 1.0 cm). Stereotactic radiotherapy was performed. Continuation of the previous regimen is recommended.	29	19	9	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**65.52 %**	31.03 %	3.45 %	-	-
	Consensus reached						
52	After the induction phase, in patients with metastatic breast cancer and bone metastases, a switch to a denosumab maintenance regimen with an interval of once every 12 weeks is possible; it is not inferior to the once-every-four-weeks regimen in time to the first skeletal event and has a better safety profile.	30	30	0	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**100.00 %**	0	0	-	-
	Consensus reached						
53	Radionuclide therapy (strontium, samarium) for the treatment of breast cancer bone metastases IS NOT RECOMMENDED. *Note*. There is no solid evidence base for the efficacy and safety of such therapeutic approaches in breast cancer. There is a high risk of prolonged/cumulative cytopenia capable of limiting systemic anticancer drug therapy.	29	18	9	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**62.07 %**	31.03 %	6.90 %	-	-
	Consensus reached						
54	The priority of the primary study endpoint in metastatic breast cancer (OS — overall survival, PFS — progression-free survival, PFS-2, TTF — time to treatment failure, ORR — objective response rate, QoL — quality of life) depends on the molecular genetic subtype and the line of therapy. Note. Expected life expectancy and other time parameters are determined by the molecular genetic subtype and the line of therapy and, accordingly, are achievable or difficult/unachievable within a reasonable study duration.	31	30	1	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**96.77 %**	3.23 %	0	-	-
	Consensus reached						

55	The most important endpoints in any line for metastatic TNBC: primary — OS, secondary — PFS, ORR, toxicity. *Note*. Given the relatively short life expectancy in mTNBC, assessment of OS is an achievable goal. To obtain robust data, it is necessary to assess the percentage of patients in the control group switched to the investigational therapy after progression.	30	28	1	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**93.34 %**	3.33 %	3.33 %	-	-
	Consensus reached						
56	For metastatic HER2+ breast cancer, priority endpoints — first and second lines: primary — PFS and OS, secondary — PFS-2, ORR, toxicity. The primary endpoint in the third and subsequent lines of therapy — OS.	30	28	0	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**93.33 %**	0	6.67 %	-	-
	Consensus reached						
57	For metastatic ER+ HER2− breast cancer, priority endpoints of the first and subsequent lines of therapy: primary — PFS, secondary — OS, ORR, toxicity.	31	28	3	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**90.32 %**	9.68 %	0	-	-
	Consensus reached						
58	Quality of life is a critical endpoint. With comparable OS, priority should be given to the strategy improving QoL.	31	30	1	0	-	-
	A. Yes B. No C. Abstain from answering	100 %	**96.77 %**	3.23 %	0	-	-
	Consensus reached						

59	When developing clinical guidelines, it is important to take into account the following: – Real-world clinical practice studies (RWE studies) do not replace the results of clinical trials (RCTs), but with high methodological quality they can serve as an important source of evidence for clinical guidelines. – Hierarchy of evidence from real-world studies: pragmatic randomized controlled trials, then comparative cohort studies, followed by case–control studies, non-comparative observational studies and case reports. – Assessment of RWE quality includes evaluation of the clarity of the research question, representativeness of the data, sample size, availability of data on key outcomes, confounders and prognostic factors, quality and standardization of data sources, and justification of the design choice (prospective/retrospective, comparison, control). – A key quality criterion for real-world studies is control of systematic biases: confounders are predefined, stratification and propensity score matching are applied, sensitivity analyses are performed. The presence of a pre-developed and documented protocol, a statistical analysis plan and transparent reporting is a mandatory condition for recognizing real-world studies as methodologically sound.	27	25	0	2	-	-
	A. Yes B. No C. Abstain from answering	100 %	**92.59 %**	0	7.41 %	-	-
	Consensus reached						
60	Quality assessment of studies is performed using the following scales: – Level of certainty of evidence: 1 — a systematic review of randomized controlled trials with the use of meta-analysis; 2 — individual randomized controlled trials and systematic reviews of studies of any design except randomized controlled trials with the use of meta-analysis; 3 — non-randomized comparative studies, including cohort studies, with pseudorandomization or propensity score matching (matching patients by the probability of treatment assignment based on baseline characteristics); prospective or retrospective studies based on registries, electronic medical records, etc., with adequate control of systematic errors; 4 — non-comparative studies, a description of a clinical case or case series, case–control studies; 5 — only a rationale for the mechanism of action of the intervention (preclinical studies) or expert opinion is available. – Level of persuasiveness of recommendations: A — strong recommendation (all considered efficacy criteria (outcomes) are important, all studies have high or satisfactory methodological quality, and their conclusions on the outcomes of interest are consistent); B — conditional recommendation (not all considered efficacy criteria (outcomes) are important, not all studies have high or satisfactory methodological quality and/or their conclusions on the outcomes of interest are not consistent); C — weak recommendation (absence of evidence of proper quality: all considered efficacy criteria (outcomes) are not important, all studies have low methodological quality and their conclusions on the outcomes of interest are not consistent). – When drawing up recommendations, along with the level of certainty of evidence and the level of persuasiveness of recommendations, the level of expert agreement is indicated.	32	28	3	1	-	-
	A. Yes B. No C. Abstain from answering	100 %	**87.50 %**	9.38 %	3.12 %	-	-
	Consensus reached						