

No.	Questionnaire:	Total Votes	Survey Results (Number of Votes, %)				
			A	B	C	D	E
1	Which method do you recommend for marking lymph nodes (LNs)?	33	13	17	1	2	-
	A. Radiopaque markers B. I-125 radioactive seeds C. I do not recommend LN marking D. Abstain	100%	39.39%	51.52%	3.03%	6.06%	-
	<i>Consensus reached</i>						
2	The optimal margin for a patient with triple-negative breast cancer after neoadjuvant systemic therapy with a partial clinical response in breast-conserving surgery is the absence of ink on invasive tumor?	29	27	2	-	-	-
	A. Yes B. No C. Abstain	100%	93.10%	6.90%	-	-	-
	<i>Consensus reached</i>						
3	Is intraoperative histological examination of surgical margins necessary during breast-conserving surgery?	34	17	14	3	-	-
	A. Yes B. No C. Abstain	100%	50.00%	41.18%	8.82%	-	-
	<i>Consensus reached</i>						
4	Is intraoperative histological examination of sentinel lymph nodes (LNs) necessary during breast-conserving surgery in primary cN0 patients?	30	16	14	-	-	-
	A. Yes B. No C. Abstain	100%	53.33%	46.67%	-	-	-
	<i>Consensus reached</i>						
5	How many margins of the breast sector should be marked during breast-conserving surgery?	34	1	5	24	1	3
	A. Two margins B. All six margins (anterior, posterior, superior, inferior, lateral, medial) with one color C. Multicolor marking of all six resection margins is necessary D. Margin marking is not required E. Abstain	100%	2.94%	14.71%	70.59%	2.94%	8.82%
	<i>Consensus reached</i>						
6	Would you recommend regional lymphatic area irradiation for a patient with cytologically confirmed axillary LN involvement (N1) who achieved (yp)N0 status after neoadjuvant systemic therapy and underwent breast-conserving surgery?	31	14	16	1	-	-
	A. Yes B. No C. Abstain	100%	45.16%	51.61%	3.23%	-	-
	<i>Consensus reached</i>						

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7	A patient with cT2N1M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+2), ER 100% (5+3=8), PR 0, HER2 0, Ki-67 45%). Recommended staging:	32	26	4	2	-	-
	A. Chest X-ray/CT, abdominal/pelvic US/CT, bone scan B. Whole-body PET-CT C. Abstain	100%	81.25%	12.50%	6.25%	-	-
	<i>Consensus reached</i>						
8	A 47-year-old patient with cT1N0M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G2 (3+2+2), ER 100% (5+3=8), PR 50% (4+2=6), HER2 0, Ki-67 35%). Breast-conserving surgery with SLNB. Postoperative pathology: metastases in 2 of 4 SLNs. Is axillary lymph node dissection recommended?	33	12	21	-	-	-
	A. Yes B. No C. Abstain	100%	36.36%	63.64%	-	-	-
	<i>Consensus reached</i>						
9	A 45-year-old premenopausal patient with pT1N2M0 left breast cancer. Postoperative pathology: IDC-NOS / IBT-NST, G2 (3+2+1), ER 100% (5+3=8), PR 50% (4+2=6), HER2 1+, Ki-67 10%, macrometastases in 4 axillary LNs without extranodal extension. Recommended adjuvant systemic therapy:	29	26	3	-	-	-
	A. Adjuvant chemotherapy followed by adjuvant ET (ET) B. Adjuvant ET only, CT not recommended C. Abstain	100%	89.66%	10.34%	-	-	-
	<i>Consensus reached</i>						
10	A 56-year-old patient with cT2N1M0 left breast cancer. Initial radical mastectomy. Postoperative pathology: IDC-NOS / IBT-NST, G1 (2+1+1), pT2N2, ER 100% (5+3=8), PR 100% (5+3=8), HER2 1+, Ki-67 8%, no BRCA1 mutation. Planned: adjuvant CT, RT, and AI. Which CT regimen do you recommend?	30	13	10	2	5	-
	A. DC B. AC-paclitaxel C. ddAC-paclitaxel D. Abstain	100%	43.33%	33.33%	6.67%	16.67%	-
	<i>No consensus</i>						
11	A 45-year-old premenopausal patient with pT1N2M0 left breast cancer. Postoperative pathology: IDC-NOS / IBT-NST, G2 (3+2+1), ER 100% (5+3=8), PR 50% (4+2=6), HER2 1+, Ki-67 10%, macrometastases in 4 axillary LNs without extranodal extension. Recommended adjuvant CT regimen:	30	11	16	3	-	-
	A. Six cycles docetaxel + cyclophosphamide B. Four cycles AC/EC q3w followed by taxanes C. Abstain	100%	36.67%	53.33%	10.00%	-	-
	<i>Consensus reached</i>						
12	A 45-year-old premenopausal patient with pT1N2M0 left breast cancer. Postoperative pathology: IDC-NOS / IBT-NST, G2 (3+2+1), ER 100% (5+3=8), PR 50% (4+2=6), HER2 0, Ki-67 10%, macrometastases in 4 axillary LNs without extranodal extension. Adjuvant chemotherapy AC×4→P×12 was given. Recommended adjuvant ET:	31	14	15	2	-	-
	A. AI with ovarian suppression B. AI with ovarian suppression and CDK4/6 inhibitors C. Abstain	100%	45.16%	48.39%	6.45%	-	-
	<i>No consensus</i>						

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13	A 59-year-old patient with cT2N0M0 left breast cancer. Underwent mastectomy with SLNB. Postoperative pathology: IDC-NOS / IBT-NST, G2 (3+2+2), pT2N0, ER 100% (5+3=8), PR 100% (5+3=8), HER2 1+, Ki-67 35%. Would you recommend extending adjuvant ET beyond 5 years?	32	17	14	1	-	-
	A. Yes B. No C. Abstain	100%	53.13%	43.75%	3.12%	-	-
	<i>Consensus reached</i>						
14	A 32-year-old patient with cT2N1M0 right breast cancer. Underwent breast-conserving surgery. Postoperative pathology: IDC-NOS / IBT-NST, G3 (3+2+3), pT2N2, ER 100% (5+3=8), PR 5% (2+1=3), HER2 1+, Ki-67 70%, macrometastases in 4 axillary LNs without extranodal extension. Received adjuvant RT, CT, and started ET with ovarian suppression. Would you add CDK4/6 inhibitors to adjuvant ET?	33	23	7	3	-	-
	A. Yes B. No C. Abstain	100%	69.70%	21.21%	9.09%	-	-
	<i>Consensus reached</i>						
15	A 67-year-old patient with cT2N3M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G2 (3+2+1), ER 100% (5+3=8), PR 0%, HER2 1+, Ki-67 20%). After neoadjuvant AC×4→P×12, underwent radical mastectomy. Postoperative pathology: incomplete response – IDC-NOS / IBT-NST, G2 (3+2+1), ypT1cN2a, ER 100% (5+3=8), PR 0%, HER2 1+, Ki-67 20%, metastases in 5/12 LNs without extranodal extension. Planned adjuvant RT. Recommended ET option:	32	10	12	9	1	-
	A. AI B. AI + CDK4/6 inhibitor for up to 2 years C. AI + CDK4/6 inhibitor for up to 3 years D. Abstain	100%	31.25%	37.50%	28.13%	3.12%	-
	<i>No consensus</i>						
16	A 55-year-old patient with cT2N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G2 (3+2+2), ER100% (5+3=8), PR100% (5+3=8), HER2 1+, Ki67 30%). Received «test» preoperative ET with tamoxifen, followed by breast-conserving surgery with SLNB converting to axillary dissection. Postoperative pathology: pT2N1a, metastases in 2/8 LNs, unchanged receptor status, Ki-67 30%. Planned adjuvant RT. Which systemic adjuvant therapy do you recommend?	32	6	9	11	4	2
	A. DC B. AC-T C. AI D. AI + CDK4/6 inhibitor E. Abstain	100%	18.75%	28.13%	34.37%	12.50%	6.25%
	<i>No consensus</i>						
17	A 68-year-old patient with cT1N0M0 (pT1N1(sn)M0) luminal breast cancer. Status post mastectomy with SLNB. Histology: invasive ductal carcinoma, 1.8×1.5×1.4 cm, G2, 1/3 LNs positive, no lymphovascular or perineural invasion, margins clear. Planned long-term ET. What RT strategy do you recommend?	32	5	13	10	4	-
	A. RT to chest wall soft tissues B. RT to chest wall soft tissues and lymphatic areas C. No postoperative RT indicated D. Abstain	100%	15.63%	40.62%	31.25%	12.50%	-
	<i>No consensus</i>						

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18	A 45-year-old patient with cT3N1M0 luminal breast cancer. Status post NAC, radical mastectomy with implant reconstruction. Pathology: invasive ductal carcinoma, 3.0×3.0×2.5 cm, G2, metastases in 2/11 LNs. Indicated postoperative RT to reconstructed breast and regional nodes:	30	7	15	8	-	-
	A. Standard fractionation (2 Gy × 25 fx) B. Moderate hypofractionation (2.67 Gy × 15 fx) C. Abstain	100%	23.33%	50.00%	26.67%	-	-
	<i>Consensus reached</i>						
19	A 40-year-old patient with cT3N1M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER100% (5+3=8), PR0, HER2 0, Ki67 60%). Received NAC ddAC×4 with primary G-CSF prophylaxis → P×12. Incomplete pCR: residual tumor G2 (3+3+1), ypT1b(m)N1M0 (ER0, PR0, HER2 0, Ki-67 35%), RCB III. No BRCA mutation. What is the optimal adjuvant systemic therapy?	33	15	6	7	5	-
	A. Capecitabine followed by adjuvant ET + ovarian suppression B. Adjuvant ET + ovarian suppression + CDK4/6 inhibitors C. Adjuvant ET + ovarian suppression D. Abstain	100%	45.46%	18.18%	21.21%	15.15%	-
	<i>No consensus</i>						
20	A 35-year-old patient with cT1cN0M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 70%, tumor size 15 mm). First-line recommendation:	33	12	21	-	-	-
	A. NAC with anti-HER2 blockade B. Surgery C. Abstain	100%	36.36%	63.64%	-	-	-
	<i>Consensus reached</i>						
21	A 28-year-old patient with cT1N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER100% (5+3=8), PR100% (5+3=8), HER2 3+, Ki-67 30%). Surgery revealed macrometastases in 3 axillary LNs. Recommended adjuvant systemic therapy regimen:	32	11	20	1	-	-
	A. Docetaxel + carboplatin + trastuzumab B. Docetaxel + carboplatin + trastuzumab + pertuzumab C. Abstain	100%	34.37%	62.50%	3.13%	-	-
	<i>Consensus reached</i>						
22	A 38-year-old patient with cT2N1M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 70%). US: upper-outer quadrant mass 22 mm, right axillary solitary LN 16 mm with loss of cortico-medullary differentiation. Fine-needle aspiration biopsy (FNAB) revealed tumor cells. Do you recommend marking the breast lesion and LN before NAC?	31	25	2	4	-	-
	A. Yes B. No C. Abstain	100%	80.65%	6.45%	12.90%	-	-
	<i>Consensus reached</i>						

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23	A 51-year-old patient with cT2N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER 20% (3+2=5), PR 5% (2+2=4), HER2 3+, Ki-67 60%). No BRCA1/2 mutation. Received NAC TCHP×6. Partial response (US: from 25×16 mm to 5×4 mm; mammography: from 23×11 mm to 6×6 mm). Planned breast-conserving surgery with SLNB. Would you recommend resection within the new tumor boundaries?	32	18	12	2	-	-
	A. Yes B. No C. Abstain	100%	56.25%	37.50%	6.25%	-	-
	<i>Consensus reached</i>						
24	A patient with cT2N1M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G2 (3+2+2), ER100% (5+3=8), PR100% (5+3=8), HER2 3+, Ki-67 50%). Received NAC TCHP, followed by surgery. Postoperative pathology: ypT1aN0 (residual tumor ≤3 mm), RCB-I, G2 (3+2+1), ER100% (5+3=8), PR100% (5+3=8), HER2 3+, Ki67 50%. Recommended adjuvant therapy regimen:	33	19	10	4	-	-
	A. ET + trastuzumab B. T-DM1 + ET C. Abstain	100%	57.58%	30.30%	12.12%	-	-
	<i>Consensus reached</i>						
25	A 39-year-old patient with cT2N2M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G2 (3+2+2), ER100% (5+3=8), PR100% (5+3=8), HER2 3+, Ki-67 50%). After NAC TCHP×6, breast-conserving surgery with ALND. Postoperative pathology: complete response – ypT0N0, RCB 0. Planned adjuvant trastuzumab x1 year + RT. Which ET do you recommend?	31	3	9	16	3	-
	A. Tamoxifen B. Tamoxifen + ovarian suppression C. AI + ovarian suppression D. Abstain	100%	9.68%	29.03%	51.61%	9.68%	-
	<i>Consensus reached</i>						
26	A 45-year-old patient with cT1N0M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 50%), no family history. Is BRCA1/2 germline mutation testing recommended?	32	24	6	2	-	-
	A. Yes B. No C. Abstain	100%	75.00%	18.75%	6.25%	-	-
	<i>Consensus reached</i>						
27	A patient with cT1N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+2), ER0, PR0, HER2 0, Ki-67 45%). Recommended staging:	33	28	4	1	-	-
	A. Chest X-ray/CT, abdominal/pelvic US/CT, bone scintigraphy B. Whole-body PET-CT C. Abstain	100%	84.85%	12.12%	3.03%	-	-
	<i>Consensus reached</i>						
28	A 45-year-old patient with cT1cN0M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 80%, tumor size 15 mm). First-line recommendation:	29	12	15	2	-	-
	A. NAC B. Surgery C. Abstain	100%	41.38%	51.72%	6.90%	-	-
	<i>Consensus reached</i>						

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29	A 61-year-old patient with cT2N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER 8% (2+2=4), PR0, HER2 1+, Ki-67 80%). After NAC AC×4→TCarb×12, mastectomy with SLNB. Postoperative pathology: complete response – ypT0N0, RCBpCR. Further management?	32	5	10	14	3	-
	A. Tamoxifen B. AI C. Observation D. Abstain	100%	15.63%	31.25%	43.75%	9.37%	-
	<i>No consensus</i>						
30	A 41-year-old patient with cT1cN0M0 (pT2N1) left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 80%). No BRCA1 mutation. After breast-conserving surgery with SLNB, planned adjuvant RT + CT. Would you recommend platinum-based adjuvant CT?	31	10	16	5	-	-
	A. Yes B. No C. Abstain	100%	32.26%	51.61%	16.13%	-	-
	<i>Consensus reached</i>						
31	Do you consider it necessary to recommend pembrolizumab in NAC with the TCb/AC/pembrolizumab regimen for patients with triple-negative breast cancer T2-4 N0-2 M0?	33	20	6	7	-	-
	A. Yes B. No C. Abstain	100%	60.61%	18.18%	21.21%	-	-
	<i>Consensus reached</i>						
32	A 40-year-old patient with cT2N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 90%). No BRCA1 mutation. Received NAC TCb/AC/pembrolizumab, well tolerated. Postoperative pathology: complete response – ypT0N0, RCBpCR. Recommended adjuvant therapy option:	33	10	18	5	-	-
	A. Continue pembrolizumab B. No adjuvant pembrolizumab C. Abstain	100%	30.30%	54.55%	15.15%	-	-
	<i>Consensus reached</i>						
33	A 35-year-old patient with cT2N0M0 left breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki67 90%) received NAC TCb/AC/pembrolizumab, well tolerated. Postoperative pathology showed residual tumor in the breast: IDC-NOS / IBT-NST, ypT1bN0 (residual <1 cm), G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 80%, RCB-I. Recommended adjuvant therapy option:	34	5	9	12	8	-
	A. Continue pembrolizumab B. Continue pembrolizumab and add capecitabine C. Capecitabine only D. Abstain	100%	14.71%	26.47%	35.29%	23.53%	-
	<i>No consensus</i>						

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34	A 28-year-old patient with cT2N0M0 right breast cancer (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 80%). Blood PCR negative for BRCA1/2 pathogenic mutations. Is mandatory NGS blood testing to exclude pathogenic mutations recommended?	33	33	-	-	-	-
	A. Yes B. No C. Abstain	100%	100.00%	-	-	-	-
	<i>Consensus reached</i>						
35	A 48-year-old patient with BRCA1-associated invasive ductal carcinoma of the left breast cT2N2M0 (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki67 80%). Received NAC AC×4 → TCarb×12. Then mastectomy with ALND. Postoperative pathology: residual IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 60%, ypT1N1 (residual tumor 12 mm, metastases in 2/10 LNs), RCB-III. Preferred adjuvant therapy for residual TNBC in BRCA mutation carriers?	34	14	16	4	-	-
	A. PARP inhibitors only B. Capecitabine followed by PARP inhibitors C. Abstain	100%	41.18%	47.06%	11.76%	-	-
	<i>No consensus</i>						
36	A 40-year-old patient with cT1N0M0 (multicentric) right breast cancer, (core biopsy: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki67 80%). NGS revealed a BRCA1 VUS. Planned subcutaneous mastectomy with immediate reconstruction. Would you recommend risk-reducing contralateral mastectomy?	33	16	15	2	-	-
	A. Yes B. No C. Abstain	100%	48.48%	45.46%	6.06%	-	-
	<i>No consensus</i>						
37	Is adjuvant olaparib justified in high-risk TNBC patients with PALB2 mutation and residual disease?	30	18	6	6	-	-
	A. Yes B. No C. Abstain	100%	60.00%	20.00%	20.00%	-	-
	<i>Consensus reached</i>						
38	A patient one year after completing comprehensive treatment for early ER+/HER2- breast cancer complains of memory loss, reduced information processing speed and psychomotor reactions, emotional lability (normal brain MRI, neurology exam). Are the following recommended: psychiatric consultation to rule out anxiety-depressive disorder, lifestyle modification (adequate physical activity), and cognitive-behavioral therapy?	33	27	2	4	-	-
	A. Yes B. No C. Abstain	100%	81.82%	6.06%	12.12%	-	-
	<i>Consensus reached</i>						

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39	In elderly patients (≥75 years) with ER+/HER2- breast cancer and visceral metastases, without geriatric syndromes or clinically significant comorbidities, should first-line therapy consider CDK4/6 inhibitors + ET?	34	27	3	4	-	-
	A. Yes B. No C. Abstain	100%	79.41%	8.82%	11.77%	-	-
	<i>Consensus reached</i>						
40	Should patients with ER+/HER2- metastatic breast cancer have tumor testing for PIK3CA/AKT/PTEN alterations?	34	31	0	3	-	-
	A. Yes B. No C. Abstain	100%	91.18%	0	8.82%	-	-
	<i>Consensus reached</i>						
41	A 40-year-old patient with cT2N1M0 right breast cancer. Core biopsy of primary tumor: IDC-NOS / IBT-NST, G2 (3+2+1), ER100% (5+3=8), PR100% (5+3=8), HER2 1+, Ki-67 25%. After comprehensive treatment, she received adjuvant AI with ovarian suppression. She developed liver/bone metastases at 15 months of adjuvant ET. PIK3CA mutation detected. Would you consider the use of the PIK3CA inhibitor inavolisib + palbociclib + fulvestrant?	34	26	3	5	-	-
	A. Yes B. No C. Abstain	100%	76.47%	8.82%	14.71%	-	-
	<i>Consensus reached</i>						
42	A 46-year-old patient with cT2N1M1 left breast cancer with bone metastases. Core biopsy of primary: IDC-NOS / IBT-NST, G2 (3+2+1), ER100% (5+3=8), PR100% (5+3=8), HER2 1+, Ki-67 25%. First-line therapy: anastrozole + CDK4/6 inhibitor + ovarian suppression + BMAs. After 2.5 years, new bone/lung metastases without visceral crisis. Lung biopsy: metastatic breast carcinoma, ER100% (5+3=8), PR100% (5+3=8), HER2 1+, Ki-67 25%. No BRCA, PIK3CA/AKT/PTEN alterations. ECOG 1. Further treatment strategy?	33	14	11	8	-	-
	A. Fulvestrant or exemestane + everolimus B. Fulvestrant + switch CDK4/6 inhibitor C. Abstain	100%	42.42%	33.33%	24.25%	-	-
	<i>No consensus</i>						
43	A 60-year-old patient with cT2N1M1 right breast cancer with bone metastases. Core biopsy of primary: IDC-NOS / IBT-NST, G2 (3+2+1), ER100% (5+3=8), PR100% (5+3=8), HER2 0, Ki-67 25%. On first-line CDK4/6 inhibitor + AI + bone-modifying agents, progressed in the lungs without visceral crisis. AKT mutation detected. Recommended second-line regimen:	33	4	21	8	-	-
	A. Alpelisib + fulvestrant B. Capivasertib + fulvestrant C. Abstain	100%	12.12%	63.64%	24.24%	-	-
	<i>Consensus reached</i>						

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44	Optimal approach for secondary bone marrow involvement in ER+/HER2- metastatic breast cancer?	32	14	12	6	-	-
	A. Chemotherapy (paclitaxel/capecitabine with possible dose reduction) B. CDK4/6 + ET C. Abstain	100%	43.75%	37.50%	18.75%	-	-
	<i>No consensus</i>						
45	When is contrast-enhanced brain MRI recommended for patients with HER2+ metastatic breast cancer?	34	13	15	5	1	-
	A. Only with clinical suspicion of brain involvement B. At start of new line of treatment C. At each follow-up D. Abstain	100%	38.23%	44.12%	14.71%	2.94%	-
	<i>No consensus</i>						
46	A 55-year-old patient with cT2N2M0 left breast cancer. Core biopsy of primary: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 80%. After comprehensive treatment (NAC 6×TCHP, surgery, adjuvant trastuzumab emtansine), liver metastases at 5 years. Core biopsy of liver lesion: metastatic breast carcinoma, ER0, PR0, HER2 0, Ki-67 80%. Recommended treatment as TNBC; anti-HER2 therapy not indicated.	31	20	9	2	-	-
	A. Yes B. No C. Abstain	100%	64.52%	29.03%	6.45%	-	-
	<i>Consensus reached</i>						
47	A 60-year-old patient with cT2N1M1 right breast cancer with lung metastases. Core biopsy of primary: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 80%. Received docetaxel + trastuzumab + pertuzumab followed by maintenance trastuzumab + pertuzumab. Progressed at 15 months with new lung metastases. Biopsy of new lung lesions showed change in subtype: metastatic breast carcinoma, ER0, PR0, HER2 0, Ki-67 60%.	34	17	15	2	-	-
	A. Further treatment as for TNBC B. Anti-HER2 therapy + CT C. Abstain	100%	50.00%	44.12%	5.88%	-	-
	<i>Consensus reached</i>						
48	For patients with brain/leptomeningeal mets from ER-/HER2+ metastatic breast cancer progressing on anti-HER2 therapy with dual blockade, T-DXd is most appropriate.	28	24	1	3	-	-
	A. Yes B. No C. Abstain	100%	85.72%	3.57%	10.71%	-	-
	<i>Consensus reached</i>						

No.	Questionnaire:	Total Votes	Survey Results (Number of Votes, %)				
			A	B	C	D	E
49	A 42-year-old patient, ECOG 1, with cT2N1M1 left breast cancer (2 bone lesions). Core biopsy of primary: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 3+, Ki-67 80%. First-line: 6 cycles docetaxel + trastuzumab + pertuzumab. Partial regression. Maintenance: trastuzumab + pertuzumab + BMAs. On follow-up: sclerotic bone lesions, LN resolution, partial regression of primary. Patient asks about surgery. Would you recommend breast/regional LN surgery with stable bone mets on anti-HER2 therapy >6 months?	34	24	8	2	-	-
	A. Yes B. No C. Abstain	100%	70.59%	23.53%	5.88%	-	-
	<i>Consensus reached</i>						
50	A 52-year-old patient, ECOG 1, with cT2N2M1 bone/liver mets left breast cancer. Core biopsy of primary: IDC-NOS / IBT-NST, G2 (3+2+2), ER100% (5+3=8), PR100% (5+3=8), HER2 3+, Ki-67 40%. First-line: 6x DHP + bisphosphonates. Partial regression. Continued trastuzumab + pertuzumab + anastrozole (1.5 years). Progression: two new liver metastases. Core biopsy of new liver lesions: metastatic breast carcinoma, G2 (3+2+1), ER100% (5+3=8), PR100% (5+3=8), HER2 1+, Ki-67 45%. Further treatment strategy?	32	4	10	3	9	6
	A. Continue trastuzumab + pertuzumab + anastrozole and add a CDK4/6 inhibitor (palbociclib) B. Continue trastuzumab + pertuzumab + anastrozole and SBRT to the two new liver lesions (oligoprogression) C. Trastuzumab + AI + CDK4/6 inhibitor D. Other E. Abstain	100%	12.50%	31.25%	9.37%	28.13%	18.75%
	<i>No consensus</i>						
51	When is contrast-enhanced brain MRI recommended for patients with TN metastatic breast cancer?	34	17	14	1	2	-
	A. Only with clinical suspicion of brain involvement B. At start of new line of treatment C. At each follow-up D. Abstain	100%	50.00%	41.18%	2.94%	5.88%	-
	<i>Consensus reached</i>						
52	A 35-year-old patient with cT2N1M1 liver mets breast cancer. Core biopsy of primary: IDC-NOS / IBT-NST, G2 (3+2+2), ER100% (5+3=8), PR100% (5+3=8), HER2 0, Ki-67 45%. Four months of AI + ovarian suppression + CDK4/6 inhibitor. Progression with new liver metastases. Biopsy of new liver lesions showed change in subtype: metastatic breast carcinoma, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 50%. Further strategy?	33	11	19	3	-	-
	A. Stop ET, treat as TNBC B. Treat as TNBC + continue ovarian suppression C. Abstain	100%	33.33%	57.58%	9.09%	-	-
	<i>Consensus reached</i>						
53	A 50-year-old patient with cT2N1M1 lung/mediastinal LN mets TNBC. Core biopsy of primary: IDC-NOS / IBT-NST, G3 (3+3+3), ER0, PR0, HER2 0, Ki-67 80%. Blood NGS negative for germline BRCA1/2/PALB2. Is tumor testing for somatic BRCA1/2 mutations recommended for PARP inhibitor consideration?	34	17	12	5	-	-
	A. Yes B. No C. Abstain	100%	50.00%	35.29%	14.71%	-	-
	<i>Consensus reached</i>						

No.	Questionnaire:	Total Votes	Survey Results (Number of Votes, %)				
			A	B	C	D	E
54	In metastatic TNBC patients with exhausted treatment options, multigene panel testing is not recommended due to low clinical utility.	34	18	10	6	-	-
	A. Yes B. No C. Abstain	100%	52.94%	29.41%	17.65%	-	-
	<i>Consensus reached</i>						
55	Special types of breast cancer with favorable prognosis include: mucinous, tubular, invasive cribriform, invasive papillary carcinoma, oncocytic carcinoma, medullary, apocrine, adenosquamous carcinoma, and salivary gland-type tumors.	32	25	4	3	-	-
	A. Yes B. No C. Abstain	100%	78.13%	12.50%	9.37%	-	-
	<i>Consensus reached</i>						
56	Special types of breast cancer with unfavorable prognosis include: pleomorphic lobular carcinoma, inflammatory carcinoma, micropapillary carcinoma, metaplastic carcinoma, neuroendocrine carcinoma.	31	23	6	2	-	-
	A. Yes B. No C. Abstain	100%	74.19%	19.36%	6.45%	-	-
	<i>Consensus reached</i>						
57	At initial presentation, any physician should inform young patients about potential fertility loss after treatment.	33	30	2	1	-	-
	A. Yes B. No C. Abstain	100%	90.91%	6.06%	3.03%	-	-
	<i>Consensus reached</i>						
58	Is controlled ovarian stimulation possible in diagnosed luminal breast cancer?	31	19	5	7	-	-
	A. Yes B. No C. Abstain	100%	61.29%	16.13%	22.58%	-	-
	<i>Consensus reached</i>						
59	At any stage of pregnancy, surgical treatment is indicated for operable breast cancer.	34	20	11	3	-	-
	A. Yes B. No C. Abstain	100%	58.82%	32.36%	8.82%	-	-
	<i>Consensus reached</i>						
60	Starting in the second trimester, chemotherapy is possible for pregnant patients with breast cancer.	34	33	0	1	-	-
	A. Yes B. No C. Abstain	100%	97.06%	0	2.94%	-	-
	<i>Consensus reached</i>						