Peer Review File

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Reviewer A

This is a well-written editorial by two Plastic Surgeons, and as a Breast Surgeon, I endorse several of their comments on access to autologous and free flap reconstruction and working collaboratively to be able to offer women all of the reconstructive options available.
Reply 1: Thank you for your comment.
Changes in the text: None

I agree that the data from the linked paper needs to be interpreted with caution, as first and foremost, the two groups of patients, Mx + Recon vs BCS + RT, are unlikely to be comparable in terms of patient, cancer and treatment variables, and this choice is unlikely to present itself as equivalent in everyday clinical practice.
Reply 2: We appreciate this comment.
Changes in the text: None

In addition, I feel that the authors could mention other data showing the difference in quality of life outcomes from different types of reconstruction e.g. from the US MROC or UK iBRA study, to highlight that not all reconstructions are necessarily the same.
Reply 3: We appreciate this comment and have included data from the MROC study published in J Clin Oncol.
Changes in the text: “A landmark study in this regard was the Mastectomy Reconstruction Outcomes Consortium (MROC) study. Among other questions, the MROC study investigated patient-reported outcomes 1 year after immediate breast reconstruction and demonstrated that patients who had undergo autologous reconstruction had greater satisfaction with their breasts and had greater psychosocial and sexual well-being than those who underwent who underwent implant-based reconstruction [10].”

Breast surgeons are also increasingly using mammaplasty and partial breast reconstruction techniques (e.g. perforator flaps) to avoid mastectomy, which has reduced the mastectomy rate in my clinical experience, thereby reducing the need for total breast reconstruction. This is usually followed by RT, so another study of this groups of patients is probably needed to investigate the impact on QoL outcomes. But this approach allows 'high-risk' patients who would not be candidates for Recon to avoid Mx. We also see a protective effect on radiation toxicity of BCS combined with breast reduction or re-shaping.
Reply 4: There are geographic differences regarding how involved breast surgeons are in the reconstructive process. At most academic medical centers, however (including at the authors’ institution), breast surgeons focus on cancer treatment only with reconstructive surgeons performing the reconstruction, including oncoplastic procedures using volume displacement and replacement procedures.

Changes in the text: None. A discussion of oncoplastic procedures is beyond the scope of this article.

The authors of the editorial may also wish to comment on the progress that has been made in terms of radiotherapy techniques over the past 20 years, moving to intensity-modulated plans and partial breast radiation in selected cases, with level 1 evidence for reduced toxicity.
Reply 5: Thank you for this suggestion.
Changes in the text: "In his noteworthy, however, that radiotherapy for breast cancer has undergone substantial changes over the past 20 years. Hence, patients who have undergone radiotherapy may, in fact, represent a rather heterogeneous cohort, with treatment modalities ranging from whole breast radiation to intensity-modulated protocols and partial breast radiation. A complete discussion of radiotherapy modalities, however, is beyond the scope of this commentary."

Other points:
Line 2- should this be Mx and Reconstruction (not Mx and Radiation)?
Reply 6: Thank you for bringing this to our attention.
Changes in the text: "…Radiotherapy versus Mastectomy and Reconstruction"

Reviewer B

While I have not had a chance to review the manuscript, the assertion that the choice of procedure is individual and patient driven seems reasonable
I disagree that a consultation with a plastic reconstructive surgeon is necessary or important in all patients eligible for either option
Reply 7: We appreciate the comment of this reviewer; however, we must respectfully disagree. Patients must be informed of ALL reconstructive options prior to undergoing definitive surgery. Hence, consultation with a plastic surgeon is a critical part of the preoperative information gathering process. A breast surgeon cannot competently counsel a patient on procedures they do not perform, e.g. microsurgical reconstruction.
Changes in the text: None.