

Peer Review File

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Reviewer Comments

Reviewer A

Comment 1: Sorry, but the article seems to me a collection of facts that come from published articles expressed in short sentences (as telegrams*) without a general well-organized structure which deserves to be considered as a review.

*Breast-conserving surgery (BCS) plus radiation treatment is the favored alternative for mastectomy in patients with breast cancer (1-9). Nowadays, around two-thirds of breast cancer patients undergo BCS (10). Since the survival of breast cancer patients increases, quality of life (QoL) after breast cancer (treatment) becomes more important. With the shift towards more BCS, there is a growing emphasis on aesthetic outcomes after surgery, which is an important aspect of QoL (11)

*The first techniques used for OPBCS were introduced at the end of the previous century (18-20). Since then, a broad range of techniques have been developed. Despite the promising role OPBCS plays in clinical practice, the demand for standardization is recognized (21-25). At the same time, the adoption rates of OPBCS are relatively slow (24)

For example, you write:

“This article provides a clinical perspective on the usage of OPBCS, highlighting the patient selection, timing, oncologic outcome, and quality of life (QoL)”.

but you start with the definition.

Reply 1: We thank the reviewer for this comment. This article is a short review of the use of OPBCS in our hospital.

We changed the last sentence of the introduction to: “This article provides a clinical perspective on OPBCS”.

Comment 2: Inpatient selection and timing you start with the use of oncoplastic techniques around the world.

Reply 2: This point is indeed valid. We start this section with the variation of the use of OPBCS in the world. However, we describe this to emphasize the large variation and differences in the selection of patients who are eligible for OPBCS. The heading may be confusing so we adjusted the headings in a more logical way. The section “patient selection and timing” is now “current use of OPBCS”

Comment 3: Oncoplastic breast-conserving surgery is breast-conserving surgery; you should differentiate BCS standard from BCS with oncoplastic techniques.

Reply 3: We have changed BCS to standard BCS (s-BCS) in the whole manuscript.

Comment 4: Before the use of an abbreviation, the rule is that the first time should be written entirely (Abstrac, ILC).

Reply 4: In the abstract, we have now written “invasive lobular carcinoma” before we used the abbreviation.

“(e.g. multifocal breast cancer, invasive lobular carcinoma (ILC), larger tumors and DCIS)”, line 48.

Comment 5: Table 1, there are not any abbreviations in the table, in the foot text abbreviations are not necessary.

Reply 5: We have removed the abbreviation section of Table 1.

Comment 6: OPBCS is mostly considered in patients with significant dead space remaining after BCS or when more than 20% of the breast volume needs to be excised (27). In the MDT only, the estimation of volume to be excised

An alternative to the two steps is a pathological study intraoperatively.

Reply 6: Pathological study intraoperatively would be ideal, however performing a frozen section of all margins during surgery would consume too much time, which is the reason for a two-step approach in patients with an increased risk of involved margins.

Comment 7: Outcomes.

Line 153. What are the surgical outcomes? they should be specified (I suppose that they can be postoperative complications, status of surgical margins, re-excision rate of conversion to mastectomy, etc.). Regarding surgical outcomes, the results of OPBCS seem to be an advantage compared to BCS without oncoplastic reconstruction (mistake). I suggest reorganizing outcomes in the following order. Surgical outcomes, oncological outcomes, and cosmetic and patient-reported outcomes

Reply 7: We thank the reviewer for this comment. The outcomes section is somewhat unorganized. We have changed the order to the suggested order; surgical outcomes, oncological outcomes, cosmetic and patient-reported outcomes. Furthermore, we highlight the type of surgical outcomes: “Regarding surgical outcomes such as excision margins, re-excision rates, and short-term surgical complications, the results of OPBCS seems to be an advantage compared to BCS without oncoplastic reconstruction”, line 185.

Comment 8: Line 180. I do not agree with this statement; currently, there are some articles (most of the retrospectives) comparing BCS standard versus oncoplastic breast-conserving surgery.

Reply 8: We are sorry to have missed this valuable data. There are indeed various studies, we changed the statement to “There are several studies reporting on QoL and cosmetic satisfaction after OPBCS compared to s-BCS, and both similar or improved results are described” and cited the two suggested articles.

Comment 9: I recommend you read these articles,

Hernanz F, Jimeno J, Paz L, Anchuelo J, González E, Muñoz P. Comparison of Conventional vs. Oncoplastic Breast Conserving Surgery in a Breast Unit with

Oncoplastic Training. World J Surg Surgical Res. 2021; 4: 1317

Concerning de Oliveira-Junior et al. “Oncoplastic Surgery in Breast-Conserving Treatment: Patient Profile and Impact on Quality of Life.” Breast Care. 2021;16(3):243–253

Reply 9: Thank you for the suggested articles.

Comment 10: Comparison between BCS vs. OBSC is not a very useful task and the hypothetical study (with a strong level of evidence) very difficult to carry out in the present situation

Reply 10: We thank the reviewer for this comment.

Comment 11: Conclusion.

“OPBCS should however not be applied in all breast cancer patients since complication rates rise while the oncological outcome is not improved compared to BCS alone”

According to the former phase if the rate of complication were zero OPBCS would be used in all breast cancer or the unique reason to not do all OPBCS is the possibility of complications

Reply 11: This is a valid comment. The complication rate is indeed not the only reason to perform BCS and how it is written right now it seems to be the case. We have changed the sentence in the conclusion to: “OPBCS should however not be applied in all breast cancer patients. The selection of patients who benefit from OPBCS as well as the timing of OPBCS techniques are best discussed in an MDT”

Comment 12: I recommend you read DOI: 10.1016/j.senol.2021.07.006

Reply 12: Thank you for the suggestion.

Reviewer B

Comment 1: lines 144-148: in the case of second surgery another disadvantage is the type of anesthesia. In fact, the re-excision alone could be performed under local anesthesia or with a Laryngeal Mask Airway. On the contrary, in delayed OPBCS, the second operation must also be performed under general anesthesia. This is a potential disadvantage for the patient

Reply 1: We thank the reviewer for this valuable comment. This is can indeed be seen as a potential disadvantage of delayed OPBCS.

Comment 2: I recommend including the main recommendations derived from the cited expert panel consensus.

Reply 2: The main recommendation from the expert panel consensus is: “Oncoplastic breast-conserving surgery should be recommended versus standard breast-conserving surgery for the treatment of operable breast cancer in adult women who are suitable candidates for breast-conserving surgery (with very low certainty of the evidence)”.

We believe that the eligibility for OPBCS depends on the tumor volume-to-breast ratio and the desire of the patient. We think that OPBCS is a beautiful and very good alternative for patients who would have otherwise been treated with a mastectomy but that is not a good alternative for all patients who are treated breast-conserving.

At this year's congress in St. Gallen, this was also the topic of discussion. As a result of this discussion, the request came to write an article on OPBCS.