



ABSI 2025 Consensus Guidelines on the Management of Breast Cancer in Low- and Middle-Income Countries

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Abstract

Background The Association of Breast Surgeons of India (ABSI) periodically publishes national consensus statements to adapt evidence-based breast cancer management to Indian realities. This 2025 update aimed to develop pragmatic, scenario-based guidance and assess concordance between expert recommendations and current clinical practice.

Methods An expert panel formulated 40 single-best-answer questions spanning screening, diagnosis, surgery, axillary management, reconstruction, systemic therapy, radiotherapy, genetics, survivorship, and delivery of care. Responses were collected from panel experts ($n=24$) and delegates ($n=159$) at the ABSI Annual Meeting 2025 (Kolkata) using identical Google Forms. Concordance was defined a priori: almost 100% (same top choice, $\geq 90\%$ in both groups), small discordance (same top, $\leq 10\%$ difference), medium discordance (same top, 10–30% difference), significant discordance ($> 30\%$ difference or different top choice). Option distributions were compared using chi-square tests.

Results Of 40 questions, 10 showed almost complete concordance, 12 small discordance, 17 medium discordance, and 1 significant discordance. Highest agreement included the following: empowering community health officers for early detection, preference for breast-conserving surgery when feasible, SLNB for node-negative early breast cancer, and mandatory fertility/psycho-sexual counselling for young patients. Divergences were noted in HER2 therapy duration in low-risk disease, radiotherapy in DCIS, reconstruction choices, and axillary management in Z0011-eligible macro-metastasis.

Conclusion Indian experts and practising surgeons show strong alignment on core surgical principles and supportive care priorities. Targeted guidance is needed for areas of practice variation to ensure uniform, evidence-informed care delivery in India.

Keywords Breast cancer · Consensus guidelines · ABSI · Expert–delegate comparison · Breast oncology · Surgical oncology

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Introduction

Breast cancer remains the most commonly diagnosed cancer in women globally, with approximately 2.3 million new cases and 670,000 deaths reported in 2022 [1]. This burden represents roughly 24% of all female cancer diagnoses and 15% of cancer-related deaths worldwide. Worryingly, projections indicate that by 2050, these numbers could escalate to 3.2 million cases and 1.1 million deaths annually, disproportionately affecting countries with lower Human Development Indices [2]. In India, the burden is particularly significant [3]: breast cancer accounted for 192,020 new cases in 2022, representing 26.6% of all cancers in women and ranking as the most common female malignancy [4]. With one in 29 Indian women expected to develop cancer during their lifetime, breast cancer stands at the forefront of India's oncology challenge. These figures underscore an urgent public health imperative: strengthening early detection infrastructure, tailoring national consensus guidelines to India's unique healthcare dynamics, and bridging gaps in access to care and outcomes.

The Association of Breast Surgeons of India (ABSI) has sought to bridge global evidence with Indian realities through national consensus statements published in 2017 and 2021 [5, 6]. Given evolving evidence — including trials influencing axillary management, oncoplastic techniques, systemic therapy de-escalation, and survivorship care — ABSI undertook its third consensus exercise in 2025. This iteration adopted a case-based, scenario-driven approach and uniquely compared expert recommendations to real-time practice patterns among national meeting delegates.

Methods

A core group of 10 senior breast surgeons from the Association of Breast Surgeons of India (ABSI) collaboratively designed 40 single-best-answer multiple-choice questions (MCQs), each including an “abstain” option. Multiple online meetings were held to iteratively refine the scenarios, grounded in international guidelines but tailored to reflect Indian clinical realities. Topics spanned screening, diagnosis, surgery, axillary staging, oncoplastic reconstruction, systemic therapy, radiotherapy, genetics, survivorship, and models of care delivery.

The finalised questionnaire was circulated electronically to 24 experts across India prior to the ABSI Annual Meeting (ABSICON 2025) held in Kolkata. During the meeting, the same form was offered to all delegates, of

whom 159 participated, via Google Forms after each case vignette was presented. An intense brainstorming session was also conducted during the ABSICON 2025, where both experts and delegates engaged in open discussion of all clinical scenarios and shared their perspectives and inputs. This approach aimed to capture real-world clinical opinions immediately following each scenario, with no prior group discussion.

Responses were tabulated as counts and percentages. Concordance between experts and delegates was pre-defined and categorised as follows: (a) almost 100% concordance—same top choice with $\geq 90\%$ of both groups in agreement; (b) small discordance—same top choice with $\leq 10\%$ absolute difference; (c) medium discordance: same top choice with 10–30% difference; (d) significant discordance— $> 30\%$ difference or divergent top choices.

Statistical comparisons of response distributions were made using chi-square tests ($2 \times k$), considering $p < 0.05$ to indicate significance.

Results

A total of 24 experts and 159 delegates completed all 40 questions, each designed as a single-best-answer multiple-choice item with an abstain option. Overall, expert–delegate concordance was high for a substantial proportion of items. Ten questions achieved almost complete agreement, 12 showed small discordance, 17 had medium discordance, and only one demonstrated significant discordance (Table 1).

The strongest alignment between experts and delegates was observed in areas where evidence is well established and consensus is widely accepted. These included the importance of addressing fertility preservation and psycho-sexual health in young breast cancer patients, the preference for breast-conserving surgery in appropriately selected early-stage cases, the role of empowering community health officers to improve early detection in rural settings, the optimal approach to axillary staging in clinically node-negative early breast cancer, and the definition of adequate surgical margins in breast-conserving surgery. In each of these domains, both groups selected the same top option with near-identical percentages, reflecting shared understanding

Table 1 Overall concordance categories for 40 questions

Concordance category	Number of questions	% of total
Almost 100% concordance	10	25%
Small discordance	12	30%
Medium discordance	17	42.5%
Significant discordance	1	2.5%

Table 2 Concordance between experts and delegates on 40 consensus statements for breast cancer management in the ABSI nationwide survey

S. no	Question	Majority option (experts versus delegates)	Experts supporting majority option (%)	Delegates supporting majority option (%)	Overlap_%	Concordance_category	p-value
1	In the Indian context, considering resource variability and population-based needs, which of the following should be considered the primary breast cancer screening modality?	Clinical breast examination (both)	58.3	44.7	75.9	Medium discordance	0.1575
2	Can empowering Community Health Officers (CHOs) improve early breast cancer detection and outcomes in rural areas?	Yes (both)	100	98.7	98.7	Almost 100% concordance	0.5806
3	Is it mandatory to go ahead with core biopsy (with ER/PR/Her2/Ki67) before proceeding with definitive treatment	Yes (both)	83.3	91.2	91.5	Small discordance	0.3844
4	In a patient with early-stage breast cancer (cT2N1M0) and no clinical signs or symptoms of metastasis, are routine staging investigations (such as PET-CT, CT chest/abdomen, or bone scan) recommended before initiating treatment?	No (both)	66.7	62.3	95.6	Small discordance	0.6774
5	Is a preoperative MRI of the breast mandatory in all women undergoing BCS for early-stage breast cancer?	No (both)	100	93.1	93.1	Almost 100% concordance	0.4134
6	In a newly diagnosed case of breast cancer with suspected metastatic disease (e.g., bone, lung), should a biopsy of the metastatic lesion be performed before initiating systemic treatment with palliative intent?	No (both)	50	53.5	96.6	Small discordance	0.9508
7	In patients with early-stage breast cancer (T1–T2, N0–1), with no contraindications to breast conservation and access to radiotherapy, should breast-conserving surgery be considered the preferred surgical option?	Yes (both)	100	98.7	98.7	Almost 100% concordance	0.5806
8	In breast-conserving surgery for invasive breast cancer, what should be considered an adequate surgical margin?	No tumor on inked margin (both)	87.5	85.5	97	Small discordance	0.9667
9	In patients undergoing breast-conserving surgery for pure DCIS, what should be considered an adequate surgical margin?	2 mm (both)	91.7	71.1	79.4	Medium discordance	0.1278
10	Is multifocal/multicentric breast cancer an absolute contraindication to breast-conserving surgery?	No—BCS can be considered if all lesions can be excised with negative margins and acceptable cosmesis (both)	91.7	81.1	89.4	Medium discordance	0.4324

Table 2 (continued)

S. no	Question	Majority option (experts versus delegates)	Experts supporting majority option (%)	Delegates supporting majority option (%)	Overlap_%	Concordance_category	p-value
11	Should intraoperative margin assessment (frozen section, imprint cytology, or cavity shaving—depending upon the resources) be routinely performed during breast-conserving surgery in patients with early-stage breast cancer?	Yes (both)	54.2	58.5	95.7	Small discordance	0.7464
12	In LABC patients undergoing post-neoadjuvant chemotherapy, which statement is most appropriate?	All LABC patients are potential candidates for post-NACT-BCS provided it is oncologically safe and cosmetically acceptable. (both)	87.5	92.5	94.8	Small discordance	0.4663
13	In BCS after NACT, resection volume should be based on:	Post-chemotherapy residual tumour (both)	95.8	83.6	83.6	Medium discordance	0.0043
14	In patients with radiologically suspicious axillary nodes, is USG-guided FNAC recommended for preoperative staging before SLNB or ALND?	Yes (both)	79.2	71.1	91.9	Small discordance	0.4095
15	Axillary staging in node-negative early breast cancer should be done by:	Sentinel lymph node biopsy (SLNB) (both)	100	98.1	98.1	Almost 100% concordance	0.7944
16	For SLNB in resource-limited settings, which statement is most appropriate?	SLNB using blue dye alone can be performed (both)	100	83.6	83.6	Medium discordance	0.1015
17	In patients with micro-metastasis identified in the sentinel lymph node, is completion ALND mandatory?	No—observation without ALND is acceptable in selected patients (both)	91.7	88.1	96.4	Small discordance	0.8008
18	In SLNB-positive (macrometastasis) patients who are Z0011-eligible, which option is most appropriate?	No further axillary treatment is needed due to coverage by tangential whole-breast RT (Z0011 trial) (both)	70.8	45.9	75.1	Medium discordance	0.0537
19	Is SLNB or TAD feasible in a subset of patients with clinically node-positive axilla after NACT?	Yes (both)	95.8	78	82.2	Medium discordance	0.1159
20	What should be the ideal timing for SLNB in clinically node-positive patients?	SLNB should be performed after NACT (both)	100	78	78	Medium discordance	0.0382
21	Breast oncoplasty is an appropriate option for:	Patients with poor tumour-to-breast ratio or volume loss > 20% (both)	75	56.6	80.5	Medium discordance	0.1875
22	Choose the most appropriate statement regarding levels of oncoplastic procedures:	The majority of breast conservations can be managed with level I oncoplasty techniques (both)	70.8	78	91.4	Small discordance	0.5725
23	What is the preferred timing for post-mastectomy breast reconstruction?	Immediate reconstruction is preferred whenever feasible (both)	95.8	80.5	84.7	Medium discordance	0.1734
24	What is the best option for post-mastectomy breast reconstruction?	Autologous flap (both)	75	48.4	73.4	Medium discordance	0.0939

Table 2 (continued)

S. no	Question	Majority option (experts versus delegates)	Experts supporting majority option (%)	Delegates supporting majority option (%)	Overlap_%	Concordance_category	p-value
25	What is the flap of choice for total autologous breast reconstruction?	DIEP flap (both)	95.8	66	70.2	Medium discordance	0.0302
26	What is the most appropriate statement regarding the use of nipple-areola sparing mastectomy (NSM) in breast cancer?	NSM is oncologically safe and can be considered in select early-stage patients without NAC involvement (both)	100	94.3	94.3	Almost 100% concordance	0.4895
27	Choose the most appropriate statement regarding genetic counselling and testing in breast cancer:	All young breast cancer patients should be offered genetic counselling and testing routinely (both)	91.7	75.5	83.8	Medium discordance	0.2029
28	Which of the following procedures can be recommended for risk reduction in BRCA-positive patients?	Both (both)	91.7	87.4	94.3	Small discordance	0.6915
29	Should post-lumpectomy whole breast radiotherapy be recommended in DCIS patients?	Selected group with high-risk features (both)	87.5	59.1	69.3	Medium discordance	0.0316
30	Can radiotherapy be omitted in elderly and low-risk patients undergoing breast-conserving surgery?	Yes (both)	91.7	75.5	83.8	Medium discordance	0.1955
31	Choose the most appropriate statement regarding NACT:	NACT should be offered to most LABC and TNBC/HER2-positive tumours > 2 cm (both)	100	92.5	92.5	Almost 100% concordance	0.3794
32	In good responders, should all cycles of neoadjuvant therapy be completed prior to surgery?	Yes (both)	95.8	91.8	96	Almost 100% concordance	0.7487
33	Can CanAssist Breast or similar low-cost prognostic tools be considered in HR-positive, HER2-negative, node-negative early breast cancer patients to guide adjuvant chemotherapy decisions in India?	Yes—they are useful, especially where multigene assays are unaffordable. (both)	79.2	69.2	89.3	Small discordance	0.2386
34	Should pembrolizumab be offered as part of neoadjuvant therapy in TNBC patients?	Yes—for locally advanced/high-risk TNBC. (both)	100	83	83	Medium discordance	0.0916
35	Should ovarian suppression as adjuvant therapy be considered in all premenopausal, hormone-positive breast cancer patients in addition to tamoxifen or chemotherapy?	Only in high-risk patients. (both)	75	57.9	82.9	Medium discordance	0.246
36	Should patient advocacy and counselling services be integrated as a routine part of breast cancer care in India?	Yes—they play a critical role in decision-making and treatment compliance. (both)	100	96.2	96.2	Almost 100% concordance	0.6261

Table 2 (continued)

S. no	Question	Majority option (experts versus delegates)	Experts supporting majority option (%)	Delegates supporting majority option (%)	Overlap_%	Concordance_category	p-value
37	In HER2-positive patients, which statement is most appropriate?	Expert—in low-risk, node-negative patients, 6 months is a reasonable option Delegates—all patients should receive 1 year of treatment	83.3	52.8	58.8	Significant discordance	0.0008
38	Should fertility preservation and psychosocial issues be addressed while treating young breast cancer patients?	Yes (both)	100	100	100	Almost 100% concordance	
39	In an oligometastatic disease with a small breast primary and complete response to systemic therapy, which of the following would you choose?	Local surgery + radiotherapy (both)	83.3	77.4	91.5	Small discordance	0.8707
40	In patients like Mrs. Savita Devi, facing significant geographical and financial constraints, what is the most appropriate approach?	Individualise the treatment based on logistical constraints, while ensuring oncological safety and avoiding treatment non-compliance. (both)	100	96.2	96.2	Almost 100% concordance	0.6261

of clinical priorities and adherence to established best practices (Table 2).

In contrast, the greatest variation arose in areas where practice patterns are more heterogeneous or influenced by institutional resources. Notable differences were seen in the management of patients with positive sentinel lymph nodes (macrometastasis) who are otherwise eligible for axillary conservation, the preferred timing and method for post-mastectomy breast reconstruction, the choice of flap for total autologous breast reconstruction, the role of whole breast radiotherapy after lumpectomy for ductal carcinoma in situ, and systemic therapy considerations in HER2-positive disease. These topics often involve weighing oncological safety against quality-of-life outcomes, resource constraints, and patient preference, which may explain the divergence in responses.

Table 3 summarises the 40 consensus statements on breast cancer management formulated through this nationwide consensus exercise, integrating evidence-based recommendations with insights derived from comprehensive expert–delegate deliberations.

Discussion

This nationwide consensus exercise, conducted under the aegis of the Association of Breast Surgeons of India (ABSI), provides a detailed snapshot of current practice patterns in breast cancer management. By comparing the responses of an expert panel with those of a broad delegate group to 40 structured, case-based multiple-choice questions, the study identifies both well-aligned and discordant areas. These findings have important implications for guideline formulation, professional education, and health policy in India.

Screening and Early Detection

Several questions addressed the role of screening and early detection strategies. There was near-complete agreement on the importance of empowering community health officers to identify early signs of breast cancer in rural areas, reflecting an acknowledgement of the shortage of specialist manpower and the proven impact of task-shifting in primary care. Similarly, consensus was strong regarding the optimal screening modality and intervals for average-risk women, with mammography preferred where feasible, supplemented by ultrasound in dense breasts. Discordance emerged in resource-limited contexts, where delegates were more likely to favour clinical breast examination as the primary screening tool, likely reflecting practical realities outside tertiary centers (Fig. 1).

Table 3 ABSI Breast Cancer Consensus Guidelines**A. Screening and Early Detection**

1. Adopt clinical breast examination as the primary population-level screening modality in India, using mammography/ultrasound where available.
2. Empower Community Health Officers to participate in breast cancer awareness, early detection, referral, and follow-up in rural areas.

B. Diagnosis and Pre-treatment Evaluation

3. Obtain a core needle biopsy with ER, PR, HER2, and Ki-67 before initiating definitive treatment.
4. In patients with early-stage breast cancer who have no symptoms or clinical suspicion of distant metastases, routine staging with PET-CT or CT (chest and abdomen) with bone scan is not recommended. Such imaging may be considered selectively, based on clinical judgment, institutional protocols, or research requirements.
5. Do not mandate preoperative breast MRI for all breast-conserving surgery candidates; use selectively.
6. Biopsy of suspected metastatic lesions before starting palliative systemic therapy is not mandatory in all cases; individualise if results would alter management.

C. Breast Surgery and Margins

7. Offer breast-conserving surgery (BCS) as the preferred option for eligible early-stage patients with access to radiotherapy.
8. Define adequate margins for invasive cancer as “no tumour on ink.”
9. For pure DCIS treated with breast conservation, aim for a 2-mm negative margin.
10. Multifocal or multicentric disease is not an absolute contraindication to BCS if all lesions can be excised with negative margins and acceptable cosmesis.
11. Perform intraoperative margin assessment during BCS where feasible (frozen section, imprint cytology, or cavity shaving).
12. After neoadjuvant chemotherapy NACT for locally advanced breast cancer, BCS may be offered when oncologically safe and cosmetically acceptable.
13. Base resection volume after NACT is based on the post-chemotherapy residual tumour rather than the initial tumour size.

D. Axillary Staging and Management

14. Undertake ultrasound-guided FNAC or core biopsy of radiologically suspicious axillary nodes for preoperative staging.
15. Use sentinel lymph node biopsy SLNB for axillary staging in clinically node-negative early breast cancer.
16. When NACT is planned, SLNB should be performed after—not before—the systemic treatment.
17. In resource-limited settings, SLNB using blue dye alone is acceptable.
18. Avoid routine completion axillary dissection for sentinel-node micrometastasis; observation with appropriate adjuvant therapy is reasonable in selected patients.
19. In Z0011-eligible patients with macrometastasis in the sentinel node, no further axillary treatment is required beyond tangential whole-breast radiotherapy.
20. After NACT, consider SLNB or targeted axillary dissection in selected patients initially presenting with node-positive disease who responded and had pre-treatment node clipping.

E. Oncoplastic Surgery and Reconstruction

21. Use oncoplastic techniques when the tumour-to-breast ratio is poor or the expected volume loss exceeds ~20%.
22. Manage most BCS defects with Level I oncoplastic techniques; reserve Level II for larger or complex defects.
23. Prefer immediate breast reconstruction after mastectomy when feasible and acceptable to the patient.
24. Favour autologous reconstruction over implants in most Indian settings, balancing patient choice, expertise, and resources.
25. Prefer a DIEP flap for total autologous reconstruction where microsurgical expertise is available.
26. Use nipple-areola-sparing mastectomy in selected early-stage patients without nipple-areola complex involvement and where oncologic safety is acceptable.

F. Genetics and Risk Reduction

27. Offer routine genetic counselling to all breast cancer patients.
28. For BRCA-positive patients, both risk-reducing bilateral mastectomy and bilateral salpingo-oophorectomy should be discussed, as both are effective in lowering cancer risk. The timing should be individualised, considering age, menopausal status, reproductive plans, and other relevant factors.

G. Radiotherapy

29. Recommend whole-breast radiotherapy after lumpectomy for DCIS in high-risk patients; consider omission in low-risk disease.
30. Consider omission of radiotherapy in carefully selected elderly, low-risk patients after breast conservation.

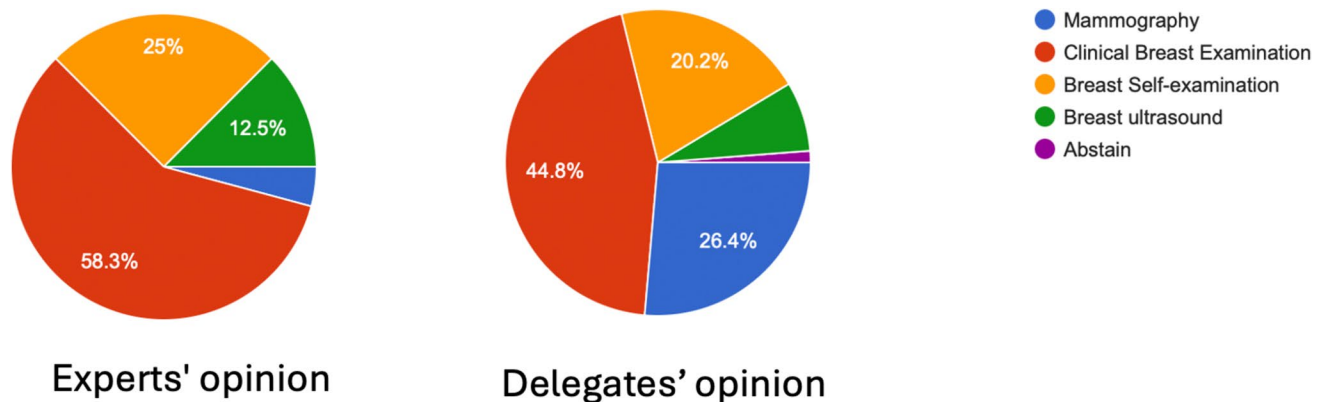
H. Systemic Therapy

Table 3 (continued)

31. Offer NACT to most locally advanced cases and to TNBC/HER2-positive tumours >2 cm to improve operability and assess response.
32. In good responders to NACT, complete all planned cycles before surgery.
33. In low-risk, hormone receptor-positive, HER2-negative, node-negative early breast cancer, when multigene assays (e.g., Oncotype DX, MammaPrint) are unaffordable, low-cost prognostic tools such as the PREDICT tool (UK NHS, free online) and CanAssist may be considered to guide adjuvant chemotherapy decisions.
34. In high-risk or locally advanced triple-negative breast cancer, pembrolizumab may be considered where accessible and affordable. Its absence should not be viewed as substandard care, as standard anthracycline- and taxane-based chemotherapy remains an effective, evidence-based option.
35. Add ovarian function suppression for premenopausal, hormone-receptor-positive patients at high risk; it is not required for all.
36. Integrate patient advocacy and counselling services as routine components of breast cancer care to support decision-making and adherence.
37. In selected low-risk, node-negative HER2-positive patients, six months of trastuzumab is a reasonable de-escalation option.

I. Survivorship, Fertility, and Supportive Care

38. Routinely address fertility preservation options and psycho-sexual health in young patients prior to therapy.
39. In oligometastatic disease with complete systemic response and a small primary, combine local breast surgery with radiotherapy.
40. Individualise treatment plans for patients facing major geographic, social, or financial barriers to ensure oncologic safety and avoid non-compliance.

**Fig. 1** Preferred primary breast cancer screening modality in India

Both Khanna et al. [7] and Mitra et al. [8] showed that clinical breast examination (CBE) is a cost-effective, culturally acceptable, and practical screening method for breast cancer in India and other LMICs, especially where mammography access is limited. Evidence from both studies demonstrates earlier stage diagnosis, with Mitra et al. reporting a 30% mortality reduction in women aged ≥ 50 years. Training community health workers, ensuring regular skill checks, and linking screening to diagnostic and treatment facilities were identified as key success factors. Limitations include variability in examiner skills and resource constraints, but the combined evidence supports making CBE a core part of India's national breast cancer control strategy until population-wide mammography becomes feasible.

Diagnosis and Staging

Questions on diagnostic pathways, including preferred imaging sequences and biopsy techniques, showed high agreement (Fig. 2). Core needle biopsy was overwhelmingly selected as the initial diagnostic modality for suspicious breast lesions, aligning with international recommendations (Fig. 2). There was near-complete agreement between the expert panel and the delegates on the role of preoperative breast MRI in women undergoing breast-conserving surgery (BCS) for early-stage breast cancer. Both groups strongly agreed that a preoperative MRI is *not mandatory* in all such cases (experts, 100%; delegates, 93.1%), reflecting almost 100% concordance ($p = 0.4134$) (Fig. 3). There was also consensus on the role

Fig. 2 Pre-treatment core biopsy of a breast lump

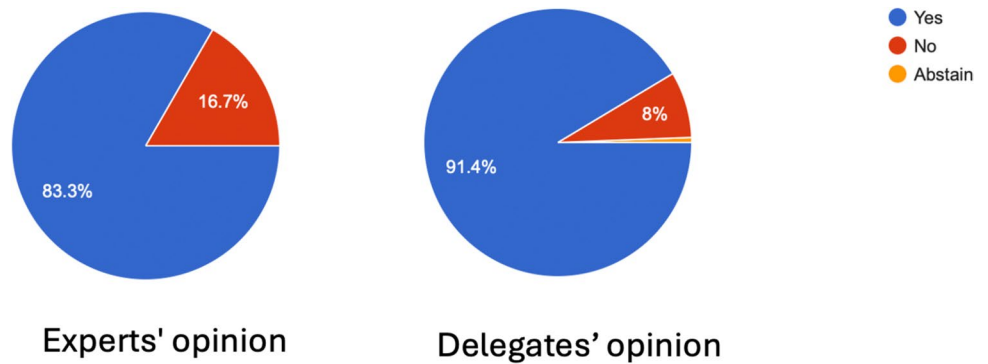


Fig. 3 Preoperative MRI before BCS in early-stage breast cancer

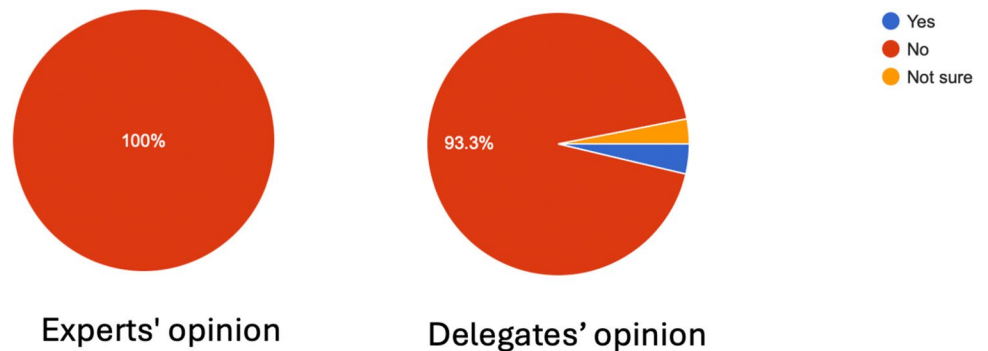
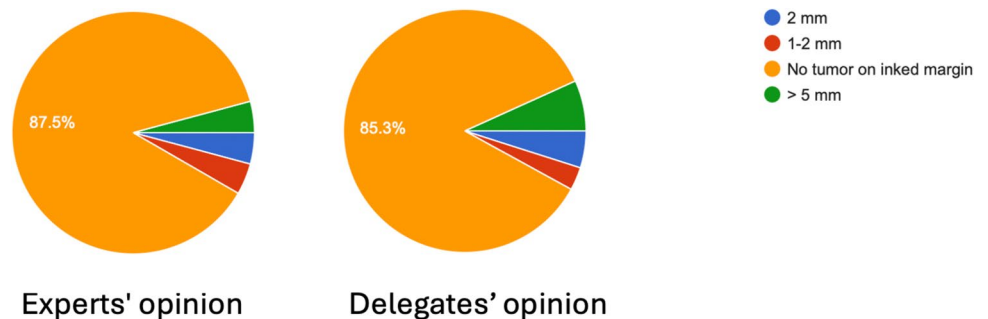


Fig. 4 Adequate surgical margin in BCS for invasive breast cancer



of image-guided sampling for axillary nodes suspicious on imaging, although delegates were somewhat more likely than experts to omit this step in clinically node-negative axillae, possibly due to limited access to interventional radiology.

Breast Surgery

In scenarios comparing breast-conserving surgery (BCS) with mastectomy for early-stage disease, there was strong consensus in favour of BCS where oncologically appropriate, with both groups citing equivalent survival outcomes and better quality of life [9, 10]. Margin assessment in BCS was also an area of high agreement, with “no tumour on ink” accepted as adequate in invasive cancer (Fig. 4). Discordance arose in multifocal and multicentric disease, where

experts more frequently supported BCS in select cases with favourable tumour biology and adequate margins, while delegates leaned toward mastectomy, reflecting differences in comfort level and exposure to oncoplastic techniques [11].

Axillary Management

Axillary staging in clinically node-negative disease saw near-universal endorsement of sentinel lymph node biopsy (SLNB) [12, 13]. For patients with SLNB-positive disease who met the ACOSOG Z0011 criteria [14], opinions diverged: while many experts favoured omitting axillary dissection, citing trial evidence, a significant proportion of delegates preferred completion dissection, possibly due to perceived medicolegal risks or lack of familiarity with the trial’s applicability in the Indian setting (Fig. 5). Similar

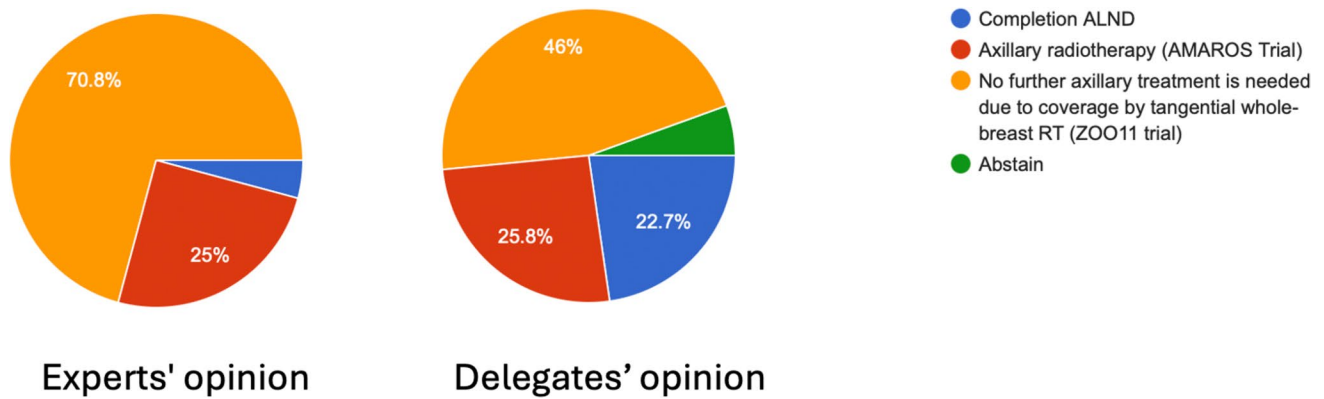


Fig. 5 Management options for SLNB-positive (macrometastasis) Z0011-eligible patients

discordance was noted for axillary management after neoadjuvant chemotherapy, where clip placement and targeted axillary dissection were more frequently endorsed by experts than delegates.

Reconstruction

Post-mastectomy reconstruction generated some of the most varied responses. Timing (immediate vs delayed) and method (autologous vs implant-based) both revealed medium to significant discordance. Experts often preferred immediate reconstruction where feasible, emphasising psychological and cosmetic benefits, while delegates more frequently opted for delayed approaches, citing logistical and cost barriers. The choice of autologous flap also varied, with experts more likely to recommend perforator flaps, reflecting access to microsurgical expertise not universally available. These gaps highlight disparities in reconstructive service availability across India [15].

Systemic Therapy

Agreement was strong for the use of neoadjuvant chemotherapy in triple-negative and HER2-positive cancers to improve operability and assess treatment response [16]. However, systemic therapy for HER2-positive disease also revealed sharp contrasts between expert and delegate opinions. Experts generally agreed that in low-risk, node-negative patients, a shorter duration of trastuzumab—such as 6 months—was a reasonable option. This view was supported by evidence from the PERSEPHONE trial [17], which demonstrated non-inferiority of 6 months compared to the standard 12 months in terms of disease-free survival, with the added benefits of reduced cardiotoxicity, lower treatment burden, and cost savings. Delegates, however,

more often favoured the conventional 1-year course, possibly reflecting adherence to current international guidelines, limited familiarity with de-escalation data, and a preference for the perceived safety of established standards [18]. Notably, this was the single question in the survey that showed the maximum discordance between expert and delegate responses. Endocrine therapy duration in hormone receptor-positive disease was another area of medium discordance, with experts more inclined toward extended therapy in high-risk cases.

Radiotherapy

Questions on adjuvant radiotherapy revealed moderate variation. While most respondents agreed on the role of whole-breast irradiation after BCS for invasive cancer [19], there was greater divergence in ductal carcinoma in situ (DCIS) cases, with some respondents favouring omission in low-risk patients. Post-lumpectomy radiotherapy indications were generally well aligned with international guidelines, though some delegates were more conservative, extending indications to borderline scenarios. A meta-analysis pooled data from four major randomised controlled trials (RCTs) involving 3680 patients with ductal carcinoma in situ (DCIS) treated with lumpectomy, comparing those who received adjuvant radiotherapy (RT) ($n = 1710$) to those who did not ($n = 1970$) [20]. Over a follow-up exceeding 10 years, adjuvant RT reduced the risk of ipsilateral breast recurrence by nearly half ($RR = 0.53$, 95% CI 0.45–0.62) and regional recurrence by a similar magnitude ($RR = 0.54$, 95% CI 0.32–0.91), corresponding to an absolute risk reduction of 15% (95% CI 12–17%) for ipsilateral recurrences. However, RT showed no significant effect on distant recurrence ($RR = 1.06$, 95% CI 0.74–1.53), contralateral breast events ($RR = 1.22$, 95% CI 0.98–1.52), or overall mortality ($RR = 0.93$, 95% CI 0.79–1.09). These findings confirm that

while postoperative RT after lumpectomy for DCIS does not improve overall survival, it substantially lowers the risk of local and regional recurrence.

Genetics and High-Risk Care

Genetic testing strategies for BRCA and other high-risk mutations showed high agreement, with targeted testing in patients meeting established criteria endorsed by both groups [21]. Preventive surgery for mutation carriers was more frequently recommended by experts, while delegates were somewhat more cautious, potentially due to differences in patient counselling experience or surgical resources.

A LMIC study [22] on 200 breast cancer patients found low baseline genetic literacy, with common misconceptions about inheritance and testing. A brief 15–20-min educational session significantly improved knowledge—awareness of bilateral inheritance rose from 28 to 79%, and understanding that family history absence does not exclude risk increased from 22 to 75% (both $p < 0.001$). Willingness to undergo testing grew from 46 to 88%. Such low-cost interventions can markedly improve awareness and uptake of genetic testing in resource-limited oncology settings.

Survivorship and Psycho-oncology

Fertility preservation and psycho-sexual counselling in young breast cancer patients emerged as one of the highest consensus areas, reflecting growing awareness about the quality of survivorship. Both groups also endorsed structured survivorship care plans and routine follow-up schedules based on risk stratification. These findings suggest successful integration of survivorship principles into Indian breast oncology practice [23].

Care Delivery Models

Questions on care coordination and multidisciplinary teams (MDTs) showed strong agreement on their central role in cancer care. Although only two survey questions addressed this, the topic was discussed in detail at the ABSICON 2025 open forum, which added context and highlighted practical challenges. Respondents emphasised the need for clear referral pathways and adaptation of care models to local resources, noting that a uniform approach is not feasible in India. Many delegates reported the absence of formal tumour boards, relying instead on informal discussions, reflecting gaps in infrastructure and institutional culture. There was also consensus that while evidence-based guidelines should remain the backbone of care, treatment must

be individualised to account for literacy, family and social support, cultural beliefs, geographic barriers, and financial constraints. Such tailoring not only improves adherence but also ensures a humane and context-sensitive approach. Importantly, involving patients in MDT discussions was seen as vital for transparency, trust, and shared decision-making, thereby improving compliance, satisfaction, and long-term outcomes [24–26].

Conclusion

This nationwide ABSI consensus highlights broad agreement on evidence-based, context-adapted breast cancer management in India, alongside key areas of discordance—most notably HER2-positive therapy duration, axillary management after neoadjuvant treatment, and reconstructive access. These gaps largely reflect resource constraints, infrastructure variability, and differences in exposure to recent evidence. Strengthening multidisciplinary care, ensuring equitable access, and promoting continuous professional education will be essential to harmonise practice and refine national guidelines in line with both evidence and Indian healthcare realities.

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Data Availability The data that support the findings of this study are not openly available due to reasons of sensitivity and are available from the corresponding author upon reasonable request.

Declarations

Competing Interests The first and second authors serve as the Editor-in-Chief and Executive Editor, respectively, of the Indian Journal of Surgical Oncology.

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