

Mastectomy, Complete

ORG: S-860 (ISC)

[Link to Codes](#)

MCG Health

Inpatient & Surgical

Care

30th Edition

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Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure is indicated for **1 or more** of the following[A](1)(2):**NNNNNNNN**
 - Ductal carcinoma in situ not appropriate for partial mastectomy (1)
 - Invasive stage I or II breast cancer not appropriate for partial mastectomy (1)
 - Stage IIIA (T3 N1 M0 stage grouping only) invasive breast cancer[B] and Stage III invasive breast cancer not appropriate for partial mastectomy (1)
 - Stage III (other than T3 N1 M0 stage grouping) invasive breast cancer and clinical response to neoadjuvant chemotherapy[B][C] (1)
 - Sarcoma of the breast(6)(7)
- ☐ Contralateral mastectomy[D][E][F] (ie, breast cancer diagnosed in one breast, desired removal of contralateral breast without known malignancy), as indicated by **1 or more** of the following(3)(4)(5)(8)(9)(10):
 - Presence of high-penetrance genetic mutation increasing risk for contralateral breast cancer (eg, BRCA1, BRCA2, TP53) [F](3)(4)
 - Prior chest irradiation before 30 years of age (eg, mantle field radiation for Hodgkin lymphoma, mediastinal, whole lung, or hemithorax radiotherapy)(3)(4)
 - Presence of moderate-penetrance or low-penetrance genetic mutation increasing risk for contralateral breast cancer and alternative approaches (chemoprophylaxis, intensified screening) not preferred[G](3)
 - Strong family history of breast cancer and alternative approaches (chemoprophylaxis, intensified screening) not preferred[H](3)
 - Patient desire for improved postoperative breast symmetry (ie, preference for bilateral complete mastectomies rather than unilateral mastectomy with reconstruction)[I](11)(12)
 - Patient desire for reduced risk of subsequent contralateral breast cancer diagnosis and treatment (eg, severe anxiety concerning possible future primary breast cancer diagnosis in contralateral breast) and alternative approaches (chemoprophylaxis, intensified screening) not preferred(12)(13)
- ☐ Bilateral prophylactic mastectomy (no current diagnosis of breast cancer),[J] as indicated by **ALL** of the following(4)(5):
 - Significantly elevated risk of breast cancer, as indicated by **1 or more** of the following:

- Presence of high-penetrance genetic mutation increasing risk for breast cancer (BRCA1, BRCA2, TP53, CDH1, PALB2, PTEN, and STK11)[J]
- Prior chest irradiation before 30 years of age (eg, mantle field radiation for Hodgkin lymphoma, mediastinal, whole lung, or hemithorax radiotherapy)
- Family history denoting a high lifetime risk of breast cancer (eg, determined via application of risk assessment models that include consideration of family history)[J]
 - Alternative approaches to elevated risk (chemoprophylaxis, intensified screening) not preferred
 - At least 10-year life expectancy[K](4)
- Inflammatory breast cancer with response to preoperative chemotherapy[L](1)
- Paget disease without associated cancer elsewhere in breast and patient preference is for complete mastectomy rather than partial mastectomy[M](1)
- Phyllodes tumor for which negative margins cannot be obtained by partial mastectomy or complete mastectomy preferred[N](1)
- Recurrence of breast cancer in breast previously treated with partial mastectomy(1)
- ☐ Stage IV (metastatic) breast cancer with mastectomy needed for palliation of localized breast pain, bleeding, infection, or fungation,[O] as indicated by **ALL** of the following:
 - Signs and symptoms not amenable to or not adequately controlled via other means (eg, topical or systemic therapy)(1)
 - Patient is expected to be able to obtain significant relief from procedure (eg, most or all of the symptomatic tissues can be removed).(1)
 - Patient has sufficient estimated life expectancy so as to allow benefit from procedure (eg, life expectancy of weeks to months or longer, not days).(1)

Alternatives to Procedure

- Alternatives include(1)(2)(4)(16):
 - Continued observation and follow-up imaging(4)
 - Hormonal therapy (eg, tamoxifen or raloxifene, or surgical or radiation ovarian ablation)(1)(16)
 - Chemotherapy(1)
 - Biomarker-targeted therapies (eg, HER2-targeted therapy)(1)
 - Partial mastectomy (breast-conserving surgery). See Mastectomy, Partial (Lumpectomy) [ISC guideline](#).
 - Mastectomy with prosthesis insertion. See Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander [ISC guideline](#).
 - Complete mastectomy with tissue flap reconstruction. See Mastectomy, Complete, with Tissue Flap Reconstruction [ISC guideline](#).

Operative Status Criteria

Goal Length of Stay: Ambulatory

Note: The definition of an ambulatory procedure depends on payer-provider contractual agreement or regulatory language (eg, CMS' Two-Midnight Rule). An ambulatory procedure may include one postoperative overnight stay in a facility; therefore, MCG's ambulatory Goal Length of Stay (GLOS) attainment calculation reports the sum of same-day and next-day postoperative discharges. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory GLOS require inpatient care (eg, medical necessity for hospital-based care across 2 or more postoperative midnights). Some of these factors are described in the Extended Stay section of this guideline.

- Ambulatory
- Inpatient (eg, medical necessity for hospital-based care across 2 or more postoperative midnights)
- Inpatient (Medicare patient, and specific procedure is on CMS Inpatient Only List)

Hospitalization

Optimal Recovery Course

Day	Level of Care	Clinical Status	Activity	Routes	Interventions	Medications
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1	• Social Determinants of Health Assessment • OR to recovery to discharge^[P] • Discharge planning	• Hemodynamic stability • Pain absent or managed postoperatively • Nausea absent or managed postoperatively • Surgical wound without evidence of infection or dehiscence • Discharge plans and education understood	• Ambulatory or acceptable for next level of care	• IV fluids for procedure • IV medications for procedure • Oral hydration^[Q] • Oral medications or regimen acceptable for next level of care • Oral diet or acceptable for next level of care	• Possible surgical drain	• Multimodal analgesia • Antiemetics • Possible prophylactic antibiotics
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(2)(17)(18)**NN**

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: Ambulatory

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Inpatient stay (eg, need for hospital-based care beyond postoperative day 1) may be needed for(2)(21)(22):
 - Failure to meet discharge criteria (recovery milestones in Optimal Recovery Course)
 - Expect brief stay extension.
 - Selected patient factors, including:
 - Comorbidity that adversely affects anesthesia or surgery and necessitates prolonged surveillance
 - Inadequate patient support structure
 - Expect brief stay extension.

See Common Complications and Conditions [ISC](#) for further information.

Discharge

Discharge Planning

- Discharge planning includes^[R]:
 - Assessment of needs and planning for care, including(24)(25):
 - Develop and modify treatment plan (involving multiple providers) as needed.
 - Evaluate and address preadmission functioning as needed.
 - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment [SR](#) for further information.
 - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool [SR](#) for further information.
 - Evaluate and address patient or caregiver preferences as indicated.
 - Identify skilled services needed at next level of care, with specific attention to:
 - Coordination of care with outpatient center (eg, infusion, radiation, dialysis, surgery)
 - Drain management(26)
 - Pain management(27)
 - Rehabilitation therapy or equipment coordination
 - Wound or dressing management
 - Early identification of anticipated discharge destination; options include(25)(28):
 - Home; considerations include:
 - Home safety assessment. See Home Safety Assessment [SR](#) for further information.

- ☐ Patient safe to go home; examples include(29)(30)(31):
 - Medical status stable for patient's condition
 - Functional care can safely be provided with available resources.
 - Mental status stable for patient's condition
 - Medication availability confirmed and reconciliation complete
 - Patient/caregiver education completed with written discharge instructions provided
 - Community resources identified and referrals made, as needed
 - Home care arranged, if indicated
 - Necessary medical equipment delivery arranged or available in home, if indicated
 - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated
- Access to follow-up care
- Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment [SR](#) for further information.
- Caregiver need, ability, and availability
- Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool [SR](#) for further information.
- Transitions of care plan complete, including(25)(28)(32):
 - Patient and caregiver education complete.
 - See Teach-Back Tool [SR](#) for further information.
 - See Mastectomy, Complete: Patient Education for Clinicians [SR](#) for further information.
- ☐ Medication reconciliation completion includes(33)(34):
 - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
 - Assess each medication for correlation to disease state or medical condition.
 - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
 - Provide reconciled medication list to all treating providers.
 - Confirm that patient or caregiver can acquire medication.
 - Educate patient and caregiver.
 - Provide complete medication list to patient and caregiver.
 - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
 - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(35)
 - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
 - See Medication Reconciliation Tool [SR](#) for further information.
- Plan communicated to patient, caregiver, and all members of care team, including(36):
 - Inpatient care and service providers
 - Primary care provider
 - All post-discharge care and service providers
- Appointments planned or scheduled, which may include(26):
 - Primary care provider(37)
 - Chemotherapy or radiation therapy
 - General surgeon(38)
 - Oncologist
 - Plastic surgeon
 - Radiation oncologist
 - Rehabilitation therapy services
 - Specialists for management of comorbidities as needed
 - Other
- Outpatient testing and procedure plans made, which may include:
 - Other
- Referrals made for assistance or support, which may include:
 - Community services
 - Financial, for follow-up care, medication, and transportation
 - Self-help or support groups(26)(38)
 - Tobacco use treatment(39)
 - Vocational rehabilitation(40)
 - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
 - Drain care supplies
 - Lymphedema pump or compression garment(41)

- Wound care equipment and supplies(42)
- Other

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Home healthcare. See Home Care Indications for Admission Section [HC](#) in Mastectomy guideline in Home Care.
 - Recovery facility care. See Recovery Facility Care Indications for Admission Section [RFC](#) in Mastectomy guideline in Recovery Facility Care.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 9 published peer reviewed articles and 1 book section.

Specialty society guidelines recommend that men with breast cancer should have surgical treatment based on the same criteria used for women.(1) **(EG 2)**

For ductal carcinoma in situ, a specialty society guideline states that total mastectomy should be performed if adequate surgical margins cannot be obtained with partial mastectomy.(1) **(EG 2)**

For breast cancer and partial mastectomy is declined or not clinically appropriate, a general surgery textbook and a specialty society guideline state that total mastectomy is the appropriate intervention for individuals with invasive stage I, II, or IIIA breast cancer, as well as for stage IIIB and IIIC breast cancer that has responded to neoadjuvant chemotherapy, to decrease cancer-related morbidity and mortality.(1)(2) **(EG 2)** A specialty society guideline notes that complete mastectomy with or without reconstruction may be appropriate after a partial mastectomy if negative margins are not achievable by a repeat excision or breast conservation is no longer desired.(1) **(EG 2)**

For inflammatory breast cancer with response to preoperative chemotherapy, a general surgery textbook and a specialty society guideline advise total mastectomy, stating that aggressive multimodality therapy is associated with relapse-free survival rates of 50% or higher.(1)(2) **(EG 2)**

A specialty society guideline states that contralateral mastectomy (CM) should be considered in patients with genetic mutations denoting an increased risk of contralateral breast cancer, a strong family history of breast cancer, a desire for improved symmetry, or in patients with severe anxiety concerning possible future primary breast cancer diagnosis in the contralateral breast.(3) **(EG 2)**

Specialty society guidelines state that bilateral prophylactic mastectomy (BPM) should be considered in individuals with a pathogenic or likely pathogenic gene mutation resulting in high risk for breast cancer, such as BRCA1, BRCA2, Li-Fraumeni syndrome (TP53 mutation), or Cowden syndrome (PTEN mutation), a family history denoting a high lifetime risk of breast cancer, or a history of thoracic radiation therapy at younger than 30 years.(4)(5) **(EG 2)**

For Paget disease, a specialty society guideline states that mastectomy (partial or total) is an option with any manifestation of Paget disease.(1) **(EG 2)**

For phyllodes tumors, a specialty society guideline states that partial mastectomy is the preferred treatment. Total mastectomy is necessary only if negative margins cannot be obtained with partial mastectomy.(1) **(EG 2)**

For palliation of stage IV breast cancer, a specialty society guideline states that surgery is reasonable after systemic therapy for refractory symptoms, such as skin ulceration, bleeding, fungation, or pain.(1) **(EG 2)**

Hospitalization

A systematic review and meta-analysis of 13 randomized controlled trials (815 patients) comparing pectoral type 2 (Pecs II) block with systemic analgesia alone for breast cancer surgery found that Pecs II block reduced postoperative opioid consumption and acute postoperative pain at all intervals during the first 24 hours after surgery.(19) **(EG 1)** A meta-analysis of 9 randomized controlled trials (614 participants) evaluating the use of paravertebral anesthesia vs general anesthesia during breast cancer surgery found that paravertebral anesthesia resulted in a reduction in postoperative analgesia use and postoperative nausea and decreased time to ambulation.(20) **(EG 1)**

Length of Stay

Analysis of a cohort of 1380 patients (31% age 65 years or older) who underwent complete mastectomy (25% bilateral) found that 90% of patients were discharged the day of or the day after surgery.(17) **(EG 2)** Analysis of procedure data for a commercially insured

population shows 93% of patients undergoing complete mastectomy were discharged the day of or the day after surgery.(18) **(EG 3)**
 Analysis of procedure data for a Medicare-insured population shows 96% of patients undergoing complete mastectomy were discharged the day of or the day after surgery.(18) **(EG 3)**

Rationale

Use of this MCG care guideline helps the clinician identify, for a given procedure, which patient-specific factors and clinical conditions are appropriate for that procedure. The evidence-based clinical criteria assist the clinician in the decision to appropriately perform a procedure, evaluating whether the potential benefits of a procedure outweigh the potential risks. For Medicare enrollees, surgical MCG care guidelines also identify which procedures CMS has designated as inpatient only.

Use of these evidence-based clinical criteria to support decision making around the need for a given procedure is of benefit to the patient, as all procedures come with inherent risk that must be balanced by anticipated clinical benefit. Utilizing evidence-based clinical criteria enables a more accurate and patient-specific decision-making process. In addition, the use of evidence-based guidelines can help reduce unwarranted variation in care, such as divergent clinical thresholds to perform a procedure for clinically similar patients that vary across geographic regions, between facilities, and among individual clinicians.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(43); 42 CFR 419.22(44); 42 CFR 422.101(45)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(46); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(47); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(48); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(49)

Medicare Coverage Determinations: Medicare Coverage Database(50)

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Footnotes

[A] For noncancer indications for mastectomy, the General Surgery or Procedure GRG  GRG guideline is appropriate. For mastectomy in the setting of gender affirmation surgery, the Gender-Affirming Surgery or Procedure GRG  GRG guideline is appropriate. [A in Context Link 1]

[B] The American Joint Committee on Cancer system on staging incorporates T (tumor size), N (nodal status), and M (metastatic) disease status, as well as anatomic stage groups (stage 0 to stage IV).(1) [B in Context Link 1, 2]

[C] A clinical response refers to significant reduction in tumor size and nodal involvement, thus in effect "downstaging" disease.(1) [C in Context Link 1]

[D] Lobular carcinoma in situ (LCIS) is not a malignancy and therefore criteria for contralateral mastectomy do not apply.(4) LCIS and atypical hyperplasia (lobular or ductal) are discussed in reference to bilateral prophylactic mastectomy. [D in Context Link 1, 2]

[E] Contralateral mastectomy (CM) reduces the risk of subsequent diagnosis of contralateral breast cancer (ie, a new primary malignancy) by 91% to 100%.(3) However, improvement in breast cancer-specific survival or overall survival has not been clearly demonstrated.(3) Predictive models have been developed to aid in estimation of a patient's risk of contralateral breast cancer.(8)(9) Patients without a pathogenic or likely pathogenic genetic variant have been estimated to have a 10-year risk of contralateral breast cancer of 2% to 5%, with very few patients having a risk above 10%.(9) An evidence-based consensus statement from a surgical oncology society states that absent a genetic predisposition, the long-term (eg, 25 years) risk of contralateral breast cancer is 10% or lower.(3) For the majority of patients diagnosed with breast cancer, the risk of contralateral breast cancer is much lower than the risk of recurrence or morbidity from the diagnosed breast cancer.(8) Another important factor in evaluating the utility of CM is whether the patient has elevated mortality risk due to a non-breast cancer diagnosis.(3)(8)(9) An evidence-based specialty society guideline concludes that CM should be discouraged in patients with metastatic, locally advanced, or inflammatory breast cancer or with a significant competing risk of mortality other than their breast cancer (eg, other malignancy, heart disease).(3) [E in Context Link 1, 2]

[F] Evidence-based specialty society guidelines are not in complete agreement concerning which genetic mutations warrant consideration of contralateral mastectomy (CM). The American Society of Clinical Oncology (ASCO), the American Society for Radiation Oncology (ASTRO), the Society of Surgical Oncology (SSO), and the National Comprehensive Cancer Network (NCCN) do agree that patients with BRCA1, BRCA2, and TP53 mutations are appropriate for consideration of CM.(4)(5)(10) Support varies for PTEN, PALB2, and CDH1 mutations. For other mutations, these guidelines favor breast surveillance with annual MRI and mammogram.(4)(5)(10) [F in Context Link 1, 2, 3]

[G] For patients with a moderate-penetrance or low-penetrance genetic mutation, the role of contralateral mastectomy is heavily dependent on patient preference determined after careful, informed, shared decision-making.(3) [G in Context Link 1]

[H] Strong family history, in the contralateral mastectomy context (current diagnosis of breast cancer), is defined as a first-degree relative with breast cancer or multiple second-degree or third-degree relatives with breast cancer.(3) This family history is associated with a 10-year to 15-year risk of contralateral breast cancer in the range of 8% to 14%.(3) For patients with a strong family history, the

role of contralateral mastectomy is heavily dependent on patient preference determined after careful, informed, shared decision-making.(3) [H in Context Link 1]

[I] Postmastectomy breast reconstruction increases the risk of infection, pain, and other complications, and may not result in desired symmetry.(11) [I in Context Link 1]

[J] Patients with high-risk family histories (eg, multiple first-degree relatives with breast cancer, one first-degree relative and 2 or more second-degree or third-degree relatives with breast cancer) should be referred for genetic counseling and testing, with treatment decisions influenced by these results.(4)(5) National Comprehensive Cancer Network (NCCN) guidelines recommend consideration of bilateral prophylactic mastectomy (BPM) in patients with high-penetrance genetic mutations that significantly increase the risk of breast cancer.(4)(5) High-penetrance mutations include BRCA1, BRCA2, TP53, CDH1, PALB2, PTEN, and STK11.(4)(5) These guidelines also note that there is no established benefit from BPM in individuals with genetic variants of moderate or low penetrance and that these patients should be managed according to their family history (eg, degree of risk determined via application of risk assessment models that include consideration of family history).(4)(5) There is no standardized or universally agreed upon degree of risk estimated by family history that would warrant consideration of BPM. The lower bound estimate of the risk of breast cancer (by 80 years of age) in genetic mutations for which BPM is considered an appropriate option are, by way of example, 37% (CDH1), 32% (STK11), and 32% (PALB2).(5) In a similar manner, an evidence-based British breast cancer guideline considers a lifetime (up to age 80 years) risk of 30% or higher as denoting high risk.(14) For patients with a personal history of lobular carcinoma in situ (LCIS) or atypical hyperplasia (lobular or ductal), an NCCN guideline strongly recommends chemoprophylaxis (administration of a risk-reducing medication such as tamoxifen, raloxifene, or an aromatase inhibitor).(4) An evidence-based consensus statement from a surgical oncology society agrees with the above NCCN recommendations.(15) [J in Context Link 1, 2, 3, 4]

[K] An evidence-based specialty society guideline concludes that if life expectancy is less than 10 years, there is minimal, if any, benefit to risk-reduction therapy or screening.(4) One source for average life expectancy estimations is the Social Security Administration actuarial life table (www.ssa.gov/oact/STATS/table4c6.html). Life expectancy can be adjusted further by clinical assessment of overall health for a given age, specifically, if the patient is in the upper quartile of health add 50%, in the lowest quartile of health subtract 50%, and in the middle 2 quartiles of health make no adjustment. [K in Context Link 1]

[L] If tumor is not responsive (ie, does not shrink), surgery is unlikely to be of benefit.(1) [L in Context Link 1]

[M] Paget disease constitutes the detection of neoplastic cells in the epidermis of the nipple-areolar complex. Associated breast cancer is detected elsewhere in the breast in 80% to 90% of patients. When associated cancer is detected, treatment recommendations depend upon the stage of the associated cancer.(1) [M in Context Link 1]

[N] Phyllodes tumors may be benign or malignant. Partial mastectomy is the preferred surgical treatment.(1) [N in Context Link 1]

[O] An evidence-based guideline concludes that the primary treatment approach for women with metastatic breast cancer and an intact primary tumor is systemic therapy, with consideration of surgery after initial systemic treatment for individuals requiring palliation of symptoms or with impending complications, such as skin ulceration, bleeding, fungation, and pain.(1) The same guideline states that surgery should be undertaken only if complete local clearance of tumor may be obtained and if other sites of disease are not immediately threatening to life.(1) Radiation therapy may be an alternative to surgery.(1) [O in Context Link 1, 2]

[P] See Ambulatory Surgery Discharge and Complications: Common Complications and Conditions [ISC](#) for further information. [P in Context Link 1]

[Q] Some patients may have their hydration needs met via alternative means (eg, percutaneous endoscopic gastrostomy tube). [Q in Context Link 1]

[R] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(23) [R in Context Link 1]

Definitions

Ductal carcinoma in situ not appropriate for partial mastectomy

- Ductal carcinoma in situ not appropriate for partial mastectomy, as indicated by **1 or more** of the following:
 - Patient preference for mastectomy rather than breast-conserving surgery(1)
 - Contraindication to radiation therapy (eg, pregnancy)(1)
 - Diffuse suspicious or malignant-appearing microcalcifications(1)
 - Insufficient margins after excision or re-excision(1)
 - Widespread disease that cannot be incorporated by local excision of a single region or segment of breast tissue with a satisfactory cosmetic result(1)
 - Genetic predisposition to breast cancer (eg, homozygous ATM mutation, BRCA mutation, pathologic p53 mutation)(1)
 - Multicentric disease[A] and **1 or more** of the following(1):
 - Age 40 years or younger

- Receipt of neoadjuvant chemotherapy or endocrine therapy
- Triple-negative breast cancer (ER-negative, PR-negative, HER2-negative)
- More than 2 lesions involving more than 2 quadrants by MRI evaluation
- Any lesion 5 cm or larger
- Multicentric pure ductal carcinoma in situ (DCIS)
- Clinical lymph node involvement of cN2 or cN3^[B]
- Prior radiation therapy to breast or chest wall^[C](1)
- Active connective tissue disease involving the skin (eg, scleroderma or lupus)^[D](1)

References

1. Gradishar WJ, et al. Breast Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 4.2025; 2025 Apr 17 Accessed at: <https://www.nccn.org/>. [accessed 2025 Apr 28]

Footnotes

- A. Multicentric disease describes breast cancer when cancer foci develop in multiple places in different quadrants of the breast.(1)
- B. Clinical N2 (cN2) is defined as either metastases in ipsilateral level I or axillary lymph nodes that are clinically fixed or matted, or as metastases only in ipsilateral internal mammary nodes in the absence of axillary lymph node metastases.(1)
- C. Prior radiation therapy to breast or chest wall is a relative contraindication.
- D. Active connective tissue disease involving the skin is a relative contraindication.

Hemodynamic stability

- Hemodynamic stability, as indicated by **1 or more** of the following:
 - Hemodynamic abnormalities at baseline or acceptable for next level of care
 - Patient hemodynamically stable, as indicated by **ALL** of the following(1)(2):
 - Tachycardia absent
 - Hypotension absent
 - No evidence of inadequate perfusion (eg, no myocardial ischemia)
 - No other hemodynamic abnormalities (eg, no Orthostatic hypotension)

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Ramgopal S, Sepanski RJ, Martin-Gill C. Empirically derived age-based vital signs for children in the out-of-hospital setting. Annals of Emergency Medicine 2023;81(4):402-412. DOI: 10.1016/j.annemergmed.2022.09.019.

Hypotension absent

- Hypotension absent,^[A] as indicated by **1 or more** of the following:
 - Hypotension absent in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 90 mm Hg^[A](1)
 - Mean arterial pressure^[B] greater than or equal to 70 mm Hg  MAP Calculator^[A](1)(2)
 - Blood pressure at patient's baseline (eg, healthy adult with low systolic blood pressure), at intentional therapeutic goal (eg, patient with heart failure), or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)
 - Hypotension absent in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 110 mm Hg in child 13 to 17 years of age^[A](3)
 - Systolic blood pressure greater than or equal to 100 mm Hg in child 6 to 12 years of age^[A](3)
 - Systolic blood pressure greater than or equal to 95 mm Hg in child 3 to 5 years of age^[A](3)
 - Systolic blood pressure greater than or equal to 90 mm Hg in child 1 or 2 years of age^[A](3)
 - Systolic blood pressure greater than or equal to 80 mm Hg in infant 6 to 11 months of age^[A](3)
 - Systolic blood pressure greater than or equal to 70 mm Hg in infant 3 to 5 months of age^[A](3)
 - Systolic blood pressure greater than or equal to 65 mm Hg in infant 1 or 2 months of age^[A](3)
 - Blood pressure at patient's baseline (eg, healthy child with low systolic blood pressure), at intentional therapeutic goal, or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.

2. Puskarich MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
3. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.

Invasive stage I or II breast cancer not appropriate for partial mastectomy

- Invasive stage I or II breast cancer not appropriate for partial mastectomy, as indicated by **1 or more** of the following:
 - Patient preference for mastectomy rather than breast-conserving surgery(1)
 - Contraindication to radiation therapy (eg, pregnancy)(1)
 - Diffuse suspicious or malignant-appearing microcalcifications(1)
 - Insufficient margins after excision or re-excision(1)
 - Widespread disease that cannot be incorporated by local excision of a single region or segment of breast tissue with a satisfactory cosmetic result(1)
 - Inflammatory breast cancer or invasive breast cancer with extensive skin or dermal lymphatic involvement(1)
 - Genetic predisposition to breast cancer (eg, homozygous ATM mutation, BRCA mutation, pathologic p53 mutation)(1)
 - Multicentric disease[A] and **1 or more** of the following(1):
 - Age 40 years or younger
 - Receipt of neoadjuvant chemotherapy or endocrine therapy
 - Triple-negative breast cancer (ER-negative, PR-negative, HER2-negative)
 - More than 2 lesions involving more than 2 quadrants by MRI evaluation
 - Any lesion 5 cm or larger
 - Clinical lymph node involvement of cN2 or cN3[B]
 - Prior radiation therapy to breast or chest wall[C]
 - Active connective tissue disease involving the skin (eg, scleroderma or lupus)[D]

References

1. Gradishar WJ, et al. Breast Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 4.2025; 2025 Apr 17 Accessed at: <https://www.nccn.org/>. [accessed 2025 Apr 28]

Footnotes

- A. Multicentric disease describes breast cancer when cancer foci develop in multiple places in different quadrants of the breast.(1)
- B. Clinical N2 (cN2) is defined as either metastases in ipsilateral level I or axillary lymph nodes that are clinically fixed or matted, or as metastases only in ipsilateral internal mammary nodes in the absence of axillary lymph node metastases.(1)
- C. Prior radiation therapy to breast or chest wall is a relative contraindication.(1)
- D. Active connective tissue disease involving the skin is a relative contraindication.(1)

Multimodal analgesia

- Multimodal analgesia involves the utilization of 2 or more analgesic agents with different mechanisms of action in order to provide additive or synergistic pain control, while minimizing side effects and reliance on opioids.(1)(2)(3)

References

1. D'Souza RS, Johnson RL. Regional and multimodal treatments of perioperative pain. In: Benzon H, editor. Practical Management of Pain. 6th ed. Philadelphia, PA 19103-2899: Elsevier; 2023:355-373.e8.
2. George S, Johns M. Review of nonopioid multimodal analgesia for surgical and trauma patients. American Journal of Health-System Pharmacy 2020;77(24):2052-2063. DOI: 10.1093/ajhp/zxaa301.
3. Finnerup NB. Nonnarcotic methods of pain management. New England Journal of Medicine 2019;380(25):2440-2448. DOI: 10.1056/NEJMr1807061.

Orthostatic hypotension

- Orthostatic hypotension,^{[A][B]} as indicated by **1 or more** of the following⁽¹⁾⁽²⁾⁽³⁾:
 - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
 - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

1. Shibao C, Lipsitz LA, Biaggioni I, American Society of Hypertension Writing Group. Evaluation and treatment of orthostatic hypotension. *Journal of the American Society of Hypertension* 2013 Jul-Aug;7(4):317-324. DOI: 10.1016/j.jash.2013.04.006.
2. Dalal AS, Van Hare GF. Syncope. In: Kliegman RM, et al., editors. *Nelson Textbook of Pediatrics*. 22nd ed. Elsevier; 2025:592-599.
3. Fang JC, O'Gara PT. History and physical examination: an evidence-based approach. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. *Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine*. 12th ed. Elsevier; 2022:123-140.

Footnotes

- A. Concomitant measurements of the heart rate are important to measure to help diagnose subtypes of orthostatic hypotension (eg, the lack of a compensatory increase in heart rate is typical of autonomic failure and an exaggerated tachycardia may be reflective of volume depletion). However, the heart rate is not a component of the definition of orthostatic hypotension, which relies upon blood pressure alone.⁽¹⁾⁽²⁾⁽³⁾
- B. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health⁽¹⁾⁽²⁾⁽³⁾:
 - Housing insecurity, as indicated by **1 or more** of the following:
 - Individual or caregiver's current living situation is **1 or more** of the following⁽⁴⁾:
 - Does not have own housing (eg, staying in a hotel, shelter, or with others)
 - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
 - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
 - Current housing has **1 or more** of the following:
 - Electrical appliances (eg, stove, refrigerator) not working or unavailable
 - Insufficient heating or cooling
 - Insufficient ventilation
 - Lead paint or pipes
 - Mold
 - Pests (eg, bugs) or rodents
 - Smoke detectors not working or unavailable
 - Food insecurity, as indicated by **1 or more** of the following⁽⁵⁾:
 - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
 - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
 - Insufficient transportation, as indicated by **1 or more** of the following⁽⁶⁾:
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
 - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
 - Insufficient utilities, as indicated by **1 or more** of the following⁽⁷⁾:
 - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
 - In the past year, electric, water, gas, or oil company threatened to shut off services.
 - Personal safety risk, as indicated by **2 or more** of the following⁽⁵⁾:
 - Individual is sometimes or frequently physically hurt by another person (including family member).
 - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
 - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
 - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
 - Insufficient dependent care, as indicated by **1 or more** of the following:
 - In the past year, individual or caregiver was unable to work due to lack of dependent care.
 - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.

- In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
- In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
- Depression risk, as indicated by **ALL** of the following(8):
 - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
 - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

References

1. Scanlon A, Reinisch C. Social determinants of health. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:18-20.
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4. Sandel M, et al. Unstable housing and caregiver and child health in renter families. *Pediatrics* 2018;14(2):e20172199. DOI: 10.1542/peds.2017-2199.
5. Children's HealthWatch Survey. Screening Instrument [Internet] Children's HealthWatch. 2024 Feb 13 Accessed at: <https://childrenshealthwatch.org/>. [accessed 2025 Mar 31]
6. PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Screening Tool. 2.0 [Internet] Association of Asian Pacific Community Health Organizations (AAPCHO) and National Association of Community Health Centers (NACHC). 2025 Accessed at: <https://prapare.org/the-prapare-screening-tool/>. [accessed 2025 Sep 08]
7. Cook JT, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics* 2008;122(4):e867-75. DOI: 10.1542/peds.2008-0286.
8. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care* 2003;41(11):1284-92. DOI: 10.1097/01.MLR.0000093487.78664.3C.

Stage III invasive breast cancer not appropriate for partial mastectomy

- Stage III invasive breast cancer not appropriate for partial mastectomy, as indicated by **1 or more** of the following(1):
 - Patient preference for mastectomy rather than breast-conserving surgery
 - Contraindication to radiation therapy (eg, pregnancy)
 - Diffuse suspicious or malignant-appearing microcalcifications
 - Insufficient margins after excision or re-excision
 - Widespread disease that cannot be incorporated by local excision of a single region or segment of breast tissue with a satisfactory cosmetic result
 - Inflammatory breast cancer or invasive breast cancer with extensive skin or dermal lymphatic involvement
 - Genetic predisposition to breast cancer (eg, homozygous ATM mutation, BRCA mutation, pathologic p53 mutation)(1)
 - Multicentric disease^[A] and **1 or more** of the following:
 - Age 40 years or younger
 - Receipt of neoadjuvant chemotherapy or endocrine therapy
 - Triple-negative breast cancer (ER-negative, PR-negative, HER2-negative)
 - More than 2 lesions involving more than 2 quadrants by MRI evaluation
 - Any lesion 5 cm or larger
 - Clinical lymph node involvement of cN2 or cN3^[B]
 - Prior radiation therapy to breast or chest wall^[C]
 - Active connective tissue disease involving the skin (eg, scleroderma or lupus)^[D]

References

1. Gradishar WJ, et al. Breast Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 4.2025; 2025 Apr 17 Accessed at: <https://www.nccn.org/>. [accessed 2025 Apr 28]
2. Neri A, et al. "Clinical significance of multifocal and multicentric breast cancers and choice of surgical treatment: a retrospective study on a series of 1158 cases". *BMC Surgery* 2015;15(1):Online. DOI: 10.1186/1471-2482-15-1.

Footnotes

- A. Multicentric disease describes breast cancer when cancer foci develop in multiple places in different quadrants of the breast.(2)
- B. Clinical N2 (cN2) is defined as either metastases in ipsilateral level I or axillary lymph nodes that are clinically fixed or matted, or as metastases only in ipsilateral internal mammary nodes in the absence of axillary lymph node metastases.(1)
- C. Prior radiation therapy to breast or chest wall is a relative contraindication.(1)
- D. Active connective tissue disease involving the skin is a relative contraindication.(1)

Tachycardia absent

- Tachycardia[A][B] absent, as indicated by **1 or more** of the following:
 - Heart rate less than or equal to 100 beats per minute in adult[A][B](1)
 - Heart rate less than or equal to 85 beats per minute in child 13 to 17 years of age[A][B](2)
 - Heart rate less than or equal to 95 beats per minute in child 6 to 12 years of age[A][B](2)
 - Heart rate less than or equal to 110 beats per minute in child 1 to 5 years of age[A][B](2)
 - Heart rate less than or equal to 120 beats per minute in infant 3 to 11 months of age[A][B](2)
 - Heart rate less than or equal to 150 beats per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.

2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Codes

ICD-10 Diagnosis: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C50.A0, C50.A1, C50.A2, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.60, D48.61, D48.62, D49.3 [Hide]

ICD-10 Procedure: 0HTT0ZZ, 0HTU0ZZ, 0HTV0ZZ

CPT®: 19303, 19307

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