ASSOCIATION OF BREAST SURGERY, UK

ABS Position Statement on Minimally Invasive Breast Surgery (MIBS)

1. Position

ABS recognises Minimally Invasive Breast Surgery (MIBS), comprising both endoscopic and robotic-assisted technique, as an evolving surgical option for nipple-sparing mastectomy, breast-conserving surgery, axillary staging and immediate reconstruction. ABS supports its responsible, monitored introduction in the UK within a structured governance, training and consent framework, with a view to determining the appropriateness of use of these options within the NHS. ABS does not support unrestricted or unsupervised diffusion into general practice.

2. Endoscopic and Robotic Technique Are Considered Separately

Endoscopic and robotic MIBS differ materially in evidence maturity, equipment, cost and international consensus status. ABS therefore reviews the international evidence, and sets training and credentialing requirements, separately for each technique, while applying one common governance, consent and audit framework to both.

- **Endoscopic:** shorter track record in the literature outside East Asia; NICE IPG296 classifies it as research-only; learning curve stabilises from around 15 cases (Hung et al., 2017). No cost-benefit evidence available yet.
- **Robotic:** improved nipple/flap viability in several series, at higher cost and longer operative time; no dedicated NICE guidance yet exists; the US FDA has cautioned that safety/effectiveness of robotic devices specifically for mastectomy is unestablished; learning curve stabilises at approximately 20–50 cases, with international consensus (IERBS/GBCC 2024) defining expert status above 15–20 cases.

3. Training, Theatre Team, and Credentialing

The same structural principles apply to both tracks, delivered through separate endoscopic and robotic courses, training centres and registry arms:

- **Recognised course before the first case**, including simulation and cadaveric/skills-laboratory training, specific to the technique (endoscopic or robotic).
- **Whole theatre team training.** Scrub, anaesthetic and ODP staff receive dedicated, technique-specific induction and are mentored through their own early cases — safe introduction depends on the whole team, not the surgeon alone.
- **Endoscopic:**
    - **Three cases proctored, as a minimum.** An experienced, technique-specific proctor must be present in-house for the surgeon's first three cases.
- **For Robotic:**
    - This process should mirror the process used within the Trust for the introduction of robotic surgery in other specialties with regards to the training, preceptorship and governance:
        - Case observation to high volume robotic centres
        - 30 hours simulation
        - ½ day wet lab training
        - 3-5 proctored sessions with an expert

- **Endoscopic and Robotic:**
  - **Interim review at a minimum of 10 cases**, and **expert/proctor status only at a minimum of 15–20 independently performed cases**, consistent with the international robotic consensus and the endoscopic learning-curve evidence.
  - **Audit from case one**, entered prospectively into a national REDCap registry (separate endoscopic and robotic arms). This should include complication rate, oncological outcome and PROMs as well as a cost benefit assessment (including operative time). It is planned that this will be a conduit for shared learning.

4. Adoption

Because rigorous, patient selection criteria apply for MIBS for mastectomy (the only evidence-based procedure currently appropriate for MIBS: small breasts, tumour-to-nipple distance, absence of skin/NAC involvement, early-stage or risk-reducing indication), the number of patients eligible for MIBS nationally is, and at least initially will remain, small. This means during the adoption phase at least:

- Only a limited number of surgeons per region can realistically accrue enough cases to reach independent practice, and expert/proctor status, within a reasonable timeframe.
- Early caseload should be concentrated in a limited number of designated centres/surgeons, these surgeons offering proctorship to newer centres.
- Case selection for MIBS should be done through a relevant MDT with appropriate MIBS expertise

5. NHS Tariff Position

Endoscopic and robotic MIBS are reimbursed under the **same NHS HRG tariff as conventional open mastectomy** (e.g. approx. £2,440–£2,800 for a simple mastectomy; £6,700 for JA27Z simple reconstruction; £11,100 for JA28Z complex reconstruction) — there is currently no technique-specific HRG. No change in tariff income is therefore expected from adopting MIBS; the additional cost of equipment, disposables or platform use must be planned for within existing tariff income or a local investment case, and any change to this tariff position must be notified to the local Contracting and Commissioning Group. Where savings are made elsewhere in the operative pathway outside of routine practice (e.g. avoidance of placement of a mesh), this change of practice needs appropriate consent, governance and audit data collection.

6. Governance, Consent and Conversion

- Local New Interventional Procedures governance approval and MHRA-compliant device use are required before any unit offers MIBS.
- Patient selection is confirmed by the multidisciplinary team.
- A clear, pre-agreed pathway for conversion to open surgery must be maintained and explicitly consented to.
- Consent is technique-specific and explicitly addresses the current evidentiary and regulatory position, including the FDA caution for robotic devices. Patient consent must be enhanced so they are aware this is innovative and there is uncertainty around outcomes.

7. What This Means for Members

Members introducing MIBS should treat it as a new, evolving technique, be clear which track (endoscopic, robotic, or both) they are introducing, and proceed only through the governance, training and consent pathways summarised here and set out in full in the MIBS Working Group Document. ABS will keep this position under review as NICE, MHRA and international consensus guidance evolve.

ABS has established a working group to aid safe adoption of this technique for its members. This working group aim to establish:

- Training and education framework
- Governance guidance
- National audit framework
- Resource development (for local Trust approval, patient resources and staff education)
- Proposal for National Breast MIBS Research programme development

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