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This article describes the development of a breast reduction guideline. This is a major achievement, which represents the culmination of a large body of work: multiple systematic reviews, consensus building, and recommendation generation. It has the potential to provide considerable benefit if developed appropriately, and if it gains traction with its target audience.

We appreciate that breast reconstruction affects a broad group of patients, whose personal circumstances and disease factors vary. Typically, these patients are faced with a genuine choice of options that may be delivered by different clinicians within the multidisciplinary team. Key aspects of these decisions have been covered in this guideline. For some of these points, systematic reviews yielded limited evidence, or were not feasible to conduct.

The Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument provides the current standard for developing guidelines, and is used by organisations like The National Institute for Health and Care Excellence (NICE) in the United Kingdom. The development of this guideline has followed most of the AGREE II criteria, and so is considered to have good methodological quality.

AGREE II provides a framework for critical appraisal, but does not make balanced consideration redundant. For a guideline to be most beneficial, it must appropriately incorporate the views of all relevant stakeholders. These include all groups involved in the breast reconstruction system such as patients, commissioners of care, family doctors and nurses, as well as surgeons. This guideline's development group comprised five plastic surgeons, two surgical oncologists, a radiation oncologist, a radiologist, a psychologist, a

nurse, and a patient advocate group representative (who holds a doctorate – probably atypical of most patients). Besides a 7:1 surgeon to "patient" imbalance, the views of key stakeholders that a patient would encounter during breast reconstruction, such as their family doctor, are not represented at all. One can envisage how consensus development discussions might proceed in a group like this. This skew may be particularly problematic when consensus is being generated from expert opinion and without the foundation of a systematic review of evidence, as was the case for parts of this guideline.

There are two risks from this:

Firstly, that it results in a guideline that simply states what surgeons already largely agree upon, and what they already do. In contrast, a guideline that contained consensus of the breadth of patients' opinions on contentious breast reconstruction issues might be of greater benefit to both surgeons and patients.

Secondly, that it results in a guideline that struggles for credibility in the broader healthcare system. Greater representation of the views of family doctors and those responsible for commissioning healthcare across the entire system would provide a "reality check" that recommendations are realistic within the pragmatic limits of a health service that must deliver affordable care for the entire population. This might have generated novel recommendations, and might result in greater adoption and implementation of the guideline. Otherwise, recommendations risk being overly surgeon-centred.

This is not to detract from the importance of this work, but to highlight that if considerable energy is to be committed to guideline development, then it is critical that its output genuinely helps the target audience's decision-making, and that its recommendations can be translated into clinical practice. This guideline was completed in 2015 and is already due to

be updated in 2018. In addition to incorporating an update of evidence, this will be an opportunity to consider whether the next iteration could better fulfil these objectives.