Supplementary Online Content


**eFigure 1.** Surgeon Attitudes About Axillary Lymph Node Dissection as Indicated by Surgeon Response to 5 Scenarios

**eFigure 2.** Surgeon Awareness of Axillary Lymph Node Dissection Propensity

**eFigure 3.** Effect of Selected Surgeon Factors on Propensity to Recommend Axillary Lymph Node Dissection (ALND)

This supplementary material has been provided by the authors to give readers additional information about their work.
**eFigure 1.** Surgeon attitudes about axillary lymph node dissection as indicated by surgeon response to 5 scenarios.

In all scenarios, the patient was a 48-year-old clinically node-negative woman with a palpable 1.5 cm Grade 3 infiltrating ductal carcinoma, estrogen receptor positive, progesterone receptor positive, HER2 negative undergoing breast-conserving surgery and sentinel node biopsy. All scenarios were prefaced with: “In a case like this, would you recommend axillary dissection for...” Allowable responses were: “Definitely yes”; “Probably yes”; “Probably no”; and “Definitely no”.

ITC, isolated tumor cells; micromets, micrometastases; macromets, macrometastases
**eFigure 2. Surgeon awareness of axillary lymph node dissection propensity.**

Surgeon awareness was assessed by asking surgeons if they performed ALND more frequently, less frequently, or with about the same frequency as their peers in the community.

ALND, axillary lymph node dissection
**eFigure 3.** Effect of selected surgeon factors on propensity to recommend axillary lymph node dissection (ALND).

Surgeon propensity to recommend ALND scale score was modeled as a continuous variable. Covariates included in the model are shown with coefficient, lower, and upper 95% confidence intervals, and overall $P$ value.

CI, confidence interval; LA, Los Angeles; ALND, axillary lymph node dissection, Multidisc Mtg, multidisciplinary meeting.