

Priorities Forum Statement

Number	53
Subject	Cosmetic interventions for individuals with gender dysphoria or post gender reassignment surgery
Date of decision	February 2016
Date refreshed	March 2017
Date of review	February 2019

GUIDANCE

The EoE SCG policy for the commissioning and treatment of people with gender dysphoria includes the following surgical treatments:

Surgical interventions approved for female to male (FtM):

- Bilateral mastectomy/reduction mammoplasty
- Hysterectomy
- Salpingectomy
- Vaginectomy
- Oophorectomy
- Phalloplasty
- Urethroplasty
- Scrotoplasty with testicular prostheses
- Hair removal from donor sites for reconstructive surgery

Surgical interventions approved for male to female (MtF):

- Clitoroplasty
- Labiaplasty
- Orchidectomy
- Penectomy
- Vaginoplasty
- Hair removal from donor sites for reconstructive surgery

The EoE SCG policy states that the following surgical procedures are NOT included:

“Other surgical procedures that may be funded by approval by PCT exceptional cases panel:

- Augmentation mammoplasty
- Hair removal where hormones do not work”

“Surgical procedures that will not be routinely funded are:

- Chondroplasty (larynx reshaping)
- Crico-thyroid approximation surgery (to raise vocal pitch)

- Rhinoplasty
- Jaw reduction
- Waist liposuction”

The EoE document notes the poor quality evidence regarding the efficacy and safety of treatment for gender dysphoria and the absence of NICE guidance. It does not provide clear direction for the treatment of patients with gender dysphoria after gender reassignment surgery (GRS), also commonly referred to as sex reassignment surgery (SRS).

Increasingly patients who have received GRS are requesting further treatment to ‘complete’ their phenotypic gender transition, which is resulting in appeals to PCT exceptions committees. In light of this a systematic literature review was conducted to answer the following question: What is appropriate cosmetic treatment following gender reassignment surgery? The rationale to this question was that where a patient has had GRS they should be treated as any other individual of their (adopted) gender with regard to eligibility to interventions for aesthetic non-clinical reasons. In addition to the literature identified in the review the following statements were made with consideration of the four ethical principles of beneficence, non-maleficence, justice (equity) and autonomy.

Main points in answer to “What is appropriate cosmetic treatment following gender reassignment surgery”?

- a. No directly relevant evidence was found regarding the question of what cosmetic treatment might be appropriate following GRS apart from the provision of phono surgery by the London policy document¹.
- b. A ‘cosmetic’ intervention might be equitably provided to a person who has had gender reassignment surgery if NOT providing the treatment undermines the person’s gender identity including their ability to function socially and be accepted as their adopted gender, rather than merely fulfilling a desire to improve ones appearance². Generally this will only be for characteristics outside the normal range for the persons adopted gender². (Statement level D, appendix)
- c. Points a and b (above) are dependent on the individuals making fully informed choices regarding the risks and implications of the procedures and the likelihood that their expectations will be realised (i.e. autonomy and non-maleficence).

All requests will therefore be considered only by PCT individual funding panels, and they will take these points into consideration in their deliberations.

References

1. *London gender dysphoria consortium criteria for approved procedures (final draft)*
2. *De Vries ALC, Doreleijers TAH, Cohen-Kettenis PT. Disorders of sex development and gender identity outcome in adolescence and adulthood: understanding gender identity development and its clinical implications. Paediatric Endocrinology Reviews, 2007; 4: 343-351.*

Other references:

3. *GIRES. Guidance for GPs, other clinicians and health professionals on the care of gender variant people. DOH 2008.*
4. *SUFFOLK PCT Low Priority Treatment PE23. Treatment of gender dysphoria December 2006*
5. *Thompson S. 2008. Gender Dysphoria COMMISSIONING POLICY. Health Commission*

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6. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 5th edn. Oxford University Press, 2001. ISBN 0-19-514332-9
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8. Mate-Kole C, Freschi M, Robin A. A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *British Journal of Psychiatry*, 1990; **157**:261-264.
9. Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR. Current management of male-to-female gender identity disorder in the UK. *Postgraduate Medicine Journal*, 2007; **83**: 638-642.
10. Wylie K, Hainsworth K, Ryles S. The support needs of people awaiting a primary assessment at a UK gender reassignment programme. *International Journal of Transgenderism*, 2007; **10**:91-97.
11. Lavin M. Mutilation, deception, and sex changes. *Journal of Medical Ethics*, 1987; **13**: 86-91.
12. Mason N. The transsexual dilemma: being a transsexual. *Journal of Medical Ethics*, 1980; **6**: 85-89.
13. Cohen-Kettenis PT, de Waal D, Gooren LJG. The Treatment of Adolescent Transsexuals: Changing Insights. *Journal of Sexual Medicine*, 2008; **8**: 1892-1897.
14. Levine B, Solomon A. Meanings and political implications of "psychopathology" in a gender identity clinic: a report of 10 cases. *Journal of Sex & Marital Therapy*, 2009; **35**: 40-57.
15. Lev AI. Disordering Gender Identity: Gender Identity Disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality*, 2005; **17**: 35-69.

Human Rights and Equalities Legislation has been considered in the formation of this guidance.

Appendix

KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS As used by Scottish Intercollegiate Guidelines Network (SIGN)

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|-----------------|---|
| 1 ⁺⁺ | High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias |
| 1 ⁺ | Well conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias |
| 1 ⁻ | Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias |
| 2 ⁺⁺ | High quality systematic reviews of case control or cohort studies
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal |
| 2 ⁺ | Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal |
| 2 ⁻ | Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal |

3 Non-analytic studies, e.g. case report, case series

4 Expert opinion

GRADES OF RECOMMENDATION

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A At least one meta-analyses, systematic review of RCTs, or RCT rated as 1⁺⁺ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1⁺, directly applicable to the target population, and demonstrating overall consistency of results

B A body of evidence including studies rated as 2⁺⁺, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1⁺⁺ or 1⁺

C A body of evidence including studies rated as 2⁺, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2⁺⁺

D Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2⁺