NHS
East and North Hertfordshire
Clinical Commissioning Group

Priorities Forum Statement

Number	**2**
Subject	**Cosmetic breast surgery**
Date of decision	**February 2017**
Date refreshed	**March 2017**
Date of review	**February 2020**

GUIDANCE

This guidance does not apply to cancer/breast reconstruction relating to cancer treatment.

This guidance applies to those over 18 years; cosmetic breast surgery will not normally be considered for those under 18. The guidance covers breast augmentation (including replacement of implants), mastopexy and breast reduction. Photographic evidence may be required to demonstrate the case that the patient meets criteria or to demonstrate exceptionality.

Cosmetic breast augmentation

Breast augmentation for small breasts and augmentation or corrective surgery for asymmetry are considered low priority and therefore not generally funded unless there is congenital absence[1].

In the case of very significant asymmetry e.g. as a result of Poland's syndrome, patients will be considered on an individual basis via the individual funding requests process.

Breast reduction

Applications for funding as an exception to the policy will normally only be considered in patients in whom the following apply:

- The individual patient's breast development is considered to be complete **AND**
- Where the BMI is stable below 27kg/m2 for at least 12 months prior to referral **AND**
- Bra cup size of greater than GG **AND**
- Where medically documented evidence of a clinically significant history of back, neck or shoulder pain, which has not resolved despite documented treatment(s), has been provided; **OR**
- Medically documented evidence of a clinically significant history of intertrigo or

[1] ***Absence of the breast:*** *A rare condition wherein the normal growth of the breast or nipple never takes place. They are congenitally absent. There is no sign whatsoever of the breast tissue, areola or nipple. There is nothing there. NB Absence of the breast, also called amastia, is frequently not an isolated problem. Unilateral amastia (amastia just on one side) is often associated with absence of the pectoral muscles (the muscles of the front of the chest). Bilateral amastia (with absence of both breasts) is associated in 40% of cases with multiple congenital anomalies involving other parts of the body as well.*

ulceration which has not responded to treatment.

Please note the above are not criteria for funding. However if these criteria are not met it is unlikely that a clinician could sustainably argue that an individual had an exceptional capacity to benefit from breast reduction.

Mastopexy (breast lift)

Not usually funded.

The replacement of prosthetic (artificial) breast implants relating to cosmetic breast enlargement

There is generally no right to routine removal and replacement of an implant within the NHS, whether or not the original surgery was carried out in either the private sector or the NHS.

Most breast implants are undertaken in the private sector. The Department of Health advises patients contemplating private surgery that breast implants are considered a long-term commitment. They do not come with a lifetime guarantee and are likely to need replacing with consequent further surgery and expense.

A young woman who has implants may expect to have further operations in her lifetime to maintain the beneficial effects of the implants. Therefore any implant surgery started privately will be expected to continue privately for consequent surgery unless an exceptional clinical reason can be supported. Should the surgeon who performed the original surgery not be available if additional treatment is required, the NHS will generally only fund removal of the implant for significant clinical reasons and replacements are not funded. If the original operation was performed by the NHS, then implant replacements after removal would usually only be funded if there are significant clinical reasons for removal (such as leakage with pain).

In the case of PIP implants, removal would be supported if, informed by an assessment of clinical need, risk or the impact of unresolved concerns, a woman with her doctor decides that is is right to do so. The NHS will replace the implants if the original operation was done by the NHS [see the accompanying CMO letter re PIP Implants].

Requests for MRI scans to detect ruptures will be undertaken within the NHS at the surgeon's discretion, but usually only when the patient has significant symptoms normally associated with rupture.

Where there is a potential for conflict of interest, for example, where the surgeon performed the original operation privately, then these patients should be referred to another NHS surgeon for opinion (except where in the acute situation this is not possible).

Male breast reduction

This procedure is not available on cosmetic grounds. An exception may be made when:

- Patient is at least 20 years of age (or demonstrated to be 2+ years post pubertal); **AND**
- Grade 3 and 4 gynaecomastis on Rohrich classification, where at least 100g of breast tissue could be surgically removed on each affected side, and there is associated ptosis; **AND**
- The patient's BMI is 25 or less; **AND**

- Underlying aetiologies have been investigated and managed – including an endocrine screen (see notes below)

Notes

1. If there is a possible aetiology noted in the patient's history, an attempt should be made to either discontinue the drug believed to be causing the gynecomastia or correct the systemic condition. If an abnormality is found on physical examination, work-up is indicated prior to consideration of surgery for the gynecomastia. If the underlying condition is treated and the gynaecomastia persists beyond 1 year, surgical correction can be considered[i] (for those that meet the criteria above)
2. There is insufficient evidence that surgery is superior to conservative measures for the management of pain; funding would not normally be approved for this indication.

Management of Psychological Issues

The NICE clinical guideline on BDD(obsessive compulsive disorder; clinical guideline 31; National Institute for Health and Clinical Excellence) states that for people known to be at higher risk of BDD or people with mild disfigurements or blemishes who are seeking a cosmetic procedure, ALL healthcare professionals should routinely consider and explore the possibility of BDD.

Therefore clinicians seeing a patient who requests cosmetic surgery should perform a BDD triage as per NICE guidance (Clinical Guideline 31: Obsessive compulsive disorder and body dysmorphic disorder. Full guideline section 10.4.2.2; page 230) and those with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific expertise in the management of BDD (section 10.4.2.3).

Patients' whose desire for surgery reflects serious psychopathological disorders (such as Body Dysmorphic Disorder (BDD), or irredeemable relationship problems would not normally be suitable for surgery, but should receive appropriate alternative treatment and support.

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

[i] *Rohrich RJ, Ha RY, Kenkel JM, Adams WP. Classification and management of gynecomastia: defining the role of ultrasound-assisted liposuction. Plast Reconstr Surg. 2003;111:909*