GUIDANCE
This guidance lists procedures that are judged to be cosmetic and will not normally be funded by the NHS. (*Cosmetic* surgery means procedures to improve appearance. It is also known as *aesthetic* surgery). Conditions resulting from trauma, burns or problems resulting from medical treatment, which need plastic surgery (surgery to reconstruct or improve the appearance after injury or illness), will usually be funded by the NHS.

The following patients should not be referred or treated, except under the circumstances indicated where the doctor responsible for their care will make a decision about the need for surgery in the light of severity of the condition and clinical priority.

Where there are exceptional individual circumstances, which are considered to override exclusions, a decision will usually be reached through a discussion between the referring GP, the CCG and the specialist clinician involved. The GP should provide supporting evidence to justify consideration and the PCT is also available to advise in individual cases.

This guidance applies to cosmetic surgery irrespective of the sub specialty of the surgeon concerned, including plastic surgery, ear nose and throat surgery, oral and maxillofacial surgery, dermatology, primary care practitioner and other surgical sub specialties.

Patients who smoke should be encouraged to stop smoking at least 8 weeks before surgery to reduce the risk of surgery and the risk of complications.

**Cosmetic guidance applies to those over 18 years and will not normally be considered for those under 18 unless specified.**

*Photographic evidence may be required to demonstrate the case that the patient meets the criteria.*

**Procedure List which should not be referred or treated:**

- **Abdominoplasty / Apronectomy (tummy tuck).**
  See guidance number 68 – removal of excess skin/ body contouring.

- **Abnormally placed hair and hirsutism**

  Laser hair depilation will **only** be considered for in the following circumstances:
- An underlying congenital abnormality leading to abnormally placed hair
- Patients with an endocrine condition leading to abnormally placed hair (this excludes polycystic ovarian syndrome- see below).
- Excess/Abnormally placed hairs due to surgical reconstruction
- To prevent recurrence of pilonidal sinus in patients who have previous episodes
- For Gender reassignment please see Gender Dysphoria, policy 53.
- Patients with Polycystic Ovarian Syndrome must satisfy the following:
  - Diagnosed in accordance with the Rotterdam criteria
  - If obese (BMI >30) must have lost 7-10% of their body weight
  - Usually this would only be funded for facial hair
  - Only one course of sessions will be funded
  - Who have substantial excess hair growth which is suitable for laser hair removal
  - Unsuccessful cosmetic management (Shaving/Waxing/Bleaching)

In cases of gender reassignment, please see policy number 53.

- Bat / prominent ears.
  Except for children less than 16 years.

- Benign skin lesions (for example: Epidermoid (“Sebaceous”) cyst, Lipoma, Skin tags, Seborrhoeic Keratoses, benign Naevi)
  Except where there is diagnostic uncertainty, a functional impairment due to the lesion (such as pain or interference with shaving or dressing), recurrent infection or discharge, suspicion of malignancy or significant psychological distress, perhaps due to the location and the size of the lesion.

If a GP is uncertain of diagnosis the patient should be referred for further assessment to an appropriate specialist.

Patients with precancerous Squamous Cell Carcinoma (SCC) skin lesions:

Precancerous skin lesions such as actinic/solar keratoses or in situ SCC of skin (Bowen’s disease) are common, and based on NICE skin tumour IOG 2006 GP may treat these using one of the recognised treatments (eg cryotherapy, topical drug treatments, curettage and cautery). The patient may be referred to an appropriate specialist.

Based on NICE guidelines: Improving outcomes for people with skin tumours including melanoma (update) 2010, GPs (who have fulfilled the requirements of the low-risk BCC accreditation process arranged by the respective PCT) can undertake removal of low-risk BCC within the framework of the DES and LES under General or Personal Medical Services when following criteria are met:

There is no diagnostic uncertainty that the lesion is a primary nodular low-risk BCC and

  - The patient is not:
    Aged 24 years or younger (that is, a child or young adult) immunosuppressed or has Gorlin’s syndrome
  - The lesion:
Is located below the clavicle (this is, not on the head or neck) is less than 1cm diameter with clearly defined margins, is not a recurrent BCC following incomplete excision, is not a persistent BCC that has been incompletely excised according to histology, is not morphoeic, infiltrative or basosquamous in appearance, is not located:
  - over important underlying anatomical structure (for example, major vessels or nerves)
  - in an area where primary surgical closure may be difficult (for example, digits or front of shin)
  - in an area where difficult excision may lead to a poor cosmetic result
  - at another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient.

If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the local specialist services for skin cancer.

If the lesion is thought to be a superficial BCC the GP should ensure that the patient is offered the full range of medical treatments (including for example, photodynamic therapy) and this may require referral to a member of the local specialist services for skin cancer.

• **Botulinum toxin**
  Except for treatment of specific pathological conditions (will need prior approval, and will be considered on a case by case basis).

• **Blepharoplasty (repair of drooping eyelids).**
  Except for upper lids only with proven visual field defects or for ectropion.

• **Congenital vascular abnormalities (e.g. congenital naevi and port wine stains).**
  Except for those which are in an obviously exposed area and demonstrably affecting employment prospects or schooling.

• **Repair of earlobes**
  Except for the repair of totally split earlobes as the result of direct trauma.

• **Face lift or browlift (rhtidectomy).**
  Except following facial paralysis, acne scarring supported by dermatological opinion or other pathological processes.

• **Gender dysphoria**

• **Hair loss**
  Any patients with alopecia or traumatic hair loss to be referred to a dermatologist at which point recommendations will be made for appropriate management including application for wigs which may have to be paid for in part by the patient. Hair extensions or weaves are not supported for the management of alopecia/traumatic hair loss.

• **Inverted nipples**
  Not funded
- **Labiaplasty**  
  See guidance number 65 - labiaplasty.

- **Liposuction (the removal of fat from specific areas).**  
  Except for lipodystrophies, lipomas (see criteria above), diabetes injection sites or post-traumatic disfigurement.

- **Male pattern baldness**  
  Not funded.

- **Mandibular or maxillary osteotomy – considered elsewhere.**

- **Removal of redundant fat or skin from the arm, buttock or thigh.**  
  See guidance number 68 – removal of excess skin/ body contouring.

- **Rhinoplasty (surgery to reshape the nose).**  
  Except for medical conditions, post surgical complications such as saddle nose and after recent trauma. There needs to be a convincing history of trauma within the previous two years of sufficient severity to cause the deformity. A humped or bent nose is not by itself sufficient evidence of injury. If the main complaint is of nasal obstruction then medical management may be more appropriate (topical nasal steroids in sufficient dosage for a trial period of 3 months), and if this fails it may be possible to relieve the obstruction surgically without modifying the external appearance of the nose.

- **Scar revision**  
  Except for (a) scars that interfere with function following burns/ trauma (ie not cosmetic); (b) serious scarring of the face; (c), severe post-surgical scarring; (d) as an incidental part of another procedure.

- **Skin ‘resurfacing’ or dermabrasion**  
  Not funded.

- **Tattoo removal.**  
  Except where a tattoo has been applied under duress, particularly in children less than 16 years, the tattoo is the source of an allergic phenomenon or in certain highly exceptional circumstances (e.g. a disfiguring facial tattoo involving offensive language, tattoos on exposed areas, which are demonstrably affecting employment opportunities).

- **Thread veins or telangiectasias.**  
  Not funded

- **Varicose veins**  
  See guidance number 9 – varicose veins.

- **All other procedures where the primary objective for surgery is to improve appearance will not normally be funded. Exceptional circumstances would need to be demonstrated via the Individual Funding Request process.**

**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.

The Human Rights Act has been considered in the formation of this guidance statement.