NHS
Bedfordshire
Clinical Commissioning Group

Excluded: Procedure not routinely funded

Bedfordshire, Hertfordshire, West Essex and Milton Keynes Priorities Forum statement

Number	**2**
Subject	**Cosmetic breast surgery**
Date of decision	**August 2017**
Date of refresh	**Dec 2019: NHSE EBI[1] statement for breast reduction added**
Date of review	**Dec 2022**

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 for asymmetry are considered low priority and therefore not generally funded unless there is congenital absence*.

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

NHS England Evidence Based Interventions (EBI) Statement (Jan 2019)[1]

Intervention
Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.

** Absence of the breast: A rare condition wherein the normal growth of the breast or nipple never takes places. 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.*

[1] https://www.england.nhs.uk/evidence-based-interventions/ebi-programme-guidance/

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Recommendation

The NHS will only provide breast reduction for women if all the following criteria are met:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.
- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
- Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).
- Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.
- Body mass index (BMI) is <27 and stable for at least twelve months.
- Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery.
- Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.
- Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size as measured by a specialist. The BMI needs to be to be <27 and stable for at least twelve months. Resection weights, for bilateral or unilateral (both breasts and one breast) breast reduction should be recorded for audit purposes.

This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to.

Gynaecomastia: Surgery for gynaecomastia is not normally funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.

Rationale

One systematic review and three non-randomised studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.

Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).

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).

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[2]: 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*

[2] https://www.nice.org.uk/guidance/cg31

OPCS codes:

B30% Prosthesis of breast including insertion, revision, removal, renewal of prosthesis
B31% Other plastic operations on breast, including reduction mammoplasty, augmentation mammoplasty, mastopexy, revision mammoplasty
B35.5 Plastic operations on nipple

Additional EBI References

1. An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010). Pages 13 & 14

2. Royal College of Surgeons – https://www.rcseng.ac.uk/- /media/files/rcs/library-and-publications/non-journal-publications/breastreduction--commissioning-guide.pdf

3. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. British Journal of Plastic Surgery, 56(3), 230–236.

4. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. Chiropractic & Osteopathy, 16(1), 1-7.

5. Singh KA, Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. Plast Reconstr Surg. 2012 Mar;129(3):562-70. PubMed: PM22090252

7. Strong B, Hall-Findlay EJ. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammaplasty Patients? Ann Plast Surg. 2014 Apr 10. PubMed: PM24727444

8. Valtonen JP, Setala LP, Mustonen PK, Blom M. Can the efficacy of reduction mammoplasty be predicted? The applicability and predictive value of breast-related symptoms questionnaire in measuring breast-related symptoms pre- and postoperatively. J Plast Reconstr Aesthet Surg. 2014 May;67(5):676-81. PubMed: PM24508223

9. Foreman KB, Dibble LE, Droge J, Carson R, Rockwell WB. The impact of breast reduction surgery on low-back compressive forces and function in individuals with macromastia. Plast Reconstr Surg. 2009 Nov;124(5):1393-9. PubMed: PM20009823

10. Shah R, Al-Ajam Y, Stott D, Kang N. Obesity in mammaplasty: a study of complications following breast reduction. J Plast Reconstr Aesthet Surg. 2011 Apr;64(4):508-14. doi: 10.1016/j.bjps.2010.07.001. Epub 2010 Aug 3. PubMed PMID: 20682461.

11. Oo M, Wang Z, Sakakibara T, Kasai Y. Relationship Between Brassiere Cup Size and Shoulder-Neck Pain in Women. The Open Orthopaedics Journal. 2012;6:140-142. doi:10.2174/1874325001206010140.

12. https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/

13. Plast Reconstr Surg. 2011 Nov;128(5):395e-402e. doi:10.1097/PRS.0b013e3182284c05.The impact of obesity on breast surgery complications.Chen CL(1), Shore AD, Johns R, Clark JM, Manahan M, Makary MA