NHS
Cheshire and Merseyside

Healthcare Commissioning Policy

Body Contouring and other excisions Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty)

Category 1 Intervention - Not routinely commissioned -

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Date:	**Version Number:**	**Section and Description of Change**
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1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Policy statement

3.1 Body contouring surgery for arms (brachioplasty), thighs (thighplasty) or buttock lift (gluteal augmentation) is not routinely commissioned

4. Exclusions

4.1 None

5. Rationale

5.1 Cosmetic surgery is not usually commissioned by the NHS.

5.2 Further, whilst body contouring surgery for arms, thighs and buttocks is commonly requested following massive weight loss (e.g. due to bariatric surgery), the functional and cosmetic gains for these procedures are generally thought to be much less compared to patients seeking abdominoplasty or similar operations.

6. Underpinning evidence

6.1 The general topic of body contouring surgery is discussed in the British Association of Plastic Reconstructive and Aesthetic Surgeons' UK commissioning guide (2017).[1] The guide was motivated by the drive to tackle obesity with increasing numbers of patients with massive weight loss and skin redundancy which has led to deformities of loose, drooping skin envelopes and residual adiposities with resultant contour irregularities. The redundant skin may lead to both physical and psychological problems. The Association lists general inclusion criteria for body contouring surgery which includes a starting BMI above 40 kg/m² (or above 35 kg/m² with comorbidities) and a current BMI of <30 kg/m² (stable for 12 months) with significant functional disturbance (both physical and psychological).

6.2 More specifically, the NHS Modernisation Agency (2005) covered all aspects of aesthetic surgery which included (amongst many others) body contouring procedures.[2] Buttock, thigh and arm lift should only be commissioned in exceptional circumstances. The rationale was that the functional disturbance of skin excess in these sites is much less than more radical surgery e.g. abdominoplasty and so it shouldn't be available on the NHS. Strangely, perhaps, there are currently no generally accepted reliable instruments for assessing skin laxity on the thighs or buttocks.[3]

6.3 **Brachioplasty** (also known as arm lift) involves removal of the tissue excess from the armpit to elbow. It may improve symptoms related to the excess skin such as rashes, blistering, irritation and may even improve mobility by removing the heavy hanging tissue.[4] Patients seeking this procedure may be distressed due to the large segment of "batwing like" lax tissue extending on the upper arm. Brachioplasty is often performed 2 – 3 years after bariatric surgery but other causes are senile elastosis and massive weight loss due to simple diet and exercise.[5] The surgery itself involves dealing with the skin redundancy and lipodystrophy or a combination of both.[6] Several methods are available to accomplish good arm contouring but there is no consensus about the best technique.[7]

6.4 Complication rates related to brachioplasty have variously been reported. In a study of 1065 patients, the overall complication rate was 28.9%. Of these, the most frequent complications were hypertrophic scarring, seroma and haematoma. Surgical revision rates ranged from 0 to 21% and nerve damage occurred in 16/1065 (1.5%) of patients.[5] The medial ante-brachial cutaneous nerve is the most common nerve injury.[8] In a much smaller study (n = 62), other complications included wound dehiscence (3.2%) and hypertrophic scarring (1.6%).[6] However, more refined techniques such as combining liposuction with a more superficial excision decreases the risk to underlying nerves and lymphatics as well as reduction of post-operative oedema.[9,10] A much larger cohort study (n = 2294 patients) concluded that complication rates from brachioplasty were much lower than previously reported. The major complications were infection (1.7%) and haematoma (1.1%).[11]

6.5 **Thigh lift** or thighplasty commonly involves removal of excess tissue from the upper inner thighs to the groin.[4] The goal is to reshape the inner thighs to improve mobility and aesthetic appearance.[12] Minor complications have been reported to occur in up to 42.5% of cases following medial thighplasty after massive weight loss although this technique is acknowledged to carry a higher complication rate than either brachioplasty or abdominoplasty.[12] It also seems that the complication rate may depend on the specific technique used by the surgeon.[13]

6.6 **Buttock lift** or gluteal augmentation has become very popular over the last few decades especially in Central and South America. When combined with fat grafting, this is commonly known as the "Brazilian buttock lift" and in the USA, the number of procedures is said to have doubled from 2014 to 2018. However, there are reports of high morbidity and mortality associated with this procedure.[14]

6.7 In summary, body contouring surgery for arms, thighs and buttocks is most commonly requested following massive weight loss (after bariatric surgery or extensive dieting) or due to senile elastosis. It is generally thought that the functional and cosmetic impact of the drooping skin is significantly less in these areas compared to patients, for example, seeking abdominoplasty or similar operations. For this reason, these procedures shouldn't be available on the NHS. In addition, the overall complication rates are higher than other cosmetic procedures. Therefore, it is not unreasonable to infer that the higher complication rate and low potential to benefit further tips this suite of body contouring procedures against routine NHS commissioning.

7. References

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8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

9. Coding

9.1 **Office of Population Censuses and Surveys (OPCS)**
Any in primary position
S03.1 Buttock lift
S03.2 Thigh lift
S03.3 Excision of redundant skin or fat of arm

S03.8 Other specified plastic excision of skin of other site
S03.9 Unspecified plastic excision of skin of other site

9.2 **International classification of diseases (ICD-10)**
With or without
Z42.2 Follow-up care involving plastic surgery of other parts of trunk
Z42.3 Follow-up care involving plastic surgery of upper extremity
Z42.4 Follow-up care involving plastic surgery of lower extremity
Z42.8 Follow-up care involving plastic surgery of other body part
Z42.9 Follow-up care involving plastic surgery, unspecified

10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.