NHS Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin099
Abdominoplasty or Apronectomy (tummy tuck)

Category 2 Intervention - Only routinely commissioned when specific criteria are met

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Last Reviewed: March 2024

This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Apronectomy or abdominoplasty are not routinely commissioned unless ALL the following criteria are met:

- Patient is aged 18 years or above
  AND
- The current BMI has remained stable for at least 12 months and is <30 kg/m^2
  AND
- The previous BMI was >40 kg/m^2 (or >35 kg/m^2 with comorbidities)
  AND
- There is no previous diagnosis of body dysmorphic disorder
  AND
- Patient is a non-smoker and there are no ongoing alcohol or drug misuse problems
  AND
- There is inflammation and/or infection of the skin folds (intertrigo) with breakdown of the integrity of the skin. *This will be demonstrated by evidence of cellulitis, skin ulceration, abscesses, lymphoedema, skin necrosis or equivalent which have been a clinically chronic* problem despite compliance with nonsurgical treatment (e.g. meticulous skin hygiene; dressings; clothing that minimizes skin fold contact; topical antifungal agents, antibiotics or corticosteroids as clinically appropriate).*

1.2 Apronectomy alone will be commissioned if the patient fulfils ALL of the criteria in (1.1 above) but is unable to slim down to a BMI of <30 kg/m^2 **AND**

- The current BMI is not >40 kg/m^2 and has remained stable for at least 12 months
  AND
- Either the current BMI is 30.0 – 35.0 kg/m^2 **OR** the current BMI is 35.1 – 40.0 kg/m^2 and the patient has lost 75% of the excess** body weight.

* "Chronic" is usually defined as a period of not less than 3 months.
** Excess weight = change of BMI relative to a maximum normal BMI of 25kg/m^2 [Calculation is: 100 x (Pre-op BMI – Current BMI) / 25]

1.3 Exclusion - Patients' suffering from problems associated with poorly fitting stoma bags are outside of this policy.

2. Core Eligibility Criteria

2.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

2.2 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 expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme. https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

3. Rationale behind the policy statement

3.1 The British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), in 2017, developed guidelines which stated that body contouring surgery can be appropriate for some medical reasons. BAPRAS deliberately chose their inclusion/exclusion criteria to reduce post-operative complications (mostly wound related) and thus maximise both safety and effectiveness of the operation.

3.2 The specified criteria for this policy have been developed according to BAPRAS and other published evidence. In addition, the views of local bariatric and plastic surgeons were also considered.

3.3 Crucially, a maximum BMI of 30 kg/m^2 has been specified for most patients. This is purely clinically driven, and it is intended to reduce the known surgical risks associated with higher BMI values.

4. Summary of evidence review and references

4.1 In 2014, NICE published its clinical guideline on obesity. This recommended bariatric surgery as a treatment option for people with obesity of a specified body mass index (BMI). [1] With the increase in bariatric surgery procedures, there has been an increased demand for body contouring surgery to manage the complex problems associated with redundant skin and abnormal body contours.[2]

4.2 Patients with massive weight loss who typically present with this skin redundancy frequently have enormous aesthetic, physical, medical and psychological associated problems.[3] These may be manifested as problems with mobility, decreased activity, body image dissatisfaction and depression. The skin itself can cause physical discomfort, lost work days/productivity and concerns about quality-of-life.[4]

4.3 In order to deal with the excess skin, there are 2 main surgical procedures. *Apronectomy* (sometimes called *panniculectomy*) removes the excess hanging skin and fat over the lower abdomen. This is a relatively simple but largely functional operation with little improvement in the abdominal appearance. The 2nd option is *abdominoplasty* which is more extensive and again involves removal of the excess skin but may also include removal of additional fat in other parts of the abdomen and correction of weakened muscles if required.[5] This is widely considered to be a cosmetic rather than functional procedure.

4.4 “Massive weight loss” is defined as a loss of 50% or more of excess body weight.[4] In addition to the above, significant functional disturbance may include infections, disability, time in hospital, (unpleasant) smell, excoriation, severe intertrigo, evidence of significant interference with activities of daily life, ulceration and depression.

4.5 Although there is a paucity of data regarding the true rate of body contouring following bariatric procedures, a large study in New York (over 37,000 patients) determined that only 6% of patients who had undergone bariatric surgery received abdominoplasty or panniculectomy.[6] Whilst 70% of bariatric patients seek body contouring (in the USA), the restriction on the number of people who eventually do receive body contouring is thought to be due to lack of insurance cover.[7] The excess skin is not perceived by insurance companies to be a disease.

4.6 The prevalence of post-operative body-contouring complications has variously been reported as 20%[8] , 29%[9] , 32.5%[10] and 41.9%[11]. The complications have included post-operative bleeding (4.8%), seroma (4.8%), infection (11.5%)[8] and wound dehiscence or ischaemia (1.9%)[3,8]. A systematic review[12] found that local complications are considerably more common than systemic ones and these were defined as seroma (15.4%), haematoma (2%), infection (1% – 3.8%), skin necrosis (3 – 4.4%), suture extrusions, hypertrophic scars, neurological symptoms, umbilical abnormalities, DVT and PE (0.3% – 1.1%), respiratory distress and death (0.04% – 0.16%).

4.7 The preoperative risk factors for these complications have also been described. These include:-high BMI (on initial diagnosis of obesity and preoperatively)[10,11,13], age[11], large resection weight[9,11,13], interval between bariatric and body contouring surgery (the sooner the better)[9], male gender[9], type 2 diabetes [9] and smoking[9]. The major risk is that of reduced wound healing.

4.8 In 2005, the NHS Modernisation Agency, in its document, “Action on plastic surgery” produced referrals and guidelines on plastic surgery.[14] This advised on explicit criteria for referral and treatment inclusion thresholds and trigger points within service level agreements and contracts. The guidance had been developed by a multi-professional group and reviewed existing policies across the NHS, taking into account any available evidence of effectiveness and outcome for individual procedures. When no robust evidence was available, the guidance represented the consensus view at that time.

4.9 Although *Action on plastic surgery* (AOPS) covered a wide variety of procedures, the guidance contained specific recommendations for “tummy tuck” (apronectomy or abdominoplasty). Either abdominoplasty or apronectomy should be offered to patients with a stable BMI between 18 – 27 kg/m² and with severe functional problems. These were defined as recurrent intertrigo between the skinfold, severe difficulties with daily living (ambulatory restrictions), post-traumatic or surgical scarring which have led to poor appearance resulting in disabling psychological distress or risk of infection and problems associated with poorly fitting stoma bags. In addition, patients should be undergoing treatment for morbid obesity and have excessive skin folds or be previously obese and have achieved a significant weight loss which has been maintained for at least 2 years.

4.10 Several years later (2009), a national audit of the then 149 Primary Care Trusts (PCTs) examined how AOPS was being implemented across the NHS.[15] This survey showed that guidelines varied widely with some PCTs refusing all procedures and others allowing the full range. In general, different, and sometimes contradictory rules governing symptoms, BMI, weights, heights, and other criteria were used. Regarding abdominoplasty specifically, there was wide variation with several factors, and these included the value of the “stable” BMI, requirement for functional problems, the time period for weight stability and whether smokers were excluded. Overall, the authors concluded that a “postcode lottery” existed in the UK despite national guidelines.

4.11 Currently, the most up-to-date (and relevant) guidance is provided by the British Association of Plastic Reconstructive and Aesthetic Surgeons' (BAPRAS) guideline on massive weight loss body contouring (2017).[4] Under the auspices of the Royal College of Surgeons, the guide was produced by a multidisciplinary panel of plastic surgeons, patients, psychologists, GP and bariatric surgeons. This guidance was originally published in 2014.[16]

4.12 The baseline inclusion criteria are the same as NICE's bariatric surgery guidance i.e. a starting BMI above 40 kg/m² (or above 35 kg/m² with comorbidities). However, for surgery to proceed, BAPRAS specify the current BMI must be <30 kg/m² (and stable for 12 months) with significant functional disturbance (both physical and psychological). Patients who are unable to slim down to a current BMI of <30 kg/m² and have lost 75% excess body weight are eligible for apronectomy only as long as they fulfil the other criteria specified above. The Association confirms the maximum required stable BMI of <30 kg/m² is clinically driven to reduce surgical risk at higher BMIs.[2] Current smokers are excluded together with those with signs of body dysmorphic disorder and also those with a current history of alcohol or drug misuse.

4.13 *In summary*, massive weight loss can occur in previously overweight/obese people who have adhered to a very strict diet/exercise regimen. More commonly, the weight loss occurs secondary to bariatric surgery. The resulting flap of skin (panniculus), although unsightly, is more of a cosmetic problem rather than a medical one. However, in a small number of cases, the excess skin can cause functional problems such as infection, intertrigo, ulceration, depression and potentially, significant interference with activities of daily life.

4.14 Removal of the skin is achieved through body contouring surgery which principally involves apronectomy (simple removal of the skin) or a full abdominoplasty (removal of the skin, excess fat, reshaping of the abdomen and re-tightening of the muscles). The former is regarded as a functional procedure and the latter is cosmetic.

4.15 The British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), in 2017, constructed guidelines where body contouring surgery is appropriate for medical reasons. BAPRAS deliberately chose the inclusion/exclusion criteria to reduce post-operative complications (mostly wound related) and thus maximise the effectiveness of the operation. The evidence-based criteria include initial and preoperative BMIs, psychological disorders and lifestyle factors.

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15. Henderson J. The plastic surgery postcode lottery in England. *International Journal of Surgery* 2009;**7**(6):550-58.
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5. Advice and Guidance

5.1 Aim and Objectives

- 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.

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

- 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.

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

- 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.

- Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms ‘men’ and ‘women’ are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

5.2 Core Principles

- 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.

5.3 Individual Funding Requests (Clinical Exceptionality Funding)

- 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 available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

5.4 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

5.5 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.

5.6 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.

6. Monitoring and Review

6.1 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.

6.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

6.3 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

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

7. Quality and Equality Analysis

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

8. Clinical Coding

OPCS-4 Procedure Codes

S02.1 Abdominoplasty
S02.2 Abdominolipectomy
S02.8 Other specified plastic excision of skin of abdominal wall
S02.9 Unspecified plastic excision of skin of abdominal wall

ICD-10 diagnosis code(s)

Z42.2 Follow-up care involving plastic surgery of other parts of trunk
Z41.1 Other plastic surgery for unacceptable cosmetic appearance

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