NHS
Modernisation Agency
Action On Plastic Surgery

Information for Commissioners of Plastic Surgery Services

Referrals and Guidelines in Plastic Surgery

Introduction

Whilst most of the work of plastic surgeons in the NHS concerns the restoration of appearance and function following trauma, cancer, degenerative conditions or congenital deformity, a number of referrals are made for conditions that are considered to be of lower priority or for treatments not usually available on the NHS.

This document seeks to provide guidance on priorities for the commissioning and delivery of plastic surgery services. Within the context of "National Standards, Local Action" this document advises on explicit criteria for referral and treatment inclusion thresholds and trigger points within service level agreements and contracts. The background of NHS plastic surgery in which this guidance sits may be seen in the accompanying booklet "The Way Forward".

Commissioners are encouraged to establish a local stakeholder commissioning group that includes plastic surgeons, GP's, patient representatives and commissioners to define their local inclusion policies, monitor their implementation and review them in the light of experience and emerging clinical evidence.

This national guidance was developed by a multi-professional sub-group of the Modernisation Agency's ***Action on Plastic Surgery*** programme. The group reviewed the existing policies in place across the NHS and considered any available evidence of effectiveness and outcome for individual procedures. Where no robust evidence was available the guidance represents a consensus view.

The group established inclusion criteria for the majority of referrals to NHS plastic surgeons that might be considered to be of lower priority or for treatments not usually available. For some of the conditions covered by this guidance, patients may also be referred to other specialists such as dermatologists, ENT surgeons, breast surgeons and oral surgeons. Commissioners will wish to ensure that the same criteria are used for all such referrals, irrespective of the specialist or location, to avoid introducing inequalities of provision and the creation of alternative referral pathways to "by-pass" the local inclusion policy.

Contents

GENERAL PRINCIPLES

Commissioners of health care should establish a Local Stakeholder commissioning group (which would include, as minimum, local commissioners of services, local Plastic Surgery Specialists, referrers and patient group representatives). The forum will inform the development an inclusion policy that reflects local needs and priorities.

Commissioners, working closely with relevant Plastic Surgery specialists and primary care, should develop referral pathways that permit the application of the inclusion policy where relevant.

Decisions will be taken on relevant patient referrals made from both primary and secondary care to plastic surgery or other specialities for conditions and treatments considered by this guidance in whatever health setting they may be seen.

The Plastic Surgery specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.

Cosmetic Surgery (surgery undertaken exclusively to improve appearance) will usually be excluded from NHS provision in the absence of previous trauma, disease or congenital deformity. In exceptional circumstances and after special consideration, the local stakeholder commissioning group may allow a referral for cosmetic surgery to proceed. These exceptional circumstances should be primarily clinical e.g..

- There is a significant likelihood that the individual will gain much higher than average benefit from the treatment
- There would be additional benefit through the avoidance of social care
- There is a high likelihood that severe psychosocial dysfunction may be alleviated

Issues around personal circumstances or concepts of `worth' to society should be avoided.

Assessment of patients being considered for referral to Plastic Surgery who may have an underlying genetic, endocrine or psychosocial condition should have had this fully investigated by a relevant specialist prior to the referral to Plastic Surgery being made.

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be permitted. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment.

An appeals mechanism should be established for patients who are excluded from treatment to have such a decision independently reviewed in a timely fashion.

Clinical research into the outcomes and health benefits of lower priority procedures should continue and national guidance and local policies should be reviewed in the light of such evidence.

Psychological assessment can form an important part of the management of some patients referred for low priority procedures. Commissioners will wish to ensure that training is provided for psychologists working in this clinical area to be able to support the implementation of the local guidelines. Whilst specific training of this type is not yet available, a suitable course is being developed at University of West of England, which may be adaptable for this purpose. The establishment of a UK wide special interest group for such psychologists would provide ongoing training and peer support: a model that works well in other aspects of clinical psychology.

Information on Specific conditions or procedures

BREAST PROCEDURES

Female Breast Reduction (Reduction mammoplasty),

Breast Reduction Surgery is an effective intervention that should be available on the NHS if the following circumstances are met:

- The patient is suffering from neck ache, backache and/or intertrigo
- The wearing of a professionally fitted brassiere has not relieved the symptoms
- The patient has a body mass index (BMI) of less than 30 kg/m^2

Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or following, this assessment, there should be access to a trained bra fitter and where it is available, laser scanning of the thorax should be considered.

Rationale

Breast reduction places considerable demand on NHS resources (volume of cases and length of surgery) and yet has been shown to be a highly effective health intervention. There is published evidence showing that most women seeking breast reduction are not wearing a bra of the correct size and that a well fitted bra can sometimes alleviate the symptoms that are troubling the patient. Recent evidence has shown that not all commercial bra fitters meet the required standards and so commissioners will need to satisfy themselves that a suitable service is available.

The upper limit of normal BMI is 25 Kg/m^2. Patients seeking breast reduction have physical restrictions on their ability to exercise and additional weight in their excess breast tissue (sometimes 3-4 Kg). Major complications for surgery in general and specifically related to breast reduction surgery have been shown to be greater if the BMI exceeds 30. Despite a higher complication rate, obese patients generally benefit from breast reduction. Local policies will need to consider both these factors in setting a BMI threshold for inclusion.

Possible pathways for breast reduction patients are included in appendix A.

Male Breast Reduction for Gynaecomastia Surgery

to correct gynaecomastia is allowable if the patient is:
Post pubertal and of normal BMI (<= 25 Kg/m^2)

There should be a pathway established to ensure that appropriate screening for endocrinological and drug related causes and/or psychological distress occurs prior to consultation with a plastic surgeon.

Liposuction may form part of the treatment plan for this condition.

Rationale

Commonly gynaecomastia is seen during puberty and may correct once the post¬pubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely it may be caused by an underlying endocrine abnormality or a drug related cause including the abuse of

anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

Breast enlargement (Augmentation mammoplasty)

Will only be performed by the NHS on an exceptional basis and should not be carried out for "small" but normal breasts or for breast tissue involution (including postpartum changes). Exception should be made for women with an absence of breast tissue unilaterally or bilaterally, or in women with of a significant degree of asymmetry of breast shape and/or volume. Such situations may arise as a result of:

- Previous mastectomy or other excisional breast surgery
- Trauma to the breast during or after development
- Congenital amastia (total failure of breast development)
- Endocrine abnormalities
- Developmental asymmetry

Patients who are offered breast augmentation in the NHS should be encouraged to participate in the UK national breast implant registration system and be fully counselled regarding the risks and natural history of breast implants. It would be usual to provide patients undergoing breast augmentation with a copy of the DoH guidance booklet "Breast implants information for women considering breast implants":

It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time.

Rationale

Demand for breast enlargement for is rising in the UK. Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery (such as implant replacement) at some point in the future, is common. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

Revision of Breast Augmentation

Revisional surgery will only be considered if the NHS commissioned the original surgery.
If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.

Rationale

Prior to the development of inclusion policies such as this, a small number of patients underwent breast augmentation in the NHS for purely cosmetic reasons. There may however be clinical reasons why replacement of the implants remains an appropriate surgical intervention. For these reasons it is important that:

Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

Patients should also be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

Breast lift (Mastopexy)

This is included as part of the treatment of Breast asymmetry and reduction (see above) but not for purely cosmetic/aesthetic purposes such as post-lactational ptosis.

Rationale

Breast ptosis (droopiness) is normal with the passage of age and after pregnancy. Patients with breast asymmetry often have asymmetry of shape as well as volume and correction may require mastopexy as part of the treatment.

Nipple Inversion

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

Rationale

Idiopathic nipple inversion can often (but not always) be corrected by the application of sustained suction. Commercially available devices may be obtained from major chemists or online without prescription for use at home by the patient. Greatest success is seen if it is used correctly for up to three months.

An underlying breast cancer may cause a previously normally everted nipple to become indrawn: this must be investigated urgently.

FACIAL PROCEDURES

Face lifts and brow lifts (Rhytidectomy)

These procedures will be considered for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery
- They will not be available to treat the natural processes of ageing

Rationale

There are many changes to the face and brow as a result of ageing that may be considered normal, however there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.

Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons)

As demonstrated by:

- Impairment of visual fields in the relaxed, non-compensated state
- Clinical observation of poor eyelid function, discomfort, e.g.. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow

Rationale

Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

Surgery on the lower eyelid (Lower lid blepharoplasty)

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale

Excessive skin in the lower lid may cause "eyebags" but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form

part of the treatment of disorders of the lid or overlying skin.

Surgery to reshape the nose (Rhinoplasty)

Rhinoplasty should be available on the NHS for:

- Problems caused by obstruction of the nasal airway
- Objective nasal deformity caused by trauma
- Correction of complex congenital conditions e.g.. Cleft lip and palate

Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment.

Correction of prominent ears (Pinnaplasty l Otoplasty)

To be available on the NHS the following criteria must be met:

- The patient must be under the age of 19 years at the time of referral
- Patients seeking pinnaplasty should be seen by a plastic surgeon and following assessment, if there is any concern, assessed by a psychologist.
- Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist

Rationale

Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. The national service framework for children defines childhood as ending at 19 years. Some patients are only able to seek correction once they are in control of the own healthcare decisions. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child.

Repair of external ear lobes (lobules)

This procedure is only available on the NHS for the repair of totally split ear lobes as a result of direct trauma

Prior to surgical correction, patients should receive pre-operative advice to inform them of:

- Likely success rates
- The risk of keloid and hypertrophic scarring in this site
- The risks of further trauma with re-piercing of the ear lobule

Rationale
Many split earlobes follow the wearing of excessively heavy earrings with insufficient tissue to support them, such that the earring slowly "cheese-wires" through the lobule. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

Operations on congenital anomalies of the face and skull
Is usually available on the NHS. Some such conditions are considered highly specialised and are commissioned in the UK through NSCAG.

Rationale
The incidence of some congenital conditions affecting the cranio-facial skeleton is small and the treatment complex. It is considered that specialised teams, working in designated centres and subject to national audit, should carry out such procedures.

Correction of post traumatic bone and soft tissue deformity of the face
Is available on the NHS.

Correction of hair loss (Alopecia)
Is available on NHS when it is a result of previous surgery or trauma including burns
Correction of male pattern baldness Is excluded from treatment by the NHS

Rationale
So-called "male pattern" baldness is a normal process for many men at whatever age it occurs.

Hair transplantation
Will not be not be allowable on the NHS, regardless of gender-other than in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

BODY CONTOURING PROCEDURES

It is recognised that the consequences of morbid obesity will become an increasing problem for the NHS and that robust inclusion criteria need to be developed to ensure that appropriate patients benefit from interventions that change the body contour.

"Tummy tuck" (apronectomy or abdominoplasty)

Abdominoplasty and apronectomy may be offered to the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m^2 and be suffering from severe functional problems:

- Those with scarring following trauma or previous abdominal surgery
- Those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery

Severe Functional problems include:

- Recurrent intertrigo beneath the skin fold
- Experiencing severe difficulties with daily living i.e. Ambulatory restrictions
- Where previous post trauma or surgical scarring (Usually midline vertical, or multiple) leads to very poor appearance and results in disabling psychological distress or risk of infection
- Problems associated with poorly fitting stoma bags

Rationale

Excessive abdominal skin folds may occur following weight loss in the previously obese patient and can cause significant functional difficulty. There are many obese patients who do not meet the definition of morbid obesity (see glossary) but whose weight loss is significant enough to create these difficulties. These types of procedures, which may be combined with limited liposuction, can be used to correct scarring and other abnormalities of the anterior abdominal wall and skin. It is important that patients undergoing such procedures have achieved and maintained a stable weight so that the risks of recurrent obesity are reduced. The availability of teams specialising in the surgical treatment of the morbidly obese ("bariatric" surgery) is limited, although this may rise with the implementation of NICE guidance in this area. Many patients therefore achieve their weight loss outside such teams and should not be disadvantaged in accessing body contouring surgery if required.

Other skin excision for contour
e.g. Buttock lift, Thigh lift, Arm lift (brachioplasty)

These procedures will only be commissioned in exceptional circumstances.

Rationale

Whilst the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance: in which case it should not be available on the NHS.

Liposuction

Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g.. Multiple lipomatosis, lipodystrophies). Liposuction is sometimes an adjunct to other surgical procedures. It will not be commissioned simply to correct the distribution of fat.

SKIN AND SUBCUTANEOUS LESIONS

A patient with a skin or subcutaneous lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment.

Fatty lumps Lipomata

Lipomata of any size should be considered for treatment by the NHS in the following circumstances:

- The lipoma (-ta) is / are symptomatic
- There is functional impairment
- The lump is rapidly growing or abnormally located (e.g., sub-fascial, sub-muscular)

Viral warts

Most viral warts will clear spontaneously or following application of topical treatments.
Painful, persistent or extensive warts (particularly in the immuno-suppressed patient) may need specialist assessment, usually by a dermatologist. For a small proportion surgical removal (cryotherapy, cautery, laser or excision) may be appropriate.

Other benign skin lesions

Clinically benign skin lesions should not be removed on purely cosmetic grounds. This will include, amongst other conditions, skin tags and seborrhoeic keratoses (warts).

Patients with moderate to large lesions that cause actual facial disfigurement may benefit from surgical excision. The risks of scarring must be balanced against the appearance of the lesion.

Epidermoid or pilar cysts (commonly known as "sebaceous cysts') are always benign but some may become infected or be symptomatic. Some may require surgical excision particularly if large or located on the face or on a site where they are subjected to trauma.

Rationale

The decision to remove benign skin lesions from conspicuous sites is a balance between the appearance of the original lesion against the likely appearance of the surgical scar. It is therefore essential that the decision is made by a practitioner fully familiar with the factors affecting the outcome of surgery in these sites and that the excision is carried out by a trained practitioner using fine instruments and sutures in an appropriate surgical setting.

Xanthelasma

Patients with xanthelasma should always have their lipid profile checked before referral to a specialist.

Many xanthelasmata may be treated with topical TCA or cryotherapy. Larger lesions or those that have not responded to these treatments may benefit from surgery if the lesion is disfiguring.

Rationale
Xanthelasma (yellow fatty deposits around the eyelids) may be associated with abnormally high cholesterol levels and this should be tested for. They may be very unsightly and multiple and do not always respond to "medical" treatments. Surgery can require "blepharoplasty type" operations and/or skin grafts.

Tattoo removal
The NHS will consider removal of tattoos in the following cases:

- Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo")

- The patient was not Gillick competent, and therefore not responsible for their actions, at the time of the tattooing.

- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psycho-social function).

Rationale
Many patients seeking tattoo removal are from disadvantaged backgrounds that did not fully recognise the implications of a tattoo on subsequent employment and life opportunities. Most tattoos may be removed by a series of outpatient treatments using an appropriate laser.

Skin hypo-pigmentation
The recommended NHS suitable treatment for hypo-pigmentation is Cosmetic Camouflage. Access to a qualified camouflage beautician should be available on the NHS for this and other skin conditions requiring camouflage.

Vascular skin lesions
NHS treatment is allowed for all vascular lesions except for small benign, acquired vascular lesions such as thread veins and spider naevi.

The planning of treatment of complex major vascular malformations is best carried out in a specialised multidisciplinary team setting.

Acne vulgaris
The treatment of active acne vulgaris should be provided in primary care or through a dermatology service.

Patients with severe facial post-acne scarring can benefit from "resurfacing" and other surgical interventions, which may be available from the plastic surgery service.
(See "skin resurfacing," section).

Rhinophyma

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment

MISCELLANEOUS

Skin "resurfacing" techniques

All resurfacing techniques, including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

Botulinum toxin

Botulinum toxin has many uses within the NHS. It is available for the treatment of pathological conditions by appropriate specialists in cases such as:

- Frey's syndrome
- Blepharospasm
- Cerebral palsy
- Hyperhidrosis

Botulinum toxin is not available for the treatment of facial ageing or excessive wrinkles.

Hair depilation (hair removal)

Hair depilation will be commissioned on the NHS for patients who:

- Have undergone reconstructive surgery leading to abnormally located hair-bearing skin
- Those with a proven underlying endocrine disturbance resulting in Hirsutism (e.g. polycystic ovary syndrome)
- Are undergoing treatment for pilonidal sinuses to reduce recurrence
- Hirsutism leading to significant psychological impairment

The method of depilation (hair removal) used should be diathermy electrolysis performed by a registered electrologist or laser. Where laser services are being developed reference to the available evidence base should be made.

Gender reassignment surgery

Gender re-assignment is a highly specialised area of clinical practice and should only be considered, assessed for and carried out as part of a recognised NHS programme of care. Each case should be considered on its individual merits.

References

Bra fitting services
Which? Online review; Health and Beauty Reports
http://trial.which.co.uk/hea(th beauty.php?id=&m_id=29&pg=pf accessed 01 January 2005

Cole RP, Shakespeare V, Shakespeare P, Hobby JA.
Measuring outcome in low-priority plastic surgery patients using Quality of Life indices.
British Journal of Plastic Surgery. 47: 117-21, 1994.

Corion LU, Smeulders M], van der Horst CM.
Correctly fitted bra.
British Journal of Plastic Surgery. 57: 588-9, 2004.

Gibbs S, Harvey I, Sterling]C, Stark R.
Local treatments for cutaneous warts
The Cochrane Library, 4: 2004. Chichester, UK: John Wiley & Sons, Ltd

Greenbaum AR, Heslop T, Morris a, Dunn KW.
An investigation of the suitability of bra fit in women referred for reduction mammoplasty.
British Journal of Plastic Surgery. 56: 230-236, 2003.

Guidance on the use of surgery to aid weight reduction for people with morbid obesity
http://www.nice.org.uk/page.aspx?o=34794 Accessed 09 January 2005

Klassen A, Jenkinson C, Fitzpatrick R, Goodacre T.
Patients' health related quality of life before and after aesthetic surgery.
British Journal of Plastic Surgery. 49(7): 433-8, 1996.

Klassen A, Fitzpatrick R, Jenkinson C, Goodacre T.
Should breast reduction surgery be rationed? A comparison of the health status of patients before and after treatment: postal questionnaire survey
British Medical Journal. 313: 454-7, 1996.

Laser treatment for skin problems
Drugs and Therapeutics Bulletin. 42(10): 73-76, 2004.

National standards, local action
Health and Social Care Standards and Planning Framework.2005/6 - 2007/8.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/Publicati0nsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticIe/fs/en? CONTENT ID=4086057&chk=ypi=WoL accessed 01 January 2005

Shakespeare V, Cole RP.
Measuring patient-based outcomes in a plastic surgery service: breast reduction surgical patients.
British Journal of Plastic Surgery. 50: 242-8, 1997.

Glossary of terms

BAPRAS. British Association of Plastic, Reconstructive and Aesthetic Surgeons (formerly BAPS).

BAPS. British Association of Plastic Surgeons.

Body mass index (BMI). This is calculated from a recent, accurate height and weight measurement using the formula: weight in Kg / (height in m)^2 and that the normal range is between 18 and 25 kg/m^2. It is recognised that rarely a patient with exceptional muscle mass may exceed a BMI of 25 without being "overweight".

Childhood. Defined as being under the age of 19 years at referral.

Congenital abnormality. Any abnormality of structure, deficiency of function or disease that is present at the time of birth.

Morbid Obesity: For the purposes of this guidance, people are defined as having morbid obesity if they have a body mass index (BMI) either equal to or greater than 40 kg/m^2, or between 35 kg/m^2 and 40 kg/m^2 in the presence of significant co-morbid conditions that could be improved by weight loss.

NSCAG. National Specialist Commissioning Advisory Group.

Plastic surgeon. A consultant who is on the specialist register of the General Medical Council for plastic surgery. They will normally be a member of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS: formally BAPS).

Plastic surgery speciality. Plastic, reconstructive and aesthetic surgeons ("plastic surgeons") are members of a team of specialists from a number of clinical backgrounds. In some circumstances the plastic surgery specialist that sees a referred patient may not be the consultant surgeon but another member of the multi-professional team.

Scanner: The body scanner used to measure breast volumes produces a 3-d image using structured white light (bands of light and dark) and the analysis of digital images from a several cameras. It is done in a large photographic booth: the woman is asked to wear close fitting underwear and the photography is automatic and in privacy. In the case of breast reduction an appropriately fitted bra is required, whilst for asymmetry no bra is worn: these methods have been shown to give the most reproducible results. These images are then subjected to further processing. The volume of the torso is calculated. A 'virtual' chest wall is generated from the data and this is subtracted from the torso to obtain breast volumes.

Trauma: an injury to living tissue caused by an extrinsic agent.

Gillick competent. In the health realm, children are considered competent to make decisions on their own behalf when they are capable of understanding fully the nature of what is proposed.

A competent child's refusal should not be overridden, save in exceptional circumstances.

The decision as to whether a child is Gillick competent (Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security, House of Lords, 1985) will usually be taken by health care professionals involved in the child's care, sometimes with input from clinical psychologists, teachers etc.

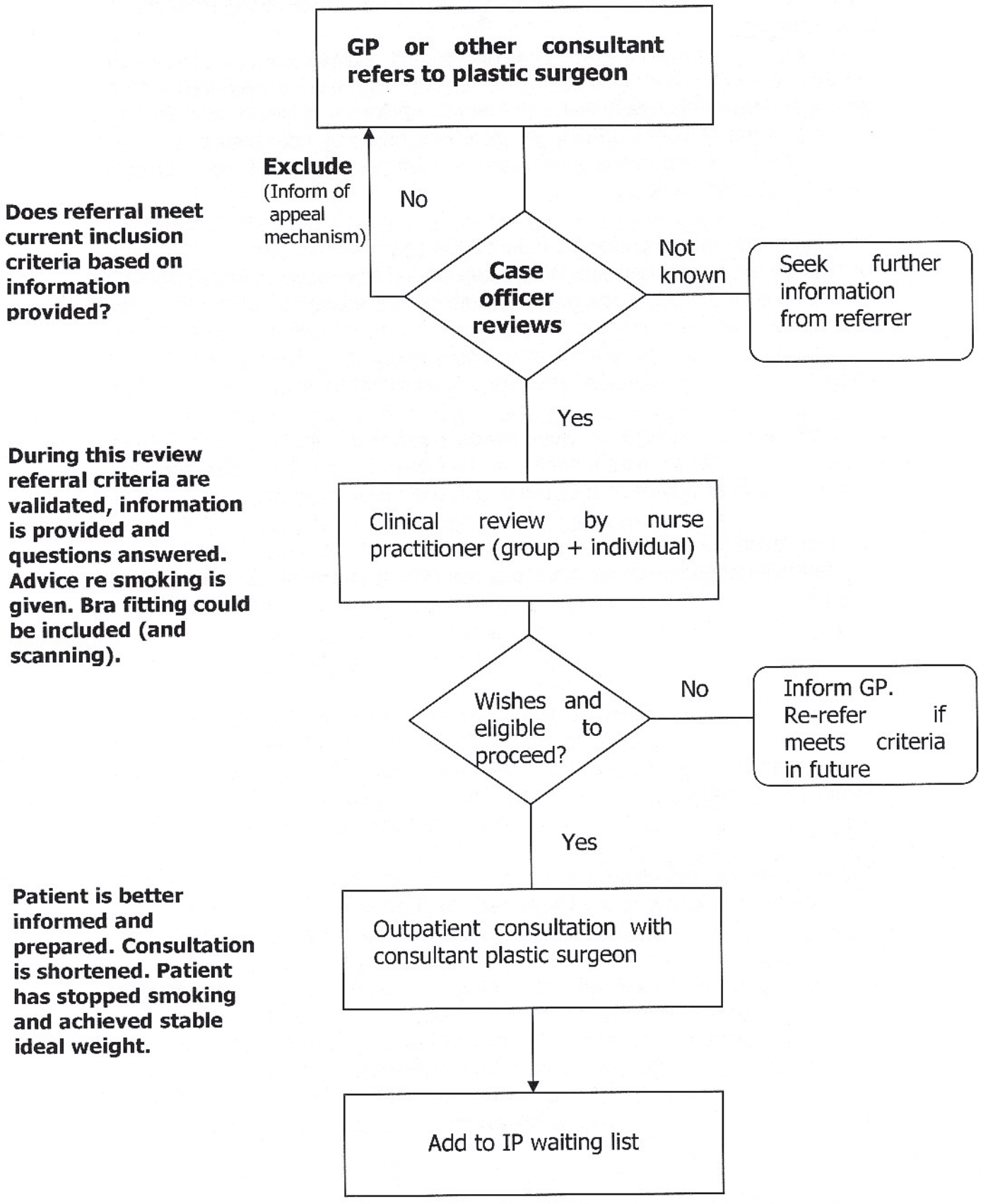
The DH issued revised guidance in July 2004 (gateway ref 3382), which did not change the original advice. Whilst this advice specifically relates to sexual health and contraception, the general rules can be applied to all health care: A doctor or health professional is able to provide (contraception, sexual and reproductive) health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- She/he understands the advice provided and its implications.

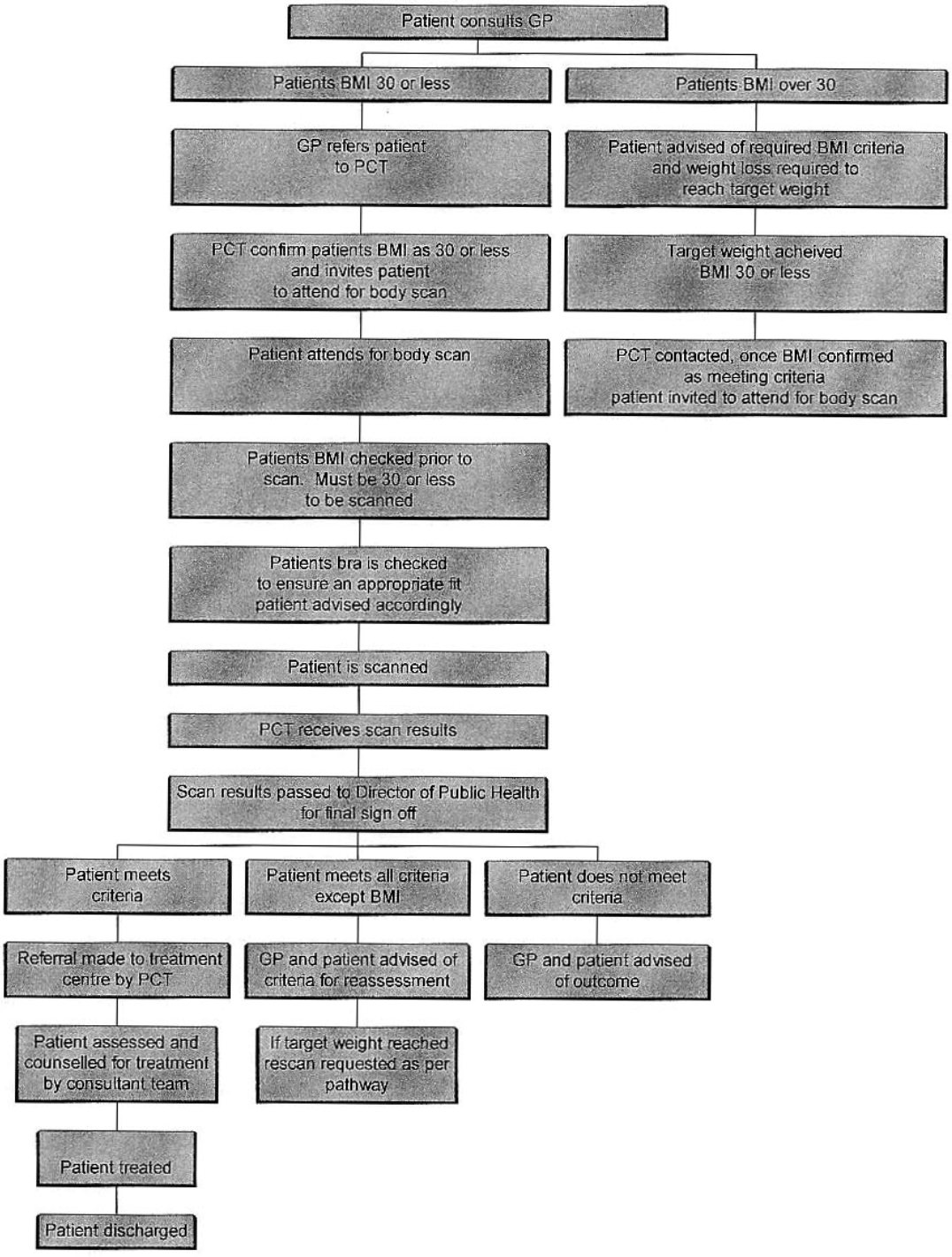
- Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above.

Appendix A1: Example patient pathway for breast reduction



Appendix A2: Potential use of Scanning in breast reduction decision pathway.



Current criteria for assessment referral

- **Does the patient want surgery**
- **Does the patient have a BMI of 30 or under?**

Current criteria for referral to a hospital consultant

- **Breast size *is larger than 1000CC per breast***
- **The ratio of combined breast volume to adjusted partial torso volume is equal to or greater than 13%**
- **BMI is less than 30**

Appendix B: Membership of the sub-qroup

Core Group	
Dr Catriona King	Action On Plastic Surgery National Director(Chair)
Mr Graeme Moir	National Clinical Advisor; Action On Plastic Surgery. Consultant Plastic Surgeon - Barts and The London NHS Trust
Mr Hamish Laing	Consultant Plastic Surgeon; The Morriston NHS Trust, Swansea, Welsh Centre for Burns and Plastic Surgery, Representative of the Welsh Assembly and Honorary Secretary of BAPS
Mr Anthony Moss	Consultant Plastic Surgeon; St Georges' NHS Trust London
Dr Richard Richards	Director of Public Health; Newark and Sherwood PCT, Joint Lead Of Nottingham City Hospital Pilot Project.
Dr Dorothy Mc Kinley	Clinical Psychologist
Mr Daren Edwards	Senior Hand Trauma Nurse; Plastic Surgery Unit, Guys and St Thomas NHS Trust
Mr A Khanna	Consultant Plastic Surgeon; Sandwell and West Birmingham NHS Trust
Dr Tim Richardson	General Practitioner; National Clinical lead for the (D) TC programme NHS MA and Member of the National Steering Board for AOPS
Contributing Members	
Dr Trudi Kemp:	Director of Public Health; SWLHA and St Georges NHS Trust
Ms Fiona Henderson	Centre for Change and Innovation, Scottish Executive
Mr Tim Guyler	Divisional Manager for Surgery; Nottingham City Hospital NHS Trust
Dr Sheru George	Consultant Dermatologist; South Bucks NHS Trust
Professor Nicola Rumsey	Research Director School of Psychology; University of the West of England Bristol