

**PARTIALLY EXCLUDED POLICY – 113**  
**BREAST REDUCTION SURGERY FOR GYNECOMASTIA RELATED TO USE OF**  
**ANTIANDROGENS AS A TREATMENT OF PROSTATE CANCER**  
**(Previously PE5c)**

Policy author: Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group supported by Public Health Suffolk, Suffolk County Council

Policy start date: February 2017

Review date: February 2020

## **1. Policy Summary**

- 1.1 Surgical management of male gynecomastia is considered a low priority procedure and should not be commissioned. Funding requests are considered by the Suffolk CCG's Individual Funding Request (IFR) Panel if there are exceptional circumstances i.e. there is something about the patient's condition or circumstances that differentiate them on the basis of need from other patients with a similar diagnosis or condition and would justify funding being provided in an individual case when it is not routinely funded for others. This guidance differs from that for gynecomastia taking into account the known side effect of antiandrogen treatment in contributing to gynecomastia development as well as other side effects including weight gain.
- 1.2 This partially excluded policy offers some guidance to the referring clinician and the IFR Panel when considering such requests. It must be clarified these are NOT referral criteria, and only supporting guidance for the IFR panel.

## **2. Background to the Procedure**

- 2.1 Gynecomastia (male breast tissue enlargement) seems to result from an imbalance between androgenic and oestrogenic influences on breast tissues. Prostate cancer is an androgen dependent neoplasm and medical treatments based on androgen deprivation, androgen receptor blockade or oestrogen administration can all contribute to development of gynecomastia.

## **3. Rationale Behind Policy Decision**

- 3.1 Surgery for gynecomastia is considered a cosmetic procedure. Cosmetic procedures are defined as "the choice to undergo an operation, or invasive medical procedure, to alter one's physical appearance for aesthetic rather than medical reasons." For this intention it is not routinely funded by the clinical commissioning group. It will be considered in certain exceptional cases as outlined below.

## **4. Guidance to IFR Panel**

- 4.1 IES and WS CCG's IFR panel will use the following guidance when considering funding requests for breast reduction in male adults with cancer treatment induced gynecomastia. As each case is considered on an individual basis on its own merits it is unlikely that patients meeting the guidance below will be automatically funded.

4.2 It is expected that prophylactic radiotherapy/ tamoxifen should have been discussed with patients in line with NICE clinical guidance CG175 (prostate cancer) if patient is being started on long term bicalutamide monotherapy.

4.3 Clinical Examination Findings (including BMI and reported visual irregularities)

- a) True gynecomastia is benign enlargement of male breast tissue. It can be defined as the presence of >2cm palpable, firm, subareolar gland and ductal tissue (not fat).
- b) Surgery to correct unilateral or bilateral gynecomastia should be considered if the patient:
  - Is post pubertal (stable height for past 6 months); AND
  - Has BMI <30kg/m<sup>2</sup>; AND
  - Has breast enlargement on at least one side which is Grade III or above using Cordova's classification system (see appendix) OR has unilateral breast enlargement with a difference of at least 2 grades (e.g. normal and Grade II differential); AND
  - Has been counselled by consultants in urology, oncology and breast surgery, and there is agreed support for surgery to meet a defined clinical need.
- c) Scarring, contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any post-surgical cosmetic irregularities will not be funded by the CCG in revision surgery.

4.4 Investigations and Conditions of Exemption

- a) True antiandrogen induced gynecomastia will be considered for funding (i.e. true breast tissue is present not just adipose tissue – pseudo gynecomastia) as above. The clinician should, however, still ensure that the following are confirmed:
  - Breast cancer has been ruled out as suspicion of cancer exempts the patient from this guidance. It is important that male breast cancer is not mistaken for gynecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.
  - Underlying endocrine or liver abnormality has been ruled out as these are separate medical conditions that exempt a patient from this guidance and alternative treatment of these conditions is likely necessary if confirmed as surgical intervention will not resolve the causative factors.
  - The condition is not due to the abuse of drugs with bodybuilding.
  - The condition is not a side effect of medication or drugs other than those associated with their cancer treatment e.g. cannabis.

4.5 Smoking Status

- a) Stipulate that patients who smoke undergoing this operation must cease smoking 3-4 weeks prior to surgery at their pre-operative consultation and urge that they continue to

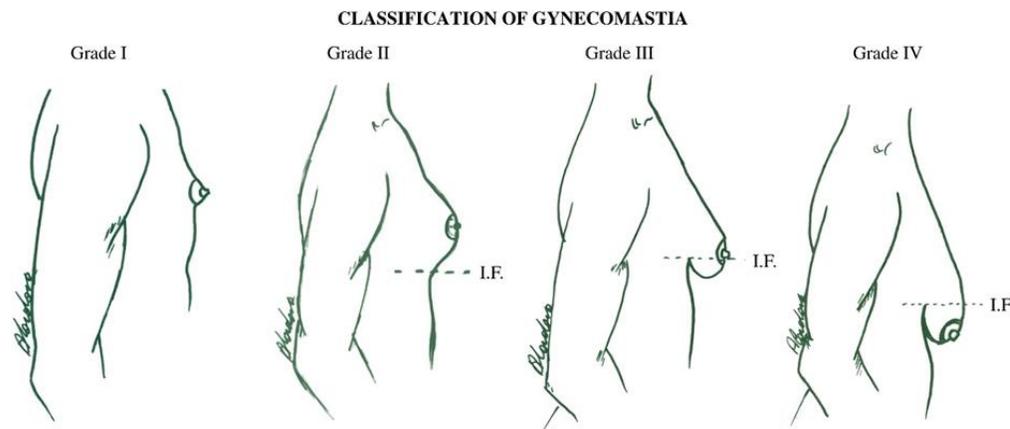
abstain from all forms of smoking for 3-4 weeks during the post-operative phase. Advise the patient that use of electronic nicotine delivery systems and other forms of nicotine (i.e. patch, gum) will show positive cotinine levels in their saliva and may trigger a positive test result when checked. AND

- b) Encourage the patient to complete a smoking cessation course with the local commissioned smoking cessation provider prior to their operation to help their abstinence. AND
- c) Stipulate that the patient undertakes a cotinine test within the 4 week window prior to their surgery to demonstrate that they are not smoking (cotinine level >10 ng/mL indicates that the patient is smoking).
- d) Advise the patient that failure to comply with these criteria will lead to their surgery being cancelled.

#### 4.6 Additional Request Submission Requirements

Applications must include at least 2 colour photographs of the chest. Photographs should go from the top of the chest down to the umbilicus. One should be taken from directly in front of the patient and another at an angle of 45 degrees (see the attached classification photos, Grades II – IV, for examples).

#### 4.7 Appendix – Classification of Gynecomastia



Classification of gynaecomastia. Grade I, increase in diameter and protrusion limited to the areolar region; Grade II, areola-nipple complex above the inframammary fold (I.F.); Grade III, areola-nipple complex at the same height as or about 1cm below the I.F.; Grade IV, areola-nipple complex more than 1cm below the I.F.

## 5. References

1. NHS Choices. What is gynecomastia. <http://www.nhs.uk/chq/Pages/885.aspx?CategoryID=61&SubCategoryID=614>
2. Narula HS, Carlson HE. Gynaecomastia--pathophysiology, diagnosis and treatment. Nat Rev Endocrinol. 2014 Nov;10(11):684-98. doi: 10.1038/nrendo.2014.139. Epub 2014 Aug 12.

3. Adriana Cordova, Francesco Moschella Algorithm for clinical evaluation and surgical treatment of gynaecomastia  
Journal of Plastic, Reconstructive & Aesthetic Surgery Volume 61, Issue 1, Pages 41-49 (January 2008)
4. NICE CG175 Diagnosis and Management Prostate Cancer <https://www.nice.org.uk/guidance/cg175>