

Corrective surgery for congenital breast asymmetry

Guidance on access to surgery

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Introduction

Breasts are considered asymmetrical when there is a noticeable difference between the breasts in terms of size, shape or nipple position.

Surgery to correct breast asymmetry should only be undertaken by NHS providers in specific circumstances where defined criteria are met. For example, corrective surgery may be undertaken where the asymmetry results from a genetic condition present from birth.

This guide sets out clear, evidence-based criteria for when surgery should be considered and when it should not for patients with breast asymmetry.

Who should read this guide?

This guide is for clinicians, provider organisations, commissioners and integrated care boards (ICBs) involved in the assessment, referral, commissioning and delivery of care for patients with congenital breast asymmetry. It will be particularly relevant to breast surgery teams, plastic surgery teams, GPs and other referrers who may be involved in investigating the underlying causes of breast asymmetry and considering whether referral for surgery is appropriate.

Rationale for the guidance

The Getting It Right First Time (GIRFT) [Breast Surgery National Specialty Report](#) identified significant variation in commissioners' approaches to funding surgery for congenital abnormalities. These findings highlight the need for a consistent, standardised set of commissioning criteria for corrective surgery in cases of congenital asymmetry.

Surgery is not commissioned by the NHS for cosmetic purposes alone. However, evidence indicates that selected patients with congenital asymmetry may derive significant benefit from intervention.

A 2020 cohort study considering the outcomes after treatment for congenital breast asymmetry found significant postoperative psychological improvements. The study included those with congenital breast asymmetry secondary to: macromastia, Poland Syndrome, tuberous breast, unilateral or asymmetric hypoplasia and amazia.

When compared with age matched controls, patients undergoing corrective surgery for breast asymmetry experienced significant postoperative improvements in self-esteem, as measured by the Rosenberg Self-Esteem Scale¹, and in three Short-Form 36v2 domains: Role - Physical, Social Functioning and Mental Health. These improvements were sustained

¹ [Rosenberg Self-Esteem Scale](#) (RSES) (1965).

for a minimum of five years. Postoperatively, asymmetry participants' quality of life was comparable to controls and did not vary by age at the time of surgery, asymmetry severity, or diagnosis.²

Clinical overview

Breast asymmetry refers to a noticeable difference between the breasts in volume, shape or nipple position. Minor differences are common, but more marked asymmetry may be associated with abnormal breast development and can present as a congenital condition.

Congenital conditions may include (but are not limited to): macromastia, Poland Syndrome, tuberous breast, unilateral or asymmetric hypoplasia, amazia (unilateral/bilateral), congenital symmastia.

Assessment should be undertaken by an appropriate specialist team to confirm the underlying cause of the asymmetry, determine whether it is congenital, and consider severity, skeletal maturity, body mass index (BMI) and treatment options. Surgery should only be considered where there is a clear clinical indication and where defined commissioning criteria are met.

² Nuzzi, L., Firriolo, J., Pike, C., et al. *The Effect of Surgical Treatment on the Quality of Life of Young Women with Breast Asymmetry: A Longitudinal, Cohort Study. Plastic & Reconstructive Surgery.* 2020; 146(4):400e-408e.

Guidance

This guidance applies to people aged 18 years and over.

Surgery for breast asymmetry for cosmetic reasons is not routinely commissioned by the NHS.

Criteria for surgery

In cases where surgery is being considered, **ALL of the following criteria** must be met:

1. The breast asymmetry has been confirmed to be the result of a congenital condition.
2. A difference of at least 250g size as estimated by a specialist. This can be assessed using partial prosthesis or by quantitative breast morphometry. Please note that 250g equates to a difference of around 2-3 cup sizes in a patient with a normal BMI.
3. The patient has a BMI of <27 which has been stable for at least 12 months.

Where possible, the larger breast should be reduced in order to avoid the long term complications of breast implants and ensure long term symmetry, regardless of changes in weight or pregnancy.

Congenital symmastia is very rare and should be considered for treatment on that basis.

Corrective procedures for inverted nipples are not recommended.

The weight of any resection and pre- and postoperative photographs should be recorded for audit purposes.

As per GIRFT and NICE guidance, discuss lifestyle modifications with people having surgery - for example, stopping smoking and reducing alcohol consumption - in order to reduce the risk of postoperative complications. See the GIRFT [Operational Implementation and Support Guide for Early Screening, Risk Assessment and Optimisation for Adult Patients](#) and the NICE guideline on [Perioperative care in adults](#) for more information.

This guidance **does not cover** the following:

- Gender reassignment surgery.
- Significant breast asymmetry following therapeutic surgery for breast disease, including mastectomy and reconstruction.



Expected outcome

The implementation of this guidance would result in a reduction in unwarranted variation in access to corrective surgery for congenital breast asymmetry across England by standardising the criteria for the consideration for surgery.

Further information

- GIRFT (2023) [Operational Implementation and Support Guide for Early Screening, Risk Assessment and Optimisation for Adult Patients](#)
- GIRFT (2021) [Breast Surgery Programme National Specialty Report](#)
- NICE (2020) [Perioperative care in adults](#)
- Nuzzi, L., Firriolo, J., Pike, C., et al. (2020) [The Effect of Surgical Treatment on the Quality of Life of Young Women with Breast Asymmetry: A Longitudinal, Cohort Study](#)
- NHS England (2019, updated 2023) [Service specification: Gender Identity Services for Adults \(Surgical Interventions\)](#)
- Association of Breast Surgery and British Association of Plastic, Reconstructive and Aesthetic Surgeons (2021) [Oncoplastic Breast Reconstruction: Guidelines for Best Practice](#)
- Reilley, A. (2006) [Breast asymmetry: Classification and management](#)

Contributors

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About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is a clinically-led national programme designed to identify and minimise unwarranted variation in treatment and care delivered. It undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Health System portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency.

The GIRFT model has now been applied in more than 50 different areas of clinical practice. It consists of five key strands:

1. Data gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
2. Peer reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.
3. National report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
4. Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.
5. Research and development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

For the latest version of this document, please see www.gettingitrightfirsttime.co.uk or [Getting It Right First Time - FutureNHS Collaboration Platform](#)

GIRFT and a greener NHS

Climate change is one of the greatest health threats and opportunities of the 21st century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation, GIRFT can play an important role in reducing the carbon emissions associated with care delivery. Through the GIRFT model, there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.



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GIRFT is part of an aligned set of programmes within NHS England