

Gynaecomastia surgery

Guidance on access to surgery

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Introduction

Gynaecomastia is a common condition which causes male breasts to swell and become enlarged. It is particularly common in adolescents and often settles over time.

Surgery to remove male breast tissue should only be undertaken by NHS providers in specific circumstances, where defined criteria are met.

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

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 gynaecomastia. It will be particularly relevant to breast surgery teams, plastic surgery teams, endocrinology services, GPs and other referrers who may be involved in investigating underlying causes 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 the funding of gynaecomastia surgery. These findings highlight the need for a consistent, standardised set of commissioning criteria for gynaecomastia surgery.

Medical treatment may avoid surgical intervention in some cases. However, the clinical course of gynaecomastia is proliferation of glandular tissue followed by fibrosis. Once fibrosis has occurred, treating the cause may stop further growth but is unlikely to reduce breast tissue already present and surgery is the only definitive treatment. A systematic review found surgical excision of significant glandular tissue, combined with liposuction, provides the most consistent results and a low rate of complications.¹

It should be noted that surgical intervention may not alleviate psychological distress.

¹ Fagerlund, A., Lewin, R., Ruffolo, G., et al. Gynaecomastia: a systematic review. *Journal of Plastic Surgery and Hand Surgery*. 2015; 49(6): 311–318.

Clinical overview

True gynaecomastia is the enlargement of the male breast due to hyperplasia of the glandular tissue. Pseudogynaecomastia is bilateral breast enlargement entirely due to adipose tissue.

Gynaecomastia is common, with a prevalence of 50% to 60% in adolescents and up to 70% in men aged 50 to 69 years. It is strongly associated with obesity.² Gynaecomastia can be due to hormonal imbalances (e.g., liver cirrhosis, renal insufficiency, gonadal failures), drug induced or physiological (such as in newborns, during puberty or older age). Medical treatments may be considered to manage pain or for cosmetic improvement, but resolution is not always possible.

Surgery for gynaecomastia should only be considered in specific circumstances, for example when gynaecomastia is due to rare congenital or endocrine causes.

² Johnson, R. and Murad, M. Gynaecomastia: pathophysiology, evaluation, and management. *Mayo Clinic Proceedings*. 2009; 84(11): 1010–1015.

Guidance

This guidance applies to both unilateral and bilateral gynaecomastia.

Given the evidence base, psychological distress alone will not meet the criteria for surgery.

Criteria for surgery

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

1. The reduction in breast tissue will be significant i.e., 250g or more or Simon Grade 3 or more.³ This can be assessed using partial prosthesis or by quantitative breast morphometry and will need to be confirmed by a specialist opinion.
2. Endocrinological causes have been investigated.
3. Those patients with significant gynaecomastia secondary to underlying endocrinological conditions should have been adequately treated for that primary condition and their referral for surgery supported by their treating doctor in writing. The referral should state that the patient's condition has not resolved with correction of the endocrinological condition.
4. In drug-induced gynaecomastia, the causative medication should be withdrawn, where clinically appropriate, for at least one year to allow resolution.
5. The patient has a body mass index (BMI) of <27 which has been stable for at least 12 months.

Patients may present in adolescence or early adulthood. This should not preclude patients from being considered if the above criteria have been met. However, if aged 25 years or younger⁴ the patient should be monitored for at least one year to allow for natural resolution.

Where patients meet the criteria and surgery is undertaken, the weight of any resection and pre- and postoperative photographs should be recorded for audit purposes.

³ Simon, B., Hoffman, S. and Khan, S. *Classification and surgical correction of gynaecomastia* *Plastic and Reconstructive Surgery*. 1973; 51(1): 48–52.

⁴ Johnson, R. and Murad, M. *Gynaecomastia: pathophysiology, evaluation, and management*. *Mayo Clinic Proceedings*. 2009; 84(11): 1010–1015.

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.
- Surgery for breast cancer.
- Gynaecomastia secondary to a different medical condition
e.g. treatment for prostate cancer.



Expected outcome

The implementation of this guidance would result in a reduction in unwarranted variation in access to male gynaecomastia surgery 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](#)
- Association of Breast Surgery and British Association of Plastic, Reconstructive and Aesthetic Surgeons (2021) [Oncoplastic Breast Reconstruction: Guidelines for Best Practice](#)
- BMJ Best Practice (2021) [Gynaecomastia](#)
- GIRFT (2021) [Breast Surgery Programme National Specialty Report](#)
- NICE (2020) [Perioperative care in adults](#)
- Association of Breast Surgery (2019) [ABS Summary Statement: Investigation and management of gynaecomastia in primary and secondary care](#)
- Kanakis, G., Nordkap, L., Bang, A. et al. (2019) [EAA clinical practice guidelines: gynaecomastia evaluation and management](#)
- NHS England (2019, updated 2023) [Service specification: Gender Identity Services for Adults \(Surgical Interventions\)](#)
- Nuzzi, L., Firriolo, J., Pike, C., et al. (2018) [The effect of surgical treatment for gynaecomastia on quality of life in adolescents](#)
- Sollie, M. (2018) [Management of gynaecomastia - changes in psychological aspects after surgery - a systematic review](#)
- Fricke, A., Lehner, G., Stark, G. et al. (2017) [Long-term follow-up of recurrence and patient satisfaction after surgical treatment of gynecomastia](#)
- Gupta, V., Yeslev, M., Winocour, J. et al. (2017) [Aesthetic breast surgery and concomitant procedures: incidence and risk factors for major complications in 73,608 cases](#)
- Thiruchelvam, P., Walker, J., Rose, K. et al. (2016) [Gynaecomastia](#)
- Fagerlund, A., Lewin, R., Rufolo, G., et al. (2015) [Gynaecomastia: a systematic review](#)
- Ordaz, D. and Thompson, J. (2015) [Gynaecomastia and psychological functioning: a review of the literature](#)
- Rew, L., Young, C., Harrison, T. and Caridi, R. (2015) [A systematic review of literature on psychosocial aspects of gynaecomastia in adolescents and young men](#)

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- Johnson, R. and Murad, M. (2009) [Gynaecomastia: pathophysiology, evaluation, and management](#)
 - Honigman, R., Phillips, K. and Castle, D. (2004) [A review of psychosocial outcomes for patients seeking cosmetic surgery](#)
 - Simon, B., Hoffman, S. and Khan, S (1973) [Classification and surgical correction of gynaecomastia](#)

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