NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin053
Hirsutism, hair removal treatments (photo-epilation, laser or electrolysis)

Category 1 Intervention – Not routinely commissioned

Contents

Last Reviewed: May 2025

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 Laser, photo-epilation therapy or electrolysis are not routinely commissioned for hirsutism.

2. Exclusions

2.1 Hair removal related to pilonidal sinus or part of a reconstruction procedure in burns patients are considered outside the scope of this policy.

3. Core Eligibility Criteria

3.1 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.

3.2 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/

4. Rationale behind the policy statement

4.1 Hirsutism is extremely common (with an approximate 10% prevalence) and one of the leading causes is polycystic ovary syndrome (PCOS).

4.2 It is generally recognised that for women with PCOS, hormone blockers, the oral contraceptive and other medication are important in the initial management.

4.3 Whilst electrolysis is effective in hair removal, this is painful and can only be used over small surface areas. Photo epilation and laser therapy, however, are more practical but published data support short-term effectiveness only.

5. Summary of evidence review and references

5.1 *Hirsutism* is the medical term which refers to the presence of excessive terminal (course) hair in androgen-dependent areas of the female body. Its presence can impact on psychological well-being, especially in young women.[1] The degree of hairiness is defined by the Ferriman Gallwey score which scores 9 areas of the body (upper lip, chin, chest, upper and lower back, upper and lower abdomen, arm, forearm, thigh & lower leg) between 0 – 4 where zero is no hair and a score of 4 represents a typical, well-virilised, healthy adult male. The condition is very common with an approximate prevalence of 10% in most populations and polycystic ovary syndrome (PCOS) is one of the leading causes.

5.2 A *BMJ* clinical review article suggests that most women with hirsutism can be treated in primary care. Referral to a specialist is appropriate if the hirsutism is particularly severe, hair growth is of recent onset and rapid progression, first and 2nd line treatments have been ineffective over 6 – 12 months, serum testosterone concentration is more than twice the upper limit of normal and if the presence of metabolic syndrome requires a multidisciplinary approach.[2]

5.3 Although PCOS and hypoandrogenism account for more than 85% of hirsutism cases, other less common causes include idiopathic hirsutism, nonclassical congenital adrenal hyperplasia, androgen secreting tumours, certain medication, hyperprolactinaemia, thyroid disorders and Cushing's syndrome.[3] Therapeutic interventions for hirsutism have included:- oral contraceptives, flutamide, spironolactone, finasteride, gonadotrophin releasing hormone analogues and metformin.[4,5] Methods of hair removal include shaving, threading, waxing and using depilatory creams.[2]

5.4 A 2006 Cochrane review examined the effect of laser and photo epilation systems for unwanted hair growth.[6] This concluded there is a short-term effect with approximately 50% in hair reduction up to 6 months after treatment. Pain, skin redness, swelling, burning hairs and pigmentary changes were infrequently reported adverse effects. Importantly, it is generally accepted that laser treatment is less effective in darker skin because a contrast is needed between the skin colour and hair pigment.[2] The ideal candidate is one with fair skin and dark hair.[7]

5.5 Although electrolysis is effective, it can be painful, time-consuming and impractical for removing hair over large areas of skin. Photo epilation, therefore, is more practical for large surface areas and is thus more popular.[3] In addition, it has also been shown that PCOS - related hirsutism may be more resistant to laser hair removal, and as a consequence, patients are advised to take their antiandrogens and other medication to optimise response.[8] Finally, although there are limited data to suggest that hair removal with laser therapy can improve quality-of-life [9,10] , to date, there is a lack of efficacy data on laser hair removal for individuals with PCOS -related *facial* hirsutism.[11]

5.6 In terms of national guidance, perhaps, the most authoritative guideline is that of the Endocrine Society Clinical Practice Guideline.[12] This was produced by USA and European Associations which commissioned 2 systematic reviews and used the best available evidence from other published systematic reviews and individual studies. This recommended photo epilation for women with auburn, brown or black hair and electrolysis for those with white or blonde hair.

5.7 In summary, hirsutism is the presence of excessive hair in androgen -dependent areas of the female body. It is extremely common (with an approximate 10% prevalence) and one of the leading causes is polycystic ovary syndrome (PCOS). It is generally recognised that for women with PCOS, hormone blockers, the oral contraceptive and other medication are important in the initial management. Whilst electrolysis is effective in hair removal, this is painful and can only be used over small surface areas. Photo epilation and laser therapy, however, are more practical but published data support short-term effectiveness only. It is also widely accepted that laser therapy is more effective in women with fair skin and dark coloured hair.

5.8 This intervention is not routinely funded in Shropshire or North Staffordshire and the policies in Greater Manchester and Mersey are similar to the current Cheshire CCG policy.

6. Advice and Guidance

6.1 **Aim and Objectives**

6.1.1 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.

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

6.1.3 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.

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

6.1.5 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.

6.1.6 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.

6.2 **Core Principles**

6.2.1 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.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 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.

6.3.2 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/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 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.

6.5.2 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.

6.6 Clinical Trials

6.6.1 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.

7. Monitoring and Review

7.1 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.

7.2 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.

7.3 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

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

8. Quality and Equality Analysis

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

9. Clinical Coding

9.1 **Office of Population Censuses and Surveys (OPCS)**
S60.6 Electrolysis of hair
S60.7 Epilation NEC

9.2 **International classification of diseases (ICD-10)**
L68.0 Hirsutism

Document Control

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Version History
Version 0.2 – January 2022 1. Little change to the existing policy. 2.References to potential exceptional funding criteria have been removed
Version 0.3 – August 2023 Statements on pilonidal sinus and burns patients added to exclusions criteria
Version 0.4 – July 2024 – re-formatted
Version 0.5 – May 2025 – This policy was part of a public engagement exercise, there were no changes made to the policy.