NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin102
Reshaping the nose (rhinoplasty/septoplasty): surgical management to address cosmetic appearance or associated respiratory impairment

Category 2 Intervention - Only routinely commissioned when specific criteria are met

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 Rhinoplasty or septoplasty (or combination) are not routinely commissioned for cosmetic reasons.

1.2 Rhinoplasty or septoplasty (or combination) are only commissioned if one of the following criteria are satisfied:

- Patient has a deviated septum (or other anatomical deformity) which is causing nasal obstruction which impacts on breathing **OR**
- Patient is experiencing anatomical deformity as a result of trauma and/or cancer treatment.

1.3 Surgical management (which may include rhinoplasty) of cleft lip and palate is routinely commissioned by NHS England. Contact details of the specialist referral centres are available here.

2. Exclusions

2.1 Revision/excision of dermoid cysts in children, when performed as part of planned care, 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 Surgery on the nose (rhinoplasty and/or septoplasty) is generally regarded as a cosmetic procedure and thus is not routinely commissioned.

4.2 In the rare circumstance when a septal defect impacts on breathing or the patient has a mechanical deformity as a result of trauma or cancer treatment, such surgery may be permitted.

5. Summary of evidence review and references

5.1 Nasal obstruction (and associated impact on breathing) can occur as a result of narrowing of the nasal valve. This may be due to one or a combination of several factors which include deviation (movement) of the septum (the cartridge wall between the nostrils), hypertrophic turbinates (the ridges of bone and tissue inside the nose) or deviation of the lateral (side) wall. *Functional rhinoplasty* (or nasal valve repair) is the term used to describe the surgical procedures used to address this problem. [1]

5.2 More specifically, a systematic review concerned with nasal obstruction and rhinoplasty reported that the major associated pathologies with obstruction were septal deviation (85%), interval valve insufficiency (34%), mild turbinate hypertrophy (71%) and severe turbinate hypertrophy (6%).[2] Almost 90% of these patients had 2 or more types of pathology.

5.3 *Septoplasty* is the term which donates the surgical correction of the deviated nasal septum only and is the most common ENT operation in adults.[3] In 2014, there were an estimated 3.9 procedures per 10,000 inhabitants in England. In terms of efficacy, an earlier (2011) systematic review on the effectiveness of septal surgery concluded there that this procedure does improve objective measures of nasal patency and thus improves nasal airflow.[4] In contrast, a more up-to-date review (2018) concluded that the current body of evidence does not support firm conclusions on the effectiveness of septoplasty for nasal obstruction due to a deviated nasal septum in adults. [3] Similarly, substantial, but low quality evidence (2008) supports the use of modern day *rhinoplasty* techniques to treat nasal obstruction. [1] However, a most recent review (2021) concluded that septoplasty alone is not suitable for most structural nasal obstructions as other anatomical structures (apart from the septum) may be involved in the obstruction.[5]

5.4 Rhinoplasty has many operative-related complications such as:- perioperative bleeding, oedema, ecchymosis (bruising) and infection. Eyelid oedema and ecchymosis were the most frequently investigated complications in a meta-analysis of complications. [6] However, nasal septal perforation is another reported complication.[7]

5.5 The NHS modernisation agency on information for commissioners of plastic surgery services recommends that rhinoplasty should be available on the NHS for problems caused by obstruction of the nasal airway, nasal deformity caused by trauma and/or correction of complex congenital conditions such as cleft lip and palate.[8] Surgery for cleft lip and palate patients represents one of the most challenging groups of patients who present as a complex surgical obstacle for even the most seasoned surgeons.[9] Thus, this highly specialised surgery is commissioned by NHS England according to its service specification.

5.6 In summary, nasal obstruction, which impacts on breathing, can occur as a result of narrowing of the nasal valve which could be due to deviation of the nasal septum or other anatomical structures in the nose. Although deviation of the septum is very common, only a small fraction of these patients will also experience nasal obstruction. Surgical correction can be achieved through septoplasty (operation on the septum only) or rhinoplasty (operation on the other structures of the nose) or a combination and the effectiveness of these procedures

is not without controversy. These techniques are also commonly used to change the cosmetic appearance of the nose with no apparent nasal obstruction although this is not usually allowed on the NHS.

5.7 Finally, surgical repair of cleft lip and palate (which may include rhinoplasty) is normally commissioned by NHS England.

REFERENCES

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7. Sonneveld KA, Sinha PK. Correction of Septal Perforation/Nasal Airway Repair. *Oral and maxillofacial surgery clinics of North America* 2021;**33**(1):119-24. doi: 10.1016/j.coms.2020.09.006
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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)

Any in primary position

E023 Septorhinoplasty using implant
E024 Septorhinoplasty using graft
E025 Reduction rhinoplasty
E026 Rhinoplasty NEC
E028 Other specified plastic operations on nose
E073 Septorhinoplasty NEC

E022 Reconstruction of nose NEC
E027 Alar reconstruction with cartilage graft
E029 Unspecified plastic operations on nose
E036 Septoplasty of nose NEC
E037 Septal reconstruction with cartilage graft
E071 Correction of stenosis of nasal pyriform aperture
E072 Septodermoplasty
E078 Other specified other plastic operations on nose
E079 Unspecified other plastic operations on nose
E044 Division of adhesions of turbinate of nose
E041 Submucous diathermy of turbinate of nose
E046 Cauterisation of turbinate of nose
E047 Surgical outfracture of turbinate of nose

9.2 International classification of diseases (ICD-10)
With or without

Q351 Cleft hard palate
Q353 Cleft soft palate
Q355 Cleft hard palate with cleft soft palate
Q357 Cleft uvula
Q359 Cleft palate, unspecified
Q360 Cleft lip, bilateral
Q361 Cleft lip, median
Q369 Cleft lip, unilateral
Q370 Cleft hard palate with bilateral cleft lip
Q371 Cleft hard palate with unilateral cleft lip
Q372 Cleft soft palate with bilateral cleft lip
Q373 Cleft soft palate with unilateral cleft lip
Q374 Cleft hard and soft palate with bilateral cleft lip
Q375 Cleft hard and soft palate with unilateral cleft lip
Q378 Unspecified cleft palate with bilateral cleft lip
Q379 Unspecified cleft palate with unilateral cleft lip
J348 Other specified disorders of nose and nasal sinuses
S022 Fracture of nasal bones
S099 Unspecified injury of head

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Version 0.2 – March 2022 – 1. Reference to cleft lip and palate has been removed as surgery for this condition is commissioned by NHS England. 2.Reference to gender dysphoria has been removed as this is covered under a separate policy statement
Version 0.3 – August 2023 – Statement on dermoid cysts in children added to Exclusions criteria
Version 0.4 – May 2025 – This policy was part of a public engagement exercise, there was no feedback received.