Anthem

Clinical UM Guideline

Subject: Mastectomy for Gynecomastia
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Description

This document addresses mastectomy performed for the treatment of gynecomastia. Gynecomastia is the unilateral or bilateral enlargement of male breast tissue attributed mainly to proliferation of ductular elements and not merely excessive breast tissue. Mastectomy for gynecomastia is a surgical procedure performed to remove glandular breast tissue from a male with enlarged breasts.

Note: Please see the following related documents for additional information:

- CG-SURG-71 Reduction Mammaplasty
- SURG.00023 Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures

Reconstructive: In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect.

Note: Not all benefit contracts include benefits for reconstructive services as defined by this document. Benefit language supersedes this document.

Clinical Indications

Medically Necessary:

Mastectomy (including reconstruction if necessary) for gynecomastia in males over the age of 18, or 18 months after the end of puberty, whichever is younger, is considered **medically necessary** when the following criteria are met:

A. The tissue to be removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment which can be discontinued (this would include drug-induced gynecomastia remaining unresolved 6 months after cessation of the causative drug therapy); **and**
B. Appropriate diagnostic evaluation has been done for possible underlying etiology;**and**
C. The individual has pain or tenderness directly related to the breast tissue (documented in the medical record) which has a clinically significant impact upon activities of daily living and has been refractory to a 3 month trial of analgesics or anti-inflammatory agents; **and**
D. Pre-operative photographs are provided.

Mastectomy for gynecomastia is considered **medically necessary,** regardless of age, when there is legitimate concern that a breast mass may represent breast carcinoma. Mammography may be of value to determine the need for surgery in some instances.

Reconstructive:
Mastectomy (including reconstruction if necessary) for gynecomastia in males over the age of 18, or 18 months after the end of puberty, whichever is younger, is considered **reconstructive** if it does not meet the medical necessary criteria above and is for drug-induced gynecomastia that does not resolve by 6 months after the cessation of drug therapy. Examples of some agents associated with the occurrence of gynecomastia are listed in the Discussion/General Information section of this document (not an all-inclusive list).

Not Medically Necessary:

Mastectomy for gynecomastia is considered **not medically necessary** when the above criteria are not met.

The use of liposuction to perform mastectomy for gynecomastia is considered**not medically necessary.**

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Excision:
When services are Medically Necessary:

CPT	
19300	Mastectomy for gynecomastia

ICD-10 Procedure	
0HBV0ZZ	Excision of bilateral breast, open approach [when specified as gynecomastia surgery]
0HTT0ZZ-0HTV0ZZ	Resection of breast, open approach [right, left or bilateral; includes codes 0HTT0ZZ, 0HTU0ZZ, 0HTV0ZZ]

ICD-10 Diagnosis	
C50.021-C50.029	Malignant neoplasm of nipple and areola, male
C50.121-C50.129	Malignant neoplasm of central portion of breast, male
C50.221-C50.229	Malignant neoplasm of upper-inner quadrant of breast, male
C50.321-C50.329	Malignant neoplasm of lower-inner quadrant of breast, male
C50.421-C50.429	Malignant neoplasm of upper-outer quadrant of breast, male
C50.521-C50.529	Malignant neoplasm of lower-outer quadrant of breast, male

C50.621-C50.629	Malignant neoplasm of axillary tail of breast, male
C50.821-C50.829	Malignant neoplasm of overlapping sites of breast, male
C50.921-C50.929	Malignant neoplasm of breast of unspecified site, male
C79.81	Secondary malignant neoplasm of breast
D05.00-D05.092	Carcinoma in situ of breast
D49.3	Neoplasm of unspecified behavior of breast
N63.0-N63.42	Unspecified lump in breast

When services may be Medically Necessary or Reconstructive when criteria are met:
For the procedure codes listed above, for the following diagnoses

ICD-10 Diagnosis	
E05.00-E05.91	Thyrotoxicosis (hyperthyroidism)
E29.1	Testicular hypofunction
E34.50-E34.52	Androgen insensitivity syndrome
N62	Hypertrophy of breast (gynecomastia)
Q98.0-Q98.4	Klinefelter's syndrome
Z79.51-Z79.52	Long-term (current) use of steroids
Z79.818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels

When services are Not Medically Necessary:
For the procedure codes listed above when medically necessary or reconstructive criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Liposuction:
When services are Not Medically Necessary:

CPT	
15877	Suction assisted lipectomy; trunk [when specified as gynecomastia surgery]

ICD-10 Procedure	
0J063ZZ	Alteration of chest subcutaneous tissue and fascia, percutaneous approach
0JD63ZZ	Extraction of chest subcutaneous tissue and fascia, percutaneous approach

ICD-10 Diagnosis	
N62	Hypertrophy of breast (gynecomastia)

Discussion/General Information

Gynecomastia results from the growth of glandular breast tissue in males. This condition should not be confused with pseudogynecomastia, which is an enlargement of the male breast due to excess fat deposition. Gynecomastia is a transient phenomenon in up to 60 to 70% of pubescent boys and is considered a normal part of male adolescence. About 30 to 40% of adult men have been found to have gynecomastia. The incidence of gynecomastia peaks at three discrete times throughout a man's life, during infancy, during puberty and in middle age and elderly men (Kanakis, 2019). Gynecomastia that is unilateral in post-adolescent age groups or that has a rapid onset is frequently associated with an underlying pathology. Medical conditions that can cause gynecomastia include chronic liver disease, Klinefelter's syndrome (47XXY), adrenal tumors, pituitary tumors, testicular tumors, end stage renal disease/dialysis, malnutrition and endocrine disorders (such as hyperthyroidism). Gynecomastia may also result as a side effect from certain drugs including, but not limited to, estrogens, androgens, spironolactone, digitalis preparations, flutamide, ketoconazole, cimetidine, anabolic steroids, alcohol, amphetamines, and marijuana. However, the cause of gynecomastia is frequently idiopathic, particularly in the adolescent age group (Kanakis, 2019; Waltho, 2017). Prior to surgical intervention, a careful clinical evaluation is needed to rule out possible pathological etiologies. When a cause of the gynecomastia is determined and addressed appropriately, spontaneous resolution of the gynecomastia usually occurs over a short period. There can be psychosocial effects related to gynecomastia and psychotherapy may be recommended. Individuals with gynecomastia should be provided with reassurance about the self-limited nature of the condition, encouragement to participate in social and physical activities, and counseling on lifestyle modifications (Ladizinski, 2014).

The enlargement of male breast tissue may be unilateral or bilateral, is usually benign in infants or adolescents. In adults, it has been suggested that approximately 45-50% of cases are associated with an underlying pathology. The most common pathologies associated with gynecomastia include systemic disease (for example, renal or hepatic disease, cancers), medications, obesity, and endocrinopathies (for example, hypogonadism or hyperthyroidism). In approximately 10% of cases, there is more than one etiology (Kanakis, 2019). Adolescent gynecomastia is considered a normal variation of puberty that rarely persists and typically spontaneously regresses within 18 to 24 months. If adolescents have surgical therapy before completion or at near completion of their puberty, the hormonal imbalance that caused the gynecomastia may cause recurrence (Cakan, 2007). Especially in children and youths, most cases of gynecomastia have no absolute indication for therapeutic intervention, as they are temporary and show a high number of spontaneous remissions (Fischer, 2014). Approximately 75% of cases resolve within 2 years of onset and 90% resolve within 3 years of onset (American Society of Plastic Surgeons [ASPS], 2015; Szar, 2023).

An initial diagnostic examination is performed to assess the type of involved tissue (for example, glandular or lipomastia) as well for symptoms of breast cancer (such as hard, non-tender and or joining underlying structures) or testicular cancer. A subsequent, comprehensive examination may be needed in those individuals aged 18 or older. The American Society of Andrology (ASA) and European Academy of Andrology (EAA) 2019 clinical practice guidelines suggests that the diagnostic evaluation include taking an extensive medical history, physical examination, laboratory testing and occasionally breast imaging (Kanakis, 2019).

The use of mastectomy for males under the age of 18 or for those who are not yet at least 18 months after the end of puberty (unless there is legitimate concern that a breast mass may represent breast carcinoma) is not considered an acceptable alternative to nonsurgical forms of treatment. A standard system used to describe the normal development of puberty and to determine if an adolescent is at or near completion of puberty is the Sexual Maturity Rating (SMR, Tanner Stage). The late stage of male puberty (Tanner stage 5) is evidenced by adult genitalia and adult type pubic hair. Completion of the Tanner stage 5 milestones typically signifies the end of puberty. Skeletal and muscle growth are also late events in male puberty.

A retrospective review by Rosen and colleagues (2010) evaluated a consecutive series of adolescents with gynecomastia and compared surgical outcomes and demographics of obese and overweight to normal weighted subjects. A single institution database queried for male "breast" specimens from 1997-2008 identified 69 cases. Data extracted included BMI criteria, which demonstrated

that 51% were obese, 16% overweight and 33% normal-weighted. Major complications (surgical hematoma requiring operative evacuation) occurred in 4 subjects (5.8%) and minor complications in 19 (27.5%). A total of 16 subjects required revision surgery. Potential etiologies other than obesity were found in 27%. Obese subjects required more extensive operations. Obese adolescents suffered greater psychological impact preoperatively but had no difference in satisfaction or complication rates, as compared to subjects of normal weights. The authors concluded that given their study results, obesity should not be used as an absolute contraindication to gynecomastia surgery. Study limitations included retrospective design of the study and a limited sample size.

Zavin and colleagues (2017) performed a large retrospective analysis comparing outcomes post gynecomastia (primarily cosmetic and elective) procedures in pediatric and adult populations. Data were extracted from the American College of Surgeons National Surgical Quality Improvement Program adult and pediatric databases for 1583 adult and 204 pediatric males. The adult population was considered overweight with a cohort BMI of 28.2 and BMI was not calculated for the pediatric population. However, a low proportion of preoperative comorbidities revealed a healthy population overall with rates of 4.9% in children and 6.4% in adults. Procedures in both groups were performed mostly on an outpatient basis. Low surgical and medical complication rates were observed within a 30-day postoperative periods for both groups with rates of 3.9% in children and 1.9% in adults. Children and adolescents required double mean operative times compared to adults (11.3 vs 56.7 minutes). Study limitations reported by the authors included results may not be representative of every practice setting; an inability to differentiate between mastectomies, liposuction procedures or a combination of both; and short follow-up period of only 30 days.

A smaller retrospective study by Choi and colleagues (2017) reported short-term surgical outcomes of gynecomastia for 71 adolescents at a single Korean facility. Bilateral subcutaneous mastectomy with liposuction was performed for adolescents with a history of gynecomastia for over 3 years with psychological distress as a result. A total of 14 subjects (19.7%) experienced complications and 3 cases (4.2%) required revision. In all, 51 subjects (71.8%) were classified as having a glandular breast component. A majority of cases (70 subjects, 98.6%) self-reported satisfaction with the results. Study limitations reported by the authors included its retrospective nature and a short follow-up period of 6 months (with annual telephone interviews, thereafter).

The ADA/EAA clinical practice guidelines note:

> Only a small proportion of patients with GM will need surgical treatment. The vast majority of patients either will experience spontaneous regression or will receive specific treatment that will relieve the underlying pathology.

However, gynecomastia, being a proliferative condition of the male breast, can occasionally lead to concern about the development of carcinomatous changes in the breast. In some cases, biopsy results do not lead to a clear distinction between non-cancerous and cancerous breast tissue. In such cases, mastectomy is indicated regardless of age to properly address those concerns.

Surgical Techniques

A variety of surgical techniques have been described as being used to perform mastectomy for gynecomastia, including direct excision, liposuction or a combination of both.

Lanitis and colleagues (2008) assessed gynecomastia surgical outcomes at a single institution between 1998 and 2007. A total of 748 males were referred to the center for breast symptoms of which 65 subjects (102 breasts) with a median age of 26 years underwent surgery for gynecomastia. Breasts were treated with mastectomies (n=82) and skin reduction (n=22). The procedures carried out were subcutaneous mastectomy or breast disk excision, with or without skin reduction. Major post-surgical complications occurred in 12 breasts and consisted of hematomas requiring evacuation, wound infection, partial nipple necrosis, dehiscence, and wound break down. The authors concluded that most males with gynecomastia can be managed conservatively and after excluding malignancy, conservative treatment could include counseling for reassurance, optimization of an individual's weight and medications.

Petty and colleagues (2010) analyzed outcomes of ultrasound-assisted liposuction with an arthroscopic shaver (arthroscopic mastectomy) to remove breast tissue and compared it with other surgical techniques for the management of gynecomastia. A retrospective study was performed on a total of 227 subjects divided into 4 groups: group 1 consisted of open incision only (n=45); group 2, open incision and liposuction (n=56), group 3 liposuction only (n=50); and group 4, liposuction and arthroscopic shaver (n=76). The authors used photographs and medical records to compare surgical results and determine complications. Complications using the liposuction plus arthroscopic shaver technique noted included hematoma (n=1), scar revision (n=1), seroma (n=2), and skin buttonhole from the arthroscopic shaver (n=1). There was no difference between groups in the overall incidence of complications or the need for reoperation. Surgical results were scored on a scale of 1 (poor) to 5 (excellent) based on photographs when available and on chart review if photographs were absent. Group 4 (liposuction plus arthroscopic shaver) was reported to have the overall highest mean score based on appearance and symmetry, presence of residual tissue, nipple contour, and prominent scarring. The authors noted that liposuction alone is unable to remove glandular/fibrous breast tissue seen in many cases of gynecomastia and that the arthroscopic shaver allows for resection of fibrous remnant tissue after liposuction. Limitations included the retrospective nature of the study in which unblinded examiners based their determinations on photographs and charts. Also, there were small sample sizes for each type of technique. Larger, high-quality studies are needed to determine the safety and efficacy of ultrasound-assisted liposuction with an arthroscopic shaver.

Qutob and colleagues (2010) investigated the use of a vacuum-assisted biopsy device (VABD) and liposuction for surgical correction of gynecomastia. A total of 36 males with gynecomastia were recruited (22 bilateral, 14 unilateral) with an average age of 33.3 years (range, 16-88 years). All underwent VABD excision and liposuction. There were no conversions to an open procedure. Of the 36 participants, 34 reported excellent satisfaction and 2 had residual gynecomastia requiring another procedure. Study limitations included a small sample size and lack of randomization. The authors concluded that a randomized, controlled trial comparing the minimally invasive approach to an open technique could help establish the best surgical options for this condition.

Song and colleagues (2014) analyzed a Chinese experience of 402 males (436 breasts) treated with mastectomy and 331 males (386 breasts) treated with liposuction techniques for gynecomastia. Age range was 15 to 82 years (mean age, 29.1 years). The primary complaint was breast enlargement associated with pain with or without a palpable lump. A total of 330 (82%) complained of breast lump and lump with pain in the mastectomy group, and 204 (61%) complained of breast enlargement and enlargement with pain in the liposuction group ($p<0.05$). There was 1 case of Klinefelter's syndrome, and another of gynecomastia resulting from hormonal therapy for prostate cancer. All excision specimens were performed for routine histological analysis which showed pathologic diagnosis in the mastectomy cases (100%). Of those undergoing liposuction, 159 (41%) had acquired pathologic diagnosis through fine needle aspiration or core biopsy. Reoperation rates in the mastectomy and liposuction groups were 1.4% and 0.5%, respectively. Liposuction was performed if breast enlargement had been present for generally more than 12 months. However, true glandular hypertrophy required a surgical glandular tissue excision and subsequent histological examination. The authors concluded that surgical treatment of gynecomastia requires an individual approach, "depending on symptoms (lump or enlargement) and requirements of patients."

Liposuction might be used and be sufficient to remove predominantly fatty breast tissue (Waltho, 2017). While adult individuals with gynecomastia typically have predominantly fatty breast tissue, younger individuals commonly have higher amounts of dense glandular tissue which requires direct glandular excision rather than liposuction (Nuzzi, 2018). However, the use of liposuction to remove glandular tissue as compared to standard surgical approaches has not been shown to produce comparable, long-term results. The

incomplete excision breast tissue could serve as a target for endogenous hormonal stimulation and result in a recurrence of the condition (Innocenti, 2017).

Definitions

Gynecomastia: An excessive development of the male mammary glands, resulting in enlargement of the male breast, due mainly to ductal proliferation with periductal edema. Mild gynecomastia may occur in normal adolescence.

Mastectomy: The surgical removal of a breast.

Pseudogynecomastia (also known as lipomastia): Enlargement of the male breast due to excess fat deposition.

Sexual Maturity Rating (SMR, Tanner Stage): A commonly used measurement of sexual maturity in children, based upon the work of Tanner et al. (1962); SMR is based upon clinical findings from physical examination, as detailed below:

Classification of Sex Maturity States in Boys*

SMR STAGE	PUBIC HAIR	PENIS	TESTES
1	None	Preadolescent	Preadolescent
2	Scanty, long, slightly pigmented	Minimal change/enlargement	Enlarged scrotum, pink, texture altered
3	Darker, starting to curl, small amount	Lengthens	Larger
4	Resembles adult type, but less quantity; coarse, curly	Larger; glans and breadth increase in size	Larger, scrotum dark
5	Adult distribution, spread to medial surface of thighs	Adult size	Adult size

*From Tanner JM: Growth at Adolescence, 2nd ed. Oxford, England, Blackwell Scientific Publications, 1962. SMR, sexual maturity rating, and Marcell AV. Chapter 12- Adolescence. In: Kliegman RM, Behrman RE, Jenson HB, Stanson BF, Editors. Nelson Textbook of Pediatrics. 18th Ed. St. Louis, MO: WB. Saunders, Inc. 2007.

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History

Status	Date	Action
Reviewed	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Discussion and References sections.
Reviewed	02/16/2023	MPTAC review. Updated Discussion, References and Websites sections.
Reviewed	02/17/2022	MPTAC review. Updated References and Websites sections.
Revised	02/11/2021	MPTAC review. Clarified length of time that a trial of analgesics or anti-inflammatory agents; added “3 months” and “removed for a reasonable time period adequate to assess therapeutic effects”. Updated Discussion, Description, References and Websites sections. Reformatted Coding section.
Reviewed	05/14/2020	MPTAC review. Updated Discussion, Description, References and Websites sections.
Reviewed	06/06/2019	MPTAC review. Updated Discussion, References and Websites sections.
New	07/26/2018	MPTAC review. Initial document development. Moved content of SURG.00085 Mastectomy for Gynecomastia to new clinical utilization management guideline document with the same title.
