Cosmetic tourism: the cost of going 'under the knife' abroad for cosmetic surgery

The tissue viability service within an acute NHS Trust, with proximity to Stansted Airport, had seen an influx of cosmetic surgery associated complications between 2022 and 2024, with, on occasion, patients arriving via ambulance directly from the airport. This article outlines the challenges involved in managing these complications.

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- Tourism

The NHS is managing the aftermath of complications that follow cosmetic surgery and, increasingly, these procedures are conducted abroad – known as 'cosmetic tourism' or 'health tourism'.

The cosmetic surgery tourism industry has risen dramatically since COVID-19, with many destinations becoming very popular. One study found a surge, by more than 5000%, in Google search trends relating to cosmetic procedures that included the terms 'Turkey' and 'Lithuania' (Murphy et al, 2022). Murray (2025) identified that more than 1.2 million tourists across Europe are visiting Turkey annually for surgical procedures; this data is supported by the British Association of Aesthetic Plastic Surgeons (BAAPS, 2023a). Furthermore, complications following cosmetic surgery carried out in Turkey in 2022 rose by 35% (BAAPS, 2023a).

The number of UK residents who undertook an international visit for medical treatment in 2023 was estimated at 431,000 – an increase of 83,000 from the previous year. However, these figures are estimated via a census (Office for National Statistics, 2023), and it is possible that all surgeries may not have been declared in this data set. Visiting Turkey instead of opting for private cosmetic surgery in the UK can prove appealing due to the following:

- Cost-effectiveness: there are many packages to Turkey on offer that include flights with airport transfer, hospital stay, a quick turn-around surgery and an opportunity to recover while on holiday, often with accommodation included.
- Long elective waiting times in the UK, with many cosmetic procedures not available through the NHS.
- Increasing cost of cosmetic procedures in the UK.
- Recommendations by influencers on social media – often offering discount codes.
- The expansion in the type and range of procedures offered in Turkey, with single, multiple or 'pick and mix' type surgeries available.
- The 4-hour flight time from the UK.

Surgical interventions such as abdominoplasty, breast augmentation, liposuction and buttock lifts are some of the more common procedures, alongside hair transplants and dental treatment. This industry is increasing substantially; adults of all genders are travelling every year for cosmetic surgery. Even Tripadvisor offers resources for finding the best cosmetic surgery packages in Turkey. However, with an increase in cosmetic tourism comes an increase in post-surgical complications, either within the country of surgery or, more commonly, on return to the UK. This increase is now so significant the NHS has dedicated an advice page for this cohort of patients (NHS, 2022).

The first point of contact the patient has with the surgeon is often on the day of the procedure. It is not unusual for the surgeon conducting the procedure not to be the consulting surgeon, or for them not to speak English. This introduces an element of danger, as discussions to minimise significant risk factors and avoid complications, such as preventing surgical wound dehiscence and surgical site infection, should be carried out in advance. Surgery requires good screening and optimisation to understand the patient's medical history and contra-indicated medication for surgery. In the UK, it is a requirement for surgery, as part of the Getting it Right First Time programme (GIRFT, 2023), to promote optimal surgical outcomes.

The necessity for a pre-operative consultation giving psychological input is extremely important, as is follow up care. However, post operative wound assessment can be challenging; it is not practical for a face-to-face follow-up consultation, especially when the procedure was performed many thousands of miles from home. Anecdotal evidence has shown that some patients with complications who contact the surgeon, are advised to liaise with their GP or, if acutely unwell, the local hospital. That said, there are clinics in Turkey that are allied to London facilities, although additional costs can often be incurred, depending on the severity of complication.

Impact on the NHS

Surgical wound care expenditure, in total, is the most expensive type of wound care for the NHS. Delayed healing in surgical wounds costs approximately £985 million, which accounts for 18.9–21.8% of the total NHS wound care expenditure (Guest et al, 2017). Although the figures represent all surgical wounds, abdominal surgery is deemed to carry a higher risk of complication, including surgical site infection and surgical wound dehiscence. The NHS accommodates more complications from cosmetic tourism when compared with similar privately conducted surgeries in the UK (Ahari et al, 2024); many are abdominal surgeries. According to new data compiled by BAAPS (2023a), a growing number of people return to the UK with complications ranging from delayed wound healing to life threatening sepsis. A national audit conducted by BAAPS showed that UK residents requiring NHS hospital treatment due to surgery conducted abroad, has increased by 94% in 3 years, with 75% citing Turkey as the origin of their surgery. The average cost to the NHS is £15,000 per person, depending on the treatment required (BAAPS, 2023a).

A systematic review of 44 studies conducted in 2022 found 589 patients with complications following cosmetic procedures abroad, and identified that wound dehiscence, seroma/haematoma and tissue necrosis all required corrective interventions within NHS organisations (Alkaelani et al, 2023). However, infection was the most prevalent complication, specifically bacterial infection (98%). Research carried out from 2022–2023 within an NHS breast unit showed that 20 out of 25 patients requiring corrective surgery had undergone the initial surgery in Turkey. Bilateral breast augmentation patients were most commonly seen, due to complications of post-operative infection and wound dehiscence (72%), all presenting within 8 weeks of surgery, at a cost to the NHS of more than £37,000 (Ahari et al, 2024). This is supported by a study within the same timeframe, where an NHS plastic surgery unit found that 78% (n=23) of cosmetic complications related to breast surgery and/or abdominoplasties, which required further emergency treatment within 8 weeks of surgery, all originally conducted in Turkey (Dalmar et al, 2024). Roberts et al (2024) in their retrospective study over 5 years in NHS Scotland, found, in 81 patients, wound dehiscence (49.4%) and wound infection (24.7%) to be the most observed complications. This equates to a financial burden on NHS Scotland of £755,559.68, an average of over £9,327.90 per patient.

Travel related antimicrobial resistance is also a growing global concern (Bokhary et al, 2021); the uptrend in cosmetic tourism and associated complications including infection is, therefore, concerning. Bacterial aetiology is varied, and antimicrobial resistance can pose significant challenges, highlighting the need for early wound intervention.

Local experience

This picture is mirrored locally. In the period 2022 to 2024, the tissue viability service (TVS) cared for, and treated, at least 10 patients with complex post-operative cosmetic surgery conducted in Turkey (nine females and one male). The procedures were predominantly abdominoplasty, liposuction and buttock lift. These do not include patients seen where surgical intervention alone sufficed and, therefore, did not require input from tissue viability. The type of post-operative complication follows previous national reported complications, namely infection, wound dehiscence, skin necrosis, debridement and haematoma. Each patient spent an average of 4 weeks in the acute NHS setting, all requiring follow up care in the community.

Unfortunately, sourcing exact data locally was difficult. Surgical interventions with ‘complications’ such as this are uncoded; there is no option to capture data for surgery of origin. However, there are accounts of several surgeons’ experiences since 2022, as outlined here. Two breast consultants operated, in total, on three patients who had undergone breast augmentations in Turkey, for complications of dehiscence and infection. One colorectal consultant indicated he alone operated on approximately six patients (primarily in Turkey) within this timeframe. A general surgical registrar was involved in 20 cases. They found wound dehiscence, necrotic tissue requiring debridement, or extensive infection needing incision and drainage. Of the 20 cases, abdominal surgery represented 95% of the total, mostly the result of procedures performed in Turkey. This is a minimum data set, it is impossible to quantify further the number of patients seen in the acute hospital within this timeframe as data is not available.

One patient flew from Turkey to Stansted airport and was transferred directly by ambulance after becoming acutely unwell during the flight. The patient, in her 30s, developed sepsis after two surgical procedures: liposuction and a ‘tummy tuck’. Emergency incision and drainage of the abdomen removed two litres of pus from the paracolic gutters, located posteriorly alongside the ascending and descending colon. Partial abdominal dehiscence

of the suture line was noted, and surgical debridement was needed to remove infected and necrotic tissue; an underlying haematoma was also found. This patient was on the TVS caseload for many weeks.

Maxillofacial surgery complications are cared for under the speciality, and at the time of writing no robust data had been captured.

Wound care requirements and aftercare

In our acute setting, the surgical interventions observed included incision and drainage, tissue debridement and, in severe cases, colorectal surgery or cosmetic reconstruction. One predicament for the TVS is if surgeons are reluctant to fully open an infected, partially dehisced abdominal wound. Full exposure of the wound bed is often easier to manage as opposed to an unhealthy partial dehiscence, which, in our experience, can take longer to heal. Once emergency surgery has finished, the challenge of wound management is primarily assigned to the tissue viability nurse. This type of wound can be awkward to manage; high exudate levels requiring optimisation is necessary but often also the main cause for increased length of stay. This cohort of patients can require re-referral to the surgical team for further debridement, due to further tissue necrosis and infection. A visible wound bed is needed to encourage healthy granulation tissue, so this can prove time-consuming and demanding for a pressured tissue viability workforce.

The most notable challenges for wound care in this patient group are:

- exudate management;
- slough;
- necrosis; and
- surgical wound dehiscence.

Commonly used techniques and products used by the TVS are:

- Cavity packing containing antimicrobials.
- Autolytic debridement products.
- Silicone backed adhesive foams.
- Super absorbent pads.
- Curettage at bedside (sharp debridement is often not appropriate, or surgical debridement is required).
- Negative pressure wound therapy (NPWT) and Veraflo installation.
- Single use NPWT, such as PICO.

Surgical wound complications invariably require follow up care in the community on discharge, increasing the workload for a challenging community caseload, with notable cost implications for associated dressings and treatments. NPWT is often used due to depth, undermining, complexity of the wound and managing excessive exudate levels. However, we have found NPWT can create an obstacle. Often patients do not want to carry the pumps, feeling they are big and bulky, too conspicuous or feel embarrassed. Equally, patients find excessive malodorous exudate intolerable when wounds are conventionally packed, so there is a dilemma.

Many patients have young families and are insistent about going home as soon as infection is under control, which can create obstacles for the acute TVS when trying to navigate complex wound discharges. The patient is often reluctant to look at the wound, or involve partners or close family members to help with wound care, despite the expected longevity of wound healing.

Anatomically, the wounds can be awkward for patients to self-manage, especially the buttock and lower abdomen. Pain management can also be tricky to manage for this patient cohort. The necessity for increased nutrition and protein intake to promote wound healing can be a contentious topic, as patients are often dieting or have gastric bands. Additionally, appetites can be suppressed due to patients' acuity.

Patients can be vocal about not 'undoing' the work conducted abroad and the associated cost or lack of funds to return for further surgery. Some have unrealistic expectations, repairing the tissue damage without any detrimental effect, such as scarring. On the other hand, some patients feel shame or stigmatised for having surgery, feeling judgement from others, even though unwarranted, and requesting only trusted staff to dress their wounds, often tissue viability nurses. Sensitivity, understanding, patience and extra time is needed for this cohort.

The timescale and complexity of discharge planning, and the psychosocial aspect of care required for this patient cohort can be demanding, particularly when we are striving to improve patient outcomes for timely wound healing and improve the patients experience. Therefore, a considerable concern and challenge is who will continue monitoring and managing the patient holistically once discharged. The criteria for district nurses is predominantly house bound patients. The criteria for most general practice nurses is simple wound care and, therefore, this type of wound is too complex. Often there are no available wound care appointments for the practice nurse. Therefore, the patient presents in A&E as they have nowhere else to go for wound care. Currently, the Trust does not operate a complex wound clinic, but it is

topical at present.

We noted several patients developed secondary infections in the community. We identified discrepancies within the clinical settings history of the NPWT pumps, indicating interference or tampering from patients, particularly where no faults were detected. Fortunately, the communication and relationship between both the community and acute tissue viability services is collaborative and cohesive.

Discussion

According to a retrospective study, which won the Hackett Memorial Prize and was published by BAAPS in 2024, 83% cited cost as the deciding factor for cosmetic surgery abroad. Of respondents, 66% regretted having cosmetic surgery, and of the 66% who responded, the proportion of types of surgery were abdominoplasty (28.1%), breast augmentation (17%) and liposuction (13.1%). The most common complications included wound related issues (33%), seroma (29.1%) and infection. Although it is widely known that all surgeries carry an element of associated risk wherever conducted, safety standards and regulations can vary significantly between countries. Quality of suturing techniques, sub-standard infection control and prevention regimen can present considerable challenges for both the patient and NHS organisation upon return to the UK. As a consequence, delayed wound healing can be significant. Surgical site infection surveillance is minimal or non-existent for this group of wound types when conducted in counties where cosmetic tourism is common. This is in contrast to the UK which has regulatory standards, and provides NHS access for appropriate aftercare. A lack of regulatory standards can significantly increase the risk of complications. Minimally invasive procedures are also conducted globally, often in inappropriate premises and by unauthorised clinicians with no formal training or qualifications. They administer injection procedures such as Botox, fillers and laser epilation, which can cause undesirable results and adverse complications such as burns, and can be a cause for malpractice or negligence (Yildirim and Yildrim, 2024).

Travel insurance is stringent; holiday policies do not cover failed surgery or associated costs on arrival back in the UK, the onus is on the patient or clinic. However, the NHS have a duty of care to treat life threatening or emergency complications, and enforcing a UK citizen to pay for NHS care is not common practice. That said, where does urgent and necessary care begin and end, especially for a complex wound requiring specialist input?

Cosmetic surgery conducted privately in the UK is also not a guarantee that best practice guidelines and standards will be followed or adhered to, and the NHS has a duty of care for all patients requiring emergency treatment. Nonetheless, physical and psychological input with complex cosmetic wounds such as these can be a significant drain to NHS resources, regardless of aetiology or country of surgery.

Conclusion

As cosmetic tourism expands so will the number of surgical complications. There is no surveillance data to capture localities with poor outcomes for cosmetic surgery and no obligation currently to record it.

There are surgical and non-surgical cosmetic procedures conducted globally, some in less salubrious premises, homes, hotel rooms, Airbnbs, beauty salons and clinics. Eight seasons of the American TV programme 'Botched' highlight some of the more extreme cases of failed complexities of cosmetic surgery. The UK TV show *The Price of Perfection* showcases the general world of aesthetics and cosmetic surgery options from head to toe, as well as the potential risks associated with beauty treatments. The show's presenter advocates the importance of research and warns against deceptive practices - but bad reviews can always be deleted! This subject is so topical that one of the biggest story lines in 2024 for *Coronation Street*, highlighted a liposuction procedure undertaken in Turkey deemed 'simple' resulting in life altering consequences, both physically and psychologically, with an emphasis on body dysmorphia.

Unfortunately, there is continuing societal pressure for the imaginary 'perfect' body; however, there is also an unseen emotional aspect to cosmetic surgery which is not purely due to vanity. Many travel with high expectations of a positive experience. In reality, there is a risk of returning with significant consequences, ranging from wound complications, extensive scarring, life changing psychological struggles, intensive care admissions or even death.

More positively, the enforcement of global regulations for cosmetic procedures appears to be changing. There is a proposal in the UK for Alice's Law (Collins, 2025) to be passed, whereby only GMC registered clinicians can perform buttock augmentation. If Alice's Law is passed, the number of people illegally practicing in the UK may reduce. Recently, BAAPS and the Turkish Society of Plastic Reconstructive and Aesthetic Surgeons came together to compile advice and guidance for

patients seeking surgery in Turkey, aiming to help protect from harm and ensure patients are aware of standards of care, before and after surgery, and what minimum expectations should be (BAAPS, 2023b). However, destinations like Turkey will always be an enticing option and, unless regulated standards of practice are enforced, the challenges with cosmetic related surgery will continue to rise. The continuing burden on the NHS with the necessity for emergency and, often, lifesaving procedures will heavily weigh on the under-resourced NHS. The significant financial implications and the trajectory for procedures such as these is extremely disturbing.

Researching this topic highlighted other complications associated with cosmetic tourism that could be explored further: risks of pulmonary embolisms and deep vein thromboses associated with flying after surgery, physical and psychological distress for the patient, families and staff caring for them, social isolation, body dysmorphia, scarring, pain, nerve damage, and antimicrobial resistance.

Finally, since September 2024, the Trusts' TVS has only received one related referral, a complication of an emerging cosmetic tourism procedure called pelvioplasty.

It would be interesting to explore increases in other UK acute hospitals related to cosmetic procedures, especially with proximity to airports flying to Turkey. From March 2026, Turkish Airlines will begin flying weekly from Stansted airport, so capturing the data for surgical complications attributed to cosmetic tourism will be monitored with much interest.

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