



The Royal Australian

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Scottish Intercollegiate Guidelines Network (SIGN) grading system for recommendations in evidence based guidelines

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Glossary

EXECUTIVE SUMMARY

INTRODUCTION

The practice of circumcision in the male refers to the surgical removal of the foreskin of the penis. This policy relates to the implications of and indications for infant male circumcision. It does not relate to cases where there is a clear clinical need for intervention, nor directly to adult male circumcision. The policy is provided as a guide to professionals when assisting parents in decision-making, and as a resource for parents.

CONTRAINDICATIONS TO NEWBORN AND INFANT

0.8%. [17, 28, 33] (Level 2++) More extensive complications including fistula formation have occasionally been reported after Plastibell use. [34] Infection is usually minor but uncommonly septicaemia and meningitis may occur and rarely these complications may lead to death, even in modern times in modern health systems. [17, 35]

Freehand circumcision and the various techniques have uncommonly resulted in penile amputation. [36-38] Mono-polar diathermy and adrenaline have also been reported to cause serious complications and should be used with caution. [36, 39] Inadvertent urethral damage and fistula formation and loss of excessive amounts of skin are other uncommon, acute complications. [40-42] Longer term complications include meatal stenosis, secondary phimosis, secondary chordee, cutaneous tags, poor cosmetic appearance and psychological trauma. [42, 43] Children with prominent pre-pubic fat may have a concealed penis following surgery, but this tends to resolve at puberty. [44] Some men strongly resent having been circumcised as infants. [45] There has been increasing interest in this problem, evidenced by the number of surgical and non-surgical techniques for recreation of the foreskin. [46, 47]

ANALGESIA

Infant circumcision without analgesia is unacceptable practice in Australia and New Zealand. Analgesic options include general anaesthesia, nerve block, topical anaesthetic and sucrose.

THE ROLE OF CIRCUMCISION IN PREVENTING DISEASE

Recent studies have found that circumcision may provide relative benefits including the potential prevention of UTIs (urinary tract infections) in infancy. Among adults in developing countries where the prevalence of sexually transmitted disease is high, circumcision reduces the risk of HIV/AIDS, syphilis and chancroid. In developed countries, circumcision may decrease the lifetime risk of penile cancer in men and cervical cancer in women among high-risk populations later in life. Despite these potential benefits, evidence must be placed in the context of study settings, local prevalence rates, timing of circumcision and cultural and religious beliefs. It should also be highlighted that circumcision provides only partial protection from the above conditions and there is a need for proper hygiene of the penis. Safe sexual practices are still essential and should not be replaced by circumcision.

Any potential benefits of circumcision must be weighed against the risks associated with circumcision.

URINARY TRACT INFECTION

Urinary tract infection (UTI) occurs in up to 4% of boys, predominately in the first year of life, and in 11% of girls.[60] UTI generally causes an acute febrile illness in boys, with 25% of boys with UTI hospitalised and receiving parenteral antibiotics. Pyelonephritis occurs in 80% of febrile infants and young boys with UTIs, and permanent kidney damage is present in about 5%. There is an association between UTIs and chronic renal disease but UTI, in the absence of congenital hypoplasia or dysplasia, has not been proven to result in chronic renal failure or hypertension. About 1 in 20,000 children with a history of UTI will develop end-stage kidney disease.[61]

UTI is more common among uncircumcised boys, especially those with underlying renal tract anomalies.[62, 63] A systematic review combining results from 12 randomised controlled trials, cohort studies, and case-control studies investigating the association of circumcision and UTI concluded that circumcision reduces the risk of UTI by 10-fold.[64] A more recent meta-analysis of 18 studies of the prevalence of UTI confirmed the greater rates of UTI in uncircumcised boys.[65] (Level 2++) Nevertheless, 111 circumcisions would be required to prevent one UTI because of the low baseline risk of UTI, and only boys at high risk of recurrent

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SEXUALLY TRANSMITTED INFECTIONS

There has been conflicting evidence regarding the a

results, a comprehensive assessment and systematic review of 37 observational studies undertaken in 2005 also showed a consistent association between male circumcision and prevention of HIV.[87, 88] A further systematic review has now been undertaken confirming these results.[89] (Level 1+) A population survey conducted in South Africa however failed to show benefit of circumcision in prevention of acquisition of HIV.[90] In addition there has been recent criticism of early cessation of clinical trials because of clear therapeutic benefit because of the tendency for this practice to over-emphasise benefit.[91] Nevertheless United Nations agencies emphasise that male circumcision should be considered as a part of a comprehensive prevention package in Africa, but that warn it does not provide complete protection against HIV.[92] (Level 1+) A systematic review published in 2008 was equivocal about the protective benefits of circumcision in protecting men who have sex with men from HIV transmission, but recommended further evaluation.[93] A Ugandan study showed that adult male circumcision did not reduce the acquisition of HIV by the female sexual partners of HIV infected, circumcised men, and suggested an increased risk of HIV acquisition in these women.[94] (Level 2)

It is still not clear that the findings from African studies, where the predominant mode of HIV transmission is heterosexual intercourse, can be extrapolated to Australia and New Zealand or other western countries, which have much lower rates of HIV infection and where the predominant mode of transmission is penile-anal sex among men.[93, 95] A recent Australian report provides some information on this issue. A longitudinal study of 1427 initially HIV-negative homosexual Australian men showed that in the 53 who later seroconverted circumcision status was not identified as a relevant factor.[75] However among those with a preference for the insertive role in anal intercourse, being circumcised was associated with a reduction in risk of HIV seroconversion.

HPV AND CERVICAL CANCER

Human papillomavirus (HPV) causes genital warts in men and women, and has been most commonly linked with cancer of the cervix, with up to 99% of cases attributed to infection by oncogenic HPV genotypes. HPV infection prevalence rates vary between 13% and 52% among men. Circumcision has been shown to protect against HPV infection in a number of studies.[96-98] (Level 2+) A case control study of cervical cancer limited to women who only ever had one male partner, found that overall there was no association between circumcision status and cervical cancer. When the analysis was limited to men who had five or more partners and sex with prostitutes, circumcision did appear to reduce cancer risk in these women.[96] (Level 2+)

The introduction of HPV vaccination is expected to dramatically reduce the incidence of HPV infection and cervical cancer. The role of these vaccines in decreasing risks of HPV infection is now well established.[99, 100] It has been acknowledged that effective implementation of the HPV vaccines may lead to the virtual eradication of cervical cancer.[101] There have been calls for the extension of immunisation programs to boys, to aid in containing their risks as well.[102, 103]

PENILE CANCER & PROSTATE CANCER

A legal convention applying to the best interest of

There are analogous situations where parents decide on medical procedures for a child that involve physical risk to the child, and where the intended benefits are primarily psychosocial. Cosmetic procedures are an obvious example – e.g. removal of skin lesions, pinning of ears, re-shaping of the skull. The psychosocial benefits (fitting in, not being subject to ridicule or exclusion) are often regarded as clearly worth the physical risks of the procedure. Obtaining bone marrow from one child for transplant to a sibling is another clear example of seeking psychosocial benefits (i.e. survival of a sibling) at the risk of physical distress and harm. Thus infant male circumcision is not ethically unique. Physical risk to children is sometimes tolerated for the sake of psychosocial benefit to them. For infant male circumcision, the issue is whether the risk/benefit ratio is within reasonable bounds, and hence able to be left to the discretion of parents.

Some of the risks of circumcision are low in frequency but high in impact (death, loss of penis); others are higher in frequency but much lower in impact (infection, which can be treated quickly and effectively, with no lasting ill-effects). Low impact risks, when they are readily correctable, do not carry great ethical significance. Evaluation of the significance of

Children may grow up to disagree with decisions that parents have made for them when they were young. This cannot always be prevented or avoided. Some decisions have to be made at the time. The later disagreement of the child does not show that the parents' decision at the time was unethical or wrong. Parents and doctors have to decide the basis of their own evaluations of benefits and burdens, being aware that they are making predictions and that nothing is guaranteed. A boy circumcised as an infant may deeply resent this when he grows older; he may want what he cannot have – not to have been circumcised. But it is also possible that a boy not circumcised as an infant (so that he can make his own decision later), may also deeply resent this. He may also want what he cannot now have – to have been circumcised as a baby.

SUMMARY OF LEGAL & ETHICAL ISSUES

In New Zealand and Australia at the present time, newborn and infant male circumcision is legal and generally considered an ethical procedure, if performed with informed parental consent and by a competent practitioner with provision of adequate analgesia. In the absence of evidence of risk of substantial harm, in

Appendix 1

Scottish Intercollegiate Guidelines Network (SIGN) grading system for recommendations in evidence based guidelines

Levels of evidence

1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias

1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1 Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++ High quality systematic reviews of case-control or cohort studies; or high quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2 Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g. case reports, case series

4 Expert opinion

Source: Harbour R, Miller J for the Scottish Intercollegiate Guidelines Network Grading Review Group. A new system for grading recommendations in evidence based guidelines. BMJ 2001;323:334-336. <http://www.bmj.com/cgi/content/full/323/7308/334>

SUMMARY STATEMENTS OF OTHER PROFESSIONAL BODIES

Canadian Paediatric Society (CPS)[120]

Canadian Medical Association Journal 1996; 154(6): 769-780. A review of literature on circumcision was undertaken by the Fetus and Newborn Committee of the Canadian Paediatric Society, with extensive discussion over a 24 month period weighing up strength of evidence to assess whether the health of boys and men was improved by neonatal circumcision. It looked at cost-effectiveness in preventing penile problems and associated urinary tract conditions. The CPS concluded that while there is evidence that circumcision results in an approximately 12 fold reduction in the incidence of UTI during infancy, evaluation of alternative methods of preventing UTI in infancy is required. There is inadequate information to recommend circumcision as a public health measure to prevent HIV transmission and reduce the incidence of penile cancer. Such an even balance exists overall for the evidence of the benefits and harms of circumcision and as such, evidence does not support recommending circumcision routinely in newborns. The position of the CPS is unchanged from that taken in 1982. The final

procedure should be trained in children's surgery, and the operation must be undertaken in an operating theatre or similar premises suitable for surgical procedures. Parents need to be made fully aware of the implications of this non-reversible operation, and the child should receive adequate pain relief during and after the procedure.

British Medical Association (BMA)[118]

The law and ethics of male circumcision – guidance for doctors. The guidance outlines good practice and safeguards which the BMA believes doctors should follow. It cites the British Association of Paediatric Surgeons' conclusion that there is rarely a clinical indication for circumcision, and doctors should be aware of this and reassure parents accordingly. Non-therapeutic circumcision is discussed in "ritualistic" terms, including circumstances where performed for religious reasons, to incorporate a child into a community, or where some want their sons to be like their fathers. The association has no policy on these issues, and a spectrum of views exists as to whether it is beneficial, neutral, harmful or even superfluous. The Association accepts the difficulty in formulating a policy where there is a lack of unambiguously clear and consistent data, and medical harms or benefits have not been unequivocally proven. Legal and ethical considerations are discussed, and male circumcision is generally assumed to be lawful provided that it is performed competently; it is believed to be in the child's best interests; and there is valid consent. The medical evidence about the health impact of male infant circumcision remains equivocal. Circumcision for medical purposes, where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate.

American Urological Association[123]

The American Urological Association, Inc.® (AUA) believes that neonatal circumcision has potential medical benefits and advantages as well as disadvantages and risks. Neonatal circumcision is generally a safe procedure when performed by an experienced operator. There are immediate risks to circumcision such as bleeding, infection and penile injury, as well as complications recognised later that may include buried penis, meatal stenosis, skin bridges, chordee and poor cosmetic appearance. Some of these complications may require surgical correction. Nevertheless, when performed on healthy newborn infants as an elective procedure, the incidence of serious complications is extremely low. The minor complications are reported to be three percent.

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Three studies from African nations published in 2005 and 2007 provide convincing evidence that circumcision reduces by 50-60% the ri

Appendix 3

Glossary

Chordee: Curvature of the penis due to scar tissue or abnormality of the corpora cavernosa (the blood containing tissue that supports an erection).

Dorsal: The back or upper surface.

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