

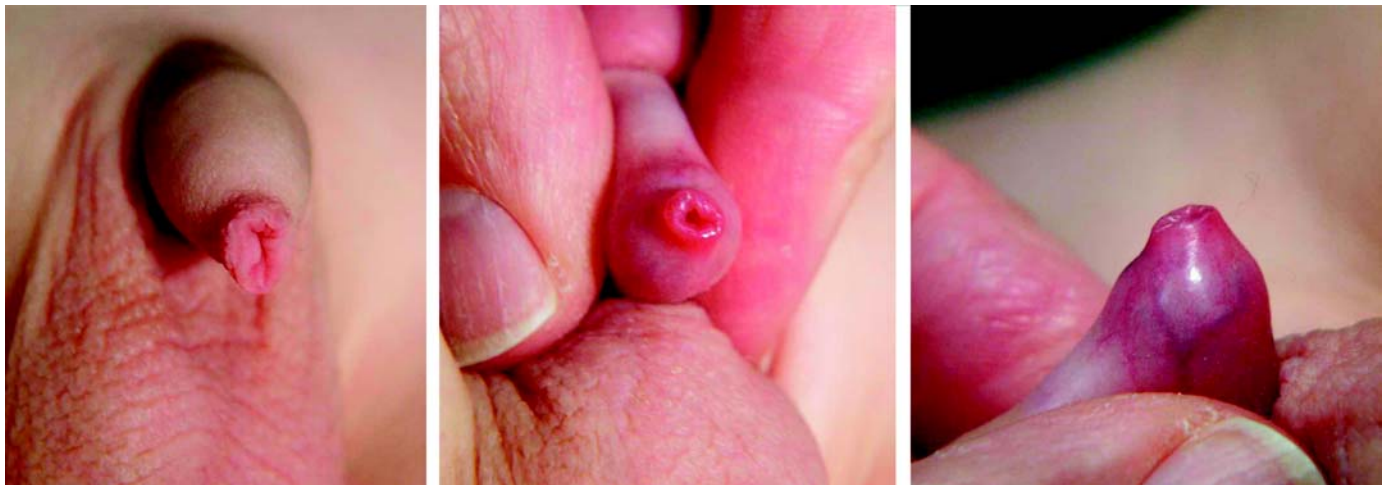
Treating phimosis

First, let's decide what we really mean by phimosis

CIRCUMCISION REMAINS A TOPIC of significant debate in Australia, even though there has been a marked reduction in the rate of circumcision in this country, which has reflected that of England, where 95% of boys were circumcised in the 1930s, declining to 6.5% in the early 1980s.¹ In this issue of the Journal (*page 155*), Spilsbury and colleagues report that many boys are circumcised for phimosis before the age of five years, despite phimosis being rare in boys of this age.² They reviewed all circumcisions in Western Australian hospitals between 1981 and 1999, recording that the rate of medically indicated circumcisions increased during that period, and that, if the 1999 rate remains stable, it would be seven times the expected incidence of phimosis in the group of boys aged less than 15 years. These findings imply a high rate of unnecessary surgery, similar to the findings from studies conducted in England.^{1,3}

Spilsbury and colleagues define phimosis as “narrowing of the preputial orifice leading to non-retractability of the prepuce”. Such a definition would result in many boys under the age of five years being diagnosed with a condition for which surgery is considered to be justified. Their use of the term phimosis seems to mean pathological

phimosis. To clarify, the prepuce is regarded as normal in boys if non-retractable because of preputial adhesions, or if the skin is physiologically non-retractable because of narrowing (ie, physiological phimosis). Figure 1 shows a normal foreskin that is non-retractable. The terms phimosis and non-retractable are not sufficiently clear in isolation, and need to be qualified. Rickwood and colleagues have recently given a succinct definition, stating that the “. . . normality, with an unscarred and pliant preputial orifice, is clearly distinguishable from *pathological* phimosis [shown in Figure 2], a condition unambiguously characterised by secondary cicatrisation of the orifice . . .”.¹ The addition of the word “pathological” or “physiological” is necessary to differentiate the different prognoses for phimosis, and, if the foreskin is not retractable because of adhesions to the glans, that information needs to have been included in the definition and documentation. Thus, rewriting the extract from the article by Spilsbury and colleagues, “many boys are circumcised for (*pathological or physiological*) phimosis before the age of five years, despite (*pathological*) phimosis being rare in this group”.



1: A normal foreskin that is non-retractable, with pouting of the most distal portion when gentle retraction is attempted.

Why does the rate of circumcision for phimosis exceed the expected rate of phimosis?

Clearly, the word “phimosis” in isolation does not have sufficient power to separate disease from a normal condition. Further, if parents feel there will not be support from the general practitioner, they may complain of symptoms in their child for the purpose of avoiding the debate about the appropriateness of circumcision for cosmetic reasons. Alternatively, the GP may support the parents’ desire to have their boy circumcised, but expect resistance from the surgeon, and thus tend to present the child as having a pathological diagnosis. Such manipulation is not surprising when dealing with such an emotive topic. Nor is it necessarily improper given the differing cultural and medical views on the value of circumcision. A further explanation for the high circumcision rate for (pathological) phimosis might be a reluctance to record non-medical circumcision as such, using the appropriate *International classification of diseases* codes.^{4,5}

What is the optimal treatment for phimosis?

A wide body of evidence shows that most boys can be treated successfully with steroid cream, and that circumcision is required only infrequently.⁶⁻⁹ Unfortunately, almost all of these studies lack the distinction between pathological phimosis, as defined by Rickwood et al,¹ and other foreskins that are non-retractable either as a result of preputial adhesions or because they are physiologically non-retractable. However, clinical experience suggests that most cases of pathological phimosis can be successfully treated with steroid cream, provided the steroid cream is applied to the partly retracted prepuce three times daily. After 4–6 weeks the prepuce should be retracted at the time of bathing and after voiding.¹⁰

It also appears that even balanitis xerotica obliterans can be successfully treated without circumcision,¹¹ particularly if steroid treatment is supplemented with the minor operation of preputioplasty, in which the distal end of the prepuce is

widened.¹² Unfortunately, because the use of the term phimosis does not recognise the variations of the normal foreskin, the roles of observation, steroid cream and circumcision have not yet been compared in a study that has used a rigorous definition of pathological phimosis.

There remains debate about the care of the normal prepuce in infant males. Parents are usually advised not to touch it, whereas the normal hygiene approach to body parts is one of not hurting, but keeping clean. The latter policy may help prevent skin irritation at the end of the prepuce, which may be part of the cause of pathological phimosis and balanitis (although this needs to be supported by appropriate studies).

Evidence-based discussion about circumcision with parents will only be able to occur once we have undertaken prospective studies of the care of the prepuce and the use of steroids for treating phimosis. Parents will then be confident that their uncircumcised boy will not develop disease attributable to the nature of the foreskin. However, we should first focus on integrating a standard definition of phimosis into the study protocols.

In the meantime, we should respect the view of parents who regard circumcision as good treatment for their child, given certain provisos. One is that they have been made aware of other options. The other is that they are making an appropriately informed decision about the management of their boy’s prepuce because they are aware that “phimosis” does not equate to “pathology”, and “pathology” does not always need surgery.

Finally, Van Howe et al warn that physicians who perform “involuntary” circumcision are required to provide full disclosure. However, they also warn that, “with current legal precedent, this may not be enough” to protect the doctor from legal action,¹³ further emphasising the need to develop sound definitions on which to base our treatment of the prepuce.

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2: This foreskin shows the dome configuration of a boy with “true” phimosis. The fibrosis and pinhole meatus are also seen.

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Refusal of parents to vaccinate: dereliction of duty or legitimate personal choice?

Despite the risks to unvaccinated children, compulsory vaccination is not the answer

IN A PLURALISTIC SOCIETY, there are many views on what constitutes acceptable child-rearing. In Australia and other Western societies, parental discretion is limited primarily by legislation against abuse or neglect. In treatment decisions, the legal starting point is that the united view of both parents is correct in identifying the child's welfare. A court will usually only override the parents' decision if the judge is convinced the child's life is endangered, such as when a child needs transfusion.² Administration of a vaccine is never immediately life-saving in this sense, except in the case of post-exposure rabies vaccine,³ but vaccination satisfies ethical criteria for preventive interventions in children: it is effective, minimally invasive, and associated with significant societal benefits.³ Indeed, the highly favourable benefit-to-risk ratio of childhood vaccination is so well documented that healthcare professionals are understandably frustrated when faced with what seems to be an irrational decision by parents to refuse vaccination. This is especially so when this decision has resulted in failure to prevent a life-threatening illness, as in the tetanus case presented by Goldwater et al (*page 175*).⁴ This case raises issues for both the clinician and society. How do healthcare professionals understand and best respond to a conscious decision not to vaccinate? In a highly immunised population, what is the balance of risks and benefits to individual children and their contacts from refusal to vaccinate? Should a case such as this propel us towards compulsory vaccination?

In Australia, vaccination is not compulsory, but various incentives and reminders aim to promote it. First, payment of the maternity allowance at 18 months and the childcare benefit requires up-to-date vaccination according to the Australian Childhood Immunisation Register (ACIR),⁵ unless a medical practitioner has notified the ACIR of a contraindication or serologically confirmed immunity, or has discussed conscientious objection with a parent. Second, at school entry, documentation of full vaccination is required in most Australian jurisdictions, with children who do not have such documentation or serological proof of

immunity to specific diseases, such as measles, able to be excluded from school attendance if suspected cases occur. Although the United States is often quoted as having laws for mandatory vaccination, the practical effect of these laws is also limited to exclusion of unvaccinated children from school during outbreaks, although preschool attendance for such children can be barred altogether.⁶ Italy is one of a few countries where there is compulsory vaccination, but only for diphtheria, tetanus, polio and hepatitis B. However, this has not been enforced for many years.⁷ To find examples of truly compulsory vaccination, it is necessary to go back to the 19th century. In England, the Vaccination Act of 1853 made smallpox vaccination compulsory for all infants in the first three months of life, on pain of fine or imprisonment. Its enactment spawned riots in several towns and an active anti-vaccination movement. In 1898, a new Vaccination Act removed these penalties and introduced the concept of "conscientious objector" into English law.⁸

In present-day Australia, most parents whose children are not fully vaccinated are not conscientious objectors, but rather face practical barriers such as recurrent minor illness, work commitments, large family size or social disadvantage.^{9,10} Parents who are strongly opposed to vaccination comprise a much smaller group. Of a large sample of 1779 Melbourne children in childcare in 1997, only 13 (0.7%) had not received any vaccines.¹⁰ This is similar to the proportion of all children Australia-wide registered with Medicare for whom there is a registered conscientious objection.⁵ In general, such parents tend to be well educated, older, female and of Anglo-Saxon background.^{11,12} Qualitative data suggest that conscientious objectors fear possible but unknown, especially long term, adverse effects of vaccines, believe that lifestyle measures to improve general immunity are viable alternatives to protection from vaccines, and often mistrust the motives of healthcare providers.^{9,12} This limits the ability of healthcare professionals to present pertinent counterarguments. Indeed, there is some evidence that parents philosophically opposed to