Inappropriate circumcision referrals by GPs

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Summary

One hundred and twenty boys were referred by GPs over a 12-month period to a paediatric urologist for circumcision. The reasons for referral were: ballooning in 36, non-retraction in 28, balanoposthitis in 36 or a combination in 15. On examination 53% had a retractile, 21% a partially retractile and 21% a non-retractile foreskin. Six patients had obvious balanitis xerotica obliterans. Only one quarter of the patients required a circumcision. The penis was not examined by the referring doctor in 15 patients. The implications of this survey are that a large proportion of general practitioners have difficulty in discriminating between a true phimosis and a developmentally non-retractile foreskin. This diagnostic inaccuracy was greatest when the referring doctor did not examine the patient.

Introduction

Circumcision is one of the oldest of all surgical procedures dating back over 4000 years. Despite a fall in popularity during the later half of this century, it remains one of the commonest operations performed on boys in this country. With the demise of religious circumcisions medical indications have become paramount. The commonest is phimosis, real or perceived. We felt that many patients were referred for an opinion regarding the presence of a phimosis unnecessarily and therefore decided to evaluate this with a prospective study at the Bristol Royal Hospital for Sick Children.

Materials and Methods

All patients referred to one paediatric urologist in a 12-month period from May 1988 to May 1989 were studied. The only requirement for inclusion in the study was that the referring GP requested an opinion on whether a circumcision was indicated or not. A standard card was completed for each patient attending the clinic detailing the reason given by the GP for referral, whether the penis had been examined by the GP, the consultant's clinical findings, and recommended treatment. If it was not clear from the referral letter whether the GP had examined the patient, a discreet inquiry of the parents yielded the answer in most cases.

Results

One hundred and twenty boys were referred in a 12-month period with an age range of 4 months to 13 years and a mean age of 5 years. The reasons given for referral were: ballooning, 36 (30%); non-retraction, 28 (23%); and balanoposthitis, 36 (30%). Fifteen patients had a combination of two or more of the above (12.5%). Five patients did not fall into any of these categories. Two were referred following school medical examinations with a presumed abnormal foreskin, one was referred with dysuria, and one because of the presence of smegma. There was only one referral for a religious circumcision.

On examination, the paediatric urologist found 64 boys (53%) with a retractile foreskin, 25 boys (21%) with a partially retractile foreskin, 25 boys (21%) with a non-retractile foreskin and six boys (5%) with balanitis xerotica obliterans (BXO). Those with BXO had the diagnosis confirmed histologically after circumcision.

All 30 patients (25%) with a true phimosis were circumcised. Eighty-four patients (70%) with a retractile foreskin were reassured and six patients (5%) with a partially retractile foreskin were either recommended no treatment or advised gentle self-retraction. A small number were recalled for review.

We correlated whether the general practitioner had examined the penis or relied upon the history alone with the clinical findings and eventual outcome. Male and female general practitioners examined similar ratios of patients (male GPs: examined 75, unexamined 12; female GPs: examined 19, unexamined 3).

Fifteen patients (14%) referred for circumcision had not been examined by their GP: 12 had a retractile foreskin, two had a partially retractile foreskin and one had a true phimosis. Only one unexamined patient was felt to merit circumcision and only three (20%) had any abnormality.

Discussion

Circumcision remains one of the commonest paediatric surgical procedures with over 20 000 boys under 15 years of age circumcised annually in this country[1].

Leaving aside the financial implications, there are risks and benefits for the patient. There is a small but definite mortality and morbidity associated with circumcision when a general anaesthetic is used. The benefits of circumcision are a reduced incidence of penile cancer and, perhaps, a reduction in infantile urinary tract infections[2]. However, carcinoma of the penis is rare in the UK and prophylactic circumcision could not be advocated solely as a protection against the disease. Similarly, whilst the evidence that routine infantile circumcision reduces the frequency of early urinary tract infections is persuasive, Winberg *et al.*[3] propose a less radical alternative. At present, routine circumcision cannot be justified on the grounds of preventing diseases at a later date.

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The only absolute indication for circumcision is the presence of a true phimosis. What constitutes a phimosis has been extensively debated but it clearly does not equate with a non-retractile prepuce. Gairdner, in 1949, described the development of the prepuce and pointed out that 10% of boys have a non-retractable foreskin at the age of 3 years[4]. Oster showed that this persisted in only 1% by the age of 17 years[5], fewer than the number actually circumcised. Of the 120 boys referred for consideration of circumcision in our series, 25% came to operation. This figure accords closely with that of Rickwood and Walker in their review of circumcisions in the Mersey region[6].

Clearly, one implication is that a large proportion of GPs have difficulty in discriminating between a true phimosis and a developmentally non-retractile foreskin. Not surprisingly, the diagnostic inaccuracy was greatest when the referring doctor did not examine the patient.

In this series, there was at least one referral for circumcision per consultant clinic, a not inconsiderable workload. As 75% required only reassurance we feel that there is room for improvement in terms of educating doctors to distinguish between a physiologically non-retractile foreskin and a pathological phimosis. Perhaps if this is achieved, the 'rape of the phallus'[7] will be increasingly recognized as an unnecessary and traumatic procedure for the majority of boys.

References

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Forthcoming events

International GCP - New Developments in Europe and Canada
8-9 June 1992, Toronto, Canada
Further details from: IBC Technical Services, Gilmoora House, 57-61 Mortimer Street, London W1N 7TD (Tel: 071 637 4383; Fax: 071 631 3214)

Introduction to Pharmaceutical Medicine
10-11 June 1992, London
Further details from: (see entry for 8-9 June 1992)

13th International Symposium on Computer Assisted Decision Support & Database Management in Anesthesia, Intensive Care and Cardiopulmonary Medicine
10-12 June 1992, Rotterdam, The Netherlands
Further details from: Dr O Prakash, Chief, Thorax Anesthesia Thorax Centre, Dijzigt Hospital, Dr Molewaterplein 50, 3015 GD Rotterdam, The Netherlands (Tel 31-10-463 5230; Fax: 31-10-463 5240)

13th International Symposium on Computers in Clinical Medicine and Anesthesiology
11-13 June 1992, Rotterdam, The Netherlands
Further details from: (see entry for 10-12 June 1992)

Allergy Problems in Buildings
12 June 1992, RSA, London
Further details from: Dr Bryan Walker, Oscar Faber Applied Research Ltd, Marlborough House, Upper Marlborough Road, St Albans AL1 3UT (Tel: 081 784 5784; Fax: 081 784 5700)

Data Handling for Medical Audit
16-17 June (*also 19-20 November*), RCGP, London
Further details from: The Royal College of General Practitioners, Corporate Development Unit, 14 Princes Gate, Hyde Park, London (Tel: 071 581 3232; Fax: 071 225 3047)

Protecting and Exploiting Biotechnological Inventions
17-18 June 1992, Brussels, Belgium
Further details from: (see entry for 8-9 June 1992)

Platelets
18-19 June 1992, London
Further details from: (see entry for 8-9 June 1992)

Managing General Practice in the 90's
19-20 June 1992 (*also 4-5 September/27-28 November*), RCGP, London
Further details from: (see entry for 16-17 June 1992

First National Conference of Medico-Legal Societies of the UK
20-21 June 1992, Birmingham
Further details from: Conference Secretariat, Birmingham Medico-Legal Society, c/o UCC Europe, 17 Salisbury Road, Moseley, Birmingham B13 8JS (Tel: 021 449 7098: Fax: 021 442 4850)

Depression: Practical Problems of Clinical Trials
24-25 June 1992, London
Further details from: ROSTRUM, Lewis House, 1 Mildmay Road, Romford, Essex RM7 7DA (Tel: 0708 735191; Fax: 0708 734876)

Biology and Pharmacotherapy of Manic-Depressive Disorders: From Molecular Theories to Clinical Practice
24-26 June 1992, Copenhagen, Denmark
Further details from: Organizing Committee, Department of Pharmacology, University of Copenhagen, 20 Juliane Maries Vej, DK-2100 Copenhagen 0, Denmark (Tel: 45 35 37 03 75; Fax: 45 35 37 72 89)

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