Male circumcision: get the timing right

The most commonly performed surgical procedure in the world — male circumcision — is done for therapeutic, prophylactic, religious, cultural and social reasons. Discussions of male infant circumcision for health reasons are always split. Proponents suggest there are significant potential health benefits including a decreased risk for some sexually transmitted infections, a decrease in HPV related penile cancer and reduced phimosis, paraphimosis. On the other hand, opponents comment on the complication rate of 1.5% and only modest benefits, while noting that it is a painful procedure for neonates with possible long-lasting effects such as lowering the threshold for pain, and that it is based on tradition not evidence.

For more than a decade, the American, Canadian and Australian pediatric specialists organizations have not recommended routine infant circumcision, noting that the existing evidence was insufficient to support it. Each of these organizations regularly reviews its guideline statements to determine if positions need to be updated. The question now is whether the findings from the randomized trials of adult male circumcision in sub-Saharan Africa that show circumcision halves the risk of acquiring HIV and decreases risk for HSV-2, and high-risk HPV in heterosexual African adult men push these organizations to change their positions on routine infant circumcision. The Paediatrics & Child Health Division of the Royal Australasian College of Physicians is the first back with its recommendation routine infant circumcision, not-}

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child with respect to HIV and HPV protection. The potential benefit from circumcision only begins to accrue when the male becomes sexually active. Thus the important question for these pediatric societies is not about a change in infant circumcision recommendations, but rather the need to address whether there would be merit in routine peripubertal male circumcision. The evidence for risks and benefits of circumcision in this age group has not been assessed in the same rigorous manner as those for infant circumcision. Modelling of potential benefits and cost-effectiveness studies would also need to be done. For example HPV vaccine for males in this age group might be a better strategy for prevention of HPV than circumcision. Some adult males may squirm at the very thought of routinely offering circumcision to peripubertal males, possibly because of perceived pain and discomfort. But infant circumcision also causes pain and discomfort. Indeed it’s curious that a painful elective procedure of no major benefit to the infant until years later would ever be deemed more acceptable than the same procedure for a peripubertal boy. The adolescent scenario would also have an additional advantage: the opportunity for informed choice by the proposed recipient of the procedure. The boy can give assent, while a neonate cannot. As well, this would provide a prime opportunity to discuss other ways to decrease risk of sexually transmitted infections whether or not the peripuber-

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