

As mentioned in our study,² all patients were initially investigated by urine cytology, which were all negative. Similarly, Feifer and colleagues⁴ found that for patients with MH, voided urine cytology added a significant cost without any diagnostic benefit in the workup for low-risk patients. In their study, it was shown that of 200 patients, 8 (4%) had low-grade urothelial bladder cancer via cystoscopy (Ta or T1 tumours). Of these 8 patients, the cytology was negative in 4 patients and atypical in 4. These cases were asymptomatic contrary to our patients with lower urinary tract symptoms. The economic study referred to by Tin and colleagues was a retrospective study depending on data collection of cases presented in 2003 and 2004 and still confirmed the role of cystoscopy, following negative cytology.

We found that 20% of our cases presented with MH had negative urine cytology, negative findings in multiphasic computed tomography, and positive cystoscopic finding – this number of close to those presenting with gross hematuria. This confirms the importance of cystoscopy as an initial diagnostic tool for high-grade MH.

Competing interests: Authors declare no competing financial or personal interests.

References

1. Tin SS, Wiwanitkit V. Microscopic hematuria and urothelial malignancy [letter]. *Can Urol Assoc J* 2014;8:395. <http://dx.doi.org/10.5489/cuaj.2440>
2. Kotb AF, Attia D. High-grade microscopic hematuria in adult men can predict urothelial malignancy. *Can Urol Assoc J* 2014;8:E481-4. <http://dx.doi.org/10.5489/cuaj.1746>
3. Davis R, Jones JS, Barocas DA, et al. Diagnosis, evaluation and follow up of asymptomatic microhematuria (AMH) in adults: AUA guidelines. *J Urol* 2012;188(6 Suppl):2473-81. <http://dx.doi.org/10.1016/j.juro.2012.09.078>
4. Feifer AH, Steinberg J, Tanguay S, et al. Utility of urine cytology in the workup of asymptomatic microscopic hematuria in low risk patients. *Urology* 2010;75:1278-82. <http://dx.doi.org/10.1016/j.urol.2009.09.091>

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Scientific evidence dispels false claims about circumcision

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A recent letter by Robert Darby¹ opposing infant male circumcision (IMC) is not evidence-based, whereas the American Academy of Pediatrics (AAP) 2012 policy supporting IMC is evidence-based.² It concluded that since benefits exceed risks, parents should receive education early in a pregnancy, providers should be trained in safe, sterile technique using local anaesthesia, and access and third party reimbursement should be provided. Not surprisingly, opponents of IMC went on the attack, denouncing the new policy and trotting out their usual array of dubious claims. The knee-jerk reactions by these so-called “child health and human rights experts” have been debunked by the AAP, as well as academic and clinical experts. But Darby ignores the AAP’s response,³ which argued persuasively that claims of “cultural bias” actually applied to the mostly European authors whose paper Darby cites. He also ignores the withering critique⁴ of the article by Svoboda and Van Howe, which he cites.⁵

While IMC does not protect “the neonate, infant or young child” from “HIV and HPV,” the benefits of IMC begin early in life, not just “when the male becomes sexually active.” Benefits include protection

against urinary tract infections,⁶ penile inflammation, inferior hygiene, phimosis, and paraphimosis.^{2,7} Such protections continue through life and in adulthood are supplemented by protection against oncogenic HPVs, genital herpes, some other sexually transmitted infections, candida, penile cancer, prostate cancer,^{2,7} and in women cervical cancer, sexually transmitted infections and bacterial vaginosis.

In contrast to Darby’s claims, the risk of an adverse event from an IMC performed by a competent operator is <0.5%, virtually all of these being easily and immediately treatable with complete resolution.^{2,7,8} His emotive rhetoric about “amputation” (a term reserved for limbs or the entire penis, not the prepuce) and the foreskin being “highly vulnerable to complications and messy cosmetic outcomes,” is extremist and supported by an anti-circumcision book and a 1999 issue of *BJU International* by opponents rather than credible evidence.

The evidence thus flatly contradicts Darby’s statement that “there is no medical justification for circumcision in infancy.” Early infancy is the best time for circumcision. Not only is it safer, simpler, cheaper and more convenient, with optimum cosmetic outcome, but IMC provides immediate lifetime protection, making it akin to vaccination.⁹ Delay means barriers will occur that in older children, adolescence and adulthood reduce the likelihood it will occur, even if the male wishes he were circumcised.⁹

In seeking support for his position, Darby cites a negative IMC policy statement in 2010 by the Royal Australasian College of Physicians (RACP), but fails to reference the devastating critique published in a RACP journal showing why the policy was not evidence-based.⁹

Darby cites his own website in claiming that IMC is in decline in Australia, while not explaining that such statistics apply to Medicare

claims, not actual circumcisions. In the United States, prevalence has risen in white, black and Hispanic men, while the general prevalence of IMC is difficult to ascertain.⁷

Darby concludes, contrary to the AAP policy, that medical personnel and parents should be advised that “routine circumcision of infants is likely to do more harm than good,” while ignoring data showing benefits exceed risks by 100 to 1 and that over the lifetime half of uncircumcised boys will experience a medical condition caused by their foreskin.⁷

If Darby’s arguments were applied logically to beneficial low-risk medical procedures, childhood vaccinations would also need to be avoided. In the interest of public health and individual well-being IMC should be promoted

and implemented as recommended by the AAP.

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References

1. Darby R. To avoid circumcision complications, avoid circumcision. *Can Urol Assoc J* 2014;8:231. <http://dx.doi.org/10.5489/cuaj.1709>
2. American Academy of Pediatrics. Circumcision policy statement. Task Force on Circumcision. *Pediatrics* 2012;130:e756-85.
3. Task Force on Circumcision. Cultural bias and circumcision: The AAP Task Force on Circumcision Responds. *Pediatrics* 2013;131:801-4. <http://dx.doi.org/10.1542/peds.2013-0081>
4. Morris BJ, Tobian AAR, Hankins CA, et al. Veracity and rhetoric in pediatric medicine: A critique of Svoboda and Van Howe’s response to the AAP policy on infant male circumcision. *J Med Ethics* 2013;40:463-70. <http://dx.doi.org/10.1136/medethics-2013-101614>
5. Svoboda JS, Van Howe RS. Out of step: Fatal flaws in the latest AAP policy report on neonatal circumcision. *J Med Ethics* 2013;39:434-41. <http://dx.doi.org/10.1136/medethics-2013-101346>
6. Morris BJ, Wiswell TE. Circumcision and lifetime risk of urinary tract infections: A systematic review and meta-analysis. *J Urol* 2013;189:2118-24. <http://dx.doi.org/10.1016/j.juro.2012.11.114>
7. Morris BJ, Bailis SA, Wiswell TE. Circumcision rates in the United States: Rising or falling? What effect might the new affirmative pediatric policy statement have? *Mayo Clin Proc* 2014;89:677-86. <http://dx.doi.org/10.1016/j.mayocp.2014.01.001>
8. El Bcheraoui C, Zhang X, Cooper CS, et al. Rates of adverse events associated with male circumcision in US medical settings, 2001 to 2010. *JAMA Pediatr* 2014;168:625-34. <http://dx.doi.org/10.1001/jamapediatrics.2013.5414>
9. Morris BJ, Waskett JH, Banerjee J, et al. A ‘snip’ in time: What is the best age to circumcise? *BMC Pediatr* 2012;12:1-15.
10. Morris BJ, Wodak AD, Mindel A, et al. The 2010 Royal Australasian College of Physicians policy statement ‘Circumcision of infant males’ is not evidence based. *Intern Med J* 2012;42:822-8. <http://dx.doi.org/10.1111/j.1445-5994.2012.02823.x>

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