

CUA guideline on the care of the normal foreskin and neonatal circumcision in Canadian infantsSumit Dave¹; Kourosch Afshar²; Luis H. Braga³; Peter Anderson⁴¹Department of Surgery (Urology), Western University, London, ON; ²Department of Urologic Sciences, University of British Columbia, Vancouver, BC; ³Department of Surgery (Urology), McMaster University, Hamilton, ON; ⁴Department of Urology, Dalhousie University, Halifax, NS; Canada**Cite as:** *Can Urol Assoc J* 2017 Dec. 1; Epub ahead of print.<http://dx.doi.org/10.5489/cuaj.5033>**Published online December 1, 2017**

Introduction

Circumcision is the oldest planned operative procedure in the history of the human civilization but there continues to be a lack of consensus and strong opposing views on whether universal neonatal circumcision should be adopted as a public health measure. The recent American Academy of Pediatrics (AAP) guideline on male circumcision (MC), reversed its prior stand stating that the “health benefits of newborn male circumcision outweigh the risks” and justify access to the procedure if the parents so choose [1]. This recommendation was primarily based on the impressive results from African trials demonstrating the protective effect of MC against Human Immunodeficiency Virus (HIV) and sexually transmitted infections (STI).

A review of the literature on MC shows evidence of a vehement debate, often clouded by strong personal biases and lack of high quality evidence. Creation of a guideline specific to the need of Canadian infant males is therefore difficult given the level of evidence provided for each potential benefit, the lack of data directly applicable to the Canadian population, the inability to quantify the true complication rate of routine circumcisions accurately, uncertainty about the health benefits of a circumcision compared with other health interventions, the ethical issues and acceptability of a surgical procedure done by parental consent for future benefits, and the costs of training and implementation of any universal neonatal circumcision policy in Canada.

Acceptance and trends of neonatal circumcision

Neonatal circumcision rates are declining across several countries including Canada and this may be a reflection of changing demographic patterns and parental beliefs. The Provincial Ministries of Health in Canada indicate circumcision rates of 51-67% in 1970. In 2009, the Public Health Agency of Canada reported an overall Canadian circumcision

rate of 31.9% for 2006-2007 [Public Health Agency of Canada, 2009]. This varied across the provinces with the rate being highest in Alberta (44.3%) and lowest in Nova Scotia (6.8%) (www.circinfo.net).

A Centers for Disease Control and Prevention (CDC) report showed a decreasing trend in US circumcision rates from 1999-2000 till 2008-2010 from 60% to 55% of newborn males [2]. In the UK between 1997-2004, circumcision rates declined from 2.6/1000 boys/year to 2.1/1000 boys/year [3]. However, a more recent study from the US using the Nationwide Inpatient Sample noted an increasing trend of neonatal circumcisions from 48% in 1988-1991 to 61% in 1997-2000, reflecting an increase of 6.8% on average every year [4].

A survey of prospective parents in the US was assessed to obtain parental views of circumcision analyzing the effect of the AAP 1999 circumcision guideline and recent HIV and Human Papilloma Virus (HPV) trials [5]. Individuals with previous circumcised sons, those born in the US and those who discussed circumcision with their partner were more likely to request circumcision. There was no change in support after reading information on recent HIV/HPV trials from Africa. A similar survey in Canada indicated that circumcision status of the father significantly influences the child's circumcision [6]. This study indicates that initial parental views rather than new evidence may continue to be the strongest determinant for neonatal circumcision.

Aims of the review

The aim of this guideline is to present the current evidence on the benefits of circumcision, the optimal anesthesia/analgesia requirements of neonatal circumcision, the possible complications of circumcision and its effect on sexual function and sensation and the care of a normal foreskin in early childhood. This guideline is directed towards pediatric care-givers who routinely examine and follow male infants, physicians who provide neonatal circumcision services and pediatric urologists and general surgeons. The current guideline is written with the purpose of being applicable to the Canadian population and health care system. The evidence presented is classified according to the Oxford system of evidence-based medicine [7].

The current guideline attempts to answer the following questions:

1. Do the potential benefits of neonatal circumcision justify performing universal neonatal circumcision in Canada?
2. For an individual patient and parent, what are the benefits and risks of a neonatal circumcision and how reliable and applicable is the evidence currently available?
3. What should be the prescribed routine foreskin care in infants, indications for medically indicated circumcision and management of physiological phimosis?

Methods

Systematic literature searches were conducted in MEDLINE including Pre-MEDLINE EMBASE, BIOSIS Previews®, Web of Science® – with Conference Proceedings, and the Cochrane Central Register of Controlled Trials electronic bibliographic databases and were restricted to either adult or pediatric studies (</> 18 years) (2002 to March 2013). All searches were restricted to studies published in English language only.

The search queries were developed using combination of subject headings and free-text terms such as circumcision, circumcision male, uncircumcised, male sexual dysfunction, sexual dysfunction physiological, sexual dysfunctions psychological, erectile dysfunction, sexual problems, sexual arousal disorder, ejaculation dysfunction, sexuality, prostatic neoplasms, prostate cancer, prostate tumor, penile neoplasms, penile cancer, urinary tract infections, phimosis, HIV infections, HIV, human immunodeficiency virus, HPV infections, STI's, using variant spellings and endings. For all searches, editorials, news and letters were excluded. The bibliographies of all relevant retrieved articles and reviews were also examined to identify further relevant articles.

A total of 2674 records were identified and after removing duplicate records and excluding non-relevant studies, 229 studies were identified for detailed analysis and included in this analysis.

Care of the normal foreskin in childhood and management of physiological phimosis***Natural history of the foreskin***

The prepuce arises from the coronal margin by a combination of folding and epithelial outgrowth and has an outer and inner layer separated by Dartos fascia. At birth, the inner foreskin is usually fused to the glans penis and should not be forcibly retracted unless it is possible to retract it with gentle traction. Initial examination of the newborn with a normal prepuce without any ventral deficiency or dorsal hood is usually (except in a baby with a megameatus intact prepuce variant of hypospadias) a reliable indicator that the urethral meatus is in a normal location and rules out significant hypospadias.

The collection of smegma (a white exudate of skin cells and keratin) separating the prepuce from the glans and repeated reflex erections are the primary mechanisms which lead to resolution of physiologic adhesions over time. This process is usually complete by 3 years of age in 90% of the boys, though this study is a reflection of the poor current data in this regard [8]. In a more recent study from Taiwan the incidence of non-retractable physiological phimosis was 50% in grade 1 boys and decreased to 35% in grade 4 and 8% in grade 7 boys [9].

When does physiological phimosis require treatment?

In the absence of clinical findings of scarring suggesting pathological phimosis, and history of recurrent urinary tract infections (UTI's) or balano-posthitis, no intervention is

required for physiological phimosis. Ballooning of the foreskin during voiding is not associated with obstructed voiding and is not an indication for circumcision [10]. Active retraction has the potential to cause micro-tears and lead to scarring and subsequently a true phimosis. Therefore, normal foreskin care in early childhood only starts once the foreskin is retractable and this will happen at varying ages. Once retractable, the child can be taught to gently retract and clean during bathing with normal soap and water. Indications for urological consultation in this age group include suspicion of true phimosis with evident scarring of the preputial ring (Fig 1), genital Lichen sclerosis (Fig 2), recurrent episodes of balanitis (Fig 3) or UTI [4]. If the foreskin is not open by 8-10 years of age, there may be an indication for steroid therapy and gentle retraction, though there is no prescribed, evidence proven age cut-off for this process.

Treatment of physiological phimosis

Several observational studies and randomized trials have investigated the role of topical steroids and preputial stretching in resolving physiologic phimosis. The key to success with these protocols lies in differentiating physiologic and true phimosis, active counseling and patient selection. Topical steroid aids by thinning the preputial skin and obliterating the stratum corneum, which then allows gentle retraction over time.

Level 1 evidence

Letendre conducted a randomized double-blind study comparing a 2-month treatment course of emollient cream versus 0.1% triamcinolone in boys 3-12 years of age [12]. At 4 months, 76% of those on triamcinolone cream responded as compared to 39% in the placebo group ($p=0.008$), with no complications. At 1 year follow up; the success rate in the steroid group had come down to 47%. In another RCT comparing a moderately potent steroid mometasone to moisturizing cream, the authors found a significantly better response rate of 88% at 8 weeks compared to 52% in the placebo group [13]. In a randomized double-blinded placebo controlled study using betamethasone, Lund et al showed an initial 74% cure rate at 4 weeks follow up [14]. At 18 months, 14% showed a relapse, but none required a circumcision. A lower success rate of 52% was noted by Nobre et al in an RCT from Brazil using 0.2% betamethasone-hyaluronidase cream in boys 3-10 years of age [15].

Success rates did not vary by steroid potency as shown by similar foreskin retraction rates using clobetasone (moderately potent steroid, success rate 77%) compared to betamethasone (highly potent steroid, success rate 81%) [16]. Side effects are rare and there was no suppression of the hypothalamic-pituitary-adrenal axis provided treatment is not prolonged beyond 8 weeks for each course [17].

Level 2–4 evidence

Zavras et al conducted a prospective study using a mildly potent steroid, fluticasone propionate (0.05%), to achieve a 91% success rate in 1185 boys referred with a diagnosis of phimosis [18]. Long-term success is maintained in over 75% of the boys following initial success with steroid therapy [19, 20]. Ku et al noted that success rates were higher in boys < 3 years of age (92%) compared to those ≥ 3 years (70%), which may reflect compliance or a higher likelihood of pathological phimosis in the older group [21]. Ashfield et al showed a reverse trend of better success rate in older boys, though the result was not found to be statistically significant at any age cut off [22]. Elmore et al showed that topical steroids as an alternative to circumcision are equally effective (74%) and safe in infants presenting with genitourinary abnormalities and UTI's [23].

Recommendations (care of the normal foreskin and physiological phimosis):

- 1. Neonatal examination of the foreskin and urethral meatus should be part of routine clinical assessment of all newborn boys. Continued examination of the foreskin without forcible retraction is recommended during yearly physical examinations to rule out pathological phimosis and document natural preputial retraction (Level 5, Grade D).**
- 2. Persistent physiological phimosis in an asymptomatic child should not be an indication for circumcision [Level 5, Grade D].**
- 3. Physiological phimosis requires treatment if associated with true balanoposthitis or recurrent UTI's [Level 5, Grade D]**
- 4. Topical steroids are the first line of treatment for persistent physiological phimosis requiring treatment with good success rates and low risk of complications (Level 1b/2b, Grade A).**
- 5. Moderately- low potency steroid (triamcinolone, clobetasone, hydrocortisone, mometasone) may have similar success compared to a highly potent steroid (betamethasone) (Level 2b, Grade B).**
- 6. Patient selection to ensure compliance, demonstrating the technique of gentle retraction of the foreskin and continued retraction after initial success is important to achieve continued success to topical steroid therapy (Level 5 Grade D).**
- 7. Recurrence of physiological phimosis is common and normally responds to another course of topical steroids (Level 2b/3 Grade C).**

Circumcision and risk of urinary tract infections

Prior evidence indicates that neonatal circumcision decreases the risk of urinary tract infections (UTI). The current debate centers on the magnitude of this effect, the overall effect given the low prevalence of male UTI, the lack of high level evidence and the need for a surgical procedure to prevent this risk. The role of circumcision in preventing UTI's

must be studied in 2 distinct subgroups: males with normal urinary tracts and those with recurrent UTI's or urological conditions predisposing to UTI like vesicoureteric reflux, posterior urethral valves, neurogenic bladders and primary megaureters.

Childhood UTI epidemiology

Prior data suggest that in boys *without* predisposing urological conditions, the estimated incidence of UTI in the first 10 years of life varies between 1 to 2% [24, 25]. The prevalence rate of UTI in symptomatic children is higher. In a meta- analysis of 18 studies, Shaikh et al estimated that in all febrile infants (males and females 0-24 months), the prevalence of UTI was 7 % (95% CI 5.5-8.4%) [26]. In older symptomatic children (2-19 years) the prevalence was 7.8% (95% CI 6.6-8.9%). Males under 3 months of age had the highest prevalence of UTI (8.7%, 95% CI 5.4-11.9). There was evidence of significant heterogeneity but no publication bias and bagged specimens were included in some studies.

Biological plausibility for the role of circumcision in UTI prevention

Circumcision prevents UTI by reducing periurethral bacterial colonization secondary to reduced adherence of bacteria to keratinized surfaces and by removing the growth promoting moist preputial environment [27-29]. Foreskin colonization with potential pathogenic bacteria occurs early and leads to an increase in protective Langerhans cells. [30]. In a case control study, circumcision decreased the bacterial colonization of the glans penis for uropathogenic bacteria when compared to boys with an intact foreskin and this effect persisted in older boys [31]. Studies have shown E. coli strains causing UTI in uncircumcised male infants resemble urosepsis strains isolated in adults [32]. In addition, data from the human immunodeficiency virus type 1 (HIV) trial in Uganda showed a decreased prevalence and load of 12 specific anaerobic bacteria following circumcision [27].

Boys with normal urinary tracts

Level 2 evidence

In a meta- analysis, among febrile male infants less than 3 months of age, the prevalence of UTI was 10 times higher in uncircumcised males (20.1% 95% CI: 16.8-23.4) than circumcised males (2.4% 95% CI: 1.4-3.5) [26]. This difference decreased in the 6-12-month group (7.3% and 0.3%) and there was no data available beyond infancy.

Translated to likelihood ratios (LR), the uncircumcised male infant (3-24 months old) has a UTI LR of 2.8 versus 0.33 for circumcised males [33]. The risk increases if this infant is of non- black race. Singh-Grewal performed a meta-analysis of 12 published studies (1 RCT, 4 cohort, 7 case-control) on 402,908 children published till 2002 and assuming a 1% risk of UTI calculated the number of circumcisions required to prevent 1 UTI as 111

[34]. The quality of the included studies was poor, with variable UTI definitions, bagged specimens in at least 6 studies and potential differential misclassification as 3/4 cohort studies were unable to account for circumcisions past the neonatal period. The overall odds ratio (OR) for a UTI in circumcised males compared to uncircumcised males was 0.13 (95% CI, 0.07 to 0.23). The single RCT by Nayir et al included in this analysis, compared bacteriuria rates between circumcised and uncircumcised boys using bag or mid stream specimens and showed a non-statistically significant OR of 0.13 in the circumcised group (95% CI, 0.01 to 2.63) [35].

A systematic review conducted by Morris et al, calculated the lifetime risk of a UTI to be 32% in uncircumcised males compared to 9% in circumcised males [36]. The authors suggested a NNT of 4.2 (95% CI 2.2-27) for preventing 1 UTI over a lifetime. A Cochrane review in 2012 failed to identify any new RCT's to include in a meta-analysis [37].

Level 2-4 evidence

Zorc et al conducted a prospective cross sectional study to identify clinical factors associated with UTI in infants <60 days of age [38]. The overall rate of UTI was 9% and after multivariable adjustment, being uncircumcised was associated with a higher UTI risk (OR 10.4; 95% CI 4.7-31.4, $p < 0.001$). According to a large population- based cohort study conducted in Canada by To et al, the relative risk of UTI requiring hospital admission in uncircumcised compared to circumcised boys was 3.7 (95% CI, 2.8-4.9) in the first year of life [39]. The number of circumcisions needed to prevent one admission for UTI in the first year of life was 195. In another well- conducted case control study from Australia which included children with urological abnormalities, Craig et al showed that the protective effects of circumcision in reducing risk of UTI extended beyond infancy [40]. In infants, the OR was marginally significant at 0.03 (95% CI 0.06-1.1). However, the OR for the >1- year group was not statistically significant (OR=0.2, 95% CI 0.01-3.7).

The rate of asymptomatic positive urine cultures (bag specimens confirmed with suprapubic aspiration) was significantly lower in a study by Simforoosh et al [41]. None of the 3000 circumcised children followed up to 15-months age had a positive culture while 2% of the 1000 uncircumcised males had a positive culture. Interestingly, several studies from Israel, where all males undergo a ritual neonatal circumcision, showed a high incidence of post-circumcision UTI [42, 43].

Boys with abnormal urinary tract

In urological conditions like high grade VUR, posterior urethral valves, primary megaureters the risk of UTI is higher.

Vesicouretric reflux: In a prospective cohort study, Alsaywid et al noted a lower non- significant incidence of new defects on DMSA scans in circumcised males with

grade IV-V VUR as compared to uncircumcised boys (5.25 versus 10.2%) [44]. However, 3 of the 4 boys in the circumcised group with new DMSA defects, did not get breakthrough UTI's. Circumcision was more effective than antibiotic prophylaxis alone or anti-reflux surgery in preventing breakthrough UTI (OR 0.9). In contrast after surgical correction of VUR, a concomitant circumcision did not decrease the risk of post-operative UTI [45]. In a small RCT conducted on children < 3 years with low grade VUR (Grade 1-3), randomized to antibiotic prophylaxis and prophylaxis plus circumcision groups, the authors noted significantly lower positive peri-urethral cultures in the circumcised group up till 9 months of follow up following which results equalized [46]. The authors also showed a significantly lower positive culture rate by urethral catheterization in the circumcised group but did not comment these patients were symptomatic.

Posterior urethral valves: Mukherjee et al showed in a retrospective cross sectional study, that circumcision in boys with posterior urethral valves significantly reduces the incidence of UTI beyond infancy by 83% [47]. Given that their cohort had a very high incidence of UTI, the NNT to prevent 1 UTI was 1 in boys with valves. UPJ obstruction and antenatal hydronephrosis: In a recent prospective study on infants with antenatally detected hydronephrosis, uncircumcised boys (adjusted OR 3.63, 95% CI: 1.2-11.2) and females had a significantly higher risk of febrile UTI compared to circumcised males [48].

Roth et al did not demonstrate a protective effect of circumcision in children with grade 3-4 hydronephrosis secondary to UPJ obstruction or obstructive megaureters in a retrospective cohort study [49]. Though unable to show statistical significance, the UTI rate was 0 in circumcised males as opposed to 8.3% in uncircumcised males. In addition, there is indirect evidence of the protective effect of circumcision in this population when comparing this study (63% circumcised) which had a 4.3% UTI rate with a similar cohort presented in a study by Song et al, which had a higher 36% UTI rate (0% circumcised) [50].

It is unclear whether medical treatment of physiological phimosis or antibiotic prophylaxis can prevent UTI's as effectively as circumcision in this subset of males. Urine specimen collection methodology is an issue and a recent study demonstrated that even catheterized specimens in uncircumcised boys could be contaminated [51]. Studies measuring the incidence of UTI's are intrinsically more difficult to interpret as most measure number of UTI episodes as opposed to number of children with UTI. Assuming a 1-2% circumcision complication rate and a 1% UTI risk in normal infants, universal neonatal circumcision cannot be justified based on a number needed to treat (NNT) of 111 [34]. Even if we accept a lower complication rate of 0.2% and a 2% UTI risk, given the effectiveness of UTI treatment, 6 UTI's will be prevented at the expense of 1 circumcision complication. This equation changes in the favor of a circumcision in those

with recurrent UTI (assuming a risk of 10%, the NNT is 11) and boys with urological abnormalities (even assuming an inflated risk of UTI with VUR being 30%, the NNT is 4) [34].

Recommendations (MC and UTI prevention):

1. **Neonatal circumcision decreases the risk of UTI (Level 2a).**
2. **The risk of UTI is low in infant males and decreases further beyond infancy (Level 2b-4).**
3. **There is paucity of level-1 evidence to justify recommending universal circumcision to prevent UTI's in normal males.**
4. **A stronger effect of neonatal circumcision in preventing UTI's in boys with urological abnormalities has been demonstrated and therefore it is recommended that a discussion with the parents is advisable for this subgroup of neonates (Level 3-4 Grade C).**

Circumcision and risk of sexually transmitted infections

A decreased risk of HIV and other STI's is the primary argument driving a change in risk-benefit assessment of male circumcision. The other benefits of MC are overshadowed to a large extent by its effect on HIV and STI's and therefore data in relation to these benefits must be scrutinized carefully to obtain evidence-based recommendations.

1. Circumcision and HIV prevention

Epidemiology of HIV infections

A recent Public Health Agency of Canada report estimated a HIV prevalence rate of 208 per 100,000 population, with an 11.4% increase compared to 2008 estimates [52]. Men who have sex with men (MSM) accounted for 47% of prevalent infections followed by intra-venous drug users (17%) and heterosexual individuals (17.6%).

Based on RCT's conducted in HIV high prevalence sub-Saharan Africa, there is clear Level 1 evidence that male circumcision reduces the risk of HIV infection in heterosexual men, in that region of the world [53-55]. In 2007, the WHO and UNAIDS recommended MC, regardless of HIV serostatus, as an additional intervention in countries with predominant heterosexually acquired HIV infection, where HIV is prevalent and circumcision rates are low [56]. Circumcision should not replace promotion of the "ABC" (Abstinence, Behavior change and correct and consistent Condom use) strategy or value of voluntary counseling and testing and care services for STI's. The CDC convened a Consultation on Public Health Issues Regarding Male Circumcision in the United States For Prevention of HIV Infection in 2007 and put forward the following key proposals [57]:

1. With respect to HIV prevention, MC is one of several partially effective risk-reduction alternatives for heterosexual men that should be used in combination with other measures.
2. There is no need or equipoise to conduct a US trial of MC for HIV prevention among men who have sex with women.
3. There is not enough evidence to make a recommendation for MC for MSM to prevent HIV infection and there may be equipoise to conduct an efficacy trial for this population.
4. For newborns, medical benefits outweigh risks and the benefits and risks should be explained to parents.

Role of prepuce in HIV infection

The protective effect of circumcision against HIV infection has been attributed to several factors. Microabrasions during intercourse may provide easier access to the virus and the likelihood of such coital trauma is higher in those uncircumcised [58]. The inner foreskin mucosa has a higher density of Langerhans cells for which HIV-1 demonstrates specific tropism in in-vitro studies [59]. Circumcision removes a majority of foreskin Langerhan cells. Pro-inflammatory anaerobes, which are supported by the anoxic microenvironment of the intact foreskin, also contribute to viral survival [60]. The lack of keratinization especially of the inner foreskin compared to a circumcised penis may also aid HIV infection [61]. In a sub analysis in the control group of the Ugandan RCT, foreskin surface area was predictive of the risk of HIV acquisition [62]. Men with the largest foreskin surface area had a 2 times higher incidence rate compared to those with the lowest quartile surface area.

In addition, higher rates of STI, such as herpes simplex virus -2 (HSV-2) and genital ulcer disease (GUD), increases susceptibility to HIV infection and circumcision may decrease HIV risk by these intermediate factors but this relationship is complex and bidirectional [63- 66].

Female to male HIV transmission

Observational studies

Following the first observational study in 1986 suggesting a decreased risk of HIV in circumcised men, several studies and a meta-analysis of 15 observational studies conducted in 2000, supported a protective effect of circumcision against HIV infection (adjusted RR 0.42, 95% CI 0.34-0.54%) [67, 68]. More recently, Warner et al conducted a cross sectional study among heterosexual African American men and analyzed the protective effects of MC in a group of men with known HIV exposure [69]. Circumcision was associated with a 51% reduction in HIV prevalence among the 394 visits by men who were exposed to HIV positive female partners (adjusted PRR 0.49, 95% CI 0.26-

0.93). In contrast, when the HIV exposure was unknown, circumcision status was not protective (adjusted PRR 1.00, 95% CI 0.86-1.15). A global epidemiological study in 118 countries concluded that circumcision was associated with a lower HIV rates, independent of religion [70]. However, for non-sub-Saharan countries with a primarily homosexual or IV drug use modality of HIV transmission, circumcision status was not associated with a lower risk of HIV infection.

Meta-analysis of HIV RCTs

A Cochrane review of the 3 trials (Table 1) concluded that medical circumcision reduces the acquisition of HIV by heterosexual men between 38-66% over 2 years, with an incidence risk ratio of 0.5 (95% CI 0.34- 0.72) at 1 year and 0.46 (95% CI 0.34-0.62) at 2 years follow up in the circumcised group compared to the non-circumcised group [71]. There was no evidence of heterogeneity (I^2 0%). With a low assumed control risk of 1% (10 per 1000 population over a 2-year period), the number needed to treat (NNT) based on this meta-analysis was 186. The combined per protocol analysis showed a stronger protective effect (IRR 0.34, 95% CI 0.24-0.47).

The possibility of behavioral disinhibition, leading to unsafe sexual practices, can potentially offset the protective effect of circumcision and this effect may be dependent on the timing of circumcision [72]. The South African trial evaluated behavioral aspects post circumcision and noted a higher mean number of sexual contacts in the circumcised group compared to the uncircumcised group [55]. The Kenyan trial also showed a statistically significant difference in the circumcised versus uncircumcised group with respect to unprotected sexual intercourse and consistent condom usage [53]. The Ugandan RCT did not find this difference even on long-term follow up [54, 73]. In a comprehensive analysis of 1309 men enrolled in the Kenyan RCT, Mattson et al evaluated risk compensation using a self-validated 18 item risk propensity score and acquisition of other STI's as a marker of risk behavior [74]. Men in this study were not clearly informed that MC reduced HIV risk and both groups received intensive counseling. STI risk was higher in the circumcised group at baseline and incident STI was higher at 6- month follow up. There was no difference in the risk scores at 6 and 12 month follow up in the 2 groups.

Male to male transmission

According to CDC estimates in 2006, of 56300 new HIV infections in the US, 53% were in men who have sex with men (MSM) males [75]. Heterosexual transmission was responsible in 31% cases. Canadian estimates are similar with more than 50% of new infections occurring in MSM males.

Evidence of an association between circumcision status and HIV infection in men who have sex with men (MSM) is limited to observational studies, not usually stratified by receptive and insertive roles. It is believed that men who practice an insertive role

during anal intercourse would likely benefit from MC while those who perform a receptive role have little or no protection. Most MSM are likely to be infected through a receptive rather than an insertive role, which would further dilute the effects of MC in this population. In a Cochrane review by Wiysonge et al, including 21 observational studies (6 cohort, 14 cross-sectional, 1 case-control; 71,693 participants) were analyzed to assess the impact of circumcision for preventing HIV infection in MSM males the risk for HIV acquisition was not associated with MC (OR 0.86, 95% CI 0.7-1.06) [76]. In a subgroup analysis of men reporting an insertive role, MC was found to be protective (3465 participants; OR 0.27, 95% CI 0.17-0.44). The overall quality of the studies included was poor with high risk of attrition and detection bias. A previous meta-analysis by Millett et al in 2008 had also reported a similar non-significant RR of 0.86 amongst all MSM men and a trend towards lower HIV risk in MSM men who practiced an insertive role (RR 0.70, 95% CI 0.2-2.2) [77].

Londish et al created a mathematical model incorporating circumcision and seropositioning in the MSM population to predict the reduction in HIV prevalence and incidence [78]. The authors predicted that in a developed country with 10% HIV prevalence, with universal circumcision, it would take 20 years to reduce HIV incidence by 5% compared to pre-intervention levels and prevalence to 9.6%.

Male to female transmission

MC can potentially decrease female partner HIV infection by a direct effect, or indirectly (over 10-20 years) at the population level by reducing the overall male prevalence. The Ugandan RCT enrolled 92 couples in the circumcised group and 67 in the control group to study the direct effects of MC in HIV positive men on female partner HIV status over a 24 month follow up [79]. This trial was underpowered and terminated early since recruitment was futile. No evidence of protection was identified (adjusted HR 1.49, 95% CI 0.62-3.57). A meta-analysis of 7 longitudinal population based studies including the Ugandan trial did not show any protective effect on female partners of circumcised males (RR 0.80, 95% CI 0.54-1.19) [80]. There was evidence of between study heterogeneity with studies showing reverse effects. In a prospective cohort study based on an RCT, conducted to assess HSV 2 suppression impact on HIV transmission, conducted in Africa 1096 serodiscordant couples were followed for a 18 month period [81]. Circumcision was associated with a 40% lower risk of HIV transmission to female partners though the results were not statistically significant (HR 0.62, 95% CI 0.35-1.10).

Conclusions on the benefit of neonatal circumcision in preventing HIV

There are several factors, which have to be considered when adopting findings from recent evidence as a basis for recommendation of neonatal circumcision in more developed countries [82-87]. The large sample size, magnitude of the effect, consistent results across the 3 trials and meta-analyses, and sound statistical methods to address

confounding factors are the primary strengths of these well conducted trials, which upholds the internal validity of the results to a large extent barring some concerns. These concerns include early trial stoppage, inadequate allocation concealment and random sequence generation, and risk of attrition bias [71, 82]. The primary issue in interpreting these results relates to external validity of these trials in the Canadian setting.

1. The MC rate in the 3 African trial sites ranged between 10-20% and HIV prevalence in these countries was between 7-25% (incidence 1.7-1.8% per year). In contrast, in Canada the MC rate is around 35% and HIV prevalence is much lower and this would lead to a substantially higher number needed to treat.
2. A difference in the modes of HIV transmission and baseline neonatal circumcision rates affects the available susceptible population, which will be protected by MC. Only a small proportion of HIV transmission is due heterosexual activity and men who have sex with men is a group not protected by MC.
3. Variations in sexual practices and behavior (including condom usage), and differences in STI prevalence will also alter the protective effects of MC.
4. Access to health care and earlier detection and treatment for HIV infected males and HPV vaccination programs may also modify the observed protective effects.
5. Ethical considerations of parental consent and racial/ethnic acceptability further complicate the issue when implementing universal circumcision programs.
6. Cost benefit analysis compared to alternative preventive strategies, should be considered and studied in a Canadian context to allow generation of a clear recommendation [87].
7. The trials were all conducted in sexually active adult men from HIV endemic areas in Africa who were motivated and interested in a free circumcision. They also received counseling as part of trial. This will result in overestimation of the protective effect, different from a more real-world setting.
8. In addition, the long- term effectiveness beyond 2 years follow up is currently only published for the Ugandan trial [73].

Recommendations (MC and HIV protection):

1. **Female to male transmission: There is compelling evidence that MC reduces the risk of HIV transmission from female partners to male (Level 1 A evidence, Grade A recommendation). The magnitude of the effect is debatable and cannot be extrapolated to Canada from the African RCT's.**
2. **Male to male transmission: Based on current evidence, MC does not provide protection for men who have sex with men (Level 2a evidence).**
3. **Women partners: Based on current evidence, MC is not protective for female partners (Level 2a-b evidence).**

4. **Universal infant circumcision cannot be recommended to prevent HIV infection based on current evidence (Grade B).**

2. Circumcision and human papilloma virus (HPV) prevention

Human papilloma virus (HPV) is the commonest STI worldwide and of the more than 100 types, about 40 can infect the ano-genital area. In the absence of vaccination, up to 75% of Canadians would have at least one lifetime HPV infection [www.phac-aspc.gc.ca]. High- risk oncogenic types like 16 and 18 are implicated in cervical, penile, vulval, vaginal, anal and some oropharyngeal cancers while low risk non-oncogenic subtypes like 6 and 11 cause genital warts. The effect of circumcision on HPV is difficult to interpret as HPV infection can be transient, affect multiple genital areas outside the foreskin, include several high risk and non-high-risk types and is significantly associated with other behavioral confounders. In addition, HPV prevalence, incidence, clearance and viral load are all potential outcomes, which can be studied and have differing health implications.

HPV in men

Level 1-2 evidence

Auvert et al showed a reduction in the prevalence of urethral high- risk HPV infection following male circumcision with a prevalence rate ratio of 0.68 (95% CI 0.52-0.89, p=0.002) in circumcised men as compared to uncircumcised men [88]. Significantly, the prevalence differences between the 2 groups were not significant for HPV type 16 but were for HPV type 18.

Six secondary trials analyzed HIV positive and negative men enrolled in the Ugandan HIV trial with regards to HPV prevalence, acquisition/incidence, clearance and viral load [89-94]. The first trial investigated the prevalence of HPV in a subgroup of participants and only included samples from the glans and coronal sulcus, a factor for possible bias due to differential infection sites in circumcised males [89, 95]. The adjusted risk ratio for prevalence of high risk HPV at 2 years follow up in the circumcised group was 0.65 (95% CI 0.46-0.90, p=0.0009) and 0.66 for low risk HPV genotypes (95% CI 0.49-0.91, p = 0.01). In a subsequent report, the same group showed that the 1- year penile shaft HPV prevalence after MC was not statistically significant lower in the circumcised group (adjusted PRR 0.66, 95% CI 0.39-1.12, p= 0.12) [90]. The third trial evaluated HPV acquisition and clearance in HIV negative men using glans and coronal sulcus samples [91]. The incidence rate of HR-HPV infection was statistically significant at 1 year (Incidence rate ratio =0.61, 95% CI 0.44-0.85) in the uncircumcised group but at 2 years follow up the effect was not statistically significant (IRR=0.64, 95% CI 0.38-1.07). The incidence of type specific HR HPV was statistically significant for only the 18 and 33 genotypes and not 16. The acquisition of new multiple

infections was lower in the circumcised group (IRR 0.45, 95% CI 0.28-0.73) compared to the non-circumcised group. Clearance rates per 100 person years were statistically significant only for types 39, 51 and 58 and overall clearance rates were higher in the circumcised group (RR=1.36, 95% CI 1.13-1.63). The fourth study in the Ugandan trial evaluated HR HPV prevalence, acquisition/incidence and clearance in HIV positive married men with or without a circumcision [92]. A random sample comprising 22% of those enrolled was tested at enrollment and at 24 months follow up. MC provided partial protection with the circumcised group (55% positive) showing lower HR-HPV prevalence at 24 months (PRR =0.77, 95% CI 0.62-0.97). The incidence rate for one or more new infections after adjustment was not statistically significant between the circumcised and non-circumcised group (IRR 0.74, 95% CI 0.54-1.01), however the proportion of men acquiring multiple new HR-HPV infections was lower in the circumcised group (IRR 0.40, 95% CI 0.19-0.84). The clearance rate of HPV infections was not significantly different between the 2 arms. In a more recent analysis of 999 men (HIV positive and negative) from the Ugandan trial, Tobian et al showed an increased HPV clearance in HIV negative circumcised men (adjusted RR 1.48, 95% CI 0.55-0.89) and lower incidence of HR-HPV acquisition in HIV positive men (IRR 0.70, 95% CI 1.67-2.44) [93]. The final study evaluated HPV viral load in circumcised and uncircumcised HPV infected men at 24 months [94]. MC decreased HPV viral load in circumcised compared to uncircumcised men for new infections acquired after enrollment but the results were statistically significant for only serotype 16 (p=0.001).

Two meta-analyses were conducted evaluating the effect of MC on HPV [96, 97]. Albero et al in 2012 analyzed data from 14 observational studies and 2 RCTs conducted between 1971 and 2010 [97]. Accepting heterogeneity in MC reporting status, sites sampled and methods of detection, in the 1784 participants analyzed with data from the 2 RCT's, the authors detected a strong inverse association between circumcision and high-risk HPV prevalence with an OR of 0.67 (95% CI 0.54-0.82). The 14 prevalence studies showed a similar pooled result of overall HPV prevalence (OR 0.57, 95% CI 0.42-0.77). HPV prevalence remained lower in circumcised men even pooling studies where the penile shaft or scrotum was sampled. There was no association found between circumcision and new genital HPV infections or clearance. A previous meta-analysis conducted by Larke et al till 2010, also showed similar prevalence results (OR 0.57, 95% CI 0.45-0.71) [96]. This prevalence difference diminished at sites away from the glans and urethra. There was weak evidence that circumcision was associated with decreased HPV incidence (RR 0.75, 95% CI 0.57-0.99) or clearance (RR 1.33, 95% CI 0.89-1.98).

Level 2c–4 evidence

The evidence in regards to effectiveness of circumcision in prevention of HPV transmission is contradictory when assessing observational and ecological studies.

Dickson et al followed 450 children from birth in a cohort study conducted in New Zealand up to 32 years of age with circumcision status reported by mothers at 3 years of age [98]. Sexual behavior was recorded at 21, 26 and 32 years along with assessment of socioeconomic and moral-religious emphasis of family. Seropositivity for HPV 16 or 18 at 32 years was lower in the uncircumcised group (Adjusted OR 1.4, 95% CI 0.85-2.2) but more associated with lifetime number of partners and moral-religious emphasis of the family of origin. Albero et al reported on 3969 participants from 3 countries followed over 4 years and used coronal sulcus/glans, penile shaft and scrotal swabs to compare HPV prevalence in circumcised and non-circumcised males [99]. A multivariable analysis adjusting for race, marital status, lifetime female sexual partners, female sexual partners in 3-6 months and male sexual partners in the past 3 months did not find any association between MC and oncogenic HPV (PR 0.95, 95% CI 0.87-1.03). MC was significantly associated with a decreased risk of non-oncogenic HPV infection. Circumcision was associated with a significantly lower HPV 16 seroincidence in MSM males reporting an insertive role during sex (Adjusted HR 0.47, 95% CI 0.28-0.98, $p=0.043$) [100].

HPV in female partners

Two trials conducted on HIV positive and negative men in Uganda analyzed transmission of HPV to female partners [101, 102]. The implications of reduced HPV infection in female partner cervical cancer rates are not clearly discernible since there are several other confounding risk factors.

In the first trial on HIV negative men and their partners, the year- 2 prevalence of HR-HPV infection in partners was 28% in the circumcised group and 39% in the uncircumcised group (PRR 0.72, 95% CI 0.60-0.85) [101]. The incidence of any HR-HPV infection between 0 and 2 years was also lower in the circumcised group female partners (IRR 0.77, 95% CI 0.63-0.93). In terms of specific HR genotypes, the results were specifically not statistically significant for HR-HPV 16 or 18. The clearance rate for all genotypes was 66% in the circumcised group partners as opposed to 59% in the uncircumcised partners ($p=0.014$). This clearance rate was reversed for HPV 16 with the uncircumcised group having a 74% clearance rate versus 52% in the circumcised group (RR 0.70, 95% CI 0.54-0.92). In a second trial on female partner HPV infection, Tobian et al studied the effect of MC in HIV infected men [102]. Circumcision status in male partners was not associated with lower HR-HPV prevalence in female partners (PRR=1.07, 95% CI 0.86-1.32, $p=0.64$) or lower HR-HPV incidence over 2 years (IRR=1.05, 95% CI 0.77-1.43) or clearance rates (RR=0.96, 95% CI 0.83-1.11).

Alternative strategies in HPV prevention

The benefit of MC on HPV infection dynamics has to be analyzed in the presence of complimentary HPV vaccination, protection offered by routine condom usage and other safe sexual practices. HPV vaccination is currently available and recommended for males (HPV 4 vaccine, 9-26 years of age), females (HPV 2 or 4 vaccine, 9-13 years and 14-26 years of age) and MSM (HPV 4 vaccine, >9 years of age) with good evidence (Level 1 evidence, Grade A recommendation) of its effectiveness and safety [National Advisory Committee on Immunization, HPV guideline 2007]. A prospective cohort study showed that correct and consistent condom usage also decreased risk of HPV transmission by 70% in young newly sexually active women [103].

Recommendations (MC and HPV infections)

- 1. HPV prevalence in men: Current evidence suggests a modest decrease in HPV prevalence in the glans and coronal sulcus up to 2 years following MC. (Level 1b evidence). The protective effect is partial, does not cover all high- risk types and is weaker further away from the glans and coronal sulcus. It is not clear whether this effect will persist into adulthood following neonatal circumcision.**
- 2. HPV clearance in men: There is no evidence (except a single RCT on HIV negative men) that MC increases HPV clearance (Level 1b-2b evidence). If it did increase clearance this may also inflate the impact of the prevalence benefits mentioned.**
- 3. HPV incidence or acquisition in men: There is no convincing evidence to suggest that MC decreases HPV acquisition or incident infections in HIV positive or negative men (Level 1b-2b evidence).**
- 4. HPV in female partners: MC lowers prevalence and incidence in partners of HIV negative men and improves clearance rates (Level 1b-2b).**
- 5. As a public health intervention, it is likely that the effect of HPV vaccination and behavioral modification will be more effective than performing universal neonatal circumcisions on all males (Grade B).**

3. Circumcision and non-ulcerative STI prevention

The most common non- ulcerative STIs are Gonorrhea, Chlamydia and Trichomonas infections. Chlamydia is the most commonly diagnosed bacterial STI with approximately 65000 cases reported in Canada in 2006. These STI's are initiated by bacterial binding to a variety of host receptors and unlike HIV a biological explanation of how circumcision can be protective against these infections is lacking.

Two RCTs have addressed the role of MC in these infections. In the Kenyan study, there was no association between circumcision status and non-ulcerative STIs but

condom usage was protective (HR 0.64, 95% CI 0.50-0.82) [104]. The Orange Farm study showed lower *Trichomonas vaginalis* infection in men only in an as-treated analysis (Adjusted OR 0.47, 95% CI 0.25-0.92) [105]. A meta-analysis of 30 observational studies failed to identify a statistically significant association between non-ulcerative STI's and MC [106].

In a prospective multi-center, U.S. study involving 2021 men there was evidence for a statistically non-significant increased prevalence and incidence of gonorrheal infection in non-circumcised men (odds ratio 1.3, 95% CI 0.9-1.7 and 1.6, 95% CI 1.0-2.6) but no difference with respect to Chlamydia infection [107]. In another prospective study, uncircumcised male partners had a higher risk of *T vaginalis* infection compared to circumcised partners of *T vaginalis* infected women (OR 1.8, 95% CI 1.1-3.2) [108]. *Mycoplasma genitalium* can cause urethritis, cervicitis and pelvic inflammatory disease. Multivariate analysis of data collected in the Kenyan HIV trial, showed a higher likelihood of *M genitalium* infection in non-circumcised men (adjusted OR 0.54, 95% CI 0.29-0.99) [109]. Washing the penis within the first hour after sex had a protective effect. In a prospective cohort study, circumcision did not seem to have any protective effect on female partners with regards to chlamydial, gonococcal and trichomonal infections [110].

Recommendations (MC and non-ulcerative STI's):

- 1. Currently, there is no significant evidence to support the protective role of MC in the acquisition of non-HPV, non-ulcerative STIs (Level 2a-b evidence, Grade B recommendation).**

4. Circumcision and prevention of genital ulcer disease (GUD) and ulcerative STIs

HSV 1 and 2, *T pallidum* (syphilis), *H ducreyi* (chancroid) and *K granulomatis* (Donovanosis) are the common causes of genital ulcer disease (GUD) with HSV infections accounting for 70-80% of the infections leading to a genital ulcer [Public Health Agency of Canada]. The true incidence of HSV 1 and 2 is unknown but these infections are very common with estimates based on serological tests suggesting at least 20% prevalence in Canada [Public Health Agency of Canada]. Chancroid is extremely rare in Canada and acquisition is primarily limited to endemic areas. Previously rare in Canada, the incidence of syphilis has shown an increase especially in MSM males and sex workers.

Women and men with GUD and HSV-2 have a higher risk of acquiring or transmitting HIV and conversely HIV infection increases the risk of GUD [111, 112]. Observational studies suggest that prevalent HSV-2 infection leads to a 2-3fold increase in the risk of HIV acquisition and this risk increases up to 7-fold with incident HSV-2 infection [113, 114]. In a HIV vaccine trial (Step study) conducted in MSM men, HSV-2 infection was an important risk factor for HIV acquisition amongst vaccine and placebo recipients (HR 2.2, 95% CI 1.4-3.5) [115]. It is likely that the correlation between these

two infections is due to high-risk sexual behavior making it unclear whether HSV-2 acquisition is an important direct cofactor for HIV infection [116-118].

HSV

Condom usage has a limited role in preventing HSV transmission with a 50% protective rate for male to female transmission. Unlike HIV, HSV transmission is less dependent upon the presence of foreskin mucosa.

Level 1-2 evidence

In the Ugandan RCT, which included HIV positive men, Tobian et al showed a lower risk of HSV 2 seroconversion in the circumcised group over 2-years follow-up (Adjusted IRR 0.70, 95% CI 0.55-0.91) [118]. Consistent condom usage had a slightly higher protective effect (Adjusted IRR 0.56, 95% CI 0.36-0.89). In a second analysis of the Ugandan RCT with HIV negative men, the partial protective effect of MC against HSV-2 seroconversion was similar [89]. Multivariate analysis of South African RCT data, did not show a protective effect for MC against HSV-2 seroincidence (IRR 0.68, 95% CI 0.38-1.22) but the effect was reversed in an as treated analysis presumably due to a 8.2% crossover rate (IRR 0.45, 95% CI 0.24-0.82) [63].

Mehta et al conducted an RCT in Kenya to assess the protective effect of circumcision against HIV, HSV-2 and GUD [65]. HSV-2 incidence did not differ by circumcision status (RR=0.94, 95% CI 0.7-1.25) but HSV-2 incident infection tripled the risk of HIV acquisition (risk ratio 3.44, 95% CI 1.52-7.80). Moreover, non HSV-GUD risk was reduced by 50 % in those circumcised (RR 0.52, 95% CI 0.37-0.73). In a multivariable model, the presence of GUD was associated with a 7 times greater risk of HIV seroconversion, suggesting that the protective effect of circumcision may be partially be mediated by reducing the risk of GUD. More than 50% of HIV seroconversions were preceded by HSV-2 or GUD.

Level 2-4 evidence

In a meta-analysis of observational studies, MC was not associated with a decreased risk of HSV-2 seropositivity (RR 0.88, 95% CI 0.77-1.01) and this effect was less protective when restricting the analysis to studies using genital examination rather than self reported circumcision status (RR 0.97, 95% CI 0.80-1.17) [106]. There was a protective effect of MC on syphilis seropositivity (RR 0.67, 95% CI 0.54-0.83) though there was significant heterogeneity amongst the studies and 2 of the largest studies included in this analysis showed the least protective effects. A definitive conclusion could not be reached for the risk of chancroid with the adjusted RR varying between 0.13-1.11.

Xu et al estimated the prevalence of circumcision in the US and examined the association between MC and HSV-2 infection using the National Health and Nutrition

Examination survey conducted on 6174 men [119]. HSV-2 infection was associated with age, race and sexual behaviors but not with circumcision status (OR 1.1, 95% CI 0.8-1.5).

Male to male HSV-2 transmission

In an observational study on 3828 men, Jameson et al found that, even in men reporting primarily an insertive role, MC was not protective against HSV-2 (Adjusted OR 0.66, 95% CI 0.27-1.63) [120]. Barnabas et al conducted a cross sectional study on MSM males and found that MC was associated with a borderline protective effect against HSV-2 infection (OR 0.7, 95% CI 0.5-1.0) [114]. In a Cochrane review of MSM males, circumcision did not have a protective role in preventing syphilis (OR 0.96, 95% CI 0.82-1.13) or HSV-2 infections (OR 0.86, 95% CI 0.62-1.2 [77]). In developed countries, the results of MC can be contradictory, with opposite direction of the effect shown in 2 longitudinal cohort studies from New Zealand [121, 122].

Non-ulcerative and ulcerative STIs in female partners

Gray et al conducted a sub trial in the Ugandan HIV RCT on 1563 HIV negative women married to men randomized to circumcised and non-circumcised groups followed for a year [123]. Adjusted analyses suggested a 22% circumcision efficacy for GUD (Adjusted PRR 0.78, 95% CI 0.61-0.99), a 45% efficacy for trichomonas (Adjusted PRR 0.55, 95% CI 0.34-0.89) and a weak 18% efficacy for bacterial vaginosis (BV) (Adjusted PRR 0.82, 95% CI 0.74-0.91). In the Ugandan RCT on HIV negative men, MC did not reduce the risk of HSV-2 acquisition in women partners of both HSV-2 negative and positive male partners [124]. In addition, in a 2008 prospective study of almost 6000 HIV negative women showed no difference in female acquisition of Chlamydia (adjusted HR 1.25, 95% CI 0.96-1.63), gonorrhea (adjusted HR 0.99, 95% CI 0.80-1.36) or T. Vaginalis (adjusted HR 1.05, 95% CI 0.80-1.36) according to circumcision status [110].

Recommendations (MC and ulcerative STI's):

- 1. Currently, there is no significant evidence to support the protective role of universal neonatal circumcision for males and females in the acquisition of ulcerative STI's (Level 2-4 evidence, Grade C recommendation).**
- 2. There is weak evidence of decreased seroconversion for HSV-2 following MC in adult men in Africa (Level 2a-b).**

Circumcision and risk of penile cancer

Epidemiology

Penile cancer is a rare disease with age standardized incidence rates of 0.3-1.0 per 100,000 men in Europe and North America, accounting for 0.4-0.6% of all malignancies [125]. The potential risk factors for penile cancer include phimosis and balanitis,

smoking, HPV infections, penile oral sex, Lichen sclerosis, premalignant conditions like Bowen's disease and erythroplasia of Queyrat, priapism, urethral stricture and PUVA therapy [126-128]. Therefore, MC for preventing penile cancer is possibly one of the several preventive interventions, which still does not account for a host of risk factors [127-129]. The International Consultation on Urologic Disease 2009 consensus publication on penile cancer prevention advocated smoking cessation as a Grade C recommendation while male HPV vaccination and universal circumcision were not recommended [128].

Biological plausibility

Penile cancer is mediated through 2 mechanisms; HR HPV infections and a subset through non- HPV mediated mechanisms related to phimosis and Lichen Sclerosus. Oncogenic HPV (mainly type 16 and 18) prevalence is noted in 40-45% of penile cancers in several systematic reviews [130-134]. In a Belgian study, HPV DNA was identified in 61% of invasive penile cancer samples with the commonest serotypes being HPV 16, 11, 56 and 18 [134]. Importantly, only 13% of the cases in this study were infected with HPV types present in HPV vaccines.

Level 2 evidence

In a meta-analysis of 8 studies (7 case control, 1 cross sectional study), Larke et al showed that circumcision < 18 years of age was protective against invasive penile cancer with a odds ratio of 0.33 (95% CI 0.13-0.83) [133]. In those circumcised as adults the risk of invasive carcinoma was increased (OR 2.71, 95% CI 0.93-7.94), presumably because surgery was performed for conditions predisposing to penile cancer.

Level 3 evidence

In a matched case control study, Tsen et al showed that phimosis was a strong risk factor for invasive penile cancer (adjusted OR 16, 95% CI 4.5-57) [135]. The protective effect of neonatal circumcision was not statistically significant when the analysis was restricted to those who did not have a history of phimosis (OR 0.79, 95% CI 0.29-2.6) and smoking was a clear identified risk factor (OR 5.9 for > 20 cigarettes/day). In another population based case control study from Denmark, Madsen et al found that penile cancer was positively associated with measures of high and early sexual activity, genital warts, unprotected sex and penile oral sex [136]. Phimosis (OR 4.9, 95% CI 1.85- 13.0), but not childhood circumcision (p=0.33) was also found to have a strong association on multivariate analyses. The authors concluded that an unretractable foreskin with HR- HPV infection might constitute the single most important risk factor for penile cancer. In a population based case control study by Daling et al, 137 men with penile cancer were compared with 671 controls [137]. Lack of childhood circumcision (OR 2.3, 95% CI 1.3-4.1), phimosis (OR 7.4, 95% CI 3.7-15.0) and cigarette smoking (OR 4.5, 95% CI 2.0-

10.1) were identified as risk factors for invasive penile cancer but after excluding patients with phimosis, the analysis did not show a protective effect of childhood circumcision.

Level 2c evidence: Indirect evidence of the role MC in preventing penile cancer can be investigated by ecological studies in countries with low circumcision rates. Denmark, with 2% circumcision prevalence, showed decreasing and lower rates of penile cancer than in the US [138]. However, in a more recent study from Denmark, there was an increase in the incidence of penile cancer from 1 to 1.3 per 100,000 men-years between 1978 and 2008 [139]. In the US, despite a decrease in circumcision rates, a 1.2% average annual incidence rate decrease has been noted between 1973 and 2003 [140].

Recommendations (MC and penile cancer):

1. **Circumcision decreases the risk of penile cancer (Level 2-3).**
2. **However, given the low incidence of invasive penile cancer, the partial protective effect of MC, and the availability of other preventive strategies like HPV vaccination, condom use and smoking cessation programs, it is difficult to justify universal neonatal circumcision as a preventive strategy for preventing penile cancer (Grade B).**
3. **Recognition and treatment of phimosis during regular health visits is recommended to decrease the risk of penile cancer (Level 5, Grade D). A genitourinary exam during puberty is recommended to ensure preputial retractibility and hygiene, rule out phimosis and counsel regarding HPV vaccination, safe sexual practices and offer the possibility of circumcision as a preventive measure against STI's while specifying the drawbacks and efficacy of other preventive measures (Grade D).**

Circumcision and risk of prostate cancer

A meta- analysis of case control studies by Taylor et al found an increased RR of prostate cancer in men with a history of STI's [141]. A recent case control study explored the association between circumcision and prostate cancer [142]. In a multivariable analysis, controlling for age, family history, race, history of STI's, number of partners and history of prostatitis, the authors did not find an overall association with circumcision (OR 0.87, 95% CI 0.74-1.02). A previous case control study from the UK, looking primarily at dietary and sexual history found a borderline association on univariate analysis between circumcision and prostate cancer risk (OR 0.62, 95% CI 0.39-0.98) [143].

Conclusion (MC and prostate cancer)

- **There is no convincing evidence on the protective effect of MC against prostate cancer (Level 3- 4 evidence, Grade B).**

Role of the foreskin in sensation and sexual function

There is ongoing controversy regarding the impact of circumcision on penile sensitivity and sexual satisfaction. It is obvious that the foreskin has sensory nerves, which are lost

following a circumcision. The primary question is whether this presumed loss of sensation or a possible decrease in glans sensitivity impacts sexual satisfaction in a measurable and consistent way after accounting for several confounders. The timing of circumcision (adult versus neonatal) may also impact this effect. The problem is amplified by the lack of a single objective measure of sensitivity (sensation varying by type and site assessed, ejaculation latency, arousal). In addition, this effect of MC has to be studied both from the men and their male and female partners' perspective. It is hard to extrapolate results of adult MC studies on sexual function and sensation to neonatal circumcision.

Adult circumcision

Level 1-2 evidence

A recent meta-analysis included 10 studies with significant heterogeneity and poor methodological quality to assess the impact of MC on sexual function [144]. There were no significant differences in sexual desire, dyspareunia, premature ejaculation, ejaculation latency time or erectile dysfunctions between circumcised and uncircumcised men. A secondary analysis of the Ugandan RCT showed no long-term differences in 4456 men randomized to immediate and delayed circumcision arms who were assessed at 6, 12 and 24 months for sexual desire, satisfaction and erectile dysfunction [145]. Though self-reported, there were some significant differences in penetration and pain on intercourse noted at 6 months favoring uncircumcised men but this difference normalized over the follow-up period. The trial showed that there was a higher improvement in sexual satisfaction in the uncircumcised group compared to the circumcised group. In comparison, another trial from Kenya noted that circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm with no sexual dysfunction as compared to uncircumcised controls [146]. Sexual dysfunction decreased significantly in both the circumcised and uncircumcised men during follow-up. The 2 trials reported very different baseline sexual dysfunction and in both the uncircumcised group reported improvement in sexual satisfaction over time. The Kenyan RCT showed a reduced risk of any self-reported coital injury in those circumcised compared to uncircumcised men (OR 0.61, 95% CI 0.54-0.68) [147]. There was a significant decrease in reported penile injuries over follow up even in the control uncircumcised group (decrease from 64% to 43%).

Level 3-4 evidence

In a survey conducted in Denmark, there was no difference in the circumcised and non-circumcised group in current sexual activity but circumcised men were more likely to report orgasm difficulties (Adjusted OR=3.26, 95% CI 1.05-4.16) [148]. In addition, women partners with circumcised spouses also noted orgasm difficulties (Adjusted OR=

2.66, 95% CI 1.07-6.66) and dyspareunia (Adjusted OR 8.45, 95% CI 3.01-23.74). Another cross-sectional study conducted in Belgium on 1369 men (1059 uncircumcised, 310 circumcised) used a self reported online version of the Self-assessment of Genital Anatomy, and Sexual Function, Male questionnaire (SAGASF-M) to measure 4 dimensions of sexual function [149]. Overall, for the penis as a whole the 2 groups differed in sexual pleasure ($p=0.044$) and discomfort/pain ($p=0.018$), both favoring the uncircumcised group. The study concluded that circumcision led to a decrease in glans sensitivity and overall penile sensitivity. In another detailed study of fine-touch pressure thresholds in circumcised and uncircumcised men, Sorrells et al noted that the glans of uncircumcised men had significantly lower pressure thresholds compared to circumcised men when adjusted for age, type of underwear and ethnicity [150]. Studies before and after circumcision in the adult population generally do not show any differences in sexual activity and function, though these studies are often hard to interpret because of the small sample size, lack of validated instruments to measure sexual function, self reported outcomes, short follow up times after circumcision and presence of medical indications for circumcision [151-154]. Intravaginal ejaculation latency time (IELT) was measured in 2 multinational studies using a stopwatch and a blinded timer [155, 156]. The significance of IELT as a measure of sexual satisfaction and sensation is debatable as a high IELT may suggest a low sensation and conversely a low IELT may suggest premature ejaculation and eventual lower sexual satisfaction. Circumcision and condom use did not impact IELT in both studies.

Neonatal circumcision

A single study compared men circumcised in the neonatal period to uncircumcised men with normal and abnormal erectile function and used quantitative somatosensory testing for assessing glans sensation [157]. Circumcised men with or without erectile dysfunction had worse vibration and better pressure thresholds but these differences disappeared when controlled for age, hypertension and diabetes.

Sexual function in partners

In an analysis of self reported sexual experience in women partners of men who participated in the Ugandan RCT before and after circumcision, Kigozi et al showed no changes in 57% and improved sexual satisfaction in 40% [158]. In 25% of the women who reported better sexual satisfaction, the reason given was related to the male seeking more frequent sex. In a study comparing uncircumcised and circumcised homosexual men as part of the HIM (Health in Men) cohort, Mao et al noted no differences in sexual difficulties or type of anal sex practiced [159]. Men circumcised after infancy were more likely to practice receptive anal sex and had a higher incidence of erection difficulties.

Conclusion

- **There is lack of any convincing evidence that neonatal circumcision will impact sexual function or cause a perceptible change in penile sensation in adulthood (Level 3-4 evidence, Grade C recommendation).**

Medical indications for childhood circumcision***Pathological phimosis***

Pathologic phimosis is an uncommon pediatric diagnosis (0.6-1.5% of boys) and is diagnosed by the presence of a whitish, fibrotic preputial ring [160]. This is different from physiological phimosis where gentle retraction during examination will show “flowering” or pouting of the preputial orifice and lack of the cicatricial ring [161-164]. Alternative treatments such as preputioplasty, dorsal slit or steroid therapy can be attempted, but depending on the severity of the scar tissue, circumcision may be the only curative option when true phimosis is diagnosed [165-166].

Genital Lichen sclerosis

Genital lichen sclerosis (LS) or balanitis xerotica obliterans is a chronic, inflammatory dermatosis of the prepuce and glans penis, which can potentially involve the meatus and urethra. The etiology is unknown and probably multifactorial with a possible autoimmune or infective etiology [167]. The disease tends to be progressive and older children; those with obesity and previous surgery tend to have more severe disease [168]. LS should be suspected when clinical examination reveals a more impressive (than phimosis) thick white ring like cicatrix at the distal preputial ring, associated with white discoloration and plaque formation. A history of secondary phimosis in a child with a previously retractile foreskin and failure of topical steroid therapy is also highly suggestive of LS [168-170]. Overall, the incidence of meatal involvement leading to stenosis is low and estimated to be around 2 % [169, 170]. Meatal or urethral involvement is more likely with a history of previous surgery and was seen in 27% in the series by Gargollo et al [168].

The incidence of this condition is underestimated and recent evidence suggests that in boys referred with a diagnosis of phimosis the incidence ranges between 10-40 % [169- 172]. In a series of 100 boys referred for phimosis, the incidence of LS was 1.8% under 6 years of age and up to 21% in those older [171]. In another prospective 10- year study by Kiss et al, the incidence of histologically confirmed LS was 40%, and 93% of LS patients had a history of secondary phimosis [170]. In another series of consecutive patients from the UK, Yardley et al noted a 34% incidence of LS in boys who underwent circumcision and an overall 12% prevalence of LS in boys referred to a specialist for foreskin problems [173]. The pathological diagnosis of LS may not correlate with clinical

suspicion, suggesting circumcision specimen should be routinely subjected to histological examination to rule out LS [174].

The use of topical steroids in LS is debatable with low response rates and requires close follow up, because disease progression may lead to glans and urethral involvement [167, 170, 175]. Circumcision is usually curative, but some children depending on the degree of involvement may need a meatoplasty, glans resurfacing or urethral reconstruction [168]. If the meatus is clearly involved a meatoplasty is indicated during circumcision. However, if the involvement is doubtful close follow up during the post-operative period and uroflowmetry assessments for up to 2 years may be indicated to rule out stenosis [176]. In addition, secondary to the Koebner phenomenon, recurrent LS may appear along scar lines of previous surgery and the use of topical steroids is an option in the post-operative period [167].

Recurrent urinary tract infections

Circumcision can be performed as an adjunct or alternative to prophylactic antibiotics in infants with UTI-predisposing urological abnormalities as described in the section on UTIs.

Contraindications of neonatal circumcision

Neonatal circumcision should be performed on medically stable, term infants without other medical conditions, which require ongoing management or increase risk of surgery. Routine neonatal circumcision should not be carried out in children with congenital anomalies of the penis, including hypospadias or epispadias (Fig 4 & 5), ventral curvature (Fig 6), penoscrotal webbing (Fig 7), and concealed penis (Fig 8). In some of these conditions, a circumcision can be performed with appropriate technical modifications but this requires a pediatric urological consult. Prior circumcision may not compromise distal hypospadias repair in children. In addition, some children with a hypospadias variant termed megameatus-intact prepuce hypospadias have a normal foreskin and a distal hypospadias only uncovered during a circumcision. [177]. Most of these children with this variant or a distal hypospadias can proceed with a circumcision. However, this requires an ability to recognize the severity of the anomaly and therefore as a general rule, all boys with hypospadias should ideally not have a circumcision, prior to a consultation by a pediatric urologist. Children with blood dyscrasias can undergo circumcision, under appropriate treatment and care [178-179].

Anesthesia for neonatal circumcision

It is clear that neonatal circumcision must be performed with adequate anesthesia and analgesia [180, 181]. The adverse physiological and behavioral responses of inadequate pain control in neonates is convincing, can lead to potential complications and alter long-term pain responses in the neonate [180-182]. Different methods used for providing

anesthesia and/or analgesia during circumcision includes general anesthesia, topical anesthetics, penile nerve blocks, oral sucrose-glucose administration, non-nutritive sucking, caudal block and various combinations of the above. In addition, the timing of neonatal circumcision may impact pain scores, with earlier surgery being beneficial [183]. Despite a standardized technique, Neonatal/Infant Pain Scores increased significantly beyond day 8 of life and all neonates beyond 3 weeks of age had a score indicating pain during the procedure.

There are 3 topical anesthetic options currently available: lidocaine-prilocaine 5% cream (EMLA), tetracaine 4% gel and liposomal lidocaine 4% cream. When compared to placebo, crying time was shortened and the heart rate reduced in children who were circumcised under EMLA [184]. The analgesic effect of EMLA takes almost 60 minutes to take effect and alone may not be sufficient to control the pain arising from foreskin removal. Wahlgren et al noted that the depth of penetration is variable with EMLA and increases with application time to approximately 6 mm after 3-4 hours [185]. Reactions to EMLA included erythema and blanching. Increased methaemoglobin levels secondary to oxidation of hemoglobin by prilocaine metabolites, was found to be within normal limits in two trials of EMLA [185]. Liposomal lidocaine is available in the US and has a shorter onset of action.

Dorsal penile (DPNB) and ring blocks are effective techniques to manage circumcision related pain. Based on a RCT that compared these 2 methods with EMLA for neonatal circumcision, there was no statistical difference in crying time and heart rate between a ring and dorsal penile nerve block while EMLA was less effective [186]. Two other trials comparing EMLA to DPNB also demonstrated significantly lower behavioral distress scores and Neonatal Infant Pain Scale scores in the dorsal nerve block group [187-188]. Cyna et al did not find a difference between caudal blocks and DPNB in a meta-analysis of 5 RCT's comparing these interventions but highlight that the possibility of a motor block, and requirement of anesthesia expertise makes a caudal block less preferable in older ambulatory children [189]. Based on the Cochrane review by Brady-Fryer, a dorsal penile nerve block is the most effective intervention for circumcision related pain with the caveat that the injection is performed appropriately [180]. A ring block has similar efficacy and may be easier and safer to use. EMLA cream and other topical anesthetics are an option when expertise with penile nerve blocks is not available and ideally should be used in conjunction with a block.

The DPNB is performed by injecting subcutaneously at the 11 and 1 o'clock positions on the dorsum of the penis close to the base of the penis using a 25-gauge needle. It is important to aspirate prior to injection to prevent intracorporeal or dorsal vein injection. A wait time of 5 to 8 minutes is recommended to achieve adequate anesthesia. Warming the lidocaine or injecting slowly can decrease the pain associated with injection. In a series of 3909, DPNB the overall complication rate was 0.18% [190].

Long et al studied the sensory distribution of the penile skin and recommend a ventral infiltration just proximal to the ventral foreskin incision to add to the dorsal nerve block [191].

Although it has been shown that analgesic methods such as oral administration of sucrose, glucose, or parenteral acetaminophen were more effective than placebo, it is widely accepted that these methods are not sufficient as sole measures for relieving the pain associated with circumcision [180, 192]. South et al suggested addition of non-nutritive sucking to DPNB based on a RCT, which showed significantly reduced crying time and salivary cortisol levels [193].

Conclusions for anesthesia and analgesia for neonatal circumcision:

- 1. A dorsal penile nerve block with a ring block, using proper technique, is the most effective technique to provide anesthesia during a neonatal circumcision (Level 1-2 evidence, Grade A recommendation).**
- 2. Topical local anesthetics alone are inferior to nerve and ring blocks and require an adequate time interval for efficacy and can be used as an adjunct to penile blocks (Level 1-2 evidence, Grade A recommendation).**
- 3. Oral sucrose, non-nutritive sucking, music and other environmental interventions should only be used as an adjunct to these methods (Level 1-3 evidence, Grade A recommendation).**

Complications of circumcision

Neonatal circumcision is a safe surgical procedure that is generally well tolerated. Circumcision complications can vary depending on the surgeon experience, technique used, parental expectation of post circumcision appearance, timing of circumcision, patient anatomic factors, gestational age and the accuracy and degree of reporting. Proper pre-operative assessment and examination recognizing possible complicating factors (webbing, ventral skin deficiency, suprapubic fat pad) and adequate post-operative instructions can prevent the commonest complications.

Neonatal circumcisions are performed in the community by a variety of practitioners and the complication rate is higher than that for procedures carried out in the hospital [194]. In addition, it is well documented that physician ability to self-rate success of a procedure is questionable [195]. When combined with the fact that some of the complications are delayed (e.g. meatal stenosis), there is a high likelihood that the actual complication rate for neonatal circumcisions may be underestimated and constitutes an immense burden to a system where the primary procedure is not covered under universal healthcare.

According to Pieretti et al, almost 5% of pediatric cases performed at a tertiary institution in the US over a 5-year span, with an estimated cost of \$685,608 were related

to complications of newborn circumcision [196]. The most frequent complications were redundant foreskin and meatal stenosis. Kokorowski et al queried the Pediatric Health Information System database from 28 freestanding pediatric hospitals in the US between 2004-2009 and identified those undergoing revision circumcision, non-newborn primary circumcision and lysis of penile adhesions following neonatal circumcision [197]. The study found a 119% increase in the ratio of revision circumcisions to total male ambulatory procedures during this time period. The median cost for revision circumcision was \$1554 and a total estimated cost of \$688,46,31 for the 28 hospitals over 6 years.

Overall complication rates

A recent systematic review on complications of neonatal and infant circumcisions noted a wide 0 to 16% (median 2%) range of adverse events in 16 prospective studies [198]. The same review also found that circumcisions performed in older children were associated with more complications (median 6%) when compared to those carried out in neonates and infants. A systematic review on safety and efficacy of non-therapeutic MC in 5228 men (15-49 years) showed a 4.8% incidence of complications [199]. The most common complication was postoperative infection (1.5%), followed by bleeding (1.3%). Complication rates in the 3 HIV trials conducted in Africa ranged between 1.7-8% [53-55].

In 1999, the AAP Task Force on Circumcision reported a complication rate of 0.2-0.6% . In contrast, the Canadian Pediatric Society has published complication rates as high as 2% for neonatal circumcision [200]. Early complications such as bleeding and infection occurred in 0.2% of 136086 male infants according to a large review [201]. This study only included complications entered on inpatient records and does not provide an estimate of long-term complications. In another US study of 130,475 newborns, conducted in Washington, US, 0.18% had a bleeding complication after MC [202]. In a trade off analysis the authors calculated that a complication could be expected in one of every 476 circumcisions, that 6 UTI's could be prevented for every complication and about 2 complications would be expected for every case of penile cancer prevented [203]. A review of complication rates following pediatric circumcision in England between 1997- 2003, showed that 1.2% of boys experienced a short-term complication and another 0.5% returned to the operating room for a revision within 6 months [3]. Post-circumcision complications can be divided into early and late complications [204-211]. Early complications include bleeding, infection, glans necrosis and amputation, delayed/early slippage of circumcision devices and very rarely death. Late complications include inadequate skin removal, cosmetic issues, inclusion cysts, adhesions and skin bridges, suture sinus tracts, ventral curvature, secondary buried penis and phimosis, urethrocutaneous fistulae and meatal stenosis.

Factors predicting complication rate

Timing of surgery can be predictive of complications as bleeding related complications are higher in older infants [212]. Penile adhesions and secondary buried penis is more likely in infants with a higher weight for length percentile [213]. The results of varying techniques may also be a possible factor affecting complication rates [209, 214]. Results from a small RCT, which compared 2 surgical techniques (sleeve vs. Plastibell®) in older children, showed that late complications occurred in 12% of the cases that used the sleeve technique versus 5% with the Plastibell® device [214]. Current on-going operator experience was shown to be an important factor in lower bleeding complication rate compared to patient related variables and long-term operator experience [215].

Penile adhesions, secondary phimosis and concealed penis

These relatively common complications of circumcision are the primary reasons for reoperation in the late post-operative period following a circumcision. They are more likely in those with an increased weight for length percentile, a large supra-pubic fat pad with abnormal dartos attachments to the skin or there is pre-existing peno-scrotal webbing or ventral penile skin deficiency. Topical steroids and occasional dilatation of the prepuce ring and retraction can lead to resolution [216, 217]. In children with a secondary concealed penis, but no phimosis, observation may be an option as the cosmetic appearance tends to improve with age and surgery should be delayed till the child is at least 3 years of age [218]. Adhesions of the mucosal collar to the glans are a common complication and can be prevented by gentle retraction and use of barrier ointments in the early post-operative period [219].

Meatal stenosis

Meatal stenosis is a common, under-reported complication of circumcision, usually requiring a ventral meatotomy for correction. It is postulated that chronic irritation of the meatus, ammoniacal meatitis and/or division of the frenular artery after circumcision may be predisposing factors. Meatal stenosis can lead to an upwardly deflected urinary stream, dysuria, urgency or difficulty with voiding and a flat uroflow curve. The incidence of asymptomatic meatal stenosis (< 5 Fr meatal caliber) can be as high as 20% though its clinical significance is debatable [208]. In a review of 1009 circumcised boys who were examined over the age of 3 years of age, Van Howe found an overall 2.8% incidence of symptomatic meatal stenosis post-neonatal circumcision [207]. Nearly all underwent a meatotomy but the exact number was unavailable. Studies with long-term follow up of circumcision report this complication fairly commonly with the incidence varying between 2.8-11%.

Recommendations:

- 1. Complication rates post- neonatal circumcision are usually low (around 2%) but given the variability in quoted complication rates and risk of**

delayed complications not treated by the original physician performing the neonatal circumcision it is likely that the overall complication rate is slightly higher (Level 2-4).

- 2. Operator experience and training, recognition of contraindications to circumcision, technique used, age and patient related variables can impact results and proper reporting and auditing of results is recommended [Level 4, Grade D].**

Cost analyses of neonatal circumcision

The potential impact of routine neonatal circumcision needs to be studied from an economic standpoint as currently parent requested circumcision is not covered under most provincial health plans in Canada. The impact on health service utilization and costs including direct and indirect procedure costs (costs of managing complications and circumcision revision, litigation costs and training costs) have to be weighed against indirect cost savings that may be potentially accrued over time, and balanced against the costs of implementing other preventive strategies.

Sansom et al performed a cost effectiveness analysis of newborn circumcision on reducing a US male's lifetime risk of HIV by applying the results of the African trials. [220]. The number of circumcisions needed to prevent 1 HIV infection was 298 for all males, ranging from 65 for black males to 1231 for white males. Newborn circumcision did not generate cost savings for the white males in the US but was a cost saving intervention for all males, African-Americans and Hispanics. Schoen et al used a third-party US payer database to calculate the cost of newborn circumcision in relation to its health benefits [221]. Using a high medically indicated need for post-neonatal circumcision and offsetting costs related to UTI, HIV, balanoposthitis and penile cancer the total lifetime net cost of a neonatal circumcision was 17 \$. The majority of the cost offset (50%) was by the cost of requiring a post- neonatal period circumcision and not the actual health benefits of a circumcision. In a contradictory study, by Van Howe, a cost utility analysis did not show circumcision to be cost effective on sensitivity analysis and on Monte Carlo simulation [222]. A recent study analyzed the impact of a reducing circumcision rate in the US on cost implications related to STI's and UTI [223]. Reducing circumcision rates from 79% to 10% would increase lifetime direct medical costs by 313\$ per foregone circumcision procedure in males.

In a resource rich setting like Canada, with a relatively lower rate of neonatal circumcisions and an increasing HIV infection risk in MSM, an alternative strategy for MSM males would be a potential strategy. Anderson et al created a mathematical transmission model to conduct an economic analysis and considered 4 strategies (circumcision of all MSM at 18 years of age, all MSM 35-44 years, all insertive MSM > 18 years, all MSM > 18 years) [224]. The model predicted a modest 3-5% decrease in

HIV infections per year after 25 years of applying these strategies. In the insertive MSM group, 118 circumcisions would need to be performed to prevent 1 HIV infection. In countries with a high HIV infection secondary to heterosexual transmission and low circumcision rates, the cost effectiveness of circumcision is more evident. [225, 226] Even in this setting, McAllister et al calculated the NNT to prevent 1 HIV infection for circumcision as 80 and modeling analysis showed that supplying free condoms was 95 times more cost effective than MC [227].

Training implications

Neonatal circumcision is performed by family physicians, obstetricians, pediatricians and urologists and this leads to non-standard training methods, varying experience during training and assessment of competency and varying surgical volumes post training. Several simulated training methods have been described using penile models to allow standardized teaching using the Mogen and Gomco clamps [228, 229]. In a survey of obstetric-gynecology residents, 63% planned to perform neonatal circumcisions, but only 44% received formal training to do so [230]. When presented with contraindications to circumcision like hypospadias, buried penis and micropenis, the average rate of correctly identified contraindications was a dismal 42%. Evidence from the Ugandan trial data showed that approximately 100 procedures are needed to gain competence in sleeve circumcision technique [231]. The rate of moderate or severe adverse events showed a statistically significant trend decreasing from 8.8% for the first 20 procedures to around 2% beyond 100. Demaria et al stressed the importance of proper training and follow up and the lack thereof of in the current Canadian health care system with unstructured training and inability to deal with contraindications and complications of neonatal circumcision [232].

Summary of results and recommendations

The effect of MC has to be analyzed at the individual and societal level. For the individual Canadian neonate, there are definite advantages of a circumcision but the exact estimates of the effect are unknown, the protection provided is not comprehensive, accrue over a life-time and can be achieved by other preventive health measures (Table 2). Evidence therefore, must be analyzed based on its quality and applicability and the GRADE system is an appropriate method to employ when we summarize our results [233]. There are also clear risks associated with this surgical procedure and parents will continue to have to weigh the potential benefits and risks of neonatal circumcision. In an overall societal perspective, given our health care system and the socio-economic and educational status of our population, universal neonatal circumcision is not justified based on the evidence available.

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Figures and Tables

Fig 1. Pathological phimosis.



Fig 2. Balano-posthitis.



Fig 3. Lichen sclerosus of the foreskin.



Fig 4. Hypospadias .



Fig 5. Epispadias.



Fig 6. Peno-scrotal webbing.



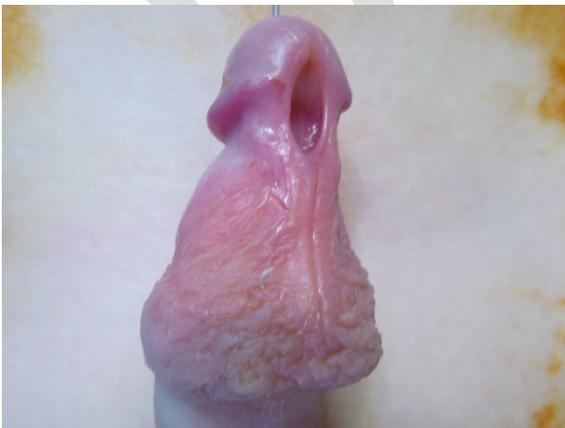
Fig 7. Concealed penis.



Fig 8. Ventral curvature.



Fig 9. Megameatus intact prepuce hypospadias variant.



Guideline: Foreskin care and neonatal circumcision

Study (location, time period)	Allocation concealment	Blinding	Inclusion criteria	n	Followup	Lost to followup	AEs	Outcomes	ITT RR (95% CI)	As treated RR (95% CI)	Covariate adjusted RR
Auvert et al (South Africa, 2002–2005)	Partial	Study personnel	Male 18–24, wishing to be circumcised	3274	Stopped at 63% of total anticipated person-years	251 (8%) 30% in circumcised and 33% uncircumcised	3.8%	Intervention: 20/1546 Control: 49/1582	0.42 (0.25–0.70)	0.24 (0.14–0.44)	0.39 (0.23–0.66)
Bailey et al (Kenya, 2002–2006)	Unclear	HIV testers Nurses counselling and doing questionnaires partially blinded	HIV-negative, 18–24 years	2784	Stopped at 87% followup	86% (1501) completed 24 month followup, overall 1283/2784 (46%) did not complete trial	1.7%	Intervention: 22/1388 Control: 47/1392	0.47 (0.28–0.78)	0.45 (0.27–0.76)	0.44–0.47
Gray et al (Uganda 2002–2006)	Partial	None specified	HIV-negative, 15–49 years	4996	Stopped at 72% person-time accrual	22% at 24 months followup	8 %	Intervention: 22/2387 Control: 45/2430	0.49 (0.28–0.84)	0.45 (0.25–0.78)	0.49 (0.29–0.81)

AE: adverse events; CI: confidence interval; ITT: intention-to-treat; RR: relative risk.

Table 2. Benefits of circumcision classified by GRADE recommendations					
Clinical benefit	Direction of evidence	Amount of effect	Level of evidence	GRADE quality of evidence	GRADE strength of recommendation
Decreased risk of UTI	Positive	0.07–0.23	Level 2	Low quality	Weak
Decreased risk of HIV	Positive	0.34–0.62	Level 1	High quality	Strong*
Decreased risk of HPV prevalence	Positive	0.57–0.77	Level 1	Moderate quality	Weak
Decreased risk of HPV incidence	Unclear	NS	Level 2	Low quality	Weak
Decreased risk of HSV	Positive	0.36–0.91	Level 2	Moderate quality	Weak
Decreased risk of penile cancer	Positive	0.13–0.83	Level 2	Low quality	Weak

*Concerns related to external validity of data for Canadian population. HPV: human papilloma virus; HSV: herpes simplex virus; UTI: urinary tract infection.

Table 3. Summary results for level 1-2 evidence benefits of circumcision classified by GRADE recommendations					
Clinical benefit	Direction of evidence	Amount of effect	Level of evidence	GRADE quality of evidence	GRADE strength of recommendation
Decreased risk of UTI	Positive	0.07-0.23	Level 2	Low quality	Weak
Decreased risk of HIV	Positive	0.34-0.62	Level 1	High quality	Strong*
Decreased risk of HPV prevalence	Positive	0.57- 0.77 Prevalence rate ratio	Level 1	Moderate quality	Weak
Decreased risk of HPV incidence	Unclear	NS	Level 2	Low quality	Weak
Decreased risk of HSV	Positive	0.36-0.91	Level 2	Moderate quality	Weak
Decreased risk of penile cancer	Positive	0.13-0.83	Level 2	Low quality	Weak

*Uncertainty related to: 1) effects of neonatal circumcision in Canadian setting; 2) whether circumcision represents a wise use of resources compared to other preventive strategies; 3) the balance of advantages versus risks of circumcision given the uncertainty of circumcision risks. HPV: human papilloma virus; HSV: herpes simplex virus; UTI: urinary tract infection.