

Save the normal foreskin

Widespread confusion over what the medical indications for circumcision are

Religious considerations apart, the commonest indications for circumcision in current surgical practice are phimosis, preputial adhesions, ballooning of the foreskin, and balanitis. Although these indications are widely accepted, consideration of the embryology, development, and pathology of the prepuce suggests that their validity is open to doubt.

The foreskin develops early in intrauterine life as a protuberance of penile epidermis that grows forwards over the glans and adheres to it. Both glans and prepuce are covered by stratified squamous epithelium, and separation occurs at a variable time from before birth to several years afterwards by desquamation. The term phimosis (from the Greek word for muzzling) is often incorrectly applied to any foreskin that cannot be retracted.

To discourage unnecessary circumcisions a distinction needs to be made between physiological and pathological non-retractility. Gairdner, who examined a large number of normal children during their first five years of life, observed that at birth only 4% of children had fully retractile prepuces, while in half the prepuce was partially retractile.¹ By the age of 5 years slightly more than 90% of boys had retractile foreskins.

Additional information was provided by Øster, who examined almost 2000 schoolchildren between the ages of 6 and 17 in whom no medical or surgical intervention had taken place.² In the 6-7 year age group 91% of boys had retractile prepuces (a similar figure to that of Gairdner), and the incidence of spontaneously retractile foreskins increased yearly until by 17 years only 1% remained non-retractile. Why this 1% of 17 year olds still had a non-retractile foreskin was not stated, but data from a subsequent study suggest that they were probably suffering from balanitis xerotica obliterans.³ This curious condition of unknown aetiology is characterised by dermal oedema, lymphocytic infiltration, basal cell degeneration, and atrophy of the stratum malpighii. Although spontaneous resolution, successful medical treatment, and, recently, laser treatment for balanitis xerotica obliterans have been reported,⁴ circumcision remains the mainstay of treatment. The condition may, however, also involve the glans or urethral meatus, resulting in meatal stenosis.⁵

Other indications for circumcision are less clear cut, but few would dispute that recurrent balanoposthitis warrants surgical treatment. Despite the clinical impression that balanitis is common in young boys, the only detailed study of this condition reported an incidence of 4% in all boys

aged up to 14.⁶ A specific organism was found in only about one third of cases, and the aetiology was uncertain. The incidence may be higher in uncircumcised children before the age of 8, although morbidity due to balanoposthitis may be offset at least partly by penile problems in children who are circumcised.^{7,8} Although the inflammation is usually mild, on occasions it causes great distress. The condition, however, is self limiting, and few children suffer more than one episode.⁶ Plainly a single attack of balanitis, which is sometimes seen in boys with fully retractile foreskins, is not a sufficient indication for circumcision. One study found penile inflammation in one in seven uncircumcised children, but most problems resolved after a single medical consultation.⁷

The increased number of urinary tract infections seen in uncircumcised young children may be due to "hospital strains" of uropathogenic P fimbriated *Escherichia coli* acquired in the unnatural environment of modern obstetric units⁹ rather than being directly related to the foreskin. Paraphimosis is rare in children and unlikely to account for a substantial number of circumcisions. Although ballooning on micturition is a commonly cited indication, the studies of Gairdner¹ and Øster² suggest that if this physical sign is ignored the symptoms will resolve as the foreskin becomes spontaneously retractile (unless balanitis xerotica obliterans develops). Preputial adhesions represent a stage in the normal process of separation of the two epithelial surfaces of the prepuce and glans. In Øster's study no preputial adhesions were seen in 95 boys aged 17, none of whom had undergone any operative procedure for separation of adhesions²—strongly suggesting that adhesions resolve spontaneously without treatment.

These data suggest that overall between 1% and 2% of boys need circumcision for medical indications. The cumulative national rate of circumcision for boys by the age of 15 is almost 7%.¹⁰ If findings from Liverpool are representative of the rest of Britain¹⁰ then many unnecessary circumcisions are performed each year at considerable cost to the health service and morbidity for the patients. In the population served by Oxford Regional Health Authority during the year to September 1990, 978 boys were circumcised out of a total estimated population of 299 600—a rate of 0.33% a year (statistics unit of Oxford Regional Health Authority). If this rate operated annually then 5.6% of boys aged 17 would be circumcised—not substantially different from the Mersey figure.¹⁰

Why then is the rate of circumcision up to six times greater than the incidence of preputial disease? Analysis of the clinical findings in children referred for circumcision reported in this week's journal suggests a difference in interpretation of symptoms and clinical signs between surgeons and general practitioners (p 28).¹¹ Clearly confusion still exists about what constitutes "pathological" phimosis as distinct from "physiological" non-retractile foreskin. Most cases of pathological phimosis result from balanitis xerotica obliterans, while the remainder may be due to a different, distinct fibrotic disease.¹² The underlying difficulty is the imprecision of the term phimosis. An important consideration is that balanitis xerotica obliterans usually develops after the age of 5 years.^{3 10} The rarity of pathological phimosis under the age of 5 is an important observation since most circumcisions are performed before this age.¹⁰

Øster wrote in the introduction to his paper² that the publication of Gairdner's article nearly 20 years earlier seemed to have made no significant impression on clinical practice.¹ Regrettably it seems that the same can be said more than 20 years after Øster's paper was published. A better understanding of the normal physiology, developmental anatomy, and pathology of the prepuce could prevent the

removal of thousands of normal foreskins over the next 20 years.

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A counsellor in every practice?

Reasons for caution

Since Balint drew attention to the importance of counselling during consultation¹ general practitioners have been increasingly aware of the power of "the skilled and principled use of relationships to help the client develop self-knowledge, emotional acceptance and growth, and personal resources."² As well as its general indications in anxiety, depression, and problems with relationships,³ counselling has been advocated for smoking cessation,⁴⁻⁷ modification of diet,^{4,8} alcohol misuse,^{9,10} postnatal depression,¹¹ addiction to tranquillisers,¹² and high risk sexual behaviour.^{13,14}

Many attempts to evaluate its effectiveness have shown little or no benefit,^{5,6,15-20} possibly due to methodological problems.²¹ When benefits have been claimed they have been small compared with the resources employed. Unsurprisingly, in the face of this evidence caution has been expressed: "Promoting a large counselling service in general practice before establishing what benefits accrue from this service is unwise."^{23,24} Nor is it surprising that a discussion paper that extolled counselling while assuming its efficacy²⁵ was greeted with some hostility.²⁶

Despite the lack of convincing evidence of its efficacy many general practitioners believe in the value of counselling and of counsellors in general practice.^{2,3,25,27} As between 10% and 30% of consulting patients have mainly emotional problems²⁷ the scope for increasing general practitioners' counselling skills^{28,29} or referring patients to an in house counsellor is substantial.

The main reason for general practitioners' enthusiasm for counselling may well be a desire to reduce contact with and responsibility for a very demanding group of patients.²⁷ If this is so then increasing the counselling skills of general practitioners may be preferable to widening the primary health care team. Counselling requires, however, a move away from the authoritarian model of distance, diagnosis, and reassurance towards a model that recognises and promotes a person's

autonomy. Many general practitioners may find this transition difficult.

Since 1990 the general practice contract has allowed reimbursement for the costs of employing counsellors. But the staffing budget is cash limited, and some practices may have to accept less than 70% reimbursement if their application is successful. Fundholding practices have more control over staffing, and many consider counsellors, along with physiotherapists and chiropodists, to be their highest priority.

Since the new contract was introduced another possibility has emerged. Many practices have applied to run health promotion clinics for managing stress, which are thinly disguised counselling sessions. The clinic fee is almost sufficient to cover a counsellor's sessional fee, thus costing the practice a minimal amount. The recently announced moratorium on new health promotion clinics has put a temporary brake on applications, but it seems probable that the new regulations from next April will encompass stress clinics, although within a cash limited total.

The stage therefore seems set for an explosion of counselling. Practices would be wise, however, not to appoint unqualified people just because they seem to have good listening skills.³⁰ However well intentioned an amateur counsellor might be, there are profound professional, ethical, and clinical issues (not least confidentiality) that must be considered. In this issue Sibbald and colleagues show that fewer than half of counsellors have received specialist training in counselling.³¹

Counsellors should be accredited by the "Rugby conference" of the British Association for Counselling³² or be chartered psychotherapists recognised by the British Psychological Society.³³ They should concentrate on non-directive counselling,² being careful to avoid dictating solutions.³⁴ They must keep accurate records, but the requirements of confidentiality may necessitate keeping some disclosures from the patients' doctors. (Some patients are not convinced that