Providing choice for the treatment of foreskin conditions: the case for reducing medical circumcisions
A virtual expert roundtable

1. Introduction

On Friday 24 July 2020, Professor Simon Kenny, National Clinical Lead for Paediatric Surgery for Getting It Right First Time (GIRFT) and Consultant at Alder Hey Children’s NHS Foundation Trust, convened a roundtable discussion on how to improve the uptake of alternative treatments to medical circumcision for foreskin conditions in boys and teenagers in the UK. The discussion brought together a range of experts with the intention to:

- Identify barriers leading to regional variation in the provision of medical circumcision and uptake of alternative treatments
- Discuss tangible solutions to improve patient choice
- Agree a clinical consensus position on the treatment of foreskin conditions
- Develop proposals for policy change
- Propose next steps and how to take them forward

This report summarises the discussion and outlines the case for reducing medical circumcisions for the treatment of foreskin conditions and enabling patients to make an informed decision about their care – as well as bringing together ideas for implementing change.

If you have any questions about this report, please contact Professor Simon Kenny at Alder Hey Children’s NHS Foundation Trust on simon.kenny1@nhs.net.

Please note circumcision of young infants for cultural/religious reasons is outside the scope of this discussion.
<table>
<thead>
<tr>
<th>Attendees</th>
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</thead>
<tbody>
<tr>
<td><strong>Miss Aruna Abhyankar</strong>, Consultant Paediatric Surgeon, Noah’s Arc Children’s Hospital, Cardiff</td>
</tr>
<tr>
<td><strong>Miss Harriet Corbett</strong>, Consultant Paediatric Surgeon, Alder Hey Children’s NHS Foundation Trust</td>
</tr>
<tr>
<td><strong>Professor Mark Davenport</strong>, Professor of Paediatric Surgery, Kings College London</td>
</tr>
<tr>
<td><strong>Mr Chris Driver</strong>, Consultant Paediatric Surgeon, Royal Aberdeen Children’s Hospital</td>
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<tr>
<td><strong>Mark Flannagan</strong>, Director of Marketing and Communications, Alder Hey Children’s NHS Foundation Trust</td>
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<tr>
<td><strong>Miss Rachel Harwood</strong>, Paediatric Surgery Registrar, Alder Hey Children’s Hospital</td>
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<tr>
<td><strong>Professor Paul Johnson</strong>, Professor of Paediatric Surgery, University of Oxford</td>
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<tr>
<td><strong>Professor Simon Kenny</strong>, National Clinical Director – Children and Young People, Consultant Paediatric Urologist, Alder Hey Children’s Foundation Trust</td>
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<tr>
<td><strong>Mr Sean Marven</strong>, Consultant Paediatric Surgeon, Sheffield Children’s NHS Foundation Trust</td>
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<tr>
<td><strong>Mr Manoj Shenoy</strong>, President, British Association of Paediatric Urologists</td>
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<tr>
<td><strong>Mr Michael Stanton</strong>, Consultant Paediatric Surgeon, University Hospital Southampton NHS Foundation Trust</td>
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<tr>
<td><strong>Martin Tod</strong>, Chief Executive, Men’s Health Forum</td>
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<tr>
<td><strong>Lauren van den Bergh</strong>, Project Manager, GIRFT</td>
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<tr>
<td><strong>Mr Nick Wilson-Jones</strong>, Paediatric Plastic and Reconstructive Surgeon, Welsh Centre for Burns and Plastic Surgery, Morriston Hospital, Swansea</td>
</tr>
<tr>
<td><strong>Mr Dan Wood</strong>, Consultant Urological Surgeon, University College London Hospital</td>
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</tbody>
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This meeting was organised by Alder Hey Children's NHS Foundation Trust and policy and communications consultants Incisive Health. It was funded by a generous donation to Alder Hey Children’s Charity.
Recommendations

1. An online resource should be developed to support clinicians that provides **clear definitions of foreskin conditions and the full range of treatment options** for each. An online decision-making support tool would help less experienced clinicians select the most appropriate treatment options for their conditions.

2. **Training should be mandatory** for clinicians across the pathway – in both private and public sectors and including sexual health clinic staff – in diagnosing foreskin conditions, the appropriate referral pathway, what treatments could be offered and how to perform alternative procedures.

3. **GP referral forms** should be introduced which ask for reasons behind the referral and justification for the decision to circumcise. This is preferable to limiting referrals as it allows for discretion and flexibility for second opinion.

4. There is a need for **greater clinical leadership in educating and informing colleagues**:
   - Experienced paediatric surgeons and urologists should consider publishing **editorial articles** in journals such as the British Medical Journal (BMJ) in an attempt to reach more clinicians.
   - BAPU, BAPS and the Royal Colleges should ensure the information they provide is balanced and sources are current, peer-reviewed and peer agreed

5. The GIRFT report should be used as the basis of discussions for **developing a formal pathway** through which foreskin conditions are referred and treated, with a goal of reducing the variations identified.

6. Children’s surgical ODNs can be used to **coordinate the patient pathway, support generalist providers and share expertise**.

7. **Integrated Care Systems should provide local oversight**, including assuming accountability for ensuring that the recommendations of the GIRFT report are implemented in a timely manner and working with ODNs to achieve functional clinical pathways.

8. An **online platform** should be developed to host accurate and up-to-date information about the different types of foreskin conditions and the full range of treatment options that are available for each.

9. Personal, Social, Health and Economic (PSHE) forums in both primary and secondary schools should be encouraged to **stimulate discussion around how penises range in appearance, the natural history of the penis and foreskin, penis hygiene and foreskin conditions** as part of sexual health education.

10. The potential for **sexual health clinics** to play a role in hosting information about foreskin conditions and treatment options, and directing patients to accurate online sources of information, should be explored.

11. Children’s surgical ODNs should be supported to collect data on the use of **circumcisions and alternative treatments** locally and nationally. The database should be accessible to GPs so any side effects reported in the months and years following surgery can be collected – including sexual discomfort, reduced sensitivity/pleasure from sex or mental ill health.
2. Background

2.1 Circumcision for medical reasons

The prepuce, also known as the foreskin, is a fold of skin which covers the glans (head) of the penis. For the majority of boys, when they are born their prepuce is plastered to the head of the penis and there is a narrow ring (opening) of the foreskin. Over time as boys grow, pass urine and begin to have erections, the narrow ring becomes wider and the adhesions between the glans and the prepuce are broken down. This happens more quickly for some boys than others: by the age of 3, approximately 60% of boys have a retractile foreskin, which increases to 80% by 10 years of age.¹

Circumcision is the surgical removal of the foreskin and has been used in the treatment of foreskin conditions for millennia. While globally many men are circumcised, this is often through parental or, less commonly, personal choice for religious or cultural reasons. Circumcision is an effective method of reducing the transmission of some sexually transmitted diseases, including Human Immunodeficiency Virus (HIV), in countries where there are high prevalence levels without adequate access to barrier contraception. The World Health Organisation has published guidance on circumcision² relevant to the affected areas of the world and this document is not intended to inform decision making about circumcision for these areas, although the importance of men having choice about their bodies is important to note. Circumcision can also be used to reduce the incidence of urinary tract infections in babies with renal anomalies and this document is not intended to be used for counselling these families.

Circumcision has a high success rate and is relatively safe, with few side effects reported.³ However, there are relatively few published studies looking at the long-term patient reported outcome measures of circumcision undertaken in children of different age groups, including the impact on their sexual and mental health.⁴ Some clinicians suspect side effects are under-reported and more common than the available evidence suggests. Recent news articles of young adults who have been circumcised highlight the negative impact that circumcision can have on men.⁵,⁶ A greater awareness of the natural history of the foreskin – which, for some, may retract naturally in their teens⁷ – has led to debate about the over-diagnosis of pathological phimosis and higher rates of circumcision than is necessary.⁹

⁵ Caroline Lowbridge, (2019), ‘My son killed himself after circumcision’, BBC News
⁷ D. Gardiner (1949) The fate of the foreskin, BMJ 2:1433-1437 (link unavailable)
⁸ J. Oster (1968) Further fate of the foreskin, Incidence of preputial adhesions, phimosis, and smegma among Danish schoolboys, Archives of Disease in Childhood.
The British Association of Urological Surgeons (BAUS), British Association of Paediatric Surgeons (BAPS) and British Association of Paediatric Urologists (BAPU) in their most recent revision of clinical commissioning guidance on foreskin conditions, published in 2016, stated that children should not be referred for, or offered, circumcision for the treatment of physiological phimosis. It recommends that other avenues should be explored first – such as the application of topical steroids or stretching.

We can see from Table 1 that there has been a small reduction in the number of phimosis diagnoses from 2014/15 to 2018/19, although it’s unclear whether or not this indicates a change in practice.

<table>
<thead>
<tr>
<th>Foreskin condition</th>
<th>Redundant prepuce, phimosis, paraphimosis</th>
<th>Leukoplakia</th>
<th>Balanoposthitis</th>
<th>Other**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>2096</td>
<td>1335</td>
<td>98</td>
<td>73</td>
</tr>
<tr>
<td>5-9</td>
<td>3922</td>
<td>3231</td>
<td>746</td>
<td>829</td>
</tr>
<tr>
<td>10-14</td>
<td>2593</td>
<td>2481</td>
<td>526</td>
<td>588</td>
</tr>
<tr>
<td>15-18</td>
<td>2173</td>
<td>2401</td>
<td>126</td>
<td>189</td>
</tr>
<tr>
<td>Total</td>
<td>10784</td>
<td>9448</td>
<td>1496</td>
<td>1679</td>
</tr>
</tbody>
</table>

Table 1: The number of foreskin conditions diagnosed in England in boys aged 1-18 in the financial year 2014/15 and 2018/19 – according to NHS Digital, Hospital Episode Statistics for England data for admitted patient care, main procedures and interventions. **Other inflammatory diseases of the penis.

Acquired phimosis secondary to lichen sclerosis (also known as balanitis xerotica obliterans or BXO) is one of the few conditions for which circumcision is considered necessary. The accuracy of diagnosis of this condition has been called into question and a recent study found there was particularly high diagnostic inaccuracy of BXO in the under-fives age group by General Practitioners (GPs) referring patients to a specialist centre.

Despite concerns around over-diagnosis, there has been a slight decrease in the number of circumcisions in boys aged 1-18 in England since 2014 (Table 2). The most significant decline was seen most recently in 2017/18 to 2018/19, where there

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12 NHS Digital, Hospital Episode Statistics (2014/15) Hospital Admitted Patient Care Activity, Diagnoses.
was a drop of 9% in the number of circumcisions performed, though changes to CCG funding for religious/cultural circumcisions may have impacted these figures. However, these numbers are high relative to the foreskin conditions reported in 2018/19, with almost 70% of boys seen with a foreskin complaint undergoing circumcision (Table 1).

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>2,444</td>
<td>2,207</td>
<td>2,071</td>
<td>1,970</td>
<td>1,655</td>
</tr>
<tr>
<td>5-9</td>
<td>3,779</td>
<td>3,521</td>
<td>3,654</td>
<td>3,506</td>
<td>3,105</td>
</tr>
<tr>
<td>10-14</td>
<td>2,370</td>
<td>2,258</td>
<td>2,371</td>
<td>2,283</td>
<td>2,183</td>
</tr>
<tr>
<td>15-18</td>
<td>1,655</td>
<td>1,749</td>
<td>1,842</td>
<td>1,853</td>
<td>1,822</td>
</tr>
<tr>
<td>Total</td>
<td>10,248</td>
<td>9,735</td>
<td>9,938</td>
<td>9,612</td>
<td>8,765</td>
</tr>
</tbody>
</table>

Table 2: The number of circumcisions in England in children from the age of 1 to 18 years over five financial years from 2014-2019 – according to NHS Digital, Hospital Episode Statistics for England data for admitted patient care, main procedures and interventions.¹⁴

The situation in England is consistent with data from Scotland, where they have also seen a reduction in circumcisions across the same period, particularly for phimosis, which have reduced by 18% (Table 3).

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>58</td>
<td>24</td>
<td>8</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>5-9</td>
<td>132</td>
<td>85</td>
<td>77</td>
<td>99</td>
<td>25</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>10-14</td>
<td>98</td>
<td>83</td>
<td>51</td>
<td>48</td>
<td>11</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>15-18</td>
<td>175</td>
<td>189</td>
<td>15</td>
<td>16</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>463</td>
<td>381</td>
<td>151</td>
<td>163</td>
<td>51</td>
<td>45</td>
<td>46</td>
</tr>
</tbody>
</table>

Table 3: The number of circumcisions performed in the treatment of different foreskin conditions in boys aged 1-18 circumcised in NHS financial years 2014/15 and 2018/19 – according to Public Health Scotland data, provided by Mr Chris Driver.¹⁵

2.2 Alternative treatments for foreskin conditions

Alternative treatments to circumcision for foreskin conditions have been available for many years but their uptake has largely remained static. Table 4 shows NHS

England data on alternative foreskin condition treatments for boys aged 1-18, performed in financial years 2014/15 and 2018/19 respectively. Other than a small rise in the number of prepuctioplasty procedures, the number of alternative procedures has slightly declined. Circumcision remains, by a factor of 9, the most common surgical procedure for the treatment of foreskin conditions in this age group. Low rates of prepuctioplasty have been attributed to a (relatively) high failure rate of approximately 30%, meaning that 3/10 boys go on to have a circumcision anyway. However, this also means that 7/10 boys have chosen to, and have been able to, keep their foreskin. Whilst the immediate ‘failure’ rate for the surgeon appears high, the positive long-term impact on boys and men has not been quantified.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Prepuctioplasty</th>
<th>Free prepuce adhesions</th>
<th>Frenuloplasty</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>433</td>
<td>526</td>
<td>245</td>
<td>203</td>
</tr>
<tr>
<td>5-9</td>
<td>195</td>
<td>158</td>
<td>451</td>
<td>406</td>
</tr>
<tr>
<td>10-14</td>
<td>182</td>
<td>181</td>
<td>235</td>
<td>250</td>
</tr>
<tr>
<td>15-18</td>
<td>141</td>
<td>157</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>951</td>
<td>1022</td>
<td>970</td>
<td>899</td>
</tr>
</tbody>
</table>

**Table 4:** The number of alternative treatments to circumcision of foreskin conditions performed in England in boys aged 1-18 in the financial years 2014/15 and 2018/19 – according to NHS Digital, Hospital Episode Statistics for England data for admitted patient care, main procedures and interventions. *Dorsal slit, stretching, manual reduction and other specified operations on prepuce.*

A limitation of these data is that the use of topical steroid creams for the treatment of foreskin conditions is not captured. It also only reflects the children referred to hospital with foreskin complaints, when some could have been successfully managed by their GP with a topical steroid cream course. Multiple research studies, and a Cochrane systematic review, suggest these less invasive steroid creams can successfully correct phimosis in upwards of 75% of cases. Uptake of topical steroid creams could account for the reduction in circumcisions in 2018/19, seen in Table 2.

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16 NHS Digital, Hospital Episode Statistics (HES) (2014/15) Hospital Admitted Patient Care Activity, Procedures and Interventions.
17 NHS Digital, Hospital Episode Statistics (HES) (2018/19) Hospital Admitted Patient Care Activity, Procedures and Interventions.
2.3 Regional variation

Historically, disparities in the rates of circumcision in the UK have followed a north/south divide and tracked affluence, with circumcision for medical reasons being performed more commonly in wealthier, Southern regions of England. Rates in Liverpool were found to be below the national average across all ages up until the age of 15. However, in 2018/19, the rate of circumcision in males aged 1-18 differed only by 0.01% (data summarised in Table 5, below).

<table>
<thead>
<tr>
<th>Devolved nation</th>
<th>Circumcisions ages 1-18</th>
<th>Male population aged 1-18</th>
<th>% boys aged 1-18 circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>8,765</td>
<td>6165219</td>
<td>0.14%</td>
</tr>
<tr>
<td>Scotland</td>
<td>701</td>
<td>530290</td>
<td>0.13%</td>
</tr>
</tbody>
</table>

Table 5: The proportion of males aged 1-18 circumcised for medical reasons (not including religious/cultural circumcisions) in 2018/19 – calculated from NHS Digital, Hospital Episode Statistics for England data for admitted patient care, main procedures and interventions, Office for National Statistics population data mid-year 2019, and Public Health Scotland data, provided by Mr Chris Driver.

2.4 Psychological impact

Although rarely cited in medical literature or public information websites (including NHS choices), and dismissed by some urologists, the potential psychological implications of circumcision have been documented for some time. Sigmund Freud wrote of circumcision anxiety in 1913, and post-traumatic stress from childhood circumcision was noted as far back as 1927. A literature review by US psychologists into the psychological effects of circumcision conducted in children and adolescents concluded that circumcision, if experienced as trauma, can cause significant psychological harm. In a recent study of 1072 boys in the Philippines who were circumcised at aged 8-16 years, 51% met the diagnostic criteria for post-traumatic stress disorder.

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24 NHS Digital, Hospital Episode Statistics (HES) (2014/15) Hospital Admitted Patient Care Activity, Procedures and Interventions.
25 NHS Digital, Hospital Episode Statistics (HES) (2018/19) Hospital Admitted Patient Care Activity, Procedures and Interventions.
2.5 Public concern

In recent years, awareness of men’s health issues, particularly mental health, have received increased public scrutiny. Campaign groups opposing circumcision have emerged,\textsuperscript{33,34} and the rare but severe side effects of circumcision have received high profile media coverage.\textsuperscript{35,36,37}

2.6 Impact on health services

Circumcision is usually an elective procedure and occupies NHS capacity. Waiting lists for elective procedures have been growing for a number of years and this trend has been significantly exacerbated by the COVID-19 pandemic.

While children have not been significantly impacted by COVID-19 directly compared to adults, the indirect effects on healthcare provision for children and young people include a significant backlog to outpatient services and non-urgent elective procedures across the NHS. Pressure on NHS elective services is likely to continue to grow, driven by four factors:

- The need to manage the backlog of patients who had treatments delayed during the pandemic
- Reduced capacity due to the infection control measures required to deliver care safely in a COVID-endemic situation
- The need to retain capacity to manage the risk of increased prevalence of COVID-19
- Staff burnout, following a period of intense pressure

Furthermore, many people are now reluctant to use hospital services and would prefer to avoid hospitals for fear of catching COVID-19 and/or burdening the NHS.\textsuperscript{38}

All of these factors mean that there is a shared interest from patients and parents, clinicians, health service managers and policymakers in exploring treatment alternatives that reduce the need to receive treatment in a hospital, where these are clinically appropriate.

\textsuperscript{33} 15Square (2020) \textit{Foreskin Health Information and Advice for Circumcised Men}.

\textsuperscript{34} Men Do Complain (2020) \textit{Stop Male Genital Mutilation}.

\textsuperscript{35} Caroline Lowbridge, (2019), \textit{‘My son killed himself after circumcision’}, BBC News.


\textsuperscript{37} BBC One (2019) \textit{A cut too far? Male circumcision}. Last broadcast 21.02.20

\textsuperscript{38} Incisive Health (2020) \textit{Impact of COVID-19 on public attitudes to engaging with the healthcare system}.
3. Overcoming barriers to uptake of alternative treatments for foreskin conditions based on clinical experience, with recommendations for change

3.1 A lack of information and training in different clinical specialities

Circumcision has become the assumed default procedure in the treatment of foreskin conditions. This has led to preconceptions from parents and patients, as well as some GPs and surgeons that it is the only option and the natural direction of the pathway following diagnosis. Normalisation has also led to the common misconception that many non or slightly retractable foreskins require circumcision – despite the existence of evidence dating back to the 1940s that boys’ foreskins can retract naturally into late teens. Treatment options should be discussed with boys and their families and the choices should be appropriate for their diagnosis (e.g. physiological phimosis or BXO) and age.

If clinicians do not encounter foreskin conditions frequently then they may not have the expertise or confidence to suggest alternatives such as the prescription of steroid creams, where appropriate. There is currently no programme of education available on foreskin conditions through the Royal College of General Practitioners (RCGPs).

It is important that all clinicians in the patient pathway – GPs and practice nurses, paediatric and adult surgeons, as well as urologists – can accurately diagnose foreskin conditions and understand the full range of treatment options available. Since surgeons ultimately perform circumcision, they also need to be equipped to engage in a dialogue with the patient about their condition and their treatment options.

There is a need to clearly define foreskin conditions and each of the options available to treat them. Terminology can be important, and it has been suggested that the phrase ‘phimosis’ is regularly used to describe what is in fact ‘normal non-retractile foreskin’ or ‘physiological phimosis’. The adjective ‘pathological’ is pejorative, implying that there is a problem which needs to be fixed. However, in many cases the foreskin may retract without any intervention later in childhood or early adulthood, or with the help of less aggressive alternatives.

There is a role for relevant reputable organisations involved in this area of health in providing up-to-date, neutral, relevant information through an easily accessible platform.
3.2 Lack of a formal patient pathway

Across the country, many boys are referred by their GP for circumcision without exploration of the diagnosis, whether circumcision is the only option or if the patient is comfortable with the recommended procedure. The age of the child relative to the natural history of the foreskin must be taken into account.

There is also variation in the treatment options offered and administered to patients with foreskin conditions after referral, particularly between district general hospitals and specialist centres. Many circumcisions are performed by non-specialist surgeons without consultation with experienced paediatric surgeons or urologists. As discussed, circumcision is a relatively simple procedure with few reported side effects, so the procedure may be seen as an easy option or a quick fix. However, exploring alternatives which may be deemed more suitable by patients and families is more complex.

Recommendations

1. An online resource should be developed to support clinicians that provides clear definitions of foreskin conditions and the full range of treatment options for each. An online decision-making support tool would help less experienced clinicians select the most appropriate treatment options for their conditions.

2. Training should be mandatory for clinicians across the pathway – in both private and public sectors and including sexual health clinic staff – in diagnosing foreskin conditions, the appropriate referral pathway, what treatments could be offered and how to perform alternative procedures.

3. GP referral forms should be introduced which ask for reasons behind the referral and justification for the decision to circumcise. This is preferable to limiting referrals as it allows for discretion and flexibility for second opinion.

4. There is a need for greater clinical leadership in educating and informing colleagues:
   - Experienced paediatric surgeons and urologists should consider publishing editorial articles in journals such as the British Medical Journal (BMJ) in an attempt to reach more clinicians.
   - BAPU, BAPS and the Royal Colleges should ensure the information they provide is balanced and sources are current, peer-reviewed and peer agreed.
Addressing this variation requires the development of a standardised pathway for the NHS and private sector, so as to ensure that all patients are supported in making an informed choice, based on all clinically appropriate management options.

A national review of paediatric general surgery and urology by the Getting It Right First Time (GIRFT) programme highlighted challenges from significant demand, poor infrastructure and a lack of data to benchmark services. The programme’s national report, due for publication in 2021, is expected to recommend reducing unnecessary surgical procedures — specifically including non-infant medical circumcision — through children’s surgical Operational Delivery Networks (ODNs) by applying evidence-based surgical decision-making.

ODNs could develop a suite of key performance indicators to ensure adherence to agreed clinical pathways.

### Recommendations

5. The GIRFT report should be used as the basis of discussions for developing a formal pathway through which foreskin conditions are referred and treated, with a goal of reducing the variations identified.

6. Children’s surgical ODNs can be used to coordinate the patient pathway, support generalist providers and share expertise.

7. Integrated Care Systems should provide local oversight, including assuming accountability for ensuring that the recommendations of the GIRFT report are implemented in a timely manner and working with ODNs to achieve functional clinical pathways.

### 3.3. Overcoming stigma through access to accurate information, imagery and advice

There is a need for a trustworthy, evidence-based online source of information about foreskin conditions at different age groups of boys, teenagers as well as their parents.

Due to the nature of foreskin conditions, there are a number of challenges to overcome in ensuring patients and parents are able to make informed decisions that are right for them as individuals.

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There is often embarrassment in discussing problems relating to the penis with family members or a doctor. Limited conversations may also mean that boys and their parents are not fully aware, or have a distorted view of, what is involved in the circumcision procedure and recovery. This may contribute to quicker decisions being made without due consideration of potential options.

Teenagers and young adults especially can feel as though their identity as a man is threatened as a result of their condition. This age group may be particularly concerned about the impact of foreskin conditions and treatments on their sex life. Potential side effects of circumcision, for instance, pain on arousal, may cause upset and the patient may prefer to explore different options to manage their condition. Doctors need advice on how to sensitively communicate with patients and understand their concerns so that the most appropriate option for the individual can be found.

Both primary and secondary schools could have an important role to play in providing information and opening up discussions about penis and foreskin health – including how penises range in appearance, penis hygiene and common foreskin complaints.

While fear and embarrassment restrict face-to-face conversations, boys will often turn to the internet to find out ‘what’s wrong with them’. Men’s Health Forum report large volumes of web traffic from boys and men looking for information about their penis and foreskin conditions.

Although turning to the internet for answers can be a positive thing, there is a risk of exposure to misinformation or opinions without evidence base. There is also a skewed perception of what ‘normal’ looks like. Often the only images teenagers and young men are exposed to is through pornography, where the male protagonist’s penis is commonly circumcised. Myths and misconceptions within this area need to be addressed if patients are to be able to make informed decisions. Images or illustrations of what the range of penises look like should to be accessible for reference, particularly to younger boys and teenagers. Developing such material needs to be done sensitively, so as to manage safeguarding issues and ensure that appropriate educational information is not caught in online filters.
3.4. A need for data and evidence
Although there is an understanding that regional variation in circumcision persists, the numbers of circumcisions performed in each hospital or even region are not published. It is therefore challenging to engage clinicians and providers in informed discussion about the extent of – and reasons for – variation, as well as to target clinical education and training effectively.

There are relatively few high-quality published studies looking at the outcomes of the psychosexual effects of circumcision in children of different age groups, access to and quality of their care, and short and long-term side effects of the procedure. This includes any potential mental health impact and interruption to the patient’s sex life – which they may feel too embarrassed to discuss with their doctor. Some clinicians suspect side effects are underreported and more common than the available evidence suggests.

An absence of evidence is not evidence of absence. Without this evidence, it could be argued that patients and parents are unable to give truly informed consent. This is particularly poignant in light of the Independent Medicines and Medical Devices Safety Review, *First, do no harm*, led by Baroness Cumberlege. Although focussed on medicines and medical devices, the review is relevant to the discussions around medical circumcision, including the finding that: “Patients are unable to make decisions that concern what happens to them because of a widespread lack of truly informed consent and a reluctance or inability by those charged with patient care and treatment to listen and, having listened, to act and where necessary remedy mistakes or misjudgements made.”

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8 An **online platform** should be developed to host accurate and up-to-date information about the different types of foreskin conditions and the full range of treatment options that are available for each.

9 Personal, Social, Health and Economic (PSHE) forums in both primary and secondary schools should be encouraged to **stimulate discussion around how penises range in appearance, the natural history of the penis and foreskin, penis hygiene and foreskin conditions** as part of sexual health education.

10 The potential for **sexual health clinics** to play a role in hosting information about foreskin conditions and treatment options, and directing patients to accurate online sources of information, should be explored.

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4. Priorities for change

The recommendations identified in the meeting and set out in this report represent a comprehensive plan to enable informed choice in relation to the management of foreskin conditions.

As a group, we identified the following priorities where we can make a difference, either acting alone or collectively:

1. Making the case for **clear pathways to educate boys, families, GPs and surgeons** about foreskin conditions and their range of treatments
2. Developing an **online decision-making support tool** to help clinicians offer an appropriate range of treatment options for different foreskin conditions
3. Producing **resources and guidelines to inform less experienced clinicians**, particularly in primary care or adult surgery, to improve the options they provide in the treatment of foreskin conditions and to reduce unnecessary referrals
4. Providing **clear definitions of pathology** for each of the different foreskin conditions, differentiating between severe (BXO) and mild (slightly retractable foreskin) conditions
5. Testing **new collaborative models for delivering care** across health systems

5. Conclusion

The discussions identified a clear need to support informed choice, but also significant opportunities to make progress, not least given the context of the need to introduce capacity-saving alternatives in light of COVID-19.
5.1 Next steps
The immediate next steps will be to:

- Develop a **clinical consensus** regarding the treatments that ought to be recommended for each foreskin condition
- Brief **religious and cultural groups** to explain scope and minimise the risk of misunderstanding of intent
- Produce a **short report** making the case for change and setting out the policy recommendations discussed at the meeting
- Engage with relevant **policymakers and stakeholders** to discuss recommendations including, NHS England & Improvement BAPS, BAUS, the RCPCH and the PHSE sexual health board
- Create a **website** to house information on foreskin conditions targeting patients of all ages, parents and clinicians and signpost readers to reputable sources
Glossary

**Balanoposthitis** – Inflammation of the penis and foreskin. It is a descriptive term rather than a diagnosis and occurs only in men with a foreskin.

**Balanitis Xerotica Obliterans (BXO)** – A common chronic, often progressive, disease of the penis affecting the foreskin and the head of the penis. If left untreated, it can affect the whole penis and scrotum.

**Circumcision** – The surgical removal of the foreskin.

**Foreskin** – The retractable sleeve of skin that covers the end of the penis; a continuation of the skin which covers the whole penis.

**Free prepuce/preputial/foreskin adhesions** – Areas of scar tissue between the top of the penis and the inside of the foreskin. These make it difficult to pullback the foreskin and keep it clean which can lead to soreness and infection. An operation to trim the foreskin (not circumcision and the full removal of the foreskin) allowing it to be pulled back can be a solution.

**Frenuloplasty** – An operation on the underside of the glans penis that is used to lengthen a short frenulum which either prevents foreskin retraction or produces symptoms.

**Frenulum** – The small tag of skin on the underside of the penis, between the foreskin and the penis shaft. Sometimes called the banjo string.

**Glans** – The head of the penis.

**Leukoplakia** – A precancerous condition recognisable by the presence of abnormal white areas on the head of foreskin of the penis. Usually occurs through chronic irritation, inflammation, infection of the penis, or by poor genital hygiene.

**Lichen Sclerosis** – A long term scarring skin condition causing itchy white patches on genitals which affects the foreskin and sometimes the head of the penis. An alternative name for BXO, though BXO is much more commonly used.

**Paraphimosis** – When the foreskin cannot be returned to its original position after being pulled back. This can cause the head of the penis to become painful and swollen and requires emergency medical treatment.

**Phimosis** – A condition where the foreskin is too tight to be pulled back over the head of the penis. This is normal in babies and toddlers but may be due to a skin condition if present in older children. It is not usually a problem unless it causes symptoms.
- **Pathological/physiological phimosis**: A condition associated with scarring of the foreskin opening leading to symptoms and non-retractability of the prepuce, usually due to balanitis xerotica obliterans.

- **Normal non-retractile foreskin**: A normal foreskin which cannot be retracted. The foreskin is ‘stuck’ to the head of the penis and usually releases over time. There is no evidence of scarring.

**Prepuce** – Another term for the foreskin.

**Preputioplasty** – an operation on a tight foreskin usually involving 3 radial incisions of the scarred prepuce, with or without steroid injection (Trimamcinolone).

**Redundant prepuce** – The inability of the foreskin to be retracted behind the head of the penis because the skin is too long and completely covers the penis when it is not erect.

**Topical steroid creams/corticosteroids** – A type of steroid medicine applied directly to the skin to reduce inflammation and irritation.