MEMORANDUM OF EVIDENCE-BASED MEDICINE
Concerning the current standard of care, which prohibits ‘PFFR’—premature, forcible, foreskin retraction:

I. FROM THE AMERICAN ACADEMY OF PEDIATRICS:
Even attempted foreskin retraction of an intact (not circumcised) boy who is non-retractile, is expressly forbidden by the American Academy of Pediatrics and has been so for a very long time.

The child’s connective membrane, a common epithelium, (often erroneously described as an ‘adhesion,’) is not pathology in need of medical intervention, especially not as a normal condition encountered on an infant or toddler who is a decade or more from natural, non-traumatic, foreskin separation.

The warning of the American Academy of Pediatrics quoted below applies to physicians, osteopaths, naturopaths, nurses, and parents alike. It is incontestable, standard medical dogma, and sound parent advice in all civilized countries:

“Until separation occurs, do NOT TRY to pull the foreskin back—especially an infant's. Forcing the foreskin to retract before it is ready may severely harm the penis and cause pain, bleeding, and tears in the skin.” (From the AAP bulletin, "Care of the Uncircumcised Penis")

The AAP warning of the resulting harm leaves no discretion for a clinician of any specialty, whether for examination, diagnosis, or treatment. We have on file archival correspondence from deluded (or dissembling) M.D.’s and R.N.’s who defend that this AAP advice was intended ‘for parents, not us.’ Anatomically, that cannot be the case. There is no way an injury to a healthy child could be considered ‘therapeutic’ performed by a clinician, while the same maneuver is forbidden to parents as ‘severely harmful.’

In any case, the AAP warning is only one of many, as we note here—at length and in comprehensive detail:

II. CURRENT MEDICAL LITERATURE—CONTRA FORCIBLE FORESKIN RETRACTION:

For up-to-date scholarship and the modern standard of care on this issue, consult the following sources, which, studied collectively, will suggest the correct—extended—timetable for penile development, and the lack of need for—indeed, the damage caused by—premature or forced retraction for alleged, aggressive cleaning. (The emphasis in each is ours).

Rudolph and Hoffman’s Pediatrics:
"The prepuce, foreskin, is normally not retractile at birth. The ventral surface of the foreskin is naturally fused to the glans of the penis. At age 6 years, 80 percent of boys still do not have a fully retractile foreskin. By age 17 years, however, 97 to 99 percent of uncircumcised males have a fully retractile foreskin. Natural separation between the glans and the ventral surface of the foreskin occurs with the secretion of skin oils and desquamation of epithelial cells, smegma. … No treatment is required for the lumps or smegma, and in particular, there is no indication ever for forceful retraction of the foreskin from the glans."

and at: http://en.wikipedia.org/wiki/Forcible_retraction_of_the_foreskin

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newborn and infant, this produces small lacerations in addition to a severe abrasion of the glans. The result is scarring and a resultant secondary phimosis. *Thus it is incorrect to teach mothers to retract the foreskin.*” 2

*Urology News* describes the correct anatomy, and warns against claiming that normal anatomy suggests pathology:3

“…Typically, the prepuce is long with a narrow tip, and the inner surface of the prepuce is fused with the outer surface of the glans so retraction is rarely possible…The fused prepuce and glans separate and spontaneous retraction of the foreskin and uncovering of the glans is usually possible by puberty. ‘Phimosis’ is often used misleadingly to describe a normal, developmental, non-retractile foreskin, implying pathology, when in reality there is none. More appropriate terms such as 'non-retractile foreskin' should be used in its place.”

*Roberton’s Textbook of Neonatology also warns:*4

“All newborn males have “phimosis”; the foreskin is not meant to be retractile at this age, **and the parents must be told to leave it alone and not to try and retract it.** Forcible retraction in infancy tears the tissues of the tip of the foreskin causing scarring, and is the commonest cause of genuine phimosis later in life.”

*Avery’s Neonatology issues a similar warning of immediate and permanent damage*:5

‘Forcible retraction of the foreskin tends to produce tears in the preputial orifice resulting in scarring that may lead to pathologic phimosis.”

*Osborne’s Pediatrics also warns about permanent damage:*

“[phimosis or paraphimosis] is usually secondary to infection or trauma from trying to reduce a tight foreskin…” “circumferential scarring of the foreskin is not a normal condition and will generally not resolve.” 6

Even the authors of baby-care books intended for the lay public understand that the foreskin and glans are effectively a single structure, naturally fused at birth –and for many years thereafter. This text, describing normal anatomy, is typical of the best:

**Leach P., Your Baby and Child from Birth to Age Five, Knopf, New York, 1990:42.**

“The penis and the foreskin develop from a single bud in the fetus. They are still fused at birth and they only gradually become separate during the first years of the boy’s life. A tight foreskin is therefore a problem which a new baby cannot have. You cannot retract his foreskin because it is not made to retract at this age. You cannot wash under it because it is only meant to be cleaned from outside in babyhood,… When [circumcision] is necessary it is usually because attempts have been made to retract the foreskin, forcibly, before it was ready to retract of its own accord.”

A medical historian notes the following about the invented and erroneous Anglophone suggestion of a need for aggressive or intrusive infant male hygiene —with its accompanying, and invented, notion of forced retraction--- and the happy historical accident that females escaped similar treatment:

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5 *Avery’s Neonatology: Pathophysiology and Management of the Newborn*, MacDonald (ed) Lippincott, 2005:1088

“To appreciate the scale of the error, [that boys need forced retraction for hygiene] consider its equivalent in women: it would be as if doctors had decided that the intact hymen in infant girls was a congenital defect known as ‘imperforate hymen’ arising from ‘arrested development’ and hence needed to be artificially broken in order to allow the interior of the vagina to be washed out regularly to ensure hygiene.” (Dr. Robert Darby, *A Surgical Temptation, The Demonization of the Foreskin and the Rise of Circumcision in Britain*, Univ. of Chicago Press, 2005:235.)

Advice to parents to retract and clean the child at each bath is nothing less than foolish Anglophone quack folklore. Such advice ignores the reality that our distant primate ancestors (and our more immediate ancestors pre-1870) did no such thing and survived nicely. Human mucosal tissue –eyes, mouth, inner nose, and genitalia– has evolved to be self-defending and mostly self-cleaning. It could hardly be otherwise.

### III.

**FORTY YEARS OF INTERNATIONAL WARNINGS AGAINST FORCIBLE RETRACTION OR ANY INTERFERANCE WITH THE NATURAL DESQUAMATION OF THE CHILD’S BALANO-PREPUTIAL LAMINA:**

A leading neonatal text, *Avery’s Neonatology*, suggests one reason why these ‘misdiagnoses’ of the male child’s natural and normal balano-preputial-lamina occur in English-language medicine and why researchers outside the U.S. discourage interfering with the child’s normal and natural development:

> “Because circumcision is so common in the United States, the natural history of the preputial development has been lost, and one must depend on observations made in countries in which circumcision is usually not practiced.” *Avery’s Neonatology: Pathophysiology and Management of the Newborn*, MacDonald (ed) Lippincott, (2005:1088)

And the overseas ‘observations’ which *Avery’s* refers to, have been readily available to better educated American physicians since 1968, as long ago as 45 years, (and are, at present, instantaneously available, –in “.29 seconds”– to anyone, including parents –and lawyers):

**DENMARK, 1968:**


> ‘Phimosis is seen to be uncommon in schoolboys, and the indications for operation even rarer if the normal development of the prepuce is patiently awaited. When this policy is pursued, in the majority of cases of phimosis, it is seen to be a physiological condition which gradually disappears as the tissues develop.” …Physiological phimosis is a rare condition in schoolboys, and it has a tendency to regress spontaneously: operation is rarely indicated. Clumsy attempts at retraction probably cause secondary phimosis, which then requires operation. ‘Preputial non-separation (‘adhesion’) occurs frequently, but separation of the epithelium takes place gradually and spontaneously as a normal biological process in the course of school life and is concluded about the age of 17.’

**AUSTRALIA, 1994:**


> “It [the foreskin] should be open and beginning to retract by three years of age but full retractability may not be achieved until many years later. Indeed nature will not permit the
assignment of a strict timetable to this process.”

JAPAN, 1997:
“It is not recommended to separate the foreskin by manipulation, which sometimes leads to bleeding or paraphimosis. And it is not necessary to surgically correct phimosis in infancy and early childhood except in the case of accompanying urological disturbance.”

BRITAIN, 1999:
Cold CJ, Taylor JR. The prepuce. BJU Int 1999;83 Suppl. 1:34-44.
“Øster confirmed in a large study that preputial non-separation (adhesions) is very common in children and teenagers. The separation of the prepuce/glans penis mucosa is usually complete by about age 17 years, as confirmed by later Chinese studies (Fig. 2) [20,21]. Recent work by Kayaba et al. verified that the preputial orifice may be tight in young boys, but resolves over time (Fig. 3) [22]. Without knowledge of the normal development of the penis, some physicians advocate childhood circumcision as a surgical treatment of normal anatomy [5]. One study stated that microscopic examination of the prepuce circumcised for phimosis showed normal histology in 46% of cases [23]. As the mean age in that study group was 8.7 years, almost half of these boys were circumcised for a normal stage of penile development [22]; a tight preputial orifice with normal histology is not pathological in young boys, but should be considered a normal stage of penile development.”

SPAIN, 2002:
“Incomplete separation between prepuce and glans penis is normal and common among newborns, progressing until adolescence to spontaneous separation, at which time it is complete in the majority of boys. Accordingly to the criteria we have sustained for years and present study's findings, circumcision has few indications during childhood, as well as forced prepuce dilation.”

INDIA, 2005:
“The prepuce could not be retracted at all so as to make even the external urethral meatus visible in 61.4% children aged 0-6 months while this decreased to only 0.9% in children aged 10-12 years. At the other end of the spectrum, while prepuce could not be fully retracted in any child below 6 months, it could be done in about 60% in the age group of 10-12 years. CONCLUSION Preputial nonseparation is the major cause of preputial nonretraction in the pediatric age group. Prepuce spontaneously separates from the glans as age increases and true phimosis is rare in children. Surgical intervention should be avoided for nonseparation of prepuce.”

TAIWAN, 2007:
“Nonretractability of the prepuce was very common among the Taiwanese newborns. Among the school boys, the degree of preputial separation and exposure of glans increased with age and progressed even more rapidly in adolescence. Very few boys still
Thus any poorly educated North American medical professional’s reference to the boy’s natural, normal, and expected balano-preputial lamina as unnatural ‘adhesions’ which must be manually reduced, lysed, or separated, or may be done so for diagnosis, is simply and inexcusably ignorant, cruel, as well as defiantly out-of-sync with 21st-century, world, standards of evidence-based medical care.

IV.

BRIEF HISTORY OF THIS IATROGENIC INJURY

Unfortunately, the practice of premature forcible foreskin retraction (PFFR) has it origins in 19th-century, puritanical, Anglophone medical folklore—not 21st-century evidence-based medicine. The following quote is from a recent article in Psychology Today, which gives a brief synopsis:

“In the mid-19th-century, before doctors discovered germs, they devised a disease theory called 'reflex neurosis.' This theory held that stimulation, (then called 'irritation' or 'neurosis') of sensitive tissue, would cause disease to appear in a distant part of the body (the reflex). As the genitals are intensely sensitive tissue, doctors blamed disease even on innocent touching 'down there.' A refinement of this theory claimed that children touched themselves because smegma, the natural substance that both sexes produce, would sour, become itchy, and draw the child's attention to his (or her) genitalia.

Thus if a boy in 1870 contracted tuberculosis, he was accused of 'irritating' his penis. The solution? Aggressive, regular, internal cleaning –or circumcision. This medical theory was a perfect fit with the sexual mores of the Victorian era. Thus began a one-hundred-year tradition in English-language medicine of vilifying the genitals, both male and female, as the source not only of disease, but also a potential temptation to offend 'moral hygiene.' Doctors reasoned that rigorous cleaning, drying-up, desensitizing (with acid, typically pure carbolic acid or phenol), or even amputation of genital mucosal tissue (i.e., circumcision) was both a medical and a moral imperative. 7

Reflex neurosis survived in English language medicine many decades after germs were discovered in the 1880’s. An entire industry of 'anti-masturbation' restraint devices for children developed. (Hoag Levins, 1996)…

It was once standard English-language medical practice (1870-1980) to forcibly separate the glans from the foreskin, either wholly by the doctor or by the parents on doctor's orders, "a little at each bath." Mothers reported disliking this chore as they knew instinctively it was injurious and painful.8 This pernicious practice is not yet dead, and many grandmothers (and poorly educated medical professionals) still cling to it, despite the fact that it is injurious and forbidden.” 9

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7 (Darby, R. A Surgical Temptation, The Demonization of the Foreskin and the Rise of Circumcision in Britain, Univ. of Chicago Press, 2005:235.)
Reflex neurosis theory, and its step-child, forcible foreskin retraction, is now well understood, world-wide, to be superstitious, pre-germ, Anglophone medical nonsense. (As well as the direct source of all those locker-room jokes about hairy palms, blindness, and insanity.)

V.

FORCIBLE FORESKIN RETRACTION OF A MALE PATIENT UNDER THREE YEARS OLD

In 1949, a British pediatrician, Douglas Gairdner, published an influential article claiming, with minimal clinical observation, that 90% of intact boys should be retractable by age three years. 10 Many observational studies, scholars, and anatomists since then have proven that Gairdner’s timetable was almost a decade off the mark. Øster, (Denmark, 1968) put the average age of full, natural, trauma-free, foreskin retraction at 10.4 years, based on clinical observation of nearly 10,000 boys. 11

Thus the true age for natural, trauma-free, foreskin retraction is widely acknowledged to slowly arrive, without worry, as late as puberty, and there is no need for early or forced retraction for any reason. There is no set timetable for natural retraction, all boys are different, and there is no need to rush this natural process. Europeans have known this for centuries.

However, during the period from 1949 to the present, even those under the influence of ‘Gairdner’s Error’ as it is called, have universally recognized that infants and toddlers under three years of age must not be forcibly retracted, due to the risk of torn tissue, trauma, infection, injury, and late-appearing, adult, sexual sequelae. Those forcibly retracting infants do not even have the excuse of claiming Gairdner’s Error.

To add insult to this injury, sometimes these injuries are inflicted on an infant during a well-baby visit or ‘WCC’, a Well-Child-Check. This is appalling, as it reflects pre-1949, 19th-century, medical nonsense. We have seen a precipitous rise in such cases as the number of intact (not circumcised) boys rises in the U.S. and circumcision rates decline nationally. These injuries are most regrettable and would not occur –or be tolerated– in Europe, Asia, Australasia, or South America.

Forcibly retracting the foreskin of a toddler under three years of age is the most unforgivable medical malpractice, replicating as it does the dismal understanding of 19th-century physicians about normal infant anatomy, which has long been considered obsolete and injurious.

VI.

OUR CONCERNS FOR THIS CHILD –AND OTHER CHILDREN

Premature forcible foreskin retraction (PFFR) inflicts permanent destruction of the natural and protective balano-preputial-lamina of male childhood, the natural male ‘hymen’ that protects the child’s erogenous foreskin from pathogens, mechanical injury, and the irritation of feces, until this tissue is needed at adulthood. Once lost, this membrane will not re-form and cannot be reconstituted. Its loss leaves the formerly sterile and sealed inter-space between the foreskin and glans, now raw and bleeding, subject to immediate and future infection.

Destruction of this protective ‘synechia,’ a common epithelium of the glans and foreskin, has no legitimate place in the armitarium of modern, ethical medical practitioners. It was, in the 1870’s –when it arose as an

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antidote to masturbation— an unjustifiable, unnecessary, traumatic, painful, permanent injury to the intact boy—and remains so.

The child who was painfully retracted will be miserable, enduring stinging on urination, oozing blood, will be in pain, restless, traumatized, and vulnerable to infection and distrusting of adults. (Parents report cases to us where the injured toddler will not even permit his diaper to be changed without screaming and writhing, while being held down by a second person.) The child will also be vulnerable to future paraphimosis emergencies and, potentially, adult sexual dysfunction.

VII.

ICD-9-605 and ICD-10-CM-N47.0 et seq. FRAUD AND THE “PHONY PHIMOSIS” DIAGNOSIS

An ignorant clinician might injure the child and include it in a well-baby office visit /‘well-child-check,’ no charge. A dishonest or greedy one will use ICD-9-605 to charge the parent, the insurance company, or Medicaid, for the injury. This is open and obvious fraud in 99.9% of these cases, esp. those lacking supporting pathology. ICD-9-605 (and November, 2014, ICD-10-CM-N47.0) reads as follows:

605 Redundant prepuce and phimosis
Adherent prepuce, Paraphimosis, Phimosis (congenital), Tight foreskin

This broad language, (based on a speech given to the AMA in 1870 attributing poliomyelitis to a normal, fused foreskin and absorbed into the World Health Organization as dogma decades later), is a sore temptation for the dishonest practitioner. ‘Adherent prepuce,’ ‘phimosis,’ and ‘tight foreskin’ for instance, are descriptions of normal anatomy in males as old as 17. None indicates pathology of any kind. What was billed for in the instant case? What is this clinic’s billing history for forced retractions? Do they claim they are ‘lysing adhesions’? Do they use ‘605’ to bill the parent’s insurer or Medicaid?

A strict requirement of photographic evidence, pathology, or better, off-site histopathology, is the only way to prevent fraudulent use of this billing code. It is our experience that ‘605’ is regularly used to extract public funds. Medicaid auditors are generally unaware of the fraud, and so it is literally like taking candy from a baby.

It is also our experience that clinicians who injure intact boys do so over and over and over, are refractory to re-education, and are completely unrepentant until cornered by their licensing agency, audited by Medicaid—or sued for malpractice. It is simply too easy to perform—and too lucrative to abandon.

VIII.

PROPER CARE OF THE INTACT CHILD

It is especially important that U.S. medical professionals of every stripe understand this medicine correctly, as Europeans do, since nearly 50% of U.S. boys (75-80% in Washington, Oregon and California) now escape circumcision, and thus many more than ever are preserved intact. These boys need to be left just as unmolested during their developmental years as they were at birth. Even given evidence of infection such as a high fever of unknown origin, there is no more need to examine the internal genitalia of an intact male infant than those of a female. NO examination of the male genitalia, even for suspected infection of unknown origin, needs to include visualization of the glans, an internal structure, by forced foreskin retraction, even for catheterization, which, in common with other medical procedures, must be done by subtle ‘feel’ and demands skill. 12

12 Obsolete protocols sometimes call for circumcision or forced retraction of infants who need catheterization, such as those with spina bifida. Such suggestions are ‘lazy’ and destructive medicine as it is quite possible to catheterize such infants without
The simplest, recommended, modern medical protocol and best practices are as follows.13

1. The infant, toddler and pre-adolescent penis should be left alone by everyone except the owner, and treated no differently than female genitalia. The simple rule is, ‘Only clean what is seen.’

2. No special care or cleaning is required, only warm water to the outer dermis, as the internal penis is naturally self-cleaning like the infant vulva, until puberty, when the patient can care for himself. Even soap should be avoided as it destroys natural immuno-alert substances. Similarly, cases of contact dermatitis and balanitis are often due to pool chemicals. These cases of irritation of the glans at the partially detached foreskin portion often present in the summer months when children swim. They do not require medical intervention, merely good advice.

3. Normal desquamation (disappearance cell-by-cell) of the entire balano-preputial lamina (BPL) may take up to 17 years or more. Only 50% of boys at age 10.4 years are retractable, and a much lower percentage will be so, of course, at any younger age.14 There is no therapeutic need to rush the separation by lysing or forced retraction. By the end of puberty, 98% of boys will be retractable, and failure of retractability even then is not itself harmful or an indication of pathology (though it may indicate iatrogenic phimosis from non-therapeutic prior forced retraction).15

4. Only the child should retract himself or attempt to do so, as any ensuing pain will tell him when to stop. Nor should he be required to forcibly retract himself at the instruction of any adult, including his medical provider, at any time.

5. The non-retractile intact child should never be forcibly retracted to examine his glans. If infection is present it will be obvious by edema, ecchymosis, or culture. No intrusive examination is medically justifiable, and further tissue damage may result in permanent adhesions, or the spreading or aggravation of iatrogenic infection.

6. ‘Ballooning’ of the partially detached foreskin upon urination is a benign event requiring merely reassurance to the parents; it is NO indication of need for medical intervention.

7. Smegma is not a carcinogen or indication of infection, and like ear wax, its appearance in both males and females is no cause for alarm. Treating it as a problem substance is ignorant, 19th century quackery, when it is well known to provide a first-line of immunological defense.16

8. Even for a fully-retractable older adolescent, only warm water should ever be used on the glans or foreskin, as soap destroys natural emollients and disturbs the natural floral balance, including lysozyme and lysozome, which provide immune protection. Warm water ONLY is the best practice, same as for the female inner vulva.

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13 A printable pamphlet for parents and medical professionals alike is available at: http://www.nocirc.org/publish/4pam.pdf
9. So called ‘pin-hole’ preputial meatus is no cause for alarm in the infant and young child as long as he can urinate a stream. The opening will naturally widen with age and the hormones of puberty if left unmolested. If injured or if retraction is forced, scar tissue may form which will, indeed, cause urinary retention or a ‘needle-spray’ urinary stream (a sign of obstruction or stenosis, more common in circumcised than intact boys.)

10. Catheterization, if therapeutically necessary and unavoidable, (when suprapubic aspiration or mid-stream ‘bagging’ is not appropriate), can be performed without visualizing the urethral meatus, by palpation and ‘feel,’ threading the catheter through the outer preputial meatus and gently probing for the inner, urethral meatus. This requires skill and attention to detail. In the neonate suspected of urinary infection, mid-stream urine sample capture or suprapubic needle aspiration is the preferred diagnostic tool to catheterization, which might itself create infection by pushing surface pathogens proximally.

11. The length of the child’s overhanging foreskin when his glans is withdrawn proximally, (admired in antiquity and called the ‘acroposthion’), is a not a matter requiring medical intervention. i.e., there is no such thing as a ‘redundant’ foreskin. All apparent ‘excess’ will be taken up by growth of the internal structure, during puberty. Amputating the so-called ‘excess’ may leave the child with insufficient sheath to cover his inner structure as he, and it, mature.

12. All treatment for rare penile infection or true, pathological phimosis (as opposed to normal physiological phimosis) should be conservative and incremental just as with females: improved hygiene (or avoidance of excessive hygiene), topicals, semi-potent steroids, eventually antibiotics or gentle stretching. Treatable irritation or transient infections of the foreskin, glans, or urinary tract are never justifiable reasons for amputation of the foreskin –exactly the same as for a female child. Well-developed, proven, conservative modalities are readily available.17 18

As cultural, ‘medicalized’ circumcision slowly dies in the U.S., and the number of intact boys rises (on the U.S. West Coast, intact boys are now over 75% of toddlers), there is, of course, an increased need for better understanding of care of the intact boy by American-trained clinicians. We provide free diaper stickers to parents that warn practitioners, “I’m Intact, Don’t Retract!” The simple hygiene rule we advise parents is, “Only Clean What is Seen.” It is no more complicated than that.

Please study the enclosed, attached, or referenced materials carefully. Share them with any consultants you retain in this case. Contact us personally, at any time you wish, by email, post, or telephone for further information on this topic about which we have many years—and many hundreds of cases—of (melancholy) experience.

Respectfully yours,

[Signature]

John Geisheker, JD, LL.M
Executive Director and General Counsel

On behalf of the Members of the Board of Directors of Doctors Opposing Circumcision and its Medical Advisors:

REFERENCES:


Avery’s Neonatology: Pathophysiology and Management of the Newborn, MacDonald (ed) Lippincott, 2005:1088


Cold CJ, Taylor JR. The prepuce. BJU Int 1999;83 Suppl. 1:34-44.


Parents and practitioners both will also find an easy-to-read article on forced foreskin retraction on Wikipedia, with extended footnotes to the relevant medical research, at:

http://en.wikipedia.org/wiki/Forcible_retraction_of_the_foreskin