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Premature, Forcible Foreskin Retraction: A Memorandum of Evidence-based Medicine

Concerning the current standard of care prohibiting premature, forcible foreskin retraction

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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 membrane connecting the foreskin to the head of the penis (called the *balano-preputial lamina*), a common epithelium often erroneously described as an 'adhesion', is not pathology in need of medical intervention. This attachment is 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 doctrine and sound parent advice, in all civilized countries:

From the AAP parent handout *"Care of the Uncircumcised Penis"*:

> "Until the foreskin fully separates, do not try to pull it back. Forcing the foreskin to retract before it is ready can cause severe pain, bleeding, and tears in the skin."[1]

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 MDs and RNs 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 further note below.

II. Current medical literature against 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 examination or 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 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.*** Especially in the newborn and infant, this produces small lacerations in addition to an 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:**

> "…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, nonretractile foreskin, implying pathology, when in reality there is none. More appropriate terms such as 'non-retractile foreskin' should be used in its place."[3]

***Roberton's Textbook of Neonatology* also warns:**

> "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."[4]

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

> "Forcible retraction of the foreskin tends to produce tears in the preputial orifice resulting in scarring that may lead to pathologic phimosis."[5]

***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.* New York: Knopf; 1990. p. 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."[7]

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:

Darby R. *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain.* University of Chicago Press; 2005. p. 235.

> "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."[8]

Advice to parents to retract and clean the child at each bath is nothing less than 19th century medical folklore. Such advice ignores the reality that our distant primate ancestors 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 interference with the natural desquamation (disappearance cell-by-cell) of the *balano-preputial lamina*

A leading neonatology text 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:

***Avery's Neonatology*: *Pathophysiology and Management of the Newborn.* MacDonald, editor. Lippincott; 2005. p. 1088.**

> "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."[5]

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 via the Internet to anyone, including parents – and lawyers).

DENMARK, 1968:

Øster J. Further fate of the foreskin: incidence of preputial adhesions, phimosis, and smegma among Danish Schoolboys. *Arch Dis Child.* 1968;43:200-3.

> "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."[9]

AUSTRALIA, 1994:

Wright JE. Further to the "Further Fate of the Foreskin." *Med J Aust.* 1994;160:134-5.

> "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."[10]

JAPAN, 1997:

Imamura E. Phimosis of infants and young children in Japan. *Acta Paediatr Jpn.* 1997;39(4):403-5.

> "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."[11]

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. Recent work by Kayaba *et al.* verified that the preputial orifice may be tight in young boys, but resolves over time. Without knowledge of the normal development of the penis, some physicians advocate childhood circumcision as a surgical treatment of normal anatomy. One study stated that microscopic examination of the prepuce circumcised for phimosis showed normal histology in 46% of cases. 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; a tight preputial orifice with normal histology is not pathological in young boys, but

should be considered a normal stage of penile development."[12] (Internal references omitted.)

SPAIN, 2002:
Morales Concepcion JC, Cordies Jackson E, Guerra Rodriguez M, *et al.* ¿Debe realizarse circuncisión en la infancia? *Arch Esp Urol.* 2002;55(7):807-11.

> "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 prepucial dilation."[13]

INDIA, 2005:
Agarwal A, Mohta A, Anand RK. Preputial retraction in children. *J Indian Assoc Pediatr Surg*. 2005;10:89-91.

> **"**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."[14]

TAIWAN, 2007:
Ko MC, Lui CK, Lee WK, *et al.* Age-specific prevalence rates of phimosis and circumcision in Taiwanese boys. *J Formos Med Assoc.* 2007;106(4):302-7.

> **"**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 suffered from unretractable prepuce by the age of 13.[15]

Thus a reference to 'adhesions' in need of lysing, by a medical professional unfamiliar with an intact boy's natural, normal, and expected *balano-preputial lamina,* is defiantly out of sync with 21st-century evidence-based medical standards.

IV. Brief history of this iatrogenic injury

The practice of premature forcible foreskin retraction has it origins in 19th-century, puritanical, Anglophone medical folklore – not 21st-century evidence-based medicine. The following brief historical background of misconceptions about care of the natural foreskin is from a recent article in ***Psychology Today***:[16]

> "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. … Doctors reasoned that rigorous cleaning, drying-up, desensitizing, or even amputation of genital mucosal tissue (i.e., circumcision) was both a medical and a moral imperative…
>
> "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. 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."[16]

Reflex neurosis theory, and its step-child, forcible foreskin retraction, is now well understood world-wide to be superstitious, pre-germ-theory, 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.[17] 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 about 10 years, based on clinical observation of nearly 10,000 boys.[9]

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 might be 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 well-child check. We have seen a precipitous rise in such cases as the number of intact

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 an 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 intact boys

Premature forcible foreskin retraction 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 space between the foreskin and glans, now raw and bleeding, subject to immediate and future infection.

The child who was painfully retracted will be miserable, enduring stinging on urination, oozing blood, will be in pain, restless, traumatized, 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.

Destruction of this protective synechia, a common epithelium of the glans and foreskin, has no legitimate place in the armamentarium of modern, ethical medical practitioners.

VII. The potential for "phimosis fraud"

A clinician unfamiliar with the normal anatomy of a healthy and normal infant boy might diagnose a newborn with an 'adherent prepuce.' Some clinicians have been known to invoke the diagnostic code (also required for billing) of ICD-9 605, which includes the diagnostic categories of "Adherent prepuce," "Paraphimosis," "Phimosis (congenital)," and "Tight foreskin." Except for paraphimosis, all of these are descriptions of ***normal anatomy*** in males as old as 17. In the absence of other confirming symptoms, none indicates pathology of any kind. However, the age of the patient under ICD-9-605 was left undeclared until recently.

As of November 2015, the old ICD-9-605 has in part been subsumed into ICD-10-CM N47.0 which covers the category termed "Adherent prepuce, newborn," thereby implying that all newborn boys have an anatomical problem in need of medical attention.

This description sets infants up for ill-advised meddling and unnecessary intervention, and is an unfortunate step backwards into the medical mythology and delusions of the mid-19th century.

How ICD-10 47.0 became enshrined as a part of modern medical care for normal, healthy baby boys is beyond comprehension.

VIII. Proper care of the intact child

As cultural, 'medicalized' circumcision slowly dies in the U.S., and the number of intact boys rises – nearly 50% of U.S. boys and over 75% on the West Coast – there is an increased need for better understanding of care of the intact boy by American-trained clinicians. These boys need to be left just as unmolested during their developmental years as they were at birth. It must be reiterated that there is *never* an indication for forceful retraction of the foreskin[2] – not for examination, not for catheterization, not to check for nor to 'help' with retractability.

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 hygiene rule is, ***"Only clean what is seen."*** It is no more complicated than that.

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 disturbs that natural floral balance, and destroys natural emollients and immunologically active substances.[18]

3. **Normal desquamation of the entire balano-preputial lamina (BPL) may take up to 17 years or more.** Only 50% of boys at age 10 years are retractable, and a much lower percentage will be so, of course, at any younger age.[9] 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).[9]

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 ***not*** an indication of need for medical intervention.

7. **Smegma is not a carcinogen or indication of infection and its appearance in both males and females is no cause for alarm.** Treating it as a problem substance is ignorant, 19th-century mythology, as it is well known to provide a first-line of immunological defense.[18]

8. **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 can, indeed, cause urinary problems.

9. **Catheterization, if therapeutically necessary and unavoidable, 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 urethral meatus. Obsolete protocols sometimes call for circumcision or forced retraction of infants who need catheterization. It is quite possible to catheterize such infants without forced retraction.

10. **The length of the child's overhanging foreskin is a not a matter requiring medical intervention**. There is no such thing as a 'redundant' foreskin. All apparent 'excess' will be taken up by growth of the inner penile structures during puberty. Amputating the so-called 'excess' may leave the child with insufficient sheath to comfortably cover his penis as he grows.

11. **All treatment for the 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.[19.20]

For further, in-depth information on the anatomy, function, development, care, and conservative treatment of the intact penis, and related topics, please visit our website at: www.doctorsopposingcircumcision.org

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