Circumcision in the Time of HIV: When Is There Enough Evidence to Revise the American Academy of Pediatrics' Policy on Circumcision?

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COMMENTARY

Circumcision in the Time of HIV: When Is There Enough Evidence to Revise the American Academy of Pediatrics’ Policy on Circumcision?

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The author has indicated he has no financial relationships relevant to this article to disclose.

The evidence for the beneficial effects of circumcision seem to have been underappreciated by the authors of the policy statement. The benefits include virtual elimination of penile cancer, as well as a marked decrease in balanoposthitis, phimosis, paraphimosis, and penile dermatosis. It has also been pointed out that the American Academy of Pediatrics listed 6 evidence-based benefits and only one minor risk (a surgical complication rate of 0.2%–0.6%).

There is little argument that circumcision reduces the incidence of urinary tract infection (UTI) in infants; the only question involves the magnitude of its beneficial effect. Some suggest that this benefit only applies to boys at high risk of UTI, whereas others point out that the cost/benefit ratio of preventing renal scarring, which may occur in 18% of boys who present with UTI, may make the procedure cost-effective.

In 2004, our colleagues in obstetrics and gynecology stated that “a consensus is forming that circumcision offers protection against UTI, penile cancer, cervical cancer, genital ulcer disease, and HIV.” The authors of this article, as well as others, discussed the various ways in which pain control during neonatal circumcision can be achieved and also concluded, as have others, that there are potential medical benefits. These data are not sufficient to recommend routine neonatal circumcision.

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is no increase in sexual dysfunction after circumcision. They further suggested that even after parents are given the most current information on the risks and benefits of circumcision, their decision is often based on social, cultural, religious, and racial factors, as well as the circumcision status of the father. It was also opined that “some of the medical literature about the procedure suffers from authors who put the fury of debate above the science.”

I suspect that, rather than using evidence-based data, some in the medical community who oppose neonatal circumcision use similar factors on which to base their opinions. Parents should always have the right to choose whether to have their neonate circumcised. However, they must be presented with accurate, unbiased, evidence-based data. A revised AAP policy that reflects the recent findings described above would provide health care professionals and parents with an appropriate tool to allow them to arrive at an informed decision.

It is very disturbing to note that the prevalence of circumcision has declined in the United States from 91% in the 1970s to 83% in the 1980s. From 1999–2000, it was 79%. In this age without an AIDS vaccine when many individuals, especially teenagers, practice risky sexual behavior and a significant number of people do not use condoms because of religious beliefs, lack of appropriate education, inability to afford them, or difficulty in acquiring them, circumcision may offer the best method for protection against certain STDs, especially HIV.

I firmly believe that there is now sufficient, new information to prompt a revised AAP policy statement regarding neonatal circumcision, considering the very significant beneficial effects and the very minor risks associated with the procedure.

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