

OMSKÆRING  
AF DRENGE

Notat

2013

## Omskæring af drenge. Notat

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# Indhold

<b>1</b>	<b>Sundhedsstyrelsens sammenfatning</b>	<b>5</b>
<b>2</b>	<b>Omskæring</b>	<b>6</b>
2.1	Kirurgiske metoder	7
2.2	Smertedækning ved omskæring	7
2.2.1	Sukkervand	7
2.2.2	Lokalbedøvende gel eller creme	8
2.2.3	Nerveblok	8
2.2.4	Fuld bedøvelse	8
2.3	Beskrivelse af den jødiske omskæring	8
2.4	Beskrivelse af den muslimske omskæring	9
2.5	Helbredsmæssige fordele	10
2.6	Komplikationer til omskæring	11
<b>3</b>	<b>Omskæring i Danmark</b>	<b>13</b>
3.1	Skøn over antal omskæringer i Danmark	13
3.2	Lovgivning og regler	13
3.3	Tilsynssager	15
3.4	Patientklager og patienterstatningssager	16
<b>4</b>	<b>Omskæring i andre land</b>	<b>17</b>
4.1	Sverige	17
4.2	Norge	17
4.3	Tyskland	17
4.4	England	18
4.5	Australien	18
4.6	USA	18
<b>5</b>	<b>Konklusion</b>	<b>20</b>
<b>6</b>	<b>Bilagsfortegnelse</b>	<b>21</b>

## Forord

Ministeriet for Sundhed og Forebyggelse har i en mail af den 1. november 2012 anmodet Sundhedsstyrelsen om at undersøge omskæring af drengebørn i Danmark, herunder at skabe et overblik over omfanget af eventuelle sundhedsmæssige problemer forbundet med rituel omskæring.

Sundhedsstyrelsen har afdækket området ved hjælp fra styrelsens faste sagkyndige i kirurgi og anæstesi og har derudover indhentet bistand fra Dansk Pædiatrisk Selskab for så vidt angår børneurologi. Styrelsen har endvidere holdt møder med forskellige interessenter på området; Det Mosaiske Trossamfund, Muslimernes Fællesråd; foreningen Intact og forsker på Seruminstituttet Morten Frisch.

Anne Mette Dons

Enhedschef for Tilsyn & Patientsikkerhed

Sundhedsstyrelsen, juni 2013.

# 1 Sundhedsstyrelsens sammenfatning

Omskæring af drenge er et kirurgisk indgreb, hvor forhuden af penis skæres bort. Omskæringen kan være medicinsk eller kulturelt/religiøst begrundet. Cirka en tredjedel af mænd verden over er omskåret. Efter Sundhedsstyrelsens oplysninger er rituel omskæring ikke forbudt ved lov i nogen lande.

I Danmark registrerer man ikke et barns religiøse tilhørsforhold, når det fødes. Der findes heller ikke en selvstændig registrering af, hvor mange rituelle dreng omskæringer der foretages i Danmark. Der foreligger derfor ikke data for, hvor mange drengebørn der får foretaget rituel omskæring i Danmark. Det er Sundhedsstyrelsens skøn, at antallet af rituelle omskæringer om året i Danmark ligger mellem 1000 – 2000 om året.

Omskæring er et kirurgisk indgreb, der efter dansk lovgivning er forbeholdt læger at foretage. Hvilken kirurgisk metode og bedøvelse der anvendes, er lægens valg i samråd med forældrene. Rituel/kulturel omskæring tilbydes ikke i det offentlige sundhedsvæsen i Danmark, hvorfor indgrebet ofte foretages på private lægeklinikker. I Sundhedsstyrelsens vejledning om omskæring præciseres, hvordan lægen udviser omhu og samvittighedsfuldhed ved omskæring af drengebørn. Det er styrelsens generelle indtryk, at vejledningen følges.

Sundhedsstyrelsen modtager et par henvendelser årligt grundet mulige komplikationer til omskæring, eller at disse ikke er udført korrekt. Patientombuddet har fra 2003-2010 behandlet 20 klager over rituel omskæring. I 11 sager er der udtalt kritik; disse sager lå før Sundhedsstyrelsens vejledning i 2005. I de restende 9 sager, efter 2005, har Patientombuddet ikke udtalt kritik af lægernes faglige virke. Patientforsikringen har de sidste 17 år fået 14 anmeldelser vedrørende rituelle omskæringer af drenge, hvoraf ingen har ført til udbetaling af erstatning.

Der har fra flere sider været rejst bekymring for seksualiteten hos den voksne mand som følge af omskæring. Selv om nogle studier tyder på, at omskæring senere hen kan føre til psykologiske og seksuelle problemer, mangler der fortsat studier over langtidseffekten af omskæring på voksne mænd, herunder på deres seksualitet. En registrering i eksempelvis Landspatientregisteret (LPR) af alle omskæringer kan overvejes mhp. evt. senere opfølgning.

Det er Sundhedsstyrelsens vurdering, at der ikke er tilstrækkelig sundhedsfaglig dokumentation til generelt at anbefale omskæring af drengebørn. Samtidig er der ikke sådanne risici ved indgrebet, når det foretages korrekt og af kompetente læger, at styrelsen finder anledning til at anbefale et forbud af rituel omskæring af drengebørn.

Det er videre Sundhedsstyrelsens opfattelse, at det ud fra et sundhedsfaglig, patientsikkerhedsmæssig synspunkt kan være en fordel, at drengebørn omskæres så tidligt som muligt, da indgrebet er mindre og giver færre umiddelbare komplikationer, når det foretages i de første uger af barnets levetid.

Komplikationer til indgrebet er få. Ifølge Sundhedsstyrelsens oplysninger, har der ikke været alvorlige komplikationer ved rituelle dreng omskæringer foretaget af læger i Danmark. Da der er dokumenteret flere komplikationer, jo ældre barnet er, kan man overveje at stille krav om, at drengebørn, der skal omskæres ud over de første leveuger, får indgrebet foretaget på en lægeklinik eller på sygehus.

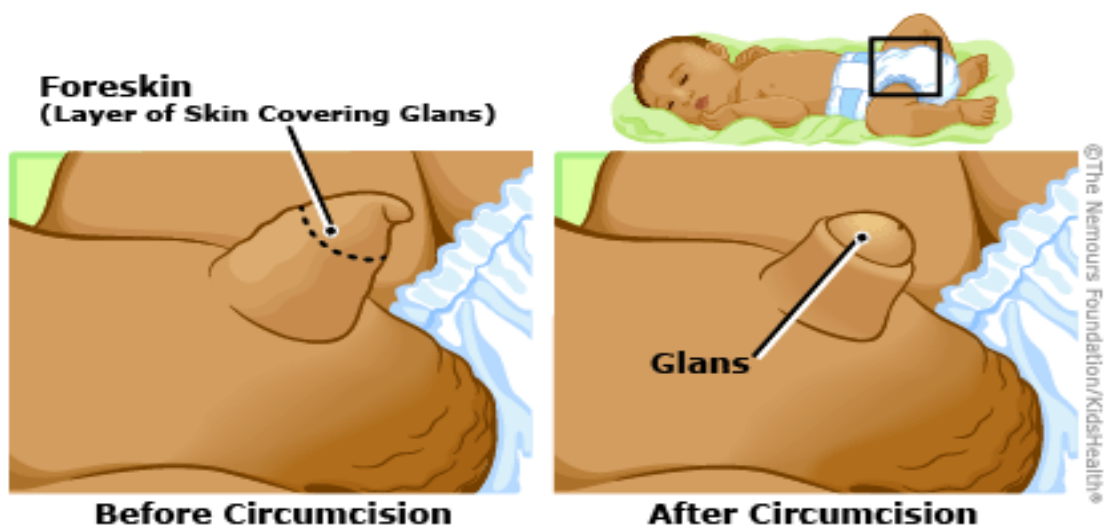
Endelig finder Sundhedsstyrelsen, at det fortsat skal være forbeholdt læger at udføre indgrebet under overholdelse af styrelsens vejledning om omskæring af drengebørn.

## 2 Omskæring

Omskæring af drenge er et kirurgisk indgreb, hvor forhuden af penis skæres bort. Omskæringen kan være medicinsk eller kulturelt/religiøst begrundet (f.eks. stammekultur, jødedom, islam eller anden kulturel tradition). Omkring en tredjedel af mænd verden over er omskåret. Antallet af rituelle omskæringer er aftagende i de fleste vestlige lande.

Omskæring er lægefagligt begrundet hos drenge ved forhudsfor snævring, hvor forhuden ikke kan trækkes tilbage over glans penis (penishovedet). Normalt forventes en dreng at kunne trække forhuden tilbage, når han er fyldt seks år. Diagnosen 'forhudsfor snævring' stilles derfor først på dette tidspunkt, med mindre drengen inden da har besvær med at lade vandet eller får betændelse under forhuden. Forhudsfor snævring kan give risiko for infektioner, fordi de hygiejniske forhold vanskeliggøres.

Det især muslimer og jøder, som lader deres drenge rituelts omskære. Mandlige konvertitter til den jødiske eller muslimske tro lader sig også omskære. Mandlig omskæring er påkrævet inden for jødedommen og stort set universel inden for islam, omend den her ikke er foreskrevet.



Dansk Pædiatrisk Selskab ved professor i pædiatri, overlæge, dr. med. Søren Rittig (specialist i nyresygdomme hos børn) har ved et møde med Sundhedsstyrelsen understreget, at der på de danske hospitaler udelukkende foretages omskæring på lægefaglig indikation, f.eks. for at mindske risiko for urinvejsinfektion hos drengebørn. Diagnosen urinvejsinfektion hos drenge under et års alderen er ofte svær at stille, og behandlingen kræver indgift af antibiotika direkte i blodbanen i mindst tre

døgn under indlæggelse på sygehus. Små drenge, der har haft betændelse i urinvejene, skal derudover følges på af en børneafdeling, fordi der er risiko for, at de udvikler arvæv i nyrene med permanent nyreskade og nyrefunktionstab til følge. Dansk Pædiatrisk Selskab finder dog, at den eksisterende viden om omskæring ikke berettiger til, at man som i USA generelt anbefaler omskæring af raske drenge med baggrund i sundhedsmæssige fordele i Danmark.

## 2.1 Kirurgiske metoder

Der findes forskellige kirurgiske metoder til omskæring. Valget af omskæringsmetoden afhænger af, hvilken teknik lægen finder mest hensigtsmæssig at bruge i det konkrete tilfælde. De mest almindelige kirurgiske instrumenter som bruges til omskæring er Gomco klemmen, Morgen klemmen og Plastik-ringen. Omskæring kan også udføres ved ”omskærelse i fri hånd”. Hvert instrument og teknik har sine fordele og ulemper, som den enkelte kirurg skal vurdere.

## 2.2 Smertedækning ved omskæring

I dag bruges forskellige metoder til bedøvelse ved omskæring alt efter barnets alder, kirurgens ønske og indgrebets type.

- Sukkervand
- Lokal bedøvende creme
- Nerveblokada
- Fuld bedøvelse.

Hvilken metode lægen vælger at bruge ved omskæring er en afvejning af, hvilken form der er mest hensigtsmæssig i det konkrete tilfælde.

### 2.2.1 Sukkervand

Studier har vist, at sukkervand af en vis koncentration (over 25 %), givet i munden under indgrebet på den nyfødte, kan have en vis smertelindrende effekt.<sup>1</sup> Dette skyldes formentlig, at sukker interagerer med kemiske processer i hjernen, som frembringer en følelse af velvære hos barnet. Denne følelse forstærkes ved suttefunktionen, f.eks. hvis sukkervandet gives på sutten. Metoden kan ikke bruges alene, men kan bruges som supplement til de andre omtalte metoder.

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<sup>1</sup> Skogsdal et al., Analgesia in newborns given oral glucose, Acta Paediatrica, 1997, 86: 217-220.

### 2.2.2 Lokalbedøvende gel eller creme

Lokalbedøvende creme er ofte brugt til nyfødte. Cremen eller gelen smøres på spædbarnets forhud 60 - 90 min før indgrebet for at opnå smertelindring. Metoden giver ikke smertefrihed, men smertelindring. Metoden er ikke egnet til større børn eller voksne.

Cremen kan give lokal irritation af huden i form af rødme, men der ses sjældent alvorlige bivirkninger, når den bruges som lokalbedøvende til omskæring hos nyfødte.

### 2.2.3 Nerveblok

Omskæringer kan foretages i lokal bedøvelse, f.eks. nerveblok, som anlægges med to injektioner af et bedøvende lægemiddel. Nerveblokade er en anæstesiform, hvor man fremkalder midlertidig blokering af nervesignalerne gennem en stor nervebane ved at sprøjte et lokalanæstesimiddel ind i nervens umiddelbare nærhed. Ofte lægges først en lokalbedøvelse.

Denne metode kan bruges til alle aldre. Lokalbedøvelse med injektion er generelt mere effektiv til at mindske smerten end brugen af hudbedøvende creme.<sup>2</sup> Dog kan selve injektionerne medføre smerte/ubehag. Barnet kan få en blodansamling ved indstiksstedet.

### 2.2.4 Fuld bedøvelse

Ved fuld bedøvelse sover barnet under indgrebet og er fuldt smertedækket. Fuld bedøvelse anbefales ikke til børn under 6 måneder, med mindre det er absolut nødvendigt. Fuld bedøvelse af spædbørn er en opgave for en erfaren speciallæge i anæstesiologi (narkoselæge) med særlig kompetence i bedøvelse af små børn.

## 2.3 Beskrivelse af den jødiske omskæring

Det Mosaiske Trossamfund i Danmark har i august 2012 udgivet ”WhitePaper – rituel omskæring af drenge”. Heraf fremgår det, at en specialuddannet person, som regel rabbineren, på barnets 8. levedag foretager omskæringen. Omskæringen foregår i hjemmet. En læge er til stede ved omskæringen. Lægen kontrollerer barnet og journalfører før og efter indgrebet. Ifølge ”WhitePaper – rituel omskæring af drenge” skal barnet før omskæringen være almindeligt velbefindende, veje omkring 3 kg eller derover og må ikke have gulsot. I tvivlstilfælde udsættes omskæringen.

En omskæring er en festlig begivenhed inden for jødedommen, og derfor er barnets forældre og øvrige familie også tilstede. Der påsmøres hudbedøvende creme ca. en time inden omskæringen. Under selve handlingen får barnet lidt vin på en sut, og dermed koncentrerer barnet sig om at sutte. Selve omskæringen foregår ved, at

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<sup>2</sup> Butler-O'hara et al., Analgesia for Neonatal circumcision: A Randomized Controlled Trial of EMLA creme versus Dorsal penile nerve Block., Pediatrics 1998.



barnet ligger på en pude på et bord. Rabbineren står på den ene side, og lægen står på den modsatte side og holder barnets ben. Rabbineren løsner forhuden og trækker den op over penishovedet og sætter en klemme i den optrukne forhud. Herved sikres, at penishovedet ikke beskadiges. Der foretages et snit oven for klemmen, og forhuden falder af. Herefter sørges der for, at også den indre forhud er trukket helt ned ved roden. Rabbineren stopper blødningen med pres og bandager. Hele seancen er overstået på to til tre minutter.

Efter ceremonien kontrollerer lægen og rabbineren, at barnet har det godt, og at bandagen er tør og ligger korrekt. Journalen underskrives og opbevares af lægen. Familien instrueres i, hvorledes bleerne de næste fem til seks bleskift vil se ud. Familien har direkte kontakt med rabbineren, og skulle familien være i tvivl om noget, besøger rabbineren altid familien umiddelbart. Rabbineren besøger familien senest dagen efter og tager som regel bandagen af, imens barnet bades. Enkelte gange lægges ny bandage for at holde forhuden nede, men oftest kan bandagen fjernes. Familien får nye instruktioner, som først og fremmest går på, at lade drengen ligge lidt uden ble ved bleskift.

Det Mosaiske Trossamfund i Danmark ved overrabbiner Bent Lexner har på et møde med Sundhedsstyrelsen forklaret, at omskæring af det jødiske samfund betragtes som én af hovedhjørnestenene i at være jøde. Omskæring er et identitetstegn for jøder og har betydning for barnets tilknytning til den jødiske kultur, dets familie og religionen. Det gælder for jødedommen i modsætning til kristendommen, at jødedommen har flere love og forskrifter, som man betragter som guddommelige, og som man ikke kan ændre på, herunder omskæringstraditionen, som har fundet sted i mere end 3000 år.

Bent Lexner understregede, at et forbud mod omskæring af drengebørn ville stride mod religionsfriheden i Den Danske Grundlov. Selvom debatten om omskæring har været oppe med jævne mellemrum, har dette ikke resulteret i en intern diskussion eller en nedgang i ønsket om omskæring inden for Det Mosaiske Trossamfund i Danmark.

Der udføres årligt ca. 15 jødiske omskæringer i Danmark. Ifølge Bent Lexner er der ikke observeret komplikationer ved de jødiske omskæringer i Danmark.

## 2.4 Beskrivelse af den muslimske omskæring

Muslimernes Fællesråd ved formand Asmat Mojaddedi, oplyste på et møde med Sundhedsstyrelsen, at Muslimernes Fællesråd er den største samarbejdsorganisation for muslimer i Danmark. Muslimernes Fællesråd har ikke officielt udmeldt synspunkter i forbindelse med omskæring af muslimske drengebørn i Danmark. Omskæringen foretages ofte på en privat lægeklinik, men nogen læger foretager også omskæringen hjemme hos barnet. Rådet er bekendt med, at en muslimsk forening i Danmark (som ikke er en del af Muslimernes Fællesråd) inviterer en læge fra udlandet hertil, som foretager omskæring af flere drenge samtidig i foreningen. Rådet er ikke bekendt med, at der i det muslimske samfund i Danmark foregår omskæringer, som udføres af personer, der ikke er læger, eller bliver udført uden bedøvelse. Muslimernes Fællesråd er ikke bekendt med antallet af muslimske omskæringer i Danmark.

Ifølge Asmat Mojadedi, som selv udfører rituelle omskæringer i sin lægepraksis i Danmark, foretages omskæringen primært i spædbarnsalderen, men forekommer også i andre aldersgrupper især inden for det tyrkiske samfund. Barnet skal være velbefindende forud for indgrebet. Der gives bedøvende hudcreme rundt om penisroden en time før, der lægges en nerveblokade. Under selve injektionen får spædbarnet lidt sukkervand. Indgrebet foregår under sterile forhold.

Asmat Mojadedi bruger primært ”ring metoden” til spædbørn. Her trækkes forhuden tilbage, og der sættes en plastikring på glans penis. Forhuden trækkes tilbage på ringen, og en steril snor strammes rundt om forhuden på ringen. Herefter klippes forhuden af med en kirurgisk saks. Den stramme snor om ringen forhindrer blødning. Ringen falder af tre til syv dage efter indgrebet.

Til større børn bruger han ”suturetoden”. Her fjernes forhuden ved hjælp af elektrokirurgi, og de to lag syes sammen med tråd.

Barnet kontrolleres på 2. dagen. Der er givet både mundtlig og skriftlig information om mulige komplikationer forud for indgrebet, og begge forældre har givet skriftligt samtykke. Ifølge den praktiserende læge får forældrene et telefonnummer, som han kan kontaktes på døgnet rundt ved tilstødende komplikationer. Lægen oplever dog sjældent komplikationer til indgrebet.

## 2.5 Helbredsmæssige fordele

Omskæring kan være nødvendigt af helbredsmæssige årsager som f.eks. forhudsfor snævring, hvor forhuden ikke kan trækkes tilbage over penishovedet, hvilket indebærer større risiko for infektion.

Det er omdiskuteret, om omskæring herudover kan have nogle sundhedsmæssige fordele. Det skal ses i lyset af, hvor mange raske drengebørn, der skal omskæres for at opnå et positivt helbredsresultat. Nogle af de undersøgelser, som underbygger de positive resultater af omskæring af drengebørn, er foretaget i Afrika, hvor de sundhedsmæssige forhold er væsentlige anderledes end i vesten.

De dokumenterede helbredsmæssige fordele:

Nedsat risiko for urinvejsinfektioner: Drengene, som er omskåret i spædbarnsalderen, har færre tilfælde af urinvejsinfektioner end drenge, som ikke er omskåret. Hyppigheden af urinvejsinfektioner hos små drenge er dog lav.

Nedsat risiko for peniskræft: Studier tyder på at peniskræft er mindre udbredt hos omskårede mænd. Peniskræft er en generelt en sjælden sygdom.

Nedsat risiko for kønssygdomme: Omskårne mænd kan have en lavere risiko for visse kønssygdomme, såsom HIV. WHO (World Health Organization) har udmeldt, at der er evidens for, at mandlig omskæring reducerer risikoen for HIV hos heteroseksuelle mænd med ca. 60 %. Derfor anbefaler WHO, at mandlig omskæring bør overvejes som en effektiv intervention mod HIV, som beskyttelse/forebyggelse i lande og regioner med heteroseksuelle epidemier, som f.eks. vis-

se områder i Afrika. WHO understreger, at mandlig omskæring kun delvis beskytter mod HIV og derfor kun er ét element i den samlede forebyggelse.

For så vidt angår urinvejsinfektioner, er hyppigheden i Danmark så lav, at der ikke er grundlag for generelt at omskære drengebørn af den årsag. Peniskræft er en meget sjælden sygdom, og derfor vil der skulle omskæres uforholdsmæssigt mange drengebørn, før et tilfælde af peniskræft kunne forebygges. Kønssygdomsproblematikken er adresseret af WHO, men de forhold, hvorunder de anbefaler omskæring, er meget forskellige fra vestlige forhold som i Danmark. Anbefalingen vedrører også voksne mænd. Sundhedsstyrelsen kan oplyse, at ingen af de store medicinske organisationer i vesten anbefaler rutinemæssig omskæring af raske drengebørn.

## 2.6 Komplikationer til omskæring

I vestlige lande antages komplikationsraten at ligge på 1-2 % af alle omskæringer. En artikel fra tidsskriftet *Pediatrics*, fra 2012, opgiver komplikationsraten i Europa til ca. 2 %.<sup>3</sup>

Omskæring af drenge kan medføre komplikationer i form af bl.a. blødning, infektion og urinrørsforsnævring. Blødning og infektion er de hyppigste komplikationer til omskæring og ofte de letteste at behandle. Dødsfald er, om end meget sjældent, beskrevet i litteraturen som følge af blødning og infektion, men der er ikke registreret dødsfald efter omskæring i Danmark.

Videnskabelige undersøgelser tyder på, at der er færre komplikationer, hvis det raske drengebarn omskæres i den nyfødte periode og under optimale forhold (erfaren læge og sterile forhold).<sup>4</sup> Dette kan forklares ved, at barnet i den nyfødte periode har moderens antistoffer til at bekæmpe en eventuel infektion, at det er mindre forhold, som opereres på, og at indgrebet ikke kræver syning. Ydermere er helingsprocessen hos nyfødte god. Komplikationsraten til en hvilken som helst operation vil altid afhænge af barnets alder ved indgrebet, den kirurgiske teknik, indikationen, udførerens kompetencer, under hvilke forhold indgrebet bliver udført, og barnets øvrige helbredsforhold.

Der foreligger kun begrænset viden om senkomplikationer i voksenlivet til omskæring, herunder seksualfunktionen. Der er behov for yderligere forskning på området.<sup>5</sup>

Sundhedsstyrelsen kan oplyse, at der ikke findes en selvstændig registrering af, hvor mange rituelle drenge omskæringer, der foretages i Danmark, ligesom der ikke findes en registrering af henvendelser til de offentlige sygehuse i forbindelse

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<sup>3</sup> *Pediatrics*, Task Force on Circumcision, 2012, Sep;130(3):e756-85

<sup>4</sup> Weiss et al., Complications of circumcision in male neonates, infants and children: a systematic review, *BMC Urology* 2010, Feb 16;10:2.

<sup>5</sup> Morten Frisch et al., Cultural Bias in the AAP's 2012 Technical report and Policy Statement on Male Circumcision, *Pediatrics*, 2013, 796-800

med komplikationer efter rituel omskæring. Dette skyldes, at der ved sygehusindlæggelser i forbindelse med komplikationer efter rituel omskæring, hverken registreres årsag til komplikationen, eller hvor operationen er foretaget i Landspatientregisteret.

Sundhedsstyrelsen modtager gennemsnitlig 2-4 henvendelser om året om komplikationer i forbindelse med omskæring af drengebørn. Årsagerne til henvendelserne fra sundhedspersonerne er primært, at der har været mistanke om, at børnene ikke har været tilstrækkeligt smertedækket i forbindelse med indgrebet. Derudover har der været sager, hvor der var mistanke om infektion, eller at indgrebet var foretaget af en person, der ikke var autoriseret læge. I ingen af sagerne har børnenes helbred været i fare. Sundhedsstyrelsen er ikke bekendt med, at der i Danmark er sket dødsfald som følge af omskæring.

Overlæge Morten Frisch ved epidemiologisk forskning, Statens Serum Institut, og adjungeret professor i seksuel sundhedsepidemiologi, Aalborg Universitet, har ved et møde i Sundhedsstyrelsen givet udtryk for, at der hos drenge, der er omskåret, kan der senere i livet opstå problemer af fysisk, psykologisk og seksuel karakter. Hans forskning viser, at mænd, der er blevet omskåret, har tre gange så høj risiko for at opleve hyppigt besvær med at opnå orgasme, og at kvinder med partnere, som er omskåret, oplever dobbelt så stor risiko for, at deres seksuelle behov ikke bliver opfyldt. Overlæge Morten Frisch er ikke modstander af rituelle omskæringer, men mener, at omskæring først bør foretages, når drengen forstår indgrebet konsekvenser og selv kan give samtykke hertil.

”Intact Denmark – foreningen mod børneomskæring” har på et møde i Sundhedsstyrelsen ved formand Lena Nyhus og næstformand Leo Milgrom oplyst, at foreningen er af den opfattelse, at rituel omskæring af drengebørn anatomisk kan sidestilles med omskæring af piger. Derfor bør rituel omskæring af drenge juridisk sidestilles hermed og forbydes ved lov, indtil myndighedsalderen er indtrådt, så drengene selv kan give samtykke til indgrebet. Foreningen er også af den opfattelse, at rituel omskæring er kønslemlæstelse med det resultat, at en væsentlig del af drengene senere ikke kan opnå en normal seksualfunktion.

Dansk Pædiatrisk Selskab ved professor i pædiatri, overlæge, dr. med. Søren Rittig, har givet udtryk for, at man bør være opmærksom på forekomsten af komplikationer til kirurgiske indgreb på børn, der foretages på ikke-lægefaglig indikation. Selskabet bakker derfor op om Sundhedsstyrelsens vejledning om omskæring af drenge fra 2005, som klart formulerer, at omskæring er et operativt indgreb, der kun må foretages af læger. Selv om der ikke foreligger landsdækkende opgørelser over komplikationer til drengeomskæringer foretaget på ikke-lægefaglig indikation, er det selskabets indtryk, at de danske børneafdelinger aktuelt kun oplever meget få tilfælde af komplikationer til omskæring, som er sårinfektion og blødning. Selskabet finder ikke anledning til at advare mod omskæring af drengebørn.

## 3 Omskæring i Danmark

For en del år siden blev rituel dreng omskæring foretaget på de offentlige sygehuse, der dog ophørte med at udføre indgrebet i 90'erne, da der ikke var tale om sygdomsbehandling. Det fik den konsekvens, at de rituelle omskæringer i Danmark i dag foregår uden for de offentlige sygehuse, enten hos privatpraktiserende speciallæger eller i hjemmet hos barnet.

Der findes ikke en registrering af, hvor mange rituelle omskæringer der foretages i Danmark, ligesom der ikke findes oplysninger om antallet af komplikationer.

### 3.1 Skøn over antal omskæringer i Danmark

I Danmark registrerer man ikke et barns religiøse tilhørsforhold, når det fødes. Sundhedsstyrelsen kan oplyse, at der i 2012 i følge Danmarks Statistik blev født ca. 3.500 drengbørn i Danmark af mødre med ikke-vestlig oprindelse. Sundhedsstyrelsen antager, at en stor del af disse mødre tilhører den muslimske trosretning.

I følge Muslimernes Fællesråd vil næsten alle muslimer i Danmark lade deres nyfødte drengbørn omskære. Herudover har Sundhedsstyrelsen fået oplyst af Det Mosaiske Trossamfund, at der omskæres omkring 15 jødiske drengbørn om året.

Det er på baggrund heraf Sundhedsstyrelsens vurdering, at antallet af mulige rituelle omskæringer om året i Danmark ligger mellem 1000 - 2000. Det skal dog understreges, at der alene er tale om et skøn baseret på ovennævnte tal.

### 3.2 Lovgivning og regler

I modsætning til omskæring af kvinder, jf. straffelovens § 245a<sup>6</sup>, er der i Danmark ikke forbud mod at omskære drengbørn. Der er så vidt Sundhedsstyrelsen har fået oplyst ikke noget land, hvor rituel omskæring af drenge er forbudt.

Det er foreskrevet i Sundhedslovens § 14, at for en patient, der ikke selv kan varetage sine interesser, indtræder den eller de personer, som efter lovgivningen er bemyndiget hertil, i patientens rettigheder, i det omfang det er nødvendigt for at varetage patientens interesser i den pågældende situation. Det betyder, at det er forældrene til barnet, der i henhold til sundhedslovens §§ 15 og 16 skal informeres om indgrebet og samtykke på barnets vegne. Hvis der er tale om en barn, der kan forstå behandlingssituationen, skal barnet informeres og inddrages i drøftelserne af behandlingen, herunder skal barnets tilkendegivelser, i det omfang de er aktuelle og relevante, tillægges betydning, jf. sundhedslovens § 20.

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<sup>6</sup> Lovbekendtgørelse nr. 1007 af 24. oktober 2012 af straffeloven § 245 a, hvoraf fremgår, at den, som ved et legemsangreb med eller uden samtykke bortskærer eller på anden måde fjerner kvindelige ydre kønsorganer helt eller delvis, straffes med fængsel indtil 6 år.

Det fremgår af autorisationslovens<sup>7</sup> § 74, at operative indgreb er forbeholdt læger at udføre. Et operativt indgreb er blandt andet defineret ved gennembrud af hud og væv. Det er således forbeholdt læger at udføre omskæring. En læge skal ved sin virksomhed udvise omhu og samvittighedsfuldhed, jf. autorisationslovens § 17.

En læge kan anvende medhjælp til at udføre omskæringen. Det er nærmere præciseret i Sundhedsstyrelsen bekendtgørelse og vejledning om autoriserede sundhedspersoners benyttelse af medhjælp (delegation af forbeholdt virksomhed),<sup>8</sup> hvordan en autoriseret sundhedsperson, i forbindelse med delegation af opgaver inden for sit forbeholdte virksomhedsområde, lever op til kravet om at udvise omhu og samvittighedsfuldhed.

Sundhedsstyrelsen har i vejledning om omskæring af drenge<sup>9</sup> konkret præciseret, hvordan man udviser omhu og samvittighedsfuldhed, når man foretager omskæring. Af vejledningen fremgår det bl.a.:

- At der skal være en læge tilstede under indgrebet, når der anvendes medhjælp til indgrebet.
- At der ved omskæring af drenge under 15 år skal foreligge et informeret samtykke fra forældremyndighedens indehaver, inden indgrebet udføres. Drenge, der er fyldt 15 år, kan selv give informeret samtykke til omskæring.
- At almindelig god faglig standard vedrørende kirurgisk hygiejne skal overholdes, herunder at operationsområdet vaskes sterilt, afdækkes og at der anvendes sterile instrumenter.
- At alle børn, også spædbørn, skal sikres den nødvendige, tilstrækkelige og tidsvarende smertelindring under indgrebet og perioden efter indgrebet.
- At lægen skal følge den faglige udvikling på området og besidde de nødvendige faglige forudsætninger for både indgrebet og smertelindringen.
- At forældrene eller forældremyndighedsindehaveren skal informeres, herunder om pleje i perioden efter indgrebet, hygiejniske forholdsregler og smertelindring.
- At der skal føres journal efter reglerne for journalføring.

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<sup>7</sup> Lovbekendtgørelse nr. 877 af 4. august 2011 om autorisation af sundhedspersoner og om sundhedsfaglig virksomhed (autorisationsloven)

<sup>8</sup> Bekendtgørelse nr. 1219 af 11. december 2009 og vejledning nr. 115 af 11. december 2009

<sup>9</sup> Vejledning nr. 9267 af 23. maj 2005 om omskæring af drenge

Hvis en person, der hverken er læge, eller virker som medhjælp for en læge, udfører omskæring, kan den pågældende person straffes med fængsel i op til et år, og under formidlende omstændigheder med bøde.<sup>10</sup> Når Sundhedsstyrelsen får mistanke om, at en opskæring ikke er foretaget af en læge, anmoder styrelsen politiet om at efterforske sagen med henblik på tiltalerejsning. Det er imidlertid Sundhedsstyrelsens erfaring, at sagerne ofte må opgives, da det ikke er muligt for politiet at finde ud af, hvem der rent faktisk har udført indgrebet.

### 3.3 Tilsynssager

Sundhedsstyrelsen fører tilsyn med den sundhedsfaglige virksomhed, der udføres af personer inden for sundhedsvæsenet.<sup>11</sup> Sundhedsstyrelsens tilsyn med autoriserede sundhedspersoner, herunder læger, er som udgangspunkt reaktivt. Sundhedsstyrelsen forudsætter, at alle autoriserede sundhedspersoner lever op til kravet om at udvise omhu og samvittighedsfuldhed under udøvelsen af deres virksomhed, herunder at de følger styrelsens vejledninger. Sundhedsstyrelsen iværksætter almindeligvis først tilsynssager, når styrelsen bliver gjort opmærksom på konkrete patientforløb.

Sundhedsstyrelsen kan dog oplyse, at fra den 1. oktober 2011 skal alle private sygehuse, klinikker og praksis, hvor der foretages lægelig patientbehandling, registreres hos styrelsen.<sup>12</sup> Sundhedsstyrelsen skal føre regelmæssigt tilsyn med behandlingsstederne. Her er der således indført et proaktivt tilsyn. Tilsynene skal øge patientsikkerheden og foregår ved, at Sundhedsstyrelsens regionale enheder, hvert tredje år aflægger et varslet tilsynsbesøg på behandlingsstedet. Hvis Sundhedsstyrelsen finder væsentlige problemer med patientsikkerheden på et behandlingssted, vil behandlingsstedet blive bedt om at rette fejl og mangler, og Sundhedsstyrelsen kan vælge at aflægge behandlingsstedet genbesøg, indtil patientsikkerheden er bragt i orden.

Det betyder, at de læger, der enten selv foretager omskæring eller vælger at benytte en medhjælp til at omskære på et behandlingssted, skal lade sig registrere i Sundhedsstyrelsen og vil få aflagt et tilsynsbesøg. Hvis en læge med eller uden en medhjælp vælger at foretage omskæring i private hjem, vil en sådan læge ikke skulle lade sig registrere i Sundhedsstyrelsen eller få aflagt et tilsynsbesøg.

Sundhedsstyrelsen fører således alene tilsyn med omskæring, når styrelsen bliver opmærksom på problemer med indgrebet eller hvis det foregår på en klinik der er registreret i Sundhedsstyrelsen. Sundhedsstyrelsen får kendskab til disse sager, når læger på de offentlige sygehuse kontakter styrelsen og gør opmærksom på, at de har fået et barn ind på sygehuset, hvor der har været komplikationer til en omskæring. Det skal dertil bemærkes, at sundhedspersoner ikke har pligt til at rette hen-

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<sup>10</sup> Autorisationslovens § 89

<sup>11</sup> Autorisationslovens § 26 og Sundhedsloven (lbkg. nr. 913 af 20. juli 2010) § 215

<sup>12</sup> Sundhedslovens § 215a og bekendtgørelse nr. 977 af 30. september 2011 om registrering af og tilsyn med visse sygehuse, klinikker og praksis.

vendelse til Sundhedsstyrelsen, hvis de får kendskab til, at et barn har fået komplikationer efter en behandling, herunder efter en rituel omskæring.

Hvis styrelsen bliver bekendt med, at barnet, efter de henvendende lægers opfattelse, er blevet omskåret af en person, der ikke er læge eller har været medhjælp for en læge, bliver sagen, som nævnt ovenfor, sendt til politiet mhp. efterforskning og tiltale.

I de sager, hvor det har været læger, der har udført omskæringer, har Sundhedsstyrelsen vurderet, at der i nogle af sagerne ikke har været udvist tilstrækkelig omhu i forbindelse med operationerne, at lægens information i forbindelse med operationerne ikke var fyldestgørende, samt at journalføringen har været mangelfuld. Sundhedsstyrelsen har også tidligere haft enkelte læger i skærpet tilsyn på baggrund af rituel omskæring af drengebørn.

### 3.4 Patientklager og patienterstatningssager

Patientombuddet har de seneste 7 år truffet afgørelse i 20 sager vedrørende rituel omskæring. Afgørelserne omhandler både danske læger og læger med anden etnisk baggrund end dansk, som i perioden 2003-2010 har foretaget rituelle omskæringer på drengebørn i Danmark.

I 11 sager har Patientombuddet udtrykt kritik af lægernes faglige virke. Behandlinger har fundet sted i perioden 2003-2006:

- En læge har i syv tilfælde fået kritik for behandling og journalføring. Denne læge har været under Sundhedsstyrelsens skærpet tilsyn bl.a. pga. af disse sager.
- En læge har i to tilfælde fået kritik for sin behandling og journalføring.
- De sidste to sager omhandler to forskellige læger, som har fået kritik for deres behandling.

I de restende 9 sager har Patientombuddet ikke udtalt kritik af lægernes faglige virke. Disse sager omhandler perioden 2005-2010, hvor Sundhedsstyrelsens vejledning om omskæring var trådt i kraft.

Patientforsikringen har de sidste 17 år fået 14 anmeldelser vedrørende rituelle omskæringer af drenge under 16 år. Af de 14 sager er:

- Fem af sagerne afvist, fordi patienten ikke var påført en skade.
- Syv af sagerne afvist, fordi erstatningen ville være under lovens minimumgrænse på 10.000 kr. I denne gruppe kan der eventuelt være sager, som ville blive anerkendt, hvis erstatningsbeløbet havde været større.
- To af sagerne er afvist, fordi patienten ikke er påført en skade i forbindelse med den offentlige efterbehandling.



## 4 Omskæring i andre land

Efter Sundhedsstyrelsens oplysninger er rituel omskæring ikke forbudt ved lov i nogen lande.

### 4.1 Sverige

Reguleringen i Sverige er stort set identisk med den danske regulering. I oktober 2001 trådte en lov i kraft (2001:499) om omskæring af drenge, hvortil Socialstyrelsen har udarbejdet forskrifter og vejledninger om omskæring af drenge. Loven blev indført af hensyn til, at omskæringer kunne foregå på betryggende vis under hensynstagen til barnet. Det er forbeholdt læger at udføre omskæringen, dog kan der også gives andre en særlig tilladelse til at udføre indgrebet (primært rabbinerne inden for det jødiske samfund). For drengebørn ældre end to måneder er det dog foreskrevet, at indgrebet skal foretages af læger.

Indgrebene foretages ikke på de offentlige sygehuse eller klinikker, da der ikke er pligt til at udføre indgrebet, med mindre det udføres på medicinsk indikation.

### 4.2 Norge

I Norge findes der ikke en særlov om omskæring af drenge. Der er ikke noget forbud mod, at rituel omskæring kan udføres inden for religiøse samfund af andre end læger.

I 2011 sendte man et lovforslag i høring om rituel omskæring af drenge. Formålet var især at sikre, at det var kompetente personer, der udførte indgrebet, at der fandtes et tilgængeligt tilbud, samt at der blev foretaget ordentlig smertedækning og opfølgning i forbindelse med indgrebet. Det indgik også i lovforslaget, at der fra det offentlige sundhedsvæsens side skulle tilbydes rituel omskæring på offentlige sygehuse, så indgrebet kunne foretages på forsvarlig vis – hovedsagelig i forbindelse med fødslen. Der er dog endnu ikke kommet en regulering på området.

### 4.3 Tyskland

I 2012 fastslog en domstol i Köln i Tyskland, at rituel omskæring var ulovlig og kunne sidestilles med legemsbeskadigelse. Det tyske parlament vedtog i december 2012 en lovændring, hvorefter rituel omskæring er lovligt i Tyskland. Det fremgår af den respektive bestemmelse, at forældre kan samtykke til, at deres barn bliver omskåret på anden indikation end lægefaglig, at indgrebet skal udføres i overensstemmelse med anerkendte kirurgiske metoder, og at indgrebet også kan udføres af andre end læger, hvis de er særligt trænet og kvalificeret i at udføre indgrebet.

## 4.4 England

I 2006 udgav den britiske lægeforening, British Medical Association, en vejledning til læger om omskæring. Vejledningen understreger, at omskæring af drenge anses for lovligt, hvis den udføres kompetent, og det skønnes, at det er i barnets interesse. Desuden skal der foreligge et informeret samtykke til indgrebet fra værge eller forældre. Omskæring i England er, ifølge Sundhedsstyrelsens oplysninger, ikke forbeholdt læger.

## 4.5 Australien

Indtil 1970'erne blev stort set alle drengebørn omskåret i Australien. Herefter har det været faldende, og i dag omskæres ca. 14 % af alle australske drenge inden for det første leveår. Der er dog stor variation mellem staterne.

I Australien har omskæring primært været foretaget kulturelt/traditionsbetinget og ikke på religiøs baggrund. Der er på nuværende tidspunkt ingen specifikke regler, som regulerer indgrebets udførelse. Omskæring i Australien er, ifølge Sundhedsstyrelsens oplysninger, ikke forbeholdt læger.

The Royal Australasian College of Physicians (RACP) udmeldte i oktober 2010, efter gennemgang af evidens på området, at de sundhedsmæssige fordele ved omskæring ikke opvejer komplikationsraten. Derfor anbefaler RACP ikke rutinemæssige omskæringer af drengebørn i Australien og New Zealand.

## 4.6 USA

Drengomskæring er lovligt i alle stater i USA. I de fleste stater er der et lovmæssigt krav om, at der skal foreligge et skriftligt samtykke fra mindst en af forældrene forud for indgrebet. Der er dog stor variation i antallet af omskæringer mellem staterne.

Ligesom i Australien blev stort set alle drengebørn i USA indtil 1970'erne omskåret. Antallet er dog faldende. Ifølge Center for Disease Control and Prevention, som er en del af den amerikanske sundhedsmyndighed, blev ca. 55 % af alle nyfødte drengebørn i USA omskåret, i 2009. Omskæring i USA er primært kulturelt og traditionsbetinget og sker ikke af religiøse grunde. Indgrebet er en af de mest almindelige kirurgiske procedurer i USA og er ifølge Sundhedsstyrelsens oplysninger ikke forbeholdt læger. Omskæringen sker som regel inden spædbarnet forlader hospitalet.

I 2012 udmeldte American Academy of Pediatrics (AAP), at de sundhedsmæssige fordele opvejer ulemperne ved indgrebet. Vurderingen begrundes med, at omskæring kan forebygge kræft i penis og seksuelt overførte sygdomme, herunder HIV og HPV-virus, der igen kan forårsage livmorhalskræft og andre cancertyper. En yderligere fordel er, at risikoen for urinvejsinfektioner minimeres. AAP har ikke fundet belæg for at sige, at omskæring påvirker mænds seksuelle funktion, følsomheden i penis eller den seksuelle tilfredsstillelse. AAP tilføjer dog, at der i deres retningslinjer ikke ligger en anbefaling om at lade alle drengebørn omskære, da de

sundhedsmæssige fordele ikke er tungtvejende nok, men hvis forældrene ønsker barnet omskåret, kan det sundhedsmæssigt godt forsvares.<sup>13</sup>

En række internationale børnelæger og forskere har rettet en kritik af AAPs udmelding. Overlæge Morten Frisch er hovedforfatter på kritikken, der er publiceret i tidsskriftet Pediatrics og underskrevet af 38 overlæger og professorer i 17 europæiske lande og Canada. De mener ikke, at der er dokumentation for eventuelle sundhedsfordele ved dreng omskæring i vesten. Deres konklusion er derfor, at der ikke foreligger tungtvejende sundhedsfaglige argumenter for dreng omskæring i vesten, og at det derfor ikke er i overensstemmelse med god lægeskik at udføre medicinsk ubegrundet dreng omskæring. Forfatterne mener omskæring bør vente til, at drenge selv kan give samtykke til indgrebet. Endvidere konkluderer de, at selvom nogle studier tyder på, at omskæring senere hen kan føre til psykologiske og seksuelle problemer, mangler der fortsat studier over langtidseffekten af omskæring.<sup>14</sup>

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<sup>13</sup> Pediatrics, Task Force on Circumcision, 2012, Sep;130(3):e756-85

<sup>14</sup> Morten Frisch et al., Cultural Bias in the AAP's 2012 Technical report and Policy Statement on Male Circumcision, Pediatrics, 2013, 796-800

## 5 Konklusion

Det er Sundhedsstyrelsens vurdering, at der ikke er tilstrækkelig sundhedsfaglig dokumentation til generelt at anbefale omskæring af drengebørn. Samtidig er der ikke sådanne risici ved indgrebet, når det foretages korrekt og af kompetente læger, at styrelsen finder anledning til at anbefale et forbud af rituel omskæring af drengebørn.

Der er videre Sundhedsstyrelsens opfattelse, at der kan være fordele ved at omskære drengebørn i de første levemåneder set fra en ud fra en sundhedsfaglig patient-sikkerhedsmæssig vinkel, da indgrebet er mindre og formentlig giver færre komplikationer.

Komplikationerne ved indgrebet er få og alvorlige komplikationer er meget sjældne. Ifølge Sundhedsstyrelsens oplysninger, har der ikke været alvorlige komplikationer ved rituelle drengeomskæringer foretaget af læger i Danmark. Da litteraturen tyder på flere komplikationer, jo ældre barnet er, kan man overveje at stille krav om, at drengebørn, der skal omskæres ud over de første leveuger, får indgrebet foretaget på en lægeklinik eller på sygehus.

Der har fra flere sider været rejst bekymring for seksualiteten hos den voksne mand som følge af omskæring. Selv om nogle studier tyder på, at omskæring senere hen kan føre til psykologiske og seksuelle problemer, mangler der fortsat studier over langtidseffekten af omskæring. En registrering i eksempelvis landspatientregisteret (LPR) af alle omskæringer mhp. senere opfølgning kan overvejes.

Endelig finder Sundhedsstyrelsen, at der fortsat skal være forbeholdt læger at udføre indgrebet under overholdelse af de sundhedslige regler, som er foreskrevet i styrelsens vejledning om omskæring af drengebørn.

## 6 Bilagsfortegnelse:

- Bilag 1:** Sundhedsstyrelsen – Vejledning om omskæring af drenge
- Bilag 2:** Whitepaper – om ritual omskærelse af drenge.
- Bilag 3:** Pediatrics. Male Circumcision. Task force on circumcision.
- Bilag 4:** Pediatrics. Cultural Bias in the AAP's 2012 Technical Report and Policy Statement. On Male Circumcision.
- Bilag 5:** Complications of circumcision in male neonates, infants and children: a systematic review.
- Bilag 6:** Socialstyrelsen – Rättsutredning om rättsläget kring omskærelse av pojkar.

## Bilag 1: Vejledning om omskæring af drenge

Sundhedsstyrelsen er i forbindelse med behandling af indberetningssager blevet opmærksom på særlige problemer knyttet til omskæring af drenge og har fundet det nødvendigt at udarbejde en vejledning vedrørende omskæring af drenge under 18 år.

### Hvem må foretage omskæring

Omskæring af drenge er efter Sundhedsstyrelsens opfattelse et operativt indgreb i lægelovens forstand, og dermed forbeholdt læger.

Læger med ret til selvstændigt virke kan anvende medhjælp, jf. den almindelige regel herom i lægeloven<sup>1</sup>. Læger skal i den forbindelse udvise omhu og samvittighedsfuldhed. Lægen skal således sikre sig, at medhjælpen er tilstrækkeligt uddannet og instrueret til at kunne varetage opgaven forsvarligt, samt føre det nødvendige tilsyn med medhjælpens virksomhed. Dette indebærer efter Sundhedsstyrelsens opfattelse, i relation til omskæring af drenge, at lægen skal være tilstede under indgrebet. Lægen er ansvarlig for det udførte indgreb, så længe medhjælpen holder sig til lægens instrukser.

Eventuelle sager om erstatning vil, efter omstændighederne, kunne dækkes af Patientforsikringen, som også omfatter privatpraktiserende læger.

### Information og samtykke

Omskæring af drenge under 15 år må ikke udføres, uden at der foreligger et informeret samtykke fra forældremyndighedens indehaver. Hvis der er tale om fælles forældremyndighed, skal begge parter informeres og give samtykke til indgrebets udførelse. En ung, der er fyldt 15 år, kan selv give informeret samtykke til omskæring<sup>2</sup>. Den, der skal give samtykke til omskæring, skal forinden modtage en fyldestgørende information om indgrebet. Informationen skal gives på en forståelig måde og skal indeholde oplysning om:

- hvordan indgrebet udføres
- smerter ved indgrebet og smertelindring
- behov for pleje og smertelindring efter indgrebet
- risici for komplikationer og bivirkninger.

Informationen skal gives mundtligt, men bør efter Sundhedsstyrelsens opfattelse tillige suppleres med skriftlig information.

I det omfang, et barn under 15 år er i stand til at forstå situationen, skal barnet informeres og inddrages i beslutningsprocessen vedr. indgrebet. Barnets tilkendegivelser skal, i det omfang de er aktuelle og relevante, tillægges betydning.

Den læge, der er ansvarlig for indgrebet, er ansvarlig for, at den givne information er fyldestgørende og forståelig. Lægen skal desuden sikre sig, at det fornødne samtykke foreligger.

<sup>1</sup> Lægelovens §6, jf. Lovbekendtgørelse nr. 272 af 19. april 2001.

<sup>2</sup> Lov om patienters retsstilling nr. 482 af 1. juli 1998, 1 §§ 6-12

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Islands Brygge 67  
2300 København S

Tlf. 72 22 74 00  
Fax 72 22 74 11  
E-post info@sst.dk  
www.sst.dk

### **Hygiejne**

Den læge, som har ansvaret for indgrebet, skal sikre sig, at almindelig god faglig standard vedr. kirurgisk hygiejne overholdes, herunder at operationsområdet vaskes sterilt, afdækkes og at der anvendes sterile instrumenter.

Side 2

### **Smertelindring**

Alle børn, også spædbørn, skal sikres den nødvendige, tilstrækkelige og tidsvarende smertelindring, som indgrebet og den postoperative periode kræver. Der skal ved valg af smertelindring tages hensyn til barnets alder, modenhedsgrad og øvrige medicinske forhold. Den smertelindring, der vælges, skal desuden være så god som mulig med så lille risiko for bivirkninger og komplikationer som muligt.

23. maj 2005

### **Operationsteknik**

Omskæring af drenge kan udføres på flere måder. Lægen skal følge den faglige udvikling på området og sikre sig, at han har de nødvendige forudsætninger for både indgrebet og smertelindringen.

**Enhed for kvalitet,  
overvågning og tilsyn**

Sundhedsstyrelsen

### **Efter operationen**

Den ansvarlige læge skal sikre sig, at forældrene eller forældremyndighedsindehaveren gives information om den postoperative pleje herunder hygiejniske forholdsregler samt smertelindring.

### **Journalføring**

Ved omskæring skal der føres journal efter vanlige retningslinjer for journalføring.<sup>3</sup>

Michael von Magnus

Lena Graversen

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<sup>3</sup> Bekendtgørelse nr. 846 af 10. oktober 2003 om lægers pligt til at føre ordnede optegnelser og Vejledning nr. 118 af 13. oktober 2003 om lægers journalføring.

# WHITEPAPER

## – OM RITUEL OMSKÆRELSE AF DRENGE

Sommeren 2012 har været præget af en meget heftig debat om, hvorvidt rituel omskærelse af drenge skal forbydes. Dette White Paper fra Det Mosaiske Troessamfund – Det Jødiske Samfund i Danmark, har til formål at give et overblik over de forskellige problemstillinger, der har været berørt i debatten. Der redegøres således for, hvordan en jødisk rituel omskærelse rent faktisk gennemføres, og den religiøse baggrund beskrives, herunder at omskærelsen er en hovedhjørnesten i jødisk selvidentifikation og religion.

Endvidere redegøres for de lægelige undersøgelser og de juridiske problemstillinger der har været fremført, og under henvisning til andre og væsentligt større lægelige undersøgelser gendrives påstandene, ligesom de juridiske argumenter ligeledes gendrives.



*August 2012*





## OM RITUEL JØDISK OMSKÆRELSE AF DRENGE

### Indledning

Sommeren 2012 har været præget af en meget heftig debat om, hvorvidt rituel omskærelse af drenge skal forbydes.

Danmark ville i givet fald være det første land i verden, som indfører et forbud mod omskærelse af drenge. Dette vel og mærke i en verden, hvor hver tredje mand er omskåret, og hvor Danmark via FN støtter WHO's omskærelsesinitiativ i Afrika.

Set fra Det Mosaiske Troessamfund – Det Jødiske Samfund i Danmark har debatten været præget af en lang række forskelligartede synspunkter, hvis forskellighed ofte har gjort debatten vanskelig at få et overblik over. Ikke mindst sammenblanding af jødiske og muslimske traditioner kan give anledning til forvirring.

Dette "White Paper" har til formål at give et overblik over de forskellige problemstillinger, der har været berørt i debatten. Der redegøres således for, hvordan en jødisk rituel omskærelse rent faktisk gennemføres, således at fremførte misforståelser kan korrigeres. En omskærelse gennemføres på det 8 dage gamle drengbarn, hvilket efter lægelige undersøgelser medfører mindst antal komplikationer og smerteoplevelse. Omskærelsen sker altid under tilsyn af en læge, i nærværelse af familien (naturligvis både kvinder og mænd), og lægen journaliserer det passerede.

Den religiøse baggrund beskrives, herunder at omskærelsen er en hovedhjørnesten i jødisk selvidentifikation og religion.

De lægelige undersøgelser og de juridiske problemstillinger har været fremført, og under henvisning til andre og væsentligt større lægelige undersøgelser gendrives påstandene, ligesom de juridiske argumenter ligeledes gendrives.

Det er for ambitiøst at forvente, at modstanderne af rituel jødisk omskærelse vil blive omvendt af denne redegørelse, men håbet er dog, at en fremtidig debat kan få et mere "informeret" afsæt.

København, august 2012

Finn Schwarz  
Formand



## Indholdsfortegnelse

<b>1. Overordnede konklusioner .....</b>	<b>6</b>
<b>2. Beskrivelse af en omskærelse, foretaget i det jødiske samfund i Danmark.....</b>	<b>11</b>
2.1 Beskrivelse af hvordan det faktisk gennemføres .....	11
2.2 Beskrivelse af hvem der er til stede – lægen, omskæreren, familien.....	12
2.3 Beskrivelse af afrapporteringen .....	13
2.4 Utilsigtede hændelser .....	13
<b>3. Den religiøse baggrund.....</b>	<b>13</b>
3.1 Baggrunden.....	13
3.2 Praksis.....	14
3.3 Nye "bevægelser" .....	14
3.4 Kristendommens pragmatisme kontra jødedommen .....	14
3.5 Betydningen for den jødiske familie og det jødiske samfund i Danmark .....	15
<b>4. Den medicinske kontekst .....</b>	<b>15</b>
4.1 Forskellen mellem mandlig og kvindelig omskærelse – forholdet til seksualitet.....	15
4.2 Morten Frisch undersøgelse.....	16
4.3 Patientforsikringens tal .....	18
4.4 WHO's rekommandationer vedrørende omskærelse .....	18
4.5 Omskærelsens betydning for livmoderhalskræft, peniscancer, infektioner, urinvejsinfektioner, prostatacancer og seksuelt overførte sygdomme .....	19
<b>5. Den juridiske kontekst.....</b>	<b>20</b>
5.1 Det danske regelgrundlag .....	20
5.2 Forholdet til børnekonventionen .....	21
5.3 Barnets selvbestemmelsesret – forældres beslutninger på barnets vegne.....	22



## 1. Overordnede konklusioner

I dette "White Paper" gennemgås en række problemstillinger, som har været anført i debatten om rituel omskærelse af drenge over sommeren 2012.

Et forbud mod religiøs omskærelse af drenge i Danmark vil være det første forbud af sin art på verdensplan.

**I afsnit 2**, der omhandler den *praktiske gennemførelse af rituel jødisk omskærelse* i Danmark, anføres følgende:

1. Rituel jødisk omskærelse foretages under tilsyn af en læge ved en omskærer i overensstemmelse med Sundhedsstyrelsens regler.
2. Omskærelsen foregår som regel i hjemmet. Nogle gange med mange gæster, nogle gange kun med deltagelse af forældrene og/eller den allernærmeste familie. Såvel kvinder som mænd deltager (naturligvis) i ceremonien.
3. Forud for omskærelsen undersøges drengen af lægen, der ligeledes journalfører før og efter indgrebet. Journalen gemmes i 10 år.
4. Omskærelsen sker ved en almindeligt anerkendt metode, der sikrer, at det alene er forhuden, der fjernes.
5. Selve omskærelsen tager mellem 2-3 minutter og opleves som havende meget lille virkning på det 8 dage gamle barn.
6. Omskæreren besøger almindeligvis – under alle omstændigheder - familien dagen efter og tager bandagen af som regel ved bad. Enkelte gange lægges ny bandage for at holde forhuden nede, da der jo ikke foretages syning, men oftest kan bandagen nu fjernes.
7. Der er ikke igennem mange år konstateret komplikationer relateret til jødisk rituel omskærelse i Danmark.

**Afsnit 3** beskriver den *religiøse baggrund for den jødiske omskærelse*.

Her anføres:

1. Den jødiske rituelle omskærelse er én af de 613 forskrifter, der findes i De 5 Mosebøger, og som jøder er forpligtet af.
2. I 1. Mosebog kapitel 17 findes udgangspunktet for denne tradition: "*Dette er min pagt med dig og dine efterkommere, som I skal holde: Alle af mandkøn hos jer skal omskæres. **v11** I skal lade jeres forhud omskære, og det skal være tegn på pagten mellem mig og jer. **v12** Otte dage gammel skal hver dreng hos jer omskæres, slægt efter slægt.*"
3. Omskærelsen betragtes af jødiske samfund ude i verden samt af det jødiske samfund i Danmark som én af hovedhjørnestenene i at være jøde, og uanset at omskærelsesdebatten

har været oppe med jævne mellemrum, har dette ikke resulteret i en intern diskussion eller en nedgang i ønsket om gennemførelse af omskærelser. Størstedelen omskæres rituel mens nogle vælger at lade omskærelse ske ved en læge.

4. Der har i debatten været peget på, at en lille gruppe amerikanske jøder anvender en metode, der ikke er en omskærelse men derimod en "prikning" i forhuden.
5. Denne lille gruppes praksis er marginal i forhold til de jødiske samfund i verden, som ikke anerkender denne fremgangsmåde som en rituel omskærelse. Denne praksis vil ikke kunne afløse den rituelle omskærelses karakter af at være en hjørnesteen i det at være jøde.
6. Omskærelse er tillige et identitetstegn for jøder. Det er et tegn på, at familien ønsker at være en del af den jødiske historie såvel i fortid som i fremtid.
7. Omskærelsen er en hovedhjørnesteen for 90 % af det jødiske folk (mænd) i verden og det samme tal gælder også for jøderne i Danmark. Uden en mulighed for omskærelse i Danmark vil det jødiske samfund inden for en overskuelig fremtid risikere at gå i opløsning.

I afsnit 4 beskrives *den medicinske kontekst*.

Her anføres det at undersøgelsen, foretaget af Morten Frisch m.fl., publiceret i 2011, kan betragtes som "en enlig svale" og er med rette kritiseret for følgende:

Der er tale om en spørgeskemaundersøgelse om en række forskellige sundhedsemner (ca. 5000 adspurgte), hvor under halvdelen af dem, der fik et spørgeskema besvarede – en så lav svarprocent er som udgangspunkt problematisk, herunder er der ingen viden om, hvorvidt de inkluderede mænd er repræsentative for den gruppe, som man ønsker at generalisere resultaterne til.

1. Af 2345 mænd, der besvarede spørgeskemaundersøgelsen, var 125 omskåret, og af 2234 kvinder, der besvarede spørgeskemaundersøgelsen var 83 samlevende med omskårede mænd.
2. Af de 125 omskårede mænd rapporterede 7 (!) mænd, at de var muslimer (5) eller jøder (2). 15 mænd rapporterede, at de var omskåret før 6 måneders alderen. Blandt de omskårede havde 14 udenlandsk baggrund. Den langt overvejende del af dem, der besvarede spørgeskemaet og tilkendegav at være blevet omskåret, må således formodes – da spørgeskemaet ikke giver mulighed for at besvare dette - at være omskåret af medicinske årsager, heraf hyppigst forhudsforsnævring og i sjældne tilfælde peniscancer, hvilket i sig selv kan have indflydelse på personens mentale opfattelse og funktionelle praktisering af sit seksualliv. I et så lille materiale er det vigtigt, at det klart fremgår af datamaterialet, om omskærelsen er udført af religiøse årsager, hvor hele forhuden fjernes, eller på basis af medicinsk indikation – og i givet fald for hvilke grupper, hvor forhuden kun fjernes delvist, idet disse oplysninger kan have en statistisk betydning for undersøgelsens analyse og udfald.
3. Undersøgelsen omhandler derfor i det væsentlige mænd, der er omskåret efter en lægelig undersøgelse og vurdering og ikke på raske personer og slet ikke på 8 dage gamle drenge, som rituel, jødisk omskærelse foreskriver. Det er derfor meget betænkeligt, at

undersøgelsen søges anvendt til at argumentere for et forbud mod rituel omskærelse og at medierne tager undersøgelsen til indtægt for et forbud. Morten Frisch sammenligner æbler og pærer og konkluderer således på forhold, som undersøgelsen ikke giver basis for at udtale sig om.

4. I en artikel, "*Does sexual function survey in Denmark offer any support for male circumcision having an adverse effect?*"<sup>1</sup> kritiseres Morten Frisch' undersøgelse (det statistiske grundlag) samt de konklusioner, Morten Frisch drager.
5. I artiklen, "*Complications of circumcision in male neonates, infants and children: a systematic review*"<sup>2</sup>, gennemgås en række undersøgelser foretaget i lande, der anvender omskærelser. Særligt skal nævnes en komplikationsrisiko på 0,2 % i en undersøgelse foretaget i USA på 130.475 omskårede mænd og en undersøgelse foretaget i Israel på 19.478 omskårede mænd med en komplikationsrisiko på 0,1%.
6. Teorien om, at omskærelse skulle medføre en mindre følsomhed, som dels skulle medføre orgasmeproblemer hos manden og smerter ved samleje hos kvinden, har ingen støtte i anden forskning hverken relateret til hetero- eller homoseksuelle oplevelser hos omskårede mænd og deres partnere, herunder meget store kliniske trials fra Afrika, som inkluderer mange tusinde mænd, der blev omskåret som voksne.
7. Klare undersøgelsesresultater viser, at såfremt omskærelsen gennemføres som en rituel jødisk omskærelse på det spæde barn er komplikationsrisikoen og oplevelse af ubehag m.v. mindst.

Morten Frisch (og de øvrige forfattere) slutter deres artikel af med at angive, at dette område skal undersøges nærmere – et forbehold for egne resultater, der på ingen måde har præget Morten Frisch' uforbeholdne udtalelser over sommeren 2012.

I relation til **Patientforsikringen** foreligger følgende:

I en 16-årig periode (1996-2012) er der anmeldt 14 patientskader efter rituel omskæring foretaget af en læge, hvoraf 2 er anerkendt af Patientforsikringen. *Ingen af disse tilfælde* har sammenhæng med rituel, jødisk omskærelse, hvorfor anførelsen af disse tal i debatten er *misvisende*.

I relation til **HIV-infektion** har en række undersøgelser resulteret i, at et ekspertpanel under WHO anbefaler, at mandlig omskærelse blev inkluderet i metoderne til forebyggelse af heteroseksuelt overført HIV i lande med høj forekomst af HIV infektion.

Følgende er i øvrigt lægeligt dokumenteret i relation til omskærelsens positive betydning:

- Betydelig **reduktion i livmoderhalskræft** hos den omskåredes partner.
- **Reduktion med to tredjedele i antallet af peniscancer** hos den omskårede.

<sup>1</sup> Bryan J. Morris m.fl. <http://ije.oxfordjournals.org/content/41/1/310.full>

<sup>2</sup> Helen A. Weiss m.fl., <http://www.biomedcentral.com/1471-2490/10/2>



- To tredjedel **færre infektioner på penishoved** og **5-10 gange færre urinvejsinfektioner**.
- Der ses langt **færre seksuelt overførte sygdomme**.
- Antal tilfælde af **prostatacancer** er mindre hos omskårede.

På verdensplan anslås det, at 1/3 af verdens befolkning af mænd er omskåret, svarende til ca. 1.2 mia. mænd. Det må umiddelbart siges at have formodningen imod sig, at den foreliggende – med rette – kritiserede spørgeskemaundersøgelse endeligt fastslår, at omskærelse giver anledning til gener hos den omskårede mand og/eller dennes partner.

Endelig i **afsnit 5** redegøres for den *juridiske kontekst*.

Det konstateres, at jødisk rituel omskærelse gennemføres i overensstemmelse med det foreliggende retsgrundlag, herunder med mulighed for at autoriserede sundhedspersoner benytter medhjælp.

I forbindelse med debatten om omskærelse er det bl.a. anført, at *FN's Børnekonvention* fra 1989 indebærer et forbud mod omskærelse af drenge.

Dette er *ikke* korrekt.

Børnekonventionens artikel 24, stk. 3, fastslår, at deltagerstaterne skal *tage alle effektive og passende foranstaltninger for at afskaffe traditionsbundne ritualer, som er skadelige for børns sundhed*.

Børnekonventionen er tiltrådt af en række stater, som anerkender omskærelse af drenge, og der er en klar opfattelse i det internationale samfund og i det juridiske miljø i Danmark, at børnekonventionen tilsigter at beskytte *female genital mutilation* (kvindelig omskærelse) og ikke angår omskærelse af drenge.<sup>3</sup>

Dette stemmer da også overens med, at ikke et eneste land i verden har et forbud mod omskærelse af drenge.

Om *barnets selvbestemmelsesret* er anført, at det er alment accepteret at forældre, mens barnet ikke er beslutningsmodent, kan træffe beslutninger på barnets vegne, og at forældre faktisk træffer en række valg på det ufødte og fødte barns vegne.

Det drejer sig bl.a. om:

- Abort – herunder abort i forbindelse med fosterdiagnostik.
- Kosmetiske operationer i relation til børn født med mere eller mindre alvorlige deformiteter. Disse kosmetiske operationer spænder fra deciderede deformiteter i ansigtet og på kroppen over hareskår og tandoperationer til mindre alvorlige tilfælde såsom tilretning af 'stritøre'.
- Rettelse af "skæve" næser mv.
- Piercing og huller i ørerne.

<sup>3</sup> Se Jurisdiktionsudvalgets udtalelse i forbindelse med indførelse af forbud mod kvindelig omskærelse samt Kirsten Ketscher i *Nye retlige design*, s. 14ff. 2003.

samt f.eks.:

- Moderens alkoholindtagelse under graviditet, som beviseligt medfører en betydelig risiko for fosterskader.
- Forældres rygning i barnets hjem, som beviseligt medfører en betydelig risiko for skader som følge af passiv rygning.
- Deltagelse i – eller netop ikke deltagelse i – generelle vaccinationsprogrammer for børn.

Det er evident, at der generelt set ikke er et ønske om at lovgive om disse forhold. Selvom det er utvivlsomt, at f.eks. en overdreven alkoholindtagelse under en graviditet har direkte betydning for uafvendelige fosterskader, er der intet ønske om at kriminalisere den gravides indtagelse af alkohol over en vis mængde, samt kriminalisere købmandens eller supermarkedets salg af alkoholiske drikke til gravide.

Omskærelsen er af stor betydning for barnets tilknytning til den jødiske kultur, sin familie og religionen og har derfor sin berettigelse på samme vilkår som almindelige kosmetiske indgreb, der også er baseret i barnets tilknytning til kultur og det omkringliggende samfund – og i øvrigt på linje med accepten af, at et barns forældre træffer en række direkte og indirekte valg på barnets vegne, som har direkte indflydelse på barnets opvækst og liv.

Et forbud, begrundet i barnets selvbestemmelsesret, vil således være et markant brud på denne linje – navnlig når der ikke foreligger medicinske tvingende grunde (som tilfældet var ved kvindelige omskærelser).

Endelig fastslås det, at Grundlovens § 67 sikrer retten til at dyrke sin religion, og bestemmelsen skal sammenholdes med Den Europæiske Menneskerettigheds artikel 9.

Det er fast antaget, at et indgreb i religionsfriheden kræver (1) lovhjemmel, (2) et legitimt formål og nødvendighed i et demokratisk samfund.

Allerede som følge af, at omskærelse af drenge ikke er forbudt i ét eneste land, der har tiltrådt den Europæiske Menneskerettighedskonvention, er der meget der taler for, at et omskærelsesforbud *ikke* er et legitimt formål og en nødvendighed i et demokratisk samfund.

Den foreliggende medicinske forskning, se bemærkningerne ovenfor, er på ingen måde entydig, hvilket selv anføres af den forskning, der er kritisk overfor omskærelse af drenge (i modsætning til hvad der var tilfældet for omskærelse af piger).

Ved vurderingen af om der foreligger et *legitimt formål og en nødvendighed i et demokratisk samfund* må man tillige tage i betragtning, hvilke andre (mere eller mindre) lignende forhold, der reguleres af lovgivningen, henholdsvis ikke reguleres af lovgivningen – den såkaldte "proportionalitetsvurdering".

Der er en betydelig risiko for, at et forbud mod omskærelse af drengebørn vil stride mod religionsfrihedsretten i den danske grundlov, set i sammenhæng med den Europæiske Menneskerettighedskonvention, da et forbud ikke kan begrundes med et legitimt formål og en nødvendighed i et demokratisk samfund og vil være ikke-proportionalt i forhold til, hvilke beslutninger forældre ellers frit kan træffe på sit barns vegne.

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## **2. Beskrivelse af en omskærelse, foretaget i det jødiske samfund i Danmark**

### **2.1 Beskrivelse af hvordan det faktisk gennemføres**

Omskæreren - nedenfor betegnet med det hebraiske udtryk *Mohel* - kontaktes af forældrene. Hvis barnet ikke er født af en jødisk mor, henvises til lægeklinikker. Mohel undersøger barnet for:

- Almindeligt velbefindende
- Barnegulsot kontrolleres ved check i øjne eller omkring lysken.
- Hypospadi og lignende.

I tvivlstilfælde kontaktes en læge.

Generelt gælder, at barnet skal veje omkring 3 kg. og må ikke have en gulsot, der kunne tyde på en bilirubin over 120. I tvivlstilfælde udsættes omskærelsen.

Hvis omskæreren (Mohels) undersøgelse viser, at forholdene i relation til en omskærelse er i orden, aftales om muligt omskærelse 8 dage efter fødslen.

Selve omskærelsen foregår som regel i hjemmet. Nogle gange med mange gæster, nogle gange kun med deltagelse af forældrene og/eller den allernærmeste familie. Såvel kvinder som mænd deltager (naturligvis) i ceremonien.

Forberedelsen forud for en omskærelse omfatter følgende:

1. Sikring af, at instrumenterne er sterile.
2. Forberedelse i hjemmet: Påsmøring af EMLA creme ca. 1 time inden omskærelsen. Barnet får ikke mad i timerne op til selve ceremonien.
3. Mohel og den tilstedeværende ansvarlige læge ankommer. Lægen kontrollerer barnet og journalfører før og efter indgrebet.

### ***Om selve omskærelsceremonien:***

Barnet ligger på en pude, og en person, man ønsker at ære, sidder med barnet på et solidt bord.

Mohel står på den ene side og lægen modsat og holder barnets ben. Mohel trækker forhuden op over glansen og sætter en klemme i den optrukkede forhud. Herved sikres, at man ikke kan beskadige penishovedet. Der foretages et snit ovenfor klemmen, og forhuden falder af. Herefter sørges der for, at også den indre forhud er trukket helt ned ved roden, og Mohel stopper blødningen med pres og bandager. Under selve handlingen får barnet lidt vin på en sut, og dermed koncentrerer barnet sig om at sutte. Hele seancen er overstået på 2-3 minutter.

Ceremonien afsluttes med, at barnet får sit jødiske navn og velsignes af Mohel.

Efter ceremonien indskrives barnet i ministerialprotokollen, og der indføres, hvem der har foretaget omskærelsen.

### ***Efter omskærelsceremonien:***

Efter ceremonien makes barnet. Derefter kontrollerer lægen og Mohel, at barnet har det godt, og at bandagen er tør og ligger ordentligt.

Journalen underskrives af lægen, og Mohel instruerer familien om, hvorledes bleserne de næste 5 til 6 bleskift vil se ud. Familien har direkte kontakt med Mohel, og skulle familien være i tvivl om noget, besøger Mohel altid familien umiddelbart.

Mohel besøger almindeligvis – og under alle omstændigheder - familien senest dagen efter og tager som regel bandagen af ved bad. Enkelte gange lægges ny bandage for at holde forhuden nede, da der jo ikke foretages syning, men oftest kan bandagen nu fjernes. Familien får nye instruktioner, som først og fremmest går på at lade drengen ligge lidt uden ble ved bleskift.

Det sker, at familier henvender sig nogle måneder efter indgrebet, idet familien fornemmer, at glansen ikke er helt fri. Årsagen er ofte, at barnet har meget "hvalpefedt", indtil det begynder at gå, og at dette bevirker, at lårene presser på penis. Mohel beroliger familien og har kun én gang været ude for, at en familie ikke ville vente til, at naturen ville klare problemet.

## **2.2 Beskrivelse af hvem der er til stede – lægen, omskæreren, familien**

En omskærelse er en festlig begivenhed, og derfor er barnets forældre og øvrige familie tilstede, foruden den tilstedeværende ansvarlige læge og omskæreren.

Det er ikke korrekt, når det i sommerens debat har været anført, at omskærelsen ikke sker i overværelse af kvinder.

### 2.3 Beskrivelse af afrapporteringen

Som anført ovenfor kontrollerer lægen barnet forud for omskærelsen og efter indgrebet og journalfører sine optegnelser.

Lægens journal opbevares såvel hos lægen som hos Mohel i 10 år.

### 2.4 Utsigtede hændelser

Under sommerens debat er det blevet anført, at der skulle være flere tilfælde af problematiske omskærelser, som har resulteret i behandling på danske sygehuse.

Dette er *ikke* korrekt. Der har igennem de sidste mange år været ét tilfælde, som resulterede i en henvendelse til Rigshospitalet. Efterfølgende konstateredes det, at den omskårede dreng var smittet af en virus, som et af drengens familiemedlemmer havde haft, og som havde resulteret i en særlig rødme. Barnet havde kort efter (og i dag) ingen gener af omskærelsen.

## 3. Den religiøse baggrund

### 3.1 Baggrunden

Den jødiske rituelle omskærelse er én af de 613 forskrifter, der findes i De 5 Mosebøger, som jøder er forpligtet af.

Da der er tale om en religiøs forpligtelse, kan den kun udføres af en jøde.

I 1. Mosebog, kapitel 17, finder vi udgangspunktet for denne tradition: "*Dette er min pagt med dig og dine efterkommere, som I skal holde: Alle af mandkøn hos jer skal omskæres. **v11** I skal lade jeres forhud omskære, og det skal være tegn på pagten mellem mig og jer. **v12** Otte dage gammel skal hver dreng hos jer omskæres, slægt efter slægt.*"

Den jødiske betegnelse for omskærelse er *Brit Milah*, der er hebraisk og betyder omskærelses**pagten** – betegnelsen forklarer bedre end noget andet den pagt som Gud indgår med Abraham, beskrevet i 1. Mosebog, kap. 17.

Denne pagt blev indgået for 3.700 år siden og har været en forankret del af jødedommen siden. To gange i Bibelen er det nævnt, at der var perioder, hvor det jødiske folk ikke foretog omskærelse/Brit Milah.

Omvendt kan man i historisk lys konstatere, hvorledes jøder har kæmpet mod magthavere, der forbød jøder at foretage omskærelse/Brit Milah. Både grækerne og romerne bandlyste omskærelse/Brith Milah, idet både grækerne og romerne helt korrekt forstod, at omskærelsen er en hjørnesten i den jødiske tro, og at forbud mod Brit Milah ville være første trin til en eliminering af det jødiske folk. Selv under disse herskere gennemførte jødiske forældre Brit Milah.

I historisk perspektiv kan også nævnes perioden under Den spanske Inkvisition, hvor det uanset, at det at være omskåret nærmest var at underskrive sin egen dødsdom, alligevel blev fastholdt, at jøder gennemførte Brit Milah.

### 3.2 Praksis

I det jødiske samfund i Danmark er der, i lighed med alle andre jødiske samfund verden over, næsten en undtagelsesfri praksis, hvorefter drengébørn bliver omskåret. Der har igennem hele den periode, hvor der har været jøder i Danmark (over 400 år), uanset at omskærelsesdebatten har været oppe med jævne mellemrum, hverken været en intern diskussion eller en nedgang i ønsket om gennemførelse af omskærelser. Størstedelen omskæres rituel mens nogle vælger at lade omskærelse ske ved en læge.

Det jødiske samfund i Danmark adskiller sig således ikke holdningsmæssigt fra jødiske samfund andre steder i verden, hvor den rituelle omskærelse af drenge anses for at være en hjørnesten i det at være jøde.

### 3.3 Nye "bevægelser"

Der har i debatten været peget på, at en lille gruppe amerikanske jøder anvender en metode, der ikke er en omskærelse, men derimod en "prikning" i forhuden.

Denne lille gruppes praksis er marginal i forhold til de jødiske samfund i verden, som ikke anerkender denne fremgangsmåde som en rituel omskærelse.

Denne praksis vil således ikke kunne afløse den rituelle omskærelses karakter af at være en hjørnesten i det at være jøde.

### 3.4 Kristendommens pragmatisme kontra jødedommen

Det gælder for jødedommen i modsætning til kristendommen, at jødedommen har bundet sig til love og forskrifter, som man betragter som nærmest guddommelige, og som man ikke bare ændrer.

Fortolkninger har altid fundet sted, men jøder har og holder fortsat fast i omskærelses-traditionen, som har været gennemgående i de mere end 3000 år.

Man er født som jøde, hvis man er født af en jødisk mor. Der findes ikke i princippet jødiske dogmer, hvilket blandt andet betyder, at man ikke kan "fratage" en jøde sin identitet som jøde.

Der er jøder, der slet ikke overholder jødiske regler i nogen som helst form, og andre der har plukket ud af disse regler og overholder de regler, som de vil. Det gælder også for omskærelse. Man kunne måske sige det på denne måde: "Det er afgørende for de fleste jøder at være omskåret, men det er ikke afgørende at være omskåret for at være jøde".

### 3.5 Betydningen for den jødiske familie og det jødiske samfund i Danmark

Brit Milah/omskærelse er naturligvis et spørgsmål om religionens påbud, men det er meget mere end dette.

Brith Milah/omskærelse er et identitetstegn for jøder. Det er et tegn på, at familien ønsker at være en del af den jødiske historie såvel i fortid som i fremtid.

For nogle familier kan der være andre grunde til ønsket om, at deres søn skal omskæres. Der er mange, der mener, at der er medicinske årsager, andre fysiologiske og endnu andre seksuelle.

Under alle omstændigheder er Brit Milah/omskærelsen en hovedhjørneste for 90% af det jødiske folk i verden og det samme tal gælder også for jøderne i Danmark. Uden en mulighed for omskærelse i Danmark vil det jødiske samfund inden for en overskuelig fremtid risikere at gå i opløsning.

## 4. Den medicinske kontekst

### 4.1 Forskellen mellem mandlig og kvindelig omskærelse – forholdet til seksualitet

For god ordens skyld skal det præciseres, at der *ingen* sammenhæng er mellem en jødisk rituel omskærelse af et 8 dage gammelt drengbarn og omskærelse af kvinder, der har sit udgangspunkt i afrikansk tradition.

Kvindelig omskærelse dækker som begreb forskellige indgreb, som overordnet har det til fælles, at kvinden gøres mindre "tilgængelig" for seksualakten, og dermed forventes det tillige, at kvindens ønske om seksuel adfærd begrænses.

I forbindelse med indførelse af det danske forbud mod kvindelig omskærelse anførtes følgende om kvindelig omskærelse i lovforslaget:

*Efter oplysninger fra Sundhedsstyrelsen er der i princippet tre former for kvindelig omskæring:*

*»Sunnaomskæring/klitoridectomi«: Sunnaomskæring bruges ofte som betegnelse for fjernelse af slimhindefolden over klitoris, men bl.a. på grund af de anatomiske forhold omkring klitoris, er der en meget betydelig risiko for at bortskære mere end blot slimhindefolden, og Sundhedsstyrelsen har oplyst, at det næppe forekommer i praksis, at dette indgreb foretages, uden at der også fjernes en del af klitoris. Klitoridectomi er betegnelsen for hel eller delvis fjernelse af klitoris.*

*»Excision«: Herved forstås hel eller delvis fjernelse af klitoris samtidig med hel eller delvis fjernelse af de små skamlæber.*

*»Infibulation«: Ved dette indgreb fjernes klitoris, de små skamlæber og en del af de store skamlæber, og de rå sårflader enten sys sammen eller holdes sammen på anden måde, således at der kun efterlades et meget lille hul til vandladning og menstruationsblod.*

*Afgrænsningen mellem de forskellige former for omskæring er i praksis ikke skarp, og der forekommer mellemformer. I lande, hvor kvindelig omskæring er udbredt, foretages indgrebet ofte af*

*uuddannede fødselshjælpere eller ældre kvinder i familien og uden bedøvelse, og det kan derfor variere meget, hvad der faktisk bliver skåret bort.*

*Omskæring, specielt infibulation, kan have nogle umiddelbare helbredsmæssige følger og en række senfølger, som dels beror på indgrebets karakter, dels på den måde, indgrebet typisk bliver foretaget på.*

*Blandt de umiddelbare følger kan nævnes smertechok og psykisk chok på grund af indgrebets karakter, blødning, smerter ved vandladning, infektioner, blodforgiftning og stivkrampe. Senfølgerne er bl.a. smerter ved menstruation, ophobning af menstruationsblod i skede og livmoder ved infibulation, underlivssmerter, kronisk underlivsbetændelse, der kan medføre sterilitet, invaliderende vandladningsproblemer, gentagne urinvejsinfektioner, komplikationer i forbindelse med graviditet og fødsel på grund af uelastisk arvæv, smerter ved samleje og andre seksuelle problemer.*

*Kvindelig omskæring er således et særdeles alvorligt indgreb, som der efter regeringens opfattelse på det kraftigste må tages afstand fra.*

Som det fremgår af denne redegørelse fra Sundhedsstyrelsen, er omskærelse af et drengbarn væsensforskellig fra kvindelig omskærelse og har hverken til formål at berøve seksualitet, eller at begrænse nydelsen heraf, og dette er da heller ikke konsekvensen af en mandlig omskærelse.

## 4.2 Morten Frisch undersøgelse

Morten Frisch har om nogen markeret sig i debatten om rituel omskærelse i sommeren 2012. Morten Frisch angiver selv, at hans grundholdning skyldes en spørgeskemaundersøgelse, som er publiceret i 2011<sup>4</sup>, og som skulle angive forhøjede komplikationsprocenter ved omskærelser hos både den mandlige og kvindelige partner.

Til forståelse af undersøgelsen skal følgende præciseres:

1. Der er tale om en spørgeskemaundersøgelse om en række forskellige sundhedsemner (5000 adspurgte), hvor under halvdelen af dem, der fik et spørgeskema besvarede – dette er som udgangspunkt problematisk, herunder er der ingen viden om, hvorvidt besvareren er *statistisk relevant*.
2. Af 2345 mænd, der besvarede spørgeskemaundersøgelsen, var 125 omskåret, og af 2234 kvinder, der besvarede spørgeskemaundersøgelsen, var 83 samlevende med omskårede mænd.
3. Af de 125 omskårede mænd rapporterede 7 (!), at de var muslimer (5) eller jøder (2). 15 mænd rapporterede, at de var omskåret før 6 måneders alderen. Blandt de omskårede havde 14 udenlandsk baggrund. Den langt overvejende del af dem, der besvarede spørgeskemaet og tilkendegav at være blevet omskåret, er således omskåret

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<sup>4</sup> Male circumcision and sexual function in men and women: a survey-based, cross-sectional study in Denmark, sammen med Morten Lindholm og Morten Grønnebæk, <http://ije.oxfordjournals.org/content/early/2011/06/13/ije.dyr104.full>



af medicinske årsager, hvoraf alvorlige tilstande som peniscancer kan være årsagen, hvilket i sig selv kan have indflydelse på personens seksualliv. Hvis flertallet af de omskårede i forvejen havde et penisfunktionsproblem (grunden til, at de blev omskåret), er det sandsynligvis dette, som resulterede i den øgede risiko for seksuelle problemer – og ikke det faktum, at de er blevet omskåret. Man kan derfor ikke benytte disse resultater til at beskrive langtidskonsekvenserne af omskærelse af raske drengebørn.

4. Undersøgelsen omhandler derfor i det væsentlige mænd, der er omskåret efter en lægelig undersøgelse og vurdering og ikke på raske personer og slet ikke på 8 dage gamle drenge, som rituel, jødisk omskærelse foreskriver. Det er derfor meget betænkeligt, at undersøgelsen søges anvendt til et forbud mod rituel omskærelse og, at medierne tager undersøgelsen til indtægt for et forbud. Morten Frisch sammenligner æbler og pærer.
5. Uanset et ringe statistisk materiale, konkluderer undersøgelsen, at omskærelse giver nedsat orgasme hos både mænd og kvinder og for kvindernes vedkommende desuden smerter og nedsat seksuel tilfredsstillelse.

Morten Frisch (og de øvrige forfattere) slutter deres artikel af med at angive, at dette område skal undersøges nærmere – et forbehold for egne resultater, der på ingen måde har præget Morten Frisch' udtalelser hen over sommeren 2012. Dette harmonerer med, at Morten Frisch allerede forud for undersøgelsen har argumenteret mod rituel omskærelse af drenge.

Morten Frisch' undersøgelse samt teorierne om et stort antal komplikationer harmonerer ikke med en lang række andre og betydeligt bredere (statistiske) undersøgelser:

1. I en artikel, "*Does sexual function survey in Denmark offer any support for male circumcision having an adverse effect?*"<sup>5</sup> kritiseres Morten Frisch' undersøgelse (det statistiske grundlag) samt de konklusioner, Morten Frisch drager.
2. I artiklen, "*Complications of circumcision in male neonates, infants and children: a systematic review*"<sup>6</sup>, gennemgås en række undersøgelser foretaget i lande, der anvender omskærelser. Særligt skal nævnes en komplikationsrisiko på 0,2% i en undersøgelse foretaget i USA på 130.475 omskårede mænd og en undersøgelse foretaget i Israel på 19.478 omskårede mænd med en komplikationsrisiko på 0,1%.

Sammenfattende kan det overordnet siges, at Morten Frisch' undersøgelse udgør "en enlig svale" og på ingen måde er det "endelige bevis" på, at det er lægeligt kontraindiceret at foretage rituel jødisk omskærelse.

Uanset dette, er der fremkommet 2 synspunkter, som skal kommenteres nærmere.

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<sup>5</sup> Bryan J. Morris m.fl. <http://ije.oxfordjournals.org/content/41/1/310.full>

<sup>6</sup> Helen A. Weiss m.fl., <http://www.biomedcentral.com/1471-2490/10/2>

For det første er det anført som en teori, at omskærelse skulle medføre en mindre følsomhed, som dels skulle medføre orgasmeproblemer hos manden og smerter ved samleje hos kvinden. Denne teori har ingen støtte i anden forskning hverken relateret til hetero- eller homoseksuelle oplevelser hos omskårede mænd og deres partnere.

For det andet er det anført, at man kan afvente, at barnet selv kan træffe et valg (f.eks. det 18. år). Der foreligger klare undersøgelsesresultater, der viser, at såfremt omskærelsen gennemføres som en rituel jødisk omskærelse på det spæde barn, er komplikationsrisikoen og oplevelse af ubehag m.v. mindst.<sup>7</sup>

### 4.3 Patientforsikringens tal

Patientforsikringen (forsikringsordningen for lægelig behandling) har redegjort for anmeldelser i relation til omskærelser i lægelig praksis. Ministeriet for sundhed og forebyggelse har i et svar den 2. juli 2012 til Folketingets Sundheds- og Forebyggelsesudvalg anført, at der i perioden 1996 – 2012 har været 65 anmeldelser til Patientforsikringen af komplikationer i relation til omskærelse.

De korrekte tal fra Patientforsikringen er:

51 anmeldelser efter ikke-rituelle omskærelser, dvs. omskærelser, der har fundet sted på en hospitaletdeling eller hos en praktiserende speciallæge – og som ofte vil være lægeligt indikeret (f.eks. forhudsforhæng). Kun 1 af disse anmeldelser er anerkendt.

14 anmeldelser efter rituelle omskærelser, udført af læger, dvs. ingen anmeldelser af rituelle, jødiske omskærelser, der udføres af en omskærer. Kun 2 af disse anmeldelser er anerkendt med udbetaling af en erstatning på 10.000 kr.

I en 16 årig periode er der således anmeldt 14 patientskader efter rituel omskæring, foretaget af en læge, hvoraf 2 er anerkendt af Patientforsikringen. *Ingen af disse tilfælde* har sammenhæng med rituel, jødisk omskærelse, hvorfor anførelsen af disse tal i debatten er *misvisende*.

### 4.4 WHO's rekommandationer vedrørende omskærelse

Flere studier har påvist lavere HIV forekomst i lande, hvor en stor del af den mandlige befolkning er omskåret. Epidemiologiske undersøgelser kan imidlertid ikke bruges til at undersøge for eventuel årsagssammenhæng, dvs. om den lavere forekomst af HIV er betinget af stor udbredelse af mandlige omskærelser.

Tre store randomiserede (lodtræknings) undersøgelser, gennemført i hhv. Sydafrika, Kenya og Uganda,<sup>8 9 10</sup> har enslydende fundet nedsat hyppighed af ny HIV smitte blandt mænd, som ved

<sup>7</sup> Helen A. Weiss m.fl., <http://www.biomedcentral.com/1471-2490/10/2> og A 'snip' in time: what is the best age to circumcise?, Bryan J. Morris m.fl. <http://www.biomedcentral.com/1471-2431/12/20>

<sup>8</sup> Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A: Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med 2005;2:e298.

<sup>9</sup> Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, Williams CF, Campbell RT, Ndinya-Achola JO: Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet 2007;369:643-656.

lodtrækning fik foretaget omskærelse umiddelbart i forhold til de mænd, som var planlagt til at blive omskåret senere.

Alle tre studier blev afbrudt før tid, da man på grund af beskyttelsen mod pådragelse af HIV-infektion blandt dem, som fik foretaget umiddelbar omskærelse, ikke fandt det etisk forsvarligt at fortsætte undersøgelserne. Risikoen for HIV-smitte blev nedsat med ca. 60 %. Samlet deltog >10.000 mænd i undersøgelserne.<sup>11</sup>

Resultaterne fra disse undersøgelser fik i 2007 et ekspertpanel under WHO til at anbefale, at mandlig omskærelse blev inkluderet i metoderne til forebyggelse af heteroseksuelt overført HIV i lande med høj forekomst af HIV infektion.<sup>12</sup>

Beregninger tyder på, at man ved fuld implementering af omskærelse i det sydlige Afrika ville kunne forhindre 1-4 millioner tilfælde af HIV-infektion over en 10-års periode.<sup>13</sup>

At WHO anbefaler omskærelse taler vel tillige imod, at omskærelse skulle medføre beskadigelser for den omskårede.

#### **4.5 Omskærelsens betydning for livmoderhalskræft, peniscancer, infektioner, urinvejsinfektioner, prostatacancer og seksuelt overførte sygdomme**

Følgende er lægeligt dokumenteret:

- Omskærelse medfører en betydelig reduktion i livmoderhalskræft hos den omskåredes partner
- Omskærelse fører til reduktion med to tredjedele i antallet af peniscancer hos den omskårede
- Der ses to tredjedel færre infektioner på penishoved og 5-10 gange færre urinvejsinfektioner, som kan føre til permanente nyreskader
- Der ses langt færre seksuelt overførte sygdomme, heriblandt herpes, syfilis og studier tyder på nedsat smitte med klamydia, som er en af hovedårsagerne til nedsat frugtbarhed hos kvinder.
- Endelig synes antallet af prostatacancer at være mindre hos omskårede mænd, set i forhold til ikke-omskårede mænd.

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<sup>10</sup> Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F, Kiwanuka N, Moulton LH, Chaudhary MA, Chen MZ, Sewankambo NK, Wabwire-Mangen F, Bacon MC, Williams CF, Opendi P, Reynolds SJ, Laeyendecker O, Quinn TC, Wawer MJ: Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet* 2007;369:657-666.

<sup>11</sup> Mills E, Cooper C, Anema A, Guyatt G: Male circumcision for the prevention of heterosexually acquired HIV infection: a meta-analysis of randomized trials involving 11,050 men. *HIV Med* 2008;9:332-335.

<sup>12</sup> WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention. <http://www.who.int/mediacentre/news/releases/2007/pr10/en/index.html>: 2007.

<sup>13</sup> Williams BG, Lloyd-Smith JO, Gouws E, Hankins C, Getz WM, Hargrove J, de Z, I, Dye C, Auvert B: The potential impact of male circumcision on HIV in Sub-Saharan Africa. *PLoS Med* 2006;3:e262.

## 5. Den juridiske kontekst

### 5.1 Det danske regelgrundlag

En række regler regulerer omskærelser af drenge i Danmark.<sup>14</sup>

I det følgende redegøres for (1) hvem der må foretage omskærelsen og (2) betydningen af et informeret samtykke.

(1) Hvem må foretage omskærelsen?

Autorisationslovens § 18 bestemmer, at Sundhedsstyrelsen skal fastsætte nærmere regler om autoriserede sundhedspersoners benyttelse af medhjælp.

Sundhedsstyrelsen har efter § 18 offentliggjort Delegationsbekendtgørelsen.

Af Delegationsbekendtgørelsens § 1 fremgår, at autoriserede sundhedspersoner, herunder læger, kan uddelegere alle former for sundhedsfaglig virksomhed til ikke-autoriserede personer, dog med undtagelse af virksomhed, der er nævnt i § 2.

Delegationsbekendtgørelsens § 2 opremser en række sundhedsfaglige virksomheder, som ikke kan delegeres ud. Af særlig interesse kan nævnes, at kosmetiske behandlinger ikke kan udføres af andre end en autoriseret sundhedsperson.

Omskærelse defineres i Sundhedsloven dog ikke som kosmetisk behandling, jf. listen nævnt i forarbejderne til Autorisationslovens kapitel 25 (LFF 2005-12-14 nr. 111).

Af forarbejderne til Autorisationslovens § 74 fremgår endvidere, at omskærelse kan uddelegeres til lægers medhjælpere.

Der anføres følgende: *"Hvis et indgreb uden terapeutisk formål er mere omfattende end den ovennævnte gennembrydning af huden, regnes dette for et operativt indgreb i § 74's forstand, og er således forbeholdt læger (og tandlæger) og disses medhjælp at udføre. Eksempler på dette er omskæring af drenge og kosmetisk behandling."*

Det følger også af Omskærelsesvejledningen, at en læges medhjælp kan udføre indgrebet.

Ifølge Delegationsbekendtgørelsens § 3, stk. 1 skal lægen sikre sig, at medhjælperen er kvalificeret til og har modtaget instruktion i at udføre opgaven.

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<sup>14</sup> Lovbekendtgørelse 2011-08-04 nr. 877 om autorisation af sundhedspersoner og om sundhedsfaglig virksomhed (herefter "Autorisationsloven"). Lovbekendtgørelse 2010-07-13 nr. 913 (herefter "Sundhedsloven"). Bekendtgørelse 2009-11-12 nr. 1219 om autoriserede sundhedspersoners benyttelse af medhjælp (delegation af forbeholdt sundhedsfaglig virksomhed) (herefter "Delegationsbekendtgørelsen"). Bekendtgørelse 1998-09-14, nr. 665 om information og samtykke og om videregivelse af helbredsoplysninger mv. (herefter "Samtykkebekendtgørelsen"). Vejledning af 23-05-2005 nr. 9267 om omskæring af drenge (herefter "Omskærelsesvejledningen"). Vejledning af 16-09-1998 nr. 161 om information og samtykke og om videregivelse af helbredsoplysninger mv. (herefter "Samtykkevejledningen")

Endvidere skal lægen i fornødent omfang føre tilsyn med medhjælperens udførelse af virksomheden.

Som anført ovenfor, er der altid en læge til stede til en jødisk omskærelse.

Lægen sikrer sig, at personen, der omskærer drengen, er kvalificeret til og har modtaget instruktion i at udføre omskærelsen, hvilke kriterier Overrabbiner Bent Lexner opfylder.

Det er således fuldstændig i overensstemmelse med dansk ret, at det er Overrabbiner Bent Lexner, der udfører selve omskærelsen, da omskærelsen er et indgreb, der kan udføres af en medhjælper.

## (2) Informeret samtykke

Som udgangspunkt må der kun udføres indgreb, som personen har givet sit informerede samtykke til, jf. Sundhedslovens § 15.

Såfremt personen er under 15 år, skal forældrene give informeret samtykke til indgrebet, jf. Sundhedslovens § 17 modsætningsvist. Dette understøttes af Samtykkevejledningens pkt. 2.1.

I øvrigt skal de formelle betingelser i Samtykkebekendtgørelsen være opfyldt, hvilket blandt andet indebærer, at samtykket skal gives frivilligt på baggrund af fyldestgørende information.

Jødiske forældre giver frivilligt samtykke til omskærelsen af deres søn efter forinden indgrebet at være informeret om indgrebets karakter, risici og konsekvenser.

Den jødiske omskærelse opfylder således de almindelige danske lovkrav til informeret samtykke, da det er forældrene, der kan give samtykket.

## 5.2 Forholdet til børnekonventionen

I forbindelse med debatten om omskærelse er det bl.a. anført, at FN's Børnekonvention fra 1989 indebærer et forbud mod omskærelse af drenge.

Dette er *ikke* korrekt.

Børnekonventionens artikel 24, stk. 3, fastslår, at deltagerstaterne skal *tage alle effektive og passende foranstaltninger for at afskaffe traditionsbundne ritualer, som er skadelige for børns sundhed*.

Børnekonventionen er tiltrådt af en række stater, som anerkender omskærelse af drenge, og der er en klar opfattelse i det internationale samfund og i det juridiske miljø i Danmark, at børnekonventionen tilsigter at beskytte *female genital mutilation* (kvindelig omskærelse) og ikke angår omskærelse af drenge.<sup>15</sup>

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<sup>15</sup> Se Jurisdiktionsudvalgets udtalelse i forbindelse med indførelse af forbud mod kvindelig omskærelse samt Kirsten Ketscher i Nye retlige design, s. 14ff. 2003.

Dette stemmer da også overens med, at ikke et eneste land i verden har et forbud mod omskærelse af drenge.

### 5.3 Barnets selvbestemmelsesret – forældres beslutninger på barnets vegne

Omskærelse af et drengebarn på otte dage besluttet udelukkende af forældrene, som oftest alene af kulturelle og religiøse årsager. Det er klart, at barnet ikke selv har indflydelse på beslutningen og omskærelse er dermed et ufrivilligt indgreb på barnets krop. Omskæringen er et varigt, fysisk indgreb, som barnet ikke senere kan gøre om.

Som det er påvist, er accepten af omskæring af drengebørn i overensstemmelse med dansk og international ret. Dette afsnit skal således drøfte, hvorvidt hensynet til barnets selvbestemmelsesret bør tillægges en særlig vægt.

Udgangspunktet er, at mennesket er født frit med ret til selvbestemmelse over eget liv og egen krop. Det er derfor som udgangspunkt det voksne menneske selv, der bestemmer over egen livsførelse og egen krop i det omfang, det ikke skader andres ret til eget liv og krop.

Det er dog alment accepteret, at forældre, mens barnet ikke er beslutningsmodent, kan træffe beslutninger på barnets vegne.

Forældre træffer således i dag en række (faktiske) beslutninger på det ufødte og fødte barns vegne. Det drejer sig bl.a. om:

- Abort – herunder abort i forbindelse med fosterdiagnostik.
- Kosmetiske operationer i relation til børn, født med mere eller mindre alvorlige deformiteter. Disse kosmetiske operationer spænder fra deciderede deformiteter i ansigtet og på kroppen over hareskår og tandoperationer til mindre alvorlige tilfælde, såsom tilretning af 'stritøre'.
- Rettelse af "skæve" næser mv.
- Piercing og huller i ørerne.

Det skal præciseres, at "deformiteter" ikke behøver at være begrundede i sundhedsstandarder. Personer med deformiteter kan have duelige og almindelige kropsfunktioner. Indgrebene er baseret på at give personen en mulighed for en almindeligt, social livsførelse. Indgrebene er derfor kulturelt og socialt bestemt.

Særligt om stritøreoperationer udtaler sundhedsminister Astrid Kragh, at det kan have alvorlige psykiske og sociale konsekvenser, såfremt man har stritører.<sup>16</sup>

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<sup>16</sup> Astrid Kraghs besvarelse af den 30. maj 2012 af Sophie Løhdes spørgsmål (S 3256)

Stritøreoperationer udføres både på børn og voksne, og der er ikke begrænsninger for, hvornår en sådan operation kan udføres og ej heller, om barnet selv indvilliger i det.<sup>17</sup>

Indgrebet foretages af kosmetiske årsager, da et manglende indgreb kan medføre psykiske og sociale konsekvenser. Det må dog konstateres, at stritører i sig selv ikke er medvirkende til den eventuelle psykiske lidelse. Den psykiske lidelse må formodes at være grundet i de sociale og kulturelle omstændigheder, da personen udvikler psykiske lidelser på baggrund af den behandling, personen modtager, når denne har stritører. Det kan således konstateres, at indgreb på mindreårige kan begrundes i sociale og kulturelle omstændigheder.

Forældrene træffer tillige i dag en række (indirekte) beslutninger på barnets vegne. Det drejer sig bl.a. om:

- Moderens alkoholindtagelse under graviditet, som beviseligt medfører en betydelig risiko for fosterskader.
- Forældres rygning i barnets hjem, som beviseligt medfører en betydelig risiko for skader som følge af passiv rygning.
- Deltagelse i – eller netop ikke deltagelse i – generelle vaccinationsprogrammer for børn.

Herudover træffer forældre naturligvis en række beslutninger på sine børns vegne, som utvivlsomt får afgørende betydning for barnets senere opvækst og liv.

Det er evident, at der generelt set ikke er et ønske om at lovgive om disse forhold. Selvom det er utvivlsomt, at f.eks. en overdreven alkoholindtagelse under en graviditet har direkte betydning for uafvendelige fosterskader, er der intet ønske om at kriminalisere den gravides indtagelse af alkohol over en vis mængde, samt kriminalisere købmandens eller supermarkedets salg af alkoholiske drikke til gravide.

Som anført ovenfor, er den jødiske omskærelse en hovedhjørnestein i barnets tilknytning til den jødiske kultur, sin familie og religionen.

Man kan spørge (som det er blevet gjort i den offentlige debat), hvorvidt tilknytningen til den jødiske kultur, familien og religionen sidder mellem benene?

Ligesom et omskåret jødisk barn senere kan fravælge kulturen, religionen og familien, vil et ikke-omskåret jødisk barn i lige så høj grad vælge eller fravælge kulturen, religionen og familien. Selvom det således ikke er en nødvendig betingelse for den jødiske tilknytning (eller det modsatte), at barnet er omskåret, har det alligevel en afgørende betydning for den kulturelle identitet og selvforståelse. Dette skal forstås på samme måde, som når et barn får

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<sup>17</sup> Se blandt andet: Privathospitalet Mølholm A/S – Patientinformation om operation for udestående ører/stritører og <http://www.ouh.dk/wm186925> (Odense Universitetshospitals beskrivelse af stritøreroperationer).

stritøreoperationer. Det er ikke nødvendigt for barnet at få stritøreoperationer for at føle tilknytning til det omkringliggende samfund, men det anses for at være af betydning for barnets muligheder dertil.

Forskellen i omskærelse og for eksempel stritøreoperationer ligger i det omkringliggende samfunds holdning til det nødvendige i indgrebet. Stritøreoperationer foretages på baggrund af sociale og kosmetiske årsager, som er mere accepteret end begrundelserne for omskærelse, der ligger i det særegne kulturelle og religiøse. Dette ændrer dog ikke ved, at stritøreoperationer i sidste ende er baseret på kulturelle årsager – men blot andre kulturelle årsager end omskærelsen.

Omskæringen er af stor betydning for barnets tilknytning til den jødiske kultur, sin familie og religionen og har derfor sin berettigelse på samme vilkår, som almindelige kosmetiske indgreb, der også er baseret i barnets tilknytning til kultur og det omkringliggende samfund – og i øvrigt på linje med accepten af, at et barns forældre træffer en række direkte og indirekte valg på barnets vegne, som har direkte indflydelse på barnets opvækst og liv.

Et forbud, begrundet i barnets selvbestemmelsesret, vil således være et markant brud på denne linje – navnlig når der ikke foreligger medicinske tvingende grunde (som tilfældet var ved kvindelige omskærelser).

#### **5.4 Religionsfrihed – og proportionalitet**

Grundlovens § 67 sikrer retten til at dyrke sin religion og Den Europæiske Menneskerettigheds artikel 9, der er sålydende:

##### **Art. 9**

*Stk.1. Enhver har ret til at tænke frit og til samvittigheds- og religionsfrihed; denne ret omfatter frihed til at skifte religion eller tro samt frihed til enten alene eller sammen med andre, offentligt eller privat at udøve sin religion eller tro gennem gudstjeneste, undervisning, andagt og overholdelse af religiøse skikke.*

*Stk.2. Frihed til at udøve sin religion eller tro skal kun kunne underkastes sådanne begrænsninger, som er foreskrevet ved lov og er nødvendige i et demokratisk samfund af hensyn til den offentlige tryghed, for at beskytte den offentlige orden, sundheden eller sædeligheden eller for at beskytte andres rettigheder og friheder.*

Det er fast antaget, at et indgreb i religionsfriheden kræver (1) lovhjemmel, (2) et legitimt formål og nødvendighed i et demokratisk samfund.

Allerede som følge af, at omskærelse af drenge ikke er forbudt i et eneste land, der har tiltrådt Den Europæiske Menneskerettighedskonvention, er der meget der taler for, at et omskærelsesforbud *ikke* er et legitimt formål og en nødvendighed i et demokratisk samfund.



Den foreliggende medicinske forskning, se bemærkningerne ovenfor, er på ingen måde entydig, hvilket selv anføres af den forskning, der er kritisk overfor omskærelse af drenge (i modsætning til, hvad der var tilfældet for omskærelse af piger).

Ved vurderingen af om der foreligger et *legitimt formål og en nødvendighed i et demokratisk samfund*, må man tillige tage i betragtning, hvilke andre (mere eller mindre) lige artede forhold, der reguleres af lovgivningen, henholdsvis ikke reguleres af lovgivningen – den såkaldte "proportionalitetsvurdering".

Som anført foroven under pkt. 5.3, accepteres det i det danske samfund, at forældre har betydelig valgfrihed og dermed beslutningsfrihed i relation til deres børn. Et forbud mod omskærelse af drenge, også i relation til denne beslutningsfrihed, siges at være ikke-proportional.

Der er således sammenfattende en betydelig risiko for, at et forbud mod omskærelse af drengebørn vil stride mod religionsfrihedsretten i den danske grundlov, set i sammenhæng med Den Europæiske Menneskerettighedskonvention, da et forbud ikke kan begrundes med et legitimt formål og en nødvendighed i et demokratisk samfund og vil være ikke-proportionalt i forhold til, hvilke beslutninger forældre ellers frit kan træffe på sit barns vegne.

*Det Mosaiske Troessamfund, Det Jødiske Samfund i Danmark  
København, august 2012*

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## Male Circumcision

### TASK FORCE ON CIRCUMCISION

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TECHNICAL REPORT

# Male Circumcision

## abstract

FREE

Male circumcision consists of the surgical removal of some, or all, of the foreskin (or prepuce) from the penis. It is one of the most common procedures in the world. In the United States, the procedure is commonly performed during the newborn period. In 2007, the American Academy of Pediatrics (AAP) convened a multidisciplinary workgroup of AAP members and other stakeholders to evaluate the evidence regarding male circumcision and update the AAP's 1999 recommendations in this area. The Task Force included AAP representatives from specialty areas as well as members of the AAP Board of Directors and liaisons representing the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the Centers for Disease Control and Prevention. The Task Force members identified selected topics relevant to male circumcision and conducted a critical review of peer-reviewed literature by using the American Heart Association's template for evidence evaluation.

Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks; furthermore, the benefits of newborn male circumcision justify access to this procedure for families who choose it. Specific benefits from male circumcision were identified for the prevention of urinary tract infections, acquisition of HIV, transmission of some sexually transmitted infections, and penile cancer. Male circumcision does not appear to adversely affect penile sexual function/sensitivity or sexual satisfaction. It is imperative that those providing circumcision are adequately trained and that both sterile techniques and effective pain management are used. Significant acute complications are rare. In general, untrained providers who perform circumcisions have more complications than well-trained providers who perform the procedure, regardless of whether the former are physicians, nurses, or traditional religious providers.

Parents are entitled to factually correct, nonbiased information about circumcision and should receive this information from clinicians before conception or early in pregnancy, which is when parents typically make circumcision decisions. Parents should determine what is in the best interest of their child. Physicians who counsel families about this decision should provide assistance by explaining the potential benefits and risks and ensuring that parents understand that circumcision is an elective procedure. The Task Force strongly recommends the creation, revision, and enhancement of educational materials to assist parents of male infants with the care of circumcised and uncircumcised penises. The Task Force also strongly recommends the development of educational materials for providers to enhance practitioners' competency in discussing circumcision's benefits and risks with parents.

The Task Force made the following recommendations:

### TASK FORCE ON CIRCUMCISION

#### KEY WORD

circumcision

#### ABBREVIATIONS

AAFP—American Academy of Family Physicians  
 AAP—American Academy of Pediatrics  
 ACOG—American College of Obstetricians and Gynecologists  
 BV—bacterial vaginosis  
 CB—caudal block  
 CDC—Centers for Disease Control and Prevention  
 CDM—Charge Data Master  
 CI—confidence interval  
 DPNB—dorsal penile nerve block  
 HPV—human papillomavirus  
 HSV—herpes simplex virus  
 IELT—Intravaginal Ejaculatory Latency Times  
 MSM—men who have sex with men  
 NHDS—National Hospital Discharge Survey  
 NIS—National Inpatient Sample  
 OR—odds ratio  
 RCT—randomized controlled trial  
 STI—sexually transmitted infection  
 UTI—urinary tract infection

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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- Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
- Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
- Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks and by ensuring that they understand the elective nature of the procedure.
- Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.
- Parents of newborn boys should be instructed in the care of the penis, regardless of whether the newborn has been circumcised or not.
- Elective circumcision should be performed only if the infant's condition is stable and healthy.
- Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.
- Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
  - Nonpharmacologic techniques (eg, positioning, sucrose pacifiers) alone are insufficient to prevent procedural and post-procedural pain and are not recommended as the sole method of analgesia. They should be used only as analgesic adjuncts to improve infant comfort during circumcision.
  - If used, topical creams may cause a higher incidence of skin irritation in low birth weight infants, compared with infants of normal weight; penile nerve block techniques should therefore be chosen for this group of newborns.
- Key professional organizations (AAP, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Society of Anesthesiologists, the American College of Nurse Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:
  - Develop standards of trainee proficiency in the performance of anesthetic and procedure techniques, including suturing;
  - Teach the procedure and analgesic techniques during postgraduate training programs;
  - Develop educational materials for clinicians to enhance their own competency in discussing the benefits and risks of circumcision with parents;
  - Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.
- The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

The American College of Obstetricians and Gynecologists has endorsed this technical report. *Pediatrics* 2012;130:e756–e785

## INTRODUCTION AND BACKGROUND

### Statement of the Issue

The American Academy of Pediatrics' (AAP) statement on circumcision of the newborn penis was last issued in May 1999.<sup>1</sup> The *Circumcision Policy Statement* recognized the health benefits of circumcision but did not deem the procedure to be a medical necessity for the well-being of the child. Since that time, substantial contributions have been made to the peer-reviewed literature concerning circumcision of males and its possible benefits. For this reason, in 2007, the AAP formed a Task Force charged with reviewing current evidence on male circumcision and updating the policy on this procedure to provide guidance to AAP membership regarding the circumcision of newborn males.

The American College of Obstetricians and Gynecologists has endorsed this technical report.

### Background

Male circumcision consists of the surgical removal of some, or all, of the foreskin (or prepuce) from the penis. It is one of the most common procedures in the world. In the United States, the procedure is most frequently performed during the newborn period. Elective circumcision performed soon after the newborn period is generally a result of deferral because of low birth weight or illness in the newborn. Circumcision after the newborn period is most commonly performed because of the infant's low birth weight or illness precluded newborn circumcision. Other infants are circumcised later in life because of the occurrence of tight phimosis and/or urinary tract infection (UTI).

The 3 most common operative methods of circumcision for the newborn male include: the Gomco clamp, the Plastibell device, and the Mogen clamp (or variations derived from the same

principle on which each of these devices is based). The elements that are common to the use of each of these devices to accomplish circumcision include the following: estimation of the amount of external skin to be removed; dilation of the preputial orifice so that the glans can be visualized to ensure that the glans itself is normal; bluntly freeing the inner preputial epithelium from the epithelium of the glans; placing the device (at times a dorsal slit is necessary to do so); leaving the device in situ long enough to produce hemostasis; and removal of the foreskin.

The extent of this practice in the United States has been estimated by various federally sponsored national surveys, each of which has its strengths and limitations; thus, multiple measures of circumcision prevalence and incidence are presented. There are large population measures of male circumcision in the United States, measuring either the occurrence (ie, incidence) of male circumcision among newborns or the existence of the circumcised state among representative samples of males in the United States at a particular period in time (ie, prevalence). The findings of these studies are qualitatively similar and consistently estimate the rate of male circumcision to range from 42% to 80% among various populations.<sup>2-6</sup>

A recent Centers for Disease Control and Prevention (CDC) study assessed trends in the incidence of in-hospital newborn male circumcision from 1999 to 2010 using 3 independent sources of discharge data on in-patient hospitalizations: the National Center for Health Statistics' National Hospital Discharge Survey (NHDS), the Agency for Healthcare Research and Quality's National Inpatient Sample (NIS), and the SDI Health's Charge Data Master (CDM).<sup>2,3</sup> These sources were used to estimate the incidence of newborn male circumcision

in the first month of life. Overall from 1999 to 2010, the CDC's weighted analysis found that the approximate percentage of newborn US males who were circumcised was approximately 59.1% according to the NHDS, 57.8% according to the NIS, and 55.8% according to the CDM. The incidence of newborn male circumcision decreased over time in all 3 data sources: from 62.5% in 1999 to 56.9% in 2008 according to the NHDS; from 63.5% in 1999 to 56.3% in 2008 according to the NIS; and from 58.4% in 2001 to 54.7% in 2010 according to the CDM (Fig 1). A key limitation is that these incidence rates were derived from hospital-based surveys and do not include out-of-hospital circumcisions; thus, these data sources underestimate the actual rate of newborn male circumcision in the first month of life.

#### NIS

The NIS is a database of 5 to 8 million hospital inpatient stays drawn from states that participate in the Healthcare Cost and Utilization Project (HCUP). In 2008, these states comprised 95% of the US population. The NIS is used to track and analyze national trends in health care utilization, delivery, and outcomes via a 20% stratified sample of 1000 community hospitals. Weights are provided to calculate national estimates.<sup>4</sup>

The NIS indicates that circumcision was performed in 57% of male newborn hospitalizations between 1998 and 2005. NIS data from 1988 to 2008 indicate that the rate of circumcision performed during newborn male delivery hospitalizations increased significantly from 48% in 1988-1991, to 61% in 1997-2000,<sup>5</sup> then declined from 61% to 56% in 2000-2008<sup>6</sup> (Fig 1). Circumcision rates were highest in the Midwestern states (74%), followed by the Northeastern (67%) and Southern states (61%). The lowest circumcision

rates were found in the Western states (30%) (Table 1).<sup>3</sup>

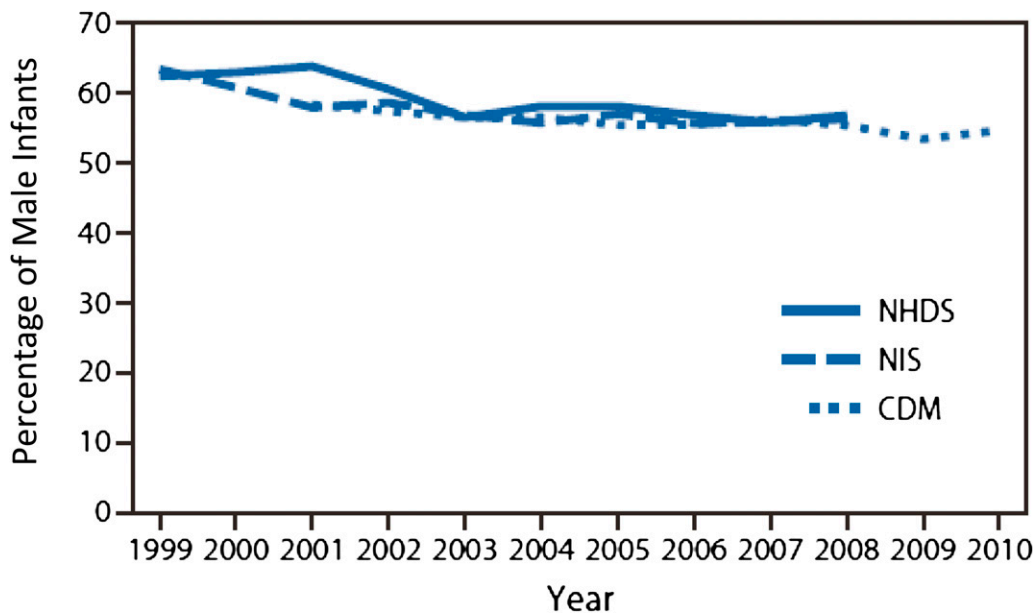
#### NHANES

The NHANES provides a snapshot of the health and nutritional status of the US population aged 14 to 59 years at the time of the survey, by using a probability sample of persons aged 0 to over 60 years. Prevalence of male circumcision is derived from participant self-report and is thus subject to misclassification. From 1999 to 2004, NHANES found that, of the 6174 men surveyed, 79% of men reported being circumcised, including 88% of non-Hispanic white men, 73% of non-Hispanic black men, 42% of Mexican-American men, and 50% of men of other races/ethnicities<sup>6</sup> (Fig 2).

However, prevalence rates are limited by the accuracy of the examiner and/or the self-report.<sup>7,8</sup> These findings underscore the necessity of using a standardized clinical examination for establishing circumcision status for the purpose of research on circumcision. It also highlights the potential difficulty of advising on care of the circumcised and uncircumcised penis when an individual and/or clinician may not know which condition is present.

#### Ethical Issues

The practice of medicine has long respected an adult's right to self-determination in health care decision-making. This principle has been operationalized through the doctrine of informed consent. The process of informed consent obligates the clinician to explain any procedure or treatment and to enumerate the risks, benefits, and alternatives so the patient can make an informed choice. As a general rule, minors in the United States are not considered competent to provide legally binding consent regarding their health care, and parents

**FIGURE 1**

Incidence of in-hospital newborn male circumcision, according to data source; United States, 1999–2010.<sup>2,3</sup>

or guardians are empowered to make health care decisions on their behalf.<sup>9</sup> In most situations, parents are granted wide latitude in terms of the decisions they make on behalf of their children, and the law has respected those decisions except where they are clearly contrary to the best interests of the child or place the child's health, well-being, or life at significant risk of serious harm.<sup>10</sup>

Parents and physicians each have an ethical duty to the child to attempt to secure the child's best interest and

well-being.<sup>11</sup> Reasonable people may disagree, however, as to what is in the best interest of any individual patient or how the potential medical benefits and potential medical harms of circumcision should be weighed against each other. This situation is further complicated by the fact that there are social, cultural, religious, and familial benefits and harms to be considered as well.<sup>12</sup> It is reasonable to take these nonmedical benefits and harms for an individual into consideration when making a decision about circumcision.<sup>13</sup>

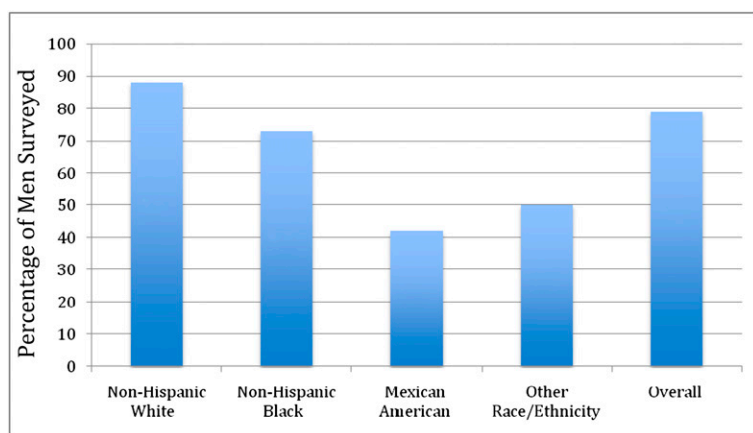
In cases such as the decision to perform a circumcision in the newborn period (where there is reasonable disagreement about the balance between medical benefits and harms, where there are nonmedical benefits and harms that can result from a decision on whether to perform the procedure, and where the procedure is not essential to the child's immediate well-being), the parents should determine what is in the best interest of the child. In the pluralistic society of the United States, where parents are afforded wide authority for determining what constitutes appropriate child-rearing and child welfare, it is legitimate for the parents to take into account their own cultural, religious, and ethnic traditions, in addition to medical factors, when making this choice.<sup>11</sup>

Physicians who counsel families about this decision should assist parents by objectively explaining the potential benefits and risks of circumcising their infant.<sup>10</sup> Because some families may opt to circumcise as part of religious or traditional practice, discussion should also encompass risks and benefits of

**TABLE 1** Multivariate Cox Proportional Hazards Regression of Selected Factors Associated With Circumcision Among Male Newborn Delivery Hospitalizations, United States, 1998–2005<sup>2</sup>

Characteristic	Weighted % of Male Infant Circumcisions	Adjusted Prevalence Rate Ratios (95% CI)
Hospital region		
Midwest	74	3.53 (3.23–3.87)
Northeast	67	2.90 (2.64–3.18)
South	61	2.80 (2.56–3.07)
West	30	1.00
Payer		
Private	67	1.76 (1.70–1.82)
Public	45	1.00
Hospital location		
Urban	66	1.29 (1.24–1.34)
Rural	56	1.00
Newborn health status		
Term, healthy	61	1.22 (1.20–1.23)
Not term, healthy	54	1.00





**FIGURE 2**  
Prevalence of male circumcision, according to self-report; United States, 1999–2004.<sup>5</sup>

having a medical professional perform this procedure in a clinical setting versus having it performed by a traditional/religious provider in a nonmedical environment.

Parents may wish to consider whether the benefits of the procedure can be attained in equal measure if the procedure is delayed until the child is of sufficient age to provide his own informed consent. These interests include the medical benefits; the cultural and religious implications of being circumcised; and the fact that the procedure has the least surgical risk and the greatest accumulated health benefits if performed during the newborn period. Newborn males who are not circumcised at birth are much less likely to elect circumcision in adolescence or early adulthood. Parents who are considering deferring circumcision should be explicitly informed that circumcision performed later in life has increased risks and costs. Furthermore, deferral of the procedure also requires longer healing time than if performed during the newborn period and requires sexual abstinence during healing. Those who are already sexually active by the time they have the procedure lose some opportunities for the protective benefit against sexually transmitted infection (STI) acquisition,

including HIV; moreover, there is the risk of acquiring an STI if the individual is sexually active during the healing process. (See the section entitled Sexually Transmitted Diseases, Including HIV.)

Finally, there is a moral obligation to take reasonable steps to reduce the risk of harm associated with the performance of any surgical intervention. These include ensuring that the providers who perform circumcision have adequate training and demonstrate competence in performing the procedure; the provision of adequate procedural analgesia and postprocedural pain control; and that the risks of infection are minimized through appropriate infection control measures, such as a sterile environment and sterilized instruments.<sup>14</sup> The Task Force advises against the practice of mouth-to-penis contact during circumcision, which is part of some religious practices, because it poses serious infectious risk to the child.

## TASK FORCE ON MALE CIRCUMCISION

### Committee Membership and Research Questions

In December 2007, the AAP formed a multidisciplinary workgroup of AAP

members and other stakeholders to evaluate the evidence on male circumcision and update the AAP's recommendations in this area. The Task Force included AAP representatives from specialty areas, including anesthesiology/pain management, bioethics, child health care financing, epidemiology, fetus and newborn medicine, infectious diseases (including pediatric AIDS), and urology. The Task Force also included members of the AAP Board of Directors and liaisons representing the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the CDC. The Task Force's evidence review was supplemented by an independent, AAP-contracted, physician and doctoral-level epidemiologist who was also part of the entire evidence review process.

### Literature Search Overview

The Task Force members identified the following topics and questions as relevant to male circumcision and to be addressed through a critical review of the peer-reviewed literature:

- What is the current epidemiology of male circumcision in the United States?
- What are the most common procedures and techniques for newborn male circumcision?
- What best supports the parental decision-making process regarding circumcision?
- What is the association between male circumcision and both morbidity and sexual function/satisfaction?
- What is the impact of anesthesia and analgesia?
- What are the common complications and the complication rates associated with male circumcision?
- What workforce issues affect newborn male circumcision?

- What are the trends in financing and payment for elective circumcision?

The group agreed on parameters for reviewing the literature on associations between male circumcision and other outcomes. The literature review comprised analytic studies (including meta-analyses) in the topic areas in English-language, peer-reviewed, scientific literature. The Task Force evaluated studies that addressed the identified clinical questions, including all meta-analyses; all randomized controlled trials; and all case-control, prospective and retrospective cohort, and cross-sectional studies based on the American Heart Association's template for evidence evaluation (see the following section). Case reports, case series, ecological studies, reviews, and opinions were excluded from the review. Although case reports and case series are important for generating hypotheses, the Task Force limited itself to reviewing analytic studies. The Task Force compiled and vetted Medical Subject Headings, which are defined by the National Library of Medicine.

Searches were conducted in Medline, Cochrane Database, and Embase for the period 1995 through 2010. The literature search produced 1388 abstracts that were reviewed by both the epidemiologist and the Task Force chair, and those citations meeting the established criteria were included; ultimately, 1014 articles were included in the review (Table 2). A second search was conducted in April 2010, which yielded 42 additional citations, of which 17 were included. All 1031 accepted articles were reviewed by the contracted physician epidemiologist and at least 1 Task Force member; any differences were resolved by consensus. In 2011, individual Task Force members also identified other key articles that appeared in the peer-reviewed literature; these articles were consulted in

the preparation of the current report and cited accordingly. These additional articles did not affect the findings of the Task Force. Areas in which there were no analytic studies available for the time period of interest are noted as such within this document.

### Evidence Quality and Use in Forming Recommendations

Articles were reviewed by using the American Heart Association's template for evidence evaluation.<sup>15</sup> The articles were also assigned a level of evidence (Table 3) based on the methodology used. Among those with evidence levels 1 through 4, the reviewers assessed the quality of the evidence as "excellent," "good," "fair," or "poor" depending on how well the methodology was applied. Articles with an evidence level of 5 or higher were not included in this review. A critical assessment was made of each article/source in terms of the research design and methods, by using the American Heart Association's template (Table 4).

## RESULTS

As a result of these findings, the Task Force made the following recommendations, which are described further in the following text:

- Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
- Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
- Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.
- Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.
- Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay, regardless of whether the newborn has been circumcised or not.
- Elective circumcision should be performed only if the infant's condition is stable and healthy.
- Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.
- Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
  - Nonpharmacologic techniques (eg, positioning, sucrose pacifiers) alone are insufficient to prevent procedural and post-procedural pain and are not recommended as the sole method of analgesia. They should be used only as analgesic adjuncts to improve infant comfort during circumcision.
  - If used, topical creams may cause a higher incidence of skin irritation in low birth weight infants, compared with infants of normal weight; penile nerve block techniques should therefore be chosen for this group of newborns.



**TABLE 2** Results from Medline, Cochrane Database, and Embase Search for 1995–2010

Clinical Topic Area <sup>a</sup>	No. of Articles Included
HIV/STI	231
Procedure and complications	219
UTI	53
Pain management	159
Penile dermatoses	107
Penile hygiene	76
Phimosis	64
Parental decision-making	60
Carcinoma (penile)	58
Carcinoma (cervical)	3
Sexual satisfaction	1

<sup>a</sup> Does not include nonclinical areas such as ethics and financing.

- Key professional organizations (AAP, AAFP, ACOG, the American Society of Anesthesiologists, the American College of Nurse-Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:
  - Develop standards of trainee proficiency in the performance of anesthetic and procedure techniques, including suturing;
  - Teach the procedure and analgesic techniques during postgraduate training programs;

**TABLE 3** Evidence Levels

Level	Definition
1	RCTs or meta-analyses of multiple clinical trials with substantial treatment effects
2	RCTs with smaller or less significant treatment effects
3	Prospective, controlled, nonrandomized, cohort studies
4	Historic, nonrandomized, cohort or case-control studies
5	Case series: patients compiled in serial fashion, lacking a control group (excluded from review)
6	Animal studies or mechanical model studies (excluded from review)
7	Extrapolations from existing data collected for other purposes, theoretical analyses (excluded from review)
8	Rational conjecture (common sense); common practices accepted before evidence-based guidelines (excluded from review)

- Develop educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents;
- Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.
- The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

### Parental Decision-Making

- Task Force Recommendations:
  - Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
  - Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.
  - Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.

The decision of whether to circumcise a male newborn is frequently made early in the pregnancy and even before conception.<sup>16–18</sup> In a cross-sectional study of parents of 55 male infants presenting to a family practice clinic for a well-child visit, 80% of parents

reported that the circumcision decision was made before a discussion occurred with the clinician about this issue. Only 4% of parents reportedly discussed circumcision with their clinician before the pregnancy.<sup>16</sup> This finding is substantiated by the 2009 AAP survey of 1620 members with a response rate of 57%, in which most respondents reported that parents of newborn male patients generally do not seek their pediatrician's recommendation regarding circumcision; only 5% reported that "all" or "most" parents "are uncertain about circumcision and seek their recommendation" about the procedure.<sup>19</sup> There is fair evidence that parental decisions about circumcision are shaped more by family and socio-cultural influences than by discussion with medical clinicians or by parental education.<sup>16,20</sup>

In 4 cross-sectional studies with fair evidence, US parents most often reported that they chose to have their newborn son circumcised for health/medical benefits, including hygiene and cleanliness of the penis (reported by 39.6%, 46%, 53%, and 67%, respectively).<sup>16,17,21,22</sup> Social concerns (such as having a father or brother who was circumcised) were also an important reason given for newborn male circumcision (22.8%, 23.5%, 28%, and 37%). Religious requirements for circumcision, such as those of the Jewish and Islamic faiths, were ranked less highly in importance (11%, 12.1%, 13%, and 19%). Although one of these studies was small and included only 55 patients drawn from a homogeneous population,<sup>16</sup> the findings coincide with the 3 larger and more diverse studies.

For parents to receive nonbiased information about male circumcision in time to inform their decisions, clinicians need to provide this information at least before conception and/or early in the pregnancy, probably as a

**TABLE 4** Assessment of Research Design and Methods

Component of Study and Rating	Excellent	Good	Fair	Poor	Unsatisfactory
Design and Methods	Highly appropriate sample or model, randomized, proper controls AND outstanding accuracy, precision, and data collection in its class	Highly appropriate sample or model, randomized, proper controls OR outstanding accuracy, precision, and data collection in its class	Adequate design but possibly biased OR adequate under the circumstances	Small or clearly biased population or model OR weakly defensible in its class, limited data or measures	Anecdotal, no controls, off target end points OR not defensible in its class, insufficient data or measures

curriculum item in childbirth classes. Information to assist in parental decision-making should be made available as early as possible. For this reason, obstetrician-gynecologists and family physicians who manage prenatal care probably have a more pivotal role in this decision than do pediatricians. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, supports prenatal pediatric visits, at which time pediatricians can provide counseling about male circumcision (<http://brightfutures.aap.org>). Medical benefits and risks need to be presented accurately and in a nonbiased fashion so families can make a decision in light of their own cultural, religious, and personal preferences.

There is fair evidence that there are financial barriers to the circumcision decision in the United States; when the procedure is not covered by insurance, parents are less likely to choose to have their child circumcised.<sup>21</sup> This finding does not seem to be true in Canada, where the prevalence of circumcision did not change after circumcision for ritual, religious, cultural, or cosmetic reasons was delisted from insurance benefits in 1994.<sup>17,23</sup>

### Care of the Circumcised Versus Uncircumcised Penis

- Task Force Recommendations:
  - Parents of newborn boys should be instructed in the

care of the penis at the time of discharge from the newborn hospital stay, regardless of whether the newborn has been circumcised or not.

This review found no systematic studies in infants and children on the care of the uncircumcised versus circumcised penis.

Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay, regardless of whether they choose circumcision or not. The circumcised penis should be washed gently without any aggressive pulling back of the skin.<sup>24</sup> The non-circumcised penis should be washed with soap and water. Most adhesions present at birth spontaneously resolve by age 2 to 4 months, and the foreskin should not be forcibly retracted. When these adhesions disappear physiologically (which occurs at an individual pace), the foreskin can be easily retracted, and the whole penis washed with soap and water.<sup>25</sup>

Circumcision reduces the bacteria that accumulate under the prepuce which can cause UTIs and, in the adult male, can be a reservoir for bacteria that cause STIs. In an internally controlled study with fair evidence, researchers cultured the periurethral and glandular sulcus of 50 children aged 1 to 12 weeks before and 4 weeks after circumcision and found the pathogenic bacteria

largely disappeared after circumcision (33 children had pathogenic bacteria before circumcision and 4 had pathogenic bacteria after circumcision).<sup>26</sup>

In adults and children, there is fair evidence that periurethral flora contains fewer pathogens after circumcision than before circumcision.<sup>26,27</sup> Because these studies looked at cultures 1 time (4 weeks after the circumcision), the long-term significance of the findings is unclear.

Penile wetness (defined as the observation of a diffuse homogeneous film of moisture on the surface of the glans and coronal sulcus) is considered a marker for poor penile hygiene and is more prevalent in uncircumcised than in circumcised men.<sup>28</sup> Penile wetness has been associated with HIV infection in 1 cross-sectional study, although the temporal relationship is unclear and the evidence level is fair.<sup>29</sup> A related study with fair evidence assessed the frequency of washing the whole penis (including retracting the foreskin for uncircumcised men) and found that not always washing the whole penis was approximately 10 times more common in uncircumcised than in circumcised men.<sup>30</sup> The relationship between penile wetness and thorough washing of the penis is unclear and, because the studies were conducted in STI clinics, the findings may not be generalizable to the population at large.

## Male Circumcision and Diseases, Morbidities, and Sexual Function/Satisfaction

### STIs, Including HIV

- Task Force Recommendation:
  - Evaluation of the current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.

The most notable research contributions to the literature since 1995 are studies of male circumcision and the acquisition of HIV and the transmission of other STIs. Review of the literature revealed a consistently reported protective effect of 40% to 60% for male circumcision in reducing the risk of HIV acquisition among heterosexual males in areas with high HIV prevalence due to heterosexual transmission (ie, Africa).

There is also good evidence from randomized controlled trials that male circumcision is associated with a lower prevalence of human papillomavirus (HPV) infection<sup>31,32</sup> and herpes simplex virus type 2 (HSV-2) transmission,<sup>31,33</sup> as well as a decreased likelihood of bacterial vaginosis (BV) in female partners.<sup>80</sup> The evidence for male circumcision being protective against syphilis is less strong,<sup>65–68</sup> however, and male circumcision was not found to be associated with decreased risk of gonorrhea<sup>84,85,91–93</sup> or chlamydia.<sup>84–89</sup>

It is biologically plausible that the circumcised state may confer protection against STIs (including HIV). Possible mechanisms for the protective effect of circumcision include the fact that the foreskin's thin inner surface is susceptible to microtears and abrasions (especially during sexual activity), which provides a port of

entry for pathogens. The foreskin also contains a high density of HIV target cells (ie, Langerhans cells, CD4 T cells, macrophages), which facilitates HIV infection of host cells. The preputial space provides an environment that is thought to “trap” pathogens and bodily secretions and favor their survival and replication.<sup>26,27,34</sup> The circumcised male has no foreskin and may likely provide a less welcoming environment for such substances. In addition, STI-containing secretions have increased contact time in the prospective uncircumcised male host, which may increase the likelihood of transmission and infection. The exposed surfaces of the uncircumcised penis do not offer the same physical barrier to resist infection that the highly keratinized surface of a circumcised penis does. Finally, the higher rates of sexually transmitted genital ulcerative disease (eg, HSV-2) observed in uncircumcised men may also increase susceptibility to HIV infection, as the presence of genital ulcers, irrespective of circumcision status, increases the likelihood of HIV acquisition.<sup>35–37</sup>

### HIV

The CDC estimates that 1.2 million people in the United States are living with HIV, the virus that causes AIDS, which is incurable. Approximately 50 000 Americans are newly infected with HIV each year; more than 619 000 people in the United States have died of AIDS since the epidemic began.<sup>38</sup> In the United States, HIV/AIDS predominantly affects men who have sex with men (MSM), who account for almost two-thirds (61%) of all new infections. Heterosexual exposure accounts for 27% of new HIV infections, and injection drug use accounts for 9% of new HIV cases. In other parts of the world (eg, Africa), heterosexual transmission is far more common.<sup>39</sup>

Fourteen studies provide fair evidence that circumcision is protective against

heterosexually acquired HIV infection in men.<sup>40–53</sup> One study with fair evidence found that male circumcision before puberty (specifically before 12 years of age) is more protective than circumcision occurring at a later age.<sup>50</sup> Three large randomized controlled trials provide good evidence of such protection.<sup>54–56</sup> A cross-sectional study with fair evidence is neutral regarding the relationship between circumcision and HIV infection.<sup>57</sup> Two other studies with a cross-sectional design provide fair evidence that circumcision increases the risk of HIV infection, although one of these studies highlights the HIV risks associated with circumcision performed outside the hospital setting and without sterile equipment and medically trained personnel.<sup>58,59</sup>

A recently published study from the CDC provides good evidence that, in the United States, male circumcision before the age of sexual debut would reduce HIV acquisition among heterosexual males.<sup>60</sup> Although individual sexual practices are difficult to predict in the newborn period, the majority of US males are heterosexual and could benefit from male circumcision. Mathematical modeling by the CDC shows that, taking an average efficacy of 60% from the African trials, and assuming the protective effect of circumcision applies only to heterosexually acquired HIV, there would be a 15.7% reduction in lifetime HIV risk for all males. This is taking into account the proportion of HIV that is acquired through heterosexual sex and reducing that by 60%. The percent reduction in HIV cases was determined by assessing the proportion of new cases of HIV infection that could be prevented by analyzing which infections would be presumed to occur in uncircumcised males and what the reduction would be if those who would not already be circumcised

would be circumcised. The proportions of transmissions prevented are lower than in Africa because a higher proportion of US HIV transmission occurs between MSM. In addition, a portion of the population would be circumcised without any policy change, and the prevented cases would only occur in the additional circumcised males. This ranges from an estimated 8% reduction in non-Hispanic white males to an estimated 21% reduction among non-Hispanic black males. The CDC study suggests that newborn circumcision performed in the United States to prevent HIV infection is cost-effective without consideration of other health benefits. The CDC recommendations state that all parents of newborn males should be given the choice of circumcision.

### *Specific HIV Risk Populations*

#### *MSM*

The association of circumcision and the decreased likelihood of HIV acquisition applies to heterosexual males. Circumcision seems to be less likely to protect MSM, however, and has not been associated with decreased acquisition of HIV among MSM.<sup>61</sup> There is fair evidence from 1 study that there is a protective effect of circumcision from HIV infection in MSM; however, this study used self-report to establish circumcision status.<sup>62</sup> One study with fair evidence is neutral regarding the relationship between circumcision and HIV infection in MSM.<sup>61</sup> It is probable that the differences found in the level of protection (or lack of protection) by studies of MSM are confounded by the fact that MSM commonly perform both receptive and insertive sex. It is not known to what extent circumcision may be protective against HIV transmission for MSM who practice insertive sex versus for those who engage in receptive sex.

#### *Heterosexual Women*

Women account for 23% of new HIV infections in the United States; HIV infection in women is primarily attributed either to heterosexual contact or injection drug use.<sup>38</sup> Two prospective cohort studies with fair evidence looked at the relationship between a woman's risk of HIV infection and whether her primary male partner is circumcised. The first study describes a protective effect but had considerable loss-to-follow-up and possible misclassification of the partners' circumcision status.<sup>63</sup> The other study showed nonsignificant protection in the high-risk group (ie, women who were more likely to have ever engaged in sex work; to have reported 2 or more partners in the last 3 months; and/or to have had a higher median lifetime number of sex partners) but neither protection nor increased risk in the study population as a whole.<sup>64</sup> A meta-analysis with good evidence of data from 1 randomized controlled trial (RCT) and 6 longitudinal analyses found little evidence that male circumcision directly reduces their female partner's risk of acquiring HIV (summary relative risk: 0.8 [95% confidence interval (CI): 0.53–1.36]); however, male circumcision's protective effect did not reach a level of statistical significance.<sup>65</sup> One Ugandan RCT study with good evidence found that, at 24 months, the risk of HIV infection among women whose male partners were circumcised was 21.7% compared with 13.4% for female partners of uncircumcised men.<sup>66</sup>

#### *Ulcerative STIs*

Genital ulcers are notable both because of the morbidity and mortality associated with the causative organism and because the presence of the ulcer itself facilitates the transmission of HIV.

#### *Syphilis*

From 2009 to 2010, there were 13 604 cases of early latent syphilis reported

to the CDC and 18 079 cases of late and late latent syphilis. The rate of primary and secondary syphilis in 2010 was 4.5 cases per 100 000 individuals, 2.2% lower than the 2009 rate. "The total number of cases of syphilis (primary and secondary, early latent, late, late latent, and congenital) reported to CDC increased 2.2% (from 44,830 to 45,834 cases) during 2009–2010."<sup>67</sup> A large percentage of syphilis cases occur in MSM; in 2010, 67% of the reported primary and secondary syphilis cases were among MSM.<sup>67</sup>

The balance of evidence suggests that male circumcision is protective against syphilis.<sup>68–70</sup> One meta-analysis with good evidence describes a protective effect (relative risk: 0.67 [95% CI: 0.54–0.83]), but there is considerable heterogeneity among the studies included.<sup>68</sup> An additional cohort study with fair evidence found that circumcised men were significantly less likely to have active syphilis at the point of study recruitment; when the men were followed up prospectively for 2 years, a protective effect was also observed but was nonsignificant.<sup>69</sup> Good evidence from a large RCT reported no reduction or trend toward reduction for male circumcision and the incidence of syphilis<sup>71</sup>; however, the extent to which protection might be afforded, and among which specific populations, is difficult to determine.

#### *Genital Herpes*

Genital herpes is an STI commonly manifested by recurrent genital ulcers caused by HSV-1 or HSV-2. HSV may not be clinically evident despite infection. Approximately 16.2% of US individuals aged 14 to 49 years have HSV-2.<sup>51,72</sup> Case reporting data for genital HSV are not available, but 2005–2008 NHANES data indicate that the percentage of NHANES participants aged 20 to 49 years who reported having



been diagnosed with genital herpes at some point was 18.9%.<sup>72</sup>

One meta-analysis with good evidence found some protective effect of circumcision against HSV-2 of borderline statistical significance.<sup>68</sup> Good evidence of the protective effect of male circumcision is available from two of the large randomized controlled trials in Africa. In the South African study, the incidence of HSV-2 was 34% lower in circumcised men.<sup>73</sup> In the Uganda study, the risk of HSV-2 infection (adjusted for other factors) was 28% lower in circumcised men.<sup>71</sup> There is fair evidence from 1 study that male circumcision protects female partners against HSV-2 infection.<sup>33</sup> Two studies with fair evidence found that there is no effect of circumcision on the risk of HSV-2 acquisition.<sup>6,74</sup>

### *Chancroid*

Chancroid is a bacterial disease spread through sexual contact. It is rare in the United States, with a total of 24 cases reported in 2010 (a rate of 0.08 case per 100 000 individuals).<sup>75</sup>

The literature search produced no individual studies since 1995 exploring the relationship between male circumcision and chancroid. One meta-analysis with good evidence found that 6 of 7 older studies (85%) described circumcision as having a protective effect against chancroid. This meta-analysis did not provide a summary value for the relationship due to differences in the definition and ascertainment of outcomes and variability among the comparison groups.<sup>68</sup> One methodologically poor meta-analysis found no effect of male circumcision on chancroid.<sup>76</sup>

### *Lymphogranuloma Venereum and Granuloma Inguinale (Donovanosis)*

The CDC reports that the frequency of lymphogranuloma venereum infection is thought to be rare in industrialized

countries, although its identification is not always obvious; the number of cases of this infection in the United States is unknown.<sup>77</sup> Granuloma inguinale is a genital ulcerative disease that is rare in the United States but endemic in some tropical and developing areas. The lesions might develop secondary bacterial infection or can coexist with other sexually transmitted pathogens.

The literature search produced no studies since 1995 exploring the relationship between male circumcision and lymphogranuloma venereum or granuloma inguinale. One meta-analysis provided fair evidence that genital ulcerative disease was more common in uncircumcised men but not to a statistically significant degree.<sup>78</sup> One cross-sectional study with fair evidence found that male circumcision was protective against genital ulcers, but the findings were based on respondents self-reporting a history of genital ulcerative disease and may not be accurate.<sup>79</sup>

### *Nonulcerative STIs*

Nonulcerative STIs generally cause inflammation and scarring along the reproductive tract. Untreated infection can cause cancer, can interfere with reproduction, and can negatively impact newborn health. Additionally, these infections can facilitate the transmission of HIV.

### *BV*

BV is a condition “in women where the normal balance of bacteria in the vagina is disrupted and replaced by an overgrowth of certain bacteria.”<sup>80</sup> BV is common among pregnant women; an estimated 1 080 000 pregnant women have BV annually.

There is good evidence from 1 large randomized controlled trial that male circumcision is protective against BV in female partners.<sup>81</sup> A small prospective

cohort study with good evidence also found that male circumcision, among other factors, was protective against BV in female partners.<sup>82</sup> A cross-sectional study with fair evidence found no effect but may have lacked the power to detect an effect.<sup>83</sup>

### *Chlamydia*

Chlamydia is the most commonly reported notifiable disease in the United States and the most common STI reported to the CDC, with 1 307 893 chlamydial infections (426.0 cases per 100 000 individuals) reported to the CDC in 2010.<sup>84</sup>

The balance of evidence does not reveal any relationship between circumcision and chlamydia infection.<sup>85–87</sup> The 1 prospective cohort study with fair evidence showed a protective effect, but the study had a composite endpoint with several STIs combined and used self-report of STI as the outcome (increasing the possibility of misclassification).<sup>88</sup> Two studies with fair evidence explored the effect of male circumcision on chlamydia infection in female partners. The first, a prospective cohort study, found a nonsignificant increased risk in the female partners of circumcised men.<sup>89</sup> The second, a cross-sectional study, found a significantly decreased risk of chlamydia infection among women with circumcised male sexual partners, but a possible selection bias may have affected results because only 51.8% of subjects had specimens for analysis.<sup>90</sup>

### *Gonorrhoea*

Gonorrhoea is the second most commonly reported STI in the United States, with 309 341 cases reported to the CDC (a rate of 100.8 cases per 100 000 individuals) in 2010.<sup>91</sup>

The evidence does not demonstrate any relationship between circumcision and gonorrhoeal infection.<sup>85,86,92–94</sup> The

studies that show a protective effect are either barely significant or have poorly defined or self-reported outcomes, thus offering only a fair level of evidence.<sup>79,88</sup>

### HPV

HPV is among the most commonly occurring STIs in the United States and can lead to the development of cancers, including cervical cancer. The population-based data from NHANES 2003–2006 indicate that the overall prevalence of high- and low-oncogenic risk HPV types was 42.5% among US women aged 14 to 59 years. The prevalence of infection was lower for the 2 viral types with the highest risk of causing cancer, however, at 4.7% for HPV type 16 and 1.9% for HPV type 18.<sup>95</sup> There is good evidence that male circumcision is protective against all types of HPV infection (nononcogenic and oncogenic). Two prevalence studies with good evidence found a 30% to 40% reduction in risk of infection among circumcised men.<sup>96,97</sup> These studies fail to provide information on the risk of acquiring HPV and may reflect persistence of HPV rather than acquisition of infection. Four studies provide fair evidence that male circumcision protects against HPV.<sup>98–101</sup> The selection of anatomic sites sampled may influence the results.<sup>98</sup>

Good evidence of the protective effect of male circumcision against HPV is available from two of the large randomized controlled trials in Africa. In the South African study, the prevalence of high-risk HPV was 32% lower in circumcised men.<sup>102</sup> In the Uganda study, the risk of oncogenic HPV infection (adjusted for other factors) was 35% lower in circumcised men.<sup>71</sup> There is also good evidence that male circumcision reduces the risk of male-to-female transmission of high-risk HPV from HIV-uninfected men. In the Uganda randomized controlled trial, the

prevalence of high-risk HPV infection was 28% lower in female partners of circumcised HIV-uninfected men, while the incidence was 23% lower.<sup>32</sup> Good evidence from another Uganda randomized controlled trial of male circumcision in HIV-infected men indicates that a circumcision did not reduce the risk of male-to-female transmission of high-risk HPV from HIV-infected men.<sup>103</sup>

### Male Circumcision and UTIs

According to the CDC, “A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney.”<sup>104</sup> UTIs are the most common type of health care–associated infection reported to the National Healthcare Safety Network among US individuals. The majority of UTIs in males occur during the first year of life. In children, UTIs usually necessitate a physician visit and may involve the possibility of an invasive procedure and hospitalization.

Most available data were published before 1995 and consistently show an association between the lack of circumcision and increased risk of UTI. Studies published since 1995 have similar findings. There is good evidence from 2 well-conducted meta-analyses<sup>105,106</sup> and a cohort study<sup>107</sup> that UTI incidence among boys under age 2 years is reduced in those who were circumcised compared with uncircumcised boys. The data from randomized controlled trials are limited. However, there are large cohort and case-controlled studies with similar findings. Given that the risk of UTI among this population is approximately 1%, the number needed to circumcise to prevent UTI is approximately 100. The benefits of male circumcision are, therefore, likely to be greater in boys at higher risk of UTI, such as male infants with underlying

anatomic defects such as reflux or recurrent UTIs.

There is fair evidence from 5 observational studies that UTI incidence among boys under age 2 years is reduced in circumcised infant boys, compared with uncircumcised boys under the age of 2.<sup>108–112</sup> The degree of reduction is between threefold and 10-fold in all studies.

There is fair evidence from a prospective study that there is a decreased prevalence of uropathogens in the periurethral area 3 weeks after circumcision, compared with similar cultures taken at the time of circumcision.<sup>113</sup> By using these rates and the increased risks suggested from the literature, it is estimated that 7 to 14 of 1000 uncircumcised male infants will develop a UTI during the first year of life, compared with 1 to 2 infants among 1000 circumcised male infants.

There is a biologically plausible explanation for the relationship between an intact foreskin and an increased association of UTI during infancy. Increased periurethral bacterial colonization may be a risk factor for UTI.<sup>114</sup> During the first 6 months of life, there are more uropathogenic organisms around the urethral meatus of uncircumcised male infants than around those of circumcised male infants (this colonization decreases in both groups after the first 6 months).<sup>115</sup> In addition, an experimental preparation found that uropathogenic bacteria adhered to, and readily colonized, the mucosal surface of the foreskin but did not adhere to the keratinized skin surface of the foreskin.<sup>116</sup>

### Cancer

#### Penile Cancer

Penile cancer is rare, and rates seem to be declining. In the United States, Surveillance, Epidemiology, and End

Results data indicate that the incidence of primary, malignant penile cancer was 0.58 case per 100 000 individuals for 1993 to 2002, a decline from 0.84 case per 100 000 individuals from 1973 to 1982.<sup>117</sup> An analysis of the Danish Cancer Registry found that the incidence of epidermoid cancer of the penis (excluding scrotal, epididymal, and nonepidermoid) declined from a rate of 1.15 cases per 100 000 individuals from 1943 to 1947 to 0.82 case per 100 000 individuals in 1988 to 1990.<sup>118</sup>

Thus, declines have been noted in nations with both low and high circumcision rates (Denmark and the United States, respectively). Declines are not explained by changing patterns in circumcision utilization; it is thought that socioeconomic and economic development factors (including effects on hygiene habits) may have an important role.

The literature review yielded 2 case-control studies; although the studies were well designed, the evidence level for case-control studies is only deemed to be fair.<sup>119,120</sup> These studies show an association between circumcision and a decreased likelihood of invasive penile cancer. For all men with penile cancer (carcinoma in situ and squamous cell carcinoma), the absence of circumcision confers an increased risk with an odds ratio (OR) of 1.5, although this finding was not significant ( $P = .07$ ), with a CI of 1.1–2.2.<sup>119</sup> An OR indicates the odds of an event happening in 1 group divided by the odds of an event happening in another group. An OR of 1 thus means that there is an equal chance for the event to occur in each group. When separated into squamous cell carcinoma and carcinoma in situ, the absence of circumcision was a risk factor for invasive squamous cell carcinoma (OR: 2.3 [CI: 1.3–4.1]) but not for carcinoma in situ (OR: 1.1 [CI not provided]).

Phimosis is a condition in which the foreskin cannot be fully retracted from the penis. A history of phimosis alone confers a significantly elevated risk of invasive cancer (OR: 11.4). In fact, in men with an intact prepuce and no phimosis, there is a decreased risk of invasive penile cancer (OR: 0.5). When excluding phimosis, the risk disappears, which suggests that the benefit of circumcision is conferred by reducing the risk of phimosis and that the phimosis is responsible for the increased risk. Other forms of penile injury or irritation likewise can pose a significant risk factor for cancer. There is accumulating evidence that circumcised men have a lower prevalence of oncogenic (high-risk) and nononcogenic (low-risk) HPV when compared with uncircumcised men, and this may be another means by which circumcision has a protective effect against invasive penile cancer (as discussed in the earlier STI section).

It is difficult to establish how many male circumcisions it would take to prevent a case of penile cancer, and at what cost economically and physically. One study with good evidence estimates that based on having to do 909 circumcisions to prevent 1 penile cancer event, 2 complications would be expected for every penile cancer event avoided.<sup>121</sup> However, another study with fair evidence estimates that more than 322 000 newborn circumcisions are required to prevent 1 penile cancer event per year.<sup>122</sup> This would translate into 644 complications per cancer event, by using the most favorable rate of complications, including rare but significant complications.<sup>123</sup> The clinical value of the modest risk reduction from circumcision for a rare cancer is difficult to measure against the potential for complications from the procedure. In addition, these findings are likely to decrease with increasing rates of HPV vaccination in the United States.

### *Cervical Cancer*

Up to 12 000 new cases of cervical cancer are diagnosed in the United States annually. Cervical cancer is a leading cause of death for women in developing countries; more than 80% of all cervical cancer deaths occur in developing countries.<sup>124</sup> Persistent HPV infection with high-risk (ie, oncogenic) types (HPV types 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 73, and 82) is the main prerequisite to developing cervical squamous carcinoma.

The association of cervical cancer, penile HPV infection, and circumcision was studied in an article of fair quality that found a protective effect of male circumcision against cervical cancer in the female partner(s) of men who have multiple female partners.<sup>100</sup> There was a lower incidence of HPV detection in circumcised men compared with uncircumcised men (5.5% and 19.6%, respectively). The OR for men who self-reported having been circumcised and who had penile HPV was 0.37 (95% CI: 0.16–0.85). In women whose partner had more than 6 lifetime sexual partners, male circumcision lowered her odds of cervical cancer significantly (OR: 0.42). The overall rate of cervical cancer for women who currently had circumcised male partners was not significantly decreased. Thus, the contribution of male circumcision to prevention of cervical cancer is likely to be small.

### *Penile Dermatoses and Phimosis*

Penile dermatoses encompass a wide range of genital skin diseases, some of which are rarer than others. These diseases can include psoriasis, inflammation (ie, balanitis, balanoposthitis), infections (ie, superficial skin and soft tissue infections such as cellulitis), lichen sclerosis, lichen planus, lichen simplex, seborrheic dermatitis, atopic

eczema, and irritant dermatitis, among others.

From 1995 to 2011, all publications addressing this concern were case series and were therefore excluded from the literature forming the current analysis. Before 1995, a New Zealand prospective cohort study with good evidence explored rates of penile problems for 635 boys from birth to 8 years of age.<sup>125</sup> Four types of penile problems were defined: first was the number of episodes of inflammation of the penis experienced by the child. Penile inflammation included balanitis, meatitis, inflammation of the prepuce, and conditions in which the penis was described as sore or inflamed without any further diagnostic elaboration. The second type was the number of episodes of phimosis experienced by the child. These episodes included every time medical attention was sought for phimosis and associated symptoms. Episodes in which the child was brought to medical attention for “tight” or “non-retractable” foreskin but was not treated were not classified as phimosis, due to the likelihood that most of these attendances resulted from parental anxiety or uncertainty about the development of the foreskin rather than any pathologic condition in the child. The third type was inadequate circumcision requiring repair or recircumcision. Fourth was postoperative infection after circumcision from birth to 8 years of age by circumcision status. Findings were inconclusive for the first year of life; the adjusted rate of problems experienced was 5.2 penile problems per 100 circumcised boys over the study period, compared with 1.2 penile problems in uncircumcised boys at risk. From ages 1 through 8 years, the rates were 6.5 penile problems per 100 circumcised boys over the study period, compared with 17.2 penile problems per 100 uncircumcised boys.

### *Sexual Function and Penile Sexual Sensitivity*

The literature review does not support the belief that male circumcision adversely affects penile sexual function or sensitivity, or sexual satisfaction, regardless of how these factors are defined.

### *Sexual Satisfaction and Sensitivity*

Literature since 1995 includes 2 good-quality randomized controlled trials that evaluated the effect of adult circumcision on sexual satisfaction and sensitivity in Uganda and Kenya, respectively.<sup>126,127</sup> Among 5000 Ugandan participants, circumcised men reported significantly less pain on intercourse than uncircumcised men.<sup>126</sup> At 2 years' postcircumcision, sexual satisfaction had increased significantly from baseline measures in the control group (from 98% at baseline to 99.9%); satisfaction levels remained stable among the circumcised men (98.5% at baseline, 98.4% 2 years after the procedure). This study included no measures of time to ejaculation or sensory changes on the penis. In the Kenyan study (which had a nearly identical design and similar results), 64% of circumcised men reported much greater penile sensitivity postcircumcision.<sup>127</sup> At the 2-year follow-up, 55% of circumcised men reported having an easier time reaching orgasm than they had precircumcision, although the findings did not reach statistical significance. The studies' limitation is that the outcomes of interest were subjective, self-reported measures rather than objective measures.

Other studies in the area of function, sensation, and satisfaction have been less rigorous in design, and they fail to provide evidence that the circumcised penis has decreased sensitivity compared with the uncircumcised penis. There is both good and fair evidence that no statistically significant differ-

ences exist between circumcised and uncircumcised men in terms of sexual sensation and satisfaction.<sup>128–131</sup> Sensation end points in these studies included subjective touch and pain sensation, response to the International Index of Erectile Function, the Brief Male Sexual Function Inventory, pudendal nerve evoked potentials, and Intravaginal Ejaculatory Latency Times (IELTs).

There is fair evidence that men circumcised as adults demonstrate a higher threshold for light touch sensitivity with a static monofilament compared with uncircumcised men; these findings failed to attain statistical significance for most locations on the penis, however, and it is unclear that sensitivity to static monofilament (as opposed to dynamic stimulus) has any relevance to sexual satisfaction.<sup>132</sup> There is fair evidence from a cross-sectional study of Korean men of decreased masturbatory pleasure after adult circumcision.<sup>133</sup>

### *Sexual Function*

There is both good and fair evidence that sexual function is not adversely affected in circumcised men compared with uncircumcised men.<sup>131,134–136</sup> There is fair evidence that no significant difference exists between circumcised and uncircumcised men in terms of sexual function, as assessed by using the IELT.<sup>129</sup>

Limitations to consider with respect to this issue include the timing of IELT studies after circumcision, because studies of sexual function at 12 weeks postcircumcision by using IELT measures may not accurately reflect sexual function at a later period. Also, the self-report of circumcision status may impact study validity. This could be in an unpredictable direction, although it is most likely that the effect would be to cause an underestimation of the association. Other biases include



participants' ages and any coexisting medical conditions.

## Analgesia and Anesthesia

- Task Force Recommendation:
  - Trained and competent practitioners, by using sterile techniques and effective pain management, should perform male circumcision. Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
  - Nonpharmacologic techniques (eg, positioning, sucrose pacifiers) alone are insufficient to prevent procedural and post-procedural pain and are not recommended as the sole method of analgesia. They should be used only as analgesic adjuncts to improve infant comfort during circumcision.
  - If used, topical creams may cause a higher incidence of skin irritation in low birth weight infants, compared with infants of normal weight, so penile nerve block techniques should be chosen for this group of newborns.

The analgesics used for newborn circumcision include nonpharmacologic and pharmacologic (topical and nerve blocks) techniques. The Task Force's review included nonnutritive sucking, a pacifier dipped in sucrose, acetaminophen, topical 4% lidocaine (ie, LMX4 cream), a eutectic mixture of lidocaine-prilocaine local anesthetic (EMLA), subcutaneous ring block, and the dorsal penile nerve block (DPNB). These methods, which reduce the pain and stress of newborn circumcision, are representative of the principles discussed in the AAP

*Policy Statement on Prevention and Management of Pain in the Neonate*, which was updated in 2006.<sup>137,138</sup> There are no evidence-based recommendations that state there is persistent pain that must be treated after the local preprocedure anesthetic wears off.

Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision, as indicated by changes in heart rate, oxygen saturation, facial action, crying, and other measures.<sup>139–145</sup> Therefore, adequate analgesia should be provided when newborn circumcision is performed. Topical 4% lidocaine, DPNB, and a subcutaneous ring block are all effective options, although the latter may provide the most effective analgesia. In addition there is good evidence that infants circumcised without analgesia exhibit a stronger behavioral pain response to subsequent routine immunization at 4 to 6 months of age, compared with both infants circumcised with analgesia and with uncircumcised infants.<sup>145</sup>

The literature search did not produce any reports of local anesthetic toxicity, such as seizures or cardiovascular instability, among the newborns receiving either local anesthetic injections or topical applications (ie, topical 4% lidocaine).

### *Nonpharmacologic Techniques*

There is good evidence that oral sucrose and oral analgesics are not different from placebo or environmental modification in their ability to control pain.<sup>141,142,144</sup> There is good evidence that a more physiologic positioning of the infant in a padded environment may decrease distress during the procedure.<sup>146</sup> There is fair evidence that sucrose on a pacifier has been demonstrated to be more effective than water alone for decreasing crying during circumcision.<sup>147–149</sup> Nonpharmacologic techniques alone are

insufficient to prevent procedural pain, however. Positioning and a sucrose pacifier should be used as analgesic adjuncts to improve infant comfort during circumcision but are not recommended as the sole method of analgesia.

### *Topical Local Anesthesia Techniques*

There is good evidence that topical anesthesia with lidocaine-prilocaine (which contains 2.5% lidocaine and 2.5% prilocaine) or 4% lidocaine is superior to no anesthesia in preventing pain during male circumcision.<sup>150</sup>

There is good evidence from a prospective cohort study that lidocaine-prilocaine cream attenuates the pain response to circumcision (as measured by using heart rate, oxygen saturation, facial actions, and time and characteristics of crying) when applied 60 to 90 minutes before the procedure.<sup>150,151</sup> There is fair evidence from an RCT that lidocaine-prilocaine cream attenuates the pain response to circumcision, although it was less effective in doing so than DPNB or ring block.<sup>152</sup> There is good evidence that topical 4% lidocaine is as effective as lidocaine-prilocaine at preventing pain.<sup>140,153</sup> Topical 4% lidocaine has the advantage of having a faster onset of action (2 g applied 30 minutes before circumcision, compared with 1 to 2 hours before circumcision for lidocaine-prilocaine). Both topical preparations require coverage with plastic wrap to keep the cream in place. Topical 4% lidocaine is the preferred topical local anesthetic (over lidocaine-prilocaine) because there is no risk of methemoglobinemia.

The most common complications reported with analgesic techniques were an 8% to 14% incidence of erythema, swelling, and blistering associated with topical analgesia.<sup>142,150,153,154</sup> There is fair evidence that adverse effects of topical anesthetic creams are

infrequent and include only either minor skin reactions (ie, erythema, swelling) or, more rarely, blistering (especially in low birth weight infants).<sup>154</sup> For this reason, penile nerve block techniques should be chosen for low birth weight infants. There is good and fair evidence that both reactions are less common with 4% lidocaine than with lidocaine-prilocaine cream.<sup>142,150,153–155</sup>

There is a theoretical risk of methemoglobinemia with lidocaine-prilocaine.<sup>152</sup> However, when methemoglobin has been measured after lidocaine-prilocaine application, the level, although elevated, was not clinically significant.<sup>150</sup> Nevertheless, there have been isolated case reports of clinically significant methemoglobinemia involving prolonged application time or use in premature infants.<sup>156,157,158</sup>

#### *DPNB*

Most commonly, DPNB consists of injections of 0.4 mL of 1% lidocaine without epinephrine on both sides of the base of the penis. Systemic lidocaine levels obtained with use of this technique reached peak concentrations at 60 minutes after injection and were well below toxic ranges.<sup>159</sup>

There is good evidence that DPNB is effective in reducing the behavioral and physiologic indicators of pain caused by circumcision, regardless of the device used.<sup>144</sup> There is good evidence that DPNB is superior to lidocaine-prilocaine in relieving pain during and after circumcision in newborns.<sup>142,160–162</sup> One good-quality prospective cohort study of 491 newborn circumcisions measured complications of DPNB analgesia; it reported an 11% incidence of bruising and a 0.2% incidence of hematoma, none of which required any change in management.<sup>163</sup> Another good-quality, blinded, randomized controlled trial found a 43% incidence of small

hematomas in preterm and term newborns circumcised by using DPNB.<sup>142</sup>

#### *Subcutaneous Ring Block*

Two studies with fair evidence found that the subcutaneous circumferential ring block (0.8 mL of 1% lidocaine without epinephrine injected at the base or midshaft of the penis) is effective in mitigating pain and its consequences during circumcision of newborns.<sup>164</sup>

One study presented fair evidence that the ring block was superior to using no anesthesia but found a 5% failure rate with the technique (1 in 20 ring block infants had heart rate and behavioral pain scores that were above the control mean during at least 50% of the measured intervals, while 19 of 20 had heart rate and pain scores less than the control mean). There were no hematomas in the infants receiving ring blocks. A second ring block study had fair evidence that the method was superior to either DPNB or lidocaine-prilocaine cream for pain relief in newborn circumcision, as the ring block seemed to prevent crying and increases in heart rate during all phases of the circumcision, with less crying and lower heart rates during foreskin separation and incision than seen with DPNB or lidocaine-prilocaine.<sup>152</sup> No complications have been reported in the use of this simple and highly effective technique.

#### *Analgesia and Anesthesia for a Circumcision After the Newborn Period*

In the United States, after the newborn period, general anesthesia is used during male circumcision because the surgical procedure takes longer and involves hemostasis and the suturing of skin edges. Use of adjuvant local anesthetic techniques in addition to general anesthesia provides longer-lasting postoperative analgesia, mini-

mizes the need for intraoperative or postoperative opioid administration, reduces adverse postoperative events such as nausea and vomiting, and decreases recovery time. Long-lasting analgesia is achieved with either penile nerve block, by using any of the methods mentioned earlier, or caudal epidural analgesia in infants and children up to 3 years of age.

General anesthesia carries a low risk of mortality (1 death per 400 000 instances of general anesthesia). The risk of adverse events (especially respiratory events) during general anesthesia remains higher in infants under 1 year of age.<sup>165</sup> These risks are minimized when the procedure is performed in infants in their optimal state of health (no active reactive airway disease or upper respiratory infection) and in a facility familiar with the anesthesia care of infants.<sup>166</sup> Additional concerns associated with surgical circumcision in older infants include time lost by parents and patients from work and/or school.

#### *Caudal Block*

Caudal block (CB) with bupivacaine is an anesthetic technique used for postoperative analgesia for circumcision in infants and older children up to 3 years of age, as an alternative to ring block and DPNB techniques. There is good and fair evidence that there is a longer time to first postoperative urination after CB without adverse clinical consequences.<sup>167,168</sup> There is good evidence for a high incidence of mild postoperative motor block and delay in walking after the CB procedure (21% to 44%) in older children.<sup>167,169,170</sup> Caudal analgesia may be less available in facilities that do not treat many pediatric patients.

#### *DPNB*

The reported failure rate of DPNB is 1% to 10%.<sup>171–175</sup> When DPNB is used

without general anesthesia in boys 3 to 5 years of age, the technique has a failure rate of 15%; for boys aged 6 and older, the failure rate is 1.5%.<sup>175</sup> There is good and fair evidence that incidence of hematoma with DPNB ranges from 0.001% to 24%; several studies report rates of approximately 6%.<sup>174–177</sup> One study with fair evidence reports a 0.001% rate of “improper needle position with bleeding” and a similar number of “medication errors.”<sup>176</sup> Studies with good and fair evidence report a 12% to 83% rate of edema in the area of injection of the local anesthetic after DPNB.<sup>174,175,177</sup>

### *Subcutaneous Ring Block*

There is good evidence for the reported 8% failure rate using the ring block.<sup>168</sup> In children, edema and distortion of tissue layers after the ring block make surgery more difficult, compared with using a CB to prevent postoperative pain.<sup>178</sup>

### *Comparison of Methods*

DPNB, subcutaneous ring block, and CB techniques may be used in conjunction with general anesthesia depending on the age of the child and are also used to provide post-circumcision analgesia. There is good evidence that there is no difference in the quality of postoperative analgesia or parent satisfaction between DPNB and CB using bupivacaine.<sup>169</sup> A comparison of CB with or without a subcutaneous ring block with bupivacaine showed good evidence that CB with a subcutaneous ring block had significantly longer duration of postoperative analgesia.<sup>168</sup> A technique describing ultrasound guidance for correct needle placement for DPNB in children under general anesthesia describes lower pain scores in the first postoperative hour and a longer interval until rescue analgesia was required.<sup>179,180</sup>

## **Complications and Adverse Events**

- Task Force Recommendation:
  - Elective circumcision should be performed only if the infant's condition is stable and healthy.
  - Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.

The true incidence of complications after newborn circumcision is unknown, in part due to differing definitions of “complication” and differing standards for determining the timing of when a complication has occurred (ie, early or late). Adding to the confusion is the comingling of “early” complications, such as bleeding or infection, with “late” complications such as adhesions and meatal stenosis. Also, complication rates after an in-hospital procedure with trained personnel may be far different from those of the developing world and/or by untrained ritual providers. For the purposes of this document, complications are grouped in terms of the timing of the procedure. (Citations for the following statements below are provided in the section after this summary.)

Significant acute complications are rare, occurring in approximately 1 in 500 newborn male circumcisions. Acute complications are usually minor and most commonly involve bleeding, infection, or an imperfect amount of tissue removed. Late complications do occur, most commonly adhesions, skin bridges, and meatal stenosis. There are 2 schools of thought regarding the cause of penile adhesions, which are common after circumcision. One is that fine adhesions represent incomplete lysis of physiologic adhesions at the time of circumcision; the other is that the fine adhesions occur because of raw serosa surfaces. It is unknown how often these late

complications require surgical repair; this area requires further study.

In general, the specific technique used does not afford a significant difference in risk of complications. However, boys undergoing circumcisions in medical facilities in industrialized settings performed by trained practitioners have fewer complications than boys in nonindustrialized nations who have circumcisions performed by poorly trained (or untrained) practitioners in nonmedical surroundings. If circumcision is performed, it is imperative that those providing the service have adequate training in the method used and resources for and practice of adequate analgesia and infection control.

Contraindications to newborn circumcision include significantly premature infants, those with blood dyscrasias, individuals who have a family history of bleeding disorders, and those who have congenital abnormalities such as hypospadias, congenital chordee, or deficient shaft skin such as penoscrotal fusion or congenital buried penis. In addition, before performing newborn male circumcision, the clinician should confirm that vitamin K has been administered, in accordance with standard practice of newborn care.<sup>181</sup>

### *Newborn Elective Circumcision*

Two large US hospital-based studies with good evidence estimate the risk of significant acute circumcision complications in the United States to be between 0.19% and 0.22%.<sup>121,123</sup> Bleeding was the most common complication (0.08% to 0.18%), followed by infection (0.06%) and penile injury (0.04%). For comparison, an audit of 33 921 tonsillectomies found an incidence of hemorrhage of 1.9% among children aged 0 to 4 years.<sup>182</sup> An Israeli prospective cohort study with fair evidence examined 19 478 male infants born in 2001 who were

circumcised primarily by trained, ritual providers in nonmedical settings, and reported similarly low complication rates. The overall complication rate was 0.34%, including bleeding in 0.08% and infection in 0.01%.<sup>183</sup> Approximately one-third of the identified complications were immediate (ie, bleeding, infection, penile injury), whereas two-thirds occurred later (ie, excess foreskin, penile torsion, shortage of skin, phimosis, inclusion cyst). There is fair evidence of a more frequent complication rate of 3.1% in a study based on abstraction of 1951 hospital medical (rather than billing) records on newborn circumcision in Atlanta.<sup>184</sup> In this study, complications were found to be much more common, with bleeding occurring in 2.1%, although most reports of bleeding were mild in nature. Likewise, a review with fair evidence of 1000 newborn circumcisions by using the Gomco clamp in a hospital setting in Saudi Arabia found an overall complication rate of 1.9%.<sup>185</sup> Bleeding occurred in 0.6%, infection in 0.4%, and redundant prepuce in 0.3%.

Late complications of newborn circumcision include excessive residual skin (incomplete circumcision), excessive skin removal, adhesions (natural and vascularized skin bridges), meatal stenosis, phimosis, and epithelial inclusion cysts. These complications are considered “late,” as opposed to “acute” (or immediate) complications such as bleeding or infection, which may still present during infancy but not during the immediate postprocedural time frame. In 1 outpatient-based study of 214 boys with poor evidence, the complications seen included adhesions (observed in 55 boys [25.6%]), redundant residual prepuce (44 boys [20.1%]), balanitis (34 boys [15.5%]), skin bridge (9 boys [4.1%]), and meatal stenosis (1 boy [0.5%]).<sup>76</sup>

Outside the United States, a cross-sectional study from Nigeria of 370 consecutive male infants (322 of whom had been circumcised) attending an infant welfare clinic for immunization with fair evidence reported an overall complication rate of 20.2%.<sup>186</sup> Complications included redundant prepuce (12.9%), excessive skin removal (5.9%), skin bridge (4.1%), and buried penis (0.4%). The majority of the procedures (81%) were performed in the hospital; 19% were performed at home. Nurses performed 56% of procedures ( $n = 180$ ), physicians performed 35% ( $n = 113$ ), and traditional circumcisers performed 9% ( $n = 29$ ). The Israeli study noted earlier with fair evidence reported a late complication of redundant prepuce in 0.2% of the 19 478 male infants studied.<sup>183</sup>

There is good evidence that circumcision of a premature infant is associated with an increased risk of later-occurring complications (ie, poor cosmesis, increased risk of trapped penis, adhesions). There is also good evidence that circumcision of a newborn who has a prominent suprapubic fat pad or penoscrotal webbing has a higher risk for the same long-term complications.<sup>187</sup> One prospective study with fair evidence examined the natural course of penile adhesions after circumcision and found that adhesions disappeared at some point 6 months postcircumcision without intervention, except for thick adhesions (called “bridging adhesions”). The authors recommended lysis for skin bridges.<sup>188</sup>

#### *Post-newborn Circumcision*

There have been few reports of acute complications after non-newborn circumcision in the United States. Furthermore, there are no adequate studies of late complications in boys undergoing circumcision in the

post-newborn period; this area requires more study.

Although adverse outcomes are rare among non-newborn circumcisions, the incidence tends to be orders of magnitude greater for boys circumcised between 1 and 10 years of age, compared with those circumcised as newborns.<sup>189</sup> As noted, general anesthesia, which is used for procedures performed after the newborn period, confers additional risk.

The most common surgical complication is excessive bleeding (eg, bleeding that did not stop with local pressure, perhaps requiring a suture), reported in 0.6% of 1742 male infants.<sup>184</sup> Contact burns were reported with electrocautery when used with metal, and it should not be used with the Gomco clamp in newborn circumcisions because it can cause devastating burns.<sup>184,190,191</sup> A study with fair evidence reviewed the records of 476 boys undergoing circumcision during childhood and found that complications occurred in 8 records (1.7%), of which 3 were related to anesthesia.<sup>192</sup> The most common surgical complication was excessive bleeding in 0.6%. In another report with fair evidence, which examined 267 patients who had circumcision by using topical glue rather than skin sutures, excessive bleeding occurred in 0.75% of cases.<sup>193</sup>

European centers report an overall complication rate of 1.2% to 3.8% for circumcisions performed in boys during the newborn or non-newborn period.<sup>194–196</sup> In a study with fair evidence of trained medical personnel in the United Kingdom, the rate of bleeding was 0.8% and of infection was 0.3%. In this study of a historical cohort of over 75 boys aged 0 to 14 years, 0.5% required surgical repair.<sup>195</sup>

In a Turkish prospective cohort study of 700 boys with fair evidence, bleeding



was reported in 2.2% of cases and infection in 1.3% of boys circumcised in a hospital, versus a bleeding rate of 3.6% and an infection rate of 2.7% in boys undergoing a nonhospital-based mass religious procedure, despite the latter procedure being performed by trained personnel.<sup>196</sup>

There are no adequate analytic studies of late complications in boys undergoing circumcision in the post-newborn period. An Iranian cross-sectional study with good evidence reported a late complication rate of 7.4%, including redundant skin in 3.6%, excessive skin removal in 1.3%, and meatal stenosis in 0.9%.<sup>197</sup>

### *Major Complications*

The majority of severe or even catastrophic injuries are so infrequent as to be reported as case reports (and were therefore excluded from this literature review). These rare complications include glans or penile amputation,<sup>198–206</sup> transmission of herpes simplex after mouth-to-penis contact by a mohel (Jewish ritual circumcisers) after circumcision,<sup>207–209</sup> methicillin-resistant *Staphylococcus aureus* infection,<sup>210</sup> urethral cutaneous fistula,<sup>211</sup> glans ischemia,<sup>212</sup> and death.<sup>213</sup>

### *Medical Versus Traditional Providers*

In general, untrained providers create more complications when performing male circumcision than do well-trained providers, regardless of whether they are physicians, nurses, or traditional religious providers. Physicians in a hospital setting generally have fewer complications than traditional providers in the community setting.

A prospective study in Kenya with good evidence found an overall complication rate of 35% in 443 children and young men aged 5 to 21 years who had traditional circumcision performed in

a village or household setting, compared with an overall complication rate of 17% in those whose circumcision was performed by trained providers in a medical setting such as a hospital, health center, or physician's office.<sup>214</sup> The most common complications were bleeding and infection; excessive pain, lacerations, torsion, and erectile dysfunction were also observed. A study in Turkey with fair evidence studied a historical cohort and found a significantly higher rate of complications when male circumcision was performed by traditional circumcisers, compared with those performed by physicians; complication rates were 85% for traditional providers versus 2.6% for physicians.<sup>215</sup>

A study in Israel with fair evidence found there was no difference in the rate of complications in newborn circumcision between hospital-based physicians and well-trained, home-based ritual circumcisers (mohels).<sup>183</sup>

### *Complications With Different Methods of Male Circumcision*

There have been few studies comparing the 3 most commonly used techniques for male circumcision in the United States (the Gomco clamp, the Plastibell device, and the Mogen clamp). Steps common to all 3 include estimation of the amount of external skin to be removed; dilation of the preputial orifice so the glans can be visualized to ensure that the glans itself is normal; bluntly freeing the inner preputial epithelium from the epithelium of the glans; placing the device; leaving the device in place long enough to produce hemostasis; and surgically removing the foreskin.

#### *Gomco Clamp*

The Gomco clamp was specifically designed for performing circumcisions. In this procedure, "the foreskin is cut lengthwise through the stretched tissue (dorsal slit) to allow

space to insert the circumcision device. The bell of the Gomco clamp is placed over the glans, and the foreskin is pulled over the bell. The base of the Gomco clamp is placed over the bell, and the Gomco clamp's arm is fitted. After the surgeon confirms correct fitting and placement (and the amount of foreskin to be excised), the nut on the Gomco clamp is tightened and left in place for 3 to 5 minutes to allow hemostasis to occur, then the foreskin is removed using a scalpel. The Gomco's base and bell are then removed."<sup>216</sup>

One study of the Gomco clamp with fair evidence reviewed 1000 newborn circumcisions in a hospital setting in Saudi Arabia and found an overall complication rate of 1.9%.<sup>185</sup> Bleeding occurred in 0.6% of cases, infection in 0.4%, and redundant prepuce in 0.3%. Another study of 521 newborn male circumcisions performed at a Houston outpatient clinic with fair evidence reported a 2.9% incidence of phimosis (trapped penis) after newborn circumcision using the Gomco clamp.<sup>217</sup>

#### *Plastibell Device*

Plastibell circumcision involves a surgical procedure in which a plastic ring is inserted under the foreskin, and a tie is placed over the ring to provide hemostasis. The ring remains on the penis for several days until the tissue necroses and the ring falls off spontaneously. Bleeding ranged from 0.8% to 3% of cases; infection occurred in 2.1% of cases.<sup>218</sup> Urinary retention<sup>219,220</sup> and problems with the Plastibell ring have been reported in 3.6% of cases.<sup>221</sup> Studies of the Plastibell device with fair and good evidence found, overall, that complications range from 2.4% to 5%.<sup>218,221–223</sup>

#### *Mogen Clamp*

The Mogen clamp is a device consisting of 2 flat blades that have a limited

(slit-like) space between them and a mechanism that draws the blades together and locks them in place. The slit is limited to 3 mm to allow the foreskin, but not the glans, to cross the opening. The preputial adhesions are gently taken down by a probe and the glans pushed downward, thereby protecting it from the blades. The prepuce distal to the glans is drawn into the slit between the blades and positioned. The blades are locked together, crushing the skin and creating hemostasis. The skin is excised from above the clamp. The clamp is removed and the skin pushed proximally into proper position.

There were no specific studies of complications of the Mogen because complications are rare; thus, one can only rely on available case reports of amputation.<sup>201,202,222–228</sup>

### Comparison

A study with fair evidence evaluated the use of the Gomco versus the Plastibell device in 350 newborn infants.<sup>229</sup> The incidence of infection was higher with the Gomco clamp (2%) versus a lower complication rate (1.3%) with the Plastibell device. Adhesions were also more common with the Gomco clamp, at a rate of 20% vs 6.6% for the Plastibell device.

### Stratification of Risks

Based on the data reviewed, it is difficult, if not impossible, to adequately assess the total impact of complications, because the data are scant and inconsistent regarding the severity of complications. For example, studies that report bleeding as a complication do not uniformly report how frequently the bleeding was controlled with local measures versus requiring a transfusion or surgical intervention. Similarly, infection is rarely further divided into local tissue infection versus bacteremia or

sepsis. Financial costs of care, emotional tolls, or the need for future corrective surgery (with the attendant anesthetic risks, family stress, and expense) are unknown.

Some reports have attempted to compare potential benefits of circumcision with reported complication rates. One study with good evidence attempted to estimate complication rates compared with benefits from male circumcision. Based on an estimate that 100 circumcisions must be performed to prevent 1 UTI, and 909 circumcisions must be performed to prevent 1 case of penile cancer, the study yields an estimate of 1 complication for every 5 UTIs prevented and 2 complications for every 1 case of penile cancer prevented.<sup>121</sup> Assuming an overall minor adverse event rate for newborn circumcision of 0.2%, and a severe adverse event rate of 0.005%, another study with fair evidence estimated that over 322 000 newborn male circumcisions are required to prevent 1 case of penile cancer per year.<sup>122</sup> Similar modeling for HIV, herpes, and HPV in the United States is not available.

A recently published CDC study found that male circumcision before the age of sexual debut was cost-effective for the prevention of HIV.<sup>60</sup> The study did not take into account the positive benefits of newborn circumcision for other conditions such as costs of caring for UTIs.<sup>106,107,110,112,230–233</sup> It also did not include recent evidence that circumcision (either as an infant or later in life) is associated with reduced risk for other STIs, penile and cervical cancers, phimosis, and penile dermatoses.<sup>36,88,234,235</sup> The authors did not include adverse effects that make newborn circumcision less cost-effective, such as bleeding, infection, and revision. Considering all these factors, however, the authors concluded that male

circumcision was a cost-effective strategy for HIV prevention in the United States.<sup>60</sup>

### Workforce Development and Male Circumcision

- Task Force Recommendations:
  - Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.
  - Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
  - Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay, regardless of whether the newborn is circumcised or not.
  - Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management. Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
  - Key professional organizations (AAP, AAFP, ACOG, the American Society of Anesthesiologists, the American College of Nurse-Midwives, and other midlevel clinicians such as

nurse practitioners) should work collaboratively to:

- Develop standards of trainee proficiency in performance of anesthetic and procedure techniques, including suturing;
- Teach the procedure and analgesic techniques during postgraduate training programs;
- Develop educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents;
- Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.

#### *Workforce Development and Parental Decision-making*

There is fair evidence that some clinicians do not convey current or medically accurate information about circumcision to parents, either verbally or in written materials.<sup>18</sup> Providing information about the risks and benefits of circumcision does not seem to lead to lower circumcision rates.<sup>236</sup>

Parents are entitled to factually correct, nonbiased information about circumcision and should receive this information from clinicians before conception and/or early in pregnancy, which is when they are making choices about circumcision. As noted, in 2009, the AAP surveyed members on their attitudes and practices around circumcision.<sup>19</sup> According to the responses, 67% of pediatricians reported discussing the pros and cons of circumcision with parents. Almost two-thirds (62%) reported that they made no recommendation regarding circumcision to the majority of their patients; 18% responded recommending to all or most of their patients' parents that circumcision be

performed; 7% reported recommending to all or nearly all of the parents of newborn males that circumcision not be performed.

As described earlier, there is fair evidence that parental decision-making about circumcision tends to occur well before the child's birth. Thus, information to assist in parental decision-making should be made available as early as possible, even as part of guidance to parents before conception occurs. For this reason, obstetrician-gynecologists and family physicians who manage women's health and prenatal care probably have a more pivotal role in this decision than do pediatricians. Public health authorities have an important role in educating the public on the role of newborn male circumcision in disease prevention.

#### *Workforce Development and Provision of Circumcision*

In the United States, obstetricians, family physicians, and pediatricians are the principal clinicians who perform newborn circumcisions in medical settings; there is no single system of training or credentialing for circumcision in use nationwide.<sup>237</sup> There is good and fair evidence of considerable variation in provider type by region and by hospital,<sup>238–240</sup> with midwives performing circumcision in some locations.<sup>18,241</sup>

Training curricula for teaching newborn circumcision in departments of pediatrics<sup>237,242</sup> and family medicine<sup>243</sup> have been described but do not provide information on how widely used they are or the trainings' results and/or effectiveness. One pediatric program's training consisted of the resident performing 3 to 5 circumcisions with assistance from a faculty instructor, 3 to 5 circumcisions under direct observation but without hands-on faculty involvement, and 2 test

circumcisions for grading and departmental credentialing.<sup>242</sup> The other 2 programs did not describe actual resident experience performing a circumcision.

Most residency training programs in the respective specialties teach techniques, including the Gomco clamp, Mogen clamp, and Plastibell device.<sup>238</sup> As of 2006, 97% of programs that included training in performance of circumcision taught the use of either local or topical anesthetics for circumcision analgesia, an increase from 45% to 74% in 1998.<sup>238–240</sup> Although case studies were excluded from this review, it was noted that 2 record reviews with fair evidence addressed the need for circumcision revision based on the medical discipline of the physician who performed the original procedure.<sup>241,244</sup>

None of the articles reviewed addressed current or future workforce needs, which seems to depend on the number of surgeries being performed, the future demand, and reimbursement for the procedure. Sustaining a workforce that is capable of counseling families and performing the newborn male circumcision procedure safely is increasingly important, as the number of clinicians who are able to perform this procedure is likely to decline with curtailment of Medicaid coverage for it in various states.

The Task Force strongly recommends the creation, revision, and enhancement of educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises. The Task Force also strongly recommends the development of educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents. A structured decision-making tool that clinicians can use to help

parents complete would assist in the decision of whether to circumcise or not. To this end, the Task Force recommends that key professional organizations (AAP, ACOG, AAFP, American Society of Anesthesiologists, American College of Nurse-Midwives, and other entities supporting midlevel clinicians) work together to develop a consensus plan about which groups are best suited to perform circumcisions in newborn males; teach the procedure and analgesic techniques during postgraduate training programs; and develop standards of trainee proficiency. In addition, health departments should be involved in the dissemination of educational materials and coordinating educational efforts with professional organizations.

### Financing Newborn Male Circumcision

- Task Force recommendation:

1. The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

The CDC estimates that, from 2005 to 2006, the average cost of providing newborn male circumcision (including physician- and facility-related costs) ranged from \$216 to \$601 across the nation.<sup>60</sup> Hospitals in states where Medicaid covers routine newborn male circumcision have circumcision rates that are 24% higher than hospitals in states without such coverage.<sup>23</sup> As of 2009, 15 states did not cover newborn male circumcision in their Medicaid programs; 2 additional states had variable coverage dependent on the enrollment plan.<sup>245</sup> There seems to be a relationship between circumcision incidence and third-party payment.

Circumcised newborns are more likely to be privately insured than publicly insured infants.<sup>246</sup> The weighted rates

of circumcision over the 13-year period from 1991 to 2005 were 40.8% for Medicaid clients versus 43.3% for the uninsured and 64.4% for insured newborns.<sup>5</sup> The associations with insurance status were independent of race/ethnicity and socioeconomic status in this study.<sup>246</sup>

As noted, a recent cost-effectiveness analysis by the CDC concluded that newborn circumcision is a societal cost-saving HIV prevention intervention.<sup>60</sup> African-American and Hispanic males in the United States are disproportionately affected by HIV and other STIs, and thus would derive the greatest benefit from circumcision; the HIV prevention evidence for non-Hispanic white males was not as strong as for African-American and Hispanic males. However, the African-American and Hispanic populations are the most likely to have Medicaid coverage.<sup>247</sup> In 2010, 50% of Hispanic children (up to age 18 years) and 54% of African-American children were covered by Medicaid, compared with 23% of white children.<sup>248</sup> Thus, recent efforts by state Medicaid programs to curb payment for newborn male circumcision affect those populations that could benefit the most from the procedure.<sup>60</sup> The CDC authors recommended that: "Financial barriers that prevent parents from having the choice to circumcise their male newborns should be reduced or eliminated."

### AREAS FOR FUTURE RESEARCH

In the course of its work, the Task Force identified important gaps in our knowledge of male circumcision and urges the research community to seriously consider these gaps as future research agendas are developed. Although it is clear that there is good evidence on the risks and benefits of male circumcision, it will be useful for this benefit to be more precisely defined in a US setting and to monitor

adverse events. Specifically, the Task Force recommends additional studies to better understand:

- The performance of elective male circumcisions in the United States, including those that are hospital-based and nonhospital-based, in infancy and subsequently in life.
- Parental decision-making to develop useful tools for communication between providers and parents on the issue of male circumcision.
- The impact of male circumcision on transmission of HIV and other STIs in the United States because key studies to date have been performed in African populations with HIV burdens that are epidemiologically different from HIV in the United States.
- The risk of acquisition of HIV and other STIs in 0- to 18-year-olds, to help inform the acceptance of the procedure during infancy versus deferring the decision to perform circumcision (and thus the procedure's benefits) until the child can provide his own assent/consent. Because newborn male circumcision is less expensive and more widely available, a delay often means that circumcision does not occur. It will be useful to more precisely define the prevention benefits conferred by male circumcision to inform parental decision-making and to evaluate cost-effectiveness and benefits of circumcision, especially in terms of numbers needed to treat to prevent specific outcomes.
- The population-based incidence of complications of newborn male circumcision (including stratifications according to timing of procedure, type of procedure, provider type, setting, and timing of complications [especially severe and non-acute complications]).
- The impact of the AAP Male Circumcision policy on newborn male



circumcision practices in the United States and elsewhere.

- The extent and level of training of the workforce to sustain the availability of safe circumcision practices for newborn males and their families.

## CONCLUSIONS

This technical report provides recommendations regarding the practice of male circumcision, particularly in the newborn period. It emphasizes the primacy of parental decision-making and the imperative for those who perform male circumcisions to be adequately trained and use both effective sterile techniques and pain management. The report evaluated current evidence regarding the effect of male circumcision on the prevention of STIs (including HIV), UTIs, cancer, and other morbidities. Evidence about complications resulting from male circumcision and the use of analgesia and anesthesia were also discussed. The Task Force concluded that the health benefits of newborn male circumcision outweigh the risks and justify access to this procedure for families who choose it.

The Task Force also made the following recommendations:

- Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
- Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
- Physicians counseling families about elective male circumcision should assist parents by explaining, in

a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.

- Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.
- Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay, whether the newborn is circumcised or not.
- Elective circumcision should be performed only if the infant's condition is stable and healthy.
- Trained and competent practitioners, by using sterile techniques and effective pain management, should perform male circumcision.
- Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
  - Nonpharmacologic techniques (such as positioning and sucrose pacifiers) alone are insufficient to prevent procedural and postprocedural pain and are not recommended as the sole method of analgesia. They should be used only as analgesic adjuncts to improve infant comfort during circumcision.
  - If used, topical creams may cause a higher incidence of skin irritation in low birth weight infants, compared with infants of normal weight, so penile nerve block techniques should be chosen for this group of newborns.
- Key professional organizations (AAP, AAFP, ACOG, the American Society of Anesthesiologists, the American

College of Nurse-Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:

- Develop standards of trainee proficiency in performance of anesthetic and procedure techniques, including suturing;
  - Teach the procedure and analgesic techniques during postgraduate training programs;
  - Develop educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents;
  - Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.
- The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

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## **Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision**

Morten Frisch, Yves Aigrain, Vidmantas Barauskas, Ragnar Bjarnason, Su-Anna Boddy, Piotr Czauderna, Robert P.E. de Gier, Tom P.V.M. de Jong, Günter Fasching, Willem Fetter, Manfred Gahr, Christian Graugaard, Gorm Greisen, Anna Gunnarsdottir, Wolfram Hartmann, Petr Havranek, Rowena Hitchcock, Simon Huddart, Staffan Janson, Poul Jaszczak, Christoph Kupferschmid, Tuija Lahdes-Vasama, Harry Lindahl, Noni MacDonald, Trond Markestad, Matis Märtson, Solveig Marianne Nordhov, Heikki Pälve, Aigars Petersons, Feargal Quinn, Niels Qvist, Thrainn Rosmundsson, Harri Saxen, Olle Söder, Maximilian Stehr, Volker C.H. von Loewenich, Johan Wallander and Rene Wijnen  
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# Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision

## abstract

FREE

The American Academy of Pediatrics recently released its new Technical Report and Policy Statement on male circumcision, concluding that current evidence indicates that the health benefits of newborn male circumcision outweigh the risks. The technical report is based on the scrutiny of a large number of complex scientific articles. Therefore, while striving for objectivity, the conclusions drawn by the 8 task force members reflect what these individual physicians perceived as trustworthy evidence. Seen from the outside, cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious, and the report's conclusions are different from those reached by physicians in other parts of the Western world, including Europe, Canada, and Australia. In this commentary, a different view is presented by non-US-based physicians and representatives of general medical associations and societies for pediatrics, pediatric surgery, and pediatric urology in Northern Europe. To these authors, only 1 of the arguments put forward by the American Academy of Pediatrics has some theoretical relevance in relation to infant male circumcision; namely, the possible protection against urinary tract infections in infant boys, which can easily be treated with antibiotics without tissue loss. The other claimed health benefits, including protection against HIV/AIDS, genital herpes, genital warts, and penile cancer, are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves. *Pediatrics* 2013;131:796–800

Circumcision rates are steadily decreasing in most Western countries around the world, including the United States.<sup>1</sup> Still, a majority of newborn male infants undergo the procedure in the United States. In its newly released Technical Report and Policy Statement on male circumcision,<sup>2,3</sup> the American Academy of Pediatrics (AAP) has changed from a neutral to a more positive attitude toward circumcision, claiming that possible health benefits now outweigh the risks and possible negative long-term consequences. The AAP does not recommend routine circumcision of all infant boys as a public health measure but asserts that the benefits of the procedure are sufficient to warrant third-party payment. In Europe, Canada, and Australia, where infant male circumcision is considerably less common than in the United States, the AAP report is unlikely to influence circumcision practices because the conclusions of the report and policy statement seem to be strongly culturally biased.

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(Continued on last page)

In this commentary, a different view is presented by non-US-based physicians and representatives of general medical associations and societies for pediatrics, pediatric surgery, and pediatric urology in Northern Europe.

### CRITERIA FOR PREVENTIVE MEDICINE

It is commonly accepted that medical procedures always need to be justified because of their invasive nature and possible damaging effects. Preventive medical procedures need more and stricter justification than do therapeutic medical procedures, as they are aimed at people who are generally free of medical problems. Even stricter criteria apply for preventive medical procedures in children, who cannot weigh the evidence themselves and cannot legally consent to the procedure.<sup>4</sup>

The most important criteria for the justification of medical procedures are necessity, cost-effectiveness, subsidiarity, proportionality, and consent. For preventive medical procedures, this means that the procedure must effectively lead to the prevention of a serious medical problem, that there is no less intrusive means of reaching the same goal, and that the risks of the procedure are proportional to the intended benefit. In addition, when performed in childhood, it needs to be clearly demonstrated that it is essential to perform the procedure before an age at which the individual can make a decision about the procedure for him- or herself.

The AAP technical report points to 4 health-related arguments in favor of circumcision: the reduced risks of urinary tract infections (UTIs), penile cancer, some traditional sexually transmitted diseases (STDs), and HIV infection and AIDS.

### URINARY TRACT INFECTIONS

According to the literature reviewed, ~1% of boys will develop a UTI within the first years of life.<sup>2</sup> There are no randomized controlled trials (RCTs) linking UTIs to circumcision status. The evidence for clinically significant protection is weak, and with easy access to health care, deaths or long-term negative medical consequences of UTIs are rare. UTI incidence does not seem to be lower in the United States, with high circumcision rates compared with Europe with low circumcision rates, and the AAP report suggests it will take ~100 circumcisions to prevent 1 case of UTI. Using reasonable European estimates cited in the AAP report for the frequency of surgical and postoperative complications (~2%), for every 100 circumcisions, 1 case of UTI may be prevented at the cost of 2 cases of hemorrhage, infection, or, in rare instances, more severe outcomes or even death.

Circumcision fails to meet the criteria to serve as a preventive measure for UTI, even though this is the only 1 of the AAP report's 4 most favored arguments that has any relevance before the boy gets old enough to decide for himself.

### PENILE CANCER

Penile cancer is 1 of the rarest forms of cancer in the Western world (~1 case in 100 000 men per year), almost always occurring at a later age. When diagnosed early, the disease generally has a good survival rate. According to the AAP report,<sup>2</sup> between 909 and 322 000 circumcisions are needed to prevent 1 case of penile cancer. Penile cancer is linked to infection with human papillomaviruses,<sup>5</sup> which can be prevented without tissue loss through condom use and prophylactic vaccination. It is

remarkable that incidence rates of penile cancer in the United States, where ~75% of the non-Jewish, non-Muslim male population is circumcised,<sup>1</sup> are similar to rates in northern Europe, where ≤10% of the male population is circumcised.<sup>6</sup>

As a preventive measure for penile cancer, circumcision also fails to meet the criteria for preventive medicine: the evidence is not strong; the disease is rare and has a good survival rate; there are less intrusive ways of preventing the disease; and there is no compelling reason to deny boys their legitimate right to make their own informed decision when they are old enough to do so.

### TRADITIONAL STDs

According to the AAP report,<sup>2</sup> there is evidence that circumcision provides protection against 2 common viral STDs: genital herpes and genital warts. However, the evidence in favor of this claim is based primarily on findings in RCTs conducted among adult men in sub-Saharan Africa. For other STDs, such as syphilis, gonorrhea, and chlamydia, circumcision offers no convincing protection. The authors of the AAP report forget to stress that responsible use of condoms, regardless of circumcision status, will provide close to 100% reduction in risk for any STD. In addition, STDs occur only after sexual debut, which implies that the decision of whether to circumcise can be postponed to an age when boys are old enough to decide for themselves.

### HIV AND AIDS

From a public health perspective, what seems to be the AAP technical report's most important argument is that circumcision may reduce the burden of heterosexually transmitted HIV

infections in the United States.<sup>2</sup> Three RCTs in Kenya, Uganda, and South Africa suggest that circumcision in adulthood may lead to a noticeable reduction in risk of heterosexual HIV acquisition in areas with extremely high HIV prevalence.<sup>7–9</sup> Specifically, the African RCTs seemed to show that adult male circumcision halves heterosexual men's (but not women's) risk of HIV infection in the first few years after the operation from 2.49% to 1.18% in high-endemic areas where viral transmission occurs mainly through heterosexual intercourse. This evidence, however, is contradicted by other studies, which show no relationship between HIV infection rates and circumcision status.<sup>10</sup>

However, there is no evidence that circumcision, whether in infancy, childhood, or adulthood, is effective in preventing heterosexual transmission in countries where HIV prevalence is much lower and routes of transmission are different, such as Europe and the United States. Sexually transmitted HIV infections in the West occur predominantly among men who have sex with men, and there is no evidence that circumcision offers any protection against HIV acquisition in this group.<sup>11,12</sup>

The African findings are also not in line with the fact that the United States combines a high prevalence of STDs and HIV infections with a high percentage of routine circumcisions. The situation in most European countries is precisely the reverse: low circumcision rates combined with low HIV and STD rates. Therefore, other factors seem to play a more important role in the spread of HIV than circumcision status. This finding also suggests that there are alternative, less intrusive, and more effective ways of preventing HIV than circumcision, such as consistent use of condoms, safe-sex programs, easy access to

antiretroviral drugs, and clean needle programs.

As with traditional STDs, sexual transmission of HIV occurs only in sexually active individuals. Consequently, from an HIV prevention perspective, if at all effective in a Western context, circumcision can wait until boys are old enough to engage in sexual relationships. Boys can decide for themselves, therefore, whether they want to get circumcised to obtain, at best, partial protection against HIV or rather remain genitally intact and adopt safe-sex practices that are far more effective.

As with the other possible benefits, circumcision for HIV protection in Western countries fails to meet the criteria for preventive medicine: there is no strong evidence for effectiveness and other, more effective, and less intrusive means are available. There is also no compelling reason why the procedure should be performed long before sexual debut; sexually transmitted HIV infection is not a relevant threat to children.

## COMPLICATIONS

As mentioned in the AAP report,<sup>2</sup> the precise risk and extent of complications of circumcision are unknown. It is clear, however, that infections, hemorrhages, meatal strictures, and other problems do occur. Incidental deaths and (partial) amputations of the penis have also been reported, but exact figures are not available. Although some studies suggest that circumcision can lead to psychological, pain-related, and sexual problems later in life,<sup>13–15</sup> population-based prospective studies of long-term psychological, sexual, and urological effects of circumcision are lacking.

It seems that the authors of the AAP report consider the foreskin to be

a part of the male body that has no meaningful function in sexuality. However, the foreskin is a richly innervated structure that protects the glans and plays an important role in the mechanical function of the penis during sexual acts.<sup>16–20</sup> Recent studies, several of which were not included in the AAP report (although they were published within the inclusion period of 1995–2010), suggest that circumcision desensitizes the penis<sup>21,22</sup> and may lead to sexual problems in circumcised men and their partners.<sup>23–29</sup> In light of these uncertainties, physicians should heed the precautionary principle and not recommend circumcision for preventive reasons.

## CONCLUSIONS

The AAP's extensive report<sup>2</sup> was based on the scrutiny of a large number of complex scientific articles. Therefore, while striving for objectivity, the conclusions drawn by the 8 task force members reflect what these individual physicians perceived as trustworthy evidence. Cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious. The conclusions of the AAP Technical Report and Policy Statement are far from those reached by physicians in most other Western countries. As mentioned, only 1 of the aforementioned arguments has some theoretical relevance in relation to infant male circumcision; namely, the questionable argument of UTI prevention in infant boys. The other claimed health benefits are also questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves. Circumcision fails to meet the commonly accepted criteria for the justification of preventive medical procedures in children.



The cardinal medical question should not be whether circumcision can prevent disease, but how disease can best be prevented.

The AAP report<sup>2</sup> lacks a serious discussion of the central ethical dilemma with, on 1 side, parents' right to act in the best interest of the child on the basis of cultural, religious, and health-related beliefs and wishes and, on the other side, infant boys' basic right to

physical integrity in the absence of compelling reasons for surgery. Physical integrity is 1 of the most fundamental and inalienable rights a child has. Physicians and their professional organizations have a professional duty to protect this right, irrespective of the gender of the child.

There is growing consensus among physicians, including those in the United States, that physicians should

discourage parents from circumcising their healthy infant boys because non-therapeutic circumcision of underage boys in Western societies has no compelling health benefits, causes postoperative pain, can have serious long-term consequences, constitutes a violation of the United Nations' Declaration of the Rights of the Child, and conflicts with the Hippocratic oath: *primum non nocere*: First, do no harm.

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#### KEY WORDS

AIDS, HIV infection, male circumcision, penile carcinoma, sexually transmitted disease, urinary tract infection

#### ABBREVIATIONS

AAP—American Academy of Pediatrics  
 RCT—randomized controlled trials  
 STD—sexually transmitted disease  
 UTI—urinary tract infection

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## Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision

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RESEARCH ARTICLE

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# Complications of circumcision in male neonates, infants and children: a systematic review

Helen A Weiss<sup>1\*</sup>, Natasha Larke<sup>1</sup>, Daniel Halperin<sup>2</sup>, Inon Schenker<sup>3</sup>

## Abstract

**Background:** Approximately one in three men are circumcised globally, but there are relatively few data on the safety of the procedure. The aim of this paper is to summarize the literature on frequency of adverse events following pediatric circumcision, with a focus on developing countries.

**Methods:** PubMed and other databases were searched with keywords and MeSH terms including infant/newborn/pediatric/child, circumcision, complications and adverse events. Searches included all available years and were conducted on November 6<sup>th</sup> 2007 and updated on February 14<sup>th</sup> 2009. Additional searches of the Arabic literature included searches of relevant databases and University libraries for research theses on male circumcision. Studies were included if they contained data to estimate frequency of adverse events following neonatal, infant and child circumcision. There was no language restriction. A total of 1349 published papers were identified, of which 52 studies from 21 countries met the inclusion criteria. The Arabic literature searches identified 46 potentially relevant papers, of which six were included.

**Results:** Sixteen prospective studies evaluated complications following neonatal and infant circumcision. Most studies reported no severe adverse events (SAE), but two studies reported SAE frequency of 2%. The median frequency of any complication was 1.5% (range 0-16%). Child circumcision by medical providers tended to be associated with more complications (median frequency 6%; range 2-14%) than for neonates and infants. Traditional circumcision as a rite of passage is associated with substantially greater risks, more severe complications than medical circumcision or traditional circumcision among neonates.

**Conclusions:** Studies report few severe complications following circumcision. However, mild or moderate complications are seen, especially when circumcision is undertaken at older ages, by inexperienced providers or in non-sterile conditions. Pediatric circumcision will continue to be practiced for cultural, medical and as a long-term HIV/STI prevention strategy. Risk-reduction strategies including improved training of providers, and provision of appropriate sterile equipment, are urgently needed.

## Background

An estimated one in three males worldwide are circumcised, with almost universal coverage in some settings and very low prevalence in others [1]. As with any surgical procedure, circumcision can result in complications [2-4]. The most common early (intra-operative) complications tend to be minor and treatable: pain, bleeding, swelling or inadequate skin removal. However, serious complications can occur during the procedure, including death from excess bleeding and amputation of the glans

penis if the glans is not shielded during the procedure [5-10]. Late (post-operative) complications include pain, wound infection, the formation of a skin-bridge between the penile shaft and the glans, infection, urinary retention, meatal ulcer, meatal stenosis, fistulas, loss of penile sensitivity, sexual dysfunction and edema of the glans penis [11]. Circumcision is commonly conducted in neonates, infants and children for religious, cultural and medical reasons, yet there have been no systematic reviews of the published literature on complications associated with the procedure at this age.

Male circumcision is of public health interest as recent randomized controlled trials (RCT) have shown that adult circumcision reduces the risk of acquiring HIV

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infection by about 60% [12-14]. Several countries with high prevalence of HIV are now planning to expand access to safe circumcision [15], and the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended considering neonatal circumcision in addition to adult circumcision as a longer-term HIV prevention strategy [16]. Pilot projects for neonatal and infant circumcisions are now being considered in several African countries, and to inform these programs, we undertook a systematic review of practices of paediatric circumcision, including prevalence, age at circumcision, types and training of providers, circumcision methods used, frequency of complications and cost. Since expansion of male circumcision for HIV prevention is recommended in regions with high rates of heterosexual transmission (in practice, much of southern and parts of eastern Africa), we carried out searches specifically for non-Western regions of the world. In this paper, we report findings of frequencies of adverse events associated with neonatal, infant and child circumcision.

## Methods

### Search strategy

PubMed, African Healthline, LILACS and the Cochrane Central Register of Controlled Trials databases were searched with keywords and MeSH terms including infant/newborn/pediatric/child, circumcision, complications adverse events, Africa, Asia and Arabic. For example, we searched PubMed with the following search terms: "Circumcision, Male" [Mesh] AND "Infant, Newborn" [Mesh] AND ("Africa" [Mesh] OR "Asia" [Mesh]); "complications" [Subheading] OR "Intraoperative Complications" [Mesh] OR "Postoperative Complications" [Mesh] AND "Circumcision, Male" [Mesh] AND ("Africa" [Mesh] OR "Asia" [Mesh]); ("Child" [Mesh] AND "Circumcision, Male" [Mesh]) AND ("Africa" [Mesh] OR "Asia" [Mesh]); ("Infant, Newborn" [Mesh] OR "Child" [Mesh]) AND ("Circumcision, Male" [Mesh] OR "Circumcision, Male/adverse effects" [Mesh] OR "Circumcision, Male/complications" [Mesh] OR "Circumcision, Male/contraindications" [Mesh] OR "Circumcision, Male/mortality" [Mesh]); "Circumcision" [Mesh] "Circumcision, Male" [Mesh] AND "Arabic".

Searches were conducted on November 6<sup>th</sup> 2007 and updated on February 14<sup>th</sup> 2009. There was no language restriction. We also searched reference lists of relevant papers, including a systematic review of complications of male circumcision in Anglophone Africa [17]. A total of 1349 published papers were identified through these searches. The abstracts of these papers were read and full copies of 223 papers with information on complications were obtained. Data were extracted by HW and NL into standardised forms in Access.

Infant and child circumcision is almost universal in the Arab world, and we conducted additional searches of the Arabic literature, including searches of relevant databases, book reviews in 10 key academic centres on Middle Eastern Studies and searches of the Hebrew University of Jerusalem libraries for Masters and PhD research thesis focused on male circumcision. Searches were conducted from June to August 2008. The Arabic literature searches identified 46 potentially relevant papers, of which six contained information on circumcision complications.

### Analysis methods and definitions

Hospital-based studies of circumcision-related complications are usually retrospective and record-based [9,18,19]. Complications in these studies are commonly recorded from discharge sheets, so tend to underestimate the true frequency of complications because events occurring after discharge are not captured. Furthermore, not all post-operative complications will be seen again at the same hospital. We therefore present results separately for prospective and retrospective studies. Age at circumcision, and type of provider (medical or non-medical) were also thought *a-priori* to be associated with frequency of complications, and we present results stratified by these factors. We define neonatal as age up to 28 days, infant as 28 days-11 months, and child as 12 months-12 years. Many studies included boys circumcised at a range of ages. We included studies in which the mean or median age at circumcision was age 12 years or younger.

Definitions of complications varied between studies. To report complications as consistently as possible between studies, we excluded all cases of oozing or bleeding which was easily stopped by compression, as these were not consistently reported in all studies. Cases of excess residual foreskin or inadequate circumcision are also excluded - these are adverse outcome of circumcision and may involve further surgery, but are not medical complications *per se*. We also excluded some other minor complications from studies as noted under individual studies. We have also reported serious adverse events separately - these include complications defined as 'severe' or 'serious' by authors, or with long-term or life-threatening sequelae.

## Results

From the 223 potentially relevant papers, we identified 52 studies from 21 countries which included sufficient information to estimate frequency of adverse events following neonatal, infant and child circumcision. The remaining papers were largely case-reports and case-series of circumcision-related complications. We excluded one study among people with haemophilia [20], as any

surgical procedure in haemophiliacs is associated with a high risk of post-operative bleeding and is not representative of general populations.

#### **Complications following neonatal or infant circumcision**

We identified 16 prospective studies of complications following neonatal and infant circumcision, from 12 countries [9-11,21-33] (Table 1). Of these, most used the Plastibell [11,22,23,25-28], with others using the Gomco clamp [21,24,30,32], freehand circumcision [9,31], or a combination of methods [27,29,33].

The median frequency of any adverse event was 1.5% (range 0-16%), and median frequency of any serious adverse event was 0% (range 0-2%). Nine studies reported no serious adverse events, but three studies reported that 1-2% of boys had a serious complication [10,27,29]. One, a Canadian study of 100 neonates circumcised in 1961/1962 using the Gomco clamp or Plastibell reported one severe infection requiring antibiotics and one severe meatal ulcer [29]. Less severe complications were reported in a further 13 boys in this study. The other two studies with serious complications were from Nigeria. In one, among 141 boys circumcised in 3 hospitals in southeast Nigeria, complications were assessed at a 6 week post-operative visit or if they presented earlier with any complication [27]. Three boys (2.1%) had a urethral laceration. The most common complications in this study were minor including bleeding (9%) and meatal stenosis (3.5%). Complications were substantially more common when circumcision had been performed freehand (27% excluding incomplete circumcision) rather than using the Plastibell (8%), and when performed by midwives (19%) rather than doctors (7%). Moreover, among the doctors, the reported frequency of complications at the public (University Teaching) hospital was 1.6%, compared to 20% at private hospitals where the level of training and supervision is lower. A much higher frequency (90%) was seen at the mission hospital, which acts as a referral centre for complicated circumcisions. Three circumcisions had been performed by a traditional birth attendant, and all three had resultant complications (one bleeding, one incomplete circumcision, and one urethral fistula). The other study was among 322 infants attending a welfare clinic in Ibadan [10], in which there were 2 cases of amputation of the glans penis and one buried (trapped) penis. Overall in this study, complications were reported in 9.3% of boys, with a further 11% having excess residual foreskin. The most common complication was excessive loss of foreskin ( $n = 16$ ; 5%). Unusually, no cases of bleeding, wound infection, or haematoma were reported in this study. The method used was not reported for the majority of infants, and complications were most frequent when the procedure was performed by nurses rather than doctors or traditional circumcisers (data not given).

Of the remaining 13 studies, five reported adverse events in 0.3% or fewer boys [9,22,26,30,32], four in around 2% [11,21,23,25], and the remaining four studies reported adverse events in up to 16% of boys [24,28,31,33]. The studies with highest frequency of complications are from Pakistan and the United Kingdom (UK). The study from Pakistan reports on 200 infants circumcised under local anaesthesia at a Military Hospital using either the freehand or bone-cutter method (a forceps-guided method which does not shield the glans) [31]. Bleeding (defined as requiring more than an application of a pressure bandage) was reported in 9% of boys, and 7% had a local infection of the skin and mucosa. In the UK study, 1129 infants were circumcised by nurses using the Plastibell under local anaesthesia [28], and overall 125 (11.1%) of infants required some degree of follow-up, with complications seen in 5.5%. The most common complication involved the Plastibell ring device itself (3.6%), which is left on after the procedure and normally takes 7-10 days to fall off. The problems included delayed separation of the ring, incomplete separation of the ring, or the ring becoming stuck on the penile shaft. In all cases, the ring was removed without need of anaesthesia and the authors report this removal was quick, simple and atraumatic.

Three studies reported substantial variation in complication frequencies by age or circumcision method. For example, a US study of circumcision by the Gomco clamp stratified by age at circumcision and found no complications in 98 boys circumcised neonatally, but that 12/32 (30%) of infants aged 3-8.5 months had post-operative bleeding requiring suture repair [24]. These 32 boys were circumcised under general anaesthesia and no complications from the general anaesthesia were reported. In another study, complications were seen more frequently using the Plastibell (12/381; 3.1%) than the sleeve technique (4/205; 1.95% [33]).

A further ten studies on neonatal/infant circumcision were retrospective hospital-record based studies (Table 2). Five of these were from the USA, two from Pakistan, one each from Israel, Oman and Turkey. Reported frequency of complications were slightly lower than for the prospective studies, with five studies finding very low frequencies ( $\leq 0.6\%$ ) [19,34-37] and four in the range 2-4% [38-41]. The study reporting the highest proportion (4% in neonates, 10% in infants) included late complications (most commonly foreskin adhesions (7.8%)), with 3 cases (1.3%) of meatitis and 3 requiring circumcision revision (1.3%) [42]. As with prospective studies in neonates and infants, few serious adverse events were reported ( $< 0.2\%$  in all studies except among infants in one US study, where 3/230 (1.3%) of infants required circumcision revisions [42]).

**Table 1 Prospective studies of frequency of complications in studies of neonatal and infant circumcision**

Author	Country	No. of patients	Age	Type of provider	Method	Follow-up period	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Al Samarrai [11]	Saudi Arabia	2000	2-3 days	Junior staff with supervision	Plastibell	6 weeks plus immunisation clinic visits	1.4% <sup>c</sup>	0%
Amir <sup>d</sup> [21]	Saudi Arabia	1000	Mean 9 days	Surgeon	Gomco clamp	1 year	1.6%	0%
Banieghbal [32]	South Africa	583	Neonatal	Surgeon	Gomco clamp	1 month	0.3%	0%
Ben Chaim [9]	Israel	19,478	Mean 8 days	83% Mohel 17% Physician	Freehand	-	0.1%	0.1%
Bhat [22]	Oman	250	Neonatal (min 1 day)	Paediatrician	Plastibell	-	0%	0%
Duncan [23]	Jamaica	205	Neonatal	Surgeon	Plastibell	1 week	1.5%	0%
Horowitz [24]	USA	130	98 neonatal 32 infants (3-8.5 months)	Pediatric urologist	Gomco clamp	3 days	Overall: 7.4% Neonatal: 0% Infants: 30%	0%
Manji [25]	Tanzania	368	7 days to 9 months	Pediatrician	Plastibell	-	2.8% <sup>e</sup>	0%
Mousavi [33]	Iran	586	<12 months	Surgeon	50% sleeve 50% Plastibell	-	Sleeve: 1.95% Plastibell: 3.1% <sup>f</sup>	Sleeve: 0% Plastibell 2.1%
Okafor [26]	Nigeria	102	Immediate post-partum	Experienced surgeon	Plastibell	1 year	0%	0%
Okeke <sup>g</sup> [10]	Nigeria	322	8 days-13 months	55% Nurses 35% Doctors 9% Trad.	-	3 month	9.3%	1.0%
Osuigwe [27]	Nigeria	141	7-9 days	54% Doctors 44% Midwives 2% Trad. birth attendants	68% Plastibell 31% freehand	6 weeks	13.5% Plastibell: 8% Freehand: 27.3%	2.1%
Palit [28]	UK	1129	Mean age 11 weeks	Trained nurses under supervision of consultant urologists	Plastibell	3 months	5.5%	0.1%
Patel <sup>d</sup> [29]	Canada	100	3-5 days old	98% Medical doctors 2% Traditional Providers	51% Gomco 47% Plastibell 2% Ritual	-	15% <sup>h</sup>	2%
Perlmutter [30]	USA	51	Neonatal	Obstetrician or resident	Gomco	Up to 2 hours	0%	0%
Rehman [31]	Pakistan	200	Infant	Surgeon	50% freehand 50% bonecutter	1 week	16%	0.5%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> 18 patients with yellowish patches of sloughed tissue and erythema who did not have an infection confirmed through cultures, 4 patients with irregular skin margin and 4 patients with inadequate skin excision were excluded

<sup>d</sup> In these studies patients who had undergone circumcision were identified retrospectively, but wherever possible patients were actively followed up to obtain accurate complication risks.

<sup>e</sup> Risks by age at circumcision: 7-14 days: 0.9%; 15 days - 2 months: 4.7%; 2 - 9 months: 11.5%

<sup>f</sup> Excludes 'excess mucosa' and 'delayed Plastibell falling off'

<sup>g</sup> Patients were identified through an immunization clinic and a physical examination was conducted to confirm circumcision status and the presence and type of complications. Uncircumcised boys were followed up to identify boys circumcised at a later age and any complications

<sup>h</sup> 31 cases of mild oozing, 7 cases of mild infection with no antibiotic treatment were excluded

**Table 2 Retrospective studies of frequency of complications in studies of neonatal and infant circumcision**

Author	Country	Year of study	Number of patients	Age	Type of provider	Method used	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Al-Marhoon [34]	Oman	1997-2000	171	Neonatal	Surgeon	Plastibell	1.2% <sup>c</sup>	0% (Two needed sutures)
Christakis [35]	USA	1987-1996	130475	Neonatal	-	-	0.2%	0.2%
Eroglu [41]	Turkey	2001-2002	214	Neonatal	Surgeon	Gomco clamp	2.3%	0% (One needed sutures)
Gee [38]	USA	1963-1972	5521	Neonatal	Supervised medical student, resident, or physician	52% Gomco clamp 48% Plastibell	1.7% Gomco 2.3% Plastibell	0.2% <sup>d</sup>
Iftikhar [36]	Pakistan	1998-2001	316	0-12 yrs (72% within 1 week of birth)	Pediatric surgeon	Plastibell (<2 yrs old) Open technique (≥ 2 yrs)	0.6%	0%
Metcalf [42]	USA	1974-1979	591	61% Neonatal 39% Post-neonatal	-	-	4% neonatal 10% infants <sup>e</sup>	0.3% neonatal 1.3% infants
O'Brien [39]	USA	1985-1986	1951	Neonatal	-	43% Gomco 9.5% Plastibell 14.5% Electrocautery 33% not specified	3.1% overall	0%
Rafiq [40]	Pakistan	2000	100	Neonatal	Surgeon	Plastibell	2%	0%
Shulman [37]	Israel	1955-1963	8000	Neonatal	Mohelim	-	0.3%	0.1%
Wiswell [19]	USA	1980-1985	100157	Neonatal	Surgeons	-	0.2% 'serious'	0.2%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> Excludes one patient unable to pass urine for 24 hours

<sup>d</sup> The authors note that 14 patients (0.2%) had 'really significant' complications - one life-threatening haemorrhage, 4 systemic infections, 8 circumcisions of infants with hypospadias, and one complete denudation of the penile shaft.

<sup>e</sup> 6 patients with hygiene concerns were excluded

### Complications following child circumcision by medically trained providers

We identified ten prospective studies of complications in children aged one year old or older following circumcision by medically trained providers (Table 3) [43-52]. The median frequency of any adverse event was 6% (range 2-14%), and median frequency of any serious adverse event was 0% (range 0-3%). Adverse events were seen most commonly among boys circumcised mainly for medical, rather than religious or cultural, reasons. In one of these studies, among boys circumcised in the UK mainly for phimosis, 4/140 boys (2.8%) required acute re-admission to hospital [49] and the frequency of any adverse events was 6.4%. In the other, a Danish study of boys circumcised mainly for balanitis or phimosis, 1/43 (2.3%) boys required re-operation following Plastibell circumcision [52]. Of the other studies, in which boys were circumcised mainly for non-medical reasons, two studies reported any adverse event in about 2% of boys [43,50], three were 2-5% [47-49], and higher frequencies (7-14%) were seen in studies from the Netherlands [51], India [44],

Iran [45] and Turkey [46]. Complications included bleeding, infection, meatal stenosis and problems with the Plastibell device. The study from the Netherlands reported on complications among 94 Muslim boys circumcised under local anaesthesia outside the hospital. Of these, 13 were seen again because of bleeding (n = 4), infection (n = 2) or swelling (n = 7) [51], excluding the two cases of mild bleeding the frequency of complications was 12%. The Indian study was also small (n = 15) and reported 2 cases of minor wound separation which did not require further surgical intervention [44]. The study from Iran was an RCT in 394 boys, in which 13 (3.3%) boys developed meatal stenosis and 26 (6.6%) had infections at the circumcision site, and 43 (10.9%) had post-circumcision bleeding. Complications were significantly less frequent among boys who parents were randomised to use a lubricant (petroleum jelly) on the circumcision site [45]. Finally, the Turkish study reports complications following a hospital-based mass circumcision exercise, in which 700 boys were circumcised over 5 days. Excluding the cases of bleeding stopped by simple compression, 8% of boys had a

**Table 3 Prospective studies of frequency of complications in studies of child circumcision undertaken by medical providers**

Author	Country	Years	Setting	N	Age	Provider	Method	Indication	Follow-up period	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Ahmed [43,59]	Comoros Islands	1997-1998	Home	3824	2-8 years	Surgical aids, nurses & midwives	Dorsal slit	Routine	11 days	2.3%	0.5%
Aldemir [48]	Turkey	2006	Hospital	200	2-9 years	Urologist	65% Smart clamp 35% Dissection	Routine	6 weeks	5%	1%
Bazmamoun [45]	Iran	2006-2007	Hospital	394	Mean 9 months	Surgeon	Sleeve	Routine	6 months	7-10% <sup>c</sup>	0%
Griffiths [49]	England	1985	Hospital	99	Mean 4.3 years	-	Dissection	85% medical 11% religious 4% other	3-5 weeks	6.4% <sup>d</sup>	2.8% <sup>e</sup>
Ozdemir [46]	Turkey	1990s	Mass circ. in hospital	700	8 days to puberty	-	Forceps guided	Routine	3 months	8% <sup>f</sup>	0%
Schmitz [51]	Holland	1997	Health centre	94	Median 3 years	GP residents under supervision of a surgeon	Freehand	Religious	1 week	12%	0%
Schmitz [50]	Malaysia	2001	Community	64	Median 10 years	Medical assistants supervised by doctors	TaraKlamp	Routine	6 weeks	1.6%	0%
Sharma [44]	India	2003	Hospital	15	2-25 years	Surgeons	Dorsal slit	Medical or religious	90 days	13.3%	0%
Sorensen [52]	Denmark	1981-1983	Hospital	43	Mean 6.5 years (range 1-13)	Surgeon (early stage in training)	Plastibell	Medical	Mean 29 months	Immediate postoperative (reported) 9.3% <sup>g</sup> Late complications (reported) 0% <sup>h</sup>	0%
Subramaniam [47]	Singapore	-	Hospital	152	Mean 7 years	Surgeon	CO <sub>2</sub> laser	Not given	-	4.6%	0.7%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> 13 boys had meatal stenosis and 26 had infection. It is not clear whether there is overlap between these two groups.

<sup>d</sup> Defined by the authors as any admission to hospital or further surgery.

<sup>e</sup> Acute re-admissions to hospital

<sup>f</sup> Includes 15 cases of inadequate circumcision, since these were accompanied by secondary phimosis

<sup>g</sup> One case of haemorrhage that stopped spontaneously, 2 cases of erythema and pus with no confirmed infection or antibiotic treatment and 24 cases of dysuria due to irritation of the meatus due to the presences of a Plastibell excluded

<sup>h</sup> Seven cases of slight irritation of the glans excluded

complication, most commonly infection (2.7%) and inadequate foreskin removal accompanied by secondary phimosis (2.1%).

Adverse events in 11 retrospective studies tended to be less frequent than for the prospective studies, probably due to under-ascertainment of complications. Most studies reported no serious adverse events (Table 4), but one [53] reported that 2/79 (2.5%) boys required circumcision revisions following circumcision by the Plastibell device. Frequencies of any adverse

event varied from 0.3% in a study from Nigeria (5 minor complications reported out of 1563 circumcisions in the hospital over a 15 year period [7]) to 12% (15/129) in South Africa (mostly bleeding, haematoma and infection) and 17.5% (28/160) among boys circumcised with a new disposable device (the Shenghuan Disposable Minimally Invasive Circumcision Anastomosis Device) in China (mainly mild oedema (10%) but also moderate oedema and 2 cases of infection).

**Table 4 Retrospective studies of frequency of complications in studies of child circumcision undertaken by medical providers**

Author	Country	Years	Setting	N	Age	Method used	Indication	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Ahmed [7]	Nigeria	1981-1995	Hospital	1563	Mean 4 years	-	Routine	0.3%	-
Atikeler [54]	Turkey	1999-2002	Hospital	782	Mean 6 years	-	Medical indication or religious reasons	2.6%	0%
Cathcart [74]	UK	1997-2004	Hospital	66519	0-15 years	-	98% Medical	1.2%	0%
Lazarus [53]	South Africa	1999-2005	Hospital	95	'boys'	-	Medical or religious	5.1%	2.5%
Leitch [69]	Australia	1960s	Hospital	200	Mean 2 years	-	71% Medical 29% Cultural	11%	0%
Millar [75]	South Africa	1985-1987	Hospital	129	3 months to 10 years	Plastibell	19 revisions	12%	-
Ozdemir [46]	Turkey	1990s	Hospital	600	8 days to puberty	Forceps guided?	Routine	1.7%	0%
Peng [76]	China	2005-2007	Hospital	160	5-12 years	Shenghu disposable device	Mainly medical	Complications whilst wearing device : 17.5% <sup>c</sup> Complications after removal of device : 0.6%	0.6%
Rizvi [64]	Pakistan	1981-1991	Hospital	3096	'children'	-	-	1.6%	-
Wiswell [18]	USA	1985-1992	Hospital	476	Mean 3 years	Freehand or sleeve	Cultural (67%) Medical (33%)	1.7%	0.2%
Yegane [77]	Iran	2002	Community	1766	71% after 2 years of age	-	-	4.6% overall (late complications) 2.8% Urologists/ surgeons 6.1% GPs/ pediatricians 9.1% Paramedics	0%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> Seventy cases of swelling pain from nocturnal erection excluded

### Complications following child circumcision by non-medically trained personnel

Table 5 summarizes the five studies of complications following circumcision by non-medically trained providers. In these studies, frequencies of adverse events are generally higher, and complications more serious, even including penile amputation [7]. A high frequency of complications was seen in a retrospective study from Turkey of 407 boys circumcised at two traditional mass circumcision events [54]. The mean age of the boys at time of circumcision was 7 years (range 1-14 years) and the procedure had taken place in non-sterile conditions by unlicensed providers. Overall, complications were seen in 73% of boys, with the most common complications being wound infection (14%), subcutaneous cysts (14%), bleeding which needed suturing (12%), and haematoma (6%). Five boys (1.3%) developed a urinary infection requiring hospitalisation and intravenous

antibiotics. A further 12% of boys were deemed to have incomplete circumcision. In addition, 3 patients with (contra-indicated) hypospadias had been circumcised indicating inadequate screening of the boys.

The retrospective study from the Philippines interviewed 114 males aged 13-51 (mean age 25.9 years), of whom 94% reported having been circumcised below the age of 14 years. Most (68%) had been circumcised by non-medical personnel, and 60% of participants reported post-circumcision complications (inflammation and swelling) to their circumciser, and 4 (3.5%) reported profuse bleeding [55]. In contrast, in a household-based study in southwest Nigeria, respondents reported very few complications (2.8%) following circumcision, mainly by traditional providers [56]. Among 750 child circumcisions, there were 12 cases reported of excessive bleeding, 6 infections, 2 cases of tetanus and one death. The authors report that, although they include the death,



**Table 5 Retrospective studies of frequency of complications in studies of child circumcision undertaken by non-medical providers**

Author	Country	Years	Setting	Number of males	Age at circumcision	Provider	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Ahmed [7]	Nigeria	1981-1995	Community	1360 (approx)	Mean 4 years	Traditional	3.4%	-
Atikeler [54]	Turkey	1999-2002	Community	407	Mean 7 years	Traditional	73% <sup>c</sup>	
Lee [55]	Phillipines	2002	Community	114	42% 5-9 years 52% 10-14 years 5% 15-18 years	32% medical 68% traditional	63% <sup>d</sup>	3.5%
Myers [56]	Nigeria	-	Community	750	Infant/child	68% traditional 25% nurse/midwife 4% doctor	2.8%	-
Yegane [77]	Iran	2002	Community	1359	71% after 2 years of age	Traditional circumcisers	2.7% (late complications)	0%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> This very high rate of complications consisted of bleeding (24%), infection (14%), incomplete circumcision (12%), subcutaneous cysts (15%), haematoma (6%), ischaemia (3%), penile adhesion (3%), and other conditions. Of the 97 cases of bleeding, 48 could not be stopped by haemostatic bandage and were sutured. Infections were treated with parenteral or oral antibiotics.

<sup>d</sup> Of these, 94% were reported swollen or inflamed penises. Four respondents (3.5% of those circumcised) reported profuse bleeding

there was insufficient information to be certain it was caused by circumcision. A study from Iran reported a late-phase complication frequency of 2.7% following traditional circumcision and a further 5% had excessive residual foreskin. This was similar to circumcisions performed by urologists or surgeons (2.8%), but lower than for GPs/paediatricians (6.1%) or paramedical personnel (9.1%). The authors argue that this is because traditional circumcisers in Iran are experienced and paramedical personnel do not receive effective training.

## Discussion

Male circumcision is a common surgical procedure, but few epidemiological studies have reported frequency of adverse events, most commonly bleeding and infection. Our review shows that serious adverse events are rare, but there is wide variation in reported frequencies of adverse events following circumcision. This is likely to be due to several factors directly associated with complications such as age at circumcision, training and expertise of the provider, the sterility of the conditions under which the procedure is undertaken and the indication (medical/cultural) for circumcision. In addition, there is variation due to methodological issues such as duration of follow-up, epidemiological study design, and definition of complications.

In general, complications (reported by parents) occur least frequently among neonates and infants than among older boys, with the majority of prospective studies in neonates and infants finding no serious complications, and relatively few other adverse events, which were minor and

treatable. The prospective studies in older boys also found virtually no serious adverse events, but a higher frequency of complications (up to 14%) even when conducted by trained providers in sterile settings [47]. The lower frequency of complications among neonates and infants is likely to be attributable to the simpler nature of the procedure in this age group, and the healing capability in the newborn. Further, a major advantage of neonatal circumcision is that suturing is not usually necessary, whereas it is commonly needed for circumcisions in the post-neonatal period. This advantage is illustrated by the US study in which no complications were seen among 98 boys circumcised in the first month of life, but 30% of boys aged 3-8.5 months had significant postoperative bleeding [24]. There are alternatives to suturing, either with the disposable clamps, or with alternatives such as cyanoacrylate glue [44] and further research in this area is needed.

Several studies stress the importance of careful training and experience of the provider, and the sterility of the setting. This was most clearly noted in a Nigerian study [27] in which 24% of boys had reported complications (including retention of excess residual foreskin), but only 1.6% of those circumcised at the public (University Teaching) hospital by medical doctors. Similarly, two case-control studies from Israel have found that UTI are 3-4 times more likely to occur following circumcised by a traditional, rather than medical provider [57,58]. However, as noted in our review, neonatal circumcision following traditional circumcision in Israel has low complication rates overall [9]. A further example is the study from the Comoros Islands which reported results of an exercise in which specific

training had been given to surgical aids and nurses to perform circumcisions. The proportion of boys with complications (2.3%) was reported to be a great improvement on that by traditional non-medically trained providers [43,59]. The high frequency of adverse events following circumcision by untrained providers in non-sterile settings is striking in two studies of traditional circumcision which found alarmingly high prevalence of around 80% [54,60]. Notably, in one of these, the self-reported frequency was much lower, illustrating the under-ascertainment that can occur in retrospective studies. Mass circumcisions are particularly risky, even when undertaken in the hospital. For example, the Turkish study of 700 children circumcised during a 5 day period recorded a complication frequency of 8%, likely due to the difficulty in providing sufficient sterile equipment and conditions [46]. The reason for surgery can also influence the risk of adverse events as seen in the studies of child circumcision where more complications were generally seen if circumcision was conducted for medical rather than religious reasons.

Our systematic review was restricted to circumcision complications among boys aged 12 years or under. However, there are several published studies of circumcision complications among adolescent and adult men (Table 6) and these indicate a generally higher frequency of complications than seen in neonates, infants and children. In the three RCTs of circumcision in adult men, complications were observed in 2-7% of HIV-negative men [14,61,62], and in 6-8% of HIV positive men [14,62]. The most detailed observational study was conducted among the Babukusu ethnic group in western Kenya. Of 562 adolescents circumcision by a medical provider (or reported as such), 18% had a complication, as did 35% of boys circumcised traditionally [60]. A sub-study in the same population directly observed 24 boys undergoing medical and traditional circumcision respectively and found that of those circumcised medically, only one boy had no adverse events, and 3 permanent adverse sequelae were reported, including one very serious life-threatening case by a 'medical' practitioner who was later found to have no documented medical qualifications [60]. Among the 12 directly observed traditional circumcisions, complications were seen in 10 boys (83%), and 4 (33%) were judged to have permanent adverse sequelae. None had fully healed by 30 days post-operation. Detailed examination showed that traditional circumcision was also associated with slower healing, more swelling, laceration and keloid scarring [60]. These results show that under non-sterile conditions, adolescent and adult circumcision can frequently be associated with severe complications. Other case-series of circumcision complications among adolescents and young men also report severe morbidity and mortality [63-68]. Reported complications tend to be more

common in this age group than for neonates and infants, even when circumcision is conducted under the 'gold standard' conditions such as in the RCTs.

A major challenge in our review was to standardise the definition of complications. For example, Okeke et al [10] report complications in 20% of boys, of which half were excessive residual foreskin - an adverse event but arguably not a medical risk. We excluded these cases where possible. Similarly, the paper by Gee et al [38] cites a total of 110 complications out of 5521 (2.0%) but states that only 14 complications (0.2%) were considered 'really significant' (one life-threatening hemorrhage, 4 systemic infections, 8 circumcisions of infants with hypospadias and one complete denudation of the penile shaft). The other complications included bleeding, infection, circumcision of hypospadias, and a Plastibell ring that was too tight. The problem of defining complications is also highlighted in the early (1961-1962) study from Canada in which moderate or severe complications (bleeding, infection, meatal ulcer, meatal stenosis and phimosis) were seen in 15 infants (15%) but a further 68 infants had mild bleeding, meatal ulcers or infection [29]. Complication risks in this study have previously been reported as 55% [4], which includes any bleeding, including oozing. A further example is the Australian study [69] which reported complications in 8% of boys, which included several cases of mild bleeding which either ceased spontaneously or with simple management such as digital pressure. We have attempted to report 'severe' or 'serious' adverse events as a separate outcome, but data on this is often limited and it would be useful to produce a standard classification of mild, moderate and severe complications following circumcision so that in future studies may be more easily comparable. Other limitations related to the design of the epidemiological studies. The length of follow-up varies between, and within, studies, and may affect the estimated frequency of complications. For this reason we tend not to term the frequency as a 'risk'. It is also possible that the lower frequencies of complications in prospective studies are due to improved procedures by practitioners or improved hygiene by patients as a result of participating in the study. Finally, a number of studies are small and the estimates of frequency of complications will be correspondingly imprecise.

We excluded one study of circumcision among patients with inherited bleeding disorders [20] as we were interested in complications in general populations. In this study, of 71 patients diagnosed from 1961-1996, 52% had a record of post circumcision bleeding. In many settings, boys are not asked about a family history of bleeding disorders and this can potentially lead to severe circumcision-related complications.

**Table 6 Frequency of complications in studies of adolescent and adult circumcision**

Author	Country	Years	Setting	N	Age	Provider	Method	Indication	Follow-up period	Frequency of adverse events <sup>a</sup>	Frequency of serious adverse events <sup>b</sup>
Auvert [14]	South Africa	2002-2004	GP offices	1495 HIV neg	18-24 years	GPs	Forceps guided	Enrolled in trial	1 month	3.6%	-
Auvert [14]	South Africa	2002-2004	GP offices	73 HIV positive	18-24 years	GPs	Forceps guided	Enrolled in trial	1 month	8.2%	-
Bailey [60]	Kenya	2004	Home or community	445	66% aged below 15 years	Traditional	-	Cultural	30-89 days	35%	24% <sup>c</sup>
Bailey [60]	Kenya	2004	Home or community	12		Traditional	-	Cultural	~3 months	83%	33% <sup>d</sup>
Bailey [60]	Kenya	2004	Hospital, health centre, or private office	562	90% aged below 15 years	Clinician <sup>e</sup>	-	Cultural	30-89 days	18% <sup>f</sup>	19% <sup>h</sup>
Bailey [60]	Kenya	2004	Hospital, health centre, or private office	12	-	Clinician <sup>j</sup>	-	Cultural	~3 months	92% <sup>e</sup>	25% <sup>i</sup>
Bowa [78]	Zambia	2004-2006	Urology outpatient clinic	900	5 months to 96 years	Trained clinical officer	Dorsal slit method	Cultural	8 weeks	3.0%	0.06% at 8 weeks
Kigozi [62]	Uganda	2003-2005	Trial operating theatre	2326 HIV neg	15-49 years	Trained physician	Sleeve method/	Enrolled in trial	6 weeks	7.4%	0.2% severe 3.3% moderate
Kigozi [62]	Uganda	2003-2006	Trial operating theatre	420 HIV positive	15-49 years	Trained physician	Sleeve method/	Enrolled in trial	6 weeks	6.0%	0% severe (3.1% moderate)
Krieger [61]	Kenya	2002-2005	Trial clinic	1475	18-24 years	Medical and clinical officers	Forceps guided	Enrolled in trial	90 days	1.8%	0% severe (0.7% moderate)
Magoha [79]	Nigeria & Kenya	1981-1998	Hospital	249	32% neonates 6% children 61% adolescent/ adult	Surgeon	Forceps guided	72% Cultural/ religious 12% Parental request 16% Medical	-	11%	2.8% severe <sup>g</sup>
Peltzer [80]	South Africa			78	Median 19 years (range 16-25)	Doctors and nurses following 1 day training		Cultural (Xhosa) initiat	-	3.8%	0%

<sup>a</sup> Cases of minor bleeding stopped with simple pressure or 'conservative management' and excessive foreskin/inadequate circumcision are not included

<sup>b</sup> Includes complications defined as 'serious' or 'severe' by authors, or with long-term or life-threatening sequelae (partial amputation of glans, urethral laceration, need for re-surgery or plastic surgery)

<sup>c</sup> Wound not healed at 60 days after surgery

<sup>d</sup> Permanent adverse sequale

<sup>e</sup> Anyone considered by the participant to be a clinician

<sup>f</sup> Including an unknown number with residual foreskin

<sup>g</sup> Includes severe haemorrhage (n = 3), scrotal laceration (n = 2), penile shaft denudation (n = 1) and glandular injury (n = 1).

## Conclusion

Male circumcision is commonly practiced and will continue to occur for religious, cultural and medical reasons. In general, complications are minor and treatable, especially at young ages, but high frequency of complications, and severe complications, are seen when the procedure is undertaken by inexperienced providers, in

non-sterile settings or with inadequate equipment and supplies. Further prospective studies with monitoring of risks following circumcision are needed to document complications using standardised definitions, and to compare the risks associated with different methods, age at circumcision, and to evaluate the impact of specific and ongoing training of providers. Such studies are

underway in some settings where male circumcision services are being expanded for HIV prevention. A set of guidelines on expansion of male circumcision have been produced by WHO/UNAIDS, and include operational guidance for scaling up male circumcision for HIV prevention, a surgical manual for male circumcision under local anaesthesia, guidance for decision-makers on human rights, ethical and legal considerations protocols for monitoring and evaluation [70].

There is a clear need to improve safety of male circumcision at all ages through improved training or re-training for both traditional and medically trained providers, and to ensure that providers have adequate supplies of necessary equipment and instruments for safe circumcision. Strategies for training and quality assurance are needed and will be context specific. In Swaziland, "Operation AB" demonstrated a comprehensive model of training teams of medical providers in safe and swift adolescent and adult circumcisions, with improved sterilization equipment and clients' education, at community-level clinics [71]. In Ghana, where neonatal circumcision is almost universal, the formal Health Service provides training to traditional providers in Accra, with training on basic hygiene and provision of necessary equipment, such as sterile gloves and dressings [72]. In South Africa it has been suggested that community health nurses create opportunities to educate traditional circumcisers of adolescents and adults on basic hygiene requirements to be met before, during and after circumcision [72], USAID/PATH/MSH have designed a training program in the Eastern Cape for training traditional providers about safe circumcision practices [73]. Links between the formal and informal health sectors should be explored elsewhere to institute quality standard practices for both traditional and medical circumcisers, for example wearing sterile gloves, using sterile instruments and appropriate aftercare, and creating a formal structure through which to monitor and regulate the conduct of circumcision. Through these steps, it is likely that the safety of this common procedure can be substantially improved.

#### Abbreviations

GP: General Practitioner; RCT: Randomised controlled trials; UK: United Kingdom; UNAIDS: The Joint United Nations Programme on HIV/AIDS; USA: United States of America; WHO: World Health Organisation.

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#### Authors' contributions

The review was designed and conducted by HW and NL. The first draft of the paper was written by HW. IS and DH critically reviewed the manuscript and approved the final version. All authors read and approved the final version of the paper.

#### Competing interests

The authors declare that they have no competing interests.

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### Rättsutredning om rättsläget kring omskärelse av pojkar

- Lagen (2001:499) om omskärelse av pojkar (OmskL)
- Socialstyrelsens föreskrifter och allmänna råd (SOSFS 2001:14) om omskärelse av pojkar.
- Omskärelse av pojkar - Rapport av ett regeringsuppdrag till Socialstyrelsen (S2005/7490/SK)

Omskärelselagen infördes för att garantera att omskärelser äger rum på ett betryggande sätt i enlighet med vad hänsynen till barnets bästa kräver och är i överensstämmelse med de krav som ställs i bl.a. FN:s konvention om barnets rättigheter när det gäller åtgärder som rör barn.

Lagen (2001:499) om omskärelse av pojkar (OmskL) trädde i kraft den 1 oktober 2001.

Socialstyrelsen har även utfärdat föreskrifter och allmänna råd (SOSFS 2001:14) om omskärelse av pojkar.

Med beaktande av svenska förhållanden, görs bedömningen inom svensk hälso- och sjukvård att det saknas medicinskt hållbara skäl för att här, generellt, utföra ingreppet av medicinskt förebyggande skäl. Omskärelser kan anses som medicinskt motiverade eller indikerade – och därmed som hälso- och sjukvård – endast i sådana fall då de utförs vid exempelvis förhudsförträngning samt vid vissa infektioner och skador. I lagen avses sådana omskärelser som företas på religiöst eller kulturellt betingade grunder (dvs. sådana omskärelser som ibland brukar betecknas som ”etniska” eller ”rituella”) och sådana omskärelser som företas på grund av uppfattningen att ingreppet generellt sett främjar hygien och bör ses som förebyggande hälsovård.

I Sverige utförs omskärelse i regel av hälso- och sjukvårdspersonal även i de fall då ingreppet görs utan medicinsk indikation. Omskärelser av pojkar utan medicinsk indikation utförs inom såväl offentligt som

privat bedriven hälso- och sjukvård. Vanligast är att ingreppet utförs i öppen vård. Ingreppet kan dock också utföras av personer som inte har medicinsk kompetens<sup>1</sup>.

Omskärrelser av den typ som omfattas här, anses inte vara hälso- och sjukvård i hälso- och sjukvårdslagens (1982:763) mening. Det är dock ett *kirurgiskt ingrepp* som enligt lagens motiv ska utföras i enlighet med *vetenskap och beprövad erfarenhet*. Ingreppet ligger nära omfånget för hälso- och sjukvården. Därtill kommer, att i lagen (1998:531) om yrkesverksamhet på hälso- och sjukvårdens område omfattas även omskärrelser av icke medicinska skäl i begreppet hälso- och sjukvård (1 kap. 2 §). Eftersom omskärrelse av det aktuella slaget inte är hälso- och sjukvård har det tydliggjorts i 2 § OmskL, att när en legitimerad läkare utför en omskärrelse enligt lagen, eller när legitimerad läkare eller legitimerad sjuksköterska ombesörjer smärtlindring enligt lagen, gäller patientsäkerhetslagen (2010:659), patientskadelagen (1996:799) och patientdatalagen (2008:355).

Med hänsyn till barnets bästa har Socialstyrelsen låtit göra en genomgång av de ärenden som rör omskärrelse av pojkar och som Socialstyrelsen på ett eller annat sätt har fått kännedom om från år 2000 till 2007. Under åren 2000–2001 utreddes två ärenden<sup>2</sup> med allvarliga komplikationer. Åren 2002 och fram till 2007 har Socialstyrelsen utrett 14 ärenden<sup>3</sup>.

I Sverige saknas idag en *rätt* att få ingreppet utfört inom den offentliga hälso- och sjukvården. Det finns därmed heller ingen motsvarande *skyldighet* för sjukvårdshuvudmännen att låta utföra ingreppet.

Socialstyrelsen konstaterar i rapporten dock att lagens utformning inte fyller sitt syfte när det gäller söner till föräldrar av muslimskt ursprung eller till andra föräldrar som låter omskära sina söner. Ett stort antal pojkar omskärs utanför hälso- och sjukvården, främst därför att föräldrarna inte vet vart de ska vända sig. I dessa fall ökar riskerna för att föräldrarna vänder sig till icke kompetenta personer. Möjligheten att i Sverige kunna utföra omskärrelser även utanför hälso- och sjukvården

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<sup>1</sup> Inom islam kan, men behöver inte, läkaren vara muslim. Inom de judiska församlingarna i Sverige finns sedan lång tid en etablerad organisation för omskärrelse av pojkar. Den som utför judiska omskärrelser kallas mohel. Det ställs inga krav på att en person måste vara läkare för att utses till mohel, men det finns moheler som också är läkare. En mohel måste vara jude och ha särskilda kunskaper om den judiska religionen. Han måste också ha genomgått särskild utbildning. Den blivande mohelen lärs upp av en erfaren mohel. Det finns dock inte någon standardiserad utbildning. Det förekommer också att en mohel omskär muslimska pojkar.

<sup>2</sup> I det ena fallet avled pojken och i det andra blev pojken okontaktbar och fördes akut till sjukhus på grund av överdosering av bedövningsmedel. I båda fallen utfördes ingreppet av legitimerade läkare och Socialstyrelsen hade anledning att göra anmälan till Hälso- och sjukvårdens ansvarsnämnd respektive till åklagare.

<sup>3</sup> I ett av dem gjordes anmälan av utföraren själv till Socialstyrelsen enligt Lex Maria. Anmälan ledde dock inte till någon kritik från Socialstyrelsen, eftersom den komplikation som uppstod (blödning) ansågs vara en normal risk vid ett sådant ingrepp.



har införts främst mot bakgrund av att det anses fungera väl inom den judiska traditionen.

Förutsättningarna för att en omskärelse skall få utföras är att den enligt 3 § OmskL sker *på begäran av*, eller efter *medgivande av*, pojakens vårdnadshavare och *efter* det att vårdnadshavaren har *informerats* om vad ingreppet innebär. Står pojken under vårdnad av två vårdnadshavare, gäller detta båda. Det är *den som ska utföra ingreppet* som själv ansvarar för att informationen ges eller att den ges av en medicinskt kunnig person. Den som ska utföra ingreppet skall förvissa sig om att information har lämnats och att pojakens vårdnadshavare, eller pojken själv, förstår den. Ett ingrepp får *inte* utföras om sådan information inte har lämnats. Den som skall utföra ingreppet skall också försöka ta reda på pojakens inställning om pojken är gammal och mogen nog att kunna ge uttryck för en sådan. En pojke får *inte* omskäras om han tydligt visar att han motsätter sig att det sker. Pojken har *vetorätt*. Även om vårdnadshavarna vill att ingreppet görs får det inte utföras mot pojakens vilja.

Enligt 4 § OmskL ska ingreppet utföras med *smärtlindring* som ombesörjs av legitimerad läkare eller legitimerad sjuksköterska, under *betryggande hygieniska förhållanden* och med hänsyn till vad som är bäst för pojken. Samma krav gäller vid omskärelser som utförs av personer med särskilt tillstånd. Hänsynen till barnens bästa måste vara avgörande när det gäller vilken smärtlindring som ska ges.

Det är enligt 5 § OmskL endast *legitimerade läkare* eller personer som har *särskilt tillstånd* som är behöriga att utföra omskärelser av pojkar. Bestämmelsen anger vilka som är behöriga att utföra omskärelser och förbjuder samtidigt andra att utföra ingreppet. På *pojkar som är äldre än två månader* får dock ingen annan person än en *legitimerad läkare* utföra omskärelse. Bakgrunden till detta är att ingreppet, enligt föredragande statsråd, är minst komplicerat när pojken är riktigt liten och att omskärelser i den judiska församlingen inte sker på pojkar som är äldre än två månader. Då det saknas en reglering i lag att läkare skall ha viss kompetens för att utföra omskärelse av medicinska skäl har man heller inte ansett att sådana krav borde införas i OmskL.

Det har det framkommit av ärenden som Socialstyrelsen har fått kännedom om via sjukvården, av enkäter riktade till BVC och av intervjuer, att det förekommer komplikationer efter omskärelser som har gjorts utanför hälso- och sjukvården. De här omskärelserna har ibland utförts under osterila förhållanden och utan eller med otillfredsställande smärtlindring för barnet. Den som har utfört ingreppet har inte haft kompetens att bedöma i vilka fall ingreppet är olämpligt att utföra. De här omskärelserna ger inte någon möjlighet till återbesök vid behov. Socialstyrelsen bedömde 2007 att det utförs 1 000–2 000 omskärelser av den här typen av varje år. De

komplikationer som oftast uppmärksammas på BVC är enligt enkätsvaren infektioner, blödningar, svårigheter att kissa och förträngningar. Andra förekommande komplikationer är att stygn har varit svåra att avlägsna, svullnad, vävnadsdöd och blodstockning. Mer än en tredjedel av de BVC som har svarat ser ofta eller ibland infektioner som komplikation. Det framkommer inte av svaren om de här infektionerna har samband med ingrepp som har utförts utanför hälso- och sjukvården.

I ärenden som har kommit till Socialstyrelsens kännedom har det i princip varit av samma karaktär som vid ovan nämnda händelser. Det har alltså bl.a. varit fråga om infektioner av olika grad, smärtpåverkan och gapande sår. Inget av dessa fall synes dock ha behövt reopereras.

I 10 av 13 ärenden som Socialstyrelsen har utrett har utförandet skett av icke behöriga personer. Ingreppen har utförts i pojkarnas hem av tillresande person(er), enligt uppgift med annan nordisk läkarlegitimation, eller i läkarens hem i ett annat nordiskt land. De har alltså saknat svensk läkarlegitimation eller särskilt tillstånd att utföra omskärrelser. I några fall har personer som inte är legitimerade läkare omskurit barn som var äldre än två månader.

I flera fall har Socialstyrelsen heller *inte* kunnat identifiera den person som har utfört omskärrelsen. Vid kontakt med föräldrarna har de inte vetat mer än ett förnamn på utföraren. Socialstyrelsen har alltså inte kunnat fortsätta utredningen i dessa fall.

Det finns landsting<sup>4</sup> som sett till att ha ett vårdavtal med en privatklinik som är specialiserad på omskärrelse av pojkar verkar fungera väl och vara säker för patienterna. Avgörande är att kliniken har ett kvalitetsarbete med uppföljning av sina operationer. Detta har redovisat en mycket låg komplikationsfrekvens. Detta är ett exempel på att sätta barnets bästa i första hand och kan förhindra att pojkar far illa inom omskärrelseverksamheten.

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<sup>4</sup> Stockholms läns landsting