Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Circumcision in Children Policy

Statement

NHS Derby and Derbyshire ICB (DDICB), in line with its principles for procedures of limited clinical value has deemed that the circumcision of children should not routinely be commissioned unless the criteria within this policy are met.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Male circumcision is a surgical procedure to remove the foreskin - it is mostly done in babies and young children but can be done at any age. Circumcision may be performed for clinical, cultural or religious reasons.

2. Recommendation

This policy covers circumcision in children aged under 16 years. Circumcision in children should not be considered on an 'on request' basis and is not indicated in a normal foreskin.

Indications for Circumcision in Children

Absolute/Medical Indications
• Penile malignancy (extremely rare condition) • Pathological phimosis (balanitis xerotica obliterans (BXO)/lichen sclerosus) • Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis • Prophylaxis against recurrent culture-proven urinary infection in boys with an uropathy or impaired kidney function

Relative Indications for Circumcision
• **Recurrent presentations of balanoposthitis** or refractory cases not responding to first line treatments (including bathing, topical steroids and antibiotics)
• **Hooded foreskin with or without hypospadias** o Hooded foreskin without hypospadias is a cosmetic abnormality, and a modified circumcision or foreskin reconstruction may be undertaken, but only after a full discussion with the parents
• **Megaprepuce** o Megaprepuce is a congenital penile malformation for which reconstruction may be carried out in infancy due to the high incidence of infection caused by the condition
• **Persistent phimosis** in children approaching puberty, following an attempted trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. o A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed

Non-Funded Indications

Non-Funded Indications for Circumcision
• Non-therapeutic 'Routine and Ritual' circumcision, i.e., on cultural or religious grounds • Dysmorphobia, as the aim of surgery is to improve functional outcomes, not mental health • Where aetiology of the presenting condition will not be improved by circumcision alone or is unrelated, for example premature ejaculation and buried penis • Preputioplasty is a viable option for management in older teenagers • Hooded foreskin without hypospadias o Hooded foreskin without hypospadias is a cosmetic abnormality

Exceptional Circumstances Funding will only be considered where there are exceptional clinical circumstances. The clinician needs to submit an application to the ICB's Individual Funding Request Panel (IFR).

Inclusion Criteria
DDICB will only support circumcision in the case of clinical needs where the patient meets the criteria outlined under the section 'Indications for Circumcision in Children' within this policy.

Exclusion Criteria
Routine and ritual circumcision will not be considered on social or religious grounds on the basis that:

- The DH advises that the legality of male circumcision for religious reasons could conflict with the Human Rights Act and current child protection legislation.
- The issue of informed consent when a young child is involved is unclear and complex.
- The risks associated with routine circumcision, such as infection and bleeding, outweigh the benefits.
- GMC and BMA guidance reflects society's disagreement as to whether circumcision is a beneficial, neutral or harmful procedure and recognises the complex issues that arise for doctors when considering whether to circumcise male children for nontherapeutic reasons. Neither the BMA nor GMC take a view as regards the lawfulness or appropriateness of circumcision for non-therapeutic reasons.

3. Rationale for Recommendation

Nearly all boys are born with non-retractable foreskins as they are still in the process of developing and are often non-retractable up to the age of 3 years old. During normal development, the foreskin gradually becomes retractable without the need for any intervention. The majority of boys will have a retractable foreskin by 10 years of age and 95% by 16-17 years of age. Inability to retract the foreskin in boys up to at least the age of 16, in the absence of scarring, is therefore, physiologically normal and does not require any intervention.

Paraphimosis (where the foreskin becomes trapped behind the glands and cannot go forward again) can usually be reduced under local anaesthetic and recurrence avoided by not forcibly retracting the foreskin. It should not be regarded as a routine indication for circumcision. There are several alternatives to treating retraction difficulties before circumcision is carried out. The BMA states that to circumcise for therapeutic reasons, where medical research has shown other techniques (such as topical steroids or manual stretching under local anaesthetic) to be at least as effective and less invasive, would be unethical and inappropriate.

Common risks of surgical circumcision include bleeding local sepsis, oozing, discomfort >7 days, meatal scabbing or stenosis, removal of too much or too little skin, urethral injury, amputation of the glands and inclusion cyst. Furthermore, long-term psychological trauma and possible decreased sexual pleasure have also been reported. There are claims that there may be health benefits associated with this procedure, for example a lower rate of penile cancer and a reduced chance of sexual transmitted diseases (including HIV among heterosexual men). However, the overall clinical and cost-effectiveness evidence is inconclusive. Condoms are far more effective (98% effective if used correctly) than circumcision for preventing STIs.

4. Useful Resources

- Commissioning guide: Foreskin conditions, Royal College of Surgeons, published 2013, accessed 01/08/23, Foreskin Conditions - Commissioning Guide — Royal College of Surgeons (rcseng.ac.uk)

5. References

- Commissioning guide: Foreskin conditions, Royal College of Surgeons, published 2013, accessed 01/08/23, Foreskin Conditions - Commissioning Guide — Royal College of Surgeons (rcseng.ac.uk)
- Management of Foreskin Conditions, A statement from the British Association of Paediatric Urologists on behalf of the British Association of Paediatric Surgeons and the Association of Paediatric Anaesthetists, published June 2006, accessed 01/08/23, circum_draft (baps.org.uk).
- Circumcision (Complete Removal of the Foreskin), The British Association of Urological Surgeons, published December 2020, accessed 01/08/23, https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Circumcision.pdf
- How does Male Circumcision Protect Against HIV Infection? Education and debat=e, Szabo R, Short R, BMJ, 320: 1592-1594, published June 2000, accessed 01/08/23, https://www.bmj.com/content/320/7249/1592
- Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations, World Health Organisation, published 17/08/20, accessed 01/08/23, https://www.who.int/publications/i/item/978-92-4-000854-0
- BHIVA–BASHH Position Statement on PrEP in UK, Second Update May 2016, accessed 01/08/23, https://www.bhiva.org/file/XuypkBDzUFcwO/BHIVA-BASHH-Position-Statement-on-PrEP-in-UK-May-2016.pdf
- Penile circumcision in under 16 years of age, Evidence based Interventions List 3 Guidance, Academy of Medical Royal Colleges, published May 2023, last accessed 01/08/23, EBI_Guidance_List3_0523.pdf (aomrc.org.uk)

6. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Consultant Urologist (CRHFT)	October 2021
Consultant Urologist (UHDBFT)	November 2021
BASHH	November 2021
Clinical Policy Advisory Group (CPAG)	November 2021
Clinical and Lay Commissioning Committee (CLCC)	January 2022
Consultant General and Vascular (Lead) and Pediatric (Lead) Surgeon (UHDBFT)	June 2023
Consultant Paediatric Surgeon (NCHT and UHDBFT)	July 2023
Consultant Urological Surgeon (CRHFT)	July 2023
Clinical Policy Advisory Group (CPAG)	September 2023
Consultant Paediatric Surgeon (NCHFT and UHDBFT)	June 2024
Consultant General and Vascular (Lead) and Pediatric (Lead) Surgeon (UHDBFT)	June 2024
Urology Consultants (UHDBFT)	June 2024
Urology Consultants (CRHFT)	June 2024
Clinical Policy Advisory Group (CPAG)	July 2024

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 3.0 • Updated background information, useful resources, references and consultation	November 2021
Version 3.1 • Policy separated into 2 policies – circumcision in adults and circumcision in children. Minor update to criteria wording in line with EBI3 wording: o Clarification that the policy applies to children aged under 16 years o Use of umbrella term 'pathological phimosis'	September 2023

○ Traumatic foreskin injury criteria updated with 'Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis' • Criteria 'persistent phimosis in children approaching puberty, following an attempted trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed' added to policy in line with EBI3 recommendations. The following non-funded indications for circumcision have been removed: • Paraphimosis – Reduction (with/without anaesthetic is preferred). Following reduction, the foreskin will continue to develop normally ○ Physiological phimosis/non-retractile healthy foreskin – Most cases resolve with advancing age with no intervention • Section 5. References updated to include EBI3 reference. Policy wording also updated to reflect the new DDICB organisation	
<u>Version 3.2</u> • CPAG agreed to extend the review date of this policy by 12 months, in agreement with clinical stakeholders, due to reduced capacity within the Clinical Policies team	July 2024
<u>Version 3.3</u> • In line with risk profile, CPAG agreed further extension to review date	September 2024